The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 03.05.2023

MEETING
3 May 2023 09:30

PUBLISHED
2 May 2023

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	3/05/23		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes from the previous meeting 01 March 2023		Chair	
1.4. Matter Arising		All	
2. Patient Story with Jess Harper		Assistant Chief Nurse	09:40
3. Chair Update		Chair	09:55
4. Chief Executive Officer Update		Chief Executive Officer	10:05
4.1. NHS Oversight Framework			
4.2. Corporate Objectives			
5. Board Assurance Framework and Corporate Risk Register		Trust Secretary	10:15
6. Quality and Safety			
6.1. Chief Nurse and Patient Safety Officer Update (verbal)		Assistant Chief Nurse	10:30
6.2. IPR Exception Report		Assistant Chief Nurse and Chief Medical Officer	
6.3. Chair Report from Quality and Safety Committee		Non Executive Director	
6.3.1. Trust Business Continuity Plan		Chief Operating Officer	
BREAK			10:55

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Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	3/05/23		09:30
7. People and Workforce			11:10
7.1. IPR Exception Report		Chief People Officer	
7.2. Chair Report from People and Culture Committee		Non Executive Director	
7.2.1. Industrial Action (verbal)		Chief Operating Officer	
7.2.2. Staff Survey (Presentation)		Chief People Officer	
7.2.3. Freedom to Speak Up Q4 Report		Assistant Chief Nurse	
7.2.4. Guardian of Safe Working Hours Q4 Report		Chief Medical Officer	
8. Performance and Finance			11:50
8.1. Chief Operating Officer Update (verbal)		Chief Operating Officer	
8.2. IPR Exception Report		Chief Operating Officer	
8.3. Long Waiters (Presentation)		Chief Operating Officer	
8.4. Finance Performance Report		Chief Finance and Planning Officer	
8.5. Chair Report from Finance, Performance and Digital Committee		Non Executive Director	
9. Governance			
9.1. Risk Management Policy		Trust Secretary	
9.2. Policy Approval Framework		Trust Secretary	

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Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	3/05/23		09:30
10. Questions from the Governors and Public		Chair	12:20
11. To Note:			
11.1. Thank you Letters (Veterans Centre Opening)			
12. Any Other Business		All	12:25
12.1. Next Meeting: 05 July 2023			

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CEO Update

1. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	03 May 2023
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	28 April 2023
Paper Reviewed By:	N/A	Paper Type:	Update
Form submitted to:	Board of Directors – Public Session	Paper FOIA Status:	Full

2. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?
This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

2. Executive Summary

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

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

3. The Main Report

- **Royal visit**

We were delighted and honoured to welcome HRH The Duchess of Edinburgh to RJAH on Tuesday 4 April to formally open our Headley Court Veterans' Orthopaedic Centre. A lot of work went into planning the day and I want to thank everybody involved in making that happen; especially Victoria Sugden, our Lead Governor and Director of The League of Friends, who oversaw it all. The visit was a big success – I think it has made a difference to morale within the hospital, and it certainly achieved our core aim of raising awareness of the work of our veterans' service team. It was wonderful to see their work highlighted on the national stage in publications ranging from the Daily Mail to Hello Magazine!

- **New Chief Nurse and Patient Safety Officer**

I am delighted to welcome our new Chief Nurse, Paul Kavanagh-Fields. Paul joined us at the start of April, having been appointed following a rigorous and competitive recruitment process. He brings a wealth of leadership experience to the Board, having previously worked in a number of Board and sub-Board level positions. Recently, Paul was responsible for the role out of the Bowel Cancer Screening Programme in Northern Ireland, and more recently has supported the North Wales Covid Response Service at a strategic level, engaging with Local Authorities, Welsh Government and Education.

- **Setting out our vision for the future**

We held a thought-provoking strategy away day at Shrewsbury Town Football Club last month, titled High-Impact Provider-led Strategy (HIPS1). More than 100 members of RJAH staff gathered for the day, which was a chance to really focus on what kind of organisation we want this to be, and where we want to get to over the next five years. I was struck by the energy and the ambition in the room, and we had some wonderful conversations about our ambition. We are still working through the outputs from the day, and I want to thank all members of the Board for their support and their input. I look forward to taking that work forward.

- **Recruitment Day**

Our recruitment challenges have continued to feature heavily in recent Board discussions, so I am delighted to report on the success of our second Recruitment Day of the year. The event last month saw around 100 people attending – with a variety of clinical and non-clinical roles being showcased. I was particularly pleased to see us attracting the next generation of nursing talent, with five 'golden tickets' being presented to students who will become substantive members of staff upon completion of their studies in the summer,

- **RJAH at the London Marathon**

The 2023 London Marathon took place at the end of last month. I was due to be running in the race for the second year in a row, but sadly had to defer my place to next year. However, we still had a large team of runners taking part to raise funds for the RJAH Charity and I want to place on record my thanks and my admiration to all of them. I look forward to

meeting them all later in the year, and to finding out how much they have raised for RJAH Charity.

- **RJAH re-accredited with Veteran Aware status**

I was delighted that RJAH was reaccredited with its Veteran Aware status, from the Veterans Covenant Healthcare Alliance (VCHA). We were initially hailed as Veteran Aware in November 2018. Veteran Aware status, which is awarded by the VCHA, reaffirms the Trust's commitment to providing the best standards of care to the Armed Forces community, past and present, and their families, based on the principles of the Armed Forces Covenant. It's a fantastic initiative that will ensure the bespoke needs of the Armed Forces community are at the heart of their care.

- **Roll-out of myrecovery across the Trust**

At the start of last month, we began to roll the myrecovery app out across the wider Trust in a phased approach, with patients automatically being invited to the platform. This follows an initial launch in September last year, when the app was made available to patients under the care of Consultant Orthopaedic Surgeon Mr Nikesh Makwana and the Shropshire Orthopaedic Outreach Service (SOOS). myrecovery is a suite of tools designed to support, empower and inform a patient through their treatment. Patients can access a range of information via the myrecovery app about the different steps of their end-to-end pathway. The app is customised to RJAH and contains a series of videos, articles and an information library specific to a treatment pathway. Over 30 different app pathways have been built for RJAH to support a range of specialties.

- **Work starting on new Theatre**

Work is getting under way to extend our Theatre complex here at RJAH. National funding has been secured for the project, which is allowing us to extend our existing Theatre development with the addition of one extra operating theatre – a step that will, with the right staff in place as well, allow us to increase our capacity as we look to reduce our waiting lists. As well as a new Theatre, the development will also include a recovery area, a staff rest room, toilets, and some cleaning areas.

- **Cost of living measures extended indefinitely**

Back in the autumn, we launched a series of measures designed to help staff navigate the cost of living crisis engulfing the country. Some of these were initially funded to run until the end of March this year but we were delighted to announce that all of the food and drink related offers have been extended indefinitely. It means staff are still able to take advantage of free breakfasts and to make the most of free coffee, tea and milk for all departments. And the ever-popular lunchtime hot meal offer is continuing too – with staff able to pick up a main meal with a green side for just £2. Originally launched as winter warmers, this offer is now known as Denbigh's Deals.

- **IPC Fayre is back**

Board members will know how hard we have worked as a Trust to tackle some significant Infection Prevention and Control (IPC) challenges over the past year. One initiative we introduced last year to raise awareness of this agenda was an IPC Fayre. It went so well that it is returning this year, taking place tomorrow (Thursday 4 May). It will feature multiple stalls which each represent an area of element of IPC to ensure staff are up to date with their

competencies and continuing professional development (CPD) log. These include safer sharps, waste management, environment and sustainability, surgical site infections, hand hygiene and hand washing assessments, and care of the patient environment.

- **Monthly Award**

At the end of March, we retired our Health Hero Award, replacing it with a new award called RJAH Stars. The rebrand was to give new impetus and a fresh feel to something that had been in place for around seven years.

There have been two winners of the Health Hero Award since our last public Board meeting:

- Our final Health Hero award was presented to **Dr James Pattison**, one of our consultant anaesthetists, and was done so in recognition of his work to prevent delaying patients and also in recognition for his support to staff when dealing with challenging clinical situations. Dr Pattison was called out by several members of our Theatres team, who commended his communication, his teamwork, and his willingness to get his hands dirty and help out in order to support colleagues and avoid cancellations.

- The first winners of our new RJAH Stars Award was our **Medical Illustration team**. The Medical Illustration Department assist clinical staff by capturing clinical photography of conditions presented by patient, which is then used for diagnosis or for recording a condition during the stages of treatment. They were nominated by Rebecca Warren, Lead Nurse for Enhanced Recovery, in recognition of commitment to and passion for the Enhanced Recovery programme – including making it possible for the Trust to relaunch Joint School in April.

Congratulations to both of our latest winners!

- **MSK (Musculoskeletal) Integration across Shropshire, Telford and Wrekin (STW)**

At the March STW Integrated Care Board (ICB) RJAH presented a proposal to further transform MSK services across STW and for RJAH to be the Strategic Lead, being responsible for designing and delivering a comprehensive MSK service with an embedded focus on prevention and population health, to address health inequalities.

STW ICB approved the appointment of RJAH as the Strategic Lead for MSK services across STW, noted the expanded high-level scope of MSK transformation and supported the principles of the future MSK transformation.

- **Midlands Partnership NHS Foundation Trust awarded University Trust status**

I'd like to extend my congratulations to Midlands Partnership NHS Foundation Trust (MPFT), which has been awarded University Trust status from Keele University in a move that will help patients, students, and colleagues in local communities. The Trust will continue to provide high quality evidence-based care while building on its strategic links with Keele University to enhance collaborative research, education, and training. The announcement is a continuation of the Trust's long-term programme to build upon research partnerships to drive innovation and will further help it develop new treatments and practices more quickly, as well as supporting development of its future workforce.

- **The Hewitt Review**

  Last month, the Rt Hon Patricia Hewitt's review into integrated care systems (ICSs) was published. It was commissioned by the chancellor, Rt Hon Jeremy Hunt, in November 2022, to look at the role and powers of Integrated Care Systems (ICS).

  The review was conducted with significant engagement with leaders from across the health and care system.

  The report makes recommendations to maximise the opportunities ICSs bring to population health and wellbeing and provides a helpful overview of the issues hindering progress and placing burden on system players.

  Key recommendations include:
  - Reducing the number of targets set at a national level.
  - Developing "high accountability and responsibility partnerships" for more mature ICSs.
  - More investment in prevention, including increasing the public health grant allocation.
  - Reducing the use of short-term funding pots.
  - Reviewing the entire NHS capital regime.

- **NHS England Leadership meeting**

Last month, the first of this financial years NHS England National Leadership meeting was held in London, hearing from and opportunity for questions and answers with the National NHS England Leadership team. Looking forward the priorities remain, reducing the elective care backlog, with a continued focus on those patients waiting the longest for treatment, cancer recovery, access to primary care, improved Urgent and Emergency Care (UEC) performance and achieving financial balance.

The long-awaited NHS Workforce plan is set to be published in the spring.

The findings of NHS England's review of delivery and continuous improvement in the NHS, was shared and NHS England launched its new approach to improvement, NHS Impact. The review was carried out by Anne Eden, NHS South East Regional Director and was commissioned to consider how the NHS can continue to deliver against its immediate priorities while also continually improving services over the long-term.
In response, NHS England has agreed three actions:

- To establish a national improvement board, which will agree national priorities for improvement-led delivery.
- To launch a single, shared 'NHS improvement approach' – which will be developed through NHS Impact.
- To co-design and establish a Leadership for Improvement programme.

4.0. Conclusion

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

NHS Oversight Framework – Quarter 3 outcome and Quarter 4 requirements

0. Reference Information

Author:	Laura Peill, Assistant Chief Executive	Paper date:	03 May 2023
Executive Sponsor:	Stacey Keegan, Chief Executive Officer	Paper Category:	Performance
Paper Reviewed by:	RJAH Executive Team meeting 11/04/2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

This letter outlines the outcome of the Quarter 3 NHS Oversight Framework review and the approach to the Quarter 4 review, including key dates and requirements.

The Board is asked to note the letter and the outcome of the Trust's Quarter 4 self-assessment.

2. Executive Summary

2.1. Context

ICB members have agreed an approach to completing assessments against the oversight framework which involves individual provider organisations completing self-assessments followed by a review by ICB members who then jointly agree the assessments prior to final submission to NHSE.

2.2. Summary

This letter covers the outcome of the Quarter 3 NHS Oversight Framework review and the requirements for the Quarter 4 assessment:

- Quarter 3 outcome - NHSE did not support the ICB's recommendation to move RJAH to segment 2 due to the level of backlog of >78 and >104wk waits and confirmed that RJAH would stay at level 3 until long waits are addressed in line with national targets.
- Quarter 4 assessment:
    - since the Q3 submission, the Trust has received formal confirmation from NHSE that the IPC undertakings have been removed and embedded improvements have been evidenced through a further assurance visit in March and the Trust's green rating against the NHSE IPC internal matrix.
    - the Trust has also made significant progress with long-waits. Although a small number of long-wating patients remain on waiting lists, plans are in place to deliver zero >104 week waits by the end of April, zero >78 week waits by the end of June and zero >65 week waits by the end of March 2024. Spinal disorders continue to be recognised nationally as a pressurised specialist service and the Trust has delivered significant improvements in areas such as validation and mutual aid co-ordination.
    - the Trust has therefore self-assessed that segment 2 is the most appropriate segment for Q4 and this has been supported by the ICB. The national submission deadline is 26 May 2023.

The Board is asked to note the letter and the outcome of the Trust's Quarter 4 self-assessment.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Our ref: SW/JG/CAT

6 April 2023

Stacey Keegan
Chief Executive Officer
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Sent via email

Dear Stacey

NHS Oversight Framework 2022-23 - Quarter 3 Outcome, Quarter 4 Key Dates

Following notification from NHSE, I am writing to you to confirm the approved Quarter 3 segmentation for NHS Shropshire, Telford & Wrekin ICB and for Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH). I will also set out the process and timescales for the Quarter 4 review. ICBs have been asked to communicate the outcomes of the Quarter 3 process directly to provider organisations and set out the proposed process for the Quarter 4 segmentation review.

Quarter 3 Segmentation Review Outcome

The segmentation of both Integrated Care Boards (ICB) and NHS Provider organisations was reviewed and approved by the Midlands Regional Support Group at its meeting on the 23 February 2023. It was agreed that for Quarter 3 NHS Shropshire, Telford & Wrekin Integrated Care Board (ICB) should remain in segment 4 of the NHS Oversight Framework. This rating is based on a quantitative and qualitative assessment of the 5 National themes and one Local Priority contained within the NHS Oversight Framework:

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

The table below sets out the segmentation and rationale driving the support needs identified.

Organisation	Segmentation	Date of Decision	Rationale
Shropshire, Telford & Wrekin ICB	4	23.02.23	▪ Performance is within the bottom quartile. ▪ Dramatic drop in performance ▪ Financial Plan not balanced. ▪ Material concern on Quality and Safety ▪ Other material concerns

Criteria						
1. Performance bottom quartile	2. Dramatic drop in performance	3. Financial Plan not balanced	4. Material concerns on governance/ leadership	5. CQC rating (trusts only)	6. Other material concerns	7. Material concern on quality and safety
Electives: 104wks bottom quartile. Risk highlighted on delivery of zero 104ww due to UEC pressures and lack of elective bed base. 78ww backlog behind plan. 52ww backlog cont. to grow. **Cancer**: 62-day backlog-610. 104-day backlog-185 **Ambulance handover:** Over 60mins-38.5%	Ambulance delays, backlog position Elective backlog position	System is one of only five nationally that submitted deficit financial plans for 2022/23. Since plan submission significant further risk has materialised which is not mitigated. The latest estimates from the system report the likely outturn deficit will be in the region of £55-66m (not conf)	No	N/a	CHC standards not met. Regional Head of CHC has proposed to escalate this system to DON and closely monitor.	Leadership / people indicators Review in Spring 2023 as progress has been made SATH – undertakings in place in place. RJAH – segment 3

Provider Segmentation agreed by the Regional Support Group (23 Feb)

The Regional Support Group also reviewed our recommendations on provider segmentation based on your self-assessment. This factored in NHSE's assessment of performance against the metrics, as well as additional qualitative views and intelligence. NHSE, on this occasion, *did not* support the ICB's recommendation to move RJAH to a level 2, due to the level of backlog of >78 and >104wk waits. They confirmed that RJAH would stay at level 3 until the long waits are addressed in line with national targets.

The table below details the confirmed position for Quarter 3:

Provider Name	Provider Type	Segmentation
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Specialist Acute Trust	3

On this basis NHSE will continue to work with our ICB and our system partners in the ongoing review and development of our improvement plans to address the key issues underlying our current segmentation.

Quarter 4 Segmentation Timetable

For the end of Quarter 4, NHSE will need to complete a full review of segmentation of ICBs and providers in accordance with the 2022-2023 NHS Oversight Framework. The national submission deadline is 26 May 2023 for this assessment. Due to the timelines, the 17 March 2023 NHSE oversight dashboard refresh will need to be used as the basis for the Quarter 4 review.

Given that NHSE are only now concluding the Q3 segmentation review, they have suggested that Q4 segmentation should be conducted on an exception only basis, where there is new data or intelligence which is material to the assessment. We are in full agreement with this and are also very mindful that we are already in early April with both Easter and more planned industrial action to navigate in the coming days.

It is on this basis that we are suggesting a light touch approach and ask that RJAH please complete the self-assessment template (Q3 attached for information and amendment for Q4) and e-mail it back to Julie Garside, Director of Planning & Performance (julie.garside@nhs.net) by close of play on the 20 April 2023. This will allow the ICB to collate and review all responses, allowing a couple of days to finalise with you and enable our combined system feedback to NHSE by their deadline of the 26 April 2023.

Thank you for your ongoing commitment to the NHS Oversight Framework segmentation review process and the continued drive for improvement across our system.

Yours sincerely

Simon Whitehouse
ICB CEO
NHS Shropshire, Telford and Wrekin

Corporate Objectives 2022/23

Committee / Group / Meeting, Date

Board of Directors, 03 May 2023

Author:	Contributors:
Name: Nia Jones Role/Title: Managing Director for Planning and Strategy	Mary Bardsley Assistant Trust Secretary

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication?

Yes

Key issues and considerations:

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

The Trusts agreed aim for 2022/23 was "Aspiring to deliver world class patient care"; and the corporate objectives aim to support the delivery of this aspiration.

The Trust's overarching corporate objectives for the past year have been:

- Develop and maintain safe services.
- Develop our Veterans service to ensure it is established as a centre of excellence.
- Support MSK integration across the System.
- Optimise the potential of digital technologies to transform the care of patients and their outcomes.
- Maintaining statutory and regulatory compliance.

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

The Senior Leader team have completed a review of the corporate objectives. The document in appendix A outlines the progress made against the underpinning objectives.

Recommendations:

That the Board:

1) Discusses and consider each of the corporate objective's, as presented at Appendix A.

Report development and engagement history:

The Corporate Objectives has been reviewed and updated by the relevant lead executive. Prior to presentation at the Board meeting a reflection session was held at the Executive Team Meeting during April 2023.

Next steps:

The Trust will consider the discussion taken place at the Board meeting and align to the work currently underway to identify the new corporate objectives for 2023/24.

The final version will be presented to the Board of Directors Public meeting in July 2023.

Appendices

Appendix A Corporate Objectives 2022/23

Corporate Objectives 2022/23

1. Developing and Maintaining Safe Services			
Our mission	**How we will do it**	**Measure**	**Update/Comment – April 2023**
Caring for Patients	Undertake full service reviews to include specialised commissioning to ensure we have the right services to serve our patients	• Service Review programme agreed by the end of Q1. • Delivery of 2022/23 service reviews in line with agreed service review programme.	Programme agreed Q1 with all services planned to complete reviews by July 2023. Service reviews progressing – Commenced programme for presenting outcomes to TMG with workplan to include service reviews on the agenda April, May, June and July 2023. This will inform the Trust combined Clinical Strategy.
	Development of a specialist revision knee service	• Service specification and resource requirements presented to FPD. • Implementation of the service specification requirements agreed by March 2023.	The Trust has been selected as one of 15 Major Revision Centres nationally. The Revision Knee service MDT is now live. The Trust has assessed its progress as fully compliant in achieving 13 of the 22 standards, with 8 identified as amber where actions are in place to progress to full compliance, and one has been assessed as red rated (psychological services).
	Securing robust and sustainable microbiology support	• Service specification agreed with service provider. • Trust membership on the N8 pathology network	There have been ongoing challenges with regards to sustaining a robust microbiology service. The decision has been made to split the existing provision into different elements. Peri prosthetic microbiology due to go live at Sheffield in Q1 2023/24, the IPC and general microbiology service is provided by SATH and the Trust is working with SATH to ensure that there is appropriate resilience to support the RJAH requirements.
	Further developing equality and inclusion initiatives for patients	• Delivery of Inclusion Action Plan	Key deliverables achieved in 2-22/23 include: • 2 facilitated patient engagement sessions completed jointly with Healthwatch re: accessibility/EDI • Accessible Information standard policy written • Learning Disability and Autism awareness training launched and > 92% for all staff achieved. • Patient video for patients with LD and autism accessing our services • PLACE assessment completed Sept 22 • Patient safety partners appointed as part of National Patient Safety strategy.

Corporate Objectives 2022/23

Caring for staff	Recruiting and retaining staff to ensure we have the right staff, in the right place at the right time	Delivery of key KPIs in our 2022/23 workforce plan: • Nursing vacancy rate: 7.2% • Medical vacancy rate: 2.5% • HCSW vacancy rate: 0% • Staff Turnover: 8%	The Trust has undertaken a number of key initiatives in 22/23. Key highlights include: • Establishment of a Recruitment and Retention working group from September 2022. • Increased the strategic grip with dedicated Director level leadership to drive the recruitment and retention agenda. • Dedicated Recruitment manager to ensure focus in this area. • The Trust has developed initiatives related to recruitment by running 2 recruitment days with positive recruitment outcomes. • Cost of Living initiatives put in place to support the Trust's retention programme. There has been an increase in the vacancy rate in 22/23 with the following outturn position: • Nurse vacancy rate increased to16.13% • Medical vacancy rate increased to 8.07% in March 2023 • HCSW vacancy rate reduced to 7 % in March 2023. • Staff turnover increased to 12.1% March 2023. However, the Trust has demonstrated that the impact of the intervention saw improvements in the second half of the year with further staff in the current recruitment pipeline that will mean 23/24 further improvement. In particular: • HCSW vacancy rate reduced from 13.28% in September to 7 % in March 2023, and will continue to reduce. • Medical vacancy rate reduced from 9.73%% to 8.07% in March 2023. • Staff turnover reduced from 12.87% in September to 12.1% in March 2023.
	Further developing equality and inclusion initiatives for staff	• Delivery of Inclusion Action Plan • Staff survey results	The following key development have been undertaken in 22/23 against the delivery of the Inclusion action plan for staff: • The Trust has commissioned external support to review the Trust's EDI policy, support with listening events and develop an EDI strategy. • WRES and WDES action plans and EDI Internal Audit recommendations action plans have been developed. Oversight is through the ED&I committee. • Veterans Network established.

Corporate Objectives 2022/23

			• A programme of events to thank staff and promote inclusion is being developed for 23/24. • Staff survey results show Improvement in discrimination metrics for Gender, disability and age, with deterioration in discrimination due to sexual orientation. • Strengthened RJAH engagement in system staff networks.
Caring for Finances	Review of funding models and service line reporting to ensure robust financial management	• Service line reports presented to FPD Committee.	SLR report presented to FPD with indicative performance based on a return to national tariff (income is on block for the current financial year). Going forward SLR will be reported on a half yearly basis.
2. Develop our Veterans service to ensure it is established as a centre of excellence			
Our mission	**How we will do it**	**Measure**	**Update/Comment – April 2023**
Caring for Patients	Develop a communications, marketing and branding strategy aimed at enhancing links with key stakeholders	• Communication, Marketing and Branding in place	Communication Strategy for Veterans completed with a phased approach planned for communication and marketing aligned to growth. Phase 1 of the strategy 22/23 included; • **'Soft Launch'/Remembrance Day –** a celebration designed to mark the end of the build phase. Done respectfully to mark Remembrance Day as well as the opening of the new building. • **Board stories –**Lt Col Carl Meyer was formally presented with his Veterans Award. This will attract further media coverage. We will look for regular opportunities to highlight the project at Board. • **Official Royal opening April 2023** with wide media coverage of the event. • **ICS board** – RJAH had the opportunity to showcase the work to the Integrated Care System (ICS) with Carl Meyer due to present our long-term vision to the ICS Board at their next meeting. • **Breakfast Club** – on-site veterans' breakfast club meetings within the Veterans' Centre as a means of connecting with the local veteran's community. • **Supporting the next generation** –In partnership with Moreton Hall School, sixth form students were welcomed for a programme of Multiple Mini Interviews at the centre on the 16th November which provided an

Corporate Objectives 2022/23

			opportunity to show the high-quality environment we can now offer in the new centre.
	Maintain Veteran accreditation and explore other relevant accreditation opportunities	• Veteran accreditation maintained • Additional accreditation application opportunities reviewed and progressed	Veteran accreditation re-accredited in 22/23. Key highlights from the areas that the Trust successfully demonstrated as part of the reaccreditation process included: • Establishment and opening of the new dedicated veteran's facility. • Board leadership for developing Veterans services. • Trust's HR policies in place to support reservists. • Veterans' awareness signposting • Actively encouraging veteran patients to be identified as such within our service on referral. • Collaboration with 202 Field Hospital • Collaboration with SATH to support ICS level joint working. The Trust has also supported other organisations to sign the Veterans Covenant in 2022/23, including: • League of Friends Charity • Orthopaedic Institute • Pave Away Ltd
Caring for staff	Identification and utilisation of key recruitment links for the Veterans service	• Phase 2 business case has supporting recruitment strategy in place	Phase 2 business case in development to include workforce plan, scheduled for completion in June 2023. The trust holds the MOD Employer Recognition Scheme Gold Award and has developed leaflets to promote the Trust as a place to work which has been shared across military groups and networks to encourage military personnel that are leaving or considering leaving to consider the Trust as the first point of contact for their future career.
	Roll out of Veterans awareness training	• Staff training to include Veterans awareness training for relevant staff	Re-launch of Veterans Aware training in 2022/23, to help give staff the tools to support veterans and members of the Armed Forces. Key development include the following: • Veterans' Awareness introduced into new starter inductions. • Information added to the staff handbook.

Corporate Objectives 2022/23

			• Board veterans training completed. • Veterans Awareness training will form part of the Trust's mandatory training in 23/24. This training is led by Becky Warren as an RJAH reservist and Sarah Kerr in order to lend credibility and authenticity.
Caring for finances	Sustainable funding model to be agreed to optimise further investment opportunities	• Business case presented to FPD on phase 2 for the Veterans service	Phase 2 (growth) business case in development, scheduled for completion in June 2023 and focus on expanding consultant capacity. Discussions taken place with MoD regarding a pilot of serving Veterans being treated at RJAH – awaiting approval. Rehabilitation SOC presented to Board and Headley Court in January 2023 with detailed business case due to be presented to FPD in June 2023.
	Programme of review to ensure best use of resource	• Deliver to agreed timescales and budget	Veterans centre delivered to time and budget. The Headley Court Veterans' Orthopaedic Centre was built by local contractor Pave Aways, onsite at The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) following a £6 million donation from The Headley Court Charity with the soft launch opening taking place in November 2022. The £6 million two-storey building features nine standard examination and clinic rooms, an enhanced treatment room for minor outpatient procedures, an assessment room, a splinting and therapy room, as well as clinic space for virtual appointments. In the main entrance of the building, there is a café and dedicated Veterans' Hub where Shropshire Council and various military charities will provide support to veteran patients and their family and friends, with issues that range from homelessness, finance, debt management, welfare, post-traumatic stress disorder (PTSD), benefits and more.

Corporate Objectives 2022/23

3. Support MSK integration across the system			
Our mission	**How we will do it**	**Measure**	**Update/Comment – April 2023**
Caring for patients	Leading the MSK Transformation Board and contributing to the delivery of the transformation programme	• MSK transformation Board Chair's reports presented to FPD committee	The Trust Chief Operating Officer has taken over as chair of the MSK transformation board since September 2022. In March 2023 the Trust took a case to the Integrated Care Board (ICB) for the organisation to be appointed the strategic lead responsible for the design and delivery of MSK services across the system. This was approved by the ICB. Revised governance structures are now being developed to take this forward.
	Standardising pathways and access for patients	• Standardised pathways to be implemented in line with MSK Transformation board implementation programme	In February 2023 the Musculoskeletal service for Shropshire and Telford (MSST) was launched. This attempts to standardise the triage and interface services across STW and provide a single point of MSK referral for primary care.
	Levelling up of outcomes for patients across all providers	• NJR outcomes • PROMs • GIRFT metrics • Model Hospital data	ICS GIRFT meeting held in January 2023 with opportunities for improvement for the STW system identified. Levelling up of outcomes for patients across all providers was a key driver for then establishment of RJAH as an MSK lead provider. Outcomes for patients will inform the scope of the transformation board workplan. Delivery will be achieved through collaboration with partners across the STW system.
Caring for staff	Integrated OD solution for MSK providers in the system	• Agreed MSK OD strategy in place for system providers	System commissioned Value Circle to provide independent support in developing the system direction of travel for MSK services. Further enabler activities will be considered as part of the MSK transformation programme plan for 23/24.
	Enhancement of non-medical roles	• Standardised pathways for integrated care. • Introduction of enhanced roles and new non-medical roles into MSK services.	In February 2023 the Musculoskeletal service for Shropshire and Telford (MSST) was launched. Business case approved for additional therapy provision for the service. Recruitment commenced in 2023 and will continue in 23/24.

Corporate Objectives 2022/23

Caring for Finances	Delivery of efficiencies outlined in the ICS plan	• Transformation programme delivered to timescales. • Achievement of 2022/23 efficiency target	Delayed go live of standardised pathways and interface model. Efficiency benefits not anticipated to be realised until 24/25, due to recruitment timelines and the requirement for backlog reduction in MSK services in 23/24. Savings of £0.7m forecast for 22/23 which is £0.5m off plan due to slippage in go live date.
4. Optimise the potential of digital technologies to transform the care of patients and their outcomes			
Our mission	**How we will do it**	**Measure**	**Update/Comment – April 2023**
Caring for Patients	Continue to develop patient facing apps to optimise patient outcomes and explore the use of artificial intelligence (AI).	• Roll out of My Recovery app to agreed clinical pathways • Complete review of new technologies • Business cases for investments presented to FPD as appropriate	My Recovery app roll out commenced in 2022/23. Currently deployed in Foot & Ankle, Arthroplasty, and Veterans and SOOS. Sports Injuries, Upper Limb and Spinal Disorder to follow in May 2023. • Over 6000 invitations sent to patients. • Over 2870 patients have engaged and responded to invitations • Over 9000 pain and quality of life scores collected direct from patients. Patients giving favourable feedback as app allows them to track and plot their own pain scores and see in a graphical format and helps understanding of their treatment plan. • The app has been shown to improve shared decision making with the patient with approx. 80% of patients giving positive feedback. Assessment of clinical service requirements for digital enablers being considered as part of the clinical service reviews. • Pilot project working alongside Radiology to test AI reads of CT Scans to provide a “second opinion” in order to improve patient safety • The aim is to increase confidence and flag any potential “errors in observation” • Trial will run for 3 months. • Opportunities identified for AI use in patient contact. Theatre developments • Digital are working alongside and bringing in suppliers to showcase equipment that can potentially be used in the future

Corporate Objectives 2022/23

			• New theatres specification to consider how to future proofing theatres technological development where possible. • "hololens" cameras being trialled to project augmented reality view Technology areas to look at opportunities in 23/24 • Theatre scheduling • Patient tracking through theatres • Scanning for safety The new Digital Strategy will be published in July 2023.
Caring for Staff	Programme of education for staff on digital awareness	• Development of appropriate training & awareness programme and demonstrate staff uptake and compliance	The Trust has undertaken engagement with staff to understand digital needs: • Local department reviews to understand digital needs have commenced across the Trust. • EPR Programme has identified training requirements, including fundamentals to ensure that staff will understand how to interact with the system. Full training plans being developed currently for all modules, including admin, clinical nurse, physician, lab technician, pharmacy, physiotherapy, radiology etc. for rollout later this year. Key areas to note are as follows: • Training Lead (fixed term) being recruited to for EPR to commence in post in May 2023. • Courses will be delivered through a mix of face to face and digital courses being available. • Digital literacy will be included and will have adaptive methods to ensure that staff have understood the content of the course. • Patient portal app will also have its own training package for staff and patients.
Caring for Finances	Commence delivery of the next stages of the EPR programme, ensuring processes are reviewed to improve workflows and outcomes	• Deliver to agreed timescales and budget. • Reports and oversight through FPD Committee	A Go Live date has been agreed between the supplier and the Trust with the aim to migrate for April 2024. Key delivery milestones achieved in 2022/23: • EPR contract signed in June 2022 • Funding has been approved and year 1 funding received from NHSE (£4m+) • Digital Transformation Programme Board established and chaired by the CEO and meets monthly.

Corporate Objectives 2022/23

			• Regular monthly updates on progress are presented to the Finance Performance and Digital Committee programme established with project group in place. • Functional Design Groups have been established to review current and future state workflows, with attendees from across the organisation. Groups include: Patient Admin, Outpatients, Bookings, Pre Op and Theatres, Testing and Reporting, Pharmacy • First pass and testing of Data Migration has commenced. • Benefit Tracking (clinical and non) workflow has commenced and currently collating baseline information to be monitored by the Digital Transformation Programme Board.
5. Maintaining statutory and regulatory compliance			
Our mission	**How we will do it**	**Measure**	**Update/Comment – April 2023**
Caring for Patients	Progress towards full compliance with accessible information standard to coincide with EPR programme	• Accessible information standards compliance included in ERP implementation programme.	The new Apollo EPR has included supplier compliance with the Accessible Information Standards (v1.1) as part of the core contract This will enable RJAH to support everyone with information or communication needs relating to disability, impairment or sensory loss. RJAH external website has been updated to incorporate accessible information standards. Synertec supporting with accessible information improvements in our appointment letters.
	Maintaining CQC rating	• Trust CQC Action plan and preparedness plans monitored through Quality and Safety Committee • Trust CQC rating	No review has taken place in 2022/23. The Trust has a CQC preparedness action plan in place with oversight through our Regulatory Oversight Group. As part of our ongoing preparation in 2022/23 the following key actions have taken place: • CQC toolkit for staff updated • Patient Safety Walkabouts (linked to the CQC domains) implemented • Regular engagement meetings with inspector and relationship manager • CQC medicines safety pilot inspection – RJAH rated good across all domains • Awaiting new CQC SOF No review has taken place in 2022/23.

Corporate Objectives 2022/23

	Delivery of IPC Improvement Programme	• Delivery of IPC Improvement plan to agreed timescales • Monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group	Completed with undertakings removed. Key highlights on the IPC programme of work to achieve this status are highlighted below: • Moved from Red to Green on NHSE IPC matrix • Strengthened governance and oversight • Increased compliance with IPC training • Introduction of new roles (housekeepers and stores) • Estates improvement and investment • After action reviews implemented post outbreak and HCAI
	Compliance with ED&I requirements	• Compliance with Regulatory requirements evidenced through Trust regulatory submissions and declarations reported to Trust Board.	Submissions completed and requirements met.
Caring for Staff	Compliance with ED&I requirements	• Compliance with Regulatory requirements evidenced through Trust regulatory submissions and declarations reported to Trust Board.	Submissions completed and requirements met. The Trust's Workforce Equality Report has been published on the trust website.
Caring for Finances	Delivery of Financial Plan	• Deliver Trust financial plan budget by 31st March 2023 • Deliver Trust efficiency programme • Ensure activity delivery plan is managed within available sources of funding	Achieved a £2.45M surplus which is £3.23M favourable to plan. Efficiency programme outturn was £184K adverse to plan. Any shortfalls will be carried forward into 23/24.
	Improve System Oversight Framework rating from SOF3 to SOF2.	• Trust improvement plan in place and delivering to agreed timescales.	The Trust self-assessment was undertaken which assessed the Trust as SOF2 status which was supported by the ICS. NHSI advised that the Trust remains at SOF3 due to NHSI requirements regarding waiting times.

Board Assurance Framework Update

Committee / Group / Meeting, Date

Board of Directors, 3 May 2023

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Mary Bardsley
Assistant Trust Secretary

Report sign-off:

N/A.

Is the report suitable for publication?:

YES

Detail of BAF 7 redacted as it contains "Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime".

Key issues and considerations:

The Board Assurance Framework (BAF) captures the risks to delivery of the Trust's strategic objectives. Those objectives are outlined at **Table 1**.

Each of the BAF risks are overseen by one of the Board's assurance committees. The BAF risks and associated oversight committees are outlined at **Table 2.**

A summary of the BAF risk scores is presented by rating in a "heat map" at **Table 3**.

The detail of the risks and associated mitigating actions etc. is outlined at **Appendix 1**. Revisions made during the last round of committee meetings are identified by tracked changes – new content in blue text; removed content in ~~struck-through, red text~~.

Work is underway to enhance presentation of the BAF. The current working draft is included at **Appendix 2**. This reflects ongoing work and is subject to change but the attached draft includes additional sections which attempt to provide additional assurance around the following issues:

- Are the mitigating actions the "right ones"? – *What are they supposed to achieve? What difference are they going to make to the situation?*
- Are the actions making a difference? – *Is the position improving? How do we know?*
- Are the planned actions going to deliver the target? – *When are we going to deliver the target level of risk? If we're not going to, what else can be done?*

During the April round of committee meetings it was requested that BAF risks be reviewed to consider whether:

1. The current "catastrophic" consequence ratings were appropriate;
2. The residual risk ratings took sufficient account of the existing controls;
3. The planned controls would deliver the target risk - if not, were additional controls required, or should the target risk be modified?

Strategic objectives and associated risks:

This work has supported the objectives outlined in Table 1:

Table 1 – The Trust's strategic objectives

Trust Objectives 2022-23
1. Developing and Maintaining Safe Services
This objective can be broken down into seven key components, undertake full service reviews, prioritising the development of a specialist knee revision service and securing robust microbiology services in 2022/23, review of funding models and service line reporting to ensure robust financial management, recruiting and retaining staff to ensure we have the right staff, in the right place at the right time, developing equality and inclusion initiatives for patients, developing equality and inclusion initiatives for staff.
2. Develop our Veterans Service to ensure it is established as a centre of excellence
This objective can be broken down into six key components, developing an communications, marketing and branding strategy aimed at enhancing links with key stakeholders, maintain veteran accreditation and explore other relevant accreditation opportunities, identification and utilisation of key recruitment links for the veterans service, roll out of veterans awareness training, sustainable funding model to be agreed to optimise further investment opportunities, programme of review to ensure best use of resource
3. Support MSK integration across the system
This objective can be broken down into six key components, leading the MSK Transformation Board and contributing to the delivery of the transformation programme, standardising pathways and access for patients, levelling up of outcomes for patients across all providers, integrated OD solution for MSK providers in the system, enhancement of non-medical roles, delivery of efficiencies outlined in the ICS plan
4. Optimise the potential of digital technologies to transform the care of patients and their outcomes
This objective can be broken down into three key components, continue to develop patient facing apps to optimise patient outcomes and explore the use of artificial intelligence, programme of education for staff on digital awareness and commence deliver of the next stages of the EPR programme, ensuring processes are reviewed to improve workflows and outcomes
5. Maintaining statutory and regulatory compliance
This objective can be broken down into seven key components, progress towards full compliance with accessible information standard to coincide with EPR programme, maintaining CQC rating, delivery of the IPC improvement programme, compliance with ED&I requirements for both staff and patients, delivery of financial plan and improve system oversight framework rating from SOF 3 to SOF 2

Table 2 – BAF risks

BAF Risk	Headline Risk	Overall score	Linked Objective(s)	Assurance Committee
1	Effectiveness of engagement with the workforce	**12**	1,2,3,4,5	P&C
2	Workforce capacity and capability	**16**	1,2,3,4,5	P&C
3	ED & I capacity and capability	**12**	1,2,3,4,5	Q&S / P&C
4	Community Infection Prevalence	**15**	1,5	Q&S
5	Insufficient capacity to meet demand	**16**	1,3,5	Q&S / FP&D
6	~~IT Staff capacity and functionality to support new ways of working~~ A lack of staff capacity, training and/or engagement could adversely affect the Trust's ability to implement new technologies and support new ways of working	**15**	1,2,3,4,5	Q&S / FP&D
7	Cyber risk – detail redacted	**16**	1,3,5	FP&D
8	Constrained resources (incorporating system investment restrictions)	**16**	1,2,3,4,5	FP&D

BAF Risk	Headline Risk	Overall score	Linked Objective(s)	Assurance Committee
9	Delivery of year-on-year efficiencies and productivity gains	16	1,2,3,4,5	FP&D
10	Compliance with strategic oversight framework	15	1,4,5	Q&S

Table 3 – "Heat map" of all BAF risks, including those overseen by the Committee (underlined, in larger text)

Likelihood	Consequences: (1) Insignificant	(2) Minor	(3) Moderate	(4) Major	(5) Catastrophic
(5) Almost certain					
(4) Likely			BAF 3	BAF 2 BAF 5 BAF 7 BAF 8 BAF 9	
(3) Occasionally / Possible				BAF 1	BAF 4 BAF 6 BAF 10
(2) Unlikely					
(1) Rare					

Recommendations:

That the Board:

1) Consider each of the BAF risks, as presented at Appendix A, and:
   - REVIEW the risk scores, existing and planned control measures, and assurances;
   - CONSIDER and AGREE any required revisions.

Report development and engagement history:

The BAF has been reviewed and updated by the relevant lead executive.

The BAF has been reviewed by the People and Culture; Quality and Safeguarding; and Finance, Planning and Digital Committees during April 2023.

Next steps:

The BAF will be reviewed and updated to reflect the Trust's objectives for 2023/24 when these are approved. The updated 2023/24 BAF will be presented in the format included for information at Appendix B. This should come into effect from June.

Appendices

Appendix A	Board Assurance Framework (BAF)
Appendix B	Revised BAF format for 2023/24 (to come into effect when new Trust objectives are agreed, circa June 2023).

Board Assurance Framework 2022-23

Effectiveness of engagement with the workforce — BAF 1

If the engagement with the workforce is not effective there is a risk that opportunities for improvement and innovation will be missed and staff morale will deteriorate with potential to result in loss of staff. Engagement can be hampered by the prioritisation of operational and clinical duties and there is potential for there to be insufficient time given to managers and clinical staff working together.

Risk Rating:

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

Risk Details:

Opened:	August 2022
Reviewed Date:	March 2023 (Board approved in January 2023)
Source of Risk:	Risk assessment
	Corporate Risk Register

Controls:

- ✓ Rolling half days
- ✓ Monthly Trust Management Group meeting to include Clinical Leads
- ✓ Staff briefing open to all staff
- ✓ Appointment of COO and strengthened operational team
- ✓ Ward / department buddying by Executive Team
- ✓ Communications and engagement strategy
- ✓ Performance framework in place
- ✓ Weekly update from CEO
- ✓ Comms bulletin
- ✓ Q&A sessions with members of the Executive Team
- ✓ Awards/Health Heroes
- ✓ Freedom to Speak up initiative
- ✓ 'Chats with Harry'
- ✓ Exec and NED board day walkabouts

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

- ✓ Medical Advisory Committee overseeing engagement with management
- ✓ Regular updates to People and Culture Committee and the Board
- ✓ NHSE Quarterly System Review Meetings
- ✓ Staff Survey
- ✓ NHS Oversight Framework
- ✓ Oversight from People and Culture Committee
- ✓ Health and Safety Committee oversight of staff health
- ✓ JCGroup partnership working

Gaps In Controls:

C5: Leadership training and bite-sized modules for wider organisation

Gaps in Assurance:

A1: Lack of real-time measure of workforce engagement levels (all staff)
A2: Responding to staff concerns in a timely manner

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Listening in action framework to be established	Chief People and Culture Officer	~~Mar 23~~ May 23	Staff listening session to be developed as part of the wider people engagement support. Listening events will support shape what staff need and steer the overall people agenda for the Trust.
C5	Leadership Training	Chief People and Culture Officer	May 23	Leadership course has been advertised across the organisation. Cohort 1 is to be the pilot for the training. Dates have been secured in the diary. Confirmation of delegates to be confirmed and invited.

Exec Lead

Chief People and Culture Officer

Lead Committee

People and Culture Committee

Board Assurance Framework 2022-23

Workforce Capacity and Capability — BAF 2

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 safely to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks. Lack of innovative roles reduces the potential staff being attracted to the organisation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	2
Likelihood	4	4	2
Total	16	16	4

Risk Details:

Opened: April 2021

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment plans to target vacancy hotspots
- ✓ Sickness absence management relaunch
- ✓ Staff turnover monitoring including exit interviews and 'itchy feet' conversations
- ✓ Leadership training to support effective management and engagement of staff – compulsory for all managers
- ✓ Business Continuity Plans
- ✓ KPI in place for overtime hours by unit, sickness absence (including reasons)
- ✓ IPR includes breakdown of activity for IJP & OJP at point of delivery
- ✓ Recruitment timeline KPIs
- ✓ Vacancy rates by professional staff group
- ✓ Nursing associate roles now in training
- ✓ Nursing strategy on a page
- ✓ Nominated EPRR Lead appointed
- ✓ Professional Development Review Compliance

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

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ People and Culture Committee oversight
- ✓ Agency usage monitoring
- ✓ Independent review of e-rostering
- ✓ Turnover and sickness absence rates
- ✓ Recruitment working group
- ✓ Quarterly review of Nursing and Midwifery retention tool

Gaps In Controls:

C3: Unit level workforce plans aligned to operational activity
C5: Exit interview completion and themes
C7: Review of flexible working and flexible working offering
C9: People Services team resource and capacity
C10: Workforce improvement plan

Gaps in Assurance:

A1: Alignment of workforce to optimise capacity
A2: Workforce plan monitoring triangulated with activity and quality
A3: Succession plan
A4: Talent management strategy
A5: CPD gaps and allowance of time
A6: Recruitment process assurance -line of sight on milestones
A7: Escalation process for staffing rota concerns

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C3	Ward and Theatre establishment review to be complete	Chief Nurse and Patient Safety Officer	~~Jan 2023~~ ~~Mar 2023~~ ~~Apr 2023~~ Jun 2023	Theatre establishment review to be confirmed. Theatre recruitment and theatre workforce model paper to be presented to the QS Committee ~~in April~~ before onward reporting to Board. Ward establishment review has been completed - actions are underway.
A1-A7	Review of workforce assurance	Chief People and Culture Officer	~~Feb 2023~~	Additional resource to support the review of people services including people service policies. Review of people services has been completed with additional support gained externally. Benchmarking resources and gaps are being mitigated
C7	Review of application of the flexible working policy	Chief People and Culture Officer	~~Feb 2023~~ ~~Apr 2023~~	A review is due to be undertaken in ~~April~~. June.

