The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 02.11.2022

MEETING
2 November 2022 09:30

PUBLISHED
16 December 2022

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	2/11/22		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes from the previous meeting 07.09.2022		Chairman	
1.4. Matter Arising		All	
2. Presentations			
2.1. Guardian of Safe Working Hours - Mr Chris Marquis		Chief Medical Officer	09:40
2.2. Veterans Award		Chief Executive Officer	09:55
3. Chairman / CEO Update		Chief Executive Officer	10:05
4. Corporate Risk Register		Acting Trust Secretary	10:15

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	2/11/22		09:30
5. Quality and Safety			10:25
5.1. Chief Nurse and Patient Safety Officer Update (verbal)		Chief Nurse	
5.1.1. IPR Exception Report		Chief Nurse	
5.1.2. Near Miss Annual Report		Chief Nurse	
5.1.3. Patient Safety Alert Annual Report		Chief Nurse	
5.1.4. Controlled Drugs and Accountable Officer Annual Report		Chief Nurse	
5.2. Chief Medical Officer Update		Chief Medical Officer	
5.2.1. Learning from Deaths Q2 Report		Chief Medical Officer	
5.2.2. Clinical Audit Annual Report		Chief Medical Officer	
5.2.3. Chair Report from Quality and Safety Committee		Non Executive Director	
5.3. IPC Improvement Plan		Chief Nurse and Patient Safety Officer	
5.4. IPC Q2 Report		Chief Nurse and Patient Safety Officer	
5.5. Chair Report from IPC Quality Assurance Committee		Non Executive Director	
BREAK			11:00

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	2/11/22		09:30
6. People and Workforce			11:15
6.1. IPR Exception Report		Chief People Officer	
6.2. Guardian of Safe Working Hours Q2 Report		Chief Medical Officer	
6.3. Chair Report from People Committee		Non Executive Director	
7. Performance and Governance			11:35
7.1. Chief Operating Officer Update (verbal)		Chief Operating Officer	
7.2. IPR Exception Report		Chief Operating Officer	
7.3. Long Waiters (Presentation)		Chief Operating Officer	
7.4. Elective Recovery Self Certification		Chief Operating Officer	
7.5. Finance Performance Report		Chief Finance and Planning Officer	
7.6. Chair Report from Finance, Planning and Digital Committee		Non Executive Director	
7.7. Chair Report from Extra Ordinary Finance, Planning and Digital Committee		Non Executive Director	
7.8. Chair Report from Audit and Risk Committee		Non Executive Director	
8. Questions from the Governors and Public		Chairman	12:10
9. Overall Board Reflection and Comments		All	12:15

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	2/11/22		09:30
10. Any Other Business		All	12:20
10.1. Next Meeting: 11 January 2023 (Public)			

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

BOARD OF DIRECTOR – PUBLIC MEETING
7 SEPTEMBER 2022 AT 9.30AM, BOARD ROOM AT RJAH
MINUTES OF MEETING

Present:

Harry Turner	Chairperson	HT
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB
Penny Venables	Non-Executive Director	PV
Sarfraz Nawaz	Non-Executive Director	SN
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:

David Gilburt	Associate Non-Executive Director	DG
John Pepper	Associate Non-Executive Director	JP
Martin Evans	Associate Non-Executive Director	ME
Denise Harnin	Interim Chief People Officer	DH
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Jacqueline Barnes	Improvement Director from NHSE/I	JB
Mary Bardsley	Assistant Trust Secretary - Minute Secretary	MB
Sheila Hughes	Governor	SH
Martin Bennet	Governor	MBe
Andrew Roberts	Research Presentation	AR

MINUTE NO	TITLE
07/09.01	**APOLOGIES** Apologies were noted from Martin Newsholme, Non-Executive Director.
07/09.02	**MINUTES OF THE PREVIOUS MEETINGS** 06 July 2022 - the minutes were agreed as an accurate reflection of the meeting and therefore approved by the Board.
07/09.03	**MATTERS ARISING** There were no further items tabled for discussion.
07/09.04	**DECLARATION OF INTERESTS** PK shared that he has recently been appointed independent director for Education at Cheshire University. PK agreed to complete a declaration of interest form.
07/09.05	**PATIENT STORY** SEA welcomed and introduced Mrs Helene Faure who attended the meeting to present her patient story. The following key points were noted: ▪ Helene was referred to the Trust by her GP with an injury to my left hand and ongoing pain – suspected arthritis. ▪ Attended an appointment where discussions were held regarding Helene's care plan ▪ An injection for pain relief was administered ▪ Helene has since undergone surgery - decompression of the carpal tunnel in both hands ▪ Helene uses the physio exercise to strengthen her hands and continues to learn how to use her hands differently in view of my arthritis ▪ The MDT were exemplary, and the care was truly coordinated Helene described her care at the Trust as excellent, noting the following 'little' things can make a significant difference to a patient's journey; 'Kindness, consistency, caring for her as

	a person who happens to be a patient, being health focused, understanding lifestyle and proposing a care plan to keep my quality of life. Phone calls and time to be heard, a choice of hot. Every contact, throughout the hospital, seemed to count for the staff so I felt safe and my privacy, dignity and what was important to me were respected.' Helene suggested that patients are given two sets of hand supports following surgery as the fabric becomes dirty within a brief period. On behalf of the Board, HT thanked Helene for her story and experiences. SEA echoed HT comments and highlighted the importance of shared decision-making regarding patient care – patient choice remains a key focus for the Trust.
07/09.06	**RESEARCH PRESENTATION** At a previous strategy meeting, the Board agreed the Research portfolio is to be increased across the organisation and therefore invited AR to attend to present an overview of the direction of moving forward. AR shared the presentation thanking PK for his guidance and Teresa Jones, Research Manager for supporting. HT reminded the Board that a Research and Education Committee is to be established. The following comments were noted: ▪ Looking forward to seeing further information following the next steps ▪ Outcomes is an important aspect of learning and although PROMs are well established within the organisation, further work is to be completed to integrated into all services ▪ Will support in attracting staff to work for the Trust The Board thanked AR for his inspirational and driven presentation and supported the request for a Business and Innovation Strategy to be created.
CHAIR AND CHIEF EXECUTIVE OFFICER UPDATE	
07/09.07	**CHAIR UPDATE** On behalf of the Board, HT welcomed Martin Evans, newly appointed Associate Non-Executive Director to the team. HT also welcomed three new elected Governors, Martin Bennet (Shropshire), Nikki Kuiper (Shropshire) and Sheila Hughes (North Wales) before thanking MBe and SH for joining today's meeting. HT confirmed the following: Willian Green has been reappointed Lead Governor; Victoria Sugden has been appointed as the Stakeholder Governor for the League of Friends following Peter David resigning from the position and Kate Betts has been reappointed the staff governor SK welcomed Denise Harnin, Interim Chief People Officer who has been supporting the Trust whilst recruitment takes place for the substantive Chief People and Culture Officer. Following an interview process in August 2022, Jane Haire has been offered and accepted the role as Chief People and Culture Officer and is due to join the Trust in the New Year. SK informed the Board that SR will be leaving the Trust at the end of the month to join Shropshire Community Trust and thanked SR for her time and commitments to the Trusts. HT updated on the following regarding to the system: ▪ The Trust continue to engage with the system and improve ways of working and relationships ▪ HT has agreed to Chair the System Integrated Delivery Committee which oversees the big-ticket items ▪ Visit from Sir Neil recently and he was impressed by the organisation ▪ Positive feedback from the region regarding 104 weeks and IPC – thank you and well done ▪ Board to Board meeting in October has been confirmed **CHIEF EXECUTIVE OFFICER UPDATE** SK highlighted the following activities and events for the Trusts: ▪ Thank you, week, – in replacement of the annual awards ceremony, the Trust arranged for a thank you week to be scheduled which saw staff get involved in a variety of activities. ▪ NOA Awards – on behalf of the Board, SK congratulated the three finalists for the annual awards. They included, path of positivity, my recovery, and the green plan

	▪ The Trust has been named as Quality Data Provider by the NJR for the fourth year ▪ Engineers within the ORLAU department have won the healthcare application award following their work to update an old-fashioned knee alignment device ▪ The Trust signed a contract with System C to provide a new electronic patient record ▪ Health Hero (July) – Congratulations to the Covid-19 Testing Team who were nominated by Pre-Op Assessment manager Jo Bidmead for working tirelessly over the past 12months ▪ Health Hero (August) – Congratulations to Ben Parrish, Steve Bishton and Louise Evans who stepped up and filled an unexpected period of leave from their manager. PV thanked SK for the positive updates and requested a copy of the Trusts green plan video following the previous Board meeting. ACTION: to circulate the Green Plan video to all Board members
PERFORMANCE REPORT	
07/09.08	**PERFORMANCE REPORT** MC explained that each exception report be presented throughout the meeting before highlighting the overall flash report: ▪ KPI for outbreaks has been incorporated into the report ▪ The content of the report is to be reviewed to improve reporting and incorporating SMART actions ▪ There is a noted high level of turn over and vacancy rates have increased ▪ 104-week waiters remain a key focus – performance is improving ▪ Performance has been measured against the original plan and resubmission – more information to follow throughout the meeting ▪ Diagnostics decrease is related to MRI capacity ▪ Improvements in sickness have been noted in August as well as vacancy rates.
EXCEPTIONAL ITEMS	
07/09.09	**BOARD ASSURANCE FRAMEWORK** The framework has been presented to the Board for consideration and approval. It was noted the document has been discussed at the Executive Team meeting and each risk will be presented to the relevant assurance committee for further debate throughout the month. SR highlighted the changes within the format and noted the summary front sheet which aligns the risks to the corporate objectives. The Board were encouraged to share any comments. The following was noted: ▪ To be discussed at the private board in October to allow detailed discussion at the Committee meetings throughout the month ACTION: add to the private board meeting in October ▪ Positive link between the risks and the objectives ▪ Highlighted that risks that are no longer on the BAF are due to the updated objective agreed by the Board ▪ Noted the document is work in progress. The Board thanked SR for the update before noting the framework
QUALITY AND SAFETY	
07/09.10	**IPR EXCEPTION REPORT – CARING FOR PATIENTS** The following was highlighted: ▪ One RJAH acquired c-diff - this was the same patient as reported in June that unfortunately had a relapse of their infection. A Post Infection Review was undertaken and determined antibiotic usage was the expected cause although all antibiotics were prescribed accordingly. ▪ One E-coli bacteraemia - Sheldon ward. Infection source not identified. There was appropriate management of the infection and no lapses in care identified. ▪ One MSSA bacteraemia Patient confirmed to have a surgical site infection which is the source. ▪ Outbreaks - this is a new IPC metric reported to Board. In July there was a total of six outbreaks (One MRSA outbreak and Five COVID-19 outbreaks) ▪ No SSIs reported in July in the IPR although there is ongoing surveillance for 12 months and two SSIs have been identified in August following surgeries in July (2 THR). ▪ A thematic review for the 5 SSIs in quarter one has been completed with recommendations being actioned through the surgical site surveillance group including focus on post op wound care and patient information.

	▪ Never event under investigation is being undertaken following a retained foreign object following a patient's shoulder surgery. The level of harm is yet to be determined. The Trust confirmed a duty of candour review being completed – both the surgeon and patient are being supported. It was suggested that at future meetings an update is received from the Chief Nurse and Chief Medical Officer on current events. DG commented on the increased numbers of falls and queried whether Bay Watch was still embedded across the organisation. SEA explained that patient harms is considered for all falls and are discussed at the next meeting. Most falls are linked to rehab patients as this is a continued risk as part of MCSI. To gain further assurance, CB agreed to scrutinise further within the committee's presentation. SK explained that bathrooms are being reviewed to support the patient's safety and informed the board that falls awareness week is being scheduled for later in the month.
07/09.11	**CHAIR REPORT FROM QUALITY AND SAFETY COMMITTEE** The following key points were highlighted: ▪ Further scrutiny of patient falls is required ▪ Full therapies service review is to be completed following the presentations of the clinical service quality report. ▪ Development of the learning from deaths paper to include learning The Board note the Chairs assurance report.
07/09.12	**LEARNING FROM DEATHS (Q1 REPORT)** RL presented the paper highlighting that following presentation at the Quality and Safety Committee, there are no concerns to escalated. RL explained that work is being undertaken to improve the presentation and detail of the report. HT asked for learning to be incorporated into the report following CB chairs update.
07/09.13	**CHAIRS ASSURANCE REPORT – IPC QUALITY ASSURANCE COMMITTEE** The following points were noted: ▪ Assurance obtained, noting the improvements implements across the organisation ▪ Nursing of MRSA patients' concerns were raised – further assurance has been requested for the next meeting SEA explained that substantial progress is being made, continue to add to the improvement plan. JB echoed SEA comments and assurance has been delivered to the committee. Following a discussion at the meeting, the CB recommended that the Board approve for the IPC Quality Assurance Committee to be extended for 6 months to continue with the high-level focus on IPC to which the Board agreed.
07/09.14	**IPC IMPROVEMENT PLAN** The Trust is currently rated amber on the NHSE IPC matrix with full inspection due at the end of this month. A Review of improvement plan and evidence in July saw overall number of actions increasing from 67 to 82. There continues to be substantial progress being made as of the 31 August there are two actions behind plan, this relates to the microbiology SLA with the impending retirement of our Consultant Microbiologist. This is being escalated via conversations with SaTH. The second delayed action is the installation of glass doors on Gladstone ward and given current increased occupancy and waiting list demand the estates team are unable to access the ward to complete the works. Key achievements include the development of the IPC dashboard, review of the hygiene code gap analysis seeing overall compliance increase to 96%, appointment of the deputy DIPC commencing in post on the 19th of September. There was also a positive visit from NHSE to theatres Baschurch and HDU in July. A Monthly self-assessment of progress against the formal undertakings is presented at NHSE Improvement Review Meetings. Next steps regarding formal assessment against undertakings outlined in section 3.2.3 which includes a sustainability questionnaire being sent to staff across the Trust.

	A huge amount of improvement has been seen across the organisation and IPC will remain a priority and focus to enable the changes to sustain. On behalf of the Board, HT congratulated the Trust on the great progress.
07/09.15	**IPC ANNUAL REPORT** SEA informed the Board that the report has been reviewed by IPC Committee and IPC Quality Assurance Committee. The annual report is set out against the ten criteria of the hygiene code. It has continued to be a challenging year with Covid impact and multiple changes in guidance the team had to respond to. An MRSA outbreak in the summer of 2021 which saw the Trust move to red in the NHSEI internal IPC matrix. An IPC improvement plan was developed in response to this with collaboration from IPC, estates and facilities, clinical and operational teams. Following a discussion, the following points were noted: ▪ The Trust look forward to seeing the comparison in the report next year ▪ Concerns were raised with the attendance at the IPC Committee – this has since be reviewed ▪ Highlighted a requirement for less reliance on bank staff, difficulty for those to engage in the training and the benefits of developing a system wide bank ▪ A review of the workforce is being undertaken to consider how we the Trust can support staff with their training. ▪ Requirement to ensure training and development is available for bank along with permanent ▪ wider conversation required around staff training as expectations of completing training has increased/time to allocated to the team. The Board noted the annual report.
07/09.16	**IPC REPORT (Q1)** SEA welcomed comments on the reviewed format of the report before highlighting the following: ▪ 2 HCAIS, 5 SSIs, All PIRs completed, 4 covid outbreaks in Q1 ▪ Improved HH/BBE audit results ▪ Cleanliness audits remain above target. April 22 saw the implementation of the national standards of cleanliness ▪ Environmental improvements seen with several ward and department refurbishments ▪ Strengthened training requirements with continual improvement seen ▪ Increased capacity within the IPC team and development of the IPC strategy ▪ Strengthened governance and upward reporting to IPCC ▪ Total of 17 QA walks undertaken with themes shared at IPCWG - storage, cleanliness of equipment, floors, and inappropriate items in shower rooms ▪ NHSE inspection in June saw the Trust move from Red to Amber ▪ Case of need Investment requested for housekeeping. An open day has been scheduled for 12 September JB informed the Board that there are three letters expected in due course, one of which is from Kirsty Morgan following her visit to review as a halfway point and highlights her feedback. In relation to the self-assessment letter, HT noted that the issues have been managed pre and post the ICS formation. If the system is assured, they will support the Trust in an application to the region. HT encouraged SEA and RL to discuss with counterparts within the ICB.
PEOPLE AND WORKFORCE	
07/09.17	**CHAIR REPORT FROM PEOPLE COMMITTEE** It was noted that the incorrect version of the chairs report was presented to the meeting, therefore it was noted that the report was to be circulated following the meeting. ACTION: circulate the people committee chair report to all Board members
07/09.18	**IPR EXCEPTION REPORT – CARING FOR STAFF** The following was exceptions were discussed: ▪ Concerning to see turnover increasing – the Trust confirmed there is further work to be completed to ensure an effective process is in place to become proactive with staff retiring.

	▪ Noted a route and branch review of the people services KPIs is being completed and an overarching action plan to address issues. ▪ Need to ensure the baseline metric are known ▪ Keeping in touch conversations were suggested, the organisation should be supportive of people development and improving – this would support retention ▪ Further information on the workforce plan and the risk of impact on delivering the plan is required ▪ Head of Strategy and Planning is in the process of completing an assessment on the operational plan for the first half of the year. Although it was noted the recruitment risks were aligned to the second half of the year. Further information to be shared at the October strategy meeting ▪ Encouraged the Trust to consider rotation approach with some profession to support training need and the trusts workforce
07/09.19	**FREEDOM TO SPEAK UP UPDATE** SR provided an update on freedom to speak up: ▪ The training has been incorporated into the Board programme ▪ Freedom to speak up champions have been recruited (8 in total). A training/induction day has been scheduled ▪ Champions include a variety of staff from across the organisation in different departments, within different profession ▪ Reinstated a freedom to speak up app to support with collecting information. The app allows you to interact with individuals and remain anonymous ▪ Freedom to speak up report is being reviewed DG queried how will the Trust publicise the champions. SR explained information will be circulated via the communications teams, posters will be created and distributed, and information will be incorporated into the staff training PK highlighted the benefits from system support with having guardians cross cover with partner organisations to which the Board agreed. HT suggested consideration on how to identify the champions is given, for examples those members of staff to have different lanyards.
07/09.20	**GUARDIAN OF SAFE WORKING HOURS (Q1)** The information has been presented to the People Committee throughout the month. RL highlighted the following: ▪ There are a total of 18 junior doctors across the trust which are noted to being treated equally ▪ The safe working hours forum has been reinstated which supports junior doctors ▪ There have been no concerns raised within Q1 The Board congratulated the Trust on the report and were content with the assurance provided.
PERFORMANCE AND GOVERNANCE	
07/09.21	**IPR EXCEPTION REPORT** The following key points were highlighted: ▪ Diagnostics performance is struggling due to the MRI capacity. The Trust are moving towards a 12hour day/7 days a week to meet the demand. There is a potential for the Trust to secure a temporary mobile scanner, however funding is to be secured. ▪ Overdue follow up and backlogs – rheumatology is to be cleared by end of October, Arthroplasty is linked to one consultant and spines activity has increased ▪ Elective activity against plan – risk relate to the anaesthetist workforce, impact from covid and number of cases per session is being reviewed ▪ Bed occupancy – a review is being completed and options are currently being considered regarding length of stay
07/09.22	**LONG WAITERS' PRESENTATION** Following MC's presentation on the long waiters, the Board discussed the following: ▪ Positive information shared relating to the MRI capacity however further assurance was requested on quality and safety. The Trust confirmed the harms review continues and patients are reviewed as part of the process. ▪ Considered the triangulation of the workforce and queried whether the Trust is going to achieve the target. The Trust confirmed that the original operational plan achieved the target, however there is a required to increase the workforce and highlighted the requirement of prioritising patients.

	▪ MC explained that following a revised target, the Trust are to ensure there are no 104-week waiters by the end of October. The Trust have been clear that this target will not be achievable due to the capacity and demand. ▪ It was confirmed that only patients waiting over 104 weeks are complex patients and MSK patients which have been transferred to the Trust. The Trust hope to report that the long waiters will be reduced to spinal patients only ▪ The reputation of the hospital was noted as many patients choose to wait longer to ensure they are cared for by the Trust and not referred to another organisation. The Trust confirmed that it is recording which patients have declined a referral. HT thanked MC and the team for bringing to the Board's attention and for ensuring an increased awareness is noted both internally and externally before asking the Trust to consider what support is required to ensure the best outcomes.
07/09.22	**FINANCE EXCEPTION REPORT** CM highlighted the following relating the Trust finances: ▪ No performance requirement to allocate ERF funding – recognise to covid pressure and challenges ▪ Retrospective claim to ERF funding ▪ Recovery against PP shortfall commenced in July which is expected to continue into August ▪ Noted the issues with activity being on track and impact on the finances – the Trust will continue to inform the Board ▪ A positive performance in July, noted the struggle ahead as H2 approaches HT thanked CM for the update and encourage regular updates to the Board to ensure early oversight and awareness. SN commented on the activity and finances going hand in hand and echoed HT comments for the Board to be made aware of the challenges and risks. PV queried the escalation beds, and the agency core spend before asking how many beds are still open? The Trust confirmed that Sheldon Ward has beds open and are currently trying to reduce to 2 beds highlighting the cost pressure. CM explained the agency spend was recently presented to the Finance, Planning and Digital Committee and agreed to circulate outside of the meeting to all board members. CM confirmed that the agency spend will still be above target if those beds were closed. ACTION: circulate the agency slide from the Finance, Planning and Digital Committee
07/09.23	**CHAIR REPORT FROM FINANCE, PLANNING AND DIGITAL COMMITTEE** The following notes were highlighted to the Board: ▪ Assurance received that the Trust is gaining an understanding on the areas and risks where activity if not being achieved ▪ Focus will continue 104, theatre, outpatient, and the overall impact on finances. Limited assurance has been noted on the papers, but verbal assurance has been gained from MC updated and the shared plan in place to support. The Board noted the Chair's assurance report.
07/09.24	**CHAIRS ASSURANCE REPORT – AUDIT AND RISK COMMITTEE** The following notes were highlighted to the Board: ▪ Policy tracker – limited assurance due to be presentation of the report ▪ Medication incidents have increased and therefore a deep dive has been requested by the Quality and Safety Committee ▪ The Committee agreed that terms of reference for internal audits will be considered at the aligned each assurance committee meeting for awareness and oversight The Board noted the Chairs assurance report.
REFLECTIONS/ANY OTHER BUSINESS	
07/09.25	**QUESTIONS FROM THE GOVERNORS** The Governors thanked the Board and asked the following questions: 1. Staff shortage is a reoccurring theme, is there a an accrue tool used and how does it benchmark against the country? SEA confirmed the Trust use the Shelford nursing toll which is assessed daily along with a safer staffing meeting being scheduled each morning. The trust continues to 97% of safe staffing levels There is further work to be completed by the Trust, noting the requirement to ensure conversations are embedded into the exit process to support with retention of staff. It was noted that there is national staff turnover data available for nursing, where approx. 10-12% however the Trusts needs to measure against specialist organisations.

	2. World class research and world class knowledge is an aspiration. How will you know who have received it? The Trust acknowledged that there needs to be an extension to the baseline to ensure comparison. A review and benchmarking will be considered in time. RL explained that there are some aspects of Research which the Trust already lead on using ACI as an example. The Trust are to establish a new Research and Education Committee which will support.
07/09.26	**QUESTIONS FROM THE PUBLIC** There were no questions shared at the meeting.
07/09.27	**OVERALL BOARD REFLECTION AND COMMENTS** The Board's reflections of the meeting included the following: ▪ Assurance gaining following queries and discussion queries ▪ Great presentation from AR and the importance of supporting him with the new direction for Research ▪ The sections of the IPR are to be separated to support the flow of the meeting ▪ Workforce issues highlighted and awareness of impact on other items is noted ▪ Theme of developing of needing engagement from system ▪ Overall good challenges and support noted ▪ Noted; policies tracker to be aligned to the Committees
FOR INFORMATION ONLY	
07/09.28	**CLOSING REMARKS:** *Thank you to Shelley* On behalf of the Trust, HT thanked SR for her wise council and support over the years adding a personal thanks in relation to supporting with embedding risk management into the organisation, being a key link to the Governors. SR has been completing a joint post with Shropshire Community Trust as the Director of Governance and will commence her role full time as of October 2022. HT thanked everyone for attending the meeting and for their contribution in the discussion.
NEXT PRIVATE MEETING: 02 NOVEMBER 2022	

BOARD OF DIRECTOR – PRIVATE MEETING
07 SEPTEMBER 2022
SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Meeting – September 2022		
CEO Update The Green Plan video to be circulated to all Board Members	Trust Secretary	Completed – circulated following the meeting
Board Assurance Framework To be tabled for discussion at the next private board meeting	Trust Secretary	Completed – added to the agenda for October.
Chairs Report – People Committee Circulate the people committee chair report to all Board members	Trust Secretary	Completed – circulated following the meeting
Finance Performance Circulate the agency slide from the Finance, Planning and Digital Committee	Chief Finance and Planning Officer	Completed – circulated following the meeting

Mr C Marquis

Guardian of Junior Doctors Working Hours

NHS Employers

Why do we need a guardian?

- Current twice-yearly monitoring mechanism mean it is not a good measure of rota safety
- Penalty bandings mean that health and safety issues are unhelpfully conflated with pay, preventing issues from being resolved
- BMA, DH and NHS Employers all agreed a new system was needed – and a system of work scheduling and exception reporting was agreed in 2013/14 negotiations
- Junior doctors concerned that employers would not act on exception reports
- It was agreed that there should be an independent person responsible for championing safe working hours

NHS Employers

The guardian will:

- Champion safe working hours
- Attend induction to explain their role to the doctors
- 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
- Provide assurance on safe working and compliance with TCS

NHS Employers

The guardian will not:

- Design rotas
- Manage individual work schedules
- Act as the educational champion
- Review every aspect of doctors' working patterns
- Intervene in every exception
- Agree working patterns or schedules with individual doctors
- Answer questions which fall outside their remit - though should know where to direct the doctor for further help (e.g. medical staffing or the BMA)

NHS Employers

Distinction between roles

- The guardian is not responsible for education and training, this remains the role of the DME.
- The guardian is not responsible for the line management of junior doctors (unless this was already part of their separate role as a clinical/educational supervisor).
- The guardian role does not replace the role of educational supervisors.
- The guardian of safe working hours should not be confused with other guardian roles such as the Caldicott guardian or Freedom to Speak up guardian.

Junior doctors
2018 contract refresh

NHS Employers
Part of the NHS Confederation

Rota rules at a glance

The below table highlights the rota rules outlined in the terms and conditions of service (TCS) and provides further notes for employers on each rule. For full details please refer to schedule 3 of the TCS.

Rule	Notes
Max 48 hour average working week	A guardian of safe working hours fine will apply if this rule is breached
Max 72 hours work in any consecutive period of 168 hours	A guardian of safe working hours fine will apply if this rule is breached
Max 13 hour shift length	On-call periods can be up to 24 hours
46-hours of rest required after any number of rostered night shifts	
Max 4 consecutive long shifts*, at least 48 hours rest following the fourth shift	Long shift (a shift rostered to last longer than 10 hours)
Max 4 consecutive long daytime/evening shifts, at least 48 hours rest following the fourth shift	Long evening shift: a long shift starting before 16.00 rostered to finish after 23.00 (a long shift starting after 16.00 will fall in to the definition of a night shift)
Max 4 consecutive night shifts. At least 46 hours rest following the third or fourth such shift	Night shift: at least 3 hours of work in the period 23.00 to 06.00. Rest must be given at the conclusion of the final shift, which could be the third or fourth
Max 7 consecutive shifts* (except on low intensity on-call rotas), at least 48 hours rest following the final shift	Low intensity on-call: duty on a Saturday and Sunday where 3 hours, or less, work takes place on each day, and no more than 3 episodes of work each day. Up to 12 consecutive shifts can be worked in this scenario provided that no other rule is breached
Max frequency of 1 in 3 weekends can be worked	Weekend work (any shifts/on-call duty periods where any work falls between 00.01 Saturday and 23.59 Sunday) Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working.
Normally at least 11 hours continuous rest between rostered shifts (separate on-call provisions below).	Breaches of rest subject to time off in lieu (TOIL) which must be given within 24 hours. In exceptional circumstances where rest is reduced to fewer than 8 hours, time will be paid at a penalty rate and the doctor is not expected to work more than 5 hours the following day. A guardian of safe working hours fine will apply in this circumstance

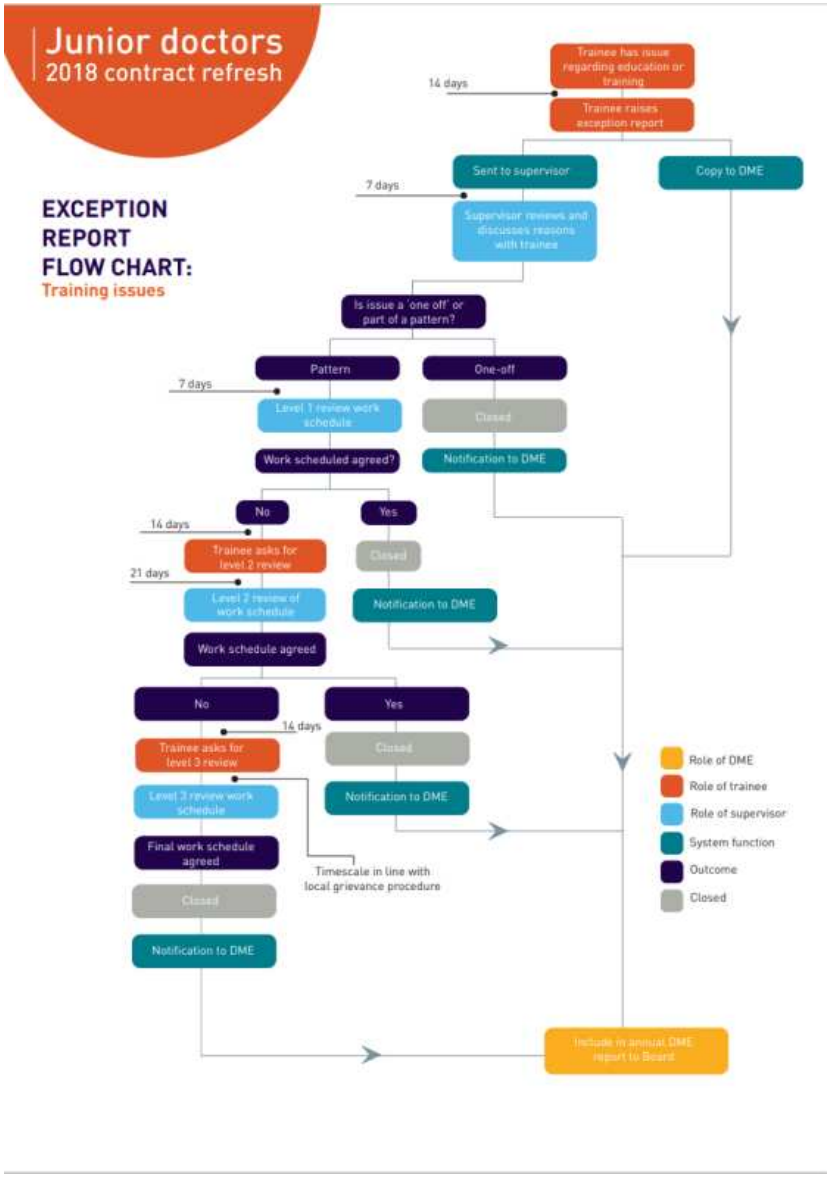
30 minute break for 5 hours work, a second 30 minute break for more than 9 hours A third 30-minute paid break for a night shift rostered to last 12 hours or more	A guardian of safe working hours fine will apply if breaks are missed on at least 25 per cent of occasions across a 4 week reference period. Breaks should be taken separately but if combined must be taken as near as possible to the middle of the shift
Specific to on-call working patterns	
No consecutive on-call periods apart from Saturday & Sunday. No more than 3 on-call periods in 7 consecutive days	A maximum of 7 consecutive on-call periods can be agreed locally where safe to do so and no other safety rules would be breached; likely to be low intensity rotas only
Day after an on-call period must not be rostered to exceed 10 hours	Where more than 1 on-call period is rostered consecutively (e.g. Saturday/Sunday), this rule applies to the day after the last on-call period
Expected rest while on-call is 8 hours per 24 hour period, of which at least 5 hours should be continuous between 22.00 and 07.00	If it is expected this will not be met, the day after must not exceed 5 hours. Doctor must inform employer where rest requirements are not met, TOIL must be taken within 24 hours or the time will be paid. A guardian of safe working hours fine will apply in this circumstance.
No doctor should be rostered on-call to cover the same shift as a doctor on the same rota is covering by working a shift	Unless there is a clearly defined clinical reason agreed by the clinical director and the working pattern is agreed by both the guardian and the director of medical education

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

NHS Employers

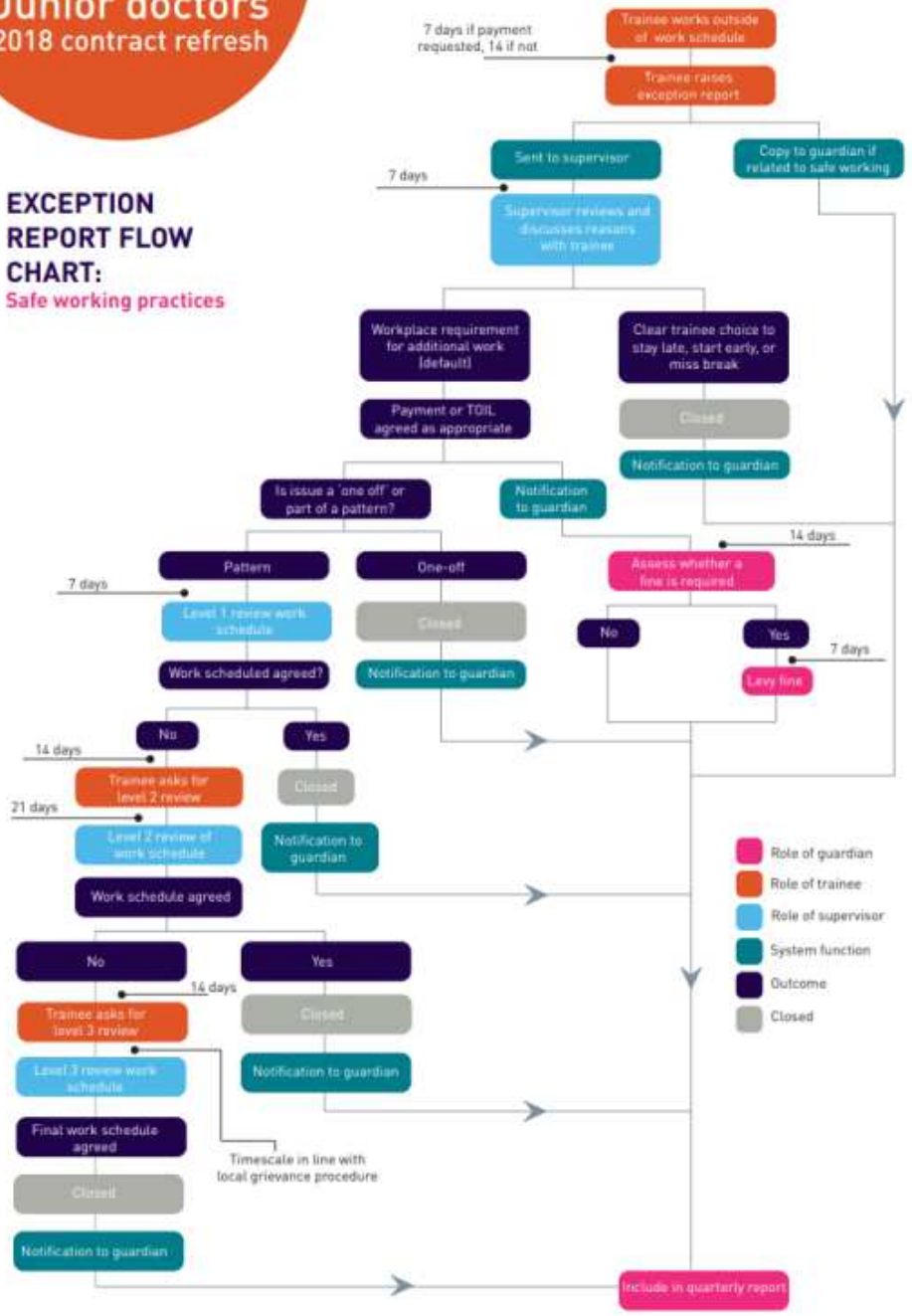
Exception reports

- Doctors should report exceptions where day-to-day work varies from that set out in the work schedule.
- They must be submitted within
  - 14 days (standard)
  - 7 days if payment is requested
  - 24 hours where there are immediate safety concerns
- Any issues should at first be addressed by the clinical or educational supervisor, to establish whether this is truly exceptional or whether it requires a work schedule review.
- The guardian of safe working hours will be able to view all exception reports.


Junior doctors
2018 contract refresh
EXCEPTION REPORT FLOW CHART:
Training issues
Trainee has issue regarding education or training
14 days
Trainee raises exception report
Sent to supervisor
Copy to DME
7 days
Supervisor reviews and discusses reasons with trainee
Is issue a 'one off' or part of a pattern?
Pattern
One-off
7 days
Level 1 review work schedule
Closed
Work scheduled agreed?
Notification to DME
No
Yes
14 days
Trainee asks for level 2 review
Closed
21 days
Level 2 review of work schedule
Notification to DME
Work schedule agreed
No
Yes
14 days
Trainee asks for level 3 review
Closed
Level 3 review work schedule
Notification to DME
Final work schedule agreed
Timescale in line with local grievance procedure
Closed
Notification to DME
Include in annual DME report to Board
Role of DME
Role of trainee
Role of supervisor
System function
Outcome
Closed

Junior doctors
2018 contract refresh

EXCEPTION REPORT FLOW CHART:
Safe working practices



NHS Employers

Quarterly reporting

- The Board and LNC 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
  - Data on rota gaps
  - Data on locum usage
  - Other data deemed to be relevant by the guardian
  - A qualitative narrative highlighting areas of good practice and / or persistent concern

NHS Employers

Data for quarterly reporting

Data will be gathered from sources such as:

- Exception reporting system
- Vacancy reports
- Locum usage report
- Qualitative feedback from the junior doctor forum

NHS Employers

Other reporting processes

- The guardian may identify issues which cannot be resolved at a local level, and should inform the Board of such issues as they arise.

- The Board will produce a consolidated annual report on rota gaps and the plan for improvement, and is responsible for providing this to external national bodies

NHS Employers

The employer's responsibility

1. Ensure sufficient time allocation (e.g. sufficient PAs in the job plan if a consultant/SAS doctor)
2. Ensure appropriate admin support to manage flows of exception reports and other information
3. Agree reporting cycle, liaison with LNC etc
4. Establish junior doctor forum to advise the guardian

The guardian's first report should inform the board whether the above actions have been implemented appropriately.

Any Questions?

0. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	2 November 2022
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	28 October 2022
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an 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

1. Adult Inpatient Survey

I think the biggest piece of news since the last public Board of Directors meeting is the publication of the results of the Adult Inpatient Survey.

The survey, which is produced annually by the Care Quality Commission, is based on feedback from more than 1,200 RJAH patients who stayed at our hospital for at least one night in November 2021.

The highlights of the survey were:

- Overall patient experience was rated best in the country, with an average mark of 9.41 out of 10
- The hospital's wards and rooms were ranked as the cleanest in the country for the third year in a row
- Patients rated our food as the best too – for the 16th time in the last 17 years
- We also scored in the top five for helping patients stay in touch with friends and family while visiting restrictions were in place during the pandemic.

2. Snowpaedic Challenge

I pledged to don my walking boots and took part in the annual charity sponsored walk, a nine mile hike up Mount Snowdon dubbed as the Snowpaedic challenge raising funds for the Orthopaedic Institute, a dedicated research and education charity. It was a great day, with the opportunity to spend time with staff and previous patients of the Trust. Well done to all those that took part.

3. London Marathon 2022

On the 2nd October, I joined fellow RJAH runners to run the 26.2 mile London Marathon in aid of RJAH charities! A truly remarkable day and huge congratulations to all that took part. We will be marking the occasion and communicating the total amount raised shortly.

4. Recognition in the NOA Awards

I'm delighted to report that RJAH won two awards at the National Orthopaedic Alliance (NOA) Excellence in Orthopaedics Awards. The winners were:

- The RJAH Green Plan in the Working Towards Net Zero – Greener NHS category;
- Path of Positivity in the Staff Wellbeing Initiative category

Congratulations to both our winners! I must also say a big well done to the myrecovery project team who were a finalist in the Patient Engagement – Supporting Patient Wellbeing category.

5. NOA Annual Conference

The National Orthopaedic Alliance (NOA) Annual Members' Conference was held in Birmingham on 19 October 2022. It was an impactful learning and networking opportunity for the orthopaedic community with over 100 guests in attendance.

The day's sessions were not only of interest to clinicians and specialist Trusts but covered the entire orthopaedic spectrum and included a wide range of topics – from the national MSK strategy, shared decision making and women in orthopaedics to data collection, orthopaedic surgical hubs, waiting lists and so much more.

6. RJAH named Quality Data Provider

The Trust received this recognition for the fourth successive year from the National Joint Registry (NJR). The NJR collect high-quality, orthopaedic data to support patient safety, quality of care and cost-effectiveness in joint replacement surgery.

7. English Veterans Awards

Our consultant Lt Col Carl Meyer, was named Reservist of the Year at the English Veterans Awards. Our Veterans Orthopaedic Service won the Health and Wellbeing Award at the same ceremony. We were unable to attend the awards to collect them in person, so are aiming to arrange a special presentation in the near future.

8. Supporting our Staff

We have been looking for ways we can further support our staff in the cost-of-living crisis, as well as boosting staff morale. We've taken a number of steps to support this, including free tea, coffee and milk for all wards and departments so staff can have hot drinks while at work.

Our most recent initiative is the introduction of free porridge, or two slices of toast, at breakfast time and a specific £2 meal at lunch times. We hope these small things can make a difference to our staff, both at work and at home.

9. Togetherness Week

During the last public Board Meeting, we were busy celebrating Togetherness Week, something we planned instead of our traditional awards as a way of recognising all of our staff for their hard work. There was a range of activities and competitions for staff to get involved with throughout the week.

However, due to the passing of Her Majesty Queen Elizabeth II, we had to postpone events taking place on final day of Togetherness Week. In October, we finished celebrations including announcing winners of our competitions and holding pizza fortnight for all our staff.

10. NHS National Leadership event

On the 13th October I attended a NHS National Leadership event in London for ICB and Trust Chief Executive Officers (CEO). The purpose being to hear from the Amanda Pritchard and the National Directors and to build on the progress made at the first event in April. The event provided further opportunity to work together as a single leadership team on the immediate priorities and longer-term strategic issues for the NHS. The agenda included,

elective and cancer recovery, discharge, workforce, and the newly published NHS England Operating Framework.

11. Electronic Patient Record (EPR) implementation

Simon Adams, Digital Director and I had met with Dr Timothy Ferris, National Director of Transformation on the 7th October; an informative meeting that enabled us to give a progress report in relation to our Electronic Patient Record (EPR) implementation and discuss further convergence of EPRs across systems.

12. League of Friends and RJAH Charity fund wheelchair accessible vehicle

Thank you to both our League of Friends and RJAH Charity who jointly funded the purchase of a wheelchair accessible vehicle, costing more than £37,000, for patients on the Midland Centre for Spinal Injuries.
The vehicle allows the team to take patients out, whether that's trips to local shopping centres, garden centres or sporting venues, all as part of their rehabilitation.
I was lucky enough to meet paediatric patient Riley Jarvis, and his dad Rhys, who have already used the adapted car. He was telling me how much fun he had being out and about again, which was lovely to hear.

13. League of Friends sign Armed Forces Covenant

Our League of Friends recently pledged their support to those who serve and have served in military roles, by signing the Armed Forces Covenant.
The Covenant was signed on behalf of the charity by Chairman Peter David and representing the Armed Forces was Lieutenant Colonel Carl Meyer, Consultant Orthopaedic Surgeon and Clinical Lead for the Veterans' Orthopaedic Service. The hospital signed the Covenant back in 2017.

14. Health Hero Award

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

- September's winner of the Health Hero Award was Gill Edwards, Cook, who was nominated by our ORLAU Manager Caroline Stewart for ensuring a diverse menu is offered for various dietary requirements in our hospital restaurant, Denbigh's.
- Our October winner was Melanie Roberts, Rheumatology Booking Clerk. Melanie received three nominations which hailed her for "showing incredible resilience, fortitude and kindness" after a colleague was signed off on sickness leave.

Congratulations to Gill and Melanie!

4.0. Conclusion

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

0. Reference Information

Author:	Sara Ellis-Anderson. Chief Nurse and Patient Safety Officer	Paper date:	2nd of November 2022
Executive Sponsor:	Sara Ellis-Anderson. Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Executive Team Meeting	Paper Ref:	N/A
Forum submitted to:	Trust Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The report is presented to the Board for information and ensure oversight of the Trusts current live 15+ rated risks, mitigations and actions being taken.

2. Executive Summary

2.1. Context

There are 8 finally approved live risks with a rating of 15 or more on the Trusts corporate risk register.

Each risk is reviewed by the Unit's that the risk is aligned to monthly and has an Executive owner for oversight.

This report covers the period 01 September 2022 to 31st of October 2022.

