The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 29.07.21

MEETING
29 July 2021 11:00

PUBLISHED
27 July 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	29/07/21		11:00
1. Part Two - Public Meeting			11:00
1.1. Declarations of Interest		Chair	
1.2. Minutes of the Previous Meeting		Chair	
1.3. Matters Arising		Chair	
2. Presentations			
2.1. Staff Story: Covid-19 Mural - Caroline Stewart		Chief Nurse and Patient Safety Officer	11:10
2.2. Arthroplasty Outcomes - Mr Geraint Thomas		Chief Medical Officer	11:20
3. Chief Executive Update (verbal)		Chief Executive	11:30
4. Quality & Safety			
4.1. Chair Report: Quality and Safety Committee		Non Executive Director	11:35
4.2. Learning from Deaths Q1 Update		Chief Medical Officer	11:40
4.3. Controlled Drug and Accountable Officer Annual Report		Chief Nurse and Patient Safety Officer	11:45
4.4. Safeguarding Annual Report		Chief Nurse and Patient Safety Officer	11:50
5. People Update			
5.1. Chair Report: People Committee		Non Executive Director	11:55

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Agenda

Location	*Date*	*Owner*	*Time*
Teams	29/07/21		11:00
6. Digital Update			
6.1. Digital Transformation - Strategy Update		Director of Digital	12:00
7. BREAK			12:05
8. Performance & Governance			
8.1. Chair Report: Audit Committee		Non Executive Director	12:20
8.2. Audit/Risk Committee Amalgamation		Trust Secretary	12:25
8.3. Chair Report: Finance, Planning and Digital Committee		Non Executive Director	12:30
8.4. Performance Report M3		Chief Performance, Improvement and OD Officer	12:35
8.5. Board Assurance Framework		Trust Secretary/Director of Governance	12:50
8.6. Governors Update (verbal)		Trust Secretary/Director of Governance	12:55
9. To Note			
9.1. Performance Report (M2)		Chief of Performance, Improvement and OD	
10. Any Other Business		All	13:00
10.1. Questions from the Public			

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Agenda

Location	*Date*	*Owner*	*Time*
Teams	29/07/21		11:00

11. Next meeting: 23rd September 2021

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD
27 MAY 2021
MINUTES OF MEETING

Present:		
Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive Officer	MB
Stacey-Lea Keegan	Chief Nurse and Patient Safety Officer	SLK
Craig Macbeth	Chief of Finance and Planning Officer	CM
Ruth Longfellow	Chief Medical Officer	RL
Kerry Robinson	Chief of Improvement, Performance and OD Officer	KR
Harry Turner	Non-Executive Director	HT
Rachel Hopwood	Non-Executive Director	RH
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB
David Gilburt	Non-Executive Director	DG
In Attendance		
Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief of People	SS
Greg Moores	Interim Director of People	GM
Hilary Pepler	Trust Board Advisor	HP
Nia Jones	Managing Director for Specialist Service Unit	NJ
Alyson Jordan	Managing Director for Support Services Unit	AJ
Jo Banks	Managing Director for MSK Unit	JB
Dawn Forrest	Managing Director for Clinical Support Unit	DF
Becky Warren	Vaccination Hub Manager	BW
Ashley Brown	Orthopaedic Registrar	AB
Governors in Attendance		
William Greenwood	Governor	WG
Russell Lucock	Governor	RLu
Kartina Morphet	Governor	KM
Colin Chapman	Governor	CC
Jan Greasley	Governor	JG
Kate Betts	Governor	KB
Victoria Sugden	Governor	VS

FC welcomed everyone to the meeting and in particular Greg Moores who has recently joined the Trust as Interim Director of People.

MINUTE NO	TITLE
27/05/1.0	**APOLOGIES** Chris Beacock, Non-Executive Director
27/05/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were accepted as an accurate record of the meeting held. It was agreed that the names of the Governors who attend the Public Board will be incorporated into the list of attendees.

27/05/3.0	**MATTERS ARISING** None
27/05/4.0	**DECLARATIONS OF INTEREST** None
	PRESENTATIONS
27/05/5.0	**PATIENT STORY** The Board of Directors agreed to defer the Patient Story due to issues relating to the volume of the video.
27/05/6.0	**STAFF STORY – RUNNING A VACCINATION HUB** FC welcomed Becky Warren, Clinical Lead for the Vaccination Centre who has been invited to present her experience and story of 'Running a Vaccination Hub'. Becky's presentation highlighted the following: • A working group was established to set up a vaccination hub following a telephone call from the Trust's Managing Director of Specialist Services. • The priorities included patient/staff safety and patient/staff experience • Overall, the team have continued to remain dedicated and passionate which has guaranteed the success of the hub. • The renovation of the hub commenced over the festive season, converting the SATH Maternity Unit into a Vaccination Centre. • Becky highlighted the fantastic support which was been received from the Maternity Colleagues, the Trust's Estate and Facilities Team and the project management team. • The team were confident and competent in administrating the vaccine and the Pharmacy staff helped ensure safety was a priority. • The management of the Pfizer immunisation was a challenge due to the requirement of storing the vaccination at a low temperature and a short expiration date • On the first day a total of 15 vaccines were administered and by day 4 this increased to approx. 400. • The team accepted a challenge after receiving two box's of the Pfizer vaccination with a short expiry date. The two boxes were equivalent to 2,340 doses which were to be administered in 48 hours. • The support from the whole of the organisation including the Senior Leader Team was outstanding. • Becky was pleased to confirm all doses were utilised with no waste. • The team then tackled a cohort of over 80s patients within the South of Shropshire who was awaiting their vaccinations but unable to travel, therefore a roaming team was created who travelled to the patients. • Over 6 weeks a total of 20,000 doses had been delivered. • The Vaccination hub became a Vaccination Centre which would give the Trust the ability to deliver the AstraZenea Vaccine. The Trust was the first regional Centre. • Becky highlighted the outstanding teamwork from the friendly car park attendees, the League of Friends, the Trusts Switchboard who were inundated with telephone calls, Amber Scott and the Communications team. • Morale was boosted by generous gifts and kind words from a variety of people. • Our Consultants supported the centre by administrating the vaccine and began a healthy competition to see who delivered the most jabs. • Becky thanked both Nia Jones and Stacey Keegan for their continued support and encouragement since leading the new vaccine team. FC expressed thanks to Becky for sharing her story and personally congratulated her on the leadership and dedication to the project. Following FC query, Becky confirmed that there has been a total of 55,198 vaccines administered by the centre.

	SS highlighted the importance of the leadership within the vaccination centre, particularly relating to the increased staffing levels. SS acknowledged the difficultly of leading a different team on a daily basis. Following FC query, SS confirmed the Trust is the lead for recruitment for the vaccination centre along with being the lead employer. There are approximately 1,000 staff members available through bank work. The Trust has been redeploying staff members across the county to support the vaccination programme including in primary care settings. DG thanked Becky for sharing her story and thanked her for the enjoyable virtual visit to the department last month. DG highlighted the number of vaccines administered in comparison to larger hospitals and congratulated the team on a tremendous achievement. HT thanked Becky for her leadership and asked upon reflection, if there are any lessons to be learnt for the future, thinking ahead to the flu vaccination season. Becky explained that it is difficult due to the constant changing medical advice and science. Becky highlighted that decisions being made nationally which could be frustrating at times due to the lack of connection between the front line and the staffing model. Becky also suggested having a designated individual to support the Switchboard with telephone calls would have been useful. MB congratulated Becky and the team on their efforts. MB informed the Board that Shropshire, Telford and Wrekin have vaccinated approximately half a million patients. He continued to explain the collaborative working between science and medicine to understand the covid-19 vaccine along with the flu vaccine in the Autumn. MB shared some feedback he had received from a patient who was pleased to be vaccinated by a world class Orthopaedic Surgeon. Becky added that the Consultants have boosted morale within the team and have worked extremely hard. They have been working in their own time and have been dedicated to ensuring good patient experience. On behalf of the Board, FC asked Becky to express thanks to all the team who have been involved in the centre as well as thanking Becky personally for her leadership.
	CHIEF EXECUTIVE UPDATE
27/05/7.0	**CHIEF EXECUTIVE UPDATE** Firstly, MB acknowledged the busy time within the hospital and the continued hard work from staff as the Trusts restarts, recovers and restores services following the pandemic. The Trust's performance plan is based upon the 2019/20 activity levels and there is a national requirement to meet the 85% activity target. The Trust continues to review ways of working to increase the levels of activity which has included additional cleaning regimes. Some additional areas which the Trust is currently reviewing to increase activity include additional staff, longer working days and weekend working. MB highlighted the Trust is pleased with the progress with the Sir Captain Tom Moore's Path of Positivity. The path has been embedded into the Trust's field and will be 2 metres wide. MB invited members to view the path when they are on site and noted further communications will be shared through social media platforms. The work has commenced on the Headley Court Veterans Centre, further information including visual impressions and timelines of the project have been made available to the public. MB informed the Board that most of the work is to be completed within this financial year and the ceremonial turf cut has been scheduled for 14th June. MB provided an update on the Integrated Care System and highlighted the following: • regional assessment was well attended with representation from the Trust, • a leaders event was attended by the Directors from the Trust,

	• an event with the community, volunteers and organisations within Shropshire, Telford and Wrekin was held • The system continues to work towards a meeting with the national NHS Director Board to discuss progress within the system. This month's health hero is a Carwyn Davies, SOOS physiotherapist, who has done a fantastic job in responding to the issues which have arisen in lockdown. He has helped to increase the virtual physio assessments. **100 YEARS OF RJAH AT GOBOWEN** MB presented the paper which outlines the plans for the Trust to celebrate the 100 years of the Hospital opening at in Gobowen. Activities to celebrate the event: • a Lecture from Marie Carter about the History of the Hospital • a festival on the field which has been organised by the League of Friends • a celebration service at Baschurch Church, which is scheduled for October FC thanked MB for the update and the Board noted the programme of events. **VIRTUAL VISITS FEEDBACK** The Trust's virtual visits took place on the 10th May. A team consisting of a Senior Leader, Governor, Non-Executive Director and Department Manager met to discuss the overall work across the Trust. The visits were based upon the Back to the Floor events. FC highlighted that the letters from the visitors to the departments are available in the meeting papers; they include the issues which were discussed and debated. FC invited members of the Board to share their experience of the virtual visits, some of the comments included: • FC – visited the infection control team and Sheldon ward. There were interesting conversations had about the past 12 months and the challenges which were faced due to the constant changes. FC said it was a heart-warming initiative to partake in. • AJ – visited the SOOS team. It was interesting to see their work especially with the requirement to cancel patients and the innovative ways of managing patients with Covid-19. • RLU – visited the Operating Department. It was an excellent experience and he found the experience fascinating. RLU expressed interest in being involved in future events. • JG – accompanied AJ in visiting the SOOS Team. It was amazing how the staff have worked through the issues and remained patient focused throughout the pandemic. The patient centres offered an amazing service FC thanked those who shared their view and commented that the overarching view of the event was valuable and powerful. On behalf of the Board, FC expressed thanks to the teams who organised the event. The Board noted the feedback.
	QUALITY AND SAFETY
27/05/8.0	**CHAIR'S ASSURANCE REPORT QUALITY AND SAFETY COMMITTEE** PK presented the Quality and Safety Assurance Report and highlighted the following: • The meeting was well attended and quorate • An update was received on the Serious Incidents and Never Events • An update was provided on the Harms review process which has progressed well. The Committee are awaiting the audit results and a paper is due to be presented to the Committee next month • The Quality priorities were considered and agreed • The Committee has no items of business to escalate to the Board of Directors The Board noted the report.

27/05/9.0	**INFECTION CONTROL BOARD ASSURANCE FRAMEWORK** SK presented the revised Infection Control Board Assurance Framework. SK reminded the Board that the framework was developed to support monitoring due to the fast pace and changing guidance relating to the Covid-19 pandemic. The Trust has completed a self-assessment against the guidance to outline any gaps in controls and mitigations are implemented to ensure good quality standards are maintained. The Quality and Safety Committee have had oversight of the document and assurance has been provided by the Infection Control Team on a regular basis. The document is structured around the 10 key lines of enquiry which link to the regulation 12 of the Health and Social Care Act. Following the previous review of the framework, SK confirmed there were no actions outstanding and evidence has been provided with completed actions. A total of 9 new standards were introduced into the revised framework with a majority of standards relating to the testing regime for both patients and staff. Following this, there were a total of 7 new actions which were to be addressed by the Trust. SK confirmed one action has been completed and the remaining 6 are on track for completion. HT questioned whether, given the experience the Trust has gained from Covid-19, there were any duties that will be become standard practice with regards to infection control. SK highlighted that through the IPR it has been reported that there is a noted decrease in other infections through the time of Covid-19. The different ways of working and processes have had a positive impact on infection control across the organisation. SK explained there is an expectation that the NHS will review guidance's that are aligned to infection control. HT continued to ask if there were specific elements that the Trust would complete as part of the standard operational procedure without the need for a national requirement. SK explained one improvement has been the enlarged space between beds, this has had a positive impact on the nurse's job role within the nursing bays. SK also highlighted the through put of entrances and exits across the site and the importance of a one-way system. SK explained that the Infection Control Committee will continue to review news ways of working to ensure the Trust remains a safe environment. MB explained that the although the social distancing rules have been relaxed the Trust remains vulnerable. The Trust will continue to remind staff that the although the Hospital is a green site organisation, there is a requirement to ensure our patients are protected and that the infection risks remain well managed. For the time being, the one-way system within the main entrance will remain in place along with asking staff to work from home. FC thanked SK and MB for their comments and noted the desire for services to return to normal as well highlighted the importance of maintaining safety and protection for both staff and patients.
	PEOPLE UPDATE
27/05/10.0	**THE LIFE OF A TRAINEE** RL introduced Mr Ashley Brown, Senior Orthopaedic Specialist Registrar. RL congratulated AB who has recently won an award for gaining the highest marks in the FRCS Orthopaedic exam. She thanked Ashley for joining the Board today to share his perspective of the life of a trainee. Ashley's presentation highlighted the following: • What is a registrar – the medical profession is a hierarchy structure. The grade of the doctor reflects the individual skill set.

	• The timetable of learning for a registrar and explained that the Trust do not have junior doctors. Those who are learning at the Trust are senior in their medical qualification. • AB is due to complete his medical training in 2 months' time and will be travelling to Toronto to complete his fellowship. • The Oswestry/Stoke rotation is a regional training rota which covers a wide variety of the organisation and is led by Consultants from the Trust. It is a 6-year training programme. Throughout the 6 years, as a trainee you are required to meet certain criteria which includes the number of operations, involvement in research/quality improvement projects and passing the examination. • In the first four years registrars are rotated through sub specialities within orthopaedics. With the final 2 years the register is rotated into their chosen sub-specialities. • Throughout the training, appraisals are held every 6 months with a panel of consultants to discuss individual's progress. The Trust ensures the Consultants have the time to undertake the appraisals. • Oswestry is considered one of the best in the country in relation to training rotations. • The fellowship exam is completed at the end of the training and it is reported that the Trust trainees have an exceptionally high pass rate. • Oswestry is successful because they continue to teach, there is a wide variety of formal teaching available alongside the training. A teaching session is available everyday which supports trainees to learn and gives them the confidence to challenge. • Regional teaching is every Friday afternoon. In the past, patients have been invited to attend the training sessions to support trainees however this is currently on hold due to Covid. • It was noted that Consultants run their own training sessions in their own time. • The daily day to day work of a trainee includes a ward walk around, attending to inpatients, joining consultants in clinic or theatres, undertaking research or audits. A more senior trainee will be able to complete a management plan for the patient independently and assist further with operations. • One of the challenges from the past year has been the difficulty for a trainee to complete the required number of operations due to the reduced activity in the Trust. • Oswestry is a fantastic place for a trainee. It was noted that registrars continue to feel supported by the Trust through the training programme. FC thanked AB for this time and for sharing his story with the Board. The Trust are aware of the high reputation in terms of the training support which has been multi-generational. It has been fascinating to hear, in real time, the personal experience, the demand for the programme and the dedication and commitment from the consultant body including the effort they put into supporting the new generation of consultants. FC congratulated AB on his recent FRCS award and questioned whether he had any suggestions or improvements which the Trust can learn from. AB explained there is a conflict between service and training, the RJAH is exceptional for supporting this which other organisations can learn from. GM asked for AB's thoughts on how the Trust can increase the employment of undergraduates. AB explained the engagement between trainees and medical students will support with leadership skills of the trainee which would be very helpful. There is a lack of communication and interaction with junior consultants within the Trust as it is not available. SS commented on the specialist training at Oswestry and noted that there is always something the Trust can improve on especially in relation to a persons' wellbeing. AB explained that there can be conflict between the Trust and the training programme due to an

	overlap of responsibility. It was noted that rotation timetables can sometimes be received late and therefore the trainee having short notice for commitments, this can sometimes be difficult. AB explained that this is not the case in Oswestry. SS thanked AB for his comments and encouraged him to share any improvement ideas with the Trust. FC commented that perhaps a reinforcement message to explain the importance of being organised with rotation timetables may be useful. As a Trust we should not underestimate the effect and distribution lack of organisation has on individuals. KR commented on the insightful talk and queried if there is anything that AB has learnt from the training system which could be reflected to other groups of staff. AB explained that the engagement, commitment and dedication from the Consultants drives and encourages the trainees to put the extra time in alongside them. AB explained that having Senior Consultants as a close mentor has been the driving force for trainees to take opportunities. FC agreed with AB comments and highlighted that the consultants add value to enhance their profession and not just the institution. MB thanked AB for representing the Arthroplasty firm so well, he explained that the public and NHS continue to call trainee doctors as 'junior doctors', the Trust will continue to educate the staff with the doctors in training and education timetable to raise awareness. MB wished AB every success in the future. The Trust will continue to support the trainees within the restoration period and highlighted the adaptions which have been completed to ensure the trainees have been able to complete their operation logbook. FC wished AB the best of luck on behalf of the Board.
27/05/11.0	**CHAIR'S ASSURANCE REPORT PEOPLE COMMITTEE** PK presented the People Committee assurance report and highlighted the following: • The meeting was well attended and noted as quorate. • A performance workshop was delivered during the first half of the meeting • The performance report highlighted low sickness levels and staff appraisals therefore a deep dive will be presented for both areas soon • There were noted issues with recruitment especially within nursing • No risks were escalated, and assurance obtained An extra-ordinary People Committee was held on 25th May and the committee received a copy of the assurance matrix which was well received by the members of the meeting. The Board noted the assurance report.
	PERFORMANCE AND GOVERNANCE
27/05/12.0	**CHAIR'S ASSURANCE REPORT AUDIT COMMITTEE** DG presented the Audit Committee assurance report and highlighted the following: • The meeting was held on 10th May which was well attended • Thank you to CM for a pre-meeting as he was required to attend a system finance meeting • Following a suggestion from External Audit, DG informed the Board that since the system working arrangements have been implemented, the Trust has agreed to take a share of the system deficit. • There has been a notable decrease in the compliance rate in relation to the declarations of interests, this will be a focus at the next meeting. • The committee approved the Audit Strategy and Annual Plan however asked Internal Audit to provide further assurance on the timetable of the plan. The Board noted the assurance report.
27/05/13.0	**CHAIR'S REPORT FOR FINANCE, PLANNING AND DIGITAL COMMITTEE**

	RH presented the Finance, Planning and Digital Committee assurance report and highlighted the following: • The meeting was well attended. There were insightful comments from colleagues. • The Committee received the revised performance report for consideration along with the performance report annual review. The methodology of the control ranges was discussed and the impact that Covid-19 has on the data points. • Scrutiny of the efficiency plan, the team have made a positive start and good progress has been made on themes. • Sought assurance on amber rated schemes relating to the efficiency plan within the system. • Going forward the managing directors will be attending the committee meetings to present a deep dive into their units on efficiency plans. The Board noted the assurance report.
27/05/14.0	**IPR ANNUAL REVIEW** KR explained that each year the Trust is required to review the integrated performance report (IPR) to ensure the targets are aligned with: • the regulatory requirements the • objectives for the Trust and • the Trusts' key focus areas of focus This year has been slightly different due to the requirement of submitting a plan for H1 and therefore anticipating changes which will be required in preparation for the H2 submission. In terms of activity, 2019/20 will be considered as the baselined year. The target for H1 is set at 70% until April and rising to 85% in July until September. This is for both inpatient and outpatient activity. There are measures in place which were presented to the Restart, Recovery and Renewal subcommittee on Friday. The mitigations will be operationally led, and the subcommittee will have oversight of overarching measures. There are several items under development which could potentially increase work through the year, these include the review of the people committee key performance indicators, the H2 plan, the system initiative including the getting it right first-time initiative. The Board continues to delegate oversight to the assurance committees, they receive their own performance report and have received the revised paper for awareness. FC thanked KR for the clear paper which highlights the transition from a challenging previous year. The Board noted the Performance Review annual report.
27/05/15.0	**PERFORMANCE REPORT MONTH 1** KR started the performance report update by thanking the Information Team who have been ensuring the Trust is compliant with best practice as the reporting transitions from the use of RAG rating to a focus on improvement and assurance. There is a training session scheduled for the Trust Strategy Board next month which will give the Board Members the opportunity to discuss and question the revised report. The format is now being standardised across the system which will support collaborative working and practice KR highlighted the key - colour coding and explained the following:

- *the variations* – reporting an improvement is a blue icon, a concern is an orange icon and no change is a grey icon.
- *the assurance* – consistently meeting the target is a blue icon, consistently not reaching the target is an orange icon and no consistency is a grey icon.

The variation tolerance levels are set in line with the regulator requirements and targets. KR explained the front sheet will outline the exception reports and that the data quality report will remain unchanged. An NHS script will be utilised to run the reports, which will support the standardisation across organisations.

KR explained that the control limits will update each month as new data is incorporated, this calculates the new mean. It was highlighted that Covid-19 will impact on some of the data due to the decrease in activity, therefore line graphs may be used to present the unstable data.

AJ presented an overview of the performance report and highlighted that the Trust met the requirement target which is outlined by NHSE/I.

Caring for Patients

- Cancer 62 days standard; falling short of target. This shortfall relates to one breach in March 2021
- 18 Weeks RTT Open Pathways (exception report included);
    - Metric is consistently failing target as expected from covid impact
    - Is showing a concerning nature which aligns to Trust response for mutual aid and restart of elective
    - All above results in a failure of assurance.
    - Actions in place monitored through Restart, Recovery & Renewal sub-committee
    - All NHS Trusts are in the same position however, it was noted the Trust was performing well
- 6 and 8 Week Wait for Diagnostics (exception report included);
    - MRI levels are similar to pre-covid however the shortfall is due to the extra cleaning regime which is required in-between patients
    - Plans are in place to increase capacity which includes Sunday working
    - Metric indicates common cause variation with variable achievement
    - Actions in place monitored through Restart, Recovery & Renewal sub-committee
- Outpatient Plan
    - For April 2021 the plan was 11,232 and the Trust achieved 12,863 outpatients
    - For May 2021 the plan is 11,184 and a forecast to deliver 11,400 outpatients
- DNA rate
    - Increased in the past month to 5.56%
    - Actions are in place to support sub specialities
    - DNA rate also includes virtual/telephone appointments

Never Events

SK informed the Board that the Trust has reported two Never Events in April – a wrong side injection and a wrong side block. SL assured the Board that there has been no harm to the patients as a result of these incidents. The Trust are following the governance process to support the investigation and immediate actions have been implemented following the first panel discussions. The final investigation report will be presented to the Quality and Safety Committee.

Caring for Finances

The Trust remains on block contracts for the period of H1. CM explained that if the Trust over performs against the activity, there will be some in month cost pressures. However, the Trust was able to mitigate those pressures in full for the first month. This was due to overachieving on the efficient trajectory. The Trust delivered a 2% efficiency saving against the planned 1%.

	There was a noted reduction relating to the Covid-19 spends which has supported the financial position overall. The Trust overachieved against plan in the first month of the year by £128k. FC queried the cash balances and how this relates to the revise reporting symbols, highlighting the no assurance symbol reported against a positive narrative. CM explained the report is currently a work in progress and further amendments will be made ahead of the next meeting. The Board noted the performance and finance report.
27/05/16.0	**CORPORATE GOVERNANCE STATEMENT** SR presented the Corporate Governance Statement and highlighted the minor amendments which have been made to reflect the current situation, there are no significant changes. The Board approved the statements which require signature from both FC and MB.
27/05/17.0	**GOVERNORS UPDATE** SR informed the Board of Directors that the Governor elections have concluded and the following individuals have been appointed: • Colette Gribble, North Wales • Phil White, Rest of England SR congratulated William Greenwood who has been appointed Lead Governor for an initial 12 month period. William will come into post in July superseding Jan Greasley. The Governors have been attending work shop sessions relating to the ICS which have been well received. SR explained the Governors have been supporting the virtual visits and the Non-Executive recruitment process with members on both the formal and stakeholder panels in June. The next Council of Governors meeting is being scheduled after the Public Board Meeting and there will be discussion on strategy within in the Trust. FC also extended his congratulations to William and welcomed him to the new role on behalf of the Trust and members of the Board.
27/05/18.0	**ITEMS TO NOTE** The Board of Directors noted the following items: • Headley Court Veterans Centre • Chair's Assurance Report Quality and Safety Committee (April 2021) • Chair's Assurance Report Finance, Planning and Digital Committee (April 2021)
27/05/19.0	**AOB** None
27/05/20.0	**QUESTIONS FROM THE PUBLIC** None
	DATE OF NEXT MEETING IN PUBLIC: Thursday 29 July 2021 11.00 via Teams
	CHAIRMAN'S CLOSING REMARKS FC commented that it has been a privilege to listen to the presentations from Becky Warren, the Vaccination Hub and Ashley Brown, a life as a trainee and encouraged all attendees to reflect on comments and observation from this morning's meetings. FC thanked everyone for their contribution and closed the meeting.

27 MAY 2021

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
Actions from Last Meeting	**Lead Responsibility**	**Progress**

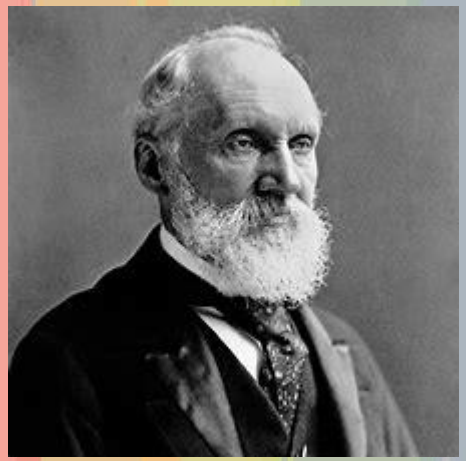
Experience of staff at RJAH responding to Covid-19

Alice Faux-Nightingale, Mihaela Kelemen,
Kerry Robinson, Caroline Stewart
John Swogger, League of Friends

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

Aspiring to deliver world class patient care

Lord Kelvin



I often say that when you can measure what you are speaking about, and express it in numbers, you know something about it; but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind.

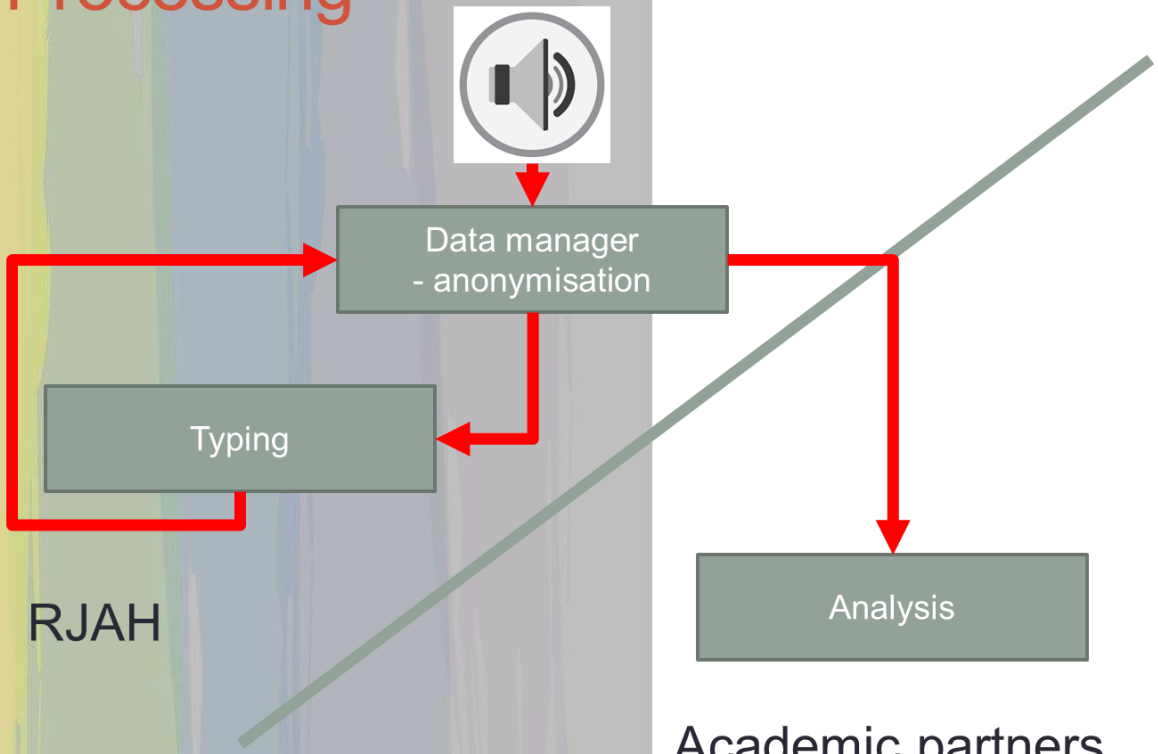
- 15 staff
  - Senior managers
  - Scientists
  - Nurses
  - Doctors
  - AHPs
  - Estates
- Prompt questions

NHS

Aspiring to deliver world class patient care

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

Processing


Data manager
- anonymisation
Typing
RJAH
Analysis
Academic partners

Thematic analysis

Emotions, opinions, observations

Themes, patterns, groups

Results

Inequalities

Ethics

Stress

Guilt

Cameraderie

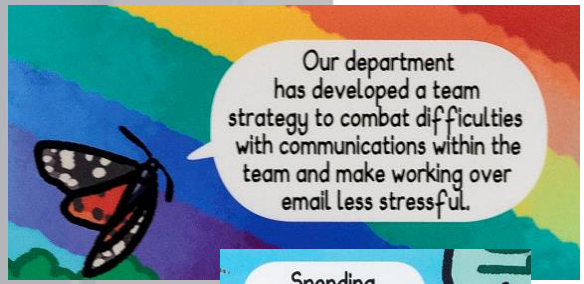
Identity

Heroes?

