The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Council of Governors 27.05.2021

MEETING
27 May 2021 13:30

PUBLISHED
26 May 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	27/05/21		13:30
1. Committee Management			
1.1. Apologies		Chair	13:30
1.2. Minutes of the Previous Meeting held on 25th March 2021		Chair	
1.3. Matters Arising		Chair	
1.4. Declarations of Interest		Chair	
2. Board Reflection		All	13:35
3. Strategy Session inc Pre-Reading		Chief Performance, Improvement and OD Officer	13:45
4. Quality Account Priorities 2021/22		Chief Nurse	13:55
5. Corporate Governance Statement		Trust Secretary	14:00
6. Questions and Answers		Trust Secretary	14:05
7. Membership Report		Trust Secretary	14:10
8. Review of Work Programme		Trust Secretary	14:15
9. Items to Note (not for discussion)			
9.1. Board Assurance Framework		Trust Secretary	14:20
10. Any Other Business			14:25
11. Date and Time of next meeting			
11.1. 29th July 2021 at 1.30pm			

Contents

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins, Chairman ☎ 4358
Chairman

COUNCIL OF GOVERNORS
THURSDAY 25TH MARCH 2021

MINUTES OF THE MEETING

PRESENT:

Frank Collins	Chair	FC
Jan Greasley	Lead Governor/Public Governor - North Wales	JG
Colin Chapman	Public Governor - Shropshire	CC
Victoria Sugden	Public Governor – Shropshire	VS
Katrina Morphet	Public Governor - Cheshire and Merseyside	KM
Russell Luckock	Public Governor – West Midlands	RL
Martin Coggon	Public Governor – North Wales	MC
Kate Betts	Staff Governor	KB

IN ATTENDANCE:

Mark Brandreth	Chief Executive Officer	MB
Shelley Ramtuhul	Trust Secretary	SR
Chris Beacock	Non-Executive Director	CB
Harry Turner	Non-Executive Director	HT
Paul Kingston	Non-Executive Director	PK
Hilary Pepler	Board Advisor	HP
Steve White	Chief Medical Officer	SW
Ruth Longfellow	Associate Chief Medical Officer	RLo
Mark Salisbury	Operational Director of Finance	MS

SECRETARY:

Mary Bardsley	Assistant Trust Secretary	MBA

MINUTE NO	TITLE	ACTION
	COMMITTEE MANAGEMENT	
1.1	**WELCOME & APOLOGIES** Apologies were received from Sarah Sheppard, Karina Wright, Rachel Hopwood, William Greenwood, Peter David, David Gilburt, Stacey Keegan and Craig Macbeth.	
1.2	**MINUTES FROM THE PREVIOUS MEETING** The minutes from the previous meetings held on 26th November 2020 were approved as a true and accurate record.	
1.3	**MATTERS ARISING** JG asked for an update on the staff incident relating to the taking of breaks. MB reassured the members of the meeting that all issues had been resolved. **ACTIONS FOLLOWING THE PREVIOUS MEETING** All actions from the previous meeting were recorded as complete.	
1.4	**DECLARATIONS OF INTEREST** FC informed the Committee that a company of which he is Chairman - Vernacare Group Ltd has completed the acquisition of Robinsons Healthcare Ltd.	

MINUTE NO	TITLE	ACTION
2.0	BOARD REFLECTION	
	Following the Board of Directors meetings earlier in the day, FC invited the Council of Governors to ask questions or offer comments. JG commented that it was interesting to find out more about the Integrated Care System (ICS) KW congratulated the Trust with the exemplar achievement relating to the Trusts food service along with the very positive friends and family test recommendations. KW also thanked the Trust for sharing an excellent presentation on spinal disorders. KW asked how the Council of Governors had been involved in the Trusts strategy and objective setting processes .MB responded that the Council were apprised of the strategic plans through historical project and development team events and through their presence of all public Board meetings where they could question the direction of travel. RL noted the phrase of a 'non-covid environment in the future' and explained he did not see a non-covid environment any time soon. FC agreed with RL and explained the comment was made to describe a future world without the current pressures of Covid, not a pure non-Covid environment. Following the Councils comments, FC clarified the following items will be addressed in the meeting ICS and the Trusts Strategy/Objective Setting. MB explained how the role of the Governor might be impacted by the establishment of the statutory ICS and encouraged members to read some of the summary publications following the government's white papers. **ACTION: SR to circulate summary publications for information.** MB continued to explained that the Trust is already leading on financial recovery and service sustainability across the ICS. The Trust will become more involved in working with the system which will include working closer with other NHS bodies and local authorities to improve health across a "system". MB suggested a further discussion once the members of the Council have had the opportunity to read the material which will be shared via SR. FC added, this is not a short term initiative and the new ICS will be embedded as the framework for service delivery going forward. FC agreed with MB and encouraged Council to read the summaries and he also suggested a workshop might be offered to the Council following the upcoming elections to support both current Governors and those who are newly elected. **ACTION: SR add a workshop the work plan** In relation to the Trusts Strategy and Objective setting, FC highlighted the importance of the Governors being involved the strategic direction of the Trust rather than the granular detail of the objective setting. The short term Trust objectives are shared with the Council via the Public Board to ensure there is awareness of the objectives. SR further explained that the objectives are set by the Board and the Governors role is to use this information to hold the Non-Executives to account throughout the year. The Governors can find the relevant information within the Board Framework for further guidance. The Council agreed to have the information shared at the next meeting. **ACTION: SR to add the Board Framework to the work plan.**	

MINUTE NO	TITLE	ACTION
	JG shared that it is apparent that the Executives and Non-Executives are working very hard at the moment and from listening to the Board report there is a tremendous amount of work being completed. JG congratulated the Team in their work. FC highlighted that all the Senior Leaders are sighted and dedicated to nurturing staff back into their roles and offering support following the recent events. RL commented on the Trust continuing to provide 3 constituencies; Shropshire, North Wales and the national specialist services. SW remined Council that the overall workload is split approx. a third in each category (in terms of income) and the amount of complex work being undertaken at present has increased. The Trust has been pleased with the work completed so far and is leading the way nationally with the Patient Reported Outcomes Measures. SW assured the Council that the Trust continues to focus on it's national roles as well as the provision of an excellent local service. RL congratulated the Trust on the high reputation it holds for the treatment received and explained he encourages this personally. FC added there is a sense of pride within the organisation. CC asked how patients are being prioritised on the revised and lengthened waiting list post-Covid. SW explained that the Trust's Consultants are required to review their own individual waiting lists (including SaTH and PRH) against the established criteria. MB added that the prioritisation is developed by a national programme that defines the criteria FC thanked the Council for their attendance at the Board of Directors meeting.	
3.0	**GOVERNOR ELECTIONS**	
	SR presented the paper outlining the proposal for the upcoming elections in constituencies where the Governors term is coming to an end, noting that some of these posts were previously extended due to the national pandemic. The Council discussed the proposal to re-align the term of any re-elected Governor in order to ensure timely turn over within the Council. The Council of Governors ***approved*** the proposals relating to the re-alignment of the terms for any re-elected Governor. SR also informed the Council that the Lead Governor role was due to be elected and presented a suggested process for the selection of a new Lead Governor. SR explained the Governors will be invited to express their interest formally in writing. The Council were advised that the expression of interest could come from those who are currently "in term" Governors rather than those who are standing for election to ensure continuity over the next term. SR highlighted that the newly elected Lead Governor will be in post for an initial fixed term 12 month period in order to allow for newly appointed governors to express an interest in the role in 2022. RL queried the reasons behind Stakeholder Governors not being able to express interest in the Lead Governor role. SR explained Stakeholder Governors are nominated by specific organisations (such as Keele University) and those entities are only required to give 1 months' notice of withdrawing that Governor from the Trust. This could lead to significant instability in the Lead Governor role where continuity of input is deemed to be an important trait. With this in mind, the Trust has advised that the Lead Governor should be drawn from the Elected Governors. FC added that it seemed right that the Lead Governor should be an individual who has been elected through public interest. SR added those who are staff governors are also exempt from expression of interest in order to ensure no conflict of	