2.2. Summary

- 1 risk has a rating of 20 (2653) relating to Theatre staffing and impact on operational delivery
- There has been 1 new risks registered with a rating of 15+ since the last report relating to potential Industrial Action
- Risk 2793 – provision of Consultant Microbiologist has increased due to current Consultant Microbiologist being off sick
- Several risks have been reduced to a residual rating below 15 since the last report with mitigations in place
- Process for reviewing and agreeing 15+ high risks through Trust Performance and Operational Improvement Board agreed

3. Conclusion

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

3. The Main Report

Datix ID	Title	Directorate	Risk Owner	Handler	Hazard, work task, activity	Existing Control Measures (mitigations)	Likelihood	Consequence	Rating (Residual)	Risk Level	Risk treatment plan/mitigations being taken	RAM - Committee	Date of assessmen	Date of review (1)
2993	Registered Nurse unavailability impacting safe staffing levels	Corporate Services	Ellis Anderson, Sara	Foskett, Kirsty	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	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.	People Committee	31/10/2022	31/10/2022
1742	Lack of autonomy to make organisational investments	Corporate Services - FINANCE	Macbeth, Craig	Salisbury, Mark	Due to ICS financial deficit the finacial framework requires all investments to be proritised and agreed by an ICS investment panel.	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.	Finance Planning & Digital Committee	20/07/2017	06/06/2022

2653	Theatre staffing- Impact of staffing levels to meet activity	MSK - MAIN THEATRES	Ellis Anderson, Sara	Flood, Rachael	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.	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)	5 - Almost Certain	4 Major	20	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. This includes 10% over-recruitment to enable/increase resilience.	People Committee	26/04/2021	31/10/2022
2911	FPD - Consultant & Anaesthetist Workforce recruitment dependencies and ongoing reliance on flexible workforce	MSK - UNIT RISK (Risk Register Only)	Mike Carr	Humphreys, Yvonne	FPD - Consultant & Anaesthetist Workforce recruitment dependencies and ongoing reliance on flexible workforce -could impact on delivery of the 2022/23 Operational plan -	Consultant recruitment Project Group established and meeting fortnightly	4 - Likely	4 Major	16	High	Sustainability plans through consultant recruitment 6.5 WTE consultant recruitment planned in 2022/23.	Finance Planning & Digital Committee	16/05/2022	31/10/2022
2913	FPD - System pressures necessitating future mutual aid support	MSK - UNIT RISK (Risk Register Only)	Mike Carr	Humphreys, Yvonne	FPD - System pressures necessitating future mutual aid support could impact on delivery of the 2022/23 Operational plan	System Sliver and Gold call oversight for decision making around system support requirements	4 - Likely	4 Major	16	High	Impact seen in Month 1 with activity reduction through provision of mutual aid. Protected services and delivery of activity for patients over 90 weeks to be maintained during mutual aid support.	Finance Planning & Digital Committee	16/05/2022	10/08/2022

2793	Provision of Consultant Microbiologist at RJAH	Specialist - HISTOPATHOLOGY	Mike Carr	Evans, Pat	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.	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.	Quality and Safety Committee	18/10/2021	31/10/2022
2633	Backlog of spinal disorders patients waiting 52+ weeks	Specialist - SPINAL DISORDERS	Mike Carr	Groome, Fran	Risk identified at Delivery Board 12/02/2021. Delays caused by Covid-19 pandemic have increased the backlog of spinal disorders patients waiting 52 weeks or more for treatment. Requires full engagement from a range of surgeons to address.	Clinical Chair and Ops Manager working on a plan, patients are being offered the choice to transfer to Stanmore for sooner surgery. Working with consultants to increase capacity and utilise gaps where possible. AHP is contacting patients who have been identified as having potential to come to harm and where necessary arranging urgent reviews with consultants - risk is still high due to the volume of patients to contact and assess	4 - Likely	4 Major	16	High	Clinical Chair and Ops Manager working on a plan 12/02/21 09/08/21 AHP being recruited to lead on HARMs reviews for all those outstanding reduce backlog by increasing IJP capacity with new appointments and fully utilising current capacity. Mutual aid being utilised.	Quality and Safety Committee	12/02/2021	28/09/2022
NEW RISK	Potential industrial action	Corporate Services - TRUSTWIDE	Denise Harnin	Andrea Martin	NHS trade unions are currently conducting either an indicative or statutory ballot to assess the level of support of their membership for strike action and action short of full strike action. The impact of this unavailability of staff is currently unknown but is a risk to patient safety and experience if activity is stood down as a result.	EPRR meetings in place for business continuity plans Safer staffing escalation SOP in place Clinical Prioritisation process in place	4 - Likely	4 Major	16	High	EPRR meetings in place to assess and monitor operational impact Communications to staff and patients to be developed when further detail is known	People Committee	31/10/2022	31/10/2022

0. Reference Information

Author:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper date:	2nd of November 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	31st of October 2022
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 progress is slower than anticipated across the organisation with several actions being taken to encourage uptake.
- October was Freedom to Speak Up Month introducing our FTSU champions and an opportunity to raise awareness making speaking up business as usual across the organisation
- 2021 Adult Inpatient Survey results were published, overall, we have again 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.
- October saw the return of our PLACE audits; overall feedback was positive with all wards have either maintained or improved their overall score from 2019.
- Patient Safety Incident Response Framework implementation plan launched with key stakeholder training sessions and focus groups.

2.3. Conclusion

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

3. The Main Report

3.1. Covid/Flu Vaccination programme

We've started out flu and covid booster campaigns on the 19th of September. Weekly reporting for the 26th of October gave 39.5% uptake for Flu and 38.6 % for Covid Booster overall. Flu uptake is approximately 10% lower than this time last year. Staff are being reminded via several communication channels on the importance of staying well this winter by having the vaccine. The vaccination hub is open to all staff and there is a peer vaccinator system in place.

3.2. Freedom to Speak Up Month

Freedom to Speak Up (FTSU) Month takes place every year in October and is our opportunity to raise awareness and make speaking up business as usual across the organisation. This year gave us the opportunity to introduce our eight FTSU champions, a new role to the organisation that supports our FTSU Guardian and promotes the FTSU values of Courage, Impartiality, Empathy and Learning.

3.3. 2021 CQC Adult Inpatient Survey

The Adult Inpatient Survey is produced annually by the Care Quality Commission. Over 1,200 RJAH patients were invited to take part following an inpatient stay in November 2021 and we had a response rate of 72% (national average is 39%).

Highlights from the report:

- We were placed in the top band of Trusts for delivering results that are “much better than expected” in 42 out of 46 questions
- We were classed as “much better” for medical care and surgery
- 81% of all responses were positive – which is the best figure nationally
- Scored top for overall patient experience – with an average mark of 9.41 out of 10
- Patients rated the food in the hospital the best – for the 16th time in the past 17 years
- Wards and rooms were ranked the cleanest for the third year in a row
- Scored in the top five of all Trusts in England for helping patients stay in touch with friends and family through the covid pandemic, when visiting restrictions were in place

3.4. Patient Led Assessments of the Care Environment (PLACE)

October also saw the return of our Patient Led Assessments of the Care Environment (PLACE), these assessments had been paused during the pandemic and although the organisation continued to conduct ‘mini’ PLACE audits we valued having our patients joining us for the full assessment on the 19th of October.

Initial findings saw all wards have either maintained or improved their overall score from 2019. Improvements were noted in the environment’s condition and appearance overall, however the Trust did see a drop in scores related to the disability/dementia domain with a theme for improvement around signage throughout the site. Sheldon Ward was noted as having very good signage examples so there is an opportunity to replicate this elsewhere in the Trust.

3.5. Patient Safety Incident Response Framework (PSIRF) Implementation

Our Patient Safety Specialists have started our Patient Safety Incident Response Framework (PSIRF) implementation plan over the next 12 months - this forms part of the NHS Patient Safety Strategy and sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents (PSI's), for the purpose of learning and improving patient safety. Replaces SIF as we know it today. The implementation plan involves training sessions and focus groups that started in October.

3.6. Conclusion

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

Appendix 1: Acronyms

Acronym	Full text
Acronym	Full text
Acronym	Full text

Trust Board - Quality & Safety
September 2022 – Month 6

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)

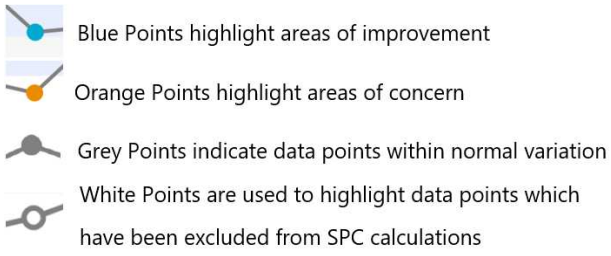
Different colours have been used to separate these trends of special cause variation:

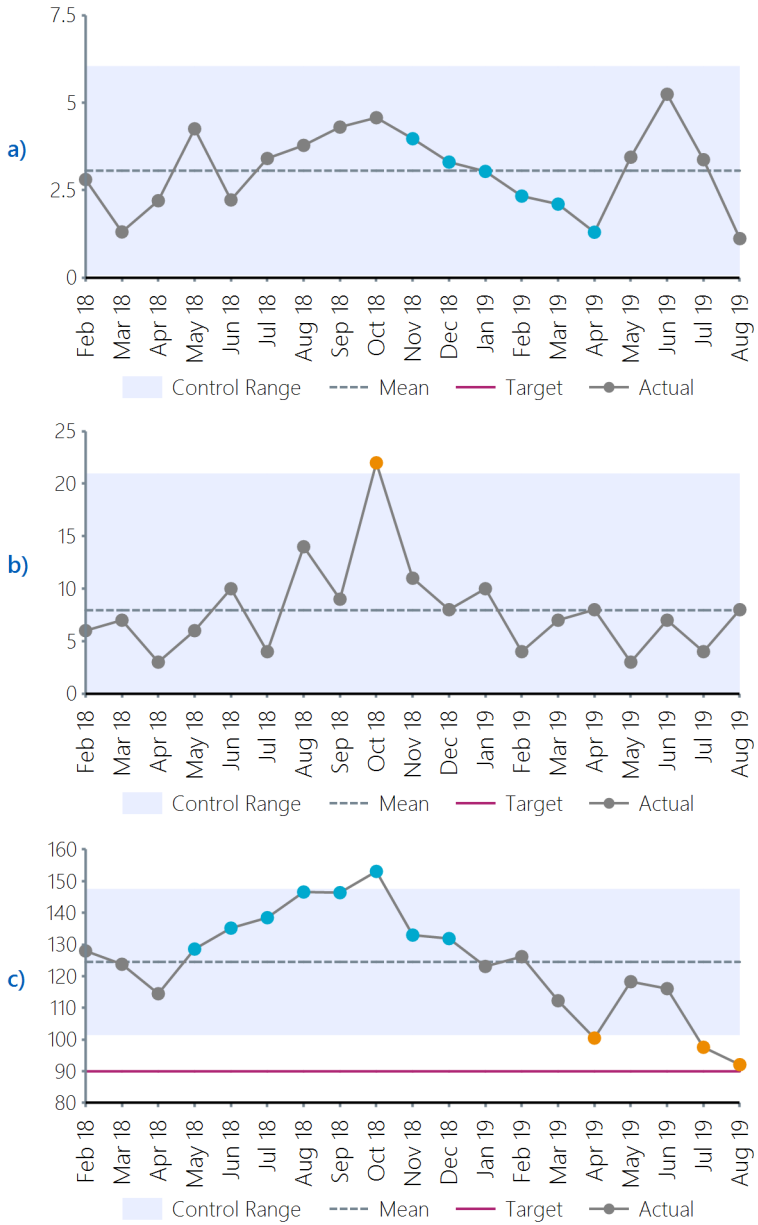
Some examples of these are shown in the images to the right:

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		
Never Events	0	0		N/A to SPC	?		16/04/18
Number of Complaints	8	4			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	?		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	?		
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		24/06/21
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	2		N/A to SPC	?	+	16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P		

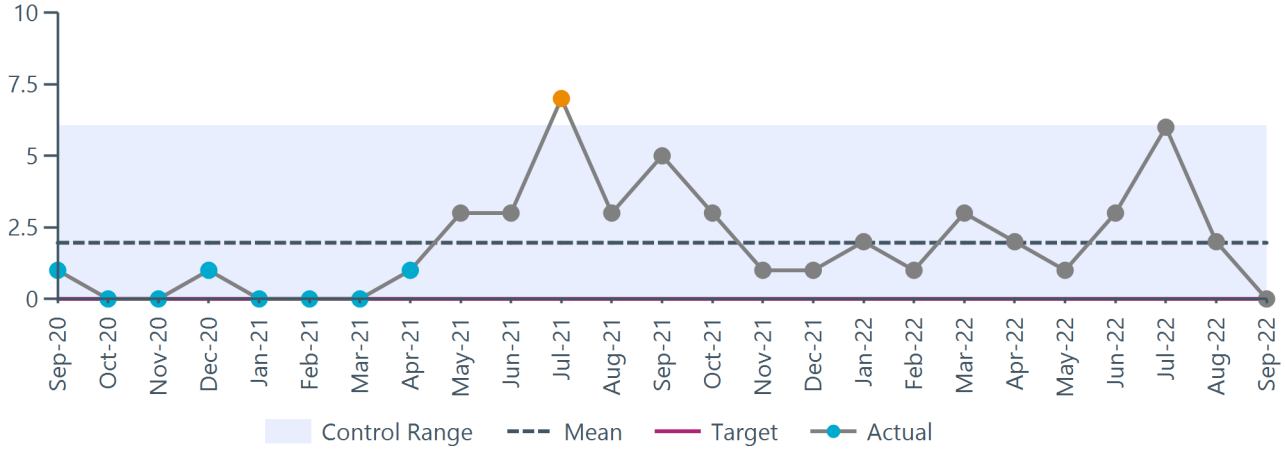
Surgical Site Infections

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

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 October-21 to September-22, there have been 25 surgical site infections. There were four additional infections confirmed in September relating to a procedures that took place in July (3) and August (1). A data quality check has been carried out with the IPC team to ensure the latest twelve month period is reported correctly.

For the latest complete quarters a breakdown as follows:
- January 22 to March 22 - 6 SSIs with all Post Infection Reviews Complete
- April 22 to June 22 - 6 SSIs with all Post Infection Reviews Complete
- July - September 22 - 8 SSIs - as at 30th September 2022 7 Post Infection Reviews due to take place within 30 days of confirmation at MDT

Actions

Actions in this area are:
- SSI prevention working group progressing action plan related to One Together Audit. Plan to repeat One Together Audit in quarter 3.
- SSI team attending regional SSI collaborative
- Expansion of surveillance and timescales being presented at IPCQAC
- MSSA decolonisation of all patients due to commence quarter 3

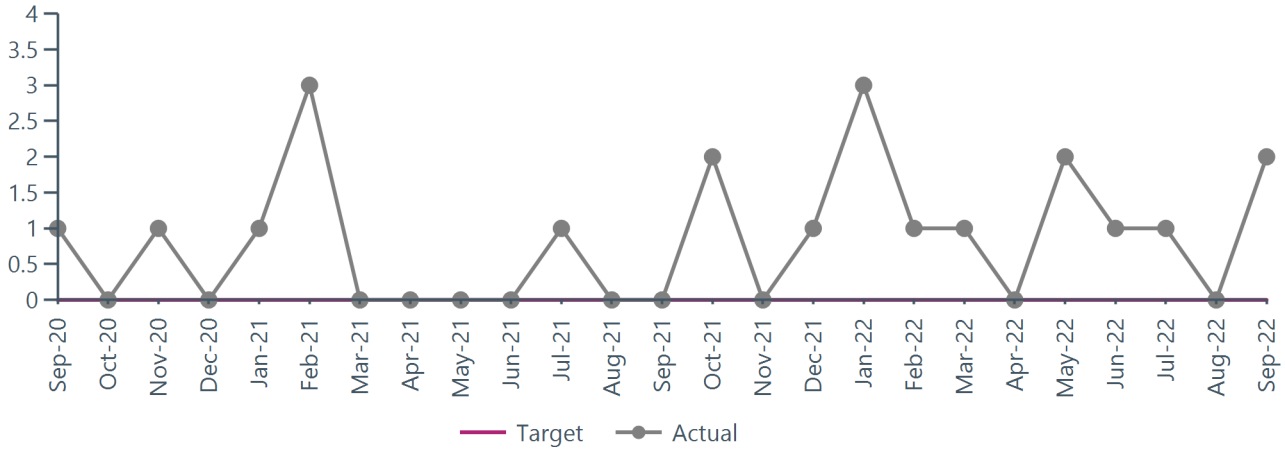
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
5	3	1	1	2	1	3	2	1	3	6	2	0

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

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



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

There were two deaths within the Trust in September, categorised as follows; expected death (1) and unexpected death (1).

Actions

An initial fact finding exercise has taken place for the unexpected death with no issues to raise.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
0	2	0	1	3	1	1	0	2	1	1	0	2

- Staff - Patients - Finances -

Reference Information

Author:	Ashling Donohoe-Harrison, Governance Lead	Paper date:	02 November 2022
Executive Sponsor:	Sara Ellis Anderson, Chief Nurse and Patient Safety Officer	Paper Category:	Governance
Paper Reviewed by:	Quality and Safety Committee 22/09/22	Paper Ref:	N/A
Forum submitted to:	Board of Directors - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

To inform the Board of near miss incidents reported in the last financial year and any themes or trends which have stemmed from this.

2. Executive Summary

2.1. Context

Near Miss - *"Today's near miss could be tomorrow's incident"*

Reporting near misses as well as actual incidents is an important step in embedding safety awareness and improving the safety culture of the Trust. Near misses can provide Trusts with valuable information and help identify patterns of near misses, an early indication that something may need attention before an incident occurs

2.2. Summary

The Trust encourages staff to report near miss incidents, both clinical and non-clinical via the incident reporting system, Datix. This report provides a summary on those incidents for the financial year 2021 - 2022.

- There has been a total of 86 near miss incidents reported in 2021/2022, which is a decrease of 96 incidents compared to the previous financial year.
- Most near miss incidents relate to medication incidents and patient diagnostics/imaging incidents with 12 reported in each category in the last financial year.
- There has been an overall decrease in the total number of incidents reported across the Trust in the last two financial year because of the decrease in activity due to Covid-19.

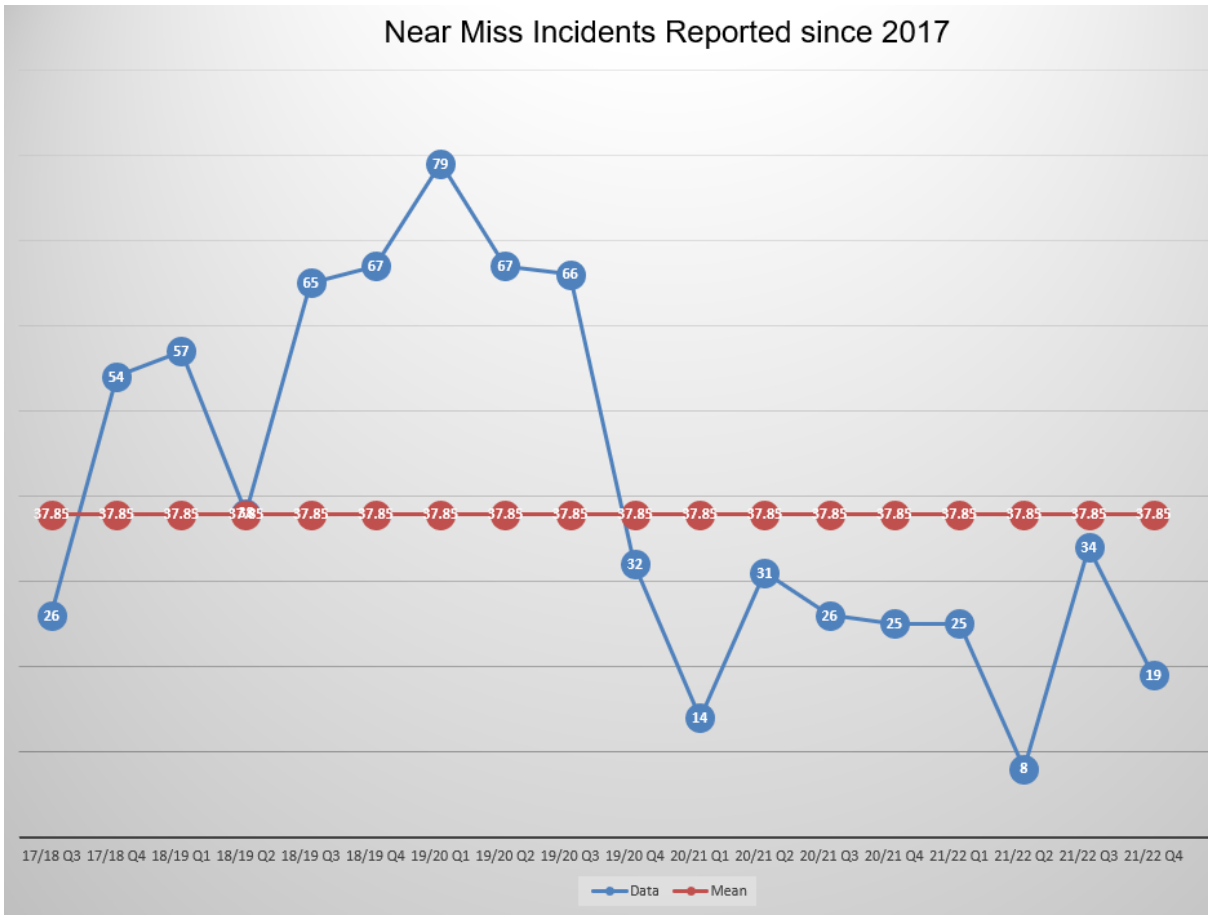
2.3. Conclusion

The Board is asked to note the reporting position on near miss incidents

3. The Main Report

3.1. Introduction

Since the introduction of the near miss categories in 2017, there has been a total of 757 incidents reported.

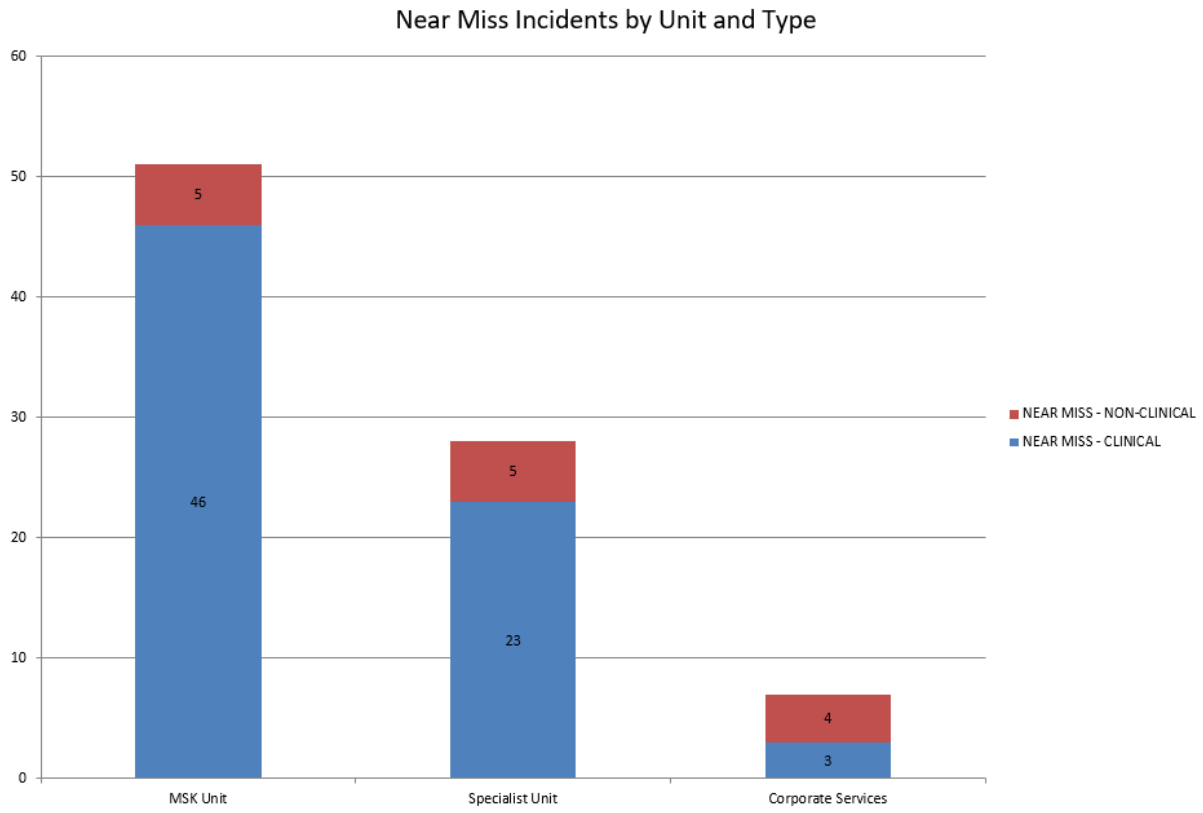


There has been a total of 86 near miss incidents reported in 2021/2022, which is a decrease of 96 incidents compared to the previous financial year.

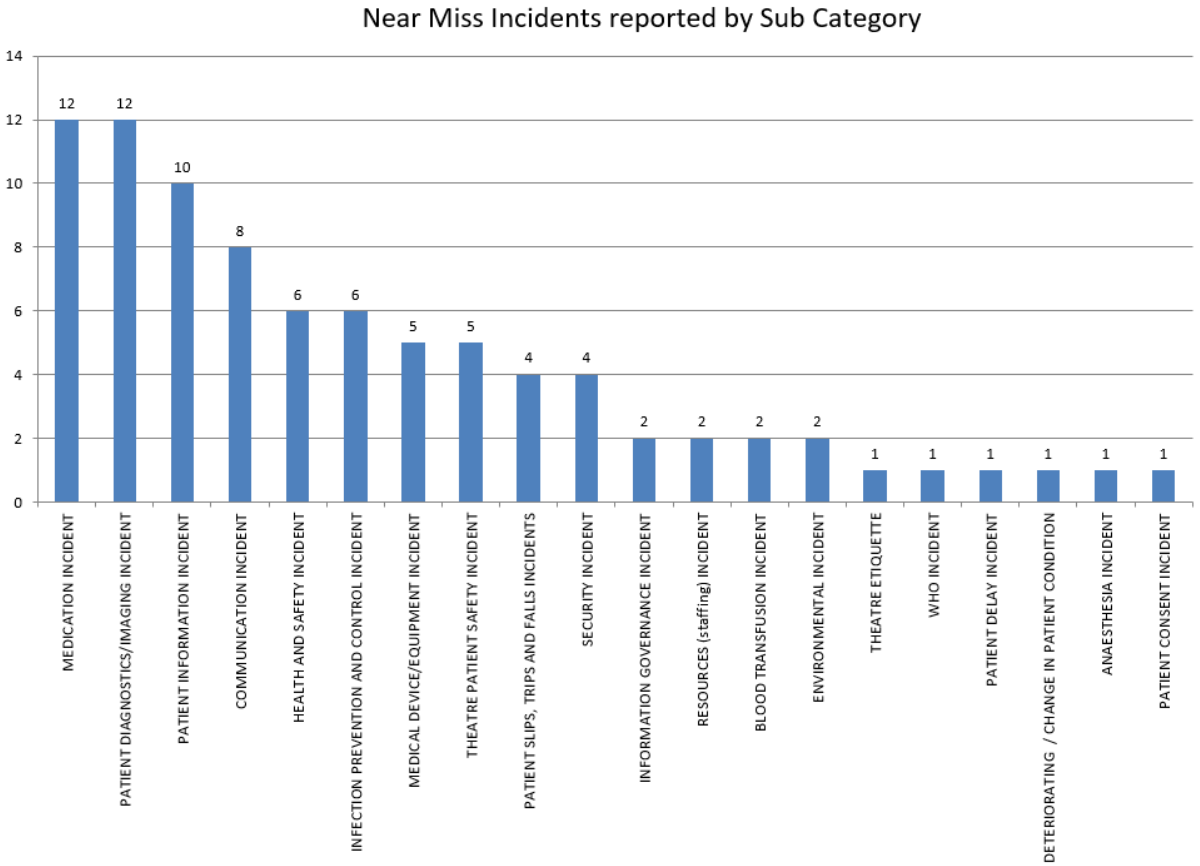
In 2021/2022 3% of the all the incidents reported were near miss incidents compared to 5% of the total incidents in 2020/2021.

There has been an overall decrease in the total number of incidents reported across the Trust in the last two financial year because of the decrease in activity due to Covid-19.

The chart below shows the distribution of near miss reporting across the Trust:



Near misses are recorded in categories, just as incidents are, allowing the Trust to build a picture of where to take action to avoid harm. The graph below shows a breakdown of near



miss incidents by category.
Most miss incidents relate to medication incidents and patient diagnostics/imaging incidents with 12 reported in each category in the last financial year.

There were 12 near miss medication incidents reported in 2021/2022 which is a decrease of 8 incidents reported compared to 20 near miss medication incidents reported in 2020/2021.

There were 12 near miss diagnostic/imaging incidents reported in 2021/2022 which is an increase of 10 incidents when compared to the 2 near miss diagnostic/imaging incidents reported in 2019/2021.

4. Conclusion

The Committee is asked to review the report, note the content and actions, and give feedback on any areas of concern.

0. Reference Information

Author:	Ian Gingell Health and Safety Manager	Paper date:	02 November 2022
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee 22/09/22	Paper Ref:	N/A
Forum submitted to:	Trust Board - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

The purpose of the paper is to give assurance to the Board that patient safety alerts are being managed and actioned appropriately.

The Committee is asked to note the content of the paper.

2. Executive Summary

2.1. Context

The paper documents the safety alerts received by the Trust and details the management process for both safety alert and field safety notices.

2.2. Summary

46 safety alerts were received between 01/04/21 and 31/03/22 of which 11 were National Patient Safety Alerts.

All relevant actions were completed within deadline.

No audit is undertaken to confirm ongoing compliance

2.3. Conclusion

The Board is asked to note the content of the paper and the need to embed an audit process to confirm ongoing compliance with safety alert requirements.

3. The Main Report

3.1. Introduction

The National Patient Safety Alerting Committee (NaPSAC) ensures that all National Patient Safety Alerts set out clear and effective system-wide actions that the Trust must take on critical patient safety issues.

The NaPSAC have developed and agreed common standards and thresholds for National Patient Safety Alerts to align all organisations that issue national alerts.

The Trust is committed to managing all safety alerts in a timely and efficient manner with completion of all actions prior to deadline dates.

3.2. Safety Alert Management Process

Safety alerts originate from the Department of Health Central Alerting System (CAS) and are received by the Trust via the 'Medical Devices Safety Officer (MDSO)' mailbox.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts that are distributed include Estates Safety Alerts, Chief Medical Officer Messages, MHRA Drug Alerts, and Medical Device Alerts.

The Health and Safety Advisor undertook the role of CAS Liaison Officer and Medical Devices Safety Officer within the 0.4 WTE provision and was responsible for overall management of the CAS process. Invaluable assistance in administering the alerts was received from the Estate's Premises Assurance Model Manager.

Progress towards completion of alert actions was monitored by relevant Committees and overall progress was monitored by the Health and Safety Committee. Executive approval was sought before the Health and Safety Advisor formally signed alerts off via the web portal. The Trust received a total of 46 safety alerts through CAS in 2021/22, all of which were either actioned within their respective deadlines or with actions planned to meet their deadlines.

All medicine related alerts were forwarded to, and managed by, the Chief Pharmacist and the Medicines Safety Officer in accordance with an approved 'Medicines Related Alert/Recall Process' flowchart.

Permission to sign off an alert as completed will be requested by the CAS Liaison Officer from the Health and Safety Committee (or other relevant formal committee if deadline would be breached by waiting for next Health and Safety Committee). Permission to sign off an alert may also be given by any Executive Director.

All formal National Patient Safety Alerts (NPSA) require Executive approval for sign-off as completed or not relevant. The Trust complied with this requirement for all NPSA alerts in 2021/22.

3.2.1. Field Safety Notices and Supply Disruption Alerts

Field Safety Notices (FSNs) are issued
directly from manufacturers or suppliers and relate to alerts, recalls and safety information of drugs and medical devices. Field Safety Notices sit outside of the CAS alerting system.

The Trust typically receives FSNs either by direct communication from a manufacturer, via NHS Supply Chain or Medical Engineering.

The process for distribution and compliance with the notices is similar to that of CAS alerts, with responsibility being held by the Medical Devices Safety Officer (Health and Safety Advisor).

A significant number of Field Safety Notices (FSN) and supply disruption alerts were also received. These were sent either directly to the Trust by manufacturers or suppliers or by NHS Supply Chain and are not captured through the CAS portal.

The Medical Devices Safety Officer managed the distribution of FSNs and monitored action completion. All required actions were taken, and confirmation returned to manufacturers where requested.

3.2.2. Safety Alert Compliance

A listing of all safety alerts received by the Trust between 1st April 2020 and 21st June 2021 can be found in appendix 2.

3.2.3. Ongoing Compliance

Whilst there is an effective process embedded for initial compliance with safety alerts, there is currently no evidence available to demonstrate ongoing compliance with alert requirements.

No audits of compliance have been undertaken. The shortfall in assurance has been highlighted at Health and Safety Committee and it was agreed that a process will be implemented to provide assurance that the Trust remains compliant with previously required actions.

3.3. Associated Risks

There is a patient and staff safety risk if initial compliance with safety alerts is not maintained, there is a further risk of enforcement action by the CQC or Health and Safety Executive.

3.4. Next Steps

The Quality and Safety Committee is asked to:

Note the content of the report and the lack of assurance around ongoing compliance.

3.5. Conclusion

The Trust has an excellent record of compliance with safety alerts and completion prior to deadlines. An effective auditing process would evidence ongoing compliance.

Appendix 1: Acronyms

CAS	Central Alerting System
FSN	Field Safety Notice
MDSO	Medical Devices Safety Officer
MSO	Medicines Safety Officer

Appendix 2: Safety Alerts Received via CAS (01/04/2021 – 31/03/2022)

Please note that alerts highlighted in blue are formal 'National Patient Safety Alerts'

Reference	Alert Title	Trust Response
NatPSA/2022/002/MHRA	UPDATED 25/05/22 Philips Health Systems V60, V60 Plus and V680 ventilators – potential unexpected shutdown leading to complete loss of ventilation	Not relevant to the Trust, V60 series ventilators not used at RJAH.
NatPSA/2022/001/UKHSA	Potential contamination of Alimentum and Elecare infant formula food products	Not directly relevant to RJAH, circulated for information
CEM/CMO/2022/006	Remdesivir for patients hospitalised due to COVID-19 (adults and adolescents 12 years and older)	Not directly relevant to RJAH, circulated for information
CEM/CMO/2022/005	Antivirals and neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalised patients	Not directly relevant to RJAH, circulated for information
CHT/2022/001	Update from the CAS Helpdesk: Change in communication for medicines supply issues	CAS management process updated to include new arrangements.
CEM/CMO/2022/004	Interleukin-6 inhibitors (tocilizumab or sarilumab) for adult patients hospitalised due to COVID-19	Not directly relevant to RJAH, circulated for information
CEM/CMO/2022/003	Palivizumab passive immunisation against respiratory syncytial virus (RSV) in at risk pre-term infants	Not directly relevant to RJAH, circulated for information
CEM/CMO/2022/002	Antivirals and neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalised patients	Not directly relevant to RJAH, circulated for information

CEM/CMO/2022/001	Antivirals or neutralising monoclonal antibodies (nMABs) for non-hospitalised patients with COVID-19	Not directly relevant to RJAH, circulated for information
SHOT/2022/001	Preventing transfusion delays in bleeding and critically anaemic patients	Action plan developed for compliance prior to deadline (15/07/2022)
CEM/CMO/2021/023	Neutralising monoclonal antibody and intravenous antiviral treatments for patients in hospital with ...	Not directly relevant to RJAH, circulated for information
SDA/2021/016	Advanz epoprostenol 0.5mg and 1.5mg powder and solvent (pH10.5) solution for infusion vials – Supply Disruption Alert	No response required, circulated for information
CEM/CMO/2021/022	Neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalised patients	Not directly relevant to RJAH, circulated for information
CEM/CMO/2021/021	Neutralising monoclonal antibodies (nMABs) or antivirals for non-hospitalised patients with COVID-19	Not directly relevant to RJAH, circulated for information
CEM/CMO/2021/011(U)	Withdrawal of the Recommendation for Consideration of Inhaled Budesonide as a Treatment Option for Covid-19	Not directly relevant to RJAH, circulated for information
CEM/CMO/2021/020	Neutralising monoclonal antibodies (nMABs) or antivirals for non-hospitalised patients with COVID-19	Not directly relevant to RJAH, circulated for information
CEM/CMO/2021/019	Update on COVID-19 Variant B.1.1.529	Circulated for information
SDA/2021/015	Hypovase (prazosin) 500 microgram tablets - Supply disruption	Alert forwarded to Medicines Safety Officer for action.
NatPSA/2021/010/UKHSA	The safe use of ultrasound gel to reduce infection risk	All actions completed, changes in practice introduced as a result if the alert.
CEM/CMO/2021/018	Casirivimab and imdevimab in the treatment of COVID-19 in hospitalised patients	Not directly relevant to RJAH, circulated for information
SDA/2021/006(U)	Champix (varenicline) 0.5mg and 1mg tablets - Supply Disruption	Alert forwarded to Medicines Safety Officer for action.

SDA/2021/014	Tocilizumab (RoActemra) 162mg/0.9ml solution for injection pre-filled syringes and pre-filled pens - ...	Alert forwarded to Medicines Safety Officer for action.
SDA/2021/013	Diazepam RecTubes 2.5mg Rectal Solution - Supply Disruption	Alert forwarded to Medicines Safety Officer for action.
SDA/2021/012	Becton Dickinson blood specimen collection - supply disruption (further update)	Appropriate mitigations put in place, no effect on patient safety.
CEM/CMO/2021/017	Casirivimab and imdevimab for patients hospitalised due to COVID-19	Not directly relevant to RJAH, circulated for information
SDA/2021/011	Becton Dickinson blood specimen collection - supply disruption (update)	Appropriate mitigations put in place, no effect on patient safety.
CEM/CMO/2021/016	Interleukin-6 inhibitors (tocilzumab or sarilumab) for patients hospitalised due to COVID-19	Alert forwarded to Medicines Safety Officer for action.
CEM/CMO/2021/015	COVID-19 Therapeutic Alert: Continuous positive airway pressure (CPAP) in patients hospitalised due to Covid-19	Not directly relevant to RJAH, circulated for information
SDA/2021/010	Becton Dickinson blood specimen collection - supply disruption	Appropriate mitigations put in place, no effect on patient safety.
NatPSA/2021/009/NHSPS	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs)	Valved FFP3 masks removed from supply. Information distributed regarding appropriate use of PAPRs
NatPSA/2021/008/NHSPS	Elimination of bottles of liquefied phenol 80%	Use of 80% phenol had ceased prior to alert being received.
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses	Not directly relevant to RJAH, circulated to DTC for information
SDA/2021/009	Glipizide (Minodiab) 5mg tablets - Supply disruption	Alert forwarded to Medicines Safety Officer for action.
SDA/2021/008	Tinzaparin sodium (10,000 IU/ml) 3,500 units in 0.35ml and 4,500 units in 0.45ml pre-filled syringes	Alert forwarded to Medicines Safety Officer for action.
NatPSA/2021/006/NHSPS	Inappropriate anticoagulation of patients with a mechanical heart valve	Not directly relevant to RJAH, circulated for information

CEM/CMO/2021/014	COVID-19 Therapeutic Alert - Palivizumab passive immunisation against respiratory syncytial virus	Not directly relevant to RJAH, circulated for information
SDA/2021/007	Dexamethasone 0.1% (Maxidex) 5ml eye drops	Alert forwarded to Medicines Safety Officer for action.
SDA/2021/006	Champix (varenicline) 0.5mg and 1mg tablets - Supply Disruption	Alert forwarded to Medicines Safety Officer for action.
NatPSA/2021/005/MHRA	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles	Not directly relevant to RJAH, circulated for information
NatPSA/2021/004/MHRA	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd	Alert forwarded to Medicines Safety Officer for action.
NatPSA/2021/003/NHSPS	Eliminating the risk of inadvertent connection to medical air via a flowmeter	Estates department completed all actions prior to deadline
CEM/CMO/2021/013	Updated Publication of Remdesivir guidance for patients hospitalised with Covid-19	Not directly relevant to RJAH, circulated for information
CEM/CMO/2021/012	Personal protective equipment and heat: risk of heat stress	Actions taken and information distributed to all PPE users.
NatPSA/2021/002/NHSPS	Urgent assessment/treatment following ingestion of 'super strong' magnets	Not directly relevant to RJAH, however radiography guidelines updated to cover potential for a relevant referral being received.
SDA/2021/002(U)	Propofol emulsion for infusion and injection (all strengths) - Supply Disruption Update	RJAH carried sufficient stock to cover the supply disruption period.
CEM/CMO/2021/011	COVID-19 Therapeutic Alert - Inhaled Budesonide for Adults (50 Years and Over) with COVID-19	Not directly relevant to RJAH, circulated for information

0. Reference Information

Author:	Maryse Mackenzie, Medicines Management Co-Ordinator	Paper date:	02 November 2022
Senior Leader Sponsor:	Sara Ellis Anderson Chief Nurse and Patient Officer	Paper written on:	22 September 2022
Paper Reviewed by:	Quality and Safety Committee 22/09/22	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is for noting in relation to RJAH compliance around the safe management of controlled drugs (CDs).

2. Executive Summary

2.1. Context

This paper is for assurance around the management of CDs at RJAH

2.2. Summary

Assurance of compliance with

- Legislation
- Controlled Drug Local Intelligence Network (CD Lin) submissions
- Care Quality Commission (CQC) requirements
- Department of Health Legislation
- CD storage requirement
- CD quarterly audit completion

2.3. Conclusion

The Board are asked to note that the for 2021-22 the Trust has been compliant with CQC requirements, CD Lin submissions, CD audit completion, CD storage requirement and CD legislation.

3. The Main Report

3.1. Introduction

The CD Accountable Officers report sets out RJAH position for 2021-22 in relation to the safe management of CDs.

3.2. CD Accountable Officers Report for 2021-22

- Trend analysis of supply patterns in clinical areas
- Reporting of untoward incidents

CD Lin reporting compliance

3.3. Associated Risks

- We have struggled with attendance to support destruction of CDs at times due to other pressures across the Trust. We have though maintained safe storage and destruction over the last twelve months.

3.4. Conclusion

The report provides assurance that RJAH manage CDs in line with CQC, CD Lin and latest Department of Health Legislation.

Appendix 1: Acronyms

CDs	Controlled Drugs
CD LIN	Controlled Drug Local Intelligence Network
CQC	Care Quality Commission

CD Accountable Officers Report for 2021-2022

Robert Jones Agnes Hunt (RJAH) annual controlled drug (CD) report.

CQC compliance 100%

RJAH CD Lin representation is 100%

Submission of occurrence reports is 100%

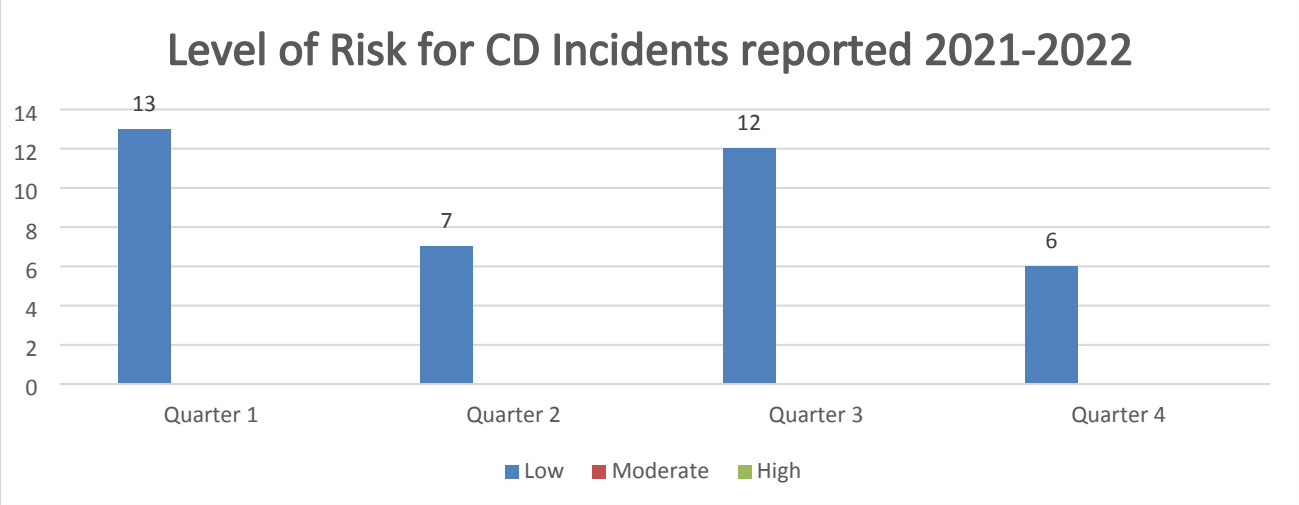
Update from 2019-2020 annual report: No outstanding actions to update.

Trend Analysis at RJAH
RJAH monitors and audits the management, prescribing and use of CDs. Discrepancies/incidents are reported via DATIX and then onto the CD Lin. The CDAO would be informed in person or by e-mail if concerns are noted/raised. Pharmacy completes monitoring of CDs and other abusable medicines monthly. Data is then reviewed and reported to the Trust Medicines Safety Officer (MSO). Any anomalies or changes in patterns noted are then reported via DATIX investigated and appropriate action taken.

For 2021-2022 any noted anomalies or changes were found to have legitimate reasons for the identified change in pattern. The Trust has a defined audit process for CDs. The West Midlands Audit tool is used for all audits undertaken. The audits results go to Matrons, Ward Managers and MSO via Tendable. Ward level action plans are produced to address any issues identified and followed up at the next re audit.

Reporting of Untoward Incidents
There have been no serious untoward incidents reported involving CDs for 2021-2022. We have reported 38 incidents via DATIX that are reportable out to the CD Lin (appendix 1).
All 38 of the reported incidents were rated as low risk, see Graph 1.

