



The Royal
Orthopaedic Hospital
NHS Foundation Trust

Trust Board (Public) June

Wednesday 5th June, 9:00h - 10:40h

Boardroom, Trust Headquarters



Notice of Trust Board Meeting in Public on Wednesday, 5 June 2024

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 5th June 2024, in the Boardroom, Trust HQ commencing at **09:00**.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Corporate Services Manager no later than 24hrs prior to the meeting, by post or e-mail, to Tammy Ferris, at the Management Offices or via email to: tammy.ferris@nhs.net

Tim Pile
Chair



AGENDA

TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters

Date 5 June 2024: 09:00h – 10:40h

Members attending

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Simon Page	Non Executive Director	(SP)
Mrs Jenny Belza	Non Executive Director	(JB)
Ms Jan Teo	Non Executive Director	(JT)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Professor Lee Jeys	Orthopaedic Oncology Consultant	(LJ)	[Item 1]
Mrs Marie Raftery	Associate Director of Operations Division 1	(MRa)	[Item 8]
Ms Helen Young	Clinical Services Manager	(HY)	[Item 8]
Mrs Michelle Hubbard	Deputy Chief Operating Officer	(MH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Patient story - BOOM Update	Presentation	LJ
09:20	2	Apologies: None Received	Verbal	Chair
	3	Declarations of Interest	ROHTB (6/24) 001	Chair
	4	Minutes of Board Meeting held in Public on 1 May 2024: <i>for approval</i>	ROHTB (5/24) 019	Chair
	5	Actions from previous meetings in public: <i>for assurance</i>	ROHTB (5/24) 019 (a)	SGL
09:25	6	Questions from members of the public	Verbal	Chair



09:26	7	Chair's and Chief Executive's update: <i>for information and assurance</i>	ROHTB (6/24) 002 ROHTB (6/24) 002 (a)	TP/JW
09:45	8	Seamless Surgery Update: <i>for assurance</i>	ROHTB (6/24) 003 ROHTB (6/24) 003 (a)	MRa/HY
09:55	9	Health Inequalities Action Plan: <i>for assurance</i>	ROHTB (6/24) 004 ROHTB (6/24) 004 (a)	NB
GOVERNANCE AND COMPLIANCE				
10:05	10	Corporate Risk Register Review: <i>for assurance</i>	ROHTB (6/24) 005 ROHTB (6/24) 005 (a)	SGL
10:15	11	Health & Safety Annual Report: <i>for approval</i>	ROHTB (6/24) 006 ROHTB (6/24) 006 (a)	SGL
UPWARD REPORTS FROM THE BOARD COMMITTEES				
10:25	12	Upward reports from the Board Committees: <ul style="list-style-type: none"> • Finance & Performance Committee • Audit Committee <ul style="list-style-type: none"> ○ Audit Committee Annual Report ○ Internal Audit Plan • Quality & Safety Committee 	ROHTB (6/24) 007 ROHTB (6/24) 008 ROHTB (6/24) 008 (a) ROHTB (6/24) 008 (b) ROHTB (6/24) 009	LW GH IR
10:35	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
	13	Performance Reports: <i>for assurance</i> <ul style="list-style-type: none"> a) Finance & Performance b) Quality 	ROHTB (6/24) 010 ROHTB (6/24) 011	
10:40	BREAK			
CLOSE: Date of next meeting: Wednesday, 3 July 2024 @ 09:00				

Notes

Quorum:

- i. No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.
- ii. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.
- iii. If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.



ATTENDANCE REGISTER – FY 2024/25 UPDATED TO MAY 2024

ATTENDANCE											
MEMBER	10/04/2023	01/05/2023	05/06/2023	03/07/2023	04/09/2023	02/10/2023	06/11/2023	04/12/2023	05/02/2024	05/03/2024	TOTAL
Tim Pile (Ch)	✓	✓									
Ian Reckless	✓	✓									
Simone Jordan	A	✓									
Gianjeet Hunjan	✓	✓									
Ayodele Ajose	✓	✓									
Les Williams	✓	✓									
Simon Page	✓	✓									
Jenny Belza	✓	✓									
Jan Teo	✓	✓									
Jo Williams	✓	✓									
Matthew Revell	✓	✓									
Nikki Brockie	✓	✓									
Marie Peplow	A	✓									
Stephen Washbourne	✓	A									
Sharon Malhi	✓	✓									
Simon Grainger-Lloyd	✓	✓									

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

* Apologies tendered as attending a national event on behalf of the ROH, mandated for all NHS trusts



TRUST BOARD DECLARATIONS OF INTEREST REGISTER

Name	Interest	Voting Member
Tim Pile Chair	<ul style="list-style-type: none"> • Council Member, Aston University 	Yes
Jo Williams Chief Executive	<ul style="list-style-type: none"> • Trustee, Versus Arthritis 	Yes
Simon Grainger-Lloyd Director of Governance	<ul style="list-style-type: none"> • None declared 	Yes
Steve Washbourne Chief Finance Officer	<ul style="list-style-type: none"> • Governor at University of Birmingham School • Independent Member of the Audit Committee at Aston University 	Yes
Marie Peplow Chief Operating Officer	<ul style="list-style-type: none"> • None declared 	Yes
Matthew Revell Medical Director	<ul style="list-style-type: none"> • Fellow of the Royal College of Surgeons • Member British Orthopaedic Association and British Hip Society • Founding Fellow of the Faculty of Medical Leadership and Management 	Yes
Nikki Brockie Chief Nurse	<ul style="list-style-type: none"> • None declared 	Yes
Sharon Malhi Chief People Officer	<ul style="list-style-type: none"> • Trustee, Victoria Academies Trust 	Yes
Michelle Hubbard Acting Executive Chief Operating Officer	<ul style="list-style-type: none"> • None Declared 	Yes
Simone Jordan Non Executive Director & Vice Chair	<ul style="list-style-type: none"> • Managing Director, Simone Jordan & Associates Limited • Non Executive Director, George Eliot Hospital NHS Trust • Member of the Chartered Institute of Personnel and Development • Acting Chair of Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB). Substantive role as Vice Chair of LLR ICB. 	Yes

Name	Interest	Voting Member
Les Williams Non Executive Director	<ul style="list-style-type: none"> • None declared 	Yes
Gianjeet Hunjan Non Executive Director	<ul style="list-style-type: none"> • Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of IHSCM • Member of HFMA • Fellow of Chartered Institute of Public Finance and Accountancy (CIPFA) • Member of Nishkam Healthcare Trust at local Gurdwara 	Yes
Ayodele Ajose Non Executive Director	<ul style="list-style-type: none"> • None declared 	Yes
Ian Reckless Non Executive Director	<ul style="list-style-type: none"> • Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust • Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust) • Director, JTER Trading Limited (company involved in property services and antiques trading) • Fellow, Royal College of Physicians • Fellow, Faculty of Medical Leadership and Management • Member of Congregation, University of Oxford • Appointed as Chief Medical Officer at Bedfordshire, Luton and Milton Keynes Integrated Care Board. This role is carried out alongside substantive post at Milton Keynes University Hospital (0.4 WTE secondment) as of 15 April 2024 for six months. 	Yes

Name	Interest	Voting Member
Simon Page Non Executive Director	<ul style="list-style-type: none"> • Deputy Chair, South Warwickshire NHS Foundation Trust (SWFT) • Owner, Weathervane Consultancy 	Yes
Jenny Belza Non Executive Director	<ul style="list-style-type: none"> • Vice Chair and Non Executive Director, Birmingham Community Healthcare Trust • Governor, University College Birmingham 	Yes
Jan Teo Non Executive Director	<ul style="list-style-type: none"> • Non Executive Director, Birmingham Community Healthcare Foundation Trust (1 March 2023 to 28 February 2026) • Company Director, 3 Castle Street (RTM) Limited • Oversight Board, K2CO (Dance Company) 	Yes



MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters

Date 1 May 2024: 0900h - 1250h

Members attending:

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mr Les Williams	Non-Executive Director	(LW)
Mrs Gianjeet Hunjan	Non-Executive Director	(GH)
Dr Ian Reckless	Non-Executive Director	(IR)
Mrs Jenny Belza	Non-Executive Director	(JB)
Mr Simon Page	Non-Executive Director	(SP)
Ms Ayodele Ajose	Non-Executive Director	(AA)
Miss Jan Teo	Non-Executive Director	(JT)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Matthew Revell	Executive Medical Director	(MR)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)

In attendance:

Miss Samantha Scone	Clinical Educator	(SS)	[Item 1]
Mrs Marie Raftery	Associate Director of Operations Division 1	(MR)	[Item 8]
Mr Nas Uddin	Associate Director of Operations Division 2	(NU)	[Item 8]
Mrs Coralie Duff	Associate Director of Operations Transformation	(CD)	[Item 8]
Mrs Joanne Thomas	Associate Medical Director Division 2	(JoT)	[Item 8]
Mrs Karen Hughes	Head of Nursing Division 2	(KT)	[Item 8]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AR)	[Item 13]
Mrs Amanda Gaston	Deputy Director of Finance	(AG)	
Mrs Michelle Hubbard	Acting Executive Chief Operating Officer	(MH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

1	Staff story (SS)	Presentation
	TP welcomed Samantha Scone (SS), Clinical Educator, to the Board meeting. SS is a Clinical Educator in the Clinical Education Team. Main role is leading on the preceptorship scheme at the Trust, which was newly launched in October 2023. SS	



provided an overview of her career history as a nurse, and her journey to the ROH. SS explained that during the Covid pandemic she took a change of career path from A&E nursing to HDU here at ROH in 2021. SS explained that she was aware of the Trust and lives locally to the hospital. SS emphasised how welcoming the hospital was and has never worked somewhere so friendly. SS explained that she has had better support, better educational opportunities at this Trust compared to previous experience. SS worked on HDU for approximately 12 months and was looking for progression. Teaching students was something that had always interested SS and a position for a secondment as a Clinical Educator came up supporting the Trainee Nurse Associates. An opportunity then came up to set up a preceptorship programme here at the Trust. SS explained there was no consistency in the programme previously and with amazing support from people across the Trust, and networking with other Trusts this has evolved. SS explained it used to only be nurse based but the new national framework guidance means it is mandatory and it covers a number of multi-disciplinary groups now. There are many enquiries from third year students enquiring about what our programme is like as they are keen to continue with us. SS explained the aim of the preceptorship programme is to grow those in their roles and not just focus on the clinical work.