MINUTE NO	TITLE	ACTION
	interests. RL thanked the Trust for the update and added that the role of a Lead Governor is not only a title but a difficult role to undertake. FC agreed with the comments and reiterated the requirement of the Lead Governor being someone who has been selected from those who have been elected publically, this will ensure credibility, stability and continuity in the Lead role and for the Council. KM highlighted there are currently just 3 potential elected Governors that this process is applicable too and queried the plans if none of the 3 expressed interest in the position. SR explained the Trust hoped that at least 1 or more of the eligible individuals would express an interest but if not, temporary arrangements would be put in place pending the recruitment a new lead Governor when the newly elected public governor's terms had commenced. FC encouraged any further comments or questions from the Council. JG suggested asked for a copy of the Lead Governor job description to be sent to each of the aforementioned 3 potential candidates in order to support them with their decision. FC agreed with the suggestion and confirmed this will take place if the Council approve the suggested recruitment process. FC also added the Trust would encourage the potential three candidates to liaise with the current Lead, JG to gain an insight into the role. The Council of Governors ***approved*** the proposals relating to appointing a Lead Governor for an initial term of 12 months.	
4.0	**NON-EXECUTIVE DIRECTOR ROLES**	
	SR informed the Council of Governors of the upcoming Non-Executive Directors recruitment. Before the discussion commenced, SR sought consent from the Chairman that the discussion could take place whilst the individuals were in the meeting. On the Chairman's recommendation, The Council agreed for those to remain in the meeting as it was a discussion relating to the process of recruitment and not individual's performance. The Council discussed the following positions: *David Gilburt, Non-Executive Director and Chair of the Audit Committee* SR informed the Council that DG was coming to the end of his second term with the Trust and therefore there is no option to extend his term as Non-Executive Director. SR highlighted the proposed recruitment process and the Council noted the newly appointed Non-Executive Director would require an Accountancy Qualification as the Chair to the Audit Committee. The Council of Governors ***approved*** the recommendation to appoint a new Non-Executive Director and Chair of the Audit Committee. *Paul Kingston, Non-Executive Director and Chair of the People Committee* SR informed the Council that PK is coming to the end of his first three years (term 1) as a Non-Executive Director and thus the Trust is able to offer PK a further three years (term 2) subject to a full review and discussion in line with the correct criteria and performance framework. FC added that he would be talking with PK about his own ambitions and once an Appraisal had been completed a recommendation would be presented for formal approval to the Council in the summer.	

MINUTE NO	TITLE	ACTION
	The Council of Governor ***approved*** the exploration of the re-appointment of Paul Kingston, Non-Executive Director.	
4.0	**ITEMS TO NOTE**	
4.1	**QUESTION AND ANSWERS** The Council discussed the Questions and Answers paper which was circulated prior to the meeting. JG commented that there has been a lot of reassurance shared throughout today's meetings and noted importance of clinical judgement when making decisions over matters such as waiting list management. The waiting times in North Wales are longer than in England. JG queried if there will be a point in the future when the Trust might no longer take on any more patients from North Wales. MB assured the Governors that this isn't the current or anticipated position and the Trust is mindful that the organisation was built to support North Wales as well as England patients. MB continued to explain that the Trust will be treating patients on priority order rather than the usual waiting time.. JG spoke about question 3 within the paper which was relating to the members of the Anaesthetics department. JG explained that the general consensus in the Governors pre-meeting was that the question had not been answered. FC explained to all the members of the meeting that the Trust is open and engaging however sharing the results of an internal investigation would be inappropriate. As Governors,, it is the duty and role of Council to ensure assurance has been received by the non-executive directors that, in this case, a satisfactory investigation has been completed along with implementation of any lesson learnt. In this specific case, details relating to the investigation had been presented to the Quality and Safety Committee at which the non-executives confirmed assurance had been delivered by the Trust that the executives had acted correctly and taken proportionate and correct actions. SR explained that there was has been no single cause for the incident and therefore there have been many factors. The written answer to the questio had focussed on learning. MB reminded the Council that the Trust has a small numbers of staff and therefore when an investigation is required, the Trust need to ensure individuals cannot be not identified. The Trust continues to ask staff to reflect on their actions and encourage them to speak up and they will sometimes only do this if they feel they can do so under cover of confidentiality. CC explained the writing response to the questions seemed vague and following the verbal response within the meeting felt that it has been explained thoroughly. JG thanked the Board for their response and for listening to the Council when speaking up. The Council ***noted*** the Questions and Answers paper.	
4.2	**MEMBERSHIP REPORT** SR provided an update on the membership for the Trust. The current membership shows a small increase. SR highlighted the anomaly in the data recorded for December which will be clarified at the next meeting. It was suggested the increase of members is linked to	

MINUTE NO	TITLE	ACTION
	the staff members joining the Trust to support the Vaccination Hub. **ACTION: SR to clarify the December data anomaly relating to the Membership report.** The Council of Governors ***noted*** the Membership Report.	
4.3	**WORK PLAN REVIEW** SR presented the work plan for 2020/21 and said this completes the work plan for the financial year. The work plan will be updated in line with 2021/22 meetings. SR highlighted that the statutory timeline for the Quality Accounts has been altered therefore this will be tabled for discussion in due course. The Council of Governors ***noted*** the Work Plan Review.	
6.0	**ANY OTHER BUSINESS**	
	Thank you to Steve White RL acknowledged that it was SW last Governor meeting and therefore thanked him for being a superb communicator over the years. RL added it has been fascinating learning from SW. JG expressed thanks to SW on behalf of Council and noted SW is loved and respected by all before wishing him all the very best in his retirement. SW thanked the Council of Governors for their kind words and added that he has enjoyed working for Trust and gaining the experience as both a Consultant and member of the Board. FC thanked the members of the meeting for their attendance and contribution before bringing the meeting to a close.	

