The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 25.07.19

MEETING
25 July 2019 11:00

PUBLISHED
23 July 2019

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	25/07/19		11:00
1. Part One - Public Meeting			
1.1. Minutes of the Previous Meeting (30 May 2019)		All	11:00
1.2. Matters Arising		All	
1.3. Declarations of Interest		All	
1.4. Patient Story		Interim Director of Nursing	11:05
1.5. Patient Experience Thank You		Chief Executive	11:20
2. Chief Executive Update		Chief Executive	11:25
3. Quality & Safety			
3.1. Chair Report: Quality and Safety		Non Executive Director	11:35
3.2. Quality and Safety Committee Annual Report		Non Executive Director	11:40
3.3. Safeguarding Annual Report		Interim Director of Nursing	11:50
3.4. Infection Control Annual Report		Interim Director of Nursing	12:00
3.5. Learning from Deaths		Medical Director	12:10
3.6. PROMS Update		Medical Director	12:15

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Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	25/07/19		11:00
4. Performance & Governance			
4.1. Chair Report: Audit Committee		Non Executive Director	12:25
4.2. Chair Report: Finance Planning and Digital Committee (verbal)		Non Executive Director	12:30
4.3. Chair Report: Risk Management Committee (to follow)		Non Executive Director	12:35
4.4. Corporate Objectives and Board Assurance Framework		Trust Sectretary	12:40
4.5. Performance Report M3		Director of Performance, Improvement and OD	12:50
4.6. Items to note			13:10
4.6.1. Governors Update (verbal)		Trust Secretary	
5. Any Other Business		All	13:15
5.1. Questions from the Public			
5.2. Next meeting: 26th September 2019			

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC SESSION
30 MAY 2019

MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Chris Beacock	Non-Executive Director	CB
Nia Jones	Director of Operations	NJ
David Gilburt	Non-Executive Director	DG
Harry Turner	Non-Executive Director	HT
Paul Kingston	Non-Executive Director	PK
Alastair Findlay	Non-Executive Director	AF

In Attendance:

Hilary Pepler	Board Advisor	HP
Shelley Ramtuhul	Trust Secretary	SR
Kerry Robinson	Director of Strategy and Planning	KR
Sarah Sheppard	Director of People	SS

FC welcomed all Board members to the Public Board.

MINUTE NO	TITLE
30/05/1.0	**APOLOGIES** Sarah Bloomfield, Interim Director of Nursing and Craig Macbeth, Director of Finance
30/05/2.0	**MINUTES OF THE MEETING 25 APRIL 2019** The minutes of the meeting held on the 25 April 2019 were agreed as an accurate representation of the meeting
30/05/3.0	**MATTERS ARISING** FC went through the actions which were noted to be completed or updates provided.
30/05/4.0	**DECLARATIONS OF INTEREST** None
30/05/5.0	**VOLUNTEERS STORY** SR introduced retired Major Brian Harper who was attending Board to talk about his involvement with the Trust's volunteers and fundraising. He has previous experience of running Military Hospitals and a very personal reason for getting involved. Brian provided the following highlights: • The history of his relationship with the hospital via the military • His involvement in the Spinal Injuries Garden about 15 years ago via the League of Friends • His experience as a patient of the Veterans Service • An outline of his reasons for becoming a volunteer • The need for more volunteers to extend to evenings and weekends • His involvement in setting up the helpdesk which has taken over 3000 enquiries • Examples of the extra mile the volunteers go including the recent boat trip with spinal injury patients • Suggestion of a taxi phone at the front of the hospital • Fundraising activities – including for the Veteran's Appeal which he is able to

	assist with from a military perspective • He personally signs thank you cards to donors • He commented that donations are often made in memory of loved ones and he has suggested a memorial book and memorial benches • He outlined the benefit he experiences from volunteering following a bereavement last year and the purpose and satisfaction it gives him FC commented on the privilege of hearing the stories of people giving up their time to become a part of the care of the Trust's patients. CB commented on the need for more volunteers and asked what more the organisation can do. Brian suggested increased advertising of the role of the volunteer within the hospital. MB thanked Brian for everything he does and for representing all volunteers. MB emphasised that patients see the volunteers as members of the team caring for them. The contribution to the hospital and its staff is really valuable and recognised. **ACTION: Memorial books and benches to be explored with the Interim Director of Nursing** **ACTION: Option of a taxi phone at the main entrance to the hospital to be explored with the Director of Finance** The Board ***noted*** the presentation.
30/05/6.0	**WOMEN IN SURGERY – GILL CRIBB, CONSULTANT ORTHOPAEDIC SURGEON** FC introduced Gill Cribb who was attending the Board to share her story of being a female surgeon in a male dominated specialty and it was particularly relevant given that it was Equality and Diversity Week. Highlights from the presentation were as follows: • The making of a Woman Surgeon • Told from a young age she couldn't be a surgeon • Overview of her path into surgery • Barriers to women in orthopaedics • View of the strength required – technique required and endurance • Lack of role models or mentors for women in particular through pregnancy or those that are new mums • Risks for orthopaedic surgeons in pregnancy • Her current role • Lady Estelle Wolfson Emerging Leaders Fellowship • The roles females have to adopt in surgery • Examples of how females are not recognised as surgeons • National picture for females in orthopaedic surgery • Improving picture for training programme – group set up to support local female trainees • Performance of female surgeons and benefits of a diverse workforce • Social media support • Overview of the work she is doing to support female trainees / surgeons FC reflected on the similarities of her experience to what he sees in the private sector. HP asked what work can be done with male colleagues. Gill felt that this was difficult

	and that generational changes are being seen, the other way to bring about change is to bring staff in from other areas of the country. MB thanked Gill for both her presentation and the work she is doing. He commented that she is helping more than she realises both internally and nationally. He reflected on the fact that there have been several occasions where there has been only one female on interview panels and the organisation needs to think about how this can be changed. MB also asked for Gill's assistance with the work in theatres and shared anecdotally an example of a female scrub nurse being moved aside and told she was not strong enough. HP picked up the point about interview panels and felt some preparative work was required ahead of these panels, to both challenge the thinking of the panel and look at the balance. She also commented there was post interview opportunities to reflect on behaviour in the interviews. HP would also like to hear more about how we can improve mentoring. SS commented that the discussions and considerations needed to start earlier, at the point of designing the roles and specifications. There is opportunity at this stage to challenge why certain attributes are being sought and also to prepare the panel better. HT commented that the organisation should set as a goal having no panel that is not diverse, this would send the right signal. MB agreed and said there needs to be creative thinking about how that can be achieved. CB commented that all panels have external assessors and therefore there was an opportunity to choose the assessors to reflect diversity. MB agreed and added that involving patients could be another opportunity. **ACTION: SS to look at interview panels and take recommendations to People Committee** KR asked what the organisation can do to attract female trainees and surgeons. Gill responded that there needs to be good support for the trainees and a look at whether the environment is right. PK asked how the Trust can support getting this into the medical curriculum. He is aware of recent examples of females still being discouraged from specialising in orthopaedics. Gill's view was that role models and mentors are the key for females considering the specialty. Gill's final point was to highlight her experience of developing the confidence to ask for help without feeling it is an acceptance of being weak and that this needs to be encouraged to all female staff. SW commented on Gill's fantastic contribution and that most of her male colleagues have at some point asked for her help and expertise. FC thanked Gill for the presentation and for prompting an interesting Board debate. The Board ***noted*** the presentation
STRATEGY AND POLICY UPDATES	
30/05/7.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • Confirmed the secondment of Bev Tabernacle, Director of Nursing and Deputy Chief Executive to Shrewsbury and Telford Hospitals and announced that Sarah

	Bloomfield will be staying on to provide continued cover as Director of Nursing and to also take on the role of Deputy Chief Executive. CM will continue to support MB with external stakeholders and partners. • MB extended his thanks to the marathon runners who have collectively raised over £25k • International Nurses Day and ODP Day were celebrated with the staff • An update on Horatio's Garden which is now at the landscaping stage and is expected to be complete at the end of July. There will be a series of events held to give everyone the opportunity to see the garden as it will not be generally accessible to the public or staff as it is a patient area. • MB highlighted the work that is ongoing to bring the Trust's policies up to date. He proposed a one off policy approval initiative to help with the approval process. This would require the attendance of at least one Non-Executive Directors with dates to be circulated for volunteers. • Lord Patrick Carter paid a private visit to the Trust. He is interested in the Trust's work on the structure and the work on culture. He has extended an invitation to have a follow-up meeting in November in the House of Lords. • Further to the conversation last month regarding car parking charges, MB provided an update on the work to supporting staff. The thoughts are to create an offer for staff with a link to wellbeing. This will be brought back to Board next month. Other initiatives include the launching of the £100k pot for staff to bid for improvements in their areas and also a BBQ being put on for staff on 6th and 7th June as a thank you staff, along with the ice cream van • Health Hero – apprentice Katie Griffiths, MCSI Admin Office. **ACTION: Dates for Policy Approval Committee to be circulated (SR)** **ACTION: Staff wellbeing offer to be brought back to the next Board meeting (SS)** MB concluded with an update on the STP. He confirmed that the STP Operational Plan has been submitted to NHS I. Over the last two weeks he has spent time with senior colleagues in health and care looking at the journey from an STP to an Integrated Care System. The two CCGs have agreed to come together to form a strategic commissioning body from 1 April next year. There is currently work underway to look at how, as a system, Primary Care Networks can be supported with a recognition that there is currently no mechanism for them to get together to speak collectively. The Board ***noted*** the Chief Executive's Update
30/05/8.0	**JOINT AUDIT AND QUALITY AND SAFETY COMMITTEE CHAIR'S REPORT** DG advised that a joint meeting of the Audit Committee and Quality and Safety Committee had been held to review and approve the Annual Report and Accounts and the Quality Account. He confirmed these were reviewed and agreed. The joint committee received a report from the auditors on the Quality Accounts with only minor recommendations issued. The joint committee recognised that the content of the annual report is driven by regulatory requirements and that they can be a difficult read for the general public. For this reason an easy to read summary will be produced for staff and the public at the annual meeting. The joint committee received the accounts along with the audit opinion and there was positive feedback on the Finance Department's preparation of the accounts and the Trust's strong financial position. The Trust's Annual Governance Statement and letter of representation were also duly

	approved. The statement of going concern was also presented and approved. The Board ***noted*** the Chair's Report.
30/05/9.0	**PEOPLE COMMITTEE CHAIR'S REPORT** PK presented the People Committee's Chair's Report and highlighted the following: • The committee was well attended • The work plan was reviewed in detail and it was recognised that this will evolve as the committee develops. • The terms of reference for the committee were reviewed and agreed. • The committee highlighted new risks regarding staff recruitment and retention and these were to be worked up and added to the risk register • The need for a medical representative was discussed and agreed • The committee recognised that there would be timing issues regarding data as the Board meets more frequently and this would remain under review • The frequency of the meetings was debated and it has since been agreed that there will be a committee workshop to look at some of the burning issues. The frequency of this Committee, along with other Board Committees will be reviewed at year-end to achieve the balance between placing demands on the executive and ensuring effective assurance processes are in place. FC commented on the importance of the cross working of the committees and was interested to see how the committee developed. **ACTION: Workforce Workshop to be set up and date circulated to People Committee members** The Board ***noted*** the presentation.
30/05/10.0	**CQC ACTION PLAN TRACKER** SR presented the tracker and reminded the Board of the previously presented action plan. The actions are being taken through the lead committees and the report presented provided an overview with details of progress against those actions that are slightly behind plan. The Board noted that there had been good progress with the actions with a number completed and those behind plan anticipated to be back on track within the month. The Board noted the CQC Action Plan Tracker
	QUALITY AND SAFETY
30/05/11.0	**AUDIT COMMITTEE CHAIR'S REPORT** DG presented the Audit Committee Chair's report and advised that he had met with the auditors prior to the meeting with good feedback regarding the Trust's financial controls. After the meeting there was a presentation from West Midlands Constabulary on Cyber Security which was a very informative session. The Board ***noted*** the Chair's Report.
30/05/12.0	**FINANCE PLANNING AND DIGITAL COMMITTEE CHAIR'S REPORT** AF provided a verbal update on the meeting held earlier in the week with the following highlighted: • The committee had reviewed M1 performance and the Cost Improvement Programme

	• The committee reviewed the service line reporting of the organisation which provides detail on the contribution and margin by service line so is an important tool in understanding how the business works • The committee received a strategic presentation on the digital agenda HT commented that sensitivity analysis had previously been discussed at Board and he asked whether this had been done. MS advised that within the finance strategy there is a sensitivity analysis, this will need to be refreshed as part of the five year plan so will come through Board for approval. The Board ***noted*** the Chair's Report
30/05/13.0	**CORPORATE OBJECTIVES AND BOARD ASSURANCE FRAMEWORK** SR presented the new format for the Board Assurance Framework which has been more closely aligned to the corporate objectives and will now form one report. SR outlined the rationale for the change in format and how the document will be managed via the assurance committees going forward. HT confirmed that the Risk Management Committee will fully scrutinise the report in July The Board ***approved*** the new format and the proposed management of the Board Assurance Framework going forward.
30/05/14.0	**PROVIDER LICENCE REQUIREMENTS – CORPORATE GOVERNANCE STATEMENT** SR presented the Corporate Governance Statement for approval. The Board ***approved*** the statement.
PERFORMANCE AND GOVERNANCE	
30/05/15.0	**PERFORMANCE REPORT – MONTH 1** KR presented the Month 1 Integrated Performance Report and highlighted that the number of KPIs included has been reduced as the Board Committees are now receiving a number of more detailed KPIs. The new format of the report was outlined with one KPI per page and the introduction of trajectories to give a three month forward look. Further performance would now be indicated as red or green only. KR highlighted the following areas of performance: • Sickness absence has been red for 5 months • Voluntary turnover has green for 9 months • The English list size is meeting trajectory • No English patients waiting over 52 weeks • Challenges with diagnostic waits • One serious incident reported in month FC said that he liked the clarity of the new format. *Caring for Staff* SS highlighted that sickness absence remained red for the fifth month in a row. There is a focus on improving the experience for staff at work. Whilst the management of sickness absence is in line with Trust policy she is currently looking at the unintended consequences of this. Further the Trust is working with NHS I on learning from other areas.

CB asked about the target changing and whether this was an external or internal decision. SS responded that this target is determined internally but needs to be a realistic target. CB asked if the target was consistent with other organisations and SS advised that it is at the higher end, for this reason the Trust is looking to see if there are actions it could be taking. MB commented this is something the organisation is worried about and there is a focus on this at departmental level. He added that this links to the four areas of operational focus as well.

HT commented that the target should be linked to benchmark data. KR advised that it is based on a retrospective review of performance. The question now needs to be whether actions demonstrate any change to the trajectory. SS advised she would include this in next the narrative next month.

ACTION: SS to include actions and impact on trajectory in next the narrative of the IPR next month.

FC asked about the data and KR confirmed that data quality audits are completed

PK asked about the 'other known causes' and SS confirmed that there is a national system for the categorisation of sickness absence. The team are looking to increase understanding of why the Trust has so many recorded as 'other'.

SS drew the Board's attention to performance in relation to turnover which is encouraging.

FC commented on the triangulation of sickness and turnover and that it gives a mixed message and KR advised that the link is visible when you look at the hotspots that have been identified.

MB commented that it in one of strategy sessions it would be worth looking at the triangulation of the performance data.

ACTION: Data triangulation to be included in a future agenda for the Strategy Board

Caring for Patients
KR highlighted the following:

- There was one serious incident reported in month, the detail of this is not being put in the public domain due to the unique set of circumstances which may lead to the patient being identifiable. This will however go through the Quality and Safety Committee in the usual way.
- Patient falls have reduced and when triangulating with bed occupancy, the falls per 1000 bed days have also fallen
- Delayed discharge rate is still a concern. This target is externally set and the Trust has invited ECIST to review its processes and is currently implementing their recommendations. It not anticipated that an impact will be seen until Q2. It is worth nothing that improved training and the introduction of the Co-ordination Centre has led to better recording.

MB commented that with regard to delayed discharges there is more that can be done to expose where the Trust is responsible for the delay or where the partner is responsible. He suggested that a deep dive is taken through Quality and Safety Committee for this purpose.

ACTION:: Delayed discharge deep dive to Quality and Safety Committee

CB asked about the falls data and whether the way it is being recorded has changed and KR advised that the recording has not changed it is just that the definition has been added to the report.

HT asked about the amber flag against falls data quality as it was not clear from the report what the issue was and whether this had a material effect. KR advised that every KPI has a data quality audit and there are a number of actions being taken but they do not have a material impact on the assurance otherwise they would be rated as red.

SW highlighted the following:

- No unexpected deaths
- Good VTE performance

NJ highlighted the following:

- Diagnostic performance - below target for both English and Welsh patients, this is being driven by high demand for these services particularly MRI and ultrasound. It is anticipated that underperformance will continue into Q2 when impact of actions will be seen.
- Theatre activity – slightly below plan this month but on plan for orthopaedic elective work, there is reduced demand currently for tumour and hand trauma work and bed capacity in MCSI remains an issue. Looking forwards it is anticipated that May and June will also be below plan. The focus is on the delivery of the required capacity consistently with three key areas of priority; governance around in job plan capacity, workforce capacity and booking and scheduling. The short term mitigations were presented to the Finance Planning and Digital Committee this month. Workforce is a particular hotspot, recruitment and training is required in some services.

FC commented on the underperformance and asked about the plan to recover the shortfall. NJ advised that this will be re-provided where possible and adjustments will be made to the targets, however, the tumour and hand trauma work will not be recovered.

CB asked about the 18 week RTT and the fact this has reduced and is projected to be below target next month. NJ advised this was anticipated during the course of the summer months, the other key area is the national focus is the waiting list size.

HT commented that in previous years the theatre activity target has been missed in June, July and August but this year those months are being entered from a lower base. He asked if there are any lessons to be learnt and NJ advised the activity has been looked at as an annual plan so mitigations have been reflected in the annual activity targets. MB added that this has been covered at length through the Finance Planning and Investment Committee and it is accepted that there is a risk.

NJ advised that the forward look for 52 weeks is good for May and June with no breaches forecasted for English or Welsh patients. The Trust is continuing to support BCU with their waiting time reductions and they are being monitored separately.

Caring for Finances

MS highlighted the following:

- It had been a financially challenging month with a deficit of £775k which was higher than the deficit forecast.
- Income was ahead of plan underpinned by the underlying case mix which was strong and private patient work being ahead of plan
- There was full risk exposure from the MSK QIPP and this is represented within the

	income position to the level of about £100k. There are a number of work streams underway to prevent this being a recurring issue • The cost base was high in the month with an adverse variance of £113k, this was predominantly due to implant expenditure and is reflective of the case mix • Cost improvement programme performance has been slow to impact and is slightly behind plan. Key areas of focus have been identified and there was good engagement in the planning stage moving into the delivery stage. There is a 20% contingency built into the plan to cover any unexpected shortfalls. • Cash is on plan at £5.1m The Board ***noted*** the Performance Report.
30/05/16.0	**ANNUAL REPORT, QUALITY ACCOUNT AND ANNUAL ACCOUNTS** DG confirmed that as previously advised the Joint Audit and Quality and Safety Committee met and approved the above statutory reports. They are presented to the Board to note prior to them being put into the public domain. The Board ***noted*** the statutory reports had been approved and submitted
30/05/17.0	**PATIENT EXPERIENCE REPORT** SR presented the Annual Patient Experience Report which had previously been presented to the Joint Audit and Quality and Safety Committee. The aspect of the report drawn to the Board's attention was the fact that there were only two Healthcare Ombudsman referrals and neither were upheld. This is a good indicator of the Trust's complaints handling performance. This year the Trust has set a priority through its Quality Account to improve learning from complaints and it is hoped this will be reflected in future reports. The Board ***noted*** the Patient Experience Report.
30/05/18.0	**GOVERNOR UPDATE** SR advised that the Governors have been involved in the following: • Two safety walkabouts this month – visited ORLAU and Sheldon • NED and Governor engagement session The Board ***noted*** the update
30/05/19.0	**FINANCE PLANNING AND DIGITAL CHAIRS REPORT – APRIL 2019** AF advised the Board that this was the paper report following the verbal update provided at the last meeting. The Board ***noted*** the Chairs Report
	ITEMS TO NOTE
30/05/20.0	**STP** MB presented the STP Update for the Board to note. The Board ***noted*** the update
30/05/21.0	**AOB** SR was asked when the Annual Report would be published and advised that it now needs to be sent to the Parliamentary Clerk for checking before being laid before Parliament and the final publication date is in July.
	DATE OF NEXT MEETING IN PUBLIC: Thursday 25 July at 11.00 in the Meeting Room 1.
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

30 MAY 2019

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
25/04/6.0 RESEARCH UPDATE PK and SS to look at the people strategy around research with a particular focus on upskilling. KR and the team to give consideration to be given to the identity of the Research Department	Director of People Director of Improvement, Organisational Development and Performance	In progress In progress
25/04/9.0 WORKFORCE PRESENTATION SR and SS to arrange a private session on the granular detail of the pension impact SS to bring back an update to a future Board to follow up on presentation	Director of People Director of People	On the agenda Added to the agenda for September
25/04/15.0 PERFORMANCE REPORT Exec Team to bring back suggestions for a staff initiative	Chief Executive	Completed – further update on the agenda
25/04/17.0 CAPITAL PROGRAMME Detailed list of medical equipment requirements to be presented to the Finance Planning and Investment Committee	Director of Finance	Added to the work plan
Actions from Last Meeting	**Lead Responsibility**	**Progress**
30/05/5.0 VOLUNTEER STORY Memorial books and benches to be explored with the Interim Director of Nursing Option of a taxi phone at the main entrance to the hospital to be explored with the Director of Finance	Director of Nursing Director of Finance	
30/05/6.0 WOMEN IN SURGERY SS to look at interview panels and take recommendations to People Committee	Director of People	Discussed at Execs, to be taken to the next People Committee
30/05/7.0 CHIEF EXECUTIVE UPDATE Dates for Policy Approval Committee to be circulated Staff wellbeing offer to be brought back to the	Trust Secretary Chief	Completed

next Board meeting	Executive / Director of People	
30/05/9.0 Chairs Report People Committee Workforce Workshop to be set up and date circulated to People Committee members	Director of People	
30/05/15.0 PERFORMANCE REPORT – MONTH 1 SS to include actions and impact on trajectory in next the narrative of the IPR next month. Data triangulation to be included in a future agenda for the Strategy Board	Director of People Director of Finance	

Chairs Assurance Report
Quality and Safety Committee 18 July 2019

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	23rd July 2019
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:		Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee for the meeting of 18th July 2019. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

Due to the timing of the committee this month it has not been possible to provide a paper Chair's Report and this will be provided at the next meeting. The Non-Executive Director Chair of the committee will provide a verbal report covering the attached agenda from the committee.

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	18/07/19		14:00
1. Introduction			
1.1. Apologies		All	
2. Declaration of Interests		All	14:00
3. Minutes from the previous meeting		Chris Beacock	14:05
4. Action Log / Matters Arising		Chris Beacock	14:10
4.1. Marcain Drug Brief		Imran Hanif	14:15
4.2. Deaths following Transfer Out (verbal)		Steve White	14:25
5. Annual Reports			
5.1. Controlled Drug Accountable Officer Annual Report		Imran Hanif	14:30
6. Caring for Patient			
6.1. Serious Incidents		Lindsay Leach	14:40
6.2. Inpatient Survey Results		Alison Harper	14:45
6.3. Infection Report (Q1)(to follow)		Sue Sayles	14:55
6.4. Histopathology Action Plan		Nicki Bellinger	15:05
6.5. Orthotics Service (verbal)		Paula Jeffreson	15:15
6.6. Learning From Deaths Report		Steve White	15:20
7. Committee Management			
7.1. Divisional Quality Report - Medicine		Karin Daelemans	15:25
7.2. CQUIN Update		Nicki Bellinger	15:35
7.3. Board Assurance Framework and Corporate Register		Shelley Ramtuhul	15:40

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Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	18/07/19		14:00
8. Governance			15:45
8.1. Legal Claims Update		Shelley Ramtuhul	
8.2. Research Committee Chair Report			
8.3. Review of Work Plan 2019/20		Shelley Ramtuhul	
8.3.1. Attendance Matrix		Shelley Ramtuhul	
9. Any Other Business			
9.1. Next Meeting: 19th September 2019			

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Committee Self-Assessment and Annual Report

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	23 July 2019
Executive Sponsor:	Sarah Bloomfield, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee (20/06/19) Audit Committee (08/07/19)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

Following discussion at the Quality and Safety Committee and Audit Committee where the document was considered and approved, the self-assessment and annual report are submitted to the Board of Directors for information.

2. Executive Summary

2.1. Context

It is good governance to have a programme of self-assessment for the organisations committees, this is particularly important for committees responsible for providing assurance to the Board.

These should look at the adequacy of the committee's terms of reference, work plans, forums of discussion and communication with a view to highlighting skills and/or knowledge gaps and identifying areas in which the committee and its processes might be more effective.

It is part of the Audit Committee's work plan to receive an annual report from each Board committee and the self-assessment forms part of this report. The annual report is designed to provide the Audit Committee with assurance regarding the governance controls and risk management processes in place within the organisation.

2.2. Summary

This paper outlines the self-assessment that has been conducted and the output from this and also presents a draft of the proposed annual report for approval and onward submission to the Audit Committee.

2.3. Conclusion

The Quality and Safety Committee is asked to consider and approve the self- assessment and further approve the annual report for submission to the Audit Committee.

3. The Main Report

3.1. Introduction

The committees of the Board have been established in accordance with the Trust's constitution and each committee is required to produce a Self-Assessment and annual report.

A self- assessment of the committee's performance and effectiveness over the last 12 months has been conducted through the following:

- Use of a self-assessment checklist looking specifically at:
  - Composition, establishment and duties
  - Compliance with the law and regulations governing the NHS
  - Internal control
  - Administrative arrangements
  - Other issues

and

- The completion of a committee member survey focussed on the committee effectiveness.

3.2. Self- Assessment Checklist

Area / Question	Yes	No	Comments / Action
Composition, Establishment and Duties			
Does the committee have written terms of reference that adequately and realistically define the Committees role?	Yes		Approved by the Trust Board and incorporated in to the Board Governance Pack
Have the terms of reference been adopted by the Board?	Yes		As above
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Yes		Yes annual review is included in the work plan with adhoc changes made as and when required
Are committee members independent of the management team?	Yes		The committee is chaired by a Non-Executive and has another Non-Executive within its membership.
Are members, particularly those new to the committee provided with relevant training?	N/A	N/A	There is no formal training for this Committee but the Trust Secretary would be available as required to talk through the role of the committee, the nature of the discussion etc for any new attendees
Has the committee established a plan for the conduct of its own work across the year?	Yes		This is set for the financial year ahead and reviewed on a monthly basis
Are changes to the current and future workload discussed and approved at	Yes		The remit is set by the Board through approval of the terms of reference and the

Board level?			workplans are reviewed at each committee meeting with an overview of any changes presented to the Board via the Chair's Report
Does the committee report to the Board regularly?	Yes		The chair of the committee presents an update to the Board on a monthly basis
Does the committee assess its own effectiveness periodically?	Yes		This is undertaken annually but as this is the Committee has only been in effect for just over 12 months this has also been conducted informally throughout the last year
Does the committee prepare an annual report on its work and performance in the preceding year?	Yes		On the agenda to be considered alongside the self-assessment
Has the committee been quorate for each meeting this year?	Yes		This is confirmed by the minutes of the meeting and reported to the Board after each meeting.
Compliance with the Law and Regulations Governing the NHS			
Does the committee review assurance and regulatory compliance reporting processes?	Yes		This is undertaken by the committee in relation to issues of quality and safety and assurance provided to the Board via the Chair's report.
Does the committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes		These would be escalated through the Trust's governance framework. The Trust's Executive Team provide updates as required.
Internal Control			
Has the committee formally considered how it integrates with other committees?	Yes		All committee work plans have been reviewed simultaneously to ensure timely flow of information from one to another. Through the Chair's report and the Executive Lead, matters can be escalated up, down or sideways to appropriate committees.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?	Yes		The Committee receives an update on the KPIs from the Integrated Performance Report and commissions deep dives as required for assurance purposes. However, the committee member survey has highlighted that this should be strengthened.
Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes		As part of the committee member survey. Standard templates are used for committee reports
Administrative Arrangements			
Does the committee have a plan of matters to be dealt with over the coming year?	Yes		This is set for the financial year ahead and reviewed on a monthly basis
Are papers circulated in good time and are minutes received as soon as	Yes		There are occasions when papers need to be delayed but the packs are circulated with

possible after the meetings?			good time and updated with papers that have been delayed for genuine reasons. If papers have been delayed to such an extent that the committee would not have sufficient time to consider them, they are deferred to the next meeting.
Does the committee meet the appropriate number of times a year?	Yes		The committee meets on a monthly basis ten times per year with no meetings in August or December.
Other Issues			
Does the Annual Report include a description of the committee's establishment and activities?	Yes		This is included in the Annual Governance Statement

3.3. Effectiveness Survey

The next section of this paper outlines the results of the survey undertaken of the committee members in relation to the effectiveness of the committee. Those areas that have changed significantly compared to the previous year have been highlighted (green for improvement / red for deterioration).

Disagree Strongly	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
The work plan gives appropriate coverage to the areas which I consider that it should be covering				
			66.67%	33.33%
The current workload facilitates adequate scrutiny of areas delegated to the Committee				
		16.67%	66.67%	16.67%
I have the appropriate skills and training to provide valuable input into the committee				
			66.67%	33.33%
I consider that the meetings are well chaired and members have sufficient opportunity to contribute				
		16.67%%	33.33%%	50.00%
I consider that the time spent on each agenda item is appropriate for sufficient scrutiny and challenge				
			83.33%%	16.67%
I have received the information which I require to consider the Trust's quality risks and their mitigations				
			83.33%	16.67%
The Committee has added value to the Trust's assurance processes				
			33.33%	66.67%
The Committee has had sufficient time/information to consider patient safety matters				
		16.67%	50.00%	33.33%

The quality of the papers and presentations ensure the Committee can add value and rigour to clinical governance				
			66.67%	33.33%
I consider that the Committee receives sufficient information on the quality KPIs to gain assurance on the Trust's performance in these areas.				
			83.33%	16.67%

Comments provided in support of the survey responses related to the following:

- Improvement in the agenda management since the establishment of a dedicated People Committee to oversee the workforce agenda
- Additional discussion could be had on outlines of serious incident reviews / RCAs and better understanding of post incident understanding and learning and feedback to staff
- Items which appear towards the end of the agenda can be rushed

3.3 Next Steps

Giving due regard to the findings of the self-assessment, the following recommendations are made:

- Consideration to be given to rotation of the agenda to ensure equal time given to agenda items
- Introduction of a serious incident action tracker to ensure dissemination of the learning and feedback to relevant staff

3.4. Conclusion

The committee is asked to consider and approve the self-assessment and agree the recommendations outlined above.

In addition, the draft annual report from the committee is attached for approval prior to submission to the Audit Committee.

Appendix 1: Acronyms

KPI	Key Performance Indicator

Quality and Safety Committee Annual Report

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	20 June 2019
Executive Sponsor:	Sarah Bloomfield, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Audit Committee	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Audit Committee is asked to consider the Quality and Safety Committee performance against its responsibilities as defined in its terms of reference.

2. Executive Summary

2.1. Context

In order to fulfil the Audit Committee's remit of ensuring that the Trust's internal control processes and systems are both comprehensive and effective all Board committees are required to submit an annual report to the Audit Committee.

2.2. Summary

This paper presents the Quality and Safety Committee Annual Report which looks specifically at:

The meetings held and attendance at the same

- Delivery of the 2018/19 work programme
- The work programme for 2019/20
- Review of the terms of reference
- Review of Committee effectiveness
- Statement of Assurance from the Committee Chair

2.3. Conclusion

The Audit Committee is asked to note the performance of the Quality and Safety Committee and consider whether it is satisfied that it has met its duties and responsibilities.

3. The Main Report

3.1. Introduction

The Quality and Safety Committee is an established committee of the Board.

The Quality and Safety Committee is accountable to the Board and is responsible for ensuring effective clinical governance throughout the Trust. It assists the Board in obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. It works 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
- ensure regulatory and statutory compliance in relation to quality and safety

The Quality and Safety Committee is chaired by a Non-Executive Director and is attended by a further two Non-Executive Directors and members of the Executive Team.

3.2. Committee Meetings Held

During 2018/19, the committee met 10 times with no meetings held in August or December.

The Chair of the Audit Committee is a member of the Committee and once a year the Quality and Safety Committee and the Audit Committee hold a joint meeting to review and sign off the Annual Report, Quality Account and Annual Accounts.

The table overleaf details core membership and outlines the number of meetings attended by each member:

Quality and Safety Committee Annual Report

Quorum: 1 Non Executive Director and 1 Executive Director

	Name	Title	Apr-18	Jun-18	Jul-18	Sep-18	Oct-18	Nov-18	Jan-19	Feb-19	Mar-19
Core Membership	Hilary Pepler	Non Executive Director	✓	✓	×	✓	✓	✓	×	×	✓
	David Gilburt	Non Executive Director	✓	×	✓	×	✓	✓	✓	×	×
	Chris Beacock	Non Executive Director	×	×	✓	✓	×	✓	✓	✓	✓
	Bev Tabernacle	Director of Nursing	✓	✓	✓	✓	✓	✓	✓	✓	×
	Steve White	Medical Director	×	×	✓	✓	×	✓	✓	✓	✓
	Nia Jones	Director of Operations	×	✓	✓	✓	×	✓	✓	×	✓
	Sarah Sheppard	Director of People	✓	×	×	×	×	×	×	×	×
	Mark Brandreth	Chief Executive	×	✓	✓	✓	×	✓	✓	×	✓
In Attendance	Nicki Bellinger	Deputy Director of Nursing	✓	×	✓	×	✓	×	×	×	×
	Shelley Ramtuhul	Trust Secretary	✓	✓	×	✓	✓	✓	✓	×	✓
	Julie Roberts	Assistant Director of Nursing and Governance	×	×	×	✓	✓	✓	✓	×	×
	Sue Pryce	Head of People Services	×	✓	✓	×	✓	✓	✓	✓	✓
	Amanda Peet	Divisional Manager Theatres	✓	✓	×	×	×	×	✓	✓	✓
	Eric Hughes	Divisional Manager Diagnostics	×	✓	×	✓	✓	×	✓	✓	×
	Paula Jeffreson	Divisional Manager Medicine	×	×	×	×	✓	✓	✓	×	×
	Gemma Brett	Interim Divisional Manager Surgery	×	×	×	×	×	×	✓	✓	×
	Kirsty Evans	Matron Surgery	✓	✓	×	×	×	✓	×	✓	×
	Sara Ellis Anderson	Matron	✓	✓	×	×	×	×	×	×	×
	Leighann Sharp	Matron Theatres	✓	✓	×	×	✓	✓	×	×	×
	Mandy Bride	Matron Medicine	×	×	×	×	×	×	×	×	✓

3.3. Delivery of the 2018/19 Work Programme

During 2018/19 the Committee approved and worked to a work programme and this has been amended at subsequent meetings to ensure that the Committee's work is appropriately prioritised.

During 2018/19 the Committee carried out the following principal activities:

Strategies and Policies

The Committee received and approved a number of policies as follows:

- Claims Policy
- Complaints Policy
- Duty of Candour Policy
- Patient Access Policy
- WHO Checklist Policy
- Consent to Examination or Treatment Policy

.

Patient Safety

The Committee received regular updates on a variety of patient safety matters as follows .

- Development and implementation of the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs).
- Falls Prevention work
- Follow up backlog
- Infection prevention and control
- Delayed discharges

The Committee received an update at every meeting on the Trust's serious incident root cause analysis outcomes.

The Committee received quarterly reports from the Trust's Learning from Death's Lead.

The Trust's Controlled Drug Accountable Officer presented a report providing assurance regarding the Trust's processes and management of controlled drugs.

Patient Experience

The Committee received six monthly reports on Patient Experience. These reports presented the data for complaints, PALs, compliments, comment cards including the friends and family test scores. The reports provided analysis of the key themes and trends and an outline of the actions that had been taken to improve patient experience.

Clinical Effectiveness

The Committee received an update from the NICE Lead outlining the NICE guidance that had been issued which was relevant to the Trust and the work being undertaken to ensure compliance.

The Committee received regular updates from the Medical Director regarding Patient Reported Outcome Measures (PROMS) and Getting it Right First Time (GIRFT)

The Committee received an annual report on the Trust's clinical audit work.

Workforce

The Committee received regular updates on the workforce performance data.

The Committee had oversight of the work undertaken by the Trust's Guardian of Safe Working Hours with quarterly reports received.

The Committee Chair received updates on Freedom to Speak Up.

At the end of 2018-19 the decision was taken to establish a People Committee and therefore going forward the Committee will no longer receive items relating to workforce.

Governance

The Committee had oversight of the Quality Impact Assessments undertaken in relation to the identified cost improvement schemes. This ensured that any change in clinical practice, clinical products, change to service delivery or change to income which have a contractual impact, was appropriately assessed before being taken forward.

The Committee received and approved the Trust's Quality Account.

The Committee established and received Divisional Quality Reports.

The Committee had oversight and scrutiny of the following committees through the receipt of a report after each meeting had taken place:

- Patient Experience Committee
- Safeguarding Committee
- Clinical Governance and Quality Committee
- Workforce Development Group
- Research Committee
- Equality and Diversity Group

In addition the Committee received and approved the Terms of Reference for the Workforce Development Group.

The Committee regularly reviewed and updated its work plan as required to ensure that its agendas were fit for purpose and enabling the Committee to meet its obligations as set by the Board.

Regulatory and Statutory Compliance

The Committee received regular update on the Histopathology Action Plan which was being implemented to progress the Trust towards UKAS accreditation.

The Committee received regular updates on progress with the action plan aimed at improving CQC compliance.

The Committee received updates on the Trust's compliance with IR(ME)R

Hot Topics

In addition to the items in its work plan, the Committee received a number of reports and presentations in order to gain assurance on issues or hot topics that had arisen within its remit. These were in the following areas:

- Updates on the work to improve the TSSU facility
- Out of Hours Outreach
- SOOS Review

3.4. Work Programme for 2018/19

During 2018/19 the Committee will maintain its oversight of the Trust's risk management via detailed reporting from the Divisions and use of the risk registers. It will continued to receive updates for areas of significant risk.

A copy of the work programme for 2018/19 is attached at Appendix A

3.5. Review of Terms of Reference

The Committee last reviewed its terms of reference in April 2019. A copy of the Terms of Reference is attached at Appendix B.

3.6 Review of Effectiveness

The Committee reviewed its effectiveness in June 2019 with regard to its performance during 2018/19. The review concluded that the Committee had met it duties and responsibilities but that the following actions should be taken to further improve the effectiveness of the Committee:

- Consideration to be given to rotation of the agenda to ensure equal time given to agenda items
- Introduction of a serious incident action tracker to ensure dissemination of the learning and feedback to relevant staff

3.7 Assurance Statement

Having considered the business undertaken during 2018/19 the Committee considers that it has fulfilled its terms of reference

Chris Beacock (Committee Chair)

On behalf of the Quality and Safety Committee

Quality and Safety Committee
Terms of Reference

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 (See attached schedule)

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non Executive Directors
- The Board will appoint a Committee chairman and deputy chairman from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- Chief Executive Officer – invited to attend as required
- Medical Director
- Director of Nursing (Governance Lead)
- ~~Director of People~~

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee chairman from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to chair meetings in the absence of the chairman.

A quorum will be one Non-Executive member and two Executive members.

3. Attendance

The Trust Secretary, Deputy Director of Nursing and Assistant Director of Nursing for Governance will be expected to attend each meeting. The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Associate Director of IMT, Chief Pharmacist and Deputy Director of HR, will only be expected to attend when a relevant paper is being presented.

A representative from each Division will be expected to attend each meeting.

The Director of Nursing shall agree the agenda with the Chair of the Committee and other attendees. 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.

4. Frequency of meetings

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

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

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting; this will be no later than the Board meeting in the following month. A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted. This is in line with the committee reporting process agreed by 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 NHSi 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 committees:
    - Patient ~~and Staff~~ Experience Committee
    - Safeguarding Committee
    - Clinical Governance & Quality Committee
- The Quality & Safety Committee shall review the Quality Accounts before submission to the Trust Board,
- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy
- ~~To receive regular reports on workforce matters.~~
- ~~To receive regular reports on Health and Safety issues.~~

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 systems for reporting and investigating Serious Incidents (SIs), near misses and other incidents.
- 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.

~~Workforce~~

- ~~Review progress made in delivering key enabling strategies such as (but not limited to) Workforce raising any significant risks regarding their delivery to the Board.~~

Approved by Board of Directors ~~24 May 2018~~

Committees of the Board – Exec, Non-Exec and Others							
	Quality and Safety	**Audit**	**Finance Planning and Digital**	**Risk**	**People**	**Remuneration and Appointment (Exec)**	**Remuneration and Appointment (Non-Exec)**
Terms of Reference Requirement	2 NEDs and 3 Execs	3 NEDs and 3 Execs	2 NEDs and 2 Execs	2 NEDs and 7 Execs [1]	2 NEDs and 3 Execs	Chairman, Chief Executive and 5 NEDs	Chairman / Senior NED + 4 Governors
Meetings Per Year	10 (plus extra-ordinary meeting with Audit)	4 (plus extra-ordinary meeting with Q&S)	10	4	4	As required	As required
Quorum	1 NED and 1 Exec	2 NEDs	1 NED and 1 Exec	1 NED and 2 Execs	1 NED and 1 Exec	(CEO Role) Chairman and 3 NEDs (Exec Role) Chairman, Chief Executive and 2 NEDs	(Chairman) Senior NED and 4 Governors (NED Role) Chairman and 4 Governors
NED Membership	(Attendance is required and makes up quorum,* denotes an open invitation)						
Frank Collins	*	*	*	*	*	✓	✓ (NED Role)
Alastair Findlay			✓			✓	✓ (Chairman)
Paul Kingston	✓	✓			✓	✓	
David Gilburt	✓	✓	✓	*		✓	
Chris Beacock	✓			✓	✓	✓	
Harry Turner		✓		✓	✓	✓	
Exec Membership	(Attendance is required and makes up quorum, * denotes an open invitation)						
CEO	✓	*	*	✓	*	✓ (Exec Role)	
Director of Nursing[2]	✓	*	*	✓	✓		
Medical Director*	✓	*	*	*	*		
Director of Finance and Planning	*	✓ (not a member)	✓	✓	*		
Director of Operations	✓	*	✓	✓	*		
Director of People	*	*	*	✓	✓	✓	
Director of Improvement, Organisational Development and Performance	*	*	✓	*	✓		
Associate Director of IT		✓	✓	*	*		
Governor Membership	(Attendance is required and makes up quorum, ^denotes an and/or)						
Lead Governor							✓
Public Governor x 2							✓
Staff Governor					*		✓
Appointed Governor							✓
In Attendance	(Attendance is required but does not make up quorum)						
Trust Secretary	✓	✓	✓	✓	✓		✓
Hilary Pepler, Board Advisor	✓				✓		
Associate Director of Performance			✓				

Head of Financial Management		✓					
Deputy Director of Nursing	✓						
Assistant Director of Nursing and Governance	✓			✓			
Divisional Governance Leads				✓			
Internal Audit		✓					
External Audit		✓					
As Required	(Attendance is by invitation, * denotes an open invitation)						
Head of People	✓			*	✓		
Associate Director of Estates and Facilities	✓	✓		*	*		
Chief Pharmacist	✓	✓		*	*		
Clinical Leads	✓			✓	✓		
Q&S Matron	✓			*	*		
Theatres and Anaesthetics Representative[3]	✓			✓	✓		
Diagnostics Representative	✓			✓	✓		
Surgery Representative	✓			✓	✓		
Medicine and Rehab Representative	✓			✓	✓		
Medical Representative				✓	✓		
Nursing Representative				✓	✓		

[1] The Executive Directors have a buddy system and therefore one of the following should attend Director of Operations / Finance and Director of People / Director of Strategy and Planning

[2] If the Director of Nursing is unable to attend an appropriate Nursing Representative will attend

[3] The divisional representatives can be one of the following:

Divisional Manager

Matron

Clinical Lead

0. Reference Information

Author:	Sara Ellis-Anderson Matron/Lead Nurse for Adult Safeguarding and Suzanne Marsden Named Nurse for Children	Paper date:	25th July 2019
Executive Sponsor:	Sarah Bloomfield	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee (20/06/19)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an annual review of children and young people and adult safeguarding within the Trust for 2018/19. The Committee is asked to note the paper.

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2018/19 in relation to children and young people and adult safeguarding and outlines key priorities for 2019/20.

This report should be read in conjunction with the Shropshire Safeguarding Children Board (SSCB) annual report on arrangements for safeguarding children and young people county wide, this document will be published in autumn 2019, as well as the Keeping Adults Safe in Shropshire Board (KASISB) annual Report for 2018/19. A link to these documents will be available on the safeguarding web page.

2. Executive Summary

2.1 Context

Annual report is provided each year for information.

2.2. Summary

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2018/19 in relation to children and young people and adult safeguarding, working in conjunction with the local children and adult safeguarding boards and local health economy.

2.3 Conclusion

The Quality and Safety Committee are asked to review the content of the report and make any recommendations and approve as appropriate.

3. The Main Report

3.1 Introduction

The Robert Jones & Agnes Hunt Orthopaedic (RJAH) NHS Foundation Trust is an organisation which has a culture that prioritises quality of care having strong leadership and focus, and good partnership working to promote 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 organisations commitment is to work alongside both the Shropshire Safeguarding Children Board (SSCB) and Keeping Adults Safe in Shropshire Board (KASISB) 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 the Safeguarding Vulnerable people in the NHS – Accountability and Assurance Framework (July 2015) which provides evidence on how the organisation meets the requirements.

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.

3.2 Our Vision

3.2.1 Children and young people

Children who need help and protection deserve high quality and effective support as soon as a need is identified. 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 when determining what action to take.

This child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families. We need to ensure all practitioners follow the principles of the Children Acts (1989 and 2004) that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary as outlined in the Working Together Document (Department of Health, 2018).

3.2.2 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.

3.2.3 Safeguarding as core business

Robert Jones and Agnes Hunt 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.
- Ensuring the Trust provides evidence on how the organisation meets the requirements of the Safeguarding Vulnerable people in the NHS – Accountability and Assurance Framework (July 2015).
- Having clear lines of accountability in place; which are accessible and promoted to all staff.
- Ensuring all staff receive safeguarding training to the level appropriate to 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, and reviewed regularly, 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 SSCB and KASISB annual objectives.

4. Shropshire Safeguarding Boards Objectives

4.1 Shropshire Safeguarding Children Board (SSCB) Objectives

In striving to achieve our vision we are also committed to supporting the Shropshire Children's Board Work Programme 2018-2019 includes the following :-

1. Childhood Neglect
Promotion and use of the 'Graded Care Profile' to identify concerns of childhood neglect.

2. Child Sexual Exploitation and children who go missing
Revised strategy in place and working well, children at risk of child sexual exploitation (CSE) are identified, helped and protected.

3. Domestic abuse

Agencies are able to identify children who are exposed to domestic abuse and services are provided to victims.

In addition to the priority areas outlined above the SSCB will seek assurance regarding the following areas of activity in relation to safeguarding children in Shropshire:

- Recognition and response to private fostering
- Awareness and systems in place to recognise and respond to Female Genital Mutilation (FGM), Forced Marriage, Honour Based Violence (HBV)
- 'Prevent' strategy and process in place and working effectively

What does this mean in day to day practice?

In practical terms this means that we will work together to improve our arrangements for keeping children safe by: -

- Ensuring staff keep the wellbeing of children at the heart of all care they provide.
- Listening to children and providing them with the help and support at the right times and in the right ways.
- Sharing information and taking action to protect children when necessary
- Ensuring our workforce is trained and competent to deal with safeguarding issues appropriately. Recognising and escalating concerns around compromised parenting, neglect, domestic abuse, FGM, HBV, Forced Marriage, Private Fostering and 'Prevent'
- Ensuring staff are aware of the possible signs of exploitation and are able to consider this as a possibility when dealing with a 'troubled' child.
- Embracing children's views and incorporating them into our practice.

4.2 Keeping Adult Safe in Shropshire Board (KASISB) Objectives

1. Preventing abuse from occurring by:
Developing a culture of caring for others
Stop harm from happening to people
Minimise the impact of dealing with abuse on our services

2. Making Safeguarding Personal and implementing personalisation – giving people as much control as possible over their lives.

3. Public and workforce awareness of their responsibility to safeguarding people and report concerns if necessary

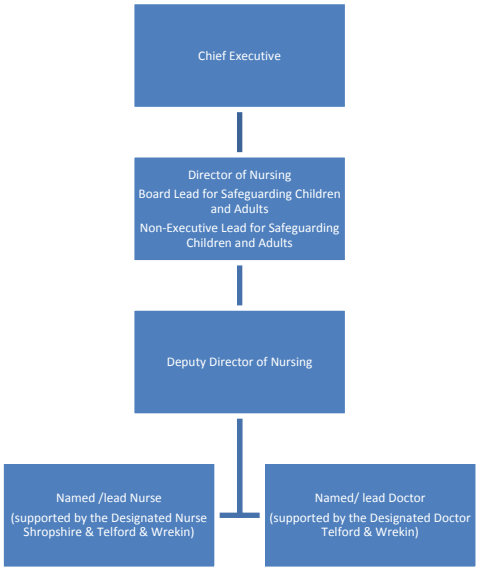
4. Establishing effective working relationships with other strategic partnerships.
The Board should not work on its own. It must work with other partner organisations so that they are clear about their role in safeguarding adults with care and support needs from abuse.

What does this mean in day to day practice?

In practical terms this means that we will work together to improve our arrangements for keeping adults with care and support needs safe by: -

- Encouraging staff to recognise and report concerns
- Ensure accurate documentation and share information to protect and support adults with care and support needs
- Embed Making Safeguarding Personal within the organisation ensuring adults with care and support needs wishes are documented within the safeguarding process
- Ensure representation from RJAH Adult Safeguarding team at KASiSB and sub-group meetings

5. Safeguarding accountability structure across the Trust



Executive Lead for safeguarding children and adults – Sarah Bloomfield, Interim Director of Nursing and Deputy CEO.

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. The Named Doctor provides expert advice and support regarding safeguarding children issues to all staff groups across the Trust. She is supported and supervised as necessary from the County wide Designated Doctor – Dr Ganesh.

Named Nurse for safeguarding children and young people - Suzanne Marsden - is the Children's Unit Manager and has 7.5 hrs per week allocated time to undertake this role as a

band 8a. Protected time for this post can be a challenge during periods of recruitment on the unit, but is managed well when the unit is fully established. The Named Nurse works closely with the Named Doctor to ensure that the Trust meets its statutory responsibilities in safeguarding children as defined in Working Together to Safeguard Children document (2018) and the Children Act (2004). This year we have promoted five staff nurses to Band 6 and one of these sisters is now leading on safeguarding which will further support the safeguarding services.

Lead 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.

Lead Nurse for adults – Sara Ellis-Anderson is responsible for safeguarding training; monitoring of 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. Currently has this role alongside the Matron role.

6. Meetings

6.1 Interagency children's meetings attendance:

- Quarterly Shropshire Safeguarding Children Board – attended by the Director/Deputy Director of Nursing.
- Quarterly Shropshire County & Telford & Wrekin Health Governance Safeguarding Committee in Shropshire - a subgroup of the Safeguarding Children Board – this meeting was attended regularly by the Named Nurse / Named Doctor but has been cancelled the latter half of the year.
- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Director / Deputy Director of Nursing. The Named and County Designated Professionals, Matrons and HR training manager attend this meeting.
- Regional Named Nurse meeting – this is held twice a year and has level 4 training incorporated into the afternoon session of the meeting.
- SSCB training Sub group and Training pool Meetings attended by the Named Nurse

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

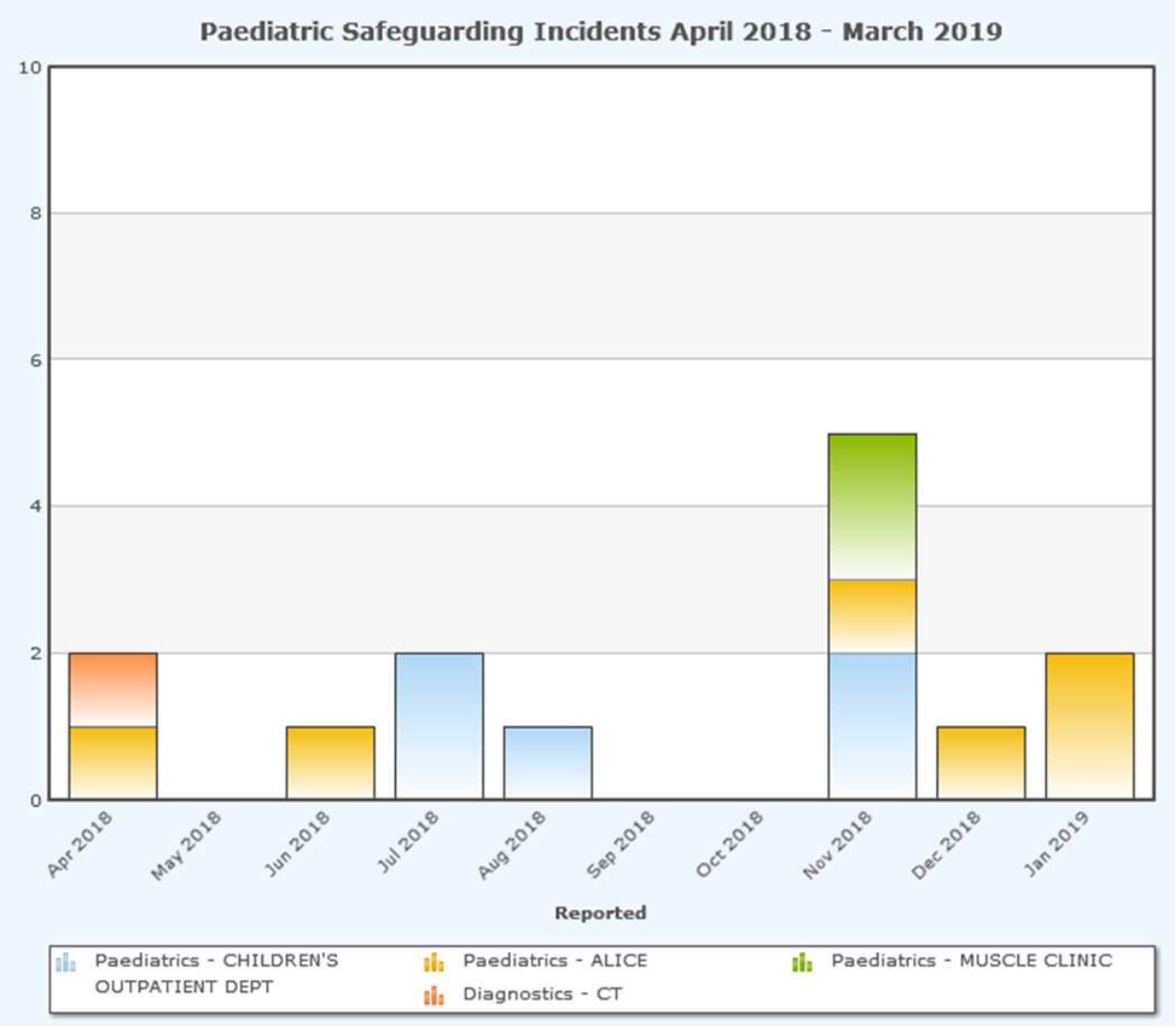
6.2 Interagency adult's meetings attendance:

- KASISB Quarterly Board meeting – attended by Director of Nursing/Lead Nurse for Adult Safeguarding.
- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Director / Deputy Director of Nursing. The Named and County Designated Professionals, Matrons and HR training manager attend this meeting.
- KASISB learning and development sub-group attended by Lead Nurse
- KASISB MCA and Deprivation of Liberty Safeguards (DOLS) sub-group attended by Lead Nurse
- Serious Organised Crime Joint Agency Group (SOCJAG) – minutes received by Lead Nurse

Information from the interagency meetings is cascaded through link meetings chaired every other month by Lead Nurse for Adult Safeguarding as well as the Trust Safeguarding Committee.