SS explained in February 2024 the ROH was awarded National Preceptorship accreditation. SS explained today is the first day for the next cohort and there are approximately 20 new colleagues that have joined the scheme.

SS shared the feedback from cohort that has just completed, and emphasised how valuable the programme is.

SS has just completed the Professional Nursing Advocate programme and is awaiting her results.

SS explained that she is going on maternity leave in July and emphasised how well she has been looked after and cannot thank the team enough for the support; something that she did not experience on her previous maternity leave at another Trust.

NB thanked SS for her commitment to get through the National Preceptorship Programme accreditation. NB asked if there was anything she would do what would that be. SS raised the concern is when the numbers begin to drop, especially with the reduction of international nurses. SS explained that this is already being considered and looking at ways to change the programme to fit.

JT enquired how do we adapt the programme to consider international nurses and their previous experience. SM explained that there is a robust induction and orientation when they arrive which incorporates a lot of pastoral care. SM explained that as an organisation we are agile enough to adapt to their needs. NB explained that we consider their previous experience, and it depends on where they are working.

IR enquired how do we support development, but also encourage people to come



<p>back to the Trust. SS explained that across the Trust you will see that people already do that and there are many opportunities. The Trust pulls you back because of how people feel, it is so kind here, it is like a community and that draws people back. We have a nice environment. IR enquired could we more proactive in secondment opportunities for colleagues to experience elsewhere. SS explained that a Clinical Educator was considering the opportunity for rotation but there is work to progress this.</p> <p>MP enquired, as the numbers might be dropping, could we widen the offering to the System and perhaps look at this as an income generator. SS explained that yes this can be offered out to people.</p> <p>NB explained in response to IR question that there are secondment opportunities with ITU at University Hospital Birmingham (UHB) already underway.</p>	
<p>2 Apologies (chair)</p>	<p>verbal</p>
<p>Apologies received and noted from Steve Washbourne. The apologies were accepted by the Board.</p> <p>Welcome to Amanda Gaston, Deputy Director of Finance, who is representing SW today.</p> <p>Welcome back to Marie Peplow, Chief Operating Officer, who has returned after a period of leave.</p>	
<p>3 Declarations of Interest (chair)</p>	<p>ROHTB (5/24) 001</p>
<p>There were no new declarations to record.</p>	
<p>4 Minutes of Board Meeting held in Public on 10 April 2024: <i>for approval (chair)</i></p>	<p>ROHTB (4/24) 027</p>
<p>The minutes of the meeting held in public on 10th April 2024 were approved by the board subject to one amendment highlighted by GH.</p>	
<p>5 Actions from previous meetings in public: <i>for assurance</i> (SGL)</p>	<p>ROHTB (4/24) 027 (a)</p>
<p>SGL confirmed the amber actions listed on the action tracker will be covered when the Staff Experience & OD Committee meet in June.</p> <p>SM provided assurance that a quarterly update on disciplinary incidents is provided at Staff Experience & OD Committee.</p>	
<p>6 Questions from members of the public (chair)</p>	<p>verbal</p>
<p>No questions were received in advance of the meeting</p>	



<p>7 Chair’s and Chief Executive’s update: <i>for information and assurance</i> (TP/JW)</p>	<p>ROHTB (5/24) 002 ROHTB (5/24) 002 (a)</p>
<p>Chief Executive Update</p> <p>JW highlighted the following:</p> <ul style="list-style-type: none"> • Seamless Surgery – Taking place this week and JW thanked MH and NB for the organisation of this. JW visited the theatres at the start of the week and was pleased to see the service being provided, along with the ideas for improvement that were being generated. • Nursing & AHP Conference – on Tuesday 30 April 2024, the ROH hosted its inaugural Orthopaedic Nursing and Allied Health Professionals Conference. Thank you to NB and the team for delivering this day. • Performance – Operational performance targets performed well in February 2024 with a reduction in the number of patients waiting over 65 weeks now being at 39, (January 68), the majority of those outstanding being in Spinal Services. • ICB – The ‘Open Conversation’ has reopened and all colleagues who work in BSol are invited to give feedback. It closes on 7th May. • All BSol Executives/Chief Executive Officer Session – This took place on Friday 26 April. <p>Chair Update</p> <p>TP provided the following highlights:</p> <ul style="list-style-type: none"> • The Trust were pleased to welcome members of the from ICB Executive Team to take them through our sustainability plan and shared with them what our intentions are. TP thanked the team for their presentations. • TP has visited a number of areas in the Trust over the past month and would highly recommend Non-Executive Directors to go and visit areas to really understand how these area works. One example was the ‘Coffee Catch Up’ which TP attend last week where approximately 100 patients attended. It was an opportunity to share how we could improve but the responses were very positive. TP encouraged others to take part. <p>AA explained that she recently participated in the ‘Tea Trolley’ and found that valuable. It really is a great way to get around the Trust.</p>	
<p>7.1 Council of Governors Update: <i>for assurance</i> (SGL)</p>	<p>Verbal</p>
<p>SGL provided an update on the Council of Governors meeting that took place on 24th April 2024.</p>	



<ul style="list-style-type: none"> • The meeting was well attended by Non-Executive Directors and Governors. • Three new Stakeholder Governors joined us. • Updates were given on Staff Survey by SM and Quality Priorities by NB • The Governors agreed the new quality priority that they will sponsor in 2024/25. • SGL provided an update on the CQC updates and the well led self-assessment work that has taken place. • The governor recruitment plan was shared as there are a number of vacancies. • A workshop was then held by RL and AG on Organisational Sustainability in the afternoon. 	
<p>8 Divisional Lookback 2023/24 and Forward Plan 2024/25: for assurance (MR/NU/CD)</p>	<p>ROHTB (5/24) 004 ROHTB (5/24) 004 (a) ROHTB (5/24) 004 (b) ROHTB (5/24) 004 (c)</p>
<p>Nas Uddin, Marie Raftery, Coralie Duff, Joanne Thomas, and Karen Hughes joined the meeting to present to the Board.</p> <p>TP welcomed the group and took the papers as read.</p> <p>NU thanked the Board for opportunity to be able to present the successes over the past 12 months.</p> <p>NU highlighted the key points from the presentation for Division 1 including:</p> <ul style="list-style-type: none"> • Achievements of targets as listed in presentation. • Successful ‘Coffee Catch Ups’ that see post operative patients come together and give them opportunity to feedback. • Mutual Aid support which demonstrates how much the ROH support the System. • Reduction of Agency nursing usage. KH explained that there has been work undertaken to reduce our vacancies and by the end of the month we should have no nursing vacancies in Division 1. We are getting a significant number of applicants and shows the reputation of ROH is spreading. • New upper limb complex spasticity service has great potential and keen to see this expand. <p>NU explained how the plans for 2024/25 have been developed in line with the Trust Strategy.</p> <p>LW recognised the enthusiasm and thanked NU for the presentation. LW queried the expansion plan and questioned would it require additional costs to deliver, is</p>	



there a coherent overarching plan for this. NU explained that to start we need to regain our market share which we have the capacity within the Trust to do that. NU explained that we are losing patients to private work, and we have the ability to get these patients back. JoT explained that a number of meetings have taken place with Finance to ensure we are maximising the potential growth through what we already have to ensure we manage within the finances we have.

SGL recognised KH and Jennifer Pearson, Head of Nursing Division2, on the implementation of the Patient Safety Incident Response Framework (PSIRF).

MH thanked NU, KH and JoT for their drive and ambition.

GH explained how encouraging it was to see there is a plan to provided outreach to ensure we are reaching out to communities. GH enquired is there a plan to continue the after care in an outreach style also. NU explained that the community outreach plan is to reach those patients that cannot get to us otherwise, initially it is about getting our footprint out into those communities.

MP raised that we should revisit the ROH Bus that we have considered before as a means of reaching those communities.

GH raised we could linked this into the education sector too.

TP enquired how many consultants are we looking for. NU confirmed 5 consultants.

TP praised the incredible achievement for last year and we have an ambitious plan for 2024/25, TP enquired can this be delivered. NU responded that the starting aim is to deliver at least 50% of this; this would be a success. In order to deliver all of it would require resource.