NEXT MEETING: 27TH MAY 2021

COUNCIL OF GOVERNORS - SUMMARY OF KEY ACTIONS

Ongoing Actions	Lead Responsibility	Progress
N/A		
New Actions	**Lead Responsibility**	**Progress**
Board Reflection: SR to circulate summary publications following the Governments white papers - for information.	SR	**Complete – circulated on 12.04.21**
Board Reflection: SR to add an ICS work shop the work plan	SR	**Complete – held on 11.05.21 and 12.05.21**

Board Reflection: SR to add the Board Framework to the work plan.	SR	**Complete**
Membership Report: SR to clarify the reasons for the December data anomaly presented	SR	

0. Reference Information

Author:	Sara Ellis-Anderson, Assistant Chief of Professions	Paper date:	27th May 2021
Executive Sponsor:	Stacey-Lea Keegan, Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	
Forum submitted to:	Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Council of Governors and what input is required?

The Council of Governors are asked to note the Quality priorities 2021/22 approved by Quality and Safety Committee on behalf of the Board and to select the priority that they wish to sponsor.

2. Executive Summary

2.1. Context

The Trust's quality priorities form an integral part of the Trust's overall strategy and the priorities outlined in this paper will set the direction for the forthcoming year. As with setting any part of the Trust's strategy it is important to gain stakeholder engagement and the following has been undertaken to ensure that there has been relevant input:

- Review and outcomes of National Staff and Patient surveys
- Themes of incidents, complaints and PALs contacts reported in the last 12 months
- Achievement and progress against the 2020/21 Quality Priorities
- A long list of quality priorities were produced and shared with staff in the form of a survey to gain wider staff engagement.

The quality priorities identified aim to; reduce avoidable harm to patients by improving patient safety, improve patient experience and ensure staff wellbeing remains a priority enabling staff with the right skills to deliver effective patient care.

2.2. Summary

Six quality priorities have been identified for 2021/22 across the domains of Patient Safety, Clinical Effectiveness and Patient Experience.

2.3. Conclusion

The Council of Governors are asked to note the Quality priorities 2021/22 approved by Quality and Safety Committee on behalf of the Board and to select the priority that they wish to sponsor.

3. The Main Report

3.1. Introduction

In determining the 2021/22 quality priorities the outcomes of the national staff and patient surveys and themes of incidents, complaints and PALs contacts reported in the past twelve months have been reviewed. Subsequently a long list of quality priorities was produced and shared with staff in the form of a survey to gain wider staff engagement.

This resulted in two quality priorities being chosen in the domains of Patient Safety, Clinical Effectiveness and Patient Experience.

3.2. Overview of the Quality Priorities

Please see appendix one for an overview of the identified quality priorities including high level objectives.

The two patient safety quality priorities, enhanced patient safety in Theatres & Diagnostics and detection and escalation of the deteriorating patient have been extended from 2020/21 with more specific focus. These will be supported by the launch of the National Patient Safety Strategy.

3.3. Next Steps

Each of the quality priorities progress will be monitored via the respective committee with upward reporting to the Quality and Safety Committee.

3.4. Conclusion

The Council of Governors are asked to note the Quality priorities 2021/22 approved by Quality and Safety Committee on behalf of the Board and to select the priority that they wish to sponsor.

Appendix One: Overview of Quality Priorities 2021/22

Priority	Metric	Lead	Executive sponsor	Clinical champion	Objective	Measure of Success
PATIENT SAFETY						
1. Enhanced patient safety in Theatres & Diagnostics	Reduce number of patient safety incidents in Theatres and Diagnostics	Ian MacLennan and James Maybin supported by Patient Safety Specialists	Ruth Longfellow Stacey-Lea Keegan	Theatre leadership MDT	To determine if the 5 steps to safer surgery is embedded in practice, in line with AfPP good practice guidance. Complete observational audits of completion of the WHO process. Review theatre and diagnostic incidents that could be linked in to non-adherence with WHO and Safety Pause processes to establish any themes and trends. To strengthen the process for the MDT to learn from incidents including near misses. Development of multi-disciplinary safety champions within Theatre and Imaging departments. Ensure adequate levels of training in Human Factors and the expected level 1 module of the HEE Patient Safety Syllabus.	Improvements in the audited compliance against the 5 steps to safer surgery (using an observational model) Multi-disciplinary Safety Champion role embedded within the departments Increased levels of associated training compliance Reduction in theatre and diagnostic incidents related to non-adherence with WHO process
2. Improve detection and escalation of the deteriorating patient	Reduce number of un-expected admissions to HDU	Craig Lammas supported by Ian MacLennan	Ruth Longfellow	James Neil (TBC)	Audit of NEWS escalation triggers to identify any themes and trends and areas for improvements. Short RCA to be conducted for all transfers out of the Trust and for unexpected admissions to HDU. Ensuring themes and learning from RCAs is shared across the MDT. Implement 24/7 Critical Care Outreach services and collect National Outreach Forum Minimum Dataset. Complete self-assessment tool against the Quality and Operational Standards for Critical Care Outreach Services.	Improvements in NEWS audits to demonstrate 90% compliance in line with deteriorating patient policy Reduced number of un-expected admissions to HDU monitored via Datix Critical Care Outreach service available 24/7

Appendix One: Overview of Quality Priorities 2021/22

Priority	Metric	Lead	Executive sponsor	Clinical champion	Objective	Measure of Success
CLINICAL EFFECTIVENESS						
3. Provide an effective, safe and healthy working environment to promote staff wellbeing	Improvements in staff survey in two primary themes resulting from the Staff Survey 20/21: • Communications with Senior Management • Workplace health and wellbeing	David Low and Sue Pryce	Sarah Sheppard	TBC	Establishment on the Staff Experience and Improvement Group Hold a series of staff focus groups, across all Units and from all (staff) levels. From the insight gained develop an action and improvement plan co-produced with staff. Re-launch quarterly pulse checks to monitor progress. Trial digital wellbeing innovations Develop safe spaces for staff Develop organisational approach to further enriching and ingraining the benefits of civility and respect	Improved responses to staff survey Increased response rates and engagement with internal quarterly pulse checks Reduction in incidents reporting incivility
4. Increasing awareness of non-medical research in practice	Improvements in Research awareness survey	Teresa Jones supported by Imran Hanif	Ruth Longfellow Stacey-Lea Keegan	Geriant Thomas (TBC)	Improve the visibility of research within the Trust through various communication methods including social media to staff and patients. To conduct a survey amongst RJAH staff to assess research awareness and engagement. Launch of Nursing Strategy to include focus on non-medical research practice Develop Research Champions for each unit and or department and offer shadow-working in the research department to enhance links. Develop academic non-medic posts to grow the research agenda	Research champions in ward and departments Improvements in Research awareness survey

Appendix One: Overview of Quality Priorities 2021/22

Priority	Metric	Lead	Executive sponsor	Clinical champion	Objective	Measure of Success
PATIENT EXPERIENCE						
5. Reduction in delayed discharges and improved patient communication	Achieve the Trust KPI of less than 2.5% of all patients delayed	Nicki Bellinger Supported by Trust Matrons	Stacey-Lea Keegan	TBC	Ensure that all patients are aware of their expected discharge date. Early discharge planning needs to commence on arrival at the Trust or pre-operatively for elective admissions. Patients are included into all discussions and goal planning for discharge. Patients are kept fully informed of the reasons for delay and this is documented in the patient's electronic record.	Reduction of delayed transfers of care to the Trust KPI metric. Patient feedback regarding communication and inclusion.
6. Improved communication to patients accessing outpatient services	Reduce number of negative comments relating to outpatient waits as a % of attendances	Liz Reece supported by Sara Ellis-Anderson	Stacey-Lea Keegan	Stuart Hay (TBC)	Establish working group to map current process and review current data sets Conduct observational audit to establish reasons for increased waiting times and to establish a mean waiting time within the department Develop KPI for outpatient waiting times based on the observational audit To review and improve current methods of communication with patients during their visit Consider digital solutions for implementation in 2022/23	Reduction in number of negative comments relating to outpatient waits Development of a KPI for ongoing monitoring

Provider Licence Declarations

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27 May 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Board of Directors	Paper Ref:	N/A
Forum submitted to:	Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Council of Governors and what input is required?