7. Referrals and incidents

7.1 Children's Safeguarding Activity (2018/2019)



Summary:

This year fourteen paediatric safeguarding incidences have been raised throughout the Trust and this is more than double the amount of investigations carried out in the last two years. We have seen two concerns highlighted from our dental admissions; Two patients where fabricated illness / emotional harm were being considered; one referral and one 'child in need' from the muscle team; two children with concerns relating to their mental health; one child accessing inappropriate material on-line and five children investigated through the safeguarding process for frequent non-attendance to appointments. It is reassuring to see that staff are now taking non-attendance to appointments seriously and are considering safeguarding as a possible reason, whilst we recognize that more work is needed, this is a positive step forward.

April 2018: Alice ward – Referral made and discussed in previous annual report. During the child's two week physio admission, many concerns were raised of a safeguarding nature during the child's stay. Following a Multi-disciplinary team (MDT) meeting in early April, a decision was made to refer this case to social services under the category of possible "Fabricated illness" Referral accepted by Cannock social services and an internal strategy meeting was held within the hour. Two emergency professional strategy meetings were held with representation from RJAH.

Conclusion:
This was an extremely challenging case, and whilst there was no clear evidence to prove fabricated illness, due to the catalogue of medical intervention endured by this young person, professionals remained concerned about the future for this child, even though the case was closed. Concluding that we did act appropriately by escalating these concerns, local professionals now have this child flagged which should assist in protecting the child in the future.
Whilst rare, it is important that professionals do think outside the box and consider the possibility of safeguarding concerns; including fabricated illness whilst reviewing children with unexplained / unusual presentations. Practitioners must ensure that they are not pressurised to undertake unnecessary investigations, as if left unchallenged, these children can experience many years of increased anxiety, inappropriate investigations and surgical interventions, which can have serious effects on the child's health and wellbeing and the outcome could even be catastrophic.

For other practitioners who see a small number of children in the practice, this is a reminder of the importance of keeping their safeguarding training up to date and also a time to consider whether partnership working with their paediatric colleagues would be beneficial to ensure the whole picture is considered in these complex cases.

April 2018: **Diagnostics- CT** raised a Datix regarding an eight year old child who was not brought for her appointment for the fourth time. Child Protection – Information Sharing (CP-IS) database check completed and no alert visible. Case reviewed by paediatrician who has spoken to the child's consultant. Plan to bring back to clinic to discuss future plan for child and family. MRI clear and referred back to GP
Learning: - The "Did not attend" Standard Operating Procedure (SOP) was not initially followed in this case, highlighting the importance of all staff being aware of the procedure.

June 2018: Alice ward - A patient attended the ward for a week's intensive physiotherapy. During the final assessment at the end of the week the child began crying. It transpired the child had overheard a traumatic event whilst on the phone to her friend 4 months ago, which was having a dramatic effect on her health and wellbeing. Patient had been previously referred to Child and Adolescent Mental Health Services (CAMHS) and has been triaged with telephone support. Mum reported concerns of self-harm, yet the child denied this. Mum has been paying for a private counsellor for her daughter since the event but thinks it would be useful for a re-assessment from CAMHS. Family given the Self-harm: Information and Advice for Parents & Carers and the Self-harm: Information and Advice for Young People leaflet. SSCB Self harm risk assessment completed and child appeared low risk. GP contacted who advised that they had already re referred to CAMHS following a visit to the surgery from Dad the previous week.
Learning: It would be useful if parents/patients had informed staff on the ward about this significant event earlier in the assessment/admission process, as the rehabilitation may have been more beneficial.

July 2018 COPD – A seven month old baby was not brought to three consecutive ultrasound appointments and a further X-Ray arranged at Wrexham. The baby had been referred for a hip check following breech presentation- higher risk of hip dysplasia. Throughout this period the practitioner had close contact with the health visitor who had not been able to contact mother and recommended she refer to social services. Patient referred to social services as per trust safeguarding policy in relation to nonattendance to appointments. Unable to do a CP-IS check as family lived in Wales. Social Worker made contact with mother and reiterated the importance of attending clinic. Baby has since been seen.
Learning: the importance of all staff following the "Did not attend (DNA)" SOP to ensure the patients receive the appropriate care.

July 2018 COPD – An eight year old child "did not attend" appointment at Wrexham, on further investigation the referral stated that the child had been taken into foster care. The foster carer's address was on the referral. However, the appointment and stickers printed were of the child's biological parent's home from which the child had been removed. This will have revealed that their child was living in Wrexham but not the foster carer's home address. This could have had safely implications for both the child and foster family. Referral letter did state that child was in foster care and address has now been changed on system.
Learning: Biological parents address must have linked via trace on Lorenzo. No clear way on Lorenzo to have alerts to highlight patients who are "looked after children." Appears to have been human error and has been shared with team.

August 2018: COPD – Six month old baby was not brought for appointment to discuss treatment for right Developmental dysplasia of the hip (DDH). Previous issues with attendance (DNAs and cancellations). There has been previous involvement of health visitor and translators to support Mother. CP-IS check was clear. Referred to social care as per SOP, due to concerns than nonattendance could be delaying the need for treatment for a dislocated hip. Baby has since been reviewed in Leighton with Social worker and Translator.
Learning: The importance of monitoring attendance and highlighting children that miss appointments, to ensure they receive the appropriate care.

November 2018: Muscle Team - attended 'Child In Need' meeting at Royal Stoke University Hospital High dependency Unit for a one year old child with a neuromuscular disorder. Child is currently in a place of safety in the High Dependency Unit (HDU). The plan for follow-up is with discharge planning meeting. Our Trust had not made the referral but were invited to attend this meeting.
Learning: Attendance to "Child in need" meetings are essential to ensure adequate sharing of knowledge within the MDT to ensure the child is supported and kept safe.

November 2018: Spinal disorders / Orthotics Outpatients- A mother expressed safeguarding concerns regarding her thirteen year old child in respect to the care provided by the father. Wrexham Social Services contacted - no open case. However other healthcare professionals who have more frequent contact with family, contacted to see if they have any concerns. Another trust was already investigating some concerns, relevant information forwarded to their safeguarding team. Two other Trusts had concerns about this child and family and Alder Hey had previously raised concerns but did not have enough evidence to proceed. Following the call from this Trust they escalated their concerns again and we were invited to a Strategy meeting in Alder Hey. Joint safeguarding referral made by Wrexham Named Nurse.
Learning: The importance of liaising with other professional involved in a child's care to gain a bigger picture.

November 2018: Muscle Team – Thirteen year old child. Safeguarding referral made in Sept 18. Named Doctor attended Section 47 Child Protection conference in Wrexham. Child put onto a Child Protection Plan under the category of Physical harm secondary to emotional harm. Learning: The practitioner recognized safeguarding concerns and followed Trust policy appropriately.

November 2018: COPD: Four year old **c**hild did not attend their second appointment in a row. Previous known concerns of domestic abuse. Unable to contact mum, discussed with GP practice and referral made to Gwynedd Social Services. Social services have reinforced the importance of attending this appointment with mum and she agreed to attend the next appointment. Patient has since been seen
Learning: The "Did not attend" SOP was followed and the situation will be monitored by specialist nurse.

Nov 2018: Dental Alice ward – Six year old child attended ward for dental surgery, safeguarding concerns highlighted under the category of neglect. Following an MDT discussion it was agreed the dentist would make the referral to Social Services.
Learning: concerns were raised by Alice ward staff, recovery and the dental team highlighting that staff in all area of the child's journey were all considering safeguarding in part of their routine assessments.

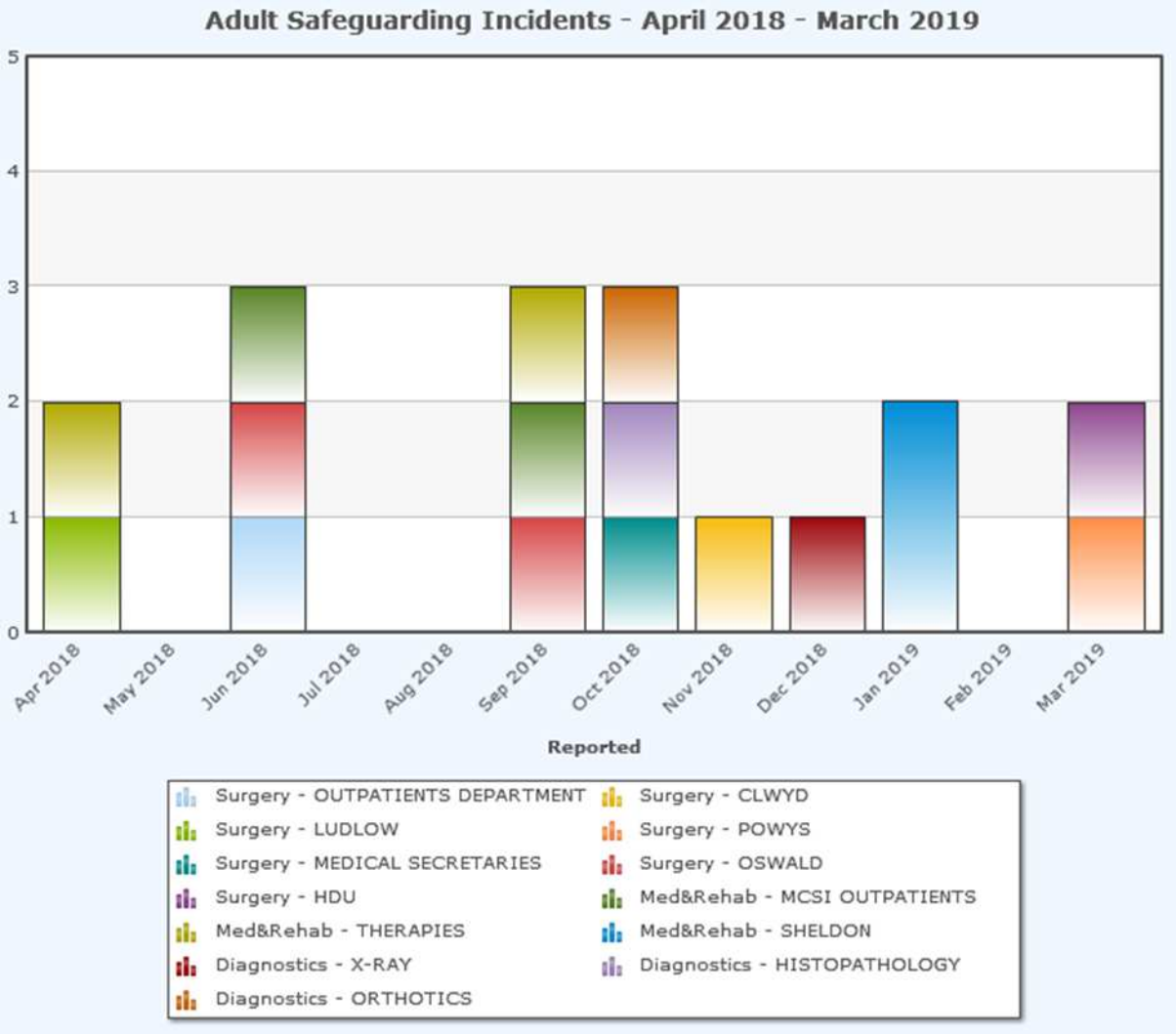
December 2018: Alice Ward - Inappropriate use of the ward IPad by a twelve year old patient. Staff member raised concerns that patient may have been watching something inappropriate on the IPAD. IPad returned to charger and checked. Inappropriate material was evident on search history. The Named Nurse discussed concerns with the patient and his mother. The mother was not surprised and disclosed she had recently had similar problems at home and had banned his phone and Xbox. School contacted with mums permission to advise them to check internet history on their computers. CAMHS referral made and patient accepted for intervention. IPAD cleared and additional firewalls installed.
Learning: Even with sophisticated firewalls, whilst rare it is still possible to come across inappropriate material on line. Parents made aware of this risk

January 2019: Alice ward – Sixteen year old patient returned from theatre very distressed and confused. Paediatric Early Warning Score (PEWS) was zero. Contacted anesthetist to review who thought it was not medication related and was thought to be psychological. Patient has had previous episodes of self-harm but did not disclose this on admission. Patient only disclosed receiving early help support due to being a young carer. Early help support worker contacted with permission, who also gave details of CAMHS worker, CAMHS worker had previously seen patient on two occasions, but said these were new symptoms and they could not have been predicted. Patient kept in overnight and reviewed by CAMHS the following morning on the ward. In a bid to prevent the need for a tier 4 bed, which he felt would not be in the young person's best interests he arranged to visit the young person at home for the next three consecutive days prior to deciding on a future pathway. Mother was happy with this decision. Patient discharged and has since been seen in clinic and is doing well.
Learning: The patient had had a telephone pre-operative appointment and it was felt it had been difficult to gain a full history through this process, never the less the young person was adequately supported and did not need to be transferred to a Tier 4 inpatient Child and Adolescent Mental Health Services.

January 2019: Dental Alice ward: Three year old child admitted for teeth extractions on the dental list. Concerns were raised regarding cleanliness/hygiene. The patient lived in Wales so a CP-IS could not be checked. Powys Social Services contacted. Patient already known to

them and on a Child Protection Plan – we were informed the child's social worker would be informed of our concerns and that the social Worker was currently visiting the family weekly.
Learning: This incident highlights that staff were able to spot safeguarding concerns and followed the safeguarding policy appropriately.

7.2 Adult Safeguarding Activity (2018/19)



Summary:
There have been no Serious Incidents (SI's) reported that have also resulted in a safeguarding referral/enquiry in 2018/19. A total of nineteen incidents were recorded in 2018/19 in comparison to seven incidents reported during 2017/18 giving assurance that safeguarding is being considered throughout the organisation. Two incidents were not recorded on the Datix system; the adult lead nurse for safeguarding has raised awareness of the importance of accurate recoding with department managers. Of the nineteen incidents seven were referred to local authority social services. Key emerging themes were disclosure of domestic abuse and patients with mental health needs requiring intervention and support.

April 2018 Ludlow ward (Datix E27054) admitted to the ward for surgery for a periprosthetic fracture and dislocated hip. On admission patient found to have two grade four pressure sores one on her left scapula and one on her left elbow. Safeguarding referral raised and forms sent as patient was had a package of care in place and district nurses attending to wound.

Safeguarding team from Gwynedd investigated and found levels of non-compliance from patient with the community including refusal of pressure relieving equipment. Documentation supported evidence that discussion had taken place explaining risks to patient. Patient had capacity consented to referral for increased package of care on discharge.

April 2018 Therapies (Datix E27040) during a physiotherapy treatment session a patient disclosed that her husband has a drinking problem and she was in tears most nights as he becomes verbally and mentally aggressive. Patient's sister was staying with her. Patient consent gained and referral made to First Point of Contact Team in Shropshire. Lessons learnt for staff: signposting to domestic abuse helplines could have been given to the patient and staff should have checked whether there were children residing at the property.

June 2018 Main Outpatients Department (Datix E27555) 70 year old lady attended Main Outpatients (MOPD) for a routine rheumatology appointment. During X-ray the patient told the Radiographer that she intended to kill herself using hose pipe she had in her car. Radiographer informed MOPD staff. Medic contacted, Mental Health Crisis Team contacted as patient was known to them. Police contacted to assess level of risk. Patient was allowed to return home with follow up from crisis team that evening.

June 2018 Midlands Centre for Spinal Injuries (MCSI) Outpatients (Datix E27693) patient arrived for routine follow up, bowel accident on arrival was noted to look like overflow, patients daughter was present and had been told by the nursing home that her father had been refusing bowel medication and suppositories. A copy of his prescribed medication chart came with him, which showed that he had not taken any oral aperients or had suppositories for four weeks. On examination the patient was found to be severely impacted and was admitted for bowel management. Safeguarding referral made to Staffordshire team following discussion with patient as they had not refused medication. Actions required additional education and training for staff within the nursing home. Patient was allowed to return with follow up from the safeguarding team.

June 2018 Oswald (Datix E27622) relating to a patient that became acutely confused and aggressive attempting to leave ward area. This is also duplicated as a DOLS incident **(Datix E27649)**

June 2018 Kenyon Patient disclosed to staff that husband was verbally abusive. Referral made to Shropshire First Point of Contact team as patient considered vulnerable and requiring a level of care on discharge following surgery. Transferred to Ludlow Community hospital and handover given in relation to safeguarding concerns raised. Lessons learnt: staff to ensure Datix is submitted to record all safeguarding incidents and referrals.

September 2018 Oswald (Datix E28301) Inpatient disclosed to anaesthetist that she felt vulnerable at home due to her husband's aggressive behaviour. Referral made to Shropshire First Point of Contact with patients consent. This was later retracted a few days later when patient and family discussed reasons for her husband's behaviour was due to a recent diagnosis of brain cancer. Patient felt safe to go home with support from her daughters and husband was awaiting further assessment.

September 2018 MCSI Outpatients (Datix E28517) Telephone call received from admissions team to inform me a patient had told her over the telephone he would commit suicide if he is not admitted on Monday for planned surgery. Police contacted to do safe and well check as regular contact not maintained with patient. Discussion with Consultant and patient admission arranged. Patient supported by MDT on admission.

September 2018 Therapies (Datix E28494) Patient contacted to rebook appointment as has failed to attend two appointments. Advised patient had been discharged due to multiple DNA's. Patient told admin staff that he was 'ready to kill himself' because he is suffering from depression and 'can't be bothered'. Concerns escalated to GP with patient consent. Patient was offered a further appointment and subsequently attended.

September 2018 Corporate (Datix E28468 – logged as visitor collapse) Resident from Derwen College with Learning Disabilities attended RJAH having absconded from the college and support workers had wet trousers and feet having walked through a stream. Patient usually has one to one care for his support needs but had recently started absconding and attending RJAH following the bereavement of his mother **(previous Datix E28398)** Referral made to Shropshire First Point of Contact team. Safeguarding adult lead nurse met with safeguarding lead for Derwen College; outcome included DOLS application, increased one to one supervision to twenty four hours and best interests meeting held.

October 2018 Medical Secretaries (Datix E28718) Patient was informed of her discharge and proceeded to express suicidal intent hanging up in a distressed state. Team were unable to contact patient and police safe and well check organised. Follow up phone call was also made to patient's GP.

October 2018 Histopathology (Datix E28618) External phone call received from member of the public. The lady stated that her blood type was AB positive and asked if she was going to die. She then progressed to disclose several things including that several members of her family had been murdered, that she had been accused of child abuse and her neighbours were trying to poison her. Contact was made with the lady's GP practice who confirmed that this lady had mental health issues and was known to the Community Mental Health Team. Matron contacted the Community Mental Health team who confirmed that they had seen the lady but she declined regular support with the team. They ensured advice was given and that she had access to the crisis team. The lady stated that she felt better after chatting with them.

October 2018 Orthotics RSH (Datix E28533) Patient attended a clinic appointment alone from her care home. Patient was known to be deaf but didn't have her hearing aids insitu, she was also known to have a poor memory and be incontinent. Patient attended wearing no shoes though she had been given protective footwear issued by orthotics one week earlier. She explained that staff at the care home were not sure how to put shoes on so this wasn't done. Care home staff had attended previous appointment and been shown how to apply footwear. Patient also disclosed that she had been denied use of a certain amount of pads at night as she was "using too many". Referral made to Shropshire First Point of Contact Team with patient consent. Social Worker allocated to visit and assess patient in the care home.

November 2018 Clwyd (Datix E28868) Patient admitted from home with existing care package in place. On admission patient found to have ungradable pressure damage to sacrum and an over-granulated supra-pubic catheter site. Referral made to Herefordshire Social Services who supported increased package of care to meet patient needs on discharge.

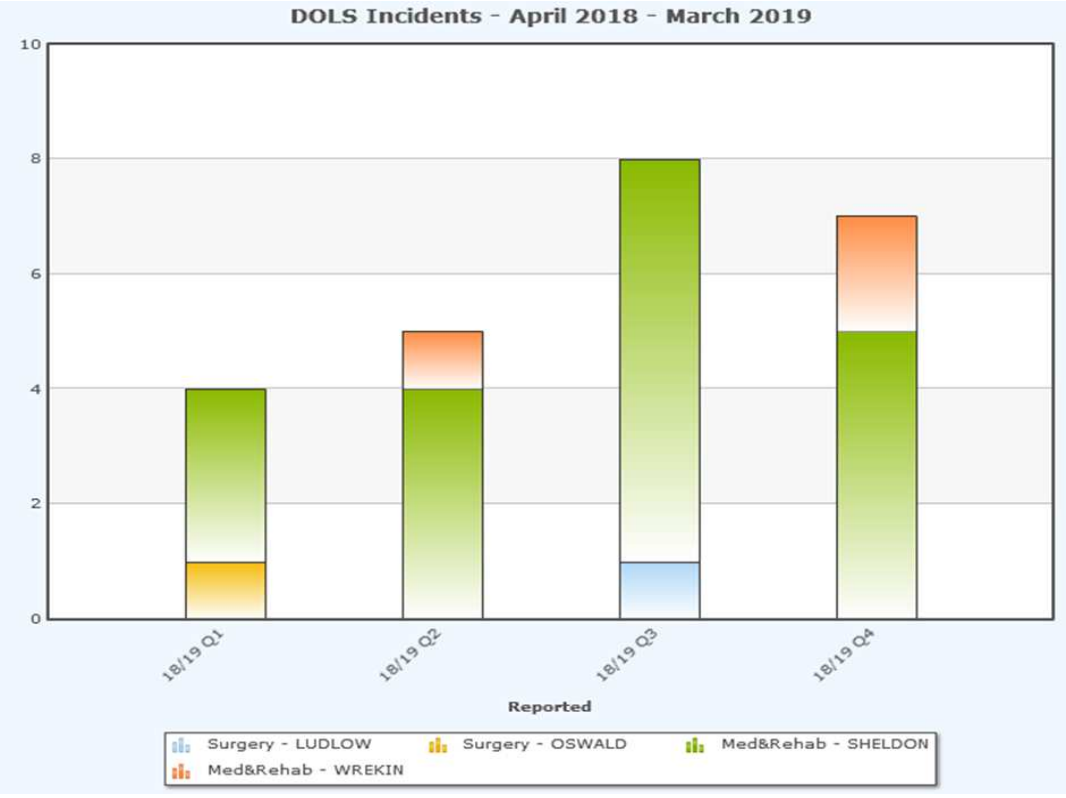
December 2018 Diagnostics – X-Ray (Datix E29239) GP Direct Access referral – during the examination patient disclosed that she had lied to her GP regarding mechanism of injury and that it was her husband's physical violence that had caused the injury on this occasion. The lady confirmed she had access to domestic abuse helpline numbers. Adult safeguarding lead nurse contacted patients GP surgery regarding patient disclosure to ask them to put a flag on their system and share the disclosure.

January 2019 Sheldon (Datix E29393) An 84 year old lady transferred from Royal Shrewsbury Hospital (RSH) for rehab following a fall at home sustaining a left impacted fracture neck of femur and had left hemi arthroplasty. On admission patient was deemed to lack capacity by consultant. Family raised concerns regarding their mum being discharged from hospital to her home address due to inappropriate behaviours displayed by her husband. The family had lasting power of attorney for health and finance. Safeguarding referral made to Shropshire social services with family consent. On further investigation patients husband was diagnosed with dementia; MDT meetings assisted discharge planning. Outcome was that both patient and her husband were allocated a place in a care home.

January 2019 Sheldon (Datix E29448) Patient admitted from home with ungradable and necrotic pressure sore. Daughter of patient described poor care during a recent admission to Whitchurch hospital and claimed pressure sore developed during the patients stay. Safeguarding referral made with patient consent. Investigation by the safeguarding team discovered patient's daughter had taken the patient home from Whitchurch hospital without formal care arranged or appropriate pressure relieving equipment in place. Case was closed by safeguarding team and appropriate support and care arranged for patient on discharge.

March 2019 Powys and HDU (Datix E30204 and E30164) Separate disclosures from both patient on HDU and patient's husband on Powys ward both claiming emotional and financial abuse from each other. Both described living within the same property but only being able to use certain rooms and restrictions imposed with money. Referral made to First Point of Contact team in Shropshire. Social Worker allocated for support and assistance with discharge planning.

8. DOLS Referrals (2018/19)



A total of 24 DOLS applications were made during 2018/19 the majority sent from Sheldon ward primarily for discharge planning and some relating to treatment given.

There was one incident recorded (E29015) on Clwyd ward where patient was referred to Rapid Assessment Intervention and Discharge (RAID) service due to the patient displaying behaviours with intent to cause harm to himself and possibly others. The patient was assessed and sectioned under section two of the Mental Health Act and treated for post-operative delirium. The section two order was lifted 24 hours later by Consultant Psychiatrist and patient continued planned care and discharged.

The Mental Capacity (Amendment) Bill is a Government bill that sets out measures to replace the Deprivation of Liberty Safeguards (DOLS) scheme in the Mental Capacity Act 2005. The objective of the Bill is to replace the current Deprivation of Liberty Safeguards (DOLS), with the new system recommended by the Law Commission – the Liberty Protection Safeguards (LPS). The policy being introduced will ensure that those requiring these safeguards will follow a streamlined, person-centred and less bureaucratic process. This change in law will have an impact on the organisation and is expected to be implemented during 2020. The Lead Nurse for Adult Safeguarding is part of Shropshire and Telford Implementation Network Group (STING). The purpose of the multi-agency group is to oversee the implementation of the Mental Capacity Amendment Act (MCAA) and the LPS across Shropshire and Telford and Wrekin.

9. Prevent Referrals (2018/19)

There have been zero prevent referrals for 2018/19.

10. Safeguarding complaints

There have been zero complaints specifically related to a safeguarding concern or element during 2018/19. The number of complaints citing staff attitude and behaviours are monitored and reported quarterly to the KASISB. Complaints are discussed at the Incidents Inquests Complaints Claims Actions Meeting (IICCAM) and escalated to the relevant safeguarding lead for advice and support with investigation if required.

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

We continued to work with the Staffordshire LADO with a case raised last year. Case now closed with no further action.

The Shropshire LADO was contacted for advice on one separate occasion with no further actions required for this case.

A sub category on Datix has now been added to monitor and record contact with the LADO.

12. The Domestic abuse policy

This policy has been instigated once this year to offer support and guidance to a member of Trust staff suffering from domestic abuse. Staff involved in this case had provided excellent support for their colleague, as per Trust Policy.

13. Training

13.1 Child safeguarding training

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 Board (SSCB) training pool and is delivered as multi agency training.

The Named Professionals maintain their own professional development and aim to attend at least one safeguarding training session each year. The Named Nurse attended a masterclass on fabricated illness Shropshire Community & Hospital Trusts; SSCB Exploitation conference Child/Adult as well as Mental Capacity and DOLS training. The Named Doctor also attended SSCB Exploitation conference Child/Adult.

Training compliance continues to be monitored against the Clinical Commissioning Group (CCG) training target of 98% - level 1, 85% - level 2 and 98% - level 3. Training figures for March 2019 were:

Level 1 – 97.56%
Level 2 – 92.87%
Level 3 – 94.44%
Level 4 – 100%

Please see appendix two for further detail – please note the RJAH Trust target is 92%

13.2 Adult safeguarding training

The Lead Nurse for adult safeguarding delivers level-one adult safeguarding training in conjunction with the Named Nurse for child safeguarding for all members of staff within the organisation. Clinical staff should complete adult safeguarding level-two training as an e-learning module. DOLS/MCA are delivered as face to face training for clinical staff and Prevent is completed as face to face and e-learning alternately.

The Lead Nurse and Doctor for Adult Safeguarding maintain their own professional development and aim to attend at least one safeguarding training session each year. Both Adult Safeguarding Leads attended KASISB/SSCB joint conference on exploitation. The Lead Nurse for adult safeguarding also attended a two day course by NHS England (NHSE) on Clinical Leadership in Safeguarding delivered at Level 4.

Training compliance continues to be monitored and reported quarterly against the CCG training target of 85%. Internally training figures are monitored against the Trust internal target of 92% and reported through the Safeguarding Committee. Training figures for March 2019 were:

Level 1 – 96.6%
Level 2 – 89.5%
Level 3 – 100%

DOLS – 78.1%
MCA – 81%
Prevent - 85.3%

Please see appendix three for further detail

MCA/DOLS have consistently been below target for 2018/19. The main reason cited was that it was challenging to release staff out of clinical areas for face to face training. DOLS and MCA training for 2019/20 now have the option of face to face or e-learning to maintain staff competency and awareness in these subjects.

Prevent training compliance is reported externally to NHSE every quarter.

14. Quality assurance and audits

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.

14.1 Audits

The following audits have been undertaken during 2018/19:

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. This information will be critical for the future development for the prevention and support of girls and women affected by FGM. To date we have not highlighted any children who have been subjected to this practice.

Monthly 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 annual MCA Audit conducted by Adult Safeguarding Lead Nurse reviewing ten sets of patient notes where patient lacked capacity. Areas for improvement included consistency of recording the capacity assessment decision as this varied greatly and raise awareness amongst staff to ensure relevant copies of Lasting Power of Attorney documentation are recorded. Good practice included MDT best interest meetings carried out with outcomes recorded.

14.2 Assurance and Performance monitoring

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

Quarterly returns to KASISB for incidents related to falls and pressure sores, patient experience and complaints with elements of safeguarding are completed for assurance.

CQC inspection in November 2018 reviewed Safeguarding across the organisation. The Trust was deemed compliant in regulation 13 Safeguarding service users from abuse and improper treatment. It was acknowledged some areas required improvement in safeguarding training compliance the CQC were assured staff were knowledgeable about the process in how to identify potential abuse and how to raise concerns.

The Adult Lead Nurse and Named Nurse revise and update the NHS Assurance and Accountability framework (NHSE, 2015) quarterly. This is reported to the joint Adult and Children Safeguarding Committee.

15. Associated Risks

There are three safeguarding risks on the Trust risk register:

1510 – No Trust flagging system in place to notify staff if child on a protection plan – Low risk scored as 6 with current mitigations in place

2031 – Undetected child abuse in the Trust – Very Low scored as 3 with current mitigations

2029 – Managing allegations against a professional who works with children or adult with care and support needs – Very Low scored as 3 with current mitigations

They are all accepted as tolerated risks and reviewed and updated as part of the NHS Assurance and Accountability framework.

16. Associated policies

Policy	Renewal date	Owner	Comments
Chaparone Policy	being updated	LR	For ratification at Clinical Quality & Governance in June 19
Supporting staff experiencing domestic abuse.	Apr-17	HR	
Prevent policy	Sep-18	SEA	For ratification at Safeguarding Committee in June 19
Management of serious incident policy	Sep-19	SR	
Safeguarding Children policy	Jun-19	SM / RK	For ratification at Paediatric Forum and Safeguarding Committee in June 19
Missing Child and adult policy	Sep-20	SM/ SEA	
Children's Clinical holding Policy	Oct-19	SM	
Child death and Bereavement Policy	Oct-20	SM	
Managing Allegations	Dec-20	SEA/SM	
Guidelines for children who miss appointments	Apr-21	SM	
Protection and Safeguarding of Vulnerable Adults (Adults with care and support needs) Policy	Dec-21	SEA	
Shropshire Multi Agency MCA guidance and procedure	Dec-21	SEA	
Guidelines for Deprivation of Liberty Safeguards (DoLs)	Dec-21	SEA	

17. Key priorities for 2019/2020

17.1 Children and young people safeguarding priorities

Safeguarding children is clearly everyone's responsibility and as a Trust it is crucial that we continue to work together to improve the service we provide. Safeguarding children is no easy task and health professionals who are faced with children who present with unclear concerns, should always consider child abuse as part of a holistic assessment of the child.

Priorities for 2019/20 are:

- To continue to improve training compliance and review staff group requiring level 3 training. Improvements have been made this year.
- Ensure Named professionals are supported to undertake essential training. This has been achieved for 2018/19.

- Ensure the Band 6 Safeguarding lead is supported to undertake further training to improve knowledge and competence
- Where possible, training should continue to be targeted at Neglect, Sexual Exploitation and Domestic abuse. This has been successful for 2018/19.
- To continue to work with partner agencies in achieving the Shropshire Safeguarding Children Board Key priorities.
- Trust board Safeguarding training to be arranged in 2019
- To develop an alternative process to enable young people to assist in auditing services on the children's unit – 15 Step Challenge.

17.2 Adult safeguarding priorities

17.2.1 2018/19 priorities achieved:

- Standards assessed against the NHS Accountability and Assurance framework bi-annually and subsequent action plan developed.
- Conducted an audit on the use of the Mental Capacity Act (MCA) and fed back audit results and any remedial actions required at link meeting and MCA/DOLS sub-group.
- Re-instated safeguarding and dementia link nurse meetings and promote link nurses within other disciplines to ensure multi-disciplinary approach.

Two priorities relating to safeguarding training compliance and embedding making safeguarding personal have continued in to 19/20 as outlined in the priorities below.

17.2.2 Priorities for 2019/20 are:

- To continue to improve training compliance particularly in relation to MCA/DOLS training.
- Review staff group requiring adult safeguarding level 3 training in line with 'Adult Safeguarding: Roles and Competencies for Health Care Staff' Intercollegiate Document (2018) and implement training against agreed trajectory.
- Embed Making Safeguarding Personal (MSP) within the organisation through production of one minute briefing and incorporation in to STAR standards. Audit of documentation in relation to safeguarding referrals made within the organisation to ensure MSP principles are applied in each case.
- Completion of the Care Act Compliance Audit for the Keeping Adult Safe in Shropshire Board within quarter one
- Ensure local SARs are shared at Safeguarding link meetings and the joint Safeguarding Committee identifying any improvements the organisation can make from shared learning.

- Implementation of Liberty of Protection Safeguards within the organisation to replace DOLS

Conclusion

This annual report provides an overview of safeguarding activity and assurance for 2018/19 as well as outlining key priorities for 2019/20. Raising awareness and training continues to remain high on our agenda, ensuring 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 One: Acronyms

SSCB	Shropshire Safeguarding Children Board
KASISB	Keeping Adults Safe in Shropshire Board
CQC	Care Quality Commission
MCA	Mental Capacity Act
DOLS	Deprivation of Liberty Safeguards
CSE	Child Sexual Exploitation
FGM	Female Genital Mutilation
HBV	Honour Based Violence
SOCJAG	Serious Organised Crime Joint Agency Group
MDT	Multi-disciplinary Team
CP-IS	Child Protection – Information Sharing
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
DDH	Developmental Dysplasia of the Hip
DNA	Did Not Attend
SOP	Standard Operating Procedure
HDU	High Dependency Unit
PEWS	Paediatric Early Warning Score
SI	Serious Incident
MOPD	Main Outpatients Department
MCSI	Midlands Centre for Spinal Injuries
RSH	Royal Shrewsbury Hospital
LPS	Liberty Protection Safeguards
STING	Shropshire and Telford Implementation Network Group
MCAA	Mental Capacity Amendment Act
IICCAM	Incidents Inquests Complaints Claims Actions Meeting
LADO	Local Authority Designated Officer
NHSE	NHS England

Appendix Two: Annual Training Report for Child Safeguarding

				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		
				3 yearly training			3 yearly training			3 yearly training			3 yearly training		
Staff Group	**Department Headcount**	**New Starters**	**Maternity/Adoption Leave**	**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**
Add Prof Scientific and Technic	65	9	1	55	54	**98.2%**	60	58	**96.7%**	0	0		0	0	
Additional Clinical Services	274	34	10	230	223	**97.0%**	231	213	**92.2%**	2	1	**50.0%**	0	0	
Administrative and Clerical	429	56	8	365	352	**96.4%**	8	6	**75.0%**	0	0		0	0	
Allied Health Professionals	170	25	11	134	134	**100.0%**	149	139	**93.3%**	12	11	**91.7%**	0	0	
Estates and Ancillary	155	16	1	138	134	**97.1%**	14	10	**71.4%**	0	0		0	0	
Healthcare Scientists	7	1	1	5	5	**100.0%**	2	2	**100.0%**	0	0		0	0	
Nursing and Midwifery Registered	335	36	12	287	285	**99.3%**	315	305	**96.8%**	27	26	**96.3%**	2	2	**100.0%**
Total without Medical Staff	**1435**	**177**	**44**	**1214**	**1187**	**97.8%**	**779**	**733**	**94.1%**	**41**	**38**	**92.7%**	**2**	**2**	**100.0%**
Medical and Dental	105	10	0	95	90	**94.7%**	105	88	**83.8%**	13	13	**100.0%**	1	1	**100.0%**
TRUST WIDE TOTAL	**1540**	**187**	**44**	**1309**	**1277**	**97.56%**	**884**	**821**	**92.87%**	**54**	**51**	**94.44%**	**3**	**3**	**100.00 %**

Appendix Three: Annual Training Report for Adult Safeguarding

		Completed "in date" Vulnerable Adults Training LEVEL 1			Completed "in date" Vulnerable Adults 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		
Staff Group	Department Headcount	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
Add Prof Scientific and Technic	65	55	51	92.7%	60	52	86.7%	0	0	N/A	16	9	56.3%	16	11	68.8%	64	55	85.9%
Additional Clinical Services	274	230	220	95.7%	225	201	89.3%	0	0	N/A	111	88	79.3%	112	91	81.3%	264	216	81.8%
Administrative and Clerical	429	365	349	95.6%	8	7	87.5%	0	0	N/A	47	40	85.1%	47	42	89.4%	421	362	86.0%
Allied Health Professionals	170	134	131	97.8%	153	132	86.3%	0	0	N/A	115	85	73.9%	120	98	81.7%	159	136	85.5%
Estates and Ancillary	155	138	133	96.4%	16	11	68.8%	0	0	N/A	0	0	N/A	0	0	N/A	154	135	87.7%
Healthcare Scientists	7	5	5	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	1	1	100.0%	6	6	100.0%
Nursing and Midwifery Registered	335	287	282	98.3%	322	303	94.1%	2	2	100.0%	163	136	83.4%	163	135	82.8%	323	275	85.1%
Total without medical staff	**1435**	**1214**	**1171**	**96.5%**	**786**	**708**	**90.1%**	**2**	**2**	**100.0%**	**453**	**359**	**79.2%**	**459**	**378**	**82.4%**	**1391**	**1185**	**85.2%**
Medical and Dental	105	95	93	97.9%	105	89	84.8%	1	1	100.0%	105	77	73.3%	105	79	75.2%	105	91	86.7%
TRUST WIDE TOTAL	**1540**	**1309**	**1264**	**96.6%**	**891**	**797**	**89.5%**	**3**	**3**	**100.0%**	**558**	**436**	**78.1%**	**564**	**457**	**81.0%**	**1496**	**1276**	**85.3%**

Infection Prevention & Control & Cleanliness Annual Report 2018/19

✓0. Reference Information

Author:	Sue Sayles, Infection Control Nurse Phil Davies, Head of Estates and Facilities	Paper date:	25th July 2019
Executive Sponsor:	Sarah Bloomfield, Director of Nursing	Paper Category:	Governance and Quality /
Paper Reviewed by:	Quality & Safety Committee 20/06/19	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

For approval from Executive Committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

In the year 2018/19 was another year of improvements and new challenges in the continuing campaign to reduce avoidable Health Care Associated Infection (HCAI) at RJAH Orthopaedic NHS Foundation Trust.

Successes include meeting our MRSA bacteraemia target of zero for the thirteenth year running and seeing a reduction in E coli bacteraemia associated with health care. However our numbers of C.difficile cases rose and at 3 cases we were over our target of 2 cases.

We are struggling with the increased requirement for side rooms as national guidance has changed to include more antibiotic resistant organisms in the list of those needing isolation and the increase in incidence of patients with ESBL carriage on the Spinal Injuries Unit has doubled from previous years. The unit currently has one bay with doors which limits the ability to effectively cohort single sex requirements, therefore a capital bid request for 3 additional sets of doors has been submitted to secure funding.

The increased flu vaccination uptake of 60.8% against a target of 75%, demonstrates the hard work of our lead Practice Nurse facilitator to raise awareness of the benefits of the flu vaccination and included a staff story to raise awareness of the seriousness of the flu virus. Working alongside TeamPrevent and additional nurse vaccinators, improved the accessibility and availability of the flu vaccine.

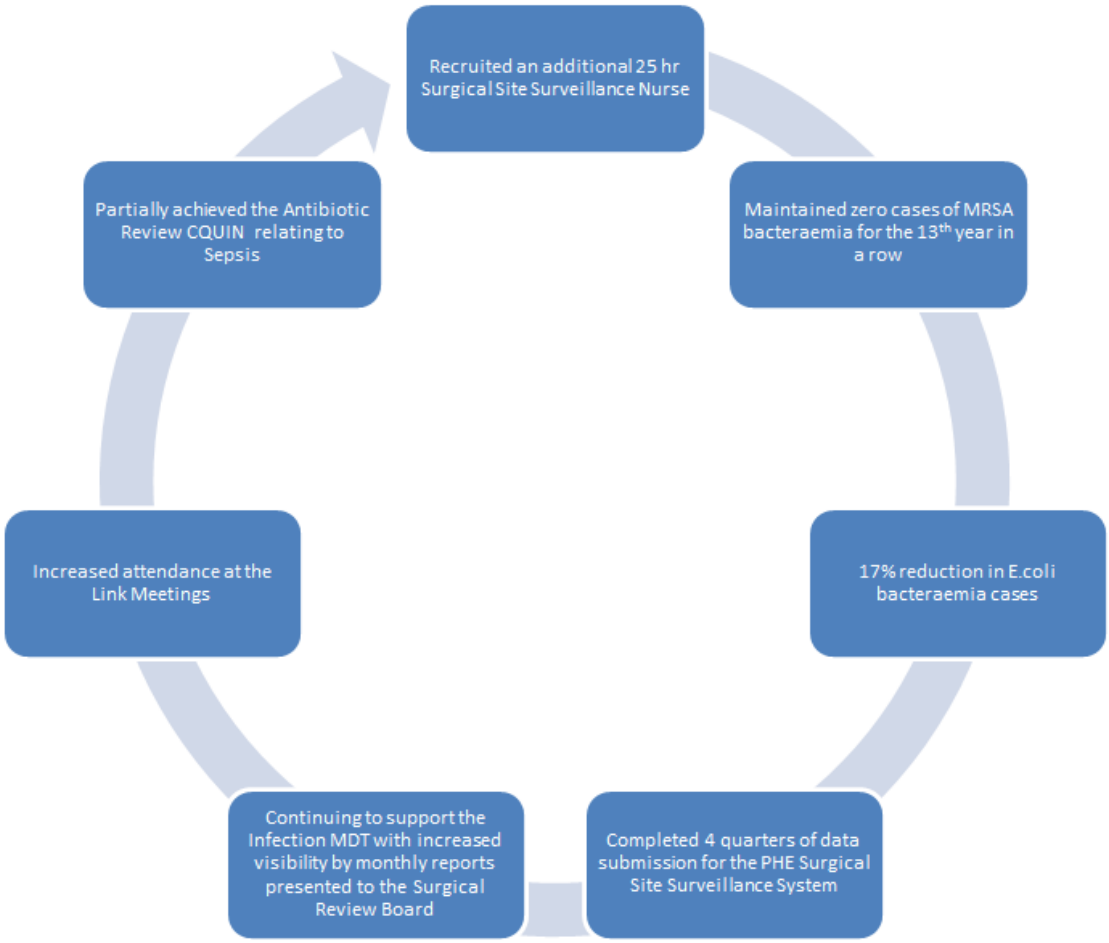
2.3. Conclusion

The Board is asked to:

(a) To note the report

(b) To discuss and determine actions as appropriate

Infection Prevention & Control Team Achievements – 2018/19



3. The Main Report

3.1. Introduction

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

3.2. Health & Social Care Act Code of Practice

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

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

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

IPC Structure

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

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

The **Infection Control Doctor (ICD)** is the Clinical Lead for the IPC service and is contracted for 3 sessions a week to include the microbiology ward round and microbiological reporting. The role includes:

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

The ICD reports to the DIPC on IPC matters.

The **Infection Prevention and Control Team** (IPCT)

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

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

- Consultant Microbiologist: 24h infection control advice is available from the on-call consultant microbiologist
- Infection Prevention and Control (IP&C) Clinical Nurse: (1 WTE) Band 7
- Surgical Site Surveillance Nurses: (1 WTE) Band 5
- Infection Control Analyst (0.8 WTE): Band 4

The **Antimicrobial Pharmacist**: The Trust employs 0.5 WTE Antimicrobial Pharmacist who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The role of the antimicrobial pharmacist includes:

- Attending and contributing to the Trust Infection Prevention & Control Committee meetings and the Antimicrobial Stewardship Committee meetings
- Supporting antimicrobial stewardship initiatives
- Participating in and contributing to the ward rounds with the ICD
- Carrying out audits in line with national guidance
- Providing training regarding antimicrobial stewardship to clinical staff within the Trust

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Infection Prevention Control Committee

The RJAH Infection Prevention & Control Committee (IPCC) is a multidisciplinary Trust committee with outside representation from Public Health England and the CCG. The IPCC oversees the activity of the IPCT and supervises the implementation of the infection control programme of work. The IPCC met every 3 months during 2018/2019.

Attendance at IPCC

	Apr 2018	*Aug 2018*	*Nov 2018*	*Jan 2019*
DIPC	*apol*	*apol*	*apol*	*apol*
ICD	✓	✓	✓	✓
IPCN	✓	✓	✓	✓
Ass. DON	✓	✓	✓	✓
SSSN	✓	*apol*	*apol*	✓
CCDC (PHE Rep)	*apol*	*apol*	*apol*	*apol*
Antimicrobial Pharmacist	*apol*	*apol*	*apol*	*apol*
Facilities Manager (Estates & Facilities Representation)	✓	✓	✓	✓
Matron (Medicine)	✓	*apol*	*apol*	✓
Matron (Surgery)	✓	✓	✓	✓
Matron (Theatre & OPD)	✓	✓	✓	✓
Theatre Manager	*apol*	✓	*apol*	*apol*
Head of IPC SCCG & TWCCG	✓	✓	✓	✓
Clinician Rep	✓	*apol*	*apol*	*apol*
TSSU Rep	✓	*apol*	✓	*apol*

The IPC Programme of Work

The IPC programme of work 2015-2018 was specifically designed to focus on achieving full compliance with the standards identified in the Code of Practice, and the achievement of National and local infection related targets, using a template set by the Shropshire & Telford & Wrekin IPC Lead – the Trust has achieved full compliance on all the standards with the exception of having a fit-for-purpose IT system to support surveillance activity; therefore the identification of a most cost-effective solution utilising internal systems and exploring local solutions continues to be required. This has been highlighted and reported on the Risk Register.

IPC Link Practitioner System

The Infection Control Link Practitioner group meets bi-monthly.

Topics of discussion for 2018/2019 have included:

- Saving Lives toolkit revised version & feedback on current audits
- Health Care Associated Infections/PIR Documentation
- Theatres Inspection Updates
- Clinimatic/Macerator Cleaning Checklist
- Catheter Associated Urinary Tract Infections (CAUTI) Datix Reporting
- Glove Awareness Week – w/c 1st May 2018
- Urinary Catheter Card
- Daniels Sharps Training
- Waste segregation update from Facilities
- CDI cases, appeals process and shared learning
- Decontamination of a side room following discharge of patients with alert organisms
- Flu vaccine updtaes
- Increased incidence of ESBL carriage
- FIT testing for FFP3 masks
- Commode cleaning station implementation

Link Nurse Attendance

Ward	*April*	*June*	*Aug*	*Oct*	*Dec*	*Feb*
Ludlow			✓	✓		✓
OPD	✓	✓	✓			✓
POAU	✓	✓	✓		✓	
Powys			✓	✓		
Clwyd	✓	✓		✓	✓	✓
HDU		✓				
Theatres	✓	✓	✓			
Anaesthetics	✓					
Recovery	✓		✓	✓	✓	
Oswald			✓		✓	✓
Radiology						
TSSU		✓				
Gladstone					✓	✓
Wrekin	✓				✓	✓
SIU OPD	✓		✓	✓	✓	✓
Kenyon						

Alice	✓					✓
Sheldon	✓					✓
Therapies		✓		✓	✓	✓
Baschurch	✓	✓	✓	✓		✓
ORLAU	✓	✓	✓	✓	✓	✓
Library personal	✓	✓	✓	✓		✓
Orthotics		✓	✓			
Porters		✓	✓	✓		
Facilites					*Education Session*	

The wards/departments are assessed on their attendance to Infection Control link meetings and feedback is given through the STAR assessment programme.

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

Mandatory Surveillance

Blood Stream Infection

- MRSA
  There were 0 cases of MRSA bacteraemia at RJAH in 2018/19. The target remains at 0 MRSA bacteraemia, any case attributed to RJAH would be considered a never event for the Trust.

- MSSA
  There were only 2 cases of MSSA bacteraemia attributed to RJAH in 2018/19. Post Infection Reviews were carried out on both occasions and lessons learnt identified and shared via Link Nurse meetings and SNAHP.

  In the first case, other skin commensals were identified which were probably skin contaminants obtained during blood culture procedure.

  The second case was a deep tissue infection was the source of the blood stream infection, root cause analysis was undertaken and lessons learnt were shared with the multi- disciplinary team.

- E. coli (gram negative bacteraemia)
  In light of the Department of Health's new ambition to reduce healthcare associated blood stream Infections by 50% by the year 2021, the Local Health Economy felt that it would be prudent to convene a group to look at more joined up ways of working locally to try to prevent blood stream infections in our patients. Infections can occur across the wider health economy (hospital and community settings); therefore, reductions can only be achieved by working together across the whole health and social care sector.

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During 2018/19 the health economy continues to focus on *E.coli* as one of the largest infection groups and this is supported by the Quality Premium for CCG's. The local health economy Infection prevention and Control (IPC) group has worked together and agreed a reduction plan with a focus to reduce E.coli by 10% or greater.

- There were 5 cases of *E.coli* bacteraemia in 2018/19 which was a 17% reduction since 17/18. All cases were reviewed individually to determine whether there were common themes to help identify priority areas for action, 1 case was related to the billary tract and the other 4 cases were linked to urinary catheters and were unavoidable.

- C. *difficile*

  There were 3 individual cases of C difficile at RJAH in 2018/19 against target of 1. The Trust appealed all 3 cases which were considered by the Commissioners in which 2 cases were upheld and agreed for removal from the Trust's actual number of cases for the purpose of calculations of financial sanctions. The 3rd case that was not upheld was declined due to not adhering to the antibiotic policy.

  The learning outcomes from the 3 cases concentrates on antibiotic prescribing and antibiotic prophylaxis. Lessons learnt include involving the surgeons in the case and tabling the surgeons responses of the rationale for further post operative antibiotic doses.

  Post Infection Reviews were carried out on all 3 occasions and lessons learnt identified and shared via Link Nurse meetings and SNAHP, an example of which is shown below:

Robert Jones and Agnes Hunt
2018/19 CDI Post Infection review Outcomes

Quarter	CCG	Date of Specimen	Ward	Appeals panel decision	Rationale for decision	Appeals Panel Additional Comments/Actions	Provider assurance
1	SCCG	04/09/18	Powys	Upheld	1. Appropriate antibiotics prescribed 2. No indication to suspect transmission	The panel noted the response by staff to the onset of diarrhoeal symptoms were immediate with timely stool specimen collection and prompt isolation.	Share the outcome of the investigation with all staff directly involved in the incident and staff from the area where the incident occurred Face to face 'Keeping the Skills Alive' training dates arranged
2	TWCCG	17/01/19	Clwyd	Upheld	1. No evidence to suggest cross infection	1. The panel request further information, as it is unclear to the reason for extra doses of cefuroxime being administered post surgery. 2.The panel noted the immediate response of staff to diarrhoeal symptoms; obtaining a timely stool specimen and prompt isolation.	Antibiotic guidelines- MRSA negative: Cefuroxime 1.5g Repeat dose every 6hours in prolonged surgery. Maximum of 3 doses. History of MRSA: Vancomycin 1g. Surgeons response "The reason for 2 antibiotic shots post surgery is due to metal implanted into the patient. It is standard protocol in RJAH in spines to give 2 post op antibiotic doses for patients having surgery with implants"

Face to face 'Keeping the Skills Alive' training delivered during October 2018, proved beneficial and provided Clwyd Ward with the knowledge and skills in the exemplary management of their first C. *difficile* infection.

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Surgical Site Surveillance (SSI)

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

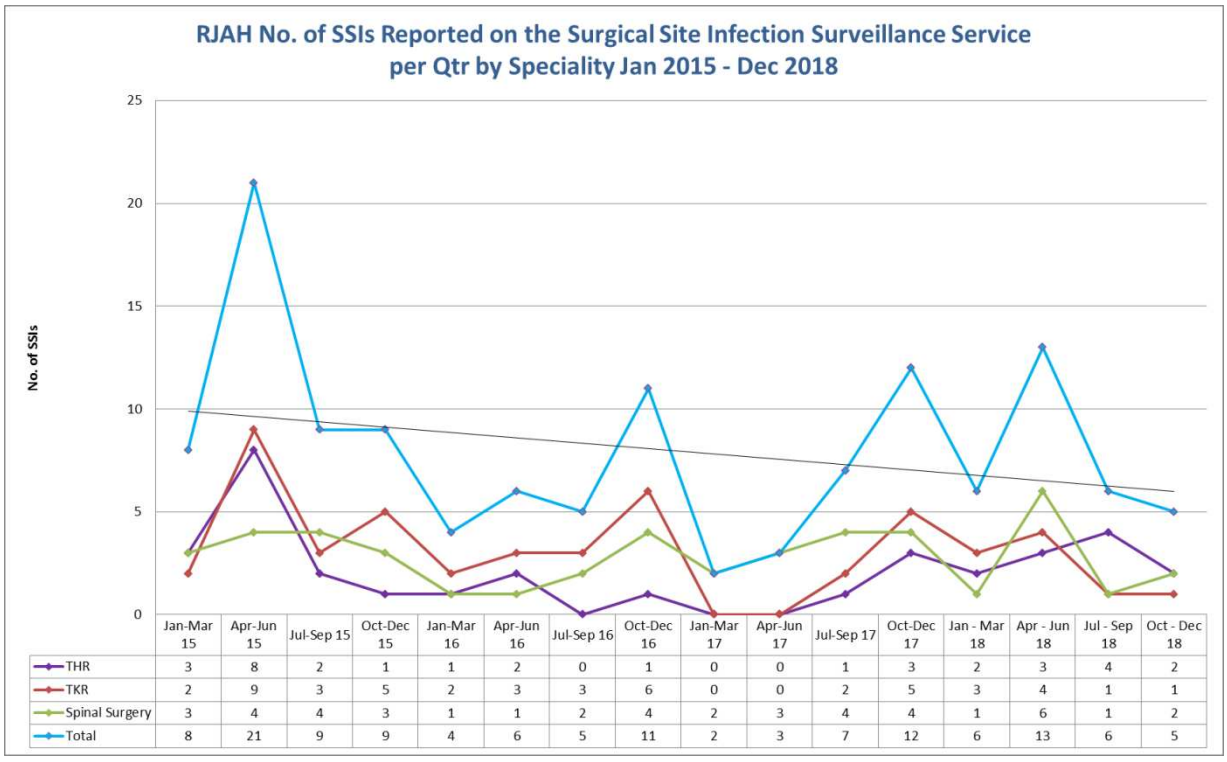
From January 2018 – December 2018, data on 4425 operations – total hip replacements, total knee replacements and spinal surgery was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 30 SSIs reported, 11 Hips, 9 Knees, 10 Spinal, compared to a total of 24 SSIs reported Jan 17 – Dec 17 (4 Hips, 7 Knees, 13 Spines).

PHE analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence falls above the 90th or below the 10th percentiles nationally for a given surgical category, enabling the Trust to benchmark itself against the national rate of infection.

Surgeon specific data allows the surgical site surveillance team to provide analysis of infection rates to individual surgeons as part of their validation and appraisal process.

The graph below shows a downward trend of the total number of SSIs that have been reported to PHE between Jan 2015 and Dec 2018. The graph also shows the breakdown by Hips, Knees and Spinal specialities.

The Trust submits surgical site infection data to the PHE database on a quarterly basis; these reports are always one quarter in arrears to allow a window of time for any infections to present, Jan 19 – Mar 19 will be reported at the end of June 2019.