JB enquired if the list of ambitions is in order of prioritisation. NU explained that is what is being worked on at the moment.

MRa highlighted the key points for Division 2:

- Praise to Imaging who have had an incredible year.
- Our DNA rates are impressive.
- Supporting system with 2 MRI spots per week and we have agreed we will increase to 3 sessions for 6 months.
- Therapies waiting list was a concern, and at peak at 45 weeks and now averaging 21-24 weeks so we are nearer to the 18 weeks wait target.
- Pharmacy is consistently delivering their TTOs within the timeframe agreed.
- It is recognised that more work is needed to support Theatres and with the Day Case Unit proposals this will help improve this.



- Anaesthetics are fully recruited with consultants.

MRa explained how the plans for 2024/25 have been developed in line with the Trust Strategy, and how Division 2 will impact this the most. MRa highlighted the following:

- Apprenticeship programme in radiography and look to grow our own.
- End to end pharmacy service to reduce any errors.
- Initiated in HDU where our occupational therapists rotate to UHB for ICU experience to maintain their skill.

MR thanked the team for the presentation and it is clear that the two divisions are working closely together now rather than seeing them as separate entities.

LW enquired about the physio waits that are still high and when will 18 weeks be delivered. MRa explained it will be nearer to the end of the year before this could be achieved. It is a very dynamic workforce that move around so we need to fill before the backlog takes hold. We need to sustain the workforce now.

SM highlighted the relationship with the university is crucial and this allows the pipeline growth.

TP enquired about ADCU opening until 10pm, what will the benefits be. MRa explained it will allow consultants to continue day case procedures longer into the day. KH explained that currently we are having to send patients to wards and discharge from there. MRa explained that colleagues are really engaged, and shift patterns have been worked up which will give them a greater flexibility in work/life balance.

CD explained how the system integration works and the shared working that has been taking place with Robert Jones Agnes Hunt (RJA) and this has supported the outpatient transformation.

CD highlighted the key points of the outpatient transformation programme:

- We are an exemplar Trust with PIFU (Patient Initiated Follow Up)
- Focus is on DNA rates. In particular DNA rates in imaging have greatly reduced through the use of DrDoctor. This has now been switched on to all our appointments.
- Focus on process and how we improve, including how we work with primary care. Working with Medical Directors at ICB to ensure the message and communications are widely available in the system.
- The work is underpinned by digital transformation.
- The green agenda is linked into the workstreams, including putting patient



<p>letters onto DrDoctor, and ensuring patients are not travelling unnecessarily.</p> <p>JW praised how amazing the team are and the work they have produced. The ambition and drive are second to none. The team’s commitment has been demonstrated in the presentations today, and JW emphasised the great pride she had of the team.</p> <p>MH echoed what JW has shared and thanked the team.</p> <p>MP thanked the team for the delivery and commented that it was a great day to return.</p> <p>TP enquired what is the ambition for PIFU, CD explained that national target is 5%, we have achieved 8% and we are aiming for 10%; once digitally enabled we could achieve 12%. CD explained that this has been clinically led and the next steps is communication.</p> <p>TP concluded the three words to describe the presentations: achievement, ambition and passion. It was uplifting and a sense of pride in the work that is being produced. TP thanked the team on behalf of the Board.</p> <p>TP enquired when will the corporate services lookback will be shared. SGL explained this is to be planned and will work with RL to confirm.</p> <p>ACTION: Provide a date of when the Corporate Services Division Lookback/Forward Plan will be shared with the Board. RL/SGL</p>	
BREAK	
<p>9 Wellbeing Action Plan Summary: <i>for assurance</i> (SM)</p>	<p>ROHTB (5/24) 005 ROHTB (5/24) 005 (a)</p>
<p>SM provided highlights from the one-page summary that has been provided as part of the meeting pack.</p> <p>SM explained that the team are currently working through creating a road map to make it more visual.</p> <p>AA enquired about the manager upskilling and asked how we measure the success of this; and queried if we had considered 360 Feedback. SM explained this is being considered and with the recruitment of the new People Promise Manager this will form part of her role.</p> <p>JB enquired how much risk is there around the funding. SM explained there is risk but currently working with the community to secure this and look at alternatives. JW explained that we need to demonstrate the benefits of continuing this to ensure we can secure funding in the future.</p>	
<p>10 Quality Priorities Update: <i>for assurance</i> (NB)</p>	<p>ROHTB (5/24) 006 ROHTB (5/24) 006 (a)</p>
<p>NB took the paper as read and highlighted the key points:</p>	



<ul style="list-style-type: none"> • At the end of 2023/24 we delivered against three of the five quality priorities that were set. Two priorities, in the spirit of continuous improvement, we want to carry on to the next year to ensure we have addressed all the learnings. • NB explained there are five proposed for next year that are still being worked through. • NB shared that we have now gone live fully on Patient Safety Incident Response Framework (PSIRF). • Health inequalities is a focus for this year so this is listed as a priority. <p>NB explained that this is still in draft, and the next steps will be for this to go Quality & Safety Committee at the end of this month, and then will come back to the Board in June for approval as part of the overall Quality Account.</p> <p>JB enquired what is the main focus on the health inequalities and queried how is it measurable. NB explained that following conversations at previous Board meetings we are aware of refinement needed, and this is being worked through. JW explained that the Chief Delivery Officer for the system explained their role is to ensure the system works on the health inequalities, and as a Trust we need to show how we can support this.</p> <p>TP explained the Governors are going to continue to sponsor the patient optimisation priority.</p>	
<p>11 MSK Transformation: <i>for assurance</i> (RL/MR)</p>	<p>ROHTB (5/24) 007 ROHTB (5/24) 007 (a)</p>
<p>RL explained the purpose of the presentation is to demonstrate the progress that has been made on MSK Transformation over the past few years.</p> <p>RL highlighted the work across the system that has evolved, and we now have a robust weekly collaborative meeting across the system in place. Partnership working has developed across this programme and is crucial.</p> <p>RL highlighted the priorities across the next 12 months:</p> <ul style="list-style-type: none"> - getUBetter App. There has been access to national funding. It is about to be offered to all NHS colleagues. - Community Appointment Day. Output from Sussex was that over 50% opted to come off the waiting list as a more holistic review of the care was taken. - Clinical Decision-Making Tool. The Ortho pathway is being worked through. - MSK Workforce Model. This needed to provide assurance. We are working with our colleagues to understand what already exists. We now have the profile in six localities, and this will now help us provide an equitable model across the six localities. <p>The success of this programme is the relationships that are being built and the collaborative working. MR emphasised the group address the current issues and are working across the system in partnership.</p>	



JT queried in the partnerships and what assurance is there for self-management. RL explained this has been considered and the product encourages motivation. Signposts within the app is individually profiled. There are ten languages available in the app and this has been matched across the needs of those that live in Birmingham and Solihull. Physical resources have been built in too, as not everyone wants to be directed to an app. A website has been built, thanks to funding from NHS Charities, which would direct you to groups that meet in person. This provides a wider range of social support to people.

SM queried the WorkWell hub and enquire how do we use the intelligence we have across our own organisations, so we don't reinvent the wheel. RL explained this is currently an idea so absolutely will evolve with what is already been done across the system.

JB queried what have we got in place to communicate with our patients and communities, and questioned how we are engaging them. RL explained that the roll out is still in pilot stage and engagement is being reviewed as part of this. The data is being considered as a system as well as nationally. From a patient engagement aspect, we have been relying on our partners, for example Versus Arthritis, and we have brought in patient feedback through them, but as we move formally to procurement, we would need to ensure patient feedback is crucial.

TP queried does this need to be more formalised in a provider collaborative way and what does success look like. TP emphasised we need to explain how this will be unified, and by working in a collaboratively way we will deliver it.

SP enquired how confident are we in changing people's behaviours. MP explained that the self-prevention was happening at ground level, and this needs to be shared with the system as to the benefits this will give, and examples of success are available to be shared.

MR explained that with the app the quantifiable are available and we are confident it does make a difference. The question is it deferring referrals or reducing referrals, and this is not clear yet.

SJ raised that an innovation process is needed and should be held at system level. JW highlighted this has been work in progress for the past five years and there are teams across the system we need to work with. As a Trust we need to pick the items that we can make the greatest impact on. Versus Arthritis are willing to work with us to produce a document that will demonstrates of the benefits. We need to look at supporting our own colleagues with physiotherapy.

SJ raised we should consider strategic partnership with other Trusts so we can achieve the same goal.