Communication

Boundaries and othering ….

NHS



Aspiring to deliver world class patient care

- We need processes and flexibility
- I don't (always) agree with Lord Kelvin
- Rigorous methodologies exist even without numbers!
- We need to tell stories
- We should watch out for boundaries

Chair Assurance Report
Quality and Safety Committee 16th July 2021

0. Reference Information

Author:	Mary Bardsley, Trust Secretary	Paper date:	29 July 2021
Director Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 15th April 2021. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1 Context

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

2.2 Summary

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

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	15/07/21		14:00
1. Introduction			14:00
1.1. Apologies		All	
1.2. Minutes from the previous meeting		Chris Beacock	
1.3. Action Log / Matters Arising		Chris Beacock	
1.4. Minutes from Joint Audit/QS meeting		Chris Beacock	
1.5. Declaration of Interests		All	
2. Caring for Patients			
2.1. Serious Incidents, Never Events & Learning from Incidents		Stacey Keegan	14:10
2.2. Pressure Ulcer Internal Audit Report		Stacy Keegan and Julie Beaumont	14:15
2.3. Inpatient Survey		Stacey Keegan	14:20
2.4. Learning from Deaths Update		Ibs Roushdi	14:25
2.5. Infection Control Covid-19 Update		Stacey Keegan	14:30
2.6. Harms Review Presentation		Dawn Forrest	14:35
3. Governance			
3.1. Legal Claims Q1		Shelley Ramtuhul	14:45
3.2. Board Assurance Framework		Shelley Ramtuhul	14:50
3.3. Efficiency Plans - Quality Impact Assessment		Stacey Keegan	14:55
3.4. Health Inequalities		Stacey Keegan	15:00
3.5. Performance Report (M3) (verbal)		Stacey Keegan	15:05
3.6. Support Services Quality Report		Alyson Jordan	15:10
3.7. MSK Quality Report		Jo Banks	15:15

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	15/07/21		14:00
4. Policies			
4.1. BODs Guidance		Jo Banks	15:20
4.2. PIFU SOP		Dawn Forrest	15:25
4.3. Management of daily x-ray imaging capacity		Dawn Forrest	15:30
4.4. Updated Harms Review Policy		Shelley Ramtuhul	15:35
5. Annual Reports			
5.1. Safeguarding Annual Report		Stacey Keegan	15:40
5.2. Controlled Drug and Accountable Officer Annual Report		Maryse Mackenzie	15:45
6. Items to Note:			15:50
6.1. CQC Strategy 2021		Stacey Keegan	
6.2. Performance Report (M2)		Stacey Keegan	
6.3. Chair Report		Stacey Keegan	
6.3.1. Patient Safety Committee (verbal)			
6.3.2. Research Committee			
6.3.3. Trust Improvement and OD Committee			
6.4. Policy Update		Shelley Ramtuhul	
6.5. Review of the Work Plan		Shelley Ramtuhul	
6.5.1. Attendance Matrix			
6.6. Patient Safety Briefing		Stacey Keegan	
7. Any Other Business			15:55
7.1. Next Meeting: 16th September at 2pm			

Learning from Deaths Update

0. Reference Information

Author:	Dr James Neil, Mortality Lead	Paper date:	29 July 2021
Executive Sponsor:	Dr Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Learning from Deaths summary was reported to Quality and Safety Committee on 16th July 2021.

The process of learning from deaths is as follows:

- 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 presents the current numbers and trends in last quarter for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

The Board of Directors is asked to note the report – there have been no concerns identified.

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
March 2021	0	0	0	0	No theme/Feedback	None required
April 2021	0	0	0	0	No theme/Feedback	None required
May 2021	0	0	0	0	No theme/Feedback	None required
June 2021	0	0	0	0	No theme/Feedback	None required

3.3. Associated Risks

There have been no risks identified.

3.4. Next Steps

- Discussions in progress with SATH concerning a link with their Medical Examiner and Bereavement system.
- LFD lead at RJAH now attends Mortality steering group at SATH.
- Shropshire LFD group having first meeting next week.
- More reviewers have been identified for MDT reviews using SJR plus system.
- Incorporate family feedback into report. None at present due to death numbers.
- (Requires setting up of a co-ordination office as part of the process to join with SATH bereavement).

3.5. Conclusion

The Board of Directors is asked to note the report. A quarterly report will continue to be presented to the Quality and Safety Committee for information and provide assurance.

Appendix 1: Acronyms

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

Controlled Drug Annual Report

0. Reference Information

Author:	Maryse Mackenzie, Medicines Management Co-Ordinator	Paper date:	23 July 2021
Executive Sponsor:	Stacey Lee-Keegan, Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

The paper has been reviewed by the Quality and Safety Committee on 16th July 2021.

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
- CQC requirements
- Department of Health Legislation
- CD storage requirement
- CD quarterly audit completion

2.3. Conclusion

For 2020-21 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 2020-21 in relation to the safe management of CDs.

3.2. CD Accountable Officers Report for 2020-21

Trend analysis of supply patterns in clinical areas

Reporting of untoward incidents

CD Lin reporting compliance

3.3. Associated Risks

Authorised destruction of CDs witness list has been expanded to support more timely destruction of CDs.

3.4. Conclusion

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

CD Accountable Officers Report for 2020-2021

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%

Storage of CDs at RJAH Orthopaedic Hospital Foundation Trust is 100% compliant

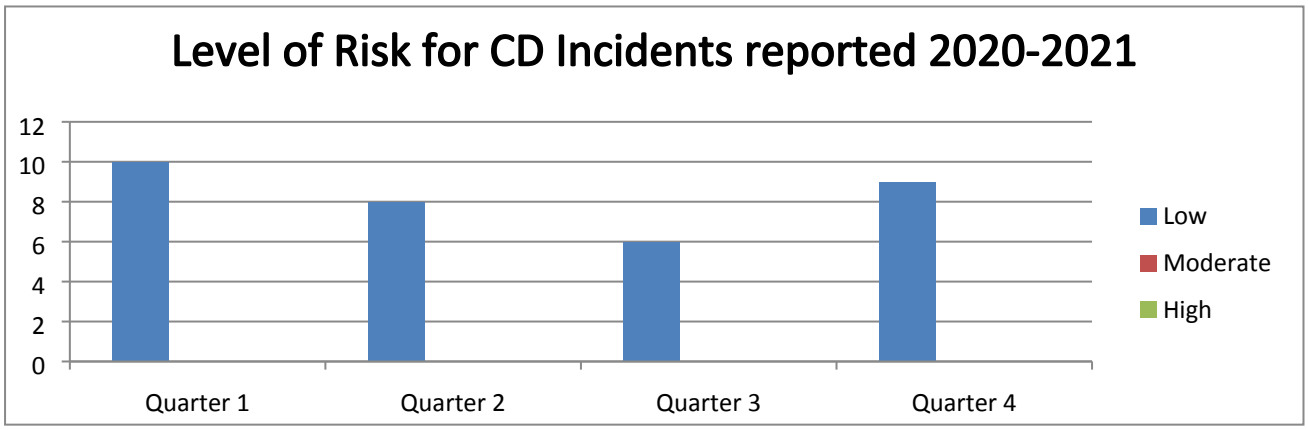
Update from 2019-2020 annual report: No outstanding actions to update.

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 2020-2021 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. 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 2020-2021. We have reported 33 incidents via DATIX that are reportable out to the CD Lin (appendix 1).
All 33 of the reported incidents were rated as low risk, see Graph 1.

Graph 1



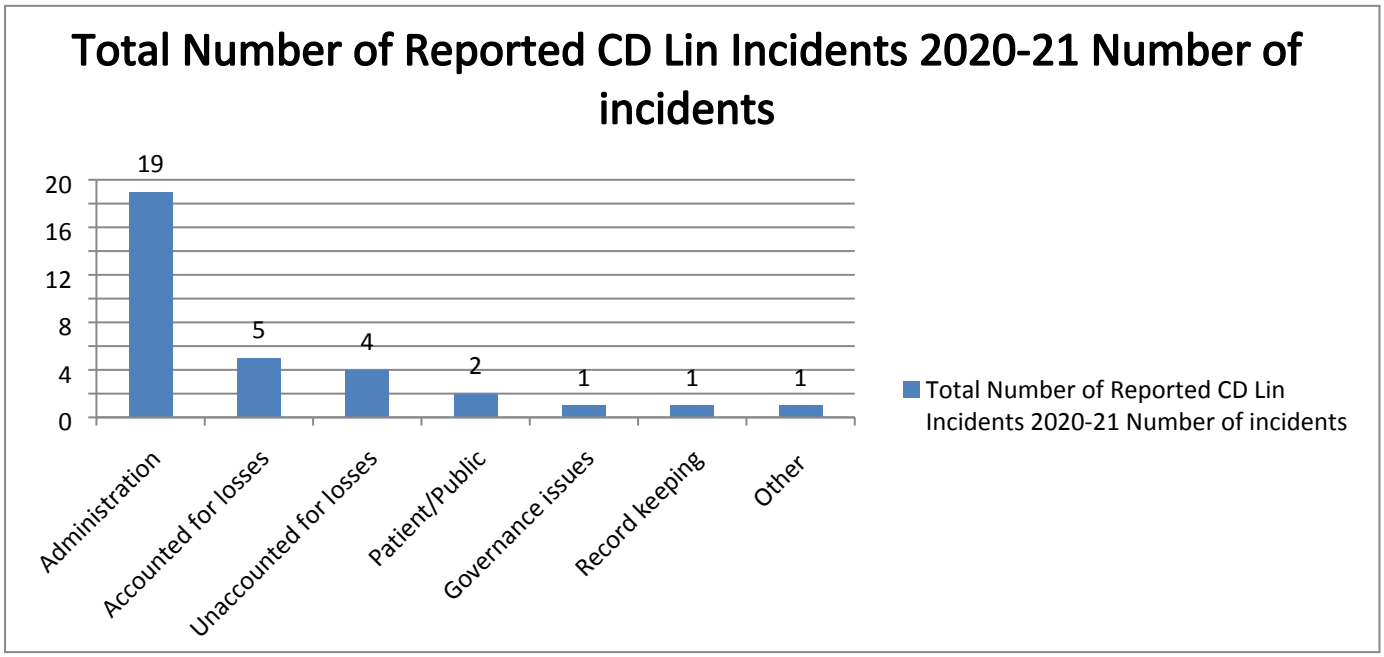
The 33 incidents for 2020-2021 came under the following categories for reporting to the CD Lin.

CD Lin reporting categories:

- Administration
- 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.
The incident categorised as other pertains to the preparation of more than one patients medication at one time.

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 2020-2021.

Submission of occurrence reports
RJAH have submitted an occurrence return for quarters 1 to 4 for 2020-2021.

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. This list has been expanded to support more timely destruction of ward stock CDs. 2019-20 Annual report we mentioned our plan to improve our timeliness of CD destruction for. This has been achieved and we do not experience the same build-up of CDs waiting to be destroyed.

Completion of Quarterly CD Audits
During 2020-2021 all areas where CDs were stored had a CD audit completed quarterly. Any aspects of non-compliance with the audit criteria are corrected at the time of the audit or the information is fed back to the area/area manager for action/sharing with their team.
Action plans are set for each audit where required, with the Medicines Management Facilitator collating and saving evidence of completion alongside audit data.

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

Appendix 1: Local Incidents by Quarter for 2020-2021

Quarter 1	Clwyd	• Oxycodone 10mg MR administered instead of the intended IR product. • Underage of 22ml noted Oxycodone liquid. 305ml in the register and only 1 new 250ml bottle as the other was empty.
	Gladstone	• Differing doses of pregabalin prescribed for the patient. 250mg in the morning and 225mg in the evening. Patient was administered 250mg instead of the 225mg intended
	Pharmacy	• Fentanyl 50mcg ordered and dispensed correctly but delivered by pharmacy to the incorrect ward
	Wrekin	• Tramadol immediate release administered instead of the prescribed modified release. • Tramadol 50mg dispensed by pharmacy for a specific patient administered to another patient instead of the intended stock. Balance discrepancy within the register. • Pregabalin 200mg administered instead of the prescribed 300mg. • Five 60mg Zomorph capsules found in patients own handbag. Their own meds from home
	Sheldon	• Underage of 30ml 335ml in the register and 1 new 300ml bottle and 5ml in the opened bottle. Oral Morphine Solution • Underage of 19ml noted when coming to the end of a bottle of Oral Morphine Solution.
Quarter 2	Oswald	• Zomorph 60mg administered four hours before the dose was due. • Gabapentin administered when Pregabalin prescribed
	Gladstone	• Incorrect medication administered Gabapentin instead of Pregabalin
	Powys	• Underage oral morphine solution >5%
	HDU	• Accidental spillage oral morphine solution
	Theatres	• Missing Ampoule of Fentanyl
	Wrekin	• Oxycodone administered to a patient in error • Pregabalin 25mg administered when patient was prescribed Pregabalin 50mg
Quarter 3	Gladstone	• Patient observed removing administered Temazepam from their mouth once the Registered Nurse had left • Second dose of Pregabalin administered instead of the required MST • Missed dose of Pregabalin • Preparation of more than one patients CD at a time
	Oswald	• Immediate release Tapentadol administered instead of modified release
	Kenyon	• On admission patient noted to be taking relatives prescribed Tramadol
Quarter 4	Clwyd	• Missed doses of Tapentadol • Accidental spillage of Oral Morphine Solution
	Sheldon	• Oral Morphine accidently spilt on the counter top during prep for administration
	Gladstone	• Not following procedure when returning patient own CDs • Tramadol dose missed • Missed dose of Zomorph • Missed dose Pregabalin as chart was taken to Pharmacy
	Wrekin	• Underage of Oral Morphine Solution
	Oswald	• Oxycodone 20mg IR administered instead of the prescribed MR

Safeguarding Annual Report

0. Reference Information

Author:	Sara Ellis-Anderson Lead Nurse for Adult Safeguarding and Suzanne Marsden Named Nurse for Children	Paper date:	29 July 2021
Executive Sponsor:	Stacey-Lea Keegan, Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Safeguarding/Quality& Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an annual review of Children and Young People and Adult Safeguarding within the Trust for 2020/21. The Committee is asked to note the report.

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2020/21 in relation to children and young people and adult safeguarding and outlines key priorities for 2021/22.

This report should be read in conjunction with the Shropshire Safeguarding Community Partnership (SSCP) annual reports. A link to these documents will be available on the safeguarding web page.

The report was presented to the Quality and Safety Committee on 16th July 2021.

2. Executive Summary

2.1 Context

An annual report is provided each year for information.

2.2. Summary

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2020/21 in relation to children and young people and adult safeguarding, working in conjunction with the Shropshire Safeguarding Community Partnership.

2.3 Conclusion

The Board of Directors are asked to note and review the content of the report and make consider recommendations.

3. The Main Report

3.1 Introduction

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

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

RJAH is committed to meeting the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (Aug 2019) and provides evidence on how the trust meets the requirements. An action plan to demonstrate compliance against the standards has been developed. This is monitored by the safeguarding team reporting on the actions and continual improvements.

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

3.2 Our Vision

Children and young people

Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as a need is identified. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, we must ensure our staff put the needs of children first when determining what action to take.

This child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.
We need to ensure all practitioners follow the principles of the Children Acts (1989 and 2004) that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary. Working Together Document (DOH 2019).

Adults with care and support needs

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

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

Safeguarding as core business

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

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

4. Shropshire Safeguarding Partnership Priorities

Shropshire Safeguarding Community Partnership (SSCP) Priorities

Children's Safeguarding Priorities

Priority 1: Exploitation (joint Adult and Children priority)
Priority 2: Neglect

Adult's Safeguarding Priorities

Priority 1: Preventing abuse and building the resilience of the individual and communities
Priority 2: Making Safeguarding Personal (MSP)
Priority 3: Reducing the number of inappropriate safeguarding concerns from adult social care and health professional including volunteers
Priority 4: Increasing community awareness of adult safeguarding

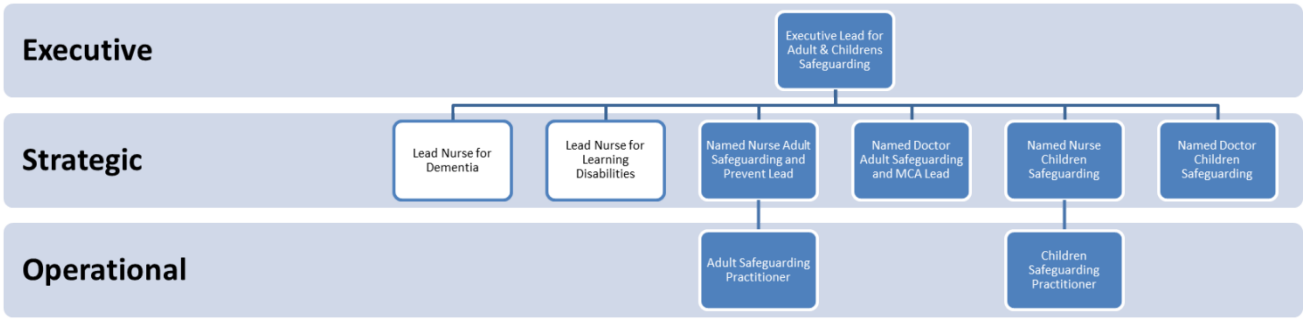
These priorities are progressed through the work of the SSCP sub-groups whose work plans detail specific activity, quality assurance and performance in relation to achieving these

priorities. Progress against the strategic plan is monitored by the SSCP Executive group on a quarterly basis. RJAH have representation at the SSCP sub-groups.

Please see embedded the annual report contribution outlining how RJAH has contributed to each of the strategic priorities of the SSCP. Please note this is for the 19/20 SSCP annual report and work against the priorities continued in to 2020/21.

Agency Contribution RJAH Final.docx

5. Safeguarding accountability structure across the Trust



Executive Lead for Safeguarding Children and Adults	Stacey-Lea Keegan, Chief Nurse and Patient Safety Officer.
Non-Executive lead for Safeguarding Children and Adults	Paul Kingston, Non Exec Director.
Named Doctor for safeguarding children and young people	Dr Richa Kulshrestha, Consultant Paediatrician allocated 1PA per week protected time, to undertake this role. Supported and supervised as necessary from the County wide Designated Doctor – Dr Ganesh.
Named Nurse for safeguarding children and young people	Suzanne Marsden - is the Children's Unit Manager and has 7.5 hrs per week allocated time to undertake this role as a band 8a Supported and supervised quarterly by Audrey Scott Ryan Designated Nurse for Safeguarding Children Telford CCG

Associate Named Nurse children	Vicki Jones Alice Ward Sister who has completed her safeguarding train the trainer course last year as well as a range of safeguarding level 3 modules to facilitate this role.
Lead Doctor for adults	Mr Srinivasa Budithi has 1 PA per week allocated and works alongside the lead nurse for adult safeguarding monitoring of referrals/cases and providing support and expert advice to staff.
Lead Nurse for adults	Sara Ellis-Anderson, Assistant Chief of Professions supported and supervised quarterly by Sarah Dempsy, Deputy Designated Safeguarding Lead Nurse at NHS Redditch and Bromsgrove CCG
Adult Safeguarding Practitioners – 1.2 FTE job share by Anne Worrall (commenced in post April 20) and Katie Harris (commenced in post March 21)	Named Safeguarding professionals are responsible for safeguarding training; monitoring of referrals/cases and advice/support to staff. Promotion of good professional practice within the organisation and a culture that all staff are aware of their personal responsibility to report concerns. Safeguarding practitioners and link nurses are responsible for embedding policy, training and education and supporting/advising staff.
Lead Nurse for Dementia	Ward Manager Lorna Edwards leads on Dementia care alongside her ward manager role supported by the Lead Nurse for Adult Safeguarding
Lead Nurse for Learning Disabilities	**To be identified**

6. Meetings

Interagency children's meetings attendance:

- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nurse. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development Manager attend this meeting.
- Regional Named Nurse meeting children – this is held twice a year and normally has level 4 training incorporated into the afternoon session of the meeting. This meeting has been opened up to adult colleagues this year. Unfortunately due to COVID restrictions the level 4 training element has not been included this year.
- SSCP Training pool Meetings attended by the Named Nurse children. During the COVID pandemic these meeting have been available on Teams monthly for extra support.
- SSCP Learning and Development Group

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

Interagency adult's meetings attendance:

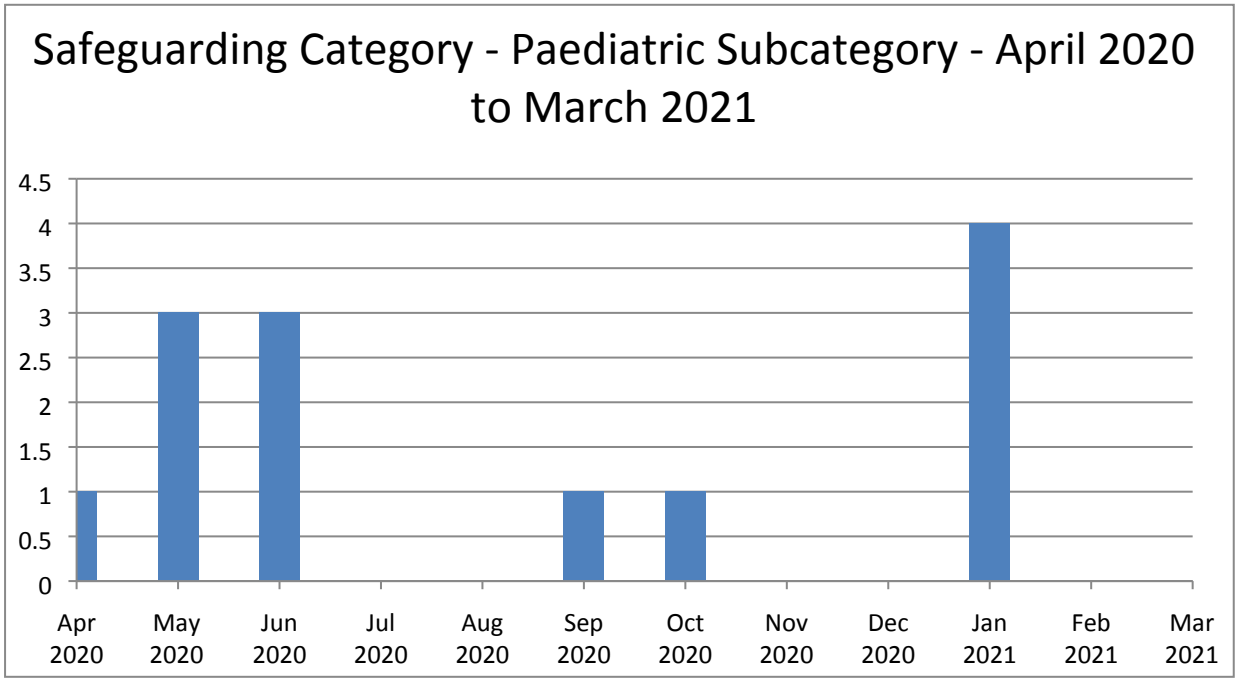
- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nursing Officer. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development manager attend this meeting.
- SSCP learning and development sub-group attended by Lead Nurse
- SSCP MCA and DOLS sub-group attended by Lead Nurse
- SSCP Assurance and Performance Meeting attended by Lead Nurse
- SSCP Domestic Abuse Priority Group attended by Lead Nurse
- SOCJAC – minutes received by Lead Nurse
- STING - Shropshire and Telford Implementation Network Group "STING" for Mental Capacity Amendment Act including - Liberty Protection Safeguards

Information from the interagency meetings is cascaded through Link meetings chaired every other month by Adult Safeguarding Practitioners as well as the Trust Safeguarding Committee.

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

7. Referrals and incidents

7.1 Children's Safeguarding Activity (2020/21)



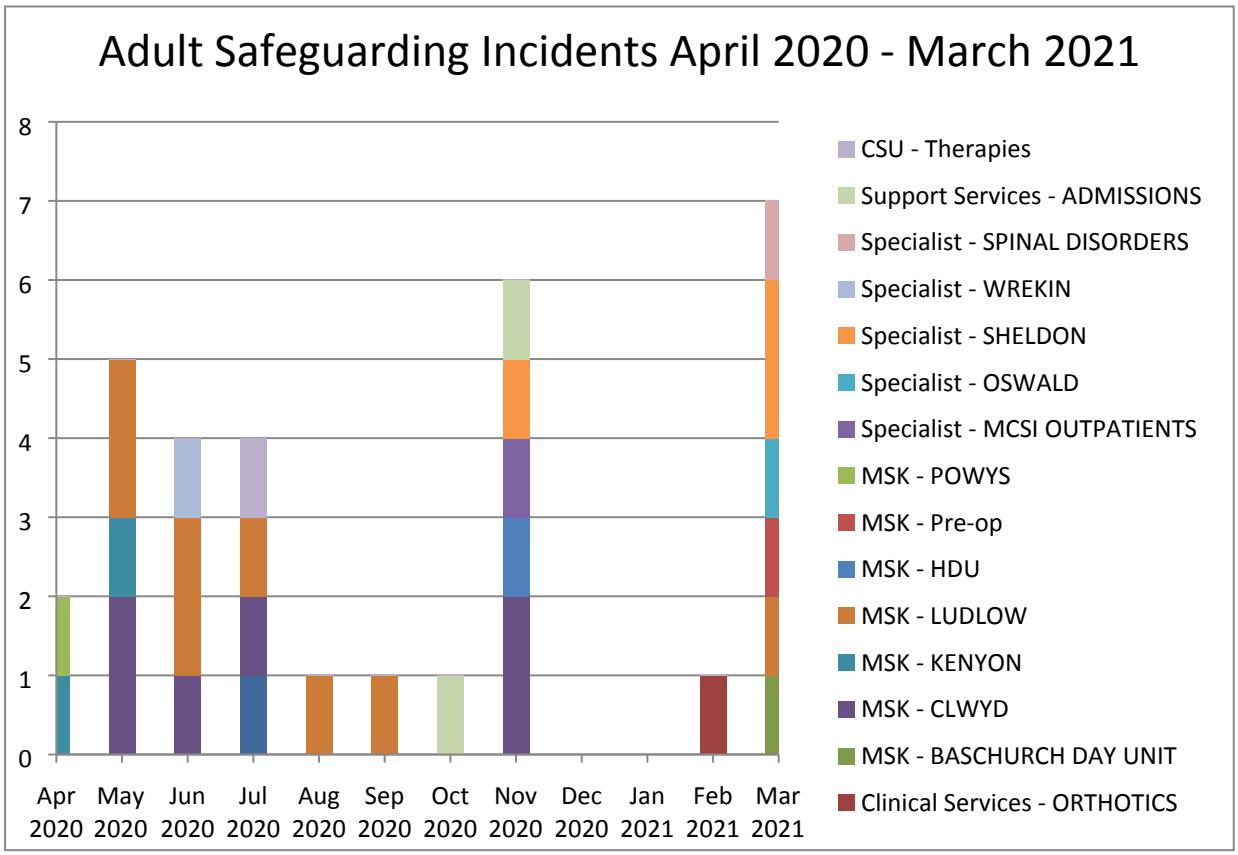
Summary:

There have been a total of 13 Children and Young People incidents reported in 2020/21. 5 incidents reported resulted in referral to the patient's local authority. One of these progressed to a section 47 enquiry resulting in the child being placed on a protection plan under the category of Neglect. 1 concern was also highlighted during a video consultation. 2 incidents related to concerns about children's welfare whilst their parents were attending clinic or theatre in the

Trust. 3 Case conferences have been attended this year - 2 were for the same child. 1 chronology of care was requested, following a sudden unexpected adolescent death in Powys. 1 social worker requesting more information following receipt of a safeguarding referral from dietician working with a child attending our service and 1 concern shared by RAID relating to an adult inpatient – when investigated, a referral had already been made prior to the patient being admitted to our Trust. There were no clear themes; however neglect concerns are seen in many of these incidents.

It should be noted that the paediatric services at the RJAH was affected by the COVID19 pandemic with staff seeing far less children than in previous years. The ward was closed for periods in the first wave, with only urgent orthopaedic surgery being completed. During the second wave the ward remained open with only small numbers of admissions. Outpatient services did continue via telephone and video links but numbers were also reduced.

7.2 Adult Safeguarding Activity (2020/21)



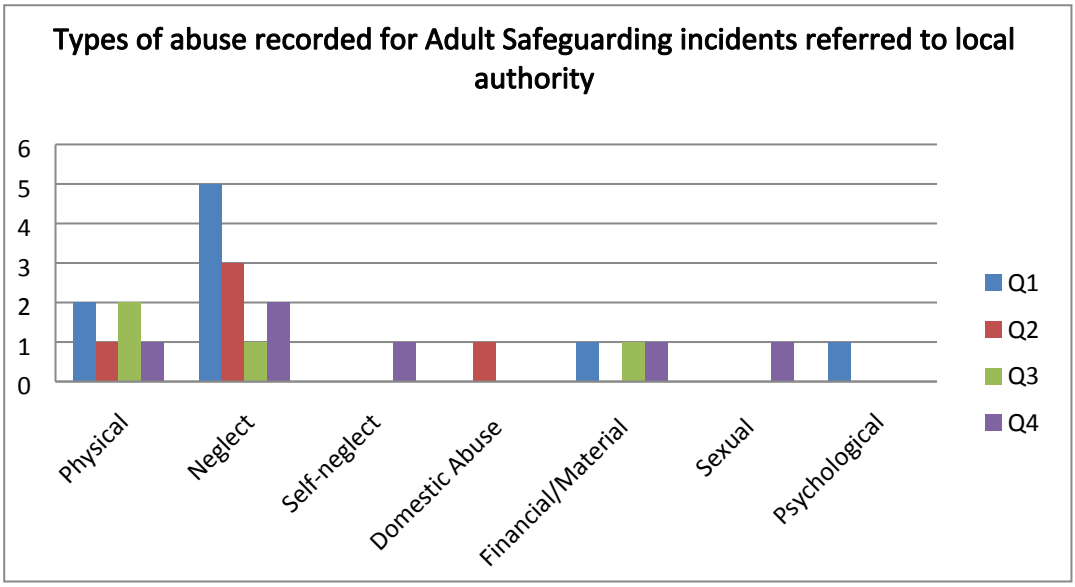
Summary:

There have been a total of 32 Adult Safeguarding incidents reported in 2020/21. 23 incidents reported resulted in referral to the patient's local authority. In addition to this 1 incident meeting the Pressure Ulcer protocol threshold recorded under the Pressure Ulcer datix category resulted in referral to the local authority. 1 incident has progressed to a section 42 enquiry. There was one chronology request for a Serious Adult Review (SAR) for a patient that attended fracture clinic when this service was at RJAH.

