The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 01.03.2023

MEETING
1 March 2023 09:30

PUBLISHED
28 February 2023

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	1/03/23		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes from the previous meeting January 2023 (to follow)		Chairman	
1.4. Matter Arising		All	
2. Staff Story: Cost of Living Presentation		Chief People Officer	09:40
3. Chair and Chief Executive Officer Update		Chair / Chief Executive Officer	09:55
4. Corporate Risk Register		Trust Secretary	10:10
5. Quality and Safety			10:20
5.1. Chief Nurse and Patient Safety Officer Update		Chief Nurse	
5.2. IPR Exception Report		Chief Nurse and Chief Medical Officer	
5.3. Chief Medical Officer Update (verbal)		Chief Medical Officer	
5.3.1. Learning from Deaths Q3 Report			
5.4. Chair Report from Quality and Safety Committee		Non Executive Director	
5.4.1. IPC Improvement Plan (inc. IPC Letter)			
5.4.2. IPC Board Assurance Framework			
5.5. Chair Report from IPC Quality Assurance Committee		Non-Executive Director	
BREAK			11:05

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	1/03/23		09:30
6. People and Workforce			11:20
6.1. IPR Exception Report		Chief People Officer	
6.2. Freedom to Speak Up Q3 Report		Chief Nurse and Patient Safety Officer	
6.3. Guardian of Safe Working Hours Q3		Chief Medical Officer	
6.4. Framework of Quality Assurance for Responsible Officers and Revalidation		Chief Medical Officer	
6.5. Chair Report from People and Culture Committee		Non Executive Director	
7. Performance and Governance			11:40
7.1. Chief Operating Officer Update (verbal)		Managing Director	
7.2. IPR Exception Report		Managing Director	
7.3. Long Waiters (Presentation)		Managing Director	
7.4. Finance Performance Report		Chief Finance and Planning Officer	
7.5. Draft Plan Submission for 2023/2024		Chief Finance and Planning Officer	
7.6. Chair Report from Finance, Performance and Digital Committee		Non Executive Director	
8. Questions from the Governors and Public		Chairman	12:20
9. Any Other Business		All	12:25
9.1. Next Meeting: 03 May 2023			

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Harry Turner ☎ 01691 404358
Chair

BOARD OF DIRECTOR – PUBLIC MEETING
11 JANUARY 2023 AT 9:30AM BOARD ROOM, MAIN ENTRANCE AT RJAH
MINUTES OF MEETING

Present:

Harry Turner	Chair	HT
Chris Beacock	Non-Executive Director	CB
Penny Venables	Non-Executive Director	PV
Sarfraz Nawaz	Non-Executive Director	SN
Martin Newsholme	Non-Executive Director	MN
Stacey Keegan	Chief Executive Officer	SK
Craig Macbeth	Chief Finance and Planning Officer	CM
Sara Ellis Anderson	Chief Nurse and Patient Safety Officer	SEA
Ruth Longfellow	Chief Medical Officer	RL
Mike Carr	Chief Operating Officer	MC

In Attendance:

Martin Evans	Associate Non-Executive Director	ME
John Pepper	Associate Non-Executive Director	JP
Denise Harnin	Chief People Officer	DH
Mary Bardsley	Acting Trust Secretary (minute secretary)	MB
Martin Bennett	Governor	MBe
Colette Gribble	Governor	CG
Kate Betts	Governor	KB
Katrina Morphet	Governor	KM
Colin Chapman	Governor	CC
Karina Wright	Governor	KW

MINUTE NO	TITLE
11/01.01	**APOLOGIES** Apologies were noted from Paul Kingston
11/01.02	**MINUTES OF THE PREVIOUS MEETINGS** 02 November 2023 – the minutes were approved as an accurate reflection of the meeting.
11/01.03	**MATTERS ARISING** There were no further items tabled for discussion.
11/01.04	**DECLARATION OF INTERESTS** There were no new declarations shared.
PRESENTATIONS	
11/01.05	**PATIENT STORY** SEA welcomed Julie Hibbs to the Board Meeting who joined to share her experience and patient journey at the Trust. Julie congratulated the Trust on the cleanliness throughout the hospital. Julie explained how she watched the housekeepers when an inpatient on Kenyon Ward and in comparisons to other Trusts labelled the organisation as 'amazing.' Julie highlighted that staff members and the League of Friends volunteers are always smiling and helpful. One improvement to consider was raised in relation to the access to a Pharmacist on a Saturday - to which the Trust has agreed to consider. Julie encouraged the Board to congratulate all teams across the organising on the work that is completed. On behalf of the Board, HT thanked Julie for her time. CB queried if Julie had chosen the Trust for her treatments and if so, what made the Trust more appealing than other organisations? Julie confirmed it was both the reputation of the Trust and the data supporting the surgeons and their speciality.

	HT queried Julie's experience when the procedure was cancelled. Julie explained that she was emotional about her surgery being cancelled as she was prepared to come to the Trust however, she explained that there were no issues or complaints to raise regarding how the process was handled. Julie noted the importance of ensuring the Trust was a safe environment for the patients and the reasons for the surgery being cancelled was explained fully. PV thanked Julie for sharing her story before asking about her experience post-surgery, querying if she had received support with rehabilitation. Julie explained that she met physiotherapist the ward following surgery who were supportive along with those staff members she has met at her follow up appointment. However, Julie decided to gain support closer to home and has since been discharged.
11/01.06	**TRANSITION SERVICE PRESENTATION** SEA welcomed Sarah Ford to the Board who joined the meeting to present an overview of the Transition Service. Sarah's' presentation contained information on the core capability framework, mapping the service, the current position and future mapping including improvement ideas. PV commended Sarah and noted that it was exciting to see the important service on the Board agenda for discussion. SK explained that it is a priority for the Trust and need to work through the detail to support the opportunity for the service to continue. ME commended Sarah's passion and presentation before explaining that as the Chair the People Committee the Trust is keen to support staff and development. ME asked if Sarah required any support or development. Sarah explained that there are challenges noted across the Trust relating to staffing but noted that the Trust has been supportive in relation to training opportunities. ME highlighted the importance of capturing the impact the service has on patients following Sarah's feedback and how this can be captured effectively, to which Sarah welcomed. MN queried how does the role interact with other professions. Sarah explained that relationship and communication between providers and GPs could be enhanced, and it noted within the future plans of the service. Sarah would also like to gain support and build relationships with schools. HT suggested a service effectiveness survey is to be completed to support the improvements within the service. It was noted that Alderhay was an effective service.
CHAIR/CHIEF EXECUTIVE OFFICER UPDATE	
11/01.07	**CHAIR UPDATE (VERBAL)** HT informed the Board that SK has been appointed the Substantive Chief Executive Officer following an interview process in December. HT thanked DH and MB for supporting the recruitment process. **CEO UPDATE (VERBAL)** • Expressed thanks to all staff member who worked over the Christmas period. • Highlighted the urgent emergency care which remains under pressure. Kenyon ward has been opened to medically fit patients to support the System. • Official opening of the Headley Court Centre took place in November. The opening was scheduled for Remembrance Day and the first veteran's patient was seen in the new centre on 1st December. • Congratulated the Marathon Runners who have raised over £40k for the Charity. A special thanks you to Veronica Lillis who held a celebratory event at her home. • Health Hero for December was the Information Department who were acknowledged for adapting to the changes internally and externally since Covid-19. • Health Hero for January was the Project Management Office who supported the Headley Court Veterans Centre.
11/01.08	**COMMUNICATIONS AND ENGAGEMENT STRATEGY** The Strategy is shared with the Board for endorsement following consideration at the People and Culture Committee in November. SK highlighted the following: • Relates to both internal and external communications. • Strengthen support regarding EDI. • Thank you to Chris Hudson, Head of Communications for supporting.

	ME confirmed the Strategy was considered at the People and Culture Committee in November – noting that discussion within the meeting related to the staffing and workforce challenges. It was noted that the Strategy needs to be aligned to the Trusts Communications on recruitment. Chris Hudson explained the Trust have launched a new recruitment campaign which included supporting veteran's network. The Board discussed the importance promoting the lifestyle choice of working at the Trust to attract new staff members to the Trust. MN echoed the comments of his colleagues – there needs to be a realistic attraction to the Trust. The Board approved the Communication and Engagement Strategy.
BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER	
11/01.09	**BOARD ASSURANCE FRAMEWORK** The framework was presented to the Board for consideration. It has undergone a review by the Executive Team and the continues to be presented at the assurance committee for discussion and challenge. There was no further update required to the framework. **CORPORATE RISK REGISTER** The report was presented to the Board for information and ensure oversight of the current 13 live risks with a rating of 15 or more. Since the last Board meeting, the Trust has established the risk management working group which has been tasked with reviewing the corporate risk register and flow of risk assurance. There has been two new high rated risk since added since last the report, these relate to • Risk 2992 – Call bell system for tetraplegic patients unavailable • Risk 2918 – Overdue outpatient appointments (replaced risk 1551) Research risks mitigated scores are under review by the Director of Research, who joined the meeting to provide an update on the risks. No risks have increased since the last report. The Board noted the corporate risk register highlighting that further work is to be completed to ensure a smooth reporting process of risks however, noted the improvements in embedded in the recent months.
QUALITY AND SAFETY	
11/01.10	**CHIEF NURSE AND PATIENT SAFETY OFFICER UPDATE (VERBAL)** • Regionally there has been a noted rise in flu and covid related admissions within acute Trusts, although this is now believed to have peaked this week from UKHSA data. There was 1 Covid outbreak on Sheldon ward in December affecting patients and staff. Covid/Flu vaccination programme progress is slower than anticipated across the organisation with several actions being taken to encourage uptake. Flu 57% and Covid 66%. • The NHSE/ICS IPC assurance visit on the 30th of December saw the Trust maintain its Green rating against the NHSE IPC matrix showing sustained improvements. • The RCN industrial action is planned for the 18th and 19th of January and plans are underway, working closely with the RCN to ensure patient safety is maintained. • The Registered Nursing digital recruitment campaign launched in December with an open day planned at the end of January as part of our ongoing nurse recruitment strategy.
11/01.11	**PERFORMANCE REPORT – QUALITY AND SAFETY** SEA reminded the Board that the performance report was in relation the November report before providing the following update: • No Serious Incident or Never Events reported in November or December. • 1 HCAI Klebsiella on Sheldon ward. The ward is trialling a new way of VIP scoring and will feedback on progress at the next SNAHP meeting. • Surgical Site Infections (SSI) - there were three additional infections confirmed in November relating to a procedure that took place in May (1), August (1) and September (1). Early indication of December data suggests 2 SSIs confirmed in January for procedures that took place in November. The Trust are working with the information team to review how we can present the data differently. Several actions have taken place in response to the increased rate of infection seen between Jul-Sept that are being monitored through IPCWG. • No outbreaks in November but one reported in December.

	The Board noted the performance report with no concerns to raise.
11/01.12	**IPC IMPROVEMENT PLAN** The Board is asked to note the report following consideration at the IPC Quality Assurance Committee. SEA highlighted the following key points (as of the 3rd of January 2023) • 0 action behind plan • 83 actions complete (an increase of 3 since last report) • 12 actions in progress with clear action owners and timescales with 4 actions due in January • Expressed thanks to all staff involved in the NHSE/ICB IPC assurance visit took place in December. • The Trust continues to be rated green on NHSE IPC Matrix demonstrating sustained improvements and continued progress. The Trust continue on a journey of continual improvement, but its clear changes are being embedded within the culture of the organisation with high levels of compliance with BBE noted as an example and the evidence that operational, clinical and estates teams continue to work collaboratively to progress estates improvements. Following HT query, SEA confirmed that one further visit is expected in March. Kirsty Morgan is supporting the ICS on how the structure will be going forward including a peer review for support. HT suggested that following the March visits, the Trust will consider if the IPC Quality Assurance Committee gain be stood down as an exceptional item on the Board. SK highlighted the culture change across the organisation which is a key achievement for the Trust. HT agreed with the comment and from personal experience has noticed the ownership of staff being proud of the changes within the wards and depts. The Board commended the Trust.
11/01.13	**INPATIENT CQC SURVEY** The Board was asked to note the paper that presents an overview of the results of the CQC Adult Inpatient Survey 2021. This paper has been reviewed and discussed at November Quality and Safety Committee. Overall, the Trust have been named by the CQC as one of the organisations placed in the top band of Trusts across England delivering results that are considered “much better than expected.” At the time that this survey was carried out, the hospital was very much in the grip of the coronavirus restrictions, despite all this, our patients tell us that we continue to deliver excellent care rated No. 1 in the country for the overall patient experience. The Trust was ranked top for 20 out of the 47 questions including overall experience and patients having confidence and trust in nursing and doctors. Other highlights include the organisation being rated number 1 for hospital food for the 16th time in 17 years and cleanliness of wards and rooms rated number 1 for the second year running. The Executive are Incredibly proud of this report but as always, the Trust will strive to maintain and improve - this will be monitored through Patient Experience Committee. HT commented on the great report and thanked to Chris Hudson for sharing Communications on the findings with the Trust.
11/01.14	**CHIEF MEDICAL OFFICER UPDATE (VERBAL)** • Critical incident – thank you to the team for supporting – review being undertaken to support learning and findings will be presented to the Quality and Safety Committee • Extended surgical teams – funding applications has been approved. RL explained the initiative is from the Royal College of Surgeons to enhance patient care and training. • Physician Associates funding has been granted – the Trust look forward to recruiting to the Arthroplasty Team • Zimmer Biomet – communications have been updated on the Trusts website to support patients who are querying. RL confirmed this recall does not affect the Trust.
11/01.15	**CHAIRS ASSURANCE REPORT – QUALITY AND SAFETY COMMITTEE**

	Due to the discussion throughout the meeting, there were no further areas to of concern or risk to escalated which have not been discussed elsewhere within the Quality and Safety section of the agenda.
PEOPLE AND WORKFORCE	
11/01.16	**PERFORMANCE REPORT – PEOPLE AND WORKFORCE** • Sickness absence – noted increase and above tolerance rate at 5.6%. The increase is in relation to an increase for covid and flu (short term illness) • Turnover – Allied Health Professionals and Nursing have been reported as highest turnover. There is a significant focus on recruitment however highlighting the importance and requirements to also focus on retention of current staff. • In month leavers – this is a new performance indicator that the Trust will be reporting on. There has been a total of 14 leavers noted in November. Reporting on this information will support the Trust in learning. • Keeping in Touch conversations are to be embedded – the Trust needs to support managers in having natural and supportive conversations with their staff. • Agency – remains above target due to using agency to cover the current vacancies. It was noted that there has been a decrease of £41k within one month. HT welcomed the in months leavers performance indications which will help support staff to remain employed by the Trust. DH agreed with the comments which will also link to embedding the keeping in touch conversations which should encourage staff to have the confidence in speaking up and asking for support.
11/01.17	**FREEDOM TO SPEAK UP (Q2 REPORT)** The Freedom to Speak Up (FTSU) quarter 2 report that has been through People and Culture Committee and is shared with the Board for information. SEA explained that there have been 5 concerns raised in this quarter; one patient safety issue, one bullying concern, one worker safety and two process/ system concerns. Three out of the 5 remain open/under review. The Trust was pleased to report none of the cases were raised anonymously and one respondent to the question 'given your experience would you speak up again' was positive. FTSU champions are collaborating closely with the Guardian with a renewed focus on improving the speaking up culture of the organisation. There is a focus on increasing awareness and visibility of the champions and rolling out the training programme. HT informed the Board that he has met informally with the campaigns earlier this week - a good opportunity to discuss the role. HT suggested the FTSU champions are invited to present at a future Board meeting. The Board supported the recommendations outlined within the report, the Committee action plan will continue to be monitored by the People and Culture Committee.
11/01.18	**CHAIRS ASSURANCE REPORT – PEOPLE AND CULTURE COMMITTEE** The Committee key focus was regarding recruitment and retention. The Committee received a deep dive presentation which was well received. It was noted that there is a lot of work being completed across the organisation to support the priority area. The Committee considered areas of improvement which include: the adverts, the website and the detail being advertised. ME challenged the organisation to make a step change and provide the Board with more detail on initiative ways to recruit and retain staff – partial assurance was noted. The Nursing staff workforce report - the Committee requested that triangulation of data is to be completed to provide further assurance. The Trust agreed to amend the report ahead of the next meeting. The Committee considered the Workforce Equality annual report which is to be formatted before uploading to the website. PV queried whether the Trust is having an initiative-taking approach in relation to AHP recruitment. The Trust confirmed a stand was open on the recent recruitment day. There is a noted gap within therapies however the Trust have received over 40 applications for 4.6 WTE posts. CB raised a questions relation to the current agency and the finances - how many shifts are covered? CB raised the question to encourage the Trust to consider if there are any patient safety or patient experience concerns. SEA confirmed the information is presented to the

	People and Culture Committee as will as Finance, Performance and Digital to ensure oversight is gained on staff wellbeing and training. SN echoed CB questions, explaining the importance of reporting the quality aspect of agency along side the formal spending. ME queried if the Trust has a sense of when process will be changed to support retention. DH explained that there is further work to be completed however there are plans in place to support the implementations of a toolkit from NHS employers – this is to support the offer of flexibility. DH also explained about the upcoming Leadership Course which is to be rolled out to managers. JP raised concerns regarding the level of BAME reporting harassment and bullying. The Trust explained the high percentage in reporting 40% answered negatively is due to the low numbers of staff answering the questions. There are improvements to be made and this is being overseen by the People and Culture Committee. HT asked the Board to reflect upon retention and how do we change the mindset of staff members across the organisation. DH explained the requirement to re-educate staff and ensuring they have the confidence to empower themselves to make decisions – raising the profile of retention is a key focus for the Trust. SN added that following a recent patient safety walkabout, recruitment and staffing levels were mentioned within the HDU department. SN explained the team spirit within the department and keeping in touch conversations were being completed and established.
PERFORMANCE AND FINANCE	
11/01.19	**CHIEF OPERATING OFFICER UPDATE (VERBAL)** System support - MC thanked the teams from across the organisation for supporting the system pressures in the recent weeks. It was noted that the time has been challenging but staff have been key in keeping our patients safe. The Trust will resume business as usual on Kenyon Ward as IPC works are scheduled to begin on Sheldon Ward. Industrial action - the proposed action is scheduled for the 18th and 19th of January. The Trust has agreed to prioritised urgent patients and long waiters. There is an option for the Trust to submit a derogation request if required. The Trust has arranged for internal communications to be shared with all staff members to support any questions or queries. A EPRR command response will be in place on the industrial action's days. In relation to performance MC highlighted the following: • There have been new standards implemented against diagnostics, therefore reporting will be amended from March. • There has been and significant improvement noted in relation to diagnostic targets. • In relation to Theatre activity, the Trust is considering a five-case joint replacement theatre session. The theatre sessions have been extended and is supporting by the Cardos review. • My recovery app is live. • System MSK transformation of standardised pathways goes live on 13th of February. • Day case rates to be improved – need to ensure visibility and comparison against the British Association Surgery is completed. The Trust will implement further changes in line with the new theatre build.
11/01.20	**PERFORMANCE REPORT** The following was highlighted: • 18 weeks – slight improvement (target to get to 67 weeks from 78 weeks) • Overdue follow up – reduction of 700 patients in November, the Trust are making good progress. • Outpatients – showing improvements but noted the gap in relation to therapies, work is being completed and reporting to the FPD Committee. • PIFU – showing an increase following patients being transferred on to the pathway in September. • On trajectory in November with 33 English patients and in a better position than expected for Welsh patients. The Trust expects to deliver the forecast for December. PV noted the positive decrease for the overdue follow-up backlog. It was noted that the rheumatology clinics impact is yet to be recorded within the performance data.

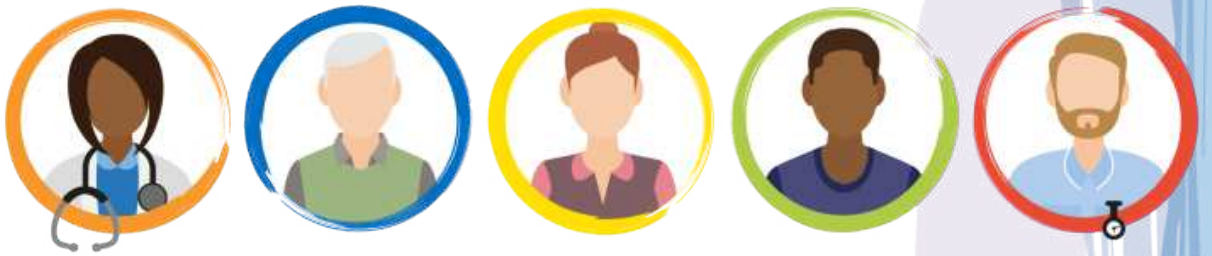
	Following a query from PV, it was confirmed that the operating framework has been shared and reviewed against the 35 categories. There are no new categories aligned to the Trust. ME thanked the Trust for the update, noting the pressure within the system, and the support the Trust has provided recently. ME encouraged the Trust to reflect upon the current support offered, and how the Trust supports the system without a detriment to the Trust own activity. MC explained that the Trust has supported the system significantly over the past few months and were content to support by opening Kenyon Ward for medical patients however, risk to the Trusts staffing levels has been raised. SK explained that due to the Trust being within a smaller ICS, it is more challenging for the Trust and local providers when supporting one another. ME encouraged the Trust to articulate the support given to system if the activity has not been delivered and targets not achieved. JP commended the Trust on the positive aspects of performance, despite the challenges within the System. John queried whether the inequalities are noted within the PIFU data. MC agreed to have an informal discussion outside of the meeting with JP to provide further assurance on reporting.
11/01.21	**FINANCE REPORT** CM provided the following key highlights in relation to the Trusts finances: • The Trust remains in the expected position with any continuation of themes. • Income shortfall – remain on some variable contracts. • Private Patient - poor month noted within November however this is due to increase in December. • The Trust still receives a level of protection from the block funding arrangements. • No new risks to raise to the Board regarding the Trust finances. CM updated the Board on the issues faced within the System: • Note a £53m combined deficit for the system which has led to national escalation. • Further actions being considered to improve the position. The Board thanked CM for the update and asked for updates on the System finances to be shared at the next meeting.
11/01.22	**CHAIR ASSURANCE REPORT – FINANCE, PERFORMANCE AND DIGITAL COMMITTEE** • The Committee met in December prior to the planning guidance, therefore, forecasting to see the financial performance for next year and the block payments not being received. • Over the past few months an increase securitise has been completed regarding the MSK efficiency reports due to the forecast. It was noted that mitigations are in place to support and a further report reflecting upon the new financial year is to be received in January. The Board noted the assurance report from SN.
11/01.23	**CHAIR ASSURANCE REPORT – AUDIT AND RISK COMMITTEE** A verbal update was provided to the Board due to the timing of the meetings. MN highlighted the following key points: • The Trust is in a sound financial position – no concerns to raise. • GGI action plan – recommendation action plan has been aligned to assurance committees. The Committee have agreed to gain assurance on behalf of the Board. • Policy Tracker – good exercise has been completed, ownership to committees noted and Executive leads have been identified. • Internal audit reports – following the appointment of the new internal auditors at the beginning of the financial year the Trust has had challenges regarding the scoring system. There have been 6 internal audits reports received this month. The Committee are focusing on the recommendations and those rated as high. It was agreed that all high risks recommendations are to be actioned by the end of March to support the Head of Internal Audit opinion. Details of the reports and subsequent actions plan are to be aligned to the relevant committee for oversight and assurance. The Board noted the update.
11/01.24	**HEADLINE PLANNING** The focus of the operational planning guidance for 2023/24 is to: • Recover core services and productivity.

	• Make progress in delivering the key ambitions in the Long-Term Plan (LTP) • Continue transforming the NHS for the future. • ICBs are expected to work together to plan and deliver a reduction in waiting times whilst delivering a balanced net system financial position. Improving productivity and efficiency will be key. • Legacy deficit from 22/23 will need to be recovered - noncompliant systems will not be able to access new capital streams. • Looking to return to performance related payment system (PbR) for majority of activity. • Further investment in Elective Recovery Fund but access only when exceeded system bespoke activity thresholds (further details awaited) • First draft plans due to be submitted on February 23rd with Final submission date to be confirmed. **In relation to finances:** • Return to Payment by Results for contracts in excess of £0.5m - income will be fully aligned to performance (based on 22/23 our full risk exposure on this is £15m) • Contracts under £0.5m will be blocked based on latest 3 year rolling average. • STW expected to also remain as block under IFP, but NHSE approval will be required. • ERF to be transacted only when additional elective activity target requirements met with baselines to be confirmed – targeted efficiency for each system, this will be the new baseline for the Trust, this will replace the 2019/20 targets/baseline used at the moment. • COVID funding further cut by 75% and embedded into tariff prices. • Base efficiency requirement of 2.2% - more will be required for systems in deficit (expected to be higher than reported) • Inflation assumes 2% pay award (any excess will be centrally funded) and 5.5% for Non-Pay (Will be challenging) • Agency cap to be set at 3.7% of total pay bill - currently at 6.3% (4.2% excluding LLP) The presentation was shared with the Board for information. The detail and assurance continue to be overseen by the FPD Committee. The Board noted the planning headlines.
ANNUAL REPORTS	
11/01.25	**ANNUAL REPORTS** HT welcomed comments and questions on the following annual reports: • Duty of Candour (Quality and Safety Committee) • Health and Safety (Quality and Safety Committee) • NICE Guidance (Quality and Safety Committee) • Human Tissue Act (Quality and Safety Committee) • Freedom to Speak Up (People and Culture Committee) • Workforce Equality (People and Culture Committee) There were no specific questions relating to the annual reports. Each Chair confirmed the appropriate report was considered the assurance Committee. The Board noted the annual reports.
11/01.26	**QUESTIONS FROM THE GOVERNORS AND PUBLIC** KM congratulated the Trust on the Communications and Engagement Strategy before suggested a quarterly update is to be reported on to the assurance committee on achieving the targets. MBe shared the following comments with the Board: • Communication and Engagement Strategy – the strategy does not state governors within the in section 4 of the document. • Highlighted the importance of using clear terminology to ensure the Trust brand and reputation are adhered too – raised concerns regarding the terminology used in relation to the transition service. • Acoustics of the rooms makes it difficult to hear all the meeting. In response to MBe comments, HT explained that the Governors are referenced as part of the public within the strategy and reassured those in attendance that the Board values support from the Governors who represent the public.

	In relation to the Transition service, HT acknowledged MBE comments but explained that this is the national description which the Trust will continue to use. HT agreed with the comment regarding the acoustics of the meeting room however due to supporting the Trust through Covid19 and training, the preferred meeting room is currently unavailable. The Board meetings will be scheduled in meeting room 1 from April onward. KB commended Sarah Ford for her passionate presentations and encouraged the Trust to reimburse Sarah for any courses she has personally paid for – the Board agreed.
ANY OTHER BUSINESS	
11/01.26	**ANY OTHER BUSINESS** There were no further items of business discussed.
11/01.27	**CLOSING REMARKS:** HT thanked everyone for attending the meeting and for their contribution in the discussions.
NEXT PUBLIC MEETING: 01 MARCH 2023	

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

Cost of Living Support



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

Aspiring to deliver world class patient care

Survey results/feedback

139 responses!

- ***100%** of staff felt increased pressure from cost of living*
- ***50%** of staff had to borrow money or go into their overdraft to pay bills*
- ***90%** labelled themselves as stress from cost of living*

I am struggling to keep on top of everything.

I do 2 or 3 bank shifts a month as well as full time. I am relying on this extra income as I am single with a mortgage.

Cost of Living Support Suggestions

Food & Drink
Coffee, tea and milk for departments
Give away wasted food at the end of the day
Discounted hot meals
Free porridge/toast/soup
Family pre-paid meals for £5
Denbigh's open on Saturday/Sunday
Buy one meal, get one free at Denbigh's

Sign-posting
Percy - money saving tips/noticeboard
Signposting e.g. Citizens Advice, Foodbanks
Use of Moneyhelper

Travel
Keep staff parking free
Free transport e.g. bus pass, discounted travel
Dedicated mini bus transfer service
Fuel allowance
Encourage lift sharing

Estate
Accommodation
Hot desks available for staff to work onsite
Laundry service
Shower facilities

Potential initiatives in partnership with LoF
Childcare support
Community fridge/pantry
Supermarket discounts/supermarket voucher
Book exchange
Clothes exchange
Percy Punnets - discounts and additions
End of the week food hamper raffle
Thrift store
Open use of the pool/gym for staff
Free flowers
Free washing powder for staff
Free sanitary products

Pay
Bank shift incentives
Non-clinical bank review
Review of staff banding against their current job roles
Equal pay to bank staff as agency staff
Pay £120 NMC fee
££ for energy use at home
Uniform allowance
Weekly bank pay
Enhanced bank extension
Real Living Wage employer

Other
Recipe of the week
Additional day of annual leave
Christmas shopping half day leave
Christmas shopping voucher
Emergency Grant
'The Work Perk'

ass patient care

Support initiatives available now..

Free tea, coffee and milk for all staff and departments

October 2022

Free breakfast porridge and toast for all staff

November 2022

Discounted hot meal for £2 (main and side)

Enhanced bank rates extended until March 2023

December 2022

Support initiatives available now..

Bank shift incentive launched

December 2022

League of Friends second-hand bookshop reopened

Money Matters session held in January 2023

January 2023

Weekly pay for bank staff launching in March 2023

March 2023

Press


RJAH Orthopaedic Hospital Retweeted
BBC Shropshire @BBCShropshire · Nov 8
.@ShropCouncil is making payments to vulnerable families, while @RJAH_NHS is offering staff a free breakfast to help cope with the rise in the cost of living.
Find out more: bbc.co.uk/news/uk-englan...
BBC
RADIO SHROPSHIRE
SHROPSH
COST OF
HELP SCH


Shropshire Star
News
Spor
NHS
News
Cost of living
Local Hubs
Crime
Politics
Health
Business
Voices
UK News
Environmer
Oswestry
Chirk
Ellesmere
Gobowen
Morda
St Martins
Free breakfast for Shropshire hospital staff


Nursing Times
'The chance of an easy, grown-up end to the dispute seems to be disappearing fast'
STEVE FORD, EDITOR
HOME
NEWS
CLINICAL
CPD
INNOVATIONS
STUDENTS
OPINION
PODCAST
EVENTS
CAREERS
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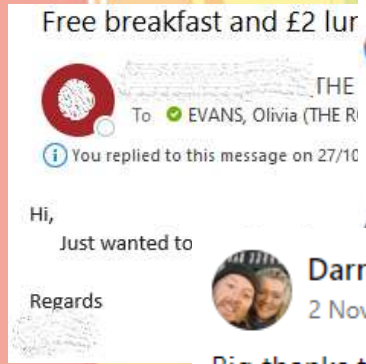
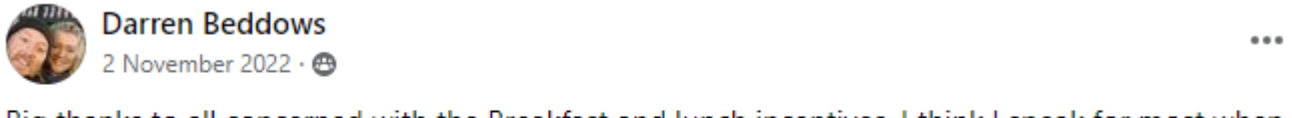
HOSPITAL
Shropshire hospital offers staff free breakfasts amid cost of living crisis
08 NOVEMBER, 2022 | BY GRAHAM CLEWS

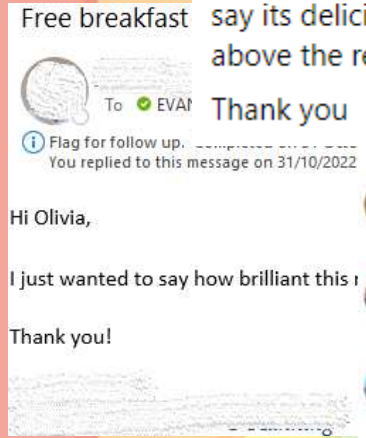
Feedback


Free breakfast and £2 lur
THE
To EVANS, Olivia (THE R
You replied to this message on 27/10
Hi,
Just wanted to
Regards


Love
Comment
Emma Fosbrook
This is amazing! Is the porridge made with milk or water?
Like Reply 17 w
Olivia Evans
Emma Fosbrook Hi Emma, I'll find out and get back to you ASAP
Like Reply 17 w


Lake Beckley
this is very kind. Thank you
Like Reply 16 w
Ruth Burton
Brilliant. This will make a massive difference for so many. Thank youm


Darren Beddows
2 November 2022 ·
Big thanks to all concerned with the Breakfast and lunch incentives, I think I speak for most when I say its delicious and very well received, it's the little things like this that make this Hospital stand above the rest.
Thank you


Free breakfast
To EVAN
Flag for follow up.
You replied to this message on 31/10/2022
Hi Olivia,
I just wanted to say how brilliant this
Thank you!