			Jun 2023	
C9	People Services capacity to be reviewed	Chief People and Culture Officer	Jun 2023	~~Case of need presented to the Executive Team. Agreed to recruit by priority however no funding has been secured. (linked to A1-A7)~~ Funding has been secured to support the recruitment within the people services department. A verbal update to be provided to the People and Culture Committee for oversight. Gaps are being mitigated until recruitment is complete.

Exec Lead

Chief People and Culture Officer

Lead Committee

People and Culture Committee

Board Assurance Framework 2022-23

EDI Compliance, delivery, accountability and leadership **BAF 3**

Potential for non-compliance with statutory and regulatory requirements. Poor staff experience impacting on staff morale and lack of inclusion, sickness absence and turnover. Inability to improve staff survey results. Potential for health inequalities to not be addressed impacting on patient experience.

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk: Corporate Risk Register

Controls:

- ✓ ED&I Committee members taking ownership to drive the agenda forward
- ✓ NHS Standard Contract requirements
- ✓ System transformation work (includes consideration of health inequalities)
- ✓ Accessible Information Standards - regular reviews
- ✓ PLACE assessments
- ✓ ED&I training (ICS) and Veteran Awareness training
- ✓ Data quality improvement plan including ethnicity and deprivation index
- ✓ Menopause awareness

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

- ✓ Staff surveys/pulse surveys
- ✓ NHSE oversight/ NHS Oversight Framework
- ✓ People and Culture Committee
- ✓ System People Board and establishment of a System People Committee
- ✓ Executive lead in place both for patients and staff
- ✓ ED&I Committee oversight
- ✓ WRES, WDES and EDS 2022 returns
- ✓ Bi-annual report on health inequalities (includes digital exclusion)

Gaps In Controls:

C1: Sustainable ED&I resource to be identified and secured
C2: Health inequalities working group
C3: Talent Management
C5: EDS 2022 self-assessment and action plan (in progress)
C6: 'It's Just Cricket' (BAME), LQBTQIA+ Friends & Women's Network

Gaps in Assurance:

A1: Effectiveness of ED&I Committee

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	ED&I resource to be secured	Chief People and Culture Officer	~~Jan 2023~~ Jun 2023	The Trust are reviewing other options regarding EDI leads. Chief People and Culture Office recruitment re-started in February 2023
C2	Health inequalities working group to be established	Chief Nurse and Patient Safety Officer	~~Jan 2023~~ Mar 2023	Request for RJAH to join Healthy Lives Steering Group (ICS). Nominated staff to join the meeting and terms of reference have been drafted
C5	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	May 2023	Healthwatch are facilitated patient led workshops in March 2023 as part of the assessment. Aiming to present to the Patient Experience Committee in May
C6	Review of all staff networks	Chief People and Culture Officer	~~Feb 2023~~ May 2023	Discussed at December EDI Committee – proposal to have one inclusion network which will be a topic at the listening events to gain a view from staff

Exec Lead

Chief People and Culture Officer

Lead Committee

People and Culture Committee / Quality and Safety Committee

Board Assurance Framework 2022-23

Community Infection Prevalence **BAF 4**

Impact on staff absence, increased potential for covid outbreaks, adverse impact on patient safety and patient experience, reputational damage, additional regulatory scrutiny, impact on the capacity of the IPC Team

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ External support from NHSE/I
- ✓ Alignment to Clinical Governance from 1 April 2022
- ✓ Investment in the IPC team
- ✓ IPC Governance role established
- ✓ Quality Management System
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Deputy DIPC recruited in partnership with Shropshire Community Trust
- ✓ Increased staff training programme
- ✓ Learning from previous SI's – actions completed
- ✓ Compliance with Covid guidance
- ✓ Sickness policy and communication
- ✓ Risk assessments
- ✓ Flu campaign
- ✓ Covid booster
- ✓ IPC ICS Meeting

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

- ✓ IPC Quality Assurance Committee
- ✓ Increased committee reporting
- ✓ External clinical governance review with focus on IPC commissioned
- ✓ People and Culture Committee oversight
- ✓ IPC Board Assurance Framework
- ✓ Flu and Covid Vaccination update report
- ✓ Gap analysis against the hygiene code

Gaps In Controls:

Gaps in Assurance:

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress

Exec Lead

Chief Nurse and Patient Safety Officer

Lead Committee

Quality and Safety Committee

Board Assurance Framework 2022-23

Insufficient core capacity to meet demand — **BAF 5**

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	4	1
Total	16	16	4

Risk Details:

Opened: November 2020

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk: Corporate Risk Register

Controls:

- ✓ Demand and capacity modelling at local level
- ✓ Monitoring of efficiency KPIs
- ✓ 6-4-2 implemented
- ✓ Recovery programmes in place for Outpatients, Theatres and Diagnostics
- ✓ Weekly tactical restart activity meeting
- ✓ Key restoration of capacity KPIs
- ✓ Weekly meetings for management of delayed discharges
- ✓ Daily dashboards
- ✓ Outpatient room usage report in place

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

- ✓ Monthly Performance Improvement Board oversight
- ✓ Inpatient Survey Performance
- ✓ System and regulatory oversight
- ✓ Internal audit regarding job planning
- ✓ Patient Experience Committee oversight
- ✓ Finance, Planning & Digital Committee oversight
- ✓ Outpatient Transformation Board restored
- ✓ STW Planned Care Delivery Board Oversight
- ✓ System Governance Framework
- ✓ Integrated Performance Reporting
- ✓ Consultant annual leave reporting through People Committee

Gaps In Controls:

C4: Impact on capacity of increasing complexity of cases due to increased waiting times
C7: Implementation of current job planning policy
C8: Inability to meet target for reducing number of patients who no longer meet 'criteria to reside'
C9: Revising STW orthopaedic model
C10: Optimising internal capacity

Gaps in Assurance:

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C4	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	~~Jan 22~~ ~~Apr 2023~~ Complete	~~A verbal updated was presented to the QS committee previously. Paper to be presented in April 2023 which outlines no difference has been noted.~~ A verbal update was presented to the Q&S Committee in February, followed by a paper at Q&S in April 2023. The paper showed the amount of complex surgery undertaken has risen steadily since 2004/05 but has remained relativity stable over the last 6 years. The Committee has request 6 monthly updates, plus further exploration of the impact of complexity, such as LOS at time in theatre and social demographic that may contribute to increased complexity.
C7	All job plans to be signed off by e-job planning	Chief Medical Officer	~~Ongoing~~ July 2023	Tracking of this to be looked at so that there is line of sight. Allocate is being used to support. Job plans signed off total 26. 1 waiting 3rd sign off. 25 waiting 2nd sign off (MJPCC). 17 awaiting 1st sign off (clinical). 2 waiting 1st sign off by manager. 25 in discussion and 12 expire – need to be renewed.

Board Assurance Framework 2022-23

C9	Revising STW MSK model	Chief Operating Officer	~~Feb 2023~~ Jun 2023	~~Actions related to phase one due to be launched on 01/02 – future phases are to be confirmed~~ RJAH confirmed as strategic lead for MSK services across STW, delivery timetable in place across 2023/24.
C10	Optimising internal capacity (theatre)	Chief Operating Officer	~~Dec 2022~~ Aug 2023 Jan 2024	~~Theatre workforce review has been completed. Action plan in place. – **ongoing process.**~~ Ongoing theatre productivity plan in place to increase throughput, RJAH performing favourable against GIRFT theatre utilisation metrics. Recruitment focus in 2023/24 weighted towards theatre and reopening 12th theatre and staffing the additional 13th theatre from January
C10	Optimising internal capacity (inpatient beds)	Chief Operating Officer	~~Jan 2023~~ Apr 2023 Jul 2023	~~Review opportunities to increase day case activity and reduce length of stay.~~ Enhanced recovery programme commenced April 2023. Ongoing work to increase day case rates.

Exec Lead

Chief Operating Officer

Lead Committee

Finance, Performance and Digital Committee

Board Assurance Framework 2022-23

~~Staff capacity and functionality to support new ways of working~~ A lack of staff capacity, training and/or engagement could adversely affect the Trust's ability to implement new technologies and support new ways of working | BAF 6

Impact on roll out of EPR, inability to adapt to emerging requirements, opportunities of the system constrained by finances, inability to progress with compliance with accessible information standard resulting in inadequately meeting patient needs and poor patient experience.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital Transformation Programme Board in place to review Digital plans, risks and progress including prioritisation.
- ✓ Workforce plan agreed for life of programme
- ✓ Digital Steering Group in place for operational delivery
- ✓ Sub groups as created by Digital Transformation Programme Board to oversee delivery of EPR implementation
- ✓ Digital Strategy and Roadmap in place 2018 – 2023
- ✓ Programme plan in place
- ✓ Outpatient processes to identify and flag patient needs before admission
- ✓ Accessible Information Working Group established
- ✓ Translation and interpretation services available
- ✓ EPR Training and awareness sessions to be scheduled prior to go live
- ✓ Functional design groups running to look at current and future state of EPR
- ✓ Recruited an EPR Trainers / Training Lead

Assurance: **Source of Assurance** 3

- ✓ ICS Digital Strategy Board
- ✓ Digital Transformation Board oversight reporting to FPD Committee
- ✓ New EPR contract includes ability to meet Data Standard Notices
- ✓ Regular reporting on progress of EPR (provided monthly) to the FPD Committee
- ✓ Oversight of Accessible Information Group and Patient Panel
- ✓ Digital Transformation Board meets monthly and has a sub group to review risks

Gaps In Controls:

C1: EPR Solution in development to address accessible information standard compliance but not in place - Proposed go live Mar – Apr 2024

Gaps in Assurance:

A1: Monitoring of additional patient needs to ensure services and facilities are suitable to meet the needs of patients

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	~~March 2023~~ May 2023	Healthwatch are facilitated patient led workshops in ~~March~~ May 2023 as part of the assessment. (date was postponed due to adverse weather)
C1	Progress with EPR Solution - Functional design groups and training	Director of Digital	~~Ongoing~~ Apr 2024	Programme in place with monitoring via Digital Group and FPD. Started in December 2023 with an expected completion date prior to go live

Exec Lead

Chief Medical Officer

Lead Committee

Quality and Safety Committee & Finance, Performance and Digital Committee

Board Assurance Framework 2022-23

Constrained resources (incorporating system Triple Lock' investment process) **BAF 8**

The local ICS has one of the biggest proportional financial deficits in the Country and is required to take action to return to break-even. In tackling this additional controls on new investments have been introduced through a triple lock process that requires three tiers of authorisation (Organisation, System and Regulator). This has led to multiple organisational approved investments being paused pending identification of system funding with consequential risks to quality, standards of care and patient experience.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Investment Decision making policy
- ✓ Triple lock process for new investments
- ✓ System financial improvement plan

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

- ✓ Executive Team scrutiny and approval process for all investment cases proposed
- ✓ Finance Planning and Digital Committee scrutiny and approval for cases over £250k
- ✓ Investment Panel within ICS comprises multi-disciplinary roles from each partner with agreed prioritisation protocol
- ✓ QEIA process in place
- ✓ IPC investment approved following amendments to triple lock process based on regulatory/safety concerns

Gaps In Controls:

C1: Unmitigated financial risks within the ICS currently stand at £59m which is preventing routine investments from occurring

Gaps in Assurance:

A1: Fully mitigated ICS financial plan – ongoing discussions with NHSE

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Ongoing discussions/engagement with NHSE regarding financial performance of ICS – now escalated to the national team	Chief Finance and Planning Officer	ongoing	~~RJAH improved on plan by £1.1m with a further £0.6m proposed non recurrently relating to Annual Leave accrual release for non clinical roles. Regular check in's on progress with NHSE and updates provided to RJAH FPD Committee~~ ICS expecting to out-turn at £65.5m deficit for 2022/23 (RJAH component a surplus of £2.4m). Attention has switched to 2023/24 with a submitted plan of £76.9m deficit for the ICS (RJAH component £0.4m deficit) System remains in escalation and regular meets with NHSE Regional and National Team.
A2	Recurrent rollover financial plan to be agreed for all ICB partners as part of 23/24 planning process	Chief Finance and Planning Officer	~~March 2023~~ Complete	Complete as part of Operational Plan submission – Cost pressures of £1.5m recognised offset by an efficiency programme of 3%
A3	Re-assessment of financial gap for 23/24 based on confirmed system allocation and agreement of organisational share of expected shortfall between ICB partners under Intelligent Fixed Payment System	Chief Finance and Planning Officer	~~March 2023~~ Complete	Complete as part of Operational Plan submission. IFP methodology amended so that income earned under PbR excluded from baseline. RJAH taking a £2m hit from the system deficit within the 23/24 plan

Exec Lead

Chief Finance and Planning Officer

Lead Committee

Finance, Performance and Digital Committee

Board Assurance Framework 2022-23

Delivery of year on year efficiencies and productivity gains — BAF 9

Operational plan requires delivery of efficiency programme and return to pre COVID levels of productivity for patient throughput

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Cost improvement schemes identified
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Tracking of theatre productivity
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews
- ✓ Agency controls in place

Assurance: Source of Assurance 3

- ✓ SLG Oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ Scrutiny at organisation, system and regional level of delivery of the financial plan
- ✓ Monitoring of CIP delivery via performance meetings
- ✓ System wide transformation Boards including MSK

Gaps In Controls:

- Agency spend running ahead of control limit driven by workforce pressures

Gaps in Assurance:

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A2	Productivity improvements to be incorporated 23/24 Operational plan as part of overall delivery plan	Managing Director for Strategy and Planning	~~March 2023~~ Complete	Completed with identified monitoring in place for 22/23 against the planned productivity benefits identified.
A3	Efficiency targets to be assessed and agreed for 2023/24 based on national planning guidance	Chief Finance and Planning Officer	~~March 2023~~ Complete	Efficiency programme of 3% agreed for 2023/24 against a minimum national requirement of 2%. Schemes fully identified

Exec Lead

Chief Finance and Planning Officer

Lead Committee

Finance, Performance and Digital Committee

Board Assurance Framework 2022-23

Compliance with Strategic Oversight Framework — **BAF 10**

Failure to satisfy NHSE criteria, continued breach of licence and SOF3, increased regulatory scrutiny, reputational damage

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: March 2023 (Board approved in January 2023)

Source of Risk:

Corporate Risk Register

Controls:

- ✓ IPC Governance role established
- ✓ Quality Management System - IPC dashboard
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Senior IPC/ Deputy DIPC recruited in partnership with Shropshire Community Trust
- ✓ Temperature checks using sustainability tool for IPC improvements
- ✓ Identification of gaps against NHS Oversight Framework
- ✓ CQC action plan and Niche well led review action plan
- ✓ CQC engagement meetings

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

- ✓ IPC Quality Assurance Committee
- ✓ NHSE oversight and support for delivery of IPC improvement plan
- ✓ Self-assessment against undertakings monthly
- ✓ Formal improvement review meeting with NHSE monthly
- ✓ Formal NHSE IPC reviews to assess compliance against IPC standards
- ✓ IPC standing agenda item at Trust Board
- ✓ Self-assessment against strategic oversight framework completed and submitted
- ✓ Regulatory Oversight Group (ROG)

Gaps In Controls:

- C4: CQC stakeholder engagement

Gaps in Assurance:

- ~~-~~ N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C4	CQC stakeholder engagement plan	Chief Nurse and Patient Safety Officer	~~Feb 2023~~ ~~Apr 2023~~ Complete	Bi-monthly CQC engagement meetings ~~are~~ have been scheduled with the new relationship manager. ~~– due to commence on 29 March 2023~~ A positive engagement meeting was held on 29/03. Discussions were held relating to never events, IPC, staffing, training, and long waiters. T priority.
C4	Self-assessment to evidence against new CQC Quality statements	Chief Nurse and Patient Safety Officer	~~Feb 2023~~ Apr 2023	CQC relationship manager has changed – statements to launch in January. PMO has been established. - delayed due to implementation of the new CQC strategy.

Exec Lead

Chief Nurse and Patient Safety Officer

Lead Committee

Quality and Safety Committee

APPENDIX 1 - Board Assurance Framework 2023-24 – PROPOSED FORMAT

Title of the risk	BAF 1

IF	*NOTE: What is the source of the risk? What is the event that might occur?*
THEN	*NOTE: What would the effect be? What would happen if that event occurred?*
LEADING TO	*NOTE: What would the implications be? How would that affect the Trust's ability to deliver its objectives?*

Linked strategic objectives:	*Insert references*
Risk appetite / Target risk score:	*Do we have a defined risk appetite that can be applied to this risk? Based on that, what is the target risk score?*
Linked system objectives / risks	
Assurance committee:	
Executive owner (strategic lead):	
Risk owner (overall managerial lead):	

Date opened:	*Insert date*	**Date last reviewed by the Board:**	*Insert date*
		Date last reviewed by the assurance committee:	*Insert date*

Example….	INHERENT RISK SCORE	INITIALSCORE (WHEN OPENED)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4	**< >**	4	4
Likelihood	5	4	**V**	3	**< >**	3	1
Total	**20**	**16**	**V**	**12**	**< >**	**12**	**4**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
Narrative to explain the existing scoring ….

APPENDIX 1 - Board Assurance Framework 2023-24 – PROPOSED FORMAT

Title of the risk — BAF 1

Existing controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having?*
C 1			
C 2			
C 3			
C 4			
C 5			
C 6			

Planned controls			
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date / impact –** *when will the measure be in place / what impact will it have?*
P 1			
P 2			
P 3			
P 4			
P 5			
P 6			

Level of confidence that the control measures deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls				
Ref:	**Description** *- If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*	**Owner –** *who would be responsible for implementing / overseeing these measures?*	**Target date / impact –** *when would the measure be in place / what impact will it have?*
G 1				
G 2				
G 3				
G 3				

Corporate Risk Register Update

Committee / Group / Meeting, Date

Board of Directors, 3 May 2023

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Kirsty Foskett,
Head of Clinical Governance, Quality & Patient Safety Specialist

Report sign-off:

N/A.

Is the report suitable for publication?:

YES

Key issues and considerations:

Strategic Risks relate to delivery of the strategic objectives of the Trust. They can be affected by factors such as capital availability; political, legal and regulatory changes; reputational issues etc. These will usually be identified at Board, or Executive level, and are generated "from the top down'. These strategic risks are captured in the Board Assurance Framework.

Operational risks concern the day-to-day running of the Trust. These are usually identified by departments or business units and are captured on local risk registers. As such, these are usually generated "from the bottom up". Where these risks become sufficiently serious they are escalated to the corporate risk register. Each entry on the corporate risk register is reviewed on a monthly basis, has an identified executive lead, and is overseen by a committee of the Board. The benchmark for this escalation has been set as scores of 15 or above.

There are eleven live risks with a rating of 15 or more on the Trust's corporate risk register that have been reviewed at Board Committee level.

The attached copy of the corporate risk register contains the following risks that also featured last month:

Risk ref.	Headline risk	Inherent Risk	Residual Risk	Target Risk (Tolerance)
2628	Pathology Laboratory Information System (LIMS)	C 4 X L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 2 **= 8**
2653	Theatre staffing impact of staffing levels to meet activity	C 4 X L 5 **=20**	C 4 X L 4 **= 16**	C 4 X L 1 **=4**
2696	MCSI registered nurse vacancies	C 4 x L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 2 **= 8**
2892	Insufficient provision of SALT to ensure effective assessment and monitoring of patients requiring a modified diet	C 4 x L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 1 **= 4**
2911	Consultant Surgeon & Anaesthetist vacancies and recruitment impacting on operational plan	C 4 X L 4 **= 16**	C 4 X L 4 **= 16**	C 4 X L 1 **= 4**
2934	Patient waiting times outside of national targets	C 4 X L 5 **= 20**	C 4 X L 4 **= 16**	C 3 X L 2 **= 6**
2992	Call bell system for tetraplegic patients unavailable	C 4 X L 4 **= 16**	C 4 X L 4 **= 16**	C 4 X L 2 **= 8**
2993	Registered Nurse unavailability impacting safe staffing levels	C 5 X L 4 **= 20**	C 4 X L 4 **= 16**	C 4 X L 3 **= 12**
2996	Organisation Capacity impacting on the effectiveness of Research	C 3 x L 5 **= 15**	C 3 x L 5 **= 15**	C 3 x L 3 **= 9**

2997	Insufficient capacity to ensure clinical research regulatory requirements	C 4 x L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 1 **= 4**
3022	Spinal Disorders capacity risk with reliance on independent sector provision including patients waiting 52+ weeks	C 4 x L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 3 **= 12**

One risk has been reduced below 15, so has been removed from the corporate risk register since March:

Datix 3043	Provision of Consultant Microbiologist at RJAH	C 4 x L 5 **= 20**	C 4 X L 4 **= 16**	C 4 X L 2 **= 8**

This risk rating was reduced bythe Associate Director of Infection Prevention and Control as "the narrative was stating there was no microbiology service which is not accurate. While we have 'lost' the previous microbiologist for on site support, there are mitigations in place and we continue to have microbiology support in a different format…Consultants are in contact with microbiology for advice almost daily and are present at the IMDT meetings for advice and guidance."

One risks that was included last time has been removed, for incorporation into the updated BAF:

1742	Lack of autonomy to make organisational investments	C 4 X L 5 **=20**	C 4 X L 4 **= 16**	C 4 X L 2 **= 8**

The full corporate risk register, including detail more detail on the mitigating actions etc, is included at **appendix A**.

Strategic objectives and associated risks:

These risks relate to the following objectives:
1. Developing and Maintaining Safe Services

These risks relate to the following Board Assurance Framework risk:
BAF 1 – Effectiveness of engagement with the workforce
BAF 2 - Workforce capacity and capability

Recommendations:

The Board is asked to:

- NOTE the risk scores, existing and planned control measures for the current corporate risks and seeking further assurance if / where required.

Report development and engagement history:

The Risk Register has been reviewed and updated by the relevant risk owner.

Next steps:

A revised risk management policy is on the agenda for consideration at this meeting.

The corporate risks will continue to be reviewed by the risk owners and reported to the Board's committees.

Acronyms

BAF	Board Assurance Framework

Appendices

Appendix A	Corporate Risk Register (Public)

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	Handler	Risk Owner	Likelihood (initial)	Consequence (initial)	Rating (initial)	Risk Level (initial)	Existing Control Measures	Likelihood (current)	Consequence (current)	Rating (current)	Risk Level (current)	Risk treatment plan/additional control measures	Likelihood (target)	Consequence (target)	Rating (target)	Risk Management	RAM - Committee	Date of assessment	Date of review (1)	Next review date
Specialist Unit	Specialist - HISTOPATHOLOGY	2628	Pathology Laboratory Information System (LIMS)	Laboratory Information System (LIMS) is currently provided by SaTH. SaTH are looking to replace their existing LIMS in line with the Pathology Network 8. Provision of RJAH Histopathology has not been included in their bid. Provision installation date June 2022, this has been delayed due to ongoing implementation issues at UHNM/Stoke, which are hopefully going to be resolved summer 2023. Implementation at SATH/RJAH will not begin until UHNM/Stoke,give the go ahead. Discussions around inclusion of RJAH in LIMS project are currently taking place.	RJAH Histopathology will not have access going forwards to a working LIMS if not considered in the bid by SATH (pathology network 8). This will impact the specimen pathway, provision of the Histopathology diagnostic reports, connection with EPR. There will be no direct link to EPR. There will be no digital audit trail of receipt of diagnostic sample through to the report being issued. Current LIMS (Telepath) not compatible with System C EPR and OrderComms project. If RJAH were to procure a standalone LIMS there would be a substantial cost implication (£250000+) lack of LIMS would increase transcription error therefore increased patient risk.	Evans, Pat	Forrest, Mrs Dawn	5 - Almost Certain	4 Major	20	High	conversation at pathology network 8 meeting and with pathology management around SATH pathology SLA around RJAH inclusion into LIMS project ongoing.	4 - Likely	4 Major	16	High	inclusion in the pathology network 8 LIMS implementation project	2 - Unlikely	4 Major	8	Treat Risk	Digital Steering Group	01/03/2021	27/03/2023	24/04/2023
MSK Unit	MSK - MAIN THEATRES	2653	Insufficient theatre staff establishment to meet activity plan, due to vacancies and recruitment	Insufficient theatre staff establishment to meet activity plan, exacerbated by increased vacancies and difficulties in recruiting. Establishment is based on 134 sessions per week. Due to a potential Trust shortage of Theatre staff it has been difficult to recruit to this establishment level. This is further impeded by a well-recognised national shortage of Theatre staff including available of skilled scrub practitioners.	Risk to delivery of Theatre session plan. This staffing shortfall reduces the number of theatres that can be safely utilised.	McIntosh, Sam	Banks, Jo	5 - Almost Certain	4 Major	20	High	Use of Bank staff, plain time, overtime and Theatre specialist Bank staff to cover shortfalls. Rolling job advert for recruitment (for Scrub and Anaesthetic practitioners) Use of agency staff	4 - Likely	4 Major	16	High	International recruitment of experienced Orthopaedic Scrub practitioner staff to cover the difficulties and shortfalls of recruiting within the UK, therefore recruiting to present establishment successfully. Nurse Recruitment campaign digital launch Nov. Open day recruitment planned for 28/01/22.	1 - Rare	4 Major	4	Treat Risk	People Committee	26/04/2021	29/03/2023	20/04/2023
Specialist Unit	Specialist - GLADSTONE	2696	Registered Nurse Vacancies on MCSI	14.8WTE registered nurse (RN) vacancies across MCSI (40% of total RN establishment). RN posts advertised continuously. Currently relying heavily on temporary staffing (agency RNs) without spinal cord injury nursing experience. MCSI requires staff with specialist spinal cord injury knowledge and skills to reduce and prevent complications and to provide effective rehabilitation to patients to ensure safe patient discharge.	Patient safety affected due to risk of complications following spinal cord injury including pressure sores, UTI, constipation, bowel impaction. Complications can lead to autonomic dysreflexia, a medical emergency, which can lead to death if complications are not treated immediately. This again requires specialist knowledge and skills. Patient safety incidents have increased Nov 2022 linked to lack of specialist spinal cord injury knowledge and skills within agency staff. Poor patient experience. Negative impact on staff wellbeing and staff morale due to increased workload and responsibilities on substantive staff. Increased staff sickness levels. Staff are unable to complete mandatory training due to staffing gaps and poor skill mix as can not be released from ward to attend training. Poor staff retention due to stress and workload pressures. Gaps in ward staffing requiring bank, agency and internal RJAH staff movement on a daily basis which has an impact on other teams/areas across RJAH due to unplanned redeployment of staff. Potential cancellation of MSK activity. Increased length of patient stay due to delay in providing specialist rehab skills due to lack of specialist spinal cord injury nursing staff. Unable to safely admit patients due to staffing levels and poor skill mix. 23/11/22- 27 P2 patients on acute waiting list plus 7 P2 patients on pressure ulcer waiting list.	Ditcher, Kirsty	Forrest, Mrs Dawn	5 - Almost Certain	4 Major	20	High	Review of staffing levels and skill mix on daily basis re ability to safely admit patients to MCSI. Enhanced bank rates offered to all staff. Internal RJAH staff movement. Block agency booking. Ongoing recruitment efforts. Senior nurses working clinical shifts.	4 - Likely	4 Major	16	High	Trust wide recruitment of RNs. Review of staffing levels and skill mix on daily basis. Possible Registered Nurse Associate recruitment.	2 - Unlikely	4 Major	8	Treat Risk	Quality and Safety Committee	21/07/2021	10/02/2023	10/04/2023
Corporate Services	Corporate Services - RJAH TRUST WIDE	2892	Insufficient provision of SALT to ensure effective assessment and monitoring of patients requiring a modified diet	The current SLA agreement with SATH offers RJAH the provision of a Speech and Language Therapist for 10.5hrs per week. A number of patient safety incidents reported recently have identified that the current provision of service, lacks the ability to ensure patient safety. The standards for special rehabilitation for Spinal Injury Patients states patients should have access to SALT provision for a minimum of 5 days a week our current MCSI patients only have provision for 1 day a week.	The insufficient provision of service inhibits: 1. Timely review and monitoring of patients with an altered swallow, requiring a modified diet. 2. The ability to complete a baseline assessment of all patients admitted to the Trust with a high-level spinal injury 3. Monitoring of IDDSI compliance 4. Providing staff education and training in managing patients with an altered swallow and the enhanced awareness needed for this cohort of patients The current provision does not support the benchmarked recommendation that all SIU should have the provision of 1WTE SALT per 40 inpatient beds.	Newton, Lisa	Ellis Anderson, Sara	5 - Almost Certain	4 Major	20	High	-SALT asked to provide education and training to Managers at the senior nurse and AHP forum. - SALT asked to provide targeted training to higher risk areas/ or where the cohort of patients usually reside. - A review of the provision textured modified diet menus - In the interim an emal update to agreed distrubution list, following a patient review advsing on level of modified diet required. - Visual cue of IDDSI levels now in all ward kitchens. - a review of the communcation mechanism for these patients	4 - Likely	4 Major	16	High	Whilst the mitgations will reduce the likelihood of a incident occuring, the provision of SALT trust wide needs to be reviewed as a matter of urgency, following the recent patient safety incidents. With sufficient provision in place, the requirements as outlined in the impact section would be adressed and there would significantly reduce the likelihood of an incident occuring.	1 - Rare	4 Major	4	Treat Risk	Quality and Safety Committee	11/05/2022	24/03/2023	24/04/2023
MSK Unit	MSK - UNIT RISK (Risk Register Only)	2911	Consultant Surgeon & Anaesthetist vacancies and recruitment impacting on operational plan	FPD -Consultant & Anaesthetist vacancy (workforce gap) and also a recruitment (new consultant) growth gap could impact on delivery of the 2022/23 Operational plan	FPD - Workforce recruitment dependencies and ongoing reliance on flexible workforce -could impact on delivery of the 2022/23 Operational plan	MacLennan, Ian	Banks, Jo	5 - Almost Certain	4 Major	20	High	Consultant recruitment Project Group established and meeting fortnightly. Use of Anaesthetist locums and and occasional list cancellations.	4 - Likely	4 Major	16	High	Sustainability plans through consultant recruitment 6.5 WTE consultant recruitment planned in 2022/23. Anaesthetist recruitment ongoing 20/1/23: Have over recruited to 3 Fellow posts, 1 Associate Specialist post vacancy, Anaesthesia Associate training posts are being progressed and the aim is to start with the first cohort in September 2023. 25/1/23 MSK Ops Manager, update: 1 wte Arthroplasty Consultant post has been recruited, subject to HR checks. 2 part time Trauma Arthroplasty Consultant posts being recruited and 1 Trauma HULU Consultant post being recruited.	1 - Rare	4 Major	4	Treat Risk	Finance Planning & Digital Committee	16/05/2022	12/04/2023	16/05/2023
Corporate Services	Corporate Services - RJAH TRUST WIDE	2934	Patient waiting times outside of national targets	Cause: Lack of capacity in sub specialties together with a failure to follow policies and embed RTT management processes. There is a pressure on a number of subspecialties where demand exceeds capacity. Resource constraints prevent commissioners investing in sufficient activity to sustain waiting times. Position at October 2016 shows that Trust is breaching open pathway target and has a number of 52-week waiters. Due to the COVID19 Pandemic, waiting lists have increased and we now have a number of 104 week waiters as of Nov 2022. Work continues to reduce our longest waiting patients, focusing on those over 78 weeks. Engagement with NHSE to provide updates and assurance on these patients.	Impact: Breach of contracts and key targets Risk of contract penalties Potential for increased costs if OJP or external capacity used. Risk of harm to patients caused by long waits. The Trust will continue to receive close scrutiny from NHS Improvement and local press - we will suffer a reputational loss.	Dalgarno, Beth	Carr, Mike	5 - Almost Certain	4 Major	20	High	Demand and capacity modelling completed Appointment of additional consultants for Knee and Sports injuries, Paediatric Orthopaedics, Upper Limb. Revised theatre allocation process in place from 1st April 2017, with 3 month forward planning of OJP theatre sessions to secure set activity level per month. Additional theatre operational with further theatres to open in October 2017 to facilitate capacity for new consultant posts Fast track recruitment days for Theatre staff reduced number of vacancies for theatres, process ongoing. New Access Policy in place with training programme for key operational staff Close monitoring of shortfall in theatre sessions through daily scheduling reviews Weekly senior team meetings and RTT Exec Comms cell RTT Board established Transformation work streams established for pre-op, outpatients, theatre utilisation, demand and capacity, follow up backlog. Project management structure established with identified Project lead, project manager and exec sponsor. CCG PLCV/ VBC authorisation process placing controls on demand to RJAH. Referrals being monitored as part of monthly planned care working group and monthly contract meeting with CCG (Service & Performance Forum) Complete roll out of Consultant training on patient choice based on patient management plan expectations.	4 - Likely	4 Major	16	High	Increase bank/agency spend to mitigate vacancies to secure additonal activity until theatre staff recruited in place and appropriately trained. Administrative review for additional resources to strengthen booking processes be confirmed, during theatres efficiencies. Daily scheduling review to ensure theatre session allocation remains on plan.3 month forward view of theatres and clinic allocation. Trajectory in place for delivery of Open pathway by Q4 2017/18. 2021 - Recruitment of substantive theatre staff from overseas underway. Recruitment of Consultant and associated staff (ie Specialist Physio and Clinical Nurse Specialists) for areas identified as being under resourced underway. Additional infrastructure required to support full recruitment to manage demand. Efficiencies and utilisation of existing resources under regular monitoring from appropriate forums. Admin review complete and Access staffing more stable. Harms Review Policy embedded and patients being managed safely via it 2023 - Further admin review undertaken, additional resource required in booking teams.	2 - Unlikely	3 Serious	6	Treat Risk	Finance Planning & Digital Committee	22/06/2022	30/03/2023	30/04/2023
Specialist Unit	Specialist - WREKIN	2992	Call bell system for tetraplegic patients unavailable	Current 'ping pong' call bell system used for tetraplegic patients is ineffective. Call bell system used by pressing 'ping pong' which sets off call bell. Acute tetraplegic patients unable to move head due to risk of neurological deterioration therefore unable to press call bells. Difficult to position ping pong bell due to lack of clamps (broken). Several incidents reported of call bell system failure in February.	Patients unable to call for assistance as required.	Coulson, Katy	Forrest, Mrs Dawn	5 - Almost Certain	4 Major	20	High	Voice monitors in use however it is difficult to hear patients calling through them during day when ward is busy/noisy. Some patients are unable to communicate verbally so unable to use voice monitors. Additional staffing 1:1 HCA in place as required.	4 - Likely	4 Major	16	High	New specialist call bell system in place which can be used using voice control/blowing/eye contact/touch 3 quotes received and funds allocated through MCSI charitable funds. Installation likely 8-12 weeks.	2 - Unlikely	4 Major	8	Treat Risk	Quality and Safety Committee	28/10/2022	17/03/2023	17/04/2023
Corporate Services	Corporate Services - RJAH TRUST WIDE	2993	Registered Nurse unavailability impacting safe staffing levels	The unavailability of registered nurses through vacancies, sickness and maternity leave is impacting the Trusts ability to meet safe staffing requirements.	The impact of this is: - Closed beds impacting operational capability - Increase use of agency nurse usage - Through increased use of temporary staffing this creates unintended issues surrounding ownership, training, adherence to policies and procedures. - Ward Managers loss of supervisory capacity - Impact to staff health and wellbeing	Foskett, Kirsty	Ellis Anderson, Sara	5 - Almost Certain	4 Major	20	High	- Increased use of temporary staffing to fill RN unavailability - Bed closures to support safe staffing levels - Ward Managers working in the safe staffing numbers - Daily State of Play meeting to discuss staffing levels - Recruitment and Retention Working Group established to achieve longer term objectives	4 - Likely	4 Major	16	High	- Proactive recruitment campaign to support recruitment of registered nurses - Uplift of Registered Nurse establishments to include maternity cover. review of establishment uplift based on the last 3 years of data for sickness, training requirements and maternity leave. - Review current workforce establishment to reflect future workforce initiatives, .i.e. Nurse Associates.	3 - Occasionally	4 Major	12	Treat Risk	People Committee	31/10/2022	17/03/2023	30/04/2023
Corporate Services	Corporate Services - RESEARCH DEPT	2990	Organisational capacity impacting on the effectiveness of Clinical Research	Operational and Clinical capacity is impacting the ability for individuals and departments to effectively engage in clinical research, projects as a contributor and collaborator, and as a developer of own research.	This impacts: - The Trusts ability to effectively engage with Clinical Research. - The ability to expand the number of research projects undertaken and the growth of local research. - Lack of research studies, impacts the Trust financially as it creates an inability to achieve the financial plan. - Reputational risk and impacts the Trusts vision of 'Aspiring to achieve world-class care'. - Lack of capacity for individual's to oversee research projects as CI/PI can increase the likelihood of breaches and trigger inspection by the MHRA.	Wales, Johanna	Longfellow, Dr Ruth	5 - Almost Certain	3 Serious	15	High	RJAH Nursing Strategy highlights the importance of Research Annual Research Day increases awareness within the Trust. Research Links in all wards / depts. to increase awareness. Opportunities for research scholarships and training grants are advertised via intranet and direct e-mails to staff. We are exploring a collaboration with UHNM CenRee centre to support new researchers with developing research projects.	5 - Almost Certain	3 Serious	15	High	Changes to format of Annual Research day to be more inclusive Strategic approach to encourage staff to be engaged in research Addition of research involvement to the appraisal process Research activity / participation to be included in all job descriptions.	3 - Occasionally	3 Serious	9	Treat Risk	Research Committee	02/11/2022	05/04/2023	30/05/2023
Corporate Services	Corporate Services - RESEARCH DEPT	2997	Insufficient capacity to ensure Clinical Research regulatory requirements	As an organisation actively participating in Clinical Research there are National and International regulatory requirements that we are required to adhere to provide assurance regarding patient safety, research quality and financial responsibility. The department's staffing establishment does not allow for adequate sponsor (RJAH Trust) oversight of Clinical Research governance requirements. The research governance officer performs all of the research governance audits for the Trust, thus there is a single point of failure for the organisation. In addition, there is currently no resource for monitoring, which is a requirement of sponsor oversight for all Trust-sponsored studies.	- Failure to meet regulatory requirements, which could have further impact in the Trusts ability to engage clinical research. - Failure to have the policies and processes in place which support good clinical practice. - critical findings at external audit/inspection, leading to rejection of data, infringement notice or prosecution. - Failure to provide evidence to support local clinical change	Wales, Johanna	Longfellow, Dr Ruth	5 - Almost Certain	4 Major	20	High	At all times staff ensure patients are safe. Improvement to systems and processes is ongoing, with continuous review of SOPs and supporting documents. Training modules for monitoring has been purchased, but staff do not currently have the capacity to undertake this training. Project managers ensure that regulatory duties are adhered to where possible, including reporting to Health Research Authority and MHRA (Medicines & Healthcare products Regulatory Agency). Monitoring for highest risk study has been performed by external contractor (as part of a reciprocal agreement with SaTH). The research governance officer and dept. administrator are improving reporting through EDGE. In the last couple of weeks have recruited a part-time project manager who will focus on monitoring for the foreseeable future. She will need training, but this measure will ensure we are monitoring at least our highest risk studies. New studies are not being taken on to allow staff to maintain compliance in existing studies.	4 - Likely	4 Major	16	High	Explore opportunities within ICS to strengthen the mitigations. A research governance task and finish group is being set-up by the Sohrpa group. Roles of research dept staff should be adjusted to allow for adequate time to meet the monitoring requirements of all sponsored studies. This has required a reduction in the number of new projects opened. However staff are still restrained by workload due to existing studies. Explore options for research governance roles to be funded by the Trust, as this is a corporate function and not funded elsewhere.	1 - Rare	4 Major	4	Treat Risk	Research Committee	03/11/2022	05/04/2023	31/05/2023

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	Handler	Risk Owner	Likelihood (initial)	Consequence (initial)	Rating (initial)	Risk Level (initial)	Existing Control Measures	Likelihood (current)	Consequence (current)	Rating (current)	Risk Level (current)	Risk treatment plan/additional control measures	Likelihood (target)	Consequence (target)	Rating (target)	Risk Management	RAM - Committee	Date of assessment	Date of review (1)	Next review date
Specialist Unit	Specialist - SPINAL DISORDERS	3022	Spinal Disorders capacity risk with reliance on independent sector provision including patients waiting 52+ weeks	FPD - Delays caused by Covid-19 pandemic have increased the backlog of spinal disorders patients waiting 52 weeks or more for treatment. Spinal Disorders are reliant on independent sector and mutual aid provision to reduce the backlog for patients as well as additional Out of Job Plan sessions at RJAH new risk combining risk 2633 and 2899.	Patients come to harm as conditions worsen. Treatment options lessened by passage of time. Risk of Trust Reputation as national focus on meeting trajectories as set out in planning guidance	Mills, Cheryl	Forrest, Mrs Dawn	5 - Almost Certain	4 Major	20	High	AHP was recruited to lead on the Harms review process. AHP is contacting patients who have been identified as having potential to come to harm and where necessary arranging urgent reviews with consultants. Harms review process underway. Back log of long waiting patients is being reduced by increasing LIP capacity with new appointments and fully utilising current capacity Independent sector and mutual aid being offered from other organisations	4 - Likely	4 Major	16	High	104/78 week daily reviews underway, OJP and mutual aid continue Additional mutual aid capacity being sought from NHS Providers	3 - Occasionally	4 Major	12	Treat Risk	Quality and Safety Committee	20/01/2023	13/03/2023	17/04/2023

Trust Board - Quality & Safety

March 2023 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

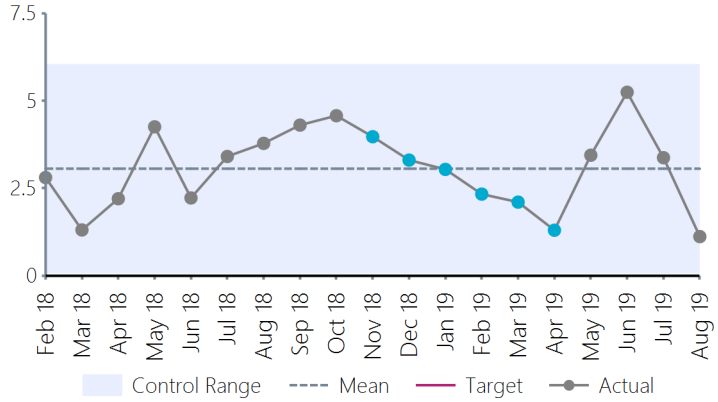
Some examples of these are shown in the images to the right:

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

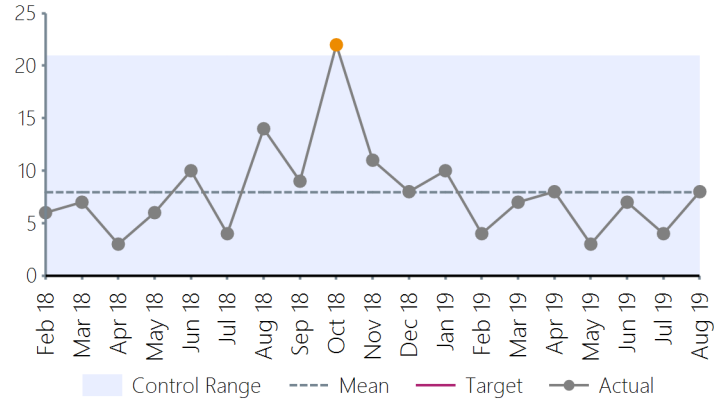
b) shows a point of concern sitting above the control range.