Graph 1



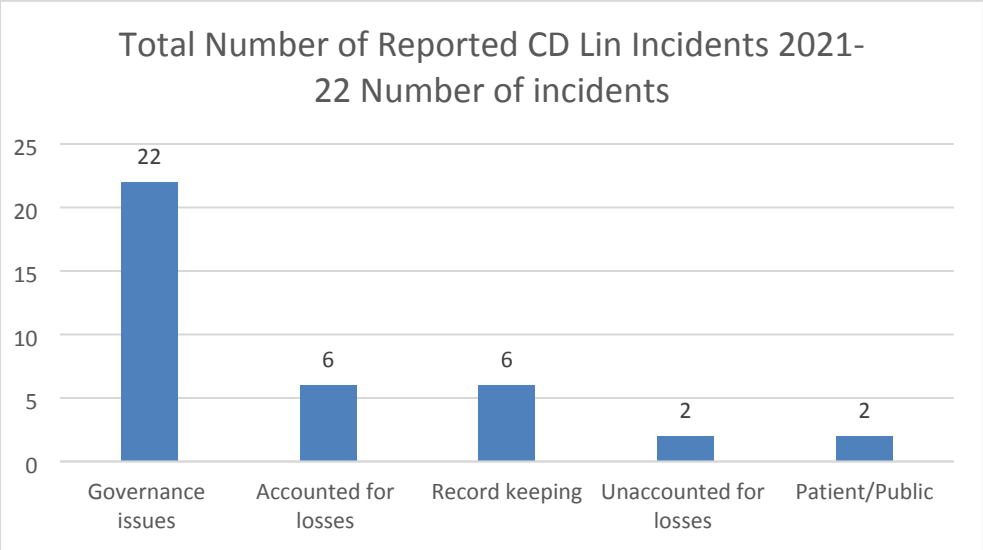
The 38 incidents for 2021-2022 came under the following categories for reporting to the CD Lin.

CD Lin reporting categories:

- Accounted for losses
- Unaccounted for losses
- Patient/Public
- Governance issues
- Record keeping
- Other

See Graph 2 for number of incidents by reporting category.

Graph 2 RJAH reported CD incidents by CD Lin Category



To Note: though not required by the CD Lin we report locally on all CD incidents regardless of the schedule they may come under.

Attendance of Controlled Drug Local Intelligence Network (CD Lin) meetings

It is a statutory requirement of the Trust's CDAO that a quarterly report is provided to the CDLIN. Regulation 29 requires CDAO to give an occurrence report to the accountable officer for the local area team that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report). RJAH have recorded 100% attendance at the CD Lin reginal meetings for 2021-2022.

Submission of occurrence reports

RJAH have submitted an occurrence return for quarters 1 to 4 for 2021-2022.

Destruction of Controlled Drugs

There are authorised witnesses for the destruction of controlled drugs. Appointments are made with the authorised staff to attend pharmacy to support the safe destruction of CDs. We have struggled with attendance at times due to other pressures across the Trust but we have maintained a safe storage and destruction over the last twelve months.

Controlled Drugs Procedure

Over this twelve month period, there has been no changes within legislation and as such no legislation changes to policy at RJAH.

Appendix 1: Local Incidents by Quarter for 2021-2022

Quarter 1	Gladstone	• Chart re-write patients evening dose of Pregabalin not marked on the chart as required. • Missed dose of Oxycodone 10mg MR • Omitted dose of Pregabalin
	Wrekin	• 10% loss oral morphine solution • Spillage of oral morphine solution
	Oswald	• Missing Pregabalin • Patient of concern bringing CD items labelled for another person
	Powys	• Missed dose of Tramadol
	Ludlow	• Inaccurate documentation
	Sheldon	• Gabapentin given instead of Pregabalin • Oral morphine solution underage <5%
	HDU	• Morphine Sulphate 1mg/ml box dropped accidently 2 vials smashed
	Main Theatres	• Labelled syringe of morphine found under pillow on return to ward from theatre
Quarter 2	Pharmacy	• Stack and register discrepancy due to inaccurate documentation
	Wrekin	• Discrepancy <5% oral morphine solution
	Gladstone	• Destruction of out of date Pregabalin capsules on the ward not in pharmacy • MST 5mg administered alongside of Oxycodone 20mg instead of Oxycodone 25mg • Pregabalin 75mg administered instead of pregabalin 50mg • Missed dose of zomorph
	Sheldon	• Missed doses of severadol as pt self-medicating and staff did not ask about CD
Quarter 3	Gladstone	• Pregabalin 300mg administered instead of Gabapentin 300mg • Dose of Tramadol administered early • Unwanted dose of Oral Morphine returned to the bottle • A dose of 275mg pregabalin was administered instead of the prescribed 225mg • Omitted dose of Pregabalin 75mg
	Ludlow	• Out of Oxycodone administered
	Pharmacy	• Incorrect supply booked out and not completed in the CD register • TTO prescription not returned to Pharmacy following delivery
	Powys	• Following accidental drop onto the floor patient own medicine destroyed but not signed out of patient own register

Quarter 3 ctd	Clwyd	• Missing Pregabalin 50mg capsule
	Wrekin	• Morphine Sulphate 20mg prescribed oxycodone 20mg administered
	Kenyon	• Accidental spillage of oral morphine solution
Quarter 4	Gladstone	• Incorrect dose of pregabalin administered • Oral Morphine Solution 10mg/5ml dose omitted • Pregabalin 75mg administered instead of the 100mg prescribed.
	Pharmacy	• Information re collection of CD TTO not obtained by staff member
	Ludlow	• Accidental spillage of oral morphine solution • Accidental spillage of oral morphine solution

0. Reference Information

Author:	Dr Ruth Longfellow Chief Medical Officer	Paper date:	2 November 2022
Senior Leader Sponsor:	Dr Ruth Longfellow Chief Medical Officer	Paper written on:	31 October 2022
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 CMO 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 CMO portfolio for members of the Trust Board on items not covered within the main agenda.

2.2. Summary

- EPR Implementation – this is now in progress, with identification of clinical staff to take part in the implementation process. In addition staff are currently able to vote for the name of our new EPR system, with a shortlist of 5 names.

- Amber Blood Alert – an amber alert was issued during October by the National Blood Transfusion Service, and is in place for 4 weeks, due to a shortage of red blood cells and platelets for transfusion. Any non-urgent surgery where blood would crossmatched should be clinically reviewed and postponed if appropriate. Two patients have had their surgery cancelled to date. We have collaborated with SaTH and attend their Emergency Blood Management group meetings to review guidance and its implications and potential risks.

- Medical workforce – we have had challenges with recruitment in certain departments, reflecting a National shortage of doctors in some specialties, particularly in anaesthetics. The situation is improving with the appointment of an anaesthetic fellows and consultant interviews this week.
  We also have Foundations Doctors in the Trust for the first time, with 2 in anaesthetics and 4 more due to start next August in other departments.

- Clinical Effectiveness – our Director of Research has now taken on the role of Director of Innovation, Audit and Outcomes, and has created an Innovations Group. The first project is to look at the management of pressure sores on MCSI.
- The Medical Examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths and becomes a statutory requirement from April 2023. RJAH is working with the Medical Examiner office at SaTH, and our Learning From Death lead is a qualified Medical Examiner and undertakes one session a week at

RSH. Progress has been made with the Data Protection Impact Assessment and data sharing between the Trusts, to allow the ME process to now include RJAH patients.

2.3. Conclusion

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

Learning From Deaths Q2

0. Reference Information

Author:	Dr James Neil, Mortality Lead	Paper date:	02 November 2022
Executive Sponsor:	Dr Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety 20/10/22	Paper Ref:	N/A
Forum submitted to:	Trust Board - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary was presented to the Quality and Safety Committee on 20 October 2022.

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/I.

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 Q2 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns or trends identified.

Positive learning from September death.

The Board is asked to note the summary report on Q2.

Learning From Deaths Q2

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes/Family feedback.	Actions
July 2022	1	1	0	0	Expected death on EOL care	None required
August 2022	0	0	0	0		None required
September 2022	2	1	0	0	1.Expected death on EOL care 2.Unexpected death post-operatively. Care reviewed by Trust Resus Officer, and discussed with the coroner. No concerns raised regarding perioperative care.	SJR in progress

3.3. Associated Risks.

None.

3.4. Next Steps

Discussions in progress with SATH concerning a link with their Medical Examiner and Bereavement system. This service likely to commence November 2022.

LFD lead now working as a Medical Examiner at SATH.

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

Learning From Deaths Q2

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: (from September death) Good EOL care, with attempts made to arrange care at home or nearer home unfortunately complicated by lack of community services and accelerated patient decline.

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

Negative learning: Not all notes scanned to EPR after death meaning overall score fell from excellent to good care.

Plan going forward to use NHSE dashboard to generate LFD reports, although these are not designed for our limited numbers per se.

Learning From Deaths Q2

Refresh report

Better Tomorrow learning from deaths, learning for lives

Making data count

NHS

Mortality Structured Judgement Review Report

Filters for status reason and hospital site are applied to the entire report

Print report | Clear all filters

Status	Hospital site if required	Quarter	Month
Complete	no site allocated	Quarter 1	Feb 22
(blank)	RJAH	Quarter 2	Mar 22
	(blank)	Quarter 4	May 22
		(blank)	Jul 22
			(blank)

Contents

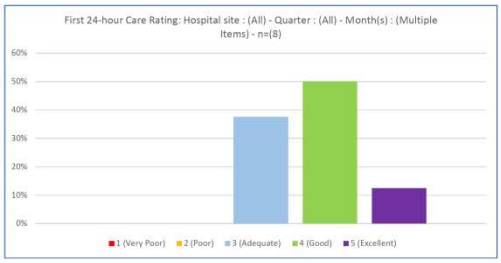
Care Ratings

First 24-hour Care Rating: Hospital site : (All) - Quarter : (All) - Month(s) : (Multiple Items) - n=(8)

Select rating: First 24-hour Care Rating

	n.	%
1 (Very Poor)	0	0.0%
2 (Poor)	0	0.0%
3 (Adequate)	3	37.5%
4 (Good)	4	50.0%
5 (Excellent)	1	12.5%
Grand Total	**8**	**100%**

**number of not applicable records -8*



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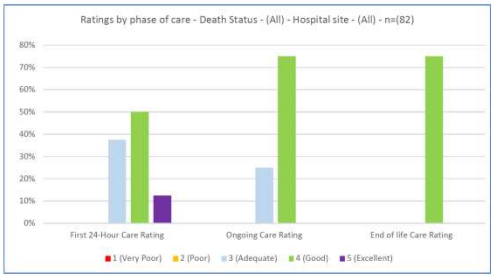
Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (Multiple Items) - n=(8)

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (Multiple Items) - n=(8)			
	First 24-Hour Care Rating	Ongoing Care Rating	End of life Care Rating
1 (Very Poor)	0.0%	0.0%	0.0%
2 (Poor)	0.0%	0.0%	0.0%
3 (Adequate)	37.5%	25.0%	0.0%
4 (Good)	50.0%	75.0%	75.0%
5 (Excellent)	12.5%	0.0%	0.0%
Grand total	**100.0%**	**100.0%**	**75.0%**

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (Multiple Items) - n=(8)			
	First 24 hour care	Ongoing care	End of life care
1 (Very Poor)	0	0	0
2 (Poor)	0	0	0
3 (Adequate)	3	2	0
4 (Good)	4	6	6
5 (Excellent)	1	0	0
Grand total	**8**	**8**	**6**

**number of not applicable records -8*



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Learning From Deaths Q2

Appendix 1: Acronyms

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

0. Reference Information

Author:	Amanda Roberts – Interim Clinical Audit Quality Lead	Paper date:	19 May 2022
Executive Sponsor:	Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mr I Roushdi, Consultant Clinical Audit Lead	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety Committee	Paper FOIA Status:	Full

1. Purpose of Paper

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

For information

2. Executive Summary

2.1. Context

This paper includes details on Clinical Audit Activity over the last financial year and a copy of the Clinical Audit Forward Plan as an appendix to this paper.

2.2. Summary

This paper states the National Audits we have been involved in, all NICE Guidance that has been audited, details of the Quality Forums that have taken place, and how many approved proposals and reports we have had in the last financial year.

2.3. Conclusion

We are asking the Trust Board members to note the Clinical Audit Annual Report ahead of publication on the document centre.

3. The Main Report

3.1. Introduction

The report summarises the clinical audit activity for 2021/2022. It provides an overview of the strategic, operational, and developmental work that has been undertaken.
Main Title Clinical Audit Annual Report

3.1.1. Overview of Clinical Audit Activity
3.1.2. Quality Forum Meetings replacing MDCAM
3.1.3. National Institute for Health and Clinical Excellence (NICE) Guidance
3.1.4. National Audits Clinical Audit Forward Plan shows if we are undertaking or not
3.1.5. Improvements through Clinical Audit and Quality Improvement
3.1.6. Update on strategy action plan
3.1.7. Strategic objectives in the year ahead

3.2. Associated Risks

3.3. Conclusion

The Trust Board are asked to read and approve the contents of this paper ahead of it being disseminated on the Document Centre-RJAH Intranet.

Clinical Audit Annual Report

2021/2022

Prepared by:

Amanda Roberts, Interim Clinical Audit Quality Lead

Oversight from:

Mr I Roushdi, Consultant Clinical Audit Lead

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

3.1 Introduction

This report summarises the clinical audit activity for 2021/22. It provides an overview of the strategic, operational and developmental work that has been undertaken.

This year has seen the department continue to focus on more realistic time frames for the completion of Clinical Audits and Quality Improvement Projects. We have increased the quality of our Clinical Audits and Quality Improvement Projects by ensuring the sample size of the projects is correct in line with the population of the inclusion criteria.

The responsibility of proposal and report approval now sits with the Unit Managers. This has proven to work well as the Unit Management team can now view the report findings and have input into actions that are required to ensure Quality Assurance is adhered to.

Responsibility for audit / project planning and actions has been devolved to the units so that there is a greater focus on Clinical Audit within the governance management structure across the Trust. Projects are approved by email or, where possible and applicable via Unit Governance Meetings. We are recruiting a new Clinical Audit Lead following the retirement of our Consultant Clinical Audit Lead. This will assist to oversee the quality of Service Improvement Projects and promote Quality Improvement within RJAH.

The Clinical Audit Quality Lead is committed to raising the profile of clinical audit and quality improvement within the Trust and she is co-organiser, with Sammy Davies (Outcomes Manager) of the new Quality Forum event, which is being held monthly from October 2021 onwards in order to provide regular opportunities for sharing learning and best practice across the organisation. This learning event is held via MS Teams and is recorded so that members of staff can watch it back later if they are unable to attend in person. Quality Forum broadens the scope of the former Multi-Disciplinary Clinical Audit Meetings to include learning from complaints, never events, serious incidents, clinical outcomes and PROMS, amongst other innovative approaches. All staff members are warmly welcome to attend the event and staff who have completed quality improvement projects are invited to present their findings and discuss their learning experience.

We are in the process of reviewing the feedback from the Quality Forum meetings to ensure it is an effective sharing of Service Improvement Projects or whether we reinstate the Multi-Disciplinary Clinical Audit Meetings bi-annually.

The Clinical Audit Quality Lead has a strong commitment to education and to providing all staff with the opportunity to access training. Last year the ability to train staff in Clinical Audit became more difficult due to social distancing guidelines and so more emphasis was placed on 1:1 coaching and training via MS Teams. There is now a plan in place to begin to provide group workshops via MS Teams and to create a series of short training videos on various aspects of Clinical Audit and Quality Improvement skills to be able to bring about positive and lasting change following an audit.

3.1.1 Overview of Clinical Audit Activity

Projects are categorised depending on their 'drivers' or rationale, which in turn inform the importance that can be given to each. The audit programme consists of national, strategic, Trust division driven projects and Service Evaluation projects which describe the allocated priority in line with HQIP guidance. A summary of the volume of Clinical Audit Projects formally received, registered, and approved by the Unit Managing Directors and Assistant Chief Nurses in 2021/2022 is given in appendix 1 and 2.

The Unit Managing Directors, Assistant Chief Nurses and the staff of the Clinical Governance Department continue to be active in raising the profile of Service Improvement Projects throughout the Trust and incorporating the Trust corporate objectives into projects.

Through the development and utilisation of the clinical audit programme, the department has provided substantial emphasis, support and expertise to clinicians and other staff in conducting high quality audit projects. All projects where necessary include recommendations and a realistic and achievable action plan in place have to ensure that any identified issues are resolved and improvement to the quality of patient care that the Trust provides implemented. Re-audits are carried out when necessary to ensure we have improved our services and successfully addressed identified issues through clinical audit.

3.1.3 Quality Forum Meetings in 2021/22

Staff who undertake Clinical Audit projects are encouraged and supported to present their findings to a multi-disciplinary audience. The Trust continues to encourage all staff to participate in the meetings and limit clinics and operations to facilitate this.

During the 2021/22 period, 6 Quality Forum Meetings chaired by Mr Kelly, Consultant Clinical Audit Lead, were held via Microsoft Teams. A list of the presentations from the meetings can be found in appendix 3. The attendance of these forums can be found in appendix 4.

3.1.4 National Institute for Health and Clinical Excellence (NICE) Guidance

All published NICE guidance used to be reviewed monthly by Unit Managers and Clinical Audit Quality Lead. The NICE Guidance process is on the Clinical Audit Risk Register as it requires review and resources to implement it following the restructure of the Trust.

Clinical Audits that are being carried out or have been carried out in 2021/22 in relation to NICE guidance include:

- National Rheumatology Audit CG 79 and QS 33
- Audit of Acute Upper GI bleed among in-patients NICE CG 141
- Evaluation into incidents of pressure ulcers during acute stage in SCI patients NICE CG 179
- Audit of clinical management of patients with DMD according to standard of care NICE HST 3
- Reaudit of botox administration in children with cerebral palsy NICE CG 145

- An audit to determine whether the Sepsis 6 pathway is being implemented and adhered to NICE NG 51
- The effectiveness of track and trigger systems in identifying deteriorating patients NICE CG 50
- Ward staff perception of nerve block education provided by the Acute Pain Service NICE NG 124
- Perioperative Management of children with cerebral palsy undergoing major surgery NICE NG 62
- Audit of compliance with the faster diagnosis standard – a retrospective review NICE NG 12

3.1.5 National Audits

National clinical audit is designed to improve patient outcomes across a wide range of health conditions. Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.
The Trust participated in the following (9) national audits during 2021/22:

- Mandatory Surveillance of HCAI
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Joint Registry (NJR)
- Case Mix Programme
- British Spine Registry
- Elective Surgery (National PROMS Programme)
- Perioperative Quality Improvement Programme (PQIP)
- Surgical Site Infection Surveillance
- Falls and Fragility Fracture Audit Programme (FFFAP)

3.1.6 – Associated Risks in line with Service Improvement

Risks associated with Service Improvement are monitored via the Assurance and Standards Unit with the Clinical Audit Quality Lead reviewing them regularly to ensure safety and assurance is kept to a minimum. The list below are the current risks that are monitored on the Trusts Risk Register. Please see 3.2 or the full Risk Register of risks associated to service improvement.

Risk Title and number	Monitoring Unit	Risk Level	Risk Rating	Risk Treatment Plan
Monitoring compliance against National Audit Requirements - 2597	Assurance and Standards	Low	6	To bring this risk to a point where it could be closed we would require an automated system to manage NICE Guidance and National Audit Requirements.
There is not enough patient engagement in Clinical Audit - 2585	Assurance and Standards	Moderate	8	1. We need a different approach to PPI in CA. The new Clinical Audit Strategy 2020-2023 sets out a plan for changing the approach. This is due for ratification shortly. 2. We need a strategy and policy for PPI in CA and an implementation plan. I plan to do this as part of the overall new Clinical Audit Strategy.

Non achievement of clinical audit work plan – 2437	Assurance and Standards	Moderate	12	The new Clinical Audit Policy published in May 2020 clearly states that the responsibility of action monitoring sits with the units. Unfortunately, at present there is no system in place to allow triumvirate managers to access the data and so there is a reliance on passing the information manually through the governance team. A business case has been written and was submitted in June 2020. Still waiting to hear whether this has been approved (15/01/2021). The new system would offer a comprehensive hosted multi-channel (multi-methodologies) service to collect, analyse report and significantly act upon real-time audits with dashboards built in so that managers simply log in to check where the audit / actions are up to. This audit module would provide a quality, end to end auditing solution, simultaneously making auditing a less time consuming and more informative process. Data Capture Devices – Provided 'ready to use' with full training and support A Library of Audits – Access to an extensive library of healthcare specific audit templates, ready to use at no extra cost, such as Ward Accreditation, Quality Accreditation and Nursing Metrics Audit Planning tools for scheduling, monitoring and management of the audit process Reporting – Real-time reporting views available from ward to board Actions, Action Plans & Alerts – Turn information into action through real time alerts of issues & non-compliance Action Reporting & Escalation – Monitor progress of improvements, actions, and escalate within an organisation
Clinical Audit staffing – 2769	Assurance and Standards	Moderate	12	Review resources for Clinical Audit and ensure they are sufficient for work being done daily and also in the event that the Clinical Audit Quality Lead is not available, the service can still run efficiently and effectively in her absence.

				A new Clinical Audit System would streamline a lot of processes that we currently undertake manually and therefore less human resource would be required.
Insecure storage of Clinical Audit data – 2692	Assurance and Standards	High	15	We require a new clinical audit system that can collect and store clinical data in a safe and secure way and enable us to respond quickly and efficiently to issues discovered in audit.
Lack of assessment of NICE Guidance – 2581	Assurance and Standards	Moderate	8	The implementation of a Clinical Audit system that automatically tracks NICE Guidance would enable us to close this risk.
Clinical audits and QI projects / actions are not completed on time and risk abandonment - 2582	Assurance and Standards	Moderate	8	A risk assessment is to be completed when an audit is being considered for abandonment. This will be documented and saved in the u drive. Evidence that overdue audits and actions have been discussed at governance meetings to be captured (meeting minutes) Outcome of audits and actions discussed at governance meetings to be fed back to the Clinical Audit Quality Lead monthly. The new process published in the Clinical Audit Policy to be implemented by the unit managers - specifically operational managers take responsibility for actions out of audits.

3.1.7 Improvements through Clinical Audit and Quality Improvement –

Good practice in Clinical Audit requires an action plan that is supported by the team with named individuals who take responsibility. Clinical Audit Registration Management System (CARMS) logs the actions and these are followed-up and updated in order to reflect the progress of actions. It is a Trust requirement to create an action plan if corrective action is required because of a clinical audit and, where appropriate, agree a date for reaudit. It is the responsibility of the units and the unit governance management processes to implement a system for tracking the progress of each action plan to ensure that the Clinical Audit cycle is completed in a timely manner. Project Leads are supported to ensure that their actions are Specific, Measurable, Achievable, Realistic and Timely (SMART). Where it is potentially valuable to bring QI tools to the table to make improvement following an audit, the CAQL can advise and / or bring the expertise of the new Quality Improvement and Operational Development Manager in to look at the project.

In the past year we have continued to encourage the teams to engage in Clinical Audit and Quality Improvement projects that are directly related to serious issues in the Trust, such as clinical incidents

are other areas at risk highlighted to us by the governance team. Many of our staff are allocated time for clinical audit through Supporting Patient Activity (SPA) and others have no direct allocation of time for this process. We have had some excellent projects that have been presented to us with robust action plans and evidence of improvement of practice and patient care. The following three projects are examples of improvement following clinical audit / quality improvement projects.

1. **Service Evaluation of Orthotic Provision for Paediatric Patients with Idiopathic Flatfoot**

The paediatric flat foot is a frequent presentation in clinical practice, a common concern to parents and continues to be debated within professional ranks. The orthotics department often receives referrals for insoles for children to improve foot position and pain. At RJAH we receive many referrals from one Consultant and fewer from another Paediatric Consultant due to their conflicting opinions on insoles. The project seeked to audit clinical outcomes for the treatment of paediatric idiopathic flatfeet, with the aim to review compliance and how often patients are wearing the orthoses.

The results of this audit shown children with flat feet concluded a very high level of patient satisfaction regarding function, revealing that a large percentage of patients do use the insoles provided.
It also shows that the use of insoles the majority of the day, most days, helps to improve pain related to excessive pronating during gait.

2. **Reaudit of the use of a safety checklist for interventional procedures in Radiology**

In 2009 the World Health Organisation introduced a checklist as part of the 'Safe surgery saves lives' document. A modified checklist, that included a 'Pause' was devised for interventional radiology to improve patient safety. The use of this checklist and 'Pause' was audited in 2020. Recommendations from this audit were made to improve compliance, including a review of the checklist, survey of staff if there were any barriers to completing the 'Pause' and checklist, an additional checklist for Ultrasound biopsies and supply information around the reasons for the 'Pause' and checklist.

The aim of this audit was to monitor the safety checklist was completed correctly for every interventional outpatient procedure in the radiology department.
Compliance with the use of the safety checklist and 'Pause' has increased significantly since the last audit. Imaging staff have shown a good understanding of the need for a safety checklist and the use of a 'Pause' and the information provided to staff on the WHO safer surgery and safety checklists has been accessed over 100 times.

Continued audit of the use of the safety checklists and 'Pause' for outpatient interventions will ensure that these standards are maintained, and by ensuring the audits can be done simply and through a digital audit tool, more staff can be involved in the audit process.

3. **CT pulmonary angiogram (CTPA) Re-audit**

CTPA is a scan that looks for blood clots in the lungs. This was a Re-audit of detection rate for pulmonary thromboembolic disease on CTPAs 10th Dec 2020-10th Dec 2021. This audit shown that our positive diagnostic rate for pulmonary embolus meets the local and national standards.

3.1.8 Strategic objectives in the year ahead

Key objectives for forthcoming year are:

1. Ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme, CQC Essential Standards of Quality and Safety, all relevant published NICE guidance, and GIRFT recommendations.
2. Develop a strategic approach towards the types of audits that are undertaken so that they focus on the main Governance areas of risk, incidents, and complaints to prioritise projects. Clinical Audit Forward Plan is to be driven by the Unit Managers in line with Clinical Audit Policy published in May 2020.
3. Improve the audit process to:
    - Increase the number of audits that have potential for quality improvement
    - Improve the timely completion of the audit cycle
    - Effectively put in place and monitor actions that result in better patient safety, patient experience, and clinical effectiveness. As part of this improvement in process, overdue audits will be risk assessed for abandonment by Unit Management Teams and the reasons for abandonment will be documented in the U drive.
4. Increase the number of audits carried out by non-medical staff to have a wider reach and embed quality improvement practices across the organisation.
5. Improve patient and public engagement in the whole audit process through the creation of a Shropshire-wide Clinical Audit and Quality Improvement Patient Group.
6. Create a Clinical Audit training programme that has CPD credit to help ensure that project leads are equipped with the skills to carry out successful audit and quality improvement projects.
7. Improve sharing of learning from clinical audits by actively promoting the audit and evaluation work of clinicians using networks both within and beyond the Trust. The Trust will be instrumental in creating opportunities for sharing, setting up key networks where possible and relevant to ensure that there are avenues for dissemination. Projects can now be shared across the Trust and beyond via the Quality Forum at RJAH and the OQICAN Learning Forum events nationally through the NOA.

3.1.9 Update on strategy action plan

AIM	HOW IMPLEMENTED	TARGET IMPLEMENTATION DATE	WHO IS RESPONSIBLE FOR THIS ACTION?	EVIDENCE OF IMPLEMENTATION	PROGRESS UPDATE
1. Ensure that the Trust is fully compliant with the requirements of published clinical guidelines in NCEPOD, CQC Essential Standards of Quality and Safety, all relevant published NICE guidance, and GIRFT recommendations (risk 2581)	Revise NICE process so that the Trust is assessing which NICE guidance is relevant monthly and documenting where we are / are not compliant	Completed	Clinical Audit Quality Lead / Governance Manager	Nice Guidance Tracker Spreadsheet	Completed - New process in place
	Set up Clinical Audit Group and Clinical Standards and Assurance Group to monitor this and escalate any concerns to Quality and Safety Committee	January 2023	Clinical Audit Quality Lead / Governance Manager / Deputy Medical Director	Minutes of group meetings	Partial Completion - New clinical effectiveness group being devised
2. Develop a strategic approach towards the types of audits that are undertaken so that they focus on the main Governance areas of risk, incidents, and complaints to prioritise projects. Clinical Audit Forward Plan to be driven by the Unit Managers in line with Clinical Audit Policy published in May 2020 (risk 2437)	Encourage Units to drive the Clinical Audit Forward Plan using governance data and trust corporate objectives	February 2023	Head of Governance / Managing Directors / Assistant Chief Nurses	Clinical Audit information pack for managers	Partial Completion - Information pack written but not disseminated yet
	Unit Governance Leads to utilise their unit governance meetings to generate discussion around potential new audits and the learning from completed audits	Completed	Clinical Audit Quality Lead / Governance Leads	Unit Governance Meeting minutes	Completed – CAQL attending Unit Governance / Board Meetings to update units when available

	Governance Leads / Clinical Audit Quality Lead to encourage collaborative working and stakeholder ship between departments and units to improve the quality of audits and their improvement outcomes	Completed	Head of Governance / Clinical Audit Quality Lead / Governance Leads	A robust and productive Clinical Audit Forward Plan that demonstrates areas of improvement using collaborative methods	Completed - see Forward Plan
3. Improve the audit process: 1. the number of audits focused on quality improvement 2. the timely completion of the audit cycle and 3. monitoring of actions that result in improvement of patient safety, patient experience, and clinical effectiveness (risk 2437). Unit Management teams will lead, and risk assess the abandonment of QI projects in Clinical Audit.	Implement an automated and managed clinical audit system to assist in the management of audit and quality improvement projects	June 2023	Clinical Audit Quality Lead / Deputy Medical Director / Governance Manager	New system required to replace CARMS	Not actioned
	Undertake an annual audit of audits which will demonstrate efficiency of audit cycle, action completion, audits abandoned, and whether reaudit shows improvement in working practices	March 2023	Clinical Audit Quality Lead	Audit of Audits Clinical Audit Report	Not actioned
4. Increase the number of audits carried out by non-medical staff to have a wider reach and embed quality improvement practices across the organisation	Encourage more audits from AHPs and nursing staff via promotion of CA as an improvement tool	March 2023	Clinical Audit Quality Lead / Governance Leads	Audit of Audits report	Not actioned
	Encourage Unit Managers to be mindful of this objective in their forward planning of audits	February 2023	Managing Directors / Assistant Chief Nurses	Unit Managers Clinical Audit Information Pack	Partial Completion - Information pack written but not disseminated yet
	Ensure Quality Forum events are not medically dominated or driven, and equal opportunity is given for all project leads to present their work	March 2023	Clinical Audit Quality Lead / Deputy Medical Director	Quality Forum event programme	Quality Forum to re commence in January 2023
5. Ensure effective patient and public engagement in Clinical Audit, putting patients at the	Write and implement Clinical Audit Patient and Public Engagement Strategy and Policy	March 2023	Clinical Audit Quality Lead	Patient and Public Engagement Strategy and Policy published	In progress – currently in discussion with the Clinical Audit Managers

heart of quality improvement activity in the Trust	Implement patient training programme to achieve this	March 2023	Clinical Audit Quality Lead	Training programme available	across ICS (at SaTH and ShropCom) about running a clinical audit patient group across the county
	Create Clinical Audit workstream in Patient Participation Group strategy so that patients are involved in audit programme design, process and reporting	March 2023	Clinical Audit Quality Lead	Patient Participation Group Minutes	
6. Create a Clinical Audit training programme that has CPD credit to ensure that project leads are equipped with the skills to carry out successful audit and quality improvement projects	e-Learning module to be created that is to be completed by project lead within the two years of commencing new audit	Completed	Clinical Audit Quality Lead	eLearning module available	Completed - eLearning in place
	Monthly and ad-hoc 1-1 training / coaching / advice sessions provided	Completed	Clinical Audit Quality Lead	Training records held by the Clinical Audit Quality Lead	Completed
	Virtual group training sessions provided monthly (basic skills and advanced skills)	Completed	Clinical Audit Quality Lead	Training records held by the Clinical Audit Quality Lead	Completed
7. Improve visibility of Clinical Audit learning by sharing across and beyond the Trust / have public-facing quality work	Ensure that presentations at the Multidisciplinary Quality Forum (formerly MDCAM) are improvement driven projects with learning to share	Completed	Clinical Audit Quality Lead	MDQF events programme and PowerPoint presentations	Completed
	Record MDQF events to share more widely	March 2023	Clinical Audit Quality Lead	Recording uploaded to Quality Forum intranet page	Quality Forum to re commence in January 2023
	Set up Quality Forum Twitter account and webpage on RJAH website	March 2023	Clinical Audit Quality Lead	Webpage Twitter feed are live and traffic is monitored	Quality Forum to re commence in January 2023
	Clinical Audit contribution to new Learning Newsletter and distributed via Communicate quarterly	April 2023	Clinical Audit Quality Lead / Governance Manager / Governance Leads	The production and publication of a Trust Learning Newsletter that features Clinical Audit work	Not actioned

	RJAH to contribute to the creation of an Orthopaedic Quality Improvement Clinical Audit Network (OQICAN) in the National Orthopaedic Alliance that can be a vehicle for learning and collaboration across specialist orthopaedic centres in the UK	Completed	Clinical Audit Quality Lead	OQICAN Terms of Reference, Policy, and Strategy OQICAN workshop PowerPoints	Completed

3.2 Associated risks

Risks associated with CA.xlsx

3.3 Clinical Audit Forward Plan 2022/23

A draft Clinical Audit Forward Plan has been created by the Clinical Audit Quality Lead (below) Please note this has not been finalised yet by Unit Managers. Please see appendix 5 for performance against 2021/22 forward plan.

Copy of Clinical Audit Forward Plan

Appendix 1:

Appendix 1 - Clinical Audit Proposals approved in 2021/2022						
Division	**Priority 1**	**Priority 2**	**Priority 3**	**Priority 4**	**Priority 5**	**Total**
MSK Unit	2	7	5	1	6	21
Specialist Unit	3	3	3	2	4	15
Clinical Services Unit	2	6	3	1	0	12
Support Services Unit	0	0	0	0	0	0
Assurance & Standards Unit	0	2	3	0	0	3
Totals	7	18	14	4	10	72

Appendix 2:

Appendix 2 - Clinical Audit Reports approved in 2021/2022						
Division	**Priority 1**	**Priority 2**	**Priority 3**	**Priority 4**	**Priority 5**	**Total**
MSK Unit	2	1	0	2	7	12
Specialist Unit	1	2	1	0	3	7
Clinical Services Unit	1	3	1	1	0	6
Support Services Unit	0	0	0	0	0	0
Assurance & Standards Unit	1	1	0	0	0	2
Totals	5	7	2	3	10	27

Appendix 3

Presentation from the Quality Forum 12 October 2021

- Isoplex / Gelaspan Allergic Reaction Incident – Sharing Learning
- Ward staff perception of nerve block education provided by the acute pain service – a review of evidence-based practice engagement
- RJAH Mortality Report 2020 – Learning from Deaths

Presentations from the Quality Forum 10th November 2021

- Mobile muscle clinic service evaluation
- Improving communication with GPs and patients on discharge in cancer services
- Standardising and rationalising post operative blood tests at RJAH Orthopaedic Hospital Foundation Trust

Presentations from the Quality Forum 09 December 2021

- Morbidity and Mortality case presentation
- Can relational leadership enhance performance?
- Compliance with VTE Documentation at RJAH

Presentations from the Quality Forum 11 January 2022

- Learning from Incidents
- Case report with a 'Silver Lining'
- Audit of the paediatric pre-operative process
- Keele's new MSc prosthetics and Orthotics developed alongside RJAH

Presentations from the Quality Forum 9 February 2022

- Upper GI Bleed NICE Guidance Clinical Audit
- Appropriateness of emergency referrals to the spinal department

Appendix 4 – Attendance Figures for Quality Forum meetings

Date	Attendance
12th October 2021	No data
10th November 2021	41
9th December 2021	31
11th January 2022	31
9th February 2022	30

Appendix 5 – Clinical Audit Forward Plan 2020/21

A summary analysis of the progress of the plan 2020-21 shows that out of the planned projects on the list:

- We took part in **84%** of national audits that we were eligible for (11/13)
- We started or completed **57%** of the audits related to our corporate objectives
- We started or completed **33%** of the audits related to NICE Guidance
- We started or completed **100%** of the audits related to CQC recommendations
- We started or completed **50%** of the audits related to policies (selected based on governance data)
- We started or completed **31%** of the re-audits scheduled for 2020-21

Further information:

- No CQUINs were set by the CCG in 2020-21 so there were no compliance audits to monitor related to these.
- Data from compliance audits in the areas of infection control, medication, and safeguarding is not currently registered under Clinical Audit, which means there is no one central place for the reporting or monitoring of this data and therefore no clear governance of what is being audited or what the results / actions out of the audits are. This is a gap and needs to go onto the risk register. During 2022/23 compliance Infection Prevention and control audits are now being registered within Clinical Audit to provide assurance of monitoring and assurance.
- Audits not completed in 2020-21, and deemed to be still relevant, were carried over to the CAFP for 2021-22.

Monitoring

The Clinical Audit Quality Lead monitors the forward plan as follows:

- Regular clinical audit progress reports are sent to the unit management teams containing information regarding planned projects.
- The Clinical Audit Forward Plan is monitored via the Clinical Effectiveness Committee on a quarterly basis.

1. Welcome	2. Presentati	3. Chairman	4. Corporate	**5. Quality**	6. People and	7. Performan	8. Questions	9. Overall	10.Any Other

Chair's Assurance Report
Quality and Safety Committee 20 October 2022

0. Reference Information

Author:	Olivia Evans, Executive Assistant	**Paper date:**	02 November 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	20 October 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality and Safety Committee meeting held on 20 October 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The Committee was quorate.
- The Committee discussed in length Delayed Transfers of Care (DTOCs) as current there are 32 patients who are delayed discharges.
- The Medicine Incident Review was presented showcasing the recommendations in place to improve both reporting and reduction of medication incidents across the Trust.
- Concerns were raised with the low level 3 safeguarding training figures.
- The Committee approved the Research Annual Report 2021/22.
- The Committee noted the Clinical Audit Annual Report 2021/22.

2.3. Conclusion

The Trust Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances is required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 20 October 2022. The meeting was quorate with 3 Non-Executive Directors and 1 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:		
Present:	Chris Beacock	Non-Executive Director (Chair)
	Penny Venables	Non-Executive Director
	Paul Kingston	Non-Executive Director
	Ruth Longfellow	Chief Medical Officer
In Attendance:	Kirsty Foskett	Head of Clinical Governance & Quality
	John Pepper	Associate Non-Executive Director
	Olivia Evans	Executive Assistant – Minute Secretary
	Lisa Newton	Assistant Chief Nurse
	Nia Jones	Managing Director for Planning and Strategy (part)
	Teresa Jones	Research Manager (part)
	Victoria Brownrigg	Head of Finance (part)
	Amanda Roberts	Clinical Audit Facilitator (part)
	Maryse Mackenzie	Medicines Management Co-ordinator (part)
	Mary Bardsley	Acting Trust Secretary (part)
Apologies:		
Sara Ellis-Anderson, Stacey Keegan, Martin Newsholme and Mike Carr		

3.2 Actions from the Previous Meeting

The Committee discussed the action plan in detail and an update was provided for each action. There were 0 actions noted as outstanding a forwarded on to the next meeting.

3.3 Key Agenda

The Committee received all items required on the work plan (except IPC agenda items) with an outline provided below for each:

Agenda Item / Discussion	Assured	Assurance Sought
1. Declaration of Interest		
There were none to note.	N/A	
2. CNO and CMO Update		
Amber alert from blood transfusion service has been received and has been put in place for 4 weeks. This relates to 2 blood groups. Cross matching of patients and blood supply is being completed and patients' operations are being determined by 2 surgeons to confirm if the patient is urgent. To date no patients have been cancelled.	Full	

Never Event briefing has been circulated to the Board. The equipment is no longer in use and feedback has been given to the suppliers. The Trust are in discussion with the lawyers to gain advice. Discussion was held regarding a national alert being and sharing information to partner organisation. This has been escalated to the system. 1 Serious Incidents has been reported this week on MCSI. There have been noted gaps in systems and process which are being addressed.	Partial Full	Incorporate an action that the scrub nurse should complete a check on the equipment following surgery (even with disposal kit)
3. Performance Report		
Complaint response time is currently below target. The Trust are focusing on the local resolution to ensure the Trust answers patients questions before discharge. NHS review of MCSI discharges – recommendations have been received with in the report which the Trust are considering. Noted the positive recording of delayed discharge as a potential harms event. The Trust confirmed the Trust has appointed a discharge manager who will support with patient flow. 2 deaths in Sept – 1 unexpected and 1 expected. There have been no concerns raised. Queries were raised regarding the spinal waiting list. The Trust confirmed that a spot purchase at a local nursing home has been ceased following clinical assurance not being received, other nursing homes are being considered. The Trust have agreed to spot purchase the winter pressure beds on Sheldon ward however additional staff is required due to the complexity of the patients. 19 patients waiting for admission – to incorporate how long have the patients have been waiting into the report. The Trust confirmed the longest waiter is since 30 July 2022 and informed the Committee that a network model of care has been implemented to support patients whilst waiting for there operation.	Full Full Full Full Full	
4. Operational Planning Framework		
Asked for further assurance on the actions which are aligned to the STW. The Trust confirmed the Chief Nurse and Patient Safety Officer would be lead for the Trust and will continue to report back to the Committee.	Full	
5. Serious Incidents and Never Events		
The Committee noted: ▪ 2 serious incidents reported in October. ▪ Never Event in August – a copy of the report and action plan is due to be presented at the next meeting. ▪ SI audit has been completed and will be presented to the Committee for consideration along with recommendations. ▪ Queried the 2 open actions on the SI report – remain open until the actions have been completed and		

embedded. Need to provide assurance to the ICS before closing.		
6. Medicine Incident Review		
The review of the Datix category "medicine not administered" in 2021-22 identified the following recommendations: ▪ Improved communications to staff. ▪ When deviation from policy is found, a systems approach should be applied to fully understand work. ▪ ePMA to be implemented. ▪ Review how change is implemented. ▪ Encourage reporting of incidents in low reporting areas.	Full	
7. PSIRF Presentation		
The new Patient Safety Incident Response Framework (PSIRF) forms part of the NHS Patient Safety Strategy and sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety. PSIRF is due to replace the current Serious Incidents Framework in the coming months. First training session has taken place on 13th October 2022. Improvements need to be sustained therefore capacity within improvement team may need to be widened.	Full	
8. Harms Presentation		
Cohort 2 has 47 initial moderate harms: ▪ 33 patients moved to low harm post clinic review. ▪ 8 patients awaiting clinic appointment outcome. ▪ 6 RCAs and DOCs underway. Cohort 3 is being discussed to be developed into business as usual.	Full	
9. CIP Quality Impact Assessment Q2		
▪ £176k adverse YTD driven by slippage in the non-QIA applicable schemes. ▪ £34k adverse for QIA applicable schemes. ▪ Orthotics procurement is being led by Jane Dewsbury with a lot of work and mitigations in place to achieve £36k saving. ▪ All the QIAs are deemed as six or below. ▪ No new schemes identified for later in the year.	Full	
10. Quality Priorities		
Two of the priorities are behind plan due to the leads currently not onsite: waiting well initiative and progress against NHS learning disability standards. All other priorities are ongoing, and actions being worked towards.	Partial	New leads are being identified for priorities which are currently behind plan.
11. Learning from Deaths Q2 Report		
A total of three deaths have occurred in quarter two (two expected and one unexpected). Discussions are in progress with SaTH concerning link with Medical Examiner. James Neil, lead for Learning from Deaths at RJAH, is now working as Medical Examiner at SaTH.	Full	

12. Clinical Audit Annual Report		
In 2021/22 the Trust participated in nine national audits, ten audits have been conducted in relation to NICE guidance and seven risks on the risk register.	Full	
13. Board Assurance Framework		
The Committee noted the BAF.	Full	
14. Legal Claims Q2 Report		
Report requires further work as to any recommendations required following claims.	Full	
15. Policy Tracker		
The Committee noted the Policy Tracker.	N/A	
16. To Note		
Research Committee Chair Report – *Noted* Research Annual Report – *Approved* Medical Devices Chair Report – *Noted* Patient Experience Committee Chair Report – *Noted* Safeguarding level 3 training is under target. Safeguarding Committee Chair Report	Full Full Full Partial Full	Work ongoing to improve reporting for level 3 training.
17. Any Other Business		
Front Sheet Template Committee approved to trial the new front sheet for Quality and Safety Committee and its sub-committees.	N/A	

3.5 Risks to be Escalated

During its business, the Committee confirmed there are no risks to be escalated to the Board.

4. Conclusion

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

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	2nd of November 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	12th of October updated 27th of October 2022
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Trust wide IPC improvement plan and progress against actions identified. The Board is asked to **note** the actions taken and seek additional assurance if required.

2. Executive Summary

2.1. Context

RJAH was escalated to red on the NHSE/I IPC Matrix and following a visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance the Trust was moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. The Trust has an IPC improvement plan in place with exit criteria. There have been formal inspections in June and September where the Trust has moved to amber and green respectively on the NHSE/I IPC matrix.

2.2. Summary

- As of the 26th of October:
  - 1 actions behind plan – scheduled for completion in November
  - 68 actions complete
  - 20 actions in progress with clear action owners and timescales with 4 new actions added since last report
- Of the 20 actions in progress, 5 due for completion in October, 5 in November, 6 in December, 1 in March 2023 and 3 in April 2023
- On-going actions will continue to be monitored monthly through IPCC and IPC Quality Assurance Committee
- A formal 6 monthly visit by NHSE took place on the 26th of September with confirmation the Trust has moved to green on NHSE IPC Matrix with assurance visits and review of SSIs in December and March. (Appendix 1)
- Formal assessment against undertakings at meeting held on 27th of October saw undertakings being fully met with confirmation letter to follow.