Like Reply 17 w
Janet Raffle
Absolutely lovely gesture x
Like Reply 17 w
Elizabeth Jane Davies
This is absolutely brilliant. A big help thank you.
Like Reply 17 w
Jacqui Greatorex
I had the chickpea curry yesterday it was delicious
Like Reply 16 w


Like Reply 17 w
Rachy A Owen
Thank you
Like Reply 17 w
Dieta Harris
Thank you another lovely gesture
Like Reply 17 w

In the future..

Reopening of the hydrotherapy pool for member of staff with MSK issues

Adding dried goods to Percy Punnets in the Main Entrance

Trialling free sanitary products for staff

Aspiring to deliver world class patient care

CEO Update

1. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	1 March 2023
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	23 February 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

- **New Trust Secretary**

I am delighted to welcome Dylan Murphy, our new Trust Secretary, to his first Public Board meeting. He has an extensive background in governance, with his most recent role being Head of Corporate Governance at Cheshire and Mersey Integrated Care Board (ICB) and, prior to that, NHS Cheshire Clinical Commissioning Group (CCG) where he worked for 7 years. He has worked in a range of organisations including North Wales Community Health Council, West Midlands Police and London Underground. We are delighted to have him on board.

- **Long Service Awards**

Having welcomed a new face to the Trust, I now move to the other end of the spectrum. Last month, we held our annual Long Service Awards, recognising staff who have clocked up 30 years of NHS service. In total we had 35 members of staff in the room to receive their certificates, having reached the milestone. It was wonderful to have the opportunity to thank all 35 individuals for the commitment they have shown to caring for patients over the last three decades: either here at RJAH or elsewhere in the NHS.

- **Director of Quality and Improvement**

This Public Board will be Jacqueline Barnes last with us as her secondment comes to an end at the end of March; I would like to take the opportunity to thank Jacqueline for her achievements since commencing with us and wish her well for the future.

- **Recruitment Day**

Our recruitment challenges have featured heavily in recent Board discussions, so I am delighted to report on the success of our first Recruitment Day of the year. The event last month saw more than 50 people attending – with 15 of those going home with a provisional job offer, and several others securing offers since then. This will be covered in more detail elsewhere in the meeting, but I wanted to put on record my thanks to everyone who made the day happen, and who are working hard on further events later in the year.

- **Keele University**

Last month I attended Keele University hosted by Professor Trevor McMillan – Vice Chancellor, along with Simon Whitehouse – STW ICS CEO and Graham Guest – Principle and CEO, Telford College. An opportunity to discuss challenges and agree actions to take forward together in relation to workforce pipeline, development, education, and retention.

- **Cost of Living support**

Board members will be aware of some of the cost of living initiatives we have introduced as a Trust, including free breakfasts and hot drinks, and subsidised 'winter warmer' lunches. In the past couple of months, we have focussed on two other areas as well:

1. Financial wellbeing – we organised and hosted a 'Money Matter' workshop for staff presented by David Pugh, a local solicitor, and Jack Fallows, a financial advisor. The session was in response to a staff survey we carried out which showed that 77% of respondents were interested in money saving tips and advice.

2. Healthy living – we have relaunched the popular fruit and veg stall. This is kindly being run by our League of Friends team and has been branded as Percy's Punnets. I have seen how well received that has been. The stall is also open to patients and visitors but offers a 10% discount to staff.

- **End of an era as Vaccination Centre closes**

The Vaccination Centre here at RJAH closed its doors in February, having administered more than 150,000 jabs since it came online in January 2021. The site has been decommissioned by the vaccination team for Shropshire, Telford, and Wrekin, who are now focussed on a more central site in Shrewsbury, while encouraging people to also get their boosters when due from their own GP surgery. I want to place on record my thanks to staff right across the Trust who went above and beyond to make the RJAH centre so successful – especially Rebecca Warren, who led the team from start to finish with great distinction.

- **Health Equality work**

I am delighted that RJAH has partnered with Healthwatch Shropshire to improve health equality for our local communities. That work is starting with some focus groups later this month, and I would encourage the public to sign up for those and help us to understand what we do well and areas for improvement, in a bid to support us in developing plans to tackle health inequalities and ensure our services meet the needs of the community. Details are on the Trust website and have been shared via our social media platforms.

- **RJAH at the London Marathon**

Board members will recall that I ran the London Marathon for the hospital charity last year and I have agreed to do it all again in April this year! My training is well under way already. This time around, I will not be the only member of the Board hitting the streets of the capital, as our Chief Medical Officer, Dr Ruth Longfellow, will be joining me. In fact, we are just two of almost 30 people who will be running for our hospital charity, and I am grateful to every one of them. Last year, our marathon runners raised an impressive £44,000 – and I am confident we will do even better this time around.

- **Clinical Shift - Outreach Team**

In February I worked a clinical night shift with the Trusts Outreach team as part of my monthly scheduled 'back to the floor' time, special thanks to Sister Becky Hammond. Valuable time to work alongside our people, practice clinically as a nurse and hear first-hand from our patients.

- **Visit from the Royal Orthopaedic Hospital, Birmingham**

At the end of January, Harry Turner and I hosted a visit with our counterparts from the Royal Orthopaedic NHS Foundation Trust, Birmingham. It was a pleasure to welcome Jo Williams – CEO and Tim Pile – Chair to the Trust, to show them around and discuss further collaboration between the Orthopaedic Specialist Trusts.

- **Urgent Emergency Care Pressures**

The Shropshire, Telford and Wrekin system continues to experience significant pressure. This is seen especially within our emergency care services and resulted last week in The Shrewsbury and Telford Hospital (SaTH) declaring another critical incident. At RJAH, we have continued to support with SaTH's most clinically prioritised orthopaedic patients including long waits, medical patients (Sheldon) and have recently supported further upper limb trauma.

- **Health Hero Award**

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

  - Our January award went to **Gayle Murphy**, who is actually my Executive Personal Assistant, so I know first hand just how worthy she was of this award. She was nominated by Ashling Donohoe-Harrison and Katie Cupitt in the Governance Team, who rightly called out her hard work, her knowledge, and her positivity.

  - Our February award was presented to the **Francis Costello Library Team** and was done so in recognition of their outstanding support to learners across the Trust. The team were nominated by two members of our MRI/CT Radiology Team, who correctly stated: "The librarians are so kind and knowledgeable, and genuinely want to see you do well in whatever you are studying."

Congratulations to our latest winners!

4.0. Conclusion

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

0. Reference Information

Author:	Alison Harper, Governance Manager; and Dylan Murphy, Trust Secretary	Paper date:	01 March 2023
Senior Leader Sponsor:	Sara Ellis Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	27 February 2023
Paper Reviewed by:	Executive Team	Paper Type:	Governance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full Disclosure
Paper to support CQC Evidence:	No	Purpose of Paper:	Assurance

1. Purpose of Paper

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

The corporate risk register forms part of the overall risk management and assurance process of the Trust. This report provides oversight of the most significant operational risks affecting the Trust's day-to-day activities, as captured in the corporate risk register, along with a summary of the measures in place to address them. The report is presented to the Board to ensure oversight of the Trust's risks that are currently rated 15 or above.

2. Executive Summary

2.1. Context

There are currently 13 approved live risks with a rating of 15 or above on the Trust's corporate risk register.

Each risk is aligned to a Unit and the appropriate Unit reviews its risks on a monthly basis. Each risk also has an Executive owner for oversight. All risks scoring 15 and above are also aligned to a Committee of the Board and are scrutinised by the appropriate committee(s).

2.2. Summary

Revisions to the register since it was last presented to the Board are outlined below. The full register is include at the appendix.

- 2 risks at a score of 15 or above have been added to the approved corporate risk register following consideration at committees of the Board:

Risk Ref.	Risk Description	Revision	Reason for revision	Where was discussed / agreed?
2628	Pathology Laboratory Information System (LIMS)	New addition to corporate risk register, following consideration at FPD.	n/a	Finance, Performance and Digital Committee
3022	Spinal Disorders capacity risk with reliance on independent sector provision including patients waiting 52+ weeks	New addition to corporate risk register, following consideration at Q&S.	Replaces risks 2633 and 2899 – discussed at Trust Performance and Operational Improvement. Risk description to be updated to reputational	Quality and Safety Committee

Risk Ref.	Risk Description	Revision	Reason for revision	Where was discussed / agreed?
			risk and patient safety risk of harm to patients waiting	

- 3 risk scores have decreased from 15 or above and have subsequently been removed from the corporate risk register:

Risk Ref.	Risk Description	Revision	Reason for revision	Where was discussed / agreed?
2913	System pressures necessitating future mutual aid support	Was included on corporate risk register in JAN. Subsequently reduced by the "Risk Handler"	The Operational Risk working group felt the risk likelihood could be reduced to "occasional", reducing the overall rating to Moderate. Revised assessment agreed by the "Risk Handler".	Operational Risk Working Group *(To be confirmed by FDP).*
2918	Overdue Outpatient appointments - replaces risk 1551	Was included on corporate risk register in JAN. Subsequently considered by Q&S as a reduced risk.	Risk rating reduced to 12 as overdue follow up list has stabilised. Plans in place for list size reduction but only to come into action from Q1 and 2 in 23/24 onwards	Quality and Safety Committee
2995	Potential for Industrial Action	Was included on corporate risk register in JAN. Subsequently considered by P&C as a reduced risk	The situation has moved on and the rating has been reduced. This will be kept under review and escalated to the corporate risk register if / when appropriate.	People and Culture Committee

- 1 risk score has reduced but is still above 16 so is still included on the corporate risk register:

Risk Ref.	Risk Description	Revision	Reason for revision	Where was discussed / agreed?
2696	Registered Nurse Vacancies on MCSI	Mitigated score reduced from 20 to 16	Agency nurse block booking in place.	Quality and Safety Committee

3. Conclusion / Recommendations

The Board of Directors is asked to:

- Review the risk scores, existing and planned control measures for each of those risks; and
- Consider any required revisions to the risk scores or seek further assurance where required.

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	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 - 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.	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	10/02/2023	10/03/2023
MSK Unit	MSK - UNIT RISK (Risk Register Only)	2911	Consultant & 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	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	07/02/2023	13/04/2023
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	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.	4 - Likely	4 Major	16	High	Explore opportunities within ICS to strengthen the mitigations. Roles of research dept staff should be adjusted to allow for adequate time to meet the monitoring requirements of all sponsored studies. This may require a reduction in the number of new projects opened. 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	08/02/2023	08/03/2023
Corporate Services	Corporate Services - RJAH TRUST WIDE	2892	Insufficient provision of SALT to ensure effective assessment and montioring 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 recommendatation that all SIU should have the provision of 1WTE SALT per 40 inpatient beds.	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 email 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	Case of need approved for additional SALT provision trust wide. SATH SLA to be updated and additional post recruited to.	1 - Rare	4 Major	4	Treat Risk	Quality and Safety Committee	11/05/2022	18/02/2023	18/03/2023

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	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
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.	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. Quarterly recruitment days. Review of theatre staffing skill mix review in March 23.	1 - Rare	4 Major	4	Treat Risk	People Committee	26/04/2021	08/02/2023	09/03/2023
Corporate Services	Corporate Services - FINANCE	1742	Lack of autonomy to make organisational investments	Due to ICS financial deficit the finacial framework requires all investments to be proritised and agreed by an ICS investment panel.	Removes RJAH autonomy and will slow down required investments.	5 - Almost Certain	4 Major	20	High	Investment requirements submitted to investment panel and clear ranking against other system priorities. Investments can only be agreed where sufficient efficiency offset is identified at system level. Non recurrent opportunities to mitigate RJAH risks from delayed investment.	4 - Likely	4 Major	16	High	Lobbying ICS to implement a diminimis level for automanous investments. Assurance on delivery of efficiencies required for sustainability plan will unlock funding to be released.	2 - Unlikely	4 Major	8	Treat Risk	Finance Planning & Digital Committee	20/07/2017	06/06/2022	10/07/2023
Corporate Services	Corporate Services - RESEARCH DEPT	2996	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	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. increase awareness. Opportunities for research scholarships and training grants are advertised via intranet and direct e-mails to staff.	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	08/02/2023	08/03/2023
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.	4 - Likely	4 Major	16	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	23/01/2023	23/02/2023

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	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
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.	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 approptiately 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	16/02/2023	16/03/2023
Specialist Unit	Specialist - HISTOPATHOLOGY	2793	Provision of Consultant Microbiologist at RJAH	Consultant Microbiology looking to retire 31st March 2022. SaTH provide consultant microbiologist PA's via SLA. SaTH have found recruitment of consultant microbiologist challenging in the past. It is not clear at this time if a consultant microbiologist with an interest in joint infection/orthopaedics will/can be recruited to enable delivery of the SLA by SaTH. It should be noted that the current Microbiologist delivers advice for activities across the Trust as per the SLA in addition to clinical.	No Consultant Microbiologist provision would be in breach of the current SLA with SaTH. Clinical advice. on site visits including ward rounds, attendance at Infection MDT and any further MDT requirements, plus the further professional advice given in line with the SLA provision would not be received. This would put all clinical services within the Trust at risk.	5 - Almost Certain	4 Major	20	High	Discussion with current service provider (SaTH) are taking place to give assurance that they are managing the risk and the SLA will be honored. Discussion ongoing with other service providers to establish if microbiology service can be obtained elsewhere.	4 - Likely	4 Major	16	High	Discussion with SaTH to provide assurance that they can continue to offer the service if and when the current Consultant Microbiologist retires Discussion with other service providers to establish if there is provision to take on RJAH microbiology service if SaTH cannot. 28/11 SLA being reviewed to understand current requirements and assess whether SaTH can provide the level of agreement required. If not, scope to source other providers.	2 - Unlikely	4 Major	8	Treat Risk	Infection Control Committee	18/10/2021	27/12/2022	24/02/2023
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	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	30/01/2023	28/02/2023

Clin. Group	Directorate	Datix ID	Title	Risk Description	Description	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 - 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.	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
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	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 IJP 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	15/02/2023	17/03/2023

0. Reference Information

Author:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper date:	23rd of February 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	1st of March 2023
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Trust Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Noting

1. Purpose of Paper

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

This paper presents an overview of key updates within the chief nurse portfolio for members of the Trust Board on items not covered within the main agenda.

2. Executive Summary

2.1. Context

This paper presents an overview of key updates within the chief nurse portfolio for members of the Trust Board on items not covered within the main agenda.

2.2. Summary

- Covid/Flu vaccination programme – Flu 58% and Covid booster 69% 22nd of Feb.
- RCN industrial action – a total of four days industrial action took place in January and February.
- Successful recruitment open day saw 15 offers being accepted on the day.
- First four trainee nurse associates qualify in March
- International recruitment continues to progress with seven nurses arriving in March
- IPC Summit saw the successful launch of the new IPC strategy

2.3. Conclusion

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

3. The Main Report

3.1. Covid/Flu Vaccination programme

Weekly reporting for the 22nd of February gave a 58% uptake for Flu and 69% for Covid Booster vaccinations overall. Flu vaccination uptake is approximately 14% lower than this time last year, this is a trend being seen across the region with average uptake of 51% across 41 organisations. Staff are being reminded via several communication channels on the importance of staying well this winter by having the vaccines. There have been no covid or flu outbreaks reported in January or February.

3.2. RCN Industrial Action

The Royal College of Nursing (RCN) members at RJAH have chosen to take strike action. Industrial action took place on the 18th and 19th of January and the 6th and 7th of February. Patient safety was maintained across the organisation on both occasions.

3.3. Nurse Recruitment Update

RJAH staff held a successful recruitment day on the 28th of January with a total of 15 offers being made. Seven Registered nurses, five student nurses, one return to practice nurse and two HCSW offers were made and accepted on the day. The student nurses were offered golden tickets and have accepted 2 year rotational posts across MSK and Specialist units.

Our first four trainee nurse associates qualify in March and are ready to take up posts across the paediatric and surgical wards. Four international nurses are landing on the 2nd of March with a further three expected to arrive at the end of March. Pastoral support is in place and accommodation has been arranged.

Two matron posts have successfully been recruited to across the Specialist and MSK unit wards.

3.4 IPC Summit and launch of strategy

We recently held our first Infection Prevention and Control Summit on the 30th of January alongside our colleagues at Shropshire Community Health Trust. It was an interactive and engaging afternoon filled with presentations, games and emotive stories - all in a bid to promote the importance of IPC. NHS England provided unity and support on the day with a presentation outlining the roles and responsibilities for an embedded IPC culture. The new IPC strategy was launched outlining four ambitions (please see appendix one).

3.5 Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
IPC Quality Improvement Ambitions

Integrated working

Collaborate with other providers across Shropshire Telford and Wrekin, to consolidate our approach to IPC

- Work collaboratively to deliver the ICS IPC Strategy
- Drive sustainability and build resilience of IPC by developing new ways of working with other provider IPC Teams
- Develop peer support processes for IPC audit

Education and Training

Innovate our approach to IPC education and training

- We will empower staff to check and challenge poor adherence to IPC practice
- Provide a central space for IPC information
- We will engage staff with National IPC initiatives and campaigns

Digital Technology

Harness technology to make IPC accessible and responsive

- The Trust will introduce technology to enhance our surveillance of Alert Organisms
- We will review our Surgical Site Infection Surveillance systems and introduce new ways of data capture and more accurate reporting

Enhanced Engagement and Involvement

Ensure IPC has Board to Floor engagement and involvement

- We will innovate and revise IPC data collection, analysis and reporting to improve all staff understanding of IPC quality metrics
- Promote a robust governance structure with clearly defined roles, responsibilities and accountability for IPC

Trust Board - Quality & Safety

January 2023 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

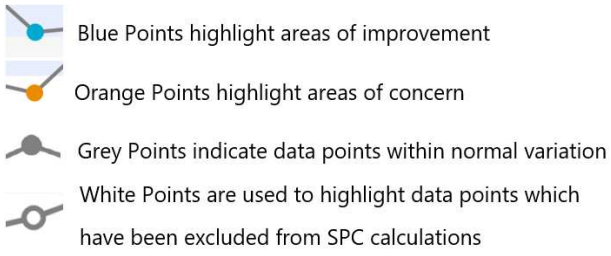
Different colours have been used to separate these trends of special cause variation:

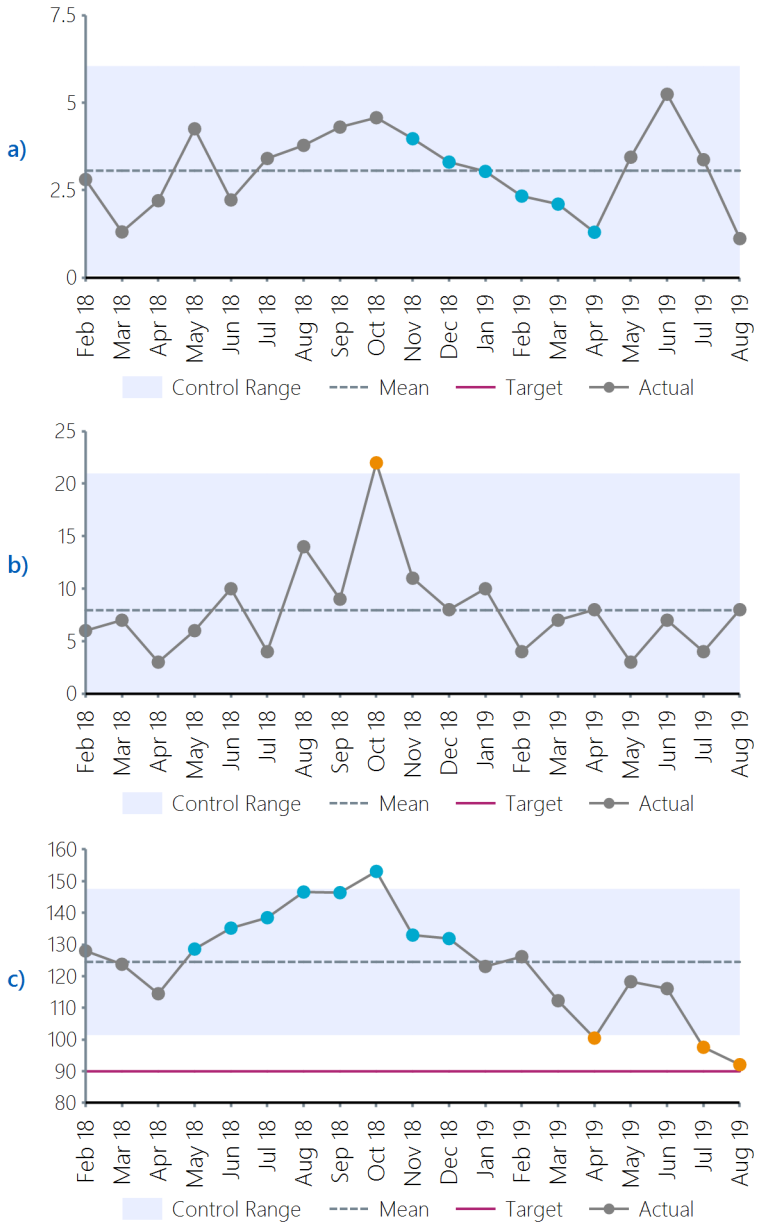
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	P		16/04/18
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	6			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired 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	P		
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	0		N/A to SPC	?		
Total Deaths	0	1		N/A to SPC	?	+	
WHO Quality Audit - % Compliance	100.00%	100.00%		N/A to SPC	P		

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.

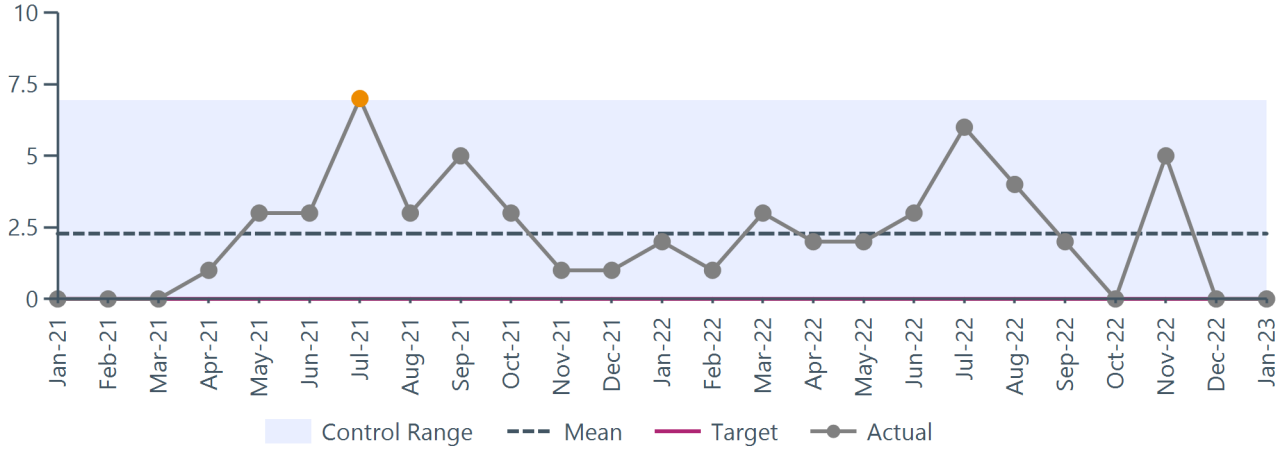
217727

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	0		

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

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 February-22 to January-23, there have been 28 surgical site infections. There were three additional infections confirmed in January, all relating to procedures that took place in November-22. A data quality check has been carried out with the IPC team to ensure the latest twelve month period is reported correctly.

Actions

Actions in this area are:

* A review of theatre cleanliness and equipment cleanliness has been completed
* The frequency of IPC Quality walks moved from 6 to 3 months
* Equipment props now included as specific question on theatre environmental IPC audit
* One Together Audit done with significant improvement. Ongoing audit against that tool now in place
* Exploring data capture for SSIs in other procedures

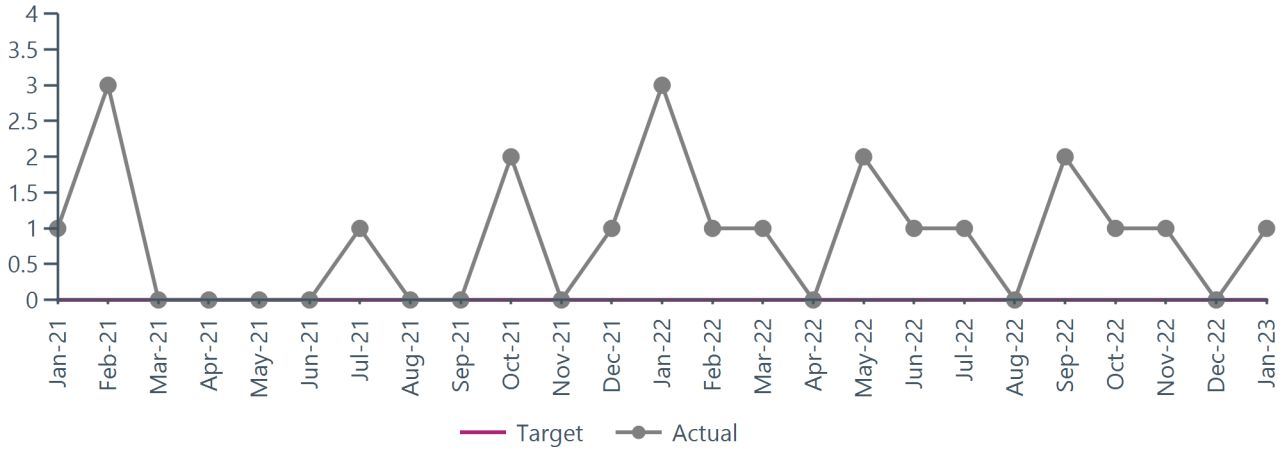
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
2	1	3	2	2	3	6	4	2	0	5	0	0

Total Deaths

Number of Deaths in Month 211172

Exec Lead
Chief Medical Office

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



Trajectory/H2 Forecast

Actual
Trajectory

What these graphs are telling us

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

Narrative

There was one death within the Trust in January; this was an expected death.

Actions

All deaths are reviewed by the Hospital Mortality Lead.

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

- Staff - Patients - Finances -

Learning From Deaths Q3 Report

0. Reference Information

Author:	Dr James Neil	Paper date:	23 January 2023
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee 23/01/2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report was presented to the Quality and Safety Committee in January 2023.

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

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

Deaths are reported through the Board of Directors.

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

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q3 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns or trends identified.

Learning from both deaths (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes/Family feedback.	Actions
October 2022	1	1	0	0	Expected death on EOL care.	None required
November 2022	1	1	0	0	Expected death on EOL care.	None required
December 2022	0	0	0	0		None required

3.3. Associated Risks.

None.

3.4. Next Steps

- Discussions complete with SATH concerning a link with their Medical Examiner and Bereavement system. This service likely to commence 2023. SATH is currently awaiting overall clearance from NHSE to expand to trial group including us, a GP practice and the hospice.
- LFD lead now working as a Medical Examiner at SATH.
- LFD lead at RJAH now attends Mortality steering group at SATH.

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

3.5. Conclusion

Positive learning:

October: Excellent EOL care and attention to family.

November: Excellent MDT care and evidence of patient centered approach.

Efforts made to tailor care to patient and their wishes.

EOL care planning performed in advance of need and then commenced when required.

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

Areas for further learning:

Initial clerking not fully documented likely due to non-standard admission route. (Admitted via clinic. Staffing levels in particular team very limited at that juncture. No effect on care).

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

Appendix 1: Acronyms

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

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:**	01 March 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	22 February 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 16 February 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 items to report.

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:

Bioknotless Briefing (shoulder)
There have been an additional 4 patients reported with retained fragments. 1 patient has been referred for a CT scan as it is not clear where the anchor is positioned. 1 patient requires further surgery to remove fragment and therefore has been recorded as moderate harm. To date, there have been a total of 14 patients reported. The Trust confirmed that feedback has been received from the MHRA however, details were unable to be shared due to confidentiality. It was confirmed that as a never event the incidents have been reported to NHS Resolutions and the Trusts solicitors have been supporting. The Trust has received one complaint to date.
The Board is asked to note the information provided and it is recommended that an update on the never event is continued to be provided via the Chairs report.

Exactech Briefing (knee)
A recall was issued in September 2022 due to a manufacturing error. The Committee received an update into the figures of the affective patients. A letter, enclosing the Exactech letter, has been sent to patients with these implants offering them an appointment - extra clinics are being scheduled. The Committee discussed the process for ensuring patients are supported. It was confirmed that 18 patients are being monitored closely due to symptoms. It was suggested that for those patients who require surgical intervention a Datix incident is to be recorded. The Trust confirmed that Duty of Candour is being explained to all patients and the Chief Medical Officer has agreed to provide regular updates to the Committee. The Board is asked to note the information provided.
The Board is asked to note the information provided and it is recommended that an update on the never event is continued to be provided via the Chairs report.

Harms Review – Risk Assessment
At the Committee meeting in January, the members of the meeting requested a risk assessment was complete to support the Trusts decision to review patients at 6months instead of the 3months (national guidance) A verbal update on the position was presented to the Committee as each firm has different rationale and decision making and therefore flowcharts/risk assessments will be produced for each speciality. Therefore, the risk assessment is due to be received at the next meeting (March 2023)

Coroner Case Summary
The Committee received a summary on the Coroner Case as the East Cheshire Coroner requested the patient's medical report. A covering letter has been sent to the coroner displaying learning actions for the Trust and how to improve the process which the family was focused on. The inquest is scheduled to take place in June 2023 and on reviewing the notes, there was no issue with how the case was managed. The Trust are considering the process of prescribing drugs at discharge to ensure effective communication is embedded.

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.