Q1 and Q2 incidents saw a predominant theme of neglect following patients having unwitnessed falls from care settings resulting in fractures. This was as a result of the trauma service being transferred to RJAH from Shrewsbury and Telford Hospitals (SATH) during the start of the Covid-19 pandemic.

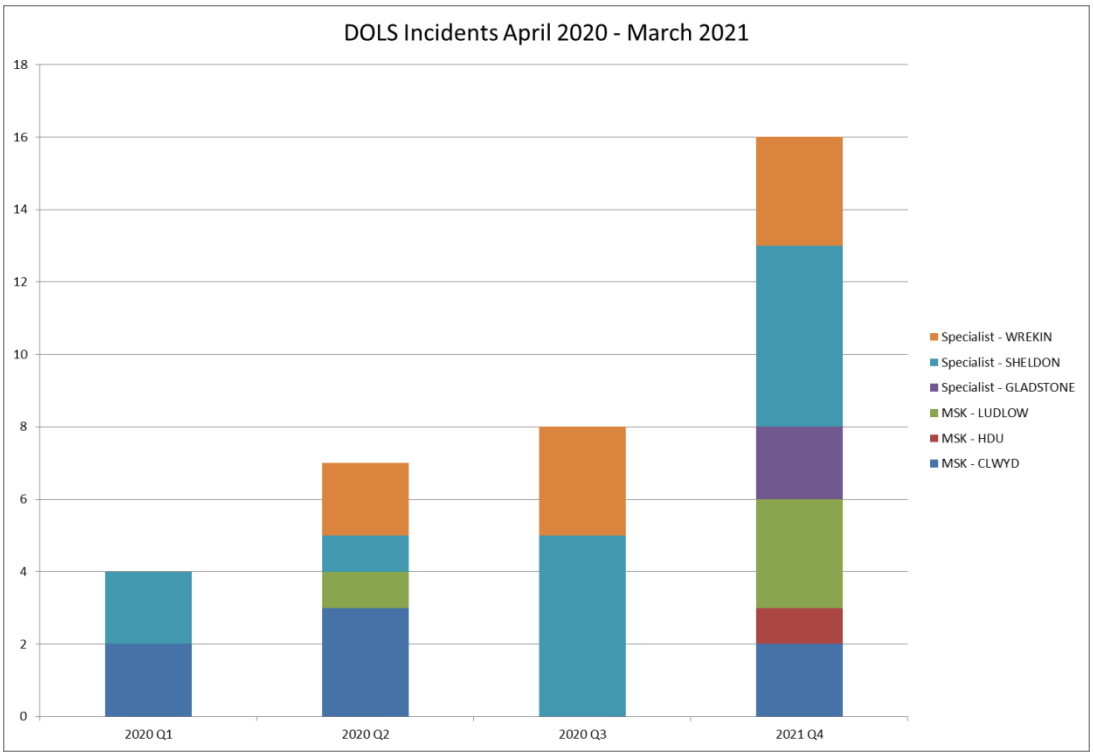
There were no clear themes in Q3 and Q4 but several categories of abuse were recorded. Please see chart below.

To ensure quality information is being recorded on Datix the Datix fields were reviewed and updated and a 'Guide to completing a Datix Incident Form following a Safeguarding Incident' was developed for staff.



For the remaining incidents recorded that did not meet threshold for referral to the local authority the predominant theme was deterioration in mental health resulting in signposting or onward referral to supporting services. There has been an increase in patient contacts to PALS and the Access team that is thought to be a direct correlation to increased waiting lists.

8. Deprivation of Liberty Safeguards (DOLS) Referrals (2020/21)



Summary:

Low numbers of DOLS in Q1 and Q2 are correlated to reduced activity across the organisation during these months. Steady increases in Q3 and Q4 despite continued lower levels of activity reflect the outputs and recommendations of the MCA/DOLS audit conducted with increased education and awareness amongst staff as to when a patient may be subject to DOLS.

The Mental Capacity (Amendment) Act sets out measures to replace the Deprivation of Liberty Safeguards (DOLS) scheme in the Mental Capacity Act 2005. The objective of the Bill is to replace the current Deprivation of Liberty Safeguards (DOLS), with the new system recommended by the Law Commission – the Liberty Protection Safeguards (LPS). The policy being introduced will ensure that those requiring these safeguards will follow a streamlined, person-centred and less bureaucratic process. This change in law will have an impact on the organisation and is expected to be implemented by April 2022. The Lead Nurse for Adult Safeguarding is part of Shropshire and Telford Implementation Network Group (STING). The purpose of the multi-agency group is to oversee the implementation of the Mental Capacity (Amendment) Act (MCAA) and the LPS across Shropshire and Telford and Wrekin. This work has been deferred due to the Covid-19 pandemic with the Code of Practice still to be published.

9. Prevent Referrals (2020/21)

There have been zero prevent referrals for 2020/21**.** The Named Nurse for adults safeguarding attended Channel Panel multi-agency training and the annual Prevent self-assessment was completed. Quarterly returns are sent to NHSE to monitor training levels and incidents reported.

10. Safeguarding complaints (2020/21)

There have been no complaints recorded in 2020/21 that have resulted in a safeguarding referral being made.

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

We have had no LADO referrals this year however, we did contact them for advice relating to a staff related incident in March 21, however this case did not meet the threshold for referral. However an action plan for training and reflection was agreed.

There have been no referrals to the Nominated Safeguarding Senior Officer (NSSO).

12. The Wellbeing policy (previously referred to as the Domestic Abuse Policy)

No formal referrals or Datix in relation to domestic abuse for RJAH staff have been recorded. A few contacts have been made for advice and guidance to Safeguarding leads.

13. Training

13.1 Child safeguarding training

The Named Nurse coordinates and delivers level-one training for staff working in the Trust and provides all staff groups across the Trust with expert advice and support regarding safeguarding children issues. Clinical staff, undertake level-two training as an e-learning module and the vast majority of level three training is accessed via the Shropshire Safeguarding Children Partnership (SSCP) training pool and is delivered as multi agency training. However this year Face to Face training was discontinued due to Covid-19 and staff were advised to complete the NHS England Level 3 Safeguarding Children eLearning module during this period. There have also been some excellent Web based training available nationally, that staff have been able to attend.

Training compliance continues to be monitored against the Trusts targets of 92%. Training figures for March 2021 were:

Level 1	**96.5%**
Level 2	**91.7%**
Level 3	**98%**
Level 4	**100%**

Please see appendix one for further detail

13.2 Adult safeguarding training

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

Training compliance continues to be monitored against the Trust target of 92%. Training figures for March 2021 were:

Level 1	**97.1%**
Level 2	**97.1%**
Level 3	**1.3%**
Level 4	**50.0%**

DOLS	**89.1%**
MCA	**88.0%**
Prevent	**92.0%**

Please see appendix one for further detail

MCA/DOLS

Although this has continued to be below target for 2020/21 there have been improvements made. The improvement is likely to be due to the implementation of the eLearning modules being available for clinical staff to complete. Application of knowledge is being tested via audit to understand areas for improvement.

Prevent training

Prevent training remains above target at 92% for 2020/21.

Adult Safeguarding training Level 3

A training needs analysis (TNA) was undertaken at the beginning of 2020/21 to identify the number of registered staff required to complete this training and this equated to 595 staff in total. This has now risen to 614 staff at the end of 2020/21.

This has been undertaken using national Intercollegiate Document (ICD) 'Safeguarding for Adults: Roles and Competencies' document (August 2018), which indicates that the following staff are required to complete Level 3 training:

Level 3: Registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role)	This includes safeguarding professionals, medical staff, general practitioners, registered nurses, urgent and unscheduled care staff, psychologists, psychotherapists, adult learning/intellectual disability practitioners, health professionals working in substance misuse services, paramedics, sexual health staff, care home managers, health visitors, midwives, dentists, pharmacists with a lead role in adult protection (as appropriate to their role).

Level 3 Adult Safeguarding training was launched in April 2020 at RJAH following the e-learning for health level 3 module being available from January 2021. Staff are required to complete 8 hours over three years.

Detailed training compliance is monitored in hours and is reported monthly via the Safeguarding Committee. **57%** of staff have completed the half day e-learning at Level 3 and this is mitigated further by our high compliance levels at Adult Safeguarding Level 2 training.

Delivery of level 3 adult safeguarding training has been challenging throughout 2020/21 due to limited e-learning courses being available and face to face training commissioned being cancelled due to Covid-19. Going forwards in 2021/22 a further analysis of the TNA will be conducted and a review of the level 3 training available with the proposal that staff will be released for one whole day to complete the required 8 hours in one session. Additional e-learning and participatory learning can still be recorded as additional continuous professional development (CPD).

14. Quality assurance and audits

14.1 Audit

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

The following audits have been undertaken during 2020/21:

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

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

An MCA/DOLS Audit was conducted across the adult surgical and medical wards interviewing a number of professions across the trust. The purpose of the audit was;

- To understand the extent to which the MCA Policy has embedded in the organisation
- To ensure that the MCA and code of practice is being used appropriately across the Trust
- To evaluate any learning points to make improvements in this area, and identify any training needs
- To be able to provide assurance to the CCG and CQC that we are following the MCA code of practice

The audit concluded and has the following recommendations that will carry forward in to 2021/22.

1. To improve staff knowledge on various aspects of MCA and DOLS documentation. Practical guidance for staff on completion of the forms to be incorporated in MCA and DOLS training session.
2. To review level of training for all staff groups, and look at how we can improve the application of theory into practice.
3. To incorporate key questions to be asked prior to admission or on admission within the surgical pathway documentation. This includes whether the patient has a Lasting Power of Attorney (LPA), an advanced decision, or a Respect form.
4. To continue providing information through bi monthly safeguarding bulletin and via the safeguarding page on the trust intranet site.
5. Develop a quality standard questionnaire to measure staff knowledge and competence on a monthly basis. Use the safeguarding team to undertake the monthly audit, and involve safeguarding link staff in this process.
6. To review Datix and undertake a safeguarding/MCA/DOLs huddle approach when a Datix has been submitted by meeting with staff to discuss the Datix, the root cause investigation, and lessons learnt.

14.2 Assurance and Performance monitoring:

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

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

An action plan has been developed to meet the requirements of the Safeguarding, Accountability & Assurance Framework (August 19). This is reviewed by the Trust Safeguarding Committee quarterly.

During 2020/21 the CCG Safeguarding Lead provided assistance in undertaking an assurance review of the organisations safeguarding practices and related activity. It covered a total of 9 domains;

1. Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (revised August 2019)
2. Service Condition 32 of the NHS Standard Contract 2020/21. (Full length)
3. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (January 2019)
4. Safeguarding Adults: Roles and Competencies for Healthcare Staff (August 2018)
5. Safeguarding Adults and Children CCG Dashboards
6. Safeguarding Adults Themes and Trends quarterly report
7. Compliance with the Strategic Safeguarding Community Partnership – this is based upon the duties to cooperate with children and adults safeguarding partnerships in fulfilling its responsibilities
8. CQC Regulation 13: Safeguarding service users from abuse and improper treatment
9. A review of the RJAH current safeguarding policies and procedures

Overall the Trust was commended on significant levels of assurance in all 9 domains with recommendations for minor improvements to be monitored through the NHS Accountability and Assurance Framework action plan.

15. Associated Risks

There are a total of fifteen related safeguarding risks on the Trust risk register. Two are assessed as moderate and these relate to the lack of mental health liaison service and mental health training and the second is related to the risk of children not being followed up as per the Did Not Attend/Was Not Brought (DNA/WNB) policy.

All remaining risks are assessed as low or very low and are monitored through the Trust Safeguarding Committee on a quarterly basis.

16. Associated policies

Policy Work plan Updated March 2021	Owner	Renewal Date
Wellbeing policy	SP	Sept 20 at People Committee
Missing child & adult policy	SM/AW	Nov-23
Child Death and bereavement policy	SM	Oct-22
Managing Allegations	HR/SM/SEA	Dec-20

Guidelines for children who were not brought to appointments	SM	Approved Mar 21 - to be uploaded
Prevent Policy	SM/RK	Aug-21
Holding children for medical interventions	SM	Nov-21
Protection and Safeguarding of Vulnerable Adults (Adults with care and support needs) Policy	SEA	Dec-21
Shropshire multi Agency guidance and procedure	SEA	Dec-21
Guidelines for Deprivation of liberty Safeguards (Dols)	SEA	Dec-21
Management of serious incident policy	SR	May-22
Chaperone Policy	LR	Jul-22
Care of Adults with a Learning Disability on admission to RJAH	AW	Approved Mar 21 - to be uploaded
Safeguarding Supervision Policy (new)	AW	

17. Key priorities for 2021/22

17.1 Joint Adult and Children's Safeguarding Priorities for 2020/21

Joint Adult & Children's Safeguarding Priorities for 2020/21		
Priority	**Objectives**	**Achieved**
To review the Trust Safeguarding Structure.	• Propose new structure to provide the organisation with resilience in the team and succession planning • Write business case to support requirements	
Update the Accountability and Assurance Framework – working towards achieving an outstanding score for "Safety" in the next CQC review	• Form safeguarding professionals working group • Update the framework with existing evidence • Create action plan that can be reviewed monthly • Self-assessment using CQC assurance document	
Develop more robust portfolio of safeguarding audits.	• Submit audit proposals to Clinical Audit Committee • Include audit as regular agenda item on Adult and Children Safeguarding Committee	
Improve Level 3 Adult safeguarding training and develop an Adult safeguarding training passport.	• Adult Safeguarding training passport to be developed by Q1 and launched for use across the organisation • Develop action plan to increase availability of level 3 safeguarding training available within the organisation by Q1 • Monitor training levels monthly and develop trajectory for achieving compliance target	
Increasing participative learning throughout the organisation	• Develop innovative ways of sharing learning and participative learning	

To embed the Pressure Sore Protocol throughout the Trust	• Develop training strategy for implementation • Work with Datix governance lead to monitor and capture data	

Four out of the six objectives were fully achieved for 2020/21. Two objectives were partially achieved.

The Adult level 3 Safeguarding training has continued to be a significant challenge due to the number of staff requiring training, the availability of training and impact of Covid-19. Going forwards in 2021/22 a further analysis of the TNA will be conducted and a review of the level 3 training available with the proposal that staff will be released for one whole day to complete the required 8 hours in one session. Additional e-learning and participatory learning can still be recorded as additional continuous professional development (CPD) using the Adult Safeguarding Training Passport.

The Pressure Sore Protocol has been embedded following an awareness session and case study example delivered at Senior Nurses and Allied Health Professionals (SNAHP) meeting. A supporting Standard Operating Procedure (SOP) has been developed and datix fields have been updated to support the risk assessment questions asked within the protocol, however a training strategy for staff to use this protocol is still to be developed.

17.2 Key priorities for 2021/22

Joint Adult & Children's Safeguarding Priorities for 2021/22		
Priority	**Objectives**	
Improve compliance with Level 3 Adult safeguarding training	• Develop action plan to increase availability of level 3 safeguarding training available within the organisation by Q1 • Monitor training levels monthly and develop trajectory for achieving compliance target	
Improve Pre-operative pathway communication to identify Safeguarding and related concerns	• Development of safety questionnaire for adult pre-op • Review safety questions asked at paediatric pre-op to include use of social media • Review pre-operative alert system and communication to wider organisation	
Monitoring our WNB and DNA policy	• Conduct regular audit and identify actions for improvement	
Mental Health provision	• Review and update associated policies • Establish staff training needs • Conduct staff self-assessment • Introduce Mental Health Champions and/or expansion of Mental Health First Aider (MHFA) role within clinical settings	

Compliance with NHSE Learning Disabilities standards	• Conduct self-assessment against standards to identify areas for improvement • Establish staff training needs • Improve identification of patients accessing services with Learning Disabilities (LD) • Improve patient communication	
Implementation of LPS	• Establish implementation group with upward reporting to Safeguarding Committee (SGC) • Increase organisational awareness of LPS in Q1/Q2 • Attend system wide multi-professional meetings to ensure collaborative approach • Review key documents when available (Impact assessment, Code of Practice, Training and Workforce strategy)	

Conclusion

This annual report evidences good progress with regard to safeguarding priorities in 2020/21, although we recognise that there is always more work to be done. It provides a transparent evaluation of both the effectiveness and challenges of the safeguarding activities for adult, children and young people.

Leadership and governance arrangements continue to be strengthened with actions regularly monitored giving accountability within the Assurance Framework. We will continue to forge links with other local partnership agencies and contribute to cross board initiatives.

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

Appendix One: Annual Training Report for Child Safeguarding & Adults at 31st of March 2021

	Completed "in date" Child Protection Training Level 1			Completed "in date" Child Protection Training Level 2			Completed "in date" Child Protection Training Level 3			Completed "in date" Child Protection Training Level 4		
	3 yearly training			3 yearly training			3 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	55	51	92.7%	1	1	100.0%	0	0		0	0	
Clinical Services Unit	300	289	96.3%	243	218	89.7%	6	6	100.0%	1	1	100.0%
MSK Delivery Unit	489	482	98.6%	412	391	94.9%	9	8	88.9%	0	0	
Office of the CEO	11	10	90.9%	0	0		0	0		0	0	
Specialist Delivery Unit	316	306	96.8%	261	233	89.3%	39	39	100.0%	2	2	100.0%
Support Services Unit	331	323	97.6%	9	7	77.8%	0	0		0	0	
Covid-19 Vaccination Centre	0	0		0	0		0	0		0	0	
Bank Staff	134	118	88.1%	97	88	90.7%	0	0		0	0	
Total without bank staff	**1502**	**1461**	**97.3%**	**926**	**850**	**91.8%**	**54**	**53**	**98.1%**	**3**	**3**	**100.0%**
TRUST WIDE TOTAL	**1636**	**1579**	**96.5%**	**1023**	**938**	**91.7%**	**54**	**53**	**98.1%**	**3**	**3**	**100.0%**

	Completed "in date" Adults Safeguarding Awareness Training Level 1			Completed "in date" Adults Safeguarding Training Level 2			Completed "in date" Adults Safeguarding Training Level 3			Completed "in date" Adults Safeguarding Training Level 4		
	3 yearly training			3 yearly training			3 yearly training			3 yearly training		
Unit	**Number to complete**	**No's completed**	**% complete**	**Number to complete**	**No's completed**	**% Complete**	**Number to complete**	**No's completed**	**% Complete**	**Number to complete**	**No's completed**	**% Complete**
Assurance & Standards Team	55	51	92.7%	1	1	100.0%	1	0	0.0%	0	0	
Clinical Services Unit	300	292	97.3%	236	231	97.9%	121	2	1.7%	1	1	100.0%
MSK Delivery Unit	489	484	99.0%	415	408	98.3%	296	1	0.3%	0	0	
Office of the CEO	11	10	90.9%	0	0		0	0		0	0	
Specialist Delivery Unit	316	310	98.1%	262	254	96.9%	163	5	3.1%	1	0	0.0%
Support Services Unit	331	322	97.3%	9	8	88.9%	8	0	0.0%	0	0	
Covid-19 Vaccination Centre	0	0		0	0		0	0		0	0	
Bank Staff	134	119	88.8%	97	88	90.7%	25	0	0.0%	0	0	
Total without Bank Staff	**1502**	**1469**	**97.8%**	**923**	**902**	**97.7%**	**589**	**8**	**1.4%**	**2**	**1**	**50.0%**
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**1636**	**1588**	**97.1%**	**1020**	**990**	**97.1%**	**614**	**8**	**1.3%**	**2**	**1**	**50.0%**

	Completed "in date" DOLS Training			Completed "in date" Mental Capacity Act Training			Completed "in date" Prevent Training		
	3 yearly training			3 yearly training			3 yearly training		
Unit	**Number to complete**	**No's completed**	**% Complete**	**Number to complete**	**No's completed**	**% Complete**	**Number to complete**	**No's completed**	**% Complete**
Assurance & Standards Team	1	1	100.0%	1	1	100.0%	55	46	83.6%
Clinical Services Unit	197	182	92.4%	199	181	91.0%	306	285	93.1%
MSK Delivery Unit	227	205	90.3%	227	202	89.0%	494	476	96.4%
Office of the CEO	0	0		0	0		11	11	100.0%
Specialist Delivery Unit	173	145	83.8%	173	144	83.2%	323	298	92.3%
Support Services Unit	1	1	100.0%	1	1	100.0%	345	323	93.6%
Covid-19 Vaccination Centre	0	0		0	0		0	0	
Bank Staff	0	0		0	0		146	107	73.3%
Total without bank staff	**599**	**534**	**89.1%**	**601**	**529**	**88.0%**	**1534**	**1439**	**93.8%**
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**599**	**534**	**89.1%**	**601**	**529**	**88.0%**	**1680**	**1546**	**92.0%**

Appendix 2
Abbreviations list

CCG	Clinical Commissioning Group
CPD	Continuous Professional Development
CQC	Care Quality Commission
DNA	Did Not Attend
DOLS	Deprivation of liberty safeguards
FGM	Female Genital Mutilation
ICD	Intercollegiate Document
IMCA	Independent Mental Capacity Advocate
LADO	Local Area Designated Officer
LD	Learning Disabilities
LPA	Lasting Power of Attorney
LPS	Liberty Protection of Safeguards
MCA	Mental Capacity Act
MCAA	Mental Capacity Amendment Act
MHFA	Mental Health First Aider
MSP	Making Safeguarding Personal
NHSE	NHS England
NSSO	Nominated Safeguarding Senior Officer
RAID	Rapid Assessment, Intervention & Discharge
SAR's	Safeguarding Adult Review
SATH	Shrewsbury and Telford Hospital
SGC	Safeguarding Committee
SOCJAC	Serious and Organised Crime Joint Action Group
SOP	Standard Operating Procedure
SSCP	Shropshire Safeguarding Community Partnership
SNAHP	Senior Nurses and Allied Health Professionals meeting
STING	Shropshire and Telford Implementation Network Group
TNA	Training Need Analysis
WNB	Was Not Brought

Chair's Assurance Report
People Committee – 1st July 2021

0. Reference Information

Author:	Mary Bardsley Assistant Trust Secretary	Paper date:	29 July 2021
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	People Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee on 1st July 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the 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 was well attended and notes as quorate
- The members of the meeting considered and approved the committee self-assessment and annual report ahead of presentation to the Audit Committee
- An update was received on the consultant capacity project plan and theatre improvement
- A total of 3 policies were considered and approved
- Assurance Chair Reports were provided with no concerns highlighted

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 1st July 2021. The meeting was quorate with 2 Non-Executive Director and 2 Senior Leaders in attendance. The full list of attendees is listed below;

Attendance:		
Harry Turner	Non-Executive Director (Chair)	HT
Chris Beacock	Non-Executive Director	CB
Alyson Jordan	Managing Director of SSU	AJ
Stacey-Lea Keegan	Chief Nurse and Patient Safety Officer	SLK
Sarah Sheppard	Chief of People	SS
Hilary Pepler	Trust Board Advisor	HP
Ruth Longfellow	Chief Medical Officer	RL
Shelley Ramtuhul	Trust Secretary	SR
David Low	Improvement and OD Manager	DL
Sue Pryce	Head of People Services	SP
Amber Scott	Trust Office PA (minutes)	AS
Attendance:		
Paul Kingston, Craig Macbeth, Mark Brandreth, Rob Freeman, Greg Moores and Kerry Robinson		

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 (Y/N)	Assurance Sought
1. People Committee Self-Assessment		
The Committee received the results from the self-assessment along with the committee annual report. The Non-Executive directors asked for numbers of responses to be recorded along with the answer to add context. At the time of the report being presented, the Chair of the committee was absent from the meeting. Therefore, approval was sourced outside of the meeting via the Non-Executives. The recommendations were agreed along with the suggestion of receiving the workplan at the beginning and end of the meeting – once for reflection and once for approval.	Yes	
2. Board Assurance Framework		
The committee received the revised framework. It was noted that currently there are no risks in relation to the flu campaign	Yes	

although this is anticipated to change within the Autumn/Winter and risks will be added when appropriate.		
3. Performance Report M2		
A Managing Director brought the committee' attention to the key aspects of the report as found in the pack and requested any comments from the committee. There were concerns about the performance report being one month behind and therefore always providing assurance to the Board late.	No	The Trust agreed to revise the meeting dates to ensure the flow of reporting is effective.
4. Theatre Team Improvement Update		
The following headlines were presented to the committee: • Improving theatre safety – human factors training / bespoke human factors training being set-up • Implemented revised WHO process • Maximising job plan flexibility – Reporting is in place and job plans are all on e-job plan, and currently being reviewed by the Access Team Managers. • Increasing Consultant Capacity • Increasing theatre staff with suitable needs – 6-4-2 planning process now in place. The Trust was commended for the progress within Theatres, although commented that the report is very technical, and does not appear to reflect the feelings of the staff within theatre. The Trust informed the Committee that the 'Be Happy' App is to be rolled out to all staff in theatre imminently, and this will enable an immediate reflection of how staff are feeling.	Yes	
5. Consultant Capacity Project Plan		
A Managing Director explained the source of and noted that the project plan board meets fortnightly. The action log is reviewed for assurances and in the future will be submitted the People Committee to provide assurance on the progress of recruitment. The committee discussed the Specialist Doctors and Fellows being reported within the plan and that these roles are not consultants and cannot be included within the recruitment plan. Also due to gaps pre-covid and the increase in activity due to restoration, questioned if the plan was realistic. The highlighted that recruitment is currently underway with several start dates in place for new consultants, although accepted that there is a lack of a forward plan. Regarding the inclusion of Specialist Doctors and Fellows, the committee agreed to amend the title. This current piece of work is focused on consultants and that there is a separate piece of work ongoing on workforce recruitment, and requested the committee not lose sight on the main focus of consultants. The committee agreed to receive an update at the next people Committee along with an update on the 5-year plan is, factoring in retirement.	Yes	

6. Remediation Policy		
The Committee received the policy which has been endorsed by LNC, replacing the Responding to Concerns policy. Noting there is a stronger process now in place and opened up for comment. It was highlighted that within the training section that it states, 'no training is required', although felt it an important element for Clinical Chairs to be sighted and informed on. The committee agreed. The policy was approved by the committee.	Yes	
7. Disciplinary & Management of Performance Procedure for Medical Staff		
It was highlighted that the wording within the policy is against the National Policy and the National requirements. The following amendments were agreed: • point 1.1.2 2nd paragraph, third line to be amended to, ' appropriately experienced and trained person'. • point 2.3.3 to be amended to reflect that a 'nil report' will be required for Board. The policy has been endorsed by LNC, the People Committee approved the policy.	Yes	
8. Trans Equality Policy		
This policy replaces the Gender Re-assignment policy, with the policy being re-worked and brought up-to-date to align with the Trust' ED&I agenda. The policy was written with the support of a colleague with lived experience and the policy was also endorsed by ED&I. The following suggestions were made: • completion of the front sheet • note the policy has been endorsed by LNC • adding signposts within the policy to support colleagues and management with individuals' changes. • The Schwartz Round has recently received personal experiences and stories from staff members and suggested these are submitted to the committee next month, to gain an understanding of the importance of the policies the Trust have in place. The committee approved the policy pending the above amends.	Yes	
9. Job Planning Internal Audit Review		
Report deferred as the report requires approval and review via Risk committee.	N/A	Item deferred
10. Freedom to Speak Up Annual Report		
The report was noted by the committee and accepted as read by the group. No comments were offered, and the report was noted.	Yes	
11. STW System Annual Report		

The committee were encouraged to read the report in full for a detailed discussion at a future meeting – this is to gain a greater understanding of the plan. The committee agreed to bring the report back for review and discussion in October 2021.	N/A	Further discussions to be held in October 2021.
12. Nursing Workforce Update		
The following highlights were shared: • Training Nursing Associates Recruitment – 12 Nursing Associates allocated for the first enrolment in September. • Combined Generic Worker Role – Scoping completed for the first role to be set in MCSI. • Strategy for 0% HCA Vacancy – Work underway on apprentices new to care which in turn will align with the Nursing Associates and back filling any gaps. • International Recruitment – Scoping further support in place for pastoral role. • Academic Orthopaedic Course – On track and out for recruitment on the Lecturer/course manager, with good interest for the role, with the 1st enrolment in October. • Nursing Students to Recruitment – Health Education England piloted a project on Team based learning and increasing clinical expansion which has offered funding for a further PDN, with a final submission being taken to NHS England for this. • Retention Scheme – Project currently underway with team-based learning and a complete paper will be submitted to the next committee. The Trusts target was to increase Nursing Students by 22 with an end result of 41.	Yes	
13. Deferred Papers		
The following papers were deferred to the next meeting due to time pressure: • People Plan Action Plan Update • Wellbeing Conversation • EDI – High Impact 6 Action Plan • Staff Survey	N/A	Due to time pressures the papers were deferred to the next meeting.
14. Chair Reports		
The following Chair Assurance Reports were noted by the committee: • Staff Experience Group & Terms of Reference • Trust Performance and Operational Improvement Board	Yes	
15. Committee Work Plan		
The committee noted the work plan.	Yes	
16. Policy Tracker		
The committee noted policy tracker.	Yes	

17. Covid-19 workforce lead		
The committee noted the work plan.	Yes	

3.4 Approvals

Approval Sought	Outcome
Remediation Policy	Approved
Disciplinary & Management of Performance Procedure for Medical Staff	Approved
Trans Equality Policy	Approved

3.5 Risks to be Escalated

In the course of its business the Committee identified no risks to be escalated.