	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17	Jul-Sep 17	Oct-Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sep 18	Oct - Dec 18
THR	3	8	2	1	1	2	0	1	0	0	1	3	2	3	4	2
TKR	2	9	3	5	2	3	3	6	0	0	2	5	3	4	1	1
Spinal Surgery	3	4	4	3	1	1	2	4	2	3	4	4	1	6	1	2
Total	8	21	9	9	4	6	5	11	2	3	7	12	6	13	6	5

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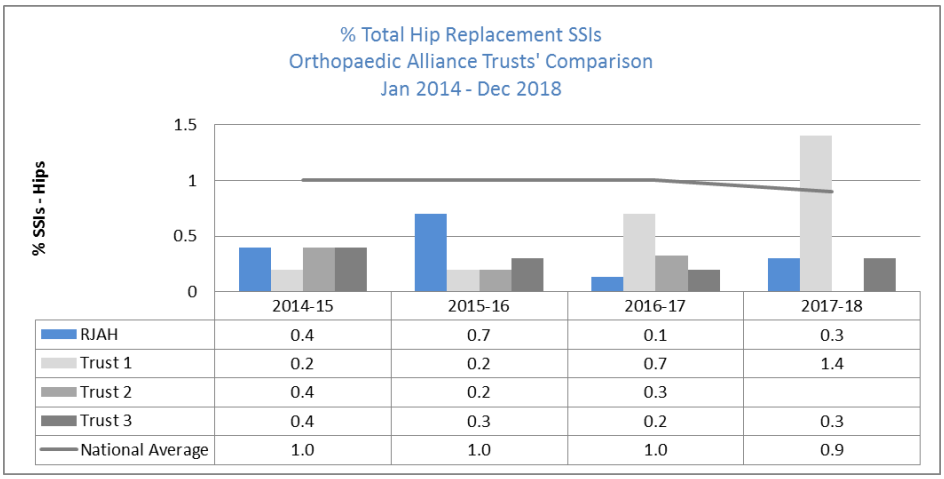
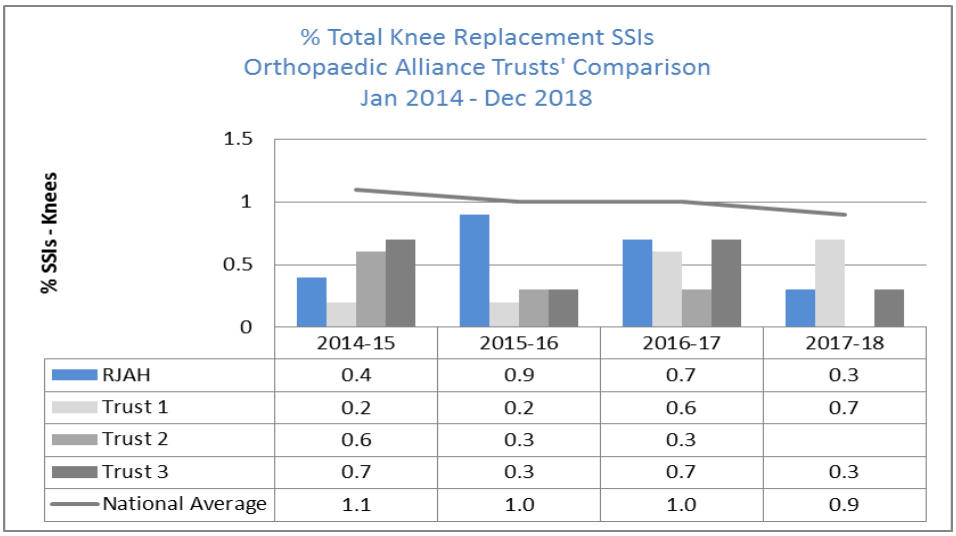
How does RJAH compare to other Trusts within the Orthopaedic Alliance who have completed 4 quarters data each year?

The following graphs show the comparison of SSI rates for Hips and Knees. RJAH consistently perform below the national average. 'Trust 2' show no data for 2017-18 as their submission for this period was 3 quarters only.

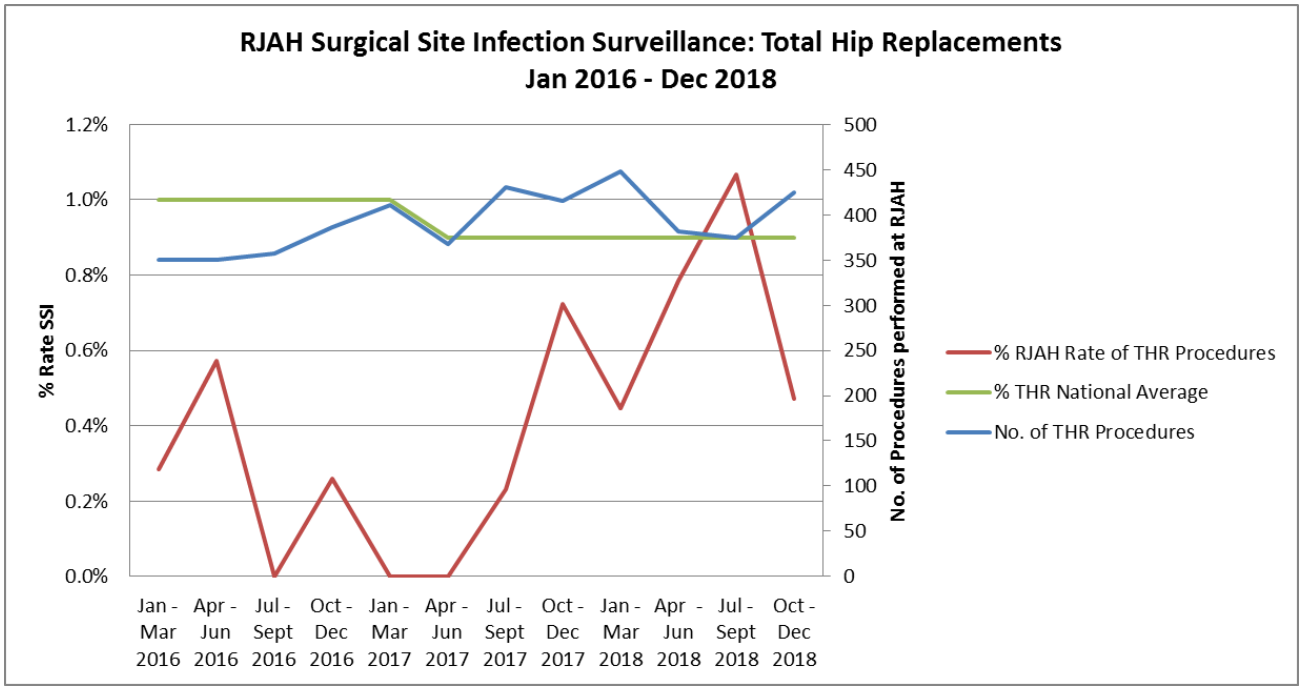


	2014-15	2015-16	2016-17	2017-18
RJAH	0.4	0.7	0.1	0.3
Trust 1	0.2	0.2	0.7	1.4
Trust 2	0.4	0.2	0.3	
Trust 3	0.4	0.3	0.2	0.3
National Average	1.0	1.0	1.0	0.9

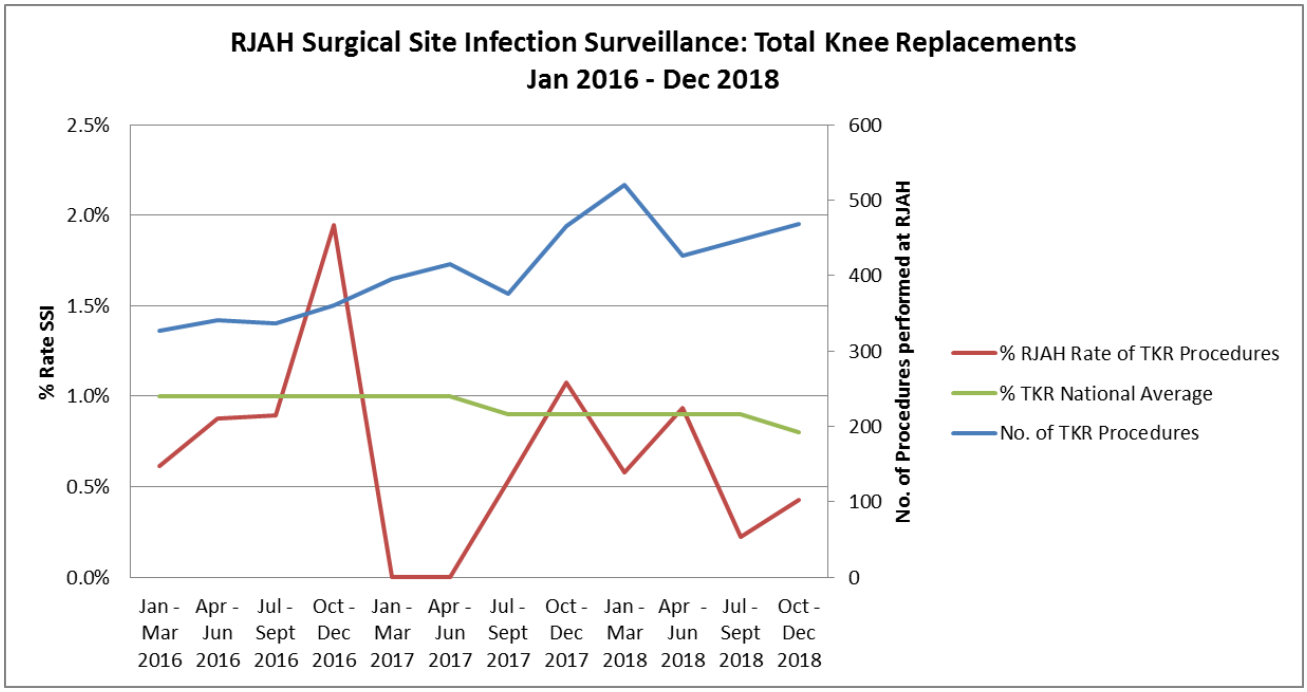


	2014-15	2015-16	2016-17	2017-18
RJAH	0.4	0.9	0.7	0.3
Trust 1	0.2	0.2	0.6	0.7
Trust 2	0.6	0.3	0.3	
Trust 3	0.7	0.3	0.7	0.3
National Average	1.1	1.0	1.0	0.9

The graph below shows the RJAH % rate of SSI for total hip replacements has been consistently below the national average through 2016 and 2018 with the exception of Jul-Sept 18.



The RJAH rate of SSI for total knee replacements has been consistently below the national average through 2016 and 2018, with the exceptions being Oct-Dec 2016, Oct – Dec 2017 and Apr – Jun 2018.



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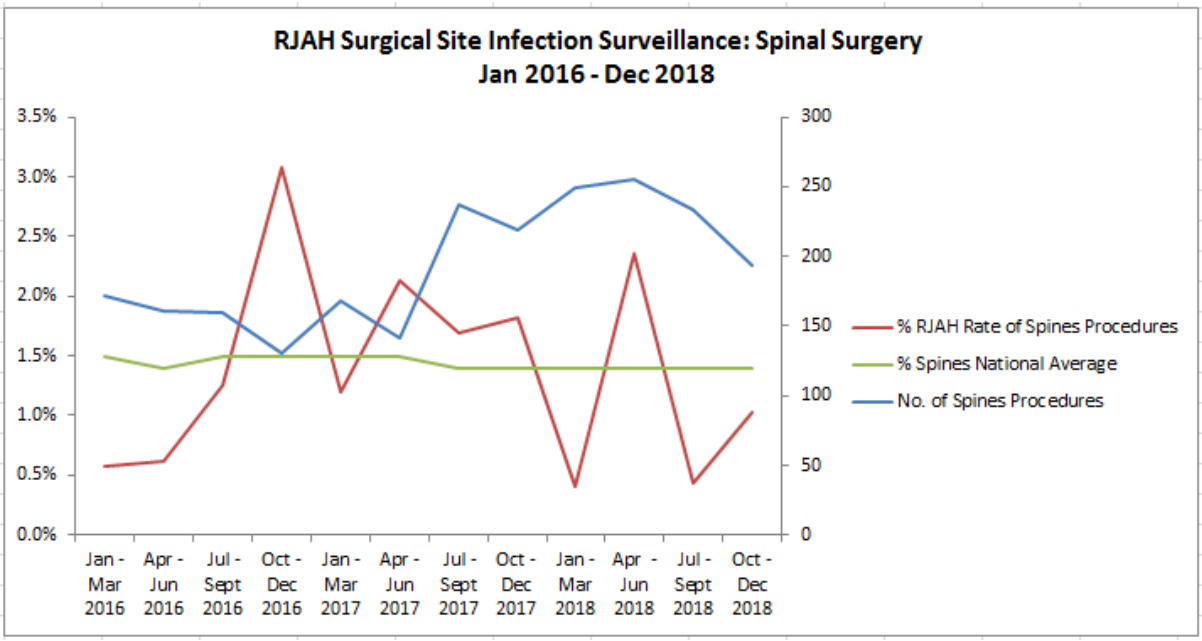
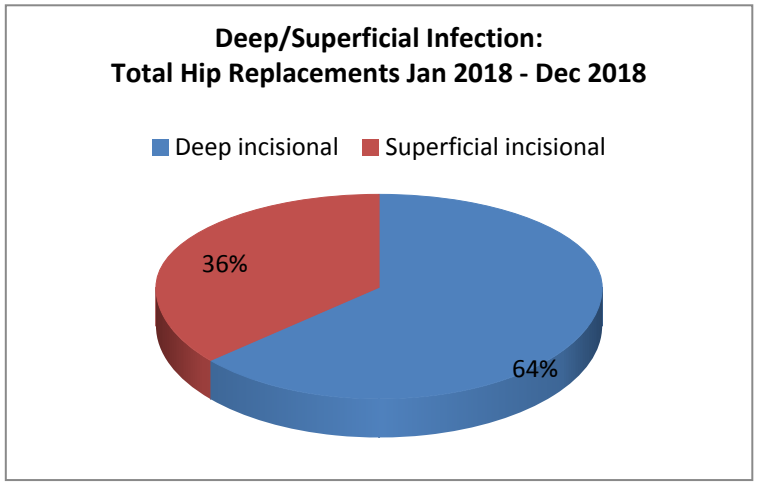
The RJAH rate of SSI for spinal surgery has been below the national average 7 quarters out of the 12 during the period Jan 2016 and Dec 2018, with peaks showing in Oct-Dec 2016 and Apr – Jun 2018.

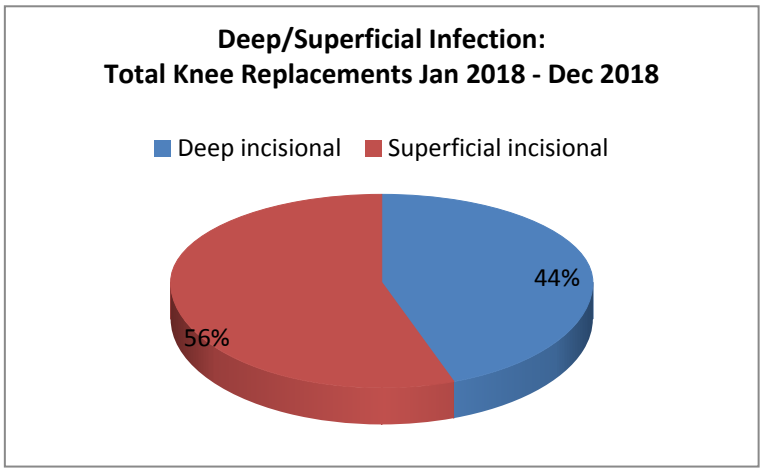


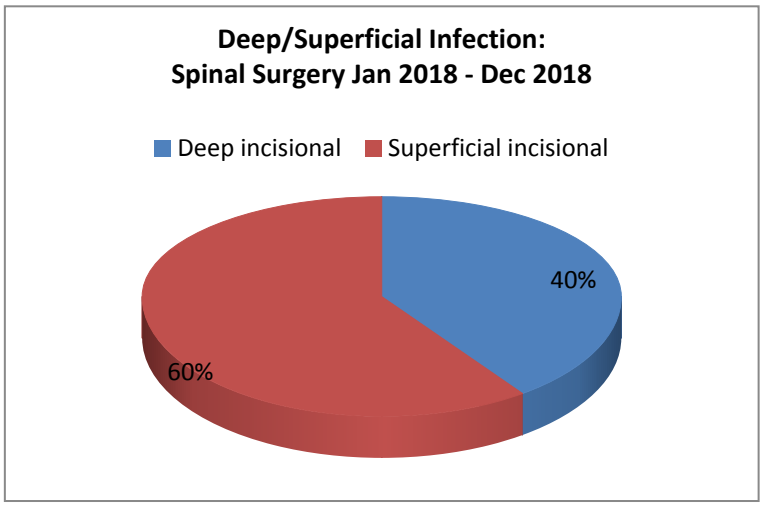
The pie charts below show the infections reported split by Deep/Superficial:

Description of Deep Incisional Infection: SSI involving the deep tissues (i.e. fascial & muscle layers and the infection appears to be related to the surgical procedure.

Description of Superficial Infection: SSI involves only the skin or subcutabeous tissue of the incision.


Deep/Superficial Infection:
Total Hip Replacements Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
36%
64%


Deep/Superficial Infection:
Total Knee Replacements Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
44%
56%


Deep/Superficial Infection:
Spinal Surgery Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
40%
60%

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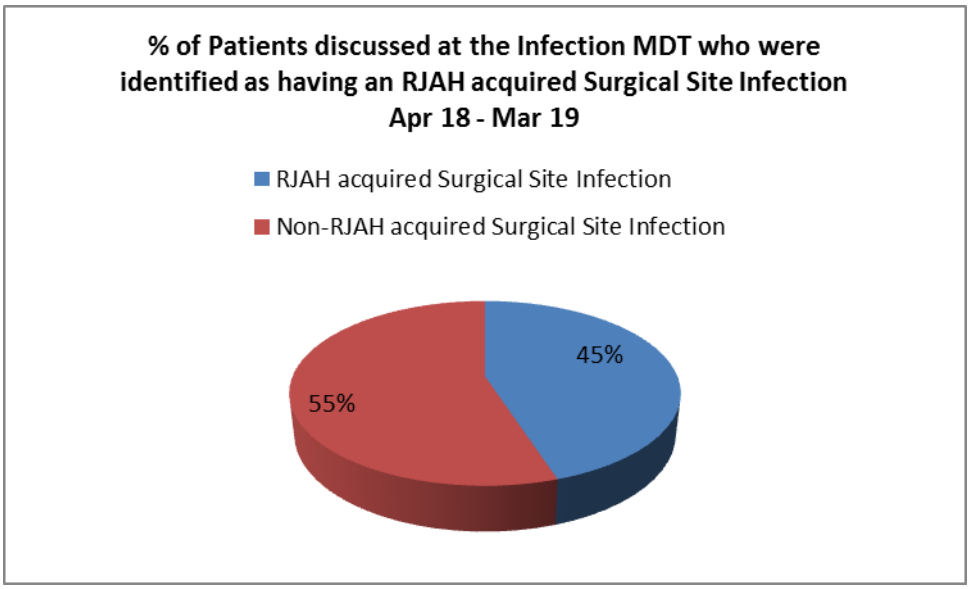
Infection MDT

The Infection MDT commenced during October 2017, led by Consultant Surgeons within the Trust to review all patients who have been identified as having a surgical site infection. The purpose of the MDT is to discuss complex infections and to make recommendations for the surgeons' treatment plan. The Infection MDT is attended by the Consultant Microbiologist, Antimicrobial Pharmacist, the Infection Prevention & Control Team, Radiologist and Histopathologist. It is an opportunity for all surgeons to share learning and peer support.

There have been 189 patients reviewed during 2018/19, of which 85 (45%) were identified as having a surgical site infection which was acquired at RJAH. PHE's Surgical Site Surveillance System requirements are to report hips, knees and spines; the Infection MDT reviews patients from all orthopaedic specialities, e.g. upper limb, lower limb, sports & spinal injuries.

The pie chart below shows the split of RJAH and non-RJAH acquired SSIs during this reporting period:



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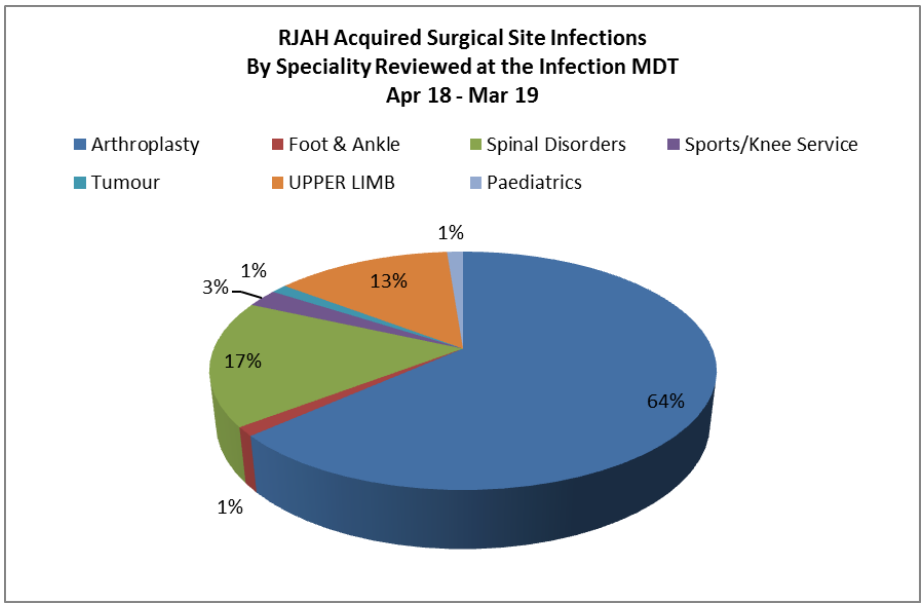
The chart below shows how the RJAH acquired surgical site infections are split by speciality during this reporting period:



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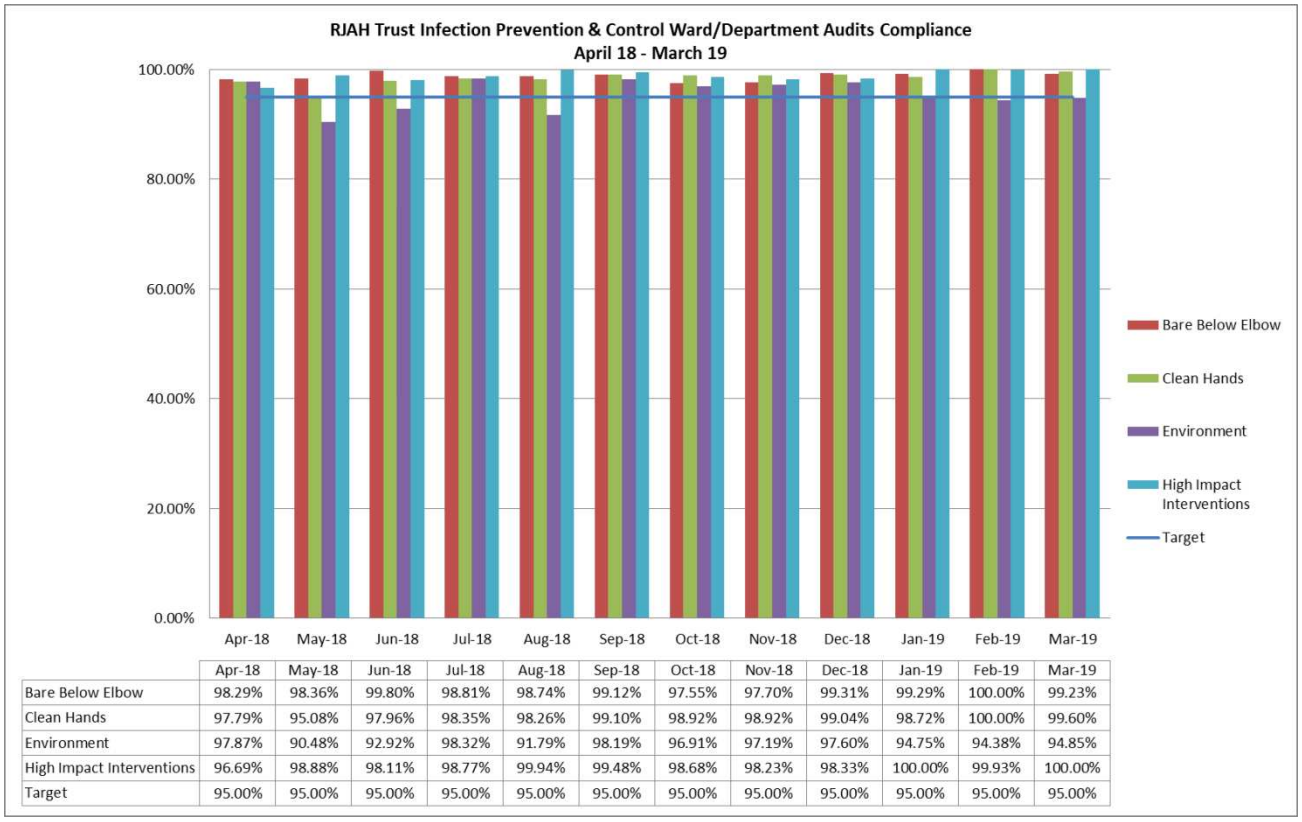
Infection Prevention & Control Ward/Department Audits

Wards and departments complete a robust package of infection prevention and control audits across the year. The toolkit comprises of environmental auditing, which highlights patterns of non-compliance to be addressed, the hand hygiene audit tool includes bare below the elbows and a revised set of High Impact Interventions (Saving Lives) tool was implemented January 2018.

The graph below shows the Trust's compliance against each of the individual audits. The results show how the Trust consistently achieves the 95% target in all areas each month, with the exception of the Environment Audits..



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Bare Below Elbow	98.29%	98.36%	99.80%	98.81%	98.74%	99.12%	97.55%	97.70%	99.31%	99.29%	100.00%	99.23%
Clean Hands	97.79%	95.08%	97.96%	98.35%	98.26%	99.10%	98.92%	98.92%	99.04%	98.72%	100.00%	99.60%
Environment	97.87%	90.48%	92.92%	98.32%	91.79%	98.19%	96.91%	97.19%	97.60%	94.75%	94.38%	94.85%
High Impact Interventions	96.69%	98.88%	98.11%	98.77%	99.94%	99.48%	98.68%	98.23%	98.33%	100.00%	99.93%	100.00%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

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

- Floors clean and in good state of repair
- Waste, bins are enclosed, foot operated and soft closing
- Waste, staff training is up to date
- Waste, bags are not tied to trolleys
- Sharps, temporary closure mechanisms are in use

Staff are encouraged to raise requisitions with the Estates department, waste and sharps awareness sessions have been held at Link meetings to support staff in raising awareness and educate staff within their departments.

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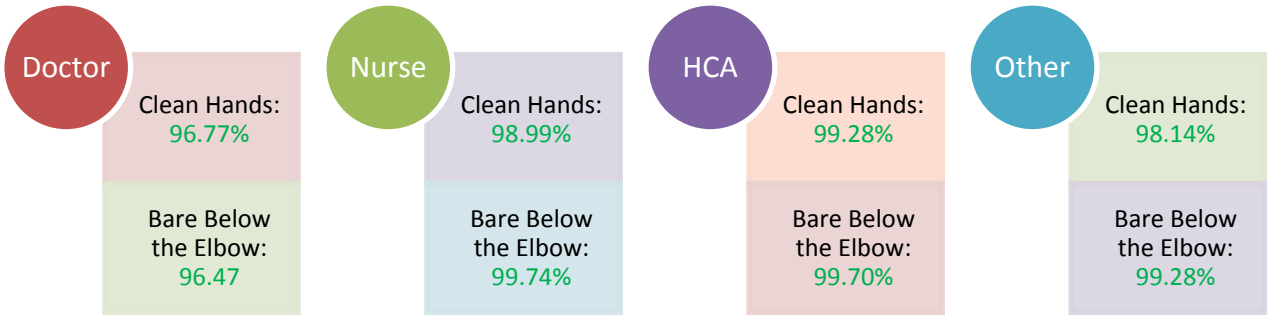
Hand Hygiene & Bare Below the Elbows

The image below shows the hand hygiene and bare below the elbow compliance split by designation. The 'Other' category captures other members of the multi-disciplinary team, such as therapy support, pharmacists and students.



Changes have been made to the hand hygiene audit form to include an action taken section for completion on areas of non-compliance where the noting of the initials of indivuals are encouraged to enable specific feedback to be provided where necessary.

High Impact Interventions (Saving Lives)

During January 2018, a revised set of High Impact Interventions (Saving Lives) audits were implemented across the Trust. The aspects of care, volume and compliance of audits are shown in the following table:

High Impact Interventions	No. audits completed	% Compliance
Antimicrobial Prescribing	354	99%
Antimicrobial Secondary Care	164	98%
Central Venous Access Devices - Insertion Action	185	100%
Central Venous Access Devices – Ongoing Care	1758	100%
Chronic Wounds - Wound Care Phase	1265	100%
Peripheral Vascular Access Devices – Insertion Action	1965	100%
Peripheral Vascular Access Devices – Ongoing Care	9090	98%
Preventing Surgical Site Infections - Intra-Operative Phase	344	100%
Preventing Surgical Site Infections - Pre-Operative Phase	180	100%
Urinary Catheter - Insertion Phase	3372	100%
Urinary Catheter - Routine Maintenance	8892	99%

Quality Validation Auditing

The peer review audits are complemented by validation audits undertaken by the infection control team.

Areas reviewed in 2018/19 are shown below. All areas received copies of audits completed alongside action plan templates and suggestions for improvements in the clinical environment. Staff are encouraged to use the 'Planet FM' system to document environmental issues requiring estates attention.

Theatres

Areas of improvements adressed include:

- De Cluttering of the theatre corridors
- No clear responsibilities for cleaning
- Dust and dirty wheels on the stacks
- Betadine staining to the floors
- Dust and debris to the floors in the ladies changing rooms

TSSU

Areas of improvements adressed include:

- Build-up of scale on the washers
- Floors and walls damaged requiring attention
- Clutter and supplies stoed on the floor
- Difficulty in cleaning TSSU B due to time

Hydrotherapy Pool

Areas of improvements adressed include:

- Staff experiencing heat exhaustion during cleaning
- Cleaning rota not identifying cleaning responsibilities
- Shower chairs require replacement
- A Hydrotherapy Pool standard operating procedure required
- A Hydrotherapy Pool emergency plan required

Orthotics

Areas of improvements adressed include:

- No privacy curtain for when patients undergoing plaster application
- Build- up of scale in the plaster sink
- Cluttered shelves with open stored clinical equipment, recommend cupboard doors to be fitted to prevent collections of plaster dust
- Clinical equipment being stored in an office environment

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Orthotics RSH

Areas of improvements adressed include:

- Limited storage for clinical equipment within clinical room
- Lack of hand hygiene facilities for office staff receiving soiled footwear
- Taping to floor mat damaged and unable to be cleaned effectively
- Poor access to sluice activities
- Poor ventilation

Gladstone

Areas of improvements adressed include:

- Lack of hand washing posters
- Extraneous items stored in the sluice
- Isolation signs not laminated
- Beds stored in corridors
- Linen cages uncovered stored in corridor
- Cluttered lockers
- Cluttered corridors

Alice

Areas of improvements adressed include:

- Wall ares around sinks in bays in poor state of repair
- Plugs in clinical hand wash basins
- No hand hygiene posters above the sinks
- Stained grout and poor finish in parents shower room
- Taps non compliant in sluice

Childrens OPD

Areas of improvements adressed include:

- Hand wash basins non compliant in the plaster room
- Paint peeling in the toilets
- Water pipes exposed in chidrens toilets
- No hand hygiene signs above the sinlks
- Bins not hard sided

Wrekin

Areas of improvements adressed include:

- Build-up of waste in the sluice
- Orange bags next to yellow bags (should be separated)
- Thick dust on the bottom of the observation machine (labelled as clean)
- Rust on floor in bathroom from old bin
- Dressing trolley cluttered and stained
- Cluttered lockers

Other Audits Undertaken include:

- Commode Audit
- Shower Chair Audit

Commodes *19	No. Compliant	% Compliance
Arm Rests Good Condition	14	74%
Back Rest Good Condition	15	79%
Foot Rest Visibly Clean	17	89%
Labelled as Clean	18	95%
Underneath of Seat Visibly Clean	18	95%
Arm Rests Visibly Clean	19	100%
Back Rest Visibly Clean	19	100%
Foot Rest Good Condition	19	100%
Frame Visibly Clean	19	100%
Frame Good Condition	19	100%
Top of Seat Visibly Clean	19	100%
Top of Seat Good Condition	19	100%
Underneath of Seat Good Condition	19	100%
Wheels Visibly Clean	19	100%
Wheels Good Condition	19	100%

Shower Chairs *15	No. Compliant	% Compliance
Labelled as Clean	8	53%
Top of Seat Visibly Clean	12	80%
Foot Rest Visibly Clean	13	87%
Foot Rest Good Condition	13	87%
Top of Seat Good Condition	14	93%
Underneath of Seat Visibly Clean	14	93%
Arm Rests Visibly Clean	15	100%
Arm Rests Good Condition	15	100%

Back Rest Good Condition	15	100%
Back Rest Visibly Clean	15	100%
Frame Visibly Clean	15	100%
Frame Good Condition	15	100%
Underneath of Seat Good Condition	15	100%
Wheels Visibly Clean	15	100%
Wheels Good Condition	15	100%

A rolling replacement programme continues and actions undertaken on individual wards.

A re-audit is scheduled for September 2019.

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

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

Cleanliness

Cleaning is provided by the Trust's in-house team of cleaners and deep cleaners; the internal team is supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis. The department has been supported by the infection control committee to recruit an extra member of staff for the theatre night shift, focusing on TSSU.

Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey. Resources are dynamically moved around the Trust so that the best standard is achieved in all areas.

As part of the agenda for change band 1 closure, all new staff will be appointed to an enhanced role where they will take ownership of the environment, in reporting anything that prohibits them from effectively cleaning. All current staff have also been offered this opportunity.

Cleanliness – Deep Cleaning

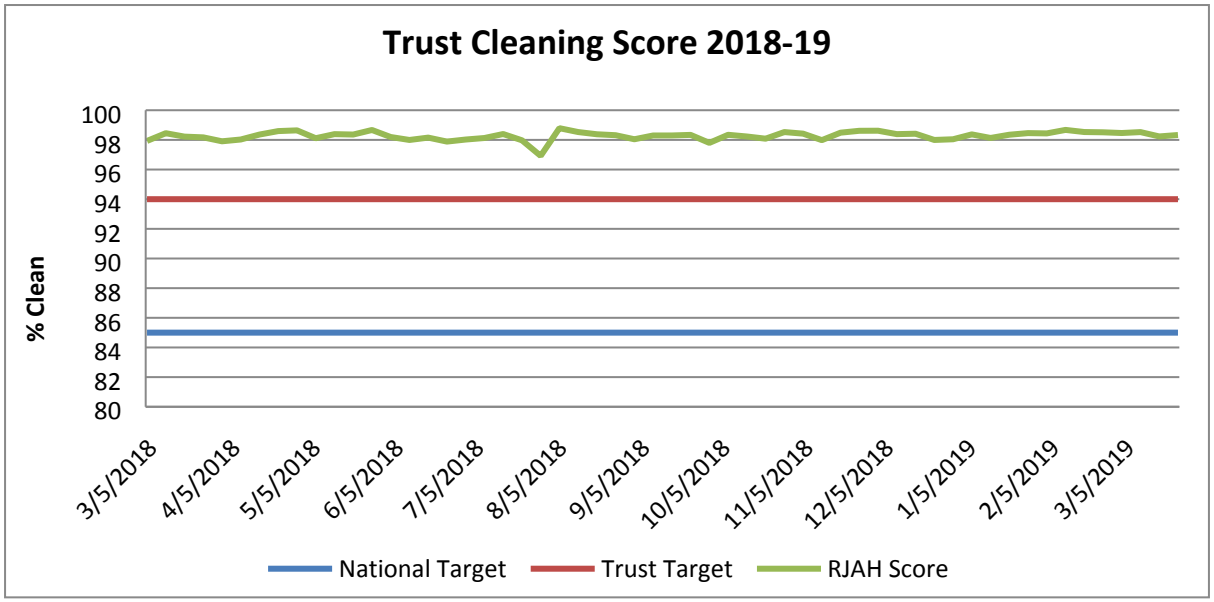
Whilst routine cleaning is completed in all areas on a daily basis, staff in high risk areas are supported with extra staff to complete a deep clean on a weekly basis. In the very high risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these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

In case of an outbreak, the Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment. The Trust now also has a working relationship with Dewpoint Solutions, whose service can be called upon in less than 24 hours. Responses to date have been quick, effective and professional.

5 side rooms have undergone HPV fogging treatment in 2018/19; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

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



Internal monitoring is carried out every day, visiting all areas on a weekly basis. Very high risk areas are monitored by a clinical team to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results, along with the patient survey, go to the Infection Prevention & Control Committee on a quarterly basis.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2018/19 the Trust achieved an average score of 98.27%.

Cleanliness – Patient Satisfaction – Internal

Feedback from service users is very important, internal monitoring very much aligns to the feedback PALS (Patient Advice and Liaison Service) receive from the patient. On a monthly basis an internal team speaks to patients one to one and also reviews feedback forms that the patient can fill in privately. The results are fed back to the Estates and Facilities team to act upon.

Further to the categorisation of cleanliness standards through the patient surveys, the department also reviews every comment as part of its 360° review and learns as a team from negative feedback but also highlights the numerous positive comments associated with the hard work of the cleaning team.

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Overall comments in 2018/19 comments have been very positive, with no overarching negative themes.

Cleanliness and Environment - Kitchen

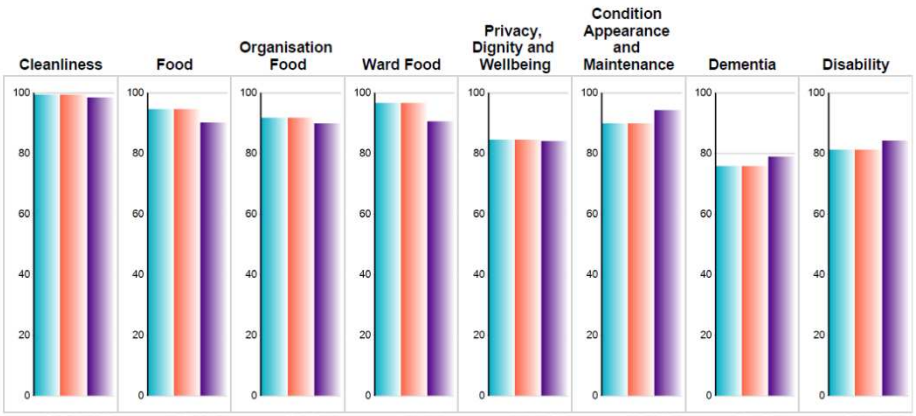
The Trust kitchen retained its 5 star food hygiene rating, undergoing an environmental health inspection in August 2018.

Supporting this inspection, the Trust procures a separate external food safety audit which produces a detailed action plan.

PLACE – Patient Led Assessment of the Care Environment

The 2018 PLACE assessment identified many positives for the Trust and also areas to work upon.

ROBERT JONES & AGNES HUNT ORTHOPAEDIC HOSPITAL- Collection: 2018



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3245.0000	268.7056	108.8275	159.8781	370.6666	1435.0000	681.3571	503.8697
Available Score (Actual)	3264.0000	283.9661	118.5880	165.3781	438.0000	1594.0000	898.8571	620.3697
Site Score	99.42%	94.63%	91.77%	96.67%	84.63%	90.03%	75.80%	81.22%
Organisation Average	99.42%	94.63%	91.77%	96.67%	84.63%	90.03%	75.80%	81.22%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

In relation to cleanliness and the environment;

- The Trust has maintained high scoring feedback across cleanliness and food metrics, shown improvement on privacy, dignity, wellbeing and disability, but has marginally lower scores for condition/appearance and dementia.
- Some findings were easy to address with immediate actions, others raised debate regarding individual perception. Longer term solutions have been raised for consideration in Trust strategies and the department feels that technology will overtake the long term need to fulfil individual criteria.
- Cleanliness maintained its high standard, consistent with previous years and the internal reporting that goes to the Infection Control Committee quarterly. The few issues identified were mostly related to attention to detail, an example build slight build-up of dust in door well ledges; all issues were resolved within days following the report.

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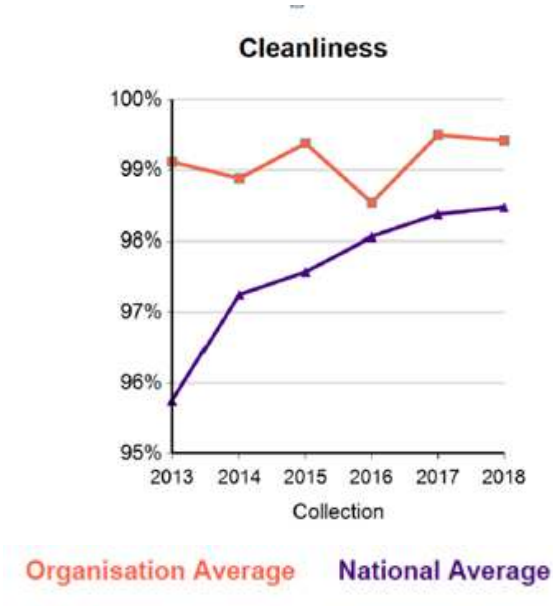


All PLACE elements are addressed through the quarterly Infection Prevention & Control Committee; these include elements that fall outside of Criterion 2; cleanliness and the environment.

In 2018/19; the Estates project team has moved forward with improvement identified through previous PLACE audits and areas picked up through internal & external audits. These have included:

- Refurbishment of Alice ward parent's facilities; including new shower room.

Infection Prevention & Control & Cleanliness Annual Report 2018/19

- Refurbishment of Kenyon ward.


- Addition of 2 additional bays on Powys & Clwyd ward.

- Redesign of Clwyd ward clinical areas to include a designated treatment room.


- Refurbishment of Male staff changing room for theatres.

- Refurbishment of the occupational therapy flat – used by patients on MCSI.

Linen

In 2018/19; quarterly review meetings continued to ensure standards relating to the provision of linen were monitored. This has included closing out of the action plan following a site audit and procuring bespoke washable covers for contingency linen supplies.

Estates Department Contribution to the Clean and Appropriate Work Environment

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

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

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

Part A: Design, installation and testing and

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

Changes to the Estates’ management structure in Q3 18/19 has led to the appointment of an Estates Manager - Compliance and Sustainability, and substantial work has been undertaken since to increase the robustness of the department’s management of conformity to relevant legislation and guidance of such.

The Estates and Facilities helpdesk system, which also incorporates the planned maintenance tracker, has been recently upgraded with a rollout later in the summer. This will enable Estates and Facilities to monitor and report on progress of works and compliance.

Water

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

Water safety is managed and controlled by the estates department to guidance HSG274 and HTM 04. The Estates department continues to employ a third party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years, or where required following incidents or significant infrastructure changes. There is a written site specific scheme of control for each inpatient premises. Eurofins provide an internet based water testing database storage and reporting for statutory

test results. There is also a three monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

The Trust have appointed an Authorising Engineer (Water) (AE(W)) in Q3 18/19. The AE(W) is a 'critical friend', a requirement of HTM 04-01b and offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

Estates Operational Service continually undertake water tests throughout the Trust estate, this water testing is carried out under legislation and guidance set out by The Health & Safety Executive and the Department of Health. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as leginaellosis; it is a method of using quantitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. During April 18 – March 19 at total of 975 water sample tests were undertaken, this is a greater frequency than required by guidance, the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to these tests, thermal disinfection has been undertaken in some areas domestic water supplies – this process has increased efficacy and reduces costs as the works are now completed by the in house Estates' Mechanical Technicians. Disinfection is often employed to manage domestic water hygiene.

Decontamination Group

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

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

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

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

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

For the year 2018/19, all theatres passed their reverification based on their install specification. The Trust AE (Ventilation) has been sighted on all reports and any remedial works required.

Installation of a local Reverse Osmosis (RO) Plant was completed in Q4 18/19. This equipment increases patient safety by supplying pure water to the endoscope washer in line with HTM 01-01d and BSEN 15883.

Ultrasonic bath periodic testing and washer disinfector (endoscopy) periodic testing is being brought in house and will be completed by the Estates Technicians from Q1 19/20.

Best Practice Sharing

The Estates & Facilities team has actively participated in sharing of good practice – this year collaborating with Shrewsbury & Telford Hospitals, The Walton Centre and Cumbrian Partnership NHS Foundation Trust.

Key areas of discussion have included:

- Monitoring – systems, public signage and action allocation.
- Compliance – particularly in relation to the Premises Assurance Model (PAM).
- Water Safety – training, control measures and general awareness of the implications of water hygiene.

Clinical Waste

The Trust had to instigate its contingency plans with regards to disposal of clinical waste. The whole team pulled together to ensure that site and site user safety was maintained at all times. There have been no incidents relating to the management of waste on site, the Trust reports on a frequent basis to NHSi and no concerns have been raised.

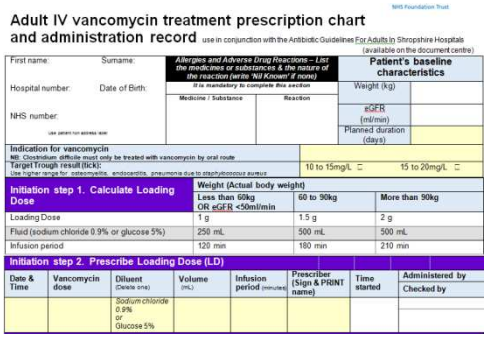
Whilst the situation has more control, the department is still working hard with its partners to ensure the smooth and compliant running of the waste service at the Trust.

3.2.4. Criterion 3: Ensure appropriate antimicrobial use

Pharmacy

Antimicrobial Stewardship 2018-19
At RJAH

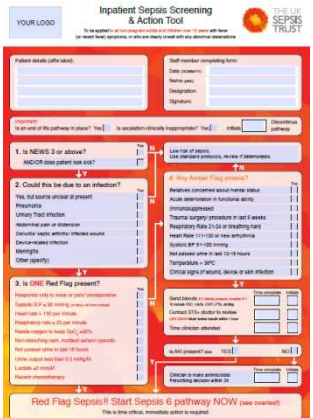
ANTIMICROBIAL STEWARDSHIP



Adult IV vancomycin treatment prescription chart and administration record

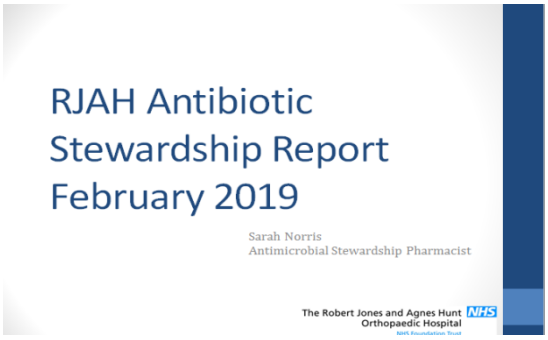
Trust wide implementation of vancomycin chart, improving vancomycin treatment dosing and patient safety.

Introduction of a Gentamicin calculator onto the RJAH intranet (Applications section), to improve gentamicin prescribing and patient safety.



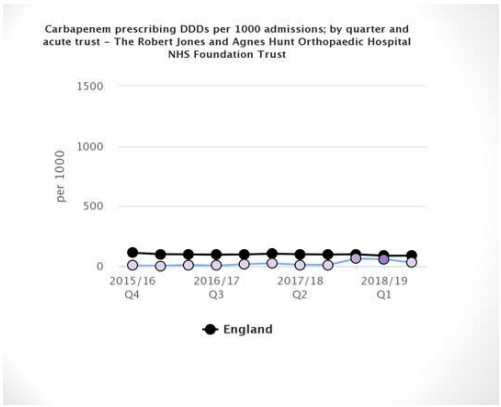
Inpatient Sepsis Screening & Action Tool

Achievement of CQUIN targets for first two quarters of the year for the review of antibiotic prescriptions for patients with sepsis



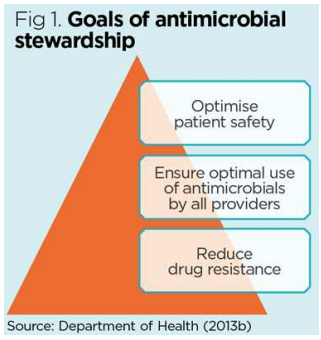
Continued contribution to the 'Local Health economy infection prevention and control and antimicrobial prescribing group' on a quarterly basis.

Continuation of ongoing programme of audit & feedback. Quarterly Point Prevalence Studies to monitor adherence to 'Start Smart- Then Focus' principles from PHE's Antimicrobial Stewardship toolkit



CQUIN payments received for total consumption of antibiotics and carbapenem usage based on low usage compared to use nationally.

Antimicrobial stewardship awareness presentation at LINK nurse meeting.



Antimicrobial Stewardship Pharmacist attendance and contribution at Infection MDT.

Pharmacist qualified as a non-medical prescriber in specific areas of antibiotic prescribing

Pharmacist attendance at The West Midlands Antimicrobial pharmacist's quarterly meeting. This aims to work collaboratively to improve standards & efficiency of antimicrobial pharmacy practice across the region, sharing best practice and innovation and bench marking regional practice.

The following are aspirations for 2019-20

Introduction of a box in the Emergency Drug Cupboard (EDC) containing antibiotics required if sepsis diagnosed in a person other than an inpatient e.g. a clinic attender or visitor.

Implementation of new drug card, incorporating specific sections for antibiotic prescribing.

To Dip or Not to Dip?

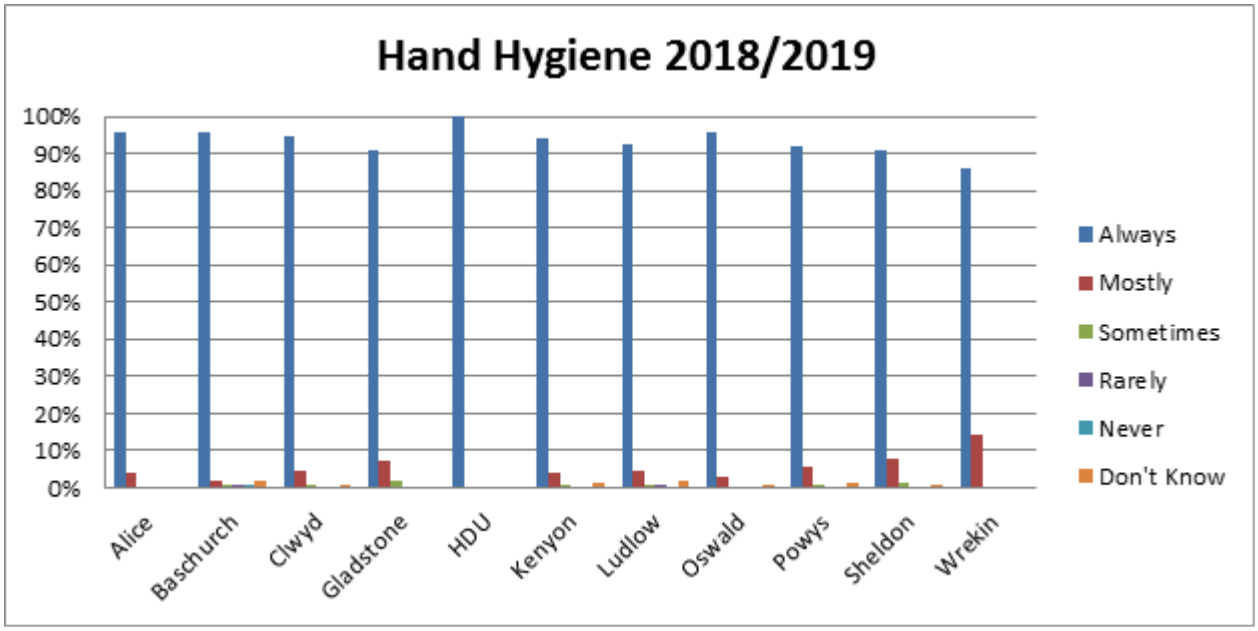
Achievement of Antimicrobial resistance CQUIN 2019/20: Lower urinary tract infection in over 65 year olds.

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

All patients with alert organisms are seen by the infection control nurse and information leaflets are provided. The microbiologist will also give advice and support to patients and their relatives upon request.

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

The patient comment cards are used as a resource of data – including a specific question asking "Did the staff practice good hand hygiene". The results shown below provide encouraging feedback from a patient's perspective.



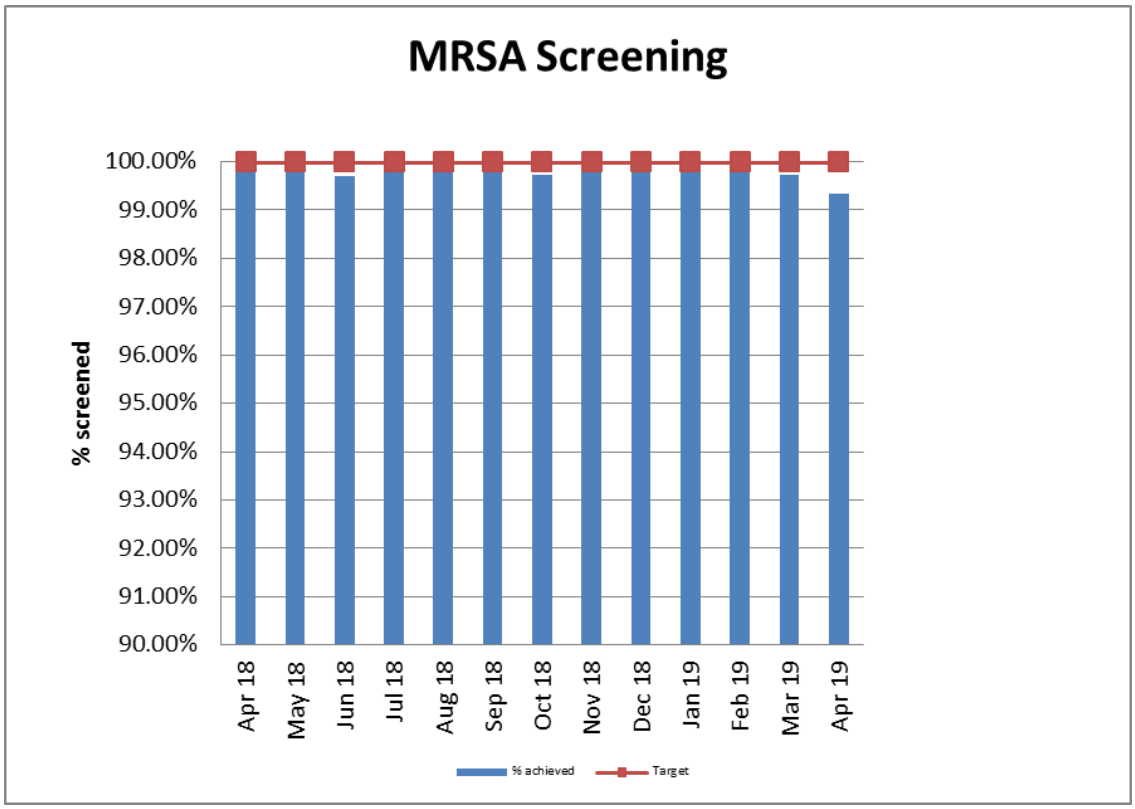
3.2.6. Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection

Patients who are at risk or require extra attention – this includes those unable to maintain high levels of hygiene standards, with poor quality skin or at risk of falls. Stakeholders receive an email with patient summaries and suggestions of actions to be in place in readiness for admission & surgery.

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

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

Infection Prevention & Control & Cleanliness Annual Report 2018/19



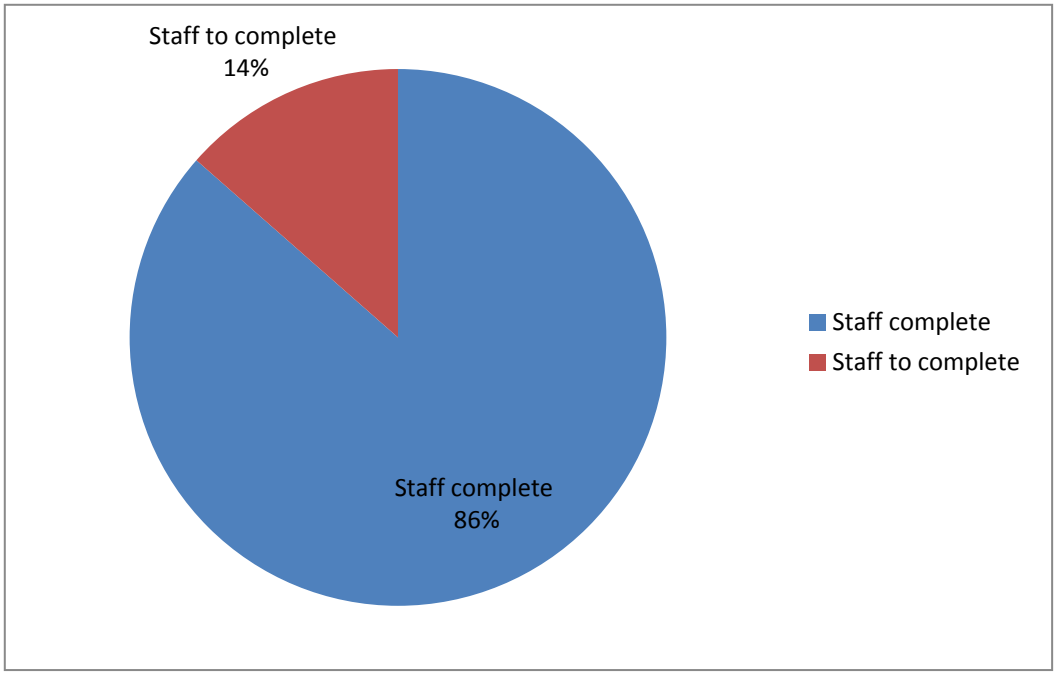
	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Eligible patients	835	1032	1049	1080	930	1025	1129	1145	895	1104	1007	1078
Screened for MRSA	835	1030	1046	1078	930	1025	1126	1145	894	1105	1005	1075
% achieved	100.00%	99.81%	99.71%	99.81%	100.00%	100.00%	99.73%	100.00%	99.89%	100.09%	99.80%	99.72%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

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

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

The provision of IPC training is met through provision of a mandatory e-learning package based on Department of Health evidence based infection control guidelines. In total, out of 1294 staff, 1119 have completed this training with 175 staff still to complete by the end 2018/19.