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

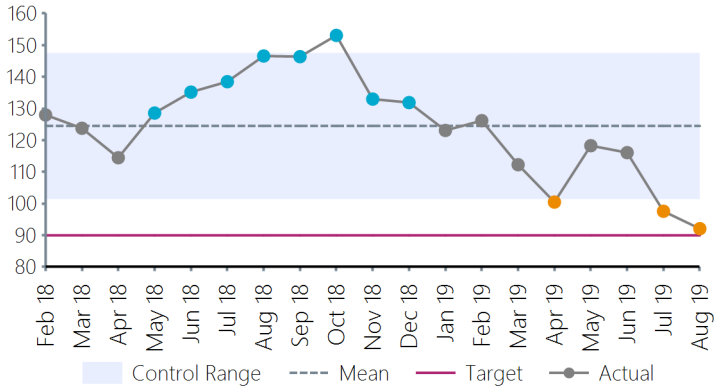
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	?	+	16/04/18
Never Events	0	0		N/A to SPC	?		16/04/18
Number of Complaints	8	9			?		11/05/18
RJAH Acquired C.Difficile	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	?		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	?		
Surgical Site Infections	0	0			?	+	

Summary - Caring for Patients

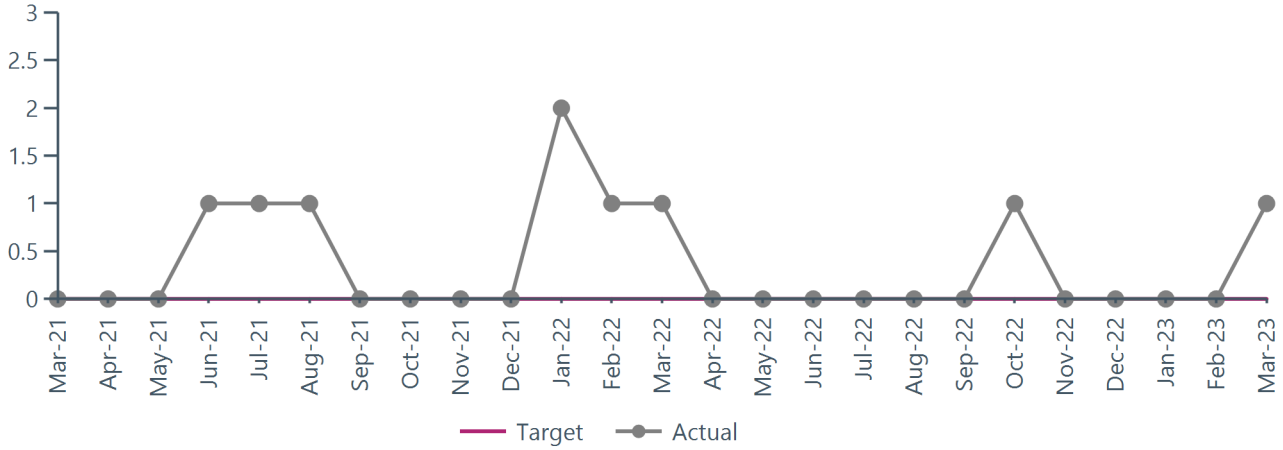
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	1		N/A to SPC	?	+	
Total Deaths	0	0		N/A to SPC	?		
WHO Quality Audit - % Compliance	100.00%	100.00%		N/A to SPC	P		

Serious Incidents

Number of Serious Incidents reported in month 211160

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

There was one serious incident reported in March. This relates to the category three pressure ulcer that was reported in February. Following review, it was confirmed as a serious incident and reported in March.

Actions

At the time of IPR production, the investigation for this incident is still underway and due for completion by the end of April. The findings will be presented to Specialist Unit Governance meeting, Specialist Unit Board meeting and if relevant, reported to Quality and Safety Committee.

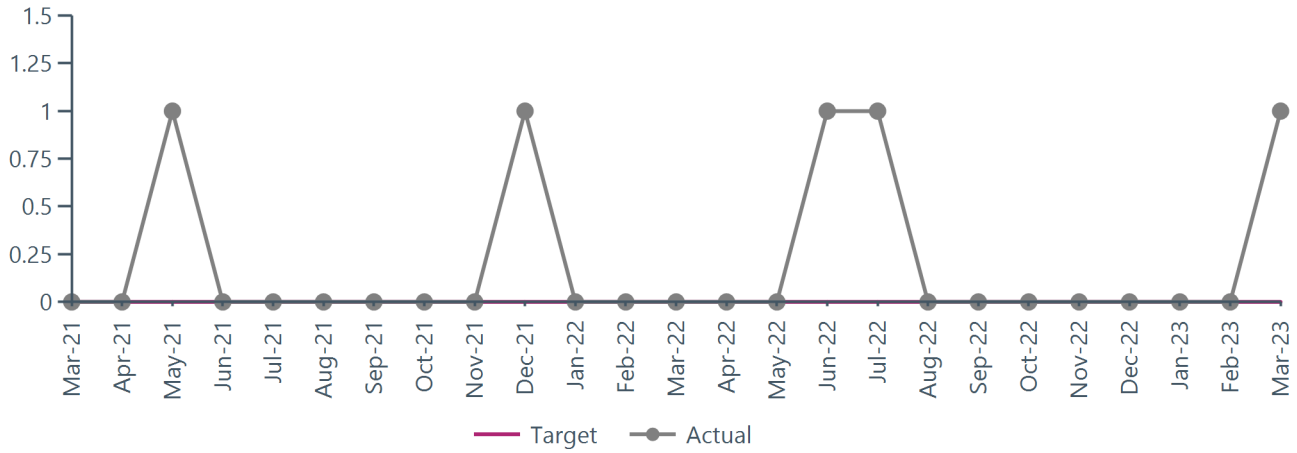
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
1	0	0	0	0	0	0	1	0	0	0	0	1

RJAH Acquired C.Difficile

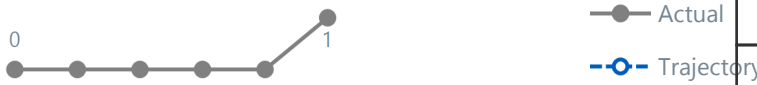
Number of cases of C.Difficile in Month 211149

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

There was one RJAH Acquired case of C.Difficile in March.

Actions

A post-infection review will be undertaken and reported through IPCCC. It must be noted that there has been a national rise in C.Difficile cases and regional collaboratives have devised a standardised post infection review tool for use which will be used for this case. Lessons learned will be shared through SNAHP, IPCCWG and IPCCC.

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

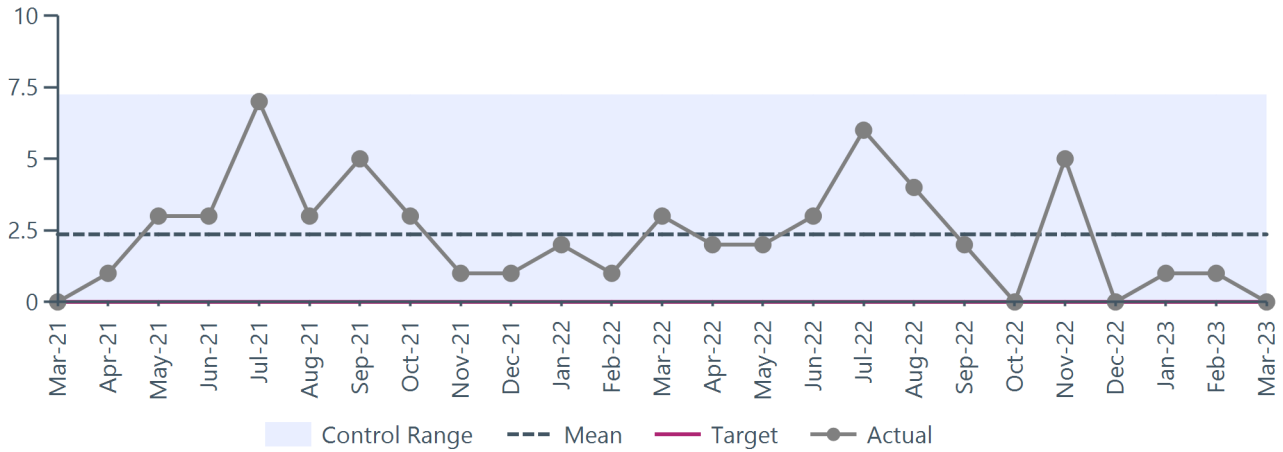
Surgical Site Infections

Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead:
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in the past twelve months. The data represented in the SPC above shows any surgical site infections that have been reported where they're shown on the graph above based on the month that the procedure took place.

In the latest twelve month period, covering April-22 to March-23, there have been 26 surgical site infections. There were two additional infections confirmed in March, relating to procedures that took place in January (1) and February (1). A data quality check has been carried out with the IPC team to ensure the latest twelve month period is reported correctly.

Actions

Post infection reviews will be undertaken for the latest confirmed SSIs and findings will be reported through IPCCC.

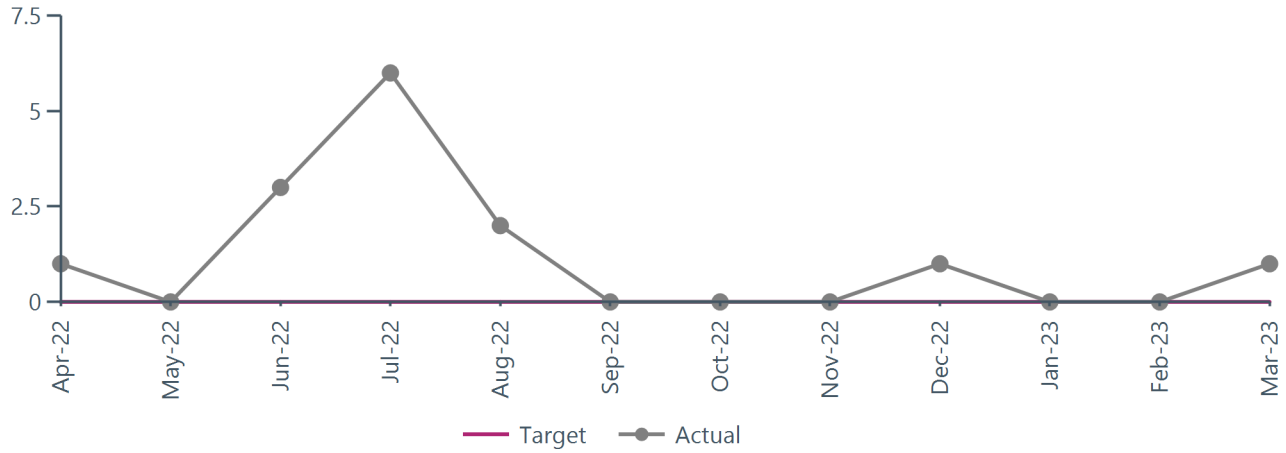
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
3	2	2	3	6	4	2	0	5	0	1	1	0

Outbreaks

Number of declared outbreaks in month 217806

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

There was one covid-19 outbreak reported in March on Sheldon ward involving four patients and four staff.

Actions

An After Action Review was held on 31st March with likely cause of outbreak considered to be patient visitor attending the ward. Outbreak management policy followed. After Action Review to be shared with ward team, SNAHP and IPCCWG. Outbreak reported through IPCCC

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	1	0	3	6	2	0	0	0	1	0	0	1

- Staff - Patients - Finances -

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	03 May 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	25 April 2023
Paper Reviewed by:	Chris Beacock, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

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

3. Assurance Report from Quality and Safety Committee

This report provides a summary of the items considered at the Quality and Safety Committee on 20 April 2023. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

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

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

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

There were no issues or concerns to raise with the Board.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework (BAF) and Corporate Risk Register

The Committee held a discussion of risks which are rated as catastrophic querying whether the residual risks are correct. It was noted that the new format of the framework will support with the risk rating. This is to also include the control measures implemented to record the actions taken to mitigate the risk.

In relation to the Corporate Risk Register – the committee asked for specific verbal updates on risks aligned to the speech and language therapist and call bell to which the Committee noted assurance was received. It was noted that research risks will be realigned to the Education, Research, and Innovation Committee.

There were no new risks identified throughout the meeting.

Integrated Performance Report

The Committee held a discussion on the following:

- Delayed discharges on MSCI and the impact on patients - The delayed discharges are currently at the lowest performance for some time. There is a national increase with spinal disorder patients therefore performance is expected to remain the same.
- Safe staffing – vacancies are measured against safety of patients by completed a staff staffing review daily.
- Cancellations – information relating to cancelations by consultant was requested however it was noted that there has been an overall increase in cancellations due to industrial action.

The Committee were assured with the actions/plans in place to support the overall performance of the Trust whilst ensuring patients are safely cared for.

Serious Incidents, Never Events and Learning from Incidents

The following information was noted:

- 1 serious incident in March - all targets are on track for completion.
- 12 additional patients have attended an appointment relating to the Bioknotless Anchors with 1 further found to have retained metal fragments. It was confirmed that the MRHA will be launching an investigation.

Legal Claims Update Q4

The details of the report will be discussed within the private board meeting due to the confidential information presented. The Committee were assured that the Trust follow the Duty of Candour process. Following a discussion, the Committee asked for consideration to be given to align new claims to serious incidents or never events.

Complexity Report

The Committee asked for further work to be completed on the report to provide assurance, in the following areas: the impact of resource in the Trust, deconditioning of patients, does the specialist nature of the Trust increase the overall complexity.

Chair Report from Patient Safety Meeting

Due to the noted increased in medication incidents, the Committee asked for further assurance on the themes which have been recorded following a deep dive.

3.3 Areas of assurance

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

CQUIN Report Q4
The Trust met all but one CQIUIN targets for 2022/23. Flu Vaccination update did not meet the expected target and therefore there was a discussion to reduce the target to 80% - non-compliance relating to personal choice.

PSIRF Implementation
The Committee were assured with the steps taken to implement the new PSIRF framework for launch in October 2023.

Radiation Safety Report
The Committee were assured with the report and action plan presented. It was noted a re-audit is scheduled as part of the contract an annual radiation meeting is held to discuss the outcomes. Actions are noted to be on track from completion by May 2023. The Committee requested that oversight of the action plan is reported through the Regulatory Oversight Group.

Trust Corporate Business Continuity Plan
The Committee were assured that the presented plans have been tested via a desktop exercise. The Committee supported the documented and is recommended that the Board approves at the next meeting.

GGI Action Plan
The Committee were content with the action plan and following a review agreed this item can be removed from the Committee workplan. The Committee commended the good work that has been completed and implemented.

Chair Report IPCC Meeting
The Committee did not think that sufficient information in relation to IPC issues was presented at the meeting to provide assurance on this matter. It was agreed that IPC items previously presented to the IPC assurance committee should appear on the Q&S workplan until such time as the committee determines that the level of scrutiny can safely be reduced.

Chair Report ICS Quality Meeting
This is shared for information only.

Committee Annual Review and Self-Assessment
Following a discussion, the Committee members agreed to further consider the documents and for comments relating to the annual report, terms of reference and self-assessment to be forwarded to the Trust Secretary with the expectation this is presented in its entirety at the next meeting.

4.0 Conclusion / Recommendation

The Board is asked to:

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

0. Reference Information

Author:	Hannah Howells Health and Safety Advisor	Paper date:	03 May 2023
Senior Leader Sponsor:	Mike Carr, Chief Operating Officer	Paper written on:	17 March 2023
Paper Reviewed by:	Quality and Safety Committee	Paper Type:	Governance
Forum submitted to:	Board of Directors – Public Meeting	Paper FOIA Status:	Non-disclosure
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Approval

1. Purpose of Paper

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

This paper presents the revised Corporate Business Continuity Plan for the Boards approval.

The paper was considered by the Quality and Safety Committee on 20th April 2023.

2. Executive Summary

2.1. Context

The Corporate Business Continuity Plan has been revised to take account of new internal roles and responsibilities and refreshed to ensure compliance with external stakeholder arrangements.

2.2. Summary

The purpose of the plan is to make the Trust ready and able to anticipate, prepare for, prevent, respond and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained.

The plan describes the arrangements for implementing and maintaining a suitable business continuity process, including roles and responsibilities of the officers with the responsibility for implementation of the policy and plans.

2.3. Conclusion

The Board is asked to approve the Corporate Business Continuity Plan.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Corporate Business Continuity Plan

If a service interruption is suspected immediately refer to Annex 2

ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

and Annex 3

BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

Quick & Easy Decision Card, Business Continuity or Major Incident

Is this a Major Incident? if yes – activate the Major Incident Response

or

Can the incident be managed locally using day to day resources?

Yes

Manage the incident through normal

NO

Does the incident affect a critical service or stop a service being delivered

Does the incident attract significant Political or Media interest?

Yes

Manage the incident through the Corporate Business Continuity Plan

and

Activate the relevant Corporate and Service Recovery Business Continuity Plans

No

Does the incident attract significant Political or Media interest?

Yes

Manage the incident through the respective Corporate and Service Recovery Business Continuity Plans

and

Ensure close involvement of the communication team

Updates to be provided to BC Incident Control Team Trust Board & NHS E AT

No

Manage the incident through the respective

Corporate and Service Recovery Business Continuity Plans

and

Updates to be provided to relevant Directors

Yes

Manage the incident through the respective Corporate and Service Recovery Business Continuity Plans

and

Ensure close involvement of the communication team

Regular Updates to be provided to BC Incident Control Team, Trust Boards and NHS E AT

No

Manage the incident through the Corporate and Service Recovery Plans

Updates to Relevant Directors

Document Version Control

Version Number	Date	Author	Description of Change
0.1	June 2018	Pete Old	Complete review of BCM arrangements and new plan.
0.3	January 2019	Nicki Bellinger/Pete Old	Complete review of BCM arrangements and new plan.
Draft - awaiting approval	January 2023	Hannah Howells, Health and Safety Advisor	Complete review of BCM arrangements and new plan.

Distribution List

INTERNAL **EXTERNAL**

Name	Name
Full electronic copies: Trust's Intranet Full paper copies:	RJAH Orthopaedic Hospital Foundation Trust
Managing Directors – MSK Delivery Unit and Specialist Delivery Unit	
Nominated Emergency Planning Officer	
Silver control (co ordination centre)	
Hospital Switchboard	
CSM's/Hospital Cover	

Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the "Trust") business continuity corporate plan is intended to provide a framework for the Trust to follow in responding to an incident or any other emergency that may impact upon the delivery of daily operations of the Trust.

The purpose of the plan is to make the Trust ready and able to anticipate, prepare for, prevent, respond and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained.

It describes the proposed plan for implementing and maintaining a suitable business continuity process, including roles and responsibilities of the officers with the responsibility for implementation of the policy and plans.

RJAH is identified under the Civil Contingencies Act (CCA) 2004 as a 'category one' responders. This means we have a legal duty to develop robust business continuity management arrangements which will help to maintain their critical functions if there is a major emergency or disruption. This could include, for example, an infectious disease outbreak, severe weather, fuel shortages, industrial action, loss of accommodation, loss of critical information, loss of communication technology (ICT) and supply chain failure.

Business continuity forms part of the national core standards for EPRR assessed annually by NHS England and commissioners. The standards for Business Continuity are;

- ISO 22301 Societal Security - Business Continuity Management Systems – Requirements1
- ISO 22313 Societal Security - Business Continuity Management Systems – Guidance
- PAS 2022 - Framework for Health Services Resilience

This plan is working toward the standards set out in national guidance.

NHS England describes a business continuity incident as;

''an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level''. (NHS England. Emergency Preparedness, Resilience and Response Framework. 2015).

Although it is not possible to predict all incidents that may occur, the Trust has reviewed and identified risks which could cause disruption to its services (Table 2.1 page 9). By following this plan and the Unit Recovery Plans, recovery of the Trust's services should be achieved, preventing complete failure and reducing the negative impact on service provision.

To ensure the plan remains effective and fit for purpose, it will be tested annually, and lessons learned from these exercises and any actual incidents will be incorporated into the plan.

This plan is a live document and will be reviewed regularly to ensure it reflects current best practice and that our trusts critical services have continuity arrangements in place.

Where there is an event causing multiple service disruption, or where all of the Trust services are affected (i.e., pandemic influenza, fuel shortage, industrial action) this plan and the Trust's Emergency Response Arrangements (the "major incident plan") will be activated simultaneously and co-ordination of the response will be passed to the Incident Management Team under the remit of the major incident plan. Several recovery teams will be convened at this time to ensure proper coordination of the response.

Table of Contents

1. Aim of Plan

The aim of this plan is to outline procedures and strategies to be implemented in the event of a service disruption affecting the ability of a Specialist Orthopaedic Hospital to deliver its normal service obligations.

1.1 Trust Definition of Business Continuity

The strategic and tactical capability of the organisation to plan for and respond to, incidents that cause or could cause business disruptions to continue business operations at an acceptable predefined level.

1.2 Objectives

- Identify the risks faced by the Trust (Risk Assessment)
- Put measures in place to prevent or mitigate impact of the identified risks
- Ensure priority clinical and lifesaving services are maintained during the disruption
- Outline recovery plan to ensure all services can be returned to normal practices in a timely manner and within acceptable timeframe (Recovery Plan)

1.3 Plan Ownership and Review

This plan is required by the Trust and will be reviewed on an annual basis as a minimum requirement. However, as business continuity planning is part of the normal business responsibility of the Trust and thus subject to regular review, especially in the event of any changes which would impact on the workability of the plan. Day to day management of the corporate plan is the responsibility of the emergency planning lead, however maintenance of Site and Unit operational business continuity plans are the responsibility of unit or department managers.

1.4 Training and Exercising

- The Trust will ensure training is made available and completed to ensure staff are familiarised with the Trust and Service plans.
- An exercise will be carried out annually to test the response outlined in the business continuity policy and supporting service plans.
- Following any exercise or live incident, this plan and any service specific plans will be reviewed and revised considering any lessons learned.

2.0 High Level Risk Assessment

Risk assessments are regularly carried out as a part of the Trust's daily business. In relation to business continuity management, a risk assessment looks at the probability and impact of specific threats that could cause disruption to the delivery of services. Threats in this context refer to issues that have the capability of impacting on the ability of the trust to deliver its services and therefore place patients at risk.

The assessment of threats is not intended to be comprehensive but a pragmatic view of events that would either prevent services from operating as normal, or, place patients at risk from services that would be interrupted.

The Trust's approach to assessing threats for the purpose of continuity management plans is to identify in advance key threats and key alternatives to service provision, including during the contracting process. However, actual events may not exactly match what has been anticipated. Recognising the complex nature of the trust and the skills of its staff, the Trust will construct a management team of the right managers and staff that will address the potential consequences of threats and put in place alternative arrangements, dynamically – according to the specific nature of the threat or incident that emerges at the time.

2.1 Key High Level Risks

This assessment is specific to this plan, other risk assessments exist which provide a comprehensive risk assessment (i.e., Local Health Resilience Partnership Risk Assessment, Shropshire and Telford Silver Partnership Risk Assessment)

Table 2.1

Threat	Impact	Mitigation
Influenza Pandemic outbreak	Loss of staff due to illness, caring responsibilities, fear, bereavement. Increase in patients, who are at increased risk. Disruption to national supply chains. Disruption to national infrastructure. Staff at increased risk – contact with symptomatic patients	Multi-agency, NHS England and Trust Pandemic Influenza Plan Stockpile of personal protective equipment for NHS staff. Infection control procedures as per Government guidance Service by service BCM Plans to mitigate loss of staff. Covid Vaccinations for all NHS Staff Annual Flu immunisation for staff Staff working from home where possible
Loss of Utilities **Water** **Electricity** **Gas/Oil**	Disruption to services; increased risk to patients and staff in community hospital settings and potential need for evacuation. Loss of phones. Where the trust occupies properties and it is not the landlord it expects the landlord to have BCM arrangements in place	Estates services have robust BCM arrangements for water, electricity, gas. There is also a built-in redundancy of certain equipment to ensure key parts of the trust infrastructure are not affected should critical equipment fail.
Loss of skilled staff or general staff for example due to industrial action	Potential disruption to patient care may put some patients at risk and also risk reputation/contractual obligation	Pre identification of priority services, flexible working, cross training where appropriate, staff retention and staff recruitment planning
Critical supply chain – specialist theatre equipment	Failure of the supply of equipment such as prosthetics result in cancelled operations and potential morbidity of patients.	Critical supplies identified and arrangements in place within the each departmental area to acquire alternative products.

Threat	Impact	Mitigation
Severe Weather	Loss of access to buildings. Staff unable to get to work placing patients at risk. Trust unable to deliver elective work with resulting financial consequence. Localised increased demand beyond resource available. Potential loss of utilities telecommunications and IT	Severe weather warnings are circulated to raise staff awareness Working from home Sharing Staff (reporting to NHS location closest to home) Re-prioritise patients for home care
Loss of, or access to buildings	Evacuation of patients No access to patient records IT loss of stored data New ways of working	Fire evacuation plans Pre-identified suitable alternative locations Some ability to expand capacity at other sites
Major disruption to fuel supplies	Staff delayed or unable to come to work placing patients at risk. Trust unable to deliver elective work with resulting financial consequence.	Fuel Plan providing access to fuel for essential services. Flexible rota management and changes base location for some
Loss of IT and telecommunications systems	Loss of data, corporate knowledge and business planning Loss of contractual activity monitoring Loss of communications Phones linked to IT systems	IT Disaster Recovery Plan meets industry standards.
Supply Chain Failure	Interruption to catering and clinical services resulting in potential sub optimal care/conditions for patients	Service continuity plans identify critical supplies and alternative suppliers for specialist supplies Local site plans outline alternative suppliers. Catering has dry/canned good contingency stock.

3.0 Service Continuity Plans

3.1 Overview

This plan is one of a suite of emergency plans owned by the Trust, common to each of these plans are the command, control and coordination arrangements that would be implemented by the Trust to coordinate its internal response to disruptive challenges.

This plan has a list of annexes called Departmental/Unit Business Continuity Plans which are completed by senior managers of the organisation who manage key services. These more detailed documents provide information at an operational level within the trust that prioritise each element of the service (to maintain or restore) and identify key staff, estate, equipment, and supplies that are required by that service to maintain or restore its critical services. Services with a lower priority rating would be assessed for their ability to backfill staff within critical services.

It recognised that the Trust relies on other stakeholders to have business continuity arrangements in place that allow the trust to continue some of its critical activities. Departmental plans recognise any interdependencies and build into contract planning the cost of contracting with providers or suppliers in providing resilient services.

3.2 Site or Service Business Continuity Plans

These are operational plans containing departmental or site business impact analysis and outline the priority services and resources required to resume and/or continue providing these specified services at an acceptable level to fulfil the Trust's obligations. These plans also describe the site from which the service operates, identifies an alternative location from which to deliver the critical services (If possible) and key property details, contact numbers and emergency procedures for:

- Fire evacuation Procedures
- Lock down Procedure
- IT failure
- Incident impact assessment form and,
- Incident Management arrangements procedure

The Business Impact Analysis is conducted at an operational level to help understand corporate risk and prioritise services to ensure critical functions are up and running as soon as possible after a disruption and also and sets out a timetable for normal resumption services.

3.3 Maximum Period of Tolerable Disruption (MPTD) - Timescales

The prioritisation of services has been set out as recovery timescales, i.e. the maximum tolerable time limit before that service is recovered and is operational again.

The recovery timescales have been set out as follows:

P1 – Immediate/Within four hours

P2 – Within 24 hours

P3 – Within 24-48 hours

P4 – Within 1 Week

4.0 Activation of Corporate or Site/Service Business Continuity Plans

The notification of an incident that may or has interrupted a Trust service can originate from any source. Warnings of potential disruption can come in the form of, for example, severe weather warnings (i.e. snow/ice, storms, extreme heat or flooding), or from an incident reported by partner organisation such as the Fire and Rescue Service or Police who might be dealing with an incident that might have an impact on the Trust's service provision (i.e. road closure, evacuation of a community, public disorder). However, most incidents that prevent a service from delivering normal levels of service provision come from internal issues such as loss of telephones.

All managers and senior staff within the Trust are expected to understand their services in some depth and will understand what will stop their service from operating. It is part of the day-to-day responsibility of managers to take such steps (see table 4.1 for a guide to **STEPS**) within their sphere of authority and expertise as required to, ensure their services continue to deliver against their objectives and when normal service is at risk of or is being disrupted then local business continuity plans must be implemented and if severe then the use this plan must be considered.

Receive and Record Information	**Risk assessment (Service and Safety)**	**Consider Policy and Procedures**	**What are the Options**	**Take actions based on prior steps**	**Apply continuous review of actions**
Consequence analysis	**Record**		Defendable/Proportionate/ **Record**		**Record**

Table 4.1 STEPS

4.1 The formal criteria to implement this plan is:

- If a critical service or more than one service is threatened with or is disrupted.

The appropriate Service Lead can activate their own service business continuity plan. However, any potential or actual interruption to service delivery must be reported to the appropriate Director as soon as possible.

If a service interruption is suspected immediately refer to Annex 2

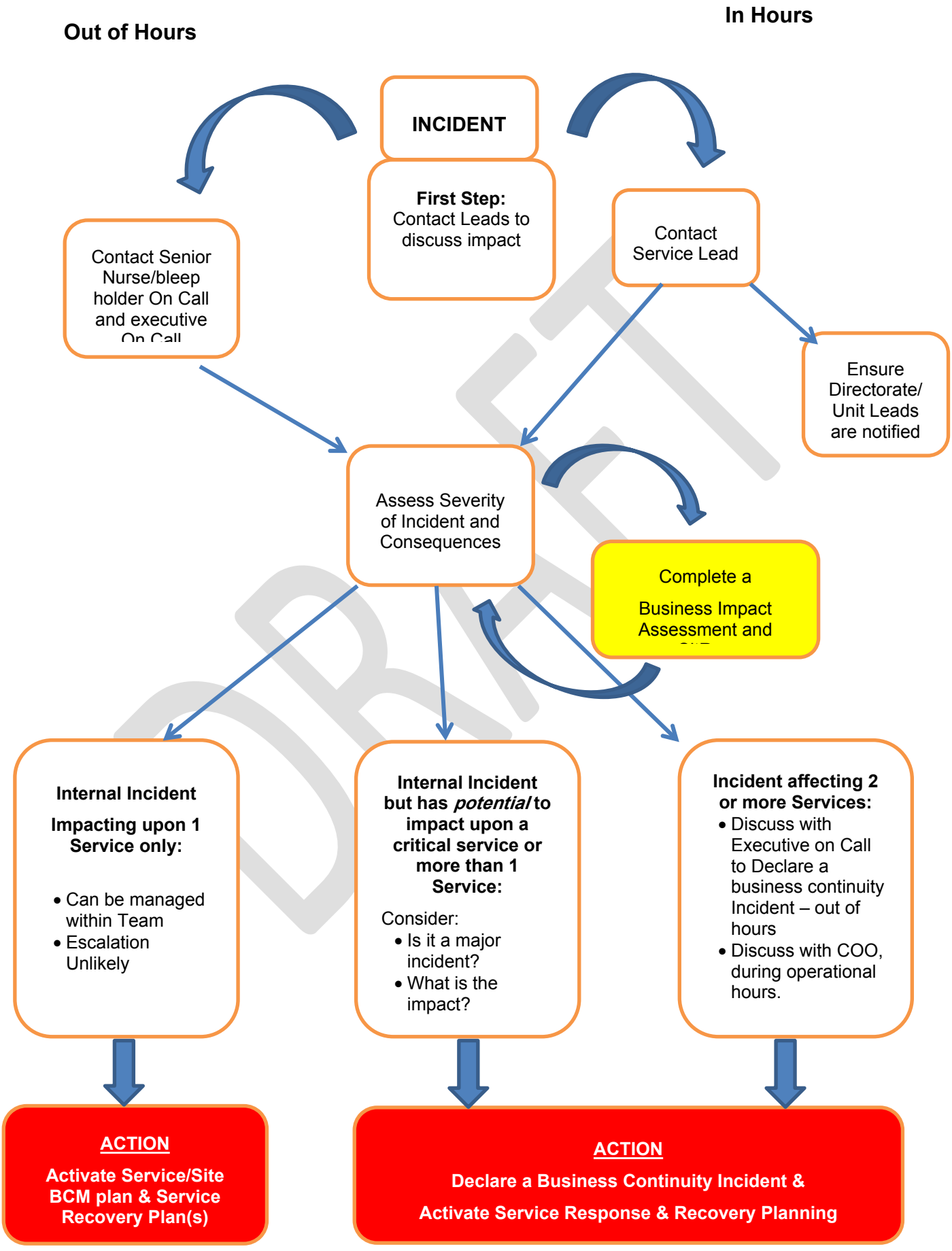
ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

AND Annex 3

BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

The activation flowchart on the next page outlines the full activation sequence.

4.2 PLAN ACTIVATION FLOWCHART



4.3 Phases of Activation

As with a major incident, there are three activation phases, which must be utilised:

Business Continuity 'Stand By' – Business Continuity Incident 'Declared' – Business Continuity 'Stand Down'

4.3.1 Business Continuity "Standby"

Will be used as an early warning of a situation which might at some later stage escalate and thus require implementation of this Plan. "Standby" allows key officers time to think, brief staff, start a business interruption log and prepare for the deployment of resources should an "Implement" message be received.

This is particularly important if an interruption occurs towards the end of a shift and staff may need to be asked to stay at work until the situation becomes clear.

Resources are not normally deployed at this stage (although this will largely depend upon circumstances) and a "Stand Down" may follow this type of alert.

4.3.2 "Business Continuity Incident - Implement Plan"

Will be used to activate the plan in its entirety, especially the Business Continuity Incident Control Team

4.3.3 "Business Continuity Stand Down"

Will be used to signify the de-activation of the Plan or that an anticipated risk has resolved. It is important that everyone in the organisation knows when the establishment has returned to 'business as usual'. It is also important that all staff and all stakeholders who helped in the response are thanked for their efforts.

5.0 Roles and Responsibilities

During a disruption, there will be a need for several people across the Trust to help in the response. The following table outlines some of the people/services required:

Individual/Team	Day to Day Role	Level of Disruption	Responsibilities
Service Leads	Normal roles and responsibilities within directorate	Individual service or one or more services affected	Coordinate response in line with plan; notify upwards

			within Trust; maintain communication
Units Managers/Senior Managers/Directors	Normal operational management of service responsibilities	Threatened or actual disruption	Follow STEPS table 4.1 If isolated to one directorate/service, manage with existing resources. Implement options to maintain critical services.
Incident Control Team (ICT)		Business Continuity incident may be called dependant on impact of service outage; one or more services disrupted	Overall corporate and strategic coordination of the response. Consider. Alerting Board, Integrated Care System/Board, Integrated Care System and NHS England Area Team of disruption; alert and work with commissioners where services have been disrupted; Staff welfare;
Communications (Trust Lead)	Dealing with communications internally and externally	If individual service affected; internal communication via Service Lead; external messaging to be routed through Trust Lead. If one or more service is affected this will be coordinated through ICT and Trust Communications Lead	Providing direct support to managers and/or Incident Command team if established.
Corporate Issues (i.e., finance, legal and insurance matters)	Via normal routes	Any	Maintain finance functions; ensure adequate insurance coverage; establish cost codes; ensure any legal advice is available and taken
IT and Telecommunications	Normal roles i.e., advising the Trust on inward and out ward	Any	Ensuring that IT services throughout are available to support the recovery of services

	facing communications and media response		
Estates & Facilities	Managing functional and safe property from which services are delivered	Threatened or actual disruption, recovery planning	Report when an estates issue threatens service provision; support the incident control team advising on impacts and corrective actions.

Table 6.1

6.0 Command, Control and Coordination

The Corporate Business Continuity Plan, if implemented, could trigger the implementation of the Trust Emergency Response Arrangements plan to achieve a trust wide response.

Some key risks have resulted in the production of specific plans that supplement the arrangements in the Trust Emergency Response Arrangements Plan. The Incident Management Team (outlined Trust Major Incident Plan and EPRR Policy) led by the Chief Executive, including the Chief Operating Officer and/or nominated Deputy, will provide strategic direction on the response to the incident. Media messages will be sanctioned by the Incident Management Team via the Media and Communications Lead to ensure continuity of messaging to the Press and public.

While the Incident Management Team will lead the response to the incident, a Business Recovery Group will be established to initiate the recovery process by working with the service areas recovery plans. This group will be led by the Executive Director lead of the service area E.g., Operations, for patient services

6.1 Business Continuity Incident Control Team (Gold/Strategic)

Comprising the Executive Team

Roles and Responsibilities:

- Provide strategic direction and overview to ensure an effective response is being undertaken
- Establish and maintain clear communication channels / provide briefings to media and public
- Manage potential harm to the reputation of the Trust.
- Provide representation at multi-agency Business Continuity meetings / groups.
- Authorise expenditure

- Authorise implantation of Corporate BCP
- Liaise as necessary with ICB's NHS E AT other formal structures implemented such as Tactical Silver Coordinating Group etc.
- Keep partners / key stakeholders informed
- Receive and consider situation reports
- Consider requesting assistance from other local authorities/agencies/parties
- Plan and co-ordinate the recovery phase of the incident.
- Maintain an accurate log of decisions made and actions taken during the incident to facilitate feedback, debrief and review. The log may also be called as evidence in an enquiry.

As a minimum, the Strategic Incident Control Team must include:

- Incident Director (Chief Executive or Nominated Deputy)
- Tactical Advisor (Chief Operating Officer/AEO)
- Communications Lead (to co-ordinate Trust media response and liaise with Interagency Media Leads)
- Administrative Co-ordinator (to ensure adequate resource and deployment of administrative support, telecommunications and establishment of an incident record filing system)
- Loggist(s) (to record all actions and minute Incident Team Meetings)
- People Services Lead – especially if staff affected or re-located
- Estates and Facilities Director
- Director of Digital
- Other Executives/Directors if deemed required.

6.2 Business Continuity Response and Recovery Group (Silver/Operational)

This group will take direction from the Gold/Strategic ICT and work to identify solutions and workarounds that will re–establish service provision based on the priorities set out in individual Service Recovery Plans. This group will also provide regular information to the Incident Control Team that will include actions taken, progress, and on-going impacts to service provision.

Roles and Responsibilities are:

- Manage the Trust's operational response to the Incident, providing a single focus for decisions likely to affect the whole organisation.
- To co-ordinate the Trust's operational response in liaison with other Trust managers.
- Ensure prioritisation of critical services
- Provide appropriate advice on tactical issues to Gold & Bronze
- Liaison between Gold & Bronze
- Implement, coordinate and monitor Service level continuity plans
- Provide representation at multi-agency Business Continuity meetings / groups where implemented
- Co-ordinate the call-in of additional staff and ensure that briefings are undertaken, and action cards are followed (See Trust Major Incident Plan)
- Provide consistent messages/ information to staff.
- Ensure effective liaison with partner agencies

The Business Continuity and Response and Recovery Group must include:

- Incident Manager(s) - if predominantly affecting patient services, this must be both Managing Directors from both Clinical Units.
- Leads for the Service Areas affected (Service Managers)
- Emergency Planning lead
- Loggist
- Communications representative
- Head of Estates and Facilities
- Ward Managers (if predominantly affecting patient services)
- Other Senior Managers if deemed required.

6.3 Business Continuity Response & Recovery Managers (Bronze/Tactical)

An initial response to an incident will be managed by the Senior Nurse/bleep holder or can be other individuals such as team leaders, case manager or hospital managers or ward staff depending on the nature of incident how widespread it is and what elements of the command, control and coordination structure has been implemented.

Their role is to take instruction and implement action given by the Business Recovery Group and report on going actions and information back to this group.

Roles and Responsibilities are;

- Manage and deliver critical services, providing a Business Impact Analysis detailing the service specific functions affected and mitigating actions being undertaken
- Assist other Trust Services (if required and able to do so)
- Collate information & provide situation reports as requested
- Respond to requests for staff by the Business Continuity Response and Recovery Group
- Implement Service level continuity plans
- Inform recovery actions that will be developed and agreed following stand down from the incident response

6.4 Incident Control Room

Smaller business interruptions must be managed, if possible, at the place closest to the point where a service is under threat. Larger business interruptions should refer to the Trust Major Incident Plan to determine command locations.

7.0 Upward Reporting Arrangements

The Trust is required to escalate any disruption to its service to the Integrated Care System/Board (ICS/ICB) the Executive on call will be responsible for judging whether to escalate based on impact of the disruption and time of day.

7.1 Key contacts for escalation

Organisation	Criteria	Contact Number
The escalation pathway will always be to the ICS first, however if unable to contact them within a reasonable time contact the NHS E Area team		
Shropshire, Telford and Wrekin ICS	Any short- or long-term suspension or stop to a contracted activity	ICS Director on Call via SATH
NHS England	Serious disruption to service delivery.	

Table 8.1

8.0 Corporate Services Business Continuity Plans – Other Trust Plans

Trust Corporate Services - Business Continuity Plans

The tables below list the Business Continuity Plans for each Corporate Service, the standard Site/Service Business Continuity Plan must be used.

8.1

CORPORATE SERVICE	PEOPLE SERVICES
Specific planning areas • ESR data type/availability • Industrial action plan	Subject Specialists: Chief People Officer Ref to policies supporting org & staff example severe weather/contact in major incident

8.2

CORPORATE SERVICE	FINANCE DEPARTMENT
Specific planning areas • Staff pay • IT systems • Emergency budget arrangements	Subject Specialists: Chief Finance Office Ref other docs i.e., SFI

8.3

CORPORATE SERVICE	ESTATES & FACILITIES

Specific planning areas	Subject Specialists: Director of Estates & Facilities
• Estate list with resilience i.e. power UPS/generation/stored potable water • Estate list with key holder for each property • Phone failure plan – how to divert phones in property failure Utilities failure plans for all owned properties	Please refer to ECP/FCP held on Switchboard and in Silver Command Control Centre

8.4

CORPORATE SERVICE	IM&T
Specific planning areas • IT Disaster Recovery Plan • Manager on-call IT advice sheet	Subject Specialists: Digital Director Informatics BCM - Defined within document

8.5 Other Trust Plans / Documentation

Document/Plans	Location
Emergency Response Arrangements	Trust Intranet Percy
Pandemic Flu Plan	Trust Intranet Percy
Trust Major Incident Plan (including Action Cards)	Trust Intranet Percy
EPRR Policy	Trust Intranet Percy
Senior Managers on Call Policy (SMOC)	Trust Intranet Percy

ANNEX 1 SERVICE IMMEDIATE RESPONSE CHECKLIST		
Incident Response – HAVE YOU	**☑**	**ACTIONS TAKEN**
Assessed the severity of the incident?	☐	
Contacted Emergency Services?	☐	
Evacuated the site if necessary?	☐	
Accounted for everyone?	☐	
Identified any injuries to persons?	☐	
Implemented your Incident Response Plan?	☐	
Started an Event Log?	☐	
Activated staff members and resources?	☐	
Appointed a spokesperson?	☐	
Gained more information as a priority?	☐	
Briefed team members on incident?	☐	
Allocated specific roles and responsibilities?	☐	
Identified any damage?	☐	

Identified critical business activities that have been disrupted?	☐	
Kept staff informed?	☐	
Contacted key stakeholders?	☐	
Understood and complied with any regulatory/compliance requirements?	☐	
Initiated media/public relations response?	☐	

ANNEX 2

ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

ACTIONS FOR CONSIDERATION:	**Tick When Complete**
Start Incident Log	
Obtain full details from caller and request further information as required: **1** **Clarify** whether a service disruption has occurred or is developing. Evaluate impact of situation: - **Can the affected service manage the incident?** - **Will other services be impacted** - **What is the impact on the community/other NHS organisations** - **IF this disruption has the potential to affect more than one service or disrupt other NHS organisations consider escalating to Major Incident – contact Chief Executive**	
Liaise with Chief Executive/Executive Team and Director of Service Area	

IF agreed Activate Business Continuity Plan	Yes/No
Locate copy of Service Recovery Plan of affected areas.	
Ensure Service Impact Analysis is carried out.	
Review Service Area Priorities in light of interruption and timing and the need to suspend non-critical functions in affected areas.	
Activate Incident Room (choose most appropriate site) if necessary	Yes/No
Alert Support Staff	
Alert other relevant staff that Plan has been activated	
Assign time for First Meeting and Advise appropriate staff	
Review Service Area Priorities in light of interruption and timing	
Decide on course of action to be taken, and record alternative actions considered and the reasons for rejection.	
Develop initial rota for Incident Room to cover all areas of responsibility for next few days	
Authorise all business interruption response expenditure as appropriate, liaising with Finance Lead as appropriate	
Continue regular briefings to staff	
Consider briefing business partners if appropriate	
Establish recovery timetable	
Consider own domestic arrangements if situation escalates	
Consider shift working, rest periods and refreshments for all staff	
Collect and collate log sheets to prepare final report	
Ensure copies of all reports are kept and filed securely.	
Thank all staff involved in response to service interruption	

Have You Considered	▪ The impact on Council and independent sector residential and nursing homes. ▪ Does the Public need warning of the incident, specific action to take, disruption to services. ▪ Will the incident impact on health staff getting to work.
Longer Term	▪ Stand people down who turn up to help early to ensure availability tomorrow or to continue providing a service within their own units. ▪ Services which have been stood down must eventually be restored. Remember the "Backlog". Always review the possibility of restoring activities as soon as practical to avoid impact of backlog. ▪ Will there be an investigation – ensure all paperwork is archived. ▪ Start thinking about a formal report of the incident to other parties such as police or trust board.

ANNEX 3

BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

Complete the following Impact Assessment when a disruption is reported/or is already occurring and will affect the Service Delivery Team. Once completed, use to make an assessment using the Service Delivery Team Continuity Plan to identify priorities and to assist in the recovery.

Service Delivery Team	
Service Delivery Manager	

Date of Disruption Occurring	Time of Disruption	Date Disruption Reported	Time Disruption Reported

Name, job title and service area of Person who made the report of the disruption	
Disruption Description **(What, why, where and how)**	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	

Mutual Aid Request Made (Y/N) and agreed with?	
Media interest expected/received	
Staff Impact	
Premises Impact	
ICT/Servers Impact	
Paper Files Impact	
Equipment Impact	
Contractor Impacts	

Time Scale	Estimated Impact on Service
First 24 Hours	
First 3 Days	
First 7 Days	

Over 7 Days	

ANNEX 4

INCIDENT CONTROL TEAM FIRST MEETING AGENDA

No	Item	Action	Action By Who	Action By When
1	**Analysis of Impact** ▪ Review Service Impact Analysis Sheets ▪ Brief team on nature, severity and impact of disruption. ▪ Identify information gaps			
2	**Confirm Roles** ▪ Agree roles and responsibilities of staff during the disruption. ▪ If required revise roles and determine if additional staff/deputies are required. ▪ Identify additional team members that they may be required ▪ Stand down members not required			
3	**Confirm Key Contacts at Scene of Disruption** ▪ Main points of contact for on-going information updates			
4	**Logs** ▪ Ensure personal logs in place (written record of significant events throughout the crisis and written record of all communications)			
5	**Recovery Management** ▪ Review recovery priorities			

	▪ Determination of support requirements.			
6	**Welfare Issues** ▪ Have members of staff, visitors or third parties been injured? ▪ What is their location? ▪ What immediate support and assistance is required? ▪ What ongoing support and assistance might be required?			
7	**Communications** ▪ Who should we inform? ▪ Are Trust's Communications Officers required? ▪ Professional Public Relations/Media advisors required? ▪ Determine which if any external regulatory bodies should be notified. ▪ Determine any internal communications that need to take place (other sites, affected services etc).			
8	**Media Strategy** ▪ Determine the media strategy to be implemented. ▪ What is the story? What is the deadline?			
9	**Legal Perspective** ▪ Determine what legal action or advice is required.			
	Next meeting ▪ Date, time, place and attendees of next meeting			

2.2. Recommendations

The Board is asked to approve the Trust Business Continuity Plan.