The Council is asked to **consider** and **comment** on the proposed declarations.

2. Executive Summary

2.1. Context

Under the NHS Provider Licence, Risk Assessment Framework and Health and Social Care Act 2012, the Trust is required to self-certify whether or not they have complied with the requirements and have the required resources available if providing commissioner requested services. Further it must confirm whether or not it has complied with governance requirements.

2.2. Summary

In accordance with the above outlined requirements, this paper presents the proposed self-assessment declarations for the Council to consider and comment.

The Board is required to make the following declarations:

a. That it has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) **Deadline 31 May**
b. That if providing commissioner requested services, it has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) **Deadline 31 May**
c. That it complies with the required governance arrangements (Condition FT4(8)) **Deadline 30 June**

2.3. Conclusion

Following review of the licence and governance requirements and the assurances in place regarding compliance, it is recommended that the Board confirm self-certification against the requirements of General Conditions G6, CoS7 and FT4(8)

3. Main Report

3.1. Background

Condition G6 requires NHS Foundation Trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

In addition, Trusts must annually review whether these processes and systems are effective and publish their G6 self-certification within one month following the deadline for sign-off (31 May)

CoS7 applies to NHS foundation trusts designated as providing commissioner requested services (CRS). This places a requirement for Trusts to confirm whether or not the required resources will be available over the next financial year.

This requirement is only applicable to NHS Foundation Trusts for 12 months from the date of authorisation in which case it applies to all services. Alternatively, after 12 months, Trusts may receive a specific designation from the Commissioner.

Condition FT4 (8) is split in to two parts:

a) NHS Foundation Trusts are required to in place processes and systems that achieve the objectives set out in the licence conditions. Whilst there is no set approach to these standards and objectives, it is expected that Trusts will have in place demonstrably effective board and committee structures, reporting lines and performance and risk management systems.
b) NHS Foundation Trusts must reflect on whether their governors have received enough training and guidance to carry out their roles.

3.2 The Trust's Position

Condition G6
When considering the requirements of Condition G6, the following evidence is brought to the attention of the Board:

- The Trust has in place an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has been subject to internal audit which found '*The Trust has in place an effective risk management system and a hierarchy of reporting arrangements to ensure the Board is provided with evidence based assurance of the adequacy of the Trust's processes for the management of risks so that its objectives can be achieved*. There were some key recommendations made regarding the link between the risk registers and the Board Assurance Framework, clarity around roles and responsibilities, risk management training and the recording of key dates in the lifecycle of a risk and these have been taken forward.

- The Audit Committee monitors effective internal controls across the organisation
- The Risk Management Committee oversees the delivery of the Trust's Risk Management Strategy and provides regular assurance to the Board.
- The Trust has in place a Board Assurance Framework which is reviewed on a monthly basis by the Executive Team and quarterly by the Risk Management Committee. Audit Committee and the Board of Directors.
- Internal and External Audit reports on regulatory compliance are undertaken throughout the year.

CoS7
The Trust does not provide commissioner requested services and as such is not required to make any declarations against this requirement.

Condition FT4 (8)
The Trust is able to demonstrate compliance with the requirements of FT4(8) should therefore self-certify that it is compliant. The full statements and evidence to support are outlined in the attachments.

The proposed statements have been circulated to the Council of Governors for their views and they are supportive of the statements being made

4. Conclusion

Following review of the licence requirements and the assurance in place regarding compliance, it is recommended that the Board confirm self-certification against the requirements of General Conditions G6, CoS7 and Condition FT4 (8).

Appendix 1: Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	N/A	Please Respond

OR

Provider Licence Declarations

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	**N/A**	Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	**N/A**	Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- The Trust has in place an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has been subject to internal audit which found '*The Trust has in place an effective risk management system and a hierarchy of reporting arrangements to ensure the Board is provided with evidence based assurance of the adequacy of the Trust's processes for the management of risks so that its objectives can be achieved*. There were some key recommendations made regarding the link between the risk registers and the Board Assurance Framework, clarity around roles and responsibilities, risk management training and the recording of key dates in the lifecycle of a risk and these have been taken forward.
- The Audit Committee monitors effective internal controls across the organisation
- The Risk Management Committee oversees the delivery of the Trust's Risk Management Strategy and provides regular assurance to the Board.
- The Trust has in place a Board Assurance Framework which is reviewed on a monthly basis by the Executive Team and quarterly by the Risk Management Committee. Audit Committee and the Board of Directors.
- Internal and External Audit reports on regulatory compliance are undertaken throughout the year.

Provider Licence Declarations

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has in place robust systems and processes of governance and assurance regarding their application is obtained via the Audit Committee and through comprehensive programme of audit
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust has in place a Board Governance Pack which outlines its governance arrangements. This is reviewed by the Board on a regular basis.
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board's committee structure and responsibilities are outlined in the Board Governance Pack. The Audit Committee has oversight of the effectiveness and completeness of those committees meeting their terms of reference.
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	a) External audit provide a Value for Money Opinion b)The Board receives and reviews the balanced scorecard and performance reports on a monthly basis c) The terms of reference and workplans for the Board and Board Committees ensure adequate oversight of compliance with all regulatory requirements with audit opinions obtained as required throughout the year d) The Board has in place a regular programme of audit which includes scrutiny of its financial management. The Board considers its going concern status on an annual basis e)All assurance committees have in place a clear remit and workplan and will utilise the following to inform business decisions; KPI's in balanced scorecard reviewed and agreed annually, programme of data quality, programme of audits overseen by the Audit Committee, Board Assurance Framework, Operational plan, Corporate Objectives (and the delivery of) f)The Trust meets monthly with NHS Improvement with regard to quality, finance and operational performance, these meetings allow for early identification of any licence issues g) As set out above (f) h) The above outlined enables the Trust to comply with all applicable legal requirements and in the event of any uncertainty independent legal advice is available
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	a) The Board is made up of suitable skill and expertise to provide leadership on all of its business, including quality of care b) The Board receives quality information through the performance report and various detailed reports from management. The Trust has in a place a Quality and Safety Committee and the Board receives a Chair's Report which higlights the topics discussed and any assurance gained. c) Quality of care data is captured as early as possible. The Trust's data quality processes are overseen by the Audit Committee. d) As outlined above (b) e) The Trust has in place several mechanisms for engaging with staff, patient and external stake holders. E.g For Patients - Patient Collaborative, Patient Panel, Inpatient Survey, for Staff - staff survey, pulse checks, big conversations, staff forums and a dedicated barometer group attended by staff across the organisation, External - quality meetings with its commissioners and regulators. f) The Trust's Chief Nurse is the lead for Quality of Care with support from the Chief Medical Officer. There is a Quality and Safety Committee which is responsible for oversight of quality issues and escalating as required to the Board.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board reviews its requirements and continues to develop plans for succession to Board and senior positions across the organisation.