3.6 Conclusion

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

Strategy Board Update - Digital

0. Reference Information

Author:	Simon Adams Director of Digital	Paper date:	29 July 2021
Executive Sponsor:	Simon Adams Director of Digital	Paper Category:	Strategy
Paper Reviewed by:	Senior Leadership Group	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is a summary of the output of the Board of Directors strategy session in relation to the Digital agenda that took place in June 2021 to ensure open and transparency in public session.

2. Executive Summary

2.1. Context

This paper summarises the outputs from the Board of Directors strategy session that took place in June 2021. This was the third virtual strategy session the Board has held with a range of discussion with focus on how Digital can enable transformation

2.2. Summary

Summary of key points from the session.

- Work to commence a new Digital Strategy will commence later this year.
- **Action** : Strategy to encompass horizon scanning
- Digital is the enabler and needs strong staff engagement to lead developments. Digital should not necessarily be the owner.
- The new Electronic Patient Record (EPR) is not a Digital Project and it is about how people work and interact.
- **Action**: Development of digital skills within the Trust is essential for staff to be able to effectively engage.
- The EPR will be a continual journey and the work will not end at implementation. It will be a journey of continual improvement
- We should not replicate existing process / pathways but review and improve as we implement
- **Action**: Engagement with Staff and patients is key
- Ensure that the goals and objectives are understood and clearly articulated.
- **Action**: Measures to understand how benefits are achieved need to be incorporated in design
- **Action** :Successful Digital transformation is about people and not just about the technology and needs to link with organisation development
- Consideration of future workforce and patients need to be considered.

- **Action**: Digital can and will improve safety, quality, and enable RJAH to deliver better workflows within booking and interactions with patients.

2.3. Conclusion

The summarised actions are in development through existing structures and an update will be presented to Finance Planning and Digital later in the year.

Chair's Assurance Report
Audit Committee 12th May 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	29 July 2021
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	Audit Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Audit Committee Meeting held on 12th July 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

Key points to highlight from the meeting

- The meeting was well attended.
- There was good progress of actions from the previous meeting with all actions completed or on updated was provided throughout the course of the meeting.
- The work plan was reviewed and agreed.
- The members of the Committee received the suggestion of amalgamating the Risk and Audit Committee for consideration.
- Papers were presented by Internal Audit, External Audit and Counter Fraud Specialist.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Audit Committee which met on 12th May 2021. The meeting was quorate with three Non-Executive Directors present. A full list of the attendance is outlined below:

Attendance:		
Attendance:		
David Gilburt	Non-Executive Director (Chair)	DG
Paul Kingston	Non-Executive Director	PK
Harry Turner	Non-Executive Director	HT
Shelley Ramtuhul	Trust Secretary	SR
Diana Owen	Head of Financial Accounting	DO
James Shortall	Counter Fraud Specialist	JS
Gurpreet Dulay	Internal Audit Representative	GD
Yasmin Ahmed	Internal Audit Representative	YA
Mo Ramzan	External Audit Representative	MR
Simon Adams	Director of Digital	SA
Mark Salisbury	Operational Director of Finance	MS
Stacey Keegan	Chief Nurse	SLK
Mary Bardsley	Assistant Trust Secretary	MBa
Apologies:		
Craig Macbeth	Chief of Finance and Planning	CM

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress was received of each. 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
1. Chair Report – Information Governance Meeting		
The Data Protection and Security toolkit standards were met before the end of June, with training compliance meeting 95% before the end of June. The dates of the meeting have been rescheduled to ensure attendance from the required members. Further information is to be incorporated when the chairs report assurance is noted not applicable. Staff mandatory training is being tracked through the performance report due to the non-compliance levels recorded. There is a continuous 4% non-compliance, this is a rolling figure, with no member of staff being continually non-compliant.	Partial	Further information to be incorporated when recording non applicable within the assurance column.
2. Cyber Security Assessment		

The detail of the paper was restricted and not accessible for FOI requests. The committee received a detailed updated on the paper, offering assurance to the committee on all actions being completed and compliance implemented.	Yes	
3. Finance Governance Pack		
The following was highlighted: • Receivables gone up by £1.4m with £0.4m being on 1 invoice raised at the end of May 2021, therefore not paid in time, along with an increase in pre-payments. • Cash up by nearly £1m due to the first payment of £1m from Headley Court of a £6m donation for the Veterans Centre. Along with this there was a £1.5m surplus in the period shown within the income and expenditure. • Performance against plan gave an overall adjusted £1.4m with the plan being £1.1m. The committee were assured on the control accounts with the reconciliation being up-to-date and complete, along with the performance ahead of plan, and commended all involved within this. The committee received an update on the aged debt, single source waivers, prompt payments – there were no concerns raised by the committee.	Yes	
4. Board Assurance Framework		
The committee received the framework in its entirety. Meeting have been scheduled with the executive leads to populate Q1 performance. The framework has been received and considered by the Risk Management Committee earlier in the month. It was agreed that the Trust Secretary would discuss a suggested new risk relating to the current CEO and Chairman leaving the organisation in 2021.	Yes	
5. Register if Hospitality and Interests		
The committee noted the documents, and it was agreed that any amendments within the report will be note in blue.	Yes	
6. Reference Costs Update		
The committee received a verbal update on the progress of reference costs. The Trust is progressing to plan, noting the focus is now on uploading the data sets into the system, then working with the supplier on the output model over the coming weeks. MS added there were no risks noted and that the submission window opens on the 21st September 2021.	Yes	
7. People Annual Report		
The committee noted the report, taking assurance from the report.	Yes	
8. Risk Annual Report		

The committee noted the report, taking assurance from the report.	Yes	
9. Amalgamation of Audit and Risk Committee		
The suggestion of amalgamating Audit and Risk committee was presented. It was noted that the duplication of workload would be reduced. There are some agenda items from the Risk Management that will be aligned to the Quality and Safety Committee. Concerns were raised over losing the oversight of risks journeys and suggested there is a process provided to the risk journey. The committee for suggested that the risk management report captures which sub committees and groups the risk has been submitted to, offering assurance to the Board that all risks have been processed correctly. The Non-Executive Directors thanked the Trust for the well established and effective Risk Management Committee to consider this proposal. The committee agreed for a set up meeting to be scheduled to ensure all aspects are capture and aligned to the relevant assurance committee. The Chairs of Audit, Risk and QS will be in attendance. The committee considered and approved the proposal.	Yes	
10. ESR Audit Report		
The Trust offered context on the follow-up of an external audit finding as part of the year end audit. A national audit had taken place on the ESR system which affects most NHS organisations, it is important that RJAH is aware of recommendations raised in this report and take action as needed. The recommendations affect RJAH being; 1. The risk around segregation of duties and user profiles within the System. 2. Reconciling ESR outputs to the input of the general ledger. The Trust are to confirm if there is any exposure to a business risk from SBS and whether assurance was required on this function.	Partial	To confirm if the Trust is exposed to specific business risk from SBS
11. LCFS Progress Report		
The activity of the new Self-Review tool, now known as the Counter Fraud Functional Standard Return is due to be completed by the deadline on the end of May 2021. The main initiative underway at the moment is a National exercise into Covid-19 procurement fraud, noting that the Trust have already undergone a local audit, the Trust already offering assurance to the Board, although this will now be reported on in depth alongside the National guidelines. The work is currently well underway and in line with the deadline of September 2021. There is a rise in mandate fraud, with supplier emails being intercepted with details included within the report, with communications being sent to Finance teams and procurement and the Trust has no risk currently.	Yes	

12. Counter Fraud Annual Report		
The Trust received a summary of the annual report and the new NHS requirements which were issued in April 2021. Due to a short time frame for the requirements being in place by the end of May 2021 and various changes, it was not possible to complete all requirements with many showing as 'Amber', although the overall rating once submission complete gave the Trust a 'Green' rating.	Yes	
13. Internal Audit Progress Report		
A progress report was received along with an update on the Audit Plan for 2021/22. Internal Audit confirmed the plan will be staggered throughout the year to enable enough time to complete all audits and reviews.	Yes	
14. Consultant Job Planning Update		
The committee noted that the recommendation has reduced to a medium level with the following now in place: • E-Rostering System • Scheduling & Forecasting Team • Activity Monitoring – Monthly report • 6-4-2 process in place The recommendations are triangulated to ensure the Trust is being fully utilised and good progress is made. The follow-up report noted that 9 recommendations are due by the end of June 2021, with 5 have been completed and removed from the tracker. The committee was informed that the non-RTT activity high level recommendation, that a target date should be set for these patients, has had a long deferral date added due to the pandemic, and focus on elective work and backlogs of waiting lists, with a revised date of March 2022.	Yes	
15. External Audit Progress Report		
A progress report was received which highlighted the Value for Money work which is due to be complete by July 2021. The committee agreed to an extra ordinary audit meeting in August 2021 to receive the value for money paper.	Yes	
16. Committee Work Plan		
The risk committee workplan will be incorporated into the Audit workplan for future meetings.	N/A	
17. Policy Tracker		
Concerns were raised over some of the policies being overdue. The report is to be amended ahead of the next committee to provide the scheduled approval date and the aligned committee.	Partial	One policy was overdue and the committee requested for this to be reviewed asap.
18. Any Other Business		
The committee agreed for the first Audit/Risk committee to take place in October 2021.	N/A	
19. Top Risks		
None raised by the committee	N/A	

3.4 Approvals

Approval Sought	Outcome
Review of the work plan	

3.5 Risks to be discussed

In the course of its business the Committee identified the following risks to be discussed:

- The leadership Board will be undergoing changes with the current CEO and Chairman due to leave within 2021

3.6 Conclusion

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

Amalgamation of Audit and Risk Committee

Author:	Shelley Ramtuhul, Trust Secretary/Director of Governance	Paper date:	29 July 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Audit Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board is asked to ***consider*** and ***approve*** the amalgamation of the Audit and Risk Committee.

2. Executive Summary

2.1. Context

In 2017 the Trust introduced a board level Risk Management Committee to its Governance Framework in response to an internal audit which had identified a number of shortfalls in the Trust's risk management processes and controls. Since this time the Trust's Risk Management Strategy has been strengthened with increased ownership of risk management throughout the organisation and both the CQC inspection in 2018 and a further internal audit conducted in 2019 reflected the significant progress made.

2.2. Summary

This paper outlines the recommendation to amalgamate the Audit and Risk Committees into one committee with the work plan of Risk Committee to be split between the 'Audit and Risk Committee' and the Quality and Safety Committee.. The rationale for this is set out in the paper. The proposal has the support of the Trust's Chief Executive and Chairman and has been discussed and agreed at Risk Management Committee and Audit Committee subject to the final approval of the Board.

2.3. Conclusion

The Board is asked to ***consider*** and ***approve*** a recommendation to amalgamate the Audit and Risk Committee.

Amalgamation of Audit and Risk Committee

3. Main Report

Background

The Risk Management Committee was established in 2017 following an internal audit which identified a number of shortfalls in the Trust's risk management processes. It was established to have oversight of the design and implementation of robust risk management processes which it did within its first year of establishment and since this time it has introduced and embedded a regular reporting regime to ensure oversight of risk management at every level of the organisation.

The Trust's risk management processes have been considered by a number of external organisations namely the Trust's internal auditors, the CQC and Niche Consulting as part of the well led reviews. These reviews did not raise any significant concerns albeit opportunities for further improvement were identified and taken forward.

Rationale for Amalgamating Risk Committee with the Audit Committee

There are several reasons for recommending the amalgamation of the two committees and these are set out below:

- It is unusual for organisations to have separate Risk Committees and the Trust recognised this when it took the step of setting the committee up. Audit Committees have overall responsibility for overseeing internal controls of which risk management forms a part, however, the Risk Management Committee was focussed on establishing and overseeing operational risk management. This is now well embedded in the organisation as evidenced by the fact that the Risk Management Committee was reduced from monthly meetings to bi-monthly meetings and eventually quarterly meetings as the level of scrutiny required reduced.
- There is a natural cross over between the Risk Management Committee and Audit Committee and whilst steps have been taken to minimise duplication it does still exist and therefore the amalgamation will remove all duplication.
- The ICS has established a governance framework with an Audit and Risk Committee and therefore this change will align the Trust's governance framework to the system.
- The amalgamation would ease the committee burden on both the Executive and Non-Executive Teams at a time when they are attending more meetings in the system but without reducing the oversight that the organisation has in place of its risk management controls and assurances.

Impact of the Proposed Amalgamation

The Audit Committee has a full work plan and therefore consideration has been given to the impact the amalgamation will have. The Risk Management Committee work plan is attached for information and it is envisaged that the work can be dealt with in the following way:

- The Committee Management items will no longer be required save for the Safer Sharps Update and Chair's Reports which would be more appropriately aligned to the Quality and Safety Committee.
- The Corporate Risk Management items to a certain extent duplicate items that are already presented to the Audit Committee but the quarterly Risk Management Report would be added to the Audit and Risk Committee work plan, as would the annual Business Continuity Plan.

Amalgamation of Audit and Risk Committee

- The Internal Audit items duplicate the reports that are already presented at Audit Committee so would not add any burden.
- The Annual Reports would all be presented at Quality and Safety Committee instead and are sufficiently staggered to ensure the Quality and Safety Committee will not be overloaded. However, the annual Corporate Risk Register report would be presented to Audit and Risk Committee.
- The Audit and Risk Committee would receive the Unit Deep Dives into Risk Management.

In consideration of the impact it is felt that the work plan would remain manageable for the newly amalgamated Audit and Risk Committee and a number of items linked to safety would be appropriately transferred to the Quality and Safety Committee, again in a manageable way.

Conclusion

The Board is asked to ***consider*** and ***approve*** a recommendation to amalgamate the Audit and Risk Committee.

Amalgamation of Audit and Risk Committee

Risk Management Committee
Work Plan 2021/22

	7th April 2021 10am-12md	7th July 2021 10am-12md	13th October 2021 10am-12md	12th January 2022 10am-12md
Committee Management				
Formal Review of Committee Effectiveness		✓		
Terms of Reference	✓			
Review of the Work Plan	✓	✓	✓	✓
Attendance Matrix (to note)	✓	✓	✓	✓
Safer Sharps Update	✓	✓	✓	✓
Chair Report from Health and Safety Committee (inc. CAS Report)	✓	✓	✓	✓
Chair Report Medical Devices Committee Report	✓	✓	✓	✓
Corporate Risk Management				
Annual Governance Statement (Draft)		✓		
Risk Appetite			✓	
Board Assurance Framework & Corporate Objectives	✓	✓	✓	✓
Risk Management Report	✓	✓	✓	✓
Business Continuity Plan and EPRR Update			✓	
Internal Audit (to be confirmed)				
Internal Audit Risk Management Update				
Internal Audit Report				
Annual Reports				
Health and Safety Annual Report			✓	
Patient Alert Report		✓		
Security Risk Assessment Annual Report			✓	
Corporate Risk Register Annual Report	✓			
Near Miss Annual Report		✓		
Policy/Strategy Oversight				
Management of Asbestos Policy (Nov. 2021)			✓	
Unit Deep Dives				
Support Services Unit	✓		✓	
Clinical Support Unit	✓		✓	
MSK Unit		✓		✓
Specialist Unit		✓		✓

Chairs Assurance Report
Finance Planning and Digital Committee 23rd July 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	29 July 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Digital	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Finance, Planning and Digital Committee was held on 25th May 2021. A verbal update will be provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

Due to the timing of the committee it is not possible to provide a paper Chair's Report. The Non-Executive Director Chair of the committee will provide a verbal update.

2.3. Conclusion

The Board is asked to note the verbal report which will be provided during the meeting.

Agenda

Location	*Date*	*Owner*	*Time*
	23/07/21		14:00

1. Introduction		14:00
1.1. Apologies	Rachel Hopwood	
1.2. Minutes from the previous meeting	Rachel Hopwood	
1.3. Action log/Matters arising	All	
1.4. Declaration of interests	All	
2. Planning		
2.1. H2 Planning 2021/22 (verbal)	Mark Salisbury	14:05
2.2. ICS Financial Strategy Development	Craig Macbeth	14:10
2.3. The Net Zero Emissions Target (to follow)	Simon Everett	14:15
3. Digital		
3.1. Cyber Security Action Plan Update	Simon Adams	14:20
3.2. NHSX Cyber Update	Simon Adams	14:25
3.3. EPR Procurement (verbal)	Simon Adams	14:30
3.4. Chair Report Digital Steering Group	Simon Adams	
3.5. Chair Report EPR Programme Board	Simon Adams	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
	23/07/21		14:00

4. Performance		
4.1. MSK Unit Efficiency Delivery Update	Jo Banks	14:35
4.2. Procurement Plan 2021/22	Helen Lewis	14:45
4.3. Restoration Report	Kerry Robinson	14:55
4.4. Performance Report M3	Kerry Robinson	15:05
4.5. RJAH Financial Performance Report M3	Mark Salisbury	15:15
4.6. Elective Recovery Fund Update	Mark Salisbury	15:20
4.7. System Financial Performance Report M3	Craig Macbeth	15:25
5. Governance		
5.1. Board Assurance Framework & Corporate Objectives	Shelley Ramtuhul	15:30
5.2. Chair's Assurance Reports:		15:40
5.2.1. ICS Sustainability Committee	Craig Macbeth	
5.2.2. MSK Transformation Programme Board	Craig Macbeth	
5.2.3. Trust Performance and Operational Improvement Board	Kerry Robinson	
5.2.4. Review of the Work Plan	Shelley Ramtuhul	
5.2.4.1. Attendance Matrix	Shelley Ramtuhul	
6. Any Other Business	All	
6.1. FPD Briefing Meeting in August		
6.2. Next meeting: 20 August or 21 September (tbc)		

Month 3 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	29/07/2021
Executive Sponsor:	Kerry Robinson	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

This paper is for information summarising the key performance indicators, highlighting areas of high or low performance for operational and financial metrics.

The committee is asked to note the overall performance as presented in the month 3 (June) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

This month sees the third month of the new IPR format, now fully utilising Statistical Process Control (SPC) graphs and NHSEI recommended variation and assurance icons.

The reading guide within the IPR gives a full explanation on the interpretation of SPC graphs and the icons to support understanding.

2.2. Changes to Note This Month

Following the training session conducted by NHSEI at the Trust Board Strategy session in June we have adopted their advice on some further evolvement to our IPR as listed below:

- All Finance measures have been changed from SPC to line graphs this month whilst we take time to increase our understanding of the use of SPC for financial information. We have taken the opportunity from NHSEI to join their national working group that are currently meeting to discuss this and will be attending our first meeting in July. Feedback from that will determine how we evolve these measures in future months. In the meantime, measures that need to be reported as exceptions will be identified by the Finance Team.
- The NHSEI session drew our attention to the impact of covid on our data. Through further discussion with them we have made changes to graphs that indicate an impact

and you will see this referenced on the exception pages. Essentially, where necessary, we have adjusted control ranges and introduced a step change.

Our internal auditors, BDO, have recently conducted a series of audits on behalf of the Trust. You will see these updated on the summary pages under the DQ Rating.

Two additional measures have been added to the IPR this month as follows:

- RJAH Acquired Klebsiella spp
- RJAH Acquired Pseudomonas

2.3. Overview

The Board through this IPR should note the following;

Caring for Patients;

- Serious Incidents
  - Low number of incidents have taken place
- 18 Weeks RTT Open Pathways
  - Metric is consistently failing target as expected from covid impact
  - Is showing a concerning nature which aligns to Trust response for mutual aid and restart of elective
  - All above results in a failure of assurance
- Patients Waiting Over 52 Weeks (English & Welsh)
  - Number of English patients is experiencing special cause variation of a concerning nature as expected given covid, both English and Welsh consistently failing target
- 6 and 8 Week Wait for Diagnostics
  - Both metrics indicate common cause variation with variable achievement of Welsh target and consistently failing English

Caring for Finances;

- Total Elective Activity
  - Although actual figure is below the baseline (19/20), did overachieve against the regulatory target of 80% of baseline delivering 80.68% elective activity
- Total Outpatient Activity
  - Metric falling short of baseline target (19/20), overachieving against the regulatory target of 80% of baseline delivering 81.25%
- Bed Occupancy – All Wards – 2pm
  - Metric is consistently failing target
- Recurrent Financial Performance (Sustainability Plan)
  - Adverse variance in month

2.4. Conclusion

The Board is asked to ***note*** the report and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
June 2021 – Month 3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

Different colours have been used to separate these trends of special cause variation; ● **blue points** have been used to show **areas of improvement** and ● **orange points** for **areas of concern.** It should be noted that SPC charts do not compare performance against targets; that is the purpose of the red and green heatmap indicators.

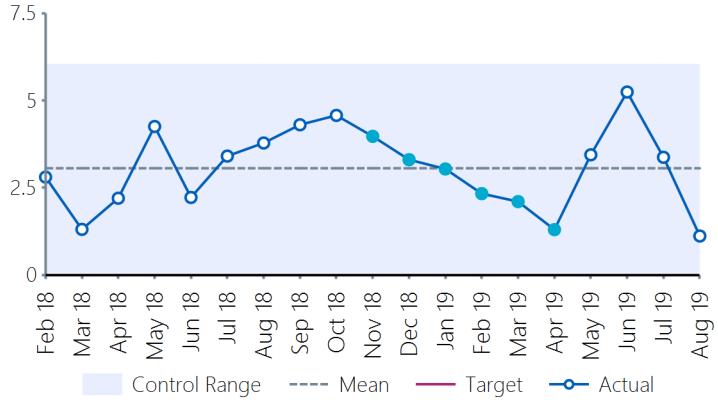
Some examples of these are shown in the images to the right:

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

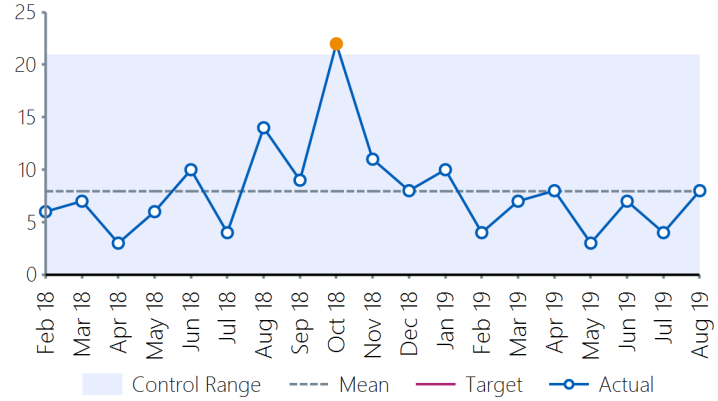
b) shows a point of concern sitting above the control range.

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

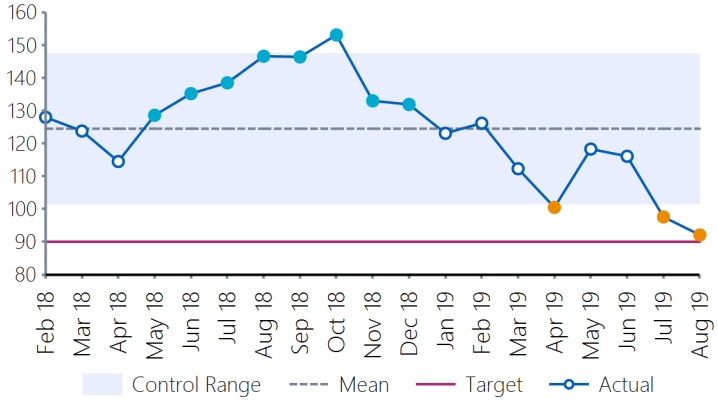
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

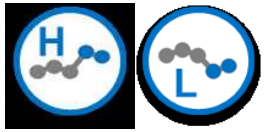
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually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

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

Variation Icons

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

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



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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	3.97%					27/02/20
Voluntary Staff Turnover - Headcount	8.00%	7.60%					24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	?	+	16/04/18
Never Events	0	0		N/A to SPC	?		16/04/18
Number of Complaints	8	17			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	?		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
31 Days First Treatment (Tumour)*	96%	100%			?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85%	100%			?		24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
18 Weeks RTT Open Pathways	92.00%	58.10%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1535	1425	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	672			F	+	24/06/21
6 Week Wait for Diagnostics - English Patients	99.00%	80.17%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	79.18%			?	+	

Summary - Caring for Finances

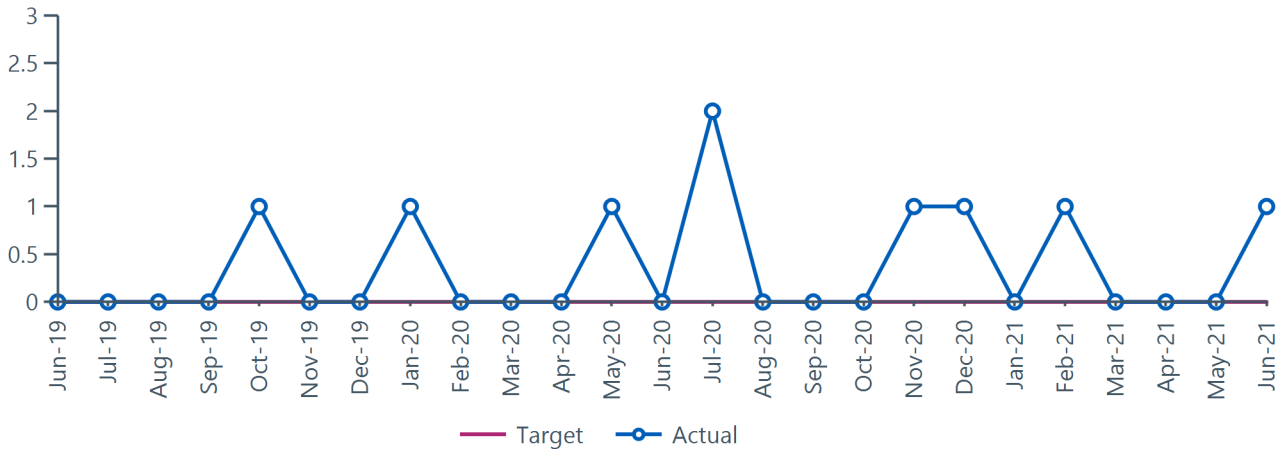
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	1030	831	825	N/A to SPC	Moving Target	+	24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	73.27%			F	+	05/09/19
Total Outpatient Activity	17036	13842	14078	N/A to SPC	Moving Target	+	24/06/21
H1 Plan Performance	261.59	576.00	565.00	N/A to SPC	Moving Target		
Income	9736	9981	10095	N/A to SPC	Moving Target		
Expenditure	9520	9451	9529	N/A to SPC	Moving Target		
Efficiency Delivered	94	228	220	N/A to SPC	Moving Target		
Cash Balance	16,093.98	17,314.00	20,733.84	N/A to SPC	Moving Target		
Capital Expenditure	667	232	579	N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	-204	-312	-297	N/A to SPC	Moving Target	+	

Serious Incidents

Number of Serious Incidents reported in month

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

There was one serious incident reported in June whereby a patient showed unexpected deterioration whilst having surgery.

Actions

The preliminary investigation is complete with some immediate actions put in place.

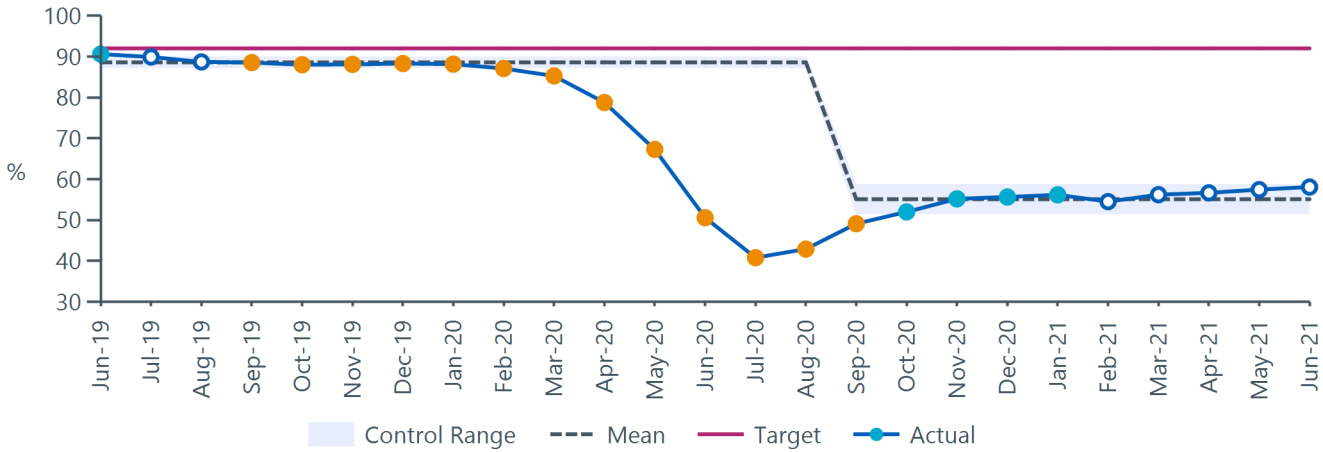
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
0	2	0	0	0	1	1	0	1	0	0	0	1

18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	58.10%		F



Trajectory/H1 Plan

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 June performance was 58.10% 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 - 7183 patients waiting of which 1639 are breaches, MS2 - 1092 patients waiting of which 615 are breaches, MS3 - 4317 patients waiting of which 3022 are breaches.