<p>SJ highlighted that much of our plans is predicated on workforce and queried what plans have we got to support this. SM explained that this is currently at a standstill. SM agreed to take this offline and work up what investment would look like.</p> <p>ACTION: Produce a workforce plan that enables support to the programmes of work attached to MSK Transformation. SM</p> <p>MP explained that workforce plan was considered as part of this programme that was produced by the Commissioning Support Unit (CSU) and this can be shared. SP challenged this is a big piece of work and we have a number of other priorities so how can be assured that we can cope with this work. RL explained that as the programme has developed, we have held on to many of these, we are now looking at the leadership of these workstreams so that this is shared across the group. RL explained there is a monthly steering group. RL would be able to provide an update at the July Board meeting.</p> <p>ACTION: Provide an update of leadership of workstreams for MSK and next steps to July Board meeting. RL</p> <p>TP challenged how do we gain people’s attention by demonstrating the benefits this programme can give.</p>	
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GOVERNANCE AND COMPLIANCE

<p>12 Board Forward Plan: <i>for assurance</i> (SGL)</p>	<p>ROHTB (5/24) 008 ROHTB (5/24) 008 (a)</p>
<p>TP thanked SGL for producing the board forward plan following last month’s meeting.</p> <p>The board agreed following discussions today the Corporate Services Lookback and forward look will need to be incorporated also into the plan.</p> <p>TP requested the balance in the quarters to be reviewed to ensure fair distribution.</p> <p>JB raised National Staff Survey needs to be included.</p> <p>AG requested under financial planning to included 2025/26 planning in Quarter 4.</p> <p>LW queried if we should be including the ICB Balanced Scorecard.</p> <p>NB raised the need to include controlled drugs and the HTA inspection.</p> <p>SGL thanked members for their comments and would look to amend the plan as required.</p> <p>ACTION: Update the Board Forward Plan to include the above discussions and reissue to Board members. SGL</p>	



13 Refreshed Board Assurance Framework: for assurance (AR)	ROHTB (5/24) 009 ROHTB (5/24) 009 (a)
<p>Adam Roberts (AR), Assistant Director of Governance & Risk, joined the meeting.</p> <p>AR explained that the six board assurance framework risks have not changed. AR explained that the summary and quarterly risk score movements will be shared with the Board on a regular basis. The summary is a simplified higher level of the six strategit risks. This will be a regular feature of the board updates.</p> <p>AR confirmed a cleansing of the corporate risks has taken place by the Executive team. Since the last presentation a ranking and rating has taken place.</p> <p>Moving forward, based on the risks and the mitigations, the next steps is for the board to discuss and approve the risk. This will take place at subcommittee level and then an upward report will be produced and shared to the Board.</p> <p>JW explained that following a discussion at Executive Team meeting it was agreed that this would be refined and shared with the Board.</p> <p>SGL confirmed that this will be available to share at the next trust board in June.</p> <p>ACTION: Provide an update Corporate Risk Register to June Trust Board. SGL/AR</p> <p>TP enquired how does the sense check take place. AR confirmed this will happen at subcommittee level.</p> <p>TP queried workforce remains red. SM explained that this will be reviewed and reduced by the time this comes to the next meeting.</p> <p>LW raised it would be helpful to include a timeframe also.</p> <p>IR queried if we are underscoring some of these risks. JW agreed and this will be discussed in the sub committees.</p> <p>SGL explained that SR4 and SR6 will be discussed at Board level, and this will be included in a future agenda to allow time to discuss.</p>	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
14 Upward reports from the Board Committees: (cttee chairs) a) Finance & Performance Committee b) Charitable Funds Committee	ROHTB (5/24) 011
Charitable Funds Committee Update – AA AA highlighted the key points from the upward report: <ul style="list-style-type: none"> The Cazenove presentation raised much discussion and many questions. A 	



<p>separate session on investments funds is to be arranged.</p> <ul style="list-style-type: none"> • The Hardship fund remains available and positive quotes were shared from those people benefitted from the fund. • Blue Heart Awards is again being supported by the Charity. • One page summary of what has been funded is now produced for each meeting as means of an update. • A number of bids were approved including Art for Health Workshop to help patients as part of their treatment plan, and research in the community supported for work to continue for a further six months. <p>JT queried how often do we look at our investment approach. JW explained that we need to agree our process with them.</p> <p>AA reached out to the Non-Executive Board members to support in meeting with Cazenove.</p> <p>Finance & Performance Committee – LW</p> <p>LW highlighted the key points from the two Finance and Performance Committee meetings that were held in April:</p> <ul style="list-style-type: none"> • 23rd April meeting was held to consider the revised Financial Plan for 2024/25 and considered proposals to achieve breakeven position. • 30th April meeting considered the year end operational, finance and workforce performance and details of this was provided in Chief Executive report shared with the Board. • Excellent performance in private patient income • Cost Improvement Programme (CIP) is a fantastic result and a credit to the team on the delivery. • A presentation on the capital plan prior to a more detailed discussion at next month took place. • It was noted further work to be done on appraisals and mandatory training. • In summary, 2023/24 has been a challenging year, but evidence of great progress and potential for further improvement particularly in productivity. The Committee expressed its gratitude to all Executives and staff involved. <p>TP thanked LW for his role as Chair of the F&P committee and the update.</p>	
MATTERS TO BE TAKEN BY EXCEPTION ONLY	
15 Performance Reports: <i>for assurance</i>	



<ul style="list-style-type: none">• Finance & Performance• Quality & Safety• Workforce	ROHTB (5/24) 012 ROHTB (5/24) 013/013(a-b) ROHTB (5/24) 014/014 (a)
The performance reports were taken as read and no queries were raised.	
Date of next meeting: Wednesday, 5 June @ 0900h	



Next Meeting: 5 June 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 23 May 2024

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.221	Wellbeing Plan	ROHTB (10/23) 005 ROHTB (10/23) 005 (a)	10/4/2023	Present the revised leadership competency framework to Staff Experience & OD Committee in October 2023	SM SGL	25/10/2023 27/03/2024 26/06/2024	Deferred to the January-March June 2024 meeting - built into Executive appraisals for 2024	
ROHTBACT.233	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	12/6/2023	Provide benchmark report on food standards and themes from patient and staff on a regular basis to relevant committees and report back to Trust Board	NB	05/06/2024 03/07/2024	Deferred to July meeting	
ROHTBACT.243	Flu Vaccination Update	ROHTB (4/24) 007 ROHTB (4/24) 007 (a)	4/10/2024	Prepare a communication campaign and provide an update to the Quality and Safety Committee in May	NB	05/06/2024 02/10/2024	Date updated to as campaign work will not commence until August/September time. Schedule for Q&S Committee in September. Update to Trust Board in October.	
ROHTBACT.250	Divisional Lookback 2023/24 and Forward Plan 2024/25	ROHTB (5/24) 004 ROHTB (5/24) 004 (a) ROHTB (5/24) 004 (b) ROHTB (5/24) 004 (c)	5/1/2024	Build into the Board Forward Plan a Corporate Services Lookback/Forward Plan presentation.	SGL	5-Jun-24	Scheduled for the July 2024 meeting	
ROHTBACT.238	EPRR Position Statement	ROHTB (2/24) 010 ROHTB (2/24) 010 (a)	2/6/2024	Provide an update on the EPRR Position Statement following the next assessment	SW	4-Sep-24	ACTION NOT YET DUE	
ROHTBACT.235	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	3/7/2024	Provide an update on themes/feedback from 'Check and Chat' sessions to Board twice a year.	JW	3-Jul-24	ACTION NOT YET DUE	

ROHTBACT.232	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	3/7/2024	Provide a preceptorship update via a staff story in approx 8 months.	NB	4-Dec-24	ACTION NOT YET DUE
ROHTBACT.239	Health Inequalities	ROHTB (3/24) 005 ROHTB (3/24) 005 (a)	3/7/2024	Provide an update on the Health Inequalities action plan, detailing how it will be delivered.	NB	5-Jun-24	On agenda for June Board Meeting.
ROHTBACT.241	Guardian of Safe Working Update	ROHTB (4/24) 002 ROHTB (4/24) 002 (a)	4/10/2024	Invite Joanne Thomes, Associate Medical Director to give an update on Women in Orthopaedics.	MR	2-Oct-24	ACTION NOT YET DUE
ROHTBACT.242	Service Accreditation	ROHTB (4/24) 006 ROHTB (4/24) 006 (a)	4/10/2024	Provide an update on progress at the May Quality & Safety Committee and September Board Meeting.	NB	4-Sep-24	To be given at the July QSC and the September Board meetings
ROHTBACT.245	Freedom to Speak Up Assurance Report	ROHTB (4/24) 010 ROHTB (4/24) 010 (a)	4/10/2024	Invite FTSU Guardian to the September Trust Board to provide an update on the national changes.	SGL	4-Sep-24	ACTION NOT YET DUE
ROHTBACT.251	MSK Transformation	ROHTB (5/24) 007 ROHTB (5/24) 007 (a)	5/1/2024	Produce a workforce plan that enables the MSK programme of work to be supported.	SM	3-Jul-24	ACTION NOT YET DUE
ROHTBACT.252	MSK Transformation	ROHTB (5/24) 007 ROHTB (5/24) 007 (a)	5/1/2024	Provide an update on the leadership of workstreams and the programmes next steps to July Board meeting.	RL	3-Jul-24	ACTION NOT YET DUE

ROHTBACT.253	Refreshed Board Assurance Framework	ROHTB (5/24) 009 ROHTB (5/24) 009 (a -g)	5/1/2024	Provide an update on the Corporate Risk Register to the June Trust Board	SGL	5-Jun-24	On June Agenda.	
ROHTBACT.222	Equality & Diversity Improvement Plan	ROHTB (10/23) 008 ROHTB (10/23) 008 (a)	10/4/2023	Ensure the disciplinary process appears on the SE&OD and Trust Board agenda with regular update and progress reports	SM	07/02/2024 27/03/2024 26/06/2024	Disciplinary includes as part of Workforce overview	
ROHTBACT.244	Board Topics Plan	ROHTB (4/24) 009	4/10/2024	Provide a detailed forward plan on the Board Topics to the May Board meeting	SGL	1-May-24	On May Board Agenda. PROPOSE CLOSURE	