Trust Board - People & Workforce
March 2023 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

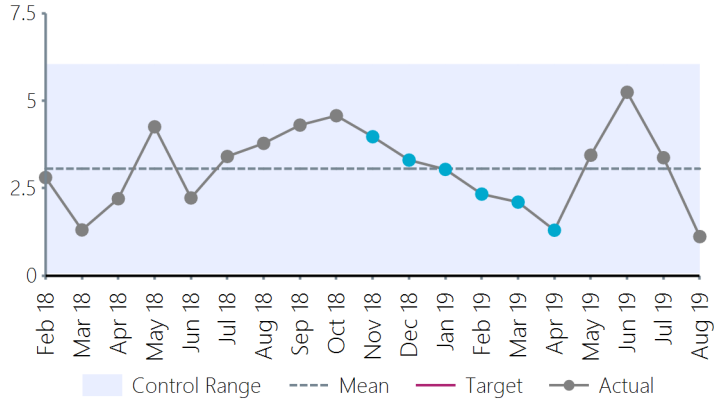
Some examples of these are shown in the images to the right:

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

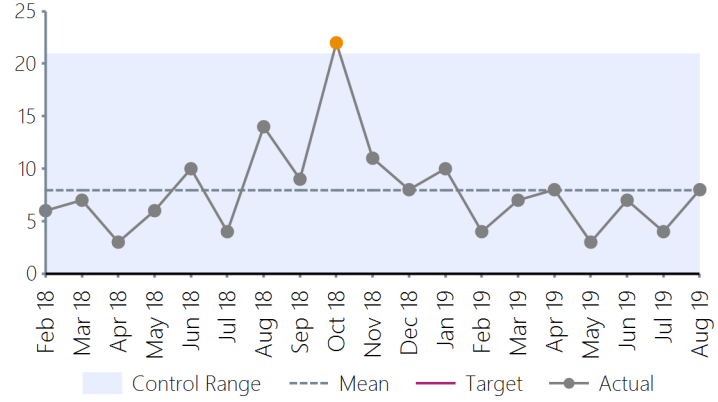
b) shows a point of concern sitting above the control range.

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

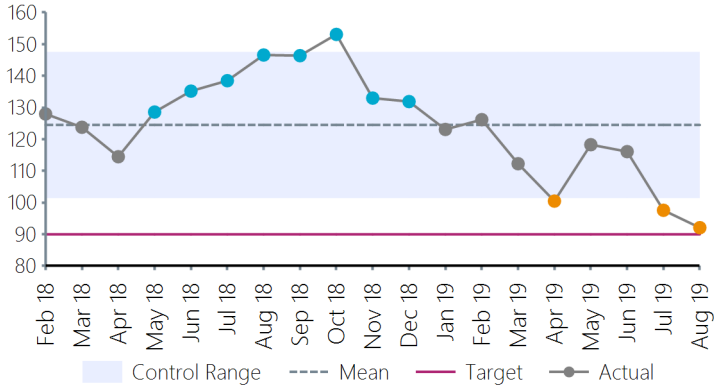
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	5.25%			?	+	27/02/20
Staff Turnover - Headcount	8.00%	12.10%		H	F	+	
In Month Leavers	18	12			?	+	
Vacancy Rate	8.00%	8.45%		H	?	+	14/03/19

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Agency Core - On Framework	132	100		N/A to SPC	?	+	
Agency Core - Off Framework		208		N/A to SPC	No Target	+	

Sickness Absence

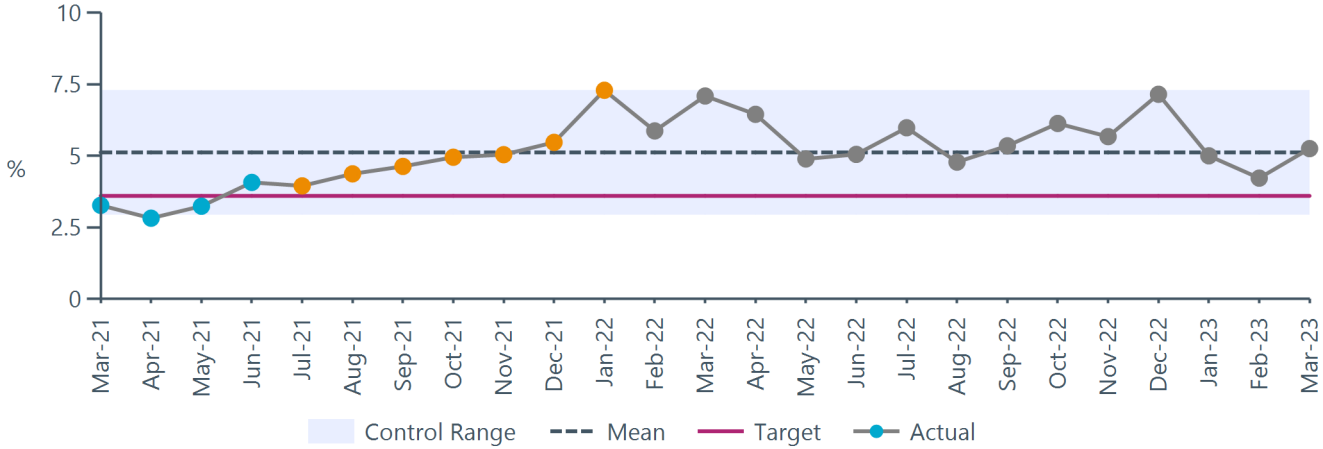
FTE days lost as a percentage of FTE days available in month 211161

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
3.60%	5.25%		

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

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

Narrative

The sickness absence reported for March is 5.25% where 'infectious diseases' accounted for 0.86%, leaving remaining sickness at 4.39%. The reported position remains within our expected control range this month. Further detail by area below:
* Specialist Unit - 5.73% (4.76% excluding 'infectious diseases') - hot spot areas; Outpatients Dept 15.54%, Sheldon Ward 9.81%
* MSK Unit - 5.68% (4.82% excluding 'infectious diseases') - hot spot areas; Therapies T&O Team 19.21%, Powys Ward 10.49%
* Corporate areas - 4.18% (2.72% excluding 'infectious diseases') - hot spot areas; Ward Housekeepers 13.85%, Finance Dept 11.52%

For overall sickness, 'anxiety/stress/depression/other psychiatric illnesses' was the highest reason for absence across all areas.

Actions

Revised sickness policy has now been approved by People Committee and is available on the Trust Intranet. A relaunch advising stakeholders on the key messages and updates to be sent out. Bite-size training sessions to undergo content review to ensure they are aligned with the updated policy and further sessions to be scheduled in quarter one. Additional resources, such as FAQs that will accompany the policy are currently in development for roll out in quarter one.

Additional resource within the People Services department commenced in March/April where roles, following a period of induction within the team, will have a focus on sickness monitoring and support to managers .

With regards to support of anxiety/stress/depression sickness, People Services Team to request a communications update that outlines the resources available to NHS staff.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
7.09%	6.45%	4.89%	5.05%	5.98%	4.78%	5.35%	6.13%	5.67%	7.15%	5.00%	4.22%	5.25%

Staff Turnover - Headcount

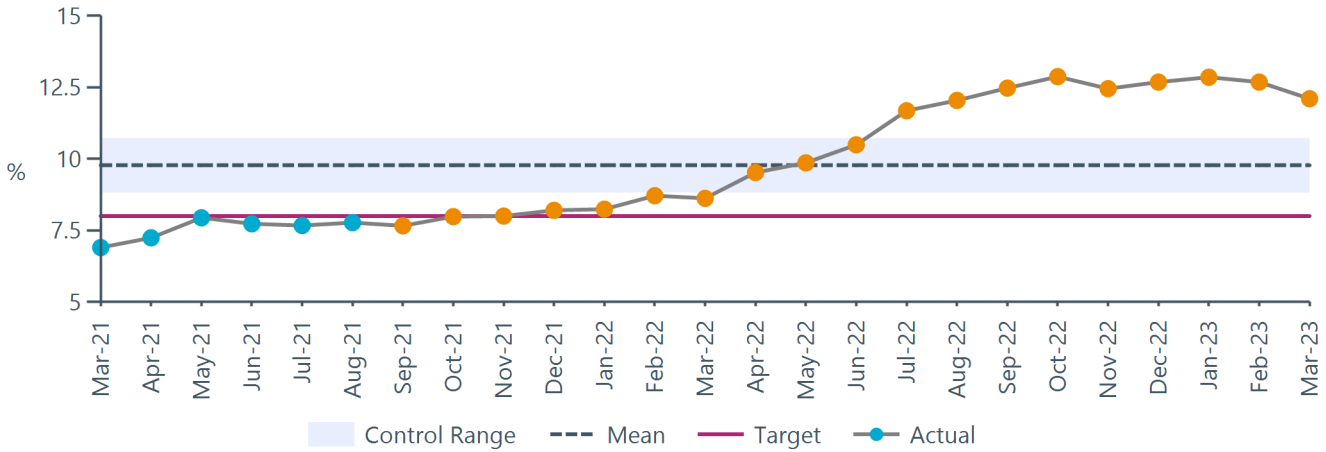
Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	12.10%	H	F

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

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

Narrative

Staff Turnover, at Trust level, has now been reported above the 8% target since November-21. The March rate of 12.10% remains above the control range. Six out of eight staff groups are reported above 8% as follows:
* Allied Health Professionals - 19.68%
* Healthcare Scientists - 14.29%
* Additional Clinical Services - 13.95%
* Nursing and Midwifery - 13.46%
* Estates and Ancillary - 11.05%
* Administrative and Clinical - 9.09%

In the latest twelve month period, April-22 to March-23, there have been 202 leavers throughout the Trust. This is in relation to a headcount in post of 1670, as at 31st March 2023. The top three reasons for leaving that accounts for 101 leavers/50% at Trust level were:
* Voluntary Resignation - Other/Not Known - 39 / 19.31%
* Voluntary Resignation - Work Life Balance - 36 / 17.82%
* Retirement age - 26 / 12.87%

Actions

* Planning in place for the next Trust Open Day on the 16th April. This is a Trust-wide open day, not just professional roles. Further ones scheduled 15th July & 8th October.
* Focus on learning and development continues with nine mandatory study days planned up until October. Focus will move away from ward based training and focus on clinical skills and scenarios. Training being linked on ESR for all staff. 'Training Wednesday' launched in March for nursing staff. These are drop in sessions that are clinically focussed and responsive to needs of the organisation, e.g. falls. Development days for Health Care Support Workers diarised until October. Development days for registered nurses being planned; these will focus on personal professional growth. An update to the Trust's Study Leave Policy is in progress. A workforce review of the Learning & Development Team is taking place. Review and improvements made to training resources available on Intranet.
* Professional Career Cafes to be launched in quarter one, run by the Assistant Chief Nurses.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
8.62%	9.52%	9.86%	10.49%	11.68%	12.04%	12.47%	12.87%	12.45%	12.68%	12.85%	12.68%	12.10%

In Month Leavers

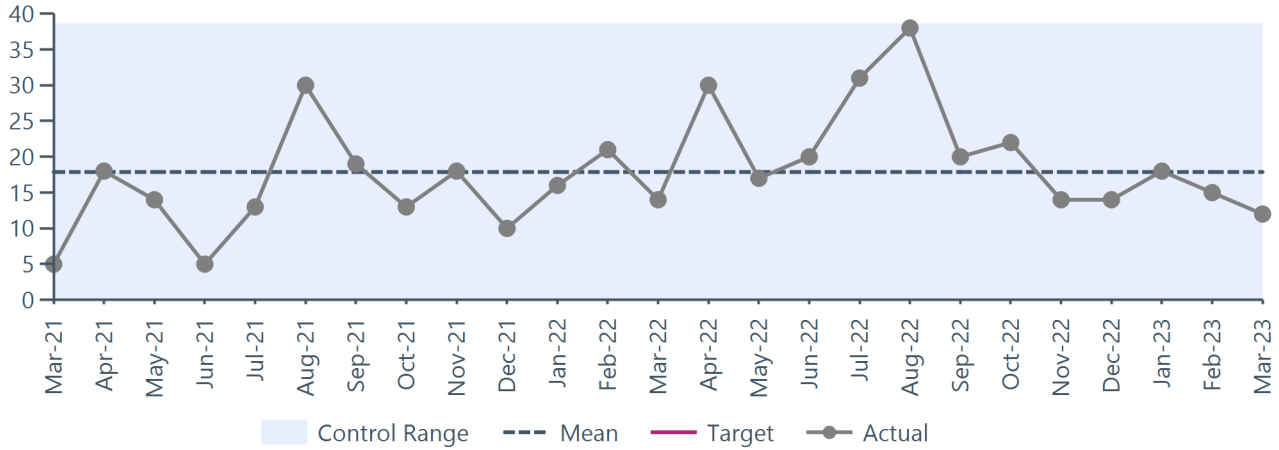
Number of leavers in month 217809

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
18	12		

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

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

Narrative

In March, twelve staff left the Trust. These were from the following areas of the Trust; Specialist Unit (6), MSK Unit (5) and Corporate areas (1).

The staff that left in March by staff group were; Additional Clinical Services (5), Nursing & Midwifery Registered (3), Administrative & Clerical (2), Allied Health Professionals (1) and Estates & Ancillary (1).

Reasons for leaving were categorised as; work life balance (5), flexi retirement (2), retirement age (1), adult dependents (1), child dependents (1), relocation (1) and to undertake further education or training (1).

Actions

* Planning in place for the next Trust Open Day on the 16th April. This is a Trust-wide open day, not just professional roles. Further ones scheduled 15th July & 8th October.
* Focus on learning and development continues with nine mandatory study days planned up until October. Focus will move away from ward based training and focus on clinical skills and scenarios. Training being linked on ESR for all staff. 'Training Wednesday' launched in March for nursing staff. These are drop in sessions that are clinically focussed and responsive to needs of the organisation, e.g. falls. Development days for Health Care Support Workers diarised until October. Development days for registered nurses being planned; these will focus on personal professional growth. An update to the Trust's Study Leave Policy is in progress. A workforce review of the Learning & Development Team is taking place. Review and improvements made to training resources available on Intranet.
* Professional Career Cafes to be launched in quarter one, run by the Assistant Chief Nurses.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
14	30	17	20	31	38	20	22	14	14	18	15	12

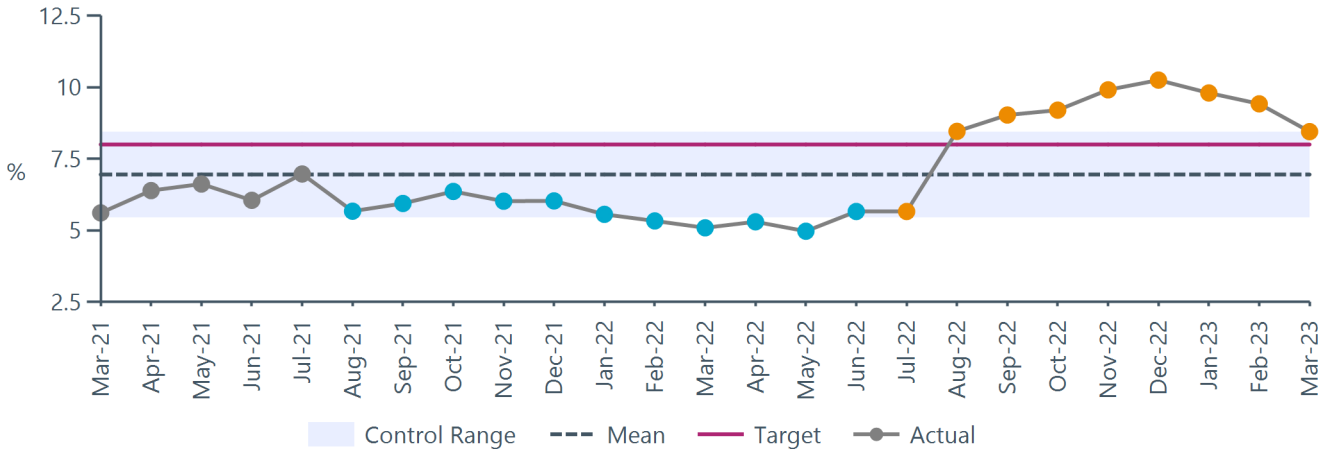
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	8.45%	H	?

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

The vacancy rate is reported at 8.45% this month and has exceeded the 8% target since August-22. This equates to vacancies across the Trust at 133.35 WTE; down from 149.00 at the end of February. The data remains special cause variation of concern above our expected control range. A breakdown by area is:
* MSK Unit - 10.70% / 73.48 WTE vacant
* Specialist Unit - 8.03% / 34.98 WTE vacant
* Corporate areas - 5.46% / 24.89 WTE vacant
Further details on the staff groups is provided against other KPIs (Nursing, Healthcare Support Workers & Allied Healthcare Professionals).

As can be seen in the SPC graph above, the vacancy rate has shown an increase from July. It must be noted, that when reviewing at a Trust-level the establishment has risen from 1518.31 WTE at the end of July to 1578.02 WTE at the end of March; an establishment increase of 59.71 WTE. Additional analysis is provided at staff group level in the covering paper that accompanies the IPR for People Committee.

Actions

* Planning in place for the next Trust Open Day on the 16th April. This is a Trust-wide open day, not just professional roles. Further ones scheduled 15th July & 8th October.
* 'Golden Ticket' being offered for registered individuals on placement with the Trust, providing offer of role once they are qualified.
* Workforce modelling for nursing and allied health professionals has begun. A forecast position for the next two financial years is in place and is reviewed on a weekly basis, taking pipeline recruitment into account. The modelling incorporates decision taken to recruit 10 student nurses twice a year (per cohort) and any known leavers such as retirement.
* Focussed effort on developing role competencies and career pathways for progression to agenda for change. This work will commence in Theatres and MCSI. Within MCSI a business case has been developed.

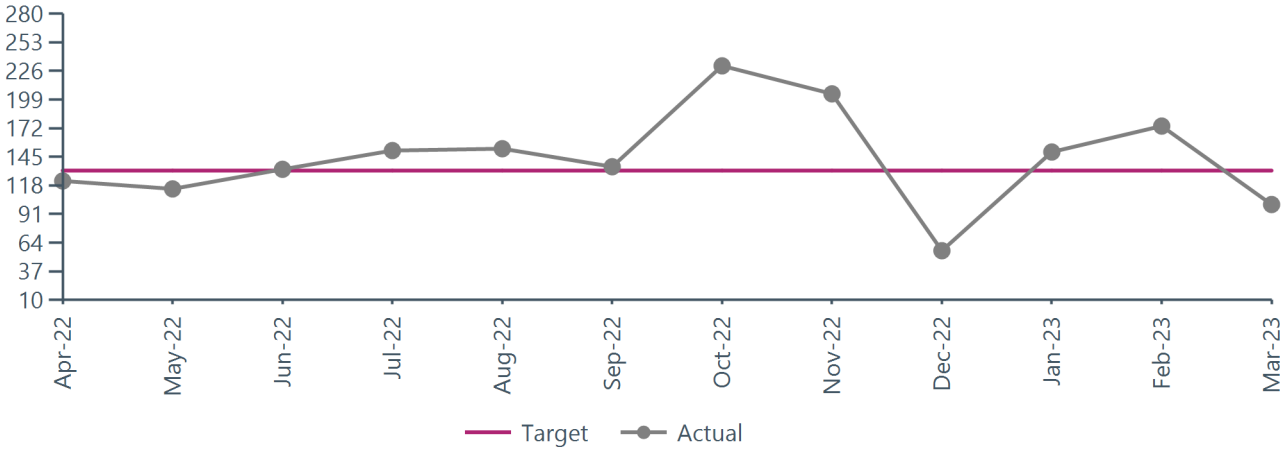
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
5.09%	5.30%	4.97%	5.66%	5.66%	8.46%	9.03%	9.20%	9.91%	10.25%	9.80%	9.42%	8.45%

Agency Core - On Framework

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency On Framework 217816

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
132	100	N/A to SPC	?



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

Remains adverse to cap driven by vacancy rates.

Actions

Recruitment plans focused on registered nursing, HCA and consultants (anaesthetics, rheumatology, MCSI).
Trainee nurse associate initiatives supported to increase clinical workforce numbers.
International recruitment second cohort.
Launch of bank incentives and bonus scheme.

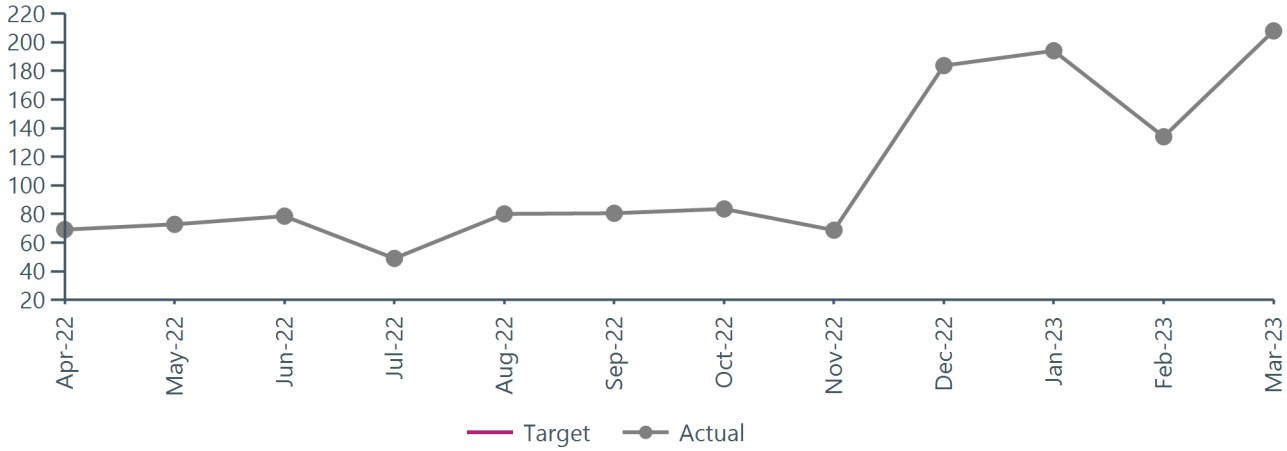
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	122	114	133	150	152	135	230	204	56	149	174	100

Agency Core - Off Framework

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

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
-	208	N/A to SPC	No Target



Trajectory/H2 Forecast

What these graphs are telling us

This measure is not appropriate to display as SPC and has no target.

Narrative

Increased levels of off framework agency usage driven by MCSI

Actions

Agency escalation policy in place, off framework agency only utilised when all other options are exhausted prior to commencement of shift.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	69	72	78	49	80	80	83	68	183	194	134	208

Chair's Assurance Report
People and Culture Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	03 May 2023
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	24 April 2023
Paper Reviewed by:	Martin Evans, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

The Trust Board has established a People and Culture Committee. According to its terms of reference: *"The purpose of the People and Culture Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:*

- *Promote excellence in staff health and wellbeing;*
- *Identify, prioritise, and manage risks relating to staff;*
- *Ensure efficient and effective use of resources."*

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

3. Assurance Report from People and Culture Committee

This report provides a summary of the items considered at the People and Culture Committee on 20 April 2023. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

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

ALERT - The People and Culture Committee wishes to bring the following issues to the Board's attention as they:

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

Powys Ward Action Plan

The Committee were assured that an action plan is in place to support identified improvements required. It was agreed that the Committee will receive a final overview of the actions in June with the agreement that exception reporting will be presented from July onwards.

The Committee discussed concerns relating to a lack of civility and respect that had been highlighted during the investigation which did not align with the Trust's values and felt that this was an opportune

time, and would send a strong message to all involved in this investigation, for the values and expectations to be promoted and reinforced across the organisation. The Committee asked for the Executive Team to consider how this could be best delivered and agreed to raise this point for consideration with the Board.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework (BAF) and Corporate Risk Register
The Committee supported the revised reporting format of the BAF and agreed this would be reviewed by the committee quarterly.

An update was requested to BAF 1 - workforce, requesting that GRIP work and recruitment days are captured within the control section to highlight the improvements being implemented.

The Committee agreed the following amendments to the corporate risk register:

- Risk 2911 'Consultant Surgeon and Anesthetist vacancies and recruitment impacting on operational plan' to be re-aligned from the Finance, Performance and Digital Committee to the People and Culture Committee for oversight and assurance.
- Risk 2653 'Insufficient theatre staff establishment to meet activity plan, due to vacancies and recruitment' control measures to be reviewed and assurance presented on the measures in place ahead of the next meeting.

There was no new risk identified for either the BAF or Corporate Risk Registers.

Performance Report
Areas to note within the performance report included:

- The operational plan was not met in March and April due to industrial action however, this was not linked to workforce and staffing.
- Noted the positive downward trend on the in-month leavers.
- Further assurance requested on the continued rise within nursing vacancies. An update was provided that the vacancy level has now started to reduce due to recent recruitment and this area will be a focus of attention for the committee at the next meeting. This focus will include a better understanding of the reasons for staff leaving the Trust.

Recruitment and Retention
The Trust continue to work hard to ensure recruitment and retention is mitigated across the organisation. It was noted that the Recruitment Open Day was successful with 95 people in attendance and 5 golden tickets being offered. The projected vacancy rate for RCN has reduced from 18.5% to 12.59%.

For future meetings, the committee requested further assurance in relation to the recruitment pipeline and forecasting, workforce trajectory to ensure delivery against the 2023/24 operational plan and improvements to training to support retention.

Training Compliance
The Committee is outstanding a full assurance report relating to statutory and mandatory training requirements and compliance. It was agreed that a review will be completed for each department and findings and recommendations presented to the committee in June.

Oversight of Planning Framework 2023/24
The Committee noted the workforce metrics within the framework and agreed the key role that the committee had in overseeing performance and progress against these targets. Further work was requested to build this overview into the main body of the performance report for future meetings.
Agency Update

It was agreed to review the alignment of the agency report to the relevant agenda item for future meetings.

In summary, further work is to be completed to better align the relevant workforce metrics within the performance report to enable triangulation and an improved understanding of what the collective data is telling us.

3.3 Areas of assurance

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

Committee Annual Report and Self-Assessment
Following a discussion, the Committee members agreed to further consider the documents and for comments relating to the annual report, terms of reference and self-assessment to be forwarded to the Trust Secretary with the expectation this is presented in its entirety at the next meeting.

Safe Staffing – Nursing Workforce Paper
The committee were assured by the data for March 2023 which showed staffing fill rates being above the Trust target thereby providing assurance that wards were sufficiently staffed.

GGI Action Plan
There are 6 actions aligned to the Committee – 3 of which have been noted as overdue. Further information was requested from the Trust in relation to course content and attendance, and it was agreed the action plan will remain on the Committee workplan.

Guardian of Safe Working Hours
Assurance was received again for Q4 with no exception reports being recorded. The Trust remains a positive outliner nationally. The ability for trainees attending training was noted as difficult within this quarter due to cancellations and work pressures and assurance was provided that this is being reviewed.

Industrial Action
A verbal update was received – the Committee are content with the processes in place to ensure staff are supported throughout the industrial actions. There were no issues raised that required further consideration by the committee.

Freedom to Speak Up Quarter Report
The Committee were assured with the information presented within the Q4 report. It was noted and welcomed that the Freedom to Speak up Guardian has agreed to formally extend their working hours to support the process. Next steps include reviewing the process to support improvements and ensuring robust processes are embedded.

The Freedom to Speak Up Annual Report was deferred to the next meeting for additional work to be carried out on the report.

Chair Reports
The Committee received and noted the Chair reports from the Joint Consultancy Group and ICS People Committee - there were no issues to raise.

4.0 Conclusion / Recommendation

The Board is asked to:

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

NHS Staff Survey 2022 and Pulse Survey

RJAH highlights

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

Headlines

- Completed questionnaires: **837**
- Response rate: **52%**
  (peer group average: 52%)
- Recommend as a place to work: **66%**
  (down 5%)
- Recommend treatment to a friend or relative: **91.1%**
  (down 3% - but still one of the best in the country)

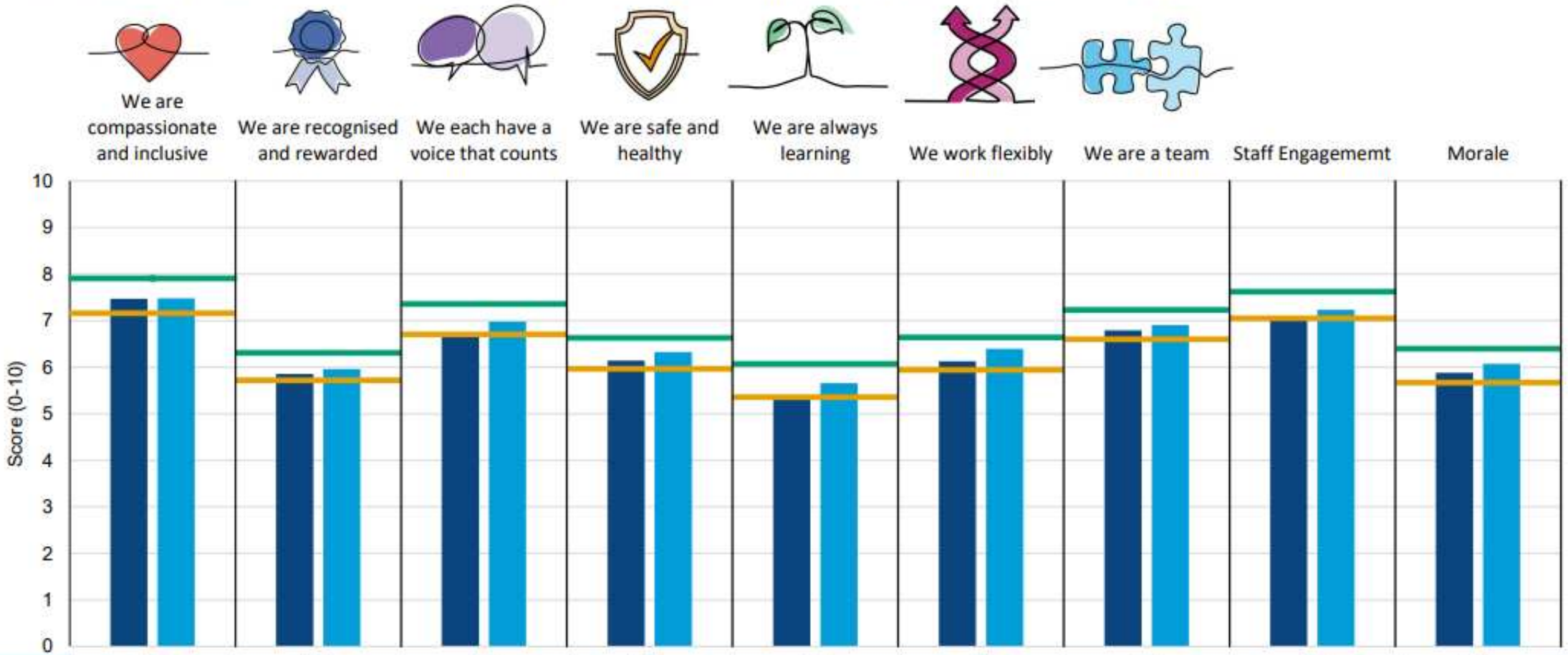
Aspiring to deliver world class patient care

People Promise Elements and Themes: Overview

Survey Coordination Centre

NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.5	5.9	6.7	6.1	5.4	6.1	6.8	7.1	5.9
Best	7.9	6.3	7.4	6.6	6.1	6.6	7.2	7.6	6.4
Average	7.5	6.0	7.0	6.3	5.7	6.4	6.9	7.2	6.1
Worst	7.2	5.7	6.7	6.0	5.4	5.9	6.6	7.1	5.7
Responses	836	834	827	828	806	831	834	836	837

The Positives

➢ *Compassionate Leadership*

Question/statement	2022	2021	Change
My immediate manager works together with me to come to an understanding of problems.	70.3%	66.9%	+3.4%
My immediate manager is interested in listening to me when I describe challenges I face.	73.4%	69.9%	+3.5%
My immediate manager cares about my concerns.	72.7%	68.7%	+3.9%
My immediate manager takes effective action to help me with any problems I face.	69.9%	65.4%	+4.5%

The Positives

- *Discrimination*

Question/statement	2022	2021	Change
On what grounds have you experienced discrimination? - **Gender**	22.6%	28.5%	-5.9%
On what grounds have you experienced discrimination? - **Disability**	9.3%	13.5%	-4.2%%
On what grounds have you experienced discrimination? - **Age**	17.9%	38.7%	-20.8%
But . . .			
On what grounds have you experienced discrimination? – **Sexual orientation**	4.8%	3.6%	+1.2%

Areas for attention

- *Working conditions and burnout*

Question/statement	2022	2021	Change
How often, if at all, do you find your work emotionally exhausting?	35.2%	31.5%	+3.7%
How often, if at all, do you feel burnt out because of your work?	32.8%	29.6%	+3.2%
How often, if at all, do you feel worn out at the end of your working day/shift?	46.4%	40.9%	+5.5%
How often, if at all, do you not have enough energy for family and friends during leisure time?	31.3%	26.6%	+4.7%
There are enough staff at this organisation for me to do my job properly	25.7%	31.8%	-6.1%

Areas for attention

- *Raising Concerns*

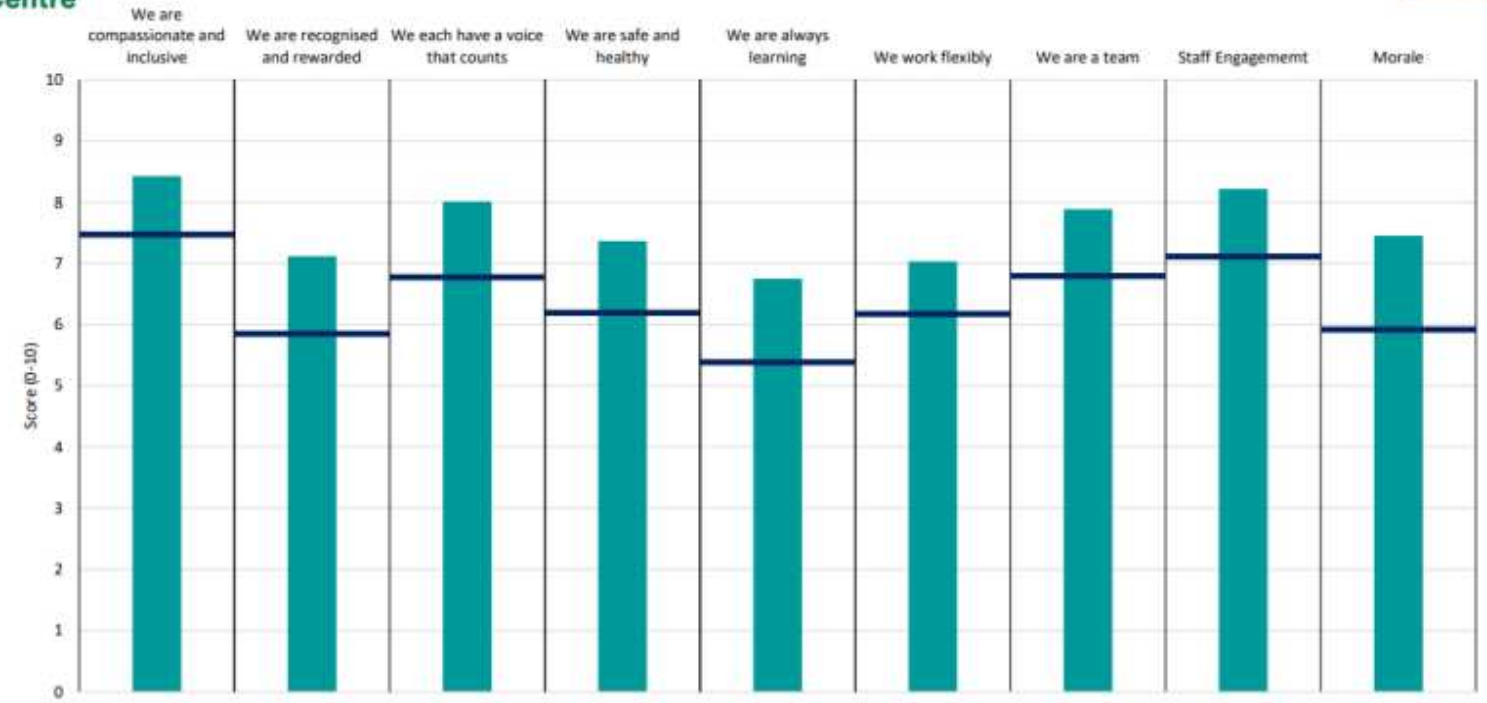
Question/statement	2022	2021	Change
I would feel secure raising concerns about unsafe clinical practice.	70.9%	77.8%	-6.9%
I am confident that my organisation would address my concern.	58.6%	66.8%	-8.2%

Departmental Differences

Survey Coordination Centre

ORLAU

NHS



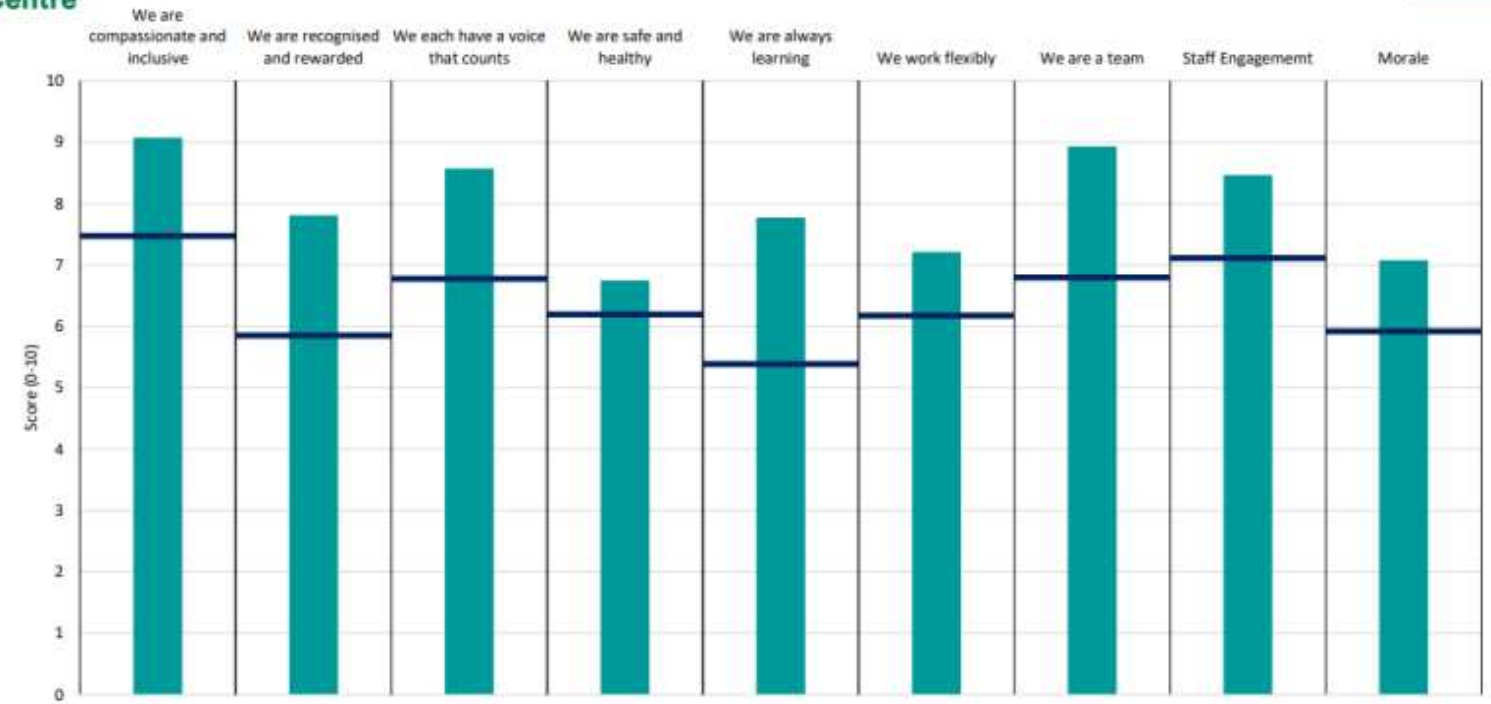
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	8.4	7.1	8.0	7.4	6.8	7.0	7.9	8.2	7.5
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	17	17	16	17	17	17	17	17	17

Aspiring to deliver world class patient care

Departmental Differences

Survey Coordination Centre

SOOS



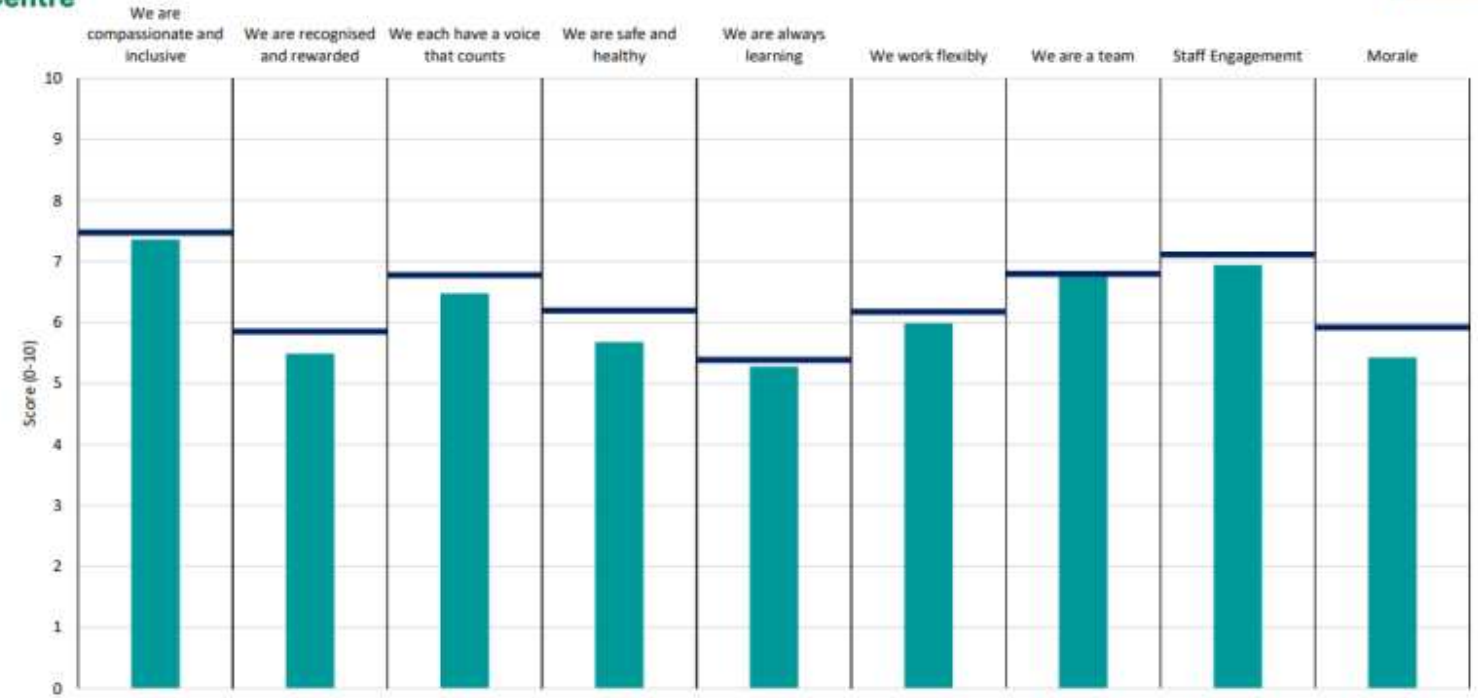
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	9.1	7.8	8.6	6.7	7.8	7.2	8.9	8.5	7.1
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	13	13	13	13	13	13	13	13	13