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

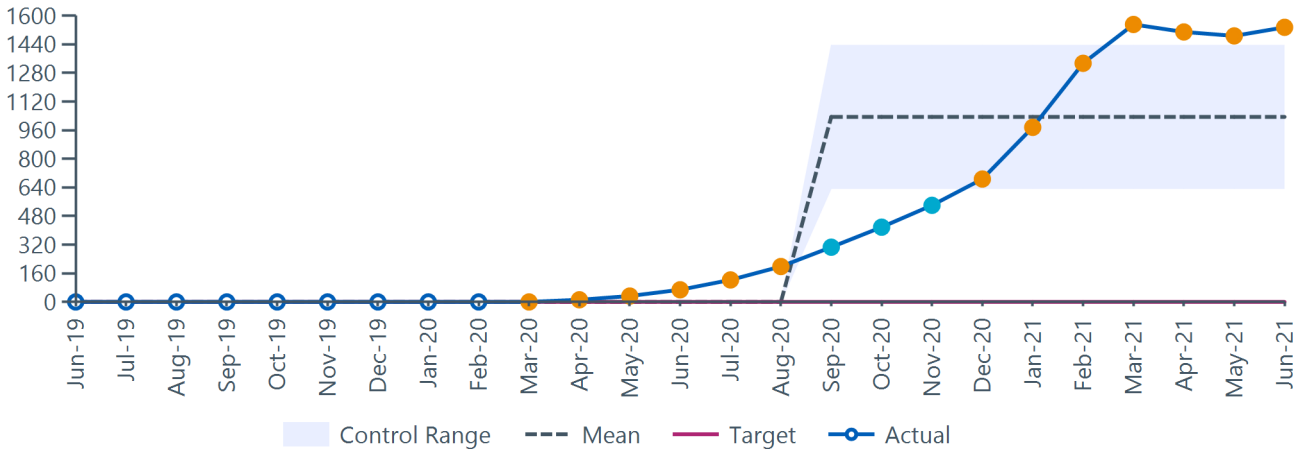
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
50.60%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	56.68%	57.46%	58.10%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1535	H	F



Trajectory/H1 Plan

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 June there were 1535 English patients waiting over 52 weeks; above our trajectory figure of 1425.

The patients are under the care of the following sub-specialities; Spinal Disorders (443), Arthroplasty (410), Knee & Sports Injuries (298), Upper Limb (227), Foot & Ankle (84), Spinal Injuries (43), Paediatric Orthopaedics (9), Tumour (8), Metabolic Medicine (8), Neurology (3) and Orthotics (2).

The number of patients waiting, by weeks brackets is:
- >52 to <=60 weeks - 317 patients
- >60 to <=70 weeks - 416 patients
- >70 weeks to <=80 weeks - 480 patients
- >80 weeks to <=90 weeks - 222 patients
- >90 weeks to <=104 weeks - 78 patients
- >104 weeks - 22 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks. We are progressing our plans to date the longest waiting patients and expect to see the outcomes of this towards the end of quarter 2.

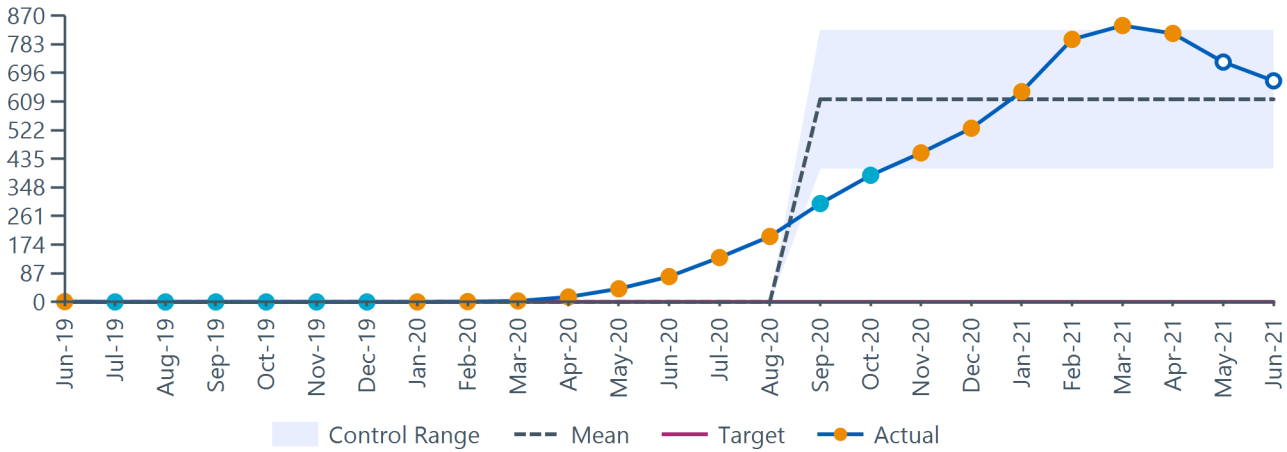
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
68	123	198	306	418	540	687	976	1334	1551	1509	1487	1535

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients waiting 52 weeks or more at month end

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	672		F



Trajectory/H1 Plan

What these graphs are telling us

Metric is experiencing common cause variation. 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 June there were 672 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (325), Arthroplasty (137), Knee & Sports Injuries (80), Upper Limb (64), Foot & Ankle (39), Spinal Injuries (12), Paediatric Orthopaedics (7), Tumour (5) and Neurology (3). The patients are under the care of the following commissioners; BCU (381), Powys (278), Hywel Dda (10), Aneurin Bevan (2) and Cardiff & Vale (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=60 weeks - 83 patients
- >60 to <=70 weeks - 190 patients
- >70 weeks to <=80 weeks - 181 patients
- >80 weeks to <=90 weeks - 113 patients
- >90 weeks to <=104 weeks - 88 patients
- >104 weeks - 17 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks. We are progressing our plans to date the longest waiting patients and expect to see the outcomes of this towards the end of quarter 2.

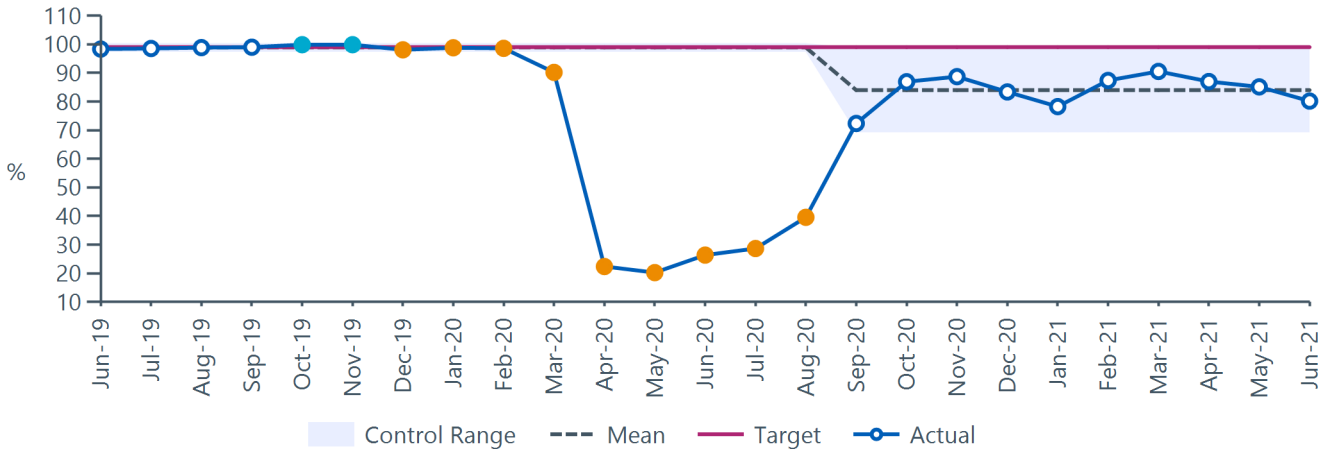
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
77	135	199	299	385	453	528	639	798	840	816	729	672

6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	80.17%		F



Trajectory/H1 Plan

What these graphs are telling us

Metric is experiencing common cause variation. 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 80.17%. This equates to 212 patients who waited beyond 6 weeks, all within the MRI modality. Of the 212 waiting, 203 are dated.

It must be noted that there were no CT breaches this month; the first time there haven't been any CT breaches since before COVID-19. It is also the second month there have been no ultrasound breaches since before COVID-19.

Actions

- Continuation of extended working hours and weekend working.
- International recruitment of Radiographers is underway and taking into account a lead-time improvements are expected by the end of quarter 2.
- Continue to monitor the demand for MRI's.
- Assess options and costs to increase MRI activity.

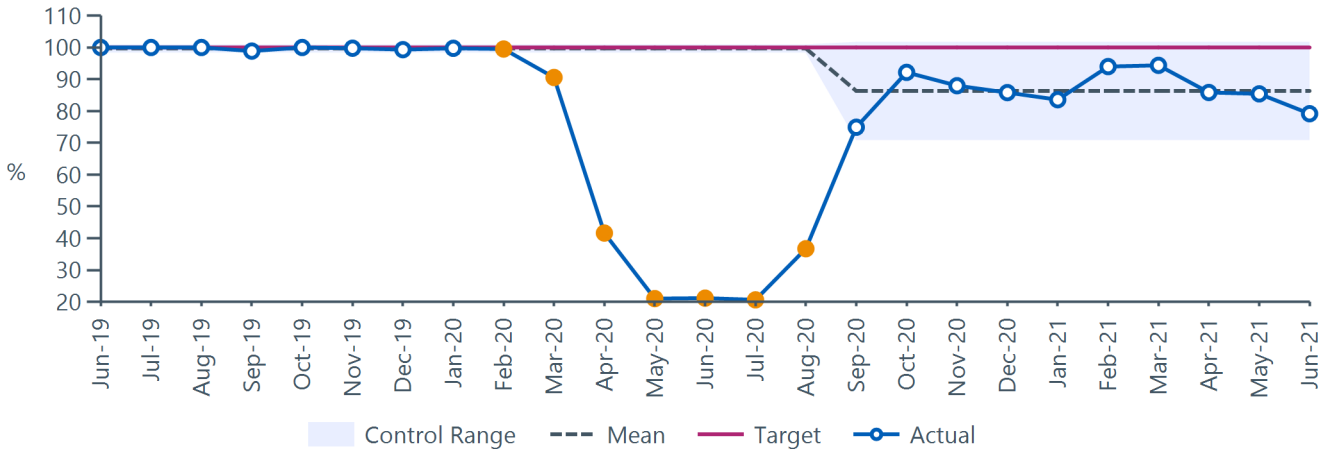
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
26.36%	28.66%	39.56%	72.35%	86.92%	88.70%	83.37%	78.24%	87.38%	90.53%	86.99%	85.13%	80.17%

8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	79.18%		



Trajectory/H1 Plan

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).

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 79.18%. This equates to 107 patients who waited beyond 8 weeks, all within the MRI modality. Of the 107 patients waiting, 105 are dated.

Actions

- Continuation of extended working hours and weekend working.
- International recruitment of Radiographers is underway and taking into account a lead-time improvements are expected by the end of quarter 2.
- Continue to monitor the demand for MRI's.
- Assess options and costs to increase MRI activity.

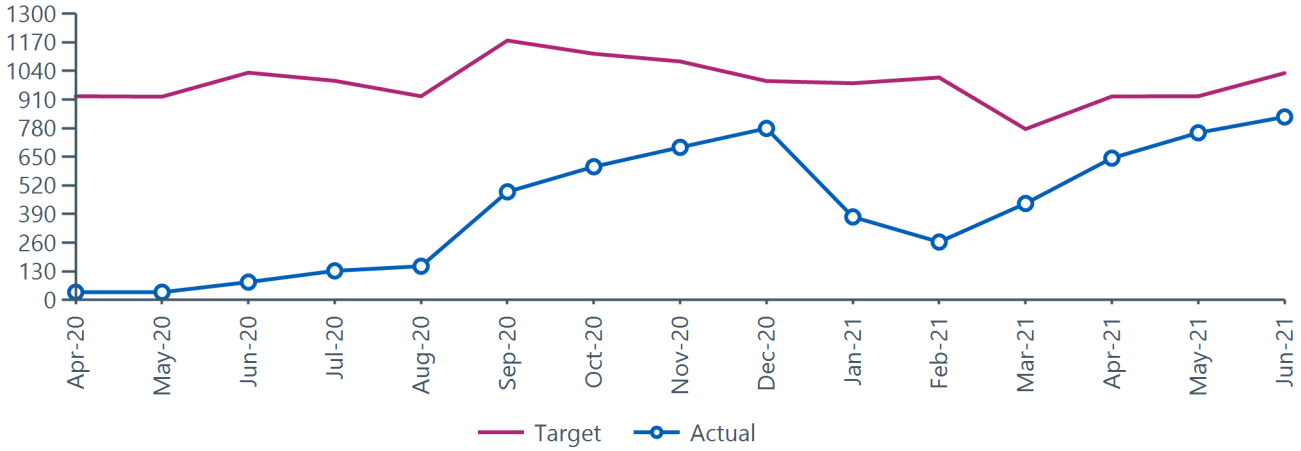
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
21%	20%	36%	74%	92%	87%	85%	83%	94%	94%	85%	85%	79%

Total Elective Activity

All elective activity in month rated against 19/20 baseline activity adjusted for working days and the impact of Covid-19

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
1030	831	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Following guidance from NHS EI we have updated the SPC graphs throughout the IPR 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. To recognise all elective work following the impact of COVID-19 , this new committee measure was added in 21/22. With the impacted months now excluded from the control range calculations on relevant KPIs throughout the IPR, this now leaves this measure without enough data points for robust reporting in SPC, so this measure is now displayed as a line graph.

Narrative

Total elective activity undertaken in June was 831 against the latest target of 1030; this is above the trajectory for June of 825. The trajectory figures are from our H1 planning resubmission and are represented in the trajectory line above. The actual achieved against the target 19/20 baseline figure is 80.68%. The June target, as set by NHS EI, was to meet 80% of baseline 19/20 activity.

This measure has not hit the monthly target since changes to work practises and environment were implemented in response to Covid-19. Activity was lost because of staff requirement to self-isolate equating to 7 patients being cancelled for this reason in June. This may be a recurring theme in the coming months. There has been considerable monthly variation since April 2020 causing the process limits to widen.

Although the Total Elective Activity plan was not met, it should be noted that the trajectory was exceeded whilst the Trust was undertaking urgent clinical activity based on clinical priority.

Actions

The Trust has submitted revised H1 plans for the highest possible levels of activity across elective services, which maximise physical and workforce capacity, prioritise the most urgent patients, incorporate clinically led reviews and validation of the waiting list, maintain effective communication with patients, address the longest waiters and addresses health inequalities, and safeguards the health and wellbeing of staff.

The Trust is aligning its demand and capacity in line with the expectations of the H1 plan.

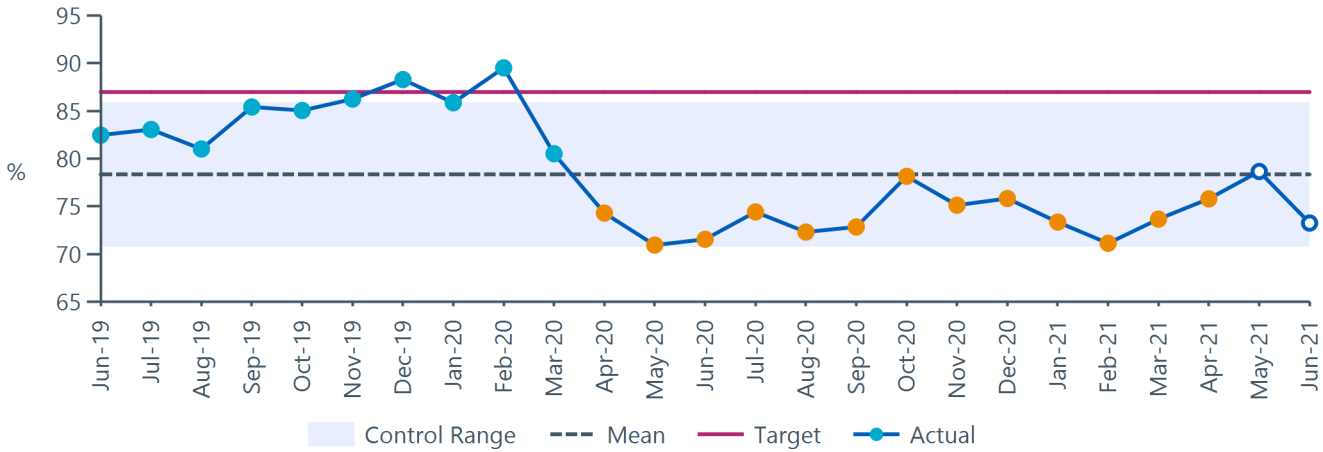
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
81	132	153	491	605	693	779	377	263	438	644	759	831

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	73.27%		F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 73.27% for June. The breakdown below gives the June occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:

MSK Unit:
- Clwyd - 65.26% - compliment of 22 beds open throughout month
- Powys - 72.43% - compliment of 22 beds open throughout month
- Kenyon - 51.20% - Ward reopened this month for part of each week with 12 beds
- Ludlow - 71.75% - compliment of 15 beds open throughout month

Specialist Unit:
- Alice - 36.82% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 69.55% - compliment of 10 beds open throughout month
- Gladstone - 89.31% - compliment of 29 beds open throughout month
- Wrekin - 89.01% - compliment of 15 beds open throughout month
- Sheldon - 74.82% - compliment of 20 beds open throughout month

Actions

A refreshed bed modelling tool is under development that will remove the reliance on historical data. It is anticipated that the tool will be available in quarter 2.

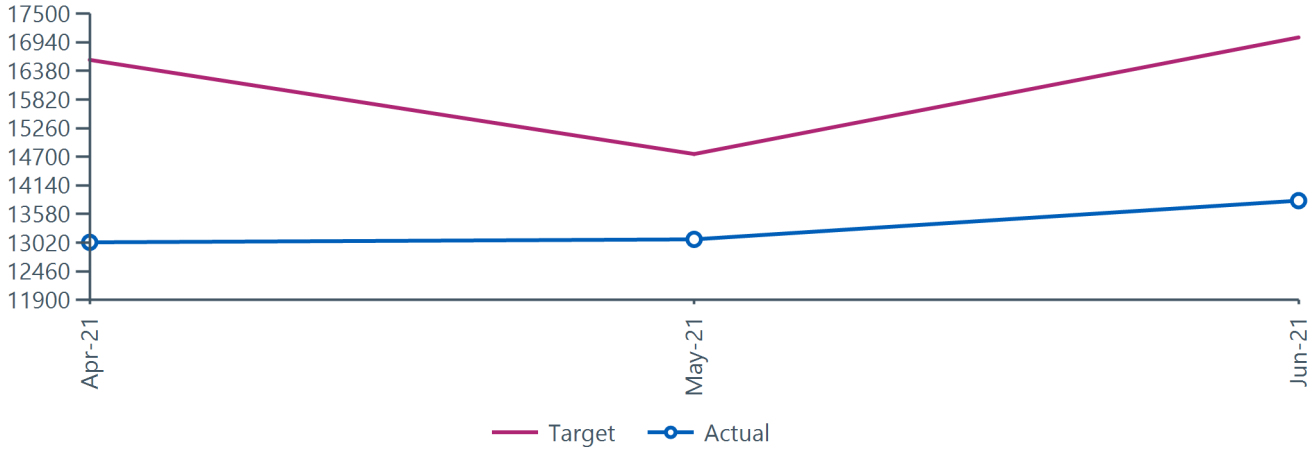
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.68%	75.81%	78.67%	73.27%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H1), Catchment Based)

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
17036	13842	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Currently this measure is not appropriate to display as SPC. Analysis will improve as more data points are added. It is recommended that 15+ data points are required for robust analysis. This measure has a moving target.

Narrative

This measure aligns with the NHS E/I inclusions and exclusions for restoration monitoring, effectively monitoring consultant-led activity, non consultant-led and unmatched/unbundled activity. The target for this measure is the 2019/20 baseline activity that was delivered, with the H1 plan included as a trajectory in the trajectory graph.
In June the total Outpatient activity undertaken in the Trust was 13842; 236 cases below our H1 plan. This is broken down as follows:
- Consultant led - 95.09% (11181 against target of 11758)
- Non consultant-led - 113.98% (1639 against target of 1438)
- Unbundled/unmatched - 115.87% (1022 against target of 882)

Outpatient activity was lost because of staff requirement to self-isolate equating to 10 clinic patients and 6 pre-op patients being cancelled for this reason in June. This may be a recurring theme in the coming months.
As at 7th July (5th working day) there were 687 missing outcomes so once administrative actions are taken with these data entries, the June position will alter. Taking into account the missing outcomes, this would mean that the Outpatient activity for June was 14529, 451 above our H1 plan of 14078. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

Investigations will be undertaken to understand the reasons why the number of missing outcomes was so high at the point the data was taken on 5th working day. It must be noted that the levels of outpatient activity delivered in June maximised the use of IJP as we did not utilise the planned levels of OJP that had been anticipated for June.

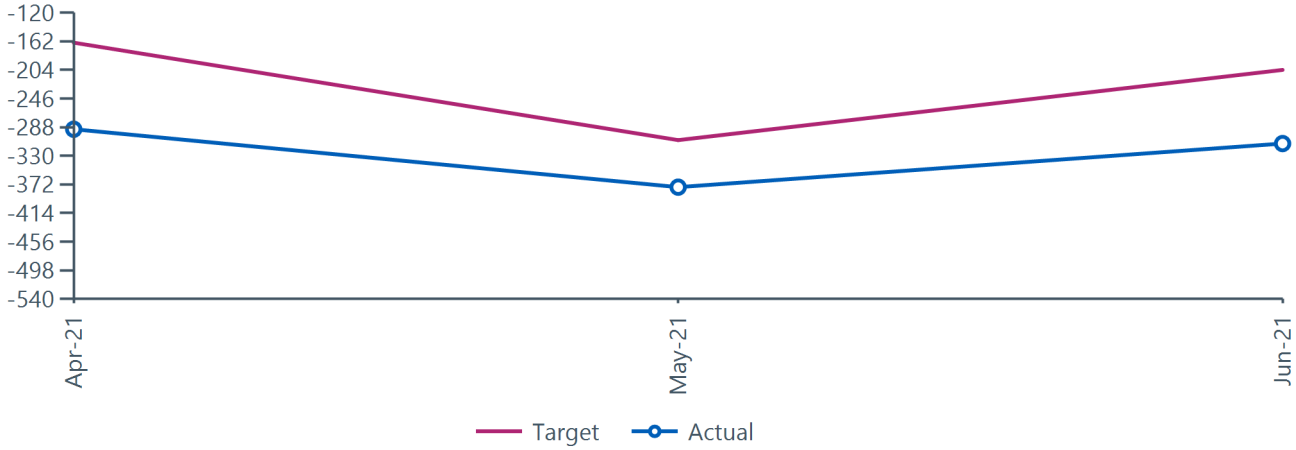
Apr-21	May-21	Jun-21
13027	13085	13842

Recurrent Financial Performance (Sustainability Plan)

Surplus/deficit normalised to represent the recurrent financial position under the intelligent fixed payment system

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
-204	-312	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Narrative

£108k adverse variance in month against the sustainability plan, £304k adverse ytd. Mainly driven by efficiency phasing (2% delivered against a 3% requirement for the sustainability plan)

Actions

Apr-21	May-21	Jun-21
-291	-376	-312

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th June 2021

Performance Against H1 Plan £'000s

Category	H1 Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	49,144	8,089	8,038	(51)	24,233	24,534	301
System Top Up Funding	2,560	427	449	23	1,280	1,303	23
Non NHS income support	878	120	120	0	518	518	0
Covid-19 Funding	1,452	242	242	0	726	726	0
Private Patient income	1,877	363	663	300	1,025	1,613	588
Other income	2,973	495	468	(27)	1,461	1,350	(111)
Pay	(34,334)	(5,689)	(5,651)	38	(16,985)	(16,842)	143
Non-pay	(19,681)	(3,276)	(3,248)	29	(9,371)	(9,671)	(300)
EBITDA	4,869	771	1,082	311	2,887	3,529	642
Finance Costs	(3,326)	(554)	(553)	1	(1,663)	(1,659)	4
Capital Donations	1,740	255	0	(255)	525	115	(410)
Operational Surplus	3,283	472	529	57	1,749	1,985	236
Remove Capital Donations	(1,740)	(255)	0	255	(525)	(115)	410
Add Back Donated Dep'n	269	45	47	2	134	140	6
Control Total	1,811	262	576	314	1,358	2,010	652
EBITDA margin	8.6%	8.2%	11.3%	3.0%	10.3%	12.3%	1.9%

Statement of Financial Position £'000s

Category	May-21	Jun-21	Movement	Drivers
Fixed Assets	79,397	79,235	(162)	Additions less depreciation
Non current receivables	1,194	1,312	118	
Total Non Current Assets	80,591	80,547	(44)	
Inventories (Stocks)	1,321	1,351	30	
Receivables (Debtors)	8,942	9,370	428	Increase linked to non NHS income performance
Cash at Bank and in hand	16,986	17,314	328	
Total Current Assets	27,249	28,034	785	
Payables (Creditors)	(15,454)	(15,517)	(63)	
Borrowings	(1,444)	(1,451)	(7)	
Current Provisions	(707)	(697)	10	
Total Current Liabilities (< 1 year)	(17,605)	(17,665)	(60)	
Total Assets less Current Liabilities	90,235	90,916	681	
Non Current Borrowings	(4,349)	(4,500)	(151)	Final Salix loan receipt
Non Current Provisions	(987)	(988)	(1)	
Non Current Liabilities (> 1 year)	(5,336)	(5,488)	(152)	
Total Assets Employed	84,899	85,428	529	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,397)	(22,397)	0	
Revenue Position	(1,456)	(1,985)	(529)	Current period surplus
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(84,899)	(85,428)	(529)	

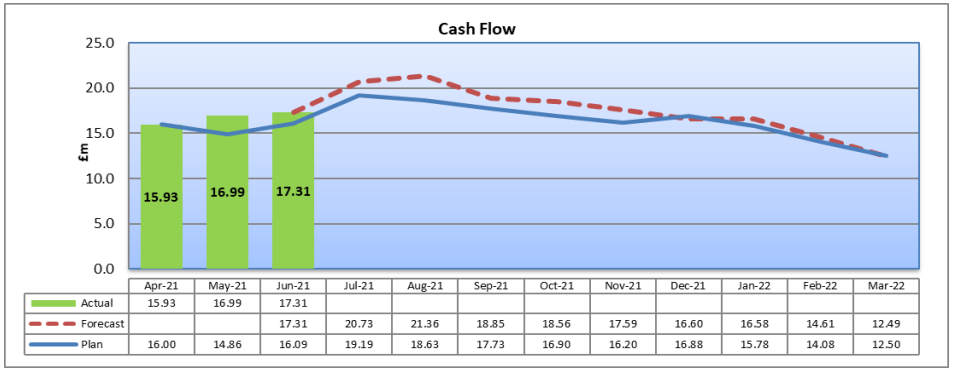
Sustainability (Recurrent) Plan 2021/22

Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,542	8,534	(8)	25,625	25,625	(0)
Private Patient income	469	469	0	1,440	1,441	1
Other income	525	519	(6)	1,580	1,561	(19)
Pay	(5,895)	(5,920)	(25)	(17,689)	(17,765)	(76)
Non-pay	(3,327)	(3,407)	(80)	(10,080)	(10,321)	(242)
EBITDA	314	195	(119)	877	541	(336)
Finance Costs	(562)	(553)	8.97	(1,686)	(1,659)	26
Capital Donations	255	0	(255)	742	115	(626)
Operational Surplus	7	(358)	(365)	(67)	(1,003)	(936)
Remove Capital Donations	(255)	0	255	(742)	(115)	626
Add Back Donated Dep'n	45	47	2	134	140	6
Control Total	(204)	(312)	(108)	(674)	(978)	(304)

Draft Finance Metrics (New Single Oversight Framework)

Performance against Financial Plan		Underlying financial plan	
Expenditure run rate		Overall trend in reported financial position	

	YTD
Debtor Days	29
Creditor Days	34

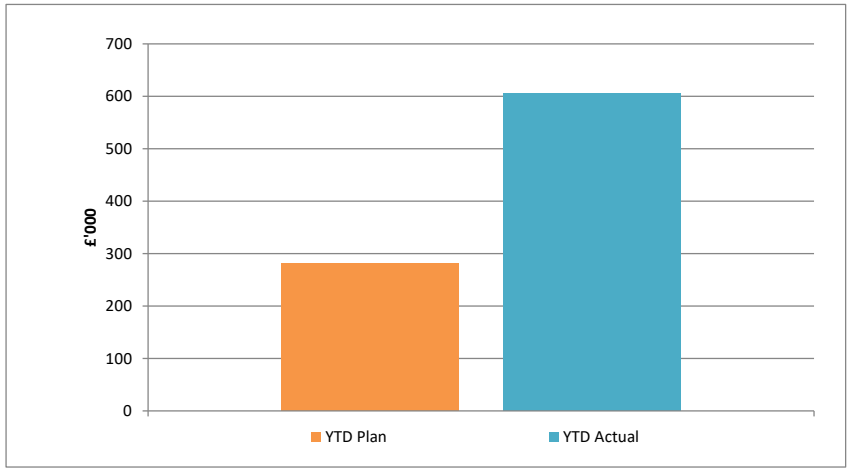


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	15.93	16.99	17.31									
Forecast			17.31	20.73	21.36	18.85	18.56	17.59	16.60	16.58	14.61	12.49
Plan	16.00	14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.50

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th June 2021

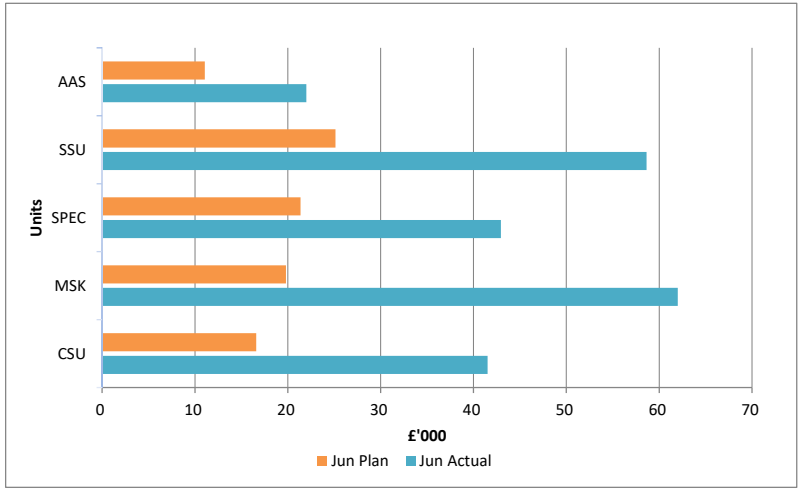
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



In Month Efficiencies

In Month Efficiencies Achievement £000's



Capital

Position as at	2122-03	Capital Programme 2021-22						
Project	**Annual Plan £000s**	**In Month Plan £000s**	**In Month Completed £000s**	**In Month Variance £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**	**Forecast Outturn**
Backlog maintenance	600	63	78	-15	94	88	6	600
I/T investment & replacement	300	40	0	40	40	0	40	300
Capital project management	100	9	10	-1	25	29	-4	100
Equipment replacement	500	50	0	50	50	0	50	500
Diagnostic equipment replacement	1,701	200	5	195	400	91	309	1,701
Diagnostic equipment replacement PDC	99	0	0	0	0	0	0	99
Contingency	500	50	18	32	100	29	71	500
EPR planning & implementation	2,000	0	0	0	0	0	0	2,000
Invest to save	200	0	0	0	0	0	0	200
Donated medical equipment	200	25	0	25	125	111	14	200
Veterans' centre	4,500	230	121	109	400	126	274	4,500
Total Capital Funding	10,700	667	232	435	1,234	473	761	10,700
Donated medical equipment	-200	-25	0	-25	-125	-111	-14	-200
Veteran's facility	-4,500	-230	-121	-109	-400	-126	-274	-4,500
Capital Funding (NHS only)	6,000	412	111	301	709	236	473	6,000

Forecast

Category	Forecast			
	Plan	Actual	Variance	Notes
Clinical Income	49,144	49,468	324	Overperformance driven by pass through drugs ERF rule changes put £0.7m of income at risk Included in forecast as required by regional guidance for M3
CCG Growth Funding	2,561	2,561	0	
System Top up Funding	878	878	0	
Covid-19 Funding	1,452	1,452	0	
Private Patient income	1,877	2,886	1,009	YTD Overperformance £588k , M4 forecast 48 cases above plan
Other income	2,973	2,732	(240)	Continued shortfalls for Denbighs, Car parking & Research
Pay	(34,334)	(34,068)	266	Covid underspends
Non-pay	(19,681)	(20,056)	(376)	Pass through drugs & PP Implants offset by Covid underspends
EBITDA	4,870	5,851	982	
Finance Costs	(3,328)	(3,324)	4	
Capital Donations	1,740	1,330	(410)	
Operational Surplus	3,282	3,857	576	
Remove Capital Donations	(1,740)	(1,330)	410	
Add Back Donated Dep'n	269	275	6	
Control Total	1,811	2,802	991	

Caring for Patients — OBJ 1

Principal Objective: Deliver the work to restart elective services

This objective can be broken down into four key components, developing and delivering an activity plan, management of the patient waiting backlog, full implementation of clinical prioritisation and harms review processes and sustaining clinical outcomes.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Modelling plan delivered to the Board
- ✓ Response to planning requirements beyond half year
- ✓ Accurate patient waiting data
- ✓ Minimisation of patients waiting over 52 weeks
- ✓ NJR outcomes
- ✓ PROMs
- ✓ KPI delivery within IPR
- ✓ GIRFT reviews
- ✓ Model hospital data top quartile performance for orthopaedic pathways
- ✓ Participation in National Clinical Improvement Programme
- ✓ Report on leadership arrangements for delayed discharges
- ✓ Number of delayed discharges (without mitigations)

Supporting Programmes of Work:

- Delayed discharge leadership review
- National Clinical Improvement Programme roll out
- System clinical prioritisation programme
- Outpatients Transformation Programme
- Delayed discharges improvement plan
- Midlands Elective Delivery Programme

Lead Director:

Chief Executive

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Progress Update:

As at M3 theatre activity and outpatient activity were falling short of the 19/20 baseline but were over achieving against the regulatory target of 80% at 84.58% for elective activity and 81.25% for outpatient activity. Virtual activity did not meet the 25% target and reported at 18.22%. MRI activity fell short of the baseline target achieving 91.52% and 99.51% of H1 plan.