KEY:

	Verbal update at meeting needed
	Major delay with completion of action or significant issues likely to prevent completion to time
	Some delay with completion of action or likelihood of issues that may prevent completion to time
C-19	Delayed completion principally due to impact of Covid-19 response
	Action that is not yet due for completion and there are no foreseen issues that may prevent delivery to time
	Action proposed for closure



TRUST BOARD

DOCUMENT TITLE:	Chief Executive's update
SPONSOR (EXECUTIVE DIRECTOR):	Jo Williams, Chief Executive
AUTHOR:	Jo Williams, Chief Executive
PRESENTED BY:	Jo Williams, Chief Executive
DATE OF MEETING:	5 June 2024

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	X	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	
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EXECUTIVE SUMMARY:

This report provides an update to members on the national context and key local activities not covered elsewhere on the agenda.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
<ul style="list-style-type: none"> Compliments received on quality of care Numbers of patients waiting excessively for treatment are reducing well Celebratory events 	<ul style="list-style-type: none"> Challenging financial & activity plan

REPORT RECOMMENDATION:

The Committee is asked to RECEIVE and ACCEPT the report for assurance

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	X	Environmental		Communications & Media	X
Business and market share	X	Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	X
Inequalities	X	Integrated Care	X	Continuous Improvement	X

Comments:

ALIGNMENT TO TRUST STRATEGY *(Indicate with 'x' all those that apply):*

Care	X	Community	X
Expertise	X	Services	X
People	X	Collaboration	X

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Details performance against Constitutional Standards

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:

ICB Objectives

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE):*

None

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date):*

None



Report to the Trust Board (in Public)

5 June 2024

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 1 May 2024 from the Chief Executive’s position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Our Care

I am extremely proud to see how our patients speak with high regard for the care we deliver at the ROH, and this is evident in the number of compliments which the Trust receives. Over the last few weeks, I have received some incredible letters describing the care and compassion which our patients have received at the ROH.

Earlier this week a patient wrote to me saying *"It is hard to express just how grateful and impressed I am by the care and treatment I have received from the ROH. Everyone at the ROH should be incredibly proud of what you do, but even more proud of the caring and considerate way you do it."*

1

Strategic objectives					
	CARE Deliver outstanding care that is safe, seamless and patient centred	EXPERTISE Innovate, improve, research and teach	PEOPLE Rated as among the best NHS hospitals to work for by our team	COMMUNITY Work with our community to reduce health inequality and support prevention	SERVICES Provide efficient, effective and sustainable services

The ROH stands out as a centre of excellence and is an example of how things can and should be done and sets the standard for others to aim for, you epitomise best practice.

I do know is that having such a positive culture doesn't come easily or by accident. I don't suppose for one minute that everything is perfect, but the key issue is that any problems are not visible to patients. Everyone, without exception, in every department, has been friendly, kind, caring, and above all professional. They eased us through a process which could have been very stressful. I salute their expertise and thank them for their humanity. Please pass on my admiration and thanks. The ROH is amazing". Thank you to our patients for taking the time to contact the Trust, it is valued and appreciated.

2.2 Our Services

2024/25 financial year continues to have a greater focus on productivity, efficiency and expenditure to deliver our ambitious financial plan of a breakeven position by the year end. As previously reported, our Board workshop in January 2024 has been a catalyst to this work and progress will be reported monthly directly to the Trust Board across the range of initiatives.

The Trust delivered a deficit position in April of £440,000 against a planned deficit of £136,000. This was underpinned by a further reduction in our agency spend with robust grip and control measures.

Activity in April 2024 was strong, delivering the plan of 1185 cases with theatre session utilisation at 85.04% against a target of 85%.

2



46 private patients were treated throughout the month against a plan of 50 patients. Our newly refreshed strategic private patient plan, which was approved at the Board meeting in March 2024, is making good progress with Executive oversight with an update due to be reviewed by the Board in June 2024.

Operational performance targets performed well in April with a reduction in the number of patients waiting over 65 weeks now at 36, (March 39), predominantly in Spinal Services.

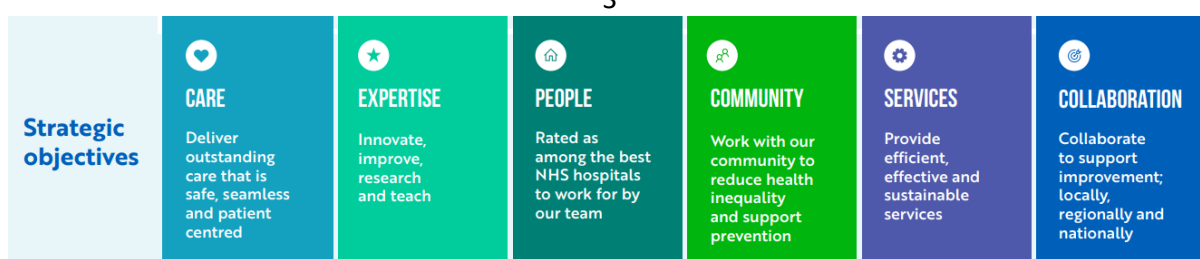
The Trust has no patients waiting over 78 or 104 weeks. Our focus is on clearing the number of patients waiting over 65 weeks, ahead of the national target of September 2024. Working with all specialities, trajectories are in place to treat patients waiting over 52 weeks. Some teams are close to this target, and it is great to see the energy and ambition to continue to reduce waiting times for our patients.

The diagnostic standard of 99% was achieved in month (100%), which again is testament to the fantastic team we have in our Imaging Services across all areas.

A reduction in physiotherapy waits across all areas was delivered in April with the teams aiming to reduce this further supported by improvement workstreams commencing in September.

2.3 Our People

On Saturday 11 May, I attended the ROH League which is a special occasion meeting with past members of staff of the ROH. It was great to share an update about the last 12 months. Next year the League will be celebrating 60 years and



I know that along with my Executive colleagues, we will ensure that the event is marked to thank the League for their commitment, dedication, and loyalty to the Trust.

On Tuesday, 28 May the Executives undertook their 'Chat & Check' visits. We visited colleagues from Imaging, Housekeeping, Catering, Education & Training, Portering and a one Executive met the Charity, Digital Transformation and Service Improvement team together. Colleagues shared their experience of working at the ROH and offered suggestions as to how we could make improvements to their working life, as well as the care to our patients.

The ROH will be hosting a service of Remembrance on 6 June 2024 to commemorate 80 years since the iconic D-Day landings.

On Friday 7 June, we will host our annual Blue Heart Staff Awards welcoming 190 staff from across the Trust. Congratulations to all the finalists and all those nominated. A special thank you to Yasmin Brown, the ROH Charity and the Communication team who have all worked so hard to make the event a very special evening.

On Monday 3 June, we are hosting our annual "thank you" event for our volunteers. All our volunteers play an important role within the ROH, working alongside staff in a variety of departments. Our volunteers come from a wide range of backgrounds, and we really value the different skills, outlooks, and experiences that our volunteers bring to the organisation. They make a real difference to the experience of our patients, relatives, and staff- thank you.



3. BSol ICS (Integrated Care System) Updates

3.1 The Birmingham and Solihull (BSol) Integrated Care Board (ICB) meets bimonthly, and next public meeting is being held on 8 July 2024.

4 NHS England/National Updates

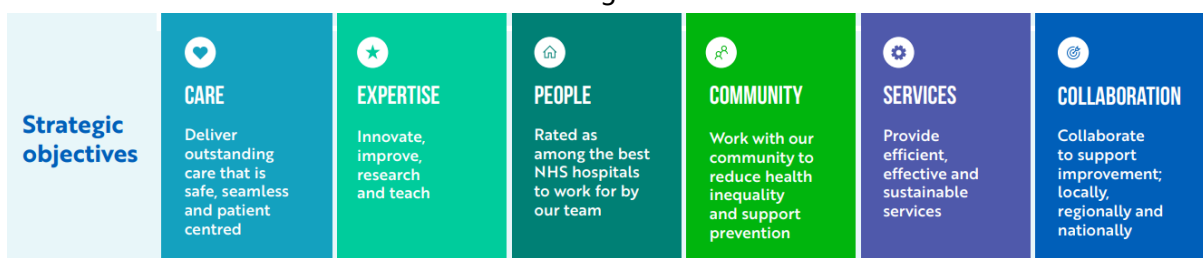
4.1 On 23 May, NHS England (NHSE) published its consultation on an updated NHS oversight and assessment framework for a period of three weeks.

Unlike the previous, more technical refresh of the framework in 2022, this is a significant review, which seeks to:

- align priorities across the NHS and with wider system partners to drive shared ownership of improvement,
- enable the sharing of good practices to support mutual improvement,
- identify where ICBs and/or providers may benefit from or require support or intervention,
- provide an objective basis for decisions about when and how NHS England intervenes using its regulatory powers.

Under the draft framework, trusts and ICBs will continue to be segmented on a scale of one to four. However, in addition to performance against the oversight metrics, segmentation will also consider each organisation's capability, and a set of 'additional considerations' that will moderate the delivery score assigned to each organisation. These considerations will account for wider system performance against key national priorities.