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature **Signature**

Name Frank Collins **Name** Mark Brandreth

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	**Certification on AHSCs and governance**	**Response**
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	
	The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	**N/A**
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		**Signature**	
Name	Frank Collins	**Name**	Mark Brandreth
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27 May 2020
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:		Paper Ref:	
Forum submitted to:	Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Council of Governors and what input is required?

The Council of Governors is asked to ***note*** the questions that have been raised by Council members since the last meeting and the answers provided by the Senior Leaders.

2. Executive Summary

2.1. Context

It was agreed that any questions and answers raised by Council members in between meetings would be collated into a paper to the Council in order that all members could benefit from the information and also to ensure there was opportunity for discussion as required.

In addition it was agreed that the Council of Governors would be proactively asked if there were any items they wished the Chairman to consider for the agenda.

2.2 Summary

This paper presents the questions and answers paper. In summary:

- The Council members requested no items for the agenda
- The Council members raised 2 questions

2.3 Conclusion

The Council of Governors is asked to note the questions raised by Council members since the last meeting and the answers provided by the Senior Leaders.

3. Main Report

3.1. Questions and Answers

Date Raised	Raised By	Question
11/05/2021	Jan Greasley	Will the £4m additional funding received at the end of the financial year be retained by RJAH or will it go back into the system?

Response Provided By Craig Macbeth, Chief Finance and Planning Officer

The £4m will be retained by RJAH and is reported in our closing accounts.

Whilst this is welcomed re-investment into services at RJAH is constrained by a system financial framework which has a maximum threshold for capital spending and is not adjusted for the additional surplus.

In the short term RJAH will therefore carry increased cash balances which provide resilience and protection against expected future deficits as we take a proportional share of the system deficit under the ICS.

Date Raised	Raised By	Question
11/05/2021	Kate Betts	During the pandemic have any RJAH staff been furloughed?

Response Provided By Sarah Sheppard, Chief People Officer

No staff were furloughed during the pandemic (as an NHS body the furlough scheme was not available for use) and although some of our services were paused due to Covid 19, staff were redeployed to other areas within the hospital, to SaTH to support services under pressure or to support the vaccination programme.

We are very proud of the way our staff adapted to extremely difficult circumstances and were willing to adapt to meet the demands we placed on them. Where staff could work from home, this was supported in accordance with government guidance and this continues in line with advice. The fact that some staff have been able to work from home for all or part of their working weeks has enabled us to support social distancing measures for patients and staff who needed to be on site.

We recognise that the past 10 months we have required our staff to be extremely flexible and agile in their daily lives and we thank our staff for embracing these challenges.

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27 May 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Equality Impact Status:	N/A
Forum submitted to:	Council of Governors	Paper FOIA Status:	Disclosable

1. Purpose of Paper

1.1. Why is this paper going to Council of Governors and what input is required?

This paper is presented to the Council of Governors to **note** the current membership position of the Trust.

2. Executive Summary

2.1. Context

As a Foundation Trust it is a constitutional requirement for the Trust to have a membership made up of public, staff and patient constituents. The aim is to ensure that the membership is sufficient in its size and make up to adequately represent the communities the Trust serves.

2.2. Summary

This report provides an update on Foundation Trust membership and representation in support of the membership strategy.

2.3 Conclusion

The Council of Governors is asked to ***note*** the information contained within this paper.

3. The Main Report

3.1. Background

This paper provides an update on membership numbers as at 01 April 2021 and on-going progress of the Trusts Public Membership Strategy.

3.2. Current Membership

The current membership total (at 01 April 2021) is 6506 which can be broken down as follows:

	As at 01 February 2021
Staff	1170
Public	5356
Total	**6526**

3.3. Membership Growth

The Council will recall that the trust membership target for 2020/21 was amended during a previous meeting to the achievement of a year on year increase. In April 2020 membership stood at 6434 and as such a 1.4% increase has been achieved over the last twelve months.