Aspiring to deliver world class patient care

Departmental Differences

Survey Coordination Centre

Nursing and Midwifery Registered



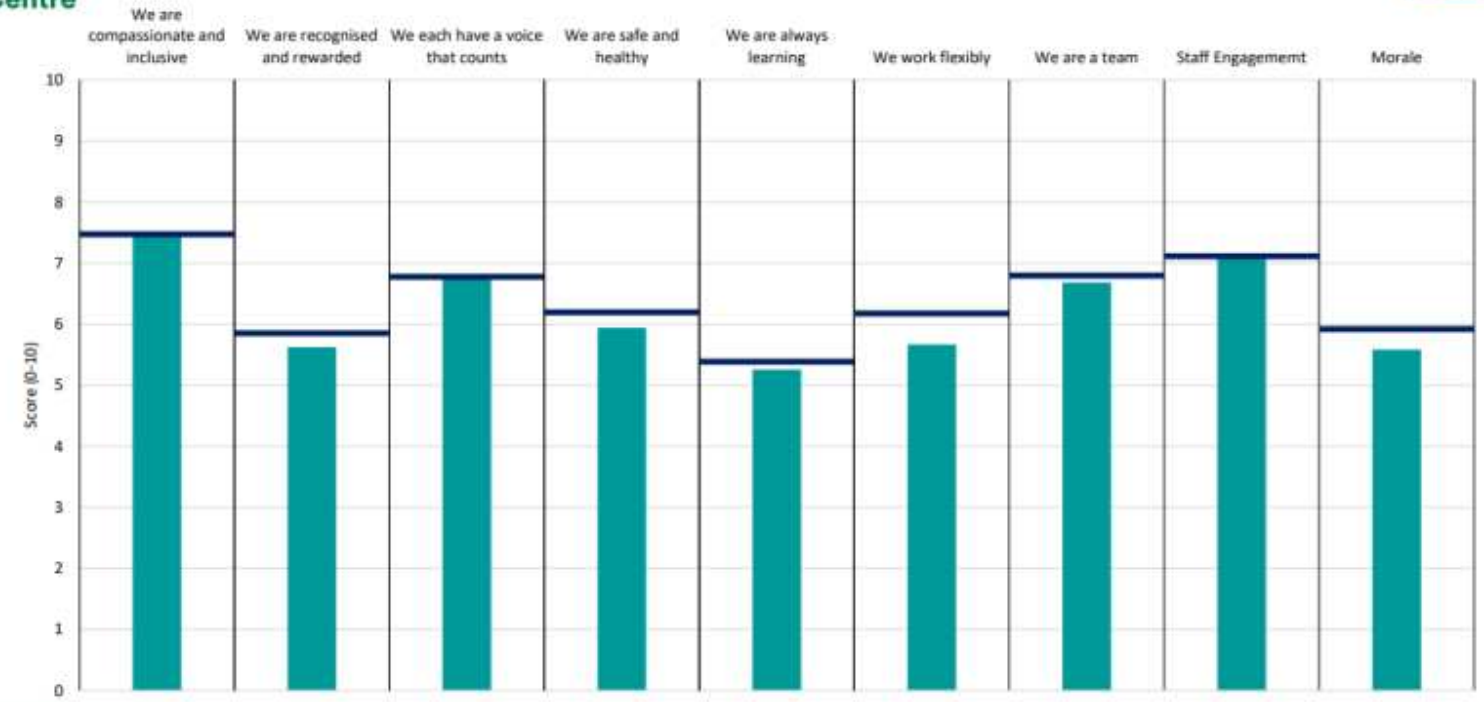
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	7.4	5.5	6.5	5.7	5.3	6.0	6.8	6.9	5.4
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	143	142	140	141	141	142	143	142	143

Aspiring to deliver world class patient care

Departmental Differences

Survey Coordination Centre

Allied Health Professionals



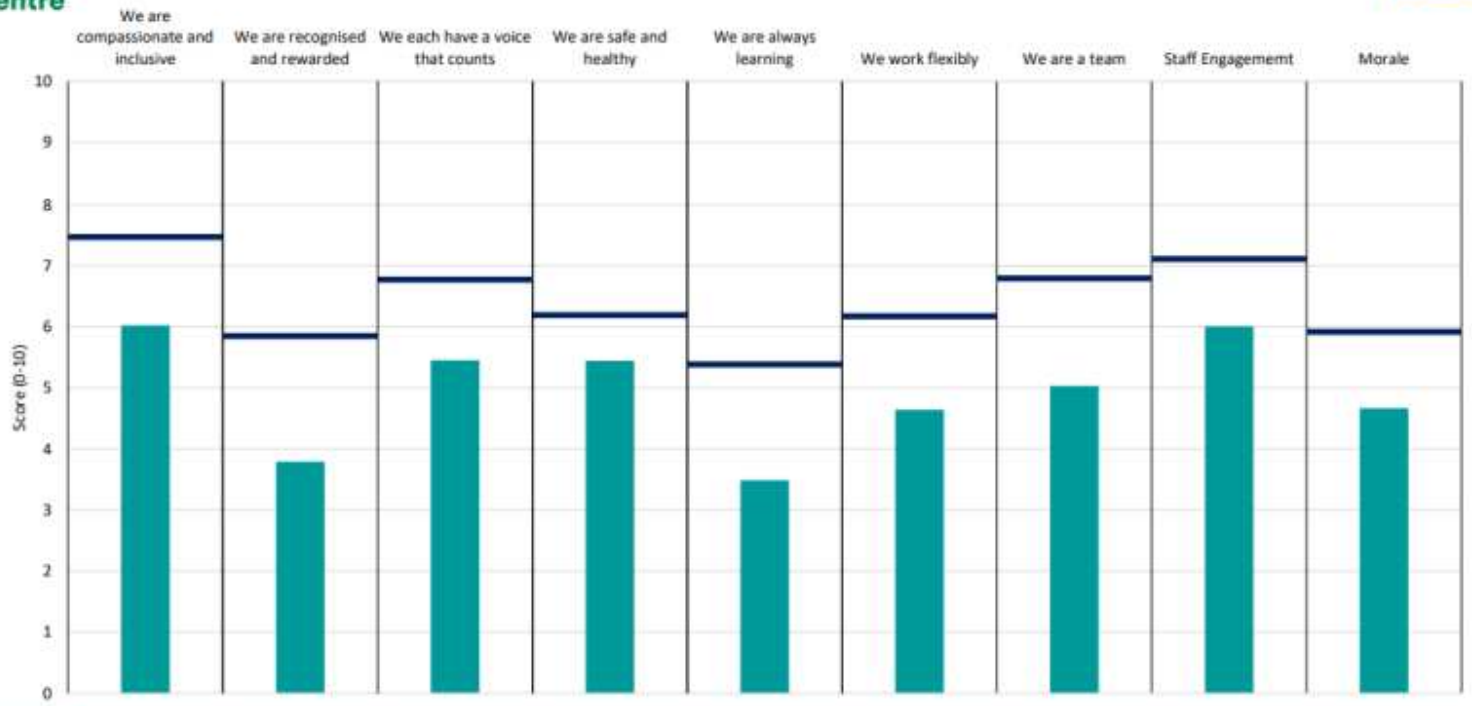
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.5	5.6	6.8	5.9	5.3	5.7	6.7	7.1	5.6
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	113	112	113	112	112	112	113	113	113

Aspiring to deliver world class patient care

Departmental Differences

Survey Coordination Centre

Theatres - Scrub & Anaesthetics



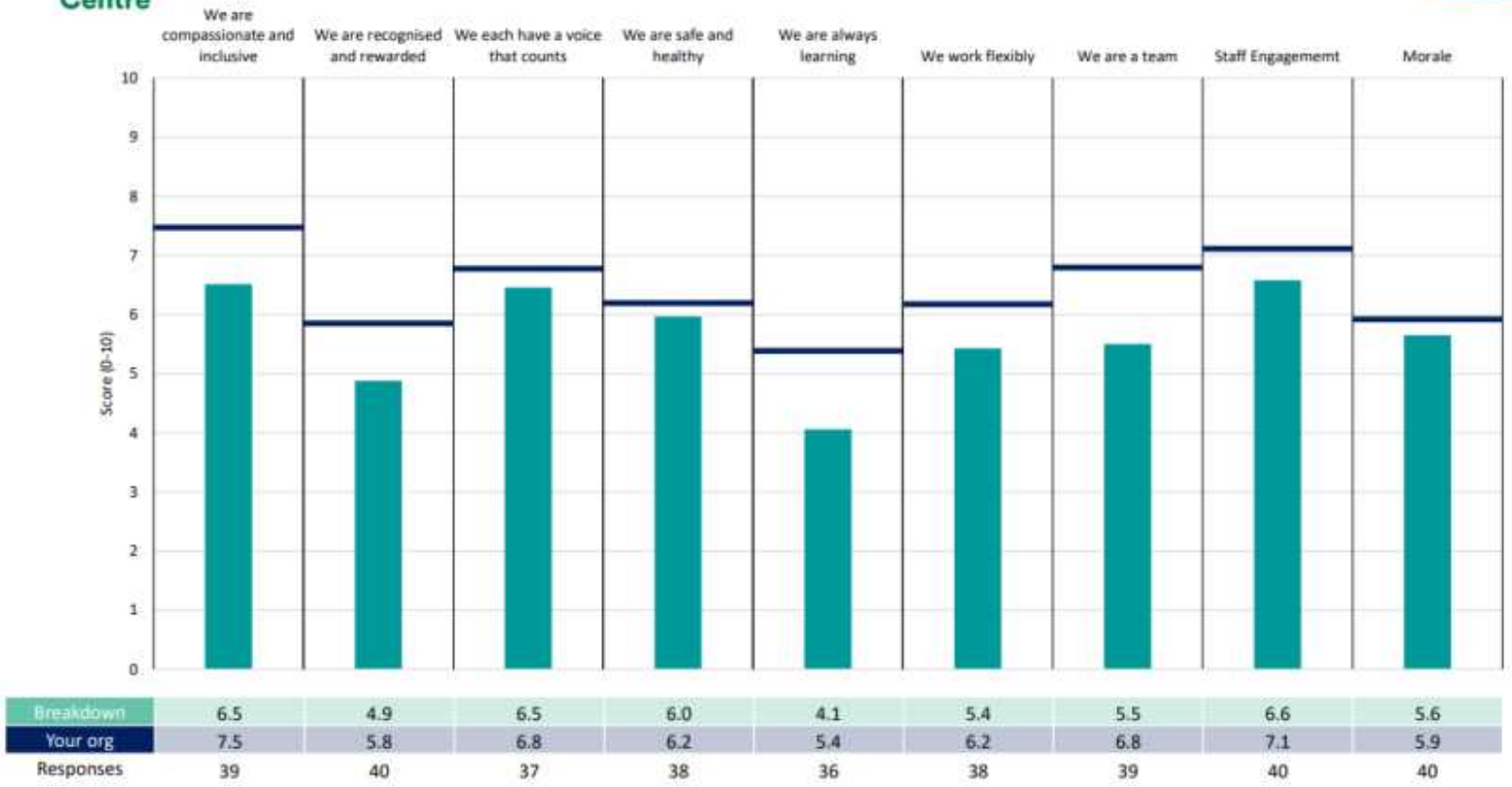
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	6.0	3.8	5.5	5.4	3.5	4.6	5.0	6.0	4.7
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	41	41	41	41	41	41	41	41	41

Aspiring to deliver world class patient care

Departmental Differences

Survey Coordination Centre

Facilities



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	6.5	4.9	6.5	6.0	4.1	5.4	5.5	6.6	5.6
Your org	7.5	5.8	6.8	6.2	5.4	6.2	6.8	7.1	5.9
Responses	39	40	37	38	36	38	39	40	40

Aspiring to deliver world class patient care

Pulse Survey

I look forward to going to work**

44.6% + 2.3 vs. NHS overall +4.6 vs. Wave 28

I am enthusiastic about my job**

56.8% - 0.7 vs. NHS overall -3.2 vs. Wave 28

Time passes quickly when I am working**

69.4% + 2.6 vs. NHS overall -0.6 vs. Wave 28

There are frequent opportunities for me to show initiative in my role**

65.8% + 4.1 vs. NHS overall +25.8 vs. Wave 28

I am able to make suggestions to improve the work of my team / department**

70.3% + 6.6 vs. NHS overall +30.3 vs. Wave 28 70.4 % UK PLC benchmark

I am able to make improvements happen in my area of work**

58.1% + 8.2 vs. NHS overall +18.1 vs. Wave 28

Care of patients / service users is my organisation's top priority**

70.7% + 5.2 vs. NHS overall +10.7 vs. Wave 28

I would recommend my organisation as a place to work**

59.9% + 13.8 vs. NHS overall +19.9 vs. Wave 28 69.2 % UK PLC benchmark

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation**

88.7% + 35.5 vs. NHS overall +8.7 vs. Wave 28

Aspiring to deliver world class patient care

Next Steps

- ***Task and Finish Group*** *– co-produce actions with our staff*
  - *Unit representation*
  - *Clinical representation*
  - *Improvement metholdology*

- ***Pulse Surveys*** *– encourage completion*
  - *Runs quarterly*
  - *Using January as a benchmark*
  - *April survey goes live on Monday*

- ***Richer data*** *– exploring app options to help us understand how our staff are feeling right now, not six months ago*

0. Reference Information

Author:	Liz Hammond, FTSU Guardian	Paper date:	03 May 2023
Executive Sponsor:	Paul Kavanagh-Fields Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	Governance
Forum submitted to:	Board of Directors – Public Meeting	Paper FOIA Status:	Partial

1. Purpose of Paper

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

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q3. The committee is asked to note the content and agree any subsequent recommendations / actions

1.2. Context

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

2. Summary

The number of cases raised has reduced this quarter. The FTSU Champions are settling into their roles and have reported concerns raised in accordance with the National Guardian guidelines.

This quarter FTSU has received two concerns relating to policies and procedures. Theses are recorded as ‘other’ on the national Guardian data base.

3. Conclusion

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

4. The Main Report

4.1. Introduction

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

4.2. Assessment of cases

This 4th Quarter, we have received two concerns. Both concerns were around process. One was about the in equability of paid leave and how it is distributed when attending courses. This has since been resolved as the Champion concerned directed them to their manager who resolved the issue.

The other concern required clarification around a new agreement relating to specialist bank and staff been allowed to go home early as well as receiving double time pay for an early start. This was escalated to the MSK Exec Manager, as the staff member had already spoken to her line manager. Clarification of the issue was feed back to the staff member.

Data For Quarter	April 2022- March 2023				
Organisation	Robert Jones & Agnes Hunt Orthopedic NHS Foundation Trust				
Size of organisation	Small Under 5,000				
Region	Midlands				
		April-June	July-Sept	Oct-Dec	Jan-March
Number of cases brought to FTSUGs per quarter		7	5	5	2
Numbers of cases brought by professional level					
Worker		1	5	5	2
Manager		2	0	0	0
Senior leader		0	0	0	0
Not disclosed		4	0	0	0
Numbers of cases brought by professional group					
Allied Health Professionals		0	0	1	1
Medical and Dental		2	0	0	0
Registered Nurses and Midwives		0	0	0	1
Administrative and clerical		1	3	1	0
Additional professional scientific and technical		0	1	1	0
Additional clinical services		0	0	1	0
Estates and ancillary		0	0	1	0
Healthcare scientists		0	0	0	0
Students		0	0	0	0
Not Known		0	0	0	0
Other		4	1	0	0
Of which there is an element of					
Number of cases raised anonymously		4	0	0	0
Number of cases with an element of patient safety/quality		3	1	1	0
Number of cases with an element of worker safety or wellbeing		0	1	1	0
Number of cases with an element of bullying or harassment		0	0	2	0
Number of cases with an element of other inappropriate attitudes or behaviours		1	1	1	0
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated					
Response to the feedback question,					
'Given your experience, would you speak up again?					
Total number of responses					
The number of these that responded 'Yes'		1	1	0	0
The number of these that responded 'No'		1	0	0	0
The number of these that responded 'Maybe'		0	0	0	0
The number of these that responded 'I don't know'		0	0	0	0

Until the end of Quarter 4, 22/23 four concerns remain open.

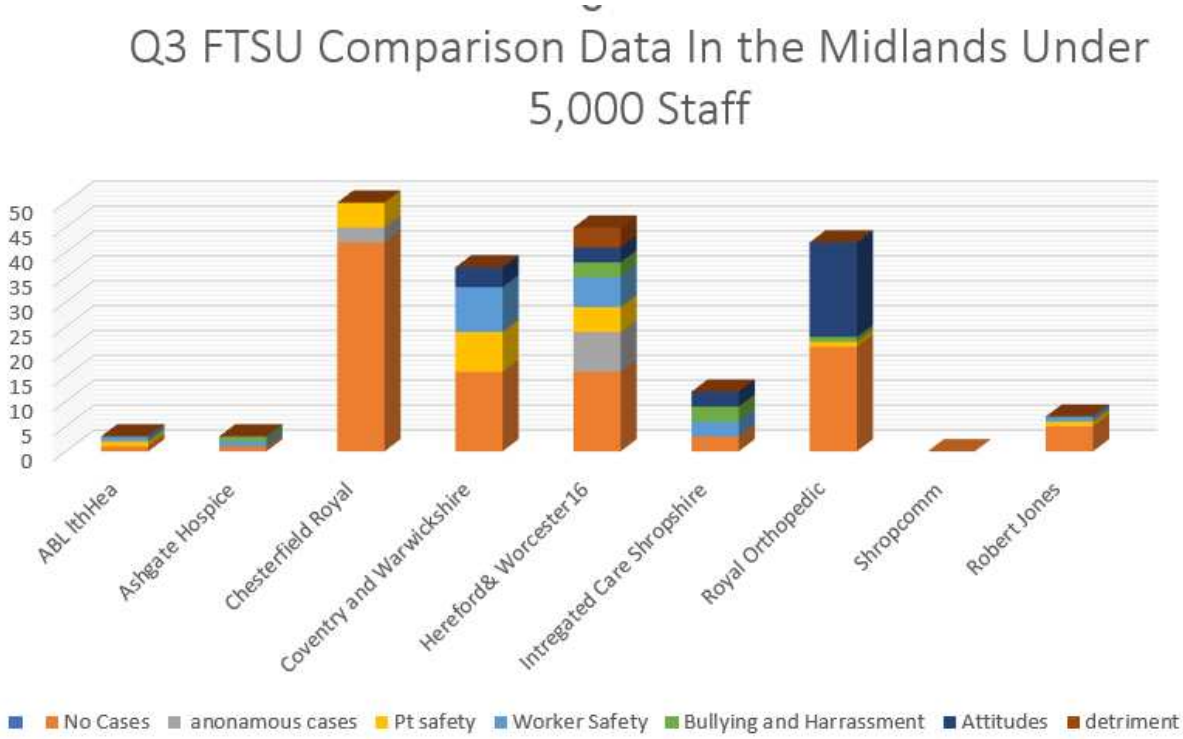
Reasons for cases remaining open are: -

Complex employee relation issues,

Cases are being actively addressed and awaiting the feedback from the investigations.

The number of concerns raised are lower than previous quarters. There are two departments which remain a concern. This area has been highlighted to the Executives and Managing director of MSK. The cases remain active. They include Powys and 2x Therapies and one corporate.

Chart from National FTSU Guardian Data



The above graph gives a comparison of Trusts in the Midlands which are considered small Trust. However, small is quantified as up to 5,000 workers.

When compiling the data, it must be noted that some concerns come under more than one theme, this then amplifies the number on concerns made.

The latest accessible data is from Q3. RJAH had no anonymous concerns raised in comparison to Hereford and Chesterfield Royal.

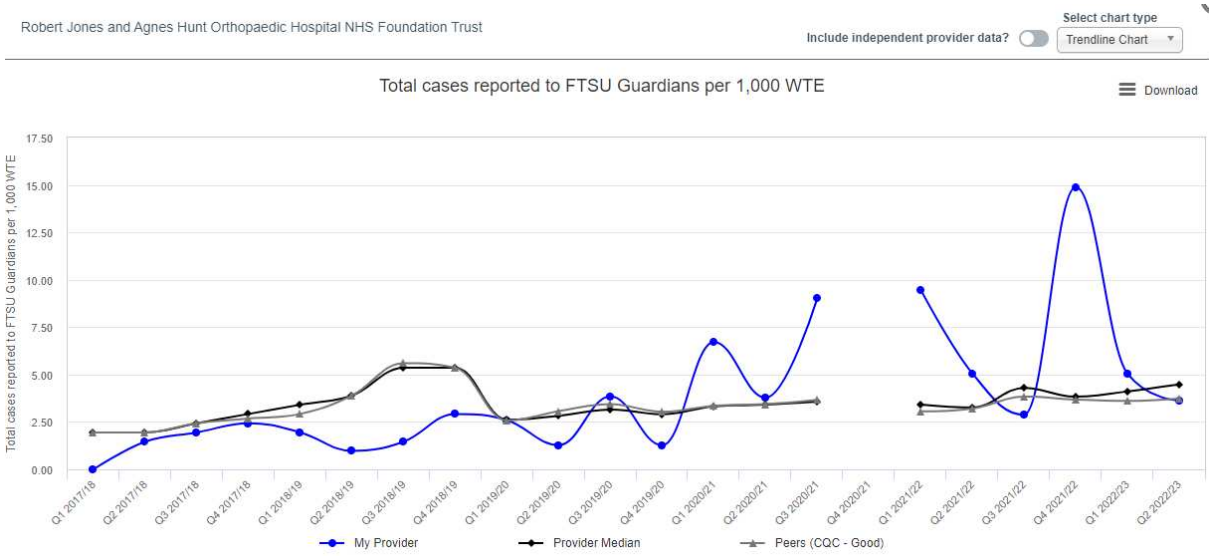
Shropshire Community Trust have not submitted any data for the last 2 years.

The Royal Orthopaedic Trust, which is similar in size, to RJAH, have had a high proportion of concerns raised about attitudes and behaviours in comparison the RJAH. RJAH and the Royal Orthopaedic have the same number of concerns raised about bullying and harassment and Pt safety.

RJAH has received more concerns raised, in Q3, than ABL Health, Ashgate Hospice and Shropshire ICS.

The model health latest data shows the total number of cases, over a period of five years, reported to the FTSUG in comparison to peer Trusts, rated as good by the CQC.

Chart taken from Model Health System Q2



Learning and Improvement

Learning and improvement is a challenge as may concerns raised are often individual difficulties and queries. However, most issues are due to poor communication and staff finding it difficult to approach and discuss the concern with their managers.

In Q4 both cases required advice and reassurance about the process of raising their concerns. Both staff members did raise the issue with their manager. Feedback from one manager could not answer the questions the staff member raised.

Training packages for Managers on how to deal with staff speaking up have been developed. The FTSU Guardian will be attending the Senior Management Teams monthly meeting in March to deliver this training session. Trust wide FTSU training is required for all Managers.

FTSU is triangulating the RJAH NGO data with Datix.

Feedback HEE training package will be completed by the Board members in April 2023. The previous session was cancelled.

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

FTSU Guardian attended the FTSU Conference. Guest speakers included Dr Jayne Chidgey-Clark National Freedom to Speak Up Guardian.

Importance of Freedom to Speak Up in healthcare Chris Hopson, Chief Strategy Officer, NHS England.

Speaking truth to power: Employee activism Megan Reitz, Director Ashridge Business School and author of Speak Up: Say What Needs to Be Said and Hear What Needs to Be Heard.

Freedom to Speak Up, a regulator's perspective Ian Trenholm, Chief Executive, Care Quality Commission.

Freedom to Speak Up, an integrated perspective Mark Fisher, Chair of Greater Manchester Integrated Care Board

Leading in Practice Lord Evans, chair Committee on Standards in Public Life.

FTSUG attends monthly regional meetings where updates and good practice is shared.

Feedback

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

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

No Staff members have responded to the feedback about their experience of FTSU service they received in Q4.

When the outcomes of the two investigations have been shared the learning needs to be implemented and recommendations implemented.

Patient Safety or worker experience issues

Themes:

FTSU has been contacted by 2 members of staff this quarter. Both issues had an element of inequality and one with an element of fraud.

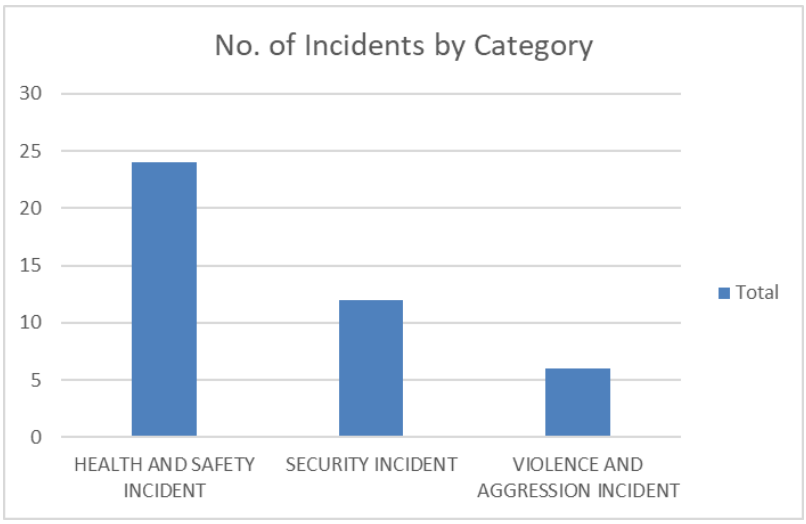
One issue was directed to the Union and the other issue was directed to the MSK executive.

Patient Safety:

The Trusts DATIX system has had 59 moderates to severe patient safety incidents in this quarter.

Worker Safety:

The Trust Datix system has captured 42 worker safety incidents. The Trust DATIX concerns do not capture the concern raised to FTSU and there are no themes that linked to FTSU concerns.



Bullying and Harassment:

There has been no bully and harassment, or attitudes and behaviours concerns raised this quarter.

The Trust Datix system has captured two cases of bullying behaviour within this quarter. The concerns came from different departments.

Increased triangulation of data is required, with the quality and inclusion. At the present time this post is vacant

4.3. Actions to improve FTSU culture.

- FTSU is impartial and confidential service.
- All concerns raised have been responded to within 48hrs and escalated if required or signposted to the appropriate department.
- Severn Champions have been trained to promote FTSU, support and signpost anyone, raising a concern, to the appropriate person. Confidentiality and a person's right to anonymity has been a key theme in the training.
- There have been no cases of anyone, who has raised a concern, reporting that they have suffered detriment due to speaking up.
- An intranet page, on Percy, specifically for FTSU is available for information and contact details of the Guardian and Champions.
- Posters identifying Exec Lead. Non-Exec, Guardian and Champions have been produced. Each department will receive a copy of these posters.
- To improve the skills, knowledge, and capability of workers to speak up Speak up and Listen Up sessions are required in all departments. Staff need to be given the tools to enable them to Speak up.
- Making HEE FTSU training would advantageous.
- FTSU presentations will start in April 2023
- A visible presence of the FTSUG around the Trust. This is restricted at this time due to ringfenced time available, to fulfil the basic requirements of the role.
- Engagement with the FTSU Guardian with departments with low DATIX reporting, repeat DATIX incidents and autonomous intervention to support staff involved in a Serious Incident with the remit of learning and improvement.

4.4. Recommendation

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

- Ensure there are visible FTSU posters accessible for all staff.
- All managers to feedback and liaise with the FTSUG about actions and learning to provide a feedback loop and share learning experiences.
- A visible presence of the FTSUG around the Trust. This is restricted at this time due to ringfenced time available, to fulfil the basic requirements of the role. An additional 7.5 hours has been allocated to the other 7.5 hours for the FTSUG which will commence in June 2023
- Consider whether FTSU HEE training packages should be mandated.
- Consider enhanced, bespoke FTSU training for all Managers and Staff.
- Consider utilizing FTSU Guardian as an autonomous worker to support staff who are involved in clinical incident and analyse the factors which lead to the incident so that the Trust can learn and make improvements whilst promoting a no-blame culture.

2.5 Conclusion

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

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	03 May 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	People and Culture Committee	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

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

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period Jul 2022

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

3.2.2 Exception reports (regarding working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Apr-22	0
May-22	0
Jun-22	0
Jul-22	0
Aug-22	1 st3 staff grade on spines +1 long term sickness
Sep-22	1 st3 staff grade on spines +1 long term sickness
Oct-22	1 st3 staff grade on spines +1 long term sickness
Nov-22	1 st3 staff grade on spines +1 long term sickness
Dec-22	1 st3 staff grade on spines +1 long term sickness
Jan-23	1 st3 staff grade on spines +1 long term sickness
Feb-23	1 long term sickness

Vacant shifts

Apr-22	0
May-22	4
Jun-22	2
Jul-22	11
Aug-22	1
Sep-22	6
Oct-22	2
Nov-22	6
Dec-22	2
Jan-23	7
Feb-23	1

Total cost - £22620

Medicine

Number of Vacancies (12 posts)

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

Vacant shifts

Apr-22	36
May-22	35
Jun-22	37
Jul-22	33
Aug-22	11
Sep-22	11
Oct-22	10
Nov-22	15
Dec-22	25
Jan-23	13
Feb-23	4
Mar-23	9

Total Cost £128321.69

MCSI

Number of Vacancies (9 posts)

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

Vacant Shifts

Apr-22	5
May-22	5
Jun-22	0
Jul-22	3
Aug-22	11
Sep-22	13
Oct-22	13
Nov-22	10
Dec-22	16
Jan-23	7
Feb-23	9

Total cost - £ 22520.20

Long Term Vacant Shifts

- MCSI has two vacancies
- T&O has run between one and two vacancies
- Medicine has a single vacancy

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended 01/02/2023, further mid-term induction scheduled

Guardian has engaged with External Audit agency MIAA (Simon Davies). Annual report produced as per recommendations.

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

Recent Junior Doctors strike action has been managed. An issue with a Junior undertaking locum work during this period which would have seen them in breach of hours and required rest was addressed proactively before this could occur. The individual has been contacted to highlight their responsibilities under the terms of the Junior Doctors Contract. The issue generally will again be highlighted at the next JDF. It is formally addressed during induction.

This report has been produced before the next scheduled four-day strike action.

3.3.2 Software System

Engagement with Allocate has occurred. We are moving to go live with Allocate Exception reporting. We still do not have a go live date. This has been an incredibly slow process.

3.3.3 Administrative support

Locally, difficulties obtaining the higher-level data to allow for a complete report have frequently occurred and are ongoing. There has been improvement, but the process is still not robust. Responsible personnel are identified and engaged with. A central area for collation of data is to be produced with a clear timetable for populating. It is hoped this will facilitate data collection for the report in a timely manner.

Associated Risk

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

A recent issue with trainees on a central English contract through RJAH but placed in North Wales has been identified. Whilst the concern was one of contracted hours and appropriate pay, it raised the question of the role of the GJDWH, as this is not one that is recognised currently in Wales.

It is felt that the Guardian would be unable to impose TOIL or fines in cases of exception reports from such trainees. Rather, they can only engage with the appropriate Clinical Leads and the Training Programme to try and settle any concerns.

This is a highly unusual and geographical problem to the Trust and one which will have to be observed for further developments.

Next Steps

Safe Working Hours: Doctors in Training

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

Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis, Guardian of Safe Working

Trust Board - Performance
March 2023 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

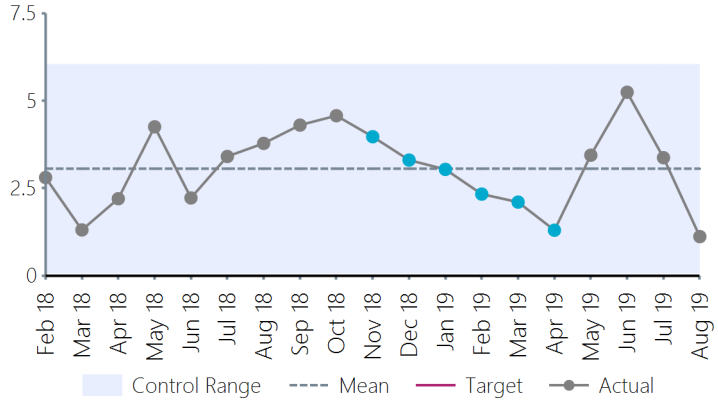
Some examples of these are shown in the images to the right:

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

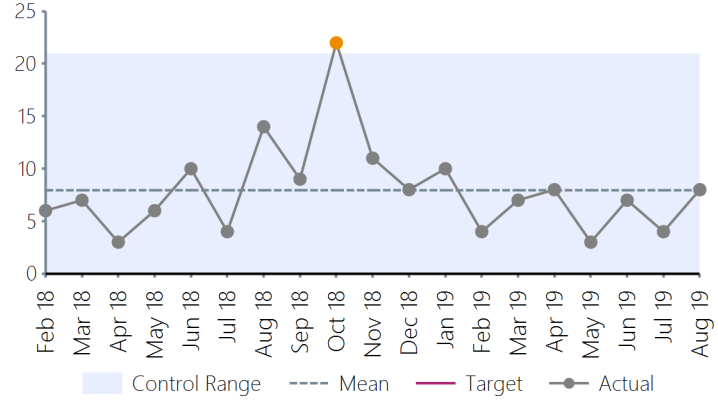
b) shows a point of concern sitting above the control range.

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

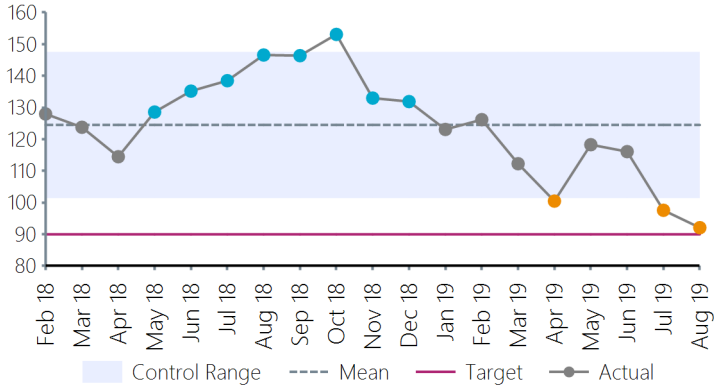
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Cancer Plan 62 Days Standard (Tumour)*	85.00%	100.00%			?		24/06/21
28 Day Faster Diagnosis Standard*	75.00%	80.77%			?		
18 Weeks RTT Open Pathways	92.00%	54.18%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,227	1,711	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		892			No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	75	247	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		196	539	L	No Target	+	
Patients Waiting Over 104 Weeks - English	0	6	0	L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		50	118	L	No Target	+	
Overdue Follow Up Backlog	5,000	12,777		L	F	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
6 Week Wait for Diagnostics - English Patients	99.00%	91.15%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	98.94%				+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,252	899	1,060			+	24/06/21
Overall BADS %	85.00%	76.92%				+	
Bed Occupancy – All Wards – 2pm	87.00%	83.76%					09/03/22
Total Outpatient Activity against Plan (volumes)	16,674	13,354				+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	5.86%				+	
Total Diagnostics Activity against Plan - Catchment Based	2,835	2,977				+	

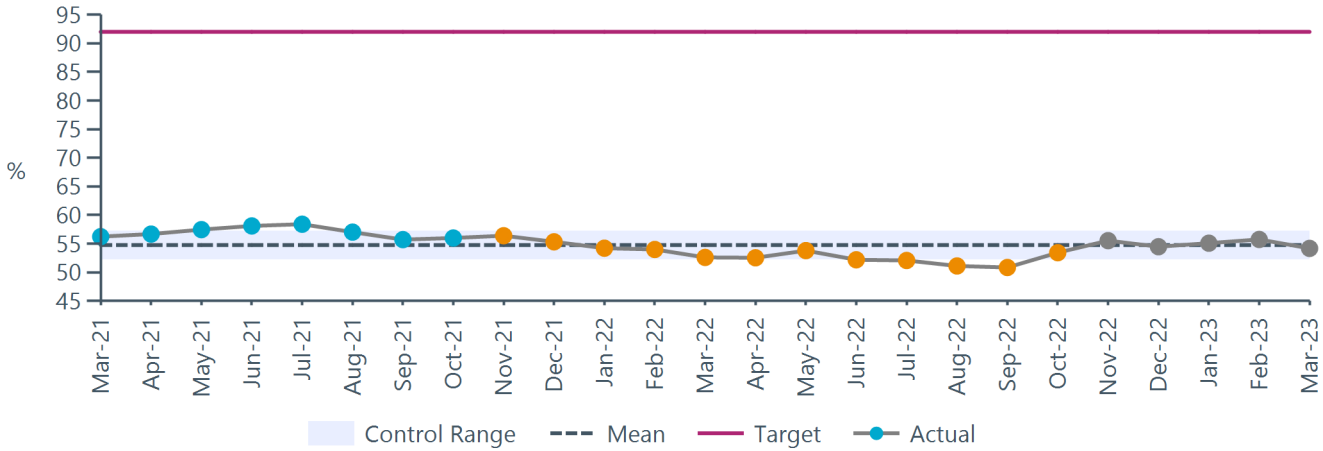
18 Weeks RTT Open Pathways

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	54.18%		F

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

Our March performance was 54.18% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:
* MS1 – 8698 patients waiting of which 2417 are breaches
* MS2 - 1337 patients waiting of which 904 are breaches
* MS3 - 4993 patients waiting of which 3565 are breaches

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patient choice / specific specialties
* Develop plans to reduce 52 week waits with ambition to eliminate them by March 2025

Actions

The Trust has been focusing on treatment of its longest waits. Agreements made for mutual aid support with both ROH and Walton. Patients being contacted and transferred where appropriate.

Plans to undertake significant level of patient validation to be undertaken; in addition to the routine validation cycles.

Planning assumptions for 2023/24 include increases in capacity throughout the year aligned to productivity and estates programmes of work. These will be reflected within the IPR trajectories in the next financial year.

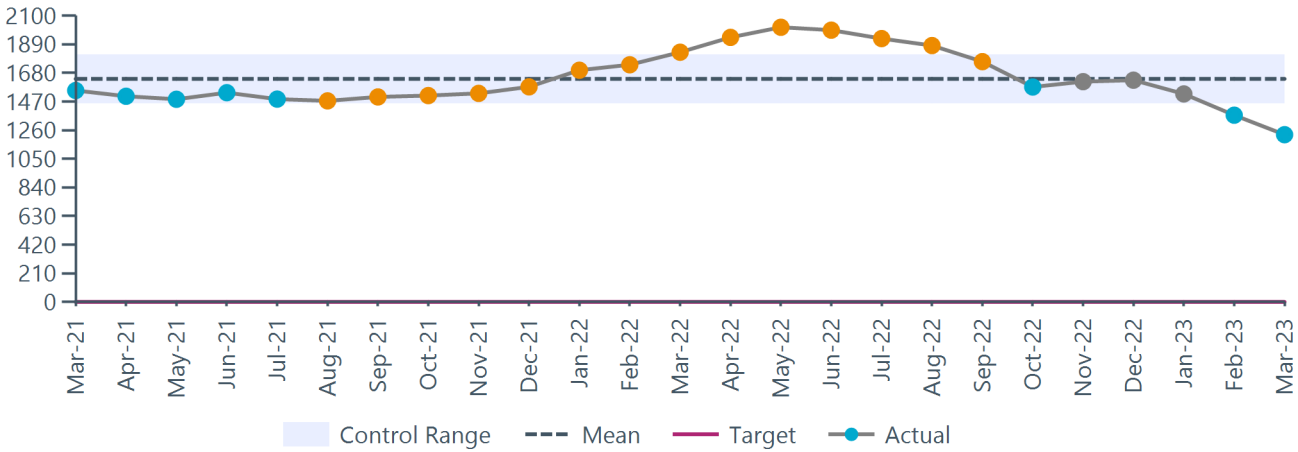
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
52.60%	52.54%	53.79%	52.19%	52.07%	51.11%	50.84%	53.43%	55.53%	54.47%	55.09%	55.74%	54.18%

Patients Waiting Over 52 Weeks – English

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,227	L	F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of March there were 1227 English patients waiting over 52 weeks; below our trajectory figure of 1711 by 484. The patients are under the care of the following sub-specialities; Arthroplasty (359), Spinal Disorders (310), Knee & Sports Injuries (209), Upper Limb (156), Foot & Ankle (138), Paediatric Orthopaedics (17), Metabolic Medicine (11), Spinal Injuries (7), Orthotics (6), Neurology (3), Tumour (3), Paediatric Medicine (1), Physiotherapy (1), Geriatrics (1), Other(5)

The number of patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 1152 patients
* >78 to <=95 weeks - 58 patients
* >95 to <=104 weeks - 11 patients
* >104 weeks - 6 patients

2022/23 operational planning guidance stipulates that Trusts should:

* Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties

The submitted plans have been reflected in the trajectory line above.

Actions

The national planning requirements issued in December stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). This is to support longer term improvements to get back to 52 weeks standards. 65+ week position visibility will appear in IPR within the next financial year. The focus will be on those patients that will trip-in to 65+ weeks within the 23/24 financial year. The Trust has submitted a plan to NHSE that forecasts zero 65+ weeks waits by March-24.

The Trust has a continuous validation programme in place whilst these patients continue to wait.

Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible.

Internal insourcing options are being explored to further increase capacity.

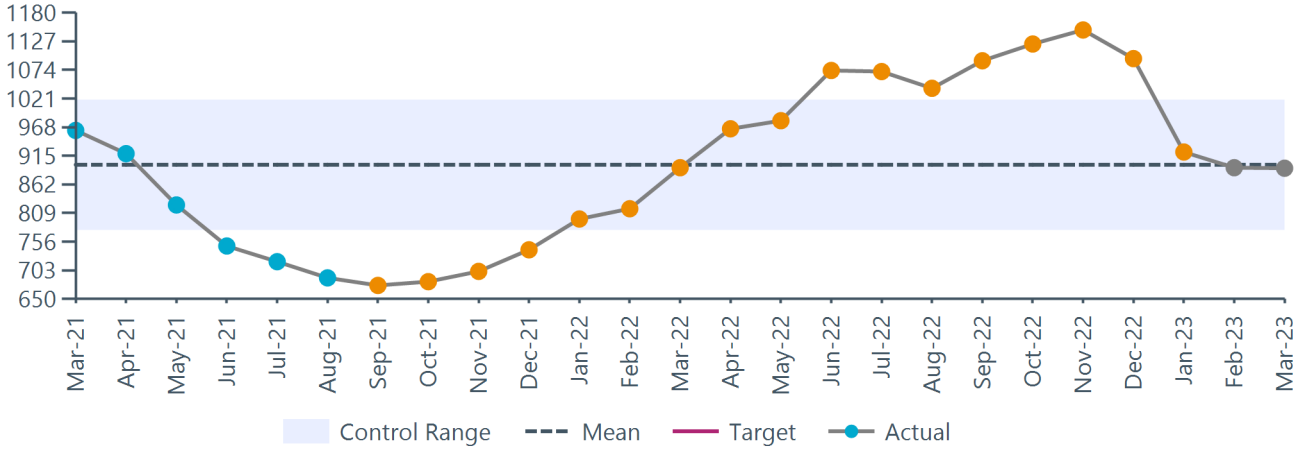
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
1832	1941	2015	1994	1932	1881	1763	1577	1616	1627	1526	1370	1227

Patients Waiting Over 52 Weeks - Welsh (Total)

Patients Waiting Over 52 Weeks - Welsh (Total) - Welsh and Welsh (BCU Transfers) combined 217788

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	892		No Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of March there were 892 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (420), Arthroplasty (148), Knee & Sports Injuries (104), Upper Limb (88), Foot & Ankle (72), Veterans (24), Paediatric Orthopaedics (23), Tumour (6), Metabolic Medicine (3), Neurology (2), Spinal Injuries (1), and Rheumatology (1).
The patients are under the care of the following commissioners: BCU (522), Powys (355), Hywel Dda (12), Cardiff & Vale (1)< Aneurin Bevan (1), and Cwm Taf University LHB (1). The number of patients waiting, by weeks brackets is:
* >52 to <=78 weeks - 696 patients
* >78 to <=95 weeks - 123 patients
* >95 to <=104 weeks - 23 patients
* >104 weeks - 50 patients

The Welsh Government issued their elective recovery guidance on the 26 April-22 where it stipulates the following:
* Eliminate the number of people waiting longer than one year in most specialties by Spring 2025
* Eliminate the number of people waiting longer than two years in most specialties by March 2023

Actions

The Welsh guidance differs from NHS England guidance. The Trust continues to monitor equity across our commissioners whilst recognising guidance and differences in pathway monitoring. The NHS England national planning requirements issued in December stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). This is to support longer term improvements to get back to 52 weeks standards. 65+ week position visibility will appear in IPR within the next financial year. The focus will be on those patients that will trip-in to 65+ weeks within the 23/24 financial year. Trajectories for our Welsh Commissioners are in development.

The Trust has a continuous validation programme in place whilst these patients continue to wait.

Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible.

Internal insourcing options are being explored to further increase capacity.

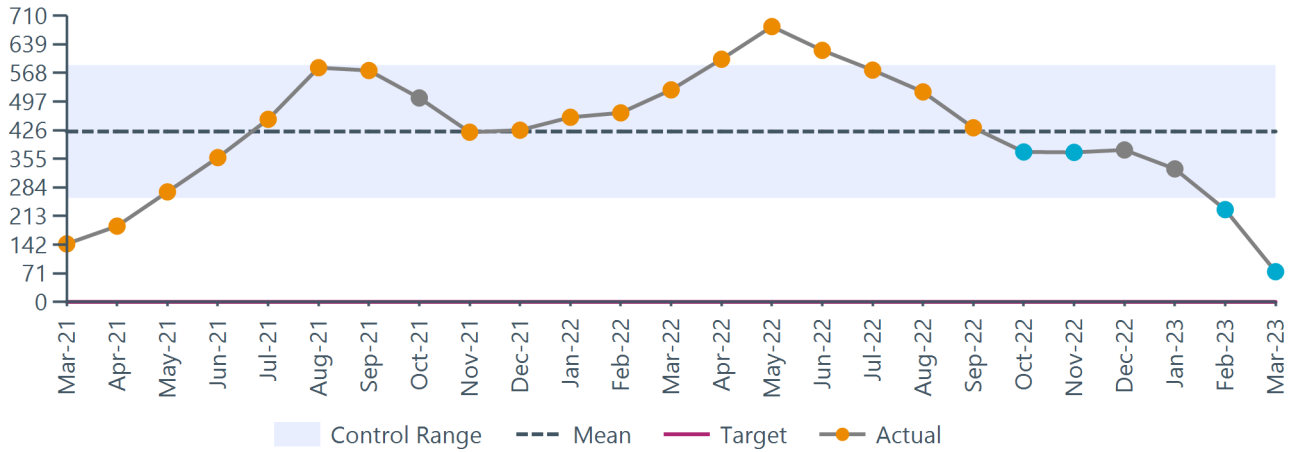
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
893	965	980	1073	1071	1040	1091	1122	1148	1095	922	893	892

Patients Waiting Over 78 Weeks - English

Number of English RTT patients waiting 78 weeks or more at month end 217774

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	75	L	F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of March there were 75 English patients waiting over 78 weeks; this was 172 patients below our trajectory of 247. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Spinal Disorders (44), Knee & Sports Injuries (9), Arthroplasty (8), Upper Limb (5), Foot & Ankle (2), Paediatric Orthopaedics (2), Orthotics (2), Spinal Injuries (1), Other (1) and Metabolic Medicine (1).