2.3. Conclusion

The Board is asked to **note** the progress being made and actions taken and seek additional assurance if required.

3. The Main Report

3.1. Introduction

The Trust declared an MRSA outbreak on the Midlands Centre for Spinal Cord Injury (MCSI) on the 20th of July 2021. The NHSE IPC team completed an assurance visit on 2nd of August 2021 highlighting areas for improvement. Subsequently RJAH was escalated to Red on the NHSE IPC Matrix and a subsequent improvement plan with external support was developed and progressed. The Trust has been moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. There are a total of 7 exit criteria that have been mapped to the undertakings

On the 22nd June 2022 there was a formal IPC review from NHSE, the trust received a formal letter acknowledging the outcome of the visit and significant improvements made, meaning that the Trust was moved from red to amber on the NHSE IPC matrix a further visit and formal IPC review from NHSE is planned for September 2022 with a focus on demonstrating sustainability of the improvements made to date.

On the 26th September 2022 the 6 monthly formal IPC review from NHSE tool place supported by a desktop review of key IPC documentation. The Trust has received the formal letter confirming that it has been moved to green on the NHSE IPC matrix with joint ICB/NHSE assurance visits planned for December and March to ensure improvements have been embedded and sustained. (appendix 1)

3.2. IPC Improvement Plan

The Chief Nurse received a letter on the 17th of February 2022 highlighting ongoing concerns around IPC and governance in line with the Code of Practice on the prevention and control of infections (Hygiene Code). There was concern raised that there had been a lack of progress against the previously agreed actions and a lack of evidence that the areas for improvement identified have been extrapolated across the Trust to reduce the risk of possible harm to others.

In response the IPC improvement plan has been developed to ensure actions are embedded trust wide and improvements are sustained. The plan has been developed to include all actions and recommendations from various sources. The IPC improvement plan has been split in to nine themes. The themes and actions have been aligned to overarching seven objectives (exit criteria).

Table 1: Overview of progress against actions IPC Improvement Plan on 26/10/2022

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	2	4	**6**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	0	2	14	**16**
3.	Trust IPC audits demonstrate improvement	0	1	14	25	**40**
4.	Trust reporting on HCAIs, outbreaks and SSIs	0	0	2	19	**21**
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**	**1**	**20**	**68**	**89**

The final two columns on the improvement plan describes the evidence required to close the action and methods of ongoing assurance. A priority column has been added to determine the priority status of each action – this will be reviewed monthly at IPCC as priorities may be subject to change. Associated risk numbers for each of the high priority actions are also referenced within the plan.

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.

There is currently one action behind plan:

No	Priority	Area for Improvement	Target completion date	Accountable Exec	Responsible Lead	RAG status
5.7	Medium	Install glass doors on Kenyon and Gladstone	30/07/2022	Chief Nurse	Phil Davies	Red

- Installation of doors has been delayed due to estates access to the areas. A risk is on the risk register. This work is now scheduled for November.

3.2.1. Sustainability

Our biggest challenge is to sustain the improvements that have been made, we can do so because of our strengthened IPC team and cleanliness team resource and our strengthened systems and processes that are now in place. Importantly our strengthened governance and oversight will enable the Board to have assurance and early identification of risks and the mitigations in place.

Strengthened IPC team and cleanliness team resource	Strengthened systems and processes including shared learning	Strengthened governance and oversight	Culture and Leadership
• New Deputy DIPC role • IPC Assurance Lead made permanent • Increase from 0.43 to 2.43 WTE SSI practitioners • Introduction of 12 month IPC Health Care Support Worker • Re-launch of IPC champions and broadened areas/departments involved • Twice weekly MDT infection ward rounds • Housekeeper recruitment • Logistics assistant role • PEAT team expansion	• Post infection reviews for HCAIs and SSIs • Quarterly thematic reviews for SSIs • After Action Review posters developed for outbreaks • SOPs developed • Policy tracker in place • Estates works prioritisation process in place • Risk assessment process in place for estates refurbishment work	• Board and committee structure – IPC Quality Assurance Committee • IPC dashboard • IPC quality walks and clear escalation procedure • IPC audit programme in place • IPC programme of works • IPC BAF and IPC hygiene code gap analysis reviewed quarterly with Board oversight	• Collective ownership and responsibility • Increased awareness and understanding • Visibility – Board walkabouts, Patient safety walkabouts, DIPC walkabouts • Peer reviews • IPC champions • Regular communication – IPC bulletin and after action reviews • Training • FTSU champions

3.2.2. Future Focus

Future focus	Risks	Mitigations
Sustainability of improvements	Inability to sustain overall levels of improvement	Early escalation to Trust Board System oversight Regular communications and engagement – IPC Summit Repeat sustainability tool in Q4
Embedding housekeeper role across the organisation	Inability to fill all posts Retention of staff	Robust induction Introduction of role – comms to the wider organisation
Case of need and subsequent implementation of ICNet	Time and resource for implementation alongside EPR programme	Allocate dedicated resource and PMO support
Strengthened Microbiology provision	Inability to recruit to impending Consultant Microbiologist retirement	Explore different roles Development of SLA with other organisations
Further System and Regional collaboration	Capacity for IPC team to attend system groups and regional collaboratives	Clear job plans and weekly DIPC/Deputy DIPC meeting to prioritise workload
Continued expansion of Surgical Site Surveillance	Capacity for SSI practitioners to continue manual data input	Use of My Recovery app to communicate with patients ICNet implementation

The microbiology SLA has been extended to March 2023. There are ongoing meetings to revise the SLA and consider other options. This work is being expedited due to the sudden sickness of our Consultant Microbiologist. Anti-microbial ward rounds continue twice weekly by anti-microbial pharmacist with remote advice from SaTH and Sheffield Microbiologists are in attendance at Infection MDT to support.

A case of need for ICNet is expected for review at the Executive team meeting in November.

3.2.3. On-going assurance and oversight

- RJAH IPC Quality Assurance Committee to continue to meet monthly with a review in March
- Monthly agenda item on Trust Board agenda to continue
- Joint System/NHSE Quarterly walk around – December and March – for assurance
- Joint System/NHSE Quarterly desktop review of SSI's – December and March (in addition to usual NHSE touch points with the system for quality oversight)

3.3. Associated Risks

- Microbiology provision and impending retirement of Consultant Microbiologist (March 23) – this risk has now escalated due to sickness of Consultant Microbiologist.
- Digital capability to support increased SSI surveillance

3.4. Conclusion

The Trust has now moved to GREEN on the NHSE Midlands Infection Prevention and Control escalation matrix and formal undertakings have been met. Further assurance visits are scheduled with NHSE and ICS in December and March focusing on sustainability of the improvements that have been made.

The improvement plan will continue to be monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group.

The Board is asked to ***note*** the actions taken and progress to date and seek additional assurance if required.

ANTT	Aseptic Non Touch Technique
AMR	Antimicrobial Resistance
BAF	Board Assurance Framework
BBE	Bare Below Elbow
CCG	Clinical Commissioning Group
DIPC	Director of Infection Prevention and Control
E&F	Estates and Facilities
HCAI	Healthcare Acquired Infection
HCSW	Health Care Support Worker
HH	Hand Hygiene
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
MCSI	Midlands Centre for Spinal Cord Injury
MRSA	Methicillin-resistant Staphylococcus aureus
NHSE/I	NHS England and Improvement
PIR	Post Infection Review
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
SLG	Senior Leadership Group
SOP	Standard Operating Policy
SSI	Surgical Site Infection
STW	Shropshire Telford and Wrekin

NHS England Midlands

To:
- Sara Ellis-Anderson
  Director of IPC &
  Interim Chief Nurse
  Robert Jones and Agnes Hunt

cc.
- Nina Morgan – Regional Chief Nurse
- Fran Steele – Director of S&T – Midlands
- Jacqueline Barnes – Improvement Director RJAH/NHSEI

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

13 October 2022

Dear Sara,

NHS England Visit 26 September 2022 and Desktop IPC Documentation Review 07 October 2022

I would like to thank you for organising the formal review visit of the Trust, this took part in two stages, an onsite review of key areas on 26 September 2022 and a desktop review of IPC related documentation on 07 October 2022. The visit took place as scheduled, following the enforcement of legal undertakings by NHSE due to concerns raised for the prevention and control of infections within the Trust.

As this visit was part of the formal review process to assess the Trusts progress in meeting the undertakings, NHSE have taken the opportunity to review the Trust against the NHSE Midlands Infection Prevention and Control internal escalation matrix. Following the improvements that have been identified both in the areas that were visited and in the new governance processes that has been observed during the desktop review I can confirm that the Trust has moved from the AMBER RAG rating to **GREEN** on our matrix.

The day started with a detailed presentation from you and your team on the work that has been completed to date and the next actions that are in progress, which set the scene of the work that has taken place in the Trust. This included the improvement plan, the improved communication pathways, the strengthened IPC team capacity and work programme, the completed and agreed estates works programme including the lessons learnt, the improvements within the cleaning and facilities teams and the new IPC vision for the Trust. Across the day we visited the Outpatients department, Clwyd and Powys Wards, Theatre and Gladstone and Wrekin Ward.

During the visit I was accompanied by various members of your multidisciplinary team, including the IPC team, Matrons, Surgeon, and ward leaders for each of the areas that were visited. I provided detailed feedback to each area immediately where good practice or improvements required were identified.

I would like to pass my thanks to the teams in these areas who were happy to show us around their areas, share the improvement works that have been undertaken and identified the areas that they are now working on, the engagement across the teams was evident throughout the day.

At the end of the visit, Trust level feedback was provided to the wider team of Executives and their staff, including yourself, the Trust Chief Executive, Medical Director and the Chief Nurse for Shropshire, Telford and Wrekin Integrated Care System. This demonstrates the level of ownership and commitment to the improvement journey within the Trust.

Below is a summary of the key findings shared on the day. Generally, there was improvement noted across the organisation and within each ward and area that was visited throughout the day. I observed that this improvement is becoming more embedded within the way in which the teams work, this should ensure the sustainability of the changes that have been made and those that are still in progress. As well as this the continued engagement that was observed across the organisation highlights that the new ways of working are becoming embedded within the culture of the organisation.

Key areas of improvement identified:

- Estates work:
    - High quality work has been completed in the plaster room and the blood room in the outpatient department.
    - Positive process which describes the handing over of the wards for estates work to be completed and handing the wards back post work, this has incorporated the learning from the previous works and resulted in a smoother transition and a safer handover for all parties.
    - High quality work that has been completed as part of the works on Clwyd and Powys wards, appreciating that there are still some outstanding actions.
    - New toilets and hand wash basins were seen on Clwyd ward, there was a notable improvement to the environment on this ward.

- The physio bars in the rehabilitation area on Sheldon ward have been repainted and are now able to be effectively decontaminated.
- The new linen room and cleaning cupboard on MCSI is now in place and functional.

- The multi-purpose room in the DXA suite has been rectified and this room has now been repurposed.
- We observed a high level of compliance with the bare below the elbow's initiative, across all staff groups.
- Improvements in the storage of the suction units and consumables on Clwyd ward in a way in which makes them available for use but are not left open in the patient's bedspace.
- On the previous visit we identified a concern with the "leg troughs" which are becoming stained inside the covers despite cleaning. It was noted that the team have devised a short term solution to this issue and whilst I would recommend this is explored further with the manufacturer, I am pleased that none of the leg troughs that we reviewed had any strike through and the new process appears to be working well, maintaining the integrity of the trough and ensuring they can be effectively decontaminated between patients.
- Improvements were observed within the shower chair storage room on Gladstone, although I appreciate that this is a temporary solution but ongoing improvements in this area were evident. Improvements were noted with the cleanliness of the shower chairs and the completion of the cleaning schedules for the chairs.

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

- The individual patient risk assessment review process was observed in place with a patient on Wrekin ward, this was a noted improvement and implementation of the learning from the outbreak. I did identify some further areas for improvement with this risk assessment process, which would include ensuring the transmission mechanisms for the infection are considered when exploring mitigations and split out different activities as the risk profile and mitigations are different, this will ensure that each patients needs are considered on an individual basis.
- There is an opportunity to further improve (and streamline) the IPC related plans and reports by referencing the actions so they do not appear on multiple plans but can be traced through the appropriate governance routes, for example the actions recorded on the BAF, but managed and monitored through the IPC improvement plan.

- On the previous review of MCSI we identified concern around the storage of items to support patient's bowel care and maintain independence, at this visit we observed the new packs in place, there is a quality improvement project in this piece of work to work with the patients and staff to ensure this supports the patients needs and continues to reduce the risks that we identified during the previous review.

- There are ongoing estates works that are required, most of the estates works that were observed during the visit had already been reported through your processes. Examples include damage noted to the wall from damp ingress in the outpatient area by the fire exit and areas of flooring where the seals have split, or the coving is separating from the floor or wall.

- Storage of items continues to be difficult within many areas of the Trust, I am aware that you have a new role in place to support the ward areas with the management of storage rooms, the benefits of this are already being observed and were reported by the ward teams during the visit. This work programme should continue, and consideration should be given as to how this can be rolled out to include other areas across the Trust. We observed significant improvement in the storeroom on Sheldon.

- Compliance with mask use has improved overall since the previous visit, however, when we observed staff wearing their masks under their chins, this seemed particularly prevalent within the porter/theatre porters (3 staff), this included when they were transferring a patient to the ward.

- The storage of toilet roll on commodes, this was observed on two of the wards visited. Given the position of the toilet roll on the side or the commode or the commode handle, there is a high risk of contamination of an item which is shared by multiple patients.

- On the previous visit we identified that the sharps boxes were difficult to put together and consequently they had not been assembled correctly. During this visit we identified two sharps bins which had not been assembled correctly, these were both rectified at the time. As well as this, I observed inappropriate items having been disposed of in the sharps bin, such as packaging and swabs. It is noted that the Trust have increased the frequency of their sharps audits because of the concerns that were identified.

- Within the theatre department there is a need to have some attention to detail for cleaning the sticky residue from equipment surfaces and the cleaning of the Velcro areas of equipment, a process for cleaning these items is required and monitoring should be undertaken.

- The cleanliness of beds across the Trust continues to be maintained, on this visit we did identify one bed that had been cleaned only on own half, this was rectified at the time of the visit and actions were underway to discuss with the team on duty.

Key themes where improvement is still required:

- Estates work is required in the theatre department, this has been reviewed and the estates team have begun the process of identifying and costing the works that need to be completed. As we discussed, the Trust are not able to facilitate the closure of theatres at this time, I would recommend a risk assessment is completed to identify the current level of risk, any mitigations and the thresholds for the Trust to close theatres to be able to complete the outstanding work. I would recommend a system discussion around additional mitigations or mutual aid to support the planning and completion of this work.

- Attention to detail when cleaning was a continued theme on this visit however the overall cleaning standards continue to improve. The areas where further attention to detail are required include the handles/groves on the water dispensers, inside dani-centres, underneath chairs, high levels, such as cupboard tops, tea trolleys, and moving items for cleaning. There was dust noted in the female theatre changing rooms, this included on the tops of locker, the vents and the smoke alarm.

- There is a requirement to review the process for cleaning theatre shoes, during the visit we identified a number of pairs of theatre shoes that were not visibly clean and there was no clear shoe cleaning process

- The cleaning of the computers on wheels remains an area where improvement is required, this is unable to be completed by the staff on the ward as these are locked by the IT department. It would be worth exploring options with the IT department around frequency of cleaning for these items considering that they are moved into all patient areas.

- There is a need to review the current processes around staff taking their bags into the theatre, these were observed to be stored on the floor by the anaesthetic machines, I would recommend a review of whether these should be allowed into the theatre department and where they should be stored.

- There were some items of theatre equipment, such as shoulder props, Alan medical body straps, positioning cushions, which are starting to fray, are not fully intact and would not be easily decontaminated – I would recommend a full theatre equipment audit to review this equipment and identify.

Next Steps

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

- Quarterly walk through of the Trust in December 2022 and March 2023, this will be in conjunction with System leads.
- Quarterly desktop review of SSI data, themes and trends and review of the processes.

I am aware that at the last visit in June we agreed that there is an opportunity to write up the MRSA outbreak on MCSI for publication and consideration for presentation at conferences to showcase the work that has been done and the changes within the organisation as a result of this work. The offer of support to you and the team with the publication process and the submission of abstracts and posters for conference remains, as I know this is something you are keen to pursue.

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

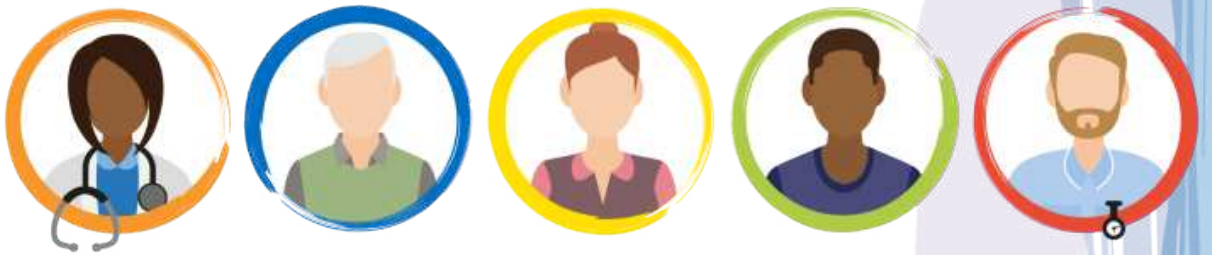
Finally, please discuss share this report with your Trust Board and confirm by email that this has been completed.

Yours sincerely,

Kirsty Morgan
Assistant Director of IPC – NHS Midlands

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

RJAH IPC Improvement Overview
6 month progress



Aspiring to deliver world class patient care

Trust Improvement Plan overview

Position as of 26th of October 22:

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	2	4	**6**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	0	2	14	**16**
3.	Trust IPC audits demonstrate improvement	0	1	14	25	**40**
4.	Trust reporting on HCAIs, outbreaks and SSIs	0	0	2	19	**21**
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**	**1**	**20**	**68**	**89**

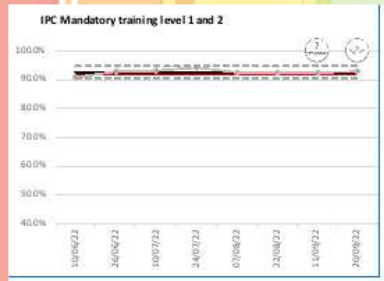
- IPC Improvement Plan split in to 9 themes linked to 7 overarching objectives
- Plan remains live and monitored through IPC working group
- Some longer term actions extend beyond October
- Of the 20 actions in progress (5 due end of this month, 5 Nov, 6 Dec and 4 March/April)
- 4 new actions added following Sept visit and internal audit themes
    - Audit of patient positioning theatre equipment
    - Review process for cleaning theatre shoes
    - Review frequency of cleaning computer on wheels
    - Risk assessment for outstanding estates work within theatres
- 1 action behind plan relating to installation of bay doors on gladstone ward due to high levels of occupancy on the ward.

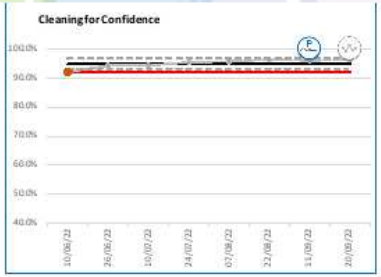
Key achievements summary

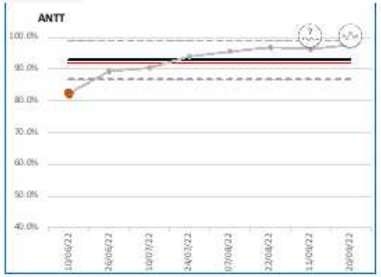
Trust wide communication and learning

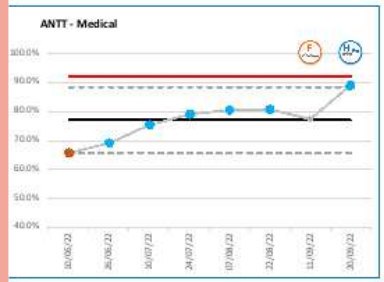
- Regular trust wide communications through managers briefings
- Fortnightly IPC bulletin by CMO/CNO to deliver key messages
- After Action Review posters produced with the team after HCAI PIRs and Outbreaks and circulated widely
- Improved IPC intranet pages with link to National IPC Manual
- Relaunch of IPC Champion/link roles and responsibilities- IPC masterclass delivered by NHSE
- IPC team working on wards alongside staff to educate and support
- IPC updates delivered at monthly Senior Nurse and Allied Health Professional Meeting and Trust Management Group
- BBE campaign

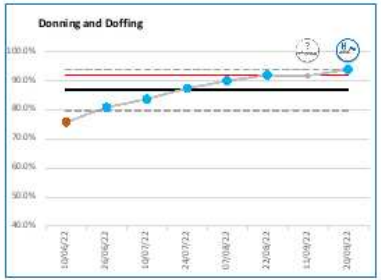
Training

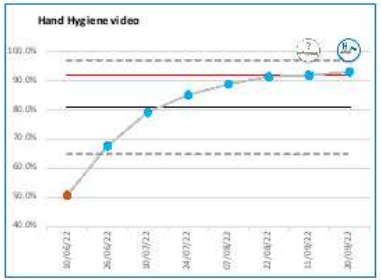


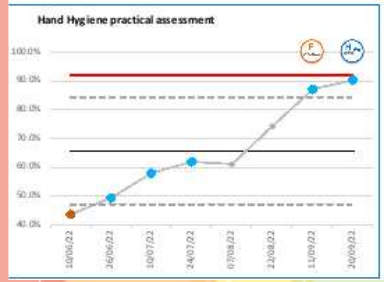












Latest training data September 22:

- IPC Mandatory level 1 and 2 and Cleaning for Confidence module consistently above target for last 6 months
- Donning and Doffing and ANTT now meeting target
- Medical ANTT training – improvements seen now at 88%
- Greatest improvements seen in Hand Hygiene video (93%) and Hand Hygiene practical assessment (90.4%) since June 22.
- Training report produced monthly and monitored through IPCC and escalated to IPC Quality Assurance Committee
- Focus on improving bank and agency staff training

Environment Estates and Cleanliness

- Significant investment in ward refurbishment of MCSI, Ludlow, Powys and Clwyd Wards completed.
- Process embedded to identify IPC related works, prioritised and risk assessed through IPC Working Group and funded through Capital Management Group.
- Greater involvement of the Operational team to co-ordinate access.
- More robust physical barriers being used to allow works to progress alongside Ward activity.
- Forward planning to protect the time and funding needed to sustain the environmental improvements.

Ward Housekeepers

- Appointed 15 ward housekeepers to date, with further recruitment planned for remaining positions.
- Robust local induction planned, involving members of the multi disciplinary team with first sessions in November.

Logistics

- Logistics assistant with focus on ward level stores commenced in September – already demonstrated efficiencies with reduced overstock and better stock rotation/control, all contributing to better organised store areas, enabling effective cleaning.
- Identified 'what good looks like' – practical aspects/improvements which will will enable long term management of storage areas.

PEAT Team

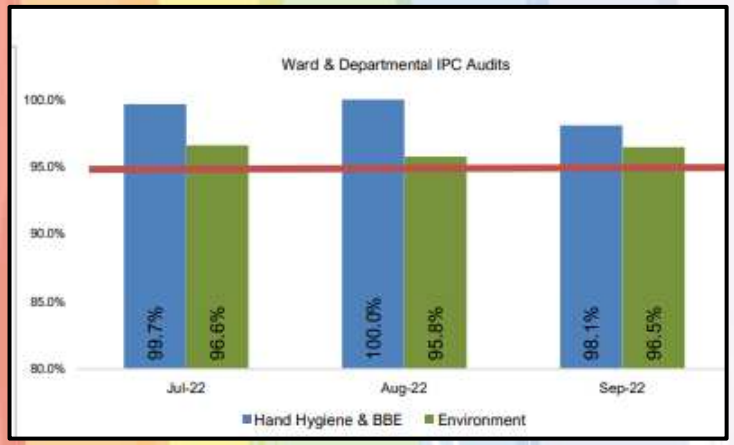
- Recruitment process underway to appoint additional PEAT team members – team to move to rotational out of hours working to support proactive deep cleaning across all shifts supporting wards, departments and theatres.

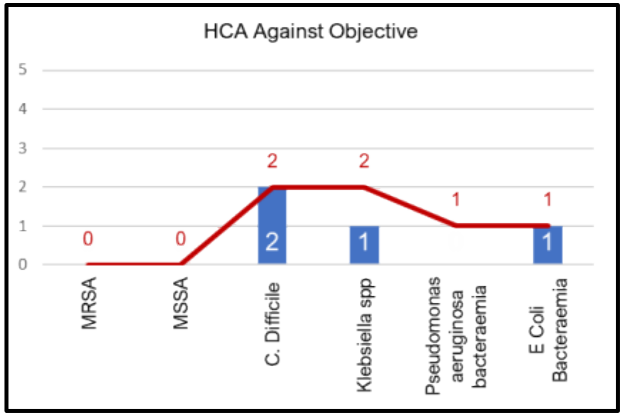
Process

- Embedded formal process of handover to and from Estates and Facilities when completing refurbishment works.

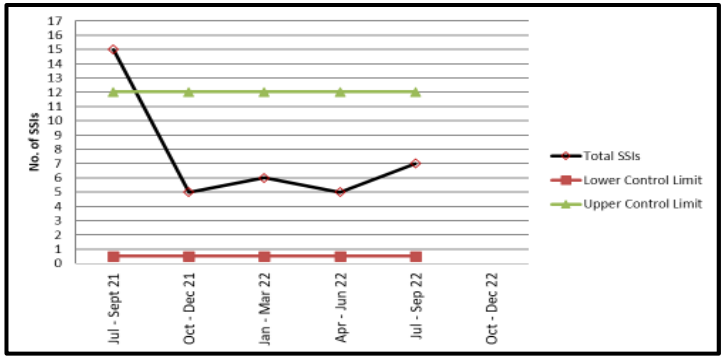
Audit compliance/HCAIs and SSIs

- No HCAI reported in August or September
- Total number of SSIs has decreased per quarter since spike seen in Jul-Sept 21
- Sustained IPC environmental and HH/BBE audits > 95% overall for last three months

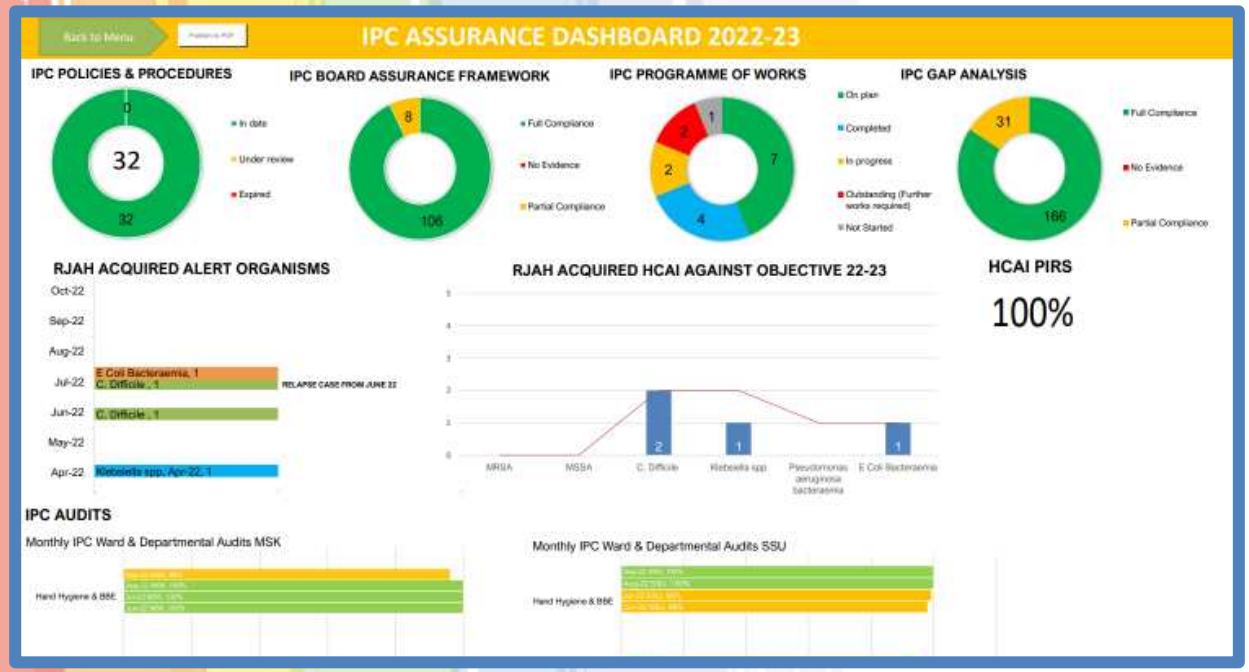




Total number of SSIs



Strengthened governance and assurance

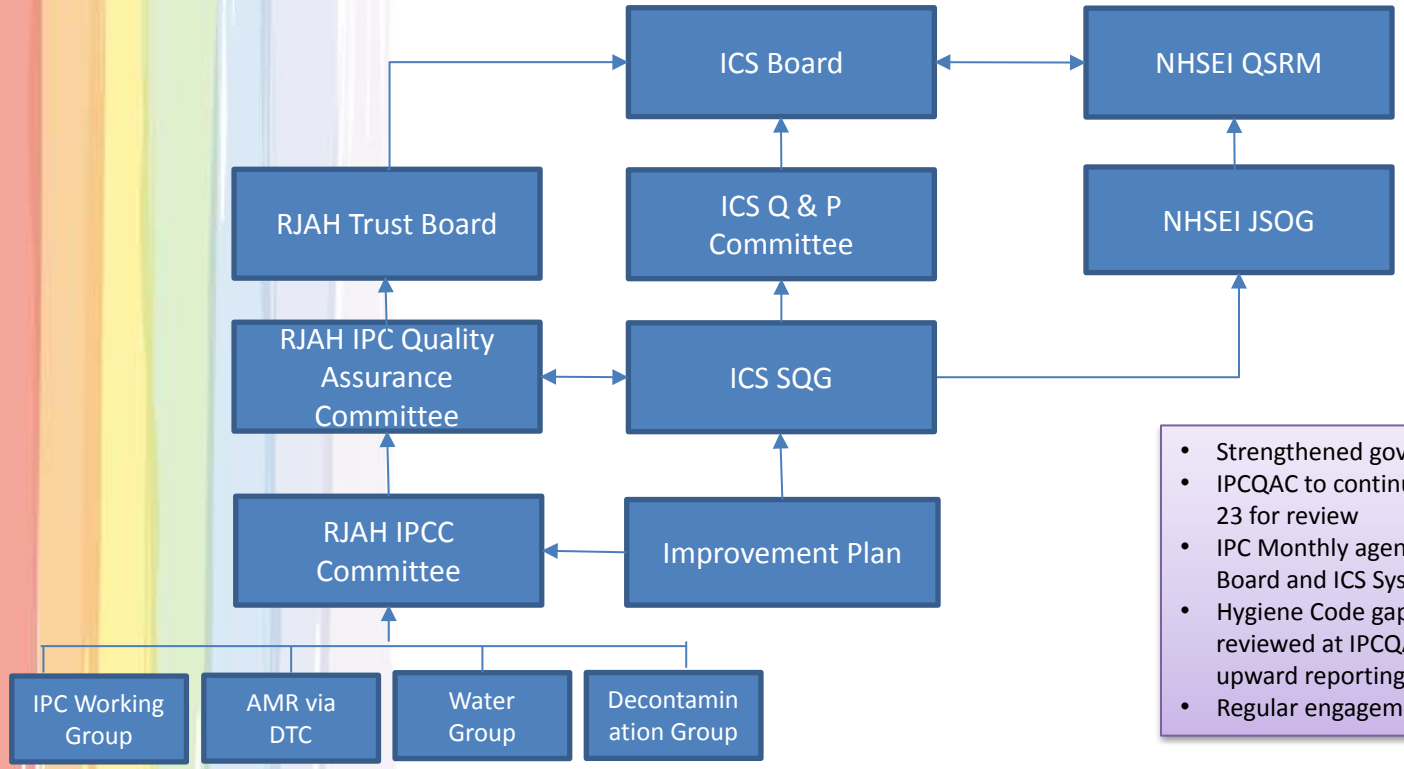


Quality Management System developed further to include:

- HCAI data and PIRs
- SSI data and PIRs
- IPC audit data and actions
- Outbreaks
- Monitoring compliance against BAF and Hygiene Code
- Monitoring progress against IPC programme of works
- Monitoring IPC policies and SOPs
- IPC Quality Assurance walks themes and trends

This is presented monthly at IPCC and IPCQAC and used to format monthly and quarterly IPC reports to Trust Board

Strengthened governance and assurance

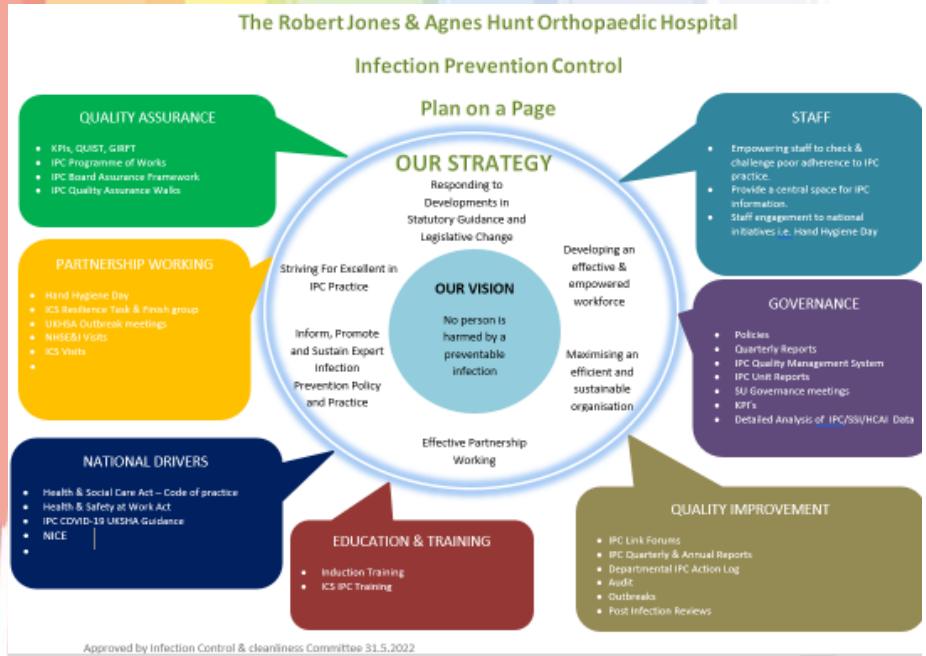


- Strengthened governance and oversight
- IPCQAC to continue monthly until March 23 for review
- IPC Monthly agenda item on RJAH Trust Board and ICS System Quality Group
- Hygiene Code gap analysis and IPC BAF reviewed at IPCQAC quarterly with upward reporting to Board
- Regular engagement meetings with CQC

Leadership and Culture

Infection Prevention

NHS



- IPC Summit scheduled for Dec 22 to include patient stories, shared learning and continued focus on roles and responsibilities
- Re-branding of IPC team
- **Vision: no person harmed by a preventable infection**

- Strengthened engagement and collective ownership across all disciplines
- Trust Board, NED and Governor engagement with Patient Safety Walkabouts
- IPC team development days
- Increased incidence reporting
- FTSU champions
- Staff development programme
- Re-launch of IPC champions

Aspiring to deliver world class patient care

Sustainability

Strengthened IPC team and cleanliness team resource	Strengthened systems and processes including shared learning	Strengthened governance and oversight	Culture and Leadership
• New Deputy DIPC role • IPC Assurance Lead made permanent • Increase from 0.43 to 2.43 WTE SSI practitioners • Introduction of 12 month IPC Health Care Support Worker • Re-launch of IPC champions and broadened areas/departments involved • Twice weekly MDT infection ward rounds • Housekeeper recruitment • Logistics assistant role • PEAT team expansion	• Post infection reviews for HCAIs and SSIs • Quarterly thematic reviews for SSIs • After Action Review posters developed for outbreaks • SOPs developed • Policy tracker in place • Estates works prioritisation process in place • Risk assessment process in place for estates refurbishment work	• Board and committee structure – IPC Quality Assurance Committee • IPC dashboard • IPC quality walks and clear escalation procedure • IPC audit programme in place • IPC programme of works • IPC BAF and IPC hygiene code gap analysis reviewed quarterly with Board oversight	• Collective ownership and responsibility • Increased awareness and understanding • Visibility – Board walkabouts, Patient safety walkabouts, DIPC walkabouts • Peer reviews • IPC champions • Regular communication – IPC bulletin and after action reviews • Training • FTSU champions

Focus for the Future – Risks and mitigations

Future focus	Risks	Mitigations
Sustainability of improvements	Inability to sustain overall levels of improvement	Early escalation to Trust Board System oversight Regular communications and engagement – IPC Summit Repeat sustainability tool in Q4
Embedding housekeeper role across the organisation	Inability to fill all posts Retention of staff	Robust induction Introduction of role – comms to the wider organisation
Case of need and subsequent implementation of ICNet	Time and resource for implementation alongside EPR programme	Allocate dedicated resource and PMO support
Strengthened Microbiology provision	Inability to recruit to impending Consultant Microbiologist retirement	Explore different roles Development of SLA with other organisations
Further System and Regional collaboration	Capacity for IPC team to attend system groups and regional collaboratives	Clear job plans and weekly DIPC/Deputy DIPC meeting to prioritise workload
Continued expansion of Surgical Site Surveillance	Capacity for SSI practitioners to continue manual data input	Use of My Recovery app to communicate with patients ICNet implementation

Questions?

RJAH Undertakings Self-Assessment overview

Name of provider organisation:	RJAH Orthopaedic Hospital NHS Foundation Trust
Date of update:	27th October 2022

Key	
	Exit Criteria achieved and embedded
	On track, and with clear evidence, to meet the exit criteria by the planned exit date
	Emerging risk of inability, or no clear evidence of ability, to meet exit criteria by the planned exit date
	Off track with high risk of inability to meet exit criteria by planned date
	Assume compliance

Section		July	August	Sept	October
	Quality of Care				
1.1					
1.2					
1.3					
1.4					
1.5					
1.6					
1.7					
1.8					
1.9					
1.10					
	Improvement				
2.1					
	Programme				
3.1					
3.2					
	Meetings and Reports				
4.1					
4.2					

Ref	RJAH Undertakings	Progress in	Key progress to date	Risks to note	Risk ID and Score	Evidence	Linked Exit Criteria
		October					
1. Quality of Care							
1.1⊠	The Trust will take all reasonable steps to address the concerns as identified in the visit report sent as part of a letter from NHS Improvement to the Chief Nurse on 17 February 2022, including carrying out the actions set out in the report in accordance with such timescales to be determined by NHS England.		*The Trust has worked to fully comply with this undertaking, *Improvement plan in place with clear timescales and responsible leads. *Plan includes all improvements required noted by NHSE, the Improvement Director, any other governance reviews and all visits that have taken place. *Plan has been presented monthly to the Trust Public Board as well as Trust committees. *Council of Governors have been sighted on undertakings and actions being taken to address throughout the last 6 months. *All actions have progressed with many delivered and sustained. *Focus this month has been on embedding and sustaining the improvement, evidenced through walk abouts and training/audits. *Additional evidence seen of sustained and embedded change in external visits and desk top reviews. *Copies of all letters received by NHSE have been shared at the public Trust Board. *The Improvement plan remains a 'live' document and will continue to be added to and reported upon to the IPC assurance committee and Trust Public Board.	None to note at this time	N/A	IPC Improvement Plan Trust Board papers (public) demonstarting progress IPC dashboard to include improvements in HH/BBE and environmental audits IPC Quality Walks and escalation SOP Hygiene Code gap analysis Letters following informal and formal NHSE IPC inspections Improved compliance with training and audits, evidenced in Trust papers and clinical practice observations	1a 1b and 1c 3 4a and 4b
1.2	By dates to be agreed with NHS England, the Trust will update its IPC improvement plan ("the Plan") to ensure that if reflects all of the latest improvement actions identified by NHS England, including demonstrating that it has sufficient capacity at both executive and other levels of management to implement the Plan.		*As detailed above, the Trust has fully complied with this undertaking. *IPC plan progressing all actions and where progress is slower than expecated, a clear mitigation is in place. *IPC plan is shared at monthly with NHSE at the Improvement Review Meeting. *IPC dashboard in place for oversight on IPC audits and training. *The content and capacity for IPC plan and IPC dashboard continues to be reviewed each week in the IPC working group and both are reported to the monthly IPC Committee and IPC Quality and Assurance Committee. *An overview of the IPC Improvement plan and progress to meet the undertakings is shared monthly at the ICS System Quality Group and ICS Quality and Perfomance Committee.	None to note at this time	N/A	IPC Improvement Plan Monthly IPC improvement plan report at IPCQAC and Board Evidence of individual actions having been implemented- photos, audits, observations, policies and procedures, meetings, changed practice. Trust IPC Strategy IPC team structure Trustwide IPC training report compliance IPCWG and IPCC minutes IPC Dashboard	1b 2a 2b and 2c
1.3	If required by NHS England, the Trust will obtain external support from sources according to a scope and timescale to be agreed with NHS England, on the matters in paragraph 1.2.		*No requests received from NHSE to initiate an external review. *Trust initiated review by the Good Governance Institute has been undertaken. IPC requirements noted are to continue the work already in progress. The report is being shared at the November Trust Board. *Trust initiated review of MRSA outbreak by a peer Trust is complete and learning being captured. *Paper for publication to share the learning from the MRSA outbreak is being progressed with the NHSE Deputy DIPC.	None to note at this time	N/A	Final report from GGI, associated evidence of going to October Trust Board and minutes demonstrating discussion and actions agreed. Final report received from Walsall NHS Trust (peer review) and evidence of actions being taken.	N/A
1.4	The Trust will, by such date as specified by NHS Improvement, agree on milestones and a timetable for delivering the Plan with NHS Improvement and will submit a monthly Board-approved progress report against delivery until such date as specified by NHS Improvement		*The Trust has complied with this undertaking in full. *The IPC Improvement Plan includes set timescales and responsible leads, and how the improvement will be sustained and monitored. *IPC Improvement Plan has been aligned to the undertakings and exit criteria timescales and shared with NHSE vis the monthly improvement meetings. *As stated above, progress against the Improvement plan is reported monthly to the IPC Committee, IPC Quality and Assurance commitee and the CNO reports to Public Trust Board progress on the IPC plan specifically.	None to note at this time	N/A	IPC Improvement Plan Evidence of agendas, papers and minutes from monthly IPC icommitee and Trust Public Board Monthly Trust presentation to IRM meetings demonstrating improvements made each month.	1a
1.5	The Trust will, as part of its Plan, review and develop robust governance processes for oversight and assurance of IPC within the Trust.		*The Trust has fully reviewed and developed robust governance processes for oversight and assurance of IPC within the Trust and also within the ICS. *Governance for IPC reviewed in with both NHSE Improvement Director and system leads and strengthened. Revised governance processes in place. *This has been reported within the monthly IRM meetings with NHSE and the ICS. *Good Governance Institute engaged to review wider governance, as described in 1.3. *Additionally, an IPC quality dashboard has been developed and implemented with monthly reporting in place to the IPC committees. *A refresh of committee reports has been undertaken to ensure reports are meaningful and assurance of actions and impact is demonstrated. *Clinically, a twice weekly MDT ward round ensures that all in-patients with infections are reviewed by an expert clinical team - IPC, pharmacy and microbiology. * A digital solution to replace the current manual process for surveillance of infections in the community is being progressed.	Digital capability for HCAI's and SSIs is being progressed. Mitigating actions in place with manual data collection and reporting.	Risk ID 2975 - Digital capability Risk Score 12	Trust Governance framework Patient Safety walkabout documentation Trust Board minutes Monthly IPC improvement plan report at IPCQAC and Board IPCQAC minutes IPCC minutes IPC Dashboard Q&S IPR IPC Programme of works IPC 12 month audit plan Hygiene Code self assessment IPC Covid BAF	1a 2a 2b and 2c
1.6	The Trust will work with system partners to review and strengthen its governance with regards to IPC in such timescales as agreed with NHS England.		*The Trust has fully complied in working with system partners and regulators to stregthen it's governance with regards to IPC. *System governance for IPC has been reviewed and monthly reporting takes place within the ICS Quality oversight group and Quality and Performance commitee is in place. *The Trust IPC team are actively engaged in system IPC working group and regional NHSE SSI working group *The Trust participates fully with system AMR work. *Joint Trust and system working is progressing community surveillance and enagaging primary care colleagues. *Regular support via the ICS CNO, deputy nurses and the new IPC lead is in place with regular meetings.	System community surveillance - work with Primary Care teams has commenced, supported by one of the NEDS (GP) and ICS leads.	Risk ID 2865 - IPC Team Capacity Risk Score 9	System Quality Group minutes System Q&S Committee papers and actions System IPC group attendance Outbreak minutes Post surveillance working group papers and minutes	7b
1.7	If required by NHS England, the Trust will commission an external review to provide assurance that the Plan has been appropriately implemented. The scope, source and timing of any external review will be agreed with NHS Improvement.		Assume compliance unless required			Weekly ID reports IRM Meeting agendas, enclosures and letters System Quality Group minutes Trust Board and ICB Board minutes CQC Engagement meeting minutes	
1.8	The Trust will arrange with NHS England, and with system partners, a series of clinical visits to review and assess progress against the implementation of the Plan. The scope and the review team will be agreed with NHS England.		*The Trust has arranged and particpiated in a number of clinical visits with NHS England, system partners, the CQC and other providers. *Trust rating further improved to GREEN following formal review in September by NSHE Deputy DIPC. *Visit on 17th October by the ICS CNO and MD was reported positively. *Further visits by NHSE are planned for December 2022 and March 2023. *Exec and NED walk abouts (both in and out of hours) continue. *Unannounced walk abouts by IPC team, CNO, senior nursing team and the wider leadership team continue as in recent months.	None to note at this time		Letters following formal inspections Trust Board minutes IPC Improvement plan and monthly report	5 6
1.9	If required by NHS England, the Trust will commission an external review to provide assurance that the Trust integrated governance structures are effective and that processes are in place to provide oversight of risks and issues in relation to IPC and clinical quality.		Assume compliance unless required	None to note at this time			
1.10	In line with the System Improvement Board Terms of Reference and the requirements of the System Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address regulatory concerns.		*Trust has fully cooperated with NHSE, the STW system, CQC and UKHSA to address the regulatory concerns. *Trust has fully worked to the agreed Terms of Reference of the monthly Improvement Review Meeting, co-chaired by NHSE and STW ICS. *Formal comunication in letter form to the Trust Chair following each IRM has been shared as part of Public Board papers. *Regular engagement with CQC with Trust Execs in place and CQC colleagues kept fully briefed on all matters IPC. *Progress against the undertakings and exit criteria reported within NHSE by the Improvement Director to the monthly Regional Joint Oversight Meeting.	None to note at this time	N/A	IRM Meeting agendas, enclosures and letters System Quality Group minutes Trust Board and ICB Board minutes showing all letters being shared in public CQC Engagement meeting minutes	7a 7b and 7c
2. Improvement Director							
2.1	The Trust will co-operate and work with an Improvement Director to oversee and provide independent assurance to NHS England on the Trust's delivery of the Plan to improve the quality of care the Trust provides.		*The Trust has fully cooperated with NHSE Improvement Director whilst in post. *Improvement Director embraced as part of the Executive Team and was invited all Executive and Board meetings, both public and private, as well as all relevant Committees. *Improvement Director provided support and independent assurance on the delivery of the IPC improvement plan, actions required, hygiene code, governance and whether progress was being delivered in practice. *CEO held weekly meetings with Improvement Director and regular meetings were held by the Chair and the Improvement Director throughout their time within the Trust.	None to note at this time	N/A	Weekly ID reports IRM Meeting agendas, enclosures and letters	7a
3. Proeramme Manaement							
3.1	The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.		*The Trust has implemented programme management and clinical governance support and has additionally increased capacity for IPC governance and IPC clinical practice. *PMO support in place with responsibility to capture all improvements and evidence relating to the Trust IPC improvement plan and relevant committee/Board meetings. *Clear governance arrangements in place both within the Trust and at System level as outlined above and agreed in the monthly Improvement Review Meetings. These are to continue and be reviewed in March 2023. *Additional capacity of the IPC team, the Nursing team (deputy DIPC) in place.	None to note at this time	N/A	Evidence drive contained on Trust IT server. Contains copies of all evidence for the IPC Improvement Plana and the wider governance associated with delivery. Includes Trust BAF, Board and committee papers, comms, photographs of works and system papers.	1a and 1b
3.2	Such programme management and governance arrangements must enable the Board to: 3.2.1.⊠obtain clear oversight over the process in delivering these undertakings; 3.2.2.⊠obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and 3.2.3.⊠hold individuals to account for the delivery of the undertakings.		*Full oversight at Board of undertakings and delivery through the Trust IPC Improvement Plan which is mapped to delivery of the undertakings. *Copies of letters from IRM are shared with the Board in public session. *Copies of this self assessment are shared with the Board. *Addiotionally, a monthly report is presented to every public board as additional assurance detailing progress of delivery of the IPC improvement journey. This will continue until March 2023 and then reviewed. *IPC risk register in place with mitigating actions. *Trust BAF refreshed and approved at Board in October - details the ongoing controls for how IPC imrpovement will continue and will be monitored.	None to note at this time	N/A	Trust Board minutes Monthly IPC improvement plan report at IPCQAC and Board IPC improvement plan and supporting papers/evidence IRM letters IPCC minutes IPCQAC chairs report Monthly IPC Quality Report containing risk register Refreshed Trust BAF	1a 1b and 1c
4. Meetings and Reports							
4.1	The Licensee will attend meetings or, if NHS England stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England.		*Trust fully compliant to date and timely responses delivered. *Monthly oversight meetings attended in full and Trust fully compliant with all requests. *Full oversight at Board of undertakings, delivery of improvement plan and NHSE feedback/requests has been maintained throughout the previous 6 months and will be maintained going forward.	None to note at this time	N/A	IRM Meeting agendas, enclosures and letters.	7a
4.2	The Licensee will provide such reports in relation to the matters covered by these undertakings as NHS England may require.		*Trust fully compliant to date and timely responses delivered. *Presentations made to each monthly improvement meetings detail progress against the unertakings.	None to note at this time	N/A	IRM Meeting agendas, enclosures and letters.	7a

0. Reference Information

Senior Leader Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	2 November 2022
Paper Reviewed by:	NA	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board - Public	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 IPC Quality Assurance Committee and what input is required?