Additional training sessions provided by the IPCN include:

- Induction training of 45 minutes for all clinical and non-clinical staff (separate sessions for junior hospital doctors).
- All new/rotational doctors receive a short induction session provided by the IPCN.
- All volunteers receive a short training presentation and hand hygiene education.
- The team is part of the work experience programme run by the Trust on a quarterly basis.
- Provided 'train the trainer' education for link practitioners.
- Engage in the work experience programme based at RJAH
- Engage in the Trust preceptorship programme
- Provided workshop training sessions at ward training days
- Well received face to face training for groups of staff such as:
  - Catering
  - Porters
  - Domestics
  - Estates Maintenance staff

3.2.8. Criterion 7: Provide or secure adequate isolation facilities

The Trust has always been able to accommodate patient isolation with minimal disruption to the running of the wards. However, due to the increase of patients carrying antibiotic resistant organisms requiring siderooms for isolation, provisions have been made for the installation of additional doors to the bays on the spinal injuries unit to enable patients with the same carriage to be cohorted together in an isolated bay with the doors acting as a barrier as well as a reminder for staff to implement standard precautions.

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

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

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

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

Infection Prevention & Control Policies & Standard Operation Procedures (SOP) are reviewed and agreed at the Infection Prevention & Control Committee.
IPC currently operates with 1 Infection Prevention & Control Policy, A framework of Infection Prevention & Control and 30 specific IPC SOP.

Policies Reviewed Published in 2018- 19	
Infection Control in the Built Environment Policy	Infection Prevention and Control Policy
Infection Control in the Built Environment Procedure	Infection Control Framework Strategy
Waste Policy	Scabies and Lice
Waste Procedure	

There has been a backlog of policies being reviewed as a result of other priorities, therefore a programme to review is set as a priority for 2019/20.

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

Team Prevent Occupational Health and Employee Wellbeing

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

Flu Campaign

Team Prevent support the Trust with their annual Seasonal Flu Immunisation Programme. The final submission results for 2018/19 season resulted in achieving 59% of all frontline healthcare workers having the flu vaccine.

Blood Borne Virus Exposure Incidents

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

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

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

2018/19 exposure incidents reported to Team Prevent was 37 which is a slight increase from 2017/18 figures if 34. 87% were due to a percutaneous injury, 10% due to a mucotaneous injury and the remaining 3% were identified as being a low risk injury.

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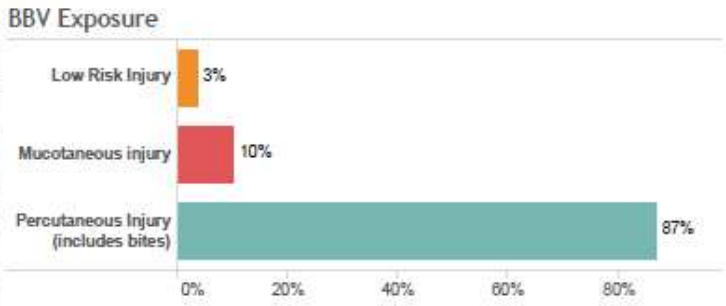
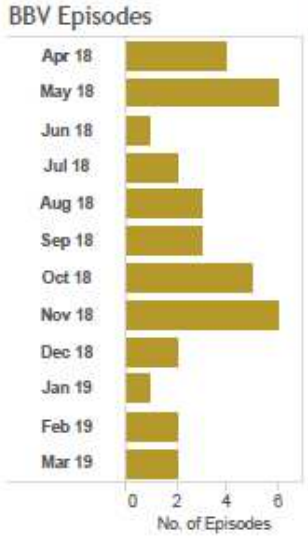
Team prevent

Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2018 to 31 March 2019
(months with zero data will not be displayed)

Innoculation/BBV Incidents

		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total
RJAH	Null	1			1		1		1	1			2	7
	Anaesthetics	1												1
	Arthritis Research Centre							1						1
	High Dependency Unit							1						1
	Housekeeping					1								1
	MCSI	1	1											2
	Orthopaedics									1				1
	Powys Ward		1								1			2
	Radiology						1							1
	Spinal Injury and Rehabilitation					1			2					3
	Theatre					1								1
	Theatres						1	1	1			1		4
	Theatres - Consultant Surgeons	1	1		1			1	2					6
	Trauma & Orthopaedics		1					1				1		3
	Tssu		2	1										3
	Total	4	6	1	2	3	3	5	6	2	1	2	2	37
Grand Total		4	6	1	2	3	3	5	6	2	1	2	2	37





Neddlestick Hospital Attended

Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2018 to 31 March 2019

(months with zero data will not be displayed)

		Month of Episode Start Date												
Question	Quest Answer	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Grand ..
Was the Injury reported out of hours and the individual obtained treatment or asse..	No	1	4	1	2	3	2	5	6	1	1	2	2	30

Classification Glossary

Low Risk Bodily Fluids - These fluids are not considered a risk UNLESS they are visibly blood stained: urine, vomit, saliva, faeces, nasal secretions, sputum, sweat, tears

Low Risk Injury - Splash on intact skin (there is no known risk of BBV transmission from exposures to intact skin)

Mucotaneous Exposure - is an exposure where there is direct contact of blood/body fluid with eyes, nose & mouth or broken skin e.g. uncovered cuts, abrasions or eczema not covered with waterproof dressing)

Percutaneous Injury (including bites) - is an exposure incident in which penetration of the skin occurs by a needle or other sharp object which may have been in contact with blood, tissue, or other body fluid before the exposure.

Safer Sharp Regulations

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

Following a recent review of safer sharps it was highlighted that there were non-safer sharps devices in use, therefore RJAH is failing to comply with above regulations.

An audit across all departments within the Trust has been planned for April 2019 and results to be fed back to the Innovation Committee.

3.3. Serious Incidents/ Periods of Increased Incidence

There were no Infection Prevention & Control Serious Incidents reported during 2018/19.

3.4. Conclusion

The year 2018/19 was another successful period in meeting the targets set by Public Health England and the Clinical Commissioning Group at RJAH Orthopaedic Hospital, with the exception of C.*difficile* and learning that the Trust has gained from these cases has increased staff awareness and effectiveness in the management of C.*difficile* infection.

The Infection prevention and control team have continued to provide an essential service to the Trust encompassing the Infection Prevention and Control service and surgical site surveillance service, microbiology ward rounds, post infection review/root cause analysis meetings and audit.

A highlight of 2018/19 was the recruitment of an additional 25hr Surgical Site Surveillance Nurse which will expand our surveillance capabilities within surgical site infections alongside increased tissue viability support for wards.

Bev Tabernacle: Director of Infection Prevention and Control

Sue Sayles: Infection Prevention and Control Nurse

June 2019

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Key Areas of Focus for 18/19

- Achieving PHE National & CCG Infection targets
- PIR of all patients reported with positive blood cultures
- IT Solution for Infection Prevention & Control
- Improve website and intranet
- Participation of Getting It Right First Time
- Extend Tissue Viability Provision
- Introduce annual competencies for ANTT.
- Provide a 5 day Wound Clinic service
- Policy Review
- Additional surgical site surveillance for all Orthopaedic Specialities

Appendix 1: Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Not Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
EPR	Electronic Patient Record
ESBL	Extended Spectrum Beta Lactamase
GIRFT	Getting It Right First Time
HCAI	Healthcare Associated Infection
HEE	Health Education England
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
IV	Intravenous
JAC	JAC – Electronic Pharmacy System
KPI's	Key Performance Indicators
MDT	Multi Disciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PALS	Patient Advice and Liason Service
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

Appendix 1: Acronyms Continued:

RCA	Root Cause Analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SCCG	Shropshire Clinical Commissioning Group
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
STAR	Sustaining Through Assessment and Review
TSSU	Theatre Sterile Services Unit
VIP	Visual Infusion Phlebitis
WTE	Whole Time Equivalent

Appendix 2: Glossary

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

Learning From Deaths

0. Reference Information

Author:	Dr James Neil, Trust Lead	Paper date:	18th July 2019
Executive Sponsor:	Mr Steve White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	N/A
Forum submitted to:	Quality & Safety Committee 18/07/219 Board of Directors 25/07/2019	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to Board.

Review of numbers.

2. Executive Summary

2.1. Context

To report the current numbers in 2019 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns identified.

All deaths expected and no issues with care.

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes	Actions/Learning Identified
March 2019	1	1	0	0	None	None
April 2019	0	0	0	0	None	None
May 2019	1	1	0	0	None	None
June 2019	1	1	0	0	None	Yes

3.3. Associated Risks

None identified.

3.4. Next Steps.

Dr Neil has met with the Shropshire community health NHS trust with the aim of sharing LFD learning with them and with SATH. Liaison plans ongoing to include SATH in annual meeting.

The Board is asked to:

Note the summary numbers.

3.5. Conclusion

Learning generated from June death. A clarification in the role of end of life care planning was required.

Ward in question now has increased awareness of EOL plan and appropriate access to documentation.

National RESPECT process (https://www.respectprocess.org.uk/) is due to roll out later this year in Shropshire which formalises end of life care and treatment ceiling discussions.

Appendix 1: Acronyms

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

PROMs Performance Overview

0. Reference Information

Author:	Samantha Davies, Quality Outcomes Manager	Paper date:	23rd July 2019
Executive Sponsor:	Steve White, Medical Director	Paper Category:	Performance
Paper Reviewed by:	Quality and Safety Committee (20/06/19)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is to note finalised 2017/18 Patient Reported Outcome Measures (PROMs) performance for the Trust for Hip Replacement and Knee Replacement surgery.

2. Executive Summary

2.1. Context

The NHS Patient Reported Outcome Measures (PROMs) programme in England was introduced in 2009 for Hip Replacement and Knee Replacement surgery. The questionnaires provide an indication of the outcomes or quality of care delivered to our NHS patients. This report provides a brief background on the modelling of health gains whilst reporting the finalised performance for 2017/18 published in February 2019. Data are provisional until a final annual publication is released each year.

2.2. Summary

The report will summarise the PROMs participation, national adjustments made and summarise 2017/18 finalised performance alongside other providers for comparison. The report will therefore cover:

- PROMs participation
- Modelling of Health Gains
- RJAH Finalised Performance – 2017/18
  - Primary Knee Replacement Outcome Scores: - 2017/18 Finalised Data
  - Revision Knee Replacement Outcome Scores: - 2017/18 Finalised Data
  - Primary Hip Replacement Outcome Scores: - 2017/18 Finalised Data
  - Revision Hip Replacement Outcome Scores: - 2017/18 Finalised Data
  - Knee Replacement Outcome Score Charts
  - Hip Replacement Outcome Score Charts

2.3. Conclusion

The committee are requested to note the published performance on the Trusts patient reported outcome measures.

3. The Main Report

3.1. Introduction

The NHS Patient Reported Outcome Measures (PROMs) programme in England was introduced in 2009 for Hip Replacement and Knee Replacement surgery. It measures health gain in patients undergoing hip replacement and knee replacement procedures in England, based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients.

The Quality Outcomes Team aims to have face-to-face contact with every patient that is coming in for hip or knee surgery. This is to explain the importance of populating the national PROMs form to aid with pathway assessments and monitor their improvement.

The PROMs form is non-mandatory for patients to populate however it is considered best practice as part of understanding the quality of care delivered to our patients. Patient reported health gains in primary knee and hip replacements are therefore also one of the measures monitored for achievement of best practice tariff. Providers must not have an average health gain significantly below the national average. For 2017/19 this was updated to be not below the lower 99.8% control limit based on the most recently published data. A minimum participation rate of 50% also falls part of the requirements for best practice tariff.

3.1.1. PROMs Participation

The summary below shows the PROMs participation and linkage with activity for the Trust for the financial year 2017/18.

The participation rates presented are estimates. The source is NHS Digital. There may be some imprecision due to preoperative questionnaires (Q1) and eligible episodes relating to different months, as patients may complete the Q1 up to months before their operation. Postoperative questionnaire (Q2) response rates are likely to be an underestimate of the true rate for more recent reporting periods, due to time delays in the return of postoperative questionnaires.

Participation Key

- Q1 = preoperative questionnaire
- Q2 = postoperative questionnaire
- HES = Hospital Episode Statistics (*submitted hospital activity*)

Table 1: Knee Replacements PROMs Participation (Primary and Revision)

DQ Item	Number	Rate	National Rate
Q1s Received	1,493	94.7%	90.2%
Q2s Issued	1,492	99.9%	96.2%
Q2s Returned	1,209	81.0%	71.1%
Q1 & HES Match	1,335	89.4%	74.1%
Q1 & Q2 Match	1,209	81.0%	68.4%
Q1 & Q2 & HES Match	1,090	73.0%	56.7%
Consent Withheld from Care Prof.	24	1.6%	2.6%

Table 2: Hip Replacements PROMs Participation (Primary and Revision)

DQ Item	Number	Rate	National Rate
Q1s Received	1,270	94.8%	88.4%
Q2s Issued	1,268	99.8%	96.2%
Q2s Returned	1,051	82.9%	72.5%
Q1 & HES Match	1,186	93.4%	76.9%
Q1 & Q2 Match	1,051	82.8%	69.7%
Q1 & Q2 & HES Match	991	78.0%	59.0%
Consent Withheld from Care Prof.	24	1.9%	2.4%

3.1.2. Modelling of Health Gains

When interpreting the organisational level results it is important that the trends shown are taken to be a starting point for further investigation rather than giving a definitive conclusion on organisational performance.

The health gains published by NHS England only include patients if they have 'complete' outcome scores from both preoperative and six-month postoperative questionnaires. Further adjustments are also done to take in to account case-mix variables (such as, age, gender, ethnicity, deprivation index derived from postcode).

The national adjustments for case-mix have been calculated using statistical models which account for the fact that each provider organisation deals with patients with different case-mixes. This is intended to allow fair comparisons between providers and England as a whole, but is not backed up by peer reviewed scientific literature and we believe that both the adjusted and unadjusted scores should always be quoted.

Some of the RJAH modelled exclusions to note are therefore as follows:

- Excludes patients where not all questions required for outcome scores were answered on the currently paper collected forms.
- Q1, Q2 and HES matches were not made.
- Case-mix variable information required as part of adjustments is incomplete. This for RJAH as an example means patients of Welsh residence will not be included as one of the adjustments uses the English Index of Multiple Deprivation (IMD). The IMD ranks each small area in England and therefore excludes patients living outside of England.

3.1.3. RJAH Finalised Performance – 2017/18

This section will display 2017/18 finalised results (updated February 2019) and historical performance for Oxford hip and knee scores. EQ-5D Index and EQ VAS score changes are not shown within this report but are available for further assessment.

The results are published with a choice of two control limits, representing two levels of statistical confidence. For a provider outside the 99.8% limits, statistical theory provides that there is a 1 in 500 chance that their results would have been so far from the England rate merely because of random variation in their patients (1 in 20 for a provider outside the 95% limits) and so there is a good indication that there is something within that provider's control that caused so substantial a difference. It does not mean that the provider is necessarily doing something 'good' (if above the upper limit) or 'bad' (if below the lower limit), but might warrant further investigation. Significantly better or worse providers are known as outliers.

Extreme results may not be down to clinical reasons. They could also be caused by random variation (irregular and erratic fluctuations or chance factors that, in practical terms, cannot be anticipated, detected, identified, or eliminated); by data quality issues; or by differences in patients' ability to benefit from the surgery that cannot be identified from the data.

The Trust receives patient level information back through NHS digital for further interpretation where the patient has consented to information from their questionnaires being shared. Utilising all intelligence available to demonstrate variance and understand the outcomes of our patients is an area that could be evolved further at our Trust.

3.1.4. Primary Knee Replacement Outcome Scores: - 2017/18 Finalised Data – Oxford Knee Score

The data source is NHS Digital. This is the finalised data release for financial year 2017/18 published in February 2019.
The unadjusted health gain for RJAH is 19.591. The modelling to obtain the adjusted health gain has reduced this to 18.541.
Shrewsbury and Telford Hospital as a local provider and the Specialist Orthopaedic alliance founder members are shown in the comparison table below.

The trust is reporting for the financial year of 2017/18 with the largest adjusted average health gain against Shrewsbury and Telford Hospital and the Specialist Orthopaedic alliance founder members.

Organisation level	Organisation name	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened	Adjusted average Post-Op Q score	Adjusted average Health Gain	Standard Deviation of adjusted Health Gain
England	ENGLAND	42,276	18.994	36.253	17.259	40,119 (94.9%)	342 (0.8%)	1,815 (4.3%)	36.253	17.259	8.390
Provider	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION	697	17.733	37.324	19.591	679 (97.4%)	2 (0.3%)	16 (2.3%)	37.535	18.541	8.039
Provider	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (RXW)	139	15.907	35.748	19.842	135 (97.1%)	0 (0.0%)	4 (2.9%)	36.940	17.946	8.614
Provider	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST (RRF)	834	17.131	35.499	18.368	799 (95.8%)	5 (0.6%)	30 (3.6%)	36.676	17.682	8.748
Provider	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RTH)	584	19.654	37.783	18.128	557 (95.4%)	5 (0.9%)	22 (3.8%)	37.442	18.447	8.282
Provider	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ)	577	17.825	35.815	17.990	554 (96.0%)	10 (1.7%)	13 (2.3%)	36.880	17.886	8.117
Provider	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN)	94	19.372	30.745	11.372	83 (88.3%)	1 (1.1%)	10 (10.6%)	32.150	13.156	8.383

**Please see Appendix 2 for descriptions of measures shown above.*

3.1.5. Revision Knee Replacement Outcome Scores: - 2017/18 Finalised Data – Oxford Knee Score

The data source is NHS Digital. This is the finalised data release for financial year 2017/18 published in February 2019.
The unadjusted health gain for RJAH is 14.870. The modelling to obtain the adjusted health gain has reduced this to 14.392.
Shrewsbury and Telford Hospital as a local provider and the Specialist Orthopaedic alliance founder members are shown in the comparison table below.

Case-mix adjusted figures not calculated where there are fewer than 30 modelled records. The whole row is highlighted in grey italics.

Organisation level	Organisation name	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened	Adjusted average Post-Op Q score	Adjusted average Health Gain	Standard Deviation of adjusted Health Gain
England	ENGLAND	1,665	16.548	29.673	13.124	1,455 (87.4%)	37 (2.2%)	173 (10.4%)	29.673	13.124	10.011
Provider	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION	54	14.315	29.185	14.870	52 (96.3%)	1 (1.9%)	1 (1.9%)	30.941	14.392	9.435
Provider	*SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (RXW)*	*7*	*15.857*	*23.286*	*7.429*	*5 (71.4%)*	*0 (0.0%)*	*2 (28.6%)*	*	*	*
Provider	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST (RRF)	60	14.000	28.383	14.383	56 (93.3%)	1 (1.7%)	3 (5.0%)	30.011	13.463	9.438
Provider	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RTH)	71	16.282	29.155	12.873	62 (87.3%)	2 (2.8%)	7 (9.9%)	28.990	12.442	10.203
Provider	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ)	60	15.350	28.467	13.117	51 (85.0%)	4 (6.7%)	5 (8.3%)	31.030	14.481	10.069
Provider	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN)	45	15.400	25.000	9.600	37 (82.2%)	2 (4.4%)	6 (13.3%)	26.787	10.238	9.774

**Please see Appendix 2 for descriptions of measures shown above.*

3.1.6. Primary Hip Replacement Outcome Scores: - 2017/18 Finalised Data – Oxford Hip Score

The data source is NHS Digital. This is the finalised data release for financial year 2017/18 published in February 2019.
The unadjusted health gain for RJAH is 25.615. The modelling to obtain the adjusted health gain has reduced this to 23.574.
Shrewsbury and Telford Hospital as a local provider and the Specialist Orthopaedic alliance founder members are shown in the comparison table below.

Organisation level	Organisation name	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened	Adjusted average Post-Op Q score	Adjusted average Health Gain	Standard Deviation of adjusted Health Gain
England	ENGLAND	36,000	17.399	40.079	22.680	35,214 (97.8%)	139 (0.4%)	647 (1.8%)	40.079	22.680	7.703
Provider	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION	585	15.130	40.745	25.615	574 (98.1%)	2 (0.3%)	9 (1.5%)	40.973	23.574	7.686
Provider	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (RXW)	147	14.510	39.626	25.116	147 (100.0%)	0 (0.0%)	0 (0.0%)	41.041	23.642	7.750
Provider	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST (RRF)	878	16.683	40.149	23.466	867 (98.7%)	1 (0.1%)	10 (1.1%)	40.314	22.915	7.549
Provider	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RTH)	492	18.270	40.272	22.002	483 (98.2%)	0 (0.0%)	9 (1.8%)	39.913	22.515	7.699
Provider	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ)	677	18.276	40.059	21.783	666 (98.4%)	3 (0.4%)	8 (1.2%)	40.112	22.713	7.520
Provider	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN)	85	17.118	37.906	20.788	80 (94.1%)	0 (0.0%)	5 (5.9%)	38.442	21.044	9.484

**Please see Appendix 2 for descriptions of measures shown above.*

3.1.7. Revision Hip Replacement Outcome Scores: - 2016/17 Finalised Data – Oxford Hip Score

The data source is NHS Digital. This is the latest provisional data release for financial year 2016/17 published in June 2018.
The unadjusted health gain for RJAH is 17.667. The modelling to obtain the adjusted health gain has reduced this to 15.912.
Shrewsbury and Telford Hospital as a local provider and the Specialist Orthopaedic alliance founder members are shown in the comparison table below.

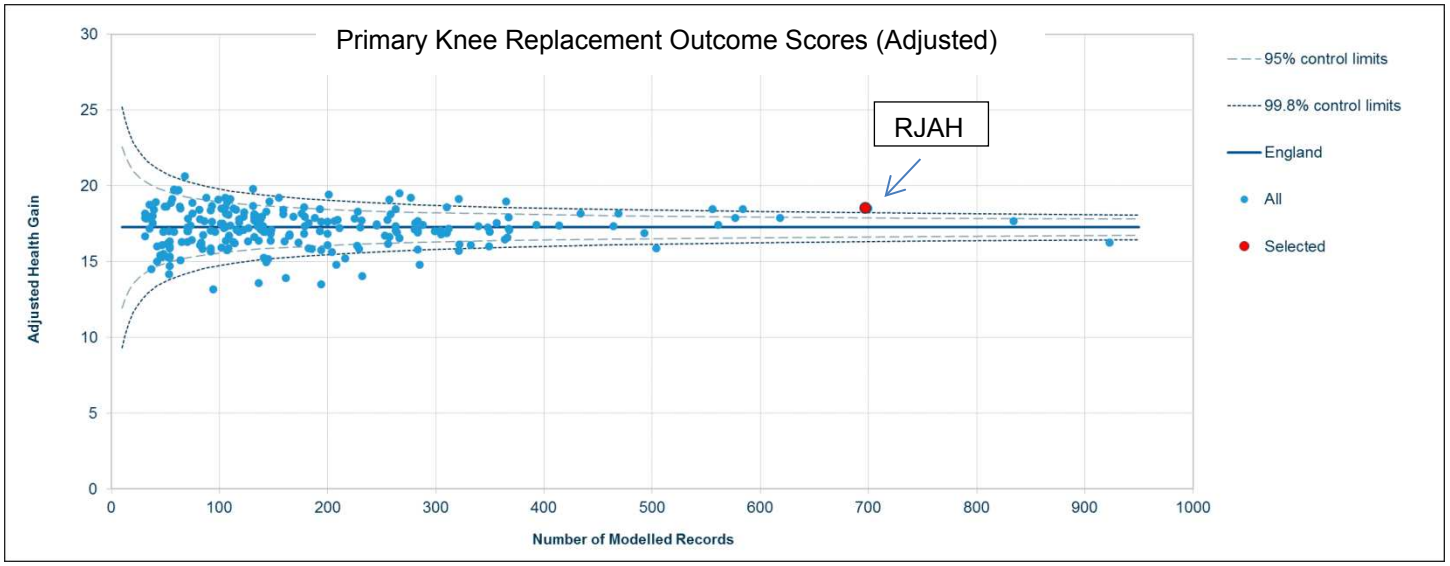
Case-mix adjusted figures not calculated where there are fewer than 30 modelled records. The whole row is highlighted in grey italics.

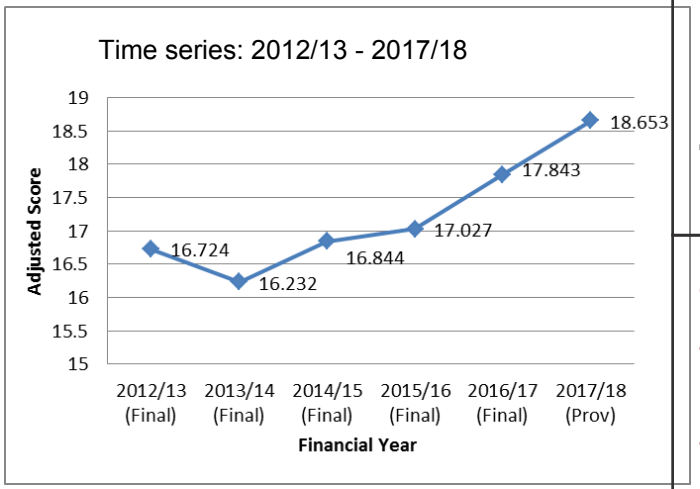
Organisation level	Organisation name	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened	Adjusted average Post-Op Q score	Adjusted average Health Gain	Standard Deviation of adjusted Health Gain
England	ENGLAND	2,036	20.499	34.400	13.901	1,757 (86.3%)	52 (2.6%)	227 (11.1%)	34.400	13.901	9.737
Provider	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION	42	18.357	36.024	17.667	41 (97.6%)	0 (0.0%)	1 (2.4%)	36.411	15.912	9.404
Provider	*SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (RXW)*	*7*	*16.857*	*30.714*	*13.857*	*7 (100.0%)*	*0 (0.0%)*	*0 (0.0%)*	*	*	*
Provider	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST (RRF)	138	18.688	32.500	13.812	127 (92.0%)	3 (2.2%)	8 (5.8%)	34.187	13.688	8.785
Provider	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RTH)	73	20.027	33.356	13.329	60 (82.2%)	2 (2.7%)	11 (15.1%)	33.288	12.790	10.748
Provider	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ)	98	20.429	34.480	14.051	86 (87.8%)	3 (3.1%)	9 (9.2%)	35.103	14.604	10.536
Provider	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN)	54	20.278	32.074	11.796	45 (83.3%)	3 (5.6%)	6 (11.1%)	32.819	12.321	9.989

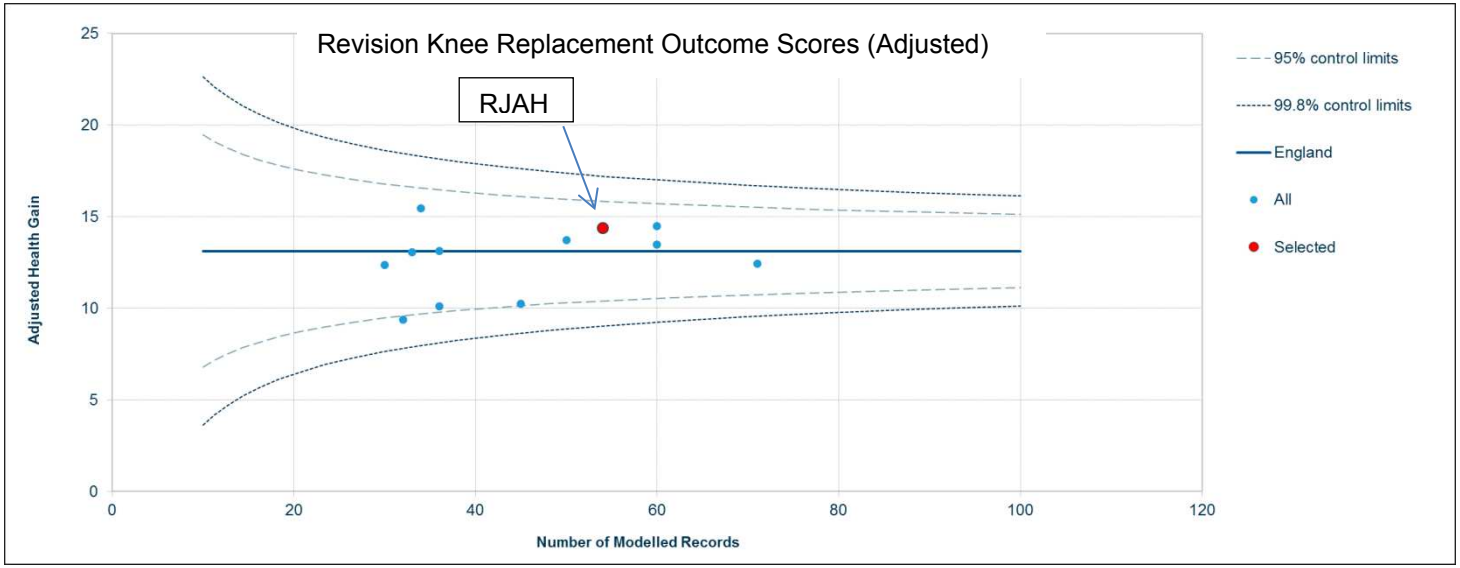
**Please see Appendix 2 for descriptions of measures shown above.*

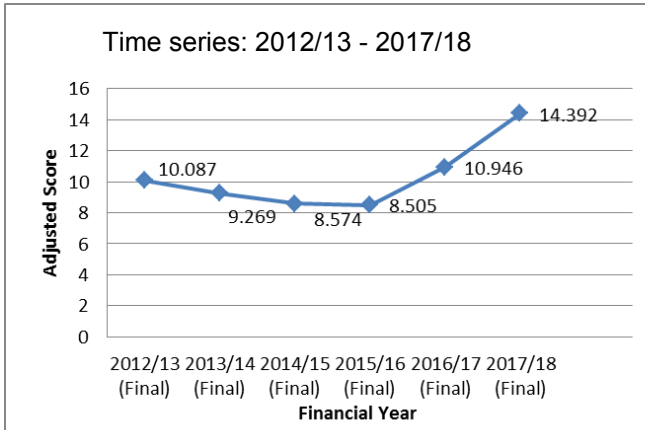
3.1.8. Knee Replacement Outcome Score Charts: - Oxford Knee Score

The funnel plot charts below represent 2017/18 finalised PROMs case-mix adjusted average health gains. The time-series charts represent the changes seen in case-mix adjusted health gains for Robert Jones and Agnes Hunt Orthopaedic Hospital from financial year 2012/13.



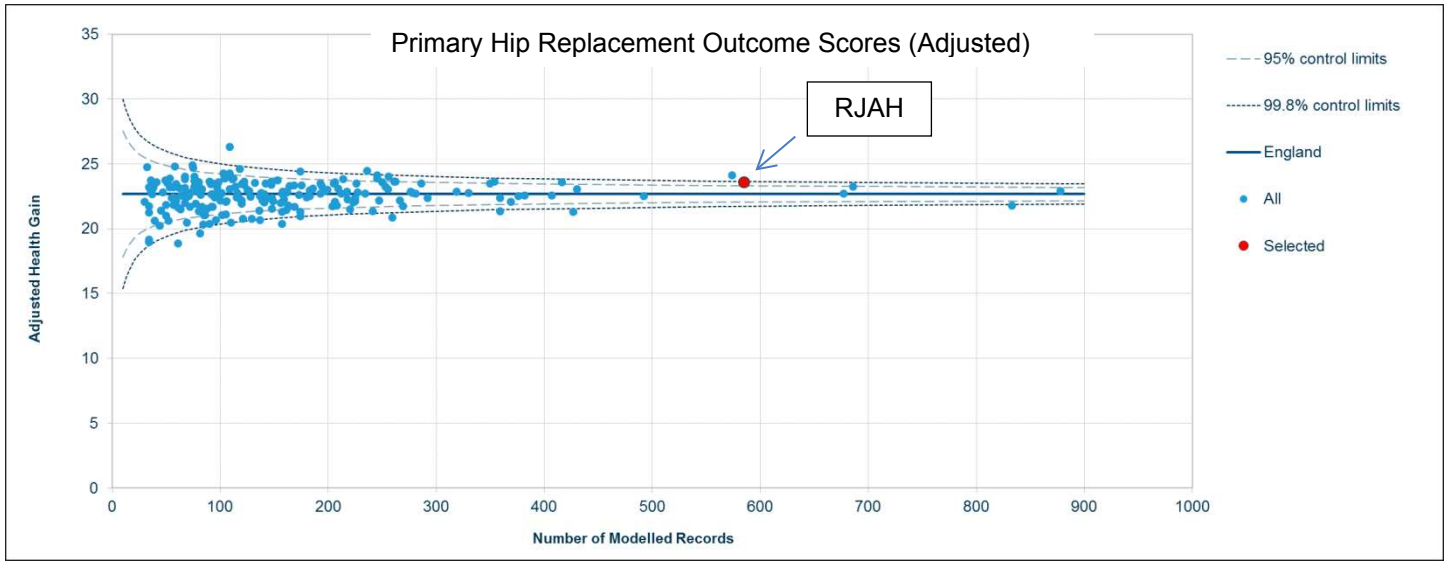


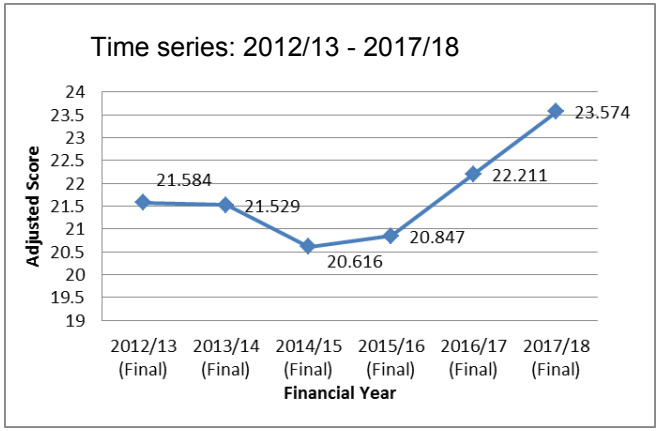


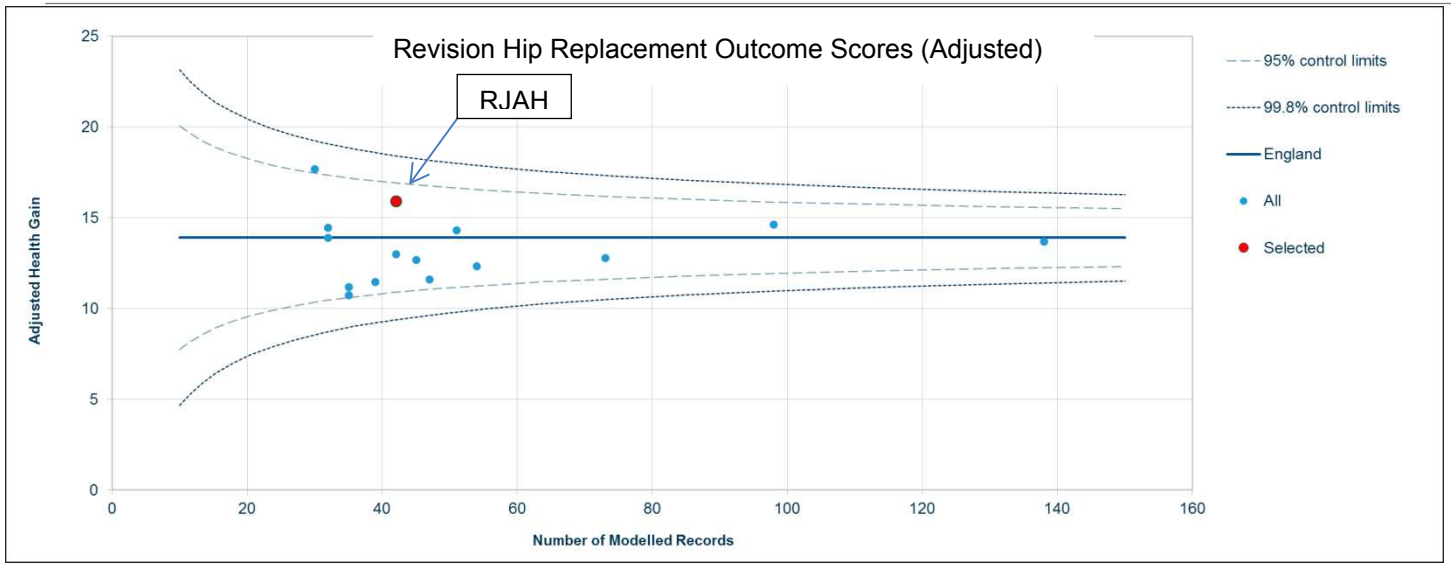


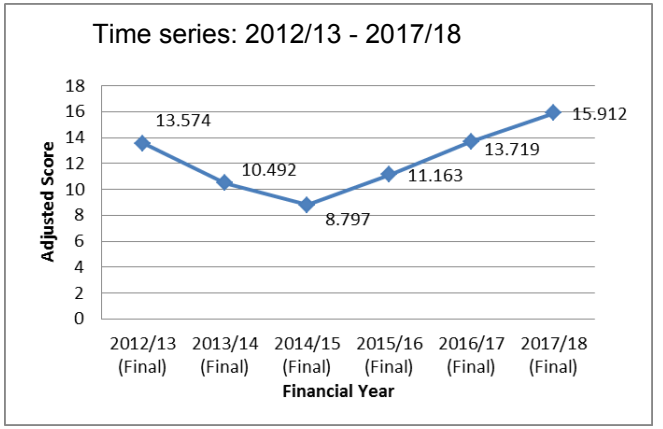
3.1.9. Hip Replacement Outcome Score Charts: - Oxford Hip Score

The funnel plot charts below represent 2017/18 finalised PROMs case-mix adjusted average health gains. The time-series charts represent the changes seen in case-mix adjusted health gains for Robert Jones and Agnes Hunt Orthopaedic Hospital from financial year 2012/13.









Appendix 1: Acronyms

PROMs	Patient Reported Outcome Measures
Q1	Preoperative Questionnaire
Q2	Postoperative Questionnaire
HES	Hospital Episode Statistics
IMD	Index of Multiple Deprivation

Appendix 2: Descriptions of measures for published PROMs findings

Column Name	Description
Modelled records	the number of questionnaire-pairs for which it has been possible to apply the casemix-adjustment model
Average Pre-Op Q Score	for the modelled records, the average unadjusted pre-operative score *(Oxford Hip/Knee Score)*
Average Post-Op Q Score	for the modelled records, the average unadjusted post-operative score *(Oxford Hip/Knee Score)*
Health Gain	unadjusted average difference between pre- and post-operative scores *(Oxford Hip/Knee Score)*
Improved/Increased%	number and rate of the modelled records for which an improvement in health was recorded *(Oxford Hip/Knee Score)*
Same/Unchanged%	number and rate of the modelled records for which no change in health was recorded *(Oxford Hip/Knee Score)*
Worsened/Decreased%	number and rate of the modelled records for which a worsening in health was recorded *(Oxford Hip/Knee Score)*
Adjusted average Post-Op Q score	casemix-adjusted average post-operative score; intended to allow fair comparisons between providers and England as a whole *(Oxford Hip/Knee Score)*
Adjusted average Health Gain	casemix-adjusted average gain in health from pre- to post-operative *(Oxford Hip/Knee Score)*
Standard Deviation of adjusted Health Gain	used to determine whether a difference from England figure is 'statistically significant' - see Funnel Plot tab *(Oxford Hip/Knee Score)*

Chair's Assurance Report
Audit Committee – 8 July 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	23 July 2019
Executive Sponsor:	David Gilburt, Non Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Audit Committee Meeting held on 8 July 2019 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was well attended
- There was good progress of actions from the previous meeting with all actions completed
- Assurance was obtained from the Information Governance Committee
- The Trust's financial governance was reviewed in detail
- An update was received on cyber security
- The Committee received updates from the Trust's Local Counter Fraud Specialist, Internal and External Auditors

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Audit Committee which met on 8 July 2019. The meeting was quorate with two Non-Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:			
Present:	David Gilburt	Non-Executive Director (Chair)	DG
	Harry Turner	Non-Executive Director	PK
Attendance:	Craig Macbeth	Director of Finance	CM
	Shelley Ramtuhul	Trust Secretary	SR
	Diana Owen	Head of Financial Accounting	DO
	James Shortall	Counter Fraud Specialist	JS
	Gurpreet Dulay	Internal Audit Representative	GD
	Yasmin Ahmed	Internal Audit Representative	YR
	Mo Ramzan	External Audit Representative	MR
	Simon Adams	Associate Director of IM&T	SA
Secretary:	Mary Bardsley	Assistant Trust Secretary	MBa

Apologies:
Apologies were received from Paul Kingston and Kerry Robinson.

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an updated on the progress of each. All actions were noted to be completed or on the agenda.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Chair Report: Information Governance		
The Committee received the Chairs report from the Information		

Governance Committee which highlighted the following key points. • On track for the new IG assessments • Partial assurance provided regarding learning from IG incidents as investigations are ongoing. • FOI requests – none have breached the 20 working day deadline • No IG concerns to escalate The Committee discussed the IG elements which may be impacted by EU Exit. The Committee was not assured regarding the oversight from the Risk Management Committee due to the timing of the next meeting and it was therefore agreed that urgent information would be shared with the Audit and Risk Management Chairs with extra-ordinary meetings arranged if needed. The Committee considered the breaches of confidentiality identified and was assured that these were not classed as serious incidents in accordance with the ICO toolkit. The committee noted the Chair's report.	Y	
2. Cyber Security Governance		
The Committee received and considered an outline of the Trust's governance for cyber security. It was noted that this had also been discussed and agreed at the Finance Planning and Digital Committee. Day to day management of cyber risks the responsibility of the IT Department. Oversight of the day to day management of risks to be the responsibility of the Finance Planning and Digital Committee Audit Committee to be responsible for testing and providing assurance to the Board on the internal controls for cyber security, with the benefit of internal and external auditor input. It was agreed that any urgent information would be shared with the chairs of the meetings. The Committee noted that a cyber security audit was planned for later in the year. The Committee noted the Trust's cyber security governance arrangements.	Y	
3. Finance Governance Pack		
The Committee received the Finance Governance Pack which showed key areas of financial governance to provide assurance to the committee on the Trust's performance and controls. The committee discussed the following: As at 31 May 2019 the Trust's income and expenditure position was £0.8m in deficit against a deficit plan of £0.7m		

Cash reduced by £0.8m as a result of year end invoice payments and slippage in the receipt of year end over-performance payments Payables increased y £1m mainly due to 2 months dividend payment, deferred income and in-year accruals. Aged Debt invoices from April and May have been chased. For the largest private patient debt a payment plan has been set up. The position will continue to be monitored and chased. Losses and Special Payments for April to May totalled £26k of which £22k related to theatre stock losses. The Committee noted that the theatre wastage had increased in May and requested a deep dive to further understand the reason for this. There were five single source waivers raised between April and May totalling £137k of which none exceeded the threshold for formal tendering. The Trust's cash balance was noted to be £0.3m behind plan. The forecast for the end of June is £0.8m above plan due to expected capital payments not being made. The Committee discussed reduction of the capital plan for the year and the need for this to be discussed before presentation to the Board. The Committee **noted** the Finance Governance Pack	Y	
4. Reference Cost		
The Committee noted that costings are on scheduled to be submitted at the end of the month New systems are in place which have supported with uploading the information Validation of the costings will be completed by the Finance Director and Deputy Director of Finance. The paper will be presented at the October meeting and will highlight the key points from the submission The Committee **noted** the update		
5. Board Assurance Framework (BAF)		
The Audit Committee has the responsibility for overseeing the Trusts risk assurance framework to ensure that the Trust has in place effective governance, risk management and internal control processes are established. The BAF has been aligned to the new objectives and delivery of the objectives is now included in the report. The Q1 data will now be populated as the quarter has been completed and this will outline any risks to delivery. The Committee considered the flow of information from Risk Management Committee to the Board given the reduced frequency of meetings and reflected on the need to change the		

date of reporting for the next year to ensure information is able to be presented to the Risk Management Committee prior to Board presentation. The Committee noted the amendments and updates that had been made to the BAF. The Committee noted that in relation to the MSK risk, KPIs for monitoring SOOS performance were in place with more robust monitoring in place via the Finance Planning and Digital Committee, it was agreed the BAF would be updated to reflect this. The Committee asked for further updates on the operational actions and it was agreed that the Finance Director would assist with these in the absence of the Director of Operations. Finally, the Chair of Risk Management Committee indicated there should be extended reflection on the BAF at the next Risk Management Committee meeting and it was agreed that the Chair of the Audit Committee would attend for this. The committee **noted** the update on the Board Assurance Framework.	Y	
6. Register of Interests and Hospitality Register		
The Committee noted there had been a drop in the percentage of completion, however, this has partly been contributed to by the fact the number of people having to complete a declaration has increased. All outstanding declarations have been chased and the Committee agreed that going forward the chaser letter should be amended to inform the person that their oracle account will be disabled if the declaration is not submitted. The Committee took assurance from the fact that that all staff have submitted a declaration within the last two years with only a small number having not made a declaration in the last 12 months. The Committee was also assured by the fact the Procurement Team receive a copy of the declaration and hospitality report. The Committee **noted** the Register of Interests and Hospitality Register.		
7. Quality and Safety Annual Report		
The Committee was asked to consider the Quality and Safety Committee performance against its responsibilities as defined in its terms of reference. The survey relating to the effectiveness of the Quality and Safety Committee highlighted improvements when compared to the previous year. Some minor areas for improvement noted in relation to the following:		

Suggestion to rotate the agenda to avoid those last on the agenda consistently getting less discussion time Introduction of an action plan tracker for the serious incident actions Term of Reference to be presented as part of the annual report. The Committee noted that these had changed as a result of the establishment of the People Committee. The committee **noted** the Quality and Safety Annual Report.	Y	
8. EU Exit Update		
The Committee received a verbal update from the Finance Director in relation to the UK exiting Europe on the 31st Oct. The contingency plans are in place with the Finance Director attending a briefing before the end of the month to share information. The Committee noted that correspondence has been shared, which include the continuity of medical supplies and medicine. The Trust is to be aligned with the national plan with local leads within the Trust. The Committee noted previous risk submissions required Non Executive input and it was agreed that a telephone conference would be scheduled if such approvals were required again. The Committee noted the challenge of sharing the information through a committee due to the timings of the Committee meetings. It was agreed that information could be shared via email with extra ordinary meetings arranged or discussion at Board if required. The Trust will continue to monitor the EU Exit status and update the Board as appropriate. The Committee **noted** the update.		
9. Counter Fraud Action Log		
Following the NHS Counter Fraud Authority (NHS CFA) review, the Trust created an action plan to address the issues raised. The committee received the revised action log which had only one outstanding action: • Trust local counter fraud contact to become accredited support LCFS. The Trusts Facilities Manager, Sian Langford has attended the training, with the final assessment due to be completed on 12th July. The Committee sought clarity on when a re-inspection was likely and the Counter Fraud Specialist advised that August / September time would seem most likely. The Committee discussed the importance of reflecting all the time spent on counter fraud in the fraud plan. The Trust Secretary and the local LCFS will have regular minuted meetings to provide evidence of the oversight and time spent.		

The Committee **noted** the update.		
10. Counter Fraud Progress Report		
The LCFS provided the Committee with the following updates: • Sian Langford had supported the work with the procurement exercise. • Date in the diary for the finance team with Trust specific recommendations to be identified. • Procurements has agreed or the exercise to be submitted • Information provided on salary overpayment fraud bulletin which has been circulated in the South of England • One allegation of fraud has been received through the Freedom to Speak Up Guardian, this has been investigated fully with no further action required.		
11. Internal Audit Progress Report		
The Committee received the Internal Audit Annual Report and noted the following: • Terms of Reference have been completed for each report • The Risk Maturity Audit has been completed • The Theatre review requires minor areas of work prior to completion of the report The Audit Chair asked for additional information to be added to the report regarding any terms of reference issues and the dates the draft reports are issued and dates of agreement. This was to support completion of the reports in timely manner. *Theatre Review* • Final close meeting to be completed with Director of Finance and Director of Operations with a draft report to be issued on Monday 15th July • The review was commenced on 20th May and is approximately 1.5 weeks behind due to annual leave • Expect final report to be available end of July • There will be recommendations on the 6 4 2 policy to enhance the system. • The report will be shared with the Finance Planning and Digital Committee for operational oversight. • Further information on the 6 4 2 requires the funding and a business case The Committee noted the progress and would await the final report. *Risk Maturity Report* • Review of the risk arrangement within the Trust with an assessment of five elements of risk management. • The outcomes were reported follows:		

	Risk Governance	Risk Assessment	Risk Mitigation	Monitoring and Reporting	Continuous Improvement
Current	Defined	Defined	Defined	Managed	Managed
Target	Managed	Managed	Managed	Managed	Managed

- Areas of good practice were noted to be the scrutiny of the BAF and its presentation at the Board.
- Areas to improve were better alignment of the gaps in controls and assurance to the action plan and consideration of the action dates.
- With regard to the risk registers it was noted that some progress columns needed to be completed at divisional level
- It was initially thought there was low compliance with training but once cross referenced with those who only access Datix the compliance had improved and stood at 85.9%
- The Trust Secretary confirmed that the report would be shared with the Governance Team to highlight their good work and to ensure the recommendations are enacted.
- Tracking of the actions will be presented to the Risk Management Committee

Follow Up Recommendations

- Sent to responsible officer in May for an update
- Follow up tracker was presented to the Exec Team meeting
- Two high level recommendations which have not been completed, a revised date of end of august has been agreed

The Committee was pleased to learn the Executive Team had reviewed the recommendations at a recent meeting and it was noted that each committee would receive internal audit reports relevant to their remits for further clarity and discussion.

The Committee asked for the booking systems recommendation to be updated to reflect recent discussions.

The Committee noted revised due dates for actions and it was discussed and agreed that any such changes should require prior approval by the relevant committee.

The Committee **noted** the internal audit update.

12. External Audi Update

The External Auditors provided the following updates:

- Confirmed the completion of the annual report and accounts
- Charitable funds work completed
- Benchmarking for Q4

• 2019/ 20 plan will be shared at the next meeting • Benchmarking against other Trusts compared to plan, achieved efficiencies, agency spend pressure, • Sector update on the charity commission guidance. The Committee suggested the slides presented could be incorporated into the AGM with further comments. The Committee **noted** the updates.		

3.4 Approvals

The Committee was not asked to make any approvals during the course of its business.

3.5 Risks to be Escalated

In the course of its business the Committee did not identify any risks for escalation:

3.6 Conclusion

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

Chairs Assurance Report
Finance Planning and Digital Committee 23rd July 2019

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	23rd July 2019
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Digital	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Finance Planning and Investment Committee Agenda for the meeting of 23rd July 2019. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

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

2.3. Conclusion

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

Finance, Planning and Digital Committee 23.07.2019

MEETING
23 July 2019 14:00

PUBLISHED
14 July 2019

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	23/07/19	Alastair Findlay	14:00

1. Introduction		14:00
1.1. Apologies	David Gilburt	
1.2. Minutes from the previous meeting	David Gilburt	
1.3. Action Log	All	
1.4. Declaration of Interests	All	
2. Finance		
2.1. Performance Overview Report (Month 3) to follow	Kerry Robinson	14:10
2.1.1. Threatre Activity, Stabilisation and Recovery Plan	Paula Jeffreson	
2.2. Finance Director Report	Craig Macbeth	14:20
3. Planning		
3.1. Energy Improvement Investment	Nick Huband	
3.2. Theatre Delivery Internal Audit	Gurpreet Dulay	
3.3. LLP Reduction Plan	Victoria Brownrigg	
3.4. QIPP Report	Mark Salisbury	
4. Digital		
4.1. Cyber Security	Simon Adams	14:30
4.2. Service Status	Simon Adams	
4.3. Chair Report: Digital Steering Group	Simon Adams	
5. Policy/Strategy Oversight		
5.1. Procurement Strategy	Helen Lewis	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	23/07/19	Alastair Findlay	14:00

6. Committee Management		
6.1. Committee Self Assessment and Annual Report	Shelley Ramtuhul	
6.2. Board Assurance Framework and Corporate Risk Register (to follow)	Shelley Ramtuhul	14:40
6.3. Review of the Workplan	Mary Bardsley	14:45
6.3.1. Attendance Matrix	Mary Bardsley	
6.4. Minutes: Capital Management Group	Craig Macbeth	14:50
7. Any Other Business		14:55
7.1. Next Meeting: 24th September 2019 at 2pm		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — OBJ 1

Achieving Outstanding Patient Safety

Principal Objective: Reduce unwarranted variation with a focus in 19/20 upon reducing avoidable harm

This objective will focus on four key areas, GIRFT principles, falls, UTIs and managing deteriorating patients.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G				G

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Key Measures:

- Lower UTIs in older people are diagnosed and treated in line with NICE guidance for 90% cases by year end
- All new devices across all disciplines are reviewed and approved through the New Devices and Procedures Committee
- Older people have recognised falls prevention measures in place. 80% compliance by year end.
- Implement quarterly audits of compliance with patient observations including NEWS.
- Ensure correct level of patient deterioration training available to reach trustwide compliance of 80% by year end.

Progress Update:

The work for diagnosing and treating lower UTIs in older people in line with NICE guidance is on track as is the process for thee review and approval of new devices.

CQUIN meetings are being held regularly and performance is on track.

The quarterly audits of compliance with patient observations is now due to commence to look at the performance across Q1 and the results will be available in Q2.

The availability of training in the management of deteriorating patients has been reviewed with capacity increased for 2019/20.