The patient waiting backlog is being monitored through the Finance Planning and Digital Committee this includes the monitoring of wait list size, clinical prioritisation groups, waiting time, referral rates. There is weekly reporting to SLG in place with regional benchmarking considered.

Patients are managed in order of clinical priority. In April we implemented that no patient should wait over 104 weeks, initially clearance of those that have waited this period of time will take place and then ensure no more patients trip over this timeline. Weekly reporting of 104 week waiters.

Harms process reported monthly to the Harms Group and Q&S Committee.

Risks:

BAF1.1	Insufficient core capacity to meet demand
BAF 1.2	Potential for increased harm to patients as waiting times increase
BAF 1.3	Inability to benchmark outcomes across all specialties

Lead Committee:

Finance Planning and Digital Committee / ~~Restart Recovery and Renewal Committee /~~ Quality and Safety Committee

BAF 1.1 Accelerate the work to restore patients cared for to pre Covid levels — OBJ 1

Principal Risk: Insufficient core capacity to meet demand

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

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

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

Assurance: Source of Assurance 3

- ✓ Monthly Performance Improvement Board oversight
- ✓ Inpatient Survey Performance
- ✓ System and regulatory oversight
- ✓ Internal audit regarding job planning
- ✓ Patient Experience Committee oversight
- ✓ Restart, Recovery & Renewal Sub-Committee Oversight
- ✓ Outpatient Transformation Board restored
- ✓ System Governance Framework

Gaps In Controls:

- C1: Lack of line of sight on system demand and capacity requirements
- C2: Potential for Gaps in job planning and governance processes to ensure full capacity utilised
- C3: Clear leadership for discharge planning
- C4: Impact on capacity of increasing complexity of cases due to increased waiting times

Gaps in Assurance:

- A2: Patient Experience Strategy overdue for review

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Collaboration with system on demand and capacity requirements	Chief Executive	~~Nov 20~~ Mar 21	System now operating with one P2 elective orthopaedic waiting list overseen by RJAH, the system has a coordinated approach to treatment by this clinical priority overseen by the Clinical Chair for MSK and a group of senior consultants - Completed
C1	Development of a system orthopaedic PTL	Director of Performance	Sep 21	CSU have been contracted to deliver this piece of work
C2	Project plan to address recommendations from job planning internal audit to be taken to completion	Chief of People	~~Mar 21~~ May 21	Actions completed and further audit review conducted, final report awaited - action complete
C3	Review of leadership for discharge planning with clear escalation structure to be articulated and actioned	Chief Nurse	Jul 21	

C4	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	Jul 21	
A2	Review of Patient Experience Strategy	Chief Nurse	~~Dec 20~~ ~~Mar 21~~ ~~Apr 21~~ Aug 21	Engagement workshops held – draft strategy going to Patient Experience Committee in April, further refinements needed and to Patient Experience Committee in July
C2	Await further audit report on job planning and implement recommendations	Chief of People	Oct 21	

BAF 1.2 Accelerate the work to restore patients cared for to pre Covid levels — OBJ 1

Principal Risk Potential for increased harm to patients as waiting times increase

As a result of national clinical prioritisation criteria and social distancing requirements there is potential for patients to wait longer and they are therefore exposed to the risk of harm, potentially resulting in poorer outcomes or more extensive procedures being required.

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Harms review process in place
- ✓ Following national NHS clinical prioritisation guidance
- ✓ Communication with patients regarding the current situation
- ✓ Access Policy in place
- ✓ Patient quality and safety monitoring via KPIs
- ✓ PROMs reporting in place
- ✓ Waiting time reporting in place

Assurance: Source of Assurance 2-3

- ✓ Patient Harms Group, Patient Safety Committee and Quality and Safety Committee to provide oversight of Harms Process
- ✓ Weekly reporting to SLG on 104 week waiters
- ✓ Regional benchmarking

Gaps In Controls:

- ~~C1: Process for managing Harms Reviews within Units~~
- ~~C3: Robust follow up back log process~~
- ~~C4: Local clinical prioritisation process not documented and approved through Trust governance routes~~

Gaps in Assurance:

- A2: Key metrics and reporting of Harms Reviews to be established and embedded

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Harms review reporting to be incorporated into Unit Governance Meetings	Chief Nurse and Trust Secretary / Director of Governance	~~Dec 20~~ ~~Jan 21~~ Apr 21	Harms Group established with regular reporting by Unit– audit of harms reviews completed, regular reporting to Q&S, Unit level trackers in place - Completed
C3	Review of follow up backlog management	Managing Director for Clinical Support Services	~~Dec 20~~ Feb 21	Patient initiated follow up introduced, data validation exercise underway for follow up backlog with new validators in past and trained up - completed
C4	Local clinical prioritisation process to be documented	MD for MSK	May 21	Completed
A2	Assurance reporting on Harms Reviews to be embedded with improvement in compliance	MD for Clinical Support Services and MD for Specialist Services	Sept 21	

BAF 1.3 Deliver the work to restart elective services — OBJ 1

Principal Risk Inability to benchmark outcomes across all specialties

Potential delay in identifying quality issues and outlying performance resulting in missed opportunities for improvement and poorer patient outcomes.

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Patient quality and safety monitoring via KPIs
- ✓ Monitoring of other outcome based indicators such as infections, readmissions etc
- ✓ GIRFT recommendations implemented

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

- ✓ Clinical Effectiveness Committee Oversight
- ✓ Proms and NJR results
- ✓ GIRFT reviews

Gaps In Controls:

- C1: Specialty level quality dashboards not available across all disciplines

Gaps in Assurance:

- A1: Benchmarking tools not available across all specialties
- A2: Clinical Effectiveness Committee is new and not yet embedded
- A3: Ability to benchmark outcomes in the post-Covid period against pre-Covid treatment and care

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Speciality level quality dashboards to be rolled out for every specialty	Chief Nurse and Trust Secretary / Director of Governance	Aug 21	Rollout has commenced with some dashboards now available, plan being devised to standardise the format and complete the rollout.
A1	Rollout of NCIP	Chief Medical Officer	Aug 21	Demonstration and launch to clinical body completed. IG considerations have been signed off
A2	Clinical Effectiveness Committee to be embedded	Chief Medical Officer	Aug 21	Terms of reference and work plan reviewed, meetings taking place

Caring for Patients — OBJ 2

Principal Objective: Maintain high infection control standards to support the restoration of activity

This objective will focus on minimising zero nosocomial infections with a focus on prevention and learning and ensuring that new or revised infection prevention and control guidance is implemented

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Key Measures:

- ✓ Number of outbreaks
- ✓ Compliance with the IPC Board Assurance Framework
- ✓ Audit programme in place with % measures of compliance and regular reporting via the IPC Committee
- ✓ Quarterly report to Quality and Safety Committee

Progress Update:

No outbreaks reported in Q1 and focus continues on the infection preventions and control assurance framework. There is enhanced resource within the IPC team to ensure timely response to emerging guidance.

Supporting Programmes of Work:

- IPC work plan
- Estates programme
- HSE Inspection Document – implementation of findings

Risks:

BAF 2.1	Inability to respond quickly enough to rapidly changing infection control national guidance
BAF 2.2	Inability to align the capital programme with the quickly changing operating environment and funding movements

New risk to be added in relation to impact of changing government restrictions on staff and patient compliance

Lead Director:

Chief Nurse and Patient Safety Officer

Lead Committee:

Quality and Safety Committee and Finance Planning and Digital Committee

BAF 2.1 Maintain high infection control standards to support the restoration of activity — OBJ 2

Principal Risk: Inability to respond quickly enough to rapidly changing infection control national guidance

Potential for non-compliance resulting in risks to staff and patient safety. Inability to maintain an up to date suite of policies for use in the organisation and staff engagement with new policies.

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ IPC Board assurance framework in place and has been revised in January 2021
- ✓ Policy Committee in place to facilitate prompt ratification of changes to policy
- ✓ System and Regional IPC networks in place with RJAH engagement
- ✓ Lateral flow testing being rolled out and robust staff Covid reporting and testing in place
- ✓ New Covid Infection Control Policy in place
- ✓ IPC Governance Lead established

Assurance: Source of Assurance 3

- ✓ Oversight from Infection Control Committee which reports to Q&S Committee
- ✓ Recent CQC review of IPC BAF
- ✓ Flu Working Group chaired by DIPC
- ✓ H&S Committee oversight

Gaps In Controls:

- ~~C1: H&S resource and capacity constraints to input into risk assessments~~

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Review of H&S resource and capacity requirements with recommendation to SLG for resource solution	Chief Nurse and Patient Safety Officer	~~Nov 20~~ ~~Feb 21~~ ~~Mar 21~~ May 21	Review has been undertaken with initial agreement to increase resource whilst system options considered – further meeting held to discuss resource scheduled in March and additional support from Governance Team to be outlined - Completed

BAF 2.2 Maintain high infection control standards to support the restoration of activity — OBJ 2

Principal Risk: Inability to align the capital programme with the quickly changing operating environment and funding movements

The operating environment is changing quickly to respond to developments with the Covid pandemic and changing infection control guidance and requirements and this has potential to impact on the Trust's capital requirements to support restoration. There is system prioritised restoration and backlog funding and the allocation of this is not yet determined which leaves uncertainty and potential for the Trust to have a shortfall or for there to be a limitation of the capital programme which in turn may impact on restoration.

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Capital Management Group in place
- ✓ Revised capital programme
- ✓ Scenario planning
- ✓ Bed capacity scheme identified to support restoration
- ✓ System capital delegated limit in place

Assurance: Source of Assurance 3

- ✓ ~~Restoration~~ Restart, Recovery & Renewal Sub-Committee and Finance Planning and Digital Committee Oversight
- ✓ Regulatory and System oversight

Gaps In Controls:

- ~~C2: System funding and timings to be confirmed~~

Gaps in Assurance:

- ~~A1: Full monitoring and assurance cannot be achieved until allocation is known~~

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C2, A1	Ongoing discussions within the system regarding capital funding	Chief of Finance	Ongoing	System funding has been agreed - completed

Caring for Patients — OBJ 3

Principal Objective: Play an active part in the wider healthcare system

This objective will focus on seeking delivery of an ambition to operate as one orthopaedic system for the ICS, playing an active part in the ICS Board and ICS Committee arrangements and supporting, and where appropriate, leading the mobilisation of the STW MSK ~~Alliance~~Transformation

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Attendance at ICS meetings
- ✓ RJAH plan which supports the system plan
- ✓ Single orthopaedic system proposal
- ✓ Reporting to Board on STW MSK ~~Alliance~~Transformation

Supporting Programmes of Work:

- System winter planning
- System Governance Framework
- Programme plans for system restoration
- Midlands Elective Delivery Programme
- System planning submission

Lead Director:

Chief of Performance, Improvement & OD and Chief Nurse and Patient Safety Officer

Objective Details:

Opened: April 2021

Reviewed Date:

Progress Update:

The resetting of STW MSK Transformation programme has taken place, with year one of the programme identifying decision for one orthopaedic system in Q4. A system orthopaedic PTL is in development, with a P2 PTL already operational.

RJAH is represented at all committees of the ICS together with the following delivery groups; Planned Care Operational Delivery Board, Acute capacity and demand group, clinical reference priority group, people programme board, hospital transformation programme board and other operational meetings as appropriate

Risks:

BAF 3.1 Management capacity inhibits engagement with the ICS

Following discussion at the Joint Audit and Risk Management Committee a further risk is being worked up in relation to the potential for conflicting governance between the Trust as a statutory organisation and the ICS and the impact of this on engagement

Lead Committee:

Finance Planning and Digital Committee ~~and Restart, Recovery & Renewal Sub~~ Committee

BAF 3.1 Play an active part in the wider healthcare system — OBJ 3

Principle Risk: Management capacity inhibits engagement

Senior management capacity is impacted as a result of carrying out dual roles at local and system level resulting in reduced pace / decision making, conflicting priorities

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Regular CEO forum
- ✓ Regular updates at Senior Leadership Group
- ✓ Chair reports from HTP, MSK Transformation received

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

- ✓ Oversight from Shadow ICS Board
- ✓ CEO Forum oversight
- ✓ ICS Governance Framework in place with identified membership for committees

Gaps In Controls:

- ~~C1: Lack of line of sight on the operational meeting structure to ensure removal of duplication~~
- C2: Absence of a system performance framework
- C3: NHSEI Single oversight framework yet to be published

Gaps in Assurance:

- A1: ICS Governance Framework in its infancy
- ~~A2: ICS line of sight on Committee terms of reference and work~~

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Operational meeting structure being developed and to be shared with SLG	Chief Executive / Trust Secretary	May 21	Completed
A1	ICS Governance Framework to be embedded and linked in with Trust's own governance	Chief Executive / Trust Secretary	May 21	Chairs reports produced to now be submitted to RJAH committees going forward - completed
A2	ICS Board to approve terms of reference / receive Chair's reports	Chief Executive / Trust Secretary	May 21	Completed
C2	ICS Performance framework in development, once consulted will be shared with SLG	Chief of Performance	Aug 21	Draft proposal has been shared with SLG on 20 July and final framework expected in line with due date
C3	SoF consultation closed, expect publication in July, will be shared with BoD	Chief of Performance	~~Jul 21~~ Sept 21	Paper drafting in progress to be shared at next Board

Caring for Patients — OBJ 4

Principal Objective: Continuously improve the delivery of services

This objective will focus on commencing the work to deliver the Headley Court Veteran's Centre, specifying a microbiology service to support the work on infection control, preparing and (if commissioned) delivering the MDT knee revision service, deliver the next stages of the business case for the new EPR, introduction of the 'Perfect Ward' and ensuring stable and effective EPRR arrangements

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Key Measures:

- ✓ Delivery of the veteran's service to time and budget
- ✓ Production of the microbiology service specification in 2021/22
- ✓ Reporting on the MDT knee revision service
- ✓ Specified stages of the EPR Business case and delivery of these
- ✓ Project plan for the Perfect Ward with full roll out by November 2021
- ✓ Delivery of actions from the 2021 review into EPRR

Progress Update:

Veteran's Centre on track and work on microbiology service ongoing. EPR Business Case progressing and being taken through Finance Digital and Planning Committee. Perfect Ward has been established. EPRR arrangements have been reviewed and recommendations taken forward.

Supporting Programmes of Work:

- Business continuity planning
- EPRR exercise programme

Risks:

BAF 4.1 — Lack of designated EPRR resource

Lead Director:

Chief Nurse and Patient Safety Officer and Chief Medical Officer

Lead Committee:

Risk Management Committee

BAF 4.1 Maintain emergency responsiveness — OBJ 4

Principle Risk: Lack of designated EPRR resource

Potential inability to provide a co-ordinated response to an interruption in service, lack of clarity around ownership and responsibilities and the required capability and expertise.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	2 ↓	2
Total	20	8 ↓	6

Risk Details:

Opened: November 2020

Reviewed Date: May 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ EPRR procedures and business continuity plans in place
- ✓ Tried and tested command and control structure
- ✓ Agreements in place across the system for mutual aid
- ✓ EPRR exercise programme
- ✓ National co-ordination of Covid pandemic

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

- ✓ Risk Management Committee oversight
- ✓ Compliance with EPRR Core Standards – substantial assurance for 19/20 submission
- ✓ NHSI/E oversight
- ✓ CSU Review of EPRR arrangements

Gaps In Controls:

- ~~C1: Variation of EPRR procedures across the system~~
- ~~C2: Lack of EPRR Lead and defined core team~~
- C3: Implementation of CSU recommendations to be completed

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
~~C1~~	~~Alignment of EPRR procedures across the system~~	~~Chief Nurse and Patient Safety Officer~~	~~Jan 21~~	~~Internal review of local EPRR procedures completed and recommendations approved at SLG~~
~~C2~~	~~EPRR role and requirements to be established with recommendation to SLG~~	~~Chief Nurse and Patient Safety Officer~~	~~Nov 20~~ ~~Feb 21~~	~~Internal review of local EPRR procedures completed and recommendations approved at SLG - completed~~
C3	Implementation of CSU recommendations	Chief Nurse and Patient Safety Officer	~~Jul 21~~ Sept 21	Implementation ongoing

Caring for Staff — OBJ 5

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

This objective will focus on delivering a recruitment plan and new staffing models established from the recovery modelling option, improving staff wellbeing, addressing any system inequalities staff may be experiencing, ensuring a safe and Covid secure environment, delivering the milestones set out in the nursing workforce strategy

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Staff survey results and sickness absence rates
- ✓ Board report on staff risk assessments
- ✓ Action plan to address any system inequalities
- ✓ All staff to have access to PPE and relevant training
- ✓ Recruitment of 15 IR nurses
- ✓ 0 HCSW vacancies
- ✓ Increase in student placements by 22
- ✓ First cohort of Nursing Associates
- ✓ Deliver an orthopaedic practice course

Supporting Programmes of Work:

- Task and finish groups
- Its Just Cricket (BAME) Network
- LGBTQ+ network
- Women's network
- Staff experience and improvement group
- Staff survey focus group
- Unit development sessions; Business Partner training & Operational Managers
- Schwartz rounds

Lead Director:

Chief of People and Chief Nurse and Patient Safety Officer

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Progress Update:

Our staff networks have been reinvigorated or established. IJC network in terms of addressing system inequalities are working to minimise the occurence of bullying, harassment and abuse and further work is planned on improvement of WRES metrics. The relaunch of our rainbow badge scheme is taking place with a week of events at the end of June.

The staff experience and improvement group have agreed a theme to base work upon of civility and respect. Schwartz rounds have been re-established. Staff survey focus groups are in progress.

Metrics on recruitment and retention looking good, wellbeing conversations being formalised, international recruitment on track, system people plan and local people plan on track

Risks:

BAF 5.1	Failure to improve staff engagement linked to communication between managers and the workforce
BAF 5.2	Potential inability to have the right workforce in the right place at the right time
BAF 5.3	Impact of Covid-19 on the workforce
BAF 5.4	Lack of designated ED& I resource and expertise

Lead Committee:

People Committee

BAF 5.1 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

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

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

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	2
Likelihood	4	3	2
Total	16	9	4

Risk Details:

Opened: April 2017

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ward / department budding with escalation of issues to SLG
- ✓ Communications and engagement strategy
- ✓ Six monthly back to the floor events / virtual visits
- ✓ Leadership training and bite-sized modules for wider organisation
- ✓ Performance framework in place
- ✓ Weekly update from CEO
- ✓ Comms bulletin
- ✓ Q&A sessions with members of the Senior Leadership Team
- ✓ Staff experience group
- ✓ Staff networks

Assurance: Source of Assurance 3

- ✓ Regular updates to People Committee and the Board
- ✓ NHS I PRM
- ✓ Staff Survey
- ✓ NHS I Oversight Framework
- ✓ Oversight from People Committee
- ✓ Health and Safety Committee oversight of staff health

Gaps In Controls:

- C1: Identified delays in Occ Health referrals, particularly in relation to work related stress
- C2: Covid restrictions preventing face to face engagement

Gaps in Assurance:

- A2: Sub-committees of People Committee to be fully established and developed
- A3: ED&I Committee effectiveness

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Deep dive into cause of delays with Occ Health referrals	Chief of People	Jun 21	Review completed and no delays identified - completed
A2	Additional focus on People Committee sub committee agenda, workplan and attendance with recommendations	Chief of People	~~Nov 20~~ ~~Apr 21~~ Jul 21	Staff Experience Committee and ED&I Committees established, further work on Resourcing Committee ongoing
A3	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Dec 20~~ Mar 22	Delayed due to pause in committee meetings, focus on BAME continuing in line with national agenda. Committee meetings recommenced and ED&I internal audit planned for Q4 of next financial year

BAF 5.2 Focus on providing an environment for our workforce to 'flourish at work' OBJ 5

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

Inadequate succession planning and talent management resulting in gaps in levels of expertise. Risk to staff morale resulting in increased turnover. Inability to increase activity safely to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks. This risk is impacted by potential reduced opportunities for international recruitment due to Covid and lack of a sustainable workforce model. Lack of innovative roles reduces the quality of staff being attracted to the organisation

Risk Rating:

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

Risk Details:

Opened: March 2018

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment plans to target vacancy hotspots
- ✓ Sickness absence management
- ✓ Staff turnover monitoring
- ✓ Leadership training to support effective management and engagement of staff
- ✓ Theatre recruitment plan in place
- ✓ Emergency staffing requirements in place to address Covid impact
- ✓ System mutual aid and redeployment MOU in place

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

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ People Committee oversight
- ✓ Agency usage monitoring
- ✓ Independent review of e-rostering
- ✓ Turnover and sickness absence rates

Gaps In Controls:

- C1: Lack of emergency planning and resilience resource impacting on ability to respond to potential second wave of Covid
- C2: Nursing strategy required
- C3: Nursing associate roles on hold due to Covid
- C4: International recruitment in progress
- C5: Flexible workforce model creates over reliance on premium cost workforce
- C6: CSU recommendations for EPRR resource to be implemented
- C7: Reporting/monitoring of overtime/additional hours
- C8: Measurements in relation to IJP & OJP
- C9: Unit workforce plans
- C10: Recruitment timeline KPIs

Gaps in Assurance:

- A1: Alignment of workforce to optimise capacity
- A2: Workforce plan monitoring against actual performance

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C2, C3, C5	Nursing strategy to be developed to include Nursing Associates	Chief Nurse	~~Nov 20~~ ~~Mar 21~~ Sep 21	Work ongoing as per previous update to Board. Nursing Associate roles rolled out
C4, C5	International recruitment to be completed	Chief Nurse	Mar 21	First cohort recruited - complete
C6	Implementation of CSU recommendations	Chief Nurse and Patient Safety Officer	~~Jul 21~~ Sep 21	Implementation ongoing
C7	Units to include reporting of overtime/additional hours in	Chief of Performance,	Jul 21	Now included – completed

	unit performance reports	Improvement and OD		
C8	Measurements being established for IJP & OJP, proposal to people committee in Jul 21	Chief of Performance, Improvement and OD	Aug 21	Proposal delivered to People Committee in July and presented to Board – completed
C10	Recruitment timeline KPI's to be included in support unit dashboard	Chief of Performance, Improvement and OD	Sep 21	In progress
A1	Review of workforce alignment required to provide assurance	Chief of Performance, Improvement and OD	~~Nov 20~~ Mar 21	Completed at Strategy Board and subsequent People Committee reporting – completed

BAF 5.3 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

Principal Risk Impact of Covid-19 on the workforce

Inability to recruit internationally or access required training to develop the workforce. Potential for absence rates to go up as staff isolate and key areas with single points of failure will have increased vulnerability. Requirement for workforce to work more flexibly, increased working from home and increased reliance on IT and Information. Increased challenges of providing a safe working environment. Potential for a third wave

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Resilience plans in place for departments
- ✓ Minimum nursing staffing levels in place to maintain safety
- ✓ System wide mutual aid with regard to staffing
- ✓ Listening sessions
- ✓ Improved IT infrastructure
- ✓ Mutual aid in place across the system
- ✓ Staff risk assessments in place
- ✓ Clinically vulnerable staff supported with redeployment / work from home opportunities
- ✓ Staff wellbeing package in place through national, system and local intiiatives

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

- ✓ Performance reporting
- ✓ Staff surveys
- ✓ NHSE/I Oversight
- ✓ People Committee Oversight
- ✓ System People Board and establishment of a System People Committee

Gaps In Controls:

- C1: Productivity measures for delivery in flexible working

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Hybrid/flexible working discussion to commence in Trust to establish working parameters to develop policy	Chief of Performance, Improvement and OD	Jan 22	Proposal for development presented to SLG on 13 July for agreement, further review against existing policy being undertaken and will be taken back to SLG for agreement on 3 Aug.