- **Board Assurance Framework and Corporate Risk Register**
  The Trust confirmed a review of the corporate risk register process is being undertaken to streamline the reporting. The Committee noted the 6 corporate risks aligned to the Committee.
- **Patient Safety Incident Review Framework (PSIRF)**
  The implementation of the framework is currently being embedded. Governance arrangements are in place and draft priorities have been identified.
- **National Inpatient Survey Action Plan**
  An action plan has been compiled. The Committee discussed patients discharge process and the importance of ensuring patients have access to services – planning and communication are key factors.
- **Performance Report**
  Noted that the cancer waiting standards have not been met, however this is due to patient choice. There has been one expected death in January. The Trust has been an increase in cancellations in February due to industrial action.
- **CQUIN Report**

The Committee noted that following 2 targets were unlikely to be achieved – For CCG8 where 70% of surgical inpatients are supported to drink, eat, and mobilise within 24 hours of surgery ending, 55% was achieved and the uptake of flu vaccinations by frontline staff is currently 56.9% against the quarter 4 target is 90%

- **GGI Action Plan**
  The Committee noted the action plan with no concerns to raise.
- **Operational Framework**
  The Trust confirmed that the final plan will be reported to the Board of Directors. The Trust confirmed clinical engagement will be sourced to gain feedback from leads of services.
- **Chair Report from sub-meetings**
  The Committee noted the following Chair's report; Patient Experience Committee, Safeguarding Committee, Patient Safety Committee, and the Research Committee.
- **Workplan (and Attendance Matrix)**
  The Committee noted the workplan which is currently under review.
- **For information only**
  The following two items were shared with the Committee for information – ICS Quality Committee Chair Report and Nurse Workforce Paper which was presented to the People and Culture Committee for assurance.

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:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	01 March 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	22 February 2023
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the next steps and recommendations being taken to move from monthly reporting of the IPC improvement plan as an exceptional item to incorporate oversight and reporting to existing governance structures.

2. Executive Summary

2.1. Context

RJAH was escalated to red on the NHSE/I IPC Matrix in February 2022 and the Trust was moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. The Trust had an IPC improvement plan in place and there have been formal IPC inspections where the Trust has now been rated as green on the NHSE/I IPC matrix. A final improvement review meeting (IRM) was held on 27th of October 2022 and the Trust has now received formal notification that undertakings have been met.

2.2. Summary

- RJAH remains Green rated on the NHSE IPC matrix
- Good progress has been made on the IPC improvement plan and the following recommendations were discussed and agreed at IPC Quality Assurance Committee:
    - Closure of IPC improvement plan against exit criteria/undertakings
    - Transfer of 12 'in progress' actions to newly formed overarching IPC Quality Improvement Plan
    - Newly formed IPC Quality Improvement Plan to be presented quarterly to Trust Board for assurance of compliance against the Health and Social Care Act Hygiene Code and the IPC Board Assurance Framework
    - Discussion with incoming chair of Quality and Safety Committee and Trust Secretary regarding workplan and incorporating the IPC agenda items for 23/24
    - 3 month review of the effectiveness of the Quality and Safety committee agenda and workplan

2.3. Conclusion

The Board is asked to note the progress made.

3. The Main Report

3.1. Introduction

RJAH was escalated to red on the NHSE IPC Matrix in February 2022 and the Trust was moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. The Trust had an IPC improvement plan in place and there have been formal IPC inspections where the Trust has now been rated as green on the NHSE IPC matrix. A final improvement review meeting (IRM) was held on 27th of October 2022 and the Trust has now received formal notification that undertakings have been met.

3.1.1 IPC Improvement Plan

In response to meet the exit criteria and undertakings an IPC improvement plan was developed to ensure actions are embedded trust wide and improvements are sustained. This improvement plan has been operationally managed through IPC working group and IPC Committee with monthly exception reporting to IPC Quality assurance committee and Trust Board.

The evidence for the improvement plan was reviewed as part of a desk top review by NHSE and the ICB on the 20th of October. A report has been received demonstrating a wealth of evidence to support the significant improvements made and progress against the exit criteria and undertakings. A follow up assurance joint IPC visit from NHSE and the ICB in December 2022 demonstrated sustained improvements and RJAH continue to be rated green against the NHSE IPC matrix.

Table 1: Overview of progress against actions IPC Improvement Plan on 03/01/2023

No.	Objective (Exit Criteria)	Not Started	Behind Plan	In Progress	Complete	Total
1.	Evidence of board assurance, senior leadership, and delivery of actions	0	0	1	5	**6**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	0	1	15	**16**
3.	Trust IPC audits demonstrate improvement	0	0	9	33	**42**
4.	Trust reporting on HCAIs, outbreaks and SSIs	0	0	1	24	**25**
5/6.	Improvement in external IPC inspections	0	0	0	3	**3**
7.	Agreement between regulators, commissioners and the System that there is evidence of significant progress and confidence in the Trust leadership Team	0	0	0	3	**3**
	Total	**0**	**0**	**12**	**83**	**95**

It has been discussed and agreed at the IPC Quality Assurance Committee that all closed and implemented actions from the IPC improvement plan can be archived and a new IPC Quality Improvement Plan developed for 2023/24. This will include transfer of the 12 actions in progress from the original plan and all new actions from all associated IPC action plans including the BAF and Hygiene Code and SSI/One Together action plan.

It is recommended progress against the newly formed IPC Quality Improvement Plan will be taken to Quality and Safety Committee and Trust Board for oversight quarterly alongside the IPC quarterly report. This will give assurance of compliance against the Health and Social Care Act Hygiene Code and the IPC Board Assurance Framework.

3.2. Recommendations agreed at IPC Quality Assurance Committee

- Closure of IPC improvement plan against exit criteria/undertakings
- Transfer of 12 'in progress' actions to newly formed overarching IPC Quality Improvement Plan
- Newly formed IPC Quality Improvement Plan to be presented quarterly to Trust Board for assurance of compliance against the Health and Social Care Act Hygiene Code and the IPC Board Assurance Framework
- Discussion with incoming chair of Quality and Safety Committee regarding workplan and incorporating the IPC agenda items for 23/24
- 3 month review of the effectiveness of the Quality and Safety committee agenda and workplan

3.3. Conclusion

The Trust has now moved to GREEN on the NHSE Midlands Infection Prevention and Control escalation matrix and formal undertakings have been met.

The Board is asked to note the recommendations agreed.

Acronyms

BAF	Board Assurance Framework
HCAI	Health Care Acquired Infection
ICB	Integrated Care Board
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IRM	Improvement Review Meeting
NHSE	NHS England
SSI	Surgical Site Infection

BY EMAIL

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Harry Turner
Chair
Robert Jones and Agnes Hunt NHS FT
Twympath Lane
Oswestry
Shropshire
SY10 7AG

27 January 2023

Dear Harry,

Re: Robert Jones and Agnes Hunt Foundation Trust Undertakings

Formal undertakings were previously agreed between NHS Improvement (now NHS England) and Robert Jones and Agnes Hunt NHS Foundation Trust (RJAH) in May 2022. These Undertakings were specifically focused on Infection, Prevention and Control concerns at the Trust and have been subject to ongoing review. The key forum to receive assurance of progress against those undertakings was the monthly Improvement Review Meeting (IRM) chaired jointly by myself and the ICB Chief Nurse, Alison Bussey. The level of assurance received through that forum combined with the positive site visit undertaken on 30 December 2022 has clearly demonstrated the progress that has been made.

I am therefore writing to confirm that the Regional Support Group (RSG) on 26 January 2023 supported the recommendation to remove the Trusts formal undertakings, on that basis please find enclosed the associated compliance certificate (Annex A)

I am sure you are already aware but to be clear that whilst RJaH was placed into segment 3 of the national oversight framework (NOF) at the same time as the original undertakings were issued the process for reviewing NOF segmentation has subsequently changed and is part of separate considerations and timings. On that basis the Trust's segment 3 category currently remains and any segmentation changes, which will also take into consideration other factors such as elective recovery, will be subject to a regional moderation process during February and depending on whether national team require further details, we would expect to be able to feedback the outcome of that process in early March

In summary well done to you and your team for the response made to the original concerns and the fact that as an organisation you have in place oversight arrangements to ensure the level of improvement demonstrated will be sustained on an ongoing basis.

Yours sincerely.

Fran Steele
Director of Strategic Transformation, North Midlands

Cc

Alison Bussey, Chief Nursing Officer, Shropshire, Telford & Wrekin ICB
Stacey Lea Keegan, Chief Executive Officer, RJaH
Nina Morgan, Regional Director of Nursing, NHSE

ANNEX A

COMPLIANCE CERTIFICATE

NHS TRUST:

Robert Jones and Agnes Hunt NHS Foundation Trust
Tympath Lane
Gobowen, Owestry
Shropshire
SY10 7AG

In this certificate, "NHS Improvement" means the National Health Service Trust Development Authority, which was abolished, and its functions transferred to NHS England on 1 July 2022 by the Health and Care Act 2022

NHS England hereby certifies that it is satisfied that the Trust has complied with all the Trust's Enforcement Undertakings accepted by NHS Improvement / England on 26 January 2023.

Signed:

Fran Steele, Director of Strategic Transformation (North Midlands) and member of the Regional Support Group (Midlands)

Date:

27 January 2023

0. Reference Information

Authors:	Sam Young, Deputy DIPC Sue Sayles, Lead IPC Nurse, Hayley Gingell, IPC Assurance Lead Anna Morris, IPC Nurse Specialist	Paper date:	1st of March 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	Updated on 23rd of Feb 2023
Paper Reviewed by:	IPC Quality Assurance Committee 12th of January 2023	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Assurance

1. Purpose of Paper

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

This paper presents the National Infection Prevention and Control (IPC) Board Assurance Framework (BAF) v1.11 published on 21 September 2022 mapped to the 10 criterions of the Health & Social Care Code of Practice. The Infection Prevention and Control Quality Assurance Committee (IPCQAC) reviewed the IPC BAF for assurance purposes on the 12th of January 2023 and the Board of Directors are asked to NOTE the report.

2. Executive Summary

2.1. Context

The IPC BAF has been developed by NHSE to support all healthcare providers to effectively self-assess their compliance against Infection Prevention and Control guidance. Following feedback and input from IPCQAC on the initial report, a full review of the IPC BAF and compliance position was conducted, highlighting any gaps around the Key Lines of Enquires (KLOE).

2.2. Summary

- There are no red rated KLOE and 23 amber partially compliant KLOE.
- Where there have been gaps in assurance identified, mitigating actions/recommendations have been described.
- To avoid duplication, resulting actions will be transferred to the Trust Quality and IPC Improvement Plan which is reviewed monthly at IPCWG for oversight and governance.
- There are significant out of date links in this version 11.1 of the BAF and these have been escalated through the System IPC Group and NHSE
- It is to be noted that an updated IPC BAF aligned to the Health and Social Care Act including recommendations for the ICS, is expected in March 2023.

2.3. Conclusion

The Board is asked to note the report.

3. The Main Report

3.1. Introduction

To resolve share ability due to file size, all embedded evidence has been removed from this document. An electronic file storage system has been created to store all evidence in support of each key line of enquiry. Evidence has been headlined in the evidence library column and each KLOE number is hyperlinked to the file where it is stored. The storage system is attached to a local server and therefore only persons with permissions to this folder will be able to view evidence. A request can be made to IPC Assurance Lead if required

3.2. IPC Board Assurance Framework Governance Tracker

IPC Board Assurance Framework Governance Tracker

IPC Board Assurance Framework is reviewed at Infection Control Quality Assurance Committee and/or Infection Control & Cleanliness Committee who will:

- Identify and assign appropriate leads/departments to key pieces of information where necessary.
- Offer assurance in terms of compliance with the Health & Social Care Act 2008 -Code of Practice on the prevention and control of infections to which the IPC Board Assurance Framework is linked.
- Monitor overall position to the compliance of all key lines of enquiry (KLOEs)
- Provide assurance of compliance, and escalate areas of concern, to the Quality & Safety Committee.

Version Control

Date	Version
May 2020	1 – Pre release
Oct 2020	1.5 – Officially published
Feb 2021	1.6
Mar 2021	1.7
Dec 2021	1.8
Sep 2022	1.11

3.3. IPC Board Assurance Framework V1.11

Key
Green: Sufficient Evidence to support compliance
Amber: Works in progress to strengthen compliance.
Red: No evidence of compliance.

Evidence library is located within the Infection Control Folder on the U drive. Permissions to the directory is required to view. Please contact the IPC Assurance Lead for access: hayley.gingell@nhs.net

Infection Prevention and Control Board Assurance Framework V1.11

1.	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

	Key lines of enquiry	Evidence & Links	Gaps in Assurance	Mitigating Actions	Date for completion	RAG
1.1	A respiratory plan incorporating respiratory seasonal viruses that includes: • point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services • segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised. • A surge/escalation plan to manage increasing patient/staff infections. • a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and	POCT is not utilised. The acute hospital conducts POCT. Included within the side room allocation SOP A surge/escalation plan is included in the Isolation Policy and Major Incident Policy. Major Incident Plan - Percy (interactgo.com) Evidence in IPC&CWG Terms of reference.				

	plan for creation of adequate isolation rooms/cohort units as part of the plan.	Draft Respiratory Plan (Content approval due 20/10/22) Side room allocation respiratory patients April 2022 IPC Working Group ToR: meets on a weekly basis and includes a disciplinary membership. IPC&C Committee ToR: meets on Monthly basis and includes a disciplinary membership Isolation Policy Outbreak Policy				
1.2	Organisational /employers risk assessments in the context of managing infectious agents are: • based on the measures as prioritised in the hierarchy of controls. • applied in order and include elimination; substitution, engineering, administration and PPE/RPE. • communicated to staff. • further reassessed where there is a change or new risk identified eg. changes to local prevalence.	Hierarchy of controls documentation attached. Included in all outbreak meetings Evidence attached in 1.1: IPC&CWG Meeting papers IPC&CWG ToR IPC Committee Meeting papers Midlands IPC Briefing takes place weekly to ensure a system wide approach to adopting Midlands regional IPC principles. ICS IPS AMR Group Minutes – Monthly Guidance Tracker ICS Trust position statements devised by IPC Lead Nurse.				

1.3	The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	ICS IPS AMR monthly meetings and Midlands IPC briefing provides platform to approve System wide approach to adopt Midlands regional IPC principles ICS IPC AMR Papers				
1.4	Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.	Risks are assessed by: Occupational Health Ward & Departmental Managers Infection Prevention & Control Team Deputy DIPC Approved by Director of Infection Prevention & Control (DIPC)				
1.5	Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	Transfer document contains IPC information (Link Transfer document) Handover from Acute or community hospitals includes IPC information as per national Infection Prevention Control Manual guidelines. (NIPCM) and Health & Social care Act criterion 5 NHS England » National infection prevention and control manual (NIPCM) for England Essential transfers and guidance is located in the Isolation Policy Draft Respiratory Policy Isolation policy Daily state of play meetings in RJAH provides a platform for communication				

		between the wards, IPC and clinical site managers.				
1.6	Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	IPC Audits are aligned to NIPCM guidance IPC Audits are undertaken electronically via Tendable by clinical areas. Analytics | Tendable Hand Hygiene & BBE: Weekly General IPC Inspection: Monthly HII Saving Lives Audits: Monthly An external hand hygiene audit is undertaken bi annually for added assurance and reported to IPC&CC A hand hygiene practical assessment training programme is in place and results are recorded on ESR. Compliance trajectories are monitored IPC&CC. A programme of Quality Assurance walks is in place undertaken by the IPC Team. A risk-based approach to reauditing is taken to assure compliance with NIPCM. The IPC Quality Management System analyses scores and highlights key themes. It unites all IPC data/activity to provide focus in areas where support is required to improvement performance/compliance. E&F Team deliver a bespoke induction that includes IPC for contractors.				

		Checklist in place for agency staff has been reviewed to strengthen assurance of IPC competency.The Trust records agency staff members on a master spreadsheet which includes IPC training date. The Trust does not accept any agency member of staff without in date IPC Training.				
1.7	The application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs	Tendable Audits are based on the ten SICPs and completed as per Tendable audit programme see details in 1.6 Analytics |Tendable IPC Quality Management System (QMS) reports Tendable audit score compliance. Tendable audit actions are owned the ward/departmental managers. The QMS monitors activity of all IPC actions and a report is presented to IPCWG on a monthly basis. IPC Action report	The IPC team do not have oversite of the detail within Tendable audit results as responsibility for completing audits is with ward/departmental managers.	Ward/ departmental managers will be required to report outstanding actions by exception in their Unit reports presented to IPC&CC Tendable audit tool is currently under review with a plan to replace with Inphase.	Review date: 01/04/2023	
1.8	IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	IPC BAF submitted to IPC&CC or IPCQA Committee depending on meeting schedule, for comment prior to submission to Trust Board. IPC BAF is approved by Trust Board as per board workplan. IPC&C Committee Papers IPCQA Committee Papers				

1.9	Trust Board has oversight of incidents/outbreaks and associated action plans.	Trust Board receives reports inline with Trust Board workplan on incidents and outbreaks. (Attach) Detailed reports are received through the Trusts governance structure including: IPC&C Working Group IPC&C Committee Papers Q&S IPC Subgroup Papers Trust Board Papers IPC Quarterly Visual Summary report located within the IPC QMS				
1.10	Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required	9 different FFP3 mask types are available for staff to be fit tested to, provided by the supply chain. 6 of which are manufactured within the UK. Mask Fit data is included in the library 1.1 folder for evidence. Fit testing is recorded on ESR.				
2	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**

2.1	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	National Standards were launched at the Trust on April 1st 2022 National Standards of Cleanliness - Percy (interactgo.com) Adherence to the guidelines is monitored via: IPC&CWG IPC&C And included in the Annual and Quarterly Report				
2.2	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	All requests are formally submitted to the Estates planning group, who meet bi monthly & provide a formal outcome for decisions				
2.3	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Adherence to the guidelines is monitored via: IPC&CWG IPC&C And included in the Annual and Quarterly Report Technical cleanliness audits are risk based and monitor cleanliness across the Trust. Efficacy audits monitor cleaning processes are being adhered to and review cleaning standards against cleaning specification for individual areas	External audit planned for February 2023		01/03/2023	

		Scores, failure themes and actions are reported through IPC working group, and formally documented through IPC & Cleanliness Quarterly Reports. Annual external audit conducted by peer specialist, provides assurance of audit standards are being applied.				
2.4	Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	Cleaning policy references enhanced and cleaning frequency in line with the NIPCM. Cleaning frequencies are in place & published on the intranet and displayed in all patient facing areas: Cleaning Policy - Percy (interactgo.com) https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=5554&SearchId=0&utm_source=interact&utm_medium=category_search&utm_term=*				
2.5	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Manufacturer's instructions are displayed in all sluices and cleaning cupboards. Current products used for environmental cleaning at RJAH do not require "contact time" Cleanliness technicians have local induction, all staff undertake 'Cleaning for Confidence' training and is recorded on ESR.	While full compliance is evidenced a review is being undertaken of the cleaning competencies for cleanliness technicians and housekeepers with a view to rolling out to clinical teams.		Progress update expected: 01/03/23	

			Process for competency sign off to include practical assessments by dedicated cleaning staff.			
2.6	For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ patient isolation rooms ○ cohort areas ○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting.	Cleaning frequencies are aligned to the patient isolation requirements and are included in the Cleaning policy and Isolation policy (See above) Cleaning sign off sheets are displayed in every area. Sign of sheets manually completed and stored in housekeeping management office to evidence compliance. Funding approved and staff appointed to dedicated touch point cleaning rolls, focusing on areas of high contamination rate.				
2.7	The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	Cleaning responsibilities agreed through IPCWG/IPCC and available via the intranet https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=5554&SearchId=0&utm_source=interact&utm_medium=category_search&utm_term=* Annual review of cleaning responsibilities will be undertaken in				

		April 2023 in line with national standards of healthcare cleanliness See 2.5 for further quality improvement works.				
2.8	A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Terminal cleaning and cleaning following AGP are conducted in line with Cleaning Policy and Isolation Policy (See above). Compliance is evidenced in cleaning sign off sheets which are on display in every area. (See above)				
2.9	Reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	Protocols are in place for the decontamination of reusable non-invasive equipment in clinical areas. I am clean stickers are used to identify when shared equipment is clean: Outlined in the Cleaning & Decontamination Policy which can be located on the intranet Decontamination Policy - Percy (interactgo.com) The IPC General Inspection monitors ongoing compliance to this practice. IPC team conduct IPC QA Walks to monitor adherence. Audit data is monitored by the IPC Quality Management System and reported through IPC&CC.				

		MiCAD technical audits monitor cleanliness of all equipment located in all clinical areas. Action report is sent to ward/departmental managers who are responsible and accountable to complete actions. Completed actions are monitored by Facilities. Spot checks are conducted by cleanliness auditors to ensure standards are met. Reports are received through IPC&CWG (As above)				
2.10	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	See 2.9				
2.11	Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	The Trust has a rolling program for competing the re-verifications and any concerns discussed at Ventilation working group, raised on risk register as required. Decontamination & Ventilation Working Group papers				
2.12	Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	The Trust has an externally contracted Authorised Engineer for ventilation. RJAH has a designated Authorised Person for ventilation as part of the Estates team. Ventilation assessment is undertaken annually. Ventilation Risks Appointment Letter – AE & AP PPM Records				

2.13	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Hierarchy of controls is completed for outbreak situations. (See above) Window opening chart is available for wards to complete. Where ventilation requires supplementation within outbreaks, air scrubbers are deployed. Information on natural ventilation is contained in the Top tips for outbreak management poster.	Documentation is often not completed regarding window opening. This has been escalated to ICS IPC meeting and is recognised as a recurring issue in all providers. There is no current approved system of recording ventilation.	Windows are opened but not evidenced.	Ongoing monitoring.	
3	**Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**
3.1	Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	Antimicrobial Pharmacist is the nominated formal lead for AMS. The lead should attend: Shropshire Telford and Wrekin (STW) ICS Antimicrobial Stewardship Group Meeting. Pharmacists Group on WhatsApp	No longer have an on-site Consultant Microbiologist. Antimicrobial Pharmacist has commenced planned leave January 2023.	SLAs are being reviewed with Sheffield for tissue samples/ aspirates and UKOMS for Infection Control Doctor support.	31/3/2023	

				Interim AMS pharmacy support has been agreed by Chief Pharmacist	
3.2	The use of antimicrobials is managed and monitored: ○ to optimise patient outcomes ○ to minimise inappropriate prescribing ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed	The use of antimicrobials is monitored at AMS Group as part of Drug & Therapeutics Committee. Agenda and minutes at DT&C Weekly antibiotic ward round. Weekly infection MDT meeting discusses AMS. (PID prevents evidence to support in line with GDPR) Quarterly Point Prevalence Survey (PPS) details evidence of antibiotic usage. Vancomycin dosing regimes have been reviewed and updated to ensure appropriate dosage and frequency according to renal function, body weight and gender. Vancomycin regime Daily review of drug charts by pharmacists who alert prescribers to any issues with AMS.	AMS should be formalised in a Reporting structure with Committee and Board oversight. Analysis of PPS data Trainee pharmacist to carry out an audit on 'the appropriateness of the total duration of antimicrobial therapy. The Trust will recommence the High Impact Intervention toolkit (HII) which incorporates AMS.	Dec 22: trainee pharmacist assigned – completion by end of March 2023 Feb 23: Copy of antibiotic usage report (PPS) has been received by the DIPC and Medical Director Relaunch of the HII Toolkit is planned April 2023.	30/4/2023

3.3	Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ○ total antimicrobial prescribing; ○ broad-spectrum prescribing; ○ intravenous route prescribing;	As 3.2	AMS should be formalised in a Reporting structure with Committee and Board oversight.			
3.4	Adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	As 3.2	AMS should be formalised in a Reporting structure with Committee and Board oversight.			
3.5	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	As 3.2	AMS should be formalised in a Reporting structure with Committee and Board oversight.			
4	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**
4.1	IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	IPC resources include written face to face, telephone and intranet. IPC team provide push and pull notifications. Patient leaflets have been developed and are available in all languages. These are located on the intranet and				

		ward/departments are responsible for printing and supplying leaflets in line with policy. Patient Care - Percy (interactgo.com) Posters are sited across the Trust for example: Cough Etiquette Hand Hygiene Outbreak Management Poster Respiratory Pathway Poster IPCN provide face to face support to staff, patients and relatives. IPC intranet page Infection, Prevention & Control - Percy (interactgo.com) IPC Bulletin				
4.2	Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Visiting is compliant to current national guidelines. Visiting advice and guidance is displayed on the Trust website and is covered in policy and information: Visiting Poster Spines ICS Visiting posters Visitors protocol Trust website				

4.3	National principles on inpatient hospital ~~visiting and maternity/neonatal services~~ will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented.	Evidence 4.2 Visiting is in line with national policy.				
4.4	Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	Evidence 4.2 Visiting is in line with national policy.				
4.5	Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Visiting is restricted during outbreaks in line with Outbreak Policy. Essential visiting is considered on a case-by-case basis by ward managers and IPC team if required. A risk-based approach is adopted when patients are explicit about having visitors and is recorded in the patients notes. (Unable to provide evidence PID in line with GDPR) Outbreak Packs are in place to support areas with outbreak management. Link to Outbreak pack				
4.6	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Evidence 4.2 Masking requirements are discussed at IPC&CWG. Final approval is through the DIPC. Comms links to mask wearing IPC Bulletin Posters displayed at entrances to clinical areas throughout the Trust.	Information to prompt compliance of respiratory hygiene and cough etiquette	Posters uploaded to the intranet and disseminated to ward and departmental managers to display in their areas. Communicated	15.11.22 Completed	

				at SNAHP 15.11.22		
4.7	if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	See 4.2 Isolation posters are located on side room doors. End of life visiting is permitted with adherence to the agreed EOL visiting SOP. Visitor booking system ensures that visitors are informed of infection status and necessary PPE requirements prior to visiting.				
4.8	Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	See 4.2				
4.9	Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Where appropriate, elements of the Toolkit have been adopted. Many of the elements in the toolkit have been superseded by the NIPCM COVID-19 guidance and Midlands Principles.		The outdated elements of the toolkit have been escalated to ICS IPC meeting and NHSE		
5.	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**

5.1	All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	Pre-Operative MRSA screening compliance is included in the IPC Quarterly Report. MRSA Admission screening continues and compliance is reported to ICB externally and IPC&CC Alert organism surveillance and monitoring is conducted in line with: MRSA Policy and SOP CPE Policy and SOP COVID-19 Preop process & SOP SOP COVID-19 Screening Requirements & LFT Process Side room allocation respiratory patients April 2022	No robust system/process that flags infection status of patients between Trusts, or tracks Alert organisms through patient history.	Action recorded on the IPC Trust wide Improvement plan. Trust is scoping the implementation of ICNET.	31/3/23	
5.2	Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM)	Signage is sited at the main entrance displaying the following: ○ Correct ways to wear a Surgical facemask ○ Wash hands, cover face make space posters located on the automatic doors ○ Clean your hands, fight against infection posters attached to hand gel dispensers. ○ Bare Below the Elbow posters also displayed at ward and departmental entrances Trust wide. ○ Seconds saves lives hand hygiene banners	Respiratory hygiene and cough etiquette posters not displayed	Posters obtained from ICS partners and displayed.	**Ongoing monitoring**	

		○ Dos and Don'ts of face mask wearing ○ Signage requesting mask wearing is required beyond the point of main entrance. A library of patient leaflets can be located via the Trust Intranet Patient Care - Percy (interactgo.com) Trust website has a patient and visiting section that contains messaging and UpToDate information for stakeholders from outside of the organisation https://www.rjah.nhs.uk/ My recovery app serves as an information platform to inform and empower patients through their treatment journey. Patients can access a wide range of information to manage their condition. Details of the app can be seen by following the link below https://www.youtube.com/watch?v=uhQmhh6OXj4				
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	See 5.1, 5.4, 5.5 Discharge/transfer checklist in place with Critical Care Transfer form in use Admission Passport for Non-Elective Surgical Admission/MCSI Adult Inpatient is in place.		ICNet will provide a more robust Infection status monitoring tool		
5.4	triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This	RJAH teams work with system partners within the capacity hub to ensure patients are placed appropriately on admission. All patients are screened for				

	should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	Covid before transfer, or after when confirmation is not available or in doubt. Patients who display respiratory symptoms are managed in line with RJAH Respiratory Policy and isolated immediately with screening conducted as per Policy and local guidance (NHSE Midlands Principles) Evidence: Information for Outpatients COVID-19 Patient swabbing requirements SOP Isolation Policy				
5.5	patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	Patients are isolated and/or cohorted when symptomatic in line with Policy. Masks are offered to symptomatic patients. Actions for suspected COVID-19 Seasonal Respiratory Policy	Where mask wearing is declined or refused, this should be documented in patients notes.	Tracking or demonstrating this will require work through by data mgt teams/clinical teams	April 2023	
5.6	patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	**See 5.4** Patients with suspected respiratory infection attending outpatients appointments are isolated and reviewed by a clinician for a decision on proceeding with clinical treatment. FRSM are expected to be worn by all patients in outpatients unless medically exempt.				
5.7	patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test	**See 5.1, 5.3, 5.4, 5.5** *Draft Respiratory Policy				

	results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	RJAH Seasonal Respiratory Policy				
5.8	patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g, priority for single room protective isolation	Consideration of protective isolation is contained within Policy. Patients who are at risk of severe outcomes of infection will be allocated a side room in protective isolation. Seasonal Respiratory Policy	.			
5.9	if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	A clinical review determines the patients fitness for procedure. Triaging is conducted through out-patient departments as per **5.4** Fitness for anaesthesia				
5.10	The use of facemasks/face coverings should be determined following a local risk assessment.	National and Regional guidance is reviewed at ICS IPC meetings. Mask wearing is discussed at IPCWG and DIPC provides the Board with recommendations based on an IPC and prevalence risk assessment. (Evidence **1.2, 1.3, 1.9**)				
5.11	patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	See **5.1, 5.4, 5.9** Actions for suspected COVID-19 patients Procedure for patients that develop COVID-19 Symptoms				
5.12	Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Regular bulletins and announcements are released by the Comms Team informing staff of vaccinations				

		available. Bulletins signpost to the knowledge hub located on the Intranet which hosts a library of information for vaccination requirements for staff. An IPC Bulletin is circulated on a bi weekly basis to ensure staff are informed of IPC requirements (see **4.6**) RJAH OH department support and arrange Covid and Flu vaccinations - see section 10. Vaccination status of patients is assessed by pharmacy teams and vaccinations are recommended/offered where appropriate.				
5.13	Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	The Trust has systems in place to identify and manage outbreaks. Outbreak Packs are in place containing information to support staff with outbreak management as well as toolkits and templates. Outbreak Policy is accessible to all staff and is located via the policy section of the Intranet. The IPC QMS has a section dedicated to outbreaks and data is fed into a visual summary report which is sited at board level. The IPC Quarterly report also includes an over- view of outbreaks. The IPC Annual Report summarises all outbreak data.				