5



5 POLICY APPROVAL

5.1 Since the Trust Board last sat, no corporate policies have been approved by the Chief Executive on the advice of the Executive Team:

6 RECOMMENDATION(S)

6.1 The Board is asked to discuss the contents of the report, and

6.2 Note the contents of the report.

Jo Williams

Chief Executive

29 May 2024

6





TRUST BOARD

DOCUMENT TITLE:		Seamless Surgery Update			
SPONSOR (EXECUTIVE DIRECTOR):		Nicola Brockie, Chief Nurse & Michelle Hubbard, Acting Chief Operating Officer			
AUTHOR:		Nicola Brockie, Chief Nurse, Michelle Hubbard, Acting Chief Operating Officer Marie Raftery, Associate Director of Operations for Division 2			
DATE OF MEETING:		5 June 2024			
PURPOSE OF THE REPORT:					
TO PROVIDE ASSURANCE	X	FOR INFORMATION ONLY		TO CREATE DISCUSSION	
EXECUTIVE SUMMARY:					
Seamless surgery week started on Saturday 27 th April 2024 to Friday 2 nd May 2024 to assess opportunities to improve productivity in theatres. The team had a slightly different approach to previous seamless surgery weeks and specifically focussed on staff engagement regarding opportunities to improve and, also undertook environmental and IPC audits within the theatre environment.					
This paper provides the board with an overview of the findings and opportunities gained from the seamless surgery week.					
ASSURANCE PROVIDED BY THE REPORT:					
POSITIVE			GAPS IN ASSURANCE/RISKS TO ESCALATE		
Many good examples of good practice identified			Risk section in main paper identifies issues around ageing equipment, IPC concerns and storage limitations		
REPORT RECOMMENDATION:					
The BOARD is requested to NOTE the action plan to support improved productivity and to improve the theatre environment.					
KEY AREAS OF IMPACT (Indicate with 'x' all those that apply):					
Financial	X	Environmental		Communications & Media	X
Business and market share	X	Legal & Policy	X	Patient Experience	
Clinical	X	Equality and Diversity	X	Workforce	X
Inequalities		Integrated Care		Continuous Improvement	
Comments:					
ALIGNMENT TO TRUST STRATEGY (Indicate with 'x' all those that apply):					
Care	X	Community			
Expertise		Services		X	
People		Collaboration			

V1.0 (May 2024)

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Risk concerning ageing theatre equipment on the Corporate Risk Register

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:

BSol Strategy

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE):*

N/A

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date):*

Seamless Surgery Presentation Board



1. Purpose

The purpose of this paper is to provide the Trust Board with an overview of the seamless surgery week and the proposed next steps. The paper includes improvement ideas that will be compiled into a comprehensive action plan to support improving productivity within theatres. The plan will also include opportunities to improve the theatre environment to continue to promote excellent infection prevention and control standards.

2. Executive Summary

The Operating theatre environment represent the pinnacle of surgical precision and patient vulnerability. In this high-stakes environment, safety is paramount, not only to ensure successful surgical outcomes but also to protect both patients and healthcare professionals. Safety in the operating theatre is multifaceted, encompassing surgical techniques, instrument integrity, staff behaviour, human factors, environmental stability, and disciplined practices.

Previous seamless surgery weeks have focussed predominantly on the patient flow through theatres and focussed on tracking metrics such as planned activity vs actual activity. The operational team undertook the traditional focus on the patient flow through theatres

The seamless surgery week was an opportunity to assess the Trust against best practice and to gather ideas to improve patient flow and in turn improve productivity and increase activity.

Weekend operating has been provided via an LLP and the week provided an opportunity to understand the differences between operating on a Saturday and in week to obtain ideas to maximise productivity.

Part of the week was supported by the Regional Getting it right first time (GIRFT) representative who provided an impartial view of improvement opportunities to feed into the Trust's overall action plan. Regular Executive walkabouts were conducted by the Chief Executive, Chief Medical Officer, Chief Nurse, Acting Chief Operating Officer, and the Chief People Officer. This included a Saturday.

A suggestion box was also left in theatres for staff to provide anonymous feedback on improvement opportunities. Circa 40 members of staff from a variety of disciplines took the opportunity to provide feedback via this method.

3. Baseline Position / Productivity Data

The table below shows theatre performance against selected metrics for the week preceding the seamless surgery week and two subsequent weeks thereafter. It shows improvements in session utilisation, in session utilisation and a reduction in the average late starts. The total number of operations carried out varies based on case mix on any given week but shows a peak of 201 cases being carried out during seamless surgery week. This was closely matched during w/c 13th May 24, with 198 procedures being completed.

W/C	Session Utilisation %	In Session Utilisation	Total operations	Avg. Late Starts (mins)	Avg. Early Finishes (mins)
22/04/24	81.30	82.03	154	35mins	114mins
29/04/24 seamless surgery week	91.04	85.34	201	37mins	75mins
06/05/24	91.57	83.23	161	28mins	34mins
13/05/24	97.74	84.47	198	34mins	82mins

4. Observations and Anonymous Feedback from real time governance

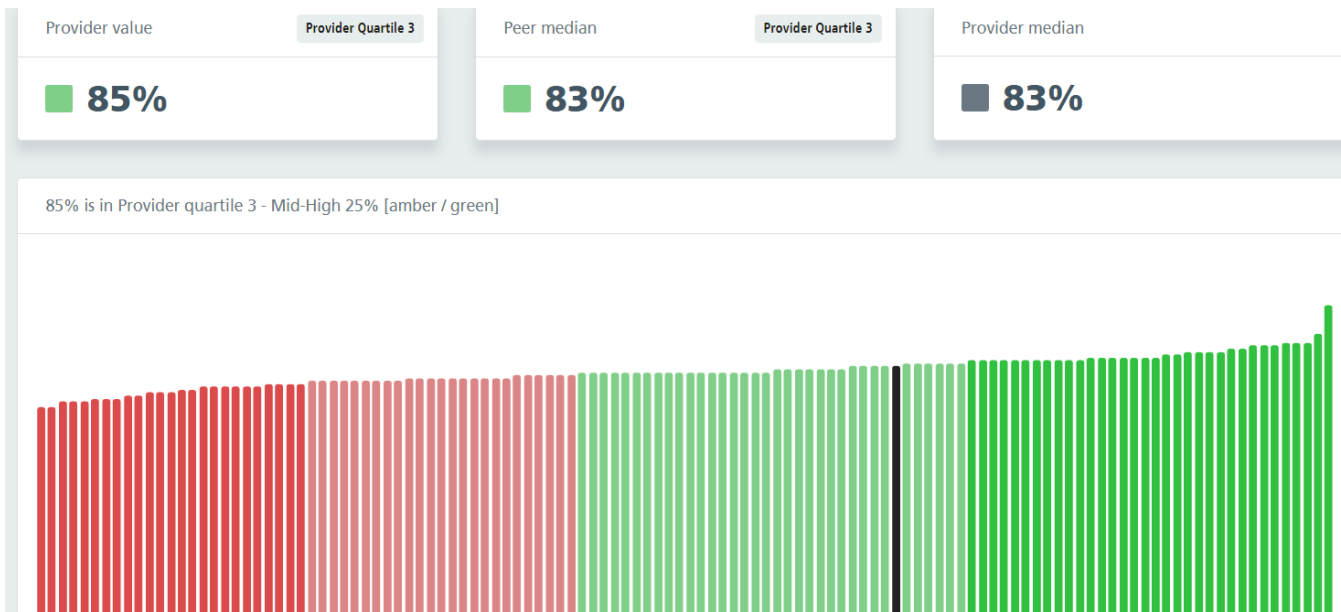
	Positive Observations / feedback	Negative Observations / Feedback
Instrument Integrity / Durability		Concerns regarding the integrity and durability of the power tools with saws not working properly and drills breaking regularly. This was observed during a Saturday list.
Equipment availability	Less lists running on a Saturday with no concerns regarding equipment availability.	Restrictions on the ability to provide Imaging in theatres due to lack of Imaging Intensifiers and the reliability of the Intensifiers available. The Trust has 5 imaging intensifiers of which some are over their 10-year life cycle.

		Unable to offer more than 3 spinal lists per day if a microscope is required for the procedure.
Attention to Sterility and Environmental Stability		Lack of storage space.
		Small changing rooms.
		Lack of space to have a break.
		Hand Sanitisers not replenished in a timely manner.
		Some concerns raised via anonymous feedback regarding cleaning time between cases – however, this was not observed during seamless surgery week.
		Broken air flow outside theatre 8. Gaffer tape used to highlight and secure damaged areas, such as the floor on the corridor from both ADCU and up to HDU.
		Lack of computer space for consultants to write up notes between cases.
		Signage within theatres
Human Factors and Staff Behaviour		Incorrect management of waste
	Grateful of executive support and attention to listen and respond to challenges	Anonymous feedback indicates that some staff arrive late.
	Observed some professional behaviours from staff	Communications with supporting services adding delays.
	Saturday lists demonstrate a true spirit of teamwork and Trust amongst the whole clinical team.	Staff talking in their own language leads to staff feeling isolated from conversations.
	Friendly and approachable staff	Time that interpreters are available.
	Free porridge for staff, however, would be beneficial if available 30 minutes earlier or in the theatre coffee room	Unplanned theatre overruns have an impact on wellbeing – especially when it becomes a theme.