This paper presents an overview on IPC, Cleanliness and Decontamination related performance from July to September 2022. The paper is intended to give assurance on current performance, outlining actions being taken to address areas of underperformance.

2. Executive Summary

2.1. Context

This paper provides an overview of Q2 Trust performance in relation to IPC, Cleanliness and Decontamination.

2.2. Summary

Key highlights from the report:

- Cleanliness scores remain consistent with Q1 performance and local and national targets have been maintained.
- 3 HCAI's reported in Q2 (1 was non-RJAH acquired)
- 8 SSI (5 Hips and 3 Knees) have been reported for the quarter. 4 out of the 8 PIRs have been completed.
- Demonstrable improvement in IPC training compliance noted
- 8 outbreaks declared for Q2, 7 of which relate to COVID-19 and 1 MRSA outbreak.

2.3. Conclusion

The Board is asked to note the content of the report and actions being taken.

		Target	Q1 Position	Current Position (Q2)
HCAIs	RJAH Acquired C.Difficile	2 annually	1	1
	Bacteraemia	1 annually	0	1
	Bacteraemia	Zero	0	0
	Bacteraemia	N/A	0	1
	spp	2 annually	1	0
	Pseudomonas	1 annually	0	0
	Outbreaks	N/A	3	8
SSIs	ALL	N/A	6	8
	Of which; hips	N/A	3	5
	Of which; knees	N/A	0	3
	Of which; spines	N/A	3	0
Audit	Environmental	95%	97%	96%
	Below Elbow	95%	99%	99%
	Assurance Walks	N/A	17	14
	MRSA screening	100%	99.81%	99.70%
Training	Completed "in date" IPC (Clinical Staff) - Annual	95%	95%	94%
	Completed "in date" IPC (Non-Clinical Staff) - 3 yearly	95%	98%	94%
	Cleaning for Confidence an Introduction	95%	97%	97%
	Cleaning for Confidence Intensive Care Units	95%	94%	99%
	Antiseptic Non-touch Technique	95%	90%	98%
	Antiseptic Non-touch Techqniue - Medical Staff	95%	20%	100%
	Donning and Doffing	95%	82%	97%
	Hand Hygiene	95%	75%	97%
	Completed "in date" Handwashing Assessment	95%	74%	93%

Summary

The Board is asked to note the progress report against the annual programme of works for the infection prevention and control report. The Board are briefed on the mandatory HCAI surveillance and key issues emerging from those results.

1 E. coli (against a target of 1
1 C.difficile (against a target of 2)
1 MSSA (Non RJAH acquired)
5 THR SSIs
3 TKR SSIs
8 Outbreaks of infection

Continued improvement in compliance in IPC training

Risks to Escalate/Concerns

HCAI post infection reviews highlighted inconsistencies in the completion/documentation of VIP scores.

IPC Quarter 2 Summary

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

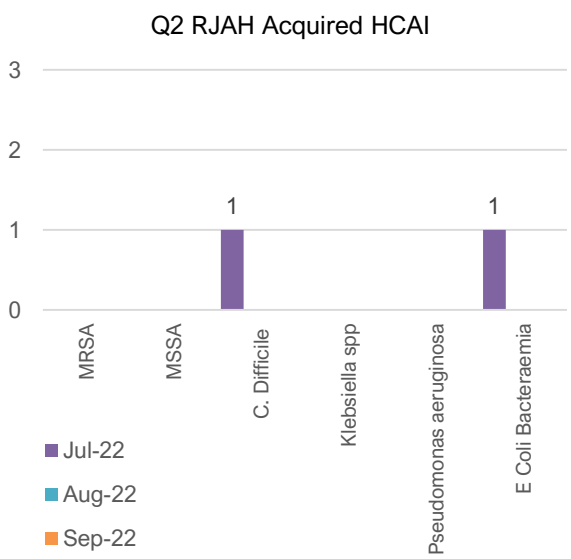
Healthcare Acquired Infections

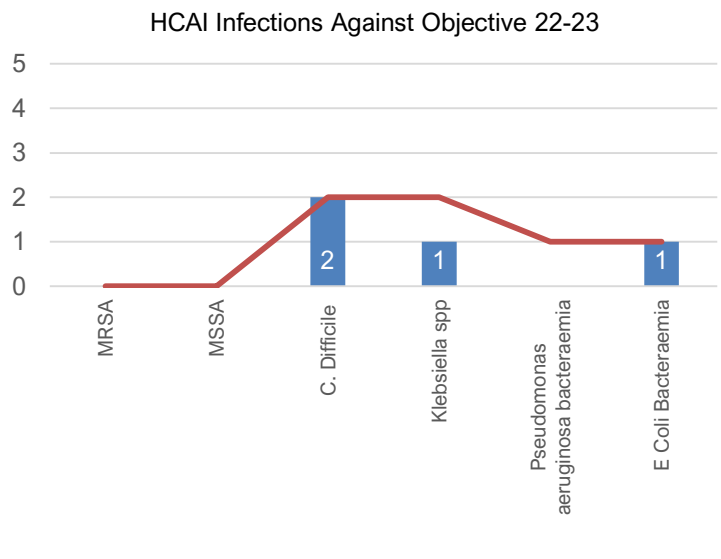
Rise in HCAI infections for Quarter 2 from the last quarter with 3 HCAI infections reported.

September 22: No HCAIs reported

August 22: No HCAIs reported

July 22:
1 C.difficile (against a target of 2) reported for Wrekin Ward (relapse episode relating to the same patient reported for June 22). Patient had numerous risk factors resulting prescribed antibiotics determined as appropriately prescribed.
1 E.coli BSI: The review concluded that all appropriate steps were followed in managing the infection and it was unavoidable. No contributory factors identified or lapses in care were. Antibiotics appropriately prescribed in a timely manner.
1 MSSA BSI: blood cultures acquired on admission. Non RJAH acquired.





Surgical Site Infections

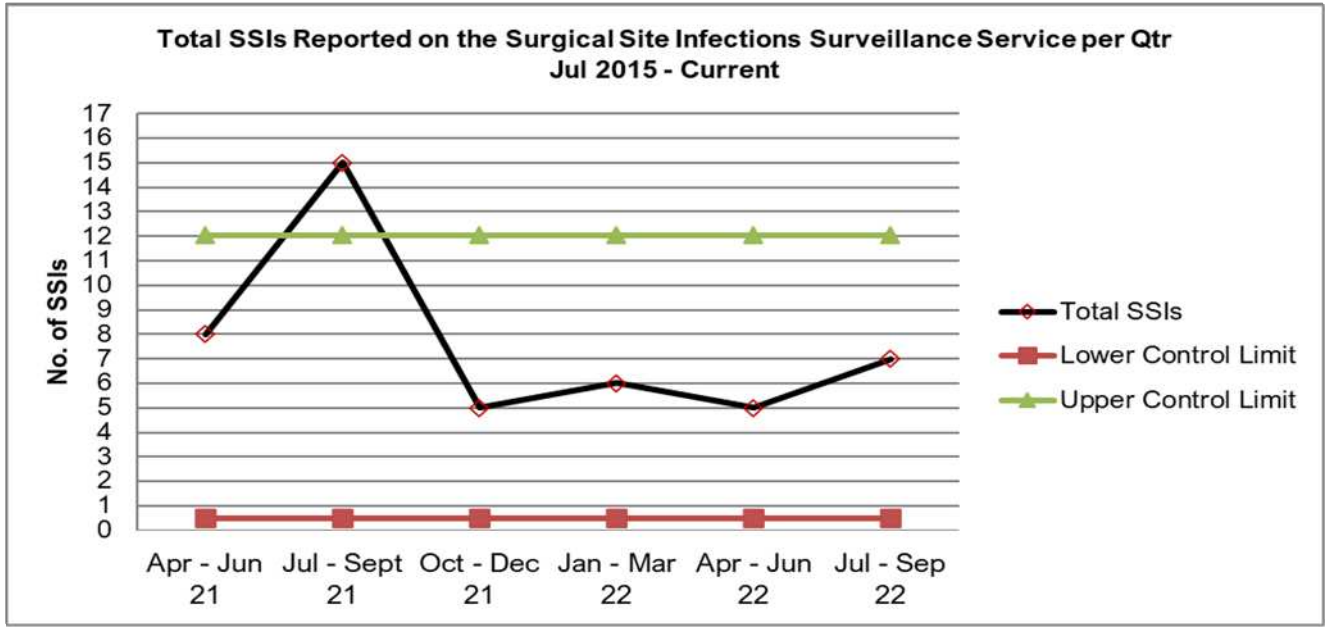
It is important to note, pre reported monthly figures can increase in line with the 12 month surveillance period for infections.

8 SSIs have been reported for Quarter 2. Four post infection reviews (PIRs) were undertaken which identified the following themes:

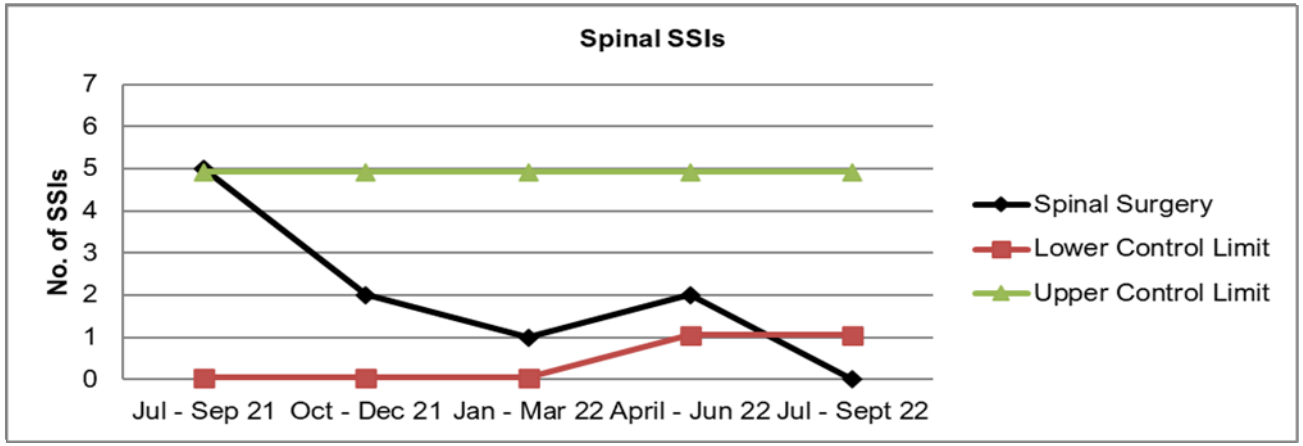
Patient warming: *Action* - Taken forward to the SSI Prevention Working Group for action.

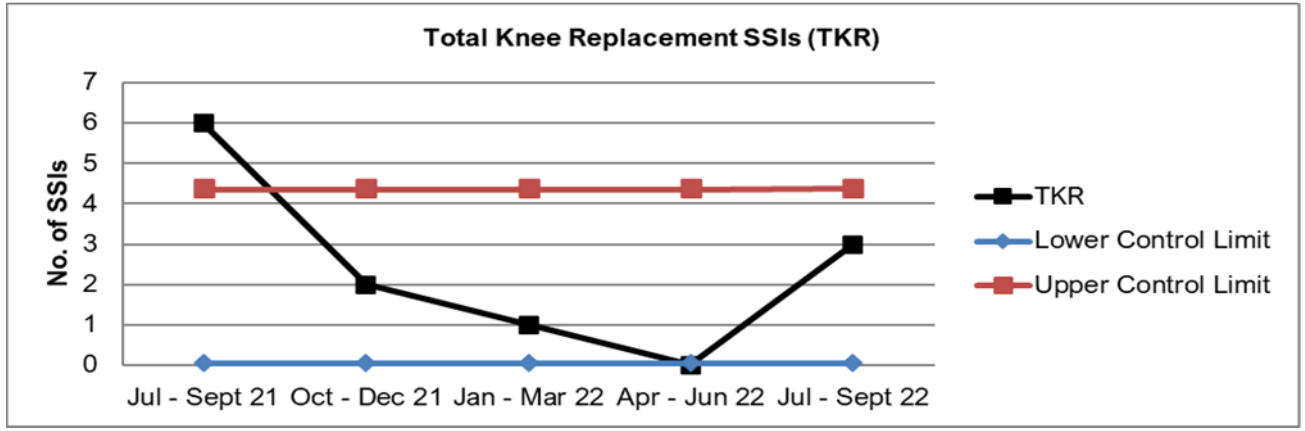
Lack of patient information & education prior to admission*: Action* - A full review of patient leaflets is being undertaken to enusre patients recieve appropraite information regarding wound care management.

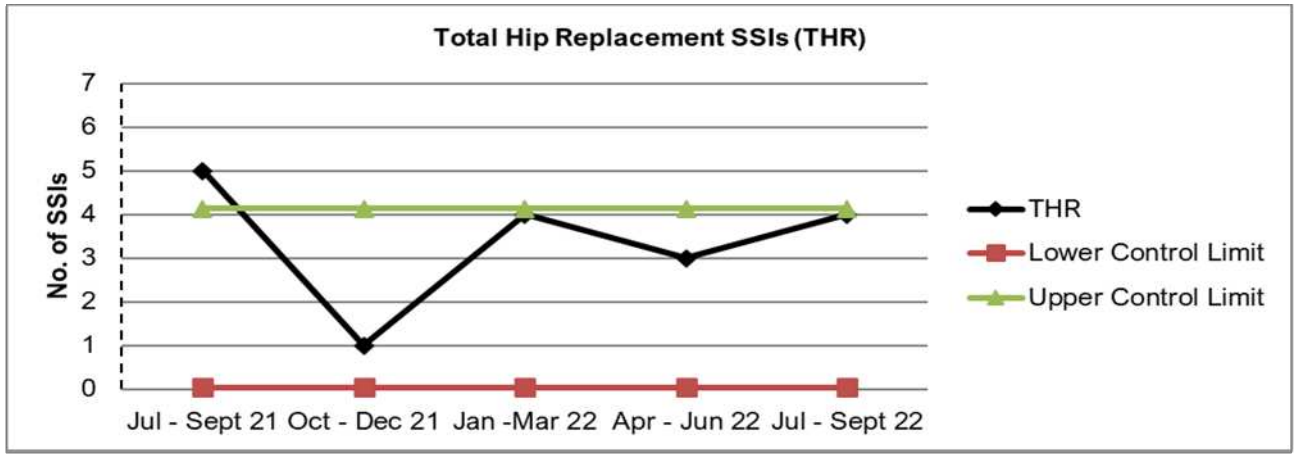
Theatre ventilation raised as a concern: *Action* - IPC team & Consultant Microbiologist met with the ventilation and



decontamination lead to discuss concerns. We were given assurance that the ventilation system in cabins 1-4 were still performing to the orignal design specification.







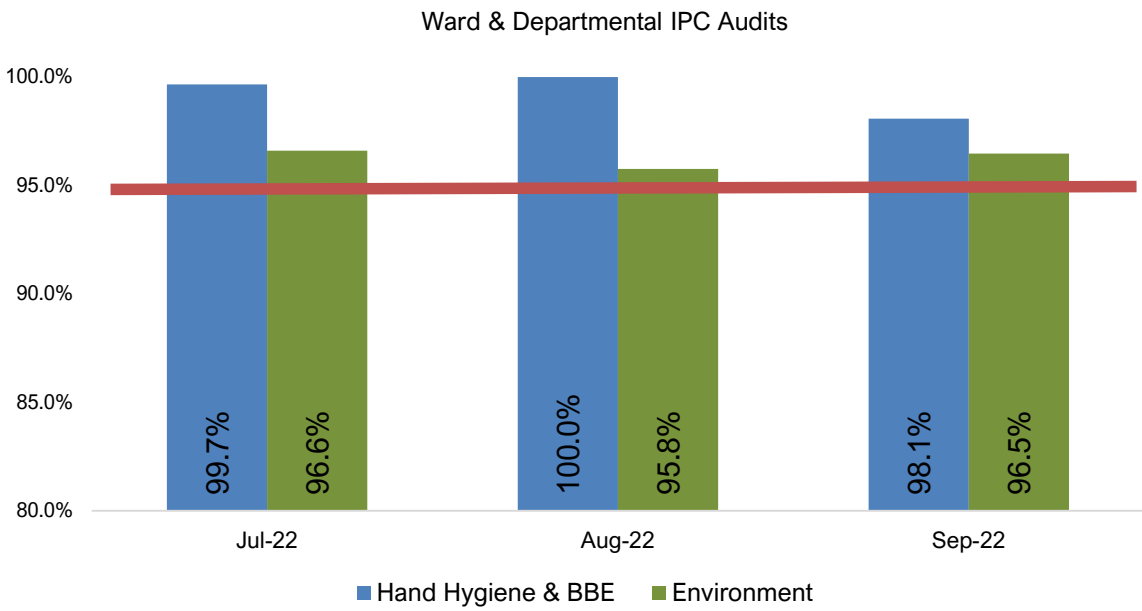
IPC Ward & Departmental Audits

General IPC/Environmental:
Wards and departments continue to monitor the environment on a monthly basis. Scores remain consistent with previous quarter.

Hand Hygiene & Bare Below the Elbow:

Wards and departments continue to monitor hand hygiene and bare below the elbow practices on a weekly basis. An overall compliance score of 99% was achieved for Quarter 2. Hand hygiene competencies are monitored via the training team in line with ESR modules.

An external hand hygiene audit was undertaken by GOJO in August. 86 observations were undertaken across 10 wards/depts which showed an overall complaince rate of 79.1%. The audit was based on the 5 moments of hand hygiene, however the auditor was unable to audit moment 2/3. Feedback has been sent to the ward/dept managers and will be discussed at SNAHP and Link

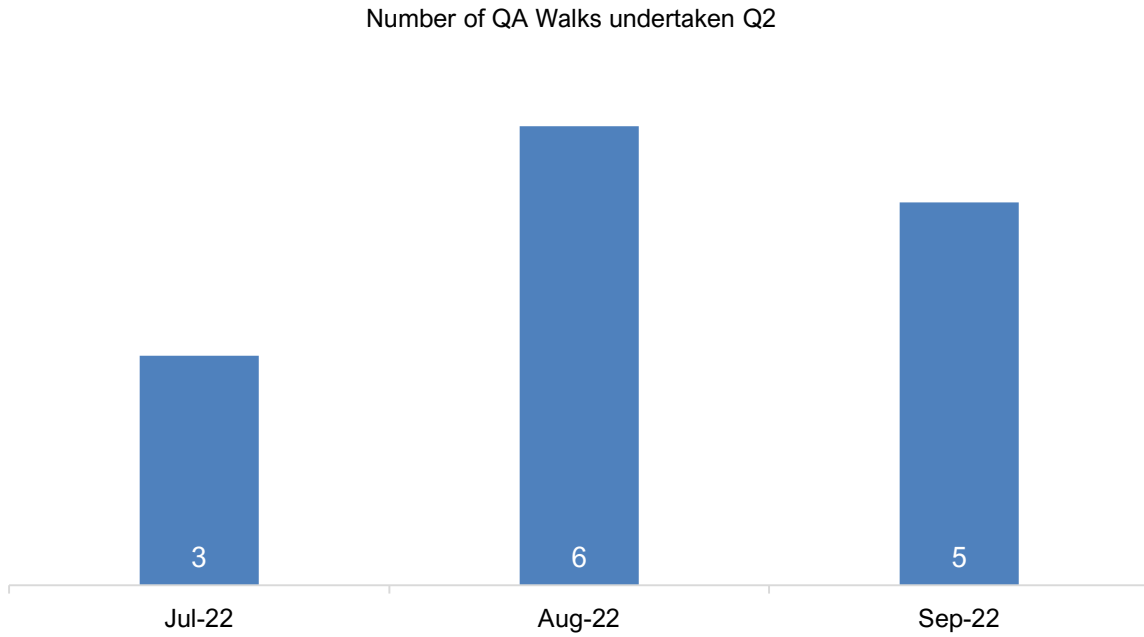


IPC Quality Assurance Walks

IPC Quality Assurance Walks continue to be undertaken by the IPC Team in line with the rolling annual programme and frequency determined by a RAG rated escalation process. The role of the IPC Healthcare Support worker has bolstered this process, enabling the IPC team to be more visible across the Trust.

Key theme for non compliance is reported to be cleanliness of the environment with high and low dust observed. Followed closely by cleanliness of equipment and estates works required. All actions generated from these audits are sent directly to the Ward/Departmental managers for their resolve.

A total of 14 QA Walks have been undertaken with observations captured in the table below:

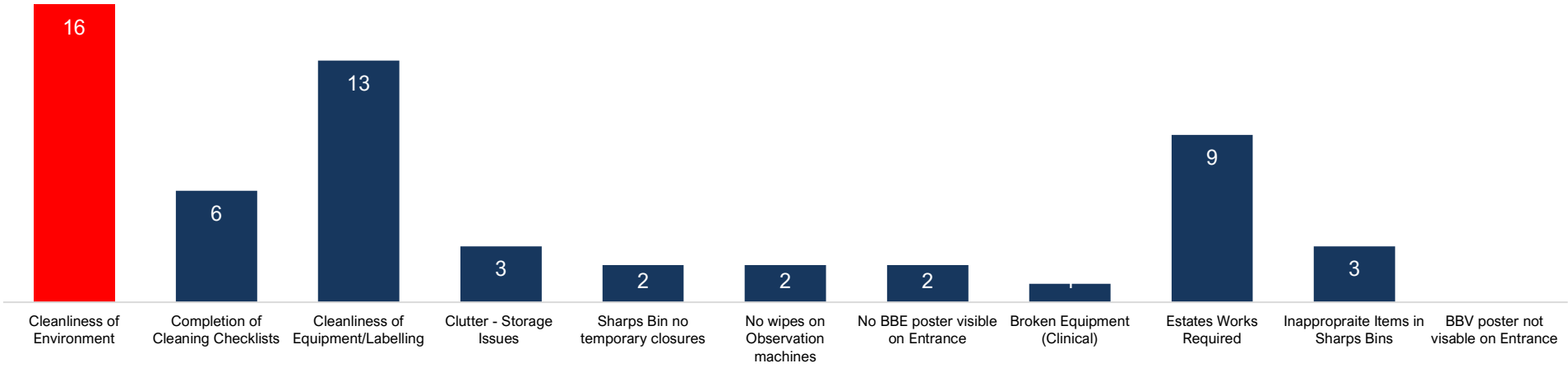


14 Quality Assurance Walks were undertaken within this quarter:

Location	No of walks & RAG status	General Observations
Clwyd	2	Jul 22: 86% Inappropraite items located in sharps bins Bed side tables in poor state of repair Boxes and mattress located on the floor. Aug 22: 92% Significant improvements observed from previous audit. Mattress and other items still being stored on floor Floor outside bay 2 in need of remedial repair Dust located in high areas
Gladstone	2	Jul 22: 81% - Bought forward in response to MRSA outbreaks declared in July 22 High and low dust located in treatment areas Cleaning records incomplete Sharps boxes over filled and contained inappropraite items Aug 22: 97% - Undertaken in response to COVID-19 outbreak in August Significant improvements observed to sharps buins with no inappropraite items found Cleaning checklists completed and reflective of standards Dust located on bed frames and high surfaces.
Wrekin	3	Aug 22: 90% & 86% undertaken in response to COVID-19 outbreak declared in August on Gladstone: Lack of wipes located on obs machines Dust locatde on lower bed frames. Cleaning records not completed High and Low dust located on treatment room Sharps box over filled and contained inappropraite items Sept 22: 88% fall in standards observed since previous audit further audit planned Oct. Cleaning checklists continue to be out of date and incomplete. Danicentres require cleaning Dust located to underside of bed Items located/stored beneath U bend under sink.
Kenyon	1	Sept 22 87.7% Not all equipment labelled as clean. No wipes located on obs trolleys. Sticky residue found under bedside table. Blood found in bm box. Floor in need to remedial works. Reaudit planned for October 22 in line with Amber escalation process.
Sheldon	1	Aug 22: 93% No Wipes located on Obs trollies Staining found on underside of bed table. Actions generated for both issues for immediate action.
Montgomery	1	Sept 22: 96% No wipes on Obs machines. No other concerns raised. Non applicable questions reducing scores. Tailoring session arranged with Tendable 17/10/22

Diagnostics	1	Jul 22: 91% Splash of bodily fluid located of side of crash trolleyand labelled as clean No wipes located Obs Trolleys. Redial works required to walls.
Therapies	1	Sept 22: 93% Crash trolley clean but not labelled. Storage areas clean and Tidy but no assurance items are clean. Cleaning checklists up to date and reflective of standards
Alice	1	Sept 22: 95%: Obs machines clean but not appropraitely labelled. High dust located in treatment room on top of cupboards.
Common Themes and Trends		Uncharacteristic rise in non compliance to sharps was seen within this quarter- with 3 instances observed in 3 different clinical areas within the same month (September 22) Health & Safety Manager is sighted due to the data link between IPC QMS and H&S QMS. Bespoke audit will be devised for Tendable to monitor Trust wide compliance to safer sharps. High and low dust reducing scores and staining to bedside tables remains a common theme and locak of wipes found of obs machines in ward areas. Trust wide replacement programme to be considered for bedside tables. Theme to be presented at IPC&C Working group

Key Themes for Non compliance



Infection Control Training - Clinical Staff

Infection Control Training - Non -Clinical

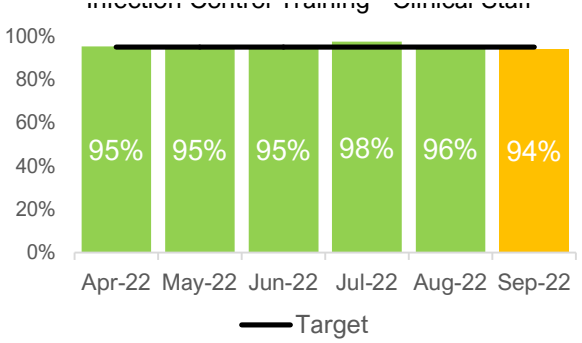
IPC Training

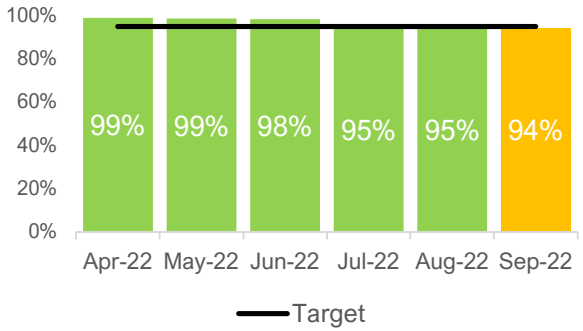
Trust continues to achieve a positive trajectory of compliance to IPC training modules.

Significant imporvements to the compliance of Aseptic Technique for medical staff achieved for September with a 100% compliance position reported end of September compared to 67% achieved in August 22.

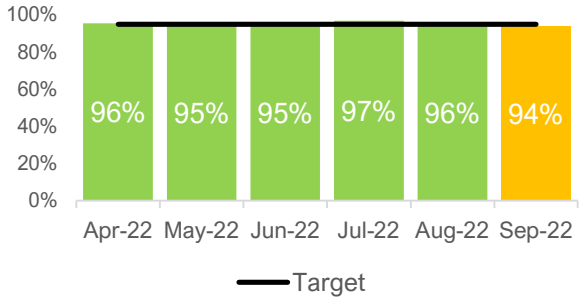
IPC HCA continues to support clinical staff with hand hygiene comptencies by delivering a programme of hand hygiene sessions.

Slight fall in compliance in September 22 to Infection Control Training for combined staffing groups falling below the 95% target for September with 96% compliance calculated for the overall quarter.

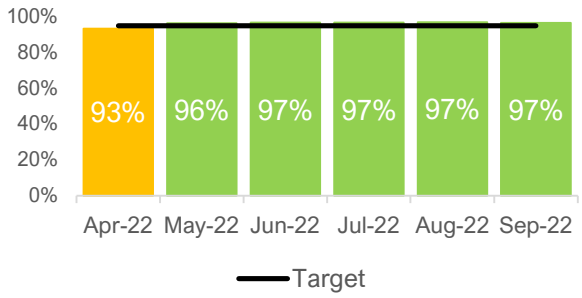




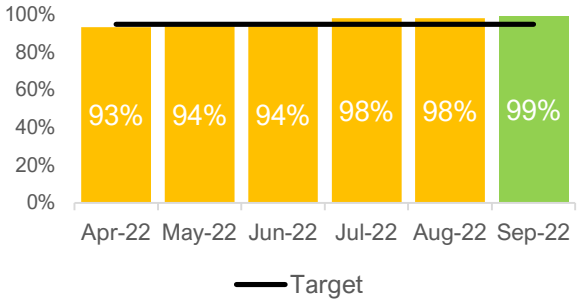
Infection Control Training - Combined Staffing Groups



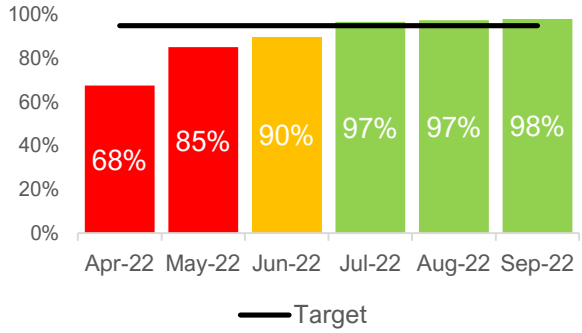
Cleaning For Confidence - An Introduction



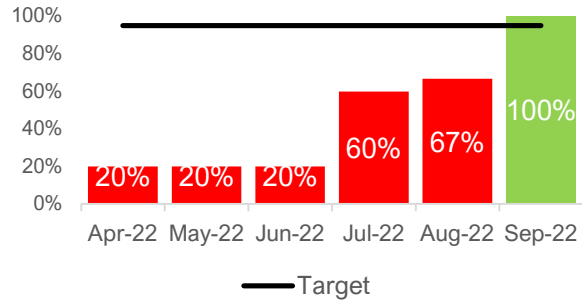
Cleaning For Confidence - Intensive Care Units

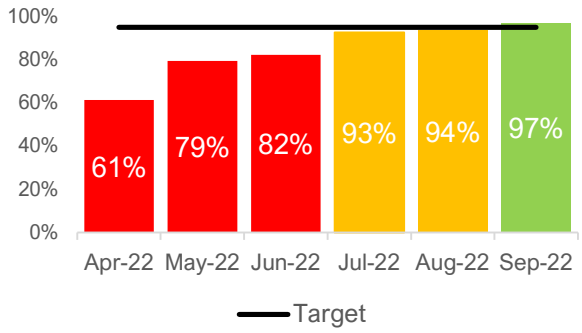


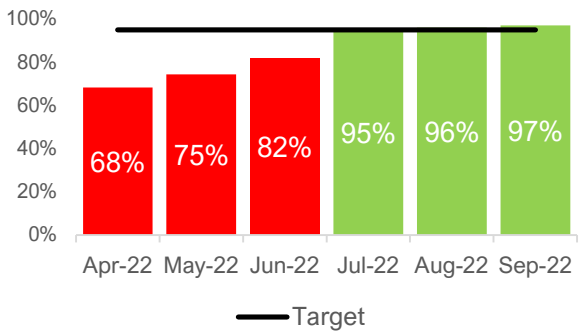
Aseptic Non-Touch Technique

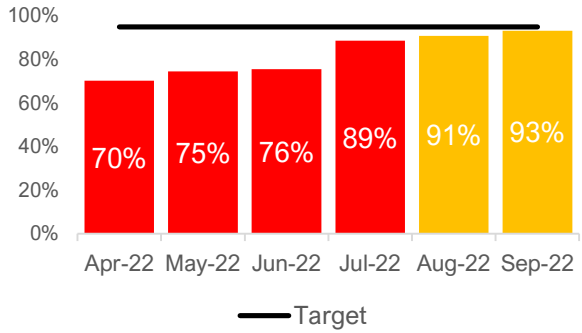


Aseptic Non-Non-Touch Technique - Medical Staff



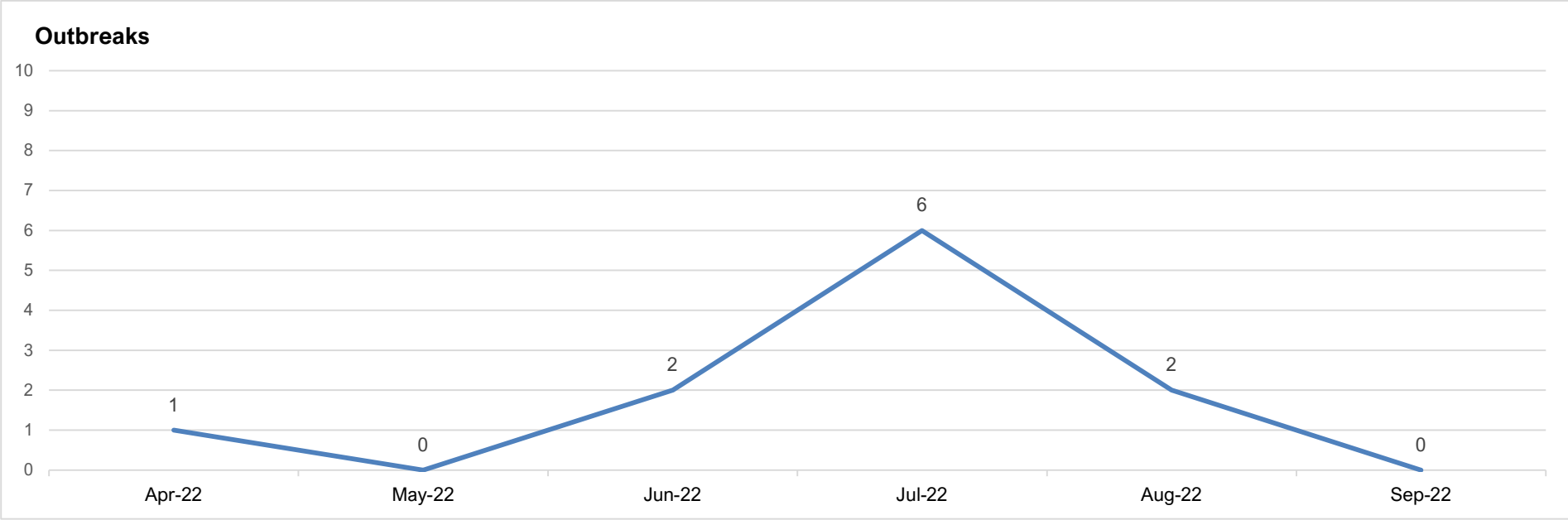






Key

Green 95% and above Amber 90-94% Red below 90%



Details of outbreaks declared in Quarter 2

Location	Month	Outbreak	Involved	Contributory factors identified
No Outbreaks declared for September 22				
Sheldon	Aug-22	COVID-19	3 patients 1 staff	Difficulties in cohorting positive patients in bays with no doors.
Gladstone	Aug-22	COVID-19	2 patients 1 staff	Delay in isolating patient when became symptomatic.
Admissions	Jul-22	COVID-19	2 Staff	No contributory factors identifed.
Kenyon	Jul-22	COVID-19	4 patients 2 staff	No contributory factors identifed.
Powys	Jul-22	COVID-19	3 Patients	No contributory factors identifed.
Gladstone	Jul-22	MRSA	5 Patients (1 index plus 4 acquistions)	Index positive MRSA patient had side room door open for patients mental health & wellbeing. Risk assessment undertaken
Theatres Implant room	Jul-22	COVID-19	2 Staff	No contributory factors identifed.
Clwyd	Jul-22	COVID-19	2 patients 1 staff	Weekly COVID-19 swabs not monitored robustly.

Outbreak Action Management

Upon closure of an outbreak all remaining open actions will be uploaded to Datix for their completion inline with Trust governace processes. The IPC Quality Management system will track the position to over all action plans with progress to inidivual actions being monitored via the weekly Infection Control & Cleanliess Working Group.

MRSA screening compliance

MRSA screening compliance remains high for Quarter 2. MRSA swabs that have not been undertaken are reported to the relevant line managers for investigation.

	July 22	Aug 22	Sept 22
Eligible patients	844	845	836
Screened for MRSA	839	845	833
% achieved	99.41%	100%	99.64%
Target	100%	100%	100%

MRSA and decolonisation

During quarter 2 a total of 4595 MRSA screening samples were received by the lab from RJAH.

2821 of these samples were taken by the Pre-Operative Assessment Unit (POAU) from 2476 patients, 8 of these patients were MRSA positive. All of these patients were decolonised/ isolated as per Trust policy.

Cleanliness

Quarterly cleaning scores have been consistent with Q1.

Maintained National and local target.

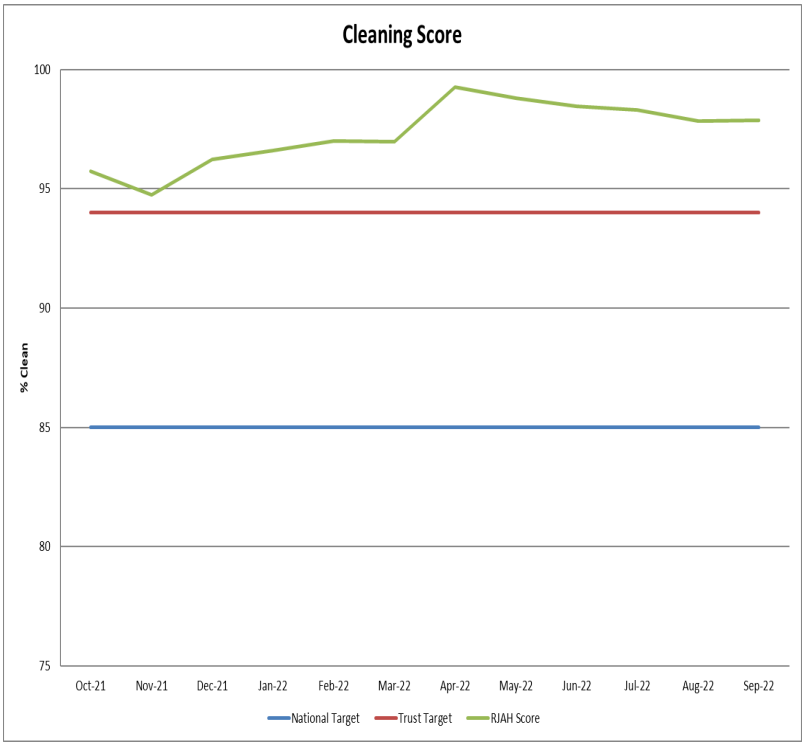
167 audits were completed;

159 audits achieved 5 star;

8 audits achieved 4 star;

0 audits were 3 star or below;

All < 5 star audits are escalated to IPC Working Group where themes and contributing factors are shared with the multi disciplinary team.

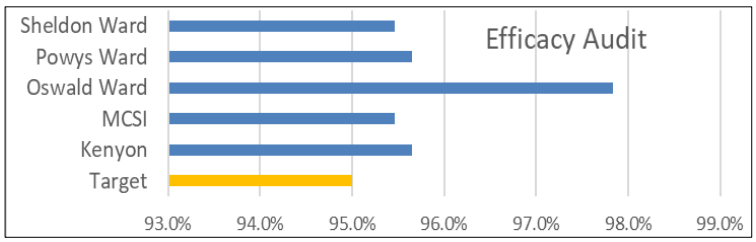


Less than 4 star – Detail

- No audits were less than 4 Star (more than 3% below 5 Star) during the quarter;

Cleaning Efficacy Audits

Due completion 6
Completed 5
Target = 95%
Average score for quarter = 96.0%



Cleaning Efficacy – Detail

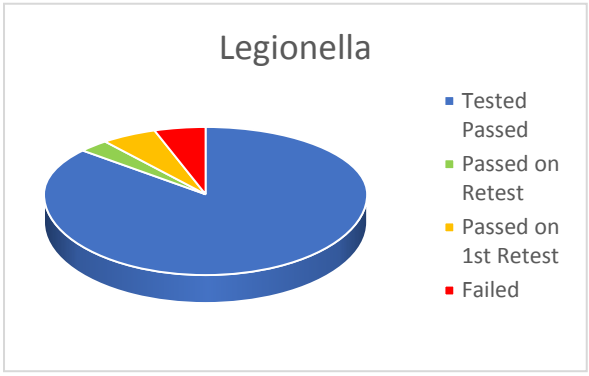
Issue	Action
Cleaning Cupboard in poor state of repair.	Trust wide audit of cleaning cupboards going to IPC Working Group for action oversight.
Decanting of products into spray bottles.	Removed at time of audit & raised with ward manager, escalate through SNAHP (E&F now have standard agenda invite).
Clinical teams incorrectly completing bedspace cleaning documentation.	Escalated to matron, roll out of new cleaning sign off sheet.

Water Safety

In line with HTM 04-01 and HSE Legionella Approved Code of Practice document, L8, the Trust conducts routine maintenance on the domestic water infrastructure across site on a planned and reactive basis. This quarter, the following water quality samples were taken.