6		Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
6.1	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**
6.2	IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	IPC education is provided in line with the NIPCM Manual located on the Trust Intranet page. IPC Policies are located on the Trust Intranet page to provide staff with up-to-date guidance and procedures. Staff complete mandatory IPC training modules (listed below) via the Skills for Health e-learning. Evidence of completion is held within the Electronic Staff Record (ESR): Infection, Prevention and Control Training L2 Cleaning for Confidence - An Introduction Cleaning For Confidence - Intensive care units Donning & Doffing Training Aseptic Technique Hand Hygiene Hand Washing Assessments Compliance to mandatory training is monitored via the Training Department and reported to IPC&CC via quarterly and annual reports. Compliance data is disseminated to all unit leads on a bi-weekly basis and fed				

		into the IPC Quality Management System. Training compliance is fed into the Quarterly visual summary sited at Board level. IPC education is delivered by the IPC team via the Trust induction programme to all new employees and volunteers. An 'A-Z of infections', located on the Trust Intranet page guides staff around the placement, management, PPE, and cleaning requirements for a variety of infections.				
6.3	Training in IPC measures is provided to all staff, including: the correct use of PPE	See 6.2 Face-to-face training in IPC measures including the correct use of PPE, is delivered by the IPC Support Worker. Weekly education sessions are available for staff who require assistance with completing hand hygiene competencies/PPE. Sessions are mapped within the IPC Quality Management System linked to training trajectories.				
6.4	All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	See 6.2/6.3				

6.5	Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	Adherence to the NIPCM on the use of PPE is monitored via IPC Ward and Departmental audits. The General IPC Inspection audit contains a dedicated section to PPE compliance. PPE compliance is reported to IPC&CC via the quarterly and annual reports IPC Quarterly & Annual Reports				
6.6	Hand hygiene is performed: ○ before touching a patient. ○ before clean or aseptic procedures. ○ after body fluid exposure risk. ○ after touching a patient; and ○ after touching a patient's immediate surroundings.	IPC Ward & Departmental audits are aligned to the 5 moments of hand hygiene. Hand Hygiene is monitored on a weekly basis via the IPC Ward & Departmental Audits undertaken via Tendable. Hand Hygiene and Personal Protective Equipment Policy is available for staff to access via the intranet: Hand Hygiene and Personal Protective Equipment Policy - Percy (interactgo.com) Posters are displayed above each hand wash basin to demonstrate the correct hand hygiene technique GOJO provide bi-annual external hand hygiene audits. Compliance is reported	An external hand hygiene audit in December 2022 showed an overall compliance score of 75%	A hand hygiene champion has been nominated for each ward/dept in order to monitor hand hygiene compliance The nominated staff members will receive hand hygiene train the trainer training by the IPC support worker. The new NHSE HH audit tool will	31/03/2023	

		to IPC&CC via the IPC quarterly and annual reports.		be adopted by RJAH		
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	Hand dryers are not located in clinical areas and are only available in public toilets. Paper towel dispensers are located close to the sinks. Hand Hygiene and Personal Protective Equipment policy outlines recommendations. This can be located via the intranet: Hand Hygiene and Personal Protective Equipment Policy - Percy (interactgo.com)				
6.9	Staff understand the requirements for uniform laundering where this is not provided for onsite.	The Uniform Policy outlines responsibilities of staff and can be located via the intranet: Uniform and Dress Code Policy - Percy (interactgo.com) An FAQ guide is located on the intranet and can be located here Uniform and Dress Code Policy FAQs - Percy (interactgo.com)	Audit required to include question to staff around their understanding of the requirements for laundering of uniform	IPC team to revise current QA walk audit questions	April 2023	
7	**Provide or secure adequate isolation facilities**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**		
7.1	Clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Advice on mask wearing is provided on the Trust Internet page. Patients are encouraged to wear a facemask in line with the Trust's Respiratory Infection Policy.	Where mask wearing is declined or refused, this should be	See 5.5	April 2023	

		IPC General inspection audit monitors compliance to patient face mask wearing. https://web.tendable.com/login	documented in patients notes.			
7.2	Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	Patients with known or suspected infections are nursed in side rooms (where available). Standard Infection Control Precautions (SICPs)/Transmission Based Precautions (TBPs) are followed as per the NIPCM. The Trust provides policies on the following alert organisms: MRSA Multi-drug Resistant Gram-Negative Respiratory Infections Trust Isolation Policy				
7.3	Patients are appropriately placed i.e., infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	The Trust Isolation Policy provides guidance to staff on patient placement for patients with infections which includes a risk assessment for situations when an isolation room is not available. Isolation policy The Respiratory Policy provides guidance around the cohorting of patients with the same infectious agent The side room allocation SOP provides a list of all side rooms with en-suite facilities, to aid decision-making around appropriate patient placement				

		Side room allocation SOP				
7.4	Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	The Seasonal Respiratory Policy NIPCM (located on the IPC Intranet at Infection, Prevention & Control - Percy (interactgo.com)				

8	Secure adequate access to laboratory support as appropriate					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	**RAG**
8.1	Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	Trust has a service level agreement (SLA) with SaTH Microbiology Services. The agreement provides laboratory testing for infectious illnesses.	No longer have an on-site Consultant Microbiologist.	SLAs are being reviewed with Sheffield for tissue samples/ aspirates and UKOMS for Infection Control Doctor support.	31/03/2023	
8.2	Patient testing for infectious agents is undertaken promptly and in line with national guidance	See policies in 5.1 FAQs can be located on the intranet relating to patient testing for COVID-19: Covid-19 patient testing FAQs - Percy (interactgo.com) Screening Requirements & LFD testing process is detailed in the COVID-19 screening requirements SOP				

		Admission/symptomatic screening includes: COVID-19 MRSA CPE (for patients admitted to Midlands Centre for Spinal Injuries who are transferred from inner-city hospitals) The IPC team receives a monthly MRSA screening compliance report which is detailed in the quarterly and annual reports that is reported to IPC&CC.				
8.3	Staff testing protocols are in place for the required health checks, immunisations and clearance	Vaccination status is obtained and monitored by Occupational Health.				
8.4	there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Test results are uploaded to EPR once processed by the Microbiology Lab. The lab produce a daily (Mon-Fri) report of all positive samples taken which is monitored by the IPC team (PID prevents evidence to support in line with GDPR).	Lack of consistent process to monitor turn around times	Trust is scoping procurement of ICNET	30/4/2023	
8.5	Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. COVID-19 Specific.	See section 5 for evidence SOP COVID-19 Screening Requirements & LFT Process The RJAH Position Statement produced in September 2022 outlines				

		the Trust's position against the regional guidelines. PCR testing is undertaken for inpatients who require a respiratory panel after a negative LFD test. Respiratory Policy Midlands IPC Management of Influenza Cases				
8.6	Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	See 8.5 PCRs are obtained on 48hrly rotational process unless Covid-19 positive in the past 90 days, where LFD test is indicated as per National and Regional guidance. Audits undertaken by the IPC Assurance Lead twice yearly to monitor Trust compliance to national screening requirements for COVID-19. Audit reports shared at IPC&CWG, IPC&C Committee. Results shared with ward managers and unit leads.				
9	**Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	
9.1	Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	See 1.7 High Impact Intervention Audits are undertaken on a monthly basis and monitored.	AMS High Impact Intervention	Dec 22: Re-launch of HII process/	28/02/2023	

			Audits not consistently undertaken.	frequencies to IPC link staff and at SNAHP		
9.2	Staff are supported in adhering to all IPC and AMS policies	See 1.7				
9.3	Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	An Outbreak pack is in place to assist managers in the management of an outbreak which includes: **Definition of an Outbreak** Outbreak policy guides steps to be undertaken in the event of an outbreak The Hierarchy of Controls outlines the mitigations for outbreak management Outbreak Top Tips sheet created by IPC Team for outbreak management as aide memoir A multidisciplinary approach is adopted to the management of outbreaks and documents created and stored on secure channel via MS Teams On formal closure of outbreak, outstanding actions are managed via the Datix system Outbreaks are reported externally via the NHS Insights Platform. Outbreaks are also reported to IPC&CC via the quarterly and annual reports.				

9.4	PPE stock is appropriately stored and accessible to staff when required as per NIPCM	PPE is stored and managed by central stores department. Dedicated staff member located in Stores to oversee stock supplies in all areas. PPE stocks and stores are audited through self-audit programme on Tendable and by IPC Team Quality Walk throughs				
10	**Have a system in place to manage the occupational health needs and obligations of staff in relation to infection**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Date for completion**	
10.1	Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy	SLA with TP Health. TP Health have a blood borne virus line, Monday to Friday 8-30am to 5pm. Employees are able to ring up regarding not only BBV incidents but also infection control queries. TP Health are involved at the request of Trust to be involved with infection outbreaks/testing (where appropriate) and delivery of results.				
10.2	Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.	Any employee referred to OH are treated in the same way. Bank, flexible, agency, and locum staff follow Testing and return to work protocols.				
10.3	A fit testing programme is in place for those who may need to wear respiratory protection.	A fit testing programme is place for all relevant staff. Department of Health Fit testers are on site to provide testing for FFP3 masks. SOP in place to outline the process for FFP3 requirements.				

10.4	Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination. • encourage staff vaccine uptake.	Staff are offered appropriate treatment, advice following IPC breaches. Where a BBV incident occurs, vaccination and follow up bloods are offered accordingly. PEP is assessed and staff are signposted to A+E. TP Health assess employees who are having difficulties with PPE and advise management so decisions can be made of mitigations/fit test failures. TP Health are very pro-vaccine and offer vaccinations in line with national guidance (Green Book). OH staff ensure all the benefits and risks are discussed with employee and documented so that informed choices can be made.				
10.5	A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. that advice is available to all health and social care staff, including specific advice to those at risk from complications.	Risk assessments are undertaken by ward and departmental managers which includes all those considered high risk of complications resulting from respiratory infections. Risk assessment document is kept locally by ward and departmental managers. Occupational health provide advice to all staff and managers.	Risk assessment process is in place No evidence as to their completion	Requires review by OD/People team/OH input Consideration to record assessments as part of on-boarding process	31/03/2023	

10.6	Testing policies are in place locally as advised by occupational health/public health.	Testing policies are in place for occupational health vaccinations programmes such as Hepatitis B , MMR,TB and chickenpox. Recall programmes are in place to ensure staff are tested following vaccine programmes. TP Health have had minimal involvement with any Covid related work at RJAH as this is completed by NHS Gains Park OH service.				
10.7	NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	The Trust continues to adhere to national COVID-19 testing protocols (**see 8.2**). Routine asymptomatic LFD testing has ceased. SOP for staff LFD testing prior to returning to work. Symptomatic and pre-shift testing compliance is sought form the Chair of Outbreak Meetings and recorded in minutes.				
10.8	Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	Department of Health fit testers provide appropriate training when undertaking fit tests on staff. Fit testing records are uploaded and monitored via Individual staff records on ESR.	No compliance target has been set by HSE or NHSE. Low uptake of fit testing for relevant staff (Report of figures is awaited)	Escalated to Chief Nurse: Comms disseminated via the IPC bulletin 19.10.22 to raise awareness of the importance	Ongoing monitoring required.	

				of staff being fit tested. Fit testers will attend ward & departmental areas to reduce the need for staff to leave their areas. Agenda item SNAHP. Compliance is monitored through IPCWG and issues escalated to DIPC		
10.9	Staff who carry out fit test training are trained and competent to do so.	Fit testing is undertaken by fully trained and competent independent Department of Health fit testers.				
10.10	Fit testing is repeated each time a different FFP3 model is used.	In the event of staff members are required to use a different type of FFP3 model, additional fit testing will be undertaken by the Department of Health testers.				
10.11	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	The Trust currently holds 9 different models of masks for staff to be fit tested to.				
10.12	Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	Staff who fail to test on current supply of masks are retested to the new brand of mask. Evidence required	Evidence not documented	Requires documented evidence that records are	31/03/2023	

				supplied and will require OD/People/H&S input to resolve	
10.13	That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	For staff who fail fit testing, powered respirator hoods are available for use in Theatres and individual wards. Departmental managers are able to purchase power hoods for use within their departments.	Requires SOP for cleaning/ decon	Facilities to develop SOP or include in decontamination Policy	31/03/2023
10.14	Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. ***there is no nationally agreed algorithm**	FFP3 SOP outlines the process in the event of staff failing fit testing. Managers are responsible assessing skill set against operational requirements.	No evidence of discussions taking place.	Requires documented evidence and will require OD/People/H&S input to resolve	31/03/2023
10.15	A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	See **10.12, 10.14, 10.15**	No evidence of discussions taking place	Requires documented evidence and will require OH/OD/People input to resolve	31/03/2023
10.16	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	Fit tests are reported onto ESR. DoH fit testers maintain their own records. ESR reports are presented at H&S Committee Routine Fit testing reports are presented at H&S Working group Tests are reported onto ESR with report taken to H&S Committee.	There requires assurance that gaps in evidence above **10.12/10.14/10.15** are addressed.	New process implemented in Nov 22 for board oversite of Fit testing reports. Reports to include **10.12** **10.14** **10.15**	31/03/2023

		Highlighted concerns are taken to H&S Committee and escalated to Quality and Safety Committee.				
10.17	staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work	See **10.7** Staff are advised accordingly inline with national guidance. If required O/H will make contact with UKHSA. Good relationships maintained with the microbiology team, who offer guidance. Return to works are managed by experienced teams of OHA/OHP clinicians. Where referral to primary care services are required O/H liaise with the GP to complete this.				

3.4. Associated Risks

- Completion of the IPC BAF is the responsibility of several Units, individuals or Departments and without collaboration, there is a risk that progress or closure may not be achieved.
- Progress on several serials is due by 31 March 2023 and there is a risk that the dates may not be met however, the new BAF is expected by then and will be presented to Committee in due course.

3.5. Recommendations

The Trust Board is asked to:

- Accept the assurance provided by the IPC BAF version 11.1
- Note the on-going progress and actions to strengthen evidence for compliance in KLOEs rated amber.

3.6. Conclusion

- Overall strong evidence of compliance with the ten criterion of the Health and Social Care Act Hygiene Code
- Areas of focus to increase compliance are: Antimicrobial stewardship, FFP3 mask fit testing and improving access to Microbiology onsite.
- Resulting actions will be transferred to the Trust Quality and IPC Improvement Plan which is reviewed monthly at IPC Working Group for oversight and governance. Completed actions will also be closed off on the BAF.
- New BAF is expected in March 2023.

Appendix 1: Acronyms

Acronym	Full text
Acronym	Full text
Acronym	Full text

Chair's Assurance Report
IPC Quality Assurance Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 March 2023
Executive Sponsor:	Sara Ellis Anderson, Chief Nurse, and Patient Safety Officer	**Paper written on:**	22 February 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 IPC Quality Assurance Committee. The Board is asked to consider the recommendations of the IPC Quality Assurance Committee.

2. Context

2.1 Context

The Trust Board has established an IPC Quality Assurance Committee. According to its terms of reference: *"The purpose of the IPC Quality Assurance 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 in relation to Infection, Prevention and Control in order 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 IPC Quality Assurance 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 IPC Quality Assurance Committee

This report provides a summary of the items considered at the IPC Quality Assurance Committee on 09 February 2023. It highlights the key areas the IPC Quality Assurance 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 IPC QA 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.

IPC Quality Report

The Committee discusses the importance of routinely reporting of surgical site infections. The Trust report effectively on hips, knees, and spines however, there is a noted gap with other service areas. It was noted that the Trust gains data from the national reporting which has a 3-month delay – the timeframe of this does not support with triggers and supporting patients sooner.

The Committee discussed the challenges faced with the implementation of the ICNET system which in time would support the reporting and have the capability to code and potential SSI – there is a noted 12-to-18-month timeframe for the system to be embedded.

The Committee wished to raise the lack of progress over the past 12 months in relation to implementation of ICNET and the reporting of other specialty SSI and have formally flagged as a risk for the organisation.

IPC Quality Committee Review

The Committee considered a summary of the activity of the Committee along with recommendations on the future governance arrangements relating to infection prevention and control agenda. After considering the report (attached as appendix 1 for reference), the Committee concluded that it has essentially delivered its purpose, as defined in its terms of reference, and IPC assurance arrangement could return to a 'business as usual' footing.

As such, the Committee recommends that the Board consider:

1. Disestablished the IPC Quality Assurance Committee and transferring responsibility for providing assurance on IPC matters, including oversight of the residual actions arising from the IPC action plan as now captured within the IPC Quality Improvement Plan, back to Quality and Safety Committee.
2. Reviewing those arrangements in three months' time with a view to re-establishing a dedicated committee of the Board if the position deteriorated and/or the Quality and Safety Committee was unable to provide the necessary focus on the IPC agenda.

It was noted that the monthly IPC meeting that has reported into the IPC Quality Assurance Committee would continue to meet. The associated work would continue but the board would receive assurance via the Quality and Safety Committee rather than an IPC Quality Assurance Committee.

3.2 Areas of on-going monitoring with new developments

ADVISE - The IPC Quality Assurance 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:

There were no agenda item to note within this section of the report.

3.3 Areas of assurance

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

IPC Improvement Plan

The Trust remains Green rated on the NHSE IPC matrix following most recent NHSE visit in December and the Trust has received formal notification undertakings have now been removed. Actions will be transferred to the overarching IPC Quality improvement plan for monitoring.

Environment and Estates Report

The Committee noted considerable assurance can be taken and steps in place to ensure the backlog of requested does not happen again. The reporting will be aligned to the IPC Committee. The Committee commended and thanked the Estates teams for all their work and support.

Chair Report IPC Committee

The Committee noted the Chairs assurance report.

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.3.

0. Reference Information

Author:	Dylan Murphy, Trust Secretary	Paper date:	9th of February 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	6th of February 2023
Paper Reviewed by:	N/A	Paper Type:	Governance and Quality
Forum submitted to:	Infection Prevention and Control Quality Assurance Committee	Paper FOIA Status:	Full disclosure
Paper to support CQC Evidence:	No	Purpose of Paper:	Approval

1. Purpose of Paper

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

This paper presents a summary of the activity of the Infection Prevention and Control Quality Assurance Committee – subsequently referred to in this report as "the Committee"; asks the Committee considers whether it has delivered its purpose; and proposes potential next steps to be recommended to the Board.

2. Executive Summary

2.1. Context

NHSE/I escalated the Trust to a RED rating on its IPC matrix in February 2022. As a result, the Trust was moved into "segment 3" of the NHS System Oversight Framework (SOF 3). SOF 3 denotes a requirement for "bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required". Accordingly, the Trust was issued with enforcement undertakings and an IPC improvement plan was developed.

The Committee was established to provide assurance in relation to IPC and delivery of the IPC improvement plan.

At the Board meeting in April 2022, it was agreed that the Committee would report directly to the Board of Directors until further notice and that all IPC agenda items be removed from the Quality and Safety Committee and realigned to the Committee

2.2. Summary

The Committee met on 10 occasions, prior to today's meeting. The Committee Chair has provided an assurance report to the Board following each meeting.

As reported to the Board on 1st February 2023, the Trust received a compliance certificate from NHSE/I on 27th January 2023 which stated that *"NHS England hereby certifies that it is satisfied that the Trust has complied with all the Trust's Enforcement Undertakings accepted by NHS Improvement / England on 26 January 2023".*

2.3. Conclusion

The Committee is asked to consider whether it has delivered its purpose and therefore whether a recommendation should be made to the Board to disestablish the Committee and transfer oversight of the residual actions, and the wider IPC agenda, to the Quality and Safety Committee.

3. The Main Report

3.1. Introduction

The Committee was established to provide assurance to the Board following the Trust's RED rating in the NHSE/I IPC matrix. The Trust has subsequently delivered the associated improvement plan to NHSE/I's satisfaction and the Trust rating in the NHSE/I IPC matrix is now GREEN. The Trust's rating within the SOF will not change until the next scheduled review of its performance against the framework (though it is hoped that the improvement in the IPC matrix rating will be reflected in an improved SOF rating).

Consideration should now be given to IPC assurance arrangements returning to a "business as usual" footing.

3.2. Establishment of the Committee

The terms of reference of the Committee define its key responsibilities as follows:

- *"Promote excellence in patient care in all aspects of Infection, Prevention and Control and monitor and review the "Quality Improvement Strategy"*

- *The purpose of the IPC Quality Assurance Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust in relation to Infection, Prevention and Control in order to:*
    - *Promote safety and excellence in patient care*
    - *Identify, prioritise and manage risk arising from clinical care*
    - *Ensure efficient and effective use of resources through evidence based clinical practice*

- *To ensure the Trust is meeting core standards and is compliant with national guidelines and regulatory requirements in relation to prevention and control of infection.*

- *To oversee the delivery of the infection prevention and control improvement plan and provide appropriate assurances to the Board and escalate any areas of concern.*

- *To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision in relation to Infection, Prevention and Control.*

- *To receive Chairs Assurance Reports from the following the Infection Control Committee*

- *The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy"*

3.3. Delivery of its responsibilities – Meetings held and items considered

The Committee has met on a monthly basis since March 2022 (excluding December 2022). Attendance at those meetings, to January 2023, is included for reference at Appendix 2.

The Committee considered a range of reports at its meetings. The workplan of the Committee, which outlines the scope of its work, is included for reference at Appendix 3.

The Committee Chair presented an assurance report to the Board following meetings of the Committee.

3.4. Delivery of its responsibilities - Progress against the IPC Improvement Plan

The Committee considered regular reports on delivery of the IPC improvement plan. Progress against the plan at 03/01/2023, as reported to the Board on the 1st of February 2023, was:

No.	Objective (Exit Criteria)	Not Started	Behind Plan	In Progress	Completed	Total
1	Evidence of board assurance, senior leadership, and delivery of actions	0	0	1	5	6
2	Trust staff have the necessary improvement skills to sustain improvement	0	0	1	15	16
3	Trust IPC audits demonstrate improvement	0	0	9	33	42
4	Trust reporting on HCAIs, outbreaks and SSIs	0	0	1	24	25
5/6	Improvement in external IPC inspections	0	0	0	3	3
7	Agreement between regulators, commissioners and the System that there is evidence of significant progress and confidence in the Trust leadership Team	0	0	0	3	3
	Total	**0**	**0**	**12**	**83**	**95**

3.5. Associated Risks

Though the formal undertakings have been delivered, there are a number of residual actions to be completed and IPC must remain an area of focus for the Trust. Should the Committee be disestablished, there would need to be a clear transfer of the residual actions, as now captured within the IPC Quality Improvement Plan, and continued assurance to the Board on issues relating to IPC.

3.6. Recommendations

The IPC Quality Assurance Committee is asked to consider:

1. Whether it has delivered its purpose, as defined in its terms of reference.

If so, the Committee is asked to consider:

2. Whether it should make a recommendation to the Board that:

   The Committee be disestablished and responsibility for providing assurance on IPC matters, including oversight of the residual actions arising from the IPC action plan as now captured within the IPC Quality Improvement Plan, be transferred back to the Quality and Safety Committee.

3. Whether there are any further actions it would recommend to provide continued assurance to the Board on performance in relation to IPC.

3.7 Conclusion

The Committee provides assurance to the Board and any decisions around the future operation of the Committee are decisions for the Board. Any agreement reached by the Committee itself on the continued operation of the Committee are therefore recommendations to the Board.

Should the Committee agree the recommendations in this paper, a corresponding paper will be submitted to the Board, seeking approval of the recommendations, principally that the Committee be disestablished and responsibility for providing assurance on IPC matters, including oversight of any residual actions arising from the IPC action plan, be transferred back to the Quality and Safety Committee.

Appendices:

Appendix 1 – Acronyms

Appendix 2 – Meetings held and attendance

Appendix 3 – Committee Workplan 2022/23

Appendix 1: Acronyms

NHSE/I	NHS England and Improvement
IPC	Infection Prevention and Control
SOF	NHS System Oversight Framework

Trust Board - People & Workforce
January 2023 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

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

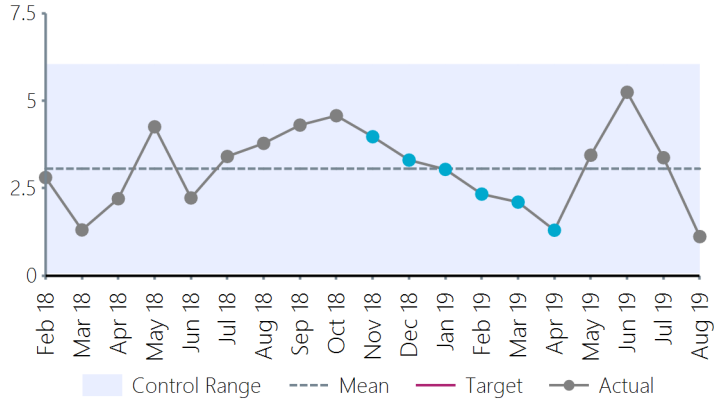
Some examples of these are shown in the images to the right:

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

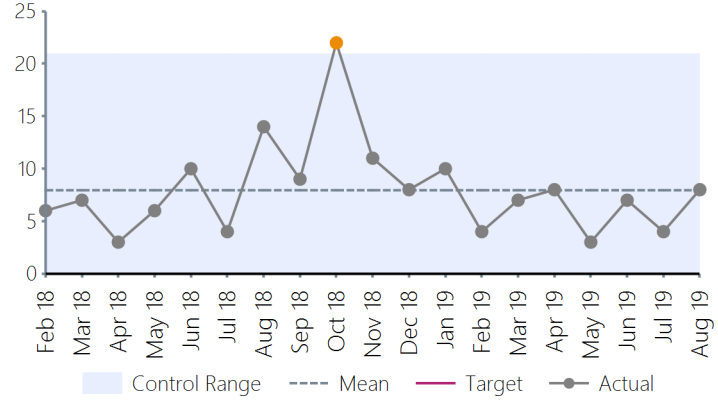
b) shows a point of concern sitting above the control range.

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.

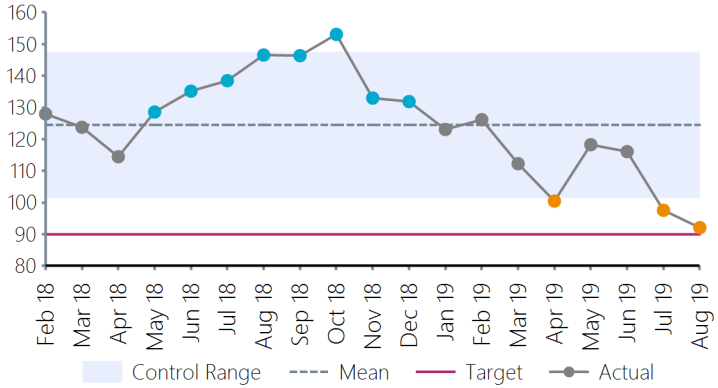
a)



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%	5.00%			?	+	27/02/20
Staff Turnover - Headcount	8.00%	12.85%		H	F	+	24/06/21
In Month Leavers		18			No Target	+	
Vacancy Rate	8.00%	9.80%		H	?	+	14/03/19

Summary - Caring for Finances

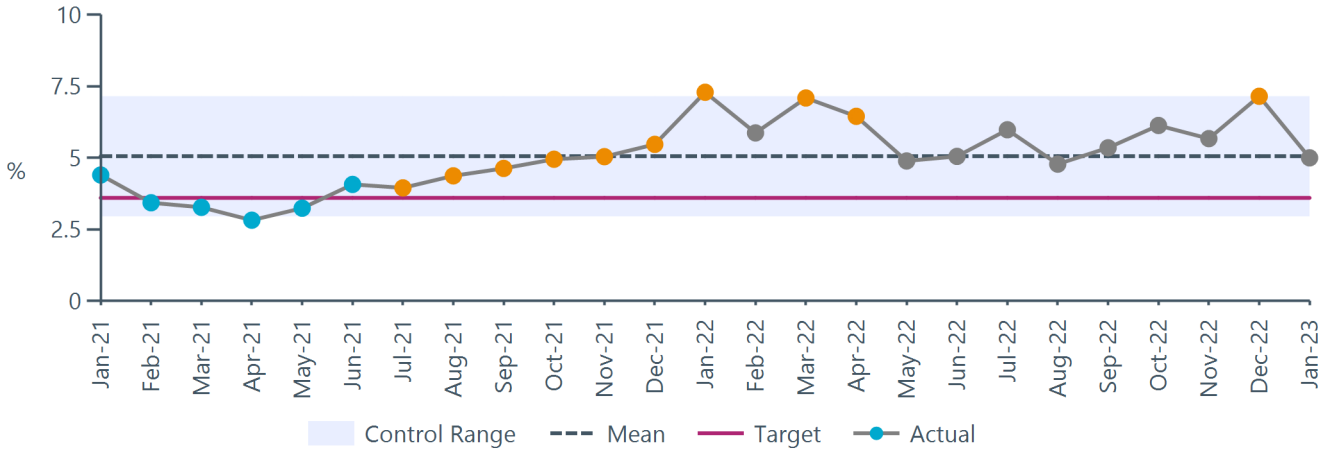
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Agency Core - On Framework	132.00	149.52		N/A to SPC	?	+	
Agency Core - Off Framework		194.11		N/A to SPC	No Target	+	

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%	5.00%		



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) as the target line sits within the control range.

Narrative

The sickness absence reported for January is 5.00% where 'infectious diseases' accounted for 0.52%, leaving remaining sickness at 4.48%. The reported position is back within our expected control range this month. Further detail by area below:

* Specialist Unit - 5.80% (5.13% excluding 'infectious diseases') - hot spot areas; Outpatient Dept 19.24%, Oswald Ward 9.07%
* MSK Unit - 5.17% (4.85% excluding 'infectious diseases') - hot spot areas; Therapies T&O Team 12.17%, Kenyon Ward 9.88%
* Corporate areas - 4.03% (3.35% excluding 'infectious diseases') - hot spot areas; Housekeeping 9.36%, Finance Dept 7.06%

'Anxiety/stress/depression/other psychiatric illnesses' was the highest reason for absence across all areas.

Actions

The Chief People Officer has commissioned a review of the Trust's Sickness Policy with an external third party. The policy is due to JCG at the beginning of March and will then follow to People Committee for final approval.

Bite-size training sessions continue with dates scheduled through to the end of March. As ASD forms one of the highest reasons for sickness throughout the Trust, the training has a focus on ensuring managers have awareness of the resources available to support staff. These resources are also featured in regular communication updates that are distributed to staff.

To support the health of the workforce, the Trust continues to encourage staff to take up the offer of both covid and flu vaccinations. The current uptake, as at 8th February is 57.25% for flu and 51.67% for covid.