BAF 5.4 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

Principal Risk Lack of dedicated ED&I resource and expertise

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

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ ED&I Committee members taking ownership to drive the agenda forward
- ✓ Resource identified within CSU to provide necessary expertise
- ✓ New Head of Organisational Development role in place and taking an active role in ED&I

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

- ✓ Staff surveys
- ✓ NHSE/I Oversight
- ✓ People Committee Oversight
- ✓ System People Board and establishment of a System People Committee
- ✓ Executive lead in place both for patients and staff
- ✓ ED&I Committee oversight
- ✓ WRES and EDS2 returns

Gaps In Controls:

- C1: Sustainable ED&I resource to be identified and secured

Gaps in Assurance:

- A1: Effectiveness of ED&I Committee
- A2: ED&I work plan requires review to ensure adequate oversight of statutory requirements

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Dec 20~~ Mar 22	Delayed due to pause in committee meetings, focus on BAME continuing in line with national agenda. Committee meetings recommenced and ED&I internal audit planned for Q4 of next financial year
A2	Review of ED&I work plan	Chief of People / Chief of Improvement, Performance and OD / Trust Secretary	~~May 21~~ Sept 21	First review of ED&I work plan undertaken with additional input from CSU being sought
C1	ED&I resource to be secured	Chief of People	May 21	Partnership arrangement with ShropComm agreed - Completed

Caring for Staff — OBJ 6

Principle Objective: Deliver the Covid and flu vaccination programme

This objective will focus on increasing the number of vaccinators and ensuring 100% of staff are offered the vaccine

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Key Measures:

✓ 100% of staff offered vaccine

Progress Update:

Further guidance awaited

Supporting Programmes of Work:

- IPC work plan

Risks:

No risks to delivery identified at the present time but an assessment will be needed when the detail of the Covid vaccine programme is known and any potential impact on the flu vaccine programme

Lead Director:

Chief Nurse and Patient Safety Officer

Lead Committee:

People Committee / Quality and Safety Committee

Caring for Finances — OBJ 7

Principle Objective: Deliver Financial Plan

This objective will focus on aligning the Trust's decision making policy with the revised System financial framework, delivering the efficiency programme, management of the activity plan within the available sources of funding, remove Covid driven costs in a timely manner, delivery of the agreed cost base, delivery of the agency control total and maintain cash balances at trajectory

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: July 2021

Key Measures:

- ✓ Deliver on budget by 31 March 2022
- ✓ Deliver agreed activity within resources
- ✓ Board reporting
- ✓ Stabilising the recurrent financial position
- ✓ Delivering a 3% efficiency programme

Progress Update:

Currently forecast to be ahead of plan for H1

Supporting Programmes of Work:

- Restoration Group
- Consultant Job Planning Task and Finish Group
- Recruitment plan
- Cost improvement programme

Risks:

BAF 7.1	Failure to achieve activity and income within agreed cost base
BAF 7.2	Inability to meet baseline activity due to heavy reliance on OJP
BAF 7.3	Impact of the new system financial framework

Lead Director:

Chief Finance Officer

Lead Committee:

Restoration Committee / Finance Planning and Digital Committee

BAF 7.1 Deliver Financial Plan — OBJ 7

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

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

Risk Rating:

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

Risk Details:

Opened: March 2018

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Cost improvement schemes identified
- ✓ QIPP schemes identified to required level
- ✓ Carter recommendations embedded in savings discussions
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Tracking of theatre productivity
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews

Assurance: Source of Assurance 3

- ✓ Monitoring of CIP delivery via performance meetings
- ✓ Oversight by FPD Committee and Performance and Improvement Board
- ✓ QIPP monitored by RJAH and CCG at contract meeings
- ✓ NHS I oversight
- ✓ KPI monitoring
- ✓ QIA process in place to ensure quality not impacted
- ✓ Restoration Board oversight

Gaps In Controls:

- C1: Reliance on flexible premium cost workforce for capacity in excess of core, some of which is not based in contract
- C2: Improved process around job planning needed
- C3: Demand and capacity completed but shows need to increase core capacity
- C4: Alignment of workforce to maximise core capacity
- C5: Restoration of non NHS income

Gaps in Assurance:

- A1: Audit of compliance with consultant job plans

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C2, A1	Deliver actions agreed to provide assurance on consultant job plan fulfilment	Chief of People	Mar 21	Monitoring in place and reporting to Audit Committee and People Committee
C1,C3	Exploration of opportunities to expand core capacity through recruitment	Chief of People	~~Dec 20~~ Apr 21	Consultant recruitment programme in place with regular updates to People Committee – 2 weekly progress meetings. - completed
C4	Review alignment of workforce with a view to varying workforce to address any identified gaps	Chief of People	~~Dec 20~~ Apr 21	Workforce plan complete with regular reviews taking place
C5	Non NHS income to be restored	Chief of Finance	~~Dec 20~~ Ongoing	Ongoing linked to restoration plans which are currently impacted by Covid. Progressing well, private patient income aligning with NHS restoration

BAF 7.2 Deliver Financial Plan — OBJ 7

Principal Risk: Inability to meet baseline activity due to heavy reliance on high proportions of out of job plan work

Potential for inability to meet activity levels if out of job plan work not accepted by required workforce, premium costs to deliver required activity levels.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	2
Likelihood	5	3	2
Total	25	16	4

Risk Details:

Opened: March 2021

Reviewed Date: July 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Demand and capacity modelling provides intelligence on high risk areas
- ✓ Forward view allocation process for out of job plan work
- ✓ Consultant Job Planning Policy

Assurance: Source of Assurance 3

- ✓ Internal audit on Consultant Job Planning
- ✓ NHS I oversight
- ✓ KPI monitoring
- ✓ Restoration Board oversight
- ✓ People Committee Oversight

Gaps In Controls:

- C1: E-Job planning still being rolled out
- C2: Recruitment plan required with resulting recruitment to reduce OJP reliance

Gaps in Assurance:

- A1: Follow up audit of job planning (planned for 21/22)

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	E-job planning roll out being progressed	MD for Support Services	Apr 21	Project plan in place with updates going to People Committee and Audit Committee
C2	Development of recruitment plans to address gap	Chief of People	~~Dec 20~~ Apr 21	As above
A1	Follow up audit to be completed	Chief of People	Dec 21	As above

BAF 7.3 Deliver Financial Plan — OBJ 7

Principal Risk: Impact of new system financial framework

Potential for impact on the Trust's ability to deliver the statutory requirement of a break even position and reduction in autonomy for appointment and investment decisions.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	2
Likelihood	5	3	2
Total	25	12	4

Risk Details:

Opened: March 2021

Reviewed Date: Julyy 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Efficiency programme in place
- ✓ Income generation from outside of the system including private work
- ✓ Effective cost controls in place

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

- ✓ ICS Shadow Board oversight
- ✓ ICS Financial Sustainability Committee oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ NHSE/I oversight

Gaps In Controls:

- C1: Exploration of further income generation opportunities outside of the system
- C2: Further participation in transformational improvement programme
- C3: Loss of autonomy over investment decisions

Assessment of further control gaps being undertaken

Gaps in Assurance:

- N/A

Assessment of assurance gaps being undertaken

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Further income generation opportunities to be explored	Chief of Finance	Ongoing	Good progress made on private patient income but the business model has changed for car parking and catering
C2	Further participation in transformational improvement programme	Chief of Finance	Ongoing	The Trust is supporting the six big ticket schemes
C3	Engagement in the system financial stabilisation programme	Chief of Finance	Ongoing	The Trust is supporting the programme and the Trust Chair is chairing the Sustainability Committee

Month 2 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst & Data Quality Lead	Paper date:	24 June 2021
Executive Sponsor:	Kerry Robinson, Chief Performance, Improvement and OD Officer	Paper Category:	Performance
Paper Reviewed by:	Senior Leader Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

This paper is for information summarising the key performance indicators, highlighting areas of high or low performance for operational and financial metrics.

The committee is asked to note the overall performance as presented in the month 2 (May) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

This month sees the second month of the new IPR format, now fully utilising Statistical Process Control (SPC) graphs and NHS EI recommended variation and assurance icons.

The scheduled Board Strategy meeting in June will include a presentation from the NHSEI 'Making Data Count' team to provide further training and oversight on this approach to presenting and utilising data.

The reading guide within the IPR gives a full explanation on the interpretation of SPC graphs and the icons to support understanding but as reminder some further explanation provided below.

Some KPIs are not appropriate to display as an SPC graph. This could be because the data points are usually zero or a small number or perhaps the metric does not have enough data points yet. It is recommended that 15+ data points are required for robust analysis. The IPR will display the variation icon as 'N/A to SPC' for these KPIs and will rate assurance based on performance against the target over the last three months.

From this month, an additional assurance icon has been introduced. The guidance from NHS EI advises that the intention of their assurance icons is to be utilised against measures that have a static target so on their advice we have introduced a 'Moving Target' icon for use against metrics that have a target that moves throughout the year, for example, as activity is based on working days that fluctuates from month to month. Over future months, our Development team will spend additional

Month 2 Integrated Performance Report

time to develop logic on this that will enable us to flag as Blue/Orange indicating improvement or deterioration with an aim to have this in use for quarter two reporting.

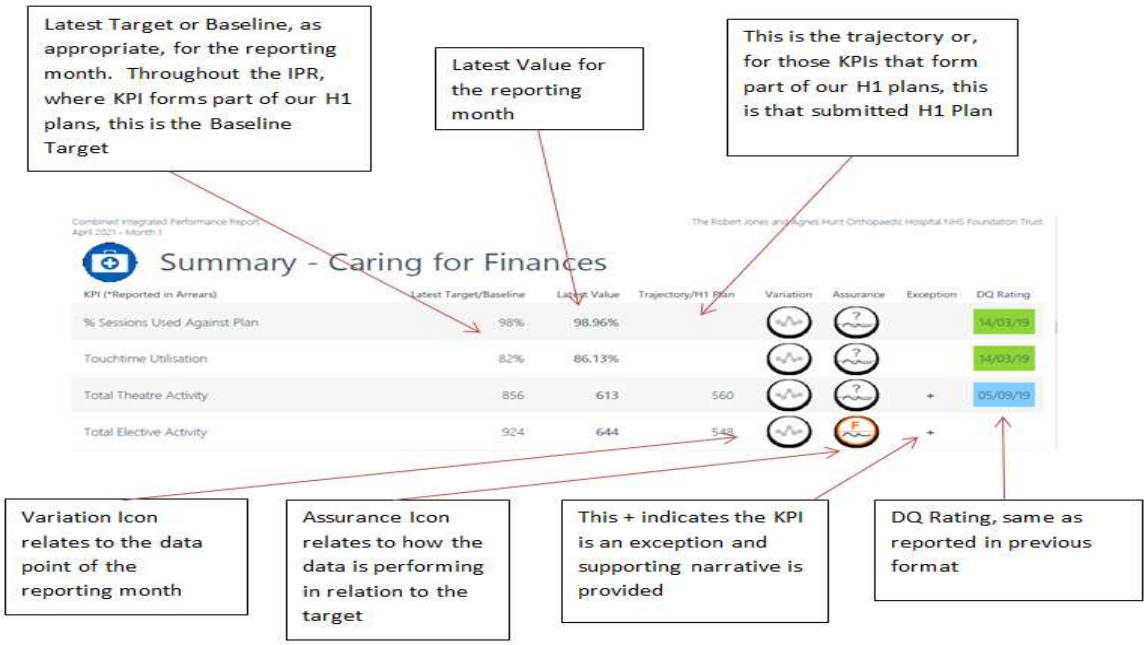
The assurance target relates to the target/baseline rather than the trajectory/H1 plan *with an update made in Month 2 to the H1 plan.*

The sections of the IPR now read as follows:

- Summary;

The summary pages remain with KPIs reported in the usual domains of Caring for Staff, Caring for Patients and Caring for Finances.

The summary page is laid out as follows:



When reading the data displayed, using Total Theatre Activity as an example from the picture above, it can be read as:

"Total Theatre Activity baseline figure was 856 (19/20 activity with adjustment for working days and covid), the performance was 613, the H1 plan was to achieve 560 (theatres proportion of the elective plan)".

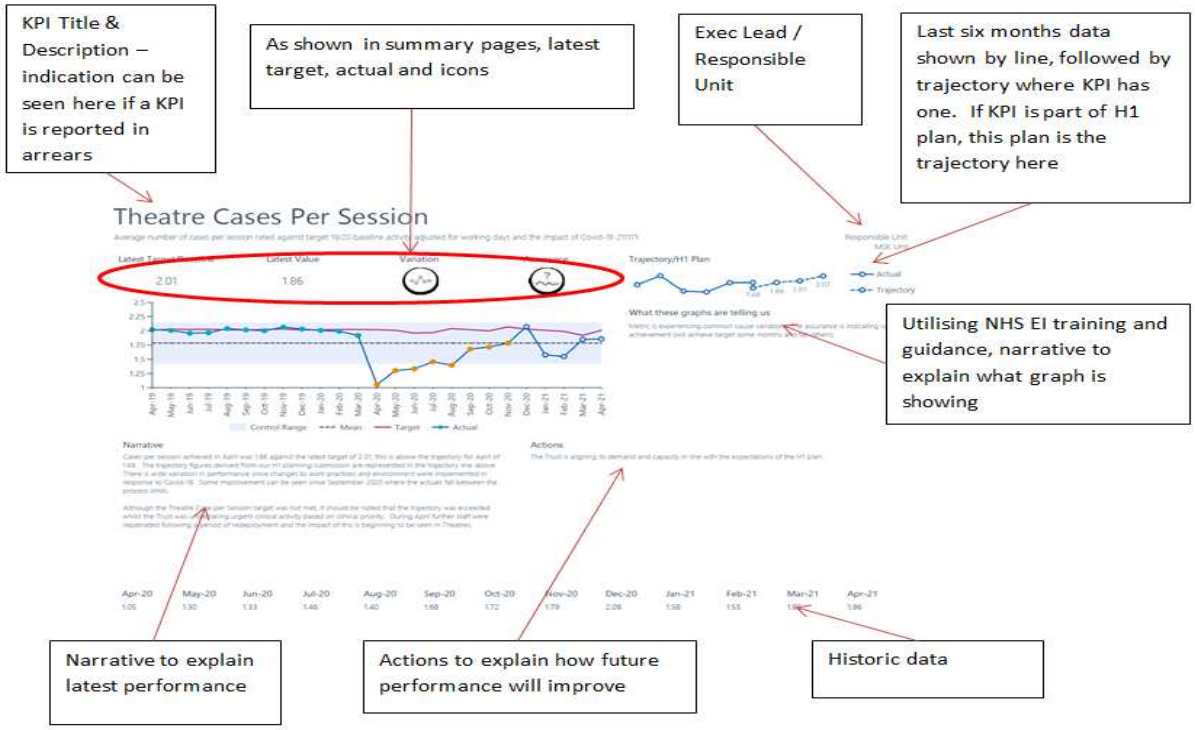
Narrative/Exception Pages;

The narrative/exception pages are included in the following circumstances:

- The icons indicate a measure should be an exception
- A metric is within common cause variation but has missed the target for three months
- A metric for low number incidents, e.g. Serious Incident or Never Event

The narrative/exception page is laid out as follows:

Month 2 Integrated Performance Report



2.2. Overview

The Board through this IPR should note the following;

Caring for Staff;

- Sickness absence;
  - 3.16% in May; this falls within normal variation.
  - Assurance indicates the target will be met some months, and fail others.

Caring for Patients;

- RJAH Acquired C.Difficile; low number of incidents have taken place.
- 18 Weeks RTT Open Pathways (exception report included);
  - Metric is consistently failing target as expected from covid impact
  - Is showing a concerning nature which aligns to Trust response for mutual aid and restart of elective
  - All above results in a failure of assurance.
  - Actions in place monitored through Restart, Recovery & Renewal sub-committee
- Patients Waiting Over 52 Weeks (Combined) (exception report included);
  - Metric is experiencing special cause variation of a concerning nature as expected given covid
  - Actions in place monitored through Restart, Recovery & Renewal sub-committee
- 6 and 8 Week Wait for Diagnostics (exception report included);
  - Metric indicates common cause variation with variable achievement of Welsh and consistently failing English
  - Actions in place monitored through Restart, Recovery & Renewal sub-committee

Caring for Finances;

- Total Elective Activity;
  - Metric indicates special cause variation of an improving nature.
  - Although actual figure is below the baseline (19/20), but did over achieve against the regulatory target of 75% of baseline delivering 81.95% elective activity
- Total Outpatient Activity
  - Metric falling short of baseline target (19/20), again over achieving against the regulatory target of 75% of baseline delivering 86.88%

- Bed Occupancy – All Wards – 2pm;
  - Metric is consistently failing target
- Expenditure
  - Metric indicates common cause variation but off target (under spent) for three consecutive months
- Cash Balance;
  - Metric is experiencing special cause variation of an improving nature being higher than planned.

2.3. Conclusion

The Board is asked to ***note*** the report and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
May 2021 – Month 2

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

Different colours have been used to separate these trends of special cause variation; • **blue points** have been used to show **areas of improvement** and • **orange points** for **areas of concern.** It should be noted that SPC charts do not compare performance against targets; that is the purpose of the red and green heatmap indicators.

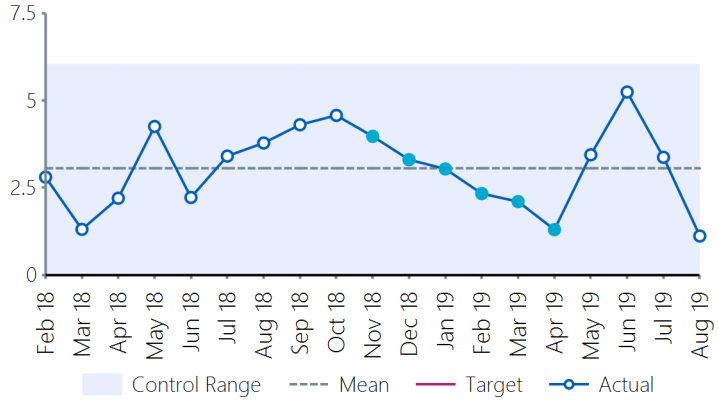
Some examples of these are shown in the images to the right:

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

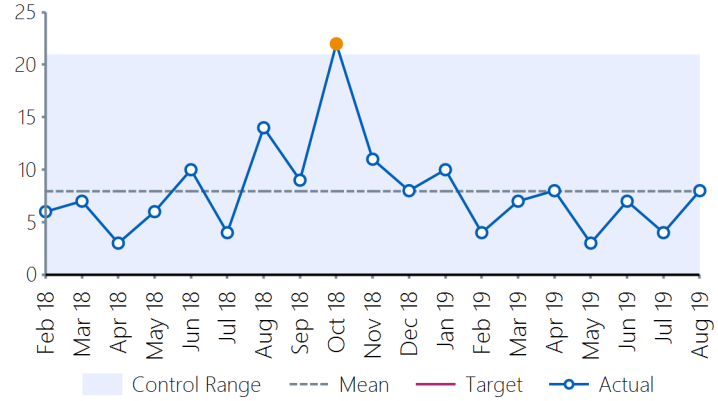
b) shows a point of concern sitting above the control range.

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

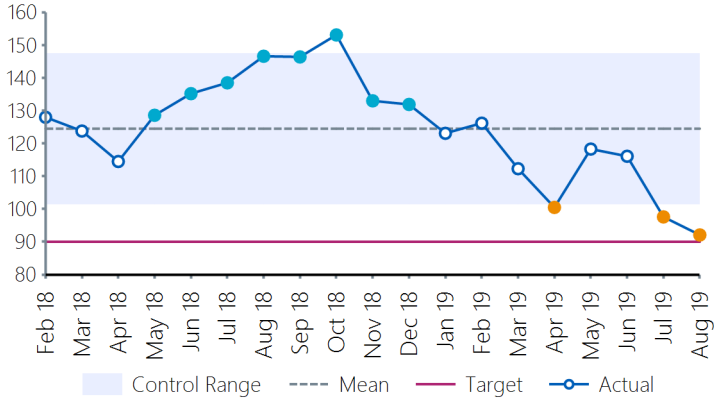
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

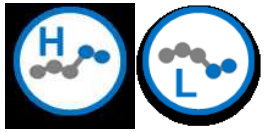
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually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

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

Variation Icons

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

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



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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	3.16%					27/02/20
Voluntary Staff Turnover - Headcount	8.00%	7.80%					05/09/19

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	P		16/04/18
Never Events	0	0		N/A to SPC	?		16/04/18
Number of Complaints	8	4			?		11/05/18
RJAH Acquired C.Difficile	0	1		N/A to SPC	?	+	16/04/18
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		06/06/19
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		16/04/18
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
31 Days First Treatment (Tumour)*	96%	100%			?		28/11/19
Cancer Plan 62 Days Standard (Tumour)*	85%	100%	100%		?		
18 Weeks RTT Open Pathways	92.00%	57.46%		L	F	+	
Patients Waiting Over 52 Weeks – English	0	1487	1450	H	F	+	28/11/19

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Patients Waiting Over 52 Weeks – Welsh	0	729		H	F	+	28/11/19
6 Week Wait for Diagnostics - English Patients	99.00%	85.13%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	85.43%			?	+	

Summary - Caring for Finances

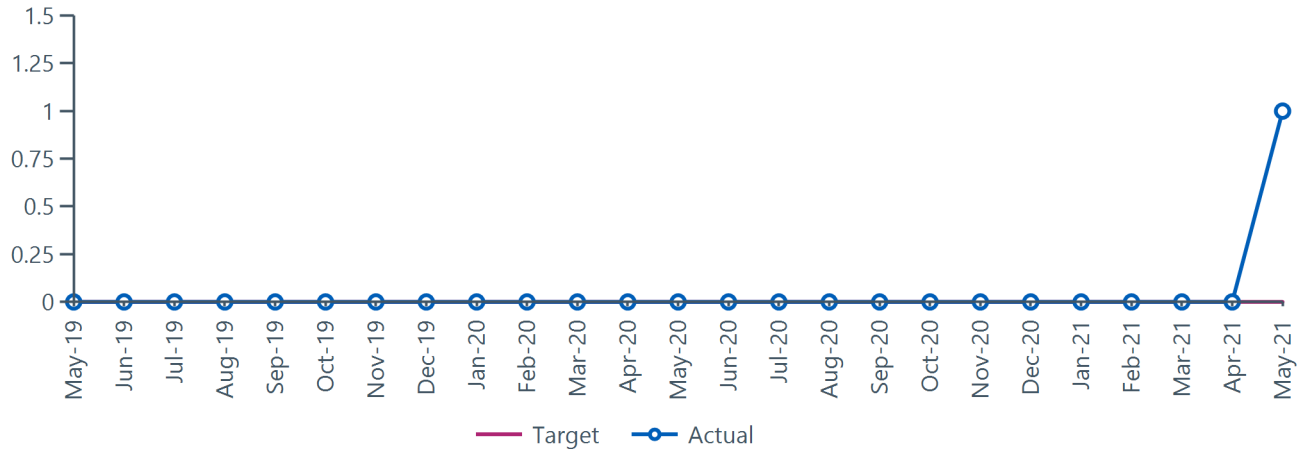
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	925	758	702	H	Moving Target	+	
Bed Occupancy – All Wards – 2pm	87.00%	78.67%			F	+	05/09/19
Total Outpatient Activity	14754	12818	11672	N/A to SPC	Moving Target	+	
H1 Plan Performance	467.34	677.00	497.00		Moving Target		
Income	9,758.89	10,039.98	10,041.00		Moving Target		
Expenditure	9,336.30	9,409.90	9,588.00		Moving Target	+	
Efficiency Delivered	94.00	221.00	94.33		Moving Target		
Cash Balance	14,858.04	16,986.00	16,875.72	H	Moving Target	+	
Capital Expenditure	451	114	667		Moving Target		

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

There was one case of hospital acquired C.Difficile during May. A post infection review meeting has taken place and confirmed the case was appropriated documented and the patient pathway was managed accordingly. Cleaning was undertaken and the room underwent fogging in accordance to policy

Actions

A system to be introduced whereby the Ward Pharmacy Technicians communicate details of antibiotics to the Antibiotic Pharmacist to provide control of antibiotic prescribing where necessary.

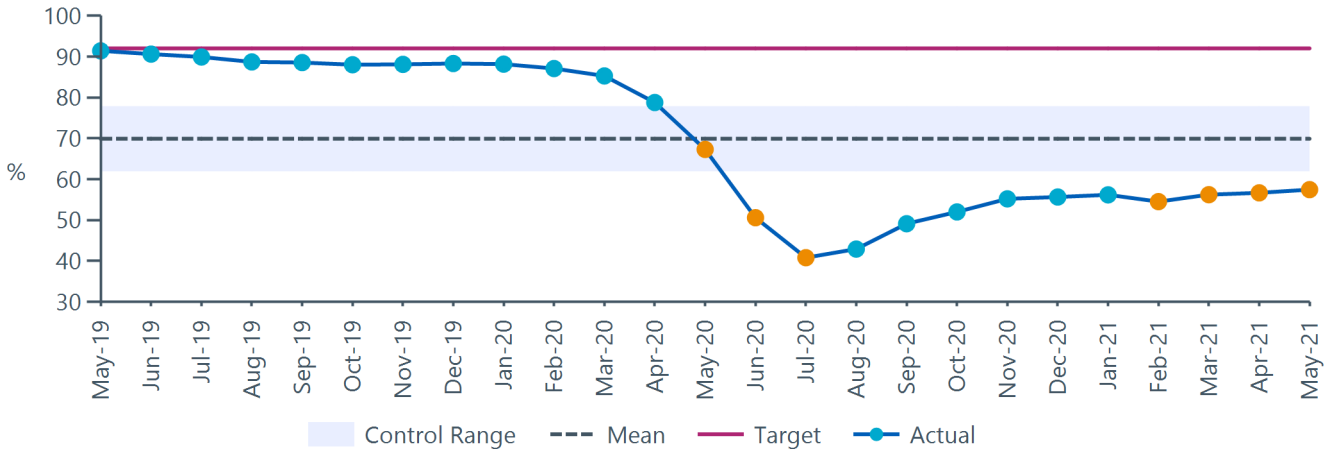
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
0	0	0	0	0	0	0	0	0	0	0	0	1

18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	57.46%	L	F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

Our May performance was 57.46% 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 - 7038 patients waiting of which 1661 are breaches, MS2 - 1133 patients waiting of which 662 are breaches, MS3 - 4250 patients waiting of which 2961 are breaches.

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

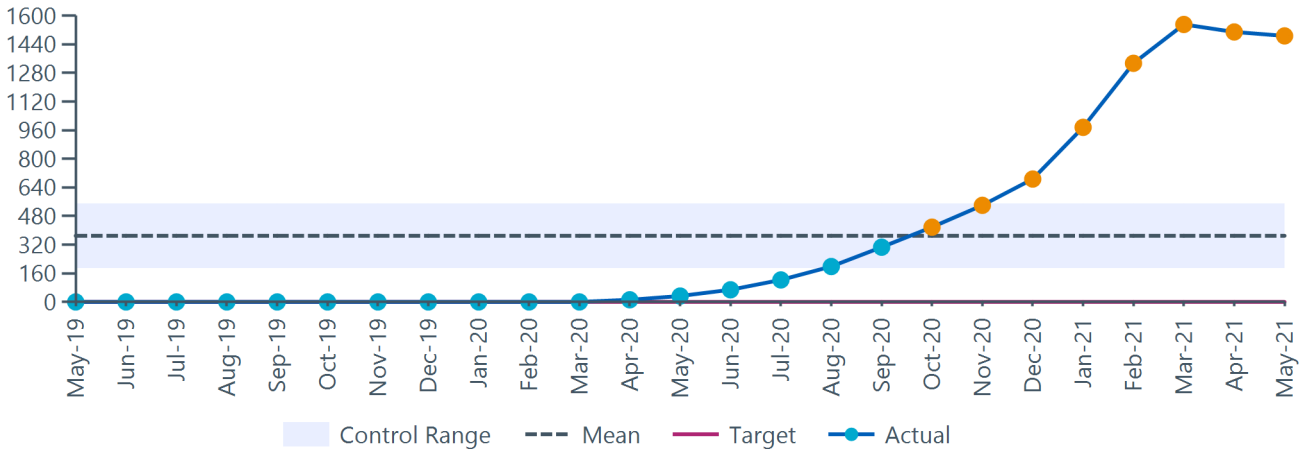
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
67.30%	50.60%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	56.68%	57.46%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1487	H	F



Trajectory/H1 Plan

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 May there were 1487 English patients waiting over 52 weeks; above our trajectory figure of 1450.

The patients are under the care of the following sub-specialities; Arthroplasty (421), Spinal Disorders (397), Knee & Sports Injuries (320), Upper Limb (195), Foot & Ankle (88), Spinal Injuries (40), Tumour (12), Paediatric Orthopaedics (9), Metabolic Medicine (3) and Neurology (2).

The number of patients waiting, by weeks brackets is:
- >52 to <=60 weeks - 276 patients
- >60 to <=70 weeks - 622 patients
- >70 weeks to <=80 weeks - 381 patients
- >80 weeks to <=104 weeks - 196 patients
- >104 weeks - 12 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks.

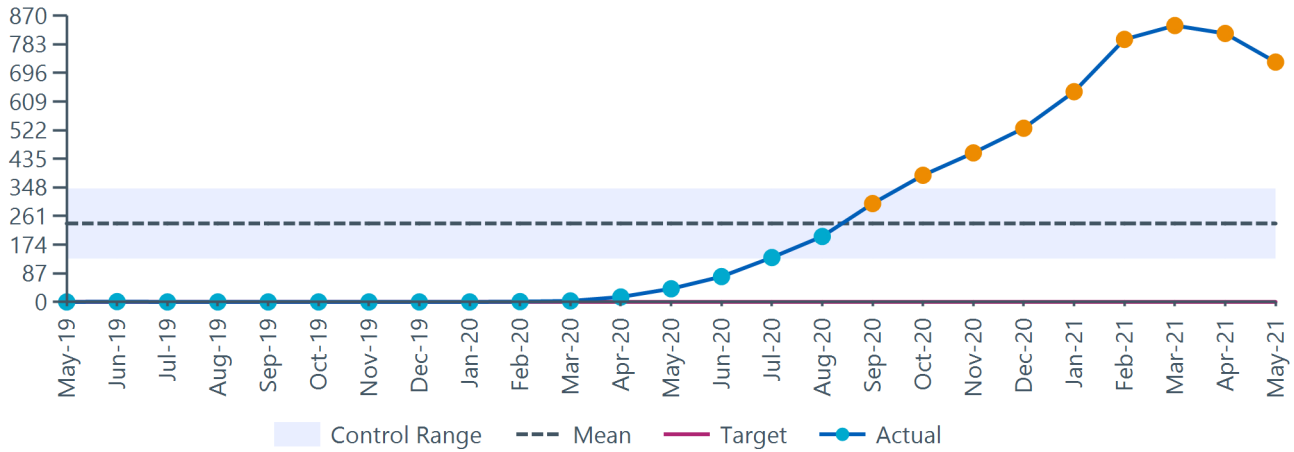
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
33	68	123	198	306	418	540	687	976	1334	1551	1509	1487

Patients Waiting Over 52 Weeks – Welsh

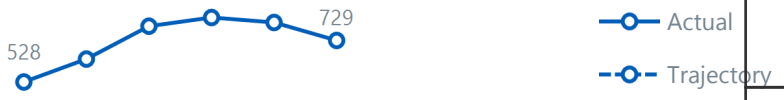
Number of RJAH Welsh RTT patients waiting 52 weeks or more at month end

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	729	H	F



Trajectory/H1 Plan



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 May there were 729 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (335), Arthroplasty (160), Knee & Sports Injuries (90), Upper Limb (63), Foot & Ankle (51), Spinal Injuries (11), Paediatric Orthopaedics (10), Tumour (6) and Neurology (3). The patients are under the care of the following commissioners; BCU (407), Powys (307), Hywel Dda (12) and Aneurin Bevan (3).

The number of patients waiting, by weeks brackets is:
- >52 to <=60 weeks - 102 patients
- >60 to <=70 weeks - 263 patients
- >70 weeks to <=80 weeks - 183 patients
- >80 weeks to <=104 weeks - 172 patients
- >104 weeks - 9 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks.