	Positive morale observed on the Saturday and reports due to incentivisation	No on call for the recovery team
Theatre planning		Non cancer case listed between 2 cancer cases.
		List orders changing on the day, for instance, Diabetic patients not always being listed 1 st on the list.
		Limited by availability of spinal microscopes and imaging intensifiers

5. Model Hospital Data

The charts below represent the Model Hospital data for the week prior to seamless surgery week and the actual Seamless Surgery week. Model Hospital data is uploaded fortnightly:



6. Risks

Risk	Mitigation
Ageing equipment at the end of its lifecycle results in breakdowns and cancelled activity. This is a recurring theme with Image Intensifiers and Spinal microscopes.	Added to the capital programme for 24/25 as a priority, however, challenges with amount of capital funding available to replace theatre equipment.
Broken power tools delay lists and can result in on the day cancellations.	Added to the capital programme for 24/25, risk assessment to be undertaken regarding number of image intensifiers vs number of power tools.
Ageing environment prone to wear and tear and closures for maintenance impacting on activity. For example, the flooring needs repairing by both Admissions and Day Case Unit (ADCU) and the High Dependency Unit (HDU).	Regular planning of maintenance profiled carefully against drops in activity for holidays.
Poor compliance with Infection Prevention and Control (IPC)	Regular IPC audits Education and re-education Team Brief to raise awareness
Lack of storage space delays flow through theatres	Plan is to expand the male changing room into anaesthetic room for theatre 4 to include extra storage space. Longer term storage could be revisited with the decommissioning of theatre 1, 2 and 4 through the introduction of a new ambulatory care short stay unit.
Lack of staff facilities impact on morale and performance	Links to male staff changing room expansion. Currently using the huddle / staff room as an extra male change space. This will be re-released as a staff break facility. Mugs have been provided in the main staff room for staff to get drinks if they do not have their own mug.

Suggestions / Improvement Ideas**Instrument integrity and durability**

- Regular audit of instruments
- Incident report faulty instruments and immediately remove from circulation

ROHTB (06/24) 003 (a)

- Contract review meetings
- Bid for capital funding

Equipment / Kit

- Review of capital equipment programme and prioritise in line with patient safety, life cycle and essentials for delivering higher productivity. Current theatre equipment capital budget is £200,000 that will be spent predominantly on a Spinal microscope.
- Opportunities to standardise implant sets further. Reducing variation in kits could lead to potential productivity gains in the event a surgeon had to take emergency leave and another surgeon covers the case.

Attention to sterility and environmental stability

- Maintenance programme to be prioritised based on essential need for maximising infection prevention and control standards. To be profiled during heightened periods of annual leave to minimise disruption to activity.
- Undertake a scoping exercise regarding storage and accessibility of equipment in a timely manner.
- Review of audit timings / programme to minimise impact on productivity.
- Volunteer housekeeper to keep the staff room and changing areas clean.
- Increased IPC presence.
- Medical Director and DIPC walkabouts.
- Quality and safety walkabouts – to expand to include waste management.
- Release a recovery bay by finding a new home for the lollipop fridge.
- Review IPC pathways around high-risk infections such as MRSA.
- A volunteer housekeeper to care for staff environment such as rest room and changing area.
- A volunteer groundskeeper to tidy the external environment surrounding theatres.
- Signage – group in place to consider what can be done starting with a revised internal map.
- Inappropriate disposal of waste – a new project group has been established with an action plan developed to address concerns around waste management

Human factors and staff behaviours

- “You said we did” campaign following anonymous feedback.
- Offer free porridge 30 minutes earlier or in the theatre staff room.
- Refurbish the staff rest area including the kitchen.
- Application to charities for smaller lockers to keep staff belongings safe.
- Plan to expand the male changing room into anaesthetic room of theatre 4 and create additional storage space. General anaesthetics to be done within the theatre.

ROHTB (06/24) 003 (a)

- Introduce regional block area.
- A box of mugs has already been provided to the theatre staff room to ensure staff have access to drinks.

List planning

- Clinician input into 6-4-2 scheduling to flag issues such as diabetes patients needing to go first and non-cancer cases to be at the end of the list.
- Electronic flag to advise ADCU/Porters that theatre is ready for the 2nd patient
- ADCU Golden patients
- Standby patients
- Review of staggered admissions by specialty
- Pilot of dual surgeon operating (High Intensity Impact Theatres (HIIT))
- Theatre scheduling meetings to be face to face
- Monitoring of re-opening of lists reasons
- Introduced a 3pm meeting to prepare for the next day to avoid any on the day issues to include colleagues from ADCU.
- Overruns – liaising with specialities regarding planning regular overruns for repeat offenders.

Top 5 priorities

- Timeline and confirmed quotes for expansion of the male changing area.
- Purchase of capital equipment to include image intensifiers, spinal microscope and power tools (awaiting approval of 24/25 allocation).
- Standby patients.
- Review of staggered admissions by speciality.
- “You said we did” campaign.

Next Steps

The next steps are as follows:

- Suggestions and improvement ideas highlighted above will be incorporated into an overall action plan against each of the 5 themes. The action plan will include timelines and how they relate to key productivity and quality metrics such as session utilisation, reduced cancellations, surgical site infections and in session utilisation.
- The ambition of Programme 1 is to aspire towards 95% session utilisation and 90% in session utilisation for theatres. Monitoring of this will be via the weekly Theatres Check and Challenge meeting. The metrics are already reported at the Finance and Performance Committee.
- Progress the Top 5 priorities outlined above.

ROHTB (06/24) 003 (a)

- Seamless Surgery approach to be adopted as a continuous improvement methodology and programmed in 6 monthly.

Recommendation

The recommendation is for the Trust Board to note and accept the update on the Seamless Surgery week and the proposed next steps.



TRUST BOARD

DOCUMENT TITLE:	Health Inequalities Update
SPONSOR (EXECUTIVE DIRECTOR):	Jo Williams Chief Executive Officer
AUTHOR:	Nicola Brockie, Chief Nurse & Rebecca Lloyd, Deputy Director of Strategy
DATE OF MEETING:	5 June 24

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE		FOR INFORMATION ONLY	x	TO CREATE DISCUSSION		TO SEEK APPROVAL	
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EXECUTIVE SUMMARY:

The purpose of this paper is to provide the Board with a 'plan on a paper' approach to tackling Health Inequalities in the next 12 months. The plan on a page approach aligns with the KPMG report shared at Audit Committee last 2023 that outline 5 key areas that required improvement:

- Data and insight
- Governance and monitoring
- System alignment
- Capacity and support
- Improvement interventions

It is recommended that the working group will feed into Quality & Safety Executive and then directly to the Trust Board. The Group will continue to develop a full 5-year plan with an aim of presenting to Board in quarter 3 of the year. The Board will, on a quarterly basis be provided with an update on the actions laid out in the plan. It should be recognised that significant work is already underway and that this work should be shared at Board in the short term for assurance.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Yearly plan of actions.	Overall plan remains in draft.

REPORT RECOMMENDATION:

The Board is asked to: note the report and agree to the approach.

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity	x	Workforce	x
Inequalities	x	Integrated Care		Continuous Improvement	x
Comments:					

ALIGNMENT TO TRUST STRATEGY *(Indicate with 'x' all those that apply):*

Care	x	Community	x
Expertise		Services	x
People	x	Collaboration	x

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Our care risk, Our communities risk

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:

BSOL Health Inequalities plan

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE):*

N/A

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date):*

Health Inequalities draft plan at Trust Board

HEALTH INEQUALITIES PLAN 2023 - 2028

2024-25 ACTION PLAN



DATA AND INSIGHT

Introduce a clear framework for collecting health inequalities data and create a dashboard to support insight and improvement.

GOVERNANCE AND MONITORING

Ensure that our governance supports consistent monitoring of health inequalities data to enable improvement.

SYSTEM ALIGNMENT

Ensure that the data we collect and actions we take, aligns with the strategic approach of BSol ICS in tackling health inequality.

CAPACITY AND SUPPORT

Build adequate leadership, capacity, support and resources to deliver our health inequalities agenda.

IMPROVEMENT INTERVENTIONS

Create a high impact action plan that prioritises measurable improvement interventions that reduce health inequality.