People Services Business Partners have had a particular focus on long-term sickness recently where they have worked with relevant managers to ensure management plans are in place for each individual. January has seen an improvement in long-term sickness with further improvement expected in February as a number of long term cases have returned to work in January and some employees have now left the Trust.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
7.29%	5.87%	7.09%	6.45%	4.89%	5.05%	5.98%	4.78%	5.35%	6.13%	5.67%	7.15%	5.00%

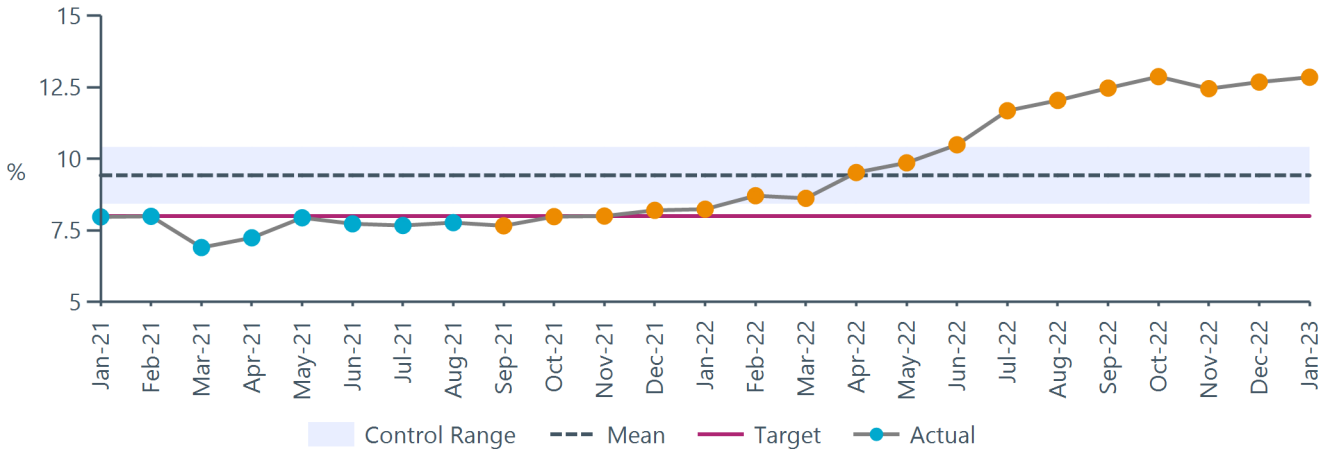
Staff Turnover - Headcount

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

Exec Lead
Chief People Office

Target/Plan	Latest Value	Variation	Assurance
8.00%	12.85%	H	F

Trajectory/H2 Forecast



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 January rate of 12.85% remains above the control range. Five out of eight staff groups are reported above 8% as follows:
* Allied Health Professionals - 18.95%
* Additional Clinical Services - 15.09%
* Nursing and Midwifery - 14.55%
* Estates and Ancillary - 12.57%
* Administrative and Clinical - 9.89%

In the latest twelve month period, February-22 to January-22, there have been 211 leavers throughout the Trust. This is in relation to a headcount in post of 1642, as at 31st January 2023. The top three reasons for leaving that accounts for 119 leavers/56% at Trust level were:
* Voluntary Resignation - Other/Not Known - 48 / 22.75%
* Voluntary Resignation - Work Life Balance - 38 / 18.01%
* Retirement age - 33 / 15.64%

Actions

* Rolling adverts continue ensuring they showcase the Trust to its fullest potential. Recruitment events being targeted to attract candidates. International recruitments for registered nurses continues.
* Focus on retention; Revision to Staff Exit Process being led by Head of Resources. Recently undertook a period of staff engagement that closed on 6th February. Communications and training now being explored before final sign off. The earlier identification of staff giving notice is being reviewed with assurance being sought to help address any reasons for leaving that are within our gift.
* System-level induction now in place to support nursing and healthcare support workers following their local induction.
* Key focus on learning and development in February that includes; Coffee and cake session held with senior nursing managers on 8th February. Learning and Development team are reviewing their development offer for clinical skills and clinical professional development. Intranet under review so staff are able to view offers and what's available to them. Study leave policy being refreshed to make it easier for staff to apply. Expanding apprenticeships at leadership level, working with Arden University.
* Focussed effort on developing role competencies and career pathways for progression to agenda for change. This work currently commencing in Theatres and MCSI.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
8.24%	8.71%	8.62%	9.52%	9.86%	10.49%	11.68%	12.04%	12.47%	12.87%	12.45%	12.68%	12.85%

In Month Leavers

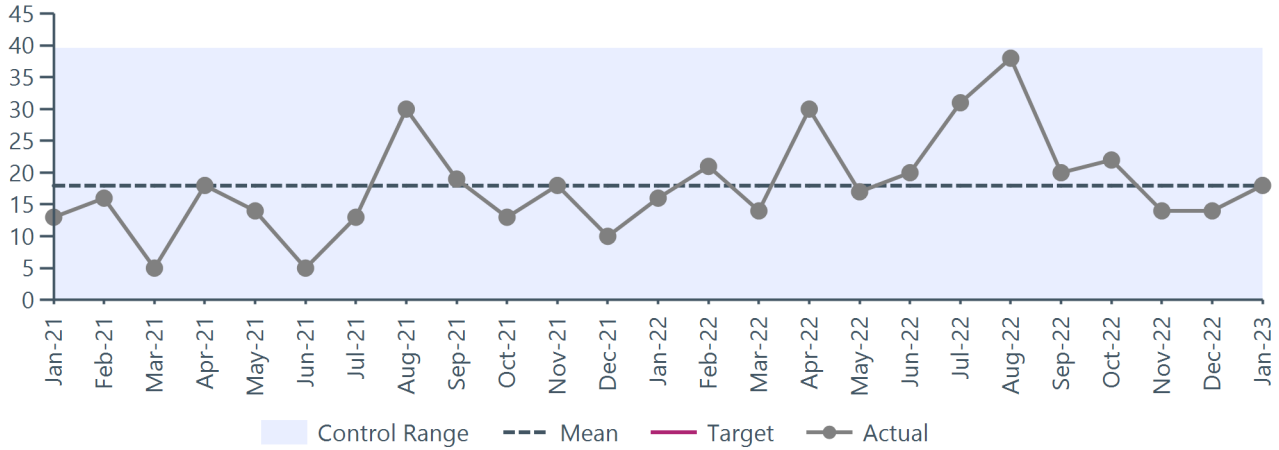
Number of leavers in month 217809

Exec Lead
Chief People Office

Target/Plan	Latest Value	Variation	Assurance
-	18		No Target

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. Target agreed for inclusion at end of quarter 4.

Narrative

In January, eighteen staff left the Trust. These were from the following areas of the Trust; MSK Unit (9), Specialist Unit (5) and Corporate areas (4). Those staff that left in January by staff group were Allied Health Professionals (5), Nursing & Midwifery Registered (5), Additional Clinical Services (4), Administrative & Clerical (3) and Estates & Ancillary (1).

Reasons for leaving were categorised as other/Not known (5), work life balance (3), retirement age (3), relocation (2), flexi retirement (2), end of fixed term contract (1), promotion (1) and to undertake further education or training (1).

IPR's covering paper proposed trajectory for consideration at People Committee last month. This was agreed as follows:
* End of quarter 4 - target of 18 leavers per month
* End of quarter 1 - target of 15 leavers per month
* End of quarter 2 - target of 10 leavers per month

Actions

* Successful Trust Open Day held on 28th January with 15 staff offered jobs on the day and further candidates set to be interviewed off the back of the event. Trust now planning a quarterly recruitment event throughout the year with next date scheduled for Sunday 16th April and further events in July and October.
* Focus on retention; Revision to Staff Exit Process being led by Head of Resources. Recently undertook a period of staff engagement that closed on 6th February. Communications and training now being explored before final sign off. The earlier identification of staff giving notice is being reviewed with assurance being sought to help address any reasons for leaving that are within our gift. Keeping in Touch conversations to be launched using the principles agreed at People Committee, with drop-in sessions to support managers to embed.
* Key focus on learning and development in February that includes; Coffee and cake session held with senior nursing managers on 8th February. Learning and Development team are reviewing their development offer for clinical skills and clinical professional development. Intranet under review so staff are able to view offers and what's available to them. Study leave policy being refreshed to make it easier for staff to apply. Expanding apprenticeships at leadership level, working with Arden University.
* Trial of Professional Career Cafes held. Communication and key principles for delivery are in development.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
16	21	14	30	17	20	31	38	20	22	14	14	18

- Staff - Patients - Finances -

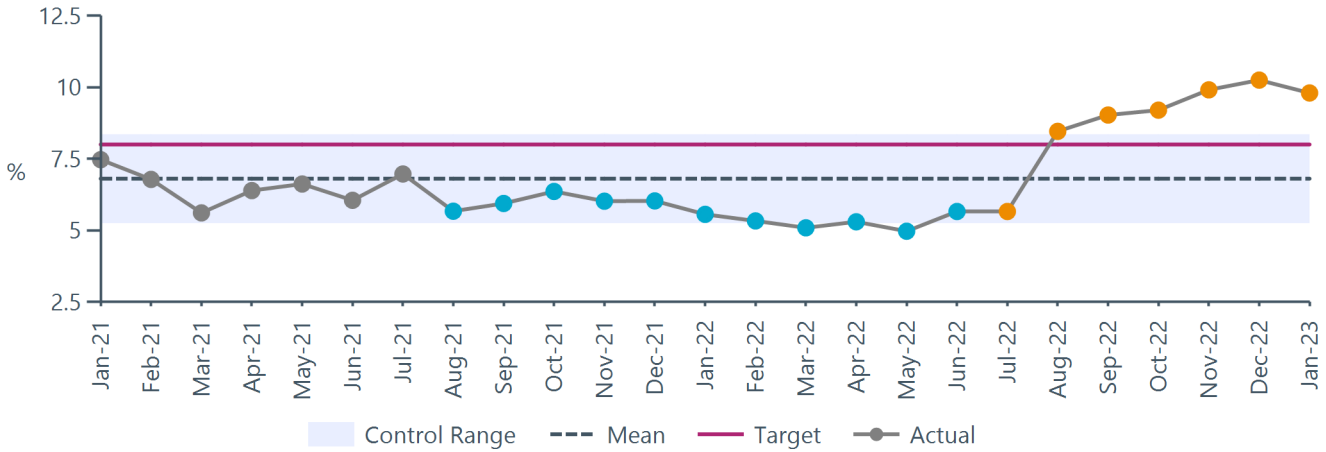
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Office

Target/Plan	Latest Value	Variation	Assurance
8.00%	9.80%	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 9.80% this month and has exceeded the 8% target since August-22. This equates to vacancies across the Trust at 154.46 WTE; down from 161.10 at the end of December. The data remains special cause variation of concern above our expected control range. A breakdown by area is:
* MSK Unit - 11.16% / 76.71 WTE vacant
* Specialist Unit - 10.54% / 45.67 WTE vacant
* Corporate areas - 7.05% / 32.08 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 1575.98 WTE at the end of January; an establishment increase of 57.67 WTE. Although when looking at an aggregate Trust-level view the vacancy rate mirrors the increased establishment, this is not the case for all staff groups. Further detail to review this by staff group is available in the covering paper that accompanies the IPR.

Actions

*Successful Trust Open Day held on 28th January with 15 staff offered jobs on the day and further candidates set to be interviewed off the back of the event. Trust now planning a quarterly recruitment event throughout the year with next date scheduled for Sunday 16th April and further events in July and October.
* Focus on retention; Revision to Staff Exit Process being led by Head of Resources. Recently undertook a period of staff engagement that closed on 6th February. Communications and training now being explored before final sign off. The earlier identification of staff giving notice is being reviewed with assurance being sought to help address any reasons for leaving that are within our gift. Keeping in Touch conversations to be launched using the principles agreed at People Committee, with drop-in sessions to support managers to embed.
* 'Golden Ticket' being offered for registered individuals on placement with the Trust, providing offer of role once they are qualified.
* Although at an initial stage, Trust beginning explore workforce modelling for nursing and allied health professionals for 23/24. Initial work to assess trends in leavers and when students available.
* Focussed effort on developing role competencies and career pathways for progression to agenda for change. This work currently commencing in Theatres and MCSI.
* Recruitment policy is being refreshed to ensure it aligns with new ways of working

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
5.56%	5.33%	5.09%	5.30%	4.97%	5.66%	5.66%	8.46%	9.03%	9.20%	9.91%	10.25%	9.80%

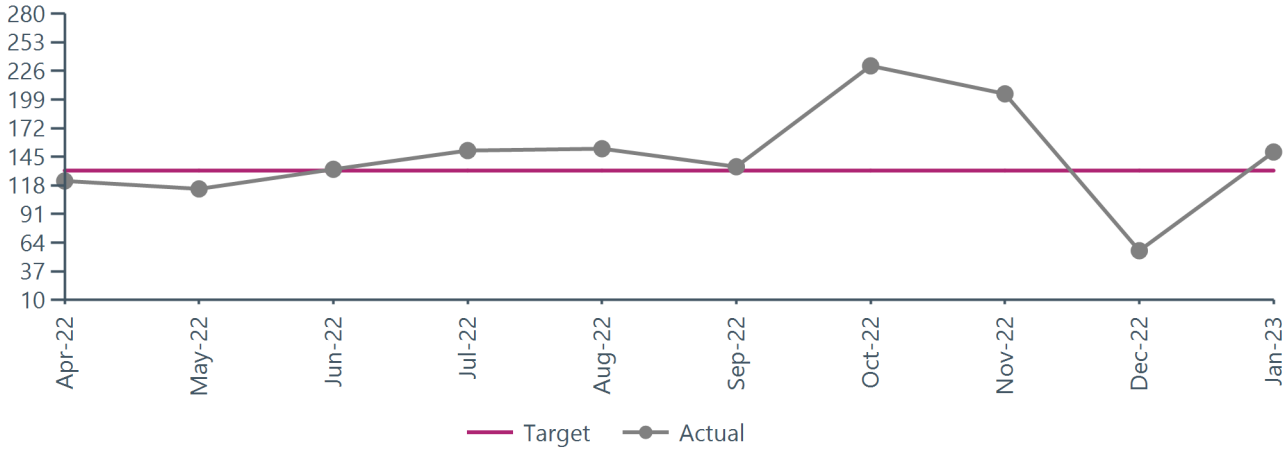
- Staff - Patients - Finances -

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 Office

Target/Plan	Latest Value	Variation	Assurance
132.00	149.52	N/A to SPC	?



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

Core agency adverse to cap driven by vacancy rates and absence levels. Increase in spend of £104k from last month.

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 H2.
Launch of bank incentives and bonus scheme.

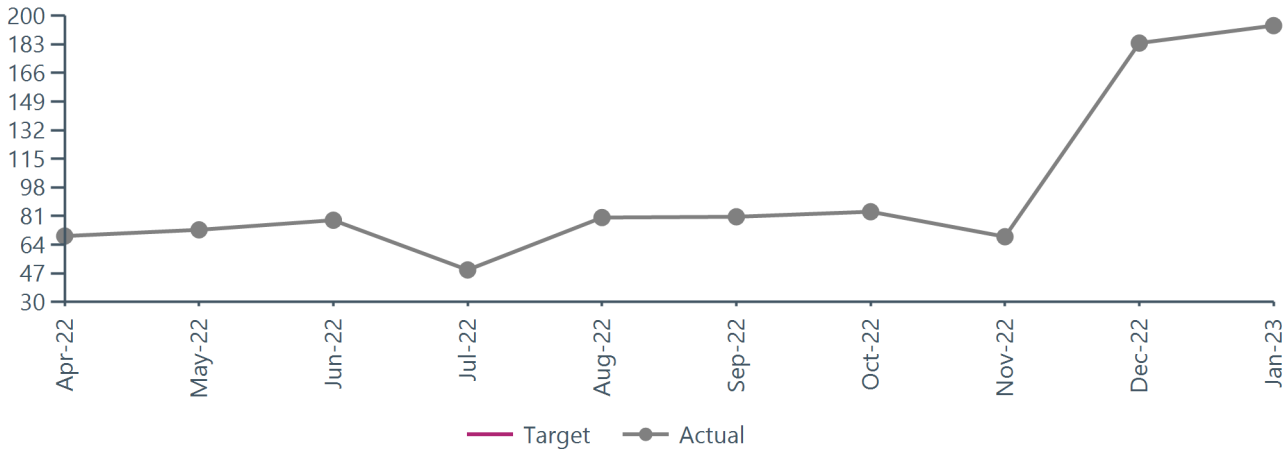
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
			122.23	114.72	133.21	150.89	152.64	135.63	230.80	204.39	56.42	149.52

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 Office

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



Trajectory/H2 Forecast

What these graphs are telling us

This measure is not appropriate to display as SPC until there are enough data points. There is no target.

Narrative

Continued workforce pressures arising from sickness and vacancies particularly on on MCSI driving usage

Actions

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

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
			69.12	72.82	78.53	49.01	80.11	80.57	83.58	68.74	183.73	194.11

Freedom to Speak Up Guardian – Q3 Report

0. Reference Information

Author:	Liz Hammond, FTSU Guardian	Paper date:	01 March 2023
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee 12/01/2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q3. Following a recommendation from the People and Culture Committee, the Board 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 (FTSUG) and Executive Lead that staff are confident in the process of Speaking Up and that appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues and that learning is being identified and shared across the Trust.

2.2. Summary

The number of cases raised has remain static. 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 one worker safety concern, one patient safety, one bullying and harassment, and one inappropriate attitudes/behaviour concern.

Conclusion

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

2. The Main Report

2.1. Introduction

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

2.2. Assessment of cases

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.

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	
Numbers of cases brought by professional level					
Worker		1	5	5	
Manager		2	0	0	
Senior leader		0	0	0	
Not disclosed		4	0	0	
Numbers of cases brought by professional group					
Allied Health Professionals		0	0	1	
Medical and Dental		2	0	0	
Registered Nurses and Midwives		0	0	0	
Administrative and clerical		1	3	1	
Additional professional scientific and technical		0	1	1	
Additional clinical services		0	0	1	
Estates and ancillary		0	0	1	
Healthcare scientists		0	0	0	
Students		0	0	0	
Not Known		0	0	0	
Other		4	1	0	
Of which there is an element of					
Number of cases raised anonymously		4	0	0	
Number of cases with an element of patient safety/quality		3	1	1	
Number of cases with an element of worker safety or wellbeing		0	1	1	
Number of cases with an element of bullying or harassment		0	0	2	
Number of cases with an element of other inappropriate attitudes or behaviours		1	1	1	
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	
The number of these that responded 'No'		1	0	0	
The number of these that responded 'Maybe'		0	0	0	
The number of these that responded 'I don't know'		0	0	0	

This quarter (3rd), the Trust has received five concerns. One worker safety advice, one patient safety concern, one bullying and harassment concern, and one inappropriate attitudes/behaviour concern.

Until the end of Quarter 3, 22/23 three contacts remain open. These are complex employee relation issues, which are being actively addressed.

The number of concerns raised remain consistent to previous quarters. There is one department which remains a concern. This area has been highlighted to the Executives and Managing Director of MSK Unit. The case remains active.

Learning and Improvement

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

In Q3 three out of the five concerns have required advice and reassurance about the process of raising their concerns to their managers. Lack of feedback from managers, from the staff members perspective, has not met their expectations. It has been concluded from this, that during the managers training module, managers will be reminded of how to manage staff expectations and give timelines, reassurance, and feedback.

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 National Guardian Office (NGO) data with Datix.

Feedback Health Education England training package will be completed by the Board members in February 2023.

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.

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

Feedback

Feedback to staff has been difficult, as once the concern has been escalated to the appropriate manager, the Guardian is sometimes taken out of the feedback loop. It is not clear if the person who has raised the concern has received feedback from the manager dealing with the escalated concern.

To counter this FTSU have contacted the person who raised the concern to check on how they are and to ascertain if they have received feedback. 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 Q3.

Patient Safety or worker experience - Themes

FTSU has been contacted, this quarter, with one patient safety issue, two bullying concern, one worker safety and one inappropriate attitudes/behaviours issue.

Patient Safety

Action taken in response to this concern involved escalating to the MSK Clinical Lead. This concern had already been raised and a Datix completed. An investigation into the issue has been actioned. The staff member has been reassured that the concern has been taken seriously and the patient concerned has been contacted. FTSU Champion continues to feedback and support staff member.

The Datix has had 57 resource incidents in this quarter. In Q3 there have been 57 incidents reported relating to staffing resource issues. This is reflective of the current staffing situation on MCSI and the need to postpone admissions from acute providers due to safe staffing levels.

Worker Safety

A worker sustained a fall at work. Alleged discrepancies with the Datix report and RIDDOR which was filled in by other staff members who did not witness the accident. Required advice on how to raise the issue. Meeting arranged with management.

The Trust Datix system has captured 37 worker safety incidents. The Trust Datix concerns do not capture that the concern has been raised to FTSU and there are no themes in the incidents reported that relate to FTSU concerns raised.

Bullying and Harassment

One exit interview has been facilitated by the FTSUG this quarter. Staff member felt that their concerns about bullying and harassment in the workplace, which were a major factor in their resignation, required an autonomous person to record reasons for leaving the Trust.

The second concern regarding bully and harassment had already been escalated by the staff member and the senior manager had arranged a prompt meeting to resolve the issue.

The Trust Datix system has captured two cases of bullying behaviour within this quarter. The concerns came from different departments. No themes were identified, in the type of concern raised, although fall under the same broad category.

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

2.3. 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
- Review the ring-fenced time for the FTSUG January 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 Committee is asked to note the content of the report and agree the recommendations as described above.

Abbreviation

FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
RJAH	Robert Jones and Agnes Hunt
NGO	National Guardian Office
Q3	Quarter Three

Guardian of Safe Working Hours Q3 Report

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	23 January 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee 23/01/2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Committee is 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 January 2023 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

Guardian of Safe Working Hours Q3 Report

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

Requirement for junior .doctor forums to be set up - principally these forums will advise the Guardian of Safe Working who will oversee the processes in the new contract designed to

Guardian of Safe Working Hours Q3 Report

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 October 2022

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	16
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	1

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.

Guardian of Safe Working Hours Q3 Report

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies (28 posts)

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

Vacant shifts

Oct 22	2
Nov 22	16
Dec 22	62

Total cost - £6945

Medicine

Number of Vacancies (12 posts) – NO DATA PROVIDED

Oct 22	
Nov 22	
Dec 22	

Vacant shifts

Oct 22	
Nov 22	
Dec 22	

Total Cost £113075.5

Guardian of Safe Working Hours Q3 Report
MCSI

Number of Vacancies (9 posts)

Oct 22	2
Nov 22	2
Dec 22	1

Vacant Shifts

Oct 22	13
Nov 22	10
Dec 22	15

Total cost - £ 9254.80

Long Term Vacant Shifts

MCSI is down to one vacancy

T&O continues to have a Spinal Staff Grade vacancy and a Long-Term sick vacancy

Medicine has failed to provide higher level data for comment

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

Engagement

Trust induction is scheduled for 01/02/2023

Guardian has engaged with External Audit agency MIAA (Simon Davies). I have feedback to the Medical Director on the report's 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.

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.

Guardian of Safe Working Hours Q3 Report

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.

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.

Following the MIAA audit, the next quarter report will include a full annual report.

Next Steps

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

3.4. Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis
Guardian of Safe Working

Guardian of Safe Working Hours Q3 Report
Appendix 1: Junior Doctor Agency and Locum usage and Rota Vacancy Report

0. Reference Information

Author:	Nilesh Makwana, Medical appraisal lead & Lorraine Fearne – Appraisal Coordinator	Paper date:	01 March 2023
Senior Leader Sponsor:	Ruth Longfellow, Chief Medical Officer & Responsible Officer	Paper written on:	16 February 2023
Paper Reviewed by:	People and Culture Committee - 16 February	Paper Type:	Quality assurance/ Performance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full
CQC Evidence	No	Purpose of Paper:	Noting

1. Purpose of Paper

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

This paper presents RJAH's Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation report which has been submitted to NHS England. The People and Culture considered the report in the Febrary meeting and recommends the Board approves.

2. Executive Summary

2.1. Context

NHSE provide the report template for completion and submission. The report is designed to demonstrate not only basic compliance but continued improvement over time.

Completion of the template should:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer,

c) act as evidence for CQC inspections.

The report covers the time period between 31st March 2021 to 1st April 2022.

2.3. Conclusion

The Trust Board is asked to approve the report confirm assurance is obtained.

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: Dr Ruth Longfellow has been appointed as Chief Medical Officer and undertakes the role of Responsible Officer

   Comments: The Responsible Officer is supported in her role by the Medical Appraisal Lead (Mr Nilesh Makwana)

   Action for next year: No further action currently.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes/~~No~~

   Action from last year: The Trust has purchased a licence for the Medical Appraisal System, PremierIT

   Comments: The Trust has appointed Lorraine Fearne as Appraisal Administrator. Premier IT has been available to use in the Trust since March 2022.

   Action for next year: Communication for the accurate and timely use of PremierIT throughout the Trust. Educating and training the doctors in the use of the software and transition from the MAG (old) system

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year

   Comments: The administrative process will be managed via the new medical appraisal software.

Action for next year: Direct link between PremierIT and GMC to be actioned

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Medical Director / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place.

Comments:

Action for next year: Review and update process and policies in accordance with the Trusts policy framework and national guidance.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified. Comments: Action for next year: Continue the annual review process

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development via the Study Leave for Consultant and Medical Staff policy and process and the appraisal and revalidation process which includes the provision of governance data and intelligence Comments: Action for next year: Continue to ensure CPD opportunities for all locum and short-term placement doctors working in the organisation are supported in line with Trust policies.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those

Action from last year: All doctors have been offered the opportunity to use the Appraisal 2020 model or MAG form.

Comments: Doctors have on the whole been positive and have made the transition to PremierIT with relative ease. The Appraisal 2022 MAG template is being integrated into the new system.

Action for next year: New Medical Appraisal Guide 2022 to be integrated into the new software. To include health and well-being questions.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: March 2022 saw the introduction of PremierIT to the Trust, since May 2022 it has been mandatory for all Doctors to use the Trusts appraisal system PremierIT and Appraisal 2020 model will shortly be available on this platform.

Comments: Doctors have in the whole been positive and have made the transition to PremierIT with relative ease.

Action for next year: Continue to support the doctors use of PremierIT through ongoing support and training.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Medical Appraisal policy in place following review and Board approval on 13/08/2020.

Policy next due for review on 13/08/2023 in accordance with Trust governance and policy process. Policy adheres to GMC Guidelines.

organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments:

Action for next year: Policy due for review by August 2023 in accordance with Trust Governance and policy framework.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: The Trust has a total of 28 trained medical appraisers, with representatives from each of the different specialities, which ensures the same appraiser cannot appraise the same doctor more than 3 times in a year period.

Comments: A number of doctors have expressed interest to take on the role of appraiser if replacements or an increase in appraisers is required.

Action for next year: No additional action required at this time.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Medical appraisers are encouraged to participate in ongoing performance review and network/development sessions which are organised quarterly.

All appraisers agreed they would attend at least one network/development session per year and this attendance is monitored.

These sessions are provided as an opportunity to discuss best practice and areas for improvement, review case studies and participate in workshops.

Comments: Recently appraisers were invited to attend session on Burnout which was well attended.

Action for next year: Plan and arrange the programme content for the network/development sessions for 2023.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead who audits all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England. An annual report of the findings is provided to the medical appraisers and submitted annually to the Board. Comments: Audits of quality assurance have been completed and highlighted no concerns or issues. Action for next year: To continue to monitor

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	117
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	114
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	0
Total number of agreed exceptions	3

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Timely recommendations are made to the GMC about fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.

Comments:

Action for next year: To continue monitoring and ensure all doctors have sufficient evidence in place in advance of their revalidation date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Revalidation recommendations made to the GMC are confirmed with the doctor. Reasons for deferred recommendations are discussed with the doctor by the Chief Medical Officer and confirmed in writing prior to the revalidation date.

Comments: The Trust has a set of criteria which doctors are required to meet before a recommendation for revalidation is submitted. Failure to meet the set criteria will mean the revalidation recommendation will be deferred until it is met.

Action for next year:Continue to monitor and early engagement/ communication with doctor if deferment is likely outcome.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: The organisation aims to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires doctors to participate in those systems and processes put in place to protect and improve patient care.

Comments:

Action for next year: To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: All doctors are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation, e.g. information about complaints, significant events and outlying clinical outcomes. This data is reviewed and discussed at their annual appraisal.

Comments: The Trust has a formal process to manage all complaints made to the Trust. All clinicians are provided with a copy of any complaints received regarding them or their practice or that of their registrars.

Action for next year: Continue to monitor

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: The Trust has policies MHPS and Freedom to Speak Up where concerns can be raised and addressed confidentially.

Comments: Policies are reviewed regularly

Action for next year: Continue maintaining policies and updates.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: The new Medical Director/RO has put in place a Professional Standards Group to comply with the above requirements. Comments: Action for next year: Ensure Professional Standards group continues to meet and data is presented to Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: To create and agree a formal process regarding transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers in local hospitals where our doctors work. Comments: Action for next year: New Medical Appraisal coordinator to create formal process especially with SaTH and Alder hey. Informal process is in place.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Any concerns are investigated locally by the Clinical Leads and Clinical Chairs supported by the Chief Medical Director/Responsible Officer, People Services Department. And Professional Standards Group

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments:

Action for next year: Continue monitoring to ensure actions and policies are fair and free from bias or discrimination.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: The Trust has a comprehensive recruitment process in place which adheres with all legislation and NHS requirements for appropriate pre-employment checks to ensure all doctors including locum and short-term doctors have the qualifications and are suitably skilled and knowledgeable to undertake their professional duties

Comments: Audits of the R&S procedures are undertaken periodically by the Trust's official auditors.

Action for next year: Continue to work with recruitment team to monitor and factor in receipt of MIPIT form and last appraisal.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

  A summary of Actions undertaken during the last year is as follows:

  - Dr Ruth Longfellow has been appointed as Chief Medical Officer and undertakes the role of Responsible Officer.
  - The Trust has purchased a licence for the Medical Appraisal System, PremierIT.
  - An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year.
  - The Medical Director / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place.

- The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified.
- All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development.
- All doctors have been offered the opportunity to use the Appraisal 2020 model or MAG form.
- March 2022 saw the introduction of PremierIT to the Trust.
- The Trust has a total of 28 trained medical appraisers.
- Medical appraisers are encouraged to participate in ongoing performance review and network/development sessions which are organised quarterly.
- The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead who audits all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England.
- Timely recommendations are made to the GMC about fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.
- Revalidation recommendations made to the GMC are confirmed with the doctor.
- The organisation aims to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires doctors to participate in those systems and processes put in place to protect and improve patient care.
- All doctors are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation and forms part of their annual appraisal review.
- The new Medical Director/RO has put in place a Professional Standards Group to comply with the above requirements.
- Any concerns are investigated locally by the Clinical Leads and Clinical Chairs supported by the Chief Medical Officer/Responsible Officer, People Services Department, in addition to the Professional Standards Group

Actions still outstanding

- Review and update process and policies in accordance with Trust policy framework and national guidance.
- Policy due for review by August 2023 in accordance with Trust Governance and policy framework.
- To create and agree a formal process regarding transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers in local hospitals where our doctors work.
- To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes.

- **Current Issues**

There are no current issues.

- **New Actions:**

The new actions to be undertaken in 2022-23 are as follows:

- To make mandatory the use of PreimierIT and Apprailsal2020 model.
- Communication, training and monitoring of PremierIT in it's first year. Ensure doctors are confident to complete their appraisals in a timely manner.
- Link PremierIT with GMC record of all licensed medical practitioners with a prescribed connection to the Trust.
- Plan and arrange the content programme for the network/development sessions for 2023.

Overall conclusion:

Due to the Coronavirus pandemic, the Trust did not receive an AOA Comparator Report for 2020-21. However, the data reviewed for the completion of this document demonstrates the Trust continues to meet the requirements set out in the Framework of Quality Assurance for Responsible Officers and Revalidation and remains compliant with the GMC standards/requirements for medical appraisals and revalidation.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Robert Jones & Agnes Hunt NHS Foundation Trust

Name: Stacey-Lea Keegan Signed: 

Role: Chief Executive Officer

Date: 9th November 2022

NHS England
Skipton House
80 London Road
London
SE1 6LH

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The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
People and Culture Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 March 2023
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	22 February 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 a number of 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 16 February 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.

Framework of Quality Assurance for Responsible Officer and Revalidation

The annual report is presented to Board for final approval. It was noted that the report demonstrates that the Trust has an appropriate process for doctor appraisals which is well managed with an appropriate infrastructure. The committee agreed to oversee progress against the actions within the report. To ensure further assurance and oversight is gained, the Committee have also asked for an anonymised case management tracker paper to be presented to committee to offer oversight on

process, conclusion and any potential trends in cases that are not in line with the culture of the Trust. The report was endorsed by the committee for approval by the Board.

Timeliness of committee papers

On reflection at the end of the meeting the committee noted the lateness of some of the papers (less than 48 hours) and it was established that this was something that is experienced at a number of other assurance committees. It was agreed that the need for timely papers for committees should be highlighted at Board level.