36 patients declined the offer of mutual aid leading to non-admitted clock stops; the patients remain on our internal waiting lists. This is in line with updated national guidance.

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 by July 2022 - exceptions are patients choice / specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patients choice / specific specialties
The submitted plans have been reflected in the trajectory line above.

Actions

As part of 23/24 planning, our Trust trajectory has been submitted to NHSE to clear this cohort in quarter 1. In line with national planning expectations the Trust aims to further reduce long waits to less than 65 weeks by March-24. Trajectories have been created for this.

The Trust has sought mutual aid to support its most challenged specialty. Agreements made with both ROH and Walton for support. Patients being contacted and transferred where appropriate.

Agreement in place to participate in the Digital Mutual Aid system that is being led by NHS England. A mutual aid co-ordinator and validation resource are in place and this resource has been extended into 23/24 to support actions being taken. Support is in place with a system provider for RJAH to accept non-spinal disorders 78+ weeks patients due to continued Orthopaedic pressures at the other provider.

Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible.

Internal insourcing options are being explored to further increase capacity.

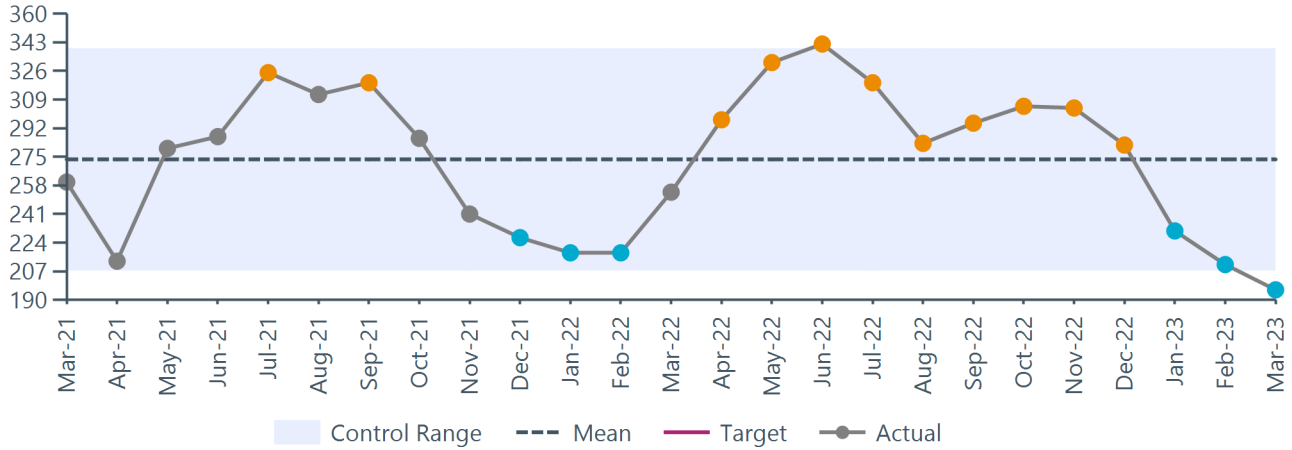
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
526	602	683	624	575	521	432	372	371	377	330	229	75

Patients Waiting Over 78 Weeks - Welsh (Total)

Patients waiting over 78 Weeks - Welsh (Total) 217802

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	196	L	No Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of March there were 196 Welsh patients waiting over 78 weeks; this was 343 patients below our trajectory of 539. The Trust plans are visible in the trajectory line above.

The patients are under the following sub-specialties; Spinal Disorders (162), Knee & Sports Injuries (15), Veterans (4), Foot & Ankle (4), Arthroplasty (3), Upper Limb (3), Paediatric Orthopaedics (2), Spinal Injuries (1), Metabolic Medicine (1) and Tumour (1).

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients in milestone 1 and there has been a focus to date patients currently waiting in this milestone, utilising capacity across the consultant workforce. Trajectories are currently in development for our Welsh Commissioners.

There have been Welsh Commissioner enquiries requesting to be part of national NHSE mutual aid efforts. This is to be further explored with regional teams.

Internal pooling is underway to further support progressing our longest waits.

Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible.

Internal insourcing options are being explored to further increase capacity.

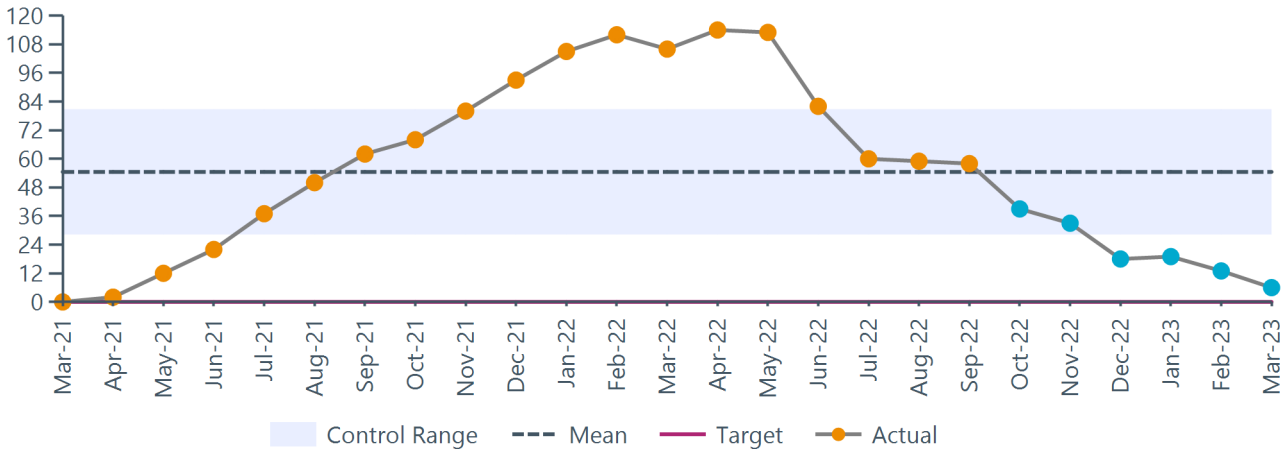
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
254	297	331	342	319	283	295	305	304	282	231	211	196

Patients Waiting Over 104 Weeks - English

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	6	L	F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of March there were 6 English patients waiting over 104 weeks. This was 6 patients above our trajectory of 0. Breakdown by sub-specialty below:

* Spinal Disorders (5) - of these spines patients, 4 are ROH transfers remaining on RJAH waiting lists until treatment complete. 1 complex patient had TCI cancelled due to industrial action.
* Arthroplasty (1) - non-spines patient had a clinical requirement for period of time between treatment

By Milestone, there were: - please note ROH patients are reported at stage of transfer and not reflective of current ROH stage
* Milestone 1 (Outpatients) - 2 patients
* Milestone 2 (Diagnostics) - 1 patients
* Milestone 3 (Electives) - 3 patients

36 patients declined the offer of mutual aid leading to non-admitted clock stops; the patients remain on our internal waiting lists. This is in line with updated national guidance.

Actions

The Trust has been taking actions that helps reduce trip-ins in subsequent months. Actions for all patients include:

* Review and application of revised interim choice guidance, issued by NHSE, continues
* Continued operational and executive discussions with the Trust's surgeons on the longest waiting patients.
* Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible
* Internal insourcing options are being explored to further increase capacity

Spinal Disorders: - actions include:
* Agreements made with both ROH and Walton for support. Patients being contacted and transferred where appropriate.
* Regular 104+ meetings held within the Trust; chaired by Chief Operating Officer or Managing Director of Specialist Unit
* Additional lists identified with consultants and being mobilised where possible.

Non-Spinal Disorders:
* We continue to support a system partner with their longest waits and clinically urgent patients.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
106	114	113	82	60	59	58	39	33	18	19	13	6

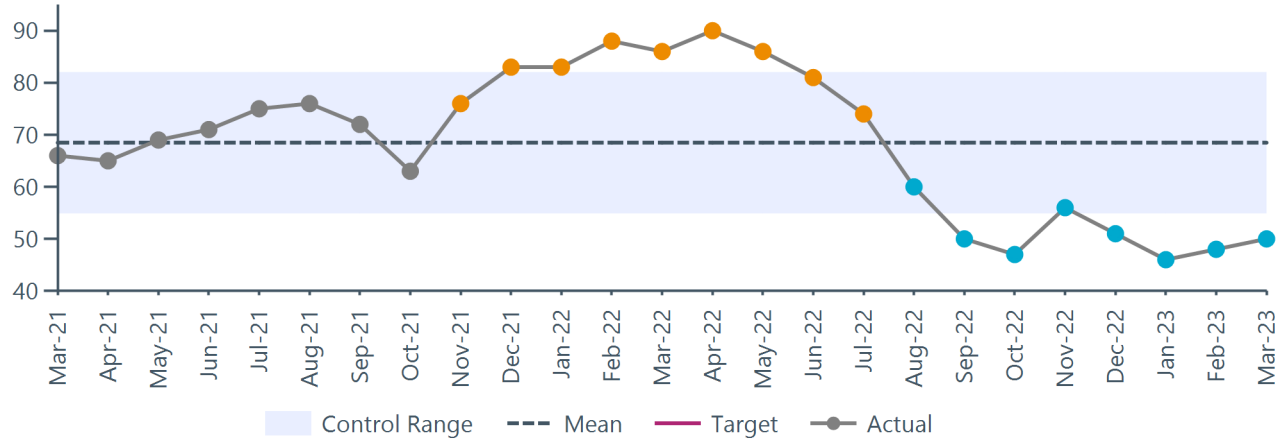
Patients Waiting Over 104 Weeks - Welsh (Total)

Patients Waiting Over 104 Weeks - Welsh (Total) 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	50	L	No Target

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of March there were 50 Welsh patients waiting over 104 weeks: below our trajectory figure of 118 by 68.

The patients are under the care of the following subspecialties:
* Spinal Disorders (48)
* Veterans (1)
*Upper Limb (1)

By Milestone, there were:
* Milestone 1 (Outpatients) - 6 patients
* Milestone 2 (Diagnostics) - 12 patients
* Milestone 3 (Electives) – 32 patients

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients in milestone 1 and there had been a focus to date patients currently waiting in this milestone, utilising capacity across the consultant workforce. Trajectories for Welsh patients are currently in development.

There have been Welsh Commissioner enquiries requesting to be part of national NHSE mutual aid efforts. This is to be further explored with regional teams.

The Trust continues to ensure oversight of all commissioners and their long waits and balance this with clinically urgent.

Continued operational and executive discussions with the Trust's surgeons on the longest waiting patients. The Trust has a harms review process in place.

Industrial Action impacts; the Trust is prioritising clinical urgent and longest waits wherever possible

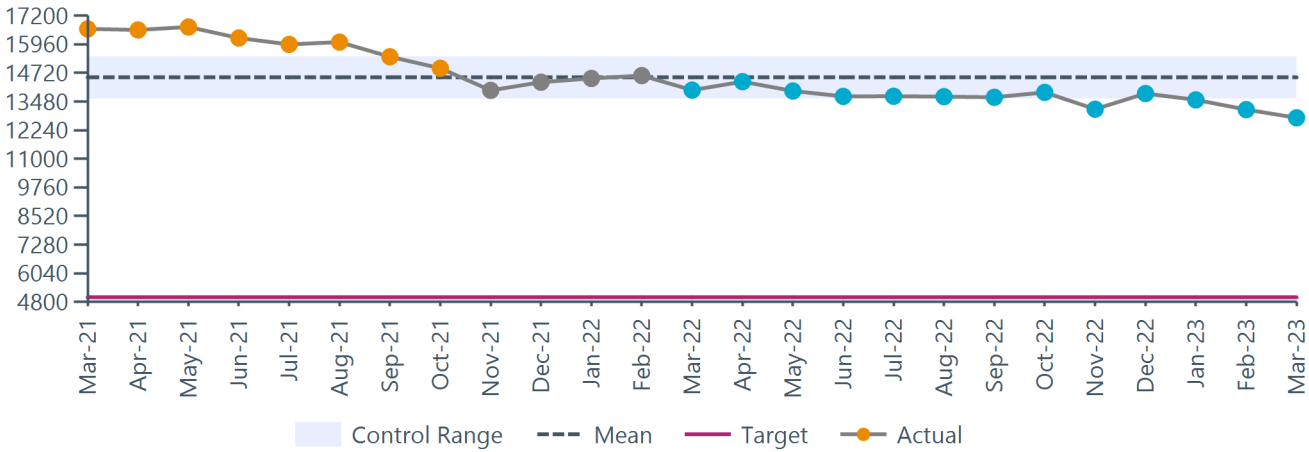
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
86	90	86	81	74	60	50	47	56	51	46	48	50

Overdue Follow Up Backlog

All dated and undated patients that are overdue their follow up appointment 217364

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	12,777	L	F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of March, there were 12777 patients overdue their follow up appointment. This is broken down by:
* Priority 1 - 8505 with 1407 dated (17%) (priority 1 is our more overdue follow-up cohort)
* Priority 2 - 4272 with 1381 dated (32%);

The backlog reduced by 355 from last month, however it is noted that 2083 patients were removed from the backlog in March (similar figure to previous months); indicating a high number of trip ins each month. MSK backlog at the end of March is 5298; 8% higher than it was in April 2020. Most sub-specialties in MSK are holding stable, however backlog has increased in the last 4 months for Foot & Ankle, Knee & Sports Injuries and SOOS. Specialist backlog at the end of March is 7479; 49% higher than it was in April 2020. Most sub-specialties in Specialist have either held relatively stable or reduced their backlog in March.

Main focus within the Trust has been on long waiters. The sub-specialities with the highest percentage of overdue follow ups are:
Arthroplasty - 18.67%; Rheumatology - 17.33%; Spinal Disorders - 11.48%;

Actions

* The Information team have developed a tool to be used by the operational teams that will calculate a trajectory for each sub-specialty based on their input of known bookings / capacity. The work on this trajectory is ongoing and a working group has commenced to support the teams with this.
* In Rheumatology, additional capacity is now in place for follow ups where it is anticipated an additional 100 patients per month will be seen.
* PIFU for overdue follow ups has begun within Spinal Disorders.
* Revalidation has commenced within Spinal Disorders.
* Outpatient task and finish groups are in place and ongoing with work continuing to progress.
* Clinical discussions are taking place with regards to validation of overdue follow ups.

Planning expectations for 2022/23 is to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, however, our plans for 2022/23 do not meet this aspiration as the Trust continues to address its overdue follow-up backlog.

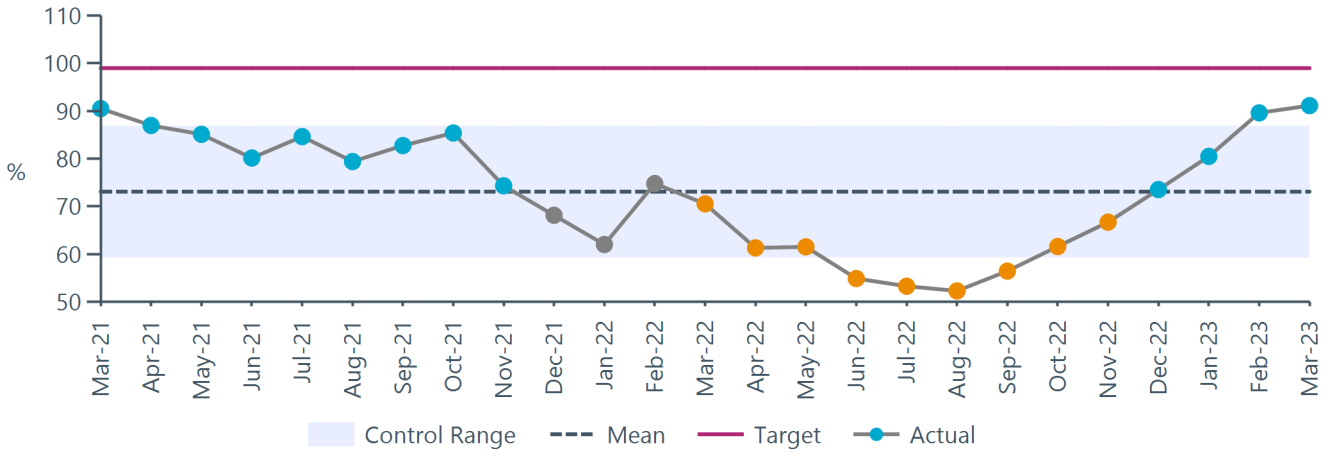
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
13976	14342	13937	13705	13710	13693	13665	13878	13151	13828	13554	13132	12777

6 Week Wait for Diagnostics - English Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
99.00%	91.15%	H	F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 91.15%; however, as can be seen in the graph above, there have now been seven months of consistent improvement.

Reported performance equates to 96 patients who waited beyond 6 weeks. Of the 6-week breaches; 10 are over 13 weeks (9 MRI and 1 CT).

Breakdown below outlines performance and breaches by modality:
* MRI - 93.86% - D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 36 with 30 dated
* CT - 96.06% - D4 (Routine - 6-12 weeks) - 5 dated
* Ultrasound - 84.32% - D4 (Routine - 6-12 weeks) - 54 with 50 dated
* DEXA Scans - 100%

The trust continues to treat by clinical priority. MRI was reported at 93.86% against a trajectory specifically for MRI at 83%.

Actions

* Staffed Mobile MRI scanner was initially installed at the beginning of November for six months in order to help reduce waiting list. This has now been extended beyond April for a smaller volume per week in order to stabilise the waiting list.
* Continue to monitor referrals as outpatient restoration increases.
* In order to support the percentage of patients receiving a diagnostic test within 6 weeks, NHSE are increasing focus on >13 weeks. This is in line with national planning guidance; by March 2025 the ambition is to achieve 95% against the 6-week standard.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
70.56%	61.33%	61.54%	54.90%	53.30%	52.31%	56.47%	61.62%	66.73%	73.55%	80.51%	89.63%	91.15%

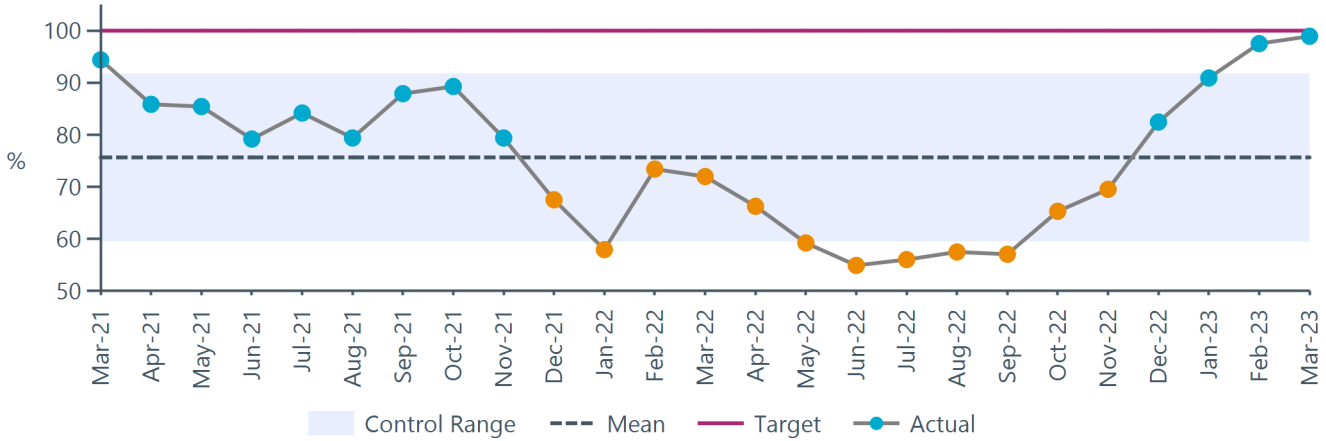
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	98.94%	H	F

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 98.94%; however, as can be seen in the graph above, there have now been six months of consistent improvement.

Reported performance equates to 4 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI - 88.76% - D4 (Routine - 6-12 weeks) - 10 dated
* CT - 100%
* Ultrasound - 100%
* DEXA Scans - 100%

It must be noted that MRI activity plans were met in March.

Actions

* Staffed Mobile MRI scanner was initially installed at the beginning of November for six months in order to help reduce waiting list. This has now been extended beyond April for a smaller volume per week in order to stabilise the waiting list.
* Continue to monitor referrals as outpatient restoration increases

The national expectations are not for this target to be achieved throughout 22/23.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
71.98%	66.27%	59.22%	54.90%	56.03%	57.48%	57.05%	65.30%	69.52%	82.44%	90.92%	97.52%	98.94%

Elective Activity Against Plan (volumes)

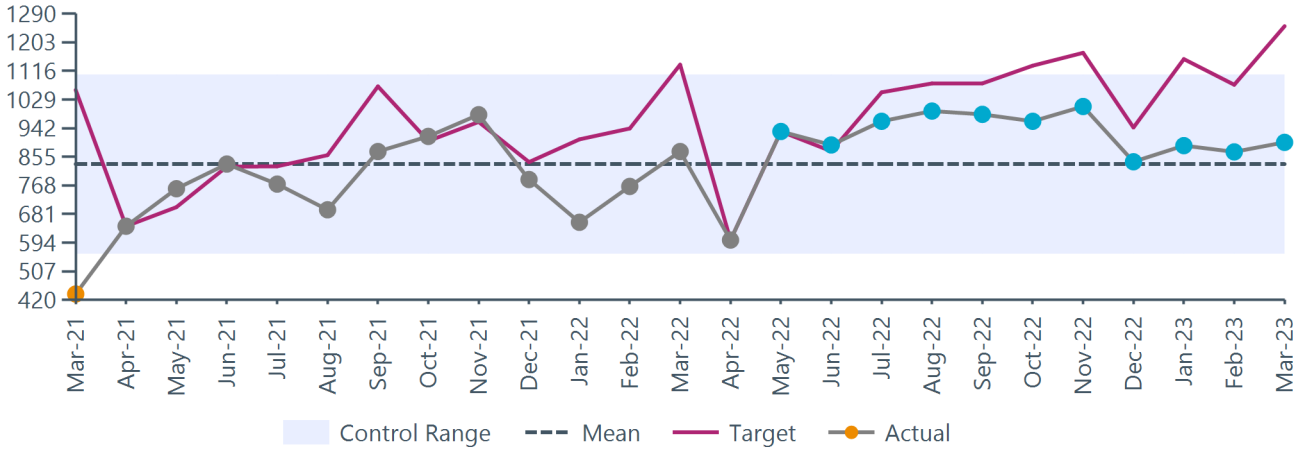
Total elective activity rated against 2022/23 plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,252	899	H	Moving Target

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

Total elective activity reported externally against plan 2022/23 in March was 899, 353 below plan 1252 (71.80%). The internal H2 trajectory for Elective Activity Against Plan (Volumes) was 1060 with 899 delivered, 161 below trajectory (84.81%). Factors affecting delivery:
- Reduction in Theatre activity resulting from industrial action 13th to 15th March equating to 42 rescheduled patients
- Workforce flexibility: challenges resulting from adverse weather conditions (snow disruption 9th & 10th March)
- Lack of OJP uptake
- Lack of Independent Sector uptake - 0 undertaken in March against a plan of 18
- 184 theatre cancellations (57 on the day and 127 ahead of TCI)
- NHS sessions behind plan (68.06%)
- Cases per session behind plan in Specialist Unit

Non theatre activity accounted for 28.14% of spells this month. Year-end performance in this metric is reporting 10835 against a plan of 12338 (87.82%).

Actions

Key themes identified for improvement:
* Exploring insourcing to grow Theatre capacity; Task and Finish Group commenced scoping.
* Workforce model – planning and retention.
* Booking and Scheduling – maximising theatre usage
* Working day effectiveness
* OJP alignment to booking processes
* Reducing cancellations

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
871	602	932	891	963	994	984	963	1008	840	889	870	899

Overall BADS %

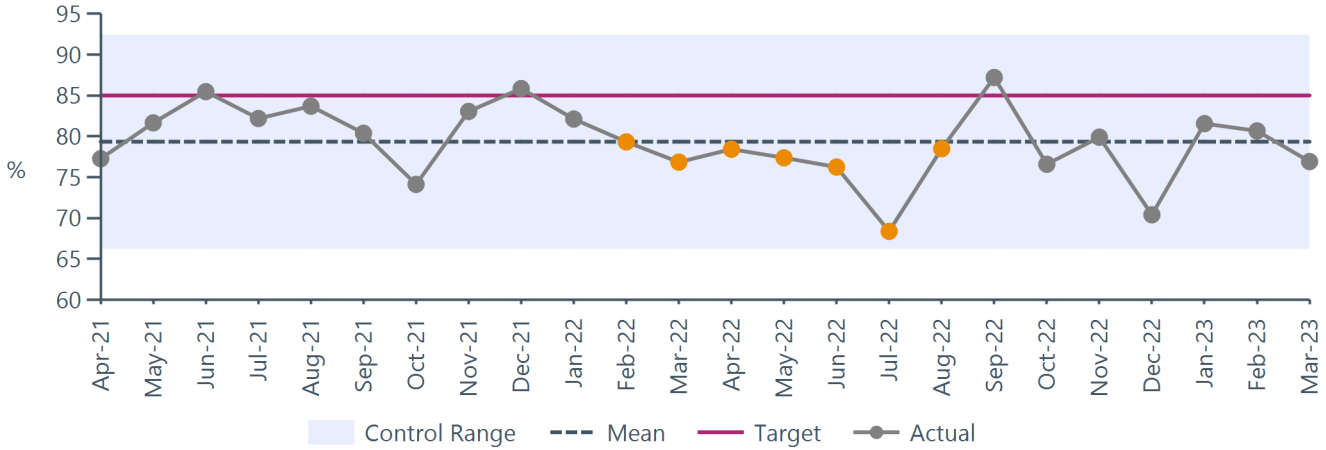
% of BADS procedures performed as a day case 217813

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	76.92%		

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

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

Narrative

This KPI has been added to monitor the overall % Trust performance of day cases against the latest online British Association Of Day Surgery directory of procedures, Orthopaedic and Urology pages. In March the Trust is reporting 76.47% BADS day cases against a target of 85%.

There is an ongoing data quality review which focuses on the timely discharge of patients to ensure they are classified correctly and therefore reflected accordingly in the % day case adherence. Work is also underway to review booking practises to align with BADS expectations.

Currently, we are reporting in line with Model Hospital, who exclude primary total replacements of hips/knees. We are carrying out further analysis of this.

Actions

Performance monitored via the Day Case Working Group and actions progressed as further understanding of metric grows.
Current actions include:
* Data quality review focusing on timely discharge of patients
* Develop strategies to minimise day case to inpatient conversions
* Improve accuracy of booking, coding, and data collection - immediate focus on Spinal Injuries day case booking practises

The Trust is exploring opportunities for expanding day case working practises to procedures that fall outside of BADS, including Spinal Disorders discectomies; anticipated start June 2023.

Further assessment of target to be carried out as understanding of metric evolves.

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
76.85%	78.43%	77.38%	76.25%	68.39%	78.49%	87.20%	76.59%	79.90%	70.41%	81.56%	80.67%	76.92%

Total Outpatient Activity against Plan (volumes)

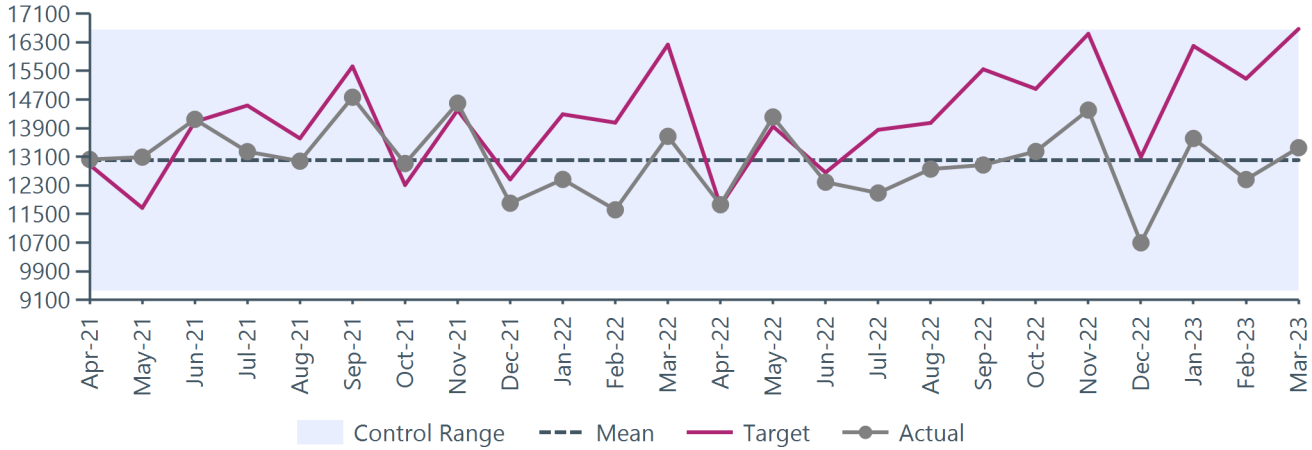
Total outpatient activity (H1 - consultant led, non-consultant led and un-bundled and H2 and 22/23 plan - consultant led and non-consultant led) against submitted plans.

217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
16,674	13,354		Moving Target

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

The plan for March was 97.95% of 19/20 against a national target of 104%. Total outpatient activity undertaken in March was 13354 against the 2022/23 plan of 16674; 3320 below - equating to 80.09%.
This is broken down as:
* New Appointments - 4047 against 5048 - equating to 80.17%
* Follow Up Appointments - 9307 against 11626 - equating to 80.05%

The sub-specialities with the lowest activity against plan in March are:
* Therapies - 1945 against 3181 - 1236 below plan - associated with cancellations, unfilled slots, class capacity reduction and high levels of sickness
* Arthroplasty - 1043 against 1675 - 632 below plan - deep dive into shortfalls is underway
* Upper Limb - 883 against 1238 - 355 below plan - deep dive into shortfalls is underway

It should be noted that the 2022/23 plan significantly increases in Q4. Year-end performance in this metric is reporting 153,866 against a plan of 174,573 (88.14%).

Actions

* Outpatient Improvement Plan which includes all aspects of Outpatient activity including Overdue Follow Ups, DNAs, PIFU, Virtual, IPC, clinic utilisations etc. Task and Finish groups are now in place which encompass all of these workstreams.
* Therapies review has been undertaken and templates to be reviewed within the service. Please note that the Therapies appointment duration of 45 minutes has been approved by MSK board, as per MUSST guidance. A benchmarking exercise has also been undertaken.
* Backlog management Plan for SOOS patients has been developed and an application to the ERF was successful. Until recruitment happens, some additional hours are being picked up within the team.
* Staffing review completed within outpatients; two phase case of need now signed off and agreed; staffing being sourced and plans adjusted accordingly.
* Recruitment (particularly consultants, therapists and radiographers). Of the AHP vacancies, 95.52% are in the recruitment pipeline.
* Orthotics recruited to their vacant posts with one person started early April. A further two vacancies have since opened up and recruitment has started.
* Work to accommodate offers of OJP from clinicians.

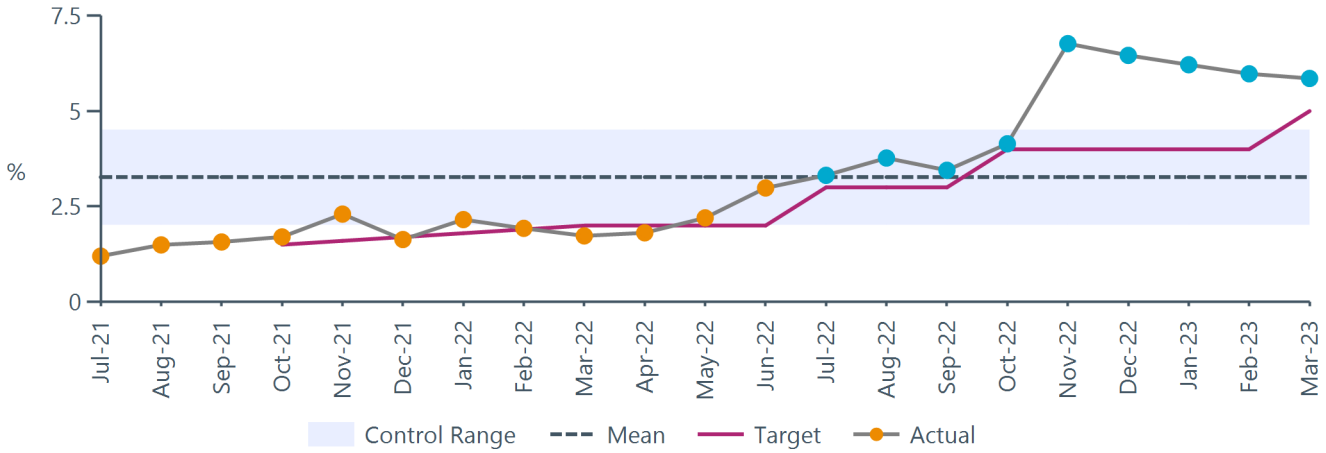
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
13672	11761	14213	12391	12088	12758	12871	13250	14407	10696	13613	12464	13354

Total Outpatient Activity - % Moved to PIFU Pathway

Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway, (Against External Plan (22/23), Catchment Based) 217715

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5.00%	5.86%	H	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatients attendances by March 2023. In March this was exceeded with 5.86% of total outpatient activity moved to a PIFU pathway.

Actions

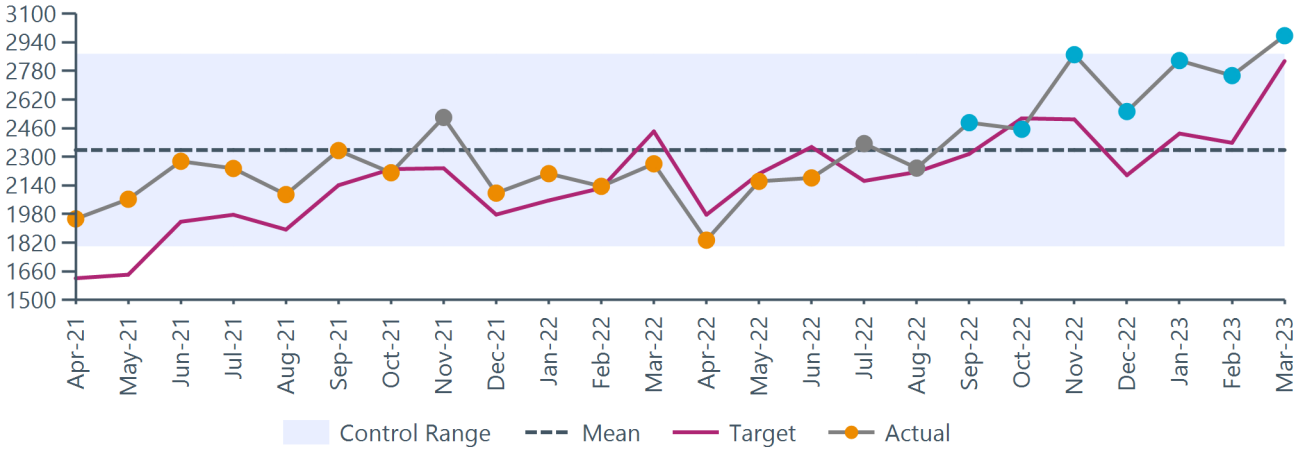
Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
1.73%	1.81%	2.20%	2.99%	3.32%	3.77%	3.45%	4.14%	6.77%	6.46%	6.21%	5.98%	5.86%

Total Diagnostics Activity against Plan - Catchment Based

Total Diagnostic Activity against Plan - (MRI, U/S and CT activity against 2022/23 plan) 217794

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,835	2,977	H	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

This metric is included as an exception as it is reported as special cause variation of an improving nature. The plan for March was 102.82% of 19/20 against a national target of 120%. In March this was exceeded as total diagnostic activity undertaken in March was 2977 against the 2022/23 plan of 2835; 142 cases above - equating to 105.01%.
This is broken down as:
- CT - 459 against plan of 532; equating to 86.28%
- MRI - 1559 against plan of 1325; equating to 117.66%
- U/S - 959 against 978; equating to 98.06%

There has been a significant improvement since November due to the installation of the staffed Mobile MRI scanner.

Actions

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
2261	1834	2163	2182	2374	2237	2491	2454	2871	2553	2838	2754	2977

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Long Waiters - 2022/23

Finance, Performance & Digital Committee

25th April 2023

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2022/23 March and April* Performance

		Plan	Actual	Difference
March	English 104+ Weeks	0	6	6
	Welsh 104+ Weeks	118	50	-68
	English 78+ Weeks	247	75	-172
	Welsh 78+ Weeks	539	196	-343

		Plan	Forecast*	Difference
April*	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	49	
	English 78+ Weeks	69	69	-133
	Welsh 78+ Weeks	-	217	
	English 65+ Weeks	476	476	0
	Welsh 65+ Weeks	-	478	

NHS England Updates:

Mutual Aid NHSE to support long wait cohort.
- Providers asked to have 0 x 78 weeks by end of March 2023
- Route to zero planned by 30th June 2023.

Patient choice: - NHSE Interim guidance - NHSE Active Monitoring RTT rule changes being made to patients declining mutual aid. Impacts English ONLY

System mutual aid: - Patients transferred from SaTH to RJAH during 2022/23.

2023/24 – FOCUS TO MOVE TO 0 X 65+ WEEKS BY MARCH 2024

*April long waits subject to further improvements e.g. % seen that do not convert, validation etc.
Welsh trajectories for 2023/24 in development.

Validation of all patients continuing. Spinal Disorders mutual aid patients are now transferred to the other providers waiting lists.

Industrial Action Impacts: - 3 x >78+ week patients impacted. All rebooked. 2 rebooked in April and 1 rebooked in May.

Mutual aid: 18th April snapshot (latest mutual aid) – 90 x patients transferred to ROH, 43 x patients transferred to Walton.

2023/24 65+ Weeks Trajectory Submitted

Latest Submitted Plan: - mutual aid impacts have been applied. ROH and Walton agreed support

- The Trust has submitted a NHSE plan that achieves zero x 65+ week waits by March 2024.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
476	402	441	454	513	467	460	365	321	303	196	0

Trendline of Cohort to Trajectory Vs Current Run Rates:

- Further NHSE templates expected to support external cohort monitoring.
- The Trust internally monitors the 'cohort' of patients through internal long wait meetings.
- The Trust is forecasting to achieve the April 2023 65+ weeks plan of 476.

EXAMPLE COHORT: - 18th April 2023 Snapshot: - 65+ weeks *(includes patients with planned treatments in month)*

English RTT >65 weeks by April 2023

Split by month of next appointment/TCI date:

	with a decisison to admit			without a decisison to admit		
	with a TCI	without TCI	% without TCI	with next appt	without next appt	% without next appt
Spinal Disorders	15	48	76.2%	36	57	61.3%
Non-Spinal Disorders	100	237	70.3%	17	20	54.1%
TOTAL	**115**	**285**	**71.3%**	**53**	**77**	**59.2%**

530

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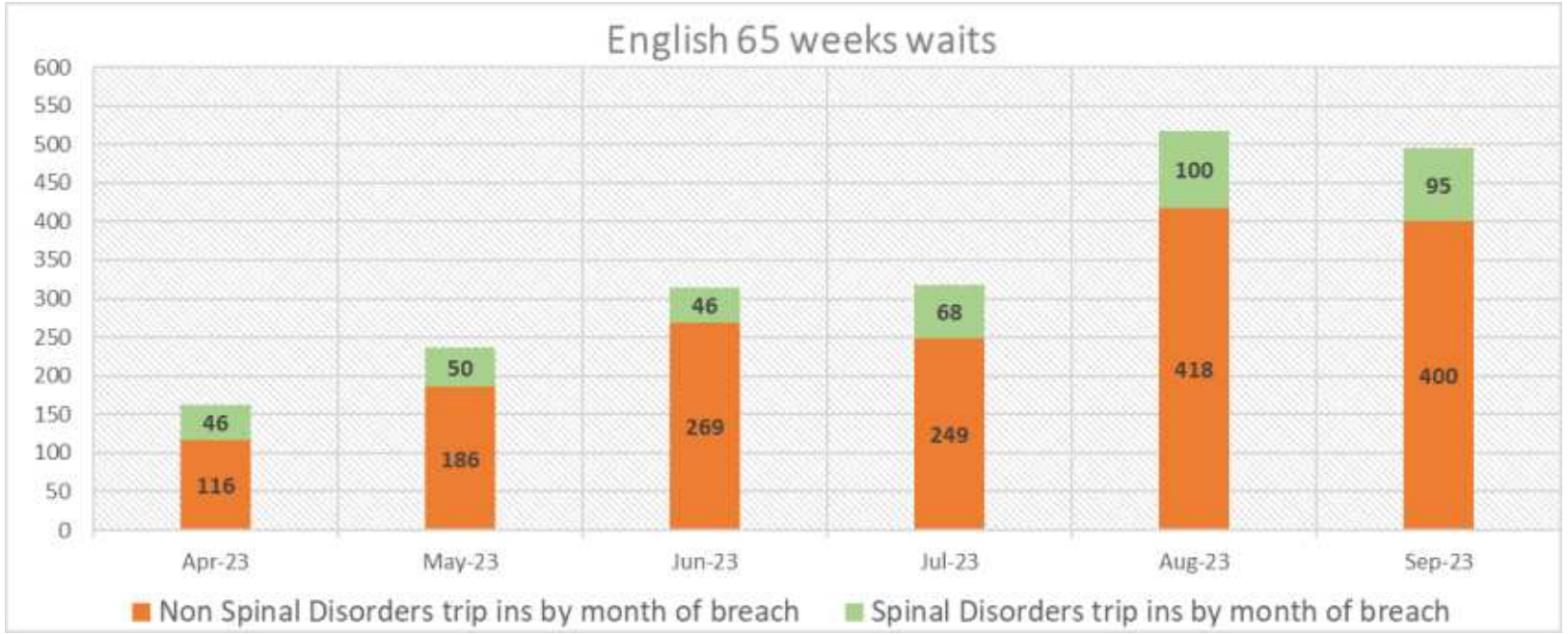
Managing The Trip-ins – 65 weeks - English

19th April Snapshot



Managing the trip-ins
Further actions 2023/24 include:

- Additional capacity options
- Continuous validation
- Mutual Aid Support

Movements will be monitored.

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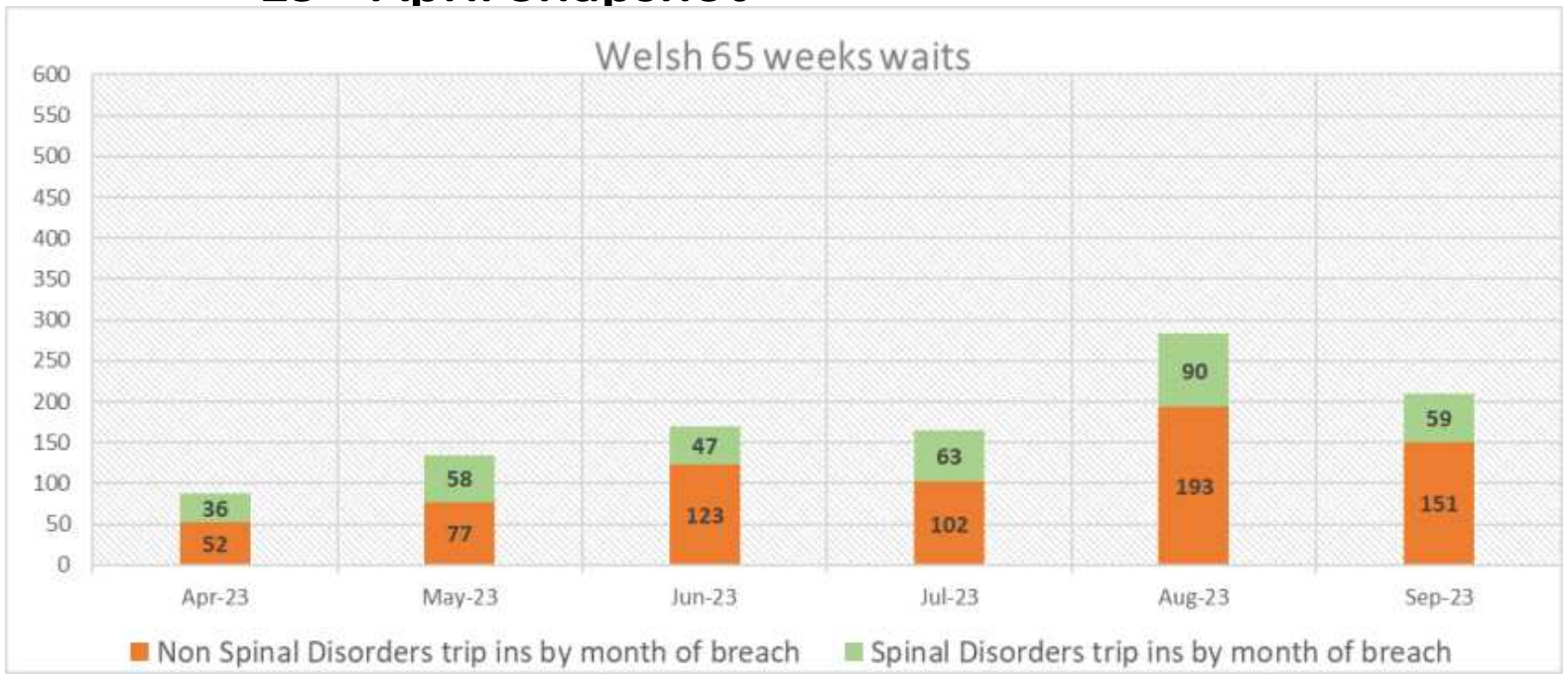
Managing The Trip-ins – 65 weeks - Welsh

19th April Snapshot



Managing the trip-ins
Further actions 2023/24 include:

- Additional capacity options
- Continuous validation
- Commissioner discussions continue for 2023/24 plans

Movements will be monitored.