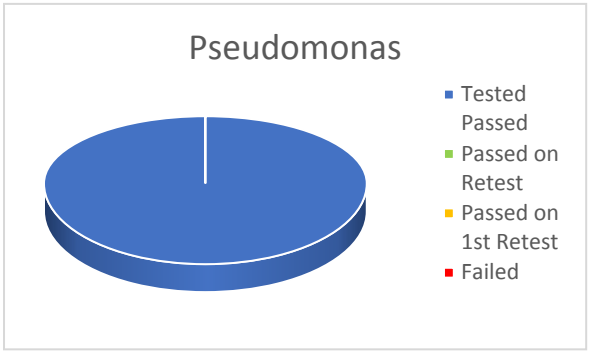
Water Safety - Legionella

Audit Count	33 Outlets
Fails	x1 Kenyon Shower x3 Maternity Clinic x1 Hydro-pool Staff
Action	Thermal disinfection Replace tap
Outcome	x1 Passed on retest x2 Passed on 1st retest x2 Failed - being retested



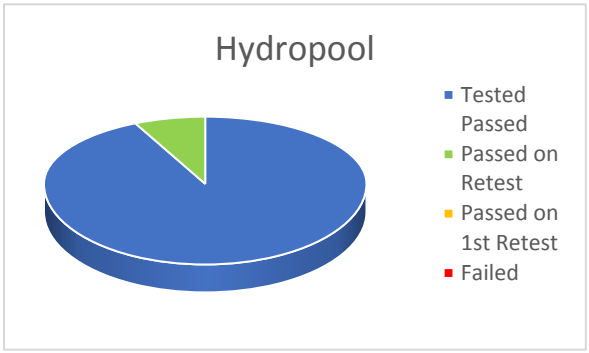
Water Safety - Pseudomonas

Audit Count	93 Outlets
Fails	No fails
Action	NA
Outcome	NA



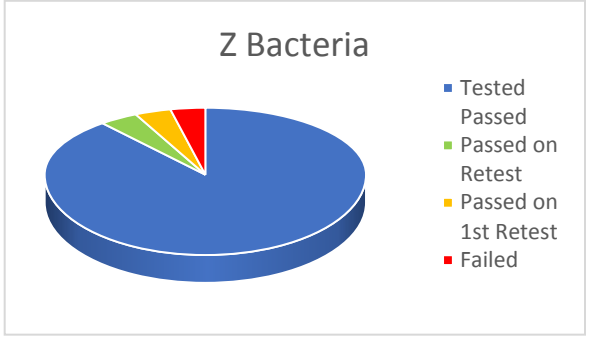
Water Safety - Hydro-pool Quality

Audit Count	12 Audits (Hydropool)
Fails	x1 Fail
Action	Backwashed filters
Outcome	x1 Passed on retest



Water Safety - Z Bacteria

Audit Count	24 Audits (Wassenberg)
Fails	x3 Fails
Action	Self disinfection
Outcome	x1 Passed on retest x1 Passed on 1st retest x1 Failed - being retested



Ventilation

All theatres are reverified annually by a third party independent contractor and subsequently reviewed by the Authorising Engineer and the Authorised Person. As risk mitigation, velocities at 1m from floor level in all Theatres are observed and recorded monthly. For assurance, velocities and performance checks are completed before being reoccupied for their intended use.

HTM 03-01 requires a minimum velocity at 1m of 0.20 m/s. All theatre *averages* are performing to this level.

	Sep-22	Aug-22	Jul-22
Theatre 1	0.28	0.32	0.28
Theatre 2	0.21	0.26	0.26
Theatre 3	0.28	0.31	0.24
Theatre 4	0.24	0.25	0.25
Theatre 5	0.34	0.36	0.27
Theatre 6	0.32	0.30	0.27
Theatre 7	0.37	0.39	0.36
Theatre 8	0.36	0.37	0.36
Theatre 9	0.32	0.33	0.31
Theatre 10	0.29	0.28	0.29
Theatre 11	0.38	0.39	0.39
Theatre 12	0.36	0.40	0.38

Decontamination

All decontamination equipment is tested and verified by the Trust and subsequently reviewed by the third party Authorising Engineer. All periodic testing of the decontamination equipment in TSSU A & B has been completed this quarter where it was due.

ASSURANCE: Sterilisation equipment remain out of service until periodic testing has successfully been completed, therefore removing associated IPC risk to patients.

	Testing Completed		
Device Type	Weekly	Quarterly	Yearly
Washer Disinfector	73%	100%	100%
Autoclave	94%	100%	100%
Wassenberg	100%	100%	[redacted]
Ultrasonic	[redacted]	100%	

Notes:

73% of Washer Disinfector tests completed because: Washer 7 out of service 9 weeks due to a leak above the machine that has damaged PC Controller, now back in service. Washer 6 out of service 1 weeks due to a leak above the machine that has damaged PC Controller – engineer booked.

94% of Autoclave tests completed because: Autoclave 2 was out of service 4 weeks due to a steam fault – now back in service following yearly test.

Chair's Assurance Report
Infection Control & Prevention Quality Assurance Committee 17 October 2022

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	2 November 2022
Executive Sponsor:	Chris Beacock and Sara Ellis Anderson	**Paper written on:**	17 September 2022
Paper Reviewed by:	N/A	**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 Trust Board and what input is required?

This paper presents a summary of the Infection Control & Prevention Quality Assurance Committee meeting held on 17 October 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of all items relating to infection, prevention, and control to the IPC Quality Assurance (QA) Committee. This Committee is responsible for seeking assurance on the IPC of the services it delivers in order that it may provide appropriate assurance to the Board.

At the Board meeting in April, it was agreed the IPC QA Committee would report directly to the Board of Directors until further notice, removing all IPC agenda items from the Quality and Safety Committee and realigning to the IPC QA Committee.

2.2 Summary

- The meeting was well attended and quorate
- The Committee received all agenda items noted within the Committee workplan
- Good progress was noted across all action plans
- Further areas for the Trust to consider include:
    - Likelihood of SSI following a revision to be reflected within the quality report
    - Further text narrative to accompany all compliance graphs to explain if there are any areas which require support
- Limited assurance noted following the MRSA summary presentation
- The Chair Report from the IPC Committee was deferred to the Quality and Safety Committee for support with the risks escalated.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Infection Control & Prevention Quality Assurance Committee which met on 17 October 2022. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Stacey Keegan	Chief Executive Officer
Ruth Longfellow	Chief Medical Officer
Kirsty Foskett	Head of Clinical Governance and Quality
In Attendance:	
Susan Sayles	IPC Nurse Specialist
Nick Huband	Director of Estates and Facilities
Mary Bardsley	Acting Trust Secretary
Sam Young	Deputy Director of IPC
Apologies:	
John Pepper, Penny Venables, Sara Ellis Anderson and Paul Kingston	

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured	Assurance Sought
Declaration of Interest		
There was no declaration of interests shared.	N/A	
IPC Live Data Dashboard		
The Committee asked for further assurance on the following: ▪ Noted the increased trend linked to the hip SSI – the Trust is awaiting the national benchmarking data to understand if the Trust is an outlier. ▪ Can the Trust enhance assurance – SSI reporting is set nationally; key issues and risks indicators are reviewed nationally as part of the bench marking data ▪ Once the SSI trend report is completed the Trust will be able to enhance the detail within the report ▪ The Trust is considering inviting eco-lab to the organisation to complete a review of the cleaning regime and process within theatres	Full	

Chair's Assurance Report
Infection Control & Prevention Quality Assurance Committee 17 October 2022

▪ One together report and action plan provided updates on SSI's		
IPC Quarterly Report (Q2)		
Further consideration to be given in relation to revision hip and knees infections and whether the increased likelihood is reflected within the report. The Trust has commenced the conversation however reporting is to be reviewed with consideration also being given to the surgical site. The Committee highlighted the 'other issues' category theme within the cleanliness section of the report. The Trust confirmed that one of the common themes included high- and low-level dust. The system as a whole is considering which wipes are being utilised therefore awaiting a system wide agreement regarding the wipes holders. The dust should improve following the recruitment of the housekeepers. It was noted that the timing of the when the audits are completed also affects the dust being reported as there is more likely to be more high/low dust recorded in the morning. Queried the potential detail hidden behind the 95% training compliance. The Non-Executive Directors asked for further consideration on how the range can be displayed or ways to highlight area of concerns for example, a text narrative to support to provide further detail for improved assurance. The Trust confirmed that all unit reports are shared in detail at the IPC Committee, any risk would be escalated within the Chair report to IPC QA Committee (if required).	Partial	Likelihood of SSI following a revision to be reflected within the report. Awaiting the recruitment of the Housekeepers to support with area noted within the 'other issues' category. An decrease within the category is expected once new staff have joined the team. Further text narrative to accompany all compliance graphs to explain if there are any cause for concerns areas
MRSA Outbreak Summary		
The Non-Executive Directors expressed the disappointment in the same issues being reported and noted between July 2021 and July 2022. The Non-Executive Directors challenge to the Trust was - do we have the right estates infrastructure to nurse patients' safely? Along with, if the index case was admitted back into the Trust, are we confident the patient can be nursed safely? The unresolved issues include: ▪ lack of agency system wide and receiving the assurance those individuals have completed their IPC training – this has been escalated within the system via the Chief Nurse to ensure training and policies are similar across system partners ▪ Deep dive into the linen and laundry to see if this was being effectively packaged ▪ Further work to be completed to ensure effective reporting, security and sign off overarching SI's ▪ Trust wide learning as this could potential happen on any ward within the organisation	Limited	It was noted that limited assurance was to be taken from the summary due to the Trust noting the unresolved issues which are to be implemented. The main factors include vacancies, agency staffing and their IPC training compliance, awaiting doors for the MSCI wards.
IPC Improvement Plan		
The Trust has moved to green on the NHSE matrix there are a subsequent 2 meetings scheduled with the regional team. ▪ 1 action behind plan – replacement of doors on MCSI ward ▪ 67 actions completed	Full	

Chair's Assurance Report
Infection Control & Prevention Quality Assurance Committee 17 October 2022

▪ 17 actions on going – with the expectation the majority of those are to be completed by November 2022. All actions will be incorporated into the IPC Programme of work which will be monitored by the IPC Committee and IPC Quality Assurance Committee. Outstanding actions will be reviewed and recorded on the risk register if necessary. The suggested way of working going forward has also been approved by Kirsty Morgan. Further assurance will be obtained from the governance arrangements embedded including audit cycles. Following a query regarding the housekeeper recruitment, the Trust confirmed 18 posts have been offered, 3 of which have been declined. The advert has been re-advertised and which closes on 18/10/2022. Finally, the members of the Committee commended the Trust on the work completed.		
One Together Action Plan		
Following the previous meeting all action dates and narratives have been reviewed. There are currently 2 actions overdue. The Committee noted the partial assurance aligned to patient warming was because the actions have been implemented but an audit process is to be embedded to provide the assurance. An annual review is scheduled with the next assessment being in November 2022. The Trust are to gain a support via a peer review.	Full	
Estates and Environment Update		
The members of the Committee commended the work which has been completed by the Estates and Facilities teams. Following a query, the Trust confirmed the team are investigating ways to ensure consequences of events are reduced for example, cladding on the walls for areas of heavy use will be completed.	Full	
Chair Report from IPC Committee		
The Committee met on 27/09/2022, the key points were highlighted to the Committee and the following risks were escalated ▪ Capacity for medical devices and training ▪ Safer sharps increased incidents resulting in linking with health & safety group to triangulate data ▪ VIP scoring documentation requires improvement with actions being developed. The Trust confirmed the scoring is currently paper based, there is a delay due to the alignment to system c. Following a discussion, the risks are to be escalated to the Quality and Safety Committee later on in the week.	Partial	Chair Report deferred to the Quality and Safety Committee for support with the risks escalated.
Committee Workplan		
The Committee reflected upon the work plan. The Committee agreed to consider a December meeting in November.	Full	
Attendance Matrix		
The attendance matrix is shared with the Committee for information only	N/A	

Items to note		
Outline of the plan for SSI which is to be expanded to other sub specialities and reported will be incorporated into the quality management system and included in the quality reports going forward. The Trust has decided to implement one speciality at a time to ensure the new process is embedded successfully.	N/A	
Any other Business		
There were no further items of business discussed.	N/A	

4. Conclusion

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

Trust Board - People & Workforce
September 2022 – Month 6

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)

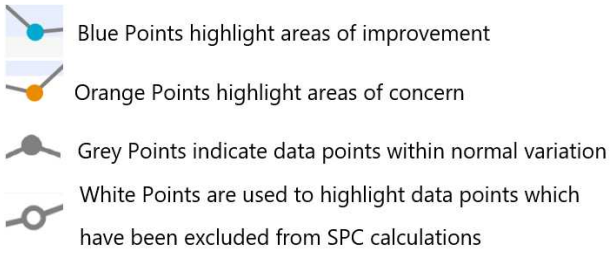
Different colours have been used to separate these trends of special cause variation:

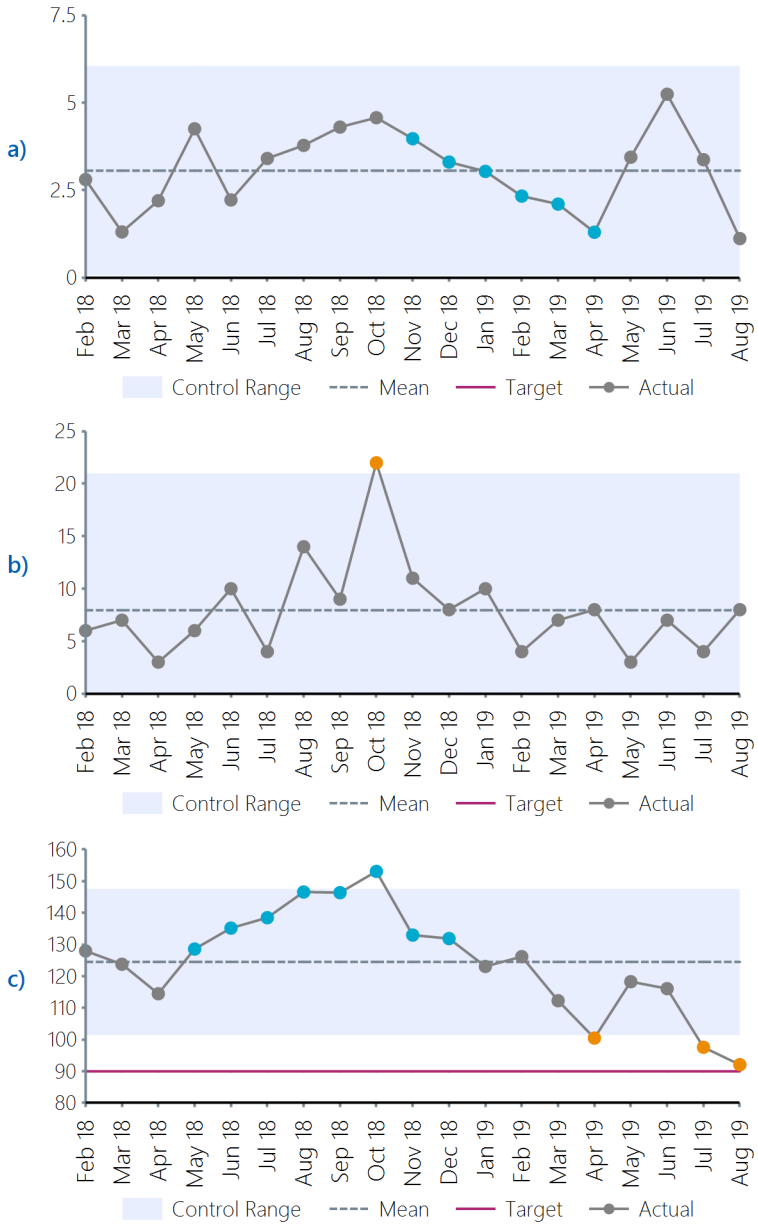
Some examples of these are shown in the images to the right:

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 Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	5.35%		H	?	+	27/02/20
Staff Turnover - Headcount	8.00%	12.47%		H	?	+	24/06/21
Vacancy Rate	8.00%	9.03%		H	P	+	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	132	216		H	?	+	

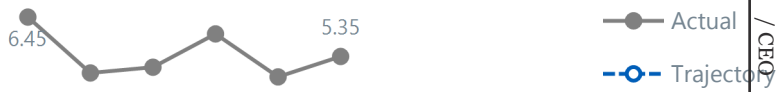
Sickness Absence

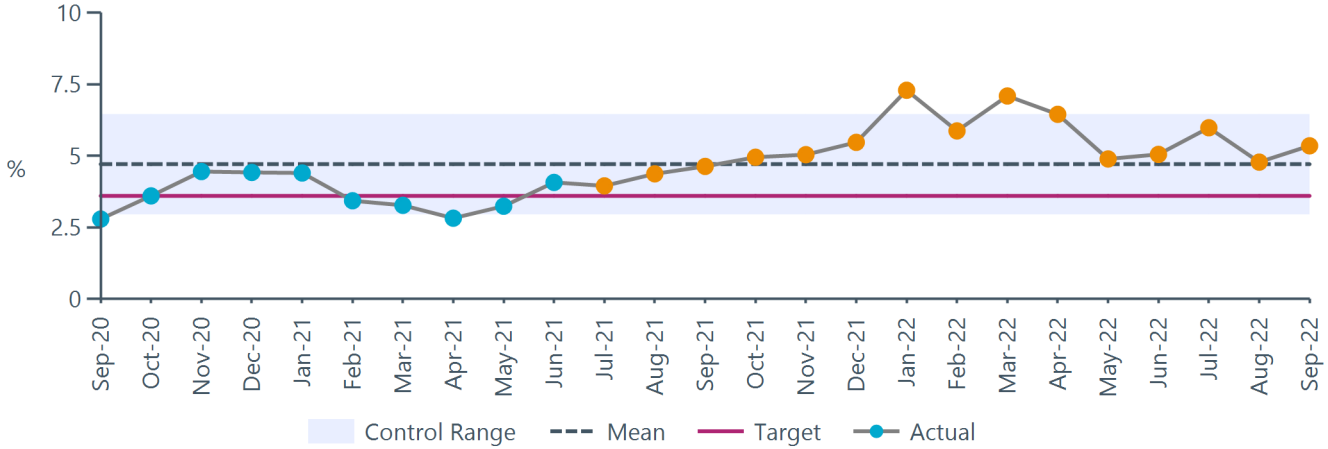
FTE days lost as a percentage of FTE days available in month 211161

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
3.60%	5.35%	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 sickness absence reported for September is 5.35% where 'infectious diseases' accounted for 0.47%, leaving remaining sickness at 4.88%. The rate is shown as special cause variation of concern but remains within our control range. Further detail below:
* Specialist Unit - 6.92% (6.48% excluding 'infectious diseases') - hot spot areas; Outpatients Department 18.70%, Alice Ward 11.92%
* Corporate areas - 4.80% (4.23% excluding 'infectious diseases') - hot spot areas; Research 21.57%, Housekeeping 13.77%
* MSK Unit - 4.77% (4.35% excluding 'infectious diseases') - hot spot areas; Theatre Support Workers 10.19%, Therapies T&O Team 8.21%

'Anxiety/stress/depression/other psychiatric illnesses' was the highest reason for absence across Specialist Unit, Corporate areas and MSK Unit.

Staff groups with the highest levels of sickness absence were; Healthcare Assistants - 10.53%, Physiotherapists 6.68%, Registered Nursing Staff 5.42%

Actions

A piece of work has been undertaken by the People Services Team whereby communication has been put together and sent to managers in the Trust. This encompasses management of all sickness, as well as any that is covid-related. Within the communications it outlines managers' responsibilities and gave links to additional support and resources available. This has met the actions stipulated last month to be complete by the end of September.

The communications sent to managers made reference to wellbeing conversations. In addition to this, a separate communication to all staff has been sent confirming the supportive aspects of wellbeing conversations and the resources and training available to staff.

As next steps, the Business Partners will be circulating dates in October for bite-size training and they are scoping an e-learning module to support managers. Additional resource has been identified within the People Services Team to help support review and monitoring of short-term sickness. For long-term sickness, a more streamlined process being developed, utilising the data from ESR to prompt milestones in period of sickness.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
4.63%	4.95%	5.04%	5.47%	7.29%	5.87%	7.09%	6.45%	4.89%	5.05%	5.98%	4.78%	5.35%

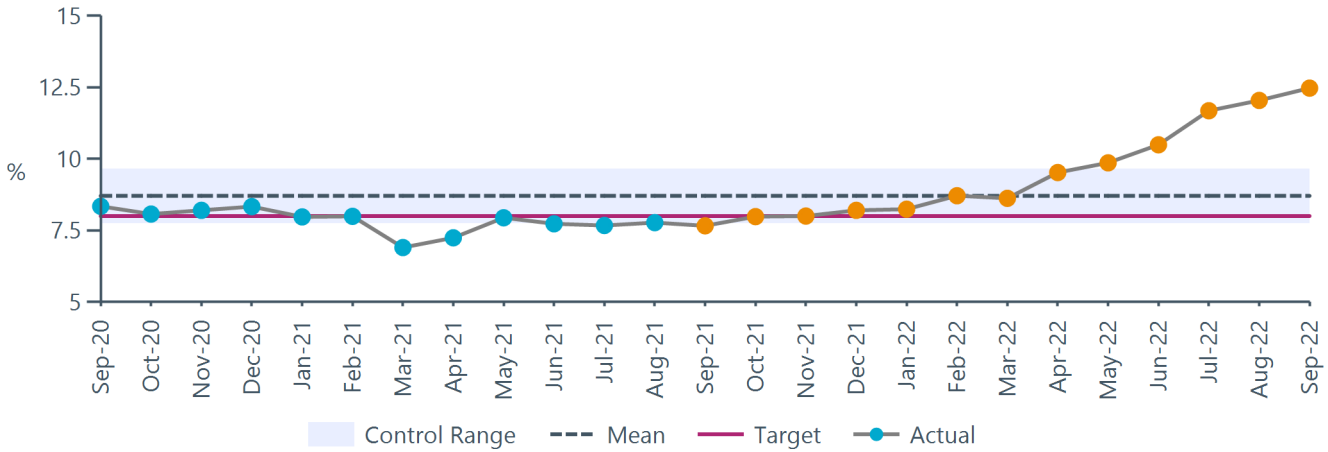
- Staff - Patients - Finances -

Staff Turnover - Headcount

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

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	12.47%	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

Staff Turnover, at Trust level, has now been reported above the 8% target since November-21. The September rate of 12.47% is now the sixth point above the control range showing continual deterioration. Six out of eight staff groups are reported above 8% as follows:
- Additional Clinic - 15.31%
- Nursing and Midwifery - 14.50%
- Estates and Ancillary - 13.70%
- Allied Health Professionals - 12.89%
- Add Prof Scientific and Technic - 10.53%
- Administrative and Clinical - 10.40%

In the latest twelve month period, October-21 to September-22, there have been 202 leavers throughout the Trust. This is in relation to a headcount in post of 1620, as at 30th September 2022. The top three reasons for leaving that accounts for 121 leavers/60% at Trust level were:
* Voluntary Resignation - Other/Not Known - 49 / 24.26%
* Retirement age - 39 / 19.31%
* Voluntary Resignation - Work Life Balance - 33 / 16.34%

Actions

Actions in relation to voluntary staff turnover include:
* Therapies has been highlighted as a 'hot spot' area. An internal review has been carried out with the decision to now commence a full service review of the service that assesses workforce and clinical pathways. Report was initially expected by the end of September but the review has been extended so report now expected with MSK Managing Director by the end of October.
* An action last month was to source benchmarking data to review RJAH performance against other specialist providers. It is now deemed appropriate to seek advice from the Recruitment Workforce Group to determine whether this would add value and potentially might be more appropriate to look at regional data rather than other specialist providers who are in a different geographic area.
* Initial assessment of exit interviews undertaken. Decision made to consider process in its entirety to identify scope for improvement. Exit interviews tabled for discussion as part of the People Committee Work Plan in October with a view to bringing a revised Staff Exit Policy to the committee in December for discussion.
* Keeping in Touching proposal to broaden current Wellbeing Conversations format, and include stay interview questions supported by Recruitment Working Group. Proposal will be considered by People Committee at their October meeting.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
7%	7%	8%	8%	8%	8%	8%	9%	9%	10%	11%	12%	12%

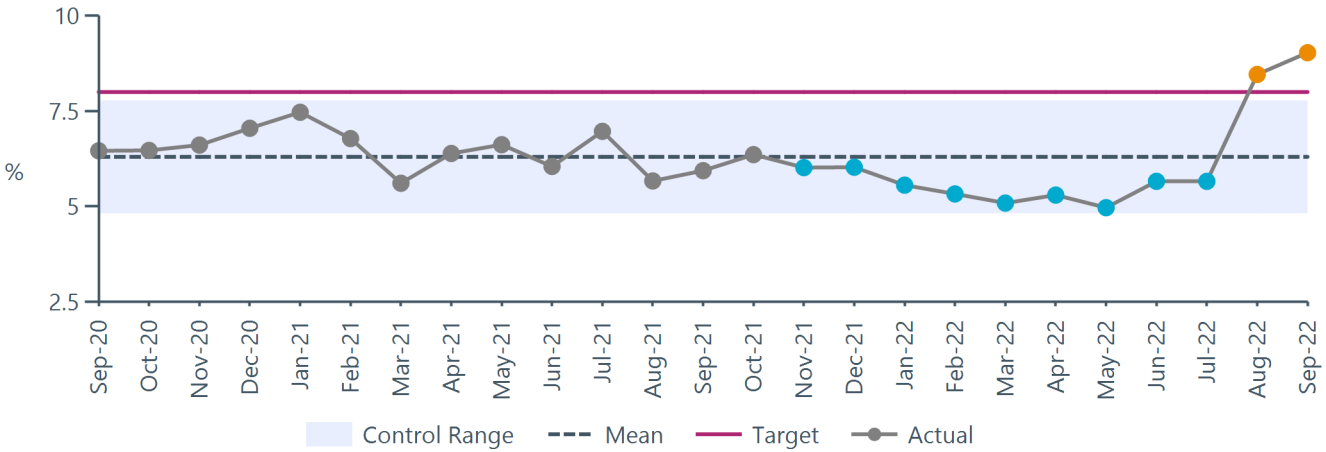
- Staff - Patients - Finances -

Vacancy Rate

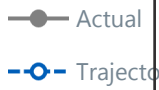
% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	9.03%	H	P



Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently meeting the target as the control range sits below the target line.

Narrative

The vacancy rate is reported at 9.03% this month and exceeds the 8% target for a second month. This equates to vacancies across the Trust at 140.12 WTE. The data point is also showing special cause variation of concern as it falls above our expected control range.

A breakdown by area is:
- Specialist Unit - 11.87%
- MSK Unit - 8.75%
- Corporate areas - 6.69%

Further details on the staff groups is provided against other KPIs (Nursing, Radiographers and Healthcare Support Workers).

Actions

Actions in this area include:
* A recruitment day took place in September for housekeeping staff. Fifteen people attended on the day, with twelve currently under offer within the recruitment process.
* Oversight of vacancies remains in place from the Information Workforce team with this now sent to the bi-weekly Recruitment Workforce Group.
* Initial assessment of exit interviews undertaken and decision made to consider the process in its entirety to identify further scope for improvement. Exit interviews are tabled for discussion as part of the People Committee Work Plan in October with a view to bringing a revised Staff Exit Policy to the committee in December for discussion.
* Rolling adverts are now in place for Nursing and Healthcare Support Worker vacancies.

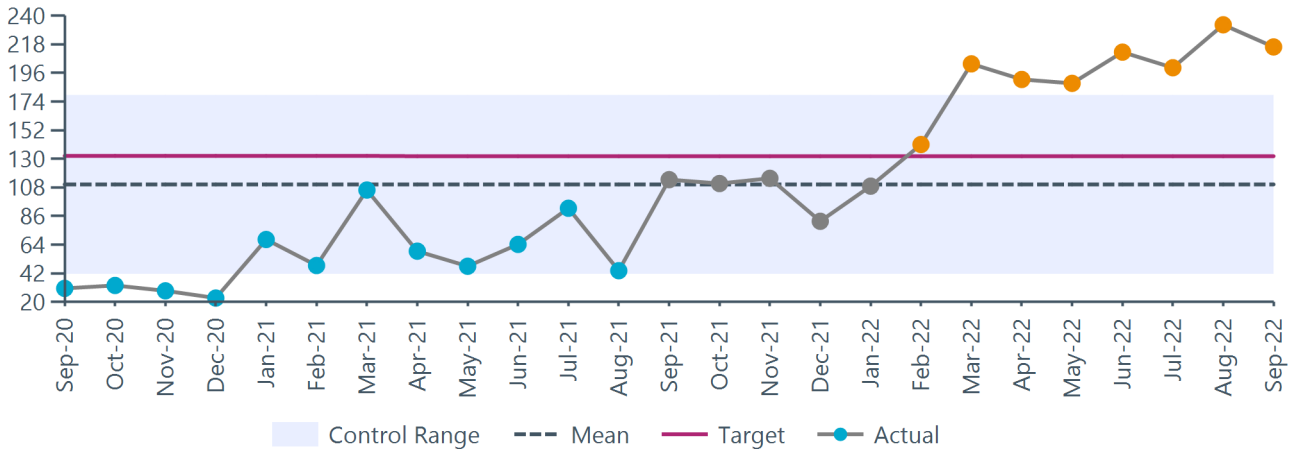
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
5.94%	6.36%	6.02%	6.03%	5.56%	5.33%	5.09%	5.30%	4.97%	5.66%	5.66%	8.46%	9.03%

Agency Core

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency only 216336

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
132	216	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).

Narrative

Core agency £84k adverse to cap driven by recruitment slippage, escalation beds open & Covid absences.

Actions

Recruitment plans for nursing, HCA's and consultants.
Reinforced agency approval procedures and oversight.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
114	111	115	82	109	141	203	191	188	212	200	233	216

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	02 November 2022
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee 20/10/22	Paper Ref:	N/A
Forum submitted to:	Trust Board - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the 2022/23 Q2 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period Jul 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	2

3.2.2 Exception reports (regarding working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Jul-21	0
Aug-21	1 (Spinal trust grade)
Sep-21	1 (Spinal trust grade)
Oct-21	0
Nov-21	0
Dec-21	0
Jan-22	0
Feb-22	0
Mar-22	1
Apr-22	0
May-22	0
Jun-22	0
Jul-22	Data not available
Aug-22	Data not available

Vacant shifts

Jul-21	13
Aug-21	4
Sep-21	2
Oct-21	1
Nov-21	4
Dec-21	10
Jan-22	17

Feb-22	0
Mar-22	3
Apr-22	0
May-22	4
Jun-22	2
Jul-22	Data not available
Aug-22	Data not available

Total cost - £35937 (July/August 22 cost not included)

Medicine - **Substantial amount of higher level data not made available**

Number of Vacancies (12 posts)

Jul - 0
Aug - 0
Sept - 0

Vacant shifts

Jul - 2
Aug - 7
Sept - 4
Total cost - £7020
Please not substantial data not available for report

MCSI

Number of Vacancies (9 posts)

Jul-21	3
Aug-21	3
Sep-21	1
Oct-21	1
Nov-21	1
Dec-21	1
Jan-22	1
Feb-22	1
Mar-22	1
Apr-22	1
May-22	1

Vacant Shifts

Jul-21	17
Aug-21	15
Sep-21	6
Oct-21	8
Nov-21	50
Dec-21	7
Jan-22	8
Feb-22	6
Mar-22	7
Apr-22	5
May-22	5

Total cost - £ 25265.55

Long Term Vacant Shifts

MCSI is down to one vacancy

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended in February 2022. During the pandemic Junior Doctor Forum was reinstated virtually and moved to a combined format recently. The last meeting was cancelled due to COVID infection.

Attendance was down from previous meetings. This has improved as face-to-face meetings have resumed. Poor attendance has, unfortunately persisted. This is an area I would like to see increased engagement with and will liaise with the Comms department to try and achieve this.

Whilst the Juniors are happy with their working hours, concerns regarding training are significant.

GSWH conference occurred this year virtually and was attended.

3.3.2 Software System

Engagement with Allocate is still awaited. Significant issues with Allocate were discussed again at the GSWH conference. It appears to be far from fit for purpose.

3.3.3 Administrative support

There are currently no agreed standards regarding support of the GSWH, despite the role being embedded. Locally, difficulties obtaining the higher-level data to allow for a complete report have frequently occurred. Recent changes in staffing have added to this challenge.

Associated Risk

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

COVID will have impacted on staffing and the requirements for short notice internal locums. The apparent spike in recent infections is likely to see this pattern recur.

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.

Appendix 1: Junior Doctor Agency and Locum usage and Rota Vacancy Report

Chairs' Assurance Report
People Committee – 20 October 2022

0. Reference Information

Author:	Larissa McElroy, Executive Assistant	**Paper date:**	02 November 2022
Executive Sponsor:	Martin Evans, Non-Executive Director	**Paper written on:**	20 October 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 20 October 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

The meeting commenced at 10am however it was not quorate until 10:30am. The areas to highlight to the Board included:

- The requirement of a detailed recruitment and retention plan – recognising the significance of retention as well as recruitment
- The need for performance data to better understand the resourcing impact on key areas of performance to assist in priorisation of focus.
- Some early signs of improvement around areas such as the length of time between sending a starting letter and sending a contract and time taken to shortlist candidates.
- Additional support required for international recruits alongside recruitment.
- Data provided around special leave approval appears particularly high, further work required to provide assurance that Trust policy is being adhered to.
- A ward closure for 24 hours due to staff sickness – further detail requested.
- Assurance sought on the join up and connectivity between the Consultant Recruitment Working Group and the Recruitment Working Group.
- Trust 5 Year People Plan 'make the difference' expires March 2023
- Request consideration of a temporary Board Committee to be established to oversee Recruitment and Retention due to the increased pressures
- Clarity to be sought from Board as to whether the role of the Committee is to approve policies or seek assurance that policies are in place and being adhered to.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the People Committee which met on 20 October 2022. The meeting was quorate (from 10:30am) with 3 Non-Executive Director, 1 Associate Non-Executive Director and 2 Executive Directors in attendance. At the time the meeting was not quorate, there were no items for approval considered. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Martin Evans	Associate Non-Executive Director (Chair)
Penny Venables	Non-Executive Director
Chris Beacock	Non-Executive Director
Sarfraz Nawaz	Non-Executive Director
Denise Harnin	Chief People Officer
Ruth Longfellow	Chief Medical Officer (part meeting)
Craig Macbeth	Chief Finance and Planning Officer (part meeting)
In Attendance:	
Mary Bardsley	Acting Trust Secretary
Nia Jones	Managing Director for Planning and Strategy (part meeting)
Lisa Newton	Assistant Chief Nurse for Specialist Unit (part meeting)
Kate Betts	Governor (observing only)
Victoria Sugden	Governor (observing only)
Larissa McElroy	Executive Assistant – Minute Secretary
Apologies:	
Paul Kingston, Stacey Keegan, Mike Carr, Sara Ellis Anderson, Kirsty Foskett, David Gilburt and Andrea Martin.	

3.2 Actions from the Previous Meeting

The Committee discussed each action, two actions were carried over to the next meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declaration of Interest		
There were no declarations shared	N/A	
Chief People Officer Update		
Several professional organisations and trade unions are currently balloting their members for industrial actions. So far, the Trust have received notification from the BMA, The Royal College of Radiologists, Physiotherapists, RCN, and Unison and Unite. They each have slightly different dates to the end of their ballot, which will implicate when any of their actions associated with those staff groups can follow. Work on contingency planning is being conducted which has included what the operational impact may be. Mitigations will also be put in place to manage such action if people were to exercise their rights and strike. Following discussions at the Local Negotiating Committee, the Trust need to revise their job planning policy as the team believe	Yes	

there are inconsistencies in practice across the Board. A review needs to be undertaken of all job plans within the organisation. The BMA also introduced a rate card for consultants which is their tariff that they believe all Trust's should be paying for out of job plan activity. Similarly, they provided one for all SAS doctors. The tariffs will be presented at the Executive Team Meeting for discussion.		
Chair Report: Recruitment Working Group & Recruitment Monthly Performance Report		
The Recruitment Working Group have been working hard in looking at the time to recruit process. The People Services team are currently troubleshooting daily with Trac queries, which shows that the model is not sustainable. To get traction and retain traction on the recruitment lines that are running, this is what is required to keep things in place. Keeping in touch and exit interview work is also ongoing. There has been a reduction in the time to hire, but it is still below target. Weekly recruitment meetings are being held and the People Services team are also working on holding interviews on behalf of other clinical areas, which is a step forwards as usually each area likes to target their own recruitment directly. International recruitment is a consistent theme for the committee and currently the Trust do not have any resource within People Services or nursing dedicated to onboarding international recruits and its pivotal to the success of the oversees recruitment schemes. If all the trained nursing staff in the pipeline who have been offered jobs but are still awaiting ratification, were deduced from the number of vacancies available, the vacancy rate would be 6.5%. HCA's have also been looked at and the rate comes down to 7.7%. The Trust lost one anesthetic candidate due to personal reasons. The committee noted that more work was needed to understand what high levels of different types of leave was being taken (such as Carers leave) to ensure that the trust policy was being adhered to properly. An update will be brought back to the next People and Culture Committee regarding the specific absence areas in the Trust that are being focused on and what improvements are being made.	Partial	The committee requested a clear action plan for recruitment and retention which articulates what's is being done, by whom and by when.
Nursing Workforce (Inc Safe Staffing)		
The nursing workforce paper provided an overview of nursing staffing levels and skill mix for quarter two; July 2022 to September 2022. It included care hours, fill rates and use of spend around temporary staffing. Vacancy positions are unlikely to improvement with significant action. The nursing team are working hard to look to see what can be done around introducing nurse associates a little faster to replace registered nurses with nurse associates if the registered nurses are not out in the wider community. Most shifts are filled with banking agency and the Trust do not run short; some of the shifts are showing as over 100%. The team have DoLS patients that require one to one bay watch; therefore, this is justified and is closely monitored by the Assistant Chief Nurse. There are 37 full time equivalent vacancies for registered nurses within the organisation. The current fill rates are above target, but bank and agency staff are heavily relied on as well as a lot of swapping and changing of staff, which can have a knock-on	Partial	The committee requested further information around the need to have closed award for 24 hours to see what lessons could be learnt. The committee requested a real focus on retention of staff alongside the recruitment work

effect on staff motivation and wellbeing. Discussions are in place with SaTH to see if bank staff can be paid weekly to help with staff incentives. Communications and advertising campaigns are also being worked on to promote new staff to the Trust. NHS staff sickness is increasing, however partial assurance was shared with the committee, that the nursing team have a daily state of play meeting to review staff and make necessary moves to ensure sites are covered effectively. Block bookings of framework agency are being utilised to ensure shifts are filled and there are also twice weekly forward looks, where the team look forward over 72 hours to ensure shifts are covered. There is a risk if plans are not worked through, and staff are unable to be recruited. Most recently and due to staff shortages, a ward needed to be closed because it could not be safely staffed for 24 hours, which created additional work for the nursing staff but also poor patient experience.		
E-Rostering Workplan & Actions		
The People Committee were brought a progress update in terms of moving the e-rostering attainment levels from level 0 to level 4. It comes to the committee on the backdrop of this highlighting a risk associated with this in quarter one, that the Trust were at level 0 and that an action plan needed to be put in place. An e-rostering system has been used in the organisation for some time and the purpose of the attainment levels is to make sure that benefits are being received from the system and how work can be moved towards utilising these benefits. The detailed action plan which includes the necessary steps takes the organisation to reaching level 2 by the end of December 22 and to reach level 4 by the end of March 2023. Levels 3 and 4 are around how the data is used to improve planning going forwards.	Yes	Progress against the action plan to be reported to future meetings
People Plan: Make the Difference		
The committee was shown the two updates that are being put into the current workforce strategy that is already in place; work stream 11; implementing and using e-rostering software to its fullest potential and work stream 12; implementing and using job-planning software to its fullest potential as the attainment levels for job planning mirror the same expectation. The committee received partial assurance from the two workstreams but asked if plans could be put in place following the expiration of the five-year strategy in April 2023. The plan has been put on the People and Culture Committee workplan to be brought back for discussion in March 2023.	Partial	The current 5-year workforce strategy ends in March 2023. The committee have requested assurance that a new workforce strategy will be developed and in place for April 2023.
Oversight of Planning Framework		
A paper was brought to the committee to share a quarterly update around the key aspects of the operational plan that are relevant to the People and Culture Committee. There are more vacancies than planned at this stage, but a number of key actions have been discussed around the recruitment working group. The elective recovery impact was also discussed and the H2 forecast has been taken through FPD, which looks at workforce impact on performance projecting 90% elective recovery against the original plan of 107%. Recruitment challenge impacts around outpatient activity will also be taken to the next FPD meeting for discussions.	Partial	The committee requested more detail of workforce shortage impact on performance to enable assurance that we are prioritising and focusing efforts.
Consultant Recruitment Plan		

There are currently 18 posts that are identified for active recruitment from a consultant workforce perspective 50% of which are in the recruitment pipeline or are starting soon. All the posts are joint posts with SaTH, and the Trust are just waiting on a response from SaTH on them. Two posts have been received back from the Royal College, so the Trust are able to hopefully progress those to adverts being placed within the next week. Four posts are also in the interview stage; one candidate was lost, therefore there are now three. Four other posts that were advertised have now commenced in post. There are challenges around anesthetics, but key specific actions have been put in place.	Partial	The committee requested further clarity on the joined up working of the Consultant Recruitment Management Group and the Recruitment Working Group.
Freedom to Speak Up Action Plan		
There were few actions within the freedom to speak up action plan that state they are awaiting appointment of the Trust Secretary. These will be fed back and realigned.	Yes	
Cost of Living Update		
An update was provided to the committee following a recent staff survey which investigated the current pressures staff are feeling. Internal ideas of support are being investigated such as bike sheds and showers. The restaurant is also being looked at to see what the Trust can do there to support. Free tea and coffee have been introduced to all staff. This work is ongoing.	Yes	
Guardian of Safe Working Hours: Q2 Report		
There were no exceptions included within the report, which means there are no issues with junior doctors having issues with the hours they are being asked to work. This report is a positive report, and the training staff are having a positive experience at the Trust.	Yes	
Keep in Touch and Exit Interviews		
A first draft of the exit interviews paper was shared with the committee. The committee felt concerned that the Trust are articulating that we expect managers to meet with their staff twice yearly, but following Trust values around caring for staff, then realistically these conversations should be happening a lot more often. It was agreed following discussions that a second draft of the policy will be worked on to incorporate a more regular conversation for staff and managers as opposed to every 6 months, alongside setting out expectations for both staff and managers.	Partial	Further work was requested to ensure that the levels of engagement expected between line manager and staff were in line with the Trusts values and expectations.
Board Assurance Framework		
The BAF was presented to the Board and Audit Committee earlier this month and the changes were shared with the committee. Those that are presented are aligned to this committee and just to note, there is further work to be done following the Board session that the Trust have with the risk management and the NHS providers session.	Yes	
Policy Tracker		
The policy tracker was presented in its entirety at the Audit and Risk Committee last week and there was noted disappointment regarding the number of overdue policies. It was agreed that each assurance committee is to receive a list of policies which are aligned to their remit. There are currently 13 policies which are linked to the People and Culture Committee; therefore, an Extraordinary People Committee date has gone into the diary to go through these on 4th November 2022.	Partial	The committee are to seek clarity as to whether it is the role of the committee to approve policies or seek assurance that policies are in place and are being adhered to.

Performance Report		
The committee noted the Performance Report. There have been a lot of recent conversations around retention, but in the report, it showed that staff are not having their personal development reviews or completely their statutory and mandatory training. It was suggested that reminders from the People Services team were not enough. This will be worked on between the Chief People Officer and the Chief Nurse for a real push on improvement with this.	Partial	The committee requested to see improvements in PDR and Mandatory training compliance levels
Chair Report Trust Performance and Operational Improvement Group		
The committee noted the Chair Report Trust Performance and Operational Improvement Group.	N/A	
Committee Work Plan		
The Committee discussed the workplan and further agenda items were included due to the increased focus on recently presented agenda items, these included: job planning, theatre model and theatre workforce, cost of living	Yes	
Any Other Business		
The Non-Executive Directors asked for the Trust to consider a Board Committee relating to Recruitment and Retention due to the increased pressures. It was noted that the way of working has had a positive effect relation to the IPC agenda.	N/A	

3.6 Risks to be Escalated

During its business the Committee agreed that there were no risks to be escalated to the Board.

Conclusion

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

0. Reference Information

Author:	Mike Carr, Chief Operating Officer	Paper date:	02.11.2022
Senior Leader Sponsor:	Mike Carr, Chief Operating Officer	Paper written on:	28.10.2022
Paper Reviewed by:	N/A	Paper Type:	Performance
Forum submitted to:	Trust Board	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Noting/ Assurance

1. Purpose of Paper

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

This paper presents an update on key operational issues and the associated actions to improve operational performance across the organisation, for the Boards information.

2. Executive Summary

2.1 Summary

- In September performance against the 104+ week clearance trajectory was 30 patients ahead of plan, although the NHSE cohort was 13 behind plan. This is forecast to be recovered by the end of October.
- NHS England have significantly increased the scrutiny on the longest waiting patients and have requested a 'route to zero' patients waiting over 104 weeks.
- The Theatre Productivity workshop was undertaken on the 5th and 6th of October, the associated action plan is now in development.
- Work is underway to improve the day to day operational processes of the Trust with a focus on site management and the cancellation of patients.
- An STW wide Strategic Command Centre is being established ahead of winter, RJAH have been asked to support.

2.3. Conclusion

The Board is asked to note the report.

3. The Main Report

Long Waiting Patients

- Validated 104+ performance for September was 30 patients ahead of schedule in total, although 13 behind plan for NHSE patients.
- For October the forecasted performance is 43 ahead of trajectory and recovery of the NHSE patients to meeting the trajectory.