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:

Recruitment and Retention

The committee acknowledged the progress that has been made on recruitment with particular recognition given to the work and productivity that resulted from the Recruitment day. It was noted that including candidates with conditional offers, international recruits and student offers in the pipeline brought nurse vacancies down from 15.09% to 6.13% and Healthcare Support workers down from 10.82% to 3.2%. The committee requested further work to be carried out to ensure that all staff are aware of the improving position in relation to staff vacancies.

The committee highlighted the importance of the work needed to improve retention of staff and have requested some early feedback on the new approach to 'keeping in touch' with staff.

Planning Guidance 2023/2024 – (request from FPD Committee)

Concerns were raised by the Committee on the assumptions made within the plan. The Committee requested further work to be carried out including linking with the ongoing recruitment work to align the forecast and present a more accurate and achievable plan. The plan is to be further discussed at the March meeting.

Industrial Action

Industrial Action is planned for 1-3 March – it was noted that the current risk is that National and Local derogation will not be available for these dates. The risk is to be reviewed and appropriately reflected within the corporate risk register.

Performance Report

The committee highlighted the need to improve mandatory training compliance levels (highlighting fire training as an example). A rolling training day option for nursing staff and a performance development review compliance process is being developed – these areas will be a key focus at the next meeting.

The committee agreed on a figure of 78% for staff availability, this being the percentage of staff available and not on annual leave, study leave, sickness etc. It was agreed that this was not to be seen as a target that required performance managing but rather an indicatory to help better understand the amount of staff at any one time that are available for duty

E-Job Planning Report and Actions

The NHS Operational Plan has been used to measure the Trust with a target of achieving level 4 by the end of March this year – the Trust will not achieve this target. The issue relates to current medical job plans and the medical job planning policy. The organisation needs to ensure these align with the current position and processes within the organisation. The policy is due to be presented to the LNC meeting in April 2023.

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.

Board Assurance Framework and Corporate Risk Register

The committee reviewed the BAF and Corporate Risk Register and no new risks were identified. A review and refresh of the BAF controls, assurances, gaps and actions for those risks aligned to the committee was requested for review at the next meeting. The Committee asked for a review of the risk 2995 (Industrial action) following the information received that day regarding the national and local derogation not being available for the next round of industrial action.

Agency Spend (Presentation)

Agency spend continues to be a significant challenge for the Trust. The Trust continue to reflect on ways to improve the current position and is discussed in detail at the Finance, Performance and Digital Committee and will continue to be monitored by this committee.

GGI Action Plan Review

Noted the progress to date and agreed the need to extend the completion date for 5 of the actions.

E-Rostering and Medical Staff Rota - Internal Audit Reports

Action plan to be added to the committee work plan to ensure oversight and assurance is gained.

Freedom to Speak Up Action Plan

Assurance gained on actions and noted the continued progress.

Nursing Workforce Report

Assurance was gained that Safe Staffing remains above target despite staffing challenges, but it was acknowledged that this had been aided by the closure of Kenyan ward. It was noted that the work is being discussed and developed via the Recruitment Working Group – the Committee requested that details on improvements implemented to address the vacancy gaps are included in the next report. Assurance was obtained on the risks related to high reliance on bank and agency staffing being mitigated by ensuring a minimum of regular staff on each shift.

Chair Report – ICS People Committee

The Committee noted the report.

EDI Policy

The Committee approved the policy which included an equality impact assessment following deferral at the previous meeting.

E-Rostering Policy

The Committee endorsed the policy, pending further formatting on the document prior to circulation. Further consideration is to be given on how assurance can be established on adherence to the policy and the key wellbeing elements within it.

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.

Trust Board - Performance
January 2023 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

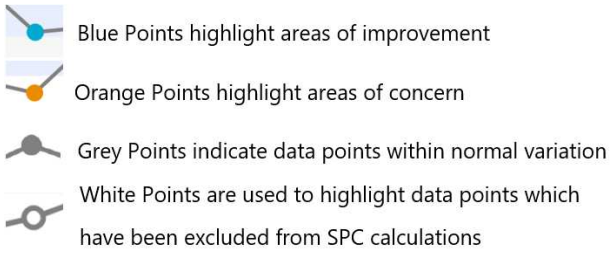
Different colours have been used to separate these trends of special cause variation:

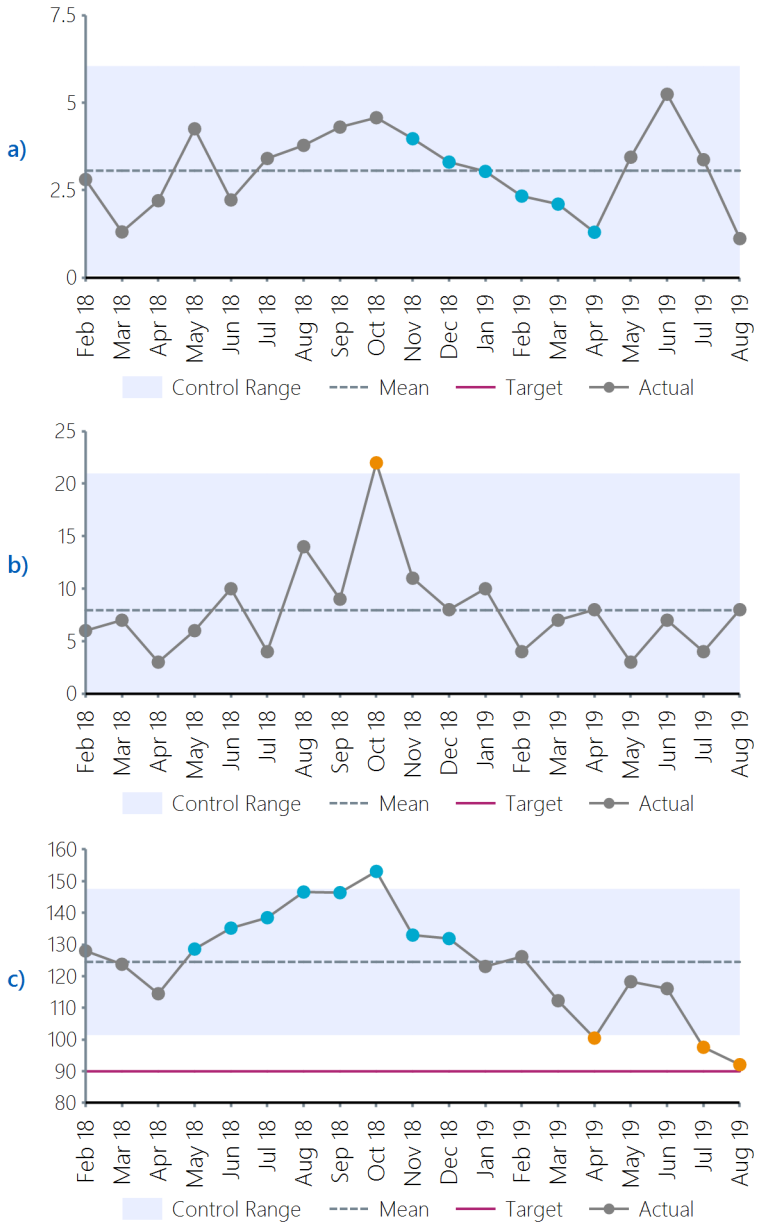
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for 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%	79.17%			?		
18 Weeks RTT Open Pathways	92.00%	55.09%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,526	1,790		F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		922		H	No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	330	327		F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		231	444		No Target	+	
Patients Waiting Over 104 Weeks - English	0	19	20	L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		46	83	L	No Target	+	
Overdue Follow Up Backlog	5,000	13,554		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%	80.51%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	90.92%				+	

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)	1,152	887	959	H	Moving Target	+	24/06/21
Overall BADS %	85.00%	81.01%			?	+	
Bed Occupancy – All Wards – 2pm	87.00%	81.12%			?	+	09/03/22
Total Outpatient Activity against Plan (volumes)	16,197	13,302			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	4.00%	5.92%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,430	2,838			Moving Target		

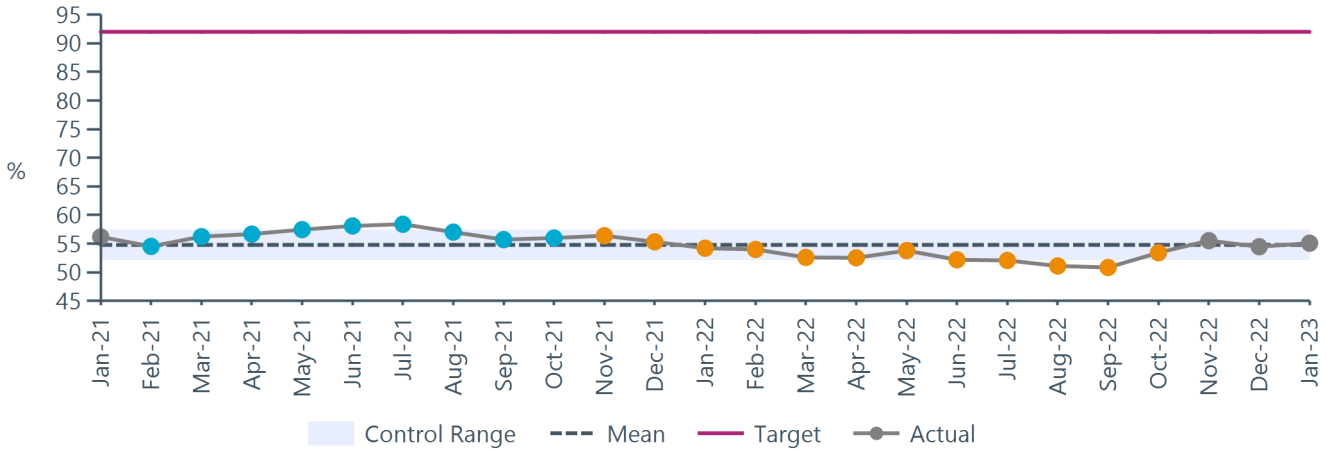
18 Weeks RTT Open Pathways

% 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%	55.09%		F

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

Our January performance was 55.09% 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 - 8396 patients waiting of which 2093 are breaches
* MS2 - 1422 patients waiting of which 1007 are breaches
* MS3 - 4937 patients waiting of which 3527 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 Operational Team is leading on revised demand and capacity assumptions to inform future planning and future waiting list management. Further detail provided against the list size and weeks waits KPIs.

We continue with validation cycles on our waiting lists to ensure pathways are reviewed at regular intervals. Trusts were asked that any patient projected to wait greater than 52 weeks by the end of March-23 was validated within a previous 12-week cycle and feedback showed the Trust performing high against this requirement.

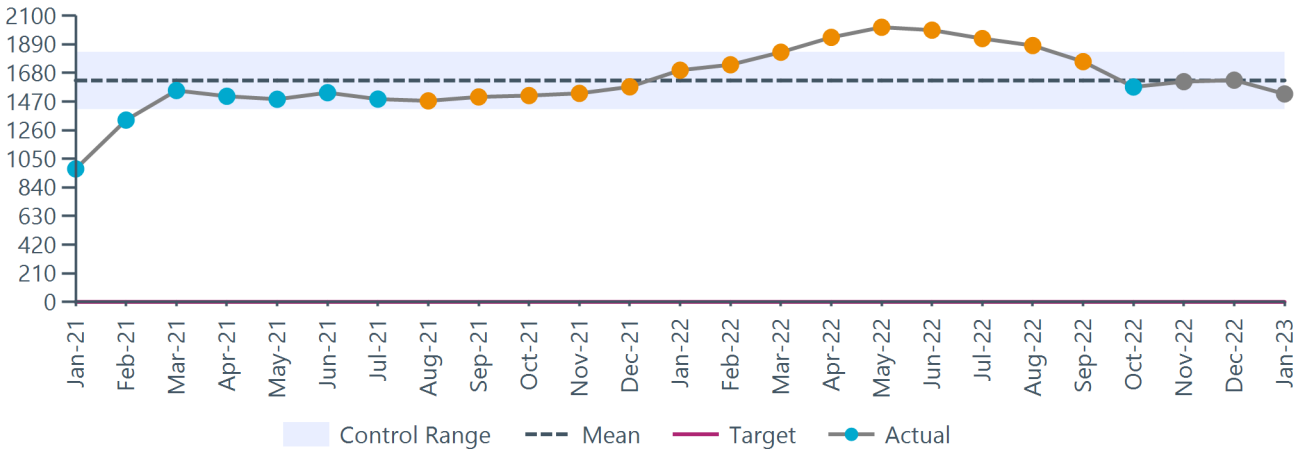
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
54.21%	53.99%	52.60%	52.54%	53.79%	52.19%	52.07%	51.11%	50.84%	53.43%	55.53%	54.47%	55.09%

Patients Waiting Over 52 Weeks – English

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
0	1,526		F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of January there were 1526 English patients waiting over 52 weeks; below our trajectory figure of 1790 by 261. The patients are under the care of the following sub-specialities; Spinal Disorders (539), Arthroplasty (383), Knee & Sports Injuries (276), Upper Limb (145), Foot & Ankle (124), Paediatric Orthopaedics (19), Spinal Injuries (18), Neurology (8), Tumour (4), Metabolic Medicine (4), Paediatric Medicine (2), Orthotics (2), Rheumatology (1) and SOOS GPSI (1).
The number of patients waiting, by weeks brackets is:
* >52 to <=78 weeks - 1196 patients
* >78 to <=95 weeks - 251 patients
* >95 to <=104 weeks - 60 patients
* >104 weeks - 19 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 future IPR from April. The focus will be on those patients that will trip-in to 65+ weeks within the 23/24 financial year.

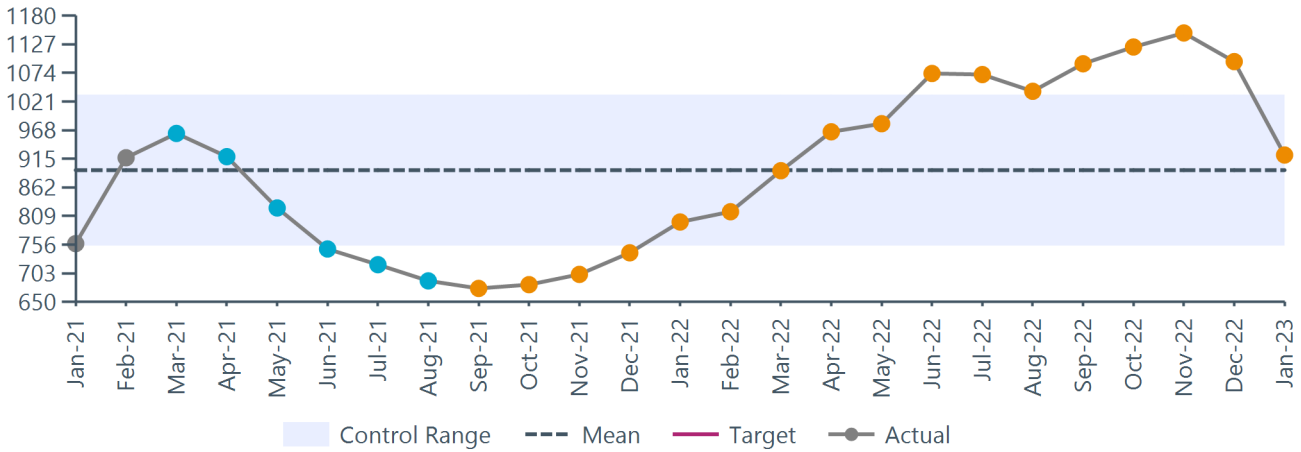
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
1700	1740	1832	1941	2015	1994	1932	1881	1763	1577	1616	1627	1526

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 Office

Target/Plan	Latest Value	Variation	Assurance
-	922	H	No Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of January there were 922 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (512), Arthroplasty (140), Knee & Sports Injuries (105), Foot & Ankle (56), Upper Limb (54), Veterans (32), Paediatric Orthopaedics (18), Tumour (3), Metabolic Medicine (2), Spinal Injuries (1), Physiotherapy (1) and Rheumatology (1).
The patients are under the care of the following commissioners; BCU (552), Powys (359), Hywel Dda (8), Abertawe Bro (1), Cardiff & Vale (1) and Cwm Taf University LHB (1). The number of patients waiting, by weeks brackets is:
* >52 to <=78 weeks - 691 patients
* >78 to <=95 weeks - 147 patients
* >95 to <=104 weeks - 38 patients
* >104 weeks - 46 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 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 future IPR from April. The focus will be on those patients that will trip-in to 65+ weeks within the 23/24 financial year.

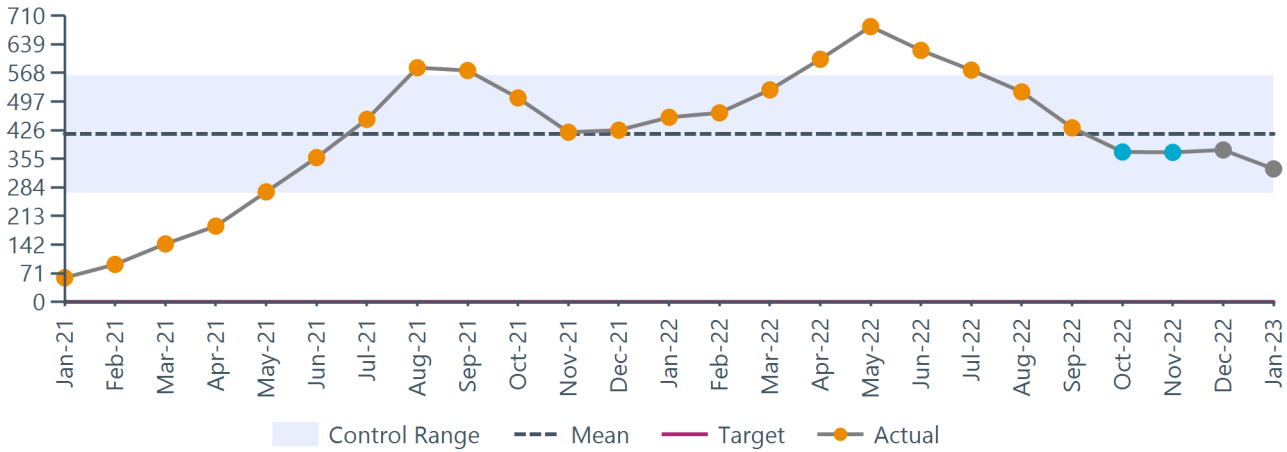
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
798	817	893	965	980	1073	1071	1040	1091	1122	1148	1095	922

Patients Waiting Over 78 Weeks - English

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
0	330		F



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

At the end of January there were 330 English patients waiting over 78 weeks; this was 3 patients above our trajectory of 327. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Spinal Disorders (158), Knee & Sports Injuries (73), Arthroplasty (67), Upper Limb (16), Foot & Ankle (10), Spinal Injuries (2), Neurology (2), Tumour (1) and Orthotics (1).

13 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

The Trust is currently monitoring, and submitting to NHSEI daily, updates on those patients who will be at 78+ weeks by the end of March. As part of 23/24 planning the Trust is putting together trajectories for a route to zero for this cohort of patients. Planning requirements also stipulate trajectories are required for 65+ weeks patients for next financial year. From April, monitoring of 65+ weeks patients will be visible within the IPR.

The Trust continues to contact patients, and seek mutual aid, to support its most pressured service. Conversations with a regional provider continue to support both non-admitted and admitted pathways. Discussions continue with other providers to offer further mutual aid. NHS EI regional team are supporting progress for further support with recent returns stipulating our spinal disorders need. Progress has been made internally in reducing and dating patients within non-admitted pathways. Support is in place for a system provider to accept non-spinal disorders 78+ weeks patients due to continued Orthopaedic pressures at this provider.

Agreement in place to participate in the Digital Mutual Aid system that is being led by NHS England. A mutual aid co-ordinator and validation resource are in place to support actions being taken. A GIRFT meeting took place on the 25th January, with the GIRFT team, exploring any available scoliosis capacity.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
458	469	526	602	683	624	575	521	432	372	371	377	330

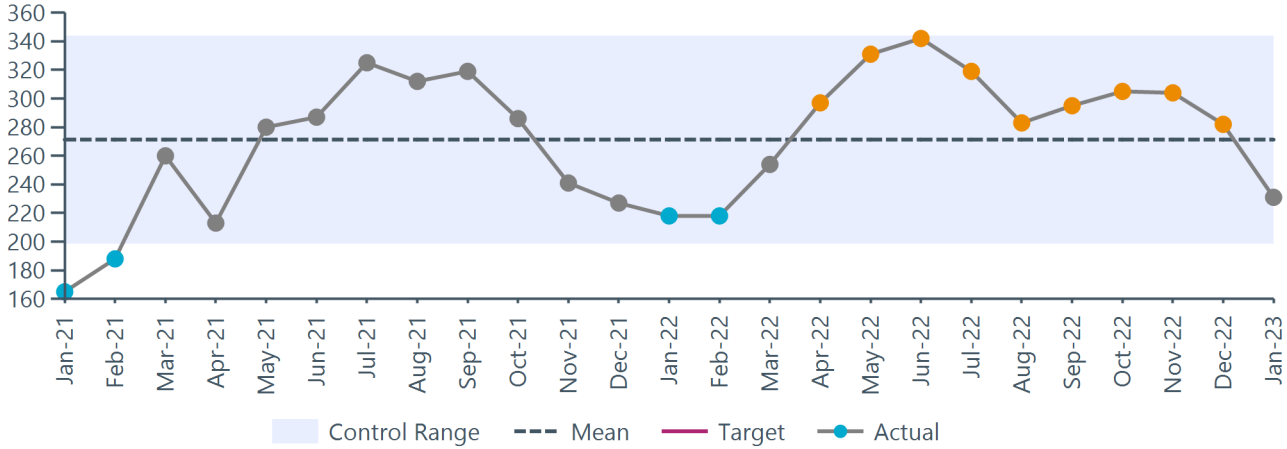
Patients Waiting Over 78 Weeks - Welsh (Total)

Patients waiting over 78 Weeks - Welsh (Total) 217802

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
-	231		No Target

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of January there were 231 Welsh patients waiting over 78 weeks; this was 213 patients below our trajectory of 444. The Trust plans are visible in the trajectory line above.

The patients are under the following sub-specialties; Spinal Disorders (194), Knee & Sports Injuries (16), Veterans (7), Foot & Ankle (5), Arthroplasty (5), Upper Limb (3) 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.

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.

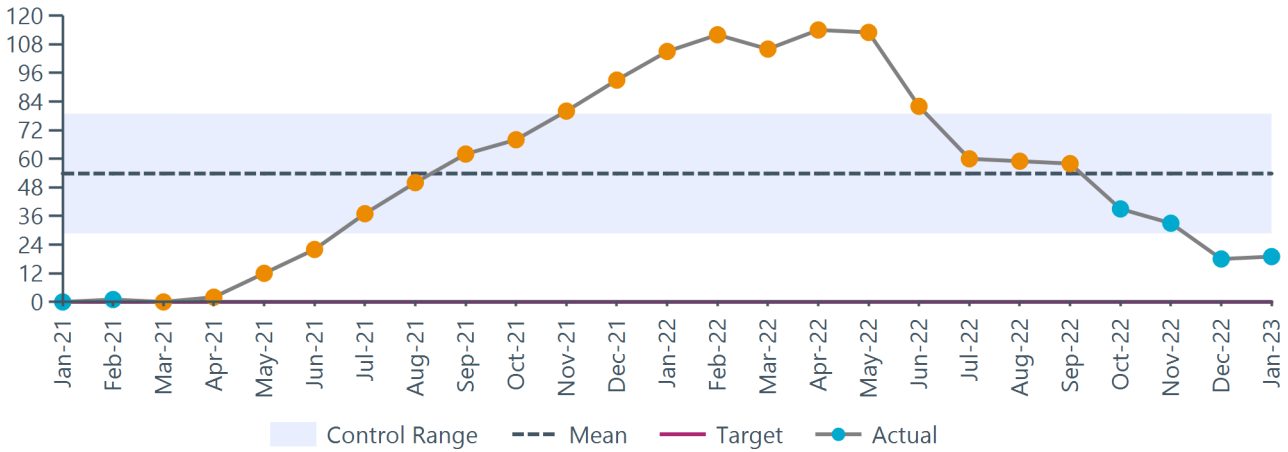
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
218	218	254	297	331	342	319	283	295	305	304	282	231

Patients Waiting Over 104 Weeks - English

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
0	19	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 January there were 19 English patients waiting over 104 weeks. This was 1 patient below our trajectory of 20. Five of these patients are included in our data but currently with ROH. Breakdown by sub-specialty below:
* Spinal Disorders (14)
* Upper Limb (2)
* Knee & Sports Injuries (2)
* Neurology (1)

By Milestone, there were:
* Milestone 1 (Outpatients) - 2 patients
* Milestone 2 (Diagnostics) - 4 patients
* Milestone 3 (Electives) - 13 patients

5 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; this has included a focus on non-admitted pathways.
For all Patients:
- Review and application of revised interim choice guidance, issued by NHSE, continues

Spinal Disorders: - actions include:
* Seeking mutual aid from ROH and active discussions with other Providers for further support.
* Continued operational and executive discussions with the Trust's surgeons on the longest waiting patients.
* Regular 104+ meetings being held within the Trust and chaired by Chief Operating Officer or Managing Director of Specialist Unit
* Escalation and monitoring through NHSE to support pathways requiring external providers support.
* 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.
* Continue to work with our laboratory for specialist ACI patients

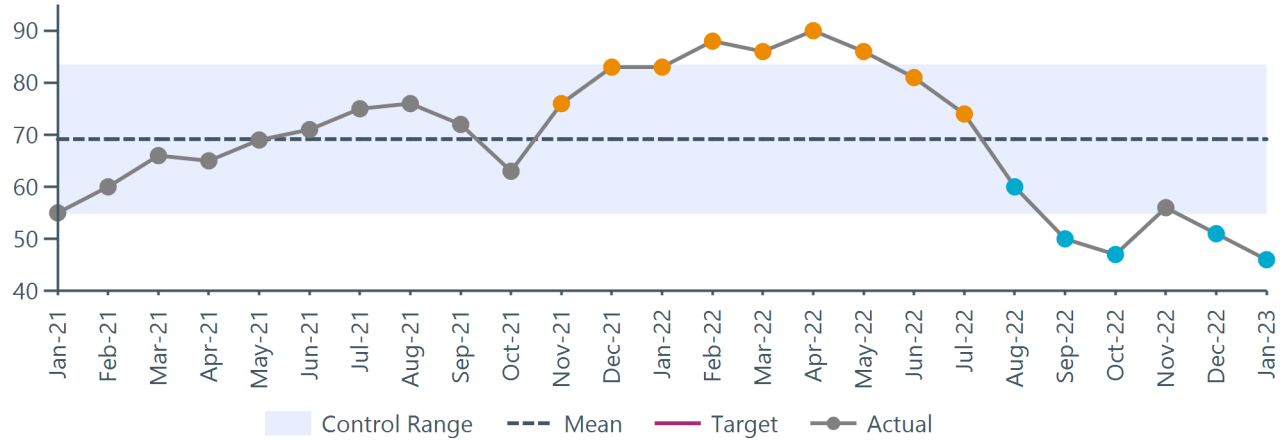
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
105	112	106	114	113	82	60	59	58	39	33	18	19

Patients Waiting Over 104 Weeks - Welsh (Total)

Patients Waiting Over 104 Weeks - Welsh (Total) 217803

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
-	46	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 December there were 46 Welsh patients waiting over 104 weeks; below our trajectory figure of 83 by 37.

The patients are under the care of the following sub-specialties;
* Spinal Disorders (45)
* Veterans (1)

By Milestone, there were:
* Milestone 1 (Outpatients) - 5 patients
* Milestone 2 (Diagnostics) - 11 patients
* Milestone 3 (Electives) - 30 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.

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.

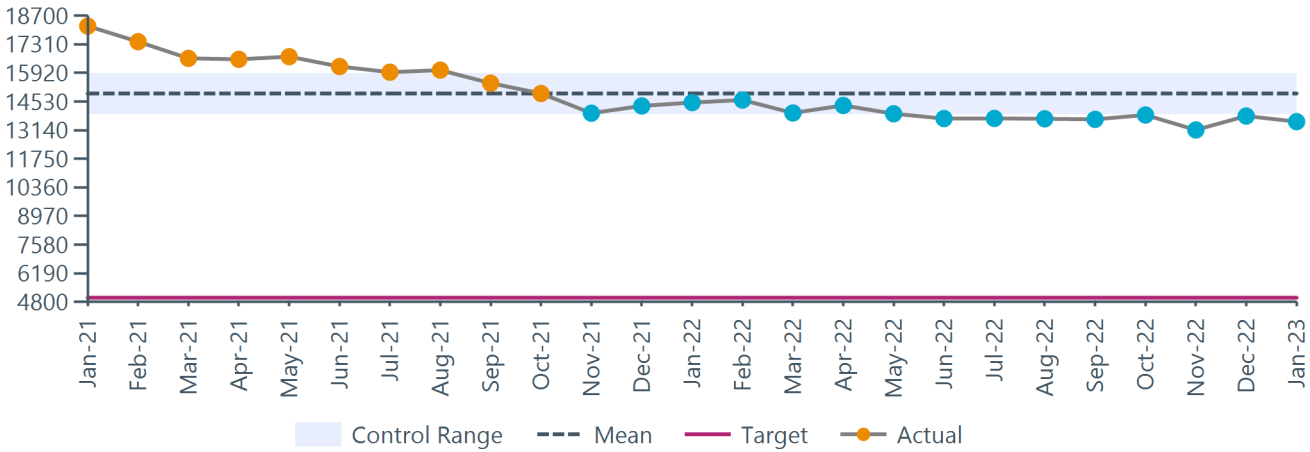
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
83	88	86	90	86	81	74	60	50	47	56	51	46

Overdue Follow Up Backlog

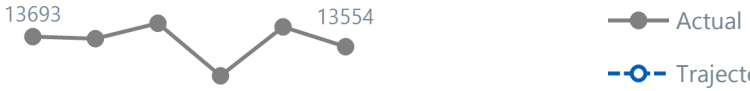
All dated and undated patients that are overdue their follow up appointment 217364

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
5,000	13,554	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 January, there were 13554 patients overdue their follow up appointment. This is broken down by:
* Priority 1 is our more urgent follow-up cohort - 8524 with 1644 dated (19%)
* Priority 2 is the lower priority - 5030 with 1543 dated (31%)

MSK backlog at the end of January is 5388, which is 9% higher than it was in April 2020. Most sub-specialties in MSK are holding stable, however Foot & Ankle backlog has increased by 256 in the last 2 months.
Specialist backlog at the end of January is 8166, which is 62% higher than it was in April 2020. Most sub-specialties in Specialist have either held or reduced their backlog in January, with the exception of Orthotics and Paediatric Orthopaedics. There has been an increased focus on validation in Specialist which has seen a reduction in the backlog from December's position. Tumour team in particular have seen a significant decrease in their backlog where validation has been both completed both by admin and clinical staff. Main focus within the Trust has been on 104 week waiters.
Sub-specialities with the highest percentage of overdue follow ups:
- Rheumatology - 18.95%; Arthroplasty - 18.40%; Spinal Disorders - 12.10%; Spinal Injuries - 8.40%

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. Trajectory to be completed for Specialist Unit by February's Trust Board.
* 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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
14482	14605	13976	14342	13937	13705	13710	13693	13665	13878	13151	13828	13554

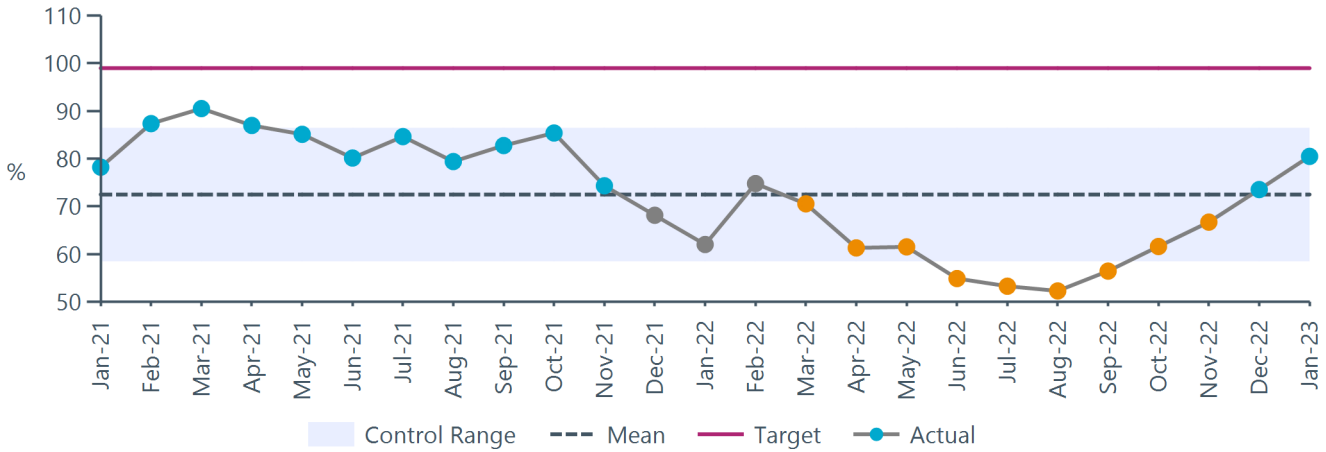
6 Week Wait for Diagnostics - English Patients

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
99.00%	80.51%	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 80.51%. This equates to 275 patients who waited beyond 6 weeks. Of the 6-week breaches; 40 are over 13 weeks (39 MRI, 1 Ultrasound). Breakdown below outlines performance and breaches by modality:

* MRI - 79.02% - D2 (Urgent - 0-2 weeks) 2 dated, D3 (Routine - 4-6 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 176 with 161 dated
* CT - 86.67% - D4 (Routine - 6-12 weeks) - 22 dated
* Ultrasound - 80.59% - D4 (Routine - 6-12 weeks) - 73 with 68 dated
* DEXA Scans - 100%

The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were initially referred to as D4 (Routine - 6-12 weeks) but were updated to urgent at a later date. MRI was reported at 79.02% against a trajectory specifically for MRI at 55%. It must be noted that all diagnostic activity plans were met in January.