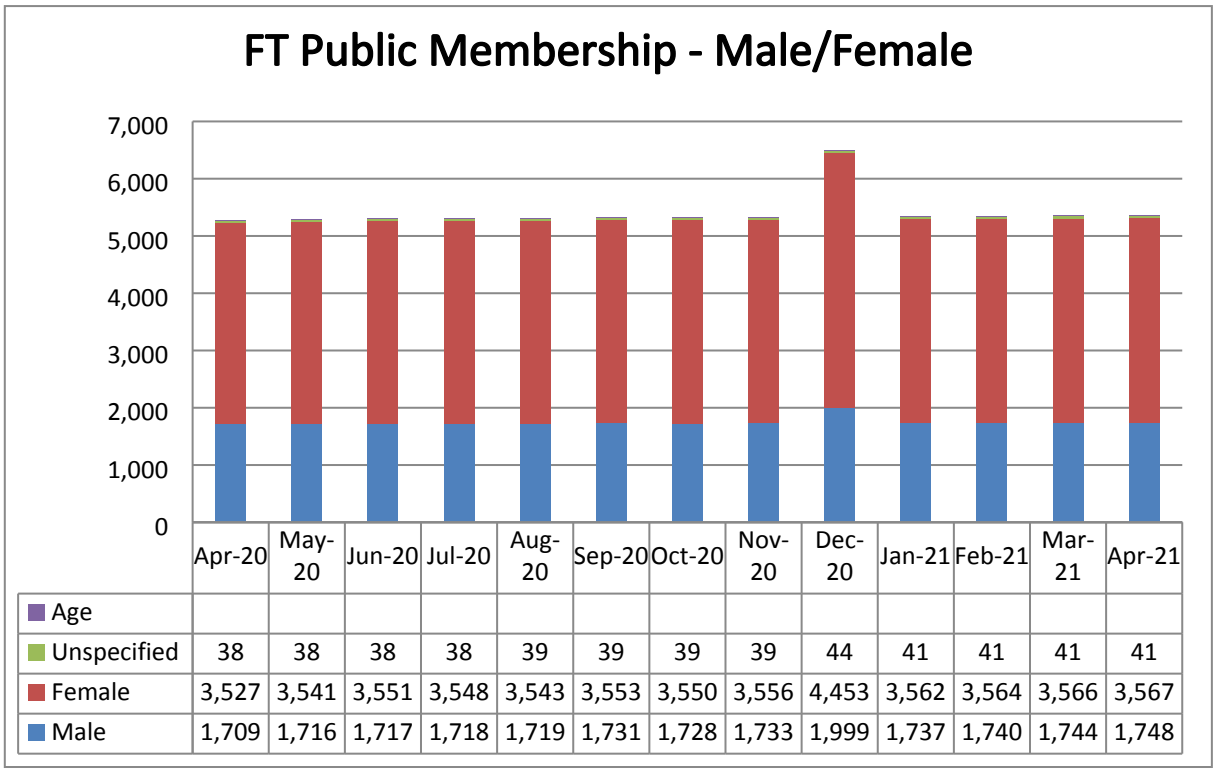
3.4 Constituencies

The breakdown of membership by public constituency, shows, as expected that Shropshire continues to provide the largest membership base.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec 20	Jan-21	Feb-21	Mar-21	Apr-21
Cheshire & Merseyside	348	348	350	351	352	353	352	354	352	351	349	353	352
North Wales	920	924	926	926	927	931	931	932	931	930	930	934	933
Powys	536	538	538	538	538	538	537	539	538	539	538	538	536
Shropshire	2,675	2,689	2,693	2,688	2,685	2,692	2,688	2,690	2,688	2,692	2,693	2,708	2,700
West Midlands	513	514	515	517	516	522	523	526	526	525	526	530	525
Rest of England & Wales	243	242	244	244	243	247	246	247	247	245	244	248	246
Out of Trust Area	39	40	40	40	40	40	40	40	40	58	65	40	64
Total	**5,274**	**5,295**	**5,306**	**5,304**	**5,301**	**5,323**	**5,317**	**5,328**	**5,322**	**5,340**	**5,345**	**5,351**	**5,356**

3.5 Gender

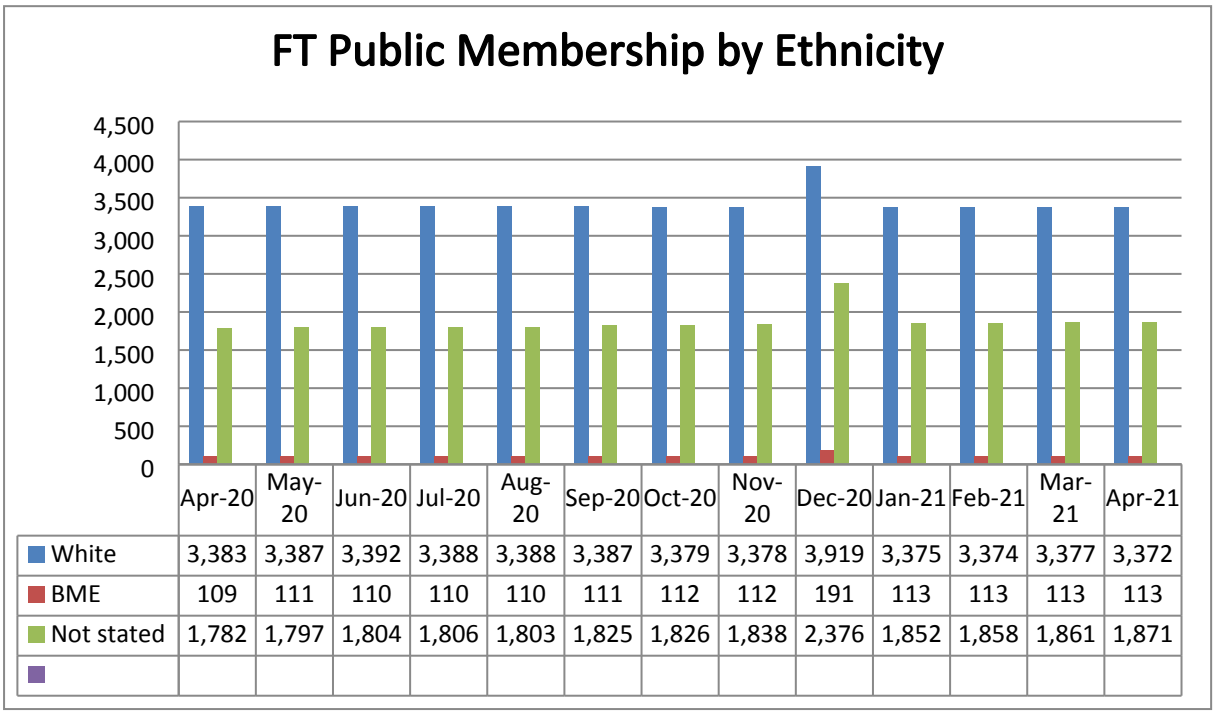
The graph below shows the split between female and male members. This demonstrates that males remain under represented within the membership. The number of male members has increased slightly over the last year.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Age													
Unspecified	38	38	38	38	39	39	39	39	44	41	41	41	41
Female	3,527	3,541	3,551	3,548	3,543	3,553	3,550	3,556	4,453	3,562	3,564	3,566	3,567
Male	1,709	1,716	1,717	1,718	1,719	1,731	1,728	1,733	1,999	1,737	1,740	1,744	1,748

3.6 Ethnicity

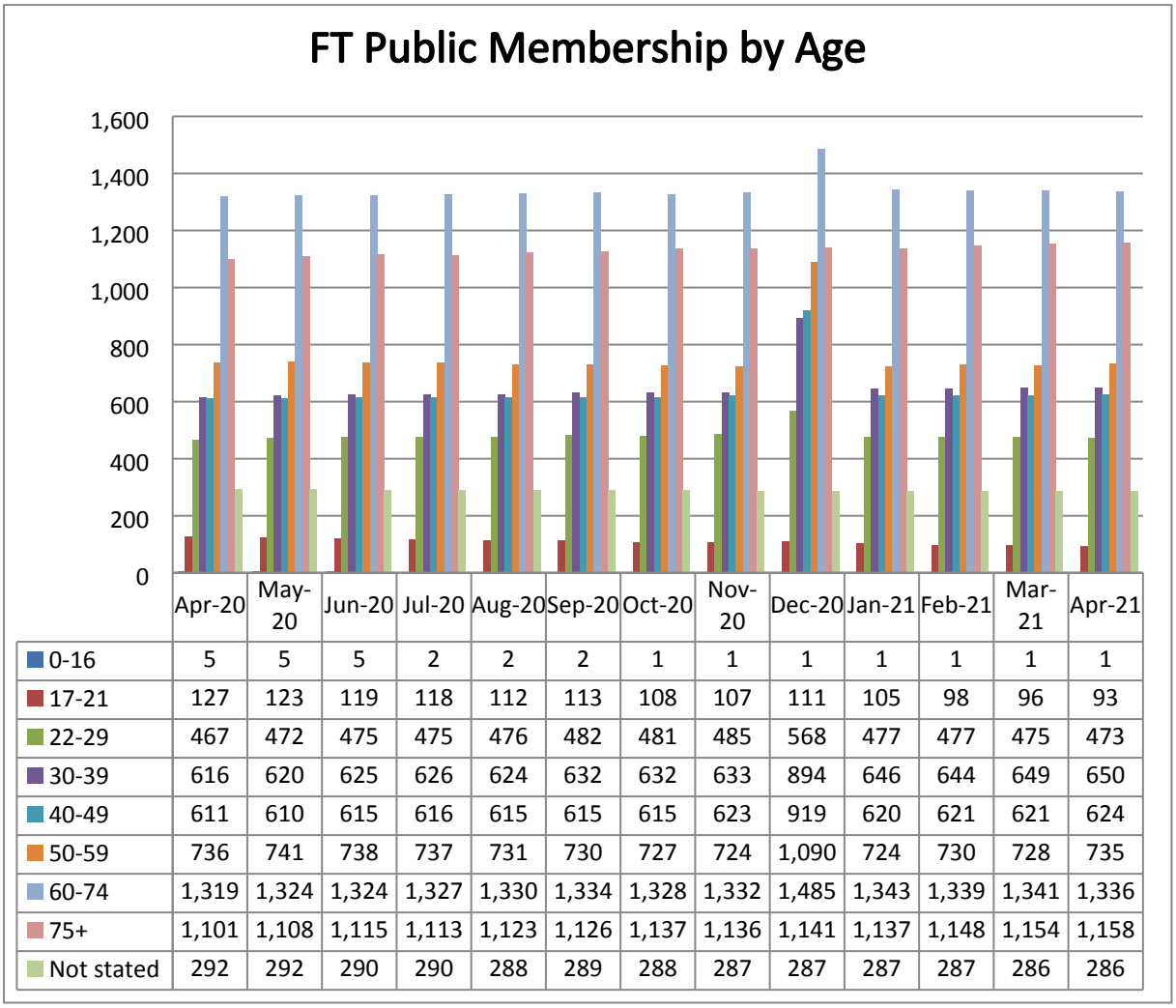
Although relatively small numbers of members are from Black and Minority Ethnic groups, compared to the local population, these groups are representative of the population and therefore the patient base.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
White	3,383	3,387	3,392	3,388	3,388	3,387	3,379	3,378	3,919	3,375	3,374	3,377	3,372
BME	109	111	110	110	110	111	112	112	191	113	113	113	113
Not stated	1,782	1,797	1,804	1,806	1,803	1,825	1,826	1,838	2,376	1,852	1,858	1,861	1,871