Supporting programmes of work

- GIRFT action plan
- CQUIN
- Outpatients protocols
- Booking and scheduling review
- Model Hospital

Risks

BAF 1.1	Engagement with the clinical workforce fails to gain traction
BAF 1.2	Failure to apply nationally recognised evidence based practice

Lead Director:

Director of Nursing & Medical Director

Lead Committee

Quality and Safety Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 1.1 NEW **OBJ 1**

Principal Risk: Engagement with the clinical workforce fails to gain traction

Inability to implement new processes aimed at reducing variation resulting in failure to reduce avoidable harm

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	3
Likelihood	3	3	1
Total	15	12	3

Risk Details

Opened: May 2019

Review Date: July 2019

Source of Risk: Risk Assessment

Corporate Risk Register? DX2178

Controls:

- ✓ Innovation Committee will ensure rationalisation of new procedures and equipment
- ✓ Forums for clinical engagement (Clinical Management Board, Clinical Cabinet, Multi-Disciplinary Clinical Audit Meeting, Medical Advisory Committee

Assurance: **Source of Assurance** **2**

- ✓ Oversight by Quality and Safety Committee
- ✓ Innovation Committee to oversee and rationalise the introduction of new techniques and equipment and to ensure evidence base.
- ✓ Operational Excellence Board
- ✓ Compliance with NICE guidance
- ✓ Participation in Clinical Audit

Gaps in Controls:

- New clinical leadership structure will provide additional control but will not be in place until October 2019
- Clarity required for roles and responsibilities

Gaps in Assurance:

- Effectiveness of Clinical Quality Governance Committee

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Implementation of new clinical leadership structure	Chief Executive	Oct 2019	Consultation underway	
Clinical Chair job descriptions to provide clarity of roles and responsibilities	Chief Executive	Jul 2019	The job descriptions have been completed and circulated to the organisation, applications received and interviews scheduled.	Completed
Review of Clinical Quality Governance Committee effectiveness to be prioritised	Director of Nursing / Trust Secretary	Jun 2019	Review undertaken and new terms of reference drafted. New meeting schedule put in place.	Completed
Further review of Clinical Quality Governance Committee effectiveness in 3 months time	Director of Nursing / Trust Secretary	Oct 2019		

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 1.2 NEW **OBJ 1**

Failure to implement nationally recognised evidence based practice

Potential for avoidable harm or prevention of reducing avoidable harm. Inability to provide world class care if practice is not evidence based

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	3
Likelihood	3	3	1
Total	15	12	3

Opened: May 2019

Review Date: July 2019

Source of Risk: Risk Assessment

Corporate Risk Register? DX2177

Controls:

- ✓ Falls collaborative
- ✓ Falls management training needs analysis and records
- ✓ Falls policy
- ✓ CQUIN
- ✓ Quality account priorities
- ✓ Divisional Quality Reports

Assurance: Source of Assurance **2**

- ✓ Oversight by Quality and Safety Committee
- ✓ Integrated Performance Report metrics
- ✓ Innovation Committee
- ✓ Quarterly update on GIRFT
- ✓ CQRM oversight of CQUIN

Gaps in Controls:

- ~~No clear work group for implementation of GIRFT principles~~
- ~~Capacity and resource to provide the deteriorating patient training~~
- Compliance with completion of falls documentation
- Benchmarking for world class

Gaps in Assurance:

- Monitoring of deteriorating patient training figures

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Working Group to be established to look at GIRFT principles	Medical Director	June 19	Initial meeting has taken place	Completed
Review of capacity and resource required to deliver the required deteriorating patient training	Director of Nursing	June 19	Review of the capacity and resource required to deliver the training has been completed and meeting has taken place to agree the plan for increasing the training provision and other aspects of patient deterioration management.	Completed
Review of falls documentation to be undertaken to understand issues with completion	Director of Nursing	July 19		

Corporate Objectives 2019/20 and Board Assurance Framework

Consideration of benchmarking opportunities with recommendations to be presented to Quality and Safety Committee	Medical Director	Jul 19		
Alignment of agreed work programme for GIRFT principles to the Trust's committee structure and work plans	Medical Director / Trust Secretary	Aug 19		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — **OBJ 2**

Delivering outstanding outcomes and experience

Principal Objective: Increased focus on MSK population health

This objective will focus on transition from volume based to value based, reactive to proactive and illness to health and wellness focus.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
A				G

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Measurements of improvement:

- Alternative contract model in place for 2020/21 more focused upon value than volume.
- Roll out of Q Lab improvement programme
- Stabilisation of SOOS to be measured through improved KPI performance

Progress Update:

During June 2019 there has been the establishment of a design group to be known as the STP MSK Design Group. The purpose of the group is to provide a forum to create, propose and recommend the required MSK pathways for the system. The alliance of MSK providers and commissioners across the Shropshire, Telford & Wrekin STP will look to provide a sustainable and effective service providing equity to ensure we meet our population needs through integrated seamless pathways.

Q lab improvement programme is progressing. Research has been undertaken and benchmarking assessments are underway. Prototypes for patient communication is being developed.

The stabilisation programme for SOOS is ongoing. Current KPIs are not being achieved. Backlog to still be addressed and falling part of stabilisation plans.

Supporting programmes of work:

- Development of system healthcare pathways
- MSK joint strategic needs assessment
- SOOS continued development
- Q Lab improvement partnership – mental health, neck and back pain
- MSK PROMs
- MSK self-management

Risks

BAF 2.1 MSK service integration fails to deliver expected benefits due to lack of understanding of the self-management and non-surgical pathways

Lead Director:

Director of Performance, Improvement & OD

Lead Committee

Finance, Planning & Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 2.1 **OBJ 2**

Principal Risk: MSK service integration fails to deliver expected benefits due to lack of understanding of the self-management and non-surgical pathways

Potential reduction in activity at the Trust with loss of contracted work, impact on stability and availability of specialist work, potential for duplicate visits for patients, inability to respond to external factors. Host commissioner in financial recovery and requires material reduction in orthopaedic spend, impact for the Trust still to be determined. Potential for local health partners to not see the benefit of specialist orthopaedic services within the system

Risk Rating:

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

Risk Details

Opened: May 2017

Review Date: July 2019

Source of Risk: External drivers

Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Monitoring of GP referrals
- ✓ Horizon scanning in place
- ✓ Regular dialogue through contract meetings
- ✓ Monthly 1:1 between the Directors of Finance and Chief Executives
- ✓ Participation in MSK service developments and SOOS
- ✓ Delivery of QIPP prior approval requirements
- ✓ STP Directors Monthly Report
- ✓ Strategy deployment linked to objective setting
- ✓ Programme plan in place
- ✓ STP governance arrangements defined
- ✓ SOOS KPIs in place
- ✓ 1st phase complexity modelling completed
- ✓ Definition of MSK agreed by the Board
- ✓ Trust representation within the STP work streams
- ✓ CEO attends Senior Leadership Meetings for the STP
- ✓ Engagement with key partners in the local health system
- ✓ Future fit response
- ✓ MSK Orthopaedic System Paper

Assurance: **Source of Assurance** **3**

- ✓ Strategy Oversight Group overseeing delivery
- ✓ Board reporting programme in place
- ✓ Clinical Cabinet established
- ✓ Local MSK Programme Board in place
- ✓ Increased Finance, Planning and Digital Committee Oversight
- ✓ Monthly performance report
- ✓ NHS I monitoring
- ✓ Shropshire CCG MSK Programme Board with weekly oversight meetings introduced
- ✓ SOOS project board in place
- ✓ Contract in place with contractual review meetings
- ✓ Monthly MSK meeting with the CCG
- ✓ Updates to Q&S Committee on quality aspects
- ✓ Planned Care Working Group
- ✓ STP updates to Board
- ✓ Board oversight of partner risks

Gaps in Controls:

- ○ Ability to implement strategy
- ○ Stakeholder relationships
- ○ System contract alignment with strategic MSK vision
- ○ Lack of triangulated system MSK reporting i.e. finance, outcomes, quality,

Gaps in Assurance:

- ○ Lack of integration of MSK provider and commissioner programme boards, together with split commissioner reporting.
- ○ Lack of integration between local and specialised commissioning for MSK conditions

Corporate Objectives 2019/20 and Board Assurance Framework

- experience, activity
- Consultant body understanding of SOOS
- No national inclusion of MSK in NHS long 10 year plan
- No inclusion of Specialised Services in the STP Operational Plan

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
MSK System Governance to be put in place	Director of Improvement, Organisational Development and Performance	Jun 19		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — OBJ 3

Delivering timely access to patient care

Principal Objective: Improving systems and processes for best care

This objective will focus on three key areas; job planning, booking and scheduling and outpatient protocols.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G				G

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Key measures:

- Implementat planning
- Implementat
- Overarching

Key Measures:

- Implementation of the internal audit recommendations linked to job planning
- Implementation of 6-4-2
- Overarching protocol in place with roll out of sub specialty

Progress Update:

Internal audit recommendations linked to job planning have been partially implemented. The Job Planning Policy is to be reviewed by LNC in August with a view to presentation to an extra ordinary Policy Committee in September. Full embedding of job plans to take place during Q2 and Q3.

Implementation of the 6-4-2 is behind plan but there the project initiation document and business case are in place to progress.

Meetings are scheduled for August to look at and agree the overarching protocol before rollout at sub specialty level.

Supporting Programmes of Work:

- E-rostering work in partnership with Collinson Grant
- Co-ordination centre
- Demand and capacity implementation
- 6-4-2 theatre planning
- Pre-op transformation
- Outpatient model
- Job planning

Risks

BAF 3.1 Inadequate operational processes

Lead Director:

Director of Operations

Lead Committee

Finance Planning and Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 3.1 **OBJ 3**

Principal Risk: Inadequate operational processes

Inability to reduce the number of rescheduled episodes, missed opportunities to prevent rescheduled appointments, reputational damage and poor patient experience, inability to backfill short notice cancellations, lack of an operational transparency model to support improvements in operations processes reducing efficiency opportunities.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	2
Likelihood	5	4	1
Total	25	16	2

Risk Details

Opened: March 2018

Reviewed Date: July 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX TBC)

Controls:

- ✓ Access Policy in place
- ✓ Pre-operative Assessment Transformation work stream
- ✓ Daily scheduling / theatre comm cell
- ✓ Admin review completed, full implementation 2018/19
- ✓ Monitoring of efficiency KPIs
- ✓ Operational Excellence transformation programme working groups
- ✓ Patient Flow Co-ordinator in place
- ✓ Bed Management Policy in place
- ✓ Care co-ordination centre in place

Assurance: **Source of Assurance** **2**

- ✓ Daily Comms Cell
- ✓ Monthly Operational Board oversight
- ✓ Oversight and assurance via the Finance Planning and Investment Committee
- ✓ Inpatient Survey Performance
- ✓ Operational Excellence Programme Board
- ✓ Oversight from Strategy Board
- ✓ Weekly RTT Meeting / Surgical Division Meeting Deep dives for areas of red performance

Gaps in Controls:

- Booking pathway timeline compliance
- Financial viability of transparency model to be assessed
- Follow up backlog project behind plan therefore management of backlog being impacted
- Gaps in job planning governance and processes
- 6-4-2 implementation

Gaps in Assurance:

- Performance deep dives still embedding

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Job Planning Policy to be reviewed and revised to ensure governance and process gaps addressed	Medical Director / Director of People	~~Jun 2019~~ Sept 2019	Policy reviewed and revised. This was due to go to the extraordinary Policy Committee on 18 July but has been rescheduled for LNC in August and Policy Committee in September	

Corporate Objectives 2019/20 and Board Assurance Framework

Development of Trust wide policy for delivery of outpatient based care	Director of Operations	Sept 2019		
Implement booking and scheduling hub and embed processes aligned to 6-4-2	Director of Operations	Sept 2019		
Review of capacity requirements to be undertaken to address short term clearance of backlog	Director of Operations	Sept 2019		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Staff — OBJ 4

Being an extraordinary place to work

Principal Objective: Focus on providing an environment for our workforce to 'flourish at work'

This objective will focus on bullying and harassment, progress in the areas identified as cultural hotspots and inclusion.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G				G

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Key measures

- Staff survey results on bullying and harassment
- Sickness absence and voluntary turnover in hotspots
- WRES / Staff survey

Progress Update:

Action plan in place to address hotspot areas of staff survey results on bullying and harassment. Next lot of survey results will be available February 2020 to assess impact.

Voluntary turnover is improving but sickness absence is not improving as expected, sickness absence monitoring is in place and reviewed on a monthly basis.

Action plan in place for WRES/ Staff Survey improvements

Supporting programmes of work:

- Workforce wellbeing
- Excellent people management
- Strategic system workforce planning
- Staff development activities
- Role development/new role programme
- Statutory and mandatory training and delivery plan
- Signature behaviours and values
- How do we do business at RJAH
- How to be a great manager at RJAH
- Inclusion and dignity activity plan
- Streamlining of processes and procedures

Risks

BAF 4.1	Failure to improve staff engagement linked to communication between managers and the workforce
BAF 4.2	Potential inability to have the right workforce in the right place at the right time

Corporate Objectives 2019/20 and Board Assurance Framework

Lead Director:	Lead Committee
Director of People / Director of Improvement, OD and Performance	People Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 4.1 **OBJ 4**

Principal Risk: Failure to improve staff engagement linked to communication between managers and the workforce

Inability to improve the culture and behaviour of the workforce, difficulties attracting staff to the organisation leading to poor patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	2
Likelihood	5	3	2
Total	20	12	4

Risk Details

Opened: Apr 17

Review Date: July 2019

Source of Risk: Staff survey results

Corporate Risk Register? (DX TBC)

Controls:

- ✓ Ward / department buddying with escalation of issues to exec team
- ✓ Communications and engagement strategy
- ✓ Six monthly big conversations
- ✓ Leadership training and bite-sized modules for wider organisation
- ✓ Workforce Development Group in place
- ✓ Established Performance Review Programme
- ✓ Additional resource in place to assist with the delivery of the engagement programme
- ✓ Performance framework in place
- ✓ Patient Safety Walkabouts

Assurance: **Source of Assurance** **3**

- ✓ Regular updates to the Quality and Safety Committee and Board
- ✓ NHS I PRM
- ✓ Staff Survey
- ✓ Pulse Checks
- ✓ NHS I Oversight Framework
- ✓ Oversight from Workforce Development Group

Gaps in Controls:

- Effectiveness of information cascade as a result of having no formal cascade process
- Establishing / re-enforcing management visibility

Gaps in Assurance:

- Service improvement expertise

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Business case to be developed for service improvement expertise	Director of Strategy and Planning	Jun 2019	Review of Service Improvement capability completed in September to now form part of drafted business case. Job description done and HR banding awaited	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 4.2 **OBJ 4**

Principal Risk: Potential inability to have the right workforce in the right place at the right time

Inadequate succession planning and talent management resulting in gaps in levels of expertise. Risk to staff morale resulting in increased turnover. Inability to increase activity safety to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	3	2
Likelihood	4	4	2
Total	16	12	4

Risk Details

Opened: March 2018

Review Date: July 2019

Source of Risk: Workforce

Corporate Risk Register? (DX 1745, DX1652)

Controls:

- ✓ Recruitment plans to target vacancy hot-spots
- ✓ Sickness absence management
- ✓ Staff turnover monitoring
- ✓ Leadership training to support effective management and engagement of staff
- ✓ Line of sight of the detail of theatre usage
- ✓ 5 year people plan in place

Assurance: **Source of Assurance** **3**

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ Turnover and sickness absence rates
- ✓ Quality and Safety Committee and Board and workforce development oversight
- ✓ Agency usage monitoring (within the cap)
- ✓ 50% of areas within target for vacancy percentages

Gaps in Controls:

- ○ Development of new roles
- ○ Resource to support maintenance of number of bank staff
- ○ Efficiency and timeliness of recruitment process
- ○ Role specific recruitment plan
- ○ Succession planning / workforce plans
- ○ Lack of available coaching resources/capability
- ○ Lack of triangulation of management information reporting
- ○ Quantification of risk relating to pension tax changes - potential for clinical staff to drop PAs
- ○ Unknown scale of STP changes
- ○ Recruitment limited by local workforce

Gaps in Assurance:

- ○ Lack of visibility to ward managers of staffing variances
- ○ Management capability review

Corporate Objectives 2019/20 and Board Assurance Framework

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Development of new roles and training routes for hard to fill roles	Deputy Director of HR	Jul 2019	Nurse Associate places with Chester University now in place and recruiting to a Senior Nurse post to lead the development and management of these roles. HEE funding received.	Completed
Service improvement of recruitment and employment checks processes	Deputy Director of HR	Jul 2019	Recruitment process reviewed and time to hire timescales improved. National Streamlining Programme due to be circulated this month and the Trust will implement this.	Completed
Development of a 5 year workforce plan which will include the identification of critical roles for succession planning purposes.	Deputy Director of HR	Jul 2019	STP revising the workforce plan, due for completion end of July	
Recruitment and retention premiums to be explored	Director of People	Jul 2019	Recruitment and retention premiums have been reviewed but the business case does not evidence this is worthwhile due to the low number of vacancies.	Completed
International recruitment to be explored	Director of People	Jul 2019	Participating with HEE on international recruitment, phased approach to be adopted, currently the priority is A&E nurses but Theatre and General Nurses to be progressed in the coming months	Completed
Implementation of the National Streamlining Programme	Director of People	Dec 2019		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Finances — OBJ 5

Spending our money wisely

Principal Objective: Develop a more clinically led infrastructure and meeting architecture

The objective will focus on increasing clinical involvement in the leadership and management and review and rationalisation of organisational meetings to ensure they are effective and fit for purpose.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G				G

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Key measures:

- Demonstrable increase in clinically led decisions
- Reduction in non-value added meetings
- Committee effectiveness to be measured

Progress Update:

Consultation on the organisation restructure has closed with Clinical Chair interviews for July and on track for post holders to be in place in October.

Review of operational meeting structures has been undertaken and a review of sub-committees of the Board committees is underway.

Committee effectiveness assessments in place for Board committees and to be rolled out for sub-committees.

Supporting programmes of work

- How we do business at RJAH
- How to be a great manager at RJAH

Risks

N/A

Lead Director:

Director of People / Associate Director of Governance

Lead Committee

People Committee

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Finances — OBJ 6

Spending our money wisely

Principal Objective: Achieve and maintain the Single Oversight Framework (SOF) score of 2 and seek to improve underlying measures.

This objective will focus on the use of resources score.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
3				2

Objective Details

Opened: April 2019

Reviewed Date: July 2019

Key Measure:

- Deliver control total trajectory for Income and Expenditure
- Deliver Agency Control total for core agency (Non LLP)
- Maintain cash balances at trajectory and enable repayment of financing commitments

Progress Update:

Control total £0.5m away from plan but with theatre recovery plan in place to bring back on track.

Agency control total for core agency (non LLP) within target

Cash balances within target

Supporting programmes of work:

- Delivery of annual CIP programme supported by:
  - MSK Joint Transformation Board
  - Operational Excellence transformation programme
  - Workforce plan
  - Procurement strategy
  - Capacity alignment
- Delivery of activity and income plan within agreed cost base supported by:
  - Establishment of Co-ordination Centre
  - Capacity alignment

Risks

BAF 6.1	Failure to achieve activity and income target within planned cost base
BAF 6.2	Instability arising from fluctuations in tariff
BAF 6.3	Lack of clear national strategy for the commissioning of our specialist services

Lead Director: Craig Macbeth

Director of Finance

Lead Committee: Finance, Performance and Digital

Finance Performance and Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.1 **OBJ 6**

Principal Risk: Failure to achieve activity and income target within planned cost base

Potential impact on Trust's financial stability, inability to grow and invest as required, impact on cash balances, single oversight framework ratings adversely affected

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	2
Likelihood	5	4	2
Total	25	16	4

Risk Details

Opened: March 2018

Reviewed Date: July 2019

Source of Risk: Financial management

Corporate Risk Register? (DX 1604)

Controls:

- ✓ Cost improvement schemes identified to required level for 2018/19 with 20% contingency
- ✓ QIPP schemes identified to required level
- ✓ Carter recommendations embedded in savings scheme discussions
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Daily tracking of theatre bookings
- ✓ Focus on theatre productivity
- ✓ Forward view of availability of LLP sessions and cost of this factored in to financial plan
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews
- ✓ Lessons learned when setting the 2018/19 plan for theatre activity
- ✓ Detailed analysis of bookings process undertaken

Assurance: **Source of Assurance** **3**

- Monitoring of CIP delivery via Divisional Performance Meetings
- Oversight by Operational Board and Finance, Planning and Investment Committee with mitigating actions identified and monitored
- QIPP monitored by RJAH and CCG at contract meetings
- NHS I oversight
- KPIs monitored via Board
- QIA process in place to ensure quality not impacted
- Planned Care Working Group oversight

Gaps in Controls:

- Further work required on future savings programmes
- Demand and capacity modelling to be completed and behind plan
- Uncertainty around compliance with consultant job plans
- Reliance on OJP some of which is not based in contract
- Implementation of action plan developed following bookings process review
- SOOS KPIs to be defined

Gaps in Assurance:

- Gaps in demand and capacity oversight
- Audit of compliance with consultant job plans

Corporate Objectives 2019/20 and Board Assurance Framework

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Complete diagnosis of drivers behind theatre activity shortfall for 2018/19 and develop and deliver action plan to improve	Director of Ops	Jun 19	Action plan for theatre recovery in place and extended FP&D Committee in July to present this. BDO report has been commissioned	Completed
Deliver actions agreed to provide assurance on Consultant Job Plan fulfilment	Director of Ops	~~Jun 19~~ Sept 2019	Being tracked as part of response to internal audit with implementation in Q2	
Agree SOOS KPIs for MSK transformation QIPP to limit exposure to risk share	Director of Improvement, Organisational Development and Performance	Jun 19	KPIs agreed and being tracked via FP&D Committee. CCG QIPP Delivery Board in place with weekly oversight meetings with the CCG	Completed
Review post surgery follow up pathway protocol for delivery of QIPP to limit exposure to risk share	Director of Ops	~~Jun 19~~ Sept 2019	MSK Board Terms of Reference being reviewed to include reflection of commissioner requirements	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.2 **OBJ 6**

Principal Risk: Instability arising from fluctuations in the tariff

Year on year fluctuations create a risk of instability, single oversight framework rating and segmentation adversely affected

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	3	3
Likelihood	5	4	2
Total	20	12	6

Risk Details

Opened: November 2016

Reviewed Date: July 2019

Source of Risk: Commissioning contract

Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Lobbying to support adverse losses via the NOA
- ✓ Trust actively participating in the development of future orthopaedic tariff as part of costing transformation programme (CTP) pilot scheme
- ✓ NOA and Expert Working Group
- ✓ Strong costing systems locally
- ✓ Participation in tariff engagement
- ✓ Programme of work through NOA to direct appropriate resources for complex procedures
- ✓ Orthopaedic complexity uplift in place

Assurance: **Source of Assurance** **3**

- ✓ Local pricing agreements to offset losses based on local PLICS
- ✓ NHS I engagement and recognition by pricing team
- ✓ NOA benchmarking
- ✓ CTP Report
- ✓ Confirmation that no organisation will lose more than 2%
- ✓ Finance Planning and Investment oversight

Gaps in Controls:

- Confirmation regarding the tariff payable by Wales is still required

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Lobbying through NOA on tariff losses	Chief Executive / Finance Director	Ongoing	12 month programme to evidence NOA findings to lobby for inclusion in tariff from 2020/21	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.3 **OBJ 6**

Principal Risk: Lack of clear national strategy for the commissioning of our specialist services

Risk of fragmentation and risk to sustainability of specialist services, centres of excellence diminished impacting on the quality of patient care for complex cases

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	3
Likelihood	4	3	2
Total	16	12	6

Risk Details

Opened: March 2018

Review Date: July 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX N/A)

Controls

- ✓ NOA collaboration
- ✓ Engagement with specialist commissioners and NHS England
- ✓ Internal definition and understanding of specialist services with a wider view beyond specialist commissioning
- ✓ Complexity modelling completed
- ✓ NHS Confederation and Federation of Specialist Hospitals collaboration on the role and potential of specialist hospitals
- ✓ Input into Clinical Reference Group for Spinal Injuries

Assurance: **Source of Assurance** **3**

- ✓ Previous national strategy for specialised commissioning
- ✓ NHS I and NHS E oversight
- ✓ Trust strategy
- ✓ STP collaboration

Gaps in Controls:

- ○ Further definition of specialist orthopaedic programme
- ○ Process to address the impact of NHS E procurement for specialised services
- ○ No early warning systems for external providers

Gaps in Assurance:

- ○ No national inclusion of MSK in NHS long term plan 10 year
- ○ Lack of integration between local and specialised commissioning for MSK conditions

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Explore opportunities to input into the NHS Confederation and Federation of Specialist Hospitals collaboration	Director of Finance and Planning	Mar 19	Paper has been published on Specialist Hospitals	Completed

Risk Owner:

Director of Nursing

Lead Committee

Finance Planning and Investment Committee

Month 3 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst and Data Quality Lead	Paper date:	25/07/2019
Executive Sponsor:	Kerry Robinson, Director of Performance, Improvement and OD	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

This paper is for information and the Board is asked to note the Month 3 (June) Integrated Performance Report.

2. Executive Summary

2.1. Context

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

2.2. Summary

In line with the Trust's Performance Management Strategy and Accountability Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust have been agreed by the sub-committees of the Board and included in this report.

The Trust remains in segment 2 of the NHS Improvement Single Oversight Framework.

Of note this month:

Caring for Staff;

- Increase in sickness absence; 4.45% against the latest 4% target.
- Turnover has now continually reduced month on month for twelve months, currently reported at 6.38% against the 8% target. This measure has been reviewed with figures being updated retrospectively.

Caring for Patients;

- No serious incidents reported in June.
- Increase in falls with one resulting in moderate harm.
- All cancer waiting times standards met in May, a third consecutive month.
- Our English RTT open pathways performance is reported at 90.61%, behind our trajectory of 91.10%. List size has increased from 7,116 at the end of May to 7,414 at the end of June. This is slightly above our trajectory of 7,350.
- No English patients waiting over 52 weeks. One Welsh patient waiting over 52 weeks with surgery taking place in July.
- Welsh diagnostics standard has improved and is reported at 100% for June. English diagnostics waits standard not met for 6 consecutive months.
- Increase in delayed discharges from 3.6% to 4.63%. Year-to-date this is reported at 5.05% against a planned threshold of 2.5%.

Caring for Finances;

- Theatre activity remains below plan and is impacting on financial position.
- Agency non-core remains above the national target.
- Outpatient activity for June was below plan however the year-to-date position is ahead of plan.

2.3. Conclusion

It is anticipated that there will be small amendments to the latest IPR layout as we progress through the year.

The Trust Board is asked to ***note*** the report and where insufficient assurance is received via the responsible sub-committee of the Board, the Board will seek additional assurance.

Integrated Performance Report
June 2019 – Month 3

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

Aspiring to deliver world class patient care

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Contents

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Reading guide

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

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

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

Key

Key Performance Indicator RAG Ratings

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

KPIs reported in arrears

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

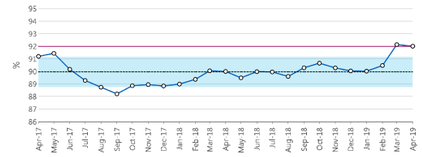
Data Quality Indicator

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

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

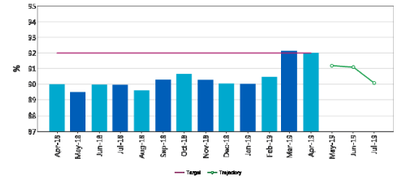
Trend graphs

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



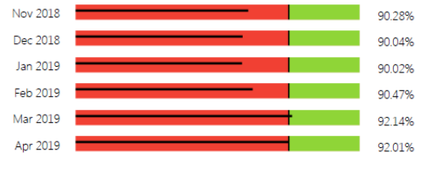
Trajectories

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



Bullet graphs

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



Thirteen-month heatmap view

Caring for Staff

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	3.4%	4.11%	3.57%	3.95%	4.39%	4.07%	4.29%	4.43%	4.58%	4.33%	4.59%	4.19%	4.45%	4%	4%	4.42%	R	
Voluntary Staff Turnover	8.64%	8.46%	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	8%	8%	6.38%	G	

Integrated Performance Report
June – Month 3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	0	0	1	1	1	1	1	0	0	2	1	1	0	0	0	2	R	Apr-18
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Total Patient Falls	10	13	10	15	20	13	16	11	10	8	5	11	16	10	30	32	G	Mar-19
RJAH Acquired Pressure Ulcers - Grades 3 or 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)	99.49%	99.23%	100%	99.45%	99.01%	99.29%	99.06%	99.18%	98.84%	98.84%	98.44%	98.52%	99.28%	95%	95%	98.76%	G	Apr-18
Number of Complaints	11	2	7	12	13	6	7	6	17	8	5	8	7	8	24	20	G	May-18
% Delayed Discharge Rate	4.99%	4.42%	3.27%	5.57%	6.1%	7.53%	8.17%	4.02%	6.05%	6.72%	7%	3.6%	4.63%	2.5%	2.5%	5.05%	R	
Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Jun-19
RJAH Acquired E. Coli Bacteraemia	0	1	0	1	0	0	0	0	0	0	0	2	0	0	0	2	R	Jun-19
RJAH Acquired C.Difficile	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	G	Apr-18
RJAH Acquired MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Unexpected Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
VTE Assessments Undertaken	99.92%	99.7%	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	95%	95%	99.82%	G	Apr-18
Cancer Two Week Wait*	100%	96.88%	100%	100%	100%	100%	100%	100%	92.86%	100%	100%	100%			93%	100%	G	
31 Days First Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			96%	100%	G	
31 Days Subsequent Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			94%	100%	G	
Cancer Plan 62 Days Standard (Tumour)*	66.67%	50%	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%			85%	100%	G	

Integrated Performance Report
June – Month 3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Cancer 62 Days Consultant Upgrade*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			85%	100%	G	
18 Weeks RTT Open Pathways	89.98%	89.96%	89.6%	90.29%	90.66%	90.28%	90.04%	90.02%	90.47%	92.14%	92.01%	91.4%	90.61%	92%	92%	91.71%	G	
Patients Waiting Over 52 Weeks – English	0	1	1	0	2	2	4	2	4	0	0	0	0	0	0	0	G	
Patients Waiting Over 52 Weeks – Welsh	2	9	8	6	3	6	7	3	6	1	0	0	1	0	0	0	G	
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)	128	121	124	87	54	72	66	52	26	0	1	6	18		0	0	G	
6 Week Wait for Diagnostics - English Patients	99.37%	98.59%	99.15%	99.16%	99.07%	98.7%	99.1%	98.91%	98.88%	97.64%	97.53%	97.21%	98.35%	99%	99%	97.72%	G	
8 Week Wait for Diagnostics - Welsh Patients	99.76%	99.77%	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	99.5%	G	

Caring for Finances

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Theatre Activity	1,023	1,053	929	1,017	1,115	1,157	883	1,094	1,024	1,082	856	970	886	1,055	2,947	2,712	R	
Bed Occupancy – All Wards – 2pm	85.73%	83.78%	86.61%	89.08%	85.94%	84.03%	84.83%	86.78%	87.62%	85.32%	81.44%	81.46%	82.49%	87%	83%	81.8%	G	
Outpatients Activity Attendances	13,609	13,631	12,885	13,792	15,939	15,298	11,440	14,995	13,616	13,718	13,727	13,753	12,920	14,143	39,822	40,400	G	
Financial Control Total	235	279	-190	152	676	621	-833	359	59	535	-775	31	-207	278	-431	-951	G	
Income	9,378	9,559	9,080	9,194	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,542	9,306.2	26,466	26,727	G	
Expenditure	9,129	9,165	9,264	9,038	9,734	9,416	8,648	9,189	9,031	9,464	9,495	9,521	8,788	9,072.42	27,027	27,804	G	
CIP Delivery	356	249	310	298	327	311	329	284	307	358	161	191	260	274	677	612	G	
QIPP Delivery Risk Impact											106	86	-67	0	0	125	R	
Agency Core	158.27	186.24	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	55	72	44	132	396	171	G	
Agency Non-Core	248.74	246.63	296.21	243.2	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	186	480	689	R	
Cash Balance	4,200	6,300	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,700	5,100	4,900	5,000	4,200	4,200	5,000	G	
Capital Expenditure	346	205	164	297	160	377	400	304	165	1,327	260	336	162	314	1,025	758	G	
Use of Resources (UOR)	3	2	3	2	2	2	2	2	2	1	3	3	3	3	3	3	G	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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Sickness Absence

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

4.45% against 4% target

Breaching target red rated

Exec Lead:
Director of People

People Committee

Narrative

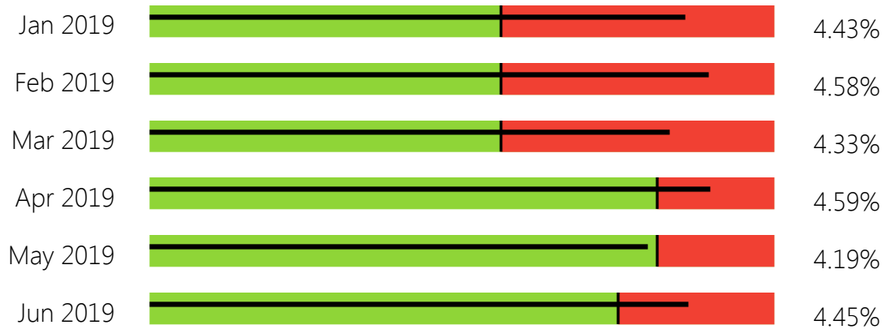
Sickness absence, predominantly short-term, increased in June. Short term sickness remains in target while long-term sickness remains above target.

The most frequent causes of long term absence were stress/anxiety/depression and MSK. The most frequent causes of short term absence were stress/anxiety/depression.

Action to Improve:Managers and HR continue to review cases of long term sickness absence and support individual cases.

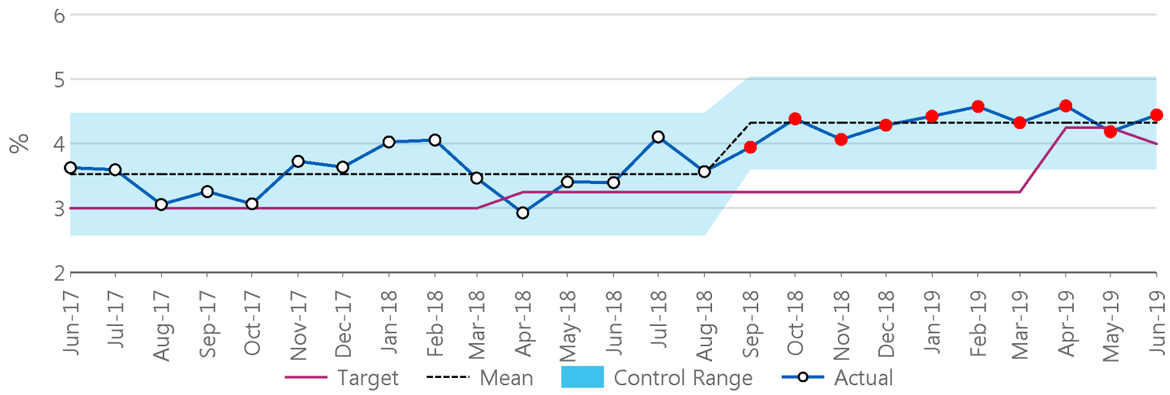
Work continues to focus on initiatives to boost staff wellbeing with focussed discussions with staff and JCG along with defining actions to reduce stress/anxiety and depression absence during the remainder of the year. A number of staff support initiatives are in place to be introduced in the autumn.

Performance against RAG ratings

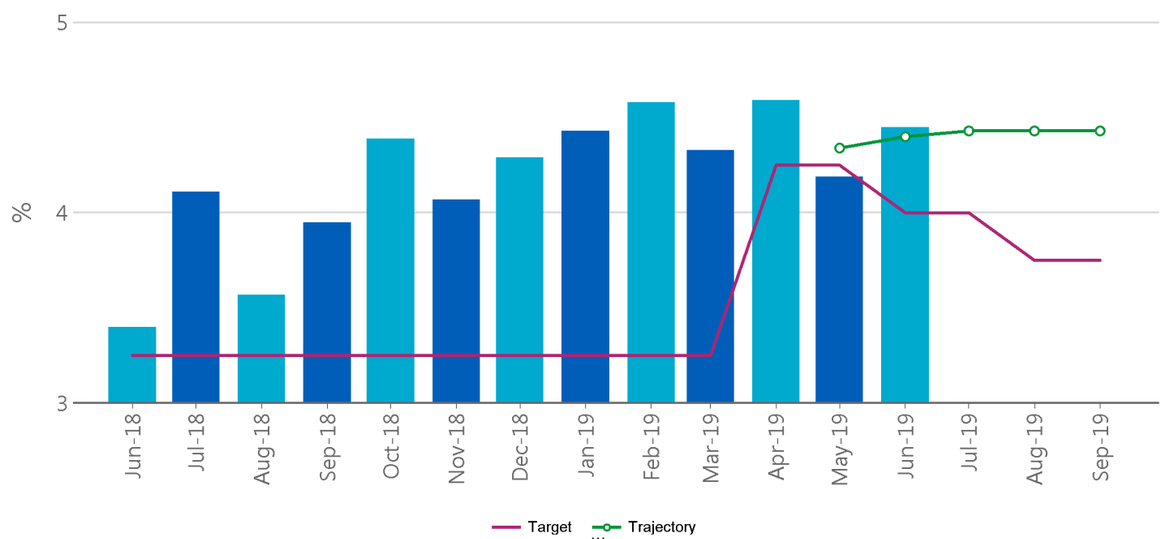


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
3.63%	3.6%	3.06%	3.26%	3.07%	3.73%	3.64%	4.03%	4.06%	3.47%	2.93%	3.41%	3.4%	4.11%	3.57%	3.95%	4.39%	4.07%	4.29%	4.43%	4.58%	4.33%	4.59%	4.19%	4.45%	4.42%

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Voluntary Staff Turnover

Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 211184

6.38% against **8%** target

Within target green rated

Exec Lead:
Director of People

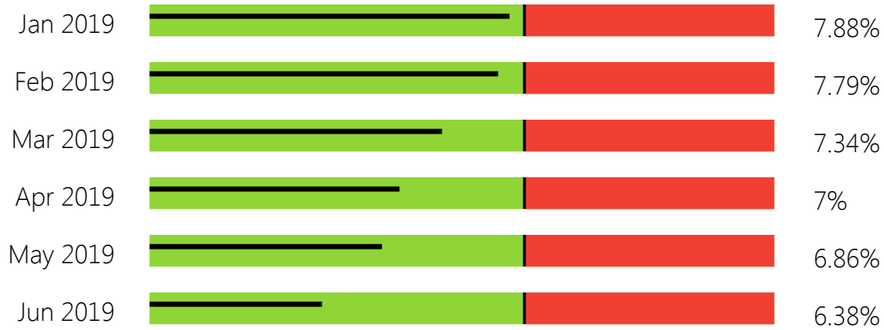
People Committee

Narrative

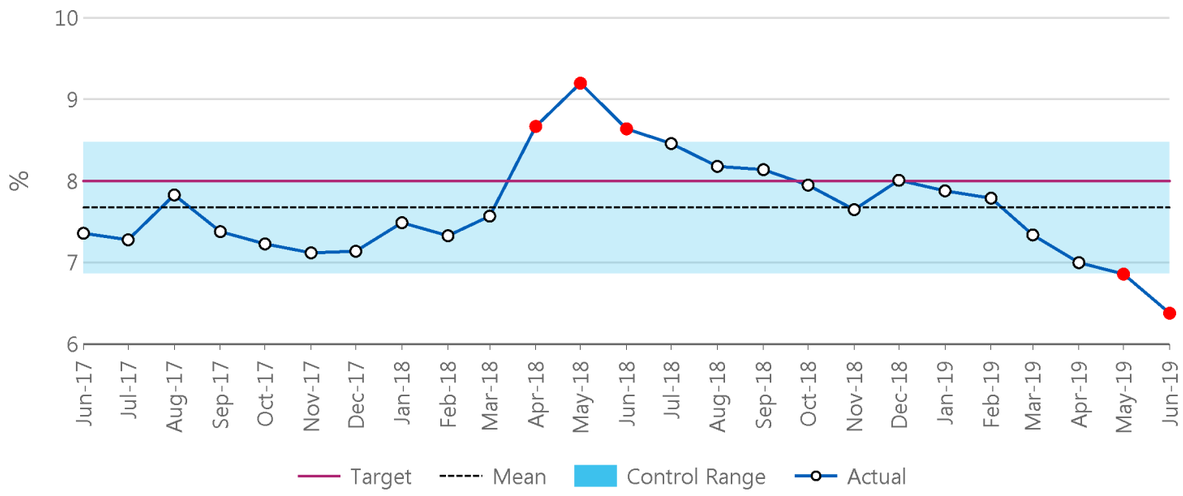
There has been a further reduction in voluntary turnover and the measure is reported below (positive) the target. There are no Divisions exceeding this target.

As part of our Data Quality audit programme this measure is currently under review where initial findings may indicate some recommendations to the way it is calculated.

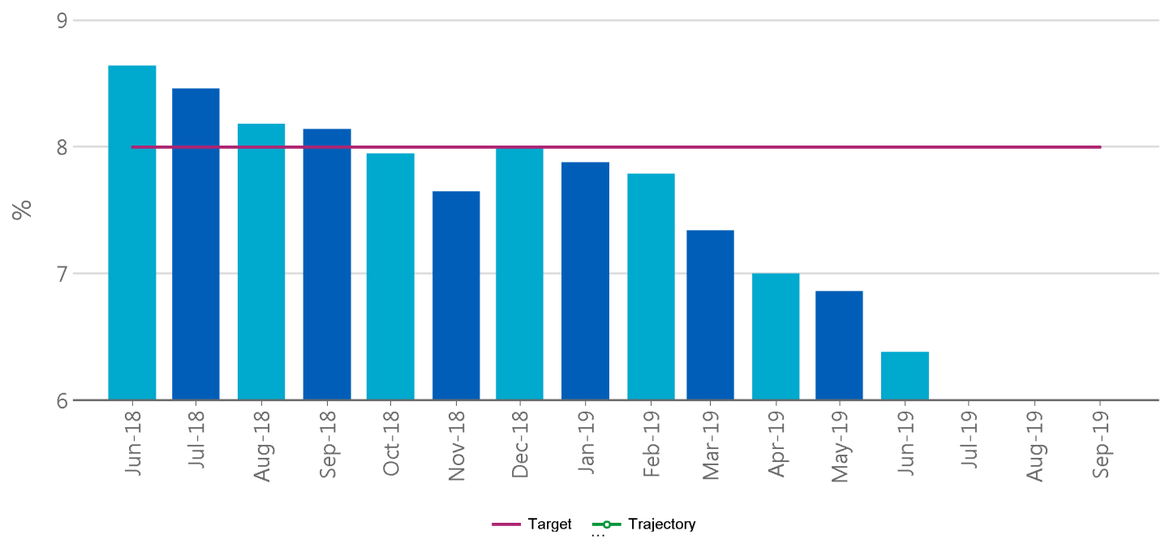
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
7.36%	7.28%	7.83%	7.38%	7.23%	7.12%	7.14%	7.49%	7.33%	7.57%	8.67%	9.2%	8.64%	8.46%	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	6.38%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Serious Incidents

Number of Serious Incidents reported in month 211160

0 against 0 target

On target green rated

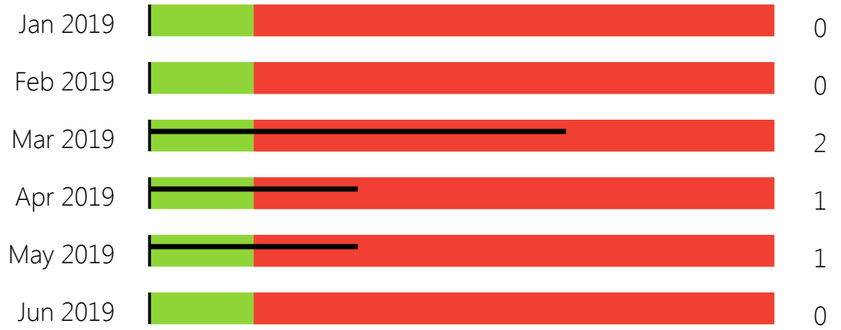
Exec Lead:
Director of Nursing

Quality and Safety Committee

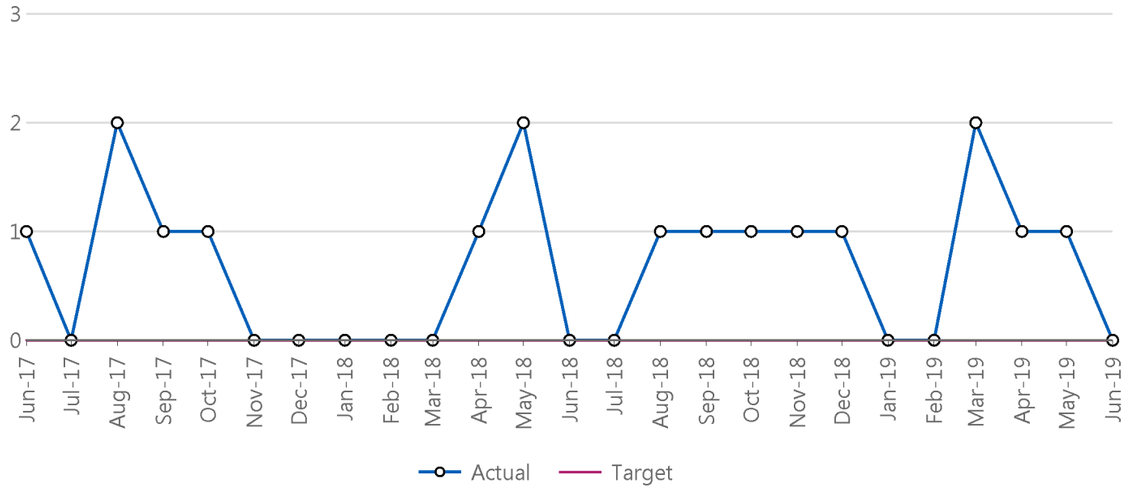
Narrative

There were no serious incidents reported in June.

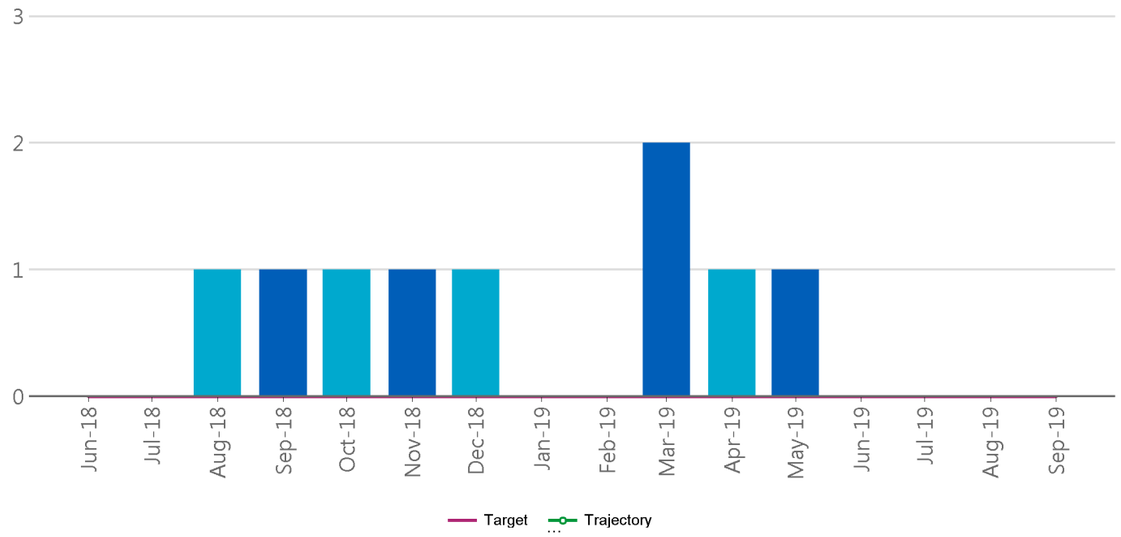
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

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NHS Foundation Trust

Never Events

Number of Never Events Reported in Month 211096

0 against 0 target

On target green rated

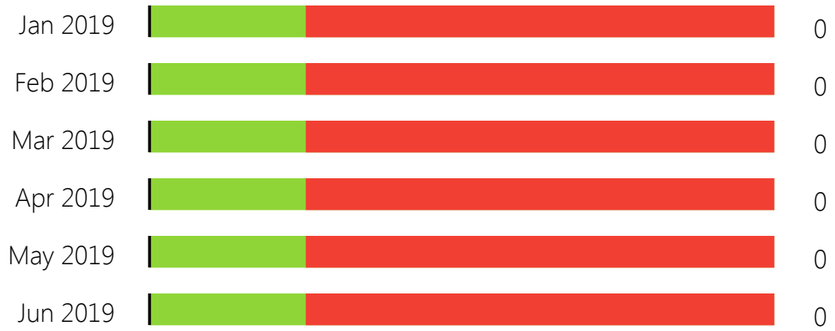
Exec Lead:
Director of Nursing

Quality and Safety Committee

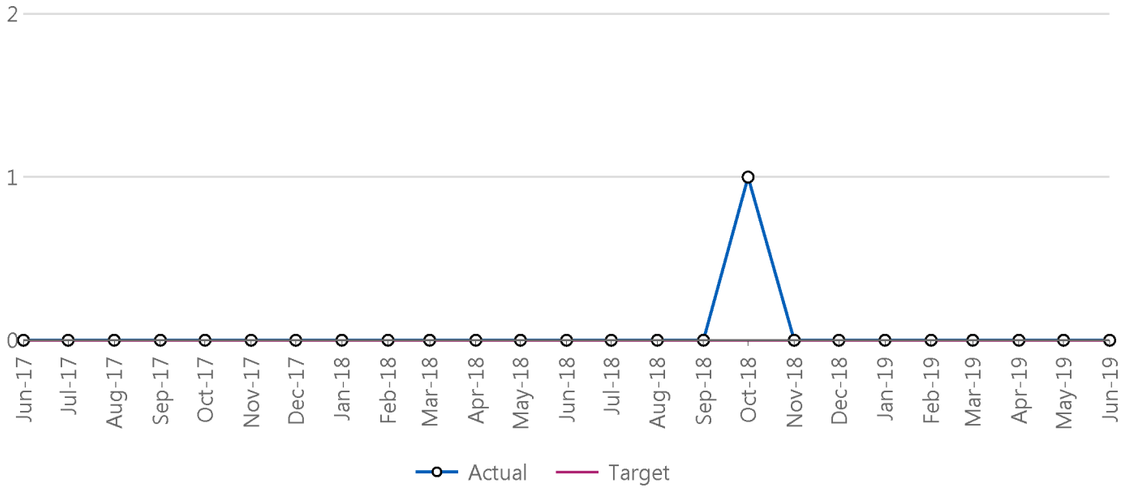
Narrative

There were no never events reported in June.

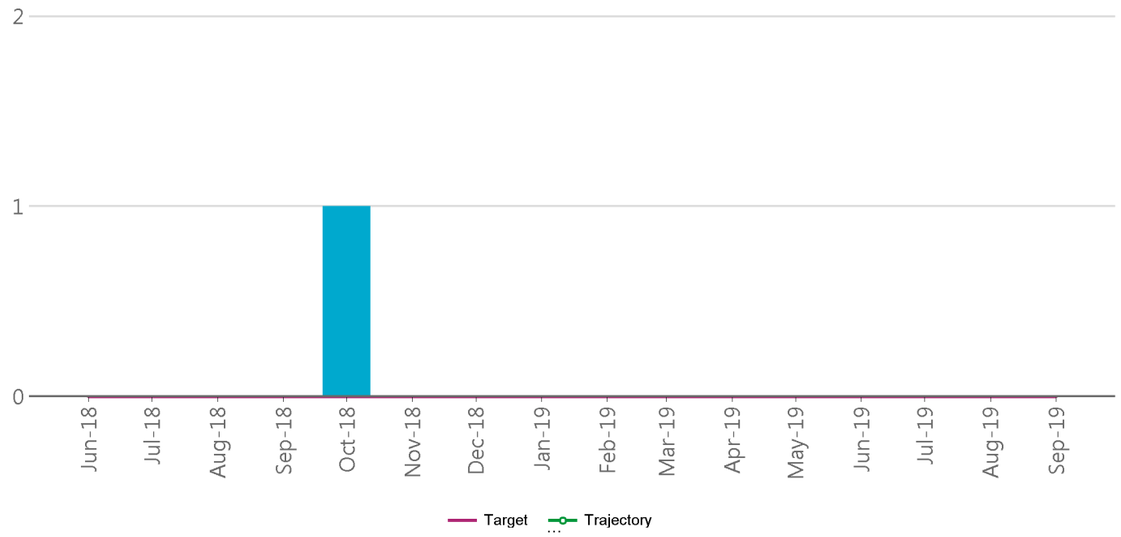
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Patient Falls

Total number of falls - excludes slips, trips and assisted slides 211176

16 against 10 target

Breaching target red rated

Exec Lead:
Director of Nursing

Quality and Safety Committee

Narrative

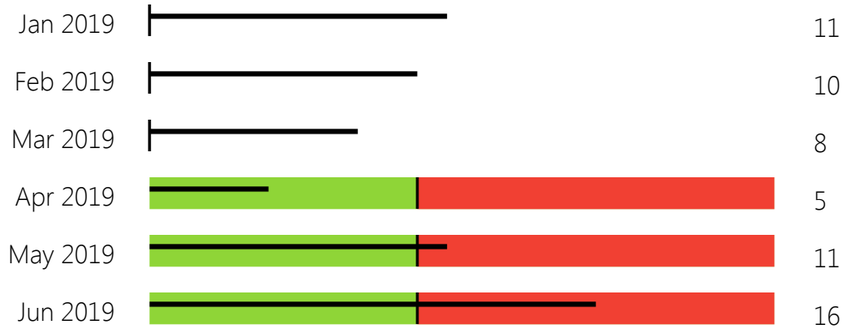
The Total Patient Falls KPI is red rated in June as there were 16 falls, 13 relating to inpatients and 3 relating to outpatients. Although this is an increase this month it falls within our control range. A full breakdown of the falls is provided here:

- No Harm (3) 18.75%
- Low harm (12) 75.00%, made up of:
  - No obvious injury but unwitnessed (5)
  - Bruising/graze (4)
  - Pain (2)
  - Bump to head (1)
- Moderate harm (1) 6.25% - fracture

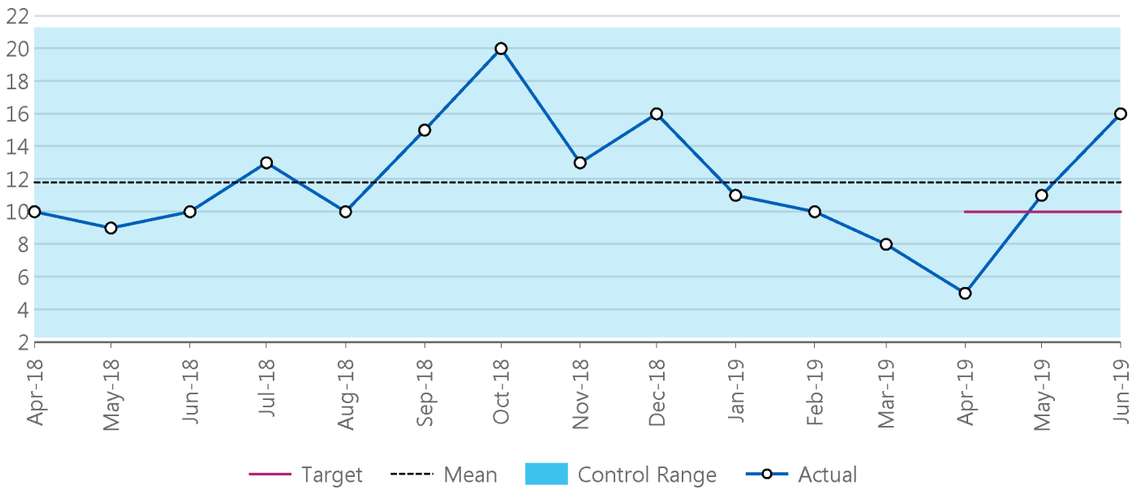
The falls occurred within the following wards/areas:

- Inpatient falls: Alice (2), Clwyd (3), Kenyon (3), Powys (2), Oswald (1), Wrekin (1), Corporate/Estates (1)
- Outpatient falls: Baschurch (1), Pre-Op (1) and Therapies (1).