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NHSE: - 78+ Weeks Updates

- Patients Dated: - Latest Trajectory and Position (April 23 cohort)

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NHSE 78+ Weeks: - Latest Trajectory and NHSE monitoring

The Trust is now forecasting a route to zero by the end of quarter 1.
Submitted NHS England (NHSE) plan:

- April 2023: - 69 breaches
- May 2023: - 31 breaches
- June 2023: - 0 breaches

NHSE Cohort Monitoring: - 16th April Snapshot EXAMPLE.

- 109 (66 + 43) patients remained within the April cohort *(includes patients with treatment in month).* Plan to get to 69.
- 6 patients waiting for a 1st appointment. 2 x late transfers and 4 x internal consultant transfers progressing.
- Patient transfers through mutual aid ongoing.

Booking for 78w cohort (April)

	Admitted			Non-Admitted			
System *Select System and Providers from below dropdowns	Total Admitted Cohort	**WITH** a recorded TCI date	**WITHOUT** a recorded TCI date	Total Non-Admitted Cohort	**WITH** a recorded Next Event date	**WITHOUT** a recorded Next Event date	Of those **WITHOUT** a recorded next event, how many are waiting for a **1st OP Appointment**
SHROPSHIRE, TELFORD AND WREKIN ICB							
The Robert Jones and Agnes Hunt Orthopaedic Hospital	66	41	25	43	25	18	6

Trust Board - Finance
March 2023 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

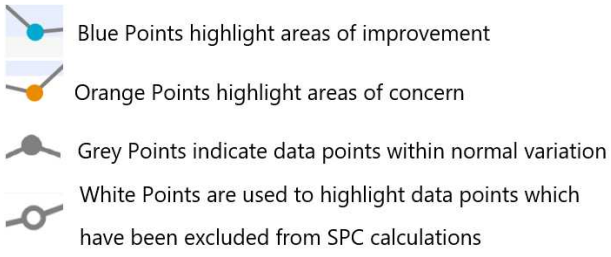
Different colours have been used to separate these trends of special cause variation:

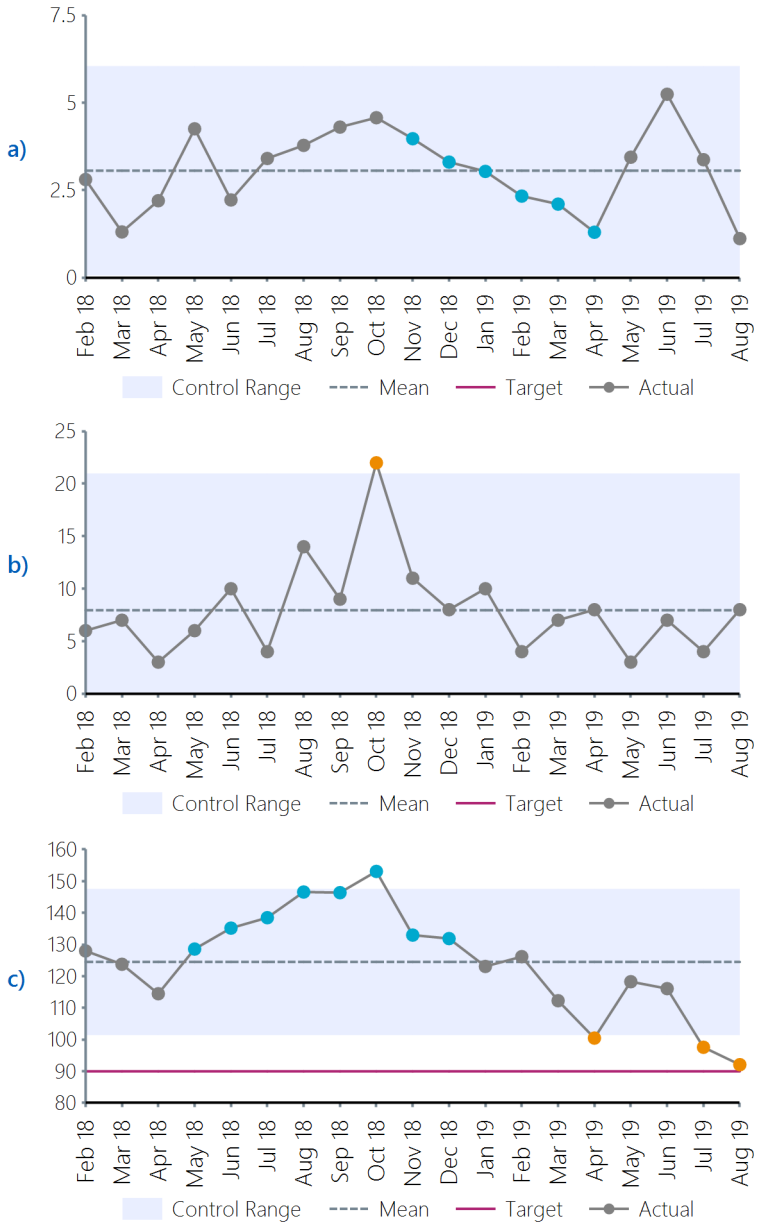
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Financial Control Total	1,025	1,236		N/A to SPC	Moving Target		
Income	12,307	20,006		N/A to SPC	Moving Target		
Expenditure	11,338	18,833		N/A to SPC	Moving Target		
Efficiency Delivered	181.67	205		N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	114.33	76		N/A to SPC	Moving Target		
Cash Balance	20,061	25,484		H	Moving Target		
Capital Expenditure	2,501	8,405		N/A to SPC	Moving Target		

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st March 2023

Performance Against Plan £'000s

Category	Annual Plan	In Month Position			22/23 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	115,065	11,148	11,937	789	115,064	117,767	2,703
Covid-19 Funding	1,411	118	118	(0)	1,411	1,411	0
Private Patient income	5,868	480	681	201	5,868	6,048	180
Other income	6,654	561	1,380	819	6,653	8,026	1,372
Pay	(78,681)	(6,618)	(7,071)	(453)	(78,694)	(77,995)	699
Non-pay	(43,762)	(4,029)	(5,431)	(1,403)	(43,722)	(46,135)	(2,413)
EBITDA	6,555	1,660	1,614	(47)	6,581	9,121	2,540
Finance Costs	(7,959)	(692)	(441)	251	(7,985)	(7,313)	673
Capital Donations	3,300	25	74	49	3,300	3,133	(167)
Operational Surplus	1,896	993	1,247	253	1,896	4,941	3,045
Remove Capital Donations	(3,300)	(25)	(74)	(49)	(3,300)	(3,133)	167
Add Back Donated Dep'n	632	56	68	12	632	651	19
Add Back Centrally Procured PPE	0	0	(5)	(5)	0	(5)	(5)
Control Total	(772)	1,024	1,236	212	(772)	2,454	3,226
EBITDA margin	5.1%	13.5%	11.4%	-2.1%	5.1%	6.8%	1.7%

Statement of Financial Position £'000s

Category	Feb-23	Mar-23	Movement	Drivers
Fixed Assets	94,806	101,148	6,342	Additions £8.4m, less revaluation £1.5m less depreciation £0.5m
Non current receivables	1,251	1,096	(155)	
Total Non Current Assets	96,057	102,244	6,187	
Inventories (Stocks)	1,309	1,307	(2)	
Receivables (Debtors)	6,165	7,812	1,647	Movements in accrued receivables including £2.7m pay award funding
Cash at Bank and in hand	34,041	25,484	(8,557)	Mainly capital expenditure
Total Current Assets	41,515	34,603	(6,912)	
Payables (Creditors)	(21,399)	(20,753)	646	Mainly movements in accruals, in particular £2.8m for the pay award, offset by decrease in outstanding invoices of £1.4m
Borrowings	(2,029)	(2,048)	(19)	
Current Provisions	(405)	(693)	(288)	Increase mainly Employee Relations liabilities
Total Current Liabilities (< 1 year)	(23,833)	(23,494)	339	
Total Assets less Current Liabilities	113,739	113,353	(386)	
Non Current Borrowings	(2,891)	(2,895)	(4)	
Non Current Provisions	(1,004)	(904)	100	
Non Current Liabilities (> 1 year)	(3,895)	(3,799)	96	
Total Assets Employed	109,844	109,554	(290)	
Public Dividend Capital	(45,888)	(45,888)	0	
Retained Earnings	(30,597)	(30,597)	0	
Revenue Position	(3,695)	(4,941)	(1,246)	Current period surplus
Revaluation Reserve	(29,664)	(28,128)	1,536	Revaluation of land & buildings
Total Taxpayers Equity	(109,844)	(109,554)	290	

Finance Metrics (NHS Oversight Framework)

Financial efficiency - variance from efficiency plan	
Financial stability - variance from break-even *	
Agency spending	

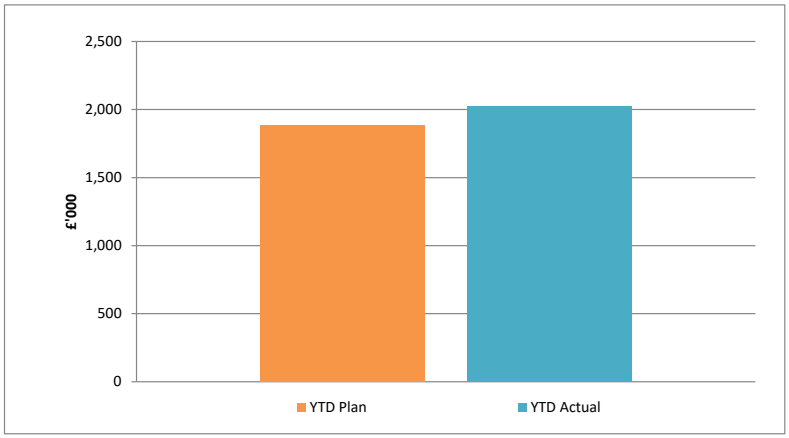
	YTD
Debtor Days	17
Creditor Days	47

* Subject to system position through IFP arrangements

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st March 2023

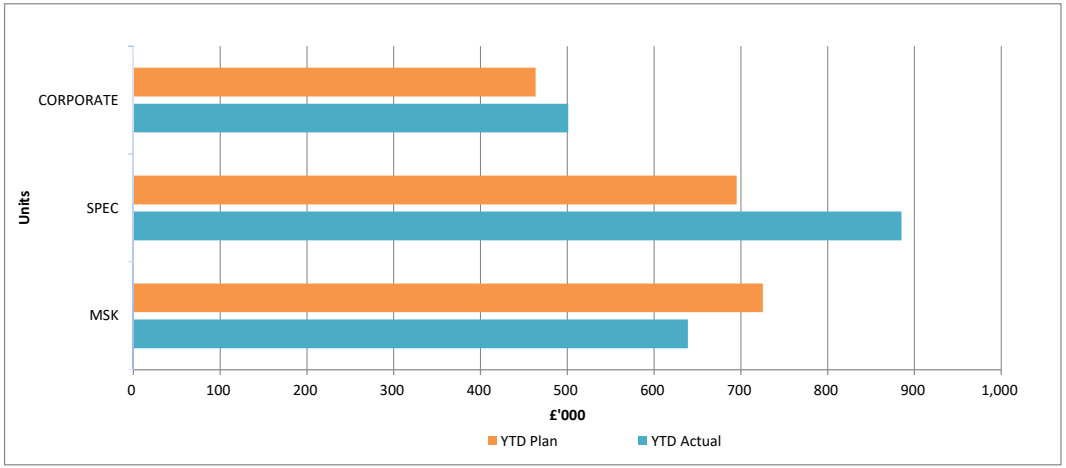
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's

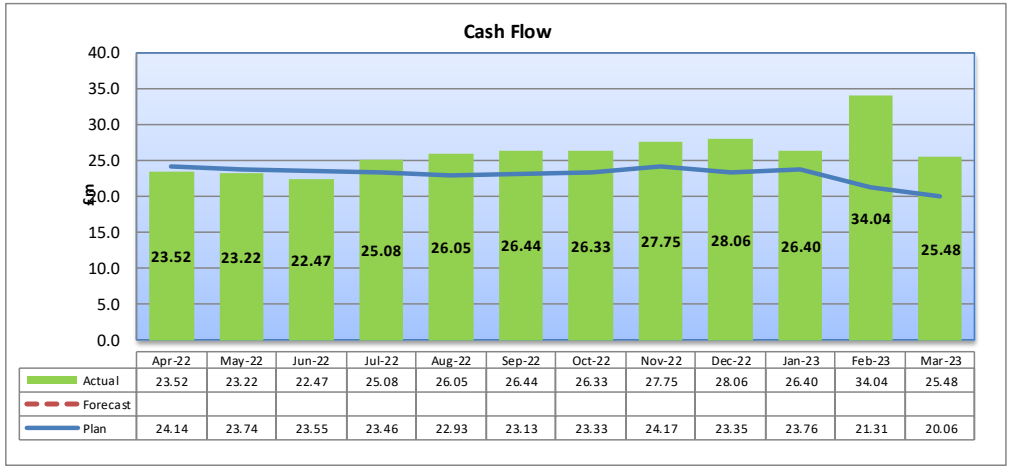


Note - Target represents original external plan which doesn't include 21/22 carry forward and stretch to cover investments reported at a unit level

Capital

Position as at	2223-11	Capital Programme 2022-23					
Project	**Annual Plan £000s**	**In Month Plan £000s**	**In Month Completed £000s**	**In Month Variance £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**
Backlog maintenance	350	20	95	-75	350	514	-164
I/T investment & replacement	300	50	310	-260	300	497	-197
Capital project management	130	11	10	1	130	124	6
Equipment replacement	750	100	477	-377	750	1,390	-640
Diagnostic equipment replacement	920	330	288	42	920	720	200
IPC & safety compliance	360	0	237	-237	360	935	-575
EPR planning & implementation	4,500	215	591	-376	4,500	4,532	-32
Invest to save	200	50	152	-102	200	193	7
Enhanced staff facilities	500	0	0	0	500	0	500
Additional theatres x 4 (replace barns)	3,000	1,500	0	1,500	3,000	0	3,000
TIF2 theatre and ward	0	0	5,034	-5,034	0	5,034	-5,034
TIF2 theatre and ward (Internal)	0	0	994	-994	0	1,023	-1,023
Leases (IFRS16)	149	0	36	-36	149	210	-61
Veterans' facility	3,200	0	32	-32	3,200	3,056	144
Veterans' facility (HEE)	0	0	-9	9	0	38	-38
Donated medical equipment	100	25	42	-17	100	77	23
Contingency	500	200	116	84	500	171	329
Total Capital Funding	14,959	2,501	8,404	-5,903	14,959	18,515	-3,556
Veterans' facility	-3,200	0	-32	32	-3,200	-3,056	-144
Donated medical equipment	-100	-25	-42	17	-100	-77	-23
NHS Capital Funding - Charge to CDEL	11,659	2,476	8,330	-5,854	11,659	15,382	-3,723
Less leases (IFRS16)	-149	0	-36	36	-149	-210	61
Charge to CDEL excluding IFRS16	11,510	2,476	8,294	-5,818	11,510	15,171	-3,661
Less in-year PDC funded schemes	0	0	-5,034	5,034	0	-5,034	5,034
Charge to CDEL for decision purposes	11,510	2,476	3,260	-784	11,510	10,137	1,373

Cash Flow



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	23.52	23.22	22.47	25.08	26.05	26.44	26.33	27.75	28.06	26.40	34.04	25.48
Forecast												
Plan	24.14	23.74	23.55	23.46	22.93	23.13	23.33	24.17	23.35	23.76	21.31	20.06

Chair's Assurance Report
Finance, Performance and Digital Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	03 May 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	02 May 2023
Paper Reviewed by:	Sarfraz Nawaz, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Finance, Performance and Digital Committee. The Board is asked to consider the recommendations of the Finance, Performance and Digital Committee.

2. Context

2.1 Context

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

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

3. Assurance Report from Finance, Performance and Digital Committee

This report provides a summary of the items considered at the Finance, Performance and Digital Committee on 25 April 2023. It highlights the key areas the Finance, Performance and Digital Committee wishes to bring to the attention of the Board.

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

ALERT - The Finance, Performance and Digital Committee wishes to bring the following issues to the Board's attention as they:

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

Financial Plan Update

The Committee approved the financial plan re-submission. The following key points were agreed to be shared with the Board:

- The planning window has been re-opened and there is another submission for the 4th May.
- The ICS position needs to improve by approx. £12 million between the partner organisations.
- The proportion based on expenditure levels for RJAH is £0.5 million therefore the Trust are being asked to increase their efficiency programme by a further £0.5 million to 3.6%
- The overall financial plan position for RJAH would meet statutory break-even requirement with an overall £0.1m surplus.

3.2 Areas of on-going monitoring with new developments

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

Board Assurance Framework
The Committee asked for BAF 6 to be reviewed to ensure the risk is consistent throughout the document and also asked for the target dates to be reviewed ahead of the Board meeting. The Committee agreed the risks and there were no new risks to incorporated.

Corporate Risk Register
The following points were agreed:

- Risk 2011 - confirmation received that the risk has now been re-aligned to the People and Culture Committee.
- In relation to the following risks – the Committee asked for the risks to be articulated clearer and to ensure the risks have been considered by the Trust Performance and Operational Improvement Group:
    - Risk 2628 - Pathology Laboratory Information System (LIMS)
    - Risk 2934 - Patient waiting times outside of national targets.
    - Risk 3044 - IT for the Orthotics service on the SATH sites

There were no new risks identified.

Long Waiters Presentation
There are currently 6 patients waiting over 104 weeks at the end of March 2023. The Trust forecast there will be 0 patients waiting over 104 weeks at the end of May 2023 (2 months behind schedule) In order to gain further assurance, the Committee asked for a deep dive into 104, 78 and 65 weeks to be presented at the next meeting.

Review of the Committee Effectiveness and Self-Assessment
It was agreed that the committee will complete this offline with an expectation that the report will be presented in its entirety at the next meeting.

3.3 Areas of assurance

ASSURE - The Finance, Performance and Digital Committee considered the following items and did not identify any issues that required escalation to the Board.

Electronic Patient Record (EPR) Update
The Committee were assured with the information presented. The highlight report outlined that the Trust are sitting amber on the RAG rating – issues related to capacity within the team which are being addressed. There were no risks to highlight to the Board and assurance is also noted though contractual routes. The Chair suggested a presentation of EPR is delivered to the Non-Executive Team in the future to support with the understanding of the project.

Key Deliverables of the Operational and Financial Plan 2023/24
The Committee welcomed the new format of the report which provides information and triangulation over the plans in place for 2023/24. It was suggested the report is also aligned to the People and Culture Committee.

Performance Report
There were no new risks or areas of concern to highlighted to the Board, the Committees focus remains on long waiters.

Productivity Dashboard
The Committee noted the report which provided assurance on the review of productivity. Further consideration is to be given to the average late start and finishes to seek any opportunities of improvement. The model health system was shared for ankle and shoulder replacements.

Financial Performance
The Committee commended the work completed by the Finance Team to deliver the financial forecast for 2022/23. The Trust were pleased to confirm the organisation was successful in delivering a £2.5m surplus which is £3.2m favourable to plan.

IT Threat Action Plan
The Committee were assured with the action plan and reporting process following the internal audit report. There are no concerns to note, and the Committee will continue to receive the action plan monthly.

Chair Reports
The Committee noted the Chair reports from the following meetings: Trust Performance and Operational Improvement Group and Capital Management Group.

4.0 Conclusion / Recommendation

The Board is asked to:

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

Risk Management Policy

Committee / Group / Meeting, Date

Board of Directors, 3 May 2023

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Paul Kavanagh-Fields
Role/Title: Chief Nurse and Patient Safety Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

Via the Trust scheme of reservation and delegation, the Board retains authority for "Approval of key policies of general application throughout the Trust". This includes policies for "risk management".

The Trust's existing Risk Management Strategy dates from 2019 and was due for review in October 2022. This was noted during the Good Governance Institute (GGI)'s review of clinical governance at the Trust, which was completed in September 2022.

GGI were subsequently commissioned to deliver a programme of risk improvement work which includes updating the framework for risk management and developing a training programme based on a learning needs analysis.

The content has been revised / updated to:

- Recast the former "Strategy" as a "Policy". The GGI will also formulate a more forward-looking "Strategy" document that describes how the Trust will enhance and embed the risk management process over the coming years
- Reflect the International Organization for Standardization (ISO) 31000 global standard definitions of risk and risk management.
- Reflect the definitions of risk appetite and risk tolerance recommended by the Good Governance Institute.
- Reflect current executive portfolios and Trust committee structure.
- Create a high-level Risk Management Group. A key role of which will be to review risks rated at 15 and above and agree the content of the Corporate Risk Register. This will replace the existing Risk Managegemnt Group (which is a more operationally-led working group)
- Clarify and formalise the assurance / escalation process from the clinical business unit risk meetings and the groups that perform a similar role in corporate service-type functions (e.g. finance, estates, HR).
- Provide revised guidance to staff on the practice of risk management, including guidance on how risks should be described; how risks should be scored; how often risk assessments should be reviewed etc.
- Reflect a requirement for staff to undertake risk management training appropriate to their grade / role.

Strategic objectives and associated risks:

The policy will indirectly support all the Trust's objectives but is particularly relevant to:
1. Developing and Maintaining Safe Services
5. Maintaining statutory and regulatory compliance

Recommendations:

That the Board:

- APPROVE the revised Risk Management Policy
- NOTE the proposed terms of reference of the newly created Risk Management Group.

Report development and engagement history:

The Good Governance Institute (GGI) reviewed the Trust's Risk Management Strategy and recommended revisions to reflect best practice. These are reflected in the proposed Risk Management Policy.

The Policy has been reviewed and endorsed by the Trust's Risk Management Working Group.

The Policy has also been reviewed and supported by the Executive Leadership Team.

The Policy and associated training plan were presented to the Audit and Risk Committee on 30 March 2023.

Next steps:

The revised Policy will be published on the Trust's intranet and will be communicated to all staff via the regular corporate communication channels.

An associated training programme has been developed and this will be rolled out to staff from June onwards.

Appendices

Appendix A	Revised Risk Management Policy
Appendix B	Risk Management Group Terms of Reference

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Title:	Risk Management Policy		
Unique Identifier:	SGY001	**Document Type:**	Policy
Version Number:	5.0	**Status:**	Approved
Responsible Director:	Chief Nurse and Patient Safety Officer		
Author:	Chief Nurse and Patient Safety Officer		
Scope:	Trust Directors, Senior Managers and all staff groups		
Replaces:	Version 4.0		
To be Read in Conjunction with the Following Documents: (list related policies)	• Health and Safety Policy • Violence Prevention and Reduction Policy • Policy for the Investigation of Incidents, Complaints and Claims. • Trust Safe Moving and Handling (Manual Handling) Policy • Control of Substance Hazardous to Health Policy • Trust Openness Whistleblowing Policy • Trust Incident Reporting Policy • Prevention and Management of Falls Policy • Security Policy • Duty of Candour Policy		
Keywords:	Risk Management, Risk Assessment, Strategy		

Considered By Executive Owner:	Chief Nurse and Patient Safety Officer	**Date Considered:**	TBC
Endorsed By:	Risk Management Group	**Date Endorsed:**	TBC
Approved By:	Audit and Risk Committee	**Date Approved:**	TBC
Issue Date:	Pending	**Review Date:**	TBC
Security Level:	**Open Access** ✓ **Confidential**	**Restricted**	

Trust Values

Template for Recording Amendments

Record of Amendments to Risk Management Policy					
Section number	Amendment	Deletion	Addition	Reason	Date
4.2	Update to job titles		Director of Finance has had Planning added to job title. Director of Strategy and Planning has become Director of Performance, Improvement and Organisational Development Safety and Risk Manager role has been removed and replaced with Health and Safety Officer	To align with current structure	October 2019
4.2	Reference to Risk Owners and Handlers		The role of the risk owner and handler has been referenced	Internal audit recommendation	October 2019
Throughout document	Updating of terminology and job titles to take account of organisational restructure within the trust and the wider NHS	Old job and organisation titles	Changes of job titles for executive directors e.g. Director of Nursing is now Chief Nurse and Patient Safety Officer; change of name of national bodies e.g. Monitor is now NHS England / Improvement.	To align with current structure at local and national level	March 2023
Throughout document	Document described as a 'policy' rather than a 'strategy'	N/A	Change of terminology	Document more closely matches the definition of a policy than a strategy in current form	March 2023
1, 2	Deletion of executive summary and re-wording of introduction	Executive summary	Simplified text	To make the document more concise	March 2023
1	Adoption of the definitions of risk and risk management set out in the ISO 31000 global standard	Previous definition	Standard definitions extracted from ISO 31000	To reflect current international guidance and best practice	March 2023

3 (renumbered to 2)	Revised definitions of strategic and operational risk	Previous definition	New definition	To differentiate more clearly between the two	March 2023
3 (renumbered to 2)	Added definitions of clinical and workforce risks	N/A	New definitions	To provide more comprehensive definitions	March 2023
4.1 (renumbered to 3.1)	Amended details of committees to reflect revised corporate governance structure in the trust	N/A	More generic description of committee responsibilities	To align with new committee structure	March 2023
4.1 (renumbered to 3.1)	Added a new risk meeting for corporate services which will review risks for these areas in the same way that business unit management teams review risks in clinical services	N/A	Description of role of meeting (section 3.1.7)	To align with current organisational structure	March 2023
4.2 (renumbered to 3.2)	Amended executive director and management responsibilities to reflect current portfolios	Removed reference to Director of Performance, Improvement and Organisational Development, Director of Governance and Director of Operations as these roles no longer exist	Role of Chief Operating Officer; added Caldicott Guardian and informatics responsibilities to Chief Medical Officer role; added Head of Clinical Governance and Quality role	To align with current organisational structure	March 2023
4.2.11	Removed reference to Local Security Management Specialist	Whole subsection	N/A	Not relevant to this policy	March 2023
4.4 (renumbered to 3.4)	Additional information re; clinical audit as a means of identifying risks to quality	N/A	Further detail re: clinical audit forward plan	To provide a more comprehensive definition	March 2023
5.3.2 and 5.3.3 (renumbered to 4.3)	Revised definitions of risk appetite and risk tolerance	Previous definitions	New definitions as recommended by the Good Governance Institute	To reflect current guidance and best practice	March 2023
5.3.3 (renumbered to 4.3.3)	Expressed risk tolerance in terms of numerical target scores, and simplified risk categories based on Good Governance Institute risk appetite matrix	Previous definitions	Numerical target scores	To provide clearer guidance to staff	March 2023
5.3.4	Deleted section and moved content	Whole section	Now included in section 4.3.1 instead	To remove duplication	March 2023
6 (renumbered to 5)	Replaced diagram with updated version	Old diagram	Revised diagram	To reflect current guidance and best practice	March 2023
6.1	Additional examples of risk sources	N/A	Extra examples	To provide additional guidance to staff	March 2023

(renumbered to 5.1)					
6.2 (renumbered to 5.2)	Additional guidance about phrasing of risks	N/A	Risks to be described in terms of cause and effect, and in plain English; also risks to be checked by clinical governance managers before going live on the risk registers	To provide additional guidance to staff	March 2023
6.3 (renumbered to 5.3)	Additional guidance about risk scoring	N/A	Advice to consult with colleagues as risk scoring can be judgemental and subjective	To provide additional guidance to staff	March 2023
6.4.1 (renumbered to 5.4.1)	Additional detail regarding different approaches to managing a risk and drafting action plans	N/A	More information about tolerated, transferred and treated risks, and target scores; requirement for action plans to be SMART	To provide a clearer explanation of the concepts	March 2023
6.4.2 and 6.4.3 (renumbered to 5.4.2 and 5.4.3)	Additional guidance about how frequently risks should be reviewed, including tolerated risks	N/A	Review timescales set based on current risk score – new subsection added (5.4.4)	To provide additional guidance to staff	March 2023
7 (renumbered to 6)	Abbreviated this section which describes the purpose of risk registers and added an explanatory diagram	Previous narrative	New diagram	To make the document more concise	March 2023
7.2 (renumbered to 6.2)	Clarification regarding risk registers in non-patient facing corporate services, which do not form part of the business unit structure	N/A	Requirement for a combined risk register for these services similar to a business unit risk register	To align with current organisational structure	March 2023
7.3 (renumbered to 6.3)	Change in practice re: inclusion of high risks in the corporate risk register	Requirement for all risks scored 15 or higher to be included in the CRR	Risk Management Group now acts as gatekeeper to CRR and escalation of high risks to this register is not automatic	To focus the CRR on risks which cannot be managed locally in business units and need corporate / executive input	March 2023
8 (renumbered to 7)	Simplified definition of the Board Assurance Framework	Old definition	New definition	To provide a clearer explanation of the concept	March 2023
9	Deleted this section	Whole section	Information about risk review now included in section 6 instead	To remove duplication	March 2023

12 (renumbered to 10)	Updated titles of policies referred to in this section	Old policy titles	New policy titles	To bring this section up to date	March 2023
13 (renumbered to 11)	Additional detail regarding training requirements for staff at different bands	N/A	Participation requirements for training at levels 1, 2, 3 and 4	To provide additional guidance to staff	March 2023
Appendix 1	Removed organogram	Old organogram	N/A	To make the document more concise	March 2023
Appendix 2 (renumbered to App 1)	Replaced GGI risk appetite matrix with updated version	Old matrix	New matrix	To reflect current guidance and best practice	March 2023

Risk Management Policy

Table of Contents

1. Introduction

The International Standards Organisation, in its global risk management standard, ISO 31000 (2018), defines risk as *"the impact of uncertainty on objectives",* and risk management as *"coordinated activities to direct and control an organisation with regard to risk".* While risk is generally understood in terms of negative consequences and failure to achieve objectives, risks can sometimes represent an opportunity, as well as a threat.

ISO define risk management processes as the *"systematic application of management policies, procedures and practices to the tasks of communication, consultation, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk".*

RJAH is a specialist provider of orthopaedics, specialist medicine, bone tumor services and paediatrics. The specialist nature of its services contributes to the complexity of the organisation. Providing specialist services carries inherent risk, with the potential for harm to service users, employees and visitors to the Trust if not adequately managed. The trust takes a holistic approach to all risks incorporating clinical, business and financial, as well as traditional safety-related topics. The risk management policy provides a basis to deliver safe high quality services, and to learn from experience.

By implementing this policy, the Trust aims to embed risk management throughout the organisation. For example, risk management can be used to question effectiveness of organisational structures and processes, and the functionality of control systems. The Board is expected to have in place a system for continuous risk management which extends from the front line through to the Board and back to the Ward. It should be able to assess the risks to the achievement of its strategic objectives and whether the trust has the right management processes and controls to achieve them.

The policy will support the Board in fully understanding current and future risks to the organisation, in ensuring that risk reduction/mitigation strategies are developed to address the risks, and in providing assurance that the controls in place to reduce those risks are working effectively. The risk management process should be:

- embedded in the day-to-day operations of the organisation
- part of the culture and way of working
- capable of responding quickly to evolving risks and escalating them to the right level of the organisation, and
- straightforward to understand and apply

To ensure that this document remains current and reflect the organisation's requirements, it will be reviewed by the Risk Management Group on an annual basis and ratified by the Audit and Risk Committee at least once every three years, and whenever significant changes to practice are proposed.

2. Purpose and Scope

The purpose of this policy is to detail the framework through which the Trust identifies and controls risks affecting its key functions and the quality of its services and furthermore, to fulfil regulatory and statutory requirements.

It applies to all substantive and temporary staff working at the Trust.

This document covers the identification and management of all risks which will predominantly fall into the following categories:

Risk	Description
Clinical	Risks affecting the quality of care and treatment provided to patients, encompassing patient safety, clinical effectiveness and patient experience.
Workforce	Risks relating to the trust's ability to recruit, retain, and develop a high-performing workforce in both clinical and non-patient facing roles, and to provide a supportive working environment.
Health and Safety	Risks which do not have the ability to directly affect individual patient care or harm the patient in a clinical or treatment focused way but may affect patients and others on site such as visitors, contractors and staff, e.g. fire, security, environmental and health and safety issues.
Financial	Risks which have the ability to affect the financial wellbeing of the Trust, including risk of fraud and claims against the Trust. This also includes protecting intellectual property.
Information Governance	Risks which pose the possibility of a breach of confidentiality, either personal or professional (e.g leak fo information sensitive to the Trust)
Reputational	Risks which affect the reputation of the Trust and its relationships with partner organisations within the health care system
Compliance	Risks of failing to fulfil the requirements of external regulators and auditors

It is also helpful to distinguish between strategic risks, which are recorded in the Board Assurance Framework, and operational risks, which are recorded in the corporate and local risk registers. Definitions are provided below:

Strategic Risks: concern the long-term strategic objectives of the trust. They can be affected by such areas as capital availability, political, legal and regulatory changes, and reputation. These will usually be identified at Board, or Executive level ('top down')

Operational Risks: Operational risks concern the day-to-day issues that the trust faces as it strives to deliver its strategic objectives. The majority of risks identified will fall into this category. An operational risk can become a strategic risk if it is serious enough to prevent achievement of the strategic objectives. Mostly, though not always, these are identified by departments or business units themselves ('bottom up') but may be escalated to executive or board level if they are sufficiently serious.

The boundaries between these categories are not always obvious, and some risks may fall into more than one category.

The Trust is committed to ensuring the safety of patients, staff and the public through risk management. This is best achieved through an open and honest culture, where concerns and challenges are discussed frankly, mistakes and adverse events are reported quickly and dealt with in a positive way, and there is an emphasis on learning and improving.

3. Organisational structure, duties and responsibilities

3.1 Committee Responsibilities

Clear lines of reporting and accountability are essential for effective risk management, and clarity about roles and responsibilities promotes a culture of transparency in decision-making. The Trust has a hierarchy of reporting arrangements to ensure the Board receives evidence-based assurance in relation to strategic and operational risks.

The Board, the Audit and Risk Committee, Quality and Safety Committee, Finance Performance and Digital Committee, People and Culture Committee, and the Risk Management Group all have a critical function in considering policy and strategic issues, and overseeing the management of risk. These structures are

designed to ensure accountability and the flow of information. In this way the Trust can identify themes and trends, and promote good practice throughout the organisation.

3.1.1 Board of Directors

The Board gains assurance that strategic risks are being appropriately managed through the Board Assurance Framework (BAF), which records the principal strategic risks facing the organisation. The Board also receives the Corporate Risk Register, and is thus sighted on the most significant operational risks. The Board accepts prime responsibility for corporate governance and the development of systems of internal control, including risk management, the BAF and compliance with Care Quality Commission (CQC) regulations, although it delegates many of its responsibilities to its committees and to management.

3.1.2 Audit and Risk Committee

The Audit and Risk Committee reviews the effectiveness of the system of risk management and internal control across the Trust. As part of this work it reviews the Board Assurance Framework in detail and receives the Corporate Risk Register, which lists major operational risks (scored 15 or higher) which cannot be managed locally in business units or departments. Furthermore, it is responsible for approving this policy.

The Audit and Risk Committee oversees the work of internal audit, external audit, the local counter fraud service, as well as the role of trust management in maintaining internal control and ensuring compliance with laws and regulations.

The Audit and Risk Committee is chaired by a Non-Executive Director and membership consists solely of Non-Executive Directors. Executives are invited to attend.

3.1.3 Board Assurance Committees

The Board has established a number of other committees covering topics such as finance and workforce. Those committees oversee strategic risks relating to their remit, as defined in their terms of reference, primarily through scrutiny of the Board Assurance Framework.

3.1.4 Risk Management Group

The Risk Management Group is an operational management committee chaired by the Chief Nurse and Patient Safety Officer, which consists of executive directors and senior managers.

The group's duties and responsibilities include the following:

- Monitoring the risk register by exception, with a focus on new risks, closed risks, risks overdue for review, and risks whose score has remained unchanged or not reached their target scores for more than twelve months
- Ensuring that risk is managed effectively in business units and non-patient facing corporate services by means of deep dive reviews of local risk registers
- Ensuring a common approach to risks which cut across business unit or departmental boundaries, and avoid duplication
- Discussing the outcomes of assessments of the risk management process, e.g. internal audit reports, and ensuring that their recommendations are implemented promptly and fully
- Adding to the Corporate Risk Register significant operational risks which cannot be managed locally within a business unit or non-patient facing corporate service, and require involvement by one or more executive directors
- De-escalating risks from the Corporate Risk Register to business unit or local risk registers when they have been mitigated such that they no longer require corporate-level oversight
- Contributing to identification and review of strategic risks for inclusion in the Board Assurance Framework
- Developing a training needs analysis for risk management and monitoring levels of participation in the training

3.1.5 Business Unit Governance Meetings and Corporate Services Risk Reviews

Each business unit holds a regular governance meeting at which it reviews its risk register in line with section 5.4.4 of this policy. For non-patient facing corporate services such as finance, informatics, estates, communications etc., which do not form part of a business unit, there are regular meetings which review risks to these services. The business unit governance meetings and corporate service meetings that consider risk report upward to the Risk Management Group.

3.2 Individual Responsibilities of Key Personnel

All staff are responsible for identifying, reporting and escalating risks and incidents promptly, thereby allowing risks to be managed and added to the risk register. In addition, staff are responsible for taking steps to avoid injuries and risks to patients, staff and visitors. Specific duties and roles of key individuals in the risk management process are summarised below:

3.2.1 Chief Executive

The Chief Executive has ultimate responsibility and accountability for risk with the Trust. They are required to sign an Annual Governance Statement, outlining the Trust's governance and assurance systems, and a Statement of Accounting Officer's Responsibilities which are submitted to NHS England, and published in the Trust's Annual Report. Generally the Chief Executive provides leadership and strategic direction, while delegating responsibility for managing different types of risks to executive directors and senior managers. However, within the executive team, they have specific management responsibility for communications and charities, and for the associated risks.

3.2.2 Chair of the Audit and Risk Committee

There is a named non-executive director who has responsibility for risk management and chairs the Audit and Risk Committee.

3.2.3 Chief Nurse and Patient Safety Officer

The Chief Nurse and Patient Safety Officer has joint lead responsibility with the Chief Medical Officer for clinical governance, for the management of risks affecting the quality and safety of patient care. In this capacity they chair the Risk Management Group, and line manage the Head of Clinical Governance and Quality and Qualituy. The Chief Nurse and Patient Safety Officer has individual responsibility for compliance with the CQC fundamental standards and is the Director for Infection Prevention and Control (DIPC). They also lead on safeguarding issues at executive level and are the accountable officer for controlled drugs.

3.2.4 Chief Finance and Planning Officer

The Chief Finance and Planning Officer is responsible for the management of financial and estates risks. The Chief Finance and Planning Officer ensures that the Trust carries out its business providing healthcare while complying with standing financial instructions and budgeting and accounting processes designed to control financial risks.

3.2.5 Chief People Officer

The Chief People Officer is responsible for the management of risk in relation to staff, including safe recruitment processes, negotiation with staff side, co-ordination of training and development programmes, and the adoption of human resources policies which enable the trust to comply with employment law.

3.2.6 Chief Medical Officer

The Chief Medical Officer has joint lead responsibility with the Chief Nurse and Patient Safety Officer for clinical governance, and thus for the management of risks affecting the quality and safety of patient care.

The Chief Medical Officer leads on the trust's digital programme and associated risks at executive level. In this capacity, they act as the Trust Caldicott Guardian. The Caldicott Guardian champions information governance within the organisation, ensuring that it meets the highest practical standards for handling patient information safely and confidentially.

3.2.7 Chief Operating Officer
The Chief Operating Officer is responsible for the performance and day-to-day management of the trust's clinical services, including their compliance with constitutional standards and patient access targets, and is therefore responsible for the management of risks relevant to their portfolio. They are also responsible for emergency planning, preparedness and resilience at executive level.

3.2.8 Head of Clinical Governance and Quality
The Head of Clinical Governance and Quality has operational responsibility for the upkeep of the risk register, for the trust's programme of risk management training, and for line management of the Clinical Governance Managers and Assistant Governance Managers.

3.2.9 Trust Secretary
As the lead for corporate governance in the trust, the trust secretary is responsible for:

- ensuring compliance with the Constitution
- accessing legal advice where appropriate
- maintaining the Trust Policy Database, to ensure version control, and Records Management
- drafting the Annual Governance Statement and the Board Assurance Framework
- maintenance of appropriate insurances and indemnities
- ensuring compliance with Freedom of Information

3.2.10 *Health and Safety Manager*
The Health and Safety Manager oversees the management of health and safety risks within the Trust and provides expert advice to managers to maintain best health and safety practice. The Health and Safety Manager acts as a Trust link with the Health and Safety Executive (HSE) and ensures trustwide health and safety audits are undertaken and action plans carried forward within the business units. The Health and Safety Manager will ensure RIDDOR reportable adverse incidents are reported to the HSE and identifies trends to mitigate recurrence.

3.2.11 Business Unit Management Teams and managers of corporate departments
The Business Unit Management Teams, and managers of central corporate departments, are responsible for applying this policy in their areas. This includes:

- Ensuring risk assessments are undertaken and action implemented
- Implementing and monitoring risk control measures within their areas of responsibility
- Ensuring that local and business unit risk registers are kept up to date
- Ensuring staff undertake mandatory and statutory training
- Ensuring that incidents are reported and, where necessary, investigated

3.2.12 Clinical Governance Managers
The Clinical Governance Managers are responsible for supporting the business unit management teams with the implementation of this policy, for acting as a link between the business units and the Clinical Governance Team, and for promoting good governance within the business units. Clinical Governance Managers also complete an initial quality review of all new draft risks from their business units before they go live on the risk register.

3.2.13 Risk Owner
Identified Risk Owners are responsible for ensuring an identified risk that has been allocated to them is managed in line with this strategy. Risk owners will normally be executive directors or senior managers of the trust.

3.2.14 Risk Handler
Identified Risk Handlers are responsible for the day to day management of identified risks that have been allocated to them. There may be occasion when a risk handler is also the risk owner of the same risk.

3.2.15 All Trust Employees
All employees of the Trust have a responsibility to:

- Work in accordance with corporate policies and procedures
- Practice within the standards of their professional bodies, relevant national standards and trust clinical guidelines
- Identify through their own departments self-assessment process and line management arrangements, any risks which they feel exist within the service and their practice
- Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided
- Attend corporate induction and participate in mandatory training

3.3 Specialist Advice

Advice and expertise in specific areas of risk is available from:

- Caldicott Guardian (Chief Medical Officer)
- Research and Development Manager
- Head of Clinical Governance and Quality
- Clinical Governance Managers
- Trust Secretary
- Health and Safety Team
- Infection Control Lead Nurse
- Local Security Management Specialist
- Local Counter Fraud Specialist

3.4 Audit

3.4.1 Internal Audit

The Trust commissions an internal audit service which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. They provide an independent, objective opinion on the design and operation of the trust's risk management and governance processes. The internal audit programme is risk-based.

3.4.2 Clinical Audit

The Chief Medical Officer sets out an annual forward programme of clinical audits, to be undertaken by the trust's own clinicians, and report results back to the Quality and Safety Committee. Risks affecting the quality of care and treatment provided by the trust may be identified through clinical audits.

3.4.3 External Audit

The Trust is required to commission an external audit service, which is provided by a firm of chartered accountants. External audit is an essential element of corporate governance, contributing to accountability for use of resources and financial stewardship. The scope of audits covers not just the financial statements but also arrangements to secure value for money. External audit reports to the Audit and Risk Committee.

4. Approaches to Risk

The Trust will adopt both a proactive and reactive approach to risk management as follows:

4.1 Pro-active Approaches to Risk Management

- Developing and maintaining the BAF and Risk Registers
- Ensuring a consistent approach to risk assessments/development of risk registers
- Developing policies and procedures, as well as a process to keep them up to date and monitor their implementation
- Maintaining an effective Safety Alert System

- Clinical Audit
- Emergency Planning, Preparedness and Resilience arrangements
- Dissemination of newly-published National Institute of Clinical Excellence (NICE) guidelines and completion of gap analyses and action plans
- Ensuring training and development of staff

4.2 Reactive approaches to Risk Management

- Learning from serious incident investigations and making improvements
- Learning from complaints and Patient Advice and Liaison Service (PALS) contacts and making improvements
- Making changes in response to litigation brought successfully against the trust, or to coroner's reports
- Implementing recommendations from National Enquiries, internal/external reviews/recommendations etc
- Implementing legislative changes and NHS national policy directives
- Using information in public domain published by the regulatory bodies such as the CQC

4.3 Risk Taking, Appetite, Tolerance and Opportunities

4.3.1 Risk Taking

The Trust acknowledges that embracing opportunities, for example developing new services or creating new job roles, usually involves taking risks. Risk is not always negative and we should be aware of the possibility of 'upside risk', i.e. uncertainties that could actually have a beneficial effect and help us to achieve our objectives.

Risk is a fact of life in healthcare. We cannot create a risk-free environment, but rather one in which risk is considered as an integral part of everything we do, and is clearly identified and controlled. The trust aims to be 'risk aware' rather than 'risk averse'.

4.3.2 Risk Appetite

Risk appetite is defined as *"the decision about the level of risk that an organisation is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings."*

Our aim is to ensure an appropriate balance between uncontrolled innovation and excessive caution, while guiding staff on the level of risk permitted and encouraging a consistent approach.

4.3.3 *Risk Tolerance*

Risk tolerance is defined as *"the boundaries within which the the Board is willing to allow the true day-to-day risk profile of the enterprise to fluctuate, while executing strategic objectives in accordance with the trust's strategy and risk appetite. It is the level of residual risk below which the Board expects its committees to operate and management to manage".* Risk tolerance is expressed in terms of the maximum permissible target score to which we aim to reduce risks through additional control measures. We have differing risk tolerances for different types of risk.