3.7 Age

The profile of public membership by age looks to have remained largely the same over the year when looking at the number of members for each category.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
0-16	5	5	5	2	2	2	1	1	1	1	1	1	1
17-21	127	123	119	118	112	113	108	107	111	105	98	96	93
22-29	467	472	475	475	476	482	481	485	568	477	477	475	473
30-39	616	620	625	626	624	632	632	633	894	646	644	649	650
40-49	611	610	615	616	615	615	615	623	919	620	621	621	624
50-59	736	741	738	737	731	730	727	724	1,090	724	730	728	735
60-74	1,319	1,324	1,324	1,327	1,330	1,334	1,328	1,332	1,485	1,343	1,339	1,341	1,336
75+	1,101	1,108	1,115	1,113	1,123	1,126	1,137	1,136	1,141	1,137	1,148	1,154	1,158
Not stated	292	292	290	290	288	289	288	287	287	287	287	286	286

4. Conclusion

The Council of Governors is asked to ***note*** the information contained within this paper.

Work Plan 2021/22
Council of Governors Committee

0. Reference Information

Author:	Gayle Murphy, Trust Office PA	Paper date:	27 May 2021
Executive Sponsor:	Shelley Ramtuhul, Associate Director of Governance	Paper Category:	Governance
Paper Reviewed by:	N/A	Agenda Reference:	N/A
Forum submitted to:	Council of Governors Committee	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Council of Governors Committee and what input is required?

The Committee is asked to ***note*** the current work plan and ***consider*** any amendments required.

2. Executive Summary

2.1. Context

On an annual basis the Committee is required to reflect on the year ahead and broadly agree its agenda. This enables the Committee to ensure that it receives timely information to enable it to meet the responsibilities that have been delegated to it by the Board of Directors.

As the year progresses it is important that the Committee keeps its work plan under review to ensure it is updated to reflect any changing priorities or external factors.

2.2 Summary

Appendix 1 is the work plan for 2021/22 which was agreed by the Committee and incorporates any amendments requested at the last meeting.

2.3. Conclusion

The Committee is asked to ***note*** the current work plan and ***consider*** any amendments required.

Work Programme Review 2021/22

	27th May 2021	29th July 2021	23rd Sept 2021 AGM	25th Nov 2021	24th March 2022
Statutory Reports					
Receive Annual Report and Accounts			X		
Receive Audit Reports			X		
Forward plan					
Consider strategic issues/priorities for Board to consider in the planning process					X
Presentation of plan		X			
Quality					
2021/22 priorities	X				
Quality Indicators to be audited	X				
Quality accounts draft presented			X		
Update on Quality Accounts Audit Actions	X	X		X	X
Trust Developments					
As & When required	X	X		X	X
COG Strategy docs					
Membership & Engagement strategy	X				
COG Governance					
COG Self-Assessment (inc review of outcomes from training)		X			
COG Annual report (for approval)		X			
COG Annual report presentation			X		
Standing items					
Membership report	X	X		X	X
Review of work programme	X	X		X	X
Question & Answer	X	X		X	X
Board Refection	X	X		X	X

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27 May 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Board of Directors	Paper Ref:	N/A
Forum submitted to:	Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Council of Governors and what input is required?

The Council is asked to ***note*** the Board Assurance Framework (BAF)

2. Executive Summary

2.1. Context

The Board of Directors uses the BAF as tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy.

The Board agreed new objectives for 2021-22 in March and as in previous years the Trust continues to align reporting of performance against the objectives with the Board Assurance Framework to facilitate full consideration of the risks to delivery.

This paper presents the BAF aligned to the new objectives.

2.2 Summary

The BAF was last presented to the Board in March 2021 and since this time it has been realigned to the new objectives. This has resulted in the following changes to the risks cited on the BAF:

- New risks have been added:
  - Inability to benchmark outcomes across all specialties
  - Management capacity inhibits engagement with the ICS
  - Lack of designated ED& I resource and expertise
  - Inability to meet baseline activity due to heavy reliance on a high proportion of out of job plan work.
  - Impact of new system financial framework

As the work on the objectives progresses there will be ongoing assessment of risks to delivery with further risks identified and added to the BAF as required.

- The following risks have been removed:
  - Infancy of system structure inhibits response
  - Inability to breakdown silo working both from an internal and external perspective

Where a risk has been removed it does not mean that it is no longer a risk that requires action it means that it is a risk that no longer has potential to impact on the delivery of the

Trust's objectives. These risks will continue to be managed through the Trust's risk management processes.

The re-aligned BAF was presented to the Joint Audit and Risk Committee on 28 April 2021 and where additional risks have been identified and agreed a note is made within the BAF to indicate the further work being undertaken on these risks.