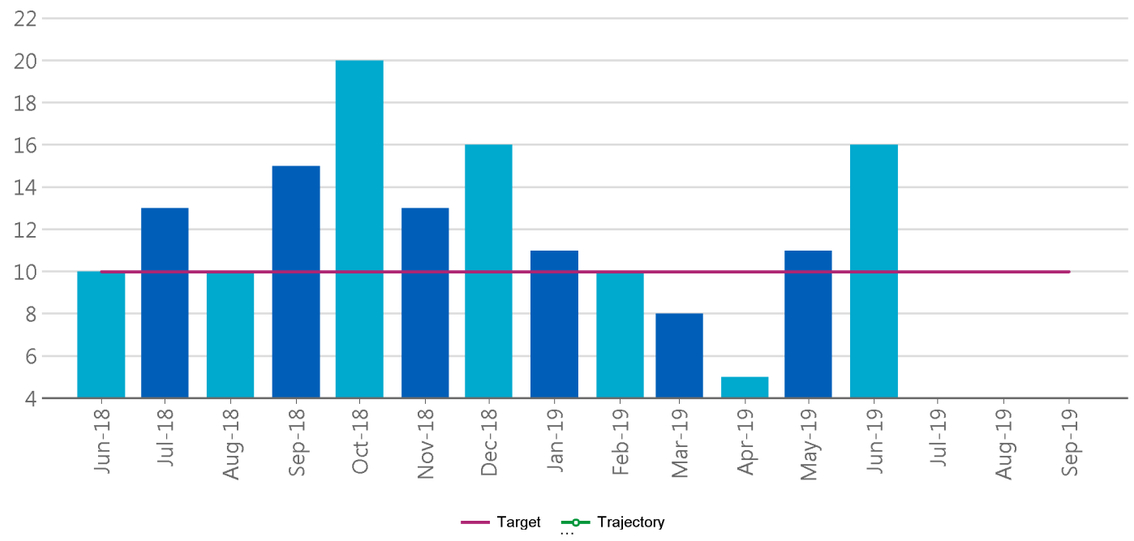
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
10	9	10	13	10	15	20	13	16	11	10	8	5	11	16	32

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired Pressure Ulcers - Grades 3 or 4

Total number of category 3 & 4 pressure ulcers acquired at RJAH 211202

0 against 0 target

On target green rated

Exec Lead:
Director of Nursing

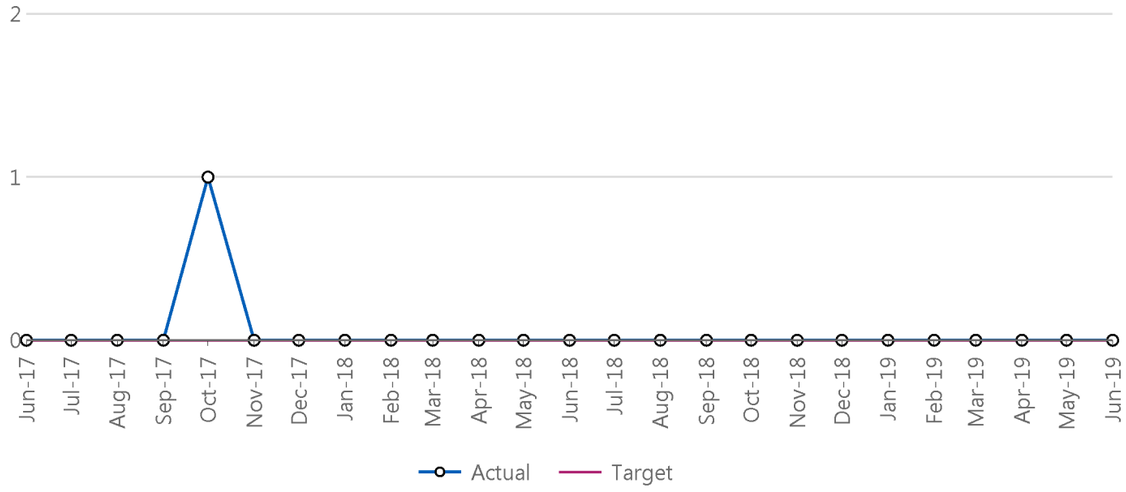
Quality and Safety Committee

Narrative

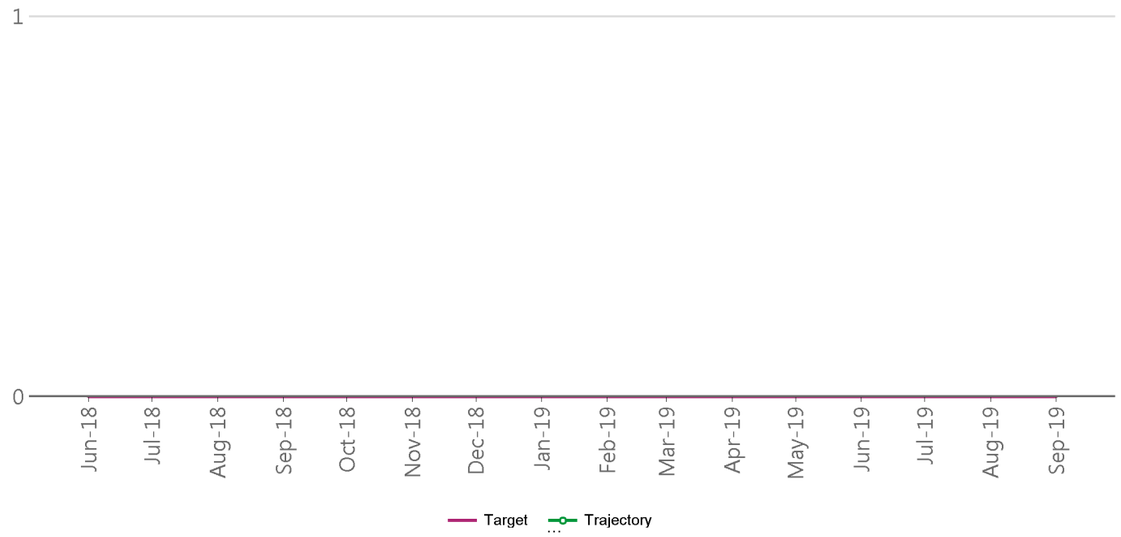
There were no category three or four pressure ulcers in June.

Performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)

99.28% against 95% target

Above target green rated

Exec Lead:
Director of Nursing

Quality and Safety Committee

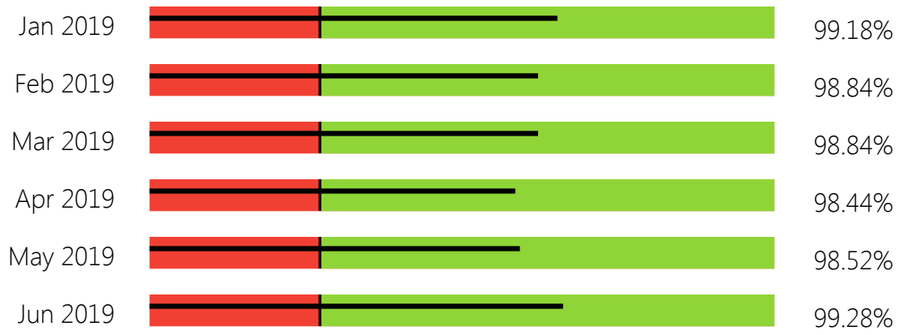
% of patients who would recommend the trust (inpatients and outpatients) 211137

Narrative

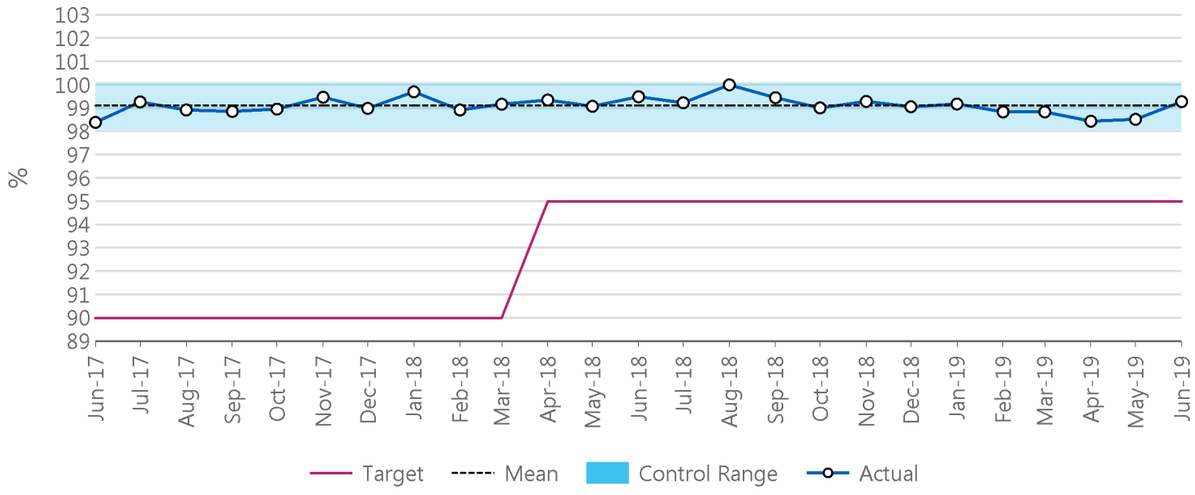
There were 839 responses collected with a breakdown as follows:
- 833 positive - giving a rate of 99.28% would recommend the Trust to friends and family
- 4 negative - giving a rate of 0.48% would not recommend the Trust to friends and family
- 2 responses as "neither likely or unlikely" or "don't know"

The number of compliments received in June was 281.

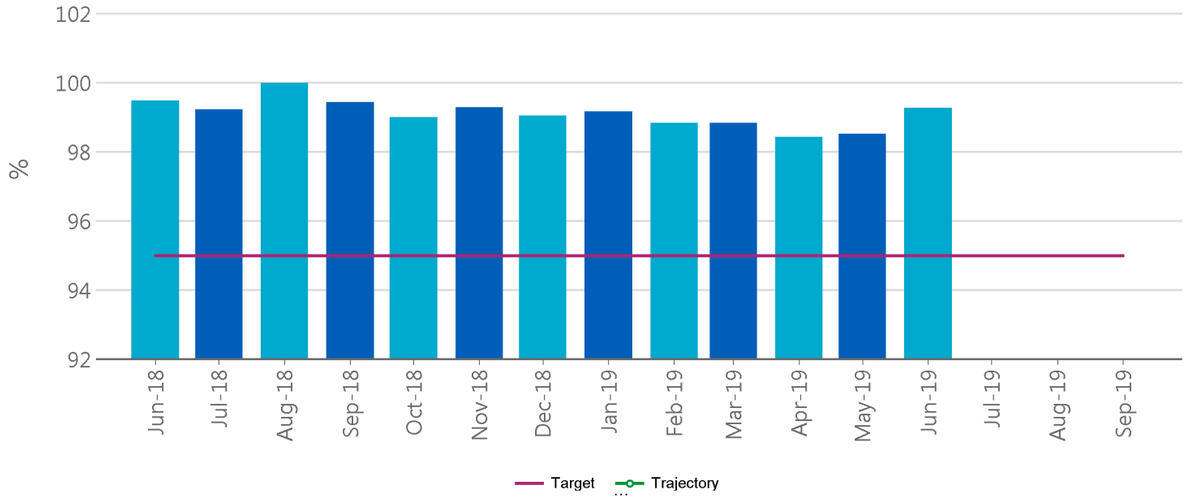
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
98.39%	99.27%	98.92%	98.86%	98.96%	99.47%	98.99%	99.7%	98.92%	99.17%	99.35%	99.08%	99.49%	99.23%	100%	99.45%	99.01%	99.29%	99.06%	99.18%	98.84%	98.84%	98.44%	98.52%	99.28%	98.76%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month 211105

7 against 8 target

Within target green rated

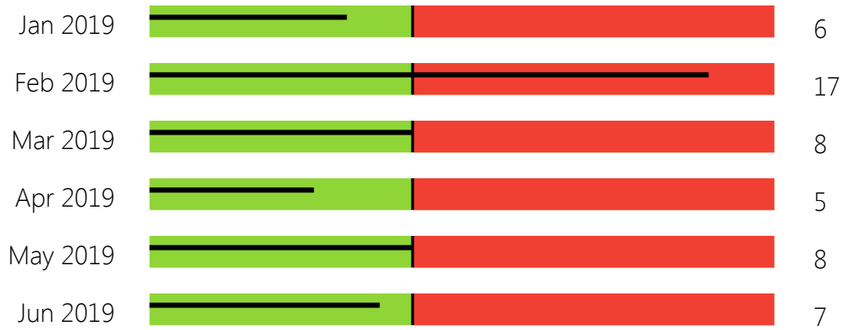
Exec Lead:
Director of Nursing

Quality and Safety Committee

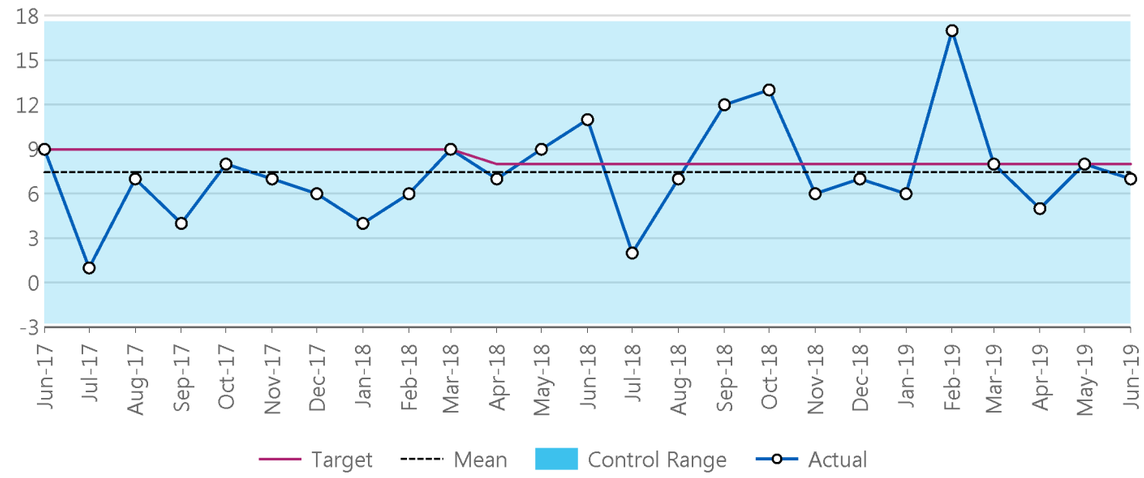
Narrative

There were seven complaints received in June. Five related to operational issues with reasons associated with waiting times (2), cancelled appointments (1), cancelled surgery (1) and treatment given (1). Two related to the quality of care with reasons associated with the information given (1) and misdiagnosis(1).

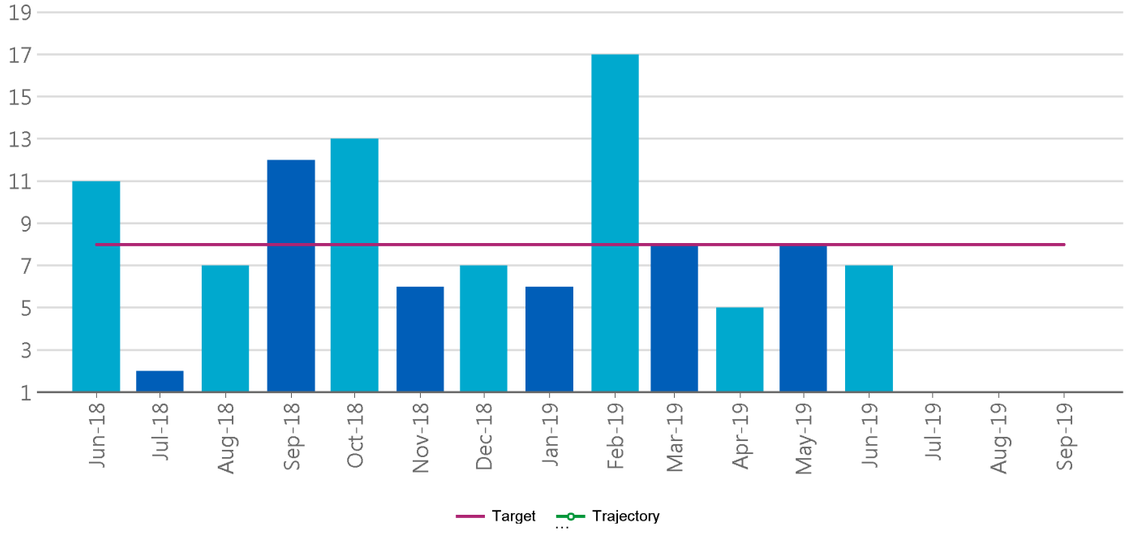
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
9	1	7	4	8	7	6	4	6	9	7	9	11	2	7	12	13	6	7	6	17	8	5	8	7	20

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

% Delayed Discharge Rate

The total number of delayed days against the total available bed days for the month in % 211001

4.63% against **2.5%** target

Breaching target red rated

Exec Lead:
Director of Nursing

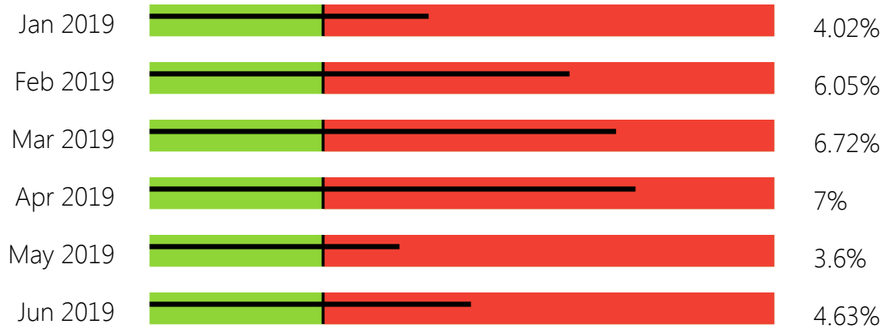
Quality and Safety Committee

Narrative

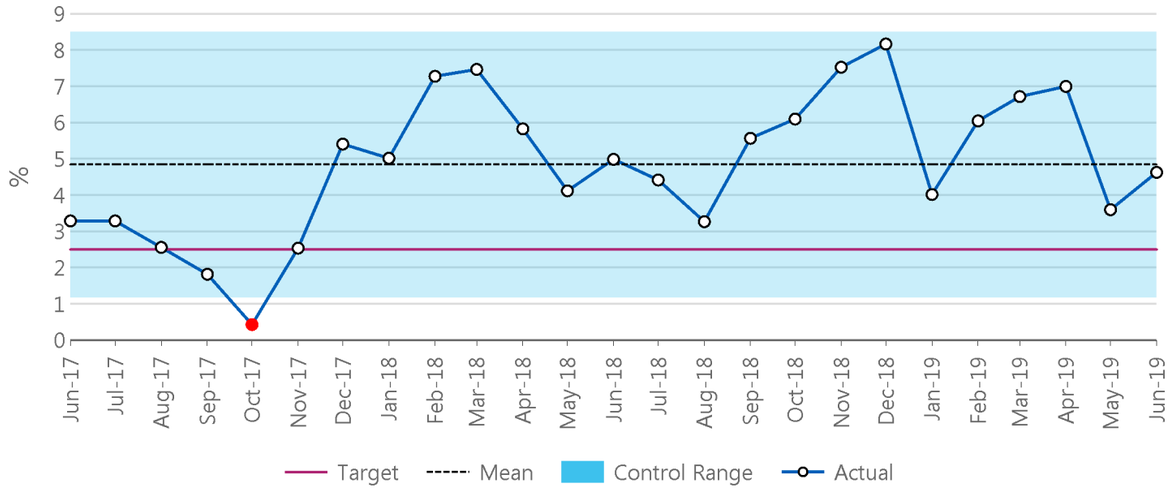
The Delayed Discharge rate is red rated this month at 4.63%. This represents an increase from May which was 3.60% (169 days and 18 patients). The total delayed days for June is 217 days; 6 spinal injuries patients amounting to 73 days, 11 care of the elderly patients with 58 delayed days and 10 surgical patients with 86 delayed days. The patients fall under the responsibility of Shropshire (14), Resident in Wales (4), Cheshire West and Chester UA (2), Dudley (2) and 5 other organisations with one patient each.

Action to Improve:Actions remain the same as those stated last month; Work is ongoing with MCSI to explore options to utilise capacity differently whilst supporting DTOC patients. A meeting is also scheduled in late July with the local authority to discuss delays.

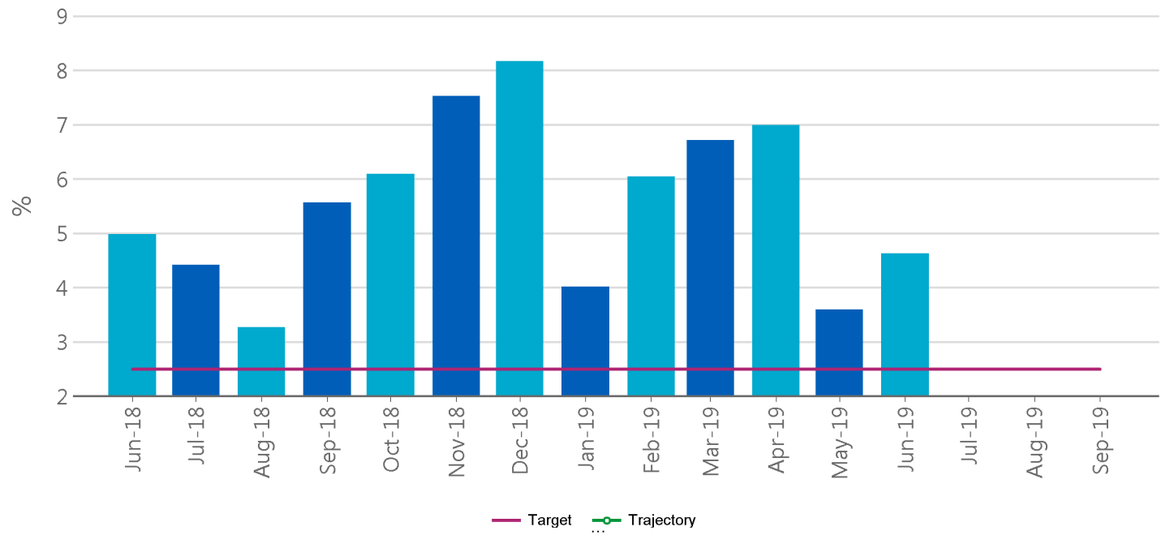
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
3.29%	3.29%	2.56%	1.82%	0.43%	2.54%	5.41%	5.02%	7.28%	7.47%	5.83%	4.12%	4.99%	4.42%	3.27%	5.57%	6.1%	7.53%	8.17%	4.02%	6.05%	6.72%	7%	3.6%	4.63%	5.05%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Mixed Sex Accommodation

Number of breaches to the mixed sex accommodation standard for non clinical reasons 212203

0 against 0 target

On target green rated

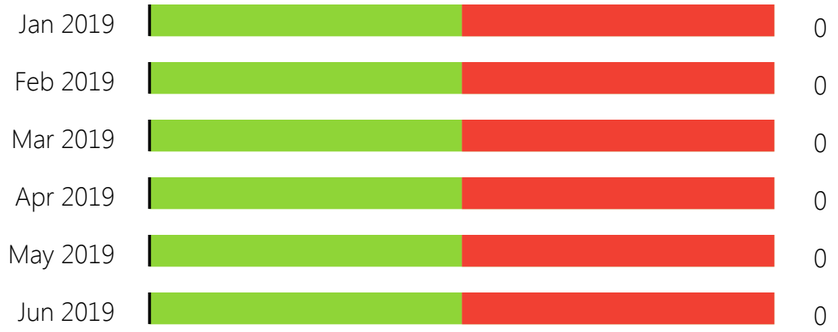
Exec Lead:
Director of Nursing

Quality and Safety Committee

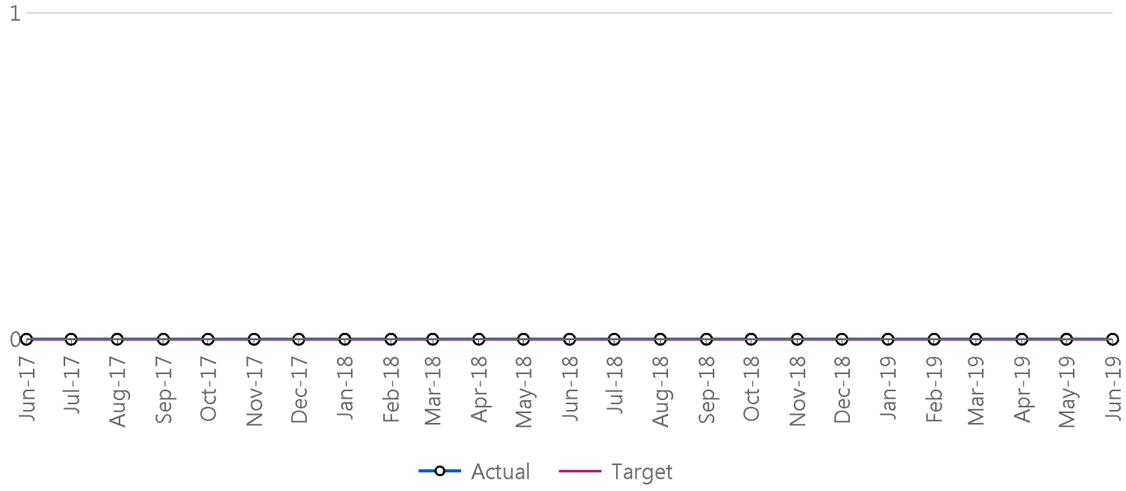
Narrative

There were no breaches of the mixed sex accommodation standard in June.

Performance against RAG ratings



Performance over 24 months –



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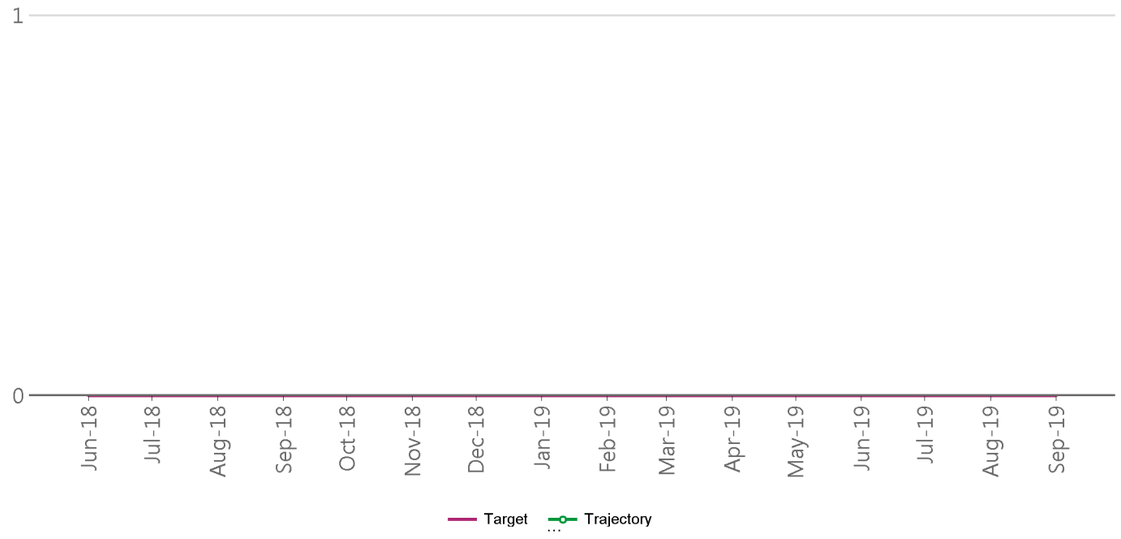


Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired E. Coli Bacteraemia

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

0 against 0 target

On target green rated

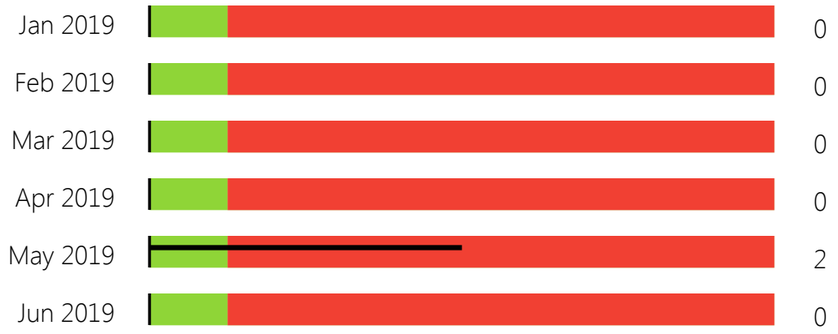
Exec Lead:
Director of Nursing

Quality and Safety Committee

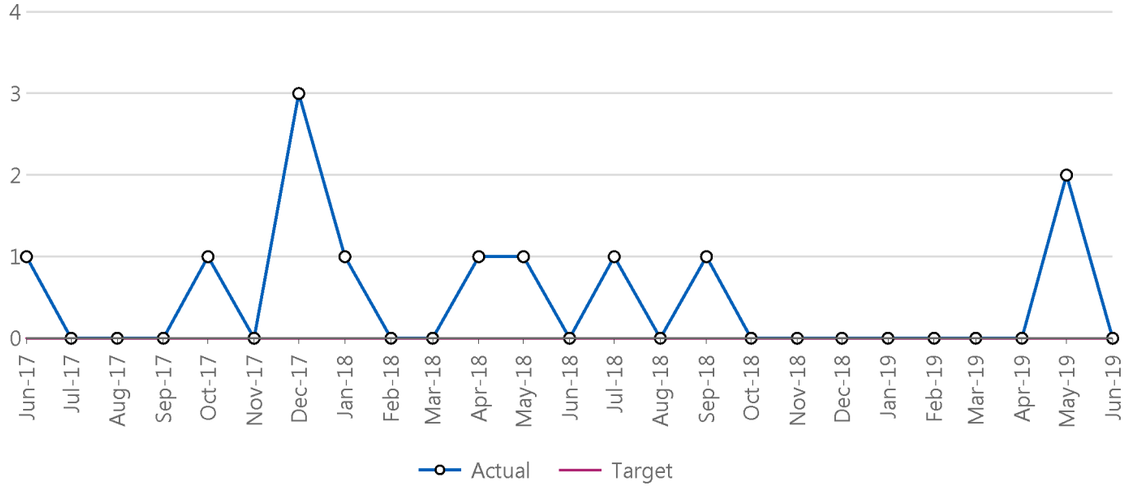
Narrative

There were no incidents reported in June.

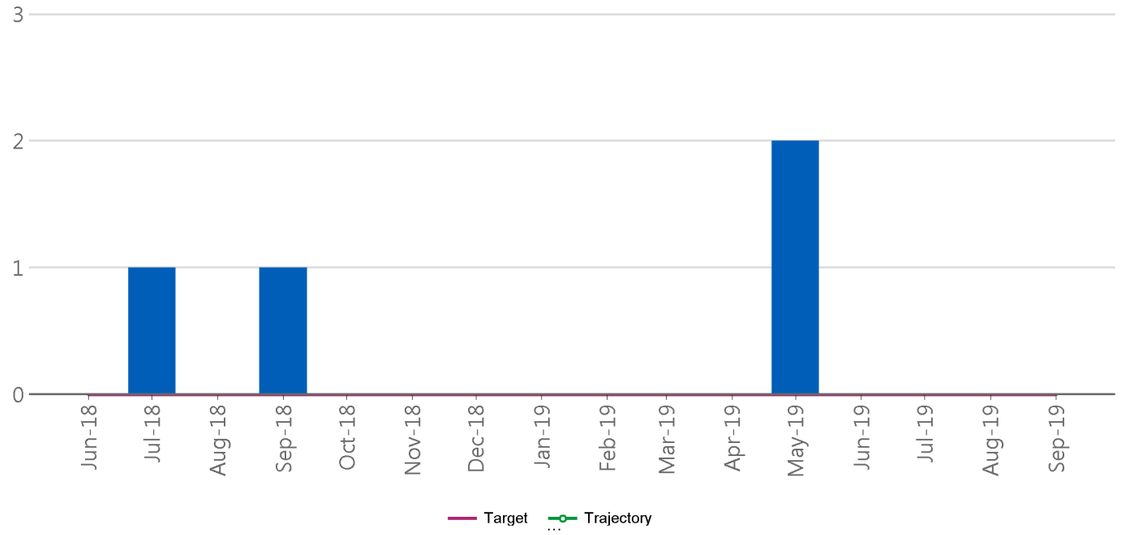
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month 211149

0 against 0 target

On target green rated

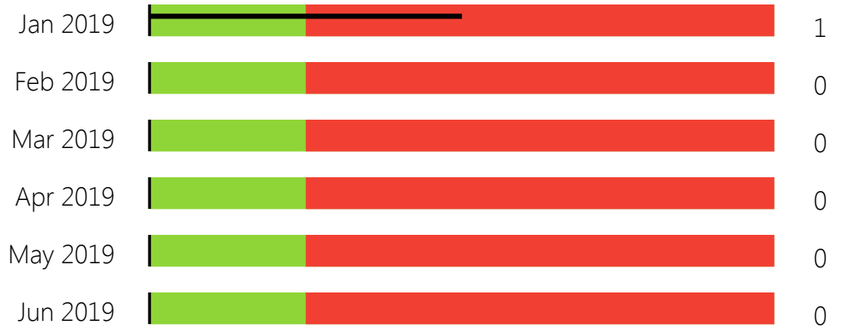
Exec Lead:
Director of Nursing

Quality and Safety Committee

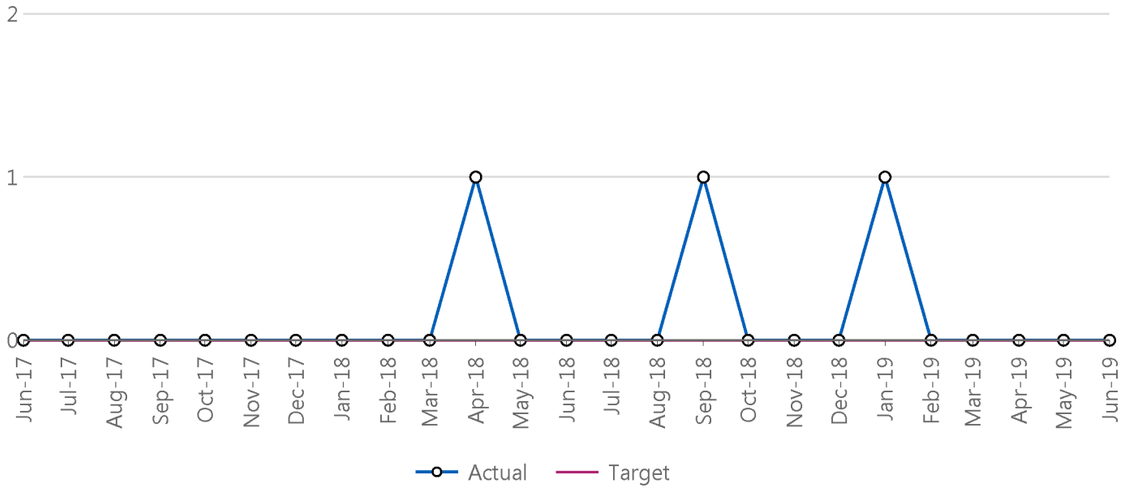
Narrative

There were no incidents reported in June.

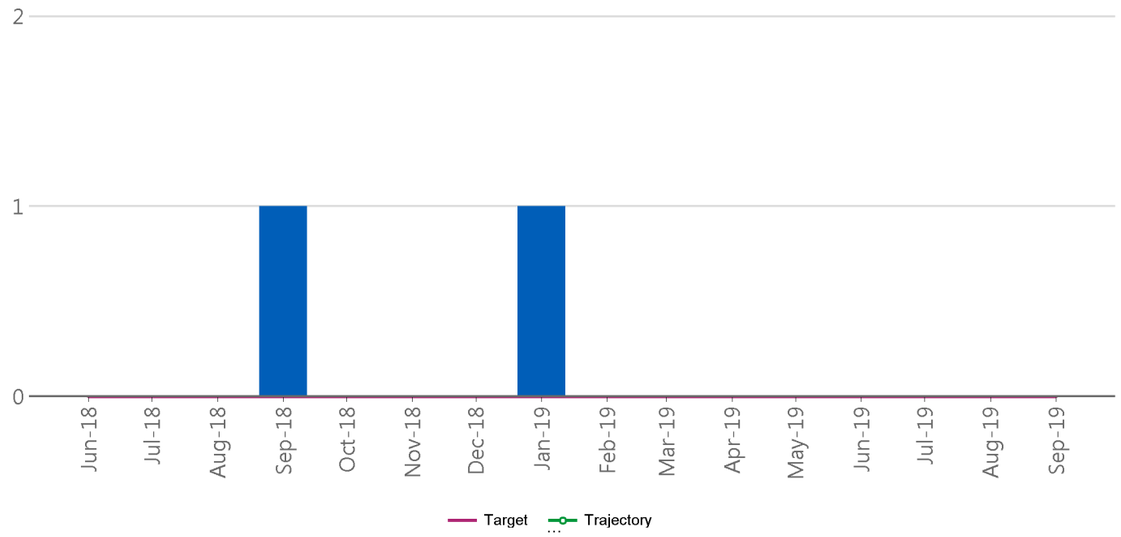
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month 211151

0 against 0 target

On target green rated

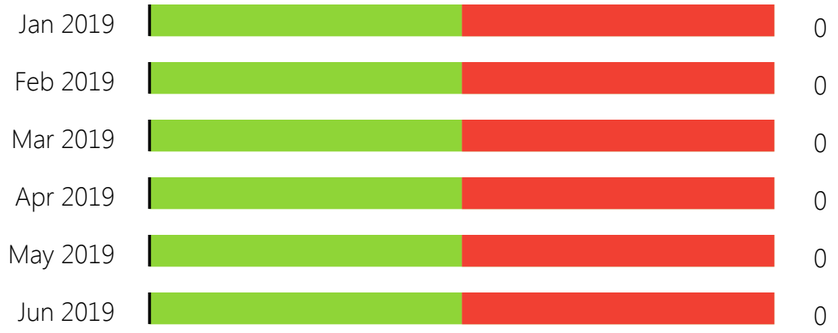
Exec Lead:
Director of Nursing

Quality and Safety Committee

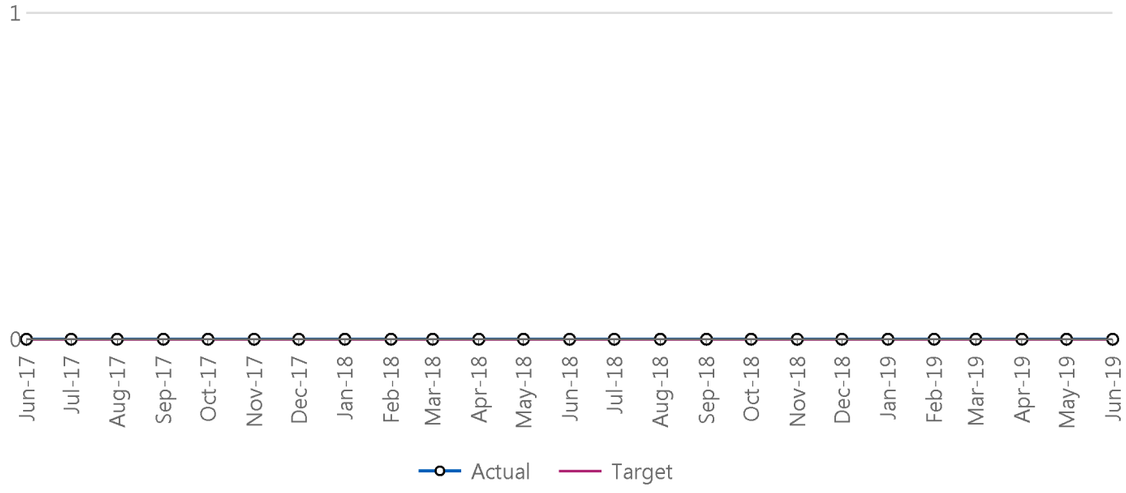
Narrative

There were no incidents reported in June.

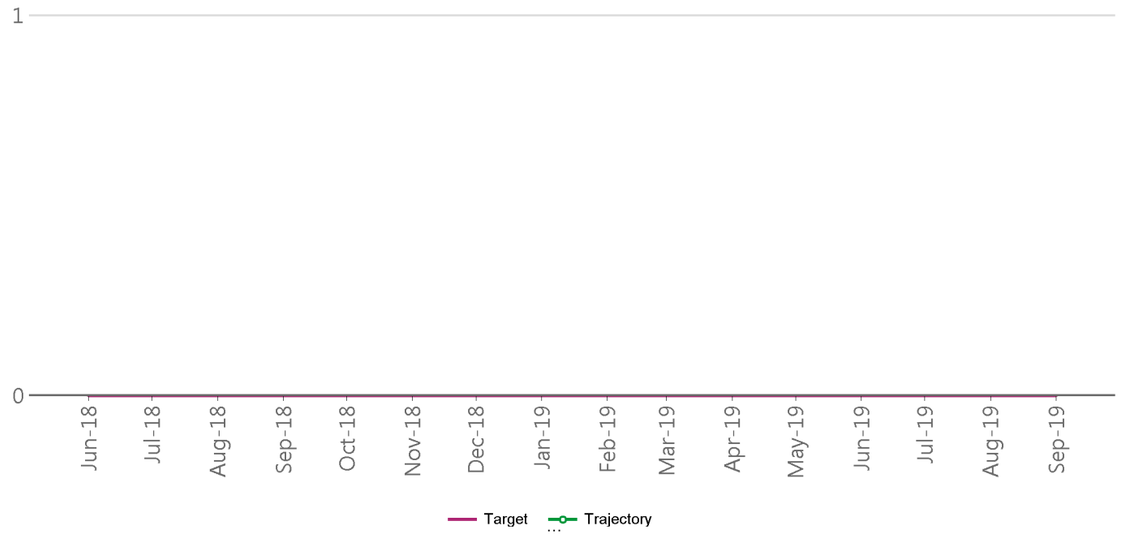
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Unexpected Deaths

Number of Unexpected Deaths in Month 211182

0 against **0** target

On target green rated

Exec Lead:
Medical Director

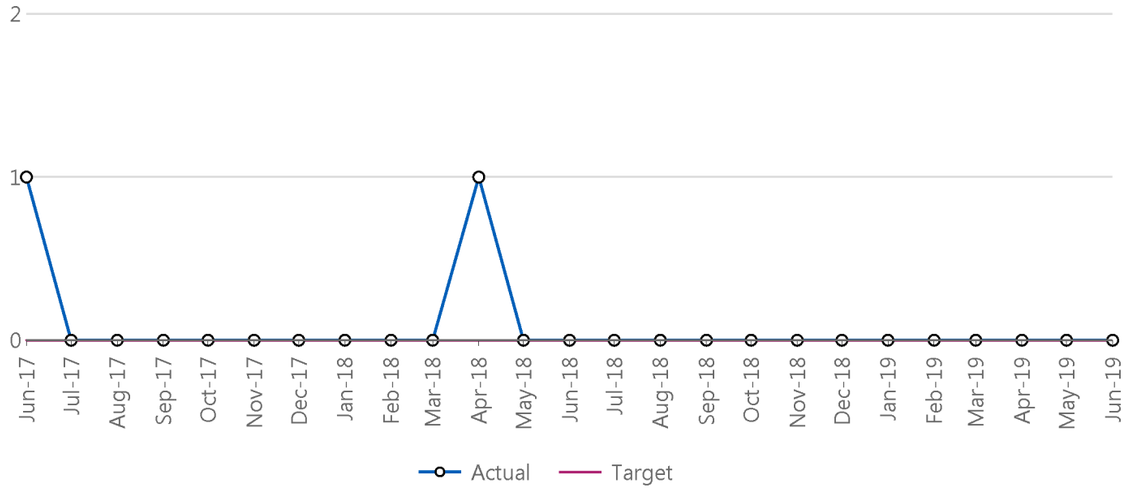
Quality and Safety Committee

Narrative

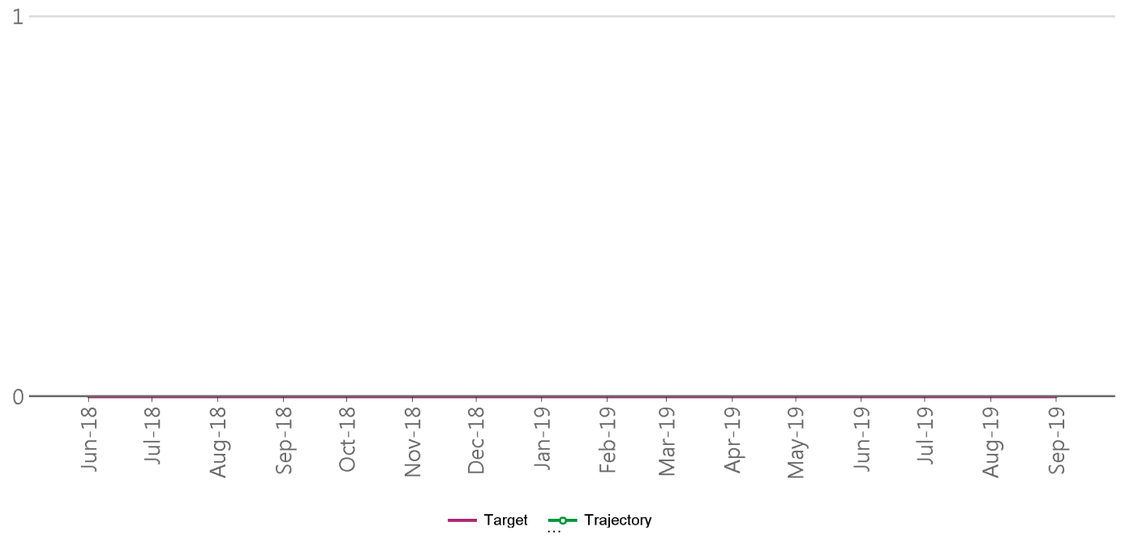
There was one death on Wrekin ward in June. This death was not unexpected.

Performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

VTE Assessments Undertaken

% of adult admissions in the month who have been risk assessed for VTE 211185

99.73% against 95% target

Above target green rated

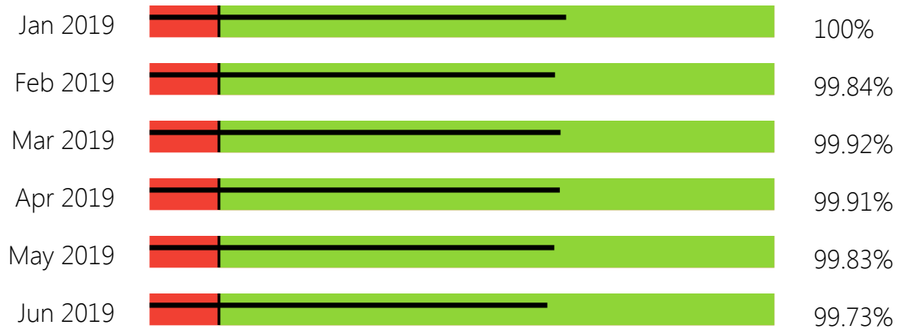
Exec Lead:
Medical Director

Quality and Safety Committee

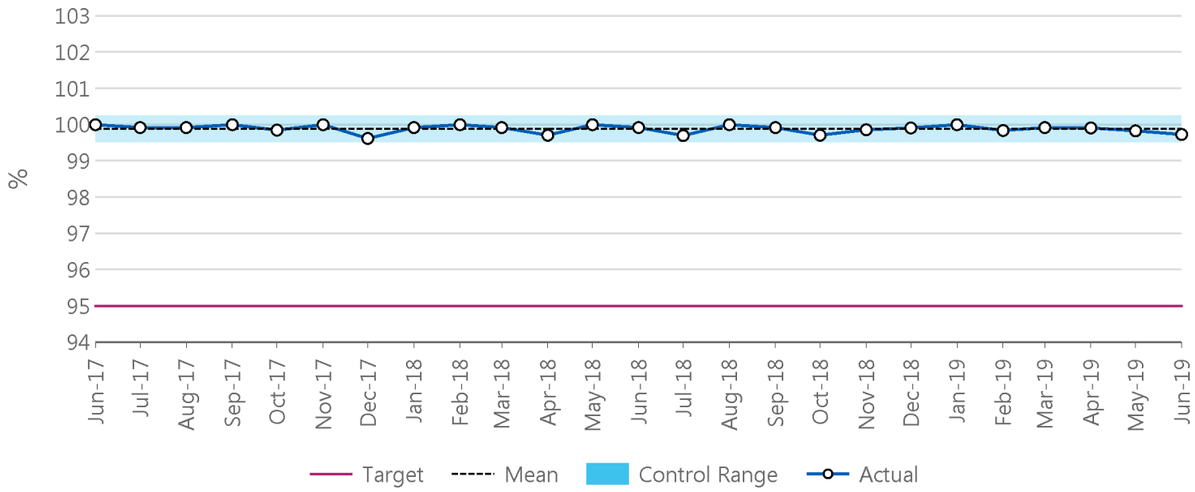
Narrative

The percentage of admissions risk assessed is reported at 99.73% in June and remains above the 95% target.

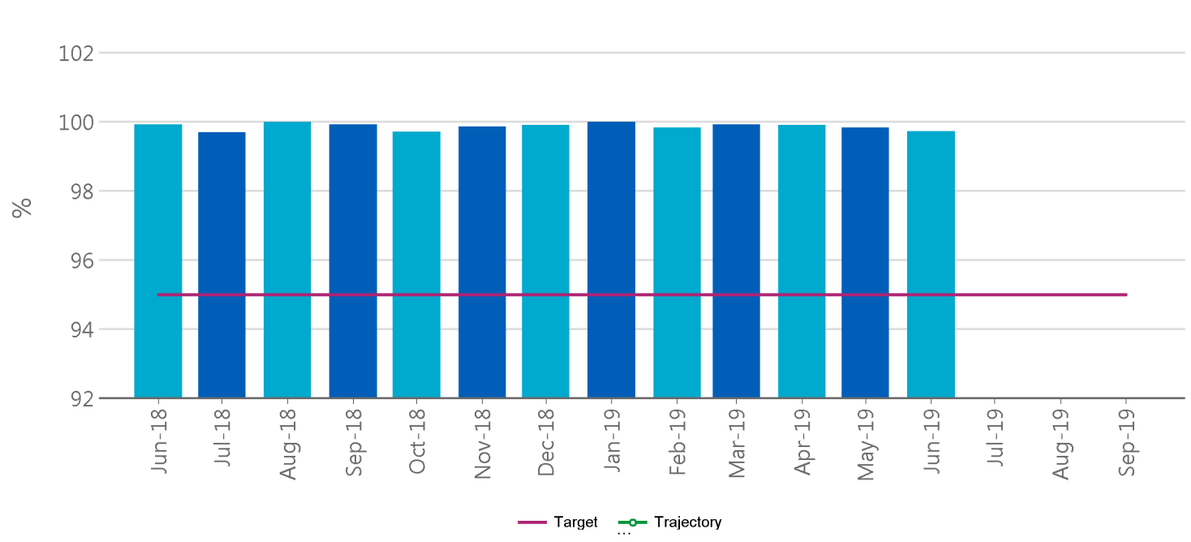
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
100%	99.92%	99.92%	100%	99.85%	100%	99.62%	99.92%	100%	99.92%	99.71%	100%	99.92%	99.7%	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	99.82%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer Two Week Wait*

% of urgent cancer referrals seen within 2 weeks (*Reported one month in arrears) 211046

100% against 93% target

green rated

Exec Lead:
Director of Operations

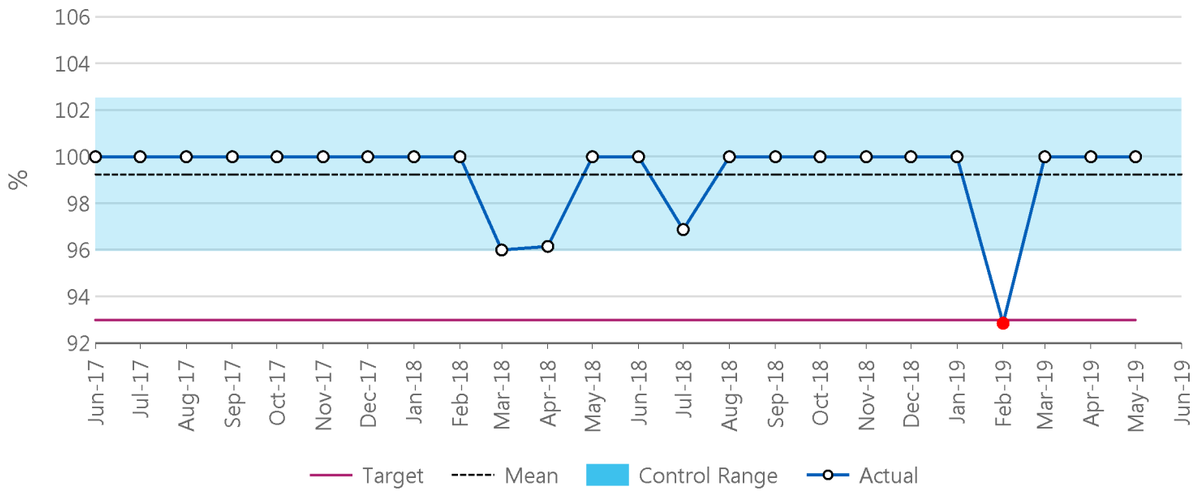
Finance, Planning and Digital Committee

Narrative

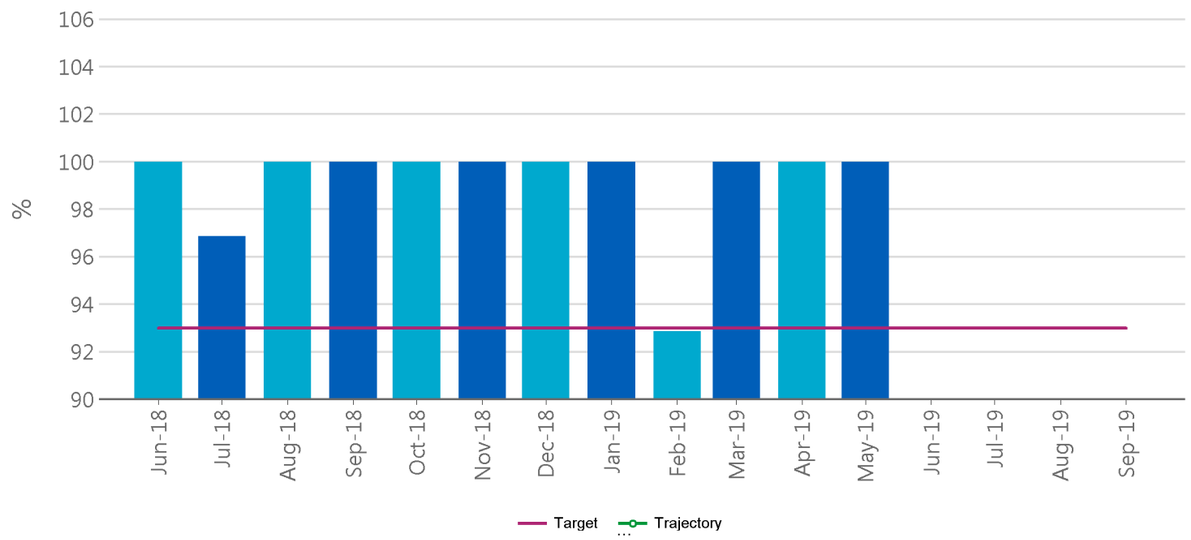
The Cancer 2 week wait standard was achieved in May and indicative data for June shows the standard will be met.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	96.15%	100%	100%	96.88%	100%	100%	100%	100%	100%	100%	92.86%	100%	100%	100%		100%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

31 Days First Treatment (Tumour)*

% of cancer patients treated within 31 days of decision to treat (*Reported one month in arrears) 211024

100% against 96% target

green rated

Exec Lead:
Director of Operations

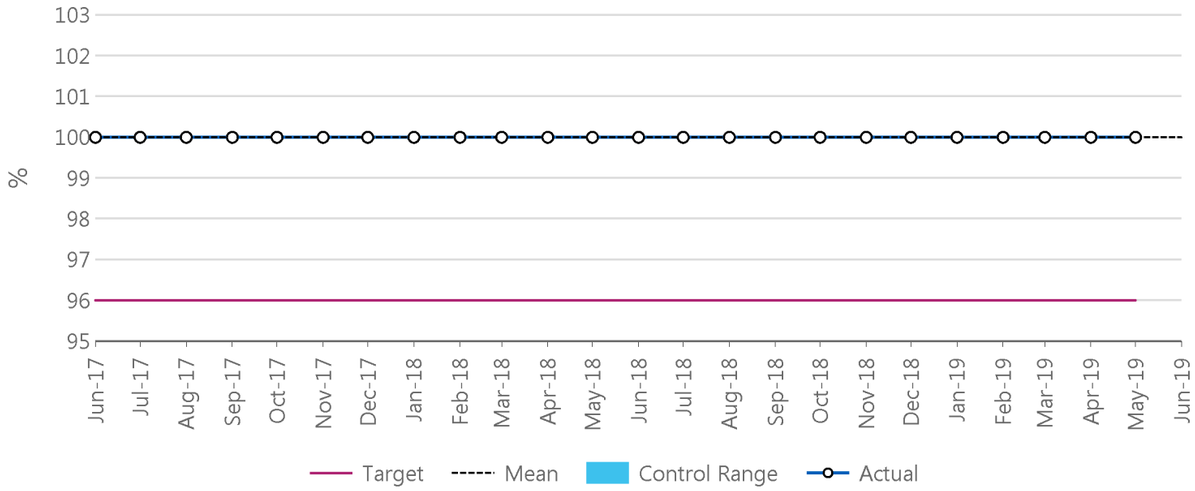
Finance, Planning and Digital Committee

Narrative

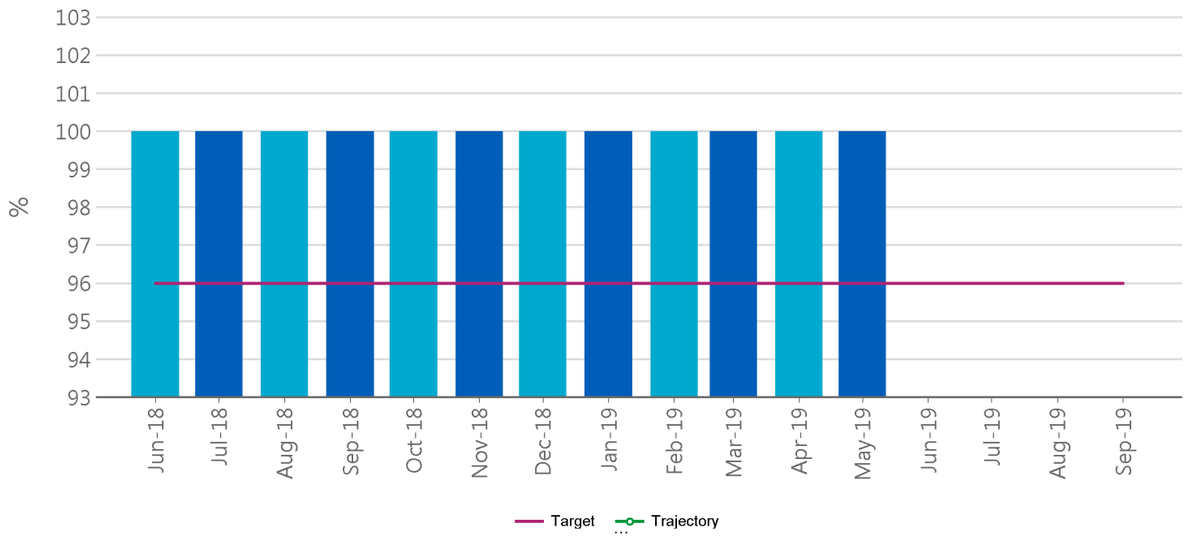
The Cancer 31 day first treatment standard was achieved in May and indicative data for June shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

31 Days Subsequent Treatment (Tumour)*

% of cancer patients subsequent treatment within 31 days of decision to treat (*Reported one month in arrears) 211023

100% against 94% target

green rated

Exec Lead:
Director of Operations

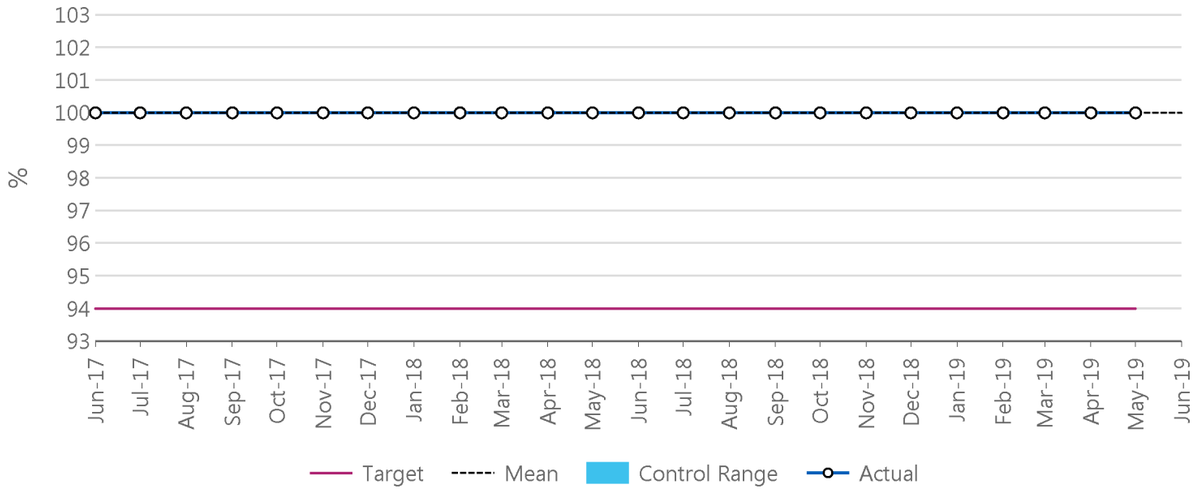
Finance, Planning and Digital Committee

Narrative

The Cancer 31 day subsequent treatment standard was achieved in May and indicative data for June shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears) 211045

100% against 85% target

green rated

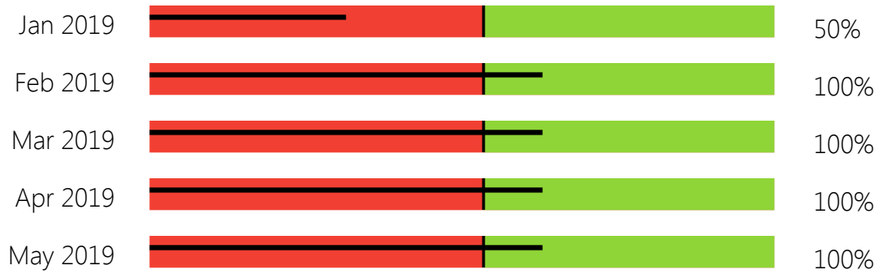
Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

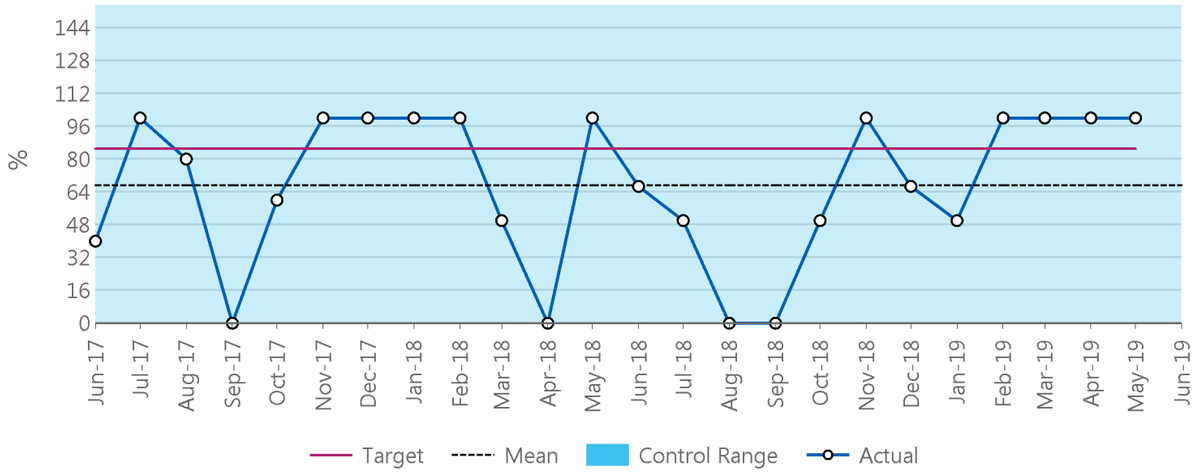
Narrative

The Cancer 62 day standard was achieved in May and indicative data for June shows achievement of the standard will continue.