Actions

* Staffed Mobile MRI scanner installed beginning of November for six months in order to help reduce the current waiting list to circa 800.
* Complete MRI demand capacity work to determine future need for Mobile MRI attendance.
* Recruitment of Radiographers to replace current vacancies.
* 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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
62.04%	74.81%	70.56%	61.33%	61.54%	54.90%	53.30%	52.31%	56.47%	61.62%	66.73%	73.55%	80.51%

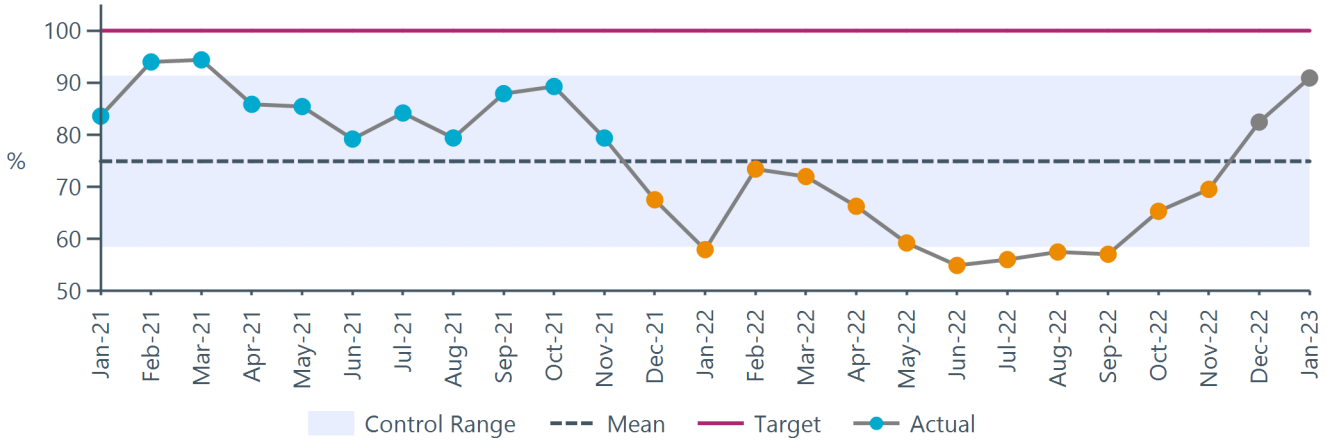
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
100.00%	90.92%		F

Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 90.92%. This equates to 53 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI - 90.91% - D4 (Routine - 6-12 weeks) - 43 with 39 dated
* CT - 97.50% - D4 (Routine - 6-12 weeks) - 1 dated
* Ultrasound - 87.32% - D4 (Routine - 6-12 weeks) - 9 dated
* DEXA Scans - 100%

It must be noted that all diagnostic activity plans were met in January.

Actions

* Staffed Mobile MRI scanner installed beginning of November for six months in order to help reduce the current waiting list to circa 800.
* Complete MRI demand capacity work to determine future need for Mobile MRI attendance.
* Recruitment of Radiographers to replace current vacancies.

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

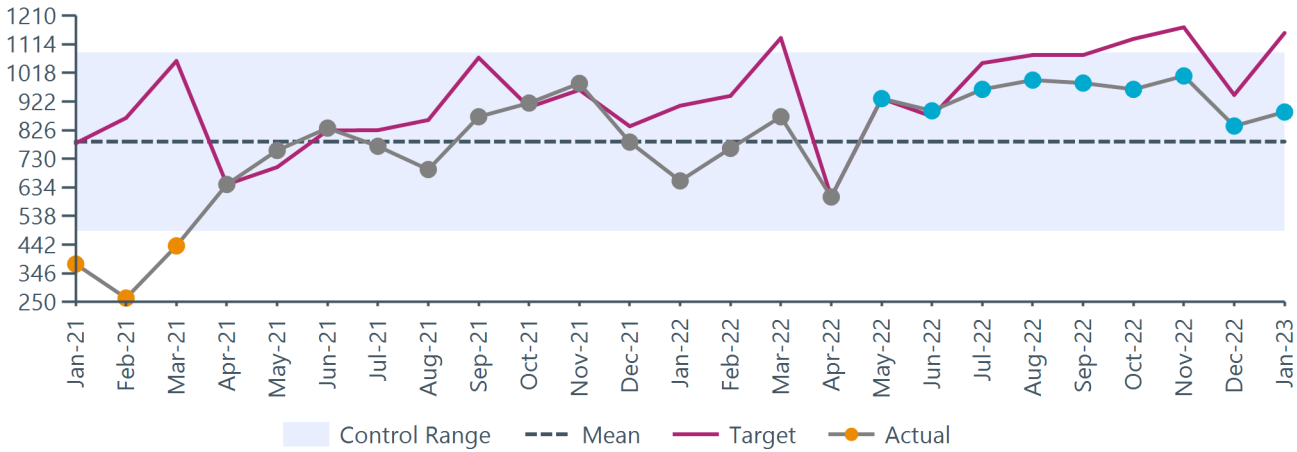
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
57.94%	73.41%	71.98%	66.27%	59.22%	54.90%	56.03%	57.48%	57.05%	65.30%	69.52%	82.44%	90.92%

Elective Activity Against Plan (volumes)

Total elective activity rated against 2022/23 plans. 217796

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
1,152	887	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

Total elective activity reported externally against plan 2022/23 in January was 887, 265 below plan 1152 (77.00%). The internal H2 trajectory for Elective Activity Against Plan (Volumes) was 959 with 887 delivered, 72 below trajectory (92.49%)
Factors affecting delivery:
* Reduction in Theatre activity resulting from industrial action 18th/19th January
* Lack of Independent Sector uptake - 0 undertaken in January against a plan of 18
* 118 theatre cancellations (46 on the day and 72 ahead of TCI)
* NHS sessions behind plan
* Cases per session behind plan in both units

Actions

Key themes identified for improvement:
* Workforce model – planning and retention.
* Booking and Scheduling – maximising theatre usage
* Working day effectiveness
* OJP alignment to booking processes
* Reducing cancellations

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
656	765	871	602	932	891	963	994	984	963	1008	840	887

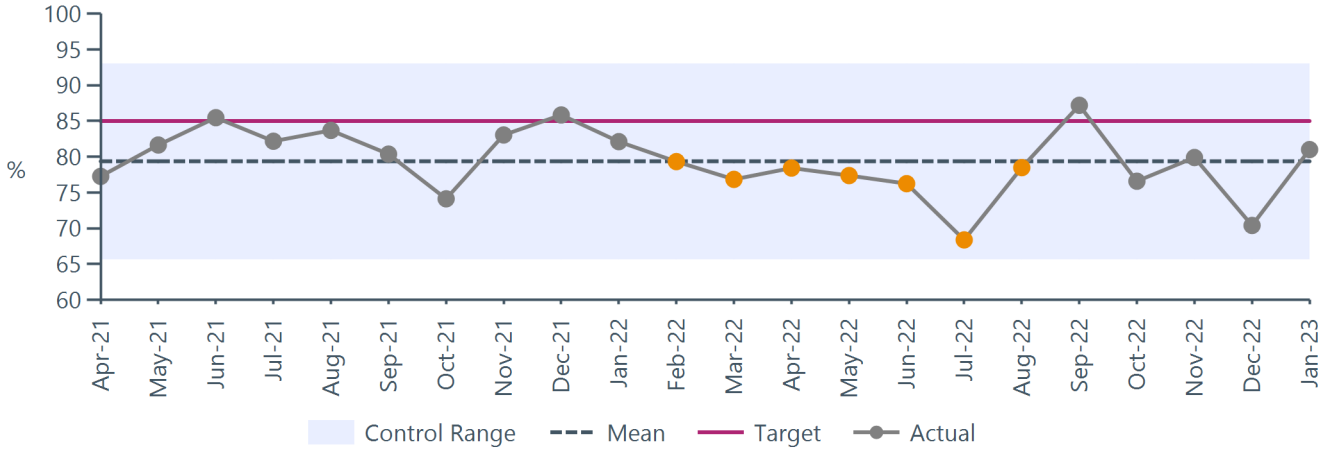
Overall BADS %

% of BADS procedures performed as a day case 217813

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
85.00%	81.01%		

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

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 January the Trust is reporting 81.01% BADS day cases against a target of 85%.

In preparation for the introduction of this new KPI, 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

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

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
82.12%	79.33%	76.85%	78.43%	77.38%	76.25%	68.39%	78.49%	87.20%	76.59%	79.90%	70.41%	81.01%

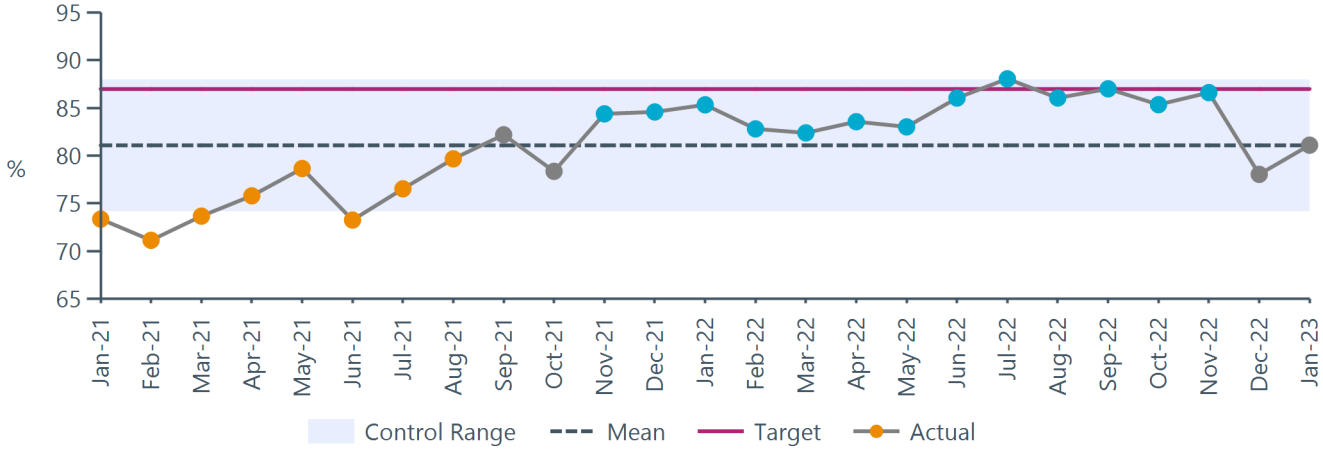
Bed Occupancy – All Wards – 2pm

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

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
87.00%	81.12%		

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

The occupancy rate for all wards is reported at 81.12% for January; within our expected control range. Breakdown provided below:
MSK Unit:
* Clwyd - 79.20% - compliment of 22 beds open throughout the month
* Powys - 83.99% - compliment of 22 beds open throughout the month
* Kenyon - 89.74% - compliment of 22 beds; ward just open a few days in the month
* Ludlow - 78.84% - compliment of 16 beds open throughout the month
Specialist Unit:
* Alice - 48.81% - compliment of 16 beds; open to 4-16 beds dependant on weekday/weekend and demand
* Oswald - 89.14% - compliment of 10 beds open throughout the month
* Gladstone - 82.71% - compliment of 29 beds open majority of month
* Wrekin - 76.61% - compliment of 15 beds open throughout the month
* Sheldon - 94.57% - compliment of 19 beds; open 15-18 throughout month with period of time physically on Kenyon Ward whilst estates work took place

Actions

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
85.35%	82.82%	82.40%	83.58%	83.03%	86.06%	88.07%	86.07%	87.02%	85.36%	86.62%	78.06%	81.12%

Total Outpatient Activity against Plan (volumes)

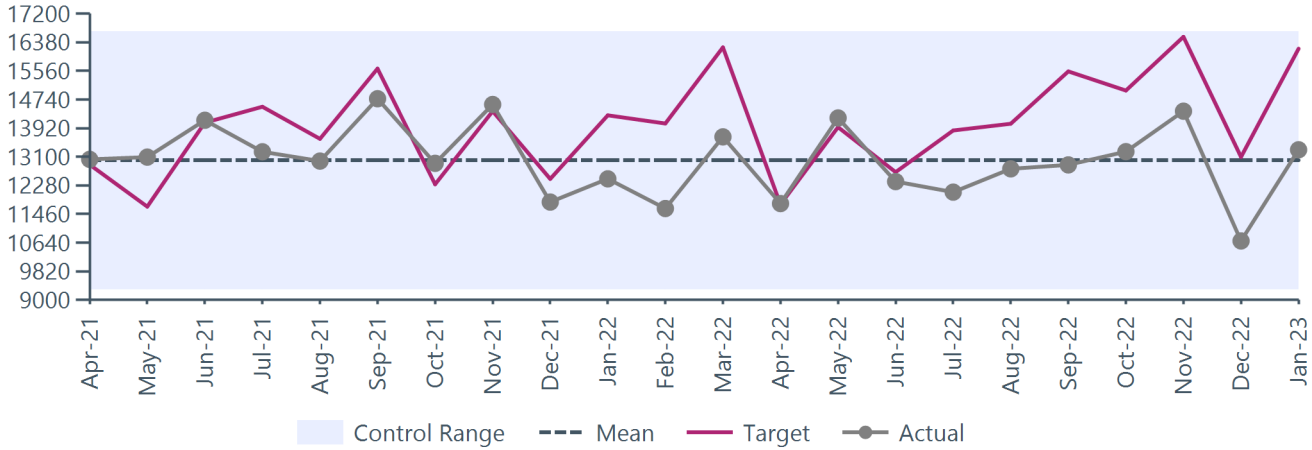
Total outpatient activity (H1 - consultant led, non-consultant led and un-bundled and H2 and 22/23 plan - consultant led and non-consultant led) against submitted plans.

217795

Exec Lead
Chief Operating Office

Target/Plan	Latest Value	Variation	Assurance
16,197	13,302		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 January was 99.80% of 19/20 against a national target of 104%. Total outpatient activity undertaken in January was 13302 against the 2022/23 plan of 16197; 2895 below - equating to 82.13%.
This is broken down as:
* New Appointments - 4079 against 4984 - equating to 81.84%
* Follow Up Appointments - 9223 against 11213 - equating to 82.25%

The sub-specialities with the lowest activity against plan in January are:
* Therapies - 1800 against 3185 - 1385 below plan - associated with cancellations, unfilled slots, class capacity reduction and high levels of sickness
* Upper Limb - 875 against 1341 - 466 below plan - shortfall in all areas of the plan, not meeting plan flex
* SOOS - 1307 against 1572 - 265 below plan - shortfall is mostly in SOOS GPSI; SOOS clinical vacancy rate remains high

It should be noted that the 2022/23 plan significantly increases in Q4.

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
* Review of Therapies appointment duration as per MUSST guidance
* Backlog management Plan for SOOS patients has been developed and an application to the ERF has been made
* 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)
* Orthotics now fully recruited to all vacant posts, start dates are April 2023

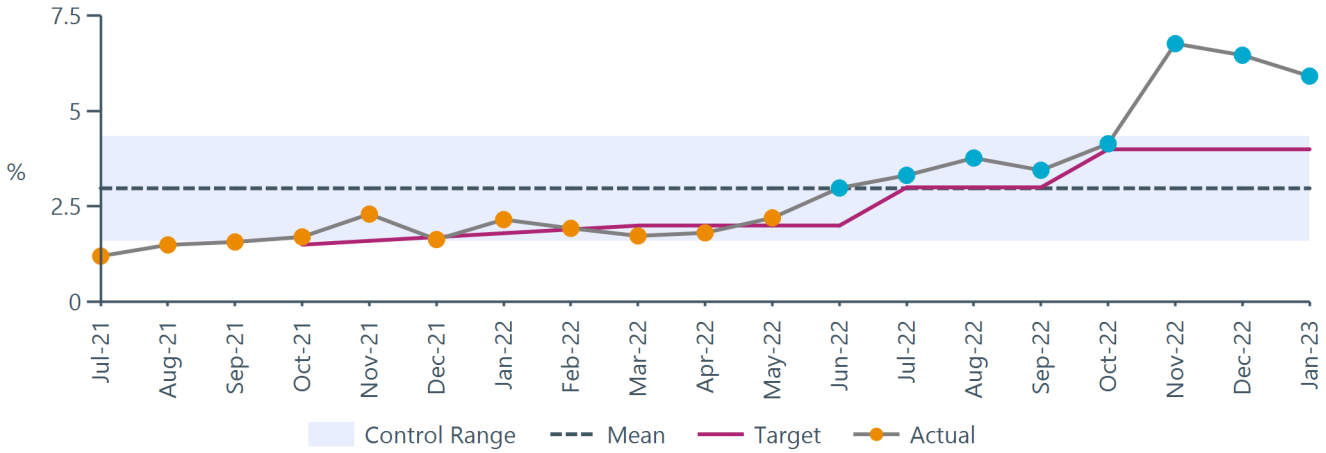
Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
12469	11619	13672	11761	14213	12391	12088	12756	12869	13248	14407	10690	13302

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 Office

Target/Plan	Latest Value	Variation	Assurance
4.00%	5.92%	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 January this was exceeded with 5.92% of total outpatient activity moved to a PIFU pathway against the 2022/23 plan of 4%.

PIFU has now been successfully implemented within Rheumatology.

Actions

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
2.16%	1.93%	1.73%	1.81%	2.20%	2.99%	3.32%	3.77%	3.45%	4.14%	6.77%	6.46%	5.92%

	IPR Position	February 2023 Unvalidated Position		
Metric	**Jan-23**	**Snapshot Date**	**Snapshot Position**	**Supporting commentary**
Sickness Absence	5.00%	2/21/2023	3.96%	Sickness Absence % within Trust on snapshot date.
Vacancy Rate	9.80%	2/21/2023	9.53%	Unvalidated. Inclusive of February's payroll transactions. Subject to change.
Never Events	0	2/21/2023	1	1 Never Event - wrong site surgery
Serious Incidents	0	2/21/2023	0	
Surgical Site Infections	0	2/21/2023	0	
Patients Waiting Over 104 Weeks - English	19	2/21/2023	16 (against trajectory of 9)	
Private Patient Activity	106.15% (69 against a plan of 65)	2/21/2023	141.18% (72 against a plan of 51)	Snapshots include upcoming booked activity. Subject to change.
Total Elective Activity against Plan	77.00% - (887 against submitted plan of 1152) 92.49% - (887 against H2 Forecast of 959)	2/21/2023	58.66% - (630 against submitted plan of 1074) 64.42% - (630 against H2 Forecast of 978)	
Total Theatre Activity against Plan	69.49% - (763 against submitted plan of 1098) 83.85% - (763 against H2 Forecast of 910)	2/21/2023	72.05% - (727 against submitted plan of 1009) 79.45% - (727 against H2 Forecast of 915)	
Total Outpatient Activity against Plan	83.39% - (13506 against a plan of 16197 snapshot date 21/02/2023)	2/21/2023	78.02% - (11923 against a plan of 15282 snapshot date 21/02/2023)	

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NHS Foundation Trust

RJAH Long Waiters - 2022/23

Trust Board

1st March 2023

Aspiring to deliver world class patient care

2022/23 January and February* Performance

		Plan	Actual	Difference
January	English 104+ Weeks	20	19	-1
	Welsh 104+ Weeks	83	46	-37
	English 78+ Weeks	327	330	3
	Welsh 78+ Weeks	444	231	-213

		Plan	Forecast*	Difference
February*	English 104+ Weeks	9	16	7
	Welsh 104+ Weeks	84	49	-35
	English 78+ Weeks	264	264	0
	Welsh 78+ Weeks	463	228	-235

**Forecast based on unvalidated position (20/02/2023)*

NHS England Updates:

Mutual Aid NHSE to support the 78+ week wait cohort.
- Providers asked to be 0 by end of March 2023
- RJAH submitted NHSE plan of 247

Currently forecasting 150 – includes SaTH transfers

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 transferring from SaTH to RJAH

*February forecast subject to clock stop predictions / numbers not converting and application of new patient choice guidance & ROH discharges
*February 78+ Weeks subject to further improvements due to volumes of outpatients still to be seen <28th February. % that do not convert.

The longest waits: - Spinal Disorders remains our challenged specialty:
Validation of all patients continuing.

English February plan = 9 patients. Current forecast: 16

- There are a small volume of non-spines. Due to specialist lab requirements (2 patient), covid unwell (1 patient) as examples.
- 4 x patients are predicted transfers to ROH remaining on our waiting lists.
- Validation and patient choice application checks continue

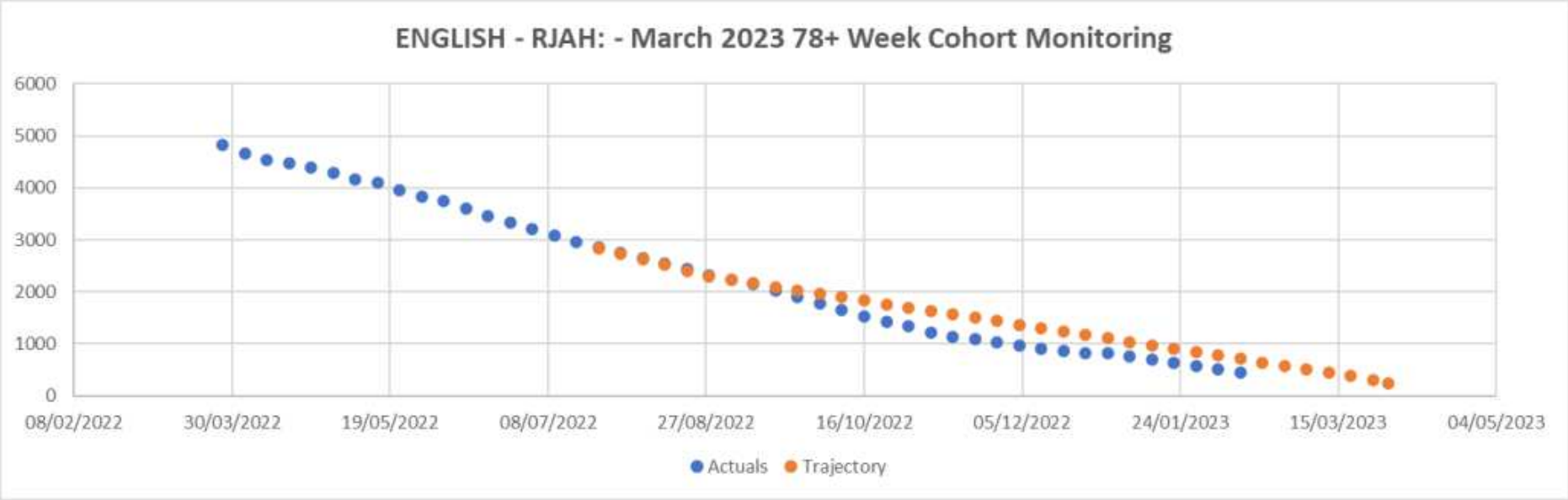
2022/23 78+ Weeks Trajectory Submitted and Run Rate

Submitted Plan:

78 weeks waits												
English RTT Waits	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust total	600	650	580	534	532	490	387	345	361	327	264	247

Trendline of Cohort to Trajectory Vs Current Run Rates:

- Mutual aid provider discussions continue to support pathways.
- Additional capacity options continually being explored.



Week ending 12th February: -

Run rate trajectory assumption = 709

Actual = 452

Difference = -257

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Milestone Visibility - Combined Waiting Lists > 78 weeks

	31.08.22		30.09.22		31.10.22		30.11.22		31.12.22		31.01.23		20.02.23* *Unvalidated	
Combined	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L
Milestone 1	287	35%	197	27%	203	30%	204	30%	153	23%	71	13%	61	13%
Milestone 2	156	19%	211	29%	191	28%	186	28%	197	30%	182	32%	163	33%
Milestone 3	366	45%	319	44%	283	42%	285	42%	309	47%	308	55%	259	54%
Total	809		727		677		675		659		561		483	

- Actions:
  - System mutual aid: - latest positions inclusive of transfers from SaTH to RJAH.
  - Non-admitted actions continue. Includes diagnostics.
  - Validation.
  - Additional outpatient and inpatient capacity being explored. Including mutual aid.
  - English interim patient choice guidance assessments for external monitoring.

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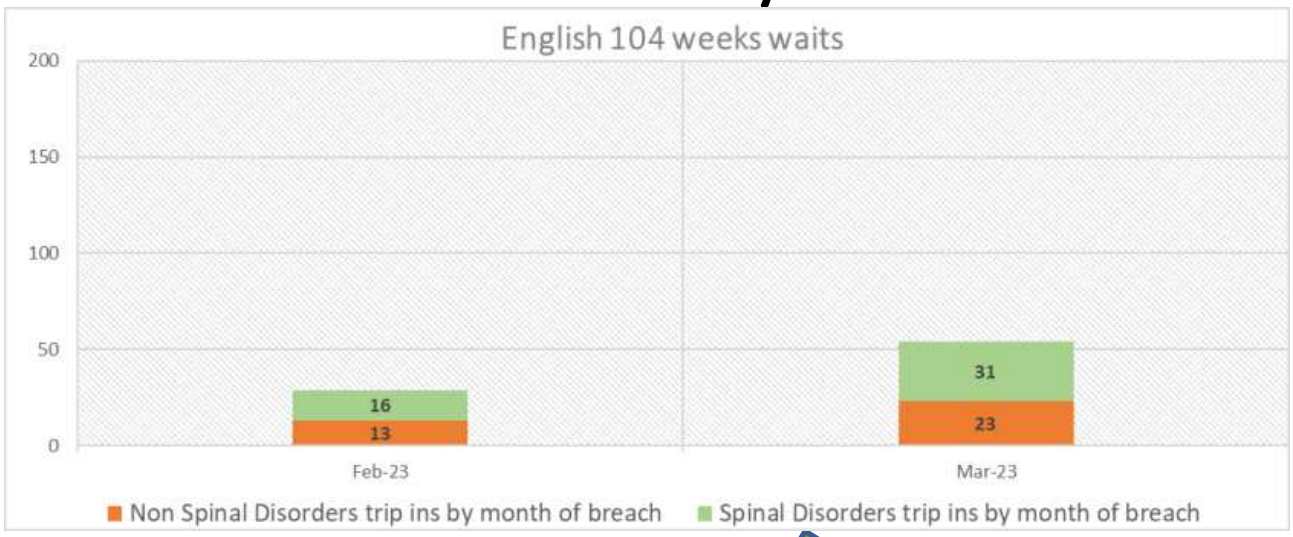
Managing The Trip-ins – 104 weeks - English

20th January

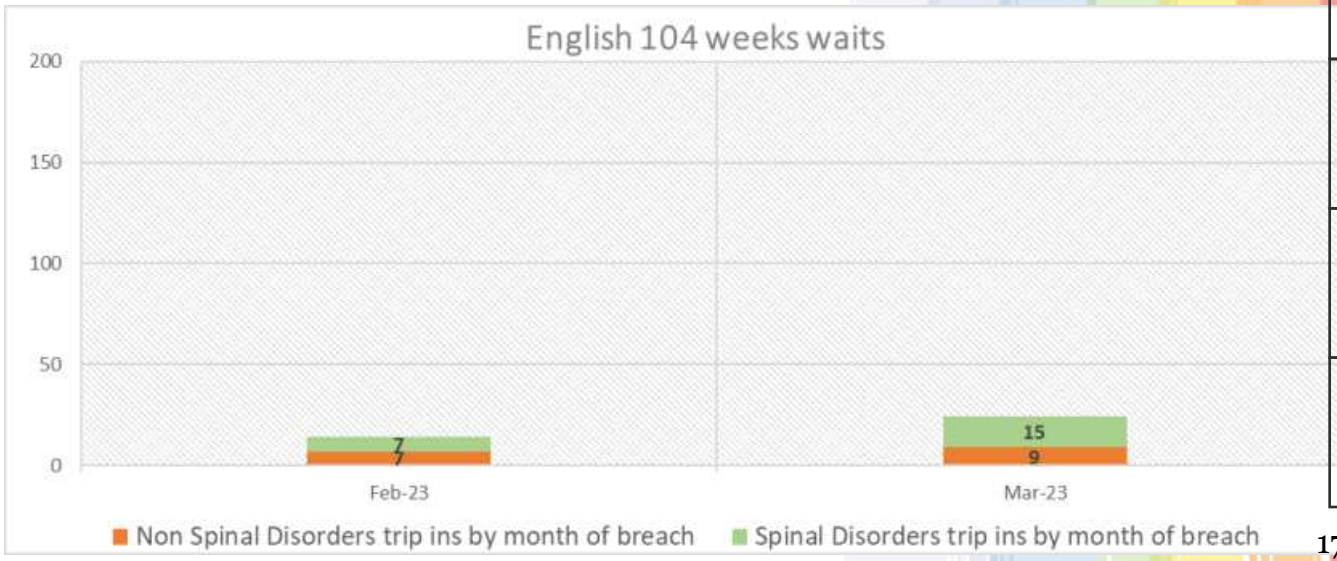


Between 20th January and 20th February. Trip-ins between February and March have reduced from 83 to 38.
Reduction of 54%