For ease of reference the source of assurance ratings used in the BAF are as follows:

Level 0 – It has not been possible to obtain assurance
Level 1 – Assurance obtained at departmental level
Level 2 – Assurance obtained at organisational level i.e supported by HR, Finance etc
Level 3 – External assurance has been obtained through audit / inspection processes

2.3. Conclusion

The Council of Governors is asked to:

- Note the re-aligned BAF for 2021-22

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

Objective Details:

Opened: April 2021

Reviewed Date:

Key Measures:

- ✓ Modelling plan delivered to the Board
- ✓ Response to planning requirements beyond Q1
- ✓ 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)

Progress Update:

Supporting Programmes of Work:

- Delayed discharge leadership review
- National Clinical Improvement Programme roll out
- System clinical prioritisation programme

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

Following discussion at the Joint Audit and Risk Management Committee a further risk is being worked up in relation to the impact of Covid restrictions on capacity

Lead Director:

Chief Executive

Lead Committee:

Finance Planning and Digital Committee (Additional oversight from Restoration 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: April 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 restoration meeting
- ✓ Key restoration of capacity KPIs
- ✓ Weekly meetings for management of delayed discharges

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
- ✓ Restoration Committee Oversight
- ✓ Outpatient Improvement Board restored
- ✓ System Governance Framework

Gaps In Controls:

- C1: Lack of line of sight on system demand and capacity requirements
- C2: 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:

- ~~A1: System governance of demand and capacity performance~~
- 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 elective orthopaedic waiting list overseen by RJAH, the system has a coordinated approach to treatment by clinical prioritisation overseen by the Clinical Chair for MSK and a group of senior consultants
C2	Project plan to address recommendations from job planning internal audit to be taken to completion	Chief of People	~~Mar 21~~ May 21	Update provided to People Committee in February and further update in May.
C3	Review of leadership for discharge planning with clear escalation structure to be articulated	Chief Nurse	Jul 21	
C4	Established reporting on impact of complexity	Chief Medical Officer	Jul 21	
A2	Review of Patient Experience Strategy	Chief Nurse	~~Dec 20~~ ~~Mar 21~~ Apr 21	Engagement workshops held – draft strategy going to Patient Experience Committee in April

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: April 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

Assurance: Source of Assurance 2

- ✓ Patient Harms Group, Patient Safety Committee and Quality and Safety Committee to provide oversight of Harms Process

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 – audit of harms reviews being undertaken
C1, A2	Clinical Audit established for Harms Reviews to inform reports to Unit	Trust Secretary	Jun 21	Audit plan has been approved via Quality and Safety Committee and data has been received. Resource being mobilised to commence audit. Q&S have approved reporting metrics going forward.
C3	Review of follow up backlog management	Managing Director for Clinical Support Services	~~Dec 20~~ Feb 21	Line of sight via Q&S Committee, data validation exercise has been completed and resource requirements identified – a small working group has been established to take the work forward and additional management resource has been put in place, patient initiated follow up policy in draft
C4	Local clinical prioritisation process to be documented	Managing Director for Support Services	May 21	Draft going through SLG in April

BAF 1.3 Deliver the work to restart elective services NEW — 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: April 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:

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:

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

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: April 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:

- ~~A1: H&S Committee effectiveness~~

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

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	4	2
Total	16	16	4

Risk Details:

Opened: November 2020

Reviewed Date: April 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 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	Discussions are ongoing, system prioritisation and funding sources still to be confirmed – system allocation awaited

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 MSK Alliance

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date:

Key Measures:

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

Progress Update:

Supporting Programmes of Work:

- System winter planning
- System Governance Framework
- Programme plans for system restoration

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 Director:

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

Lead Committee:

Restoration Committee

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

Principle Risk: Management capacity inhibits engagement

Inability to make quick and co-ordinated decisions, potential for conflicts between partner organisations interests, varying levels of performance within the system.

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: April 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Regular CEO forum
- ✓ Regular updates at Senior Leadership Group

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

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	Operational side of ICS Governance Framework being developed
A1	ICS Governance Framework to be embedded and linked in with Trust's own governance	Chief Executive / Trust Secretary	May 21	
A2	ICS Board to approve terms of reference / receive Chair's reports	Chief Executive / Trust Secretary	May 21	Trust responsible for the Financial Sustainability Committee and preparing these reports

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:

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:

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

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	3	2
Total	20	12	6

Risk Details:

Opened: November 2020

Reviewed Date: April 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	

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

Objective Details:

Opened: April 2021

Reviewed Date:

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

Progress Update:

Supporting Programmes of Work:

- Task and finish groups
- Its Not Just Cricket (BAME) Network

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

Following discussion at the Finance Planning and Digital Committee and the Joint Audit and Risk Management Committee a further risk is being worked up in relation to risk around IT systems and cyber security and also a risk in relation to the loss of autonomy over staffing investment decisions and leadership appointments

Lead Director:

Chief of People and Chief Nurse and Patient Safety Officer

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: April 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
- ✓ 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

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	
A2	Additional focus on People Committee sub committee agenda, workplan and attendance with recommendations	Chief of People	~~Nov 20~~ Apr 21	People Committee has moved to monthly meetings and work is underway on sub structure
A3	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	Dec 20	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	3	2
Likelihood	4	4	2
Total	16	12	4

Risk Details:

Opened: March 2018

Reviewed Date: April 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

Gaps in Assurance:

- A1: Alignment of workforce to optimise capacity

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Review of emergency planning resource requirements and potential solution with system to be explored.	Chief Nurse	~~Jan 21~~ Mar 21	Review has been conducted by the CSU and report presented to SLG with recommendation approved - completed
C2, C3, C5	Nursing strategy to be developed to include Nursing Associates	Chief Nurse	~~Nov 20~~ Mar 21	Work ongoing as per update to Board in January – strategy engagement sessions with Senior Nurses held in March
C4, C5	International recruitment to be completed	Chief Nurse	Mar 21	Work ongoing as per update to Board in January – international recruitment interviews commenced
C6	Implementation of CSU recommendations	Chief Nurse and Patient Safety Officer	Jul 21	
A1	Review of workforce alignment required to provide assurance	Chief of Performance, Improvement and OD	~~Nov 20~~ Mar 21	Modelling presented to Strategy Board however planning guidance still awaited and restart plan ready to be implemented

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

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: April 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:

- N/A

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress

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

Principal Risk Lack of dedicated ED&I resource and expertise

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

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: April 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	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	

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:

Key Measures:

✓ 100% of staff offered vaccine

Progress Update:

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:

Key Measures:

- ✓ Deliver on budget by 31 March 2022
- ✓ Deliver agreed activity within resources
- ✓ Board reporting
- ✓ Stabilising the recurrent financial position
- ✓ Delivering a 5% efficiency programme

Progress Update:

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: April 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	Job planning audit recommendations being progressed – update provided to People Committee
C1,C3	Exploration of opportunities to expand core capacity through recruitment	Chief of People	~~Dec 20~~ Apr 21	Recruitment plans in place with update to the Board and People Committee- medical and dental recruitment plan to go to People Committee for implementation and monitoring
C4	Review alignment of workforce with a view to varying workforce to address any identified gaps	Chief of People	~~Dec 20~~ Apr 21	Planning underway with workforce to be aligned once resource requirement confirmed
C5	Non NHS income to be restored	Chief of Finance	~~Dec 20~~ Mar 21	Ongoing linked to restoration plans which are currently impacted by Covid.

BAF 7.2 Deliver Financial Plan NEW — 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: March 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	Medical and dental recruitment plan to go to People Committee for implementation and monitoring
A1	Follow up audit to be completed	Chief of People	Dec 21	

BAF 7.3 Deliver Financial Plan NEW — 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: March 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	
C2	Further participation in transformational improvement programme	Chief of Finance	Ongoing	
C3	Engagement in the system financial stabilisation programme	Chief of Finance	Ongoing	