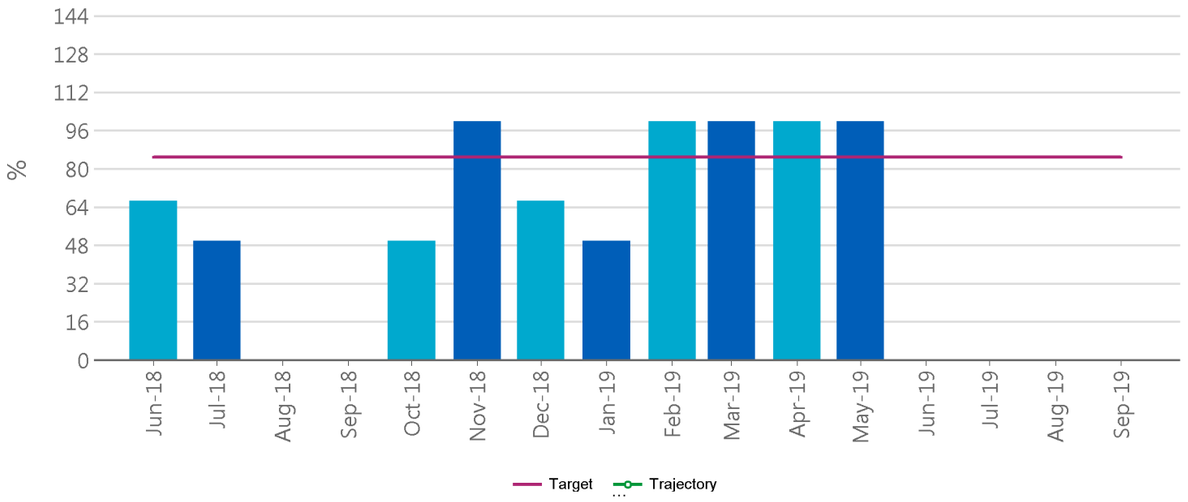
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
40%	100%	80%	0%	60%	100%	100%	100%	100%	50%	0%	100%	66.67%	50%	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%		100%

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

Cancer 62 Days Consultant Upgrade*

% of cancer patients treated within 62 days of date of upgrade (*Reported one month in arrears) 211044

100% against 85% target

green rated

Exec Lead:
Director of Operations

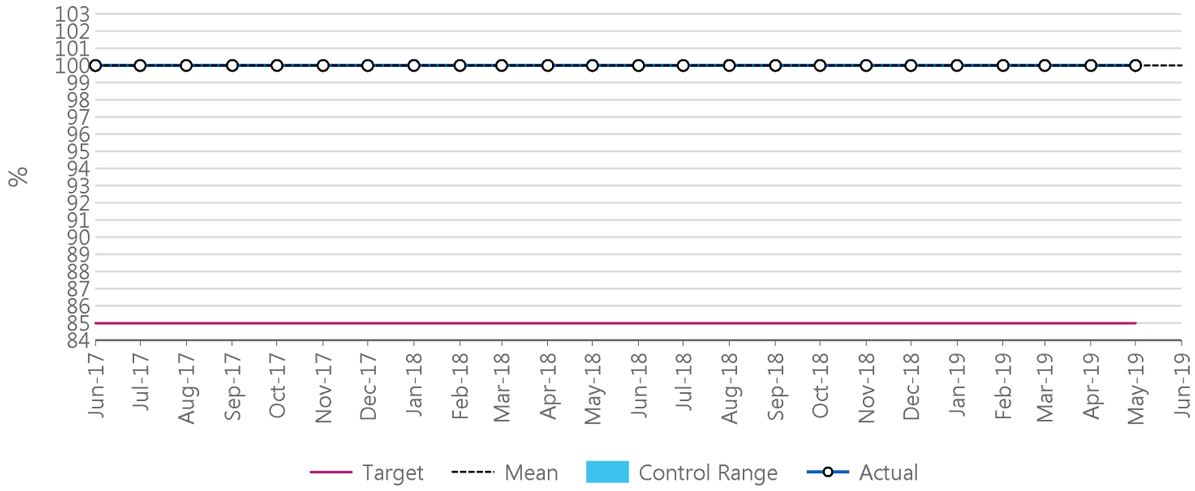
Finance, Planning and Digital Committee

Narrative

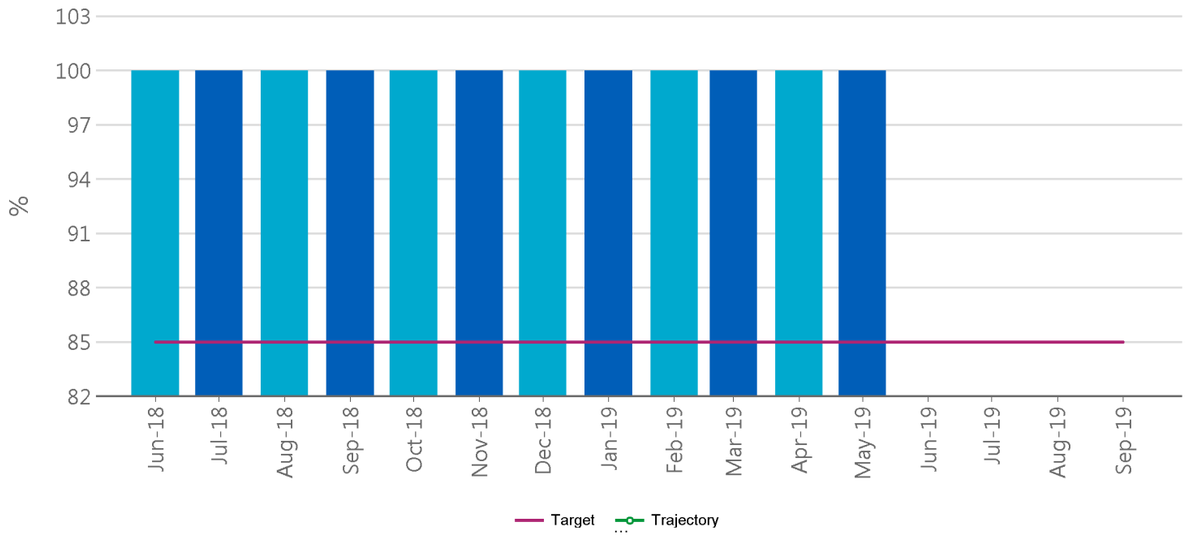
The Cancer 62 day consultant upgrade standard was achieved in May and indicative data for June shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

18 Weeks RTT Open Pathways

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

90.61% against **92%** target

Below target red rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Narrative

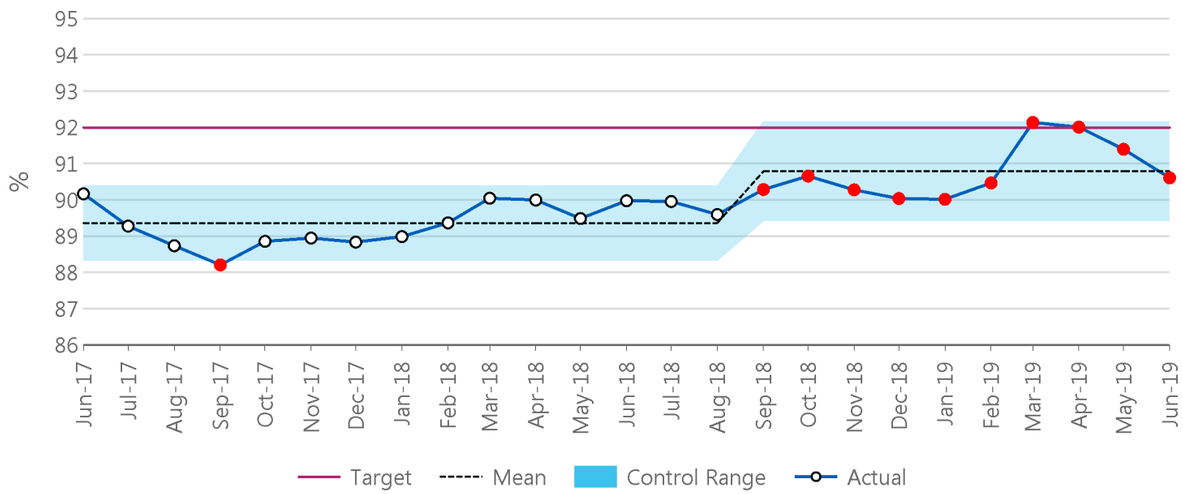
Our June performance was 90.61% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The total numbers of breaches increased from 612 in May to 696 in June. The reported position was behind our trajectory plan of 91.10%.

Action to Improve:Our RTT performance is aligned with the reduced activity delivered in June. Focus on increased activity from August onwards will impact on this metric.

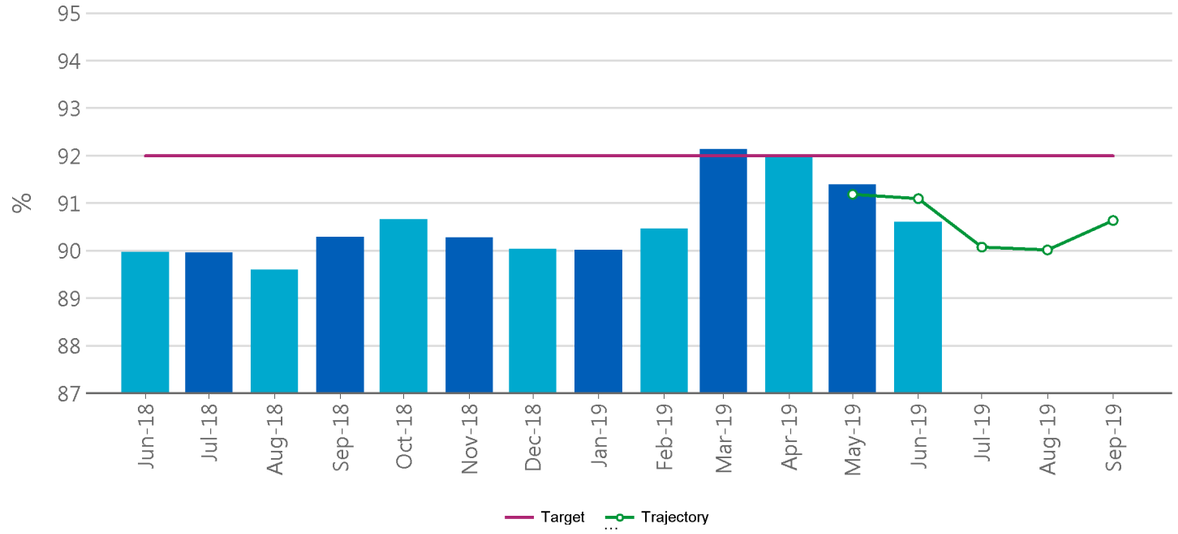
Performance against RAG ratings

Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
90.17%	89.28%	88.74%	88.21%	88.86%	88.95%	88.84%	88.99%	89.37%	90.05%	90%	89.49%	89.98%	89.96%	89.6%	90.29%	90.66%	90.28%	90.04%	90.02%	90.47%	92.14%	92.01%	91.4%	90.61%	91.71%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – English

Number of English RTT patients currently waiting 52 weeks or more 211139

0 against 0 target

On target green rated

Exec Lead:
Director of Operations

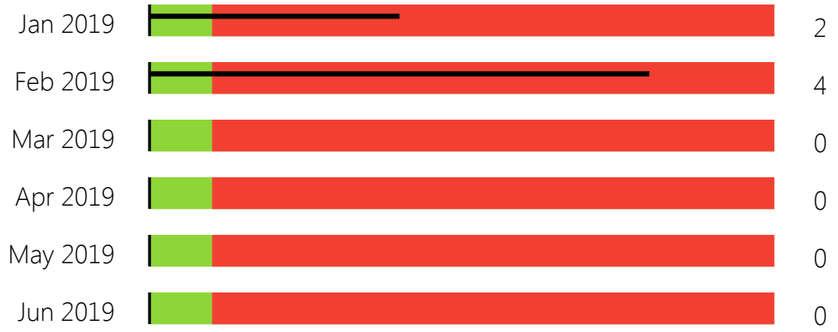
Finance, Planning and Digital Committee

Narrative

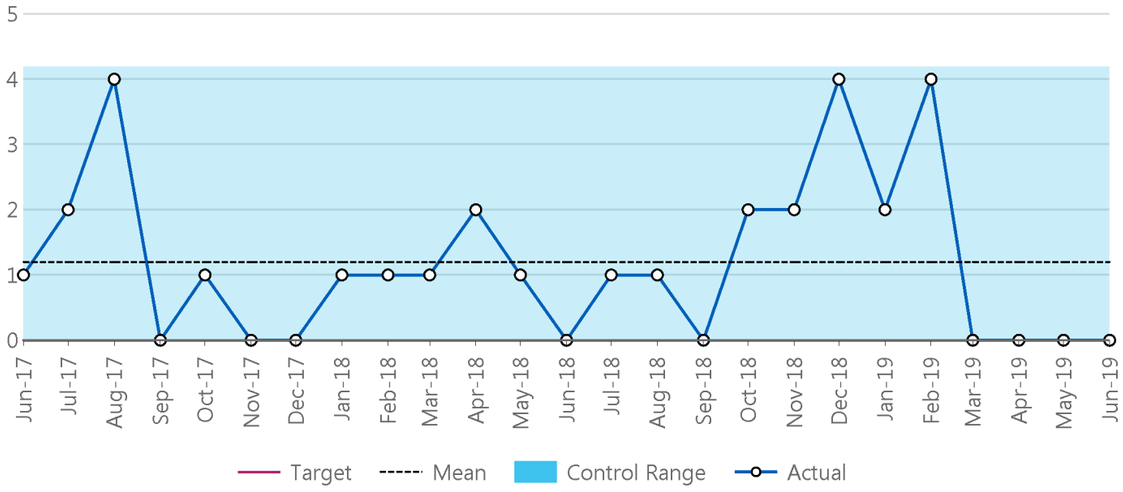
At the end of June there were no English patients waiting over 52 weeks.

The forecast figures show predicted 52+ weeks waits as follows:
- End of July - 1 (Spinal Disorders)
- End of August - 0
- End of September - 3 - Arthroplasty (1), Foot & Ankle (1), Spinal Disorders (1)

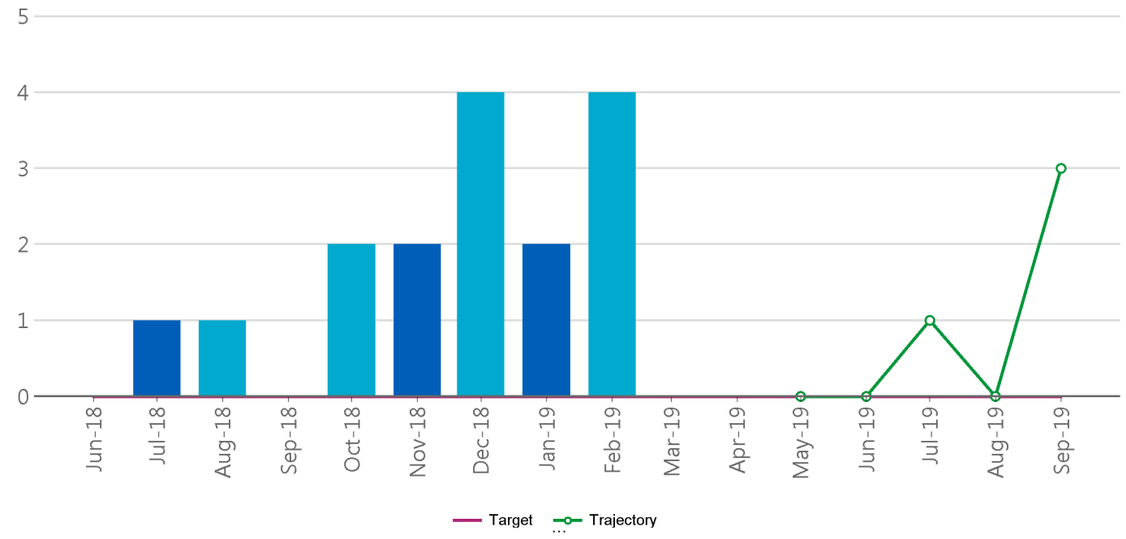
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
1	2	4	0	1	0	0	1	1	1	2	1	0	1	1	0	2	2	4	2	4	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients currently waiting 52 weeks or more 211140

1 against 0 target
Breaching target red rated

Exec Lead:
Director of Operations

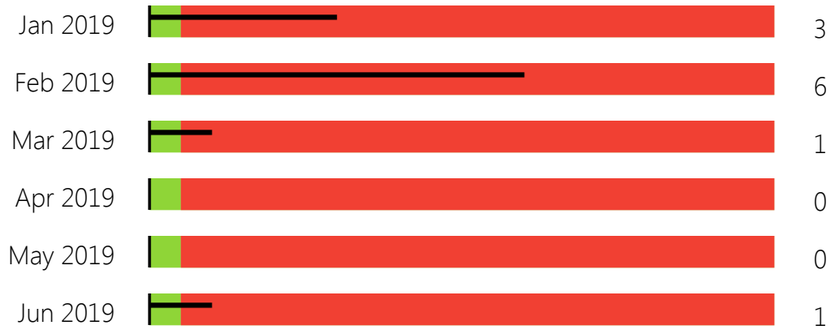
Finance, Planning and Digital Committee

Narrative

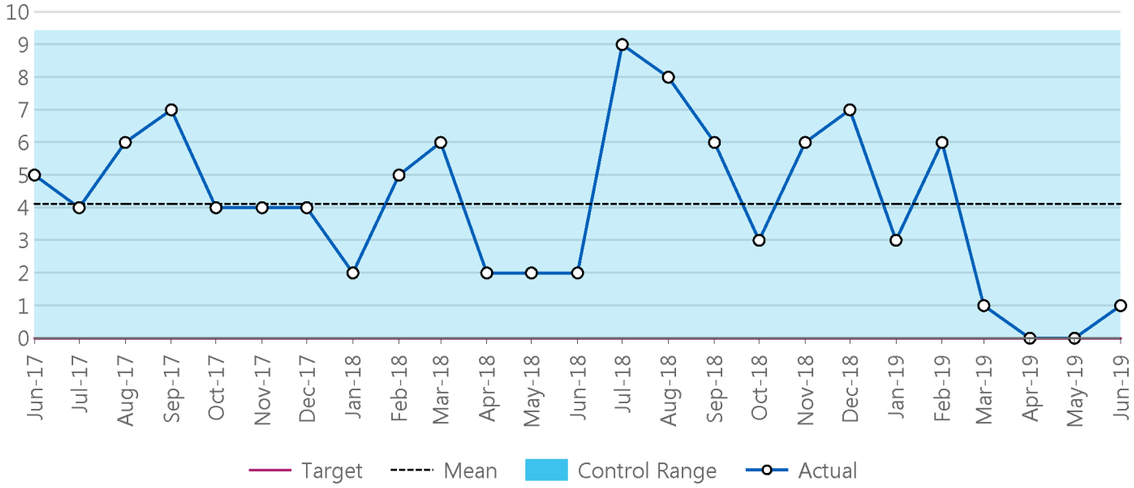
At the end of June there was one Welsh patient waiting over 52 weeks. They were a Spinal Disorders patient who unfortunately had been dated but surgery had to be cancelled. The patient has now been treated in early July.

The forecast figures show predicted 52+ weeks waits as follows:
- End of July - 0
- End of August - 3 (all Spinal Disorders)
- End of September - 15 - Spinal Disorders (9), Arthroplasty (4), Foot & Ankle (1), Paediatric Orthopaedics (1)

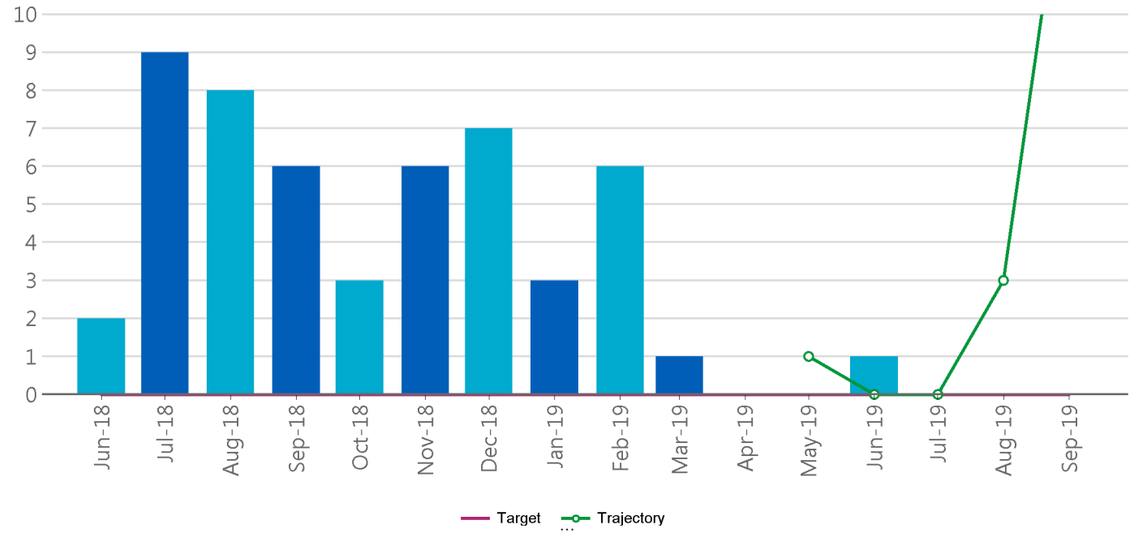
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
5	4	6	7	4	4	4	2	5	6	2	2	2	9	8	6	3	6	7	3	6	1	0	0	1	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)

18 against N/A target

Number of BCU transfer Welsh RTT patients currently waiting 52 weeks or more. 211141

Narrative

At the end of June there were 18 Welsh patients waiting over 52 weeks who were transfers of care from BCU.

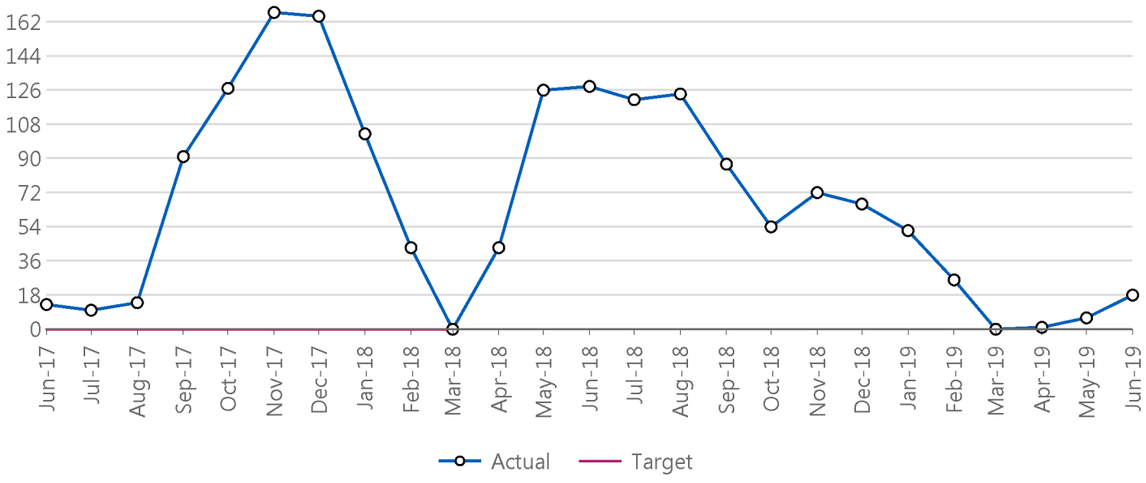
The forecast figures show predicted 52+ weeks waits as follows:
- End of July - 24
- End of August - 6
- End of September - 19

We have recommenced transfers of BCU patients to support waiting list reductions in North Wales for 2019/20. The current forecast is based on transfers received to date, the forecast will be refined in future months as further patients are transferred. The target for this measure is to treat all patients transferred by year-end.

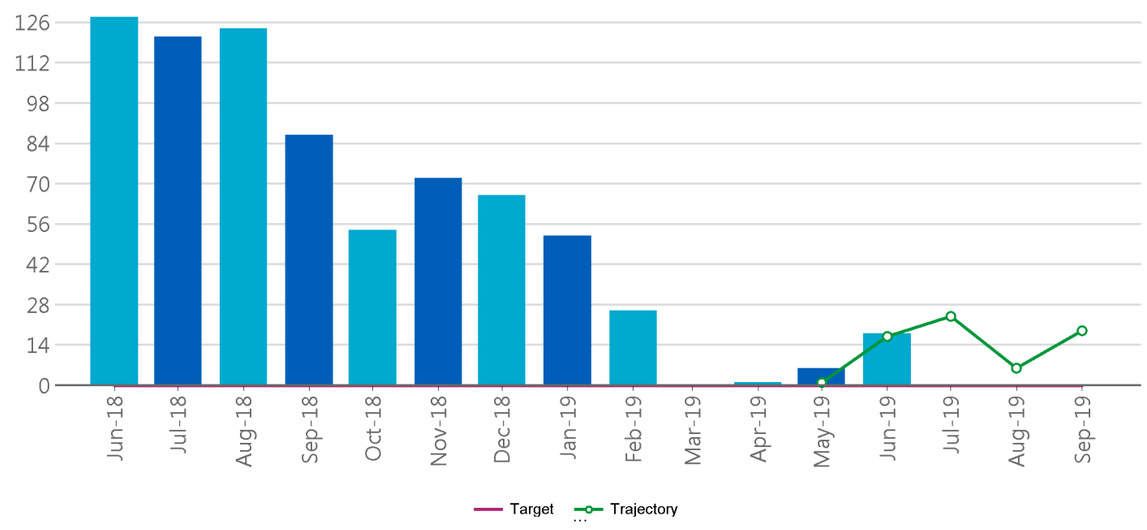
Performance against RAG ratings

Jan 2019	52
Feb 2019	26
Mar 2019	0
Apr 2019	1
May 2019	6
Jun 2019	18

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
13	10	14	91	127	167	165	103	43	0	43	126	128	121	124	87	54	72	66	52	26	0	1	6	18	0

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

6 Week Wait for Diagnostics - English Patients

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

98.35% against **99%** target

Below target red rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Narrative

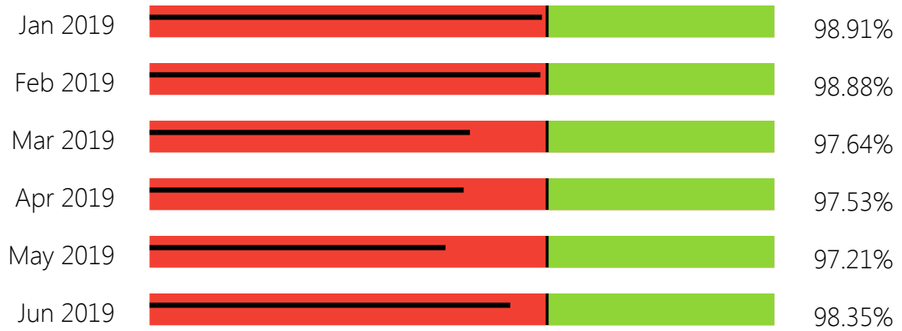
The 6 week standard for diagnostics was not achieved this month and is reported at 98.35%. This equates to 13 patients who waited beyond six weeks. The reasons associated with the delays were cancellations (2), delays in the request to Diagnostics (3), delay in protocol (3), booking error (3) and capacity (2).

Action to Improve:Actions relating to MRI:
- Continue to refer SOOS referrals direct to SaTH
- Continue RAS redirection of GP direct access referrals
- Continue to transfer GP direct access referral to SaTH

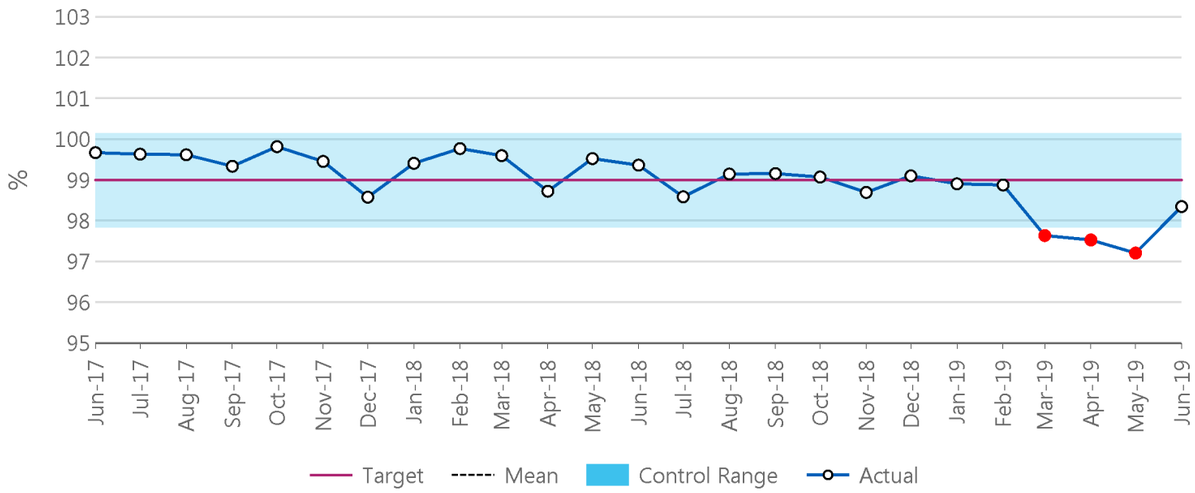
Actions relating to late referrals:
- Continue to monitor late referrals to the Division

Actions relating to 'delay in protocol':
- Investigate the process of referrals to gain a better understanding why these are causing delays

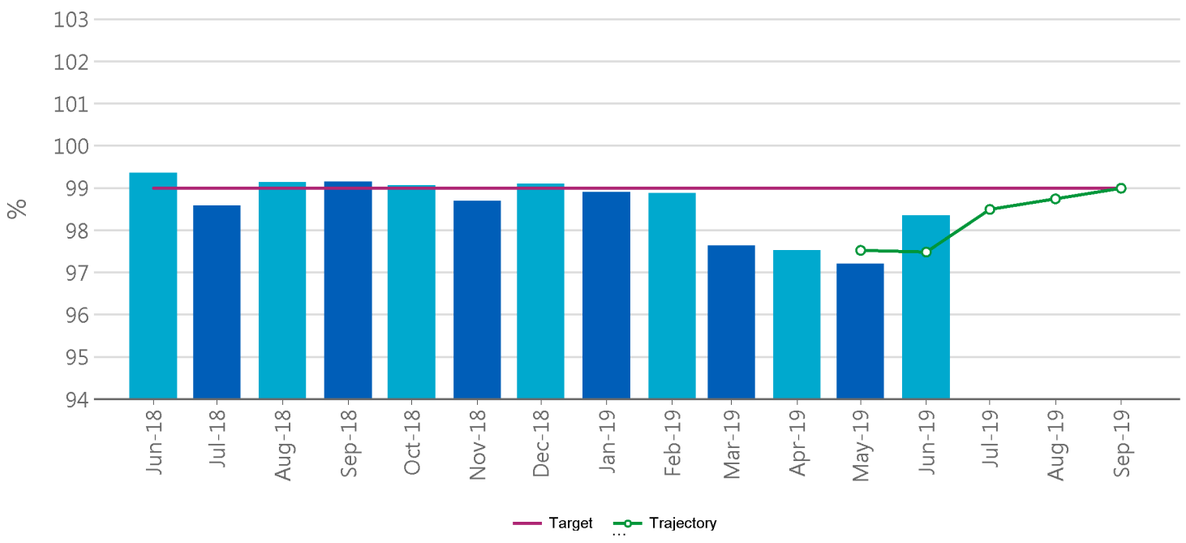
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
99.67%	99.63%	99.62%	99.34%	99.82%	99.46%	98.58%	99.41%	99.77%	99.6%	98.73%	99.53%	99.37%	98.59%	99.15%	99.16%	99.07%	98.7%	99.1%	98.91%	98.88%	97.64%	97.53%	97.21%	98.35%	97.72%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

8 Week Wait for Diagnostics - Welsh Patients

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

100% against **100%** target

On target green rated

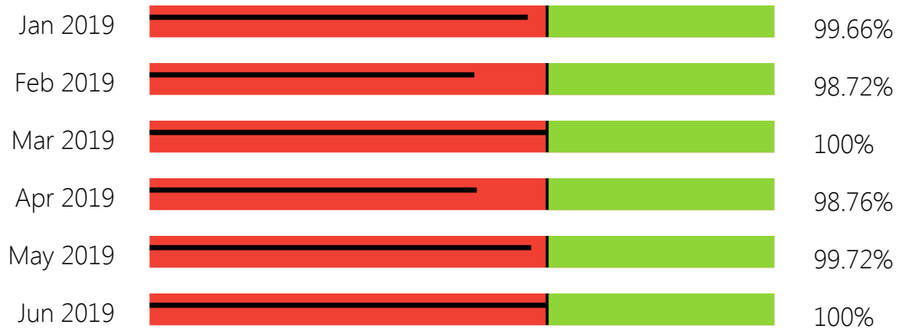
Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

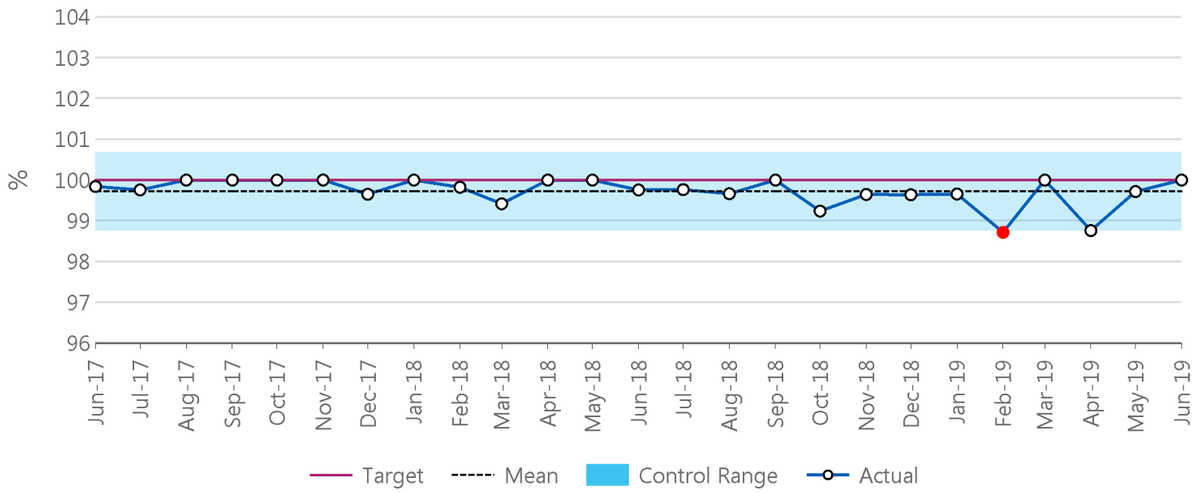
Narrative

The 8 week standard for diagnostics was achieved this month and is reported at 100%.

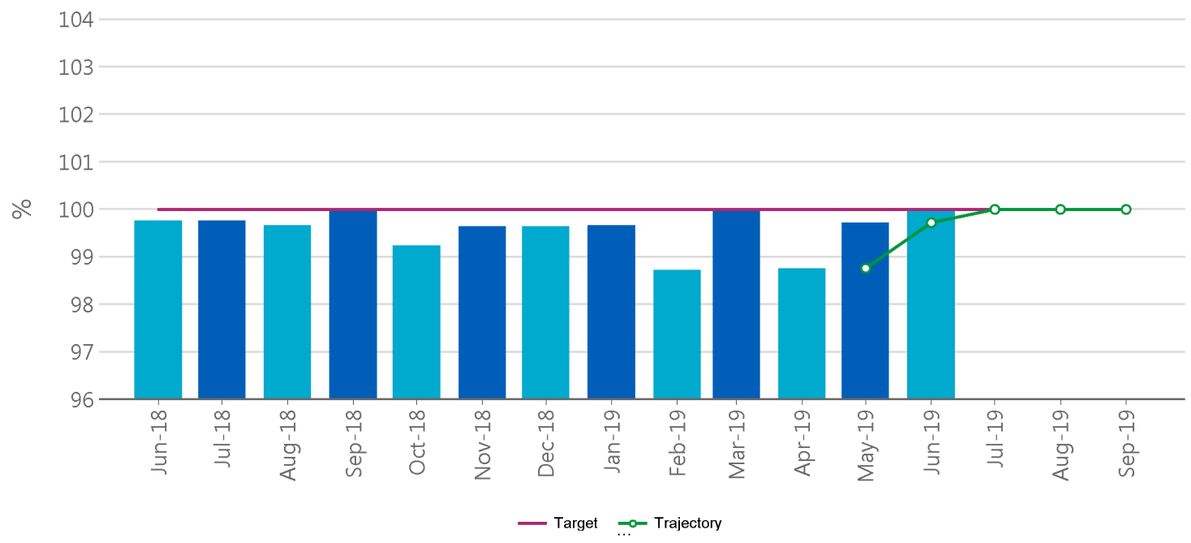
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
99.84%	99.76%	100%	100%	100%	100%	99.65%	100%	99.82%	99.42%	100%	100%	99.76%	99.77%	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	99.5%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Theatre Activity

Activity in theatres in month 214243

886 against **1,055** target

Below target red rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

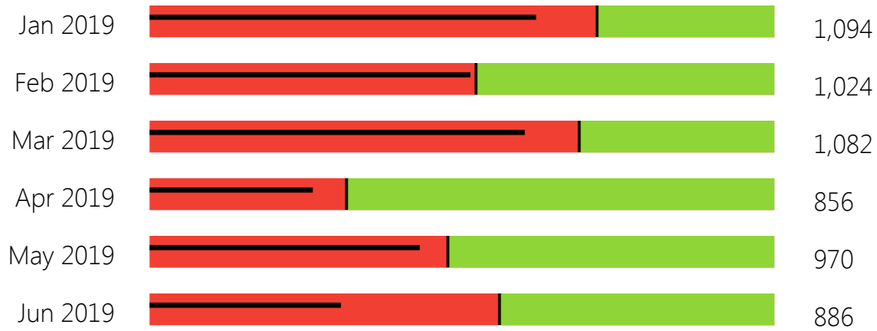
Narrative

A breakdown of Total Theatre Activity against plan is:
- T&O - 793 against plan of 940 (-147 cases)
- MCSI - 32 against plan of 44 (-12 cases)
- Private Patients - 61 against plan of 71 (-10 cases)

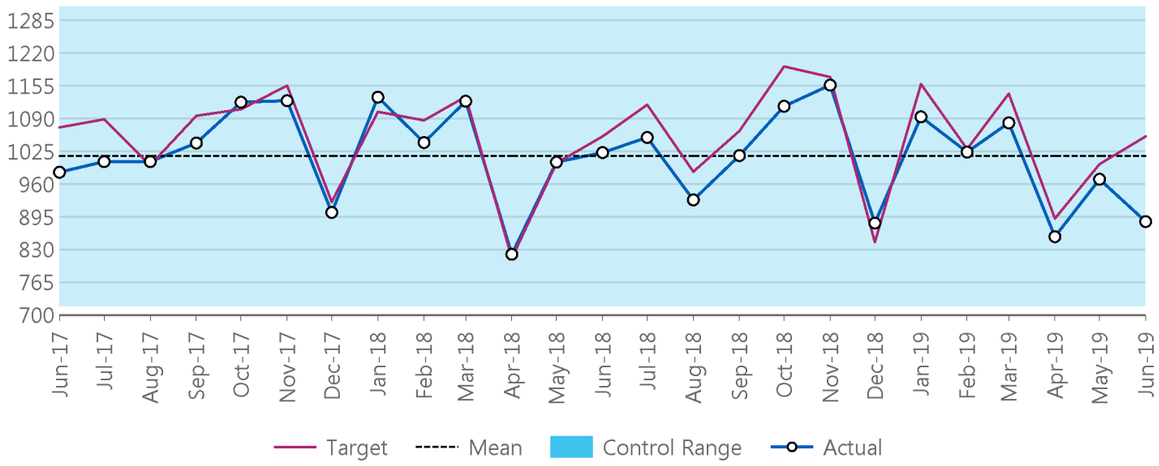
There are multiple factors impacting this in June; Higher than planned annual leave for consultants, high consultant sickness, short-notice cancellations and allocation of out of job activity not aligned to theatre and surgeon availability.

Action to Improve:An action plan is in place to improve the August and September position, as it is anticipated that July will also be behind plan. Areas of focus are: continue to scope additional theatre sessions, pooling of patients to maximise use of in-job plan lists, continual review of cases booked into sessions to ensure lists are fully utilised and a waiting list initiative for spinal injury patients.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
984	1,005	1,005	1,042	1,123	1,126	904	1,133	1,043	1,125	821	1,004	1,023	1,053	929	1,017	1,115	1,157	883	1,094	1,024	1,082	856	970	886	2,712

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm 211039

82.49% against **87%** target

Within target green rated

Exec Lead:
Director of Operations

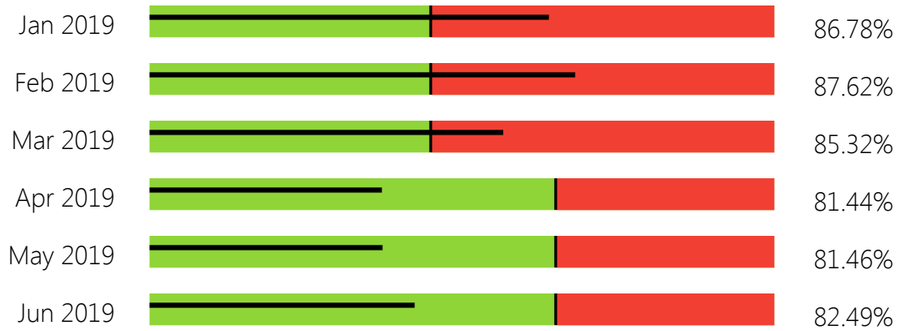
Finance, Planning and Digital Committee

Narrative

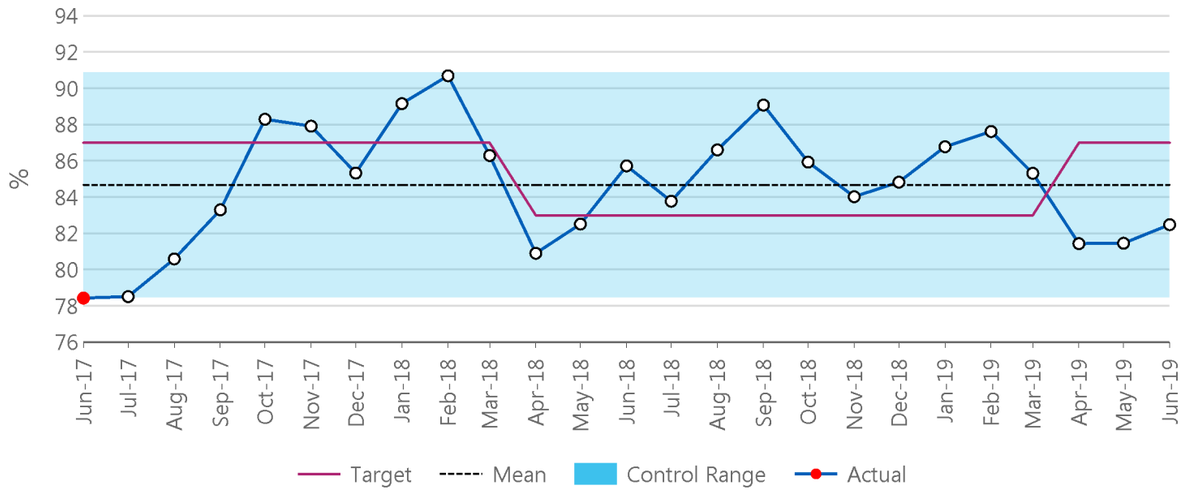
The occupancy rate for all wards is green rated this month at 82.49%. Occupancy across the Surgical Wards was:
- Alice 40.63%
- Clwyd 84.29%
- Kenyon 77.24%
- Ludlow 80.96%
- Powys 85.92%
- Oswald 75.25%

Occupancy within the Medicine Division was:
-Gladstone 93.74%
- Wrekin 93.47%
- Sheldon 83.96%

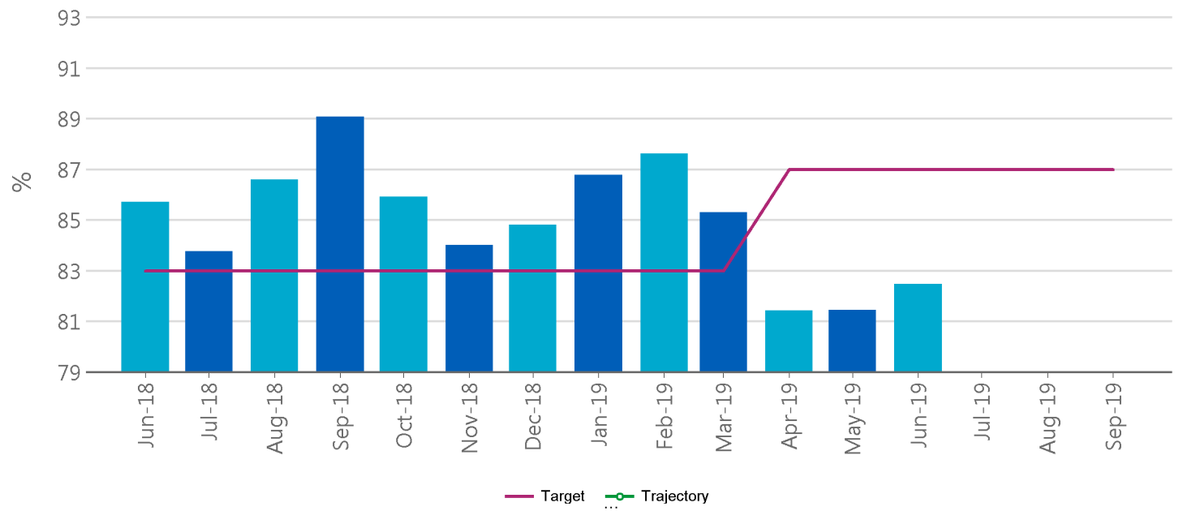
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
78.44%	78.52%	80.59%	83.3%	88.3%	87.92%	85.33%	89.16%	90.7%	86.3%	80.91%	82.52%	85.73%	83.78%	86.61%	89.08%	85.94%	84.03%	84.83%	86.78%	87.62%	85.32%	81.44%	81.46%	82.49%	81.8%

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NHS Foundation Trust

Outpatients Activity Attendances

Number of attendances seen in Outpatient clinics - excludes SOOS and NCG as they are block contracts 216313

12,920 against **14,143** target

Below target red rated

Exec Lead:
Director of Operations

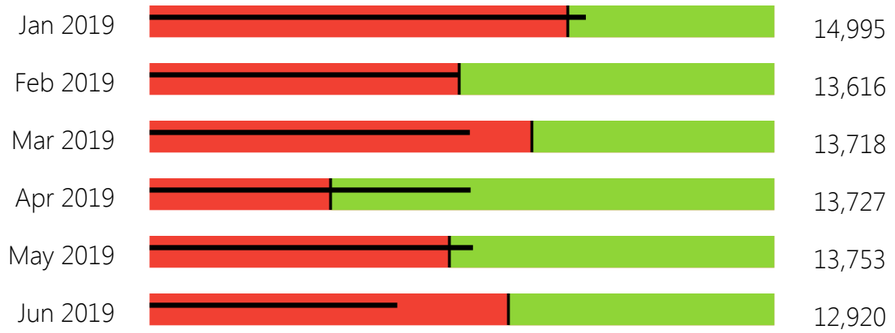
Finance, Planning and Digital Committee

Narrative

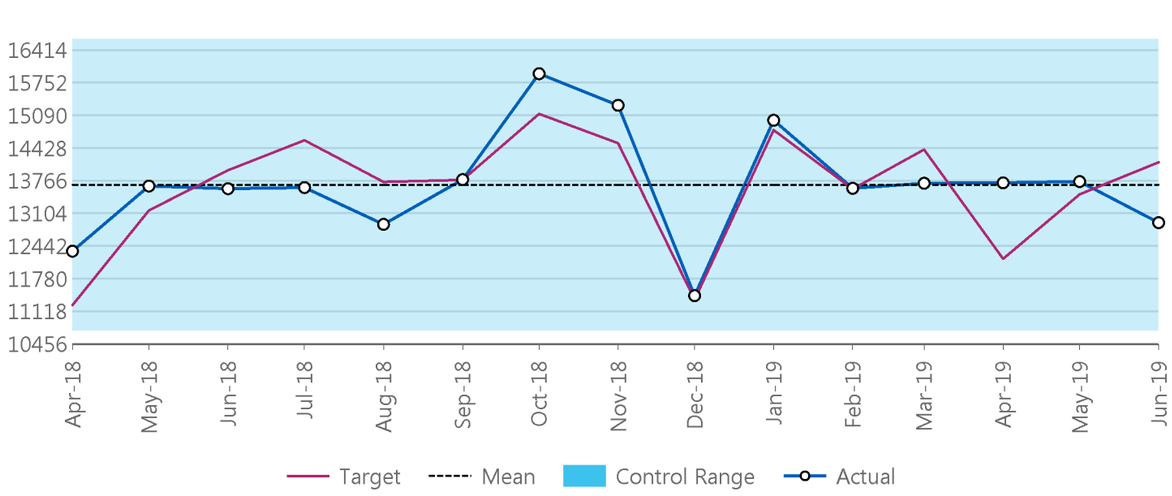
The number of attendances was behind plan in month 3 with 12920 attendances seen against a plan of 14143. A divisional breakdown is:
- Surgery - 6479 against a plan of 7143 (-664)
- Medicine - 5225 against a plan of 5656 (-431)

Action to Improve:Although the latest month position was behind plan, the year to date position is ahead of plan.