- There has been a significant step change in scrutiny from NHSE regarding the English patient cohort, with daily meetings with regional colleagues to provide assurance on progress.
- NHSE are requesting all providers to develop a 'route to zero' by the end of November.
- For November there is increased Mutual Aid support from ROH NHS Trust (approx. 10 patients) with further support being identified up to March 2023.

		Plan	Actual	Difference
September	English 104+ Weeks	45	58	13
	Welsh 104+ Weeks	93	50	-43
	English 78+ Weeks	490	432	-58
	Welsh 78+ Weeks	337	295	-42

		Plan	Forecast*	Difference
October*	English 104+ Weeks	39	39	0
	Welsh 104+ Weeks	97	54	-43
	English 78+ Weeks	387	408	21
	Welsh 78+ Weeks	336	327	-9

**Forecast based on unvalidated position (21/10/2022)*

Demand and Capacity Modelling

- Whilst good progress is being made to reduce the number of long waiting patients (78+ weeks) the overall waiting list size remains relatively static.
- Long term clearance trajectories are under development based on achieving the key milestones of 78 / 52 / 18 weeks. This will be reported back via FPD.

Theatre Productivity

- The theatre workforce and operational model workshop was held on the 5th and 6th October, supported by Carados.
- The associated improvement plan is now under development.

Site Management

- The Site management Task & Finish group launched on 17th October, with the initial focus on the following areas;
  - Developing a bed management tool
  - Improving the timeliness of discharge
  - Engaging patients in the discharge planning process
  - Expansion capacity

- Transport
- To improve our day to day operational processes the following operating policies are under development;
  - Bed management SOP
  - Patient Cancellation SOP

Shropshire Telford& Wrekin System Strategic Control Centre

- NHSE have set the expectation that all Integrated Care Systems stand up Strategic Control Centres ahead of winter. The purpose of these is to maintain senior oversight of flow across the system.
- RJAH have been asked to support the Strategic Commander rota whilst dedicated resources are recruited into.

Improvement Framework

- The Trust improvement framework has been redrafted with the intention to share amongst committees and the Trust Board in November and December ahead of a launch in early 2023.

IPR Snapshot

	IPR Position	October 2022 Unvalidated Position		
Metric	**Sep-22**	**Snapshot Date**	**Snapshot Position**	**Supporting commentary**
Sickness Absence	5.35%	26/10/2022	5.95%	Sickness Absence % within Trust on snapshot date.
Vacancy Rate	9.03%	26/10/2022	9.25%	Unvalidated. Inclusive of October's payroll transactions. Subject to change.
Never Events	0	24/10/2022	1	
Serious Incidents	0	24/10/2022	1	
Surgical Site Infections	0	24/10/2022	0 (1)	1 SSI confirmed in October relating to surgery in September
Patients Waiting Over 104 Weeks - English	58	26/10/2022	39	Forecast end of October position (subject to validation)
Private Patient Activity	100% (56 against a plan of 56)	26/10/2022	93.94% (62 against a plan of 66)	Snapshots include upcoming booked activity. Subject to change.
Total Elective Activity against Plan	91.28% (984 against a plan of 1078)	26/10/2022	78.00% - (883 against submitted plan of 1132) 118.21% - (883 against H2 Forecast of 747)	
Total Theatre Activity against Plan	83.66% (845 against a plan of 1010)	26/10/2022	75.60% (821 against a plan of 1086)	
Total Outpatient Activity against Plan	81.67% (12,696 against a plan of 15,546)	26/10/2022	86.93% - (13038 against submitted plan of 14998) 96.60% - (13038 against H2 Forecast of 13497)	

1. Welcome	2. Presentati	3. Chairman	4. Corporate	5. Quality	6. People and	**7. Performa**	8. Questions	9. Overall	10.Any Other

Trust Board - Performance
September 2022 – Month 6

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)

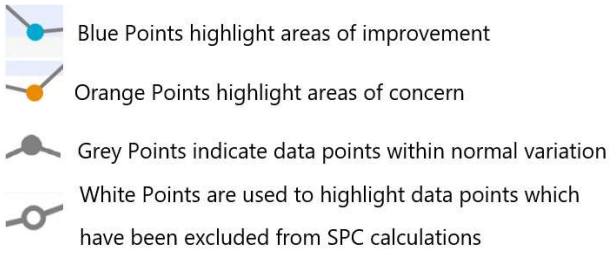
Different colours have been used to separate these trends of special cause variation:

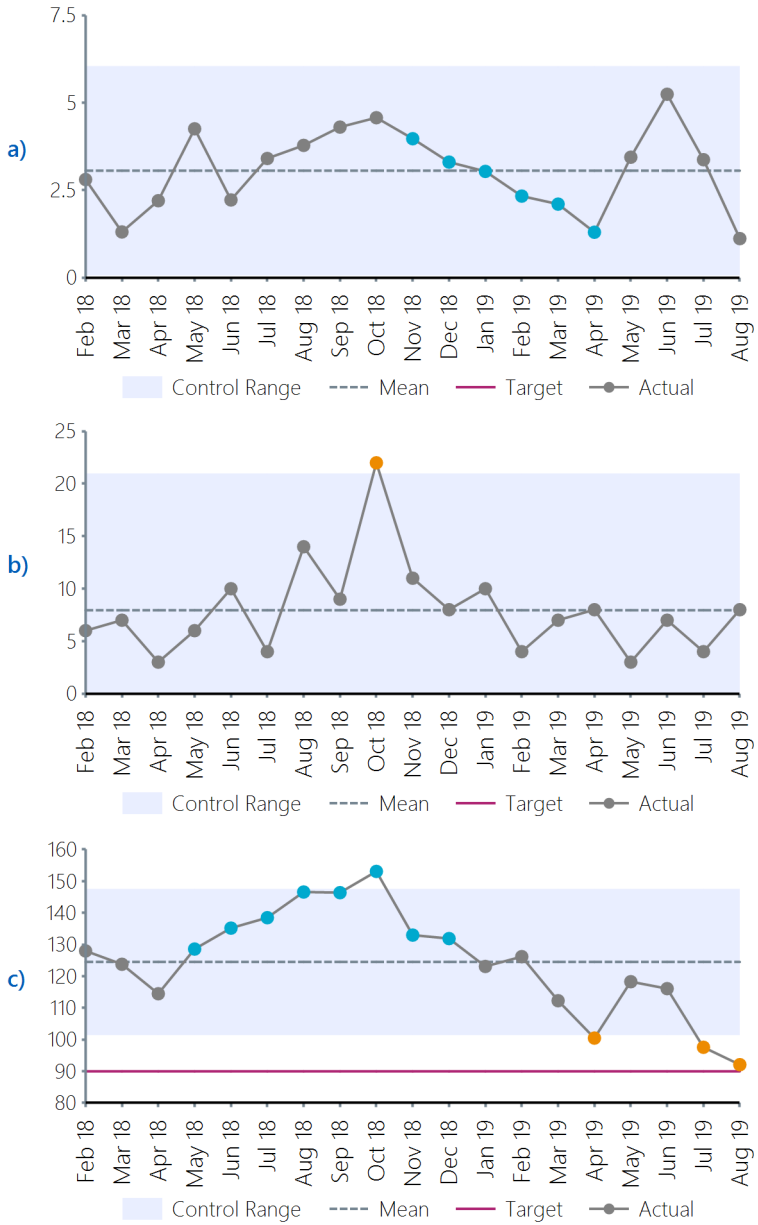
Some examples of these are shown in the images to the right:

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
31 Day Subsequent Treatment (Tumour)							
Cancer Plan 62 Days Standard (Tumour)*	85.00%	66.67%				+	
18 Weeks RTT Open Pathways	92.00%	50.84%				+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,763	1,945			+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,091			No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	432	490			+	
Patients Waiting Over 78 Weeks - Welsh (Total)		295	337		No Target	+	
Patients Waiting Over 104 Weeks - English	0	58	45			+	
Patients Waiting Over 104 Weeks - Welsh (Total)		50	93		No Target	+	
Overdue Follow Up Backlog	5,000	13,665				+	

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%	56.47%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	57.05%				+	

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)	1,078	984		H	Moving Target	+	
Bed Occupancy – All Wards – 2pm	87.00%	87.02%		H	F	+	09/03/22 Risk
Total Outpatient Activity against Plan (volumes)	15,546	12,696			Moving Target	+	
Total Outpatient Activity - % Moved to PIFU Pathway	3.00%	3.47%		N/A to SPC	Moving Target		
Total Diagnostics Activity against Plan - Catchment Based	2,316	2,491			Moving Target		

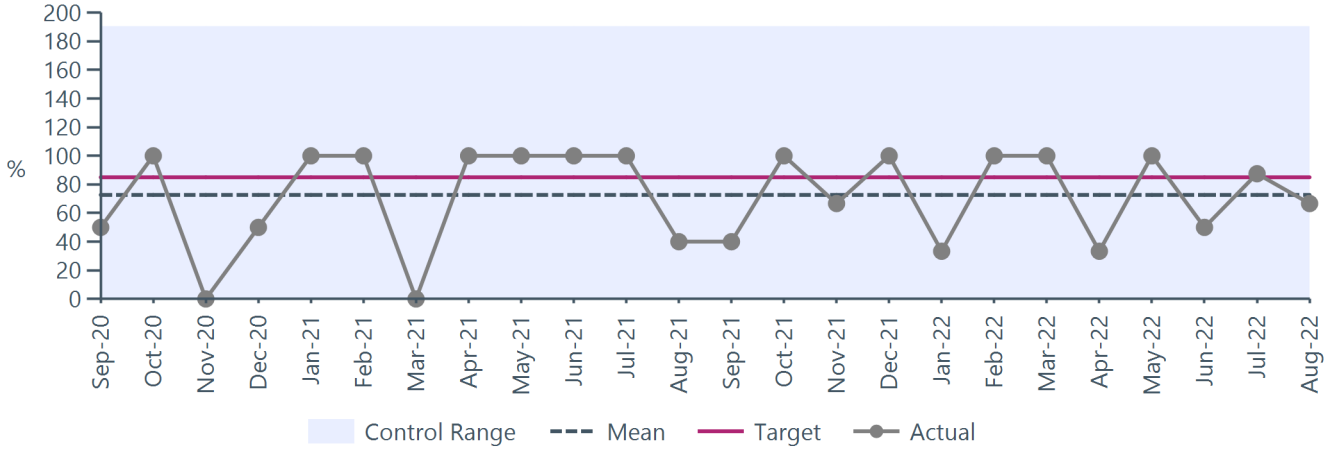
Cancer Plan 62 Days Standard (Tumour)*

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	66.67%		

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 Cancer Plan 62 Days Standard was not met in August (reported one month in arrears). RJAH was accountable for three shared pathways where one breached the standard. This was due to the complexity of the patient pathway where multiple investigations were required (some at other sites).

Actions

The one breach pathway was a result of complexity and multiple investigations necessary, therefore there are no applicable actions deemed necessary.

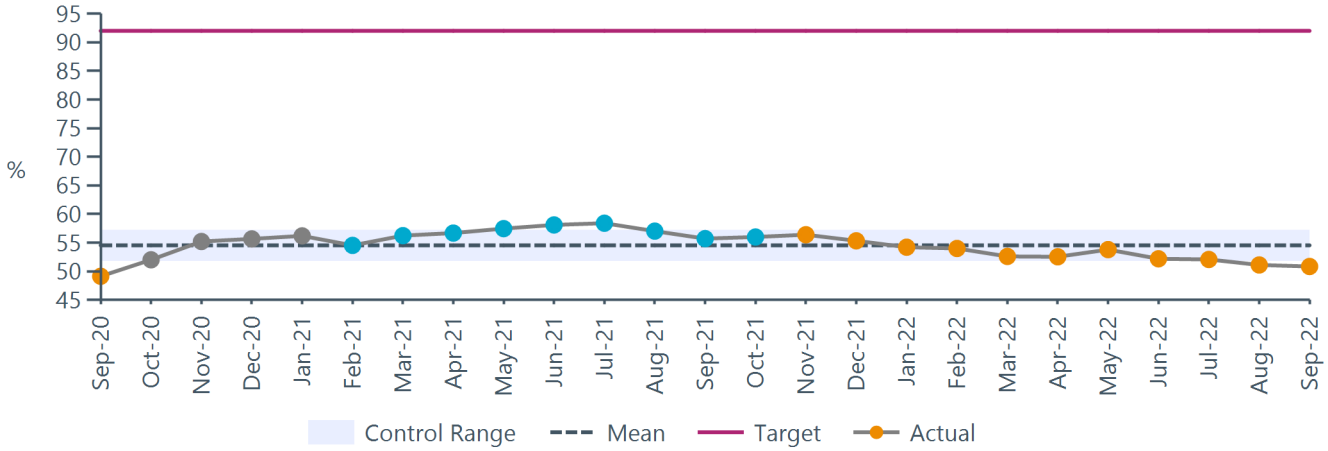
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
40%	100%	66%	100%	33%	100%	100%	33%	100%	50%	87%	66%	

18 Weeks RTT Open Pathways

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	50.84%	L	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.
Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

Our September performance was 50.84% 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 - 7468 patients waiting of which 2139 are breaches
* MS2 - 1690 patients waiting of which 1179 are breaches
* MS3 - 4797 patients waiting of which 3542 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 a RTT recovery trajectory for full pathways performance back to 18 weeks. This will be presented to FPD in December.
Further detail provided against the list size and weeks waits KPIs.

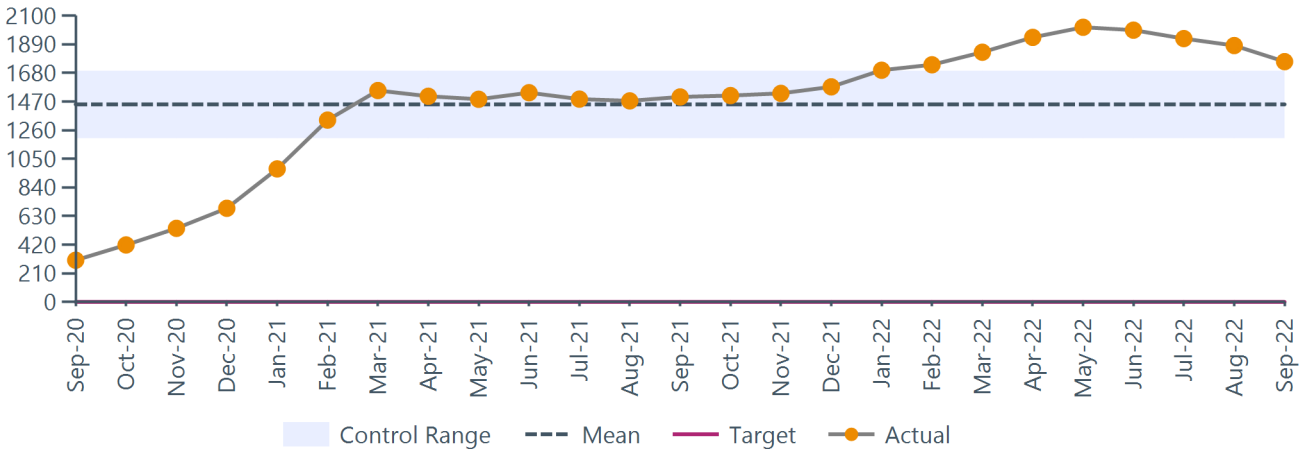
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
55.71%	55.99%	56.39%	55.33%	54.21%	53.99%	52.60%	52.54%	53.79%	52.19%	52.07%	51.11%	50.84%

Patients Waiting Over 52 Weeks – English

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,763	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.

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

Narrative

At the end of September there were 1763 English patients waiting over 52 weeks; below our trajectory figure of 1945 by 182. The patients are under the care of the following sub-specialities; Spinal Disorders (800), Knee & Sports Injuries (316), Arthroplasty (200), Upper Limb (148), Veterans (127), Foot & Ankle (98), Spinal Injuries (38), Paediatric Orthopaedics (17), Neurology (6), Metabolic Medicine (5), Tumour (5), Rheumatology (1), Orthotics (1) and Occupational Therapy (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1331 patients
- >78 to <=95 weeks - 282 patients
- >95 to <=104 weeks - 92 patients
- >104 weeks - 58 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 Trust is currently focusing on greater than 52 weeks that will be 78 weeks by the end of March. Increased bookings for non-admitted pathways is where concentrated efforts are being made. Please see 78+ weeks indicator for further actions.

During October the Trust has also submitted a bid to the regional NHS England team recognising the support required for validation, waiting list additional data submissions and mutual aid co-ordination. These aspects all support with further reductions and governance/reporting of actions being taken.

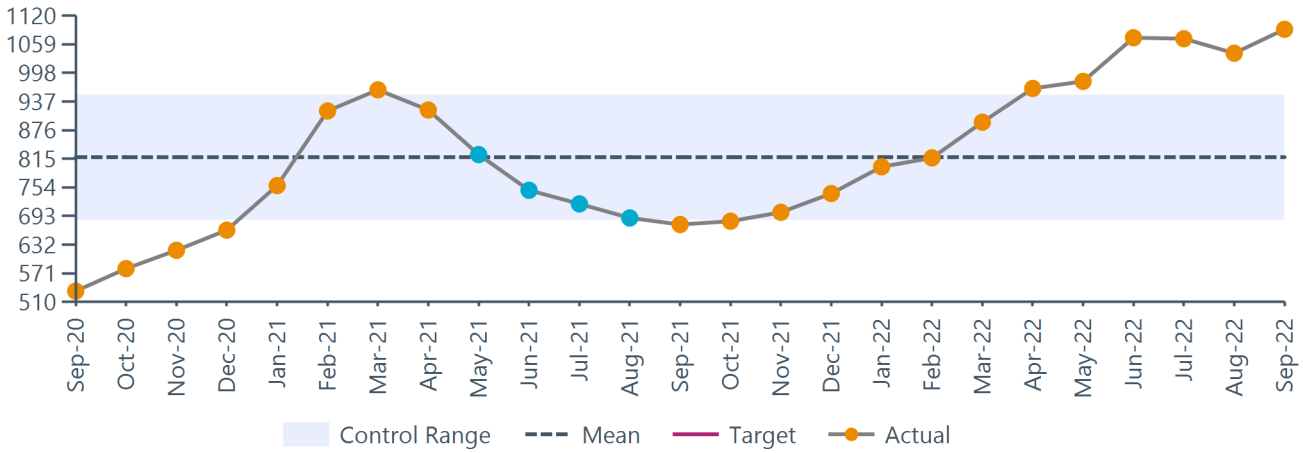
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
1504	1514	1530	1578	1700	1740	1832	1941	2015	1994	1932	1881	1763

Patients Waiting Over 52 Weeks - Welsh (Total)

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,091	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 September there were 1091 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (713), Arthroplasty (136), Knee & Sports Injuries (90), Upper Limb (58), Foot & Ankle (36), Veterans (21), Paediatric Orthopaedics (18), Spinal Injuries (10), Metabolic Medicine (3), Tumour (3), Neurology (2) and Physiotherapy (1).
The patients are under the care of the following commissioners; BCU (604), Powys (477), Hywel Dda (8), Abertawe Bro (1) and Cardiff & Vale (1). The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 796 patients
- >78 to <=95 weeks - 196 patients
- >95 to <=104 weeks - 49 patients
- >104 weeks - 50 patients

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

Actions

The Trust is currently focusing on greater than 52 weeks that will be 78 weeks by the end of March. Increased bookings for non-admitted pathways is where concentrated efforts are being made. Please see 78+ weeks indicator for further actions.

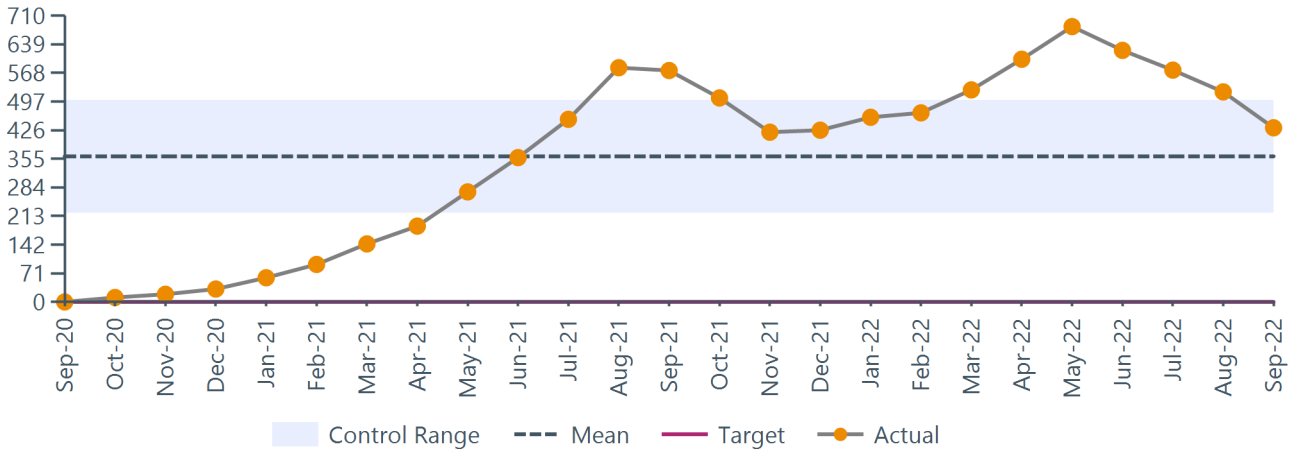
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
675	682	701	741	798	817	893	965	980	1073	1071	1040	1091

Patients Waiting Over 78 Weeks - English

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	432	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

At the end of September there were 432 English patients waiting over 78 weeks; this was 58 patients below our trajectory of 490. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Spinal Disorders (295), Knee & Sports Injuries (70), Upper Limb (19), Arthroplasty (17), Spinal Injuries (9), Veterans (7), Foot & Ankle (6), Tumour (3), Paediatric Orthopaedics (3), Metabolic Medicine (1), Rheumatology (1) and Orthotics (1).

The greater than 78 weeks proportion of waiting list was 3.8% and the end of August and has reduced to 3.1% at the end of September.

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 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. Independent sector mutual aid has been for admitted pathways only to date. NHS EI regional team are also 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.

Utilisation of capacity across the consultant workforce continues.

During October the Trust has also submitted a bid to the regional NHS England team recognising the support required for validation, waiting list additional data submissions and mutual aid co-ordination. These aspects all support with further reductions and governance/reporting of actions being taken.

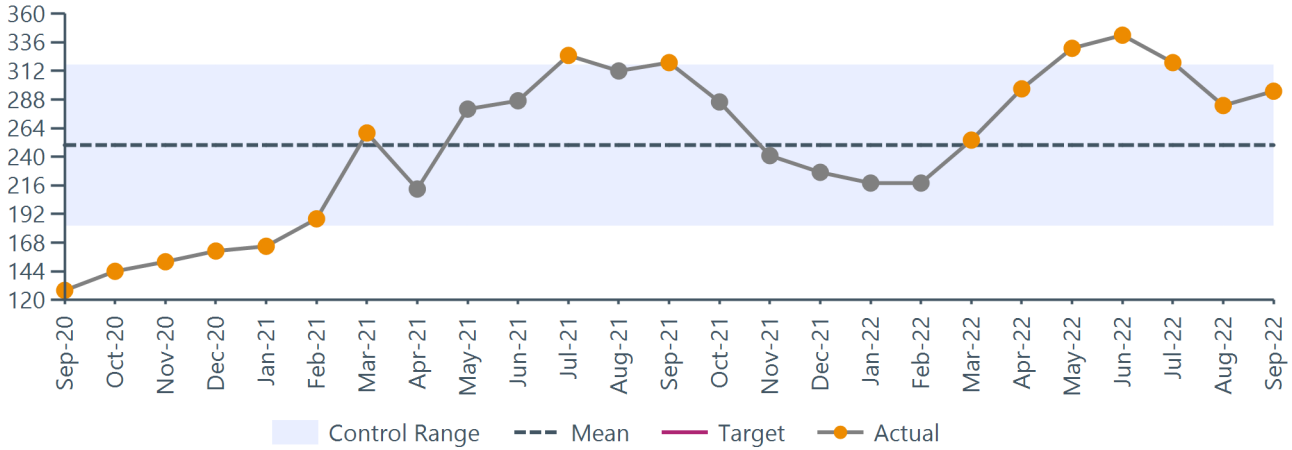
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
574	506	421	426	458	469	526	602	683	624	575	521	432

Patients Waiting Over 78 Weeks - Welsh (Total)

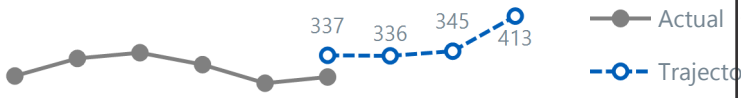
Patients waiting over 78 Weeks - Welsh (Total) 217802

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	295	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 September there were 295 Welsh patients waiting over 78 weeks; this was 42 patients below our trajectory of 337. The Trust plans are visible in the trajectory line above.

The patients are under the following sub-specialties; Spinal Disorders (250), Knee & Sports Injuries (21), Upper Limb (10), Arthroplasty (5), Foot & Ankle (3), Veterans (3), Spinal Injuries (2) and Neurology (1).

Actions

Progress has been made in reducing and dating patients within non-admitted pathways with utilisation of capacity across the consultant workforce. In line with Welsh Assembly expectations, the Trust aims to clear all milestone 1 patients waiting over 78 weeks by the end of December

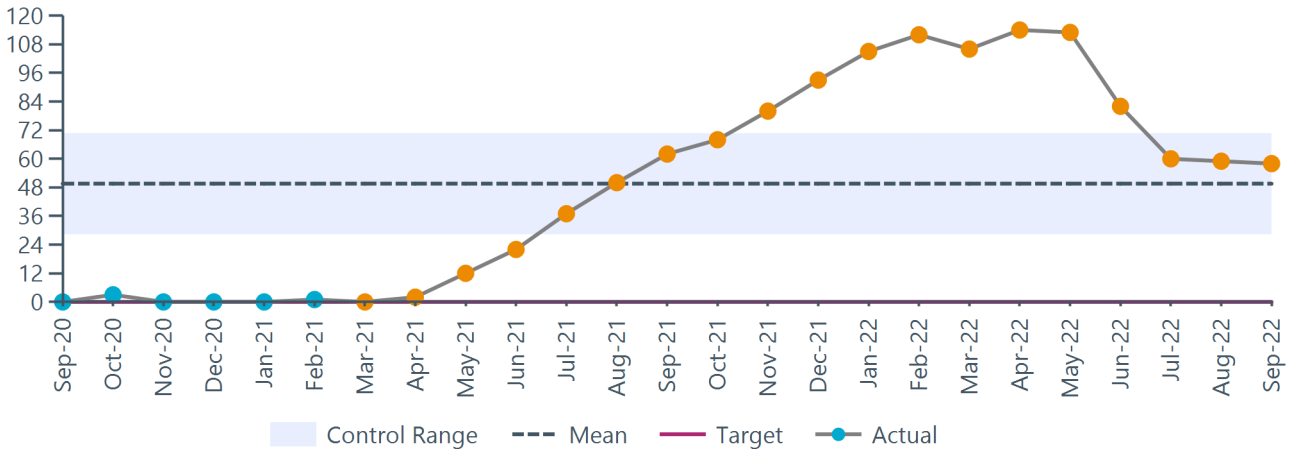
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
319	286	241	227	218	218	254	297	331	342	319	283	295

Patients Waiting Over 104 Weeks - English

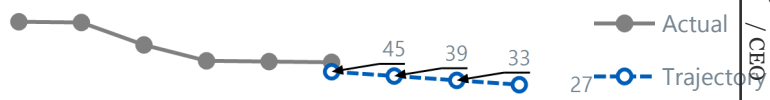
Number of English RTT patients waiting 104 weeks or more at month end 217588

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	58	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

At the end of September there were 58 English patients waiting over 104 weeks, above our trajectory figure of 45 by 13. The patients are under the care of the following sub-specialities, with further details on the volume by priority;
- Spinal Disorders (53) - P2 (1), P3 (14), P4 (21), Not on Elective WL yet so no priority (17)
- Arthroplasty (2 - both P3)
- Knee & Sports Injuries (1 - P4)
- Paediatric Orthopaedics (1 - Not on Elective WL yet so no priority)
- Spinal Injuries (1 - P4)

By Milestone, there were:
- Milestone 1 (Outpatients) - 2 patients
- Milestone 2 (Diagnostics) - 15 patients
- Milestone 3 (Electives) - 41 patients

Actions

The Trust has been taking actions that helps reduce trip-ins in subsequent months. Continued support remains in place for a system partner. This contributed to a small number of the breaches seen this month.
Current actions include:
- Seeking mutual aid from ROH and Indepedant Sector
- Looking to pool capacity within spinal disorders
- Daily 104+ meetings being held within the Trust and chaired by Chief Operating Officer or Managing Director of Specialist Unit

The Trust is contacting patients, and seeking mutual aid, to support its most pressured service. This is progressing with a regional provider and multiple independent sector providers. RJAH also continues to work with its system partner to look at other orthopaedic services that require long waiter support.

Actions have been taken to progress and reduce the volume waiting in non-admitted pathways. See long waiting patients presentation.

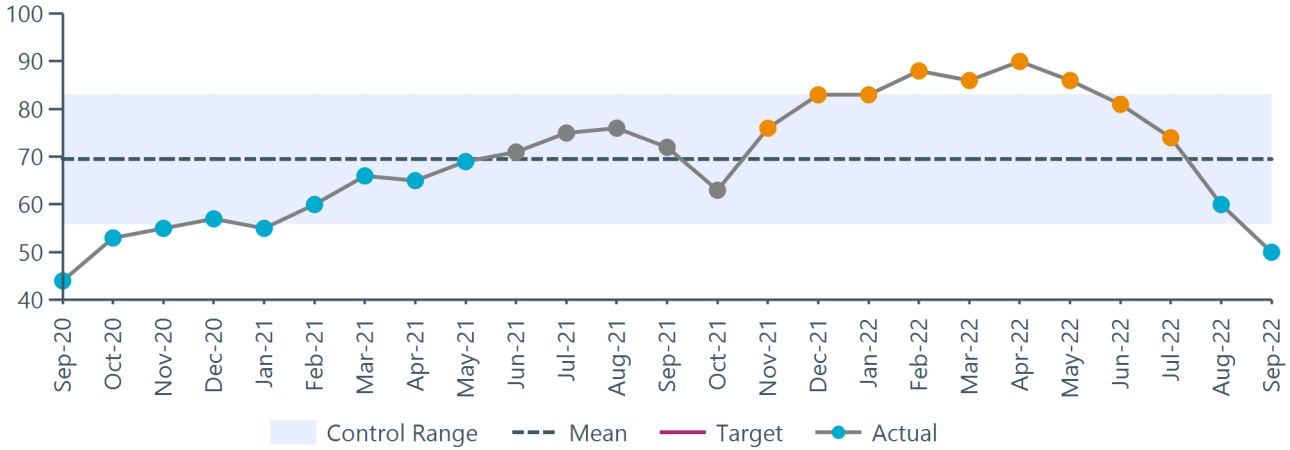
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
62	68	80	93	105	112	106	114	113	82	60	59	58

Patients Waiting Over 104 Weeks - Welsh (Total)

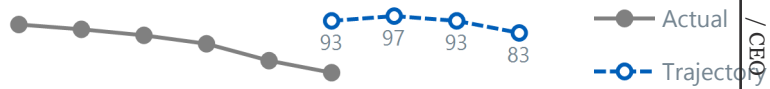
Patients Waiting Over 104 Weeks - Welsh (Total) 217803

Exec Lead:
Chief Operating Officer

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



Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of September there were 50 Welsh patients waiting over 104 weeks; below our trajectory figure of 93 by 43.

The patients are all under the care of the Spinal Disorders sub-specialty, with further details on the volume by priority;
- Spinal Disorders (50) - P3 (19), P4 (22), Not on Elective WL yet so no priority (9)

By Milestone, there were:
- Milestone 1 (Outpatients) - 1 patients
- Milestone 2 (Diagnostics) - 8 patients
- Milestone 3 (Electives) - 41 patients

Actions

The Trust has been taking actions that also reduce trip-ins in subsequent months. Actions have been taken to progress and reduce the volume waiting in non-admitted pathways. See long waiting patients presentation.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
72	63	76	83	83	88	86	90	86	81	74	60	50

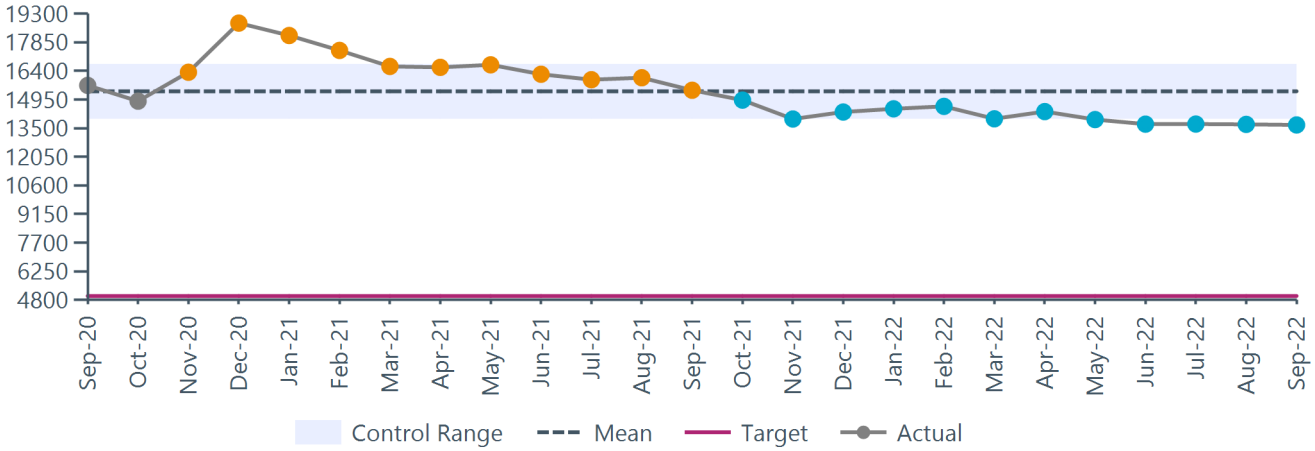
Overdue Follow Up Backlog

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	13,665	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 September, there were 13665 patients overdue their follow up appointment. This is broken down by:
- Priority 1 is our more urgent follow-up cohort - 8841 with 1687 dated (19%)
- Priority 2 is the lower priority - 4824 with 1301 dated (27%)

MSK backlog at the end of September is 5188. In April 20 it was 4928, it later increased to as high as 10545 and has steadily been reducing.
Specialist backlog at the end of September is 8477. In April 20 it was 5016, it later increased to 8938 and has remained in the 8-9 thousand range.
Sub-specialities with the highest percentage of overdue follow ups:
- Rheumatology - 20.82%; Arthroplasty - 17.71%; Spinal Disorders - 9.75%; Spinal Injuries - 9.05%

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

Actions

A trajectory has been agreed for Rheumatology for the next 3 months. The information team have developed a tool for use by the operational teams for all specialties that will calculate a trajectory for each sub-specialty based on their input of known bookings / capacity. This tool is going to start testing/review in October.
- In Rheumatology, additional capacity is now in place for follow ups where it is anticipated an additional 100 patients per month will be seen. In November, an additional consultant starts in Rheumatology.
- The Trust has a number of Transformational projects in progress, such as PIFU, that will support in further reductions in this area
- Consultants to increase desk-top reviews for their overdue follow up patients
- Further analysis on-going to understand how overdue follow ups have increased/decreased due to practice changes within different sub-specialties by October '22

This has been flagged as a hot topic for Units to provide an update at the next Trust Performance Operational Improvement Board

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
15422	14923	13965	14319	14482	14605	13976	14342	13937	13705	13710	13693	13665

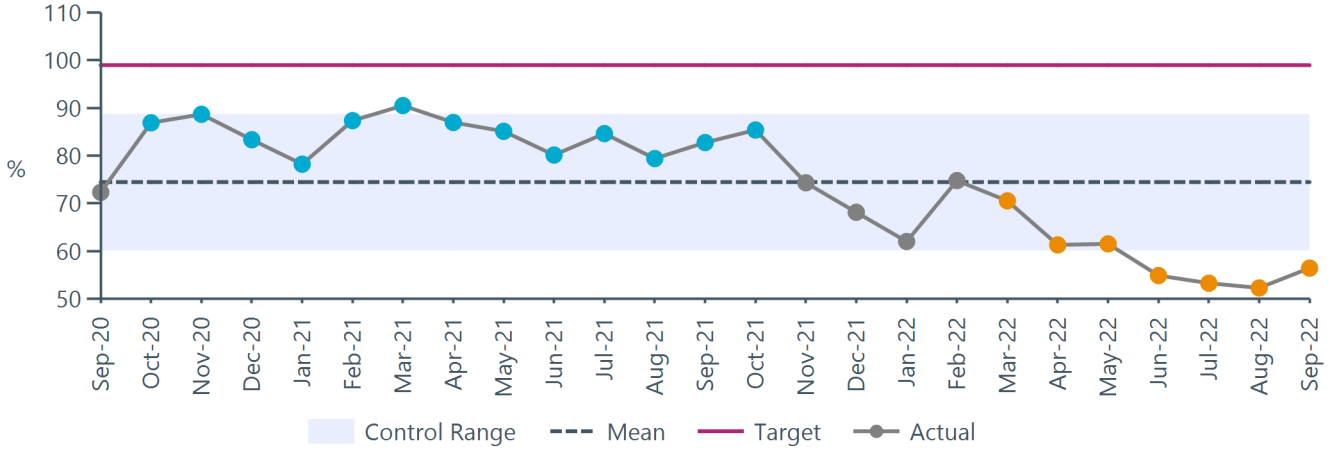
6 Week Wait for Diagnostics - English Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
99.00%	56.47%	L	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.

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 56.47%. This equates to 828 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 47.45% - D2 (Urgent - 0-2 weeks) 12 with 11 dated, D3 (Routine - 4-6 weeks) - 12 dated, D4 (Routine - 6-12 weeks) - 749 with 362 dated
- CT - 89.66% - D2 (Urgent - 0-2 weeks) 1 undated, D4 (Routine - 6-12 weeks) - 8 with 2 dated
- Ultrasound - 85.93% - D2 (Urgent - 0-2 weeks) 1 dated, D3 (Routine - 4-6 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 43 with 41 dated
- DEXA Scans - 100%

With the agreement of staff, the extended weekend working was implemented during September and activity figures reflect this. All MRI/CT staff are cross trained and deployed as necessary.
The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were initially referred as D4 (Routine - 6-12 weeks) but were updated to urgent at a later date and the 1 undated breach further information is required before an appointment can be made. MRI was reported at 47.45% against a trajectory specifically for MRI at 57%. It must be noted that both MRI and Ultrasound activity plans were met in September.

Actions

Capacity has increased from September for MRI where they are now operating 8am to 8pm, 7 days per week to support backlog clearance. A procurement process for mobile MRI scanner has been initiated.

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

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
82.78%	85.42%	74.35%	68.16%	62.04%	74.81%	70.56%	61.33%	61.54%	54.90%	53.30%	52.31%	56.47%

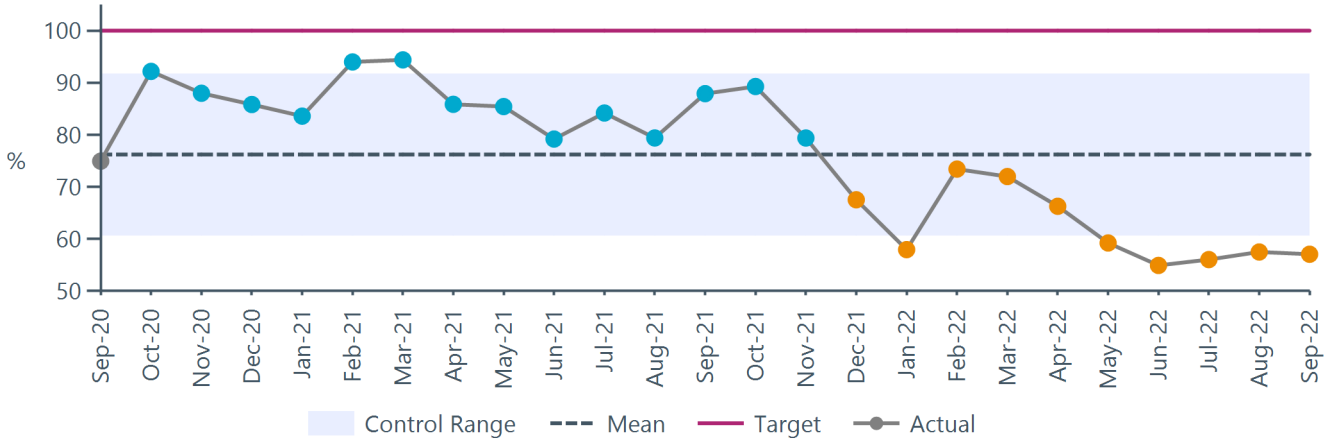
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	57.05%	L	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.

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 57.05%. This equates to 393 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 52.24% - D2 (Urgent 0-2 weeks) - 3 dated, D3 (Routine 4-6 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 379 with 209 dated
- CT - 78.79% - D4 (Routine - 6-12 weeks) - 7 with 3 dated
- Ultrasound - 97.40% - D4 (Routine - 6-12 weeks) - 2 with 1 dated
- DEXA Scans - 100%

With the agreement of staff, the extended weekend working was implemented during September and activity figures reflect this. All MRI/CT staff are cross trained and deployed as necessary.
The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were initially referred as D4 (Routine - 6-12 weeks) but were updated to urgent at a later date. It must be noted that both MRI and Ultrasound activity plans were met in September.

Actions

Capacity has increased from September for MRI where they are now operating 8am to 8pm, 7 days per week to support backlog clearance. A procurement process for mobile MRI scanner has been initiated.

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

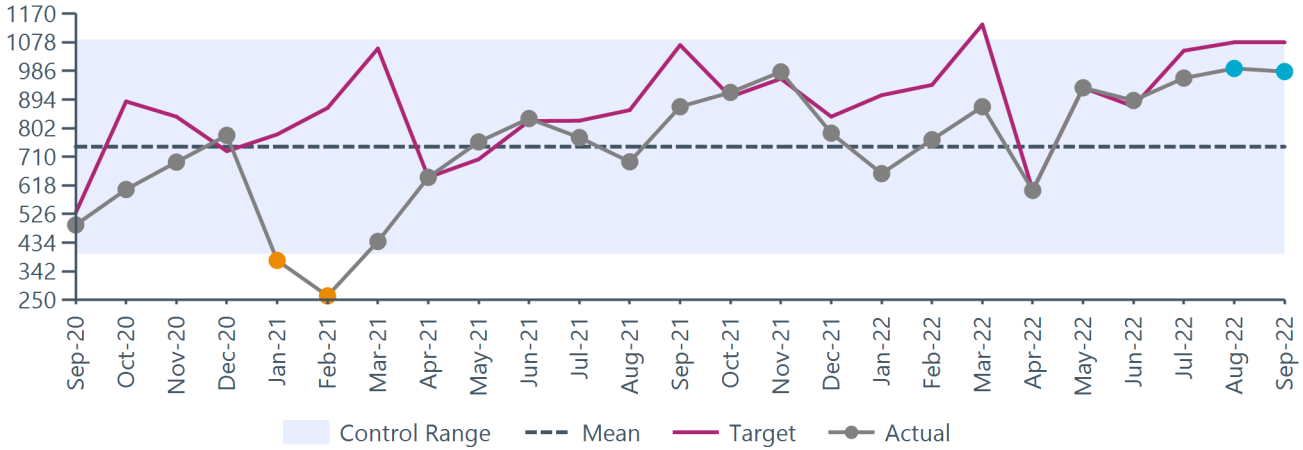
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
87.91%	89.28%	79.38%	67.51%	57.94%	73.41%	71.98%	66.27%	59.22%	54.90%	56.03%	57.48%	57.05%

Elective Activity Against Plan (volumes)

Total elective activity rated against 2022/23 plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,078	984	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 plan for September was 91.7% of 19/20 baseline against a national target of 104%. This metric is included as an exception as it is reporting special cause variation of an improving nature. Beginning October, the Trust will be monitoring this KPI internally against agreed H2 trajectories, as seen in the graph above.

Total elective activity undertaken in September was 984, 94 behind the 2022/23 plan of 1078 equating to 91.28%. Non-theatre activity is reporting 24.80% of the total and Theatre activity is 75.20% of the total.

Several factors contributed to the shortfall in September elective activity:
- Lack of Independent Sector uptake - 0 undertaken in September against a plan of 18
- 35 on the day theatre cancellations and 108 ahead of TCI date (some attributed to unscheduled public holiday and closure of theatres for maintenance work)
- NHS sessions behind plan
- Cases per session behind plan in Specialist unit

Actions

A full review of Theatre staffing and Theatre processes is underway and due to complete in November (Caradoc Review). Once finalised, findings and actions formulated by MSK unit Managing Director.