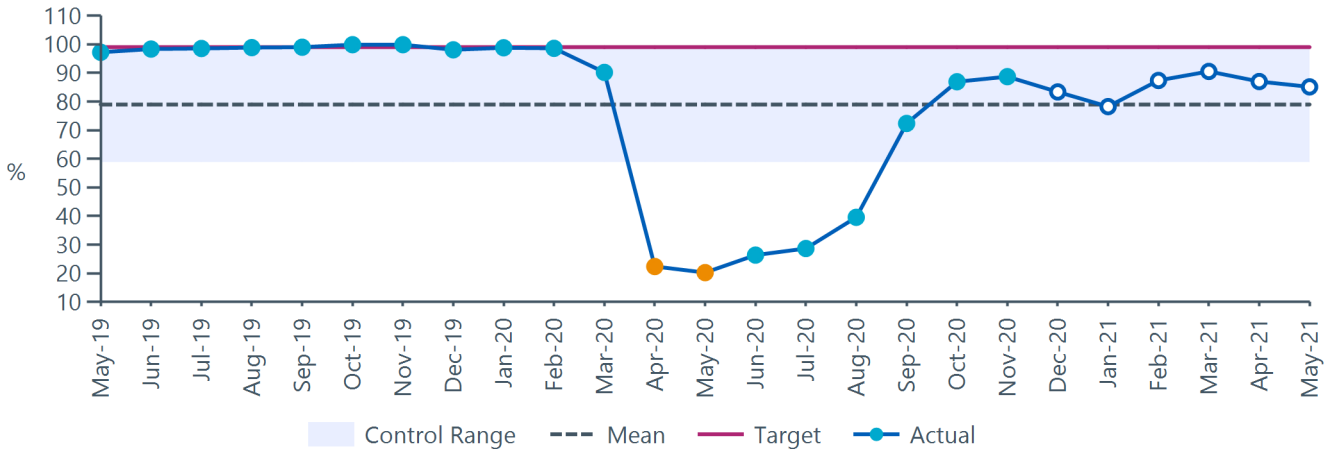
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
40	77	135	199	299	385	453	528	639	798	840	816	729

6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	85.13%		F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 85.13%. This equates to 150 patients who waited beyond 6 weeks.
The breaches occurred in the following modalities:
- MRI (148 - with 145 dated)
- CT (2 dated)

The majority of breaches relate to the MRI modality and although performance for the H1 Plan Total MRI against baseline - Catchment Based was reported at 98% in May the improvement has not been seen in waiting times due to increased demand in this modality.

Actions

'Continuation of extended working hours and weekend working. International recruitment of Radiographers is underway and taking into account a lead-time improvements are expected by the end of quarter 2. Continue to monitor the demand for MRI's.

May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
20.24%	26.36%	28.66%	39.56%	72.35%	86.92%	88.70%	83.37%	78.24%	87.38%	90.53%	86.99%	85.13%

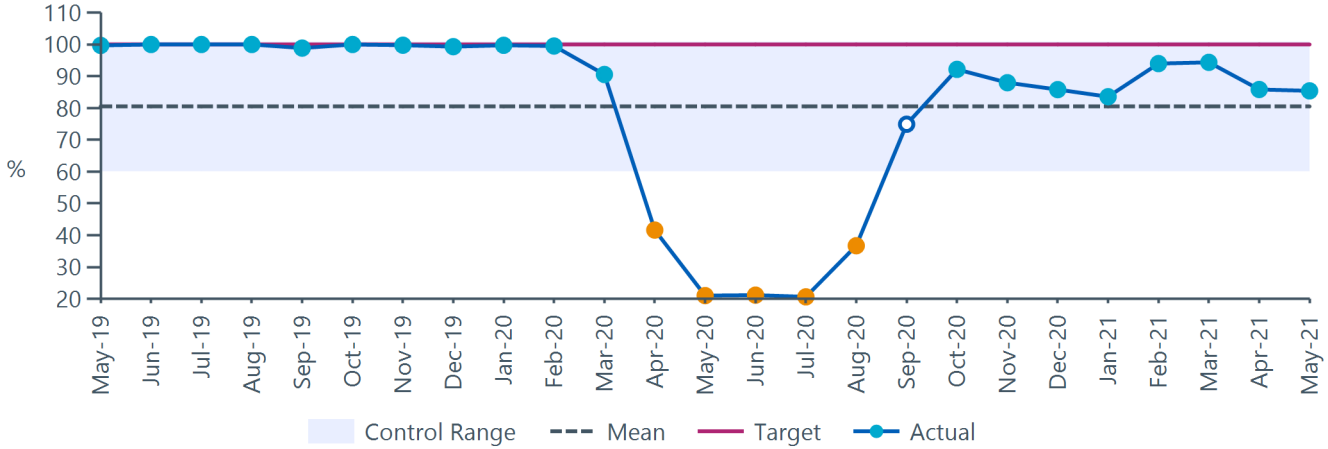
8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	85.43%		

Trajectory/H1 Plan



What these graphs are telling us

Following a period of concern in Q1 of last year, the metric is showing eight months of improvement. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 85.43%. This equates to 72 patients who waited beyond 8 weeks.
The breaches occurred in the following modalities:
- MRI (72 dated)

The majority of breaches relate to the MRI modality and although performance for the H1 Plan Total MRI against baseline - Catchment Based was reported at 98% in May the improvement has not been seen in waiting times due to increased demand in this modality.

Actions

'Continuation of extended working hours and weekend working. International recruitment of Radiographers is underway and taking into account a lead-time improvements are expected by the end of quarter 2. Continue to monitor the demand for MRI's.

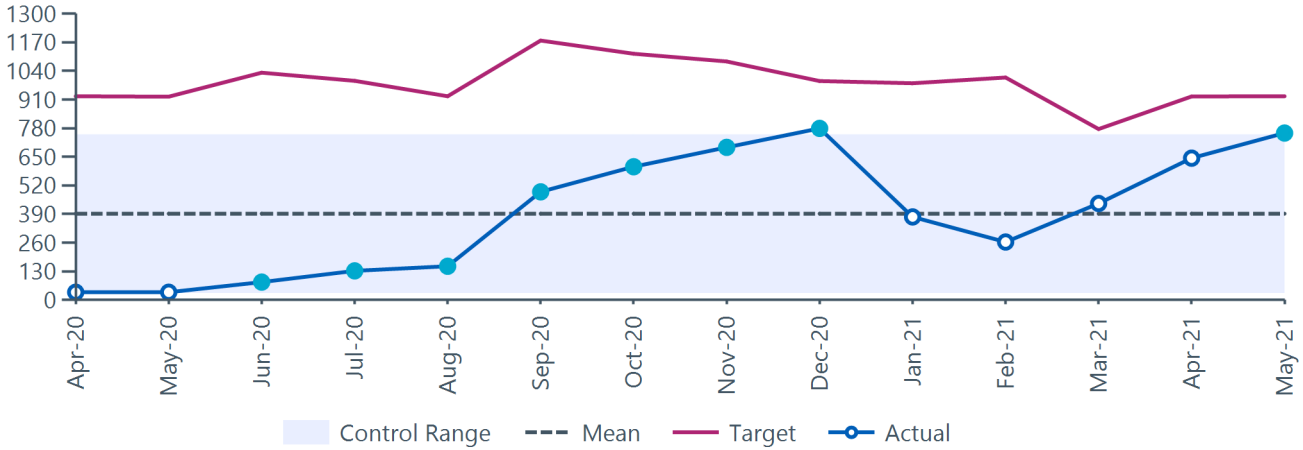
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
21%	21%	20%	36%	74%	92%	87%	85%	83%	94%	94%	85%	85%

Total Elective Activity

All elective activity in month rated against 19/20 baseline activity adjusted for working days and the impact of Covid-19

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
925	758	H	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

Total elective activity undertaken in May was 758 against the latest target of 925; this is above the trajectory for May of 702. The trajectory figures are from our H1 planning resubmission and are represented in the trajectory line above. The actual achieved against the target 19/20 baseline figure is 81.9%. The May target, as set by NHS EI, was to meet 75% of baseline 19/20 activity.

This measure has not hit the monthly target since changes to work practises and environment were implemented in response to Covid-19. There has been considerable monthly variation since April 2020 causing the process limits to widen.

Although the Total Elective Activity plan was not met, it should be noted that the trajectory was exceeded whilst the Trust was undertaking urgent clinical activity based on clinical priority. The impact of repatriation of staff following a period of redeployment is beginning to be seen in the increased activity numbers.

Actions

The Trust has submitted revised H1 plans for the highest possible levels of activity across elective services, which maximise physical and workforce capacity, prioritise the most urgent patients, incorporate clinically led reviews and validation of the waiting list, maintain effective communication with patients, address the longest waiters and addresses health inequalities, and safeguards the health and wellbeing of staff.

The Trust is aligning its demand and capacity in line with the expectations of the H1 plan.

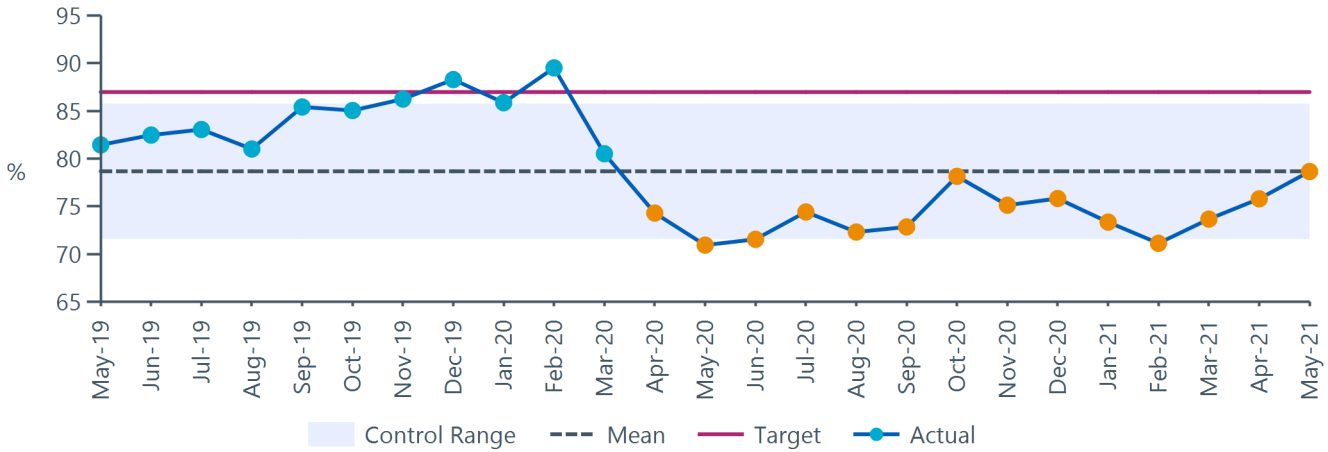
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
35	81	132	153	491	605	693	779	377	263	438	644	758

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	78.67%		F



Trajectory/H1 Plan

What these graphs are telling us

Fourteen months of concerning performance. Metric is consistently failing the target.

Narrative

The occupancy rate for all wards is reported at 78.67% for May. The breakdown below gives the May occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:
MSK Unit:
- Clwyd - 69.94% - compliment of 22 beds open throughout majority of month
- Powys - 69.35% - compliment of 22 beds open throughout majority of month
- Kenyon - Ward closed throughout month
- Ludlow - 80.96% - compliment of 15 beds open throughout month

Specialist Unit:
- Alice - 46.05% - compliment of 16 beds; open to 4-12 beds throughout month
- Oswald - 76.67% - compliment of 10 beds open throughout month
- Gladstone - 93.09% - compliment of 29 beds open throughout month
- Wrekin - 97.18% - compliment of 15 beds open throughout month
- Sheldon - 78.03% - compliment of 20 beds open throughout month

Actions

A refreshed bed modelling tool is under development that will remove the reliance on historical data. It is anticipated that the tool will be available in quarter 2.

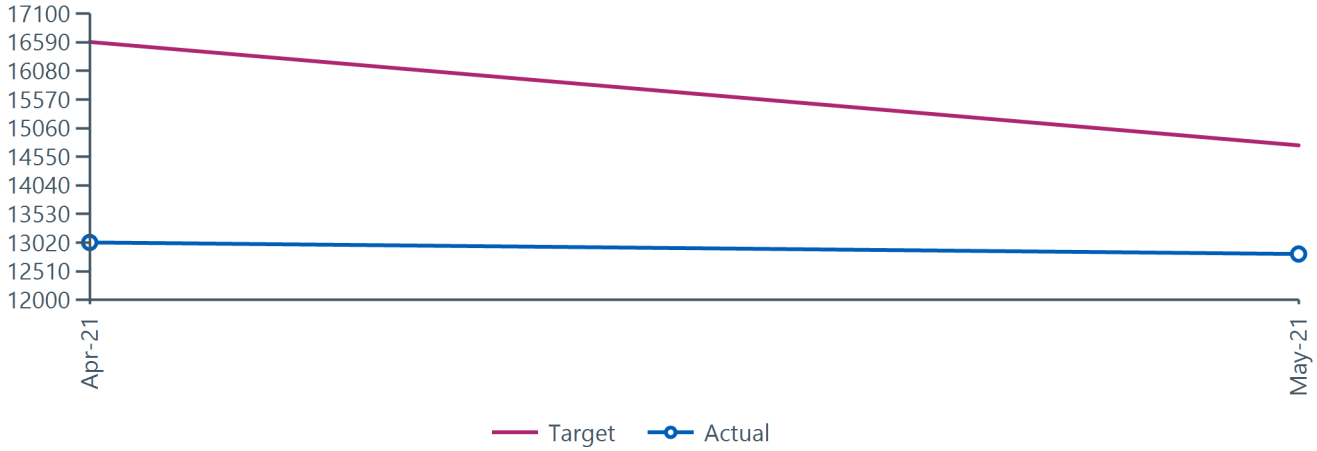
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
70.96%	71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.68%	75.81%	78.67%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H1), Catchment Based)

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
14754	12818	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Currently this measure is not appropriate to display as SPC. Analysis will improve as more data points are added. It is recommended that 15+ data points are required for robust analysis. This measure has a moving target.

Narrative

In May the total Outpatient activity undertaken in the Trust was 12,818; 1,936 below the 19/20 baseline of 14,754. The actual achieved against the target 19/20 baseline figure is 86.88%; therefore the trust exceeded the 75% H1 plan. Overall, the Trust was 1,146 cases above the H1 plan.

As at 7th June (5th working day) there were 274 missing outcomes so once administrative actions are taken with these data entries, the May position will alter and the figures will be updated for the IPR next month. Taking into account the missing outcomes, this would mean that the Outpatient activity for May was 13,093 which would be 1,661 below the baseline of 14,754. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

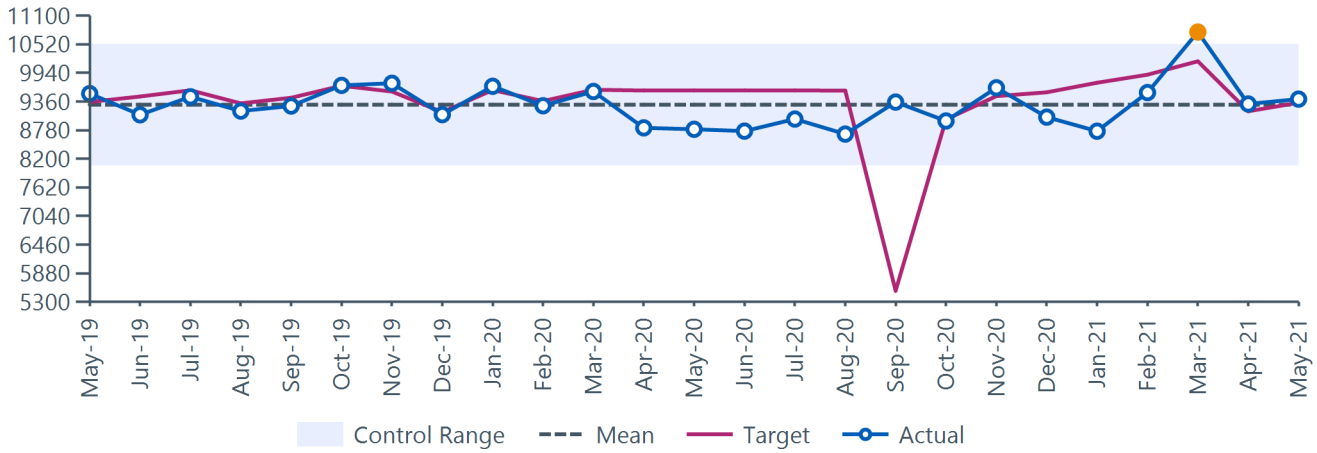
Apr-21	May-21
13024	12818

Expenditure

All Trust expenditure including Finance Costs

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
9,336.30	9,409.90		Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target but has been off target for three consecutive months so triggered as an exception.

Narrative

Overall £74k adverse in month

Pay £52k favourable
- Covid costs favourable

Non pay £126k adverse
- Private patient implants adverse
- Covid costs adverse

Note: vaccination hub/workforce services £451k of costs recharged to Shrewsbury and Telford Hospitals (SaTH) in month (excluded from these figures)

Actions

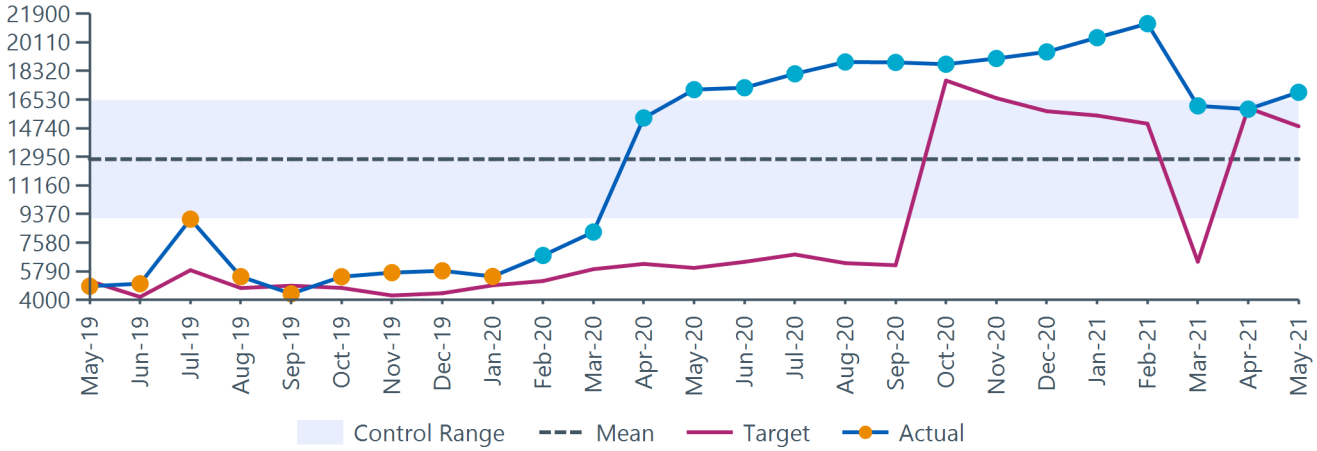
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
8799	8761	9006	8701	9350	8967	9640	9045	8760	9542	10769	9311	9409

Cash Balance

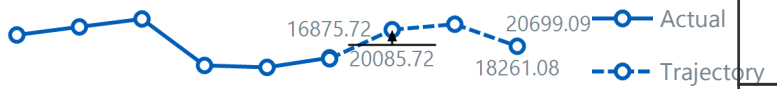
Cash in bank

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
14,858.04	16,986.00	H	Moving Target



Trajectory/H1 Plan



What these graphs are telling us

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

Narrative

£2.1m favourable against plan - driven by Veterans Centre donation and increased Private Patient advance payments received.

Actions

May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
17150	17270	18140	18880	18850	18740	19100	19510	20402	21278	16137	15928	16986

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st May 2021

Performance Against H1 Plan £'000s

Category	H1 Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	48,450	8,072	8,099	27	16,144	16,495	351
System Discretionary Funding	2,560	427	427	0	853	853	0
System Top Up Funding	1,194	199	199	0	398	398	0
Covid-19 Funding	1,452	242	242	0	484	484	0
Private Patient income	1,877	332	632	300	661	950	288
Other income	2,973	487	442	(45)	966	882	(84)
Pay	(33,996)	(5,659)	(5,606)	52	(11,296)	(11,192)	104
Non-pay	(19,325)	(3,123)	(3,257)	(134)	(6,094)	(6,423)	(329)
EBITDA	5,185	977	1,176	199	2,116	2,447	331
Finance Costs	(3,326)	(554)	(546)	8	(1,109)	(1,106)	2
Capital Donations	1,740	170	5	(165)	270	115	(155)
Operational Surplus	3,599	593	635	42	1,277	1,456	179
Remove Capital Donations	(1,740)	(170)	(5)	165	(270)	(115)	155
Add Back Donated Dep'n	269	45	47	2	90	94	4
Control Total	2,127	467	677	210	1,097	1,434	338
EBITDA margin	9.3%	10.5%	12.3%	1.8%	11.4%	12.8%	1.4%

Sustainability (Recurrent) Plan 2021/22

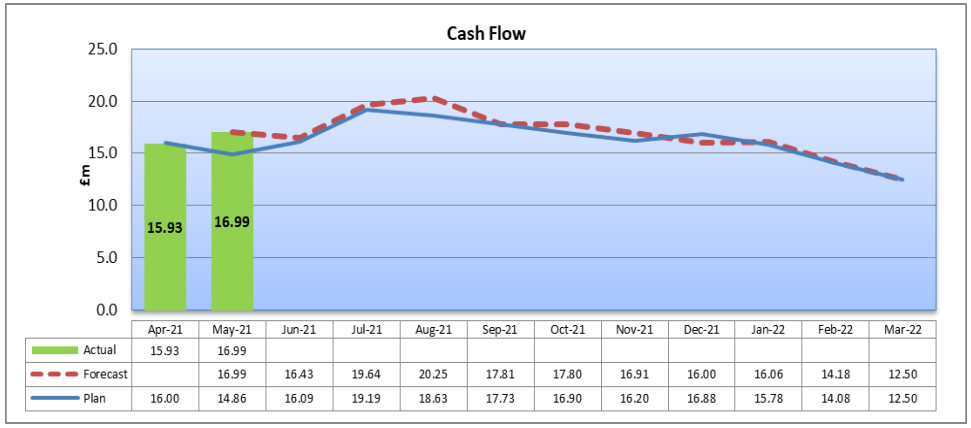
Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,542	8,558	16	17,084	17,083	(0)
System Top Up Funding	0	0	0	0	0	0
System Discretionary Funding	0	0	0	0	0	0
Covid-19 Funding	0	0	0	0	0	0
Private Patient income	476	476	0	971	972	1
Other income	530	523	(6)	1,055	1,042	(13)
Pay	(5,901)	(5,927)	(25)	(11,794)	(11,845)	(51)
Non-pay	(3,435)	(3,515)	(80)	(6,753)	(6,915)	(162)
EBITDA	**211**	**116**	**(95)**	**563**	**338**	**(225)**
Finance Costs	(562)	(546)	16	(1,124)	(1,106)	17
Capital Donations	170	5	(165)	487	115	(371)
Operational Surplus	**(181)**	**(426)**	**(245)**	**(74)**	**(653)**	**(579)**
Remove Capital Donations	(170)	(5)	165	(487)	(115)	371
Add Back Donated Dep'n	45	47	2	90	94	4
Control Total	**(307)**	**(384)**	**(77)**	**(471)**	**(674)**	**(204)**

Statement of Financial Position £'000s

Category	Apr-21	May-21	Movement	Drivers
Fixed Assets	79,677	79,397	(280)	Additions less depreciation
Non current receivables	1,250	1,194	(56)	
Total Non Current Assets	80,927	80,591	(336)	
Inventories (Stocks)	1,338	1,321	(17)	
Receivables (Debtors)	9,963	8,942	(1,021)	Decrease in accrued receiveables
Cash at Bank and in hand	15,928	16,986	1,058	Veterans Centre donation
Total Current Assets	27,229	27,249	20	
Payables (Creditors)	(16,415)	(15,454)	961	Payment of Welsh penalties for 20/21 underperformance
Borrowings	(1,315)	(1,444)	(129)	Salix Loan timing
Current Provisions	(707)	(707)	0	
Total Current Liabilities (< 1 year)	(18,437)	(17,605)	832	
Total Assets less Current Liabilities	89,719	90,235	516	
Non Current Borrowings	(4,470)	(4,349)	121	Salix Loan timing
Non Current Provisions	(985)	(987)	(2)	
Non Current Liabilities (> 1 year)	(5,455)	(5,336)	119	
Total Assets Employed	84,264	84,899	635	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,397)	(22,397)	0	
Revenue Position	(821)	(1,456)	(635)	Current period surplus
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(84,264)	(84,899)	(635)	

Capital service	1	I&E Margin	1
Liquidity (days)	1	Variance in I&E Margin	1
Agency	1		

	YTD
Debtor Days	28
Creditor Days	48

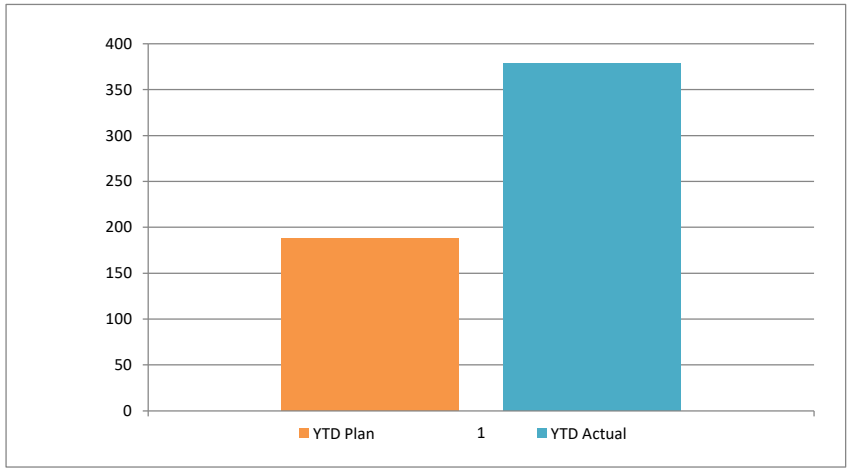


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	15.93	16.99										
Forecast		16.99	16.43	19.64	20.25	17.81	17.80	16.91	16.00	16.06	14.18	12.50
Plan	16.00	14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.50

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st May 2021

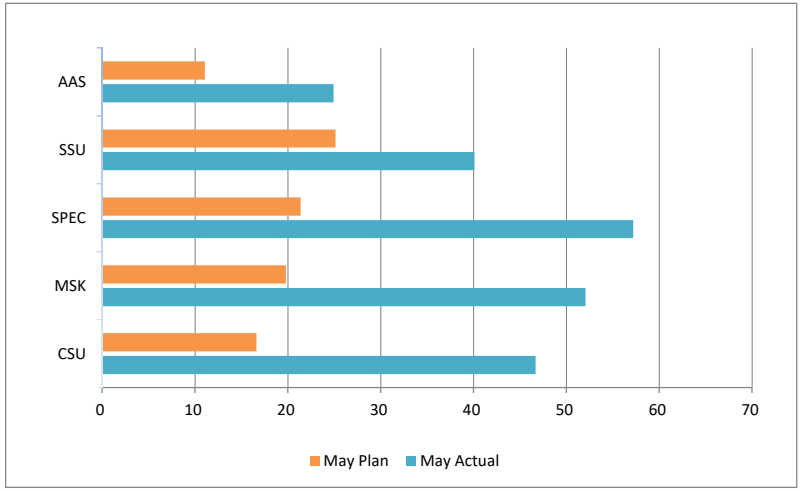
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



In Month Efficiencies

In Month Efficiencies Achievement £000's



Capital

Position as at	2122-02	Capital Programme 2021-22						
Project	**Annual Plan £000s**	**In Month Plan £000s**	**In Month Completed £000s**	**In Month Variance £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**	**Forecast Outturn**
Backlog maintenance	600	23	9	14	31	10	21	600
I/T investment & replacement	300	0	0	0	0	0	0	300
Capital project management	100	8	10	-2	16	19	-3	100
Equipment replacement	500	0	0	0	0	-0	0	500
Diagnostic equipment replacement	1,701	200	80	120	200	85	115	1,701
Diagnostic equipment replacement PDC	99	0	0	0	0	0	0	99
Contingency	500	50	11	39	50	11	39	500
EPR planning & implementation	2,000	0	0	0	0	0	0	2,000
Invest to save	200	0	0	0	0	0	0	200
Donated medical equipment	200	0	0	0	100	111	-11	200
Veterans' centre	4,500	170	5	165	170	5	165	4,500
Total Capital Funding	10,700	451	114	337	567	240	327	10,700
Donated medical equipment	-200	0	0	0	-100	-111	11	-200
Veteran's facility	-4,500	-170	-5	-165	-170	-5	-165	-4,500
Capital Funding (NHS only)	6,000	281	110	171	297	125	172	6,000

Forecast

Category	Forecast			
	Plan	Actual	Variance	Notes
Clinical Income	48,450	49,495	1,045	£694k ERF funding, £276k pass through drugs
CCG Growth Funding	2,561	2,561	0	
System Top up Funding	878	878	0	
Covid-19 Funding	1,452	1,452	0	
Private Patient income	1,877	2,505	628	M3 Forecast additional 43 cases £340k income
Other income	2,973	2,744	(228)	Continued shortfalls for Denbighs, Car parking & Research
Pay	(33,966)	(34,036)	(71)	ERF £339k offset by Covid underspends £204k
Non-pay	(19,355)	(20,046)	(690)	ERF £355k, pass through drugs £276k & PP Implants £181k offset by Covid underspends £90k
EBITDA	4,870	5,554	684	
Finance Costs	(3,328)	(3,325)	3	
Capital Donations	1,710	1,555	(155)	
Operational Surplus	3,252	3,785	532	
Remove Capital Donations	(1,710)	(1,555)	155	
Add Back Donated Dep'n	270	274	4	
Control Total	1,812	2,504	691	