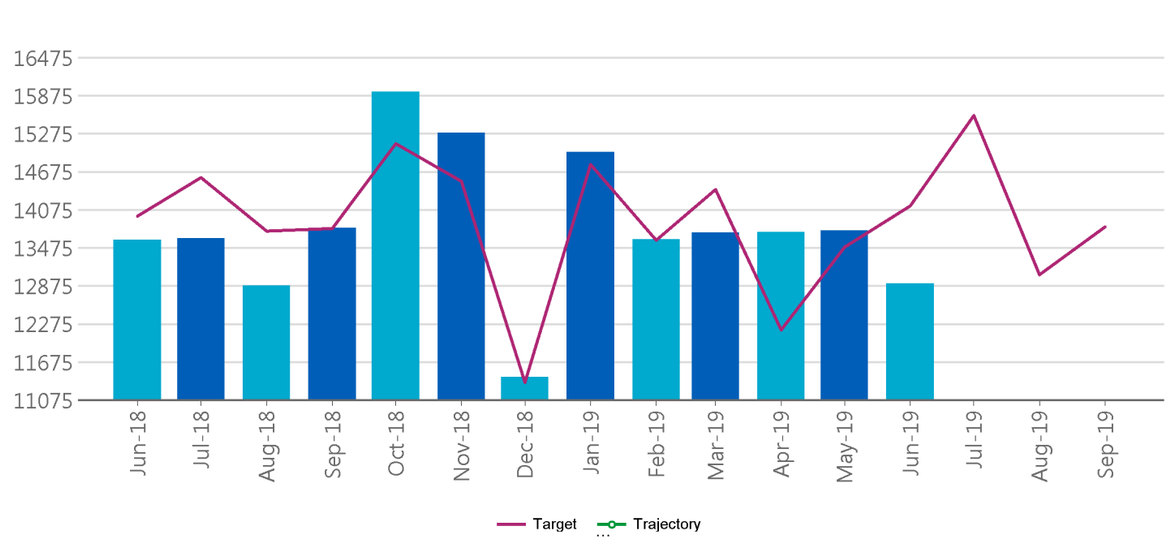
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
12,342	13,662	13,609	13,631	12,885	13,792	15,939	15,298	11,440	14,995	13,616	13,718	13,727	13,753	12,920	40,400

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

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding 215290

-207 against **278** target

red rated

Exec Lead:
Director of Finance

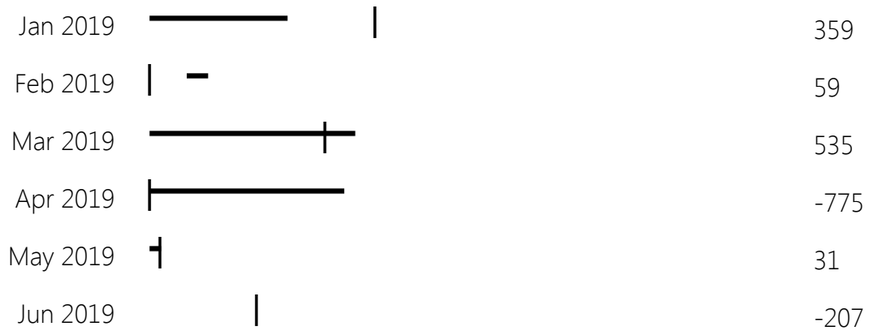
Finance, Planning and Digital Committee

Narrative

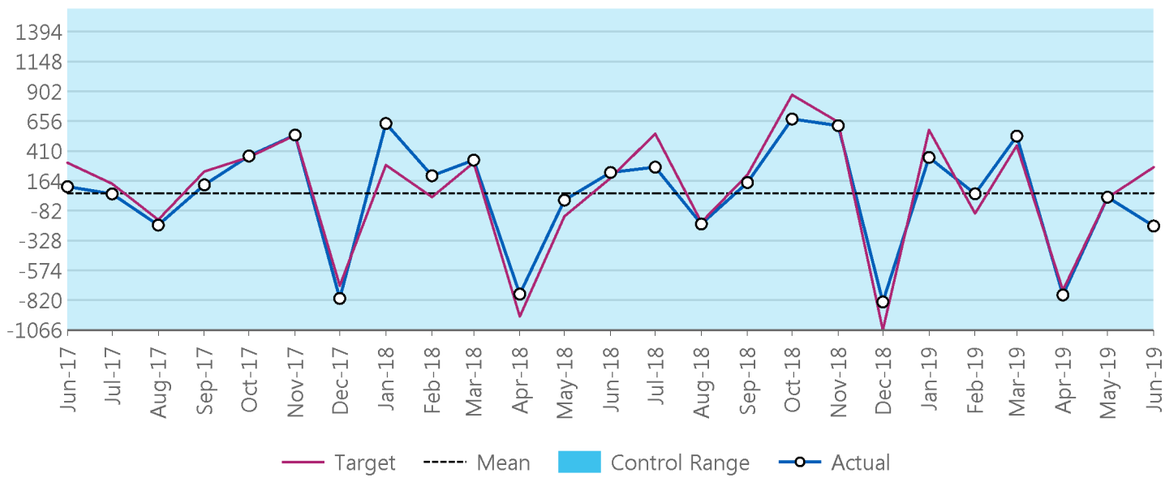
- £485k adverse in month,
- £519k adverse variance to plan year to date

Action to Improve:Adverse variance driven by shortfall in theatre activity (actions covered in income dashboard)

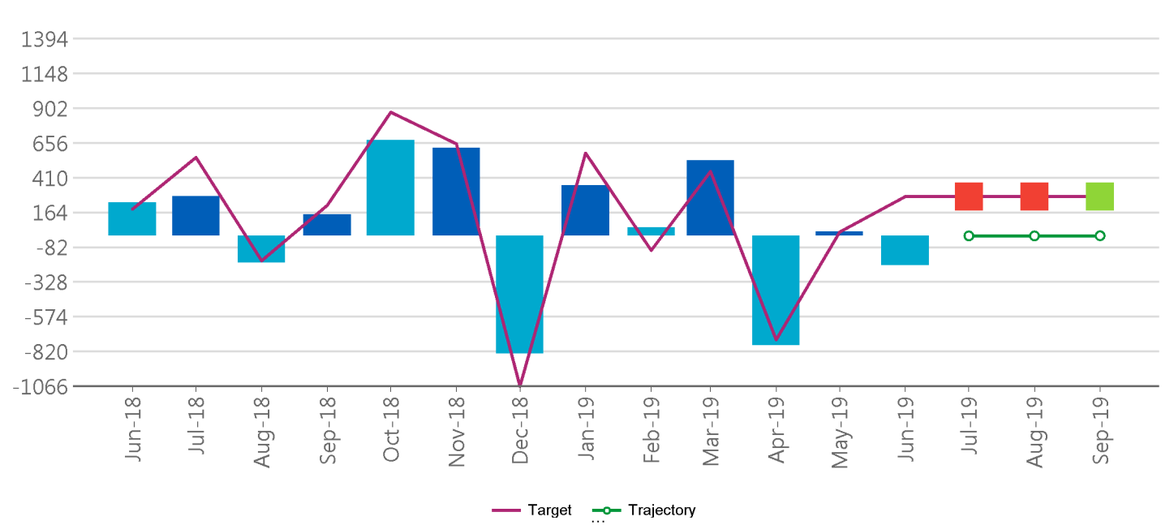
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
118	58	-199	133	371	544	-804	639	208	337	-768	7	235	279	-190	152	676	621	-833	359	59	535	-775	31	-207	-951

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

Income

All Trust Income, Clinical and non clinical 216333

8,542 against **9,306.2** target

Below target red rated

Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

Narrative

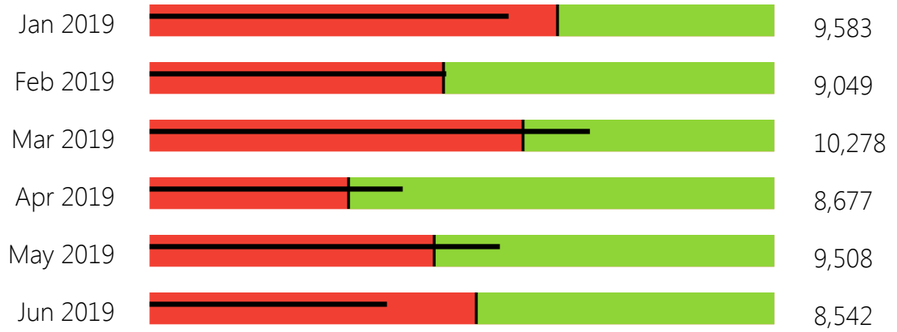
Overall £766k adverse in month:

Clinical income £731k adverse
- Theatre activity behind plan 144 cases £650k adverse
- Medicine and diagnostics division £80k adverse

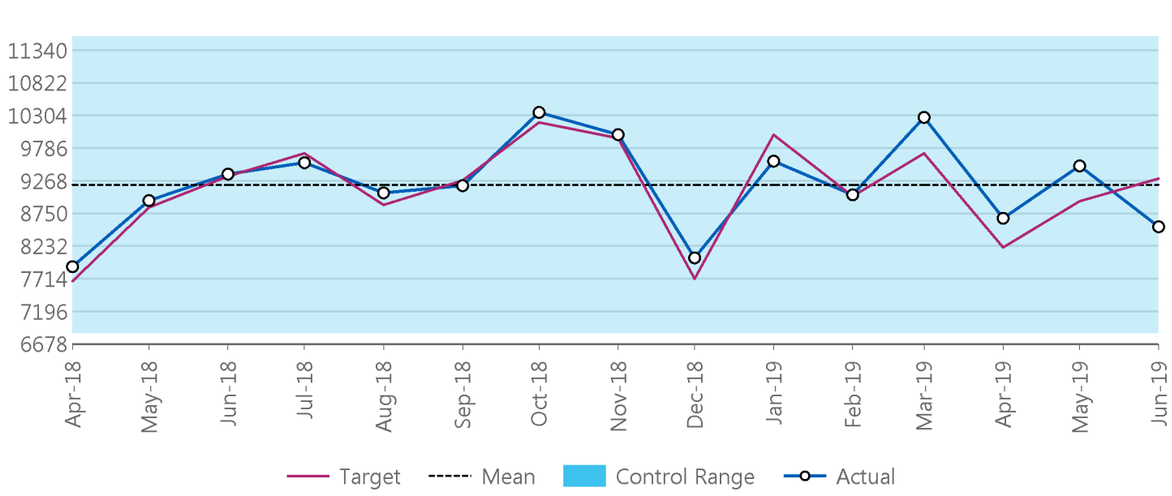
Private Patients £32k adverse in month

Action to Improve:Recovery actions developed for shortfall in theatre activity:
- Expected further shortfall in July
- Actions underway to recover August position
- Actions underway to stabilise delivery September onwards
- CEO chaired activity recovery board
- Performance review focus on delivery and action plans
- Weekly theatre delivery board in place

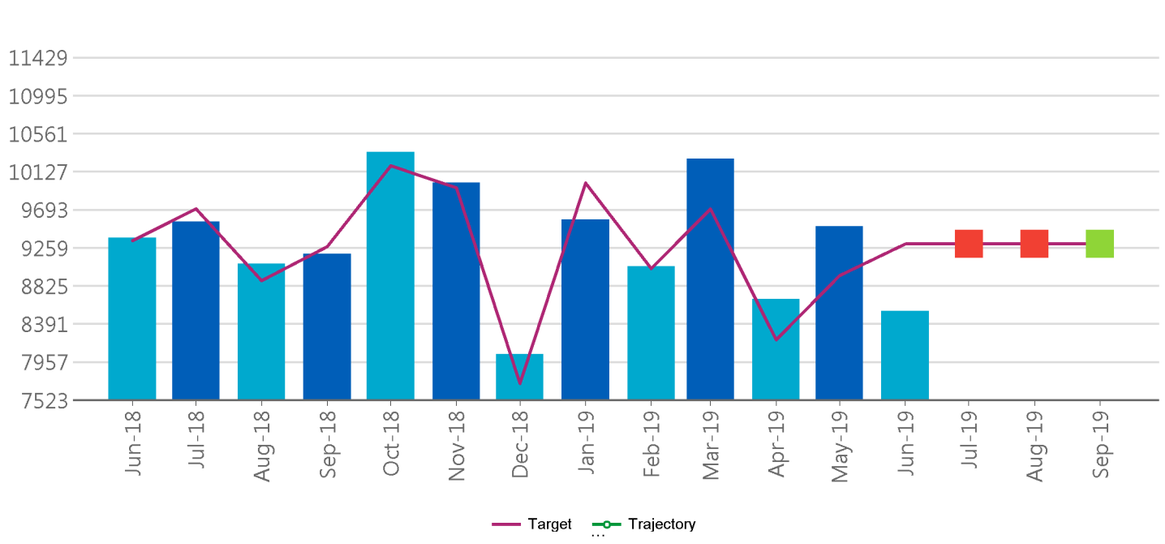
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
7,909	8,958	9,378	9,559	9,080	9,194	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,542	26,727

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

Expenditure

All Trust expenditure including Finance Costs 216334

8,788 against **9,072.42** target

Within target green rated

Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

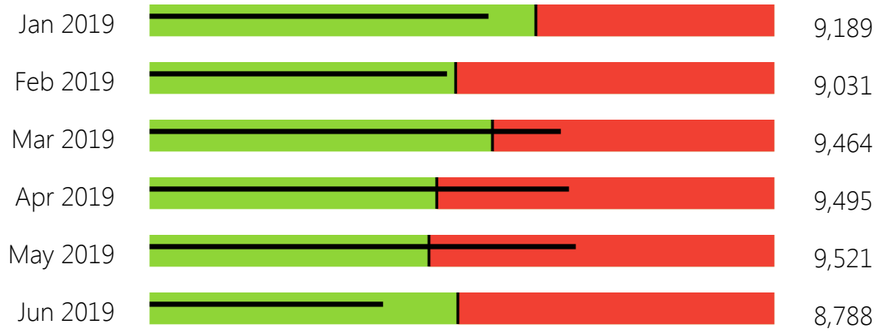
Narrative

- Overall £285k favourable in month:

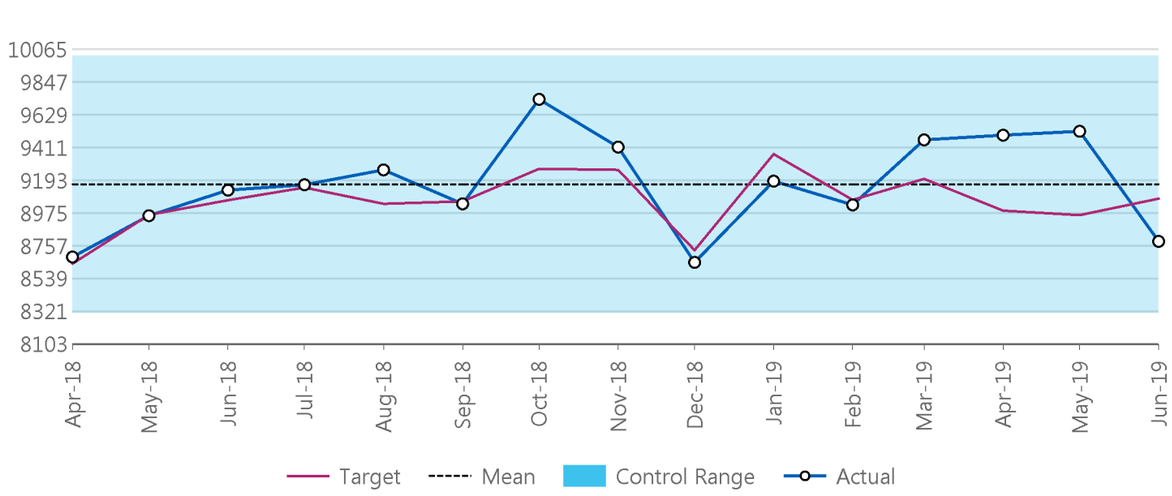
Non pay:
- Implants and Theatre consumables
- LLP linked to reduced activity volumes

Pay:
- Reduced OJP & Agency
- Nursing pressures continued in the Medicine division

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
8,684	8,959	9,129	9,165	9,264	9,038	9,734	9,416	8,648	9,189	9,031	9,464	9,495	9,521	8,788	27,804

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

CIP Delivery

Cost Improvement Programme requirement 215298

260 against **274** target

Below target green rated

Exec Lead:
Director of Finance

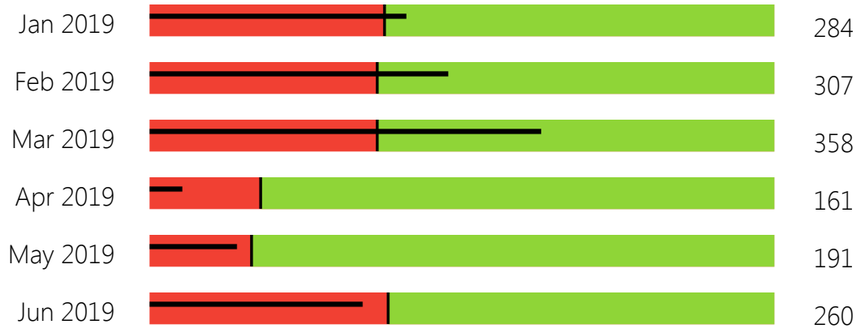
Finance, Planning and Digital Committee

Narrative

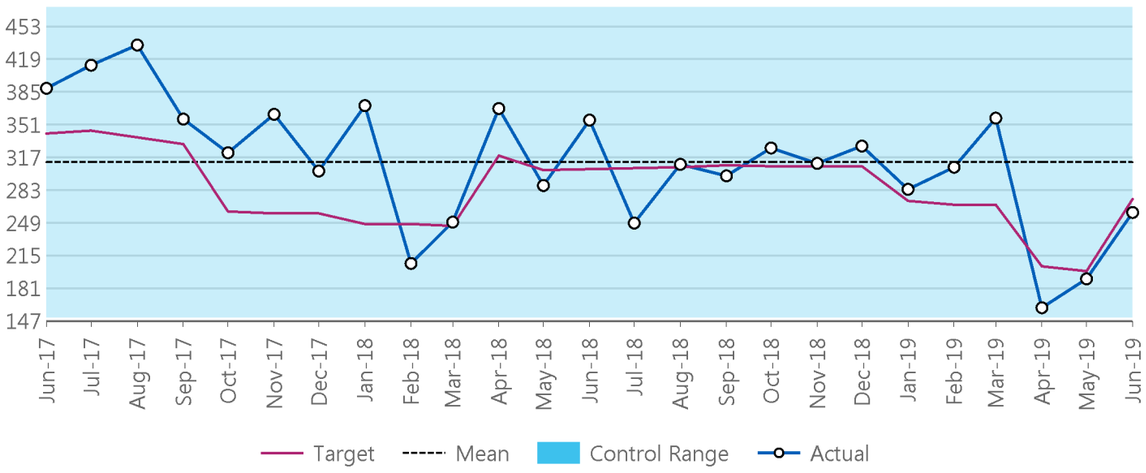
£14k adverse against plan in month
£65k adverse against plan YTD

Action to Improve:Identification of 20% contingency CIP ongoing
Action plan for divisions with unidentified schemes monitored through performance review meetings

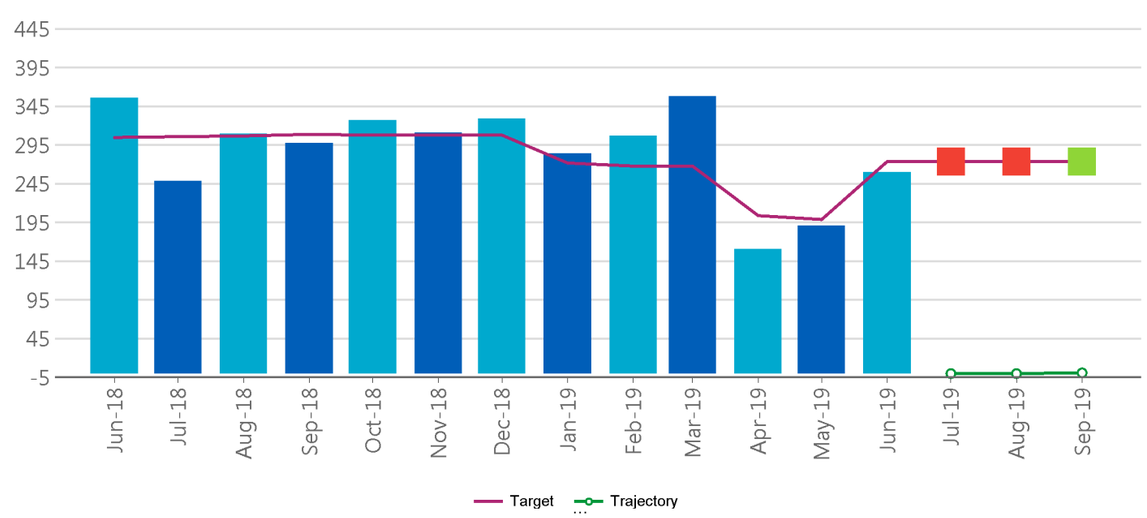
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
389	413	434	357	322	362	303	371	207	250	368	288	356	249	310	298	327	311	329	284	307	358	161	191	260	612

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

QIPP Delivery Risk Impact

MSK Transformation QIPP 216335

-67 against 0 target

Below target green rated

Exec Lead:
Director of Finance

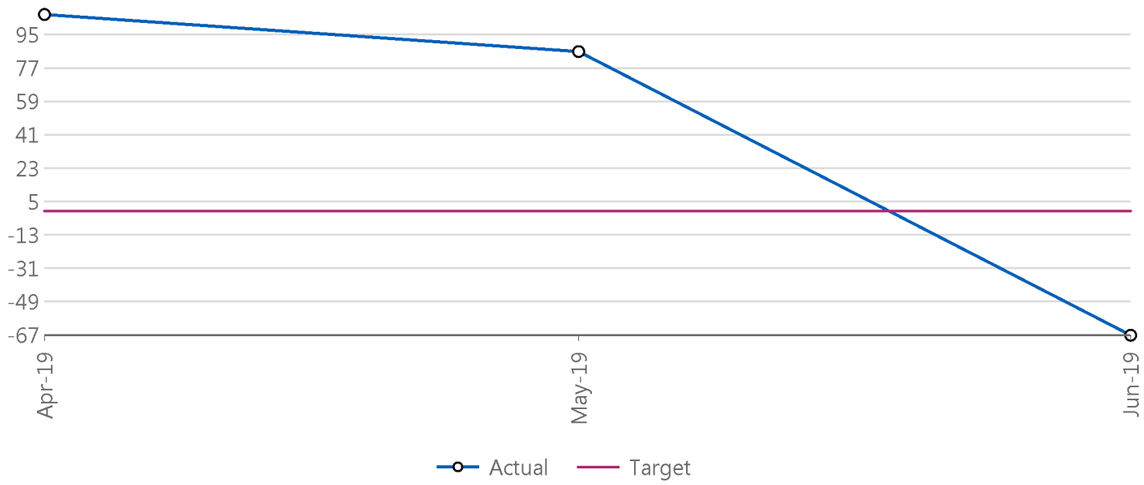
Finance, Planning and Digital Committee

Narrative

No MSK QIPP risk share in month due to shortfall in activity, £125k risk provided for ytd

Performance against RAG ratings

Performance over 24 months –



Trajectory

Heatmap performance over 24 months

Apr	May	Jun	YTD
106	86	-67	125

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

Agency Core

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency only 216336

44 against 132 target

Within target green rated

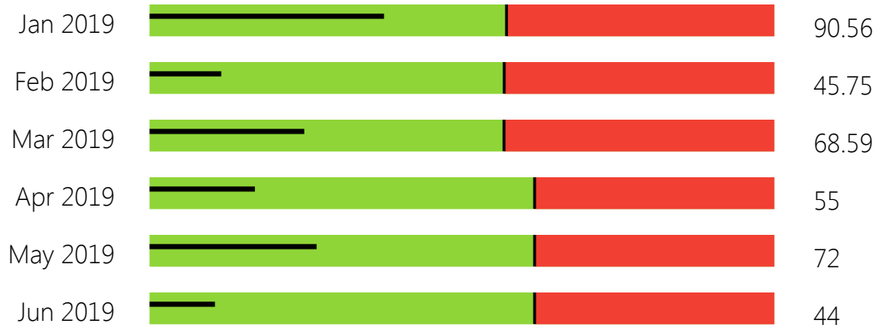
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

Narrative

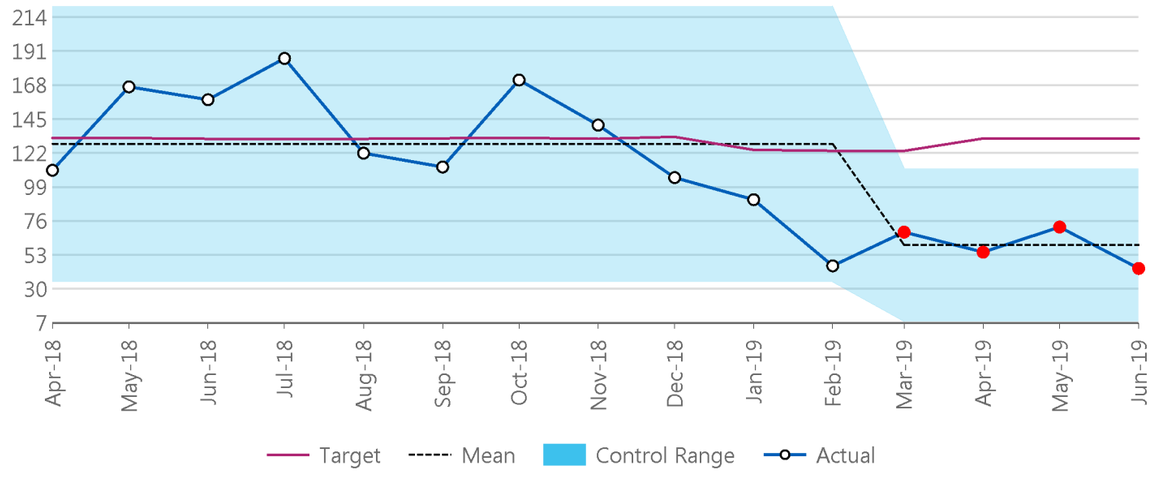
Core agency spend £87k favourable against cap in month

Performance against RAG ratings

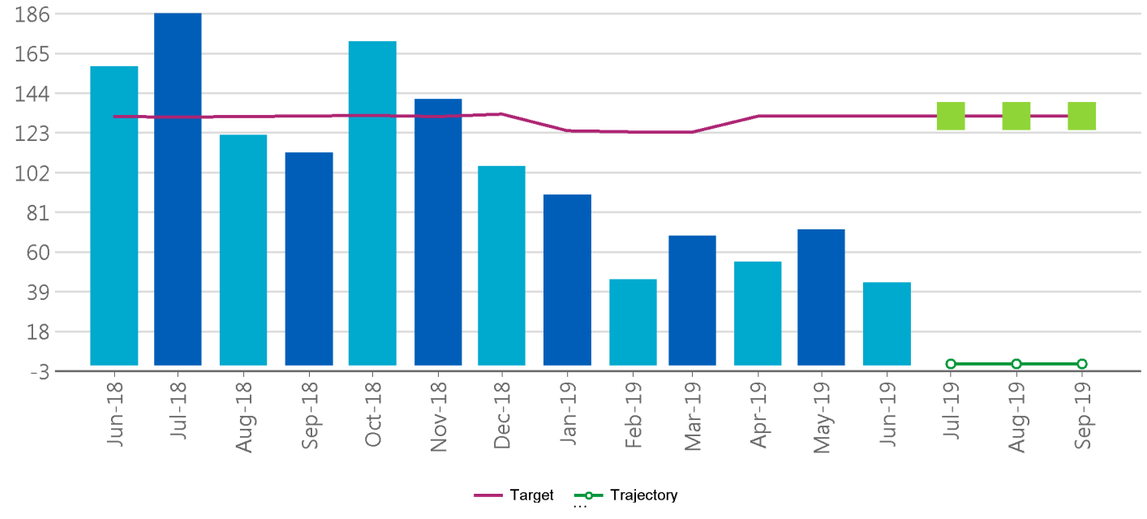


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
110.49	167	158.27	186.24	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	55	72	44	171

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

Agency Non-Core

Annual ceiling for total agency spend introduced by NHS Improvement - Non Core Agency 216337

221 against **186** target

Breaching target red rated

Exec Lead:
Director of Finance

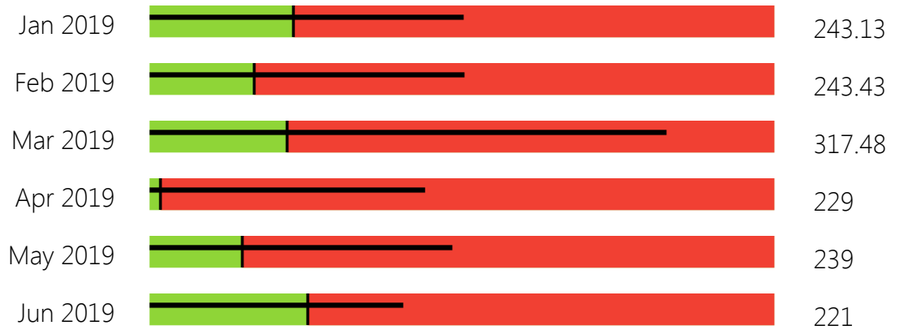
Finance, Planning and Digital Committee

Narrative

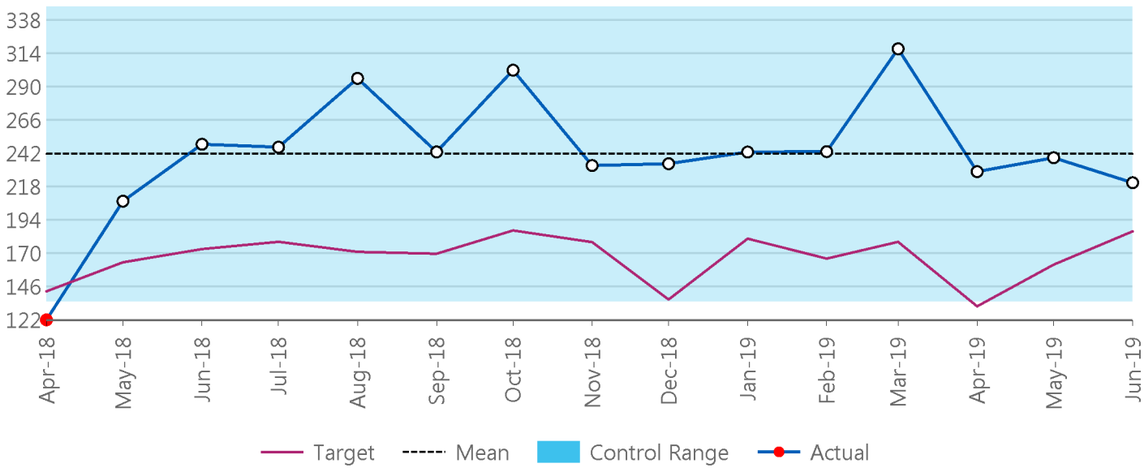
Non core agency spend £35k adverse against cap in month

Action to Improve:Agency limit for LLP does not align to operational plan - NHSI aware. Long term plan to reduce OJP to no more than 20% of total activity is dependent upon new consultant appointments and job plan productivity.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
122.26	207.73	248.74	246.63	296.21	243.2	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	689

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank 215300

5,000 against **4,200** target

Above target green rated

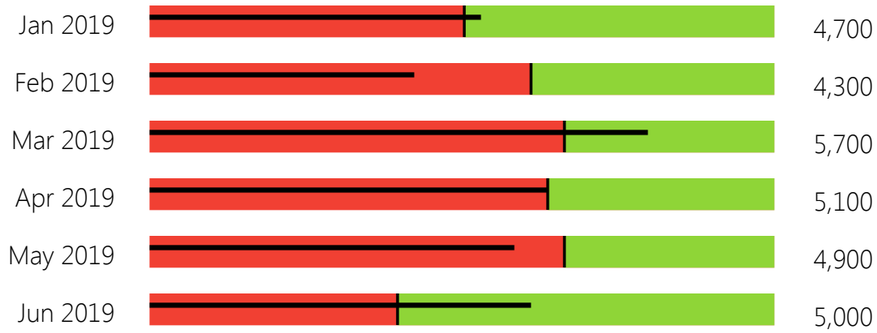
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

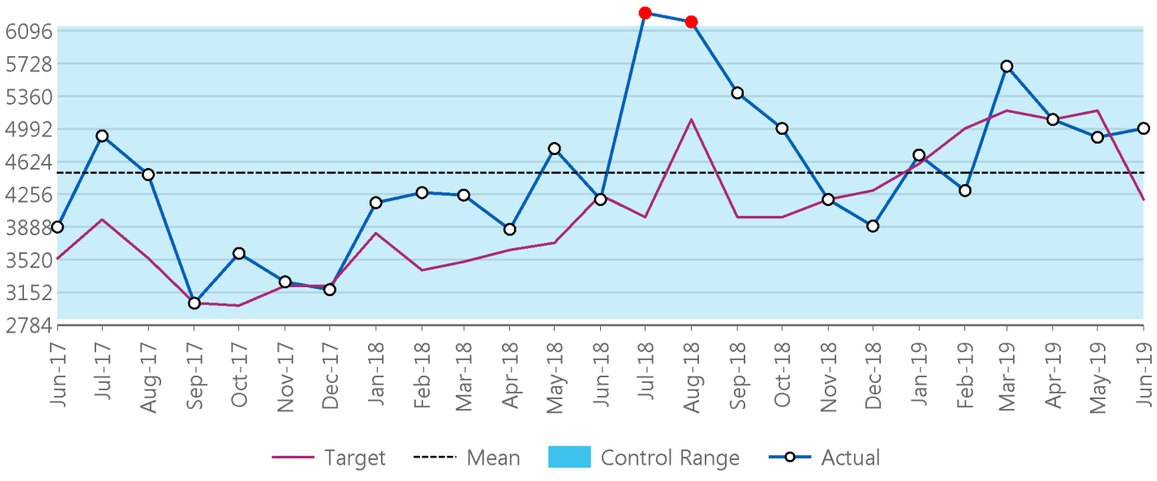
Narrative

Cash balances favourable against plan £0.8m driven by slippage in under performance repayments expected in June.

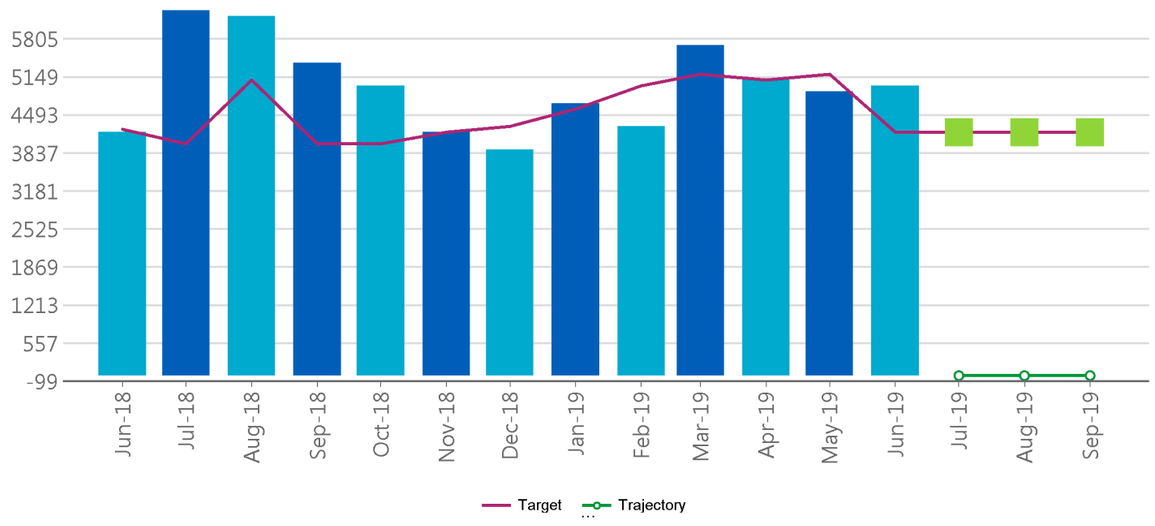
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
3,890	4,916	4,480	3,032	3,593	3,272	3,184	4,163	4,277	4,249	3,863	4,773	4,200	6,300	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,700	5,100	4,900	5,000	5,000

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Capital Expenditure

Expenditure against Trust capital programme 215301

162 against 314 target

green rated

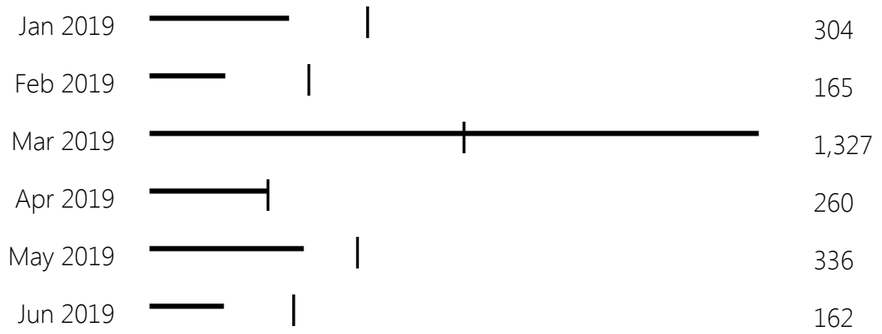
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

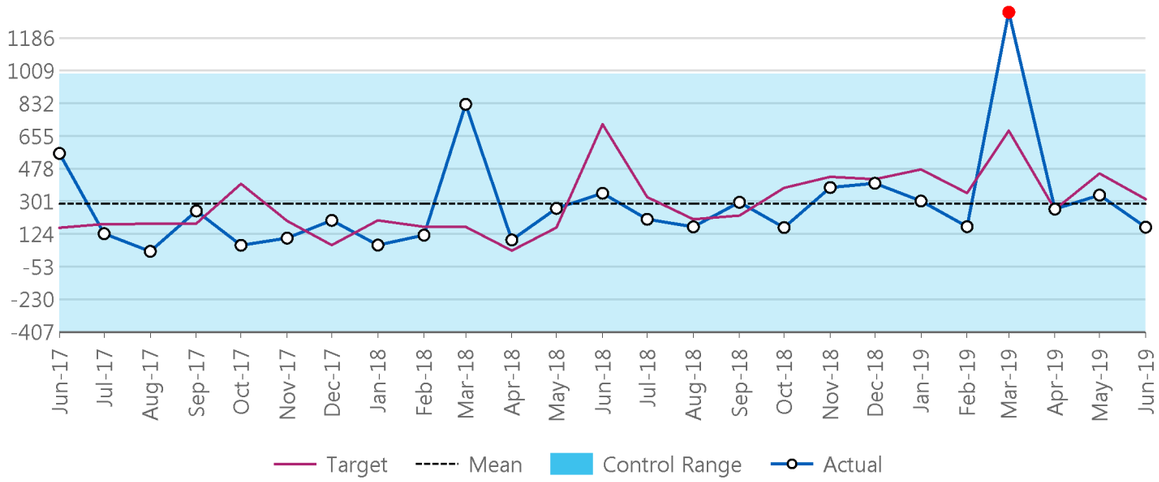
Narrative

Capital spend of £162k in month, £152k favourable in month

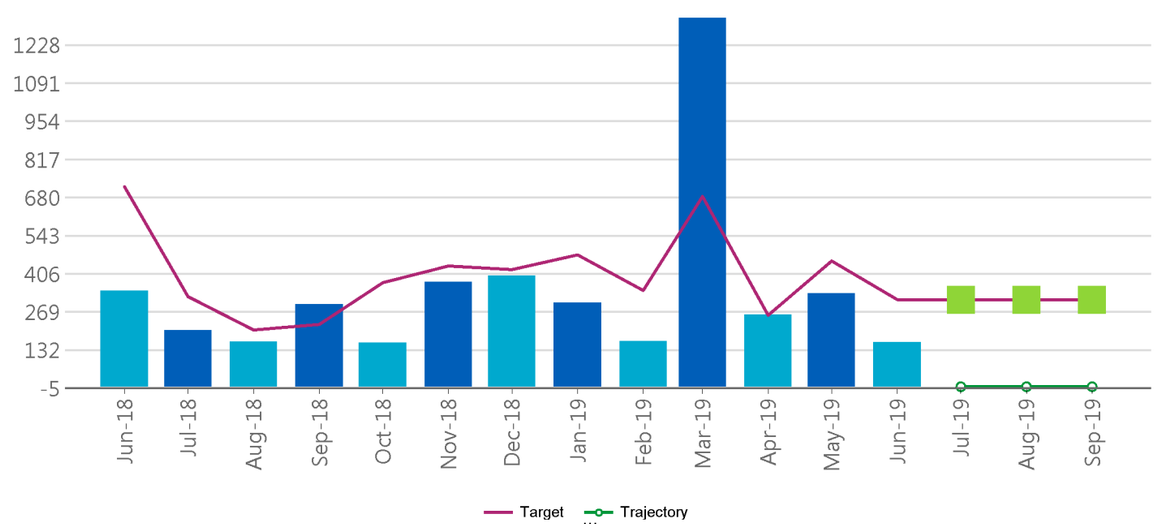
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
562	127	31	250	64	103	199	65	119	828	93	264	346	205	164	297	160	377	400	304	165	1,327	260	336	162	758

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator 215302

3 against 3 target

On target green rated

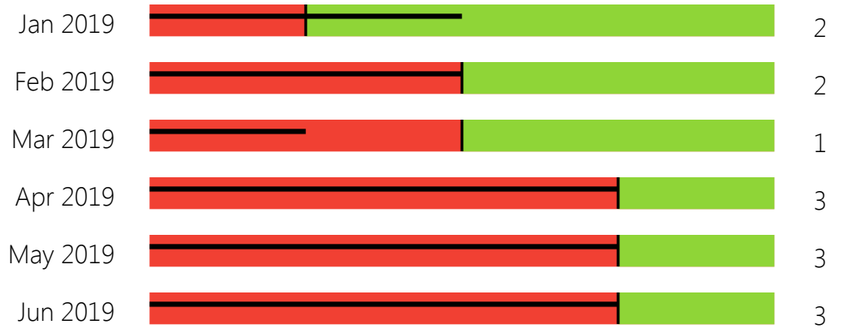
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

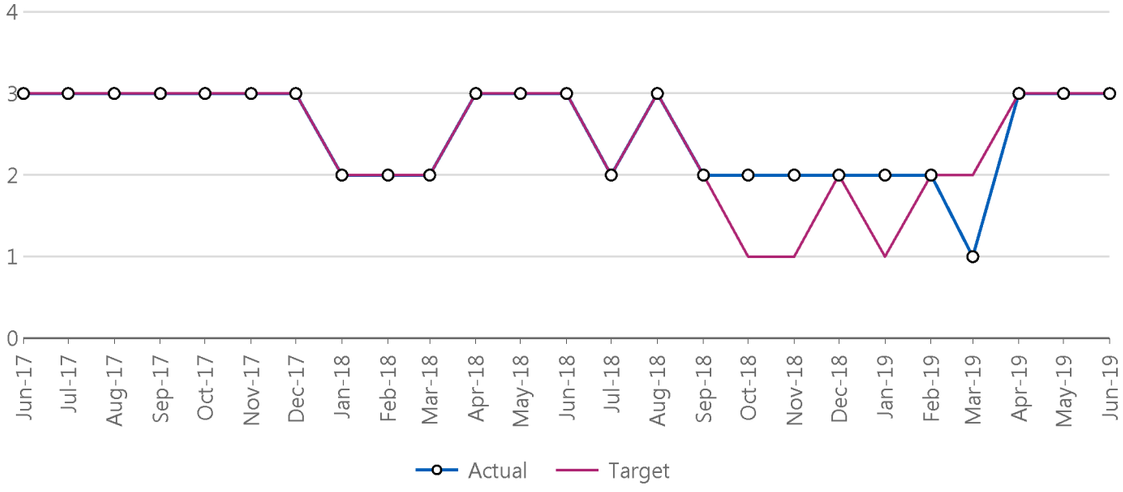
Narrative

UOR is on plan in month

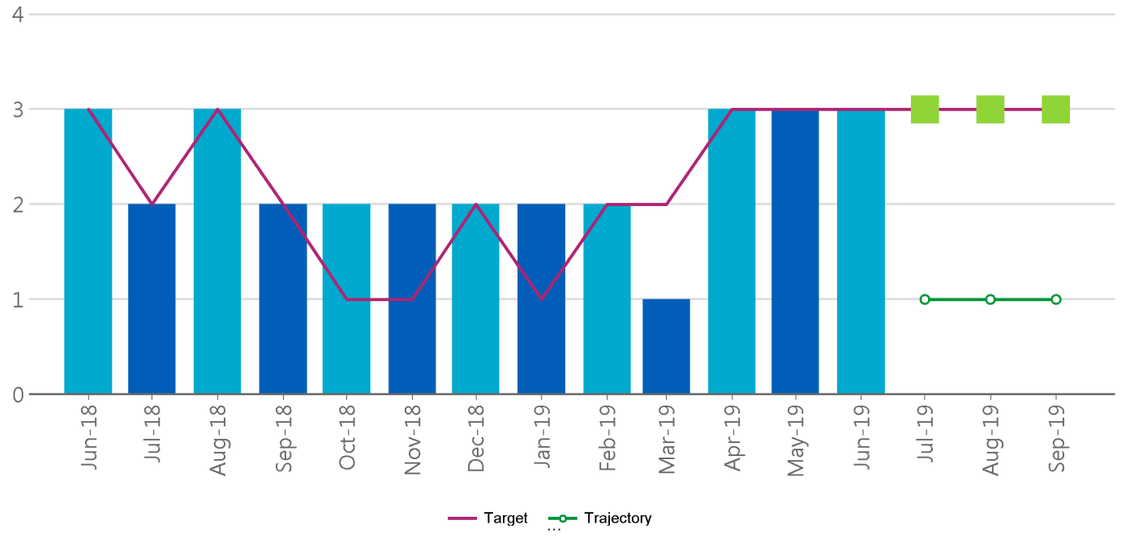
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th June 2019

Income and Expenditure £'000s

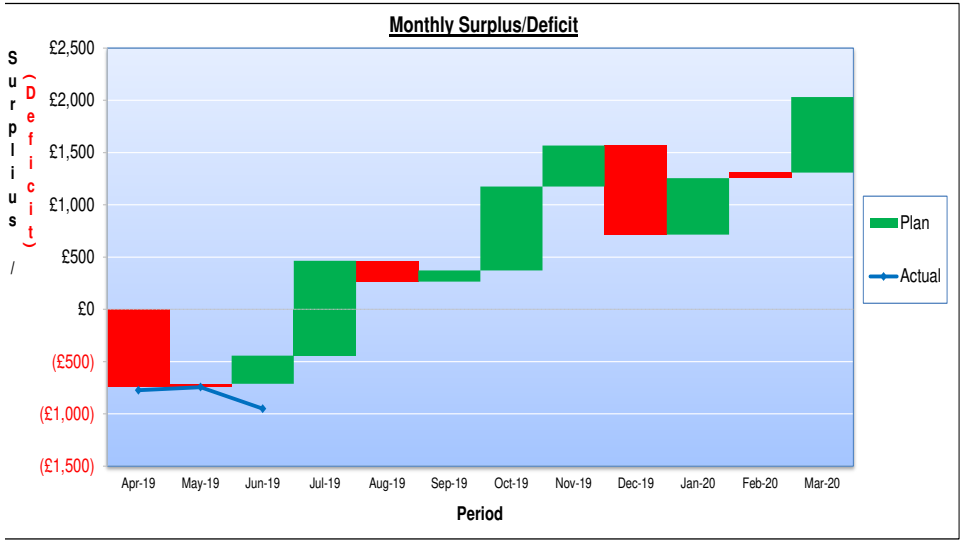
Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	103,145	8,688	7,868	(820)	24,689	24,057	(632)
PSF	372	19	0	(19)	56	0	(56)
Private Patient income	5,854	499	467	(33)	1,426	1,463	37
Other income	6,004	508	507	(1)	1,520	1,507	(13)
Pay	(64,828)	(5,395)	(5,284)	111	(16,341)	(16,147)	194
Non-pay	(43,776)	(3,664)	(3,404)	260	(10,649)	(10,749)	(99)
EBITDA	6,772	655	154	(502)	701	130	(570)
Finance Costs	(4,890)	(403)	(404)	(1)	(1,206)	(1,212)	(6)
Capital Donations	150	10	7	(3)	30	7	(23)
Operational Surplus	2,032	262	(244)	(506)	(475)	(1,075)	(600)
Remove Capital Donations	(150)	(10)	(7)	3	(30)	(7)	23
Add Back Donated Dep'n	521	44	44	(0)	130	131	1
Remove PSF	(372)	(19)	0	19	(56)	0	56
Control Total exl PSF	2,031	278	(207)	(485)	(431)	(951)	(519)
PSF Earnt	372	19	0	(19)	56	0	(56)
Control Total	2,403	296	(207)	(503)	(375)	(951)	(575)
EBITDA margin	5.9%	6.8%	1.7%	-5.0%	2.5%	0.5%	-2.1%

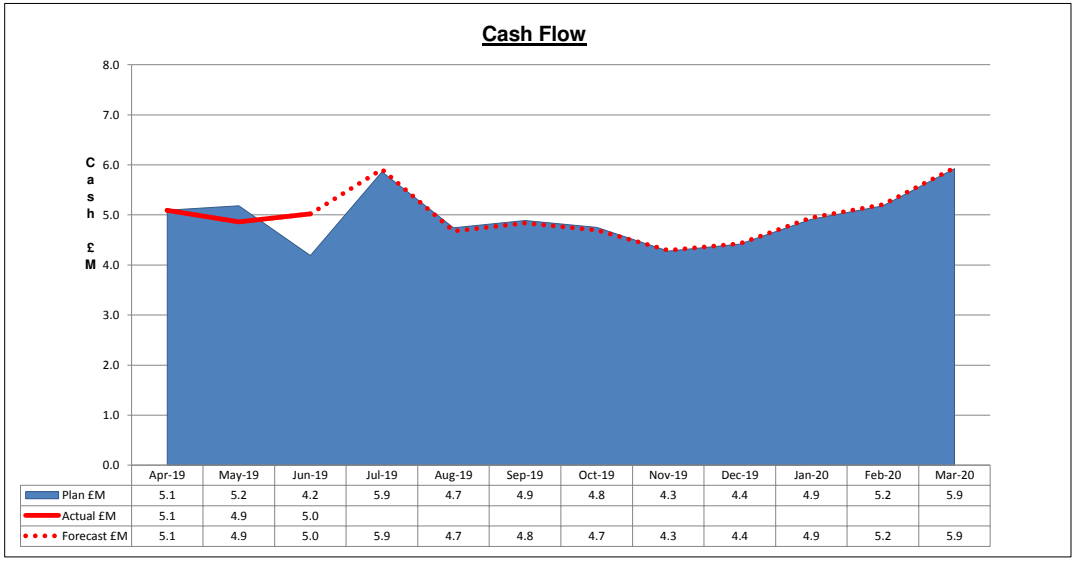
Capital service	4	I&E Margin	4
Liquidity (days)	1	Variance in I&E Margin	4
Agency	1		
Overall UOR	3		

	Jun-19	YTD
Debtor Days	25	25
Creditor Days	33	33

Statement of Financial Position £'000s

Category	May-19	Jun-19	Movement	Drivers
Fixed Assets	71,598	71,508	(90)	
Non current receivables	768	887	119	RTA (ICR) debtors
Total Non Current Assets	72,366	72,395	29	
Inventories (Stocks)	1,177	1,112	(65)	
Receivables (Debtors)	9,067	8,293	(774)	Reduction in clinical income accruals - contract activity
Cash at Bank and in hand	4,861	5,023	162	
Total Current Assets	15,105	14,428	(677)	
Payables (Creditors)	(11,301)	(10,885)	416	Partial settlement of 1819 contract underperformance
Borrowings	(1,214)	(1,225)	(11)	
Current Provisions	(87)	(88)	(1)	
Total Current Liabilities (< 1 year)	(12,602)	(12,198)	404	
Total Assets less Current Liabilities	74,869	74,625	(244)	
Non Current Borrowings	(5,884)	(5,884)	0	
Non Current Provisions	(146)	(146)	0	
Non Current Liabilities (> 1 year)	(6,030)	(6,030)	0	
Total Assets Employed	68,839	68,595	(244)	
Public Dividend Capital	(33,718)	(33,718)	0	
Revenue Position	(15,047)	(15,047)	0	
Retained Earnings	831	1,075	244	Current period deficit, before control total adjustment
Revaluation Reserve	(20,905)	(20,905)	0	
Total Taxpayers Equity	(68,839)	(68,595)	244	



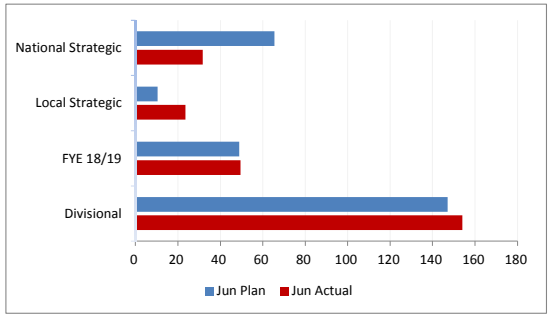


Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th June 2019

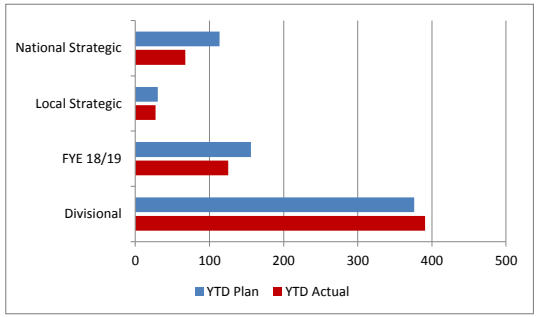
Cost Improvement Programme

CIP by Theme

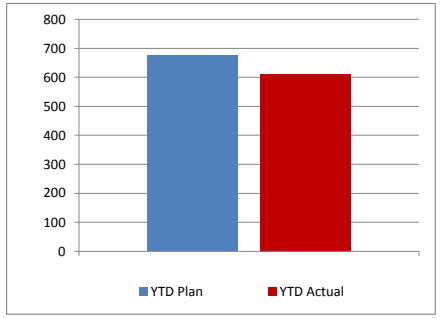
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

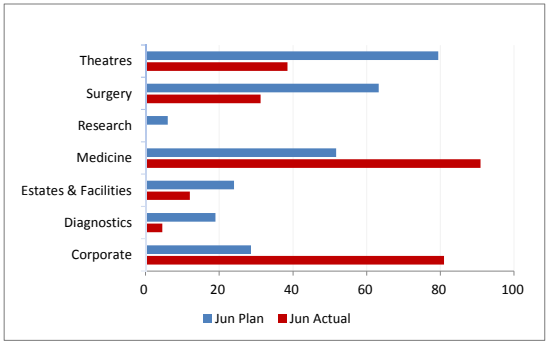


Trust YTD Achievement Against YTD Plan £000's

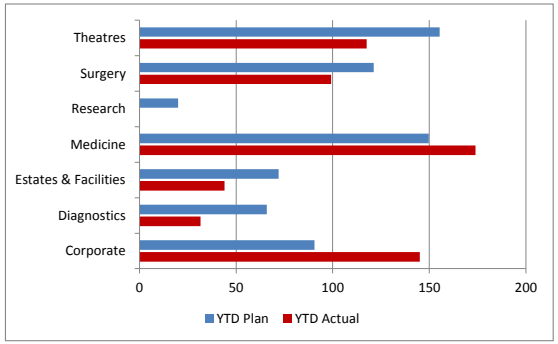


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

312	10%	b
922	31%	g
1,381	46%	a
385	13%	r
3,000	100%	

Capital

Year to date capital programme £000's

Position as at	1920-03	Capital Programme 2019-20			
Project	Annual Plan £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
TSSU improvements & refurbishment	1,350	550	454	96	1,350
Diagnostic equipment replacement	1,000	0	0	0	1,000
Replacement I/T network	400	225	184	41	400
EPR development	100	25	16	9	100
Digital Developments	100	0	0	0	100
Invest-to-save schemes	300	0	0	0	300
I/T investment & replacement	300	90	6	84	250
Backlog maintenance	400	50	44	6	300
Equipment & service continuity	500	30	23	7	500
Project management	100	25	25	0	100
Trust improvement bids	100	0	0	0	100
Contingency	300	0	0	0	300
NHS Capital Funding	4,950	995	752	243	4,800
Donated equipment / building works	150	30	7	23	150
Total Capital Funding (NHS & Donated)	5,100	1,025	758	267	4,950

Commissioner Performance

Year To Date Commissioner Income against Plan £m