The Trust's risk appetite and tolerance are set out in the table below:

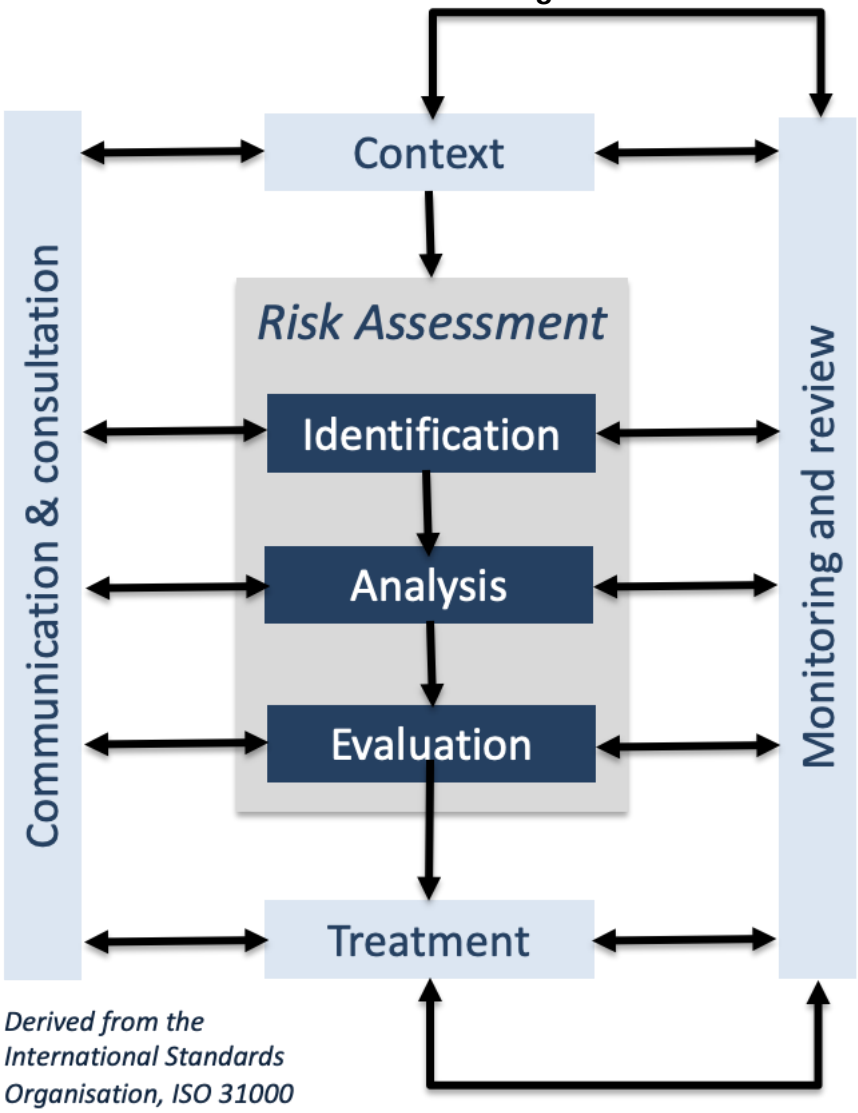
Type of Risk	Risk Appetite	Risk Tolerance *Maximum permissible target score for risk*	Rationale
Financial Risk / Value for Money	Open	9	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.

Type of Risk	Risk Appetite	Risk Tolerance *Maximum permissible target score for risk*	Rationale
Compliance / Regulation	Cautious	6	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision
People (Workforce)	Cautious	6	We are prepared to take limited risks with regard to our workforce. If attempting to innovate, we would seek to understand where similar solutions had been successful elsewhere before taking any decision.
Quality / Outcomes	Cautious	6	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Reputation	Open	9	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.

5. The Risk Management Process

An overview of the risk management process in use in the Trust is shown in the diagram below.

Overview of Risk Management



5.1 Risk Identification

The Trust takes both a proactive and reactive approach to identifying risks with the potential to cause any of the following: injury, complaint, litigation, damage to the environment or property, failure to maintain services and/or the quality of services provided by the Trust, failure to meet national targets, damage to reputation, financial loss etc.

The first stage is to identify the risks the Trust carries. This will be achieved by considering the Trust strategic objectives and the area's ability to achieve these. Other considerations are listed below and in Appendix 3. It should be noted that the list is not exhaustive.

Sources of risk are both internal and external:

- **Internal sources of risk** may include, for example: adverse incidents complaints or claims; non-compliance by the trust with legal duties; environmental hazards; obsolete or faulty equipment; ineffective communication channels, unclear policies and procedures; etc.
- **External sources of risk** include, for example: the economic climate; cybersecurity threats; changes in national policy and legislation; also hazard warnings and recommendations received by the Trust from regulators - such as the Medicines & Healthcare Products Regulatory Agency (MHRA), National NHS England, Care Quality Commission, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), etc.

For a further non-exhaustive list of risk considerations refer to Appendix 3.

5.2 Risk Assessment

All risks that are identified will be assessed using the Trust risk grading matrix at Appendix 3. The risk assessment process may identify single or multiple risks that require the creation of a risk record(s) on the risk register.

Risk assessments should be carried out by a manager with suitable experience and knowledge of the subject. Risk assessments should be discussed with the appropriate managers and clinicians to agree actions to mitigate or reduce potential risks. The key steps in the process are as follows:

1. Identify hazards (a hazard is anything which has the potential to cause harm or loss)
2. Establish which hazards are most dangerous and to whom
3. Assess adequacy of existing controls (the measures already in place to reduce the level of risk)
4. Assess how likely the risk is it to occur and what the impact would be if it did
5. Multiply the likelihood score by the impact score using the matrix to define the level of risk
6. Assign responsibility for the risk to an appropriate senior manager or clinician
7. Devise plans to meet any shortcomings
8. Establish how changes can be introduced

When completing a risk assessment, it is essential to describe the risk in terms of its cause and effect, i.e. what is giving rise to the risk, and what may happen if the risk materialises, rather than simply stating an issue or concern, such as “low staffing levels” or “obsolete equipment”. Risks should also be described in plain English, without excessive jargon or acronyms that may not be understood by people working outside the service or business unit which has identified the risk.

All risk assessments originating from within business units will be reviewed by a Clinical Governance Manager before going live on the risk register. The clinical governance manager will check that all sections of the assessment have been completed, that the risk is expressed clearly, and that the risk score (see 5.3 below) appears reasonable given what is known about the issue.

For risks originating in non-patient facing corporate services, which do not form part of business units and do not therefore have a clinical governance manager, draft risk assessments should be reviewed by a senior manager within the department which has identified the risk, before going live on the risk register.

5.3 Risk Evaluation

Risks are evaluated to establish the level of risk as part of the risk assessment process above, using the risk matrix which enables a systematic approach to risk evaluation (see Appendix 3). The level of risk is estimated by quantifying and combining consequences and likelihoods. Three risk ratings should be calculated for each risk: initial, current and target:

- **Initial** risk rating reflects the level of risk in the absence of any controls. In other words, this is the *inherent* risk.
- **Current** risk rating reflects the level of risk taking into account the controls currently in place (this enables assessment of the effectiveness of the controls, and is sometimes known as the *residual* risk)
- **Target** risk rating is the level of risk that could realistically be achieved once further actions have been taken and extra controls put in place. The target risk rating should not be higher than the trust’s risk tolerance for that type of risk (see section 4.3.3)

Scoring of risks requires judgement and can sometimes be subjective. Thus, it is advisable to consult with one’s colleagues or manager about the scores to be assigned to the risk before finalising the risk assessment.

5.4 Risk Treatment or Acceptance

Once the risk has been identified and assessed a plan must be put in place to manage the risk. The Trust is committed to ensuring that the severity of any risk is minimised to an acceptable level, i.e within the Trust's agreed risk tolerance. Whatever action is to be taken should be documented in an action plan, which will be recorded on the relevant risk registers alongside the risk assessment. The action plan should make clear who is responsible for the action and the deadline for completion. Actions should be SMART: specific, measurable, achievable, relevant, and time-limited.

5.4.1 Risk Treatment

In the NHS, by far the most common approach to managing a risk is to take action intended to reduce the likelihood of the risk materialising, or its impact if it does ('treating' the risk). However, this is not the only way that risks are managed and in some circumstances a different approach may be appropriate. The four main approaches are described below:

- **Terminate** - some risks may only be managed by terminating them entirely (avoiding the risk by not undertaking the activity that leads to the risk occurring, e.g. by closing down a service)
- **Treat** - existing controls are measures currently in place when a risk is identified to control the risk. If existing controls are not adequate, i.e. gaps are identified, an action plan should be produced to mitigate the risk by implementing additional controls.
- **Transfer** – the best way of managing some risks is to transfer them to a third party who will carry the risk on the trust's behalf, usually in return for payment, for example by taking out an insurance policy, or outsourcing a service.
- **Tolerate (accept the risk)** – where the current score of the risk is already within the trust's risk tolerance levels and no further controls are necessary, or where the cost of reducing or eliminating the risk any further may be disproportionate and / or create significant new risks elsewhere.

We can access internal expertise to decide on the most appropriate options to manage the risks and seek external advice, if required (e.g. from the CQC, NHS Resolution, NHS England, Health and Safety Executive, Internal Audit, other local NHS trusts, etc.).

5.4.2 Risk Acceptance

If following a risk assessment and consideration of the controls in place, it is considered that the risk has been adequately mitigated to an acceptable level, i.e in line with the Trust's risk tolerance, then the risk should be marked as tolerated, but should be reviewed annually thereafter to ensure the risk has not increased to a level where further action becomes necessary.

5.4.3 Risk Escalation

The level of the organisation at which a risk is monitored and managed, and in which risk register it appears, depends primarily on the current risk score. Operational risks may appear on the local, business unit or corporate risk registers. Risks directly affecting the delivery of the Trust's strategic objectives are recorded on, and managed through the Board Assurance Framework. The table below sets out the appropriate level of escalation for each of the risk levels:

Risk Rating	Responsible for Remedial Action	Responsible for Risk on Register	Risk Register Escalation Level
Green 1-3 Very Low Risk	Departmental Managers	Departmental Managers	Local Risk Register Business Unit *(or combined corporate departments)* Risk Register
Yellow 4-6 Low Risk	Departmental Managers	Departmental Managers	Local Risk Register Business Unit *(or combined corporate departments)* Risk Register

Risk Rating	Responsible for Remedial Action	Responsible for Risk on Register	Risk Register Escalation Level
Orange 8-12 Moderate Risk	Business Unit *(or corporate service)* Management Teams	Business Unit *(or corporate service)* Management Teams	Business Unit *(or combined corporate departments)* Risk Register
Red 15-25 High Risk	Business Unit *or corporate service)* Management Teams	Business Unit *or corporate service)* Management Teams *with oversight from central Governance Team*	Business Unit (*or combined corporate departments)* Risk Register Corporate Risk Register *(if escalated by Risk Management Group)*
Strategic risks (any score)	Executive Directors	Executive Directors	Board Assurance Framework

A rolling programme of review is in place to ensure that the risks are captured, recorded and scored correctly, mitigated to the greatest extent possible, and escalated to the right level of the organisation.

5.4.4 Review of live risks

The business units review their risk registers at their unit governance meetings to monitor progress of the implementation of action plans. Non-patient facing corporate services, such as estates or informatics do the same through the corporate services risk meeting. How frequently an individual risk is reviewed depends on its score – see table below:

Risk Type	Score	Review Frequency
Very Low	1-3	Annually
Low	4-6	6 monthly
Moderate	8-12	Bimonthly
High	15+	Monthly
Tolerated	Any	Annually

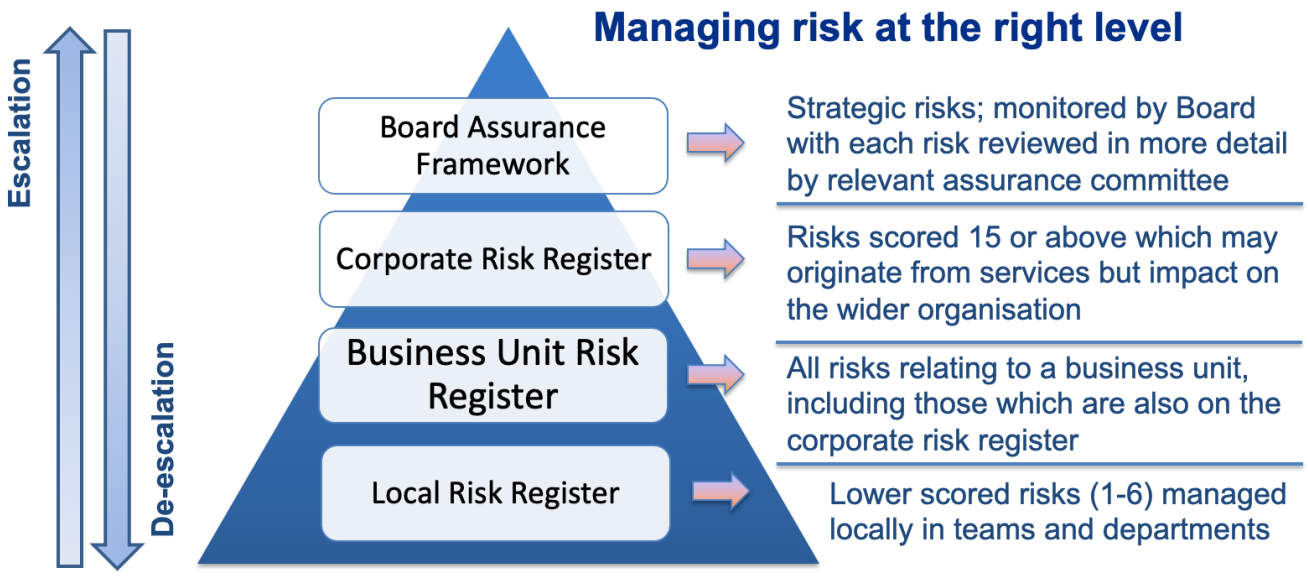
They have authority to adjust the risk score once actions have been implemented to close gaps, and/or tolerate a risk if necessary. Business units and non-patient facing corporate departments are held to account for their management of risk by the Risk Management Group through a rolling programme of deep dives.

6. Risk Registers

A risk is formally registered through the creation of a risk record. This is an electronic record on the Datix system (see below) of the risk assessment and the actions required to mitigate the risk. Each risk will have a risk owner and risk handler assigned (see section 4.2 for the responsibilities of risk owners and handlers). Together, these risk records form a risk register. There are risk registers at departmental, business unit and corporate level.

Risk registers are vital tools which support management and review of risks and the prioritisation of risk reduction activities according to risk scores. The risk registers feed into the BAF where there is potential for impact on delivery of the Trust's strategic objectives. They are dynamic living documents which are populated through the organisation's risk assessment process and are updated regularly.

Datix is the organisation's risk management database system. It is used to generate risk registers and other reports about the management of risks, incidents, complaints and claims. It enables risks to be escalated to appropriate level of risk register. These are outlined in more detail below, and summarised in the following diagram:



6.1 Local Risk Register

This register relates to risks with a current risk rating of 1-6 and will be managed by departmental managers and escalated to the relevant business unit management team (or to the corporate services risk review meeting for non-patient facing corporate departments) as and when required. These risks will be discussed at local team meetings.

6.2 Business Unit Risk Register

The business unit risk register includes all risks relating to the business unit irrespective of the risk level. However the risks are escalated upwards through different levels of management according to the risk level. As outlined above, risks with a rating of 1-6 are managed at departmental level. Risk from 6-12 are managed by the business units with support from the Clinical Governance Managers. Any risks rated as 15+ remain the responsibility of the business units but may also require escalation to executive and Board level via the corporate risk register (see below).

Non-patient facing corporate services (finance, informatics, estates, human resources, communications, etc.) will also retain risk registers similar to a business unit risk register. These will be reviewed via local management arrangements and the risks will be overseen and escalated as appropriate to the Risk management meeting. (see section 3.1.5).

6.3 Corporate Risk Register

All new risks scored 15 or higher will be considered by the Risk Management Group for inclusion in the corporate risk register (CRR) so that they can be monitored and managed at an organisation-wide level. Escalation to the CRR is not automatic, as some risks scored 15 or higher may be capable of being managed locally in business units or non-clinical corporate departments. Risks should be added to the CRR where they require executive director involvement to resolve, or solutions which need input from more than one business unit or corporate service.

The Risk Management Group can also remove risks from the CRR (de-escalation) if it judges that the level of risk has reduced, e.g. because of actions taken by management. Risks de-escalated from the CRR will be assigned to one of the business units, or the relevant corporate department, to manage.

The Corporate Risk Register will be monitored by the Risk Management Group, and will also be reported to the Audit and Risk Committee, and Board.

6.4 Risk Register Format

The risk registers, regardless of the level, must include the following information:

- Source of the risk (including, but not limited to, incident reports, risk assessments and local risk registers. These can be internal and external sources)
- Description of risk
- Categorisation of risk as strategic, operational or both
- Existing control measures
- Initial, current and target risk scores
- Action plan to manage the risk
- Date the risk was identified
- Review date of risk
- Risk owner and risk handler

7. The Board Assurance Framework

A Board Assurance Framework is defined by HM Treasury as "*a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect".* The BAF brings together the trust's strategic objectives with the principal risks which may prevent those objectives from being achieved. It lists the controls in place to manage those risks, and how the board obtains assurance that those controls are working effectively. It identifies any gaps in controls or assurances, and includes an action plan to close those gaps. It is a robust, evidence-based and objective document.

The BAF helps the board to focus its scrutiny on the issues of greatest risk, and also shapes the work of the board and its committees through their cycles of business.

It is maintained by the Trust Secretary and reviewed at the Audit and Risk Committee at each meeting and by the Board of Directors quarterly. Other board committees scrutinise those strategic risks in the BAF which are relevant to their terms of reference.

8. Organisational Learning

The Trust will continue to promote an open learning culture so that we can learn from experience – including when things go wrong - and share local examples of good practice. In particular, analysis of themes and trends from incidents, complaints, litigation and clinical audits can draw attention to emerging risks in the trust.

These are some of the ways in which Trust learns from its risk management and governance processes:

- Adverse incidents, complaints and claims are triangulated in monthly reports and discussed at the Quality and Safety Committee and disseminated to business unit management teams;
- National reports and external enquiries are reviewed at the Quality and Safety Committee or its sub-groups. A local action plan is drawn up and implemented in the business units;
- Adaptations to training programmes are made in response to learning from risks and incidents;
- Financial forecasts are adjusted in the light of identified risks; and,
- Identified groups consisting of executive directors and senior clinical managers receive daily or weekly incident reports.

9. Communication of the Policy

The Trust's Risk Management Policy will be made available on the intranet. Managers should make new staff aware of arrangements for risk management and governance in their departments through local induction. All staff are introduced to the principles outlined in the policy at corporate induction.

Amendments to the policy will be communicated as and when they occur.

10. Associated Documentation

This policy provides an overall framework for managing risks. It is recommended, therefore, that it be read in conjunction with the following documents which provide guidance about managing specific types of risk.

- Health and Safety Policy
- Violence Prevention and Reduction Policy
- Policy for the Investigation of Incidents, Complaints and Claims.
- Trust Safe Moving and Handling (Manual Handling) Policy
- Control of Substance Hazardous to Health Policy
- Trust Openness Whistleblowing Policy
- Trust Incident Reporting Policy
- Trust Duty of Candour Policy
- Prevention and Management of Falls Policy
- Security Policy

11. Training

To ensure that all staff can access the training needed to fulfil their job roles and to develop professionally, the trust has a Learning and Development Policy. The training required for Risk Management is planned, delivered and audited in accordance with this policy. The Risk Management Group complete a training needs analysis for risk and governance and review it annually.

The level of training which staff are required to undertake depends on their seniority and level of management responsibility. All staff will receive a basic awareness of risk management through mandatory training, while managers and clinical leaders will receive more tailored and in-depth training. Executive and non-executive directors will be kept up to date with developments in risk management, and clinical governance more generally, through the board development programme. Training requirements are set out in detail in the training needs assessment.

In addition to formal training, the clinical governance team can provide ad hoc support with use of the Datix system and a risk management 'how to' guide will be made available.

Appendix 1 Risk Appetite Matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

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Appendix 2 Risk Considerations

- The Trust will review compliance with the Care Quality Commission requirements on an on-going basis to identify any risks
- Effective health and safety audits and inspections and implementation of resulting action plans
- Each Director will be responsible for ensuring that departmental risk assessments are carried out, producing directorate risk registers and taking action to avoid/minimise risk as appropriate
- Regular multi-disciplinary review of incidents, complaints and claims data
- Patient and staff feedback surveys
- Public perceptions of the NHS e.g. media reviews
- Root Cause Analysis following serious adverse incidents
- Underlying root causes of incidents, complaints and claims
- Concerns raised by Trade Unions
- Whistle blowing
- Coroners reports
- Financial forecasting and reports Board Quality walkabouts
- New legislation and guidance
- Recommendation and reports from assessment/inspections from internal and external bodies
- Safety alerts
- Non Clinical/Generic Risk Assessments completed by staff
- Incident Reports
- Serious Adverse Incident Reports
- Directorate Risk Registers (for the Corporate Risk Register)
- Health and Safety Audits
- Regular Health and Safety Checks e.g. Window checks, Fire Inspections
- Complaints
- National Guidance/Reports
- Patient's conditions (e.g. inherent risk of falls in people with dementia)
- Major incident (drill or live)
- Deficiencies with effective controls assurance standards
- Deficiencies with various elements of the CQC standards
- Recommendations and reports from external agencies such as NHSLA, Health and Safety Executive, Patient-led Assessments of the Care Environment (PLACE) etc
- Actions taken to reduce risks which could not be or were not implemented for various reasons such as resource limitations
- Any other sources of information that could be considered to be a threat to patient, staff visitors, environmental safety or the organisations wellbeing
- Estates risk profile
- Financial/business plans/IT reports
- Underlying causes related to poor trends identified from key performance indicators
- Considerable deficiencies in/non-compliance with staff mandatory training

Appendix 3 Risk Assessment Matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Occasionally / Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 3 Risk scoring = Consequence x Likelihood (C x L)

	Consequences				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Occasionally / Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	Significant Risk
15 -25	High Risk

Risk Management Group

Terms of Reference draft v02

Purpose
The purpose of the Risk Management Group is to:

- provide leadership for the risk management agenda in the trust;
- provide assurance that risks are being identified proactively and managed appropriately;
- support the development of, and ensure compliance with, robust policies and processes for risk management

This group will oversee the management of risk mainly by exception, focusing on, for example, new, closed and changed risks; and on risks which are overdue for review or have consistently failed to reach their target score. It will scrutinise the application of risk management in business units and corporate services through periodic 'deep dives' into their risk registers, holding leaders in those services to account for their management of risks. It will also act as the gatekeeper to the corporate risk register, deciding whether risks scored 15 or higher require executive involvement and corporate oversight, or can be managed locally.

Membership
The core membership of the group is as follows:

- Chief Nurse and Patient Safety Officer (Chair)
- Trust Secretary (deputy chair)
- Assistant Chief Executive
- Assistant Chief Nurses
- Managing Directors for Specialist and MSK units, or designated deputy
- Head of Clinical Governance and Quality
- Head of Finance
- Head of Estates and Facilities
- Health and Safety Manager
- Director of Digital
- Clinical Governance Managers

Attendance
A quorum shall be a minimum of six members, which must include the chair or deputy, one member of the clinical governance team, and two representatives from each of the business units, of whom one should be the assistant chief nurse (or a deputy nominated to attend on their behalf) and the other the managing director (or a deputy nominated to attend on their behalf).

Members should nominate a deputy to attend on their behalf if they are unable to be present, and the secretary of the group will maintain an attendance log.

Frequency of meetings
The group will meet monthly. Frequency of meetings can be escalated to fortnightly or weekly if required.

Reporting arrangements

Reporting from the group
The Risk Management Group reports upward to the Audit and Risk Committee. It will also report to the Quality and Safety Committee in respect of clinical risks and to other board committees (Finance, Performance and Digital; and People and Culture) in respect of significant risks relevant to their remits.

Representatives of business units and corporate services at the group will be responsible for ensuring that key messages and outcomes from the meeting are disseminated in their units or departments. A chair's assurance / escalation report will be completed following each meeting.

Reporting to the group
The business unit governance meetings, and the corporate services meetings that consider risk, will report upward to the Risk Management Group, by exception.

Objectives
RJAH Orthopaedic Hospital NHS Foundation Trust is committed to providing a systematic process for identifying risks attached to new and current business activities.

The objectives of the Risk Management Group are as follows:

Risk Management Framework

- To develop and endorse the trust's risk management policy, prior to approval by the Audit and Risk Committee
- To contribute to the development of the trust's risk management strategy / improvement plan, and ensure that it is implemented
- To ensure that the trust's approach to risk management satisfies the requirements of statutory bodies such as the Care Quality Commission, NHS England and NHS Resolution.

Risk Management Practice

- To monitor the risk register by exception, with a focus on new risks, closed risks, risks overdue for review, and risks whose score has remained unchanged or not reached their target scores for more than twelve months
- To ensure that risk is managed effectively in business units and corporate services by means of deep dive reviews of business unit and corporate departments' risk registers
- To ensure a common approach to risks which cut across business unit or departmental boundaries, and avoid duplication
- To discuss the outcomes of assessments of the risk management process, e.g. internal audit reports, and ensure that their recommendations are implemented promptly and fully

Escalation and de-escalation of risks

- To add to the Corporate Risk Register of significant operational risks which cannot be managed locally within a business unit or corporate service, and require involvement by one or more executive directors
- To de-escalate risks from the Corporate Risk Register to business unit or local risk registers when they have been mitigated such that they no longer require corporate-level oversight
- To contribute to identification and review of strategic risks for inclusion in the Board Assurance Framework

Training

- To develop and update a training needs analysis for risk management
- To monitor levels of participation in the training

Risk Culture

- To ensure that the way risks are managed is consistent with the trust's risk appetite as defined by the Board
- To promote an open risk management culture which enables learning and positive change

In pursuit of these objectives, meetings of the group will follow a standard agenda. This agenda will include:

- Escalation reports from the unit and corporate function risk discussions;
- Review of the current Corporate Risk Register;
- Review of all risks currently rated at 15 or above (and consideration of their inclusion on the Corporate Risk Register);
- A report on the overall risk profile of the Trust.

The group will have a work programme which sets out the issues that it will discuss and the papers that it will receive over the course of a year.

An action log will be maintained which will record the actions required resulting from meetings, with responsibilities and deadlines allocated to individuals.

Policy Approval Framework

Committee / Group / Meeting, Date

Board of Directors, 3 May 2023

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

N/A.

Is the report suitable for publication?:

YES

Key issues and considerations:

The Trust's scheme of reservation and delegation places particular responsibilities on the Board and its committees in relation to the review and approval of policies. These responsibilities are reflected in the Trust's Policy Approval Framework (referred to subsequently as "the Framework").

The Framework was last reviewed and approved in November 2021. Board members have since requested clarity on its interpretation / implementation.

The scheme of reservation and delegation states that both the Board and its committees have a role in approving policies. There are however differences in the respective roles of the Board and its committees and the scope of the policies considered at Board and committee level is different. The revised Framework makes a distinction between the "approval" of policies at the Board and "ratification" of policies at the committees.

The Board sets the overall strategic direction of the Trust. The Board is responsible for approving core, corporate policies that relate to effective governance. These policies require ownership at Board level. The Board is expected to be familiar with the content of these corporate policies and is required to "approve" the content of such policies. These primarily relate to:

- Codes of conduct;
- Health and safety;
- Whistle blowing;
- Business continuity; and
- Risk management.

Generally, the committees' role is to provide assurance to the Board. The remit of the committees can be very broad and policies relating to that remit may be technical in nature. As such, the committees are not expected to be familiar with the detail outlined in such policies. Committees may seek assurance on the proposed content but the relevant executives are responsible for developing and proposing the content. The committees' role is to seek assurance that all relevant steps have been taken in the development of such policies. The revised Framework defines this as "ratifying" rather than "approving" policies.

In accordance with the revised Framework, committees will ratify policies if they are assured that they have been developed, or revised:

1. With reference to relevant:
    a. Legislation;
    b. Regulatory requirements;
    c. Statutory guidance; and
    d. Good practice.
2. Having taken appropriate expert / professional advice;
3. Having involved the relevant advisory / decision-making groups within the Trust;
4. Having engaged key external stakeholders, where appropriate; and
5. With the support of the relevant senior executive.

In line with their general responsibilities around providing assurance to the Board, committees may also seek assurance on the existence of, and compliance with, policies that are relevant to their remit.

The scheme of reservation and delegation sets out some specific, additional responsibilities for the Board and its committees. The committee responsibilities relate primarily to the Audit and Risk Committee. These specific responsibilities are set out in revised Framework.

Strategic objectives and associated risks:

The framework will indirectly support all the Trust's objectives but is particularly relevant to:
1. Developing and Maintaining Safe Services
5. Maintaining statutory and regulatory compliance

Recommendations:

That the Board:
APPROVE the revised Policy Approval Framework.

Report development and engagement history:

A paper on the underpinning principles that are reflected in the revised Framework was considered by the Board at a private Board meeting on 30 March 2023.

Next steps:

Should the revised Framework be approved:

- The revised Framework will be published on the Trust's intranet and will be communicated to staff via the regular corporate communication channels.
- The updated policy approval templates will be launched as one element of a wider suite of revised templates and guidance that have been developed.
- Committee terms of reference will be reviewed and updated as necessary to reflect the principles outlined in the revised Framework.

Appendices

Appendix A Revised Policy Approval Framework*

*The attached version is a "clean" copy of the Framework. Changes are outlined in the "version control sheet" but a full tracked-change copy can be provided to Board members if requested.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	Policy Approval Framework		
Unique Identifier:	POL001	**Document Type:**	Policy
Version Number:	12.0	**Status:**	
Responsible Director:	Chief Nurse and Patient Safety Officer		
Author:	Trust Secretary		
Scope:	Trust Wide		
Replaces:	Version 11.0		
To be Read in Conjunction with the Following Documents: (list related policies)	• Corporate Records Management Policy • Equality Impact Assessment Procedure		
Keywords:	Policy, Procedure, SOP, document management		

Considered By Responsible Director:	Chief Nurse and Patient Safety Officer	**Date Endorsed:**	
Endorsed By:	Executive Team	**Date Approved:**	
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Contents

Version Control Sheet

Record of Amendments to: Policy Framework v11.0				
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
Cover	Revision of title to Policy Approval Framework			To provide clarity on the purpose of the framework
Throughout	Replacing “Policy” with “Framework" when referring to this document.			To avoid confusion between this document and the policies it refers to.
Throughout	Minor formatting and presentational changes			To provide greater clarity.
3.0	Replacing definition of “Matters Reserved for the Board”.	Removal of “Document agreed by the Board which formally sets out the matters which it reserves to itself to approve.”	Addition of “Matters which the Board has reserves to itself to approve.”	To provide a more accurate definition.
3.0			Addition of definitions of “Approval” and “Ratification”	To provide clarity on the respective roles of the Board and committees.
4.	Reordering of roles and responsibilities section			To reflect the hierarchy of Board, then Committees, then individual post holders / roles
4	Replacing the previous section on individual committees’ roles with revised content.			Reflecting the principles outlined in the revised Framework in relation to “approval” and “ratification”.
4.14	Replacing the previous “Document Author” content			Reflecting the Policy Authors’ responsibility to provide the committee with the necessary information.
5.1.2	Amendment of “policy style and format” section.	Removal of previous detail on policy formatting.	Sign-posting to the policy / procedure format.	Future-proofing the Framework document and avoidance of repetition.
5.1.4	Renaming the “consultation” section and content.	Removal of previous references to “consultation”	Addition of references to “engagement”	To make a distinction between engagement and consultation.
5.2	Reworking of previous “Policy Ratification” section.	Removal of previous table.	Addition of reference to “Approval” as well as “Ratification”. Addition of table that reflects the SORD.	To reflect the requirements set out elsewhere in the Framework.
5.2.1	Revision of “New Policies” section	Removal of “All new policies must be consulted on with relevant staff groups before being submitted to the appropriate ratifying body for ratification.“	Addition of “All new policies must be developed in accordance with paragraph 4.14 before submission to the appropriate ratification / approval body.”	To reflect the requirements set out elsewhere in the Framework.
6.1	Revision of “Implementation” section			To reflect the requirements set out elsewhere in the Framework.

Record of Amendments to: Policy Framework v11.0				
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
6.4	Revision of "Training and Dissemination" section	Removal of references to "Training"	Addition of references to "Communication".	
Appendix		Removal of appended "Policy and Procedure" template		Future-proofing the Framework document and avoidance of repetition.
Record of Amendments to: Policy Framework v10.0				
Amendments approved by: Senior Leader Group 19/10/2021				**Date**
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**
Page one	Front sheet			Change of titles and dates
Page five	Change of title			
Page five	Update to the Committee names			
Page six	Update to the Committee names			
Page eight	Reporting timeframe			Aligned to the Audit and Risk Committee

Policy Approval Framework

1.0 Introduction

The policies and procedures of the Trust are intended to provide a framework to ensure that the work of the Trust is conducted in such a manner as to enable the organisation to provide world class care and fulfil its statutory and contractual obligations.

All new policies and procedures throughout the Trust will be developed and managed in accordance with this framework. Existing policies and procedures will be amended as they become due for revision and updating.

2.0 Purpose and Scope

2.1 Purpose

This framework has been developed to ensure that all policies have been approved at the appropriate level, are accessible, understandable and are reviewed within defined time periods.

2.2 Scope

This framework applies to all staff that are responsible for developing, drafting and authorising policies.

This policy does not include patient information leaflets, standard operating procedures (SOPs) or other procedures which will be subject to other guidance.

3.0 Definitions

Strategy
A long term plan to achieve an objective.

Policy
A policy is a set of guiding or governing principles, which meets all or most of the following criteria:

- It supports the Trust's strategies
- It is a governing principle that mandates or constrains actions
- It has Trust wide application
- It will change infrequently and sets a course for the foreseeable future
- It helps to ensure compliance with overarching principles, legislation, national policy directives or professional guidance
- It helps to reduce organisational risk

Procedures
A procedure is a required series of steps followed in a regular order in order to achieve a defined outcome.

Guideline
A guideline is a set of systematically developed standards or rules, which may assist in the decision about how to apply an agreed policy. Guidelines are often used to underpin a policy, and represent good practice.

Matters Reserved to the Board
Matters which the Board has reserves to itself to approve.

Approval
The Board or Committee approving the content of a policy.

Ratification
A Committee confirming that a policy has been developed in accordance with a robust process.

4.0 Roles and Responsibilities

4.1 Board of Directors

The Board sets the overall strategic direction of the Trust. The Board is responsible for approving core, corporate policies that relate to effective governance. These policies require ownership at Board level. The Board is expected to be familiar with the content of these corporate policies. The Board "approves" such policies.

4.2 All Committees of the Board

Generally, the committees' role is to provide assurance to the Board. The remit of the committees can be very broad and policies relating to that remit may be technical in nature. As such, the committees are not expected to be familiar with the detail outlined in such policies. Committees may seek assurance on the proposed content but the relevant executives are responsible for developing and proposing the content. The committees' role is to seek assurance that all relevant steps have been taken in the development of such policies before it "ratifies" them for adoption by the Trust.

In line with their general responsibilities around providing assurance to the Board, committees may also seek assurance on the existence of, and compliance with, policies that are relevant to their remit.

4.3 Audit and Risk Committee

The Audit and Risk Committee has a particular role in:

- Approving policies relating to counter-fraud and managing conflicts of interest. The committee is expected to be familiar with the content of these corporate policies.
- Reviewing the adequacy of certain policies on behalf of the Board (and making a recommendation to the Board on their approval). These chiefly relate to the corporate policies that are reserved for approval by the Board.
  The Committee has an associated role to provide assurance to the Board that the Trust "*complies with its own policies and all relevant external regulations and standards of governance and risk management".*
- Providing assurance to the Board on particular elements of the Annual Report and Accounts and associated financial policies (and making a recommendation to the Board on their approval).

4.9 People and Culture Committee

The People and Culture Committee has a particular role in monitoring and supporting the development of the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.

4.10 Chief Executive Officer

The Chief Executive Officer has overall responsibility for the strategic and operational management of the organisation which includes ensuring that all documents comply with all legal, statutory and good practice requirements.

4.11 Chief Nurse and Patient Safety Officer

The Chief Nurse and Patient Safety Officer is accountable to the Trust Board for ensuring compliance with this framework in all parts of the Trust.

4.12 Executive Directors

Executive Directors are accountable to the Chief Executive for:

- identifying and developing policies relevant to their area of responsibility;
- ensuring that these policies are reviewed, kept up to date, and reapproved as required; and
- ensuring the implementation of policies relevant to their area of responsibility.

4.13 Trust Secretary

The Trust Secretary is responsible for ensuring that policies have been through the correct approval procedure and meet the document control requirements before they are posted on the Trust's intranet and that copies of policies are published, filed and archived in accordance with this framework.

4.14 Policy Authors

The policy author must ensure policies have been developed, or revised:

1. With reference to relevant:
    a. Legislation;
    b. Regulatory requirements;
    c. Statutory guidance; and
    d. Good practice.
2. Having taken appropriate expert / professional advice;
3. Having involved the relevant advisory / decision-making groups within the Trust;
4. Having engaged key external stakeholders, where appropriate; and
5. With the support of the relevant senior executive.

4.15 All Staff, Contractors and Students

All staff, contractors and students must comply with the policies which apply to them. This includes temporary and agency staff.

5.0 The Development, Ratification, Publication and Archiving of a Policy

5.1 Policy Development

5.1.1 Executive Lead

The responsible director must determine if a new policy is required, this will include a review of existing documents to determine if an existing document should either be amended or replaced.

5.1.2 Policy Style and Format

All policies should be written in a style which is concise and clear using unambiguous terms and language and follow the Trust's template for policies / procedures (which is available on the Trust's intranet).

5.1.3 Equality

All Policies must be developed in accordance with the Trust's Policy on the Equality Delivery Scheme.

5.1.4 Engagement

Engagement is a key part of policy development. The policy author should identify any relevant stakeholders and their required level of involvement.

5.2 Policy Approval / Ratification

As described at section 3:

- "Approval" equates to the Board or Committee approving the content of a policy.
- "Ratification" equates to a Committee confirming that a policy has been developed in accordance with a robust process.

Policies must be approved / ratified in accordance with the Trust's scheme of reservation and delegation:

Board / Committee	Role
Board of Directors	Approval and revision of Trust-wide Policy Management guidance. Approval of key policies of general application throughout the Trust, including: • codes of conduct • health and safety policy • whistle blowing • business continuity • risk management Approval of any significant changes in accounting policies or practices. Approval of treasury policies, including foreign currency exposure and the use of financial derivatives.
Audit and Risk Committee	Approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Framework. These will include: • Counter Fraud Policy • Management of Conflicts of Interest Policy
Audit and Risk Committee	Review the adequacy of: • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications. • The policies and procedures for all work related to fraud and corruption as required by NHS Protect and best practice. • The policies and procedures promoting an anti-bribery and corruption culture. This will include the "Whistle blowing" and Standards of Business Conduct policies and the Declaration of Interests and Hospitality registers
Audit and Risk Committee	Review the Annual Report and Financial Statements before submission to the Board, focusing particularly on: • The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee; • Changes in, and compliance with, accounting policies and practices
Audit and Risk Committee	Seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management.
NED Remuneration and Appointment Committee	Recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers.
People Committee	Monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.

If it is unclear which Committee is responsible for approving a policy, recommending approval of a policy, or ratifying a policy, the Executive Lead shall make a recommendation to the Executive Team on the proposed review / approval route.

5.2.1 New Policies

All new policies must developed in accordance with paragraph 4.14 before submission to the appropriate ratification / approval body.

5.2.2 Review of existing policies

Policies will normally be reviewed every three years, unless agreed otherwise when it is approved. It is however conceivable that policies may need updating in the meantime to remain current and in line with national guidance and legislation.

If a policy is updated within its review date the following options are available to the author:

1. Minor changes which do not materially change the spirit of the policy can be made with the approval of the responsible Executive Director without recourse to the ratifying body; or
2. If a review results in the identification of material changes to the spirit of the policy or an impact on existing processes, the policy must be submitted to the appropriate ratifying body.

5.3 Publication of a Policy

The policy author is responsible for ensuring the policy, once ratified, is made available for publication on the Trust Intranet. In order to publish a policy, the following must be submitted to the Trust Secretary:

- The new / updated policy
- A copy of the minute confirming ratification
- A completed equality impact assessment

The Trust Secretary will establish procedures for the numbering of policies prior to publication and the filing, retention and archiving of policies that are no longer applicable or have been superseded.

6.0 Implementation and Monitoring of the Policy Framework

6.1 Implementation plan

All new or revised policies should be reviewed and ratified / approved in line with this framework from the date of approval by the Board.

6.2 Communication and Dissemination

This framework will be published on the staff intranet and communicated to staff via the regular corporate communication channels.

Staff can seek advice from their Director or the Trust Secretary if they require further guidance on the development of policy documents.

6.3 Monitoring

Compliance with this policy will be monitored on a rolling basis by the Trust Secretary. As part of the checks which are performed prior to any policy being uploaded onto the intranet, any policy which is not compliant will be returned to the document author for amendment. A summary of policies reviewed / approved / ratified during the year will be provide to the Audit and Risk Committee.

In addition, each ratifying body will receive a report at least quarterly on the status of policies within their remit.

6.4 Review

This framework will be subject to review no later than three years after its approval date.

Air Vice Marshal Anthony J Stables CBE
Chairman Headley Court Charity
3, The Salterns, Bay Drive
Norton, Yarmouth
Isle of Wight
PO41 0BD

Mr Harry Turner
Chair
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Oswestry
Shropshire
SY10 7AG

10 April 2023

Dear Harry,

Please forgive this typewritten note but it represents a significant improvement over my handwriting! I trust that you had a trouble-free return journey to Portugal, my own journey along eight different motorways occasioned not one delay!

What a wonderfully joyous event we experienced on Tuesday last with HRH setting everyone at ease and a lot of smiling and laughing all round. Thank you for your kind hospitality and for the opportunity to be a part of this milestone event. It has been a very successful project and I know that my trustees are delighted with the outcome, a centre which will be a fitting legacy to almost seventy years of world class defence medical rehabilitation at Headley Court.

That legacy means a great deal to me personally for having experienced three high impact vertical helicopter crashes (not entirely my fault) in the late 60s and early 70s, an eminent consultant orthopaedic surgeon told me, in 1981, that I would never fly again. Given one last throw of the dice, I was admitted to Headley Court and after six weeks of treatment I was pronounced fit to fly with a proviso that I return to Headley Court annually for the remainder of my service career. So, I became an annual patient for the next twenty-five years and probably the longest serving patient in the history of the place, but I kept flying! Thus, I owe my career and probably my life to Headley Court.

I spoke briefly with Carl about the future. As you will know, my trustees have resolved to dissolve the Headley Court Charity this year. Effectively, this would mean assigning the overage clause associated with the sale of the Headley Court estate and any residue funding to a charity with comparable purpose. We have identified two such armed forces charities and I have invited them to address my Board on 26 July at the RAF

Benevolent Fund in Portland Place. Recognising that there is no equivalent 'receiver charity' at RJ&AH, we previously discussed the option for the Headley Court Charity to be maintained with existing trustees standing down to be replaced by appointees of your Foundation Trust. My trustees are open to this proposal and I mentioned to Carl that an opportunity presented to address my trustees on 26 July at 1300. I think that Mike is sorting out the detail.

For now though, thank you again for your generous welcome and kind hospitality.

I have written separately to Victoria.

Warm wishes,

Tony

Scanned and sent to GM 11/4/23

BAGSHOT PARK

Mr Harry Turner
Chairman, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH))
Tympath Lane
Gobowen, Oswestry
Shropshire
SY10 7AG

6th April 2023

Dear Harry,

The Duchess of Edinburgh has asked me to write and convey her gratitude to you and all your team following Her Royal Highness's visit to The Robert Jones & Agnes Hunt Orthopaedic Hospital this week.

The Duchess was delighted to have the opportunity to formally open the Headley Court Veterans' Orthopaedic Centre and to spend time with the staff and volunteers delivering such a remarkable service for your patients. It was wonderful to see the pride and enthusiasm in everyone who attended. Thank you for giving up your time to be part of the visit and helping to host Her Royal Highness on the day.

The Duchess is mindful that her visits required a great deal of planning and has asked that her thanks be extended to everyone who worked hard on the preparations. Please give our special thanks to Stacey Keegan and Lieutenant Colonel Carl Meyer in particular, as well as everyone else in your team who ensured things went smoothly on the day. It is very much appreciated.

Her Royal Highness sends you her very best wishes and hopes you enjoy a peaceful Easter Break.

Kind regards,

Jason

PS: Pleased we could reunite two former colleagues!

Jason Keen
Assistant Private Secretary to TRH The Duke & Duchess of Edinburgh

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SELINA GRAHAM
The High Sheriff of Shropshire (2022-2023)

4th April 2023

Dear Harry (if I may?)

We were barely introduced, but I feel I know you having posed for so many photographs with you! I hope that you caught your plane and had a lovely remainder of your holiday – what a worthwhile trip back you had! I'm sure that there were months of planning that went into the 'Royal Opening' but it appeared to go so seamlessly, with the semblance of utter relaxation and calm. Everybody was so delighted to be there, and so proud of the Centre – even I feel proud of it – and I've never ever been there before – although I have been hearing about it

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throughout my Diwedd year!

Thank you so much for inviting my husband and me – we had some great conversations, took away lots of thoughts & ideas for the future – and of course the vicarious pride in the success & achievements of all those involved in the vision and the creation of the Veterans' Centre, and in pulling together the wonderful Royal Celebration that was today.

With a daughter passing out from Sandhurst next week, I have a particular interest in the welfare of our veterans and it was a great pleasure to meet so many people today - fundraisers, volunteers, donors, staff and dignitaries all coming together to witness the opening of this important building and celebrate the service it provides. Please pass on my thanks to all involved in today. It was a triumph!

With very best wishes

Selina