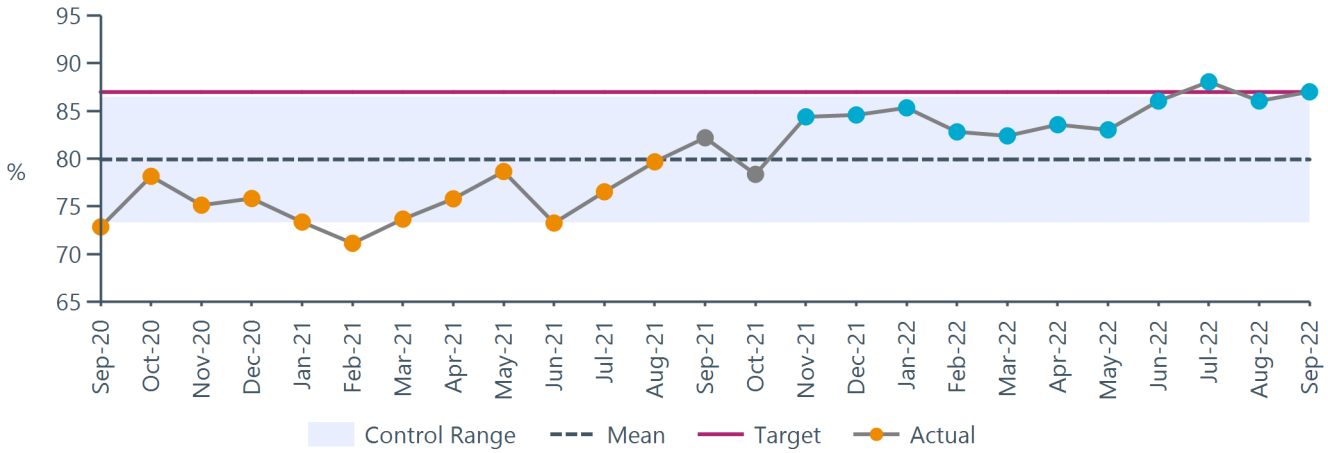
Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
871	917	983	786	656	765	871	602	932	891	963	994	984

Bed Occupancy – All Wards – 2pm

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
87.00%	87.02%	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 occupancy rate for all wards is reported at 87.02% for September and remains shown as special cause variation with sustained improvement. Breakdown provided below:
MSK Unit:
- Clwyd - 72.16% - compliment of 22 beds - ward closed 9th-28th
- Powys - 82.73% - compliment of 22 beds - ward closed 1st to 8th
- Kenyon - 84.96% - compliment of 22 beds open all month
- Ludlow - 88.84% - compliment of 16 bed open all month

Specialist Unit:
- Alice - 42.23% - compliment of 16 beds; open to 4-16 beds dependant on weekday/weekend and demand
- Oswald - 89.67% - compliment of 10 beds open all month
- Gladstone - 96.32% - compliment of 29 beds open all month
- Wrekin - 97.09% - compliment of 15 beds open all month
- Sheldon - 93.03% - compliment of 19 beds; open 15-19 throughout month

Actions

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
82.21%	78.37%	84.40%	84.60%	85.35%	82.82%	82.40%	83.58%	83.03%	86.06%	88.07%	86.07%	87.02%

Total Outpatient Activity against Plan (volumes)

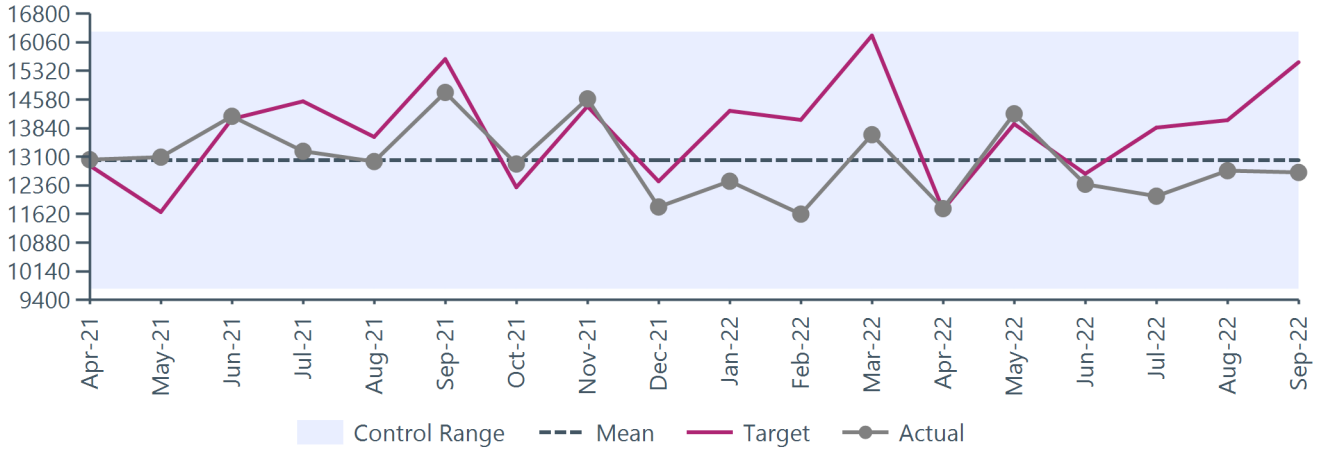
Total outpatient activity (H1 - consultant led, non-consultant led and un-bundled and H2 and 22/23 plan - consultant led and non-consultant led) against submitted plans.

217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
15,546	12,696		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 September was 94.60% of 19/20 against a national target of 104%. Total outpatient activity undertaken in September was 12696 against the 2022/23 plan of 15546; 2850 cases below - equating to 81.67%.
This is broken down as:
- New Appointments - 4095 against 4941 - equating to 82.88%
- Follow Up Appointments - 8601 against 10605 - equating to 81.10%

The sub-specialities with the lowest activity against plan in September are:
- Physiotherapy - 1734 against 2769 - 1035 cases below - associated with cancellations, unfilled slots, class capacity reduction and high levels of sickness
- Arthroplasty - 1114 against 1701 - 587 cases below - associated with higher levels of annual leave and study leave
- Upper Limb - 792 against 1130 - 338 cases below - shortfall can mainly be seen against the plan flex

Now that a H2 forecast is in place for theatre activity and elective spells, the same work will be done for outpatients and will go through FPD committee before adding to the IPR.

Actions

- Outpatient Improvement Plan which includes all aspects of Outpatient activity including Overdue Follow Ups, DNAs, PIFU, Virtual, IPC, clinic utilisations etc.
- Review clinic templates within sub-specialities to maximise number of appointments
- Therapies is currently under a service review with report expected by the end of October
- Backlog management Plan for SOOS patients has been developed and an application to the ERF has been made
- Review of staffing within outpatients to meet current demand
- Recruitment (particularly consultants and therapists)

A revised H2 outpatient activity plan being developed as already done for elective activity.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
14765	12914	14599	11804	12469	11619	13672	11761	14213	12391	12082	12742	12696

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

RJAH Long Waiters - 2022/23

Trust Board
November 2022

Aspiring to deliver world class patient care

2022/23 September and October* Performance

		Plan	Actual	Difference
September	English 104+ Weeks	45	58	13
	Welsh 104+ Weeks	93	50	-43
	English 78+ Weeks	490	432	-58
	Welsh 78+ Weeks	337	295	-42

		Plan	Forecast*	Difference
October*	English 104+ Weeks	39	39	0
	Welsh 104+ Weeks	97	54	-43
	English 78+ Weeks	387	408	21
	Welsh 78+ Weeks	336	327	-9

Forecast based on unvalidated position (21/10/2022)

NHS England Revised Expectations:

Providers to have a 'Route to Zero' for end of November 2022 (zero breaches).

*October forecast subject to clock stop predictions / numbers not converting

*October 78+ Weeks subject to further improvements due to volumes of outpatients still to be seen <31st October. % that do not convert.

The longest waits: - Spinal Disorders remains our challenged specialty:

English October forecast = 39 patients

- 33 Complex (30 Spinal Disorders, 3 complex SaTH transfers)
- 0 Capacity
- 6 Patient Choice (Spinal Disorders)

Aspiring to deliver world class patient care

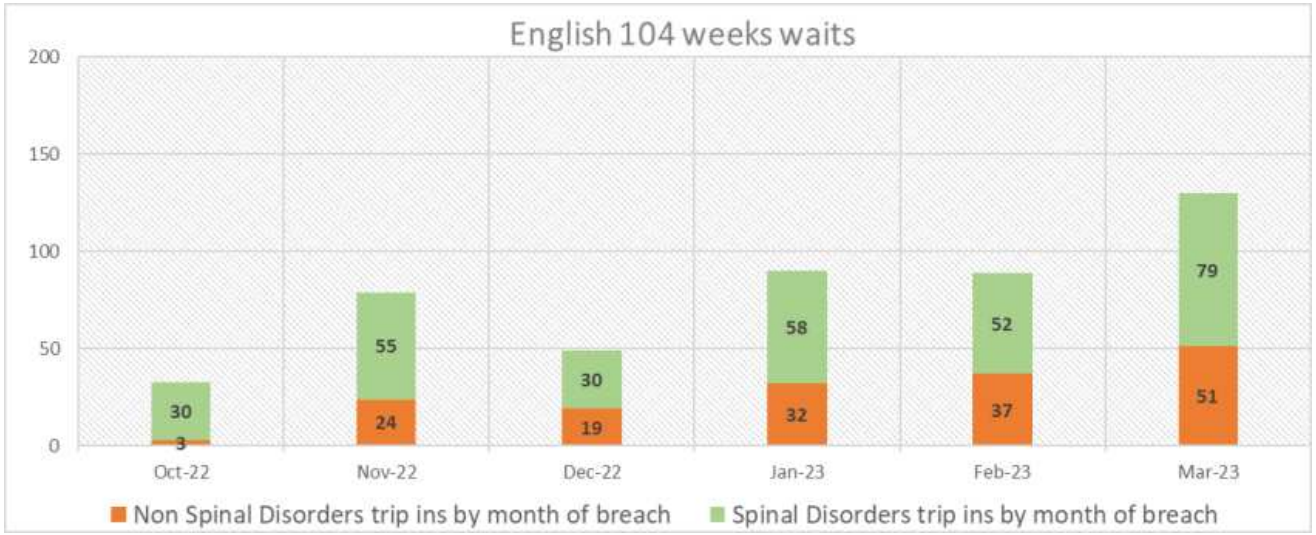
Milestone Visibility - Combined Waiting Lists > 78 weeks

	31.07.22		31.08.22		30.09.22		21.10.22 *Unvalidated	
Combined	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L
Milestone 1	419	47%	287	35%	197	27%	189	27%
Milestone 2	84	9%	156	19%	211	29%	214	31%
Milestone 3	391	44%	366	45%	319	44%	292	42%
Total	894		809		727		695	

- Actions:
  - New consultants commenced in August 2022.
  - Additional outpatient and inpatient capacity being explored.
  - Additional diagnostic capacity being scoped.
  - There's actions being undertaken to ensure milestone 3 scans are up-to-date.

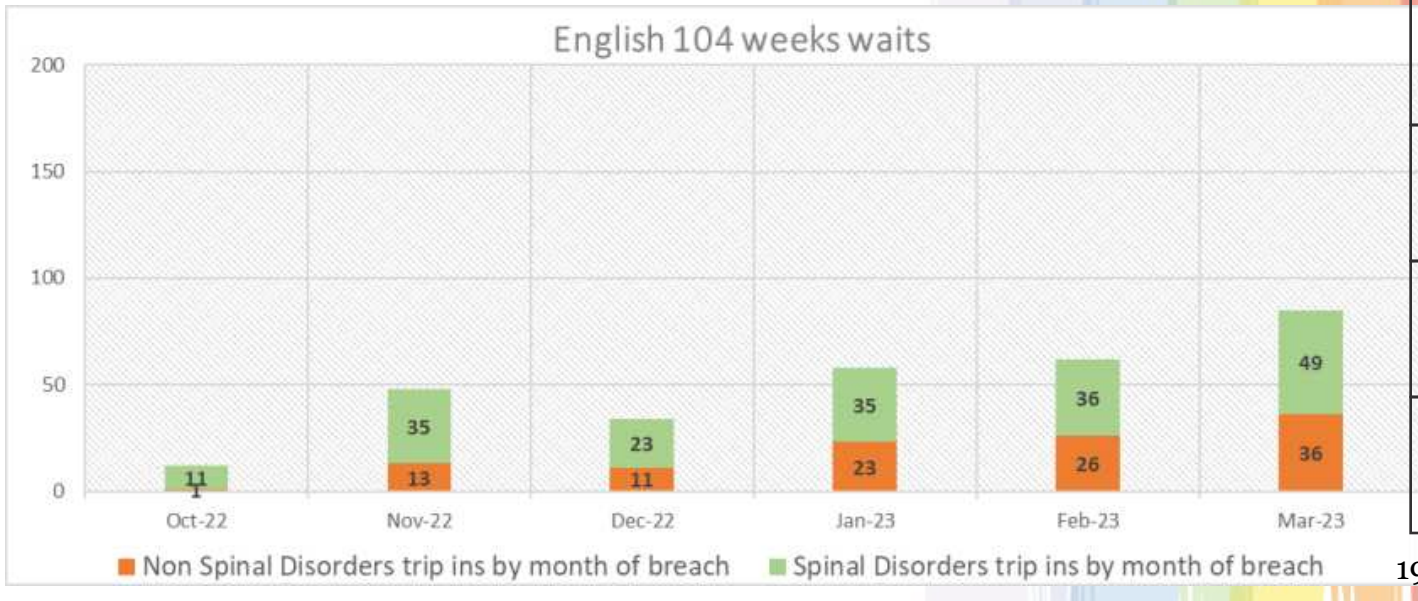
Managing The Trip-ins – 104 weeks - English

21st September



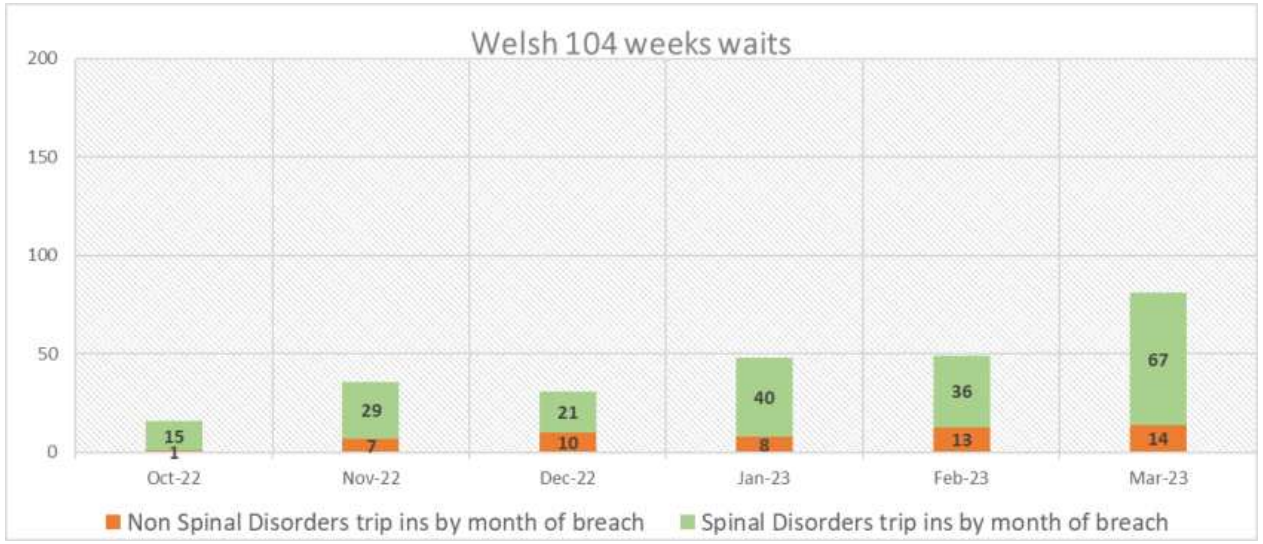
Between 21st September and 24th October. Trip-ins between October and March have reduced from 470 to 299.
Reduction of 36%

24th October



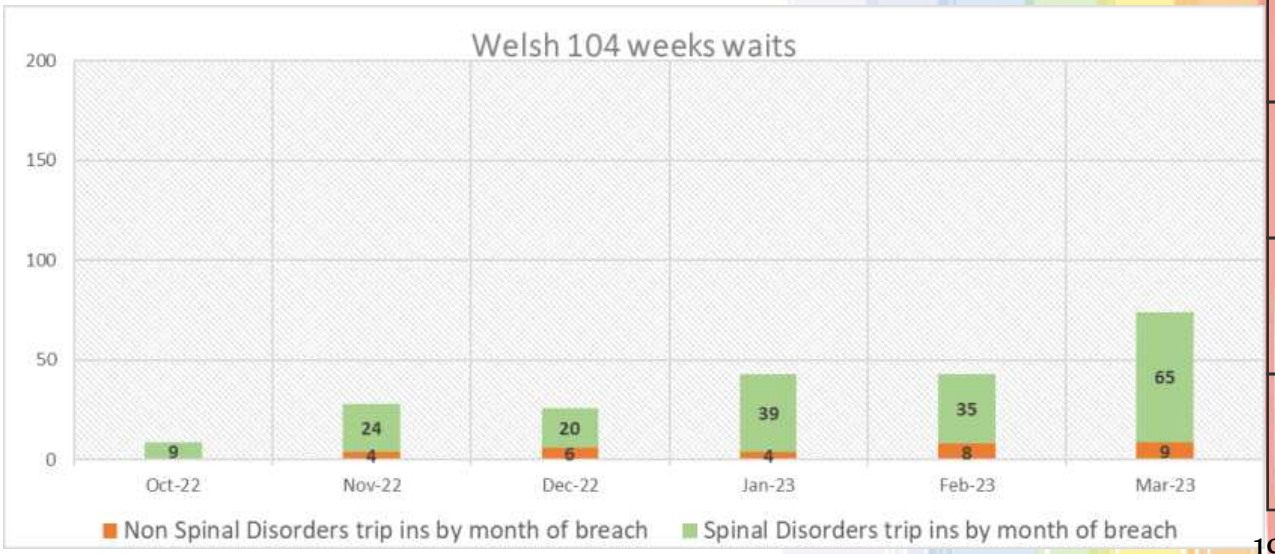
Managing The Trip-ins – 104 weeks - Welsh

21st September



Between 21st September and 24th October. Trip-ins between October and March have reduced from 261 to 223. Reduction of 15%

24th October



To: NHS Trust and Foundation Trust chief executives and chairs

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

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management

Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

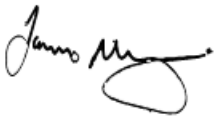
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Ref	Elective Recovery Self-certification requirement	Status	RAG	Further actions required
a	Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.	The Trust's lead Executive Director is the Chief Operating Officer.	Green	
b	That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	The Key Performance Indicators within the Trust's Integrated Performance Report are owned by the relevant committees including Quality & Safety Committee and Finance, Planning & Digital Committee. Deep dive performance reports including progress against plans and benchmarking information are also presented to committees on a rotational basis and when areas require additional focus.	Green	
c	Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.	The Trust has an agreed plan for patients waiting 78+ weeks with 247 patients forecast to be waiting by the end of March 2023; the Trust's request to the mutual aid hub was informed by this forecast.	Green	
d	Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	Not applicable.	N/A	
e	Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.	The Trust has an Outpatient Improvement Plan in place and this is overseen by the Trust's Finance, Performance and Digital Committee. The plan includes productivity opportunities and further GIRFT opportunities will be explored.	Amber	Further development and implementation of the Outpatient Improvement plan.
f	Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.	Regional feedback is expected during the w/c 31st October and the Trust's Outpatient Improvement Plan will be updated accordingly.	Amber	Further development and implementation of the Outpatient Improvement plan.
g	Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	Resources are in place and the Trust plans to comply with the national validation milestones. The Trust has regular validation reporting in place for assurance purposes and performance is overseen by the Finance, Planning and Digital Committee. A deep dive presentation on validation was received by the committee in October covering technical, clinical and patient validation and further updates will be presented as a part of the work plan.	Green	
h	Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	All patients listed for surgery are prioritised in line with national prioritisation categories and the Trust tracks the waiting times for these patients. This process was recently audited by the Trust's internal auditors.	Amber	The Trust currently records the priority status of each patient listed for surgery and planned date of surgery. Further work on average waits will be carried out as outlined in the Trust's internal audit report, this will improve oversight of waiting times for each cohort. Substantial assurance was given on the waiting list audit however further improvement work will continue across operational and access teams.

i	Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.	Theatre productivity is covered in detail at the Trust's Finance, Planning & Digital Committee and high-level key performance indicators are presented to Trust Board monthly.	Amber	Consideration will be given as to whether further theatre productivity key performance indicators should be added to the Board level Integrated Performance Report and a non-executive director will be identified as a sponsor.
j	Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.	Model Health System productivity data is routinely reviewed by the Trust and a report was taken to the Trust's Finance, Planning & Digital committee in October covering productivity assessments including benchmarking against other providers using Model Hospital data. Further analysis of Model Hospital data will be carried out in coming months.	Amber	The Trust will revise day case key performance indicators, benchmark against other Trusts and integrate any changes into the theatre utilisation dashboard.
k	Confirm your SROs for theatre productivity.	The Trust's SROs are the Chief Operating Officer and Associate Clinical Director for Theatres and Anaesthetics; this has been communicated to NHS England.	Green	
l	Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England	MRI services operate 12 hours per day, 7 days per week. CT services operate 12 hours per day, 5 days per week and the CT waiting list size is at an optimal level.	Green	

Trust Board - Finance
September 2022 – Month 6

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)

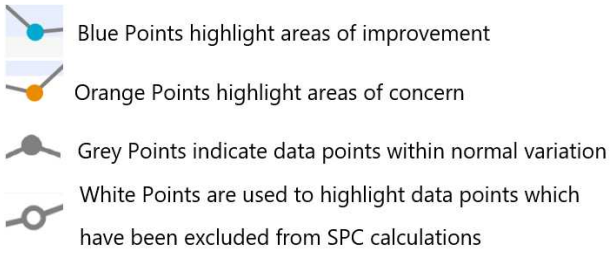
Different colours have been used to separate these trends of special cause variation:

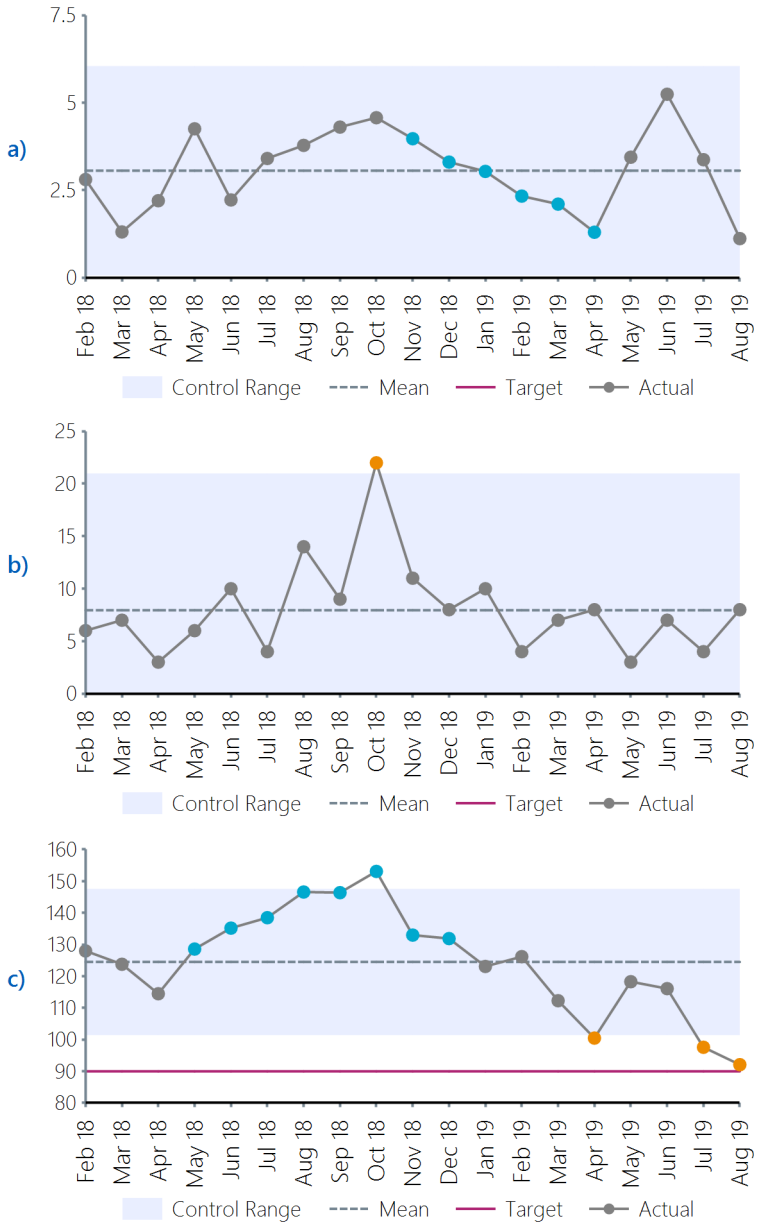
Some examples of these are shown in the images to the right:

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 Finances

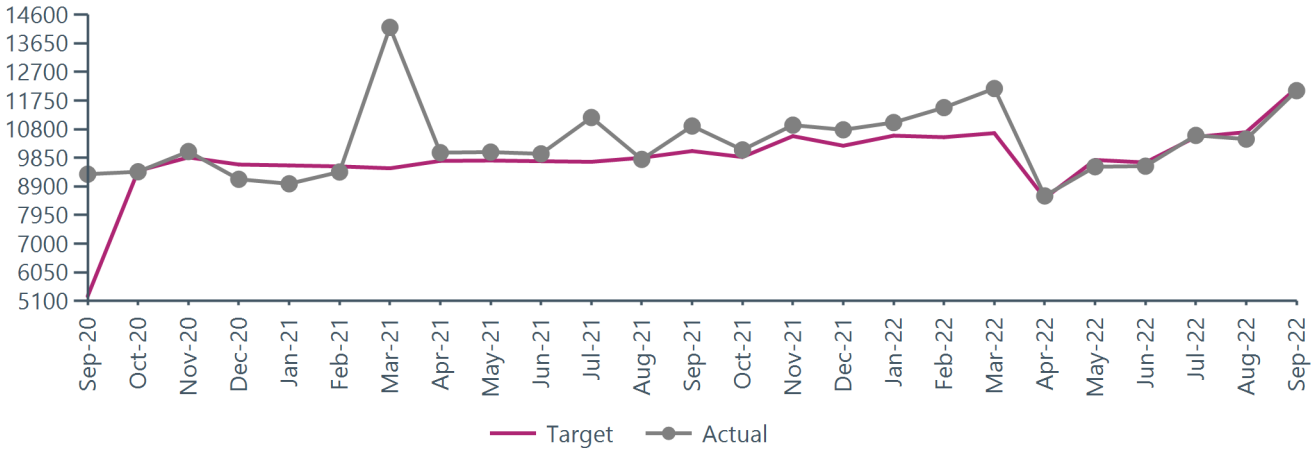
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Financial Control Total	465	581		N/A to SPC	Moving Target		
Income	12,165	12,079		N/A to SPC	Moving Target	+	
Expenditure	11,755	11,548		N/A to SPC	Moving Target		
Efficiency Delivered	152	164		N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	0	0		N/A to SPC	P		
Cash Balance	23,128	26,438		H	Moving Target		
Capital Expenditure	1,230	923		N/A to SPC	Moving Target		

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
12,165	12,079	N/A to SPC	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

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

Narrative

Income £235k adverse excluding pass through income:
- NHS Clinical Income adverse driven by activity

Partially offset by :
- RTA favourable driven by increased notifications
- Private Patient recovery favourable

Actions

Ongoing Private patient activity recovery.

Delivery of NHS activity against revised operational plan forecast

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
10905	10113	10935	10780	11021	11516	12150	8585	9554	9573	10594	10471	12079

0. Reference Information

Author:	Lorraine Fearne	**Paper date:**	25th October 2022
Executive Sponsor:	Sarfraz Nawaz and Craig Macbeth	**Paper written on:**	27th October 2022
Paper Reviewed by:	N/A	**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 of Directors and what input is required?

This paper presents a summary of the Finance, Planning & Digital Committee meeting held on 25th October 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was well attended and quorate
- Restoration of activity continues to fall beneath national requirements and planned levels. Value Weighted Activity noted as the currency being used by NHSE to track performance and this to be included in KPI's going forward.
- 104 weeks progress report received showing expecting to be back on original plan trajectory for end of October for England. Noted ongoing pressures to accelerate clearance and mutual aid discussions taking place with RoH
- Review of Theatre efficiency opportunities in progress and to be reported to future FPD
- MSK Services Efficiency Delivery forecast had deteriorated. A update on mitigating actions was requested to be brought to next Committee.
- Outpatientrevised H2 forecast – Shows a deteriorating position and concerns that this is a matter requiring greater intervention/attention to improve.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning and Digital Committee which met on 25 October 2022. The meeting was quorate with 2 Non-Executives and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Craig Macbeth	Chief Finance & Planning Officer
Mike Carr	Chief Operating Officer
Stacey-Lea Keegan	Chief Executive Officer
Simon Adams	Director of Digital
In Attendance:	
Mark Salisbury	Operational Director of Finance
Jo Banks	Managing Director of MSK Unit (Part)
Nia Jones	Managing Director for Planning and Strategy
Steph Wilson	Performance Insight & Improvement Manager
Lorraine Fearne	Executive Assistant – Minute Secretary
Apologies:	
John Pepper, David Gilbert Simon Jones - Governor	

3.2 Actions from the Previous Meeting

All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declaration of Interest		
There were no declarations shared	N/A	
Matters Arising		
None raised	N/a	
Chair Report EPR Programmed Board Update		
• Investment agreement with NHSE to be signed off to ensure flow of money, anticipated release January. • Statement Gateway Stage 0 has been signed off with System C and noted the contract is capped against inflation for the next 10 years • Staff engagement has been sought to name EPR system.	Yes	

• Concerns regarding System C planning raised and addressed with communication in writing to the supplier and NHSE. • Risk noted for Trusts blood services, Interface issue between System C and SaTH, mitigation plan being produced the Trusts pathology service SLA also being reviewed.		
Performance and Restoration Update		
• Significant % drop for Septembers figures, related to step change in Sept 20 and not productivity, Trust expected to overperform in November and December against revised forecast activity levels. • Value Weighted Assessment recognized as the reporting mechanism the Trust will be measured on regionally. Committee and Trust recognise much greater understanding needs to be known of the complexities of this reporting. Exception report update • Cancellations are rising • Cancellation SOP is currently being reviewed. • Moving focus to overall waiting list size. Still focus on 104/78 weeks but the overall waiting list size is not changing, some modelling has been requested which will be broken down by specialty to review what is needed to be done to achieve the key milestones 78/52/18 week. • Diagnostics – reported MRI running 12 hours days 7 days a week. High level of demand still being seen, additional mobile scanner expected onsite next week.	Partial	The NED's asked how does the Trust run in parallel the requirements to reduce all lists to get to a sustainable quality service of care and as a Board how do they monitor this and provide support to the Board and Executives to prevent future bottlenecks Understand the VWA reporting format and it's complexities.
Productivity Dashboard		
Reports now include the average late starts and average early finish in minutes. This is in line with how nationally elective hubs are being monitored against in regard to ROI. Ultimate plan is to have a theatre dashboard that aligns with the Carados review that provides a clear baseline and clear trajectories to seek opportunities.	Partial	Understand why we have delayed starts, early finish and improve turn around time resulting in efficiencies to book in more cases
Long Waiters and Validation		
Considerable effort by teams to get back on track after falling behind in September. Trust would be ahead of trajectory without SaTH patients joining the Trusts wait lists. ROH will not transfer our patients to their lists and will remain with the Trust. 78 weeks reduced by 200 since the beginning of August keeping Trust on the trajectory of where we reported we would be in March.	Yes	

Route 0 for November as been requested, current trajectory is 33. Technical validation added to slides useful and provides the assurance the Committee were looking for.		
National and Regional Elective Recovery (Verbal)		
NHSE are conducting a deep dive to understand the complexities of an average tariff assumption as opposed to activity which has historically been monitored. Investigation being conducted by System to reconcile the VWA received.	Partial	Systems investigation to be brought to Committee to review.
Financial Performance - M6		
• £581k surplus in month 6 so progress towards clearing the deficit. • £118k favorable to plan In line with the plan provided to the regulator Clinical income adverse due to activity shortfalls £360k, partially offset by; • RTA £82k favorable in month driven by increased notifications • Private patient recovery £44k. Detailed forecast position linked to new operational planning assumptions improves the outcome position overall which will result in breakeven against the planned deficit of £772k. This is partly due to an improvement in forecast income from NHSE Specialised Commissioning	Yes	
MSK Services Efficiency Delivery Update		
£265,000 at year end is currently at risk and not in the plan. 15 schemes to be reviewed for cost saving not detailed on plans and no financial forecast provide.	No	Given the deficit the Committee has requested a monthly review.
Outpatient Restoration Deep Dive		
Original H2 plan was to deliver 99% against baseline, the do nothing forecast for H2 is at 86%. Mitigating actions have been put in place which improved figures by 1%. Further quantifiable improvements are still to be identified. Key areas impacting on delivery: • Vacancies (existing and new post recruitment) • Not just surgical vacancy issues, Therapy Services is an issue. • OJP uptake has had an impact. Less OJP sessions planned against H2 plan. • Update between original and June submission reviewing service areas where we thought further opportunity for improvement. Not realized any benefits in these areas identified in the June submission.	No	Full review of therapies Consider how do we need to tackle the outpatient problem differently?

• DNA's above predicted rates • Change in practices in Therapy services that have resulted in reductions in patients per session Concerns raised regarding therapies, change of working practices have significantly reduced patient numbers. No significant change of status since June.		
Waiting List Management Internal Audit		
The report from MIAA was noted	Yes	
Policies for approval: Agency Staffing Authorisation Policy		
Committee formally approved and agreed with recommendation for transfer of ownership to People Committee for ongoing detailed review of agency spend.	Yes	
Board Assurance Framework and Corporate Objectives		
To be reviewed quarterly in line with Audit Committee timetable	Yes	
Chair Reports		
Trust Performance and Operational Improvement Board – 23/09/22 The Committee noted the report **Capital Management Group 28 September 2022** The Committee noted the report **Procurement & Steering Group, Tuesday 4th October 2022** The Committee noted the report **STW MSK Transformation Programme Board** The Committee noted the report **Veterans Centre Project Board – 18th October 2022** The Committee noted the report	Yes Yes Yes Yes Yes	
Review of the Work Plan		
The work plan was considered and noted by the Committee.	N/A	
Attendance Matrix		
The attendance matrix is shared with the Committee for information only.	N/A	
Any Other Business		
None to note	N/A	

3.5 Committee Cross Cover

- Agency tracking to transfer to People Committee

3.6 Risks to be Escalated

- Ongoing challenge from NHSE to improve 104 week performance
- Outpatient restoration is a significant outlier and will impact long waits going forward

3. Conclusion

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

Chairs Report
Extraordinary Finance, Planning and Digital Committee

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	2 November 2022
Executive Sponsor:	Sarfraz Nawaz, Committee Chair	**Paper written on:**	19 October 2022
Paper Reviewed by:	N/A	**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 of Directors and what input is required?

This paper presents a summary of the Extraordinary Finance, Planning and Digital meeting held on Thursday 13th October 2022 to approve the Trust's New Theatre Build Business Case. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Extraordinary Finance, Planning and Digital Committee met to review and approve the Trust's New Theatre Build Business Case.

2.2 Summary

- The meeting was quorate
- The purpose the meeting was to consider and approved the business case for the new Theatre build.
- The Committee approved the business case (prior to being presented to the System) highlighting the importance of the People and Culture Committee gaining oversight and assurance regarding the workforce plan. The Committee agreed to escalate the risk to the Board of Directors.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Extraordinary Finance, Planning and Digital Committee which met on Thursday 13th October 2022. The meeting was quorate with two Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Craig Macbeth	Chief Finance & Planning Officer
Mike Carr	Chief Operating Officer
Attendees:	
John Pepper	Associate Non-Executive
Mark Salisbury	Operational Director of Finance
Nia Jones	Managing Director for Planning and Strategy
Apologies:	
None to note.	

3.3 Key Agenda

Agenda Item / Discussion	Assured	Assurance Sought
1. Business Case: New Theatre Build		
The Trust advised that the business case follows the strategic plan presented to Board to develop 4 new theatres. The Trust has the opportunity to submit a request for £5m worth of national funding which would support phrase one of the plans. The Trust will also need to gain approval from the System as part of the submission. Key points raised included: • Total cost of build £10.385m. Funding application for £5m • 282 elective cases in 23/24, 1126 elective cases in 24/25 – this would deliver a 9% increase in elective activity • Increased workforce required The Committee queried the following: • Whether the Trust would switch self-funding to central funding if it became available. Currently the Trust are unaware of any further funding • Concerns were raised in relation to the nursing workforce due to the current challenges within recruitment. The Committee therefore have		The Committee approved the business case (prior to being presented to the System) highlighting the importance of the People and Culture Committee gaining oversight and assurance regarding the workforce plan. The Committee agreed to escalate the risk to the Board of Directors.

requested support from the People Committee to ensure a robust plan is in place and oversight is sought. • The likelihood of not delivering the plan has been highlighted in the business case as well as the movement of £3.2m ERF funding independent sector into this business plan. • The Trust confirmed the annual return figure being presented as a loss was to demonstrate the level of capital charges incurred due to the build of the theatre.		

3.4 Approvals

Approval Sought	Outcome
New Theatre Build Business Case	The Committee agreed to approve the New Theatre Build Business Case.

3.6 Risks to be Escalated

The Committee approved the business case (prior to being presented to the System) highlighting the importance of the People and Culture Committee gaining oversight and assurance regarding the workforce plan. The Committee agreed to escalate the risk to the Board of Directors.

4. Conclusion

The Board of Directors is asked to note the approval and the risk escalated following the approval of the New Theatre Build Business Case.

Chair's Assurance Report
Audit and Risk Committee - 11 October 2022

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	2 November 2022
Executive Sponsor:	Martin Newsholme, Committee Chair	**Paper written on:**	19 October 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Audit and Risk Committee meeting held on 11th October 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

Key points to highlight from the meeting

- The meeting was quorate
- Limited assurance was gained regarding the process of reviewing policies timely.
- Partial assurances were noted against those papers aligned to the risk management section of the agenda. There is further work to be completed to improve the process and reporting of risks within the organisation. The Board is to reflect upon the risk management session from NHS providers to agree and embed further changes.
- The Trust congratulated the Finance Team who had been awarded the highest level of accreditation (Level 3 accredited)

2.3. Conclusion

The Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report
Audit and Risk Committee - 11 October 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Audit and Risk Committee which met on 11th October 2022. The meeting was quorate with three Non-Executive Directors and one Associate Non-Executive Director in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Martin Newsholme	Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Paul Kingston	Non-Executive Director
Martin Evans	Associate Non-Executive Director
In Attendance:	
Craig Macbeth	Chief Finance & Planning Officer
Simon Adams	Director of Digital (Part)
Diana Owen	Head of Financial Accounting
Linda Elliott	MIAA Senior Audit Manager
Darrell Davies	MIAA Senior Anti-Fraud Manager
Anne-Marie Harrop	MIAA Regional Assurance Director
Mo Ramzan	External Audit Representative
Kirsty Foskett	Head of Clinical Governance, Quality & Patient Safety Specialist
Mary Bardsley	Acting Trust Secretary
Amber Scott	Executive Assistant – Minute Secretary
Apologies:	
Sarfraz Nawaz and David Gilburt	

3.2 Actions from the Previous Meeting

The Committee noted that all the actions from the previous meeting were completed.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured	Assurance Sought
Declaration of Interest		
None received from the Committee	N/A	
Part 1 - Audit		
Finance Governance Pack		
Following the presentation of the key highlights, there were no concerns to be raised. The Non-Executive Directors queried the impact of the energy increases and inflation on the forecast. It was confirmed that in relation to energy the Trust have no exposure this year as the energy has already been purchased, next year there is 30% exposure with a noted increase to 70% exposure for the following year, noting that the Trust are in a strong position	Full	

compared to other organisations. In terms of the inflation rates, there are external contracts which are subject to annual review. A list is being compiled of these contracts to take for discussion with NHSE as part of the System to ensure a transparent evidence base in terms of inflation pressures.		
Register of Interest and Hospitality Register		
The report noted there are thirteen declarations outstanding as of the end of September (10x Band 7/Managers and 3x Consultants) There have been zero entries recorded onto the hospitality register since the last meeting in July 2022. The Trust agreed to review the email which is circulated to staff to see if updating the wording and referencing the policy will support in collating the data.	Full	
People Committee Annual Report		
The Committee were assured that the People Committee had fulfilled their roles and responsibilities noted within the terms of reference. Following review of the report, the Committee raised concerns over the terms of reference membership when compared to other Committees. It was requested that the Chairman is consulted to what membership is required at People Committee to enable a review and align the quorum to other Committees. Due to the changes within the membership of the Committee since April 2022, it was agreed a 6monthly self-assessment is to be completed.	Full	The Trust is to consult with the Chairman to review the Committee membership, quorum expectations along with clarification regarding voting rights for associate Non-Executive Directors.
Finance, Planning & Digital Annual Report		
The Committee were assured that the Finance, Planning and Digital Committee had fulfilled their roles and responsibilities noted within the terms of reference which included: • Financial performance and the associated operational performance • The Trust's transformation program • Financial investments and post project evaluations following major investments • Financial risk assessment and management • Business and performance risk • The Trust's digital agenda including Information Technology sustainability	Full	
Policy Tracker		
As of the end of September there were twenty-seven overdue policies – 15 of which have been reviewed and have been scheduled to be presented at an upcoming meeting for consideration. A list of the overdue policies was shared for information. There was noted disappointment in the number of overdue documents, suggesting an urgent review of the policy tracker to ensure validation is correct.	Limited	The full list of outstanding policies to be circulated and the policy tracker is to be aligned to each committee for further oversight and scrutiny.
HFMA Audit Self-Assessment		
The Committee were informed that as part of the financial settlement agreed nationally for the of 2022/23 operational plan, all NHS organisations are required by the regulator to undertake self-assessment on financial governance and processes by 30th September 2022. Once this is completed and is satisfactory, the internal auditors will review it by 30th November to give assurance on outputs and recommendations; any recommendations are required to be	Partial	

actioned by 31st January 2023. Accordingly, the Trust only has Partial Assurance as the review is not complete. The Trust congratulated the Finance Team who had been awarded the highest level of accreditation being Level 3 accredited, adding that this is a great achievement.		
Counter Fraud – Progress Report		
The Committee were assured with the processes and support in place from the Counter Fraud specialist. The key focus areas for the team included: ▪ Providing a draft version of the Anti-Fraud, Bribery & Corruption Policy, and Response Plan for consideration ▪ Developing a programme of fraud awareness training to staff. ▪ consulted with the payroll manager to arrange for the circulation of a series of pay slip messages across the year ▪ There has been one query received which was not deemed to be a fraud matter but one that should be dealt with via a management/HR referral.	Full	
Internal Audit Progress Report		
A substantial assurance opinion was received following the waiting list management review. It was noted that the Trust have demonstrated that the organisation has effective controls in place. Internal Audit remain on target to deliver the outstanding reports. A discussion was held over the process for extending the dates of actions within the action plans. The Committee concluded that the Trust do not have a process for this. Further to this, actions noted as 'partial,' were discussed. It was confirmed that those actions related to the lack of evidence currently received. The Committee took assurances from this, as MIAA are seeking the additional evidence and prior to marking the actions as complete.	Full	The Chief Finance and Planning Officer and Chair of the Committee are to meet to agree a process to review action plan extensions. Internal Audit Reports and actions plans are to be presented at the relevant Committee for oversight
External Audit Progress Report & Audit Plan		
The Trusts developments and key audit risks included: ▪ at M5 the Trust is reporting a deficit of £2.4m, slightly above the £2.3m deficit plan. ▪ The Trust is forecasting a £0.8m deficit on 31 March 2023 in line with plan, whilst recognising a range of risks, including in respect of ERF income, agency costs and recovery of private patient income shortfalls, which it expects to offset through mitigating actions. ▪ The Trust has set efficiency requirements of £2.6m and forecasts that this will be achieved by the year- end. Month five actual efficiency is £1.1m which is slightly ahead of plan. ▪ IFRS 16, Leases, will be accounted for in full for the 2022/23 financial statements including transition impacts. A disclosure was included in the 2021/22 financial statements with an estimated impact which will be re-evaluated.	Full	
Part 2 - Risk Management		
Board Assurance Framework		

The Board Assurance Framework was presented noting it was approved by the Board earlier in October. The committee noted the framework highlighting that reflections following the Board Risk Management Session were to be incorporated into the framework along with aligning to the corporate risk register.	Partial	Noted as a working progress, the framework is to be reviewed following reflections at Board relating to the Risk Management Session.
Risk Management Process Training		
The Committee welcomed the risk management process training and commended the governance team for the work that has been completed. The Committee requested, whilst the review is underway, that consideration is given to ensure the risks relevant are tabled for discussion at each assurance Committee to gain additional assurance and oversight of each risk aligned to their remit.	N/A	
Risk Management Summary Report		
The Committee were presented with the highlights from the data drawing attention to the Trust have not reaching the 21-day target for review and approval of incidents, due to operational constraints, there is an improvement on the previous month's trajectory. Extensive discussions were held in relation to the risks and mitigations within the report, with concerns over the accuracy and quality of the information provided. The Trust confirmed that once there is assurance that each risk has been identified, and aligned correctly, this will then allow discussions to be held more locally around the mitigations of these risks for focus and improvement.	Partial	Noting that the registers are a working progress following the risk management session, the Trust are to complete a full review of the risk registers.
Chair Report: Information Governance Committee		
The following highlights were shared: ▪ Data Protection Officer has left the Trust therefore a gap. Discussions are underway with MIAA to find an interim solution for this until a permanent replacement is sought. ▪ 2 SARs breaches within the reporting period ▪ 1 FOI breach of deadline ▪ Meeting not quorate due to diary issues although approval sought outside of the Committee for pertinent issues	Partial	The Trust is required to have a Data Protection Officer, there is currently a gap, and this is being investigated via the Executive Team.
Committee Workplan 2022/23		
The following items were deferred to the next meeting: ▪ Security Annual Report ▪ Audit and Risk Committee Annual Report and Self-Assessment. The Committee agreed for all Committee Annual Reports to be presented to the Audit and Risk Committee in July	N/A	

3.4 Approvals

There were no items for approval.

3.5 Risks to be Escalated

There were no risks to be escalated to the Board.

4. Conclusion

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