Managing the trip-ins
Future actions 2022/23 include:

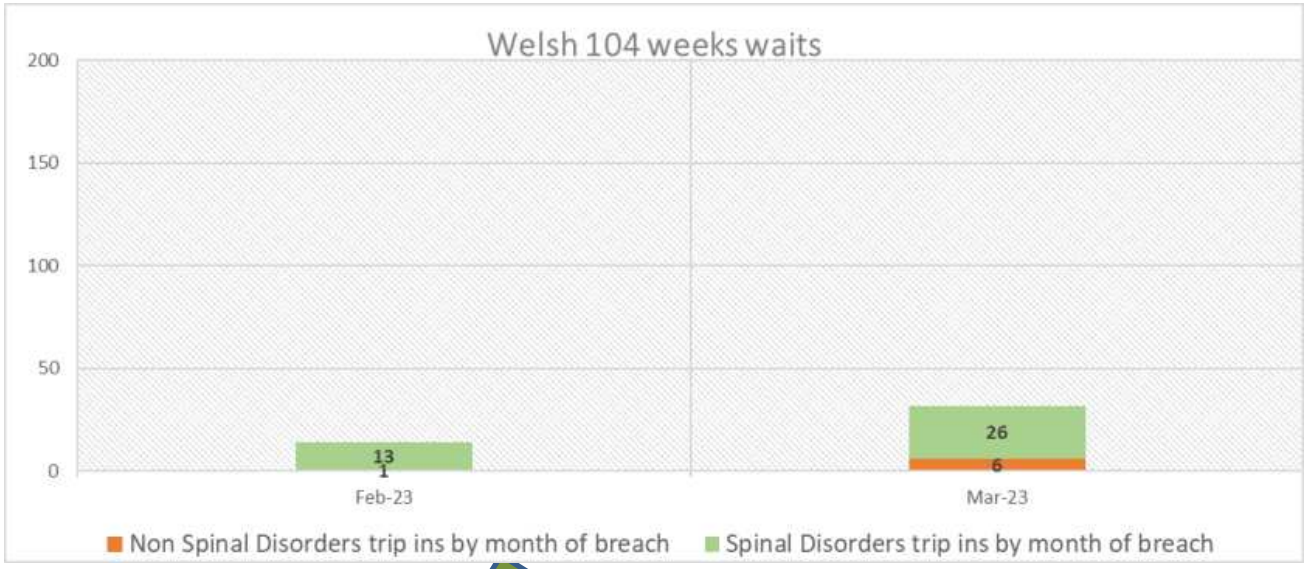
- Additional capacity options
- 78+ Weeks Route to Zero
- Cohort monitoring of 65+ weeks
- Continuous validation
- Further mutual aid
  - Inclusive of Walton

20th February



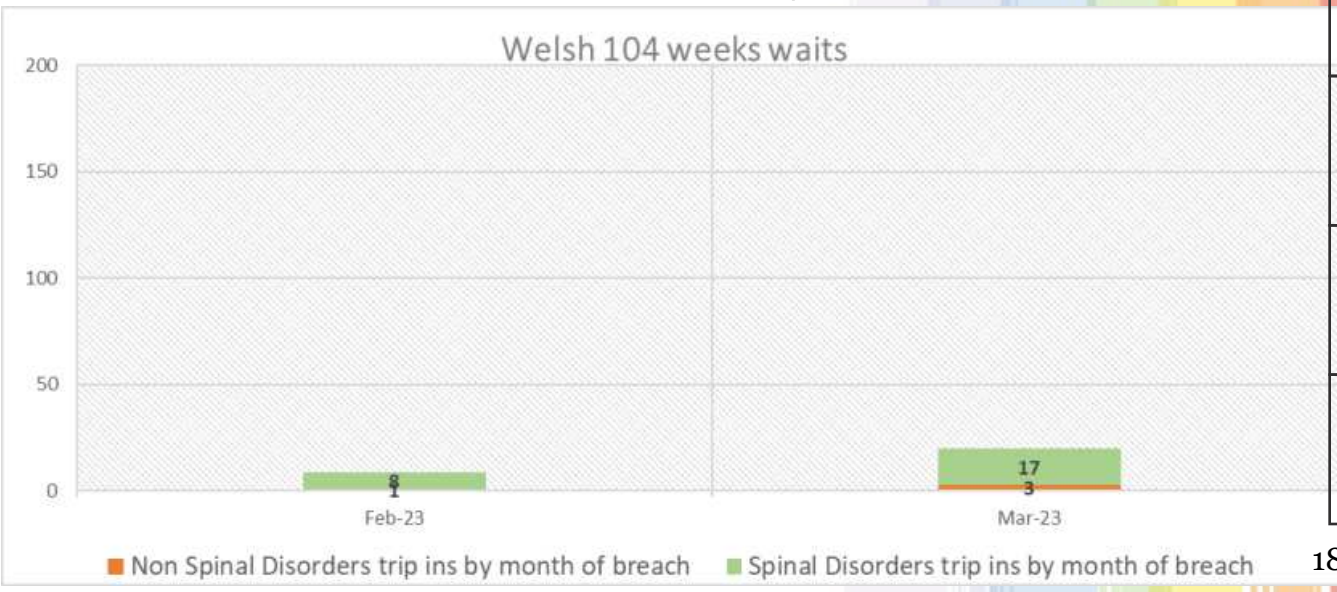
Managing The Trip-ins – 104 weeks - Welsh

20th January



Between 20th January and 20th February. Trip-ins between February and March have reduced from 46 to 29.
Reduction of 37%

20th February



Managing the trip-ins
Future actions 2022/23 include:

- Additional capacity options
- Continuous validation

Trust Board - Finance
January 2023 – Month 10

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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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)

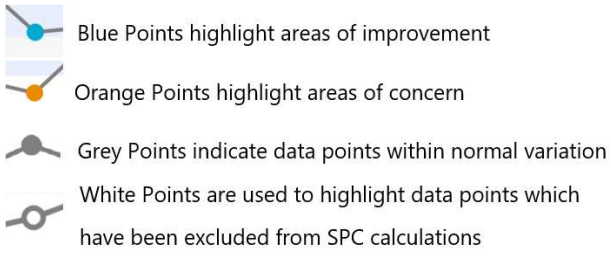
Different colours have been used to separate these trends of special cause variation:

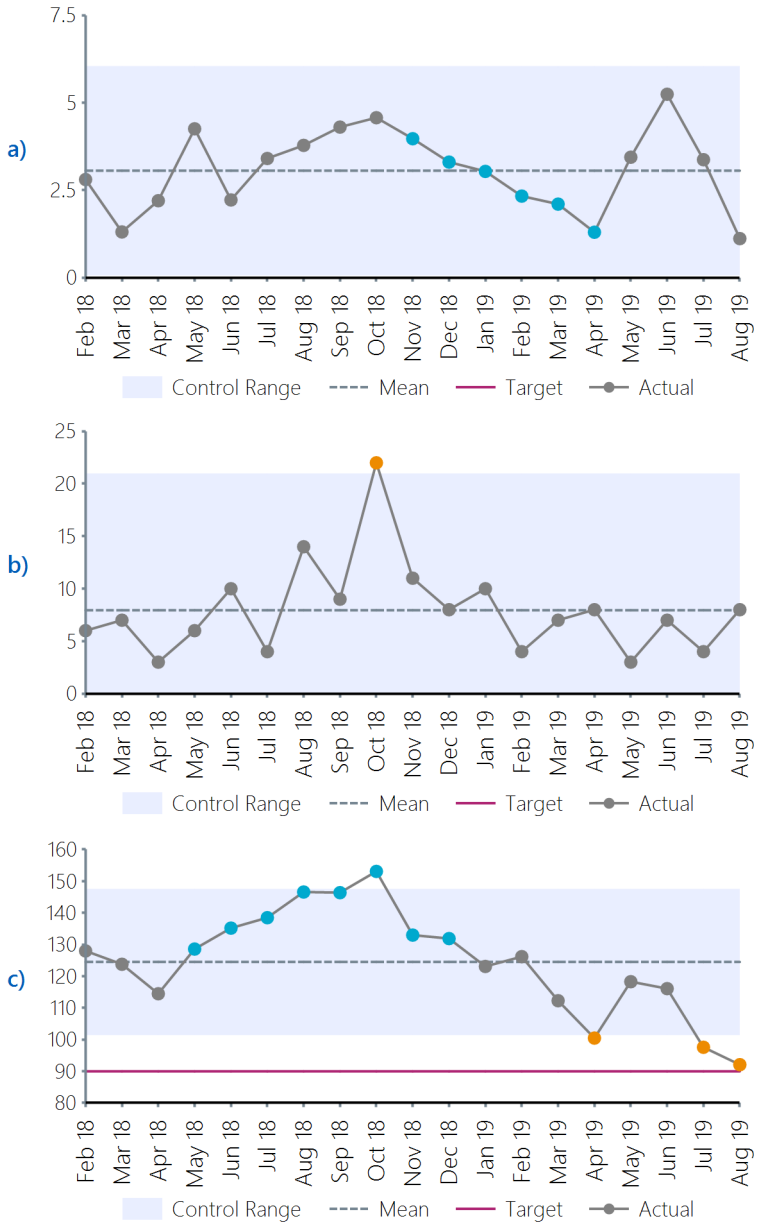
Some examples of these are shown in the images to the right:

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

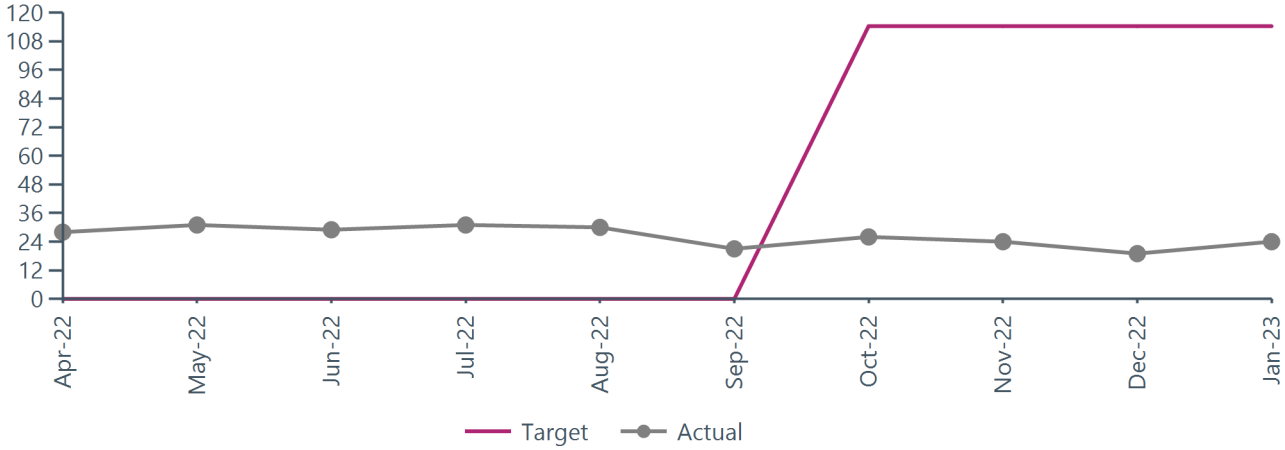
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Financial Control Total	234	2,431	371	N/A to SPC	Moving Target		
Income	11,462	13,312	11,251	N/A to SPC	Moving Target		
Expenditure	11,283	10,960	10,879	N/A to SPC	Moving Target		
Efficiency Delivered	167.67	182	161	N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	114.33	24	95	N/A to SPC	Moving Target	+	
Cash Balance	23,758	26,404		H	Moving Target		
Capital Expenditure	1,053	337		N/A to SPC	Moving Target		

Big Ticket Item (BTI) Efficiency Delivered

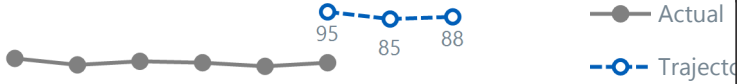
MSK Transformation 217785

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
114.33	24.00	N/A to SPC	Moving Target



Trajectory/H2 Forecast



What these graphs are telling us

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

Narrative

Revised Go Live date 13th Feb23 for interface service, digital solution and single point of access.
Business case approved for recurrent investment into therapies at system level - progressing with recruitment and host provider agreed.

Actions

Ensure successful Go Live for MSST interface service and supporting infrastructure.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
			28	31	29	31	30	21	26	24	19	24

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st January 2023

Performance Against Plan £'000s										
Category	Annual Plan	In Month Position			22/23 YTD Position			Forecast Position		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	115,065	10,232	12,041	1,809	94,350	95,924	1,574	115,065	116,421	1,356
Covid-19 Funding	1,411	118	118	(0)	1,176	1,176	0	1,411	1,412	1
Private Patient income	5,868	555	479	(77)	4,939	4,674	(265)	5,868	5,749	(119)
Other income	6,654	556	675	119	5,538	5,980	441	6,653	7,035	382
Pay	(78,681)	(6,602)	(6,250)	352	(65,509)	(64,511)	998	(78,700)	(77,568)	1,132
Non-pay	(43,762)	(3,989)	(4,074)	(85)	(35,921)	(36,122)	(202)	(43,729)	(43,627)	102
EBITDA	6,555	870	2,988	2,118	4,573	7,119	2,547	6,568	9,422	2,854
Finance Costs	(7,959)	(692)	(636)	56	(6,602)	(6,309)	293	(7,973)	(7,623)	350
Capital Donations	3,300	0	43	43	3,275	3,039	(236)	3,300	3,300	0
Operational Surplus	1,896	178	2,395	2,217	1,245	3,849	2,604	1,895	5,099	3,204
Remove Capital Donations	(3,300)	0	(43)	(43)	(3,275)	(3,039)	236	(3,300)	(3,300)	0
Add Back Donated Dep'n	632	56	79	23	521	530	9	632	632	0
Control Total	(772)	234	2,431	2,197	(1,509)	1,340	2,849	(773)	2,431	3,204
EBITDA margin	5.1%	7.6%	22.4%	14.9%	4.3%	6.6%	2.3%	5.1%	7.2%	2.1%

Statement of Financial Position £'000s				
Category	Dec-22	Jan-23	Movement	Drivers
Fixed Assets	92,645	92,432	(213)	Additions less depreciation
Non current receivables	1,264	1,230	(34)	
Total Non Current Assets	93,909	93,662	(247)	
Inventories (Stocks)	1,289	1,320	31	
Receivables (Debtors)	4,892	6,100	1,208	Increase in accrued receivables, prepayments and outstanding invoices.
Cash at Bank and in hand	28,063	26,404	(1,659)	Significant capital and annual invoices paid in month
Total Current Assets	34,243	33,824	(419)	
Payables (Creditors)	(22,925)	(19,910)	3,015	Mainly decrease in clinical income accruals due to recognition of Welsh block and release of partial annual leave accrual.
Borrowings	(2,050)	(2,054)	(4)	
Current Provisions	(432)	(404)	28	
Total Current Liabilities (< 1 year)	(25,407)	(22,368)	3,039	
Total Assets less Current Liabilities	102,745	105,118	2,373	
Non Current Borrowings	(3,658)	(3,649)	9	
Non Current Provisions	(1,018)	(1,004)	14	
Non Current Liabilities (> 1 year)	(4,676)	(4,653)	23	
Total Assets Employed	98,069	100,465	2,396	
Public Dividend Capital	(36,354)	(36,354)	0	
Retained Earnings	(30,598)	(30,598)	0	
Revenue Position	(1,453)	(3,849)	(2,396)	Current period surplus
Revaluation Reserve	(29,664)	(29,664)	0	
Total Taxpayers Equity	(98,069)	(100,465)	(2,396)	

Finance Metrics (NHS Oversight Framework)

Financial efficiency - variance from efficiency plan	
Financial stability - variance from break-even *	
Agency spending	

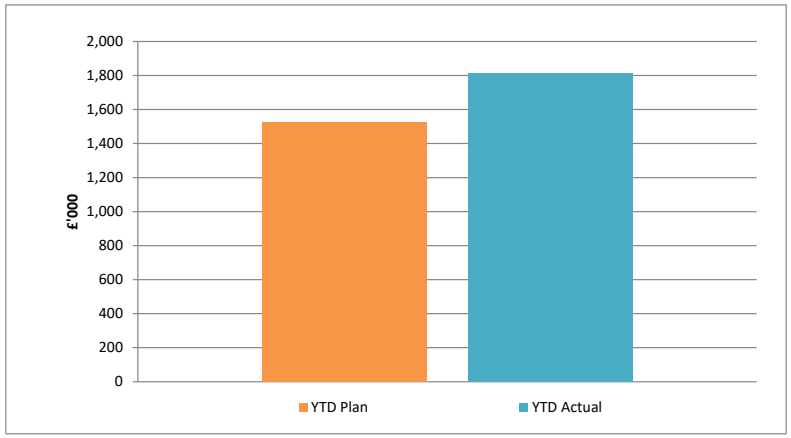
* Subject to system position through IFP arrangements

	YTD
Debtor Days	14
Creditor Days	53

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st January 2023

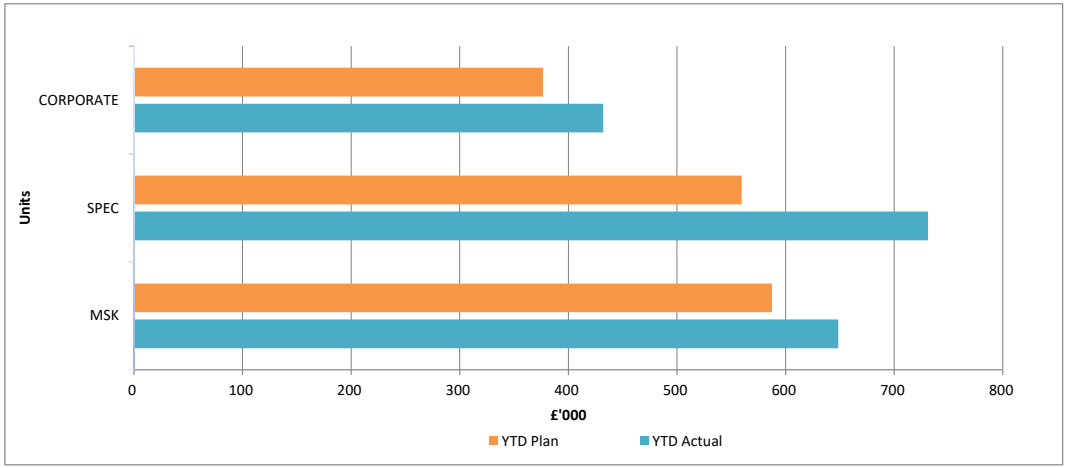
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's

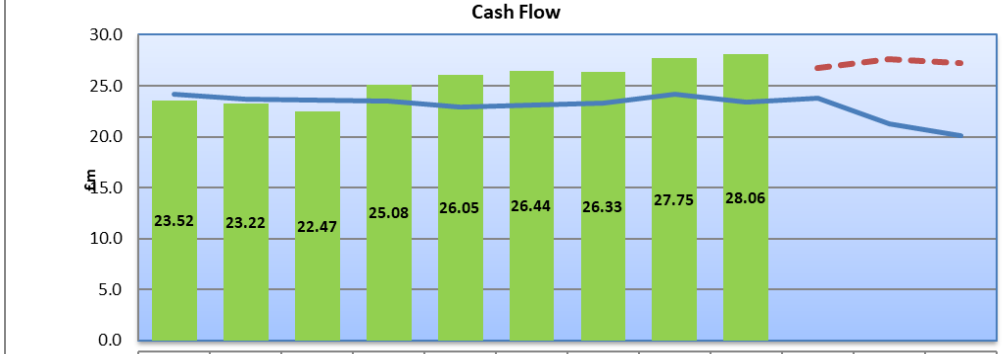


Note - Target represents original external plan which doesn't include 21/22 carry forward and stretch to cover investments reported at a unit level

Capital

Position as at	2223-10	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**	**Forecast Outturn £000s**	**Forecast Variance £000s**
Backlog maintenance	350	25	47	-22	305	290	15	434	84
I/T investment & replacement	300	50	42	8	200	81	119	600	300
Capital project management	130	11	10	1	108	103	5	130	0
Equipment replacement	750	75	65	10	575	853	-278	1,350	600
Diagnostic equipment replacement	920	0	-0	6	590	306	284	720	-200
IPC & safety compliance	360	0	41	-41	310	682	-372	900	540
EPR planning & implementation	4,500	717	62	655	4,068	1,575	2,493	4,500	0
Invest to save	200	0	0	0	150	41	109	200	0
Enhanced staff facilities	500	0	0	0	200	0	200	0	-500
Additional theatres x 4 (replace barns)	3,000	0	0	0	0	0	0	0	-3,000
TIF2 theatre and ward	0	0	0	0	0	5	-5	5,034	5,034
Leases (IFRS16)	149	75	0	75	149	174	-25	249	100
Veterans' facility	3,200	0	43	-43	3,200	3,003	197	3,200	0
Veterans' facility (HEE)	0	0	0	0	0	49	-49	58	58
Donated medical equipment	100	0	0	0	75	35	40	100	0
Contingency	500	100	32	68	300	47	253	228	-272
Total Capital Funding	14,959	1,053	337	716	10,230	7,244	2,986	17,703	2,744
Veterans' facility	-3,200	0	-43	43	-3,200	-3,003	-197	-3,200	0
Donated medical equipment	-100	0	0	0	-75	-35	-40	-100	0
NHS Capital Funding - Charge to CDEL	11,659	1,053	294	759	6,955	4,205	2,750	14,403	2,744
Less leases (IFRS16)	-149	-75	0	-75	-149	-174	25	-249	-100
Charge to CDEL excluding IFRS16	11,510	978	294	684	6,806	4,031	2,775	14,154	2,644
Less in-year PDC funded schemes	0	0	0	0	0	-5	5	-5,034	-5,034
Charge to CDEL for decision purposes	11,659	1,053	294	759	6,955	4,200	2,755	9,369	-2,390

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			
Forecast										26.76	27.63	27.22
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

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

Operational Plan 2023/24

Draft submission 23rd February 2023

Aspiring to deliver world class patient care

Key Headlines

- Overall value weighted activity threshold of 103% of 19/20 baseline for STW as a system

- Activity above the 103% earns full tariff income through Elective Recovery fund to incentivise backlog waiting list clearance. Activity below will trigger a full tariff income reduction

- For the first draft plan we have submitted the following:
  - Theatres 102% (this activity carries the highest weighting)
  - Other inpatient 105%
  - Outpatient 99%
  - Diagnostics 110% CT, 108% US, 121% MRI

- More to do on 78 week clearance plan and 65 week target by April 2024 (currently non compliant)

Theatre activity Improvements

- Draft Theatre plan includes 5 improvement schemes that are expected to increase our current level of activity by 992
  - 258 linked to productivity
  - 734 linked to workforce (vacancies filled from November and new theatre staffed from January)

Start Date for initiative	Initiative	23/24 Activity Impact
Baseline Position	**Do Nothing (11 theatres)**	**9,873**
Nov-23	Workforce Improvement (12 Theatres Nov 23)	435
Jan-24	Elective Hub Development (13 Theatres Jan 24)	299
Oct-23	Productivity - Extended Days	63
Apr-23	Productivity - 5 Joints/List	147
Apr-23	Productivity - P2s in spinal emergency capacity	48
Theatre Activity Plan (including interventions)	**NHS Cases**	**10,865**

Outpatients activity Improvements

- Draft Outpatient plan includes 5 improvement schemes to deliver activity in 23/24 that are expected to increase our current level of activity by c20,000 attendances
- c14,000 linked to additional clinic capacity (Veterans Centre)
- c4,000 linked to recruitment
- c2,000 linked to OJP

	Start Date for Initiative	Initiative	
Baseline		Do Nothing (D&C model)	157,765
	Apr-23	OJP aligned to 22/23 levels	1,652
	Apr-23	Additional OPD Room Capacity	13,753
	Apr-23	DNA Improvement	1,215
	Jul-23	2 spinal middle grades	1,918
	May-23	Staffing profile adjustment Orthotics/ORLAU	1,558
OP Draft Activity Plan - Feb 23			177,861

Risks to delivery (to be tracked at nominated oversight Committee)

Risks Description	C	L	Risk	Actions/Mitigations	Assurance Committee
Theatre Build Construction risk to delivery to time and budget.	4	3	12	Theatre Project Board established this month for oversight. Currently finalising detailed design with supplier and has been brought in line with budget at this stage. Lead in time for equipment currently under review.	FPD Committee
Workforce Recruitment insufficient to support planned activity	4	3	12	Recruitment plan in place for recruitment activities, need to monitor outputs to ensure that on track to deliver to target dates. The Trust is currently contingency planning with Insourcing companies to mitigate workforce risks.	People Committee
Industrial action impacting on planned activity	4	4	16	Deterioration on activity plan due to ongoing industrial action. This cannot be built into the operational plan. The Trust will continue with it's careful planning and report impact.	People Committee
OJP uptake below planned levels for 23/24	4	3	12	Meeting has taken place with LLP which communicated 23/24 plan. LLP confirmed that available dated offered remain well above plan. Keep under review.	FPD Committee

Further improvements in scope for Final Plan (30th March)

- Theatres:
  - Insourcing contract under discussion (Theatre Teams/Anaesthetists)

- Outpatients:
  - Therapies improvement plan
  - Triangulation with efficiency programme initiatives

- Diagnostics:
  - Potential extension of mobile MRI scanner (ends April)

Draft Financial Plan

	£m I&E	Key Assumptions
2022/23 Updated Underlying Position	**-1.2**	
Inflation	-3.2	Income 1.8%, pay inflation 2.1%, non pay 5.5%, cost of capital 10%. Largely covered by efficiency factor but capital charges £0.4m remain unfunded.
Baseline Welsh capacity reallocated to English capacity recurrently	-0.3	Longstanding issue previously addressed through ERF, needs funding from growth as additional activity for English commissioners
Diagnostic Capacity Workforce Increases (MRI, Ultrasound, CT)	-0.2	Longstanding issue - MRI, Ultrasound & CT improvement to waiting times, needs funding through growth allocation
Casemix - long waiters priority for treatment	-1.2	Driven by complexity & acuity of long waiting patients implants, consumables, drugs, orthotics, need to assess income casemix offset.
Cost Pressures	-1.5	INCOME: Vaccination hub £0.1m, MCSI PP £0.2m, research contribution £0.1m. PAY: CSM extended working £0.05m, various small pressures £0.05m, CEA £0.3m. NON PAY: Building rates £0.25m, CNST £0.1m, TRAC £0.1m, various small pressures £0.15m.
Efficiency 2.2% required by planning guidance	2.8	Efficiency factor assumption 2.2% based on operational planning guidance
Elective recovery funding - STW	4.4	Subject to confirmation
Elective recovery funding - Inter system	1.4	Subject to confirmation
Theatre development (TIF2) impact	-1.4	Aligned to TIF SFBC, net pressure driven by cost of capital assumed to be funded through SDF or transformation support
Mobile MRI capacity	-0.6	Placeholder until activity confirmed
2023/24 Recurrent Position	**-1.0**	
Theatre development (TIF2) impact non recurrent	-0.4	Aligned to TIF SFBC, net pressure driven by cost of capital assumed to be funded through SDF or transformation support
Vacancy factor reinstated non recurrently	0.5	Based on workforce plan recruitment assumptions
2023/24 Draft Plan Internal Performance Driven	**-0.9**	
RJAH share of system deficit through IFP	-4.2	Subject to refreshed IFP arrangements
2023/24 Draft Plan	**-5.1**	

- Deficit of £5.1m (£4.2m relates to system IFP adjustment)
- System IFP still to be refreshed – basis for 23/24 still to be finalised
- Includes confirmed Elective Recovery Fund income of £5.8m (element from Specialised Commissioning awaited)
- Internal efficiency programme of 2.2% in line with national requirement
- Includes £1.5m of cost pressures
- Includes extension of mobile MRI scanner but excludes Insourcing contract costs
- Assumes 103% weighted activity achieved – no adjustment for under/over performance

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance, Performance and Digital Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 March 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	22 February 2023
Paper Reviewed by:	Martin Newsholme, Committee Deputy 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 21 February 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.

There were no new areas of risk to highlight to the Board.

3.2 Areas of on-going monitoring with new developments

ADVISE - The insert name 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:

Performance Report and Long Waiters Presentation

The Committee thanked the team for their continued efforts on reducing patients waiting 104+ and 78+ weeks - noting the continued blocker being spines. The Committee requested a further focused

report to be presented on spines alone, to incorporate the capacity and demand and highlight any issues and risks requiring escalation. It was also suggested reviewing patient pathways and comparing these to other Trusts, to offer alternative practices of treatment, to which the Committee agreed. The Committee noted partial assurance.

Planning Oversight (Financial and Operational)

Following a review since the last meeting (January) improvement have been noted relating to:

- improvement from £8.4m deficit to £5.1m
- ERF allocations assumption £5.8m of which £3.7m has been mapped to costs to support activity delivery.
- ERF is currently at risk as the draft activity submission currently takes us to 102% against the 103% target.
- IFP adjustment assumes £4.2m deduction but still needs to be reset at a system level.

The Committee noted the amendments made, requesting further confidence on the deliverability of the plan to offer assurance to the Committee members – partial assurance was noted.

RTT Trajectories

Partial assurance was noted in relation to the RTT trajectories; 78 weeks currently forecasting 0 for the end of March 2024 and 65 weeks currently forecasting 154 for the end of March 2024. The achievement of the plan requires significant support via mutual aid from other specialist providers.

EPR Update

Concerns were raised over the slow start made by the consultant and greater clarity was requested on progress against milestones– partial assurance was noted.

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.

Corporate Risk Register

It was noted that further work is to be completed to ensure the smooth reporting process of the corporate risks. The Trust is to review the report to improve the reporting of escalation points.

National and Regional Elective Recovery Programme

December was the latest being compared from a national perspective, with 81% outpatients' restoration against 19/20 levels and 90% inpatient. The Trust will continue to monitor.

Productivity Dashboard and Day Cases

The Committee took assurance from the actions in place to support productivity and day cases, those actions included enhanced recovery programme and benchmarking performance against peers.

RJAH Financial Report

Overall, the Committee took assurance from the report noting the full forecast for the year being £2.4m surplus which is £3.2m.

Contracts and Investments Register

The Committee discussed the SLA which are at risk of non-payment – the Committee were advised that these are relatively low risk due to system relationships and the focus to date has been on customer SLA's. The Committee agreed for the information to be presented to unit Board meeting to support planning from April 2023.

Service Line Reporting

The Trust provided background detail as this was the first report presented since Covid19. The governance arrangements were confirmed, and it was noted that the majority to service lines are reporting consistently with 19/20 baseline. The Committee took assurance from the report.

Specialist Unit Efficiency Delivery Update

The Trust commended the paper which included a first draft of the efficiencies for the next year. Focus remains on transformations and cost reduction with service managers working with clinical leads.

Chair Reports

The Committee noted the Chairs assurance reports from the following meetings: Digital Transformation Programme Board, Trust Performance and Operational Improvement Group, MSK Transformation Board, Capital Management Group and Sustainability Working Group.

Security Update

There were no risks or concerns to raise, and assurance was obtained.

IT Threat and Management Action Plan

Chair's Assurance Report
Finance, Performance and Digital Committee

All actions following the review are due to be completed by the end of the month – no concerns were raised.

4.0 Conclusion / Recommendation

The Board is asked to:

1. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
2. NOTE the content of section 3.3.