	What are we trying to deliver?	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Data & Insight	Introduce a clear framework for collecting health inequalities (HL) data and create a dashboard to support insight and improvement	<ul style="list-style-type: none"> • Patient progress dashboard update to Q&SC • Business Intelligence team building v1 of Health Inequalities dataset. • Data Quality Group – to and scope & agree KPI'S • System to support with benchmarked data 	<ul style="list-style-type: none"> • Identify key areas of focus once dashboard launched i.e. what are the issues we need to address? 		<ul style="list-style-type: none"> • Data to inform improvement interventions for 2025-26
Governance & Monitoring	Ensure that our governance supports consistent monitoring of health inequalities data to enable improvement.	<ul style="list-style-type: none"> • Refine ROH Health Inequalities Plan • Reporting structure agreed - QSE then direct to Board. • BAF updated to highlight Health Inequalities 	<ul style="list-style-type: none"> • Quarterly reporting structure commence to Board 		
System Alignment	Ensure that the data we collect and actions we take, aligns with the strategic approach of BSol ICS in tackling health inequality	<ul style="list-style-type: none"> • Build brief for Versus Arthritis – ‘State of MSK Health for BSOL’ • Work with ‘I can’ to support recruitment form local population – acting as anchor institute 	<ul style="list-style-type: none"> • Introduce Employment Advice & Support into all MSK pathways • Scope and explore how the Professional frameworks & national strategies (AHP Strategies) can start to address local HL. 	<ul style="list-style-type: none"> • Publish ‘State of MSK Health for BSOL’ and associated priorities • Develop an action plan to deliver 	
Capacity & Support	Build adequate leadership, capacity, support and resources to deliver our health inequalities agenda.	<ul style="list-style-type: none"> • Finalise Health Inequalities training offer for staff (Health disparities & Health inequalities module on e-learning) 	<ul style="list-style-type: none"> • Launch awareness webpage and focus week. 	<ul style="list-style-type: none"> • Primary Care Education events commence (GP Engagement) 	
Improvement Interventions	Create a high impact action plan that prioritises measurable improvement interventions that reduce health inequality	<ul style="list-style-type: none"> • Launch of bi-monthly MSK Health Prevention Programme in schools • Patient information improvements • Undertake a waiting list profile v’s opportunities to improve access to people from deprived areas. 	<ul style="list-style-type: none"> • MSK Community Appointment Day • MSK Awareness & Education Event (ROC) – Summer • ‘getUBetter’ introduced to occupational health • Review and analysis the outcome of profile 	<ul style="list-style-type: none"> • MSK Awareness & Education Event (ROC) - Winter • Action plan developed and in place. • Scoping potential use BSOL PTL to address system HE. 	<ul style="list-style-type: none"> • Finalise plan for additional community clinics • Digital inclusion



TRUST BOARD

DOCUMENT TITLE:	Corporate Risk Register – Top 10 Risks
SPONSOR (EXECUTIVE DIRECTOR):	Simon Grainger-Lloyd, Director of Governance
AUTHOR:	Helen Genders, Corporate Governance Lead
DATE OF MEETING:	5 June 2024

PURPOSE OF THE REPORT:			
TO PROVIDE ASSURANCE	X	FOR INFORMATION ONLY	TO CREATE DISCUSSION
			TO SEEK APPROVAL

EXECUTIVE SUMMARY:

A ‘check and challenge’ of the entries on the Corporate Risk Register was currently undertaken by the Executive Team facilitated by the Governance Team. The purpose of the session was for the Executives to challenge each other around the scoring, relativities and mitigations in place to control the risks. It was also designed to ensure that there was agreement on the ten risks that were the most critical to the organisation. The various risks, as the Board has seen previously, are also aligned to one of each of the strategic risks on the Board Assurance Framework.

In summary, the following risks were agreed as being the most important to the Trust and are listed here in order of severity:

1. Risk Reference 293 (Financial stability)
2. Risk Reference 1298 (IT disruption due to cyber attacks)
3. Risk Reference 1780 (Employee turnover)
4. Risk Reference CE1 (Run Rate pressure)
5. Risk Reference 1423 (Strategic workforce planning capability)
6. Risk Reference 27 (Reduced availability of suitably qualified junior doctors)
7. Risk Reference 770 (Aging Theatres’ engineering plant)
8. Risk Reference 1425 (High number of days lost to stress, anxiety and MSK)
9. Risk Reference 1181 (IT systems alerts and flagging)
10. Risk Reference MD1 (Level of organ system support available)

There has been significant focus on improving the risk management framework at the ROH over the past three years, including work to cleanse the risk management system of closed risks and to educate staff on how the log and phrase risks. This process has been overseen at the Executive Team, with Board oversight through the Audit Committee. There remains further work to do to develop a training package for risk management and to refine the current risk management solution to better suit the needs of the Trust. This work is planned through 2024/25.

By way of a further update to the Board, the outcome of the recent annual Internal Audit review into the BAF and Risk Management system at the ROH has generated an opinion of ‘Significant Assurance, with minor improvements’. This feeds into the proposed positive Head of Internal Audit Opinion for 2023/24.

V1.0 (May 2024)

ASSURANCE PROVIDED BY THE REPORT:					
POSITIVE			GAPS IN ASSURANCE/RISKS TO ESCALATE		
<ul style="list-style-type: none"> Positive discussions and challenge at the Executive Team level. Creates a common understanding between Board members of the key risks facing the organisation, a position which is valuable should there be an external inspection of assessment by regulators. 			<ul style="list-style-type: none"> Further work to do to refine the risk management technical system and the systematically train staff in risk management. 		
REPORT RECOMMENDATION:					
The Board is asked to: receive this update as assurance.					
KEY AREAS OF IMPACT <i>(Indicate with 'x' all those that apply):</i>					
Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x
Inequalities	x	Integrated Care	x	Continuous Improvement	x
Comments:					
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>					
Care	X	Community	X		
Expertise	X	Services	X		
People	X	Collaboration	X		
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Risks are individually aligned to the various strategic risks on the Board Assurance Framework.					
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:					
ICB Objectives: • Protect people from harm					
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>					
None					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
Executive Team in May 2024.					



Corporate Risk Register - May 2024



Risk Reference	Date risk opened	Accountable Exec Lead	Oversight Committee	Risk Owner	Risk Summary	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Likelihood	Severity	Residual risk rating	Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Likelihood	Severity	Target Risk Rating	Review Date
293	23.09.2013	Executive Director of Finance and Performance	Finance and Performance Committee	Executive Director of Finance and Performance	There is a risk that the Trust's financial stability and sustainability will be adversely impacted due to underperformance of activity, increase in costs and tariffs are insufficient to support ongoing service delivery.	4	5	20	Startpoint budgets agreed and signed off by Trust Board and local budget holders Cost Improvement Programme signed off by the Trust Board and local budget holders, and monitored through the CIP Board Monthly budget reports and budget holder meetings to support local management of finances Directorate Performance Management meetings, providing challenge to Directorates on their financial performance and agreeing interventions and actions as appropriate "Perfecting Pathways to continue to deliver activity and operational process improvements Continuing performance meetings for each division Delivery of the theatre/ward business case development and subsequent uplift in activity. Ongoing working transition of the paediatric services and modelling of the impact once the patient pathways have been finalised in order to establish the activity/contribution 'gap'. On-going discussions with the STP to develop a revised model for orthopaedics across the Birmingham and Solihull region.	4	4	16	↔	April 2024 Update by CFO: Improved productivity and increase throughput will be essential in delivering a longer term sustainable position for the the Trust. Specific schemes are being identified as part of the wider organisaional sustainability plan as discussed in CE1 below.	6 monthly review	2	4	8	Apr-24
1298	18.12.2016	Executive Director of Finance and Performance	IM&T Programme Board	Head of IT	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyber attack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training	5	4	20	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network. Full update on Cyber Security prepared and submitted to Finance and Performance Committee. Improving Cyber Security Resilience Report has been prepared to provide assurances on critical controls to reduce the risks of ransomware and denial of service attacks as recommended by NCSC. Cyber Security Consultant has been employed to develop Trust's plans.	4	4	16	↔	April 2024 update: risk updated by Head of IT. Meeting with UHB in April to agree a compliant patching cycle. TPro replaced Winscribe and is fully supported. Head of Cyber Security and Information Governance leading the Cyber Security function. Cyber training compliance is currently at 68%. New IG/Cyber Training going live at the end of April 2024 to help with increase in compliance.	Ongoing	2	4	8	Apr-24
1780	09.06.2022	Chief People Officer	SE & OD Committee	Chief People Officer	There is a risk that employee turnover will continue to rise month on month if the issues that cause it remain unaddressed. A low number of exit interviews being conducted and completion of exit questionnaires has high potential of a risk of continued and ongoing increases in turnover within the workforce. A lack of understanding about the reasons behind people leaving the Trust is having a significant impact on turnover levels, agency & bank spends and engagement levels within existing staff who remain.	5	4	20	A new steering group has been formed to look at the issues contributing to high levels of turnover in addition to addressing inconsistent vacancy data. Recruitment and retention action plan. Data in recent months indicates that turnover has stabilised and has been within Trust target for the last 3 months.	4	4	16	↔	December 2023 Human Resources Team update: Data has been reviewed and the Trust is now reporting turnover below Trust target for the last 3 months.	Monthly review	1	4	4	Dec-23
CE1	Pre Feb 2021	Chief Executive	Trust Board	Chief Executive	There is a risk that Current Financial Modelling suggests that the Trust(and ICS) has a significant run rate pressure over the next four years (2022-2026)	5	4	20	Further work is being undertaken by each Provider to understand the nature of their individual pressure, and the degree to which this is being generated by an expected reduction in Income post COVID, an increase in the cost base of delivering services post COVID, increased costs of service restoration and backlog reduction, or a combination of all of these things. Additionally the ROH is leading system work on the MSK pathway in preparation for the production of a case-for change document. Further detailed planning work is being undertaken by each provider and is coordinated through the ICS. A system investment Committee is being stood up to review investment decisions across providers, and further work around productivity, efficiency an sustainability, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to specifically support Trusts in reducing the current identified gap.	4	4	16	↔	April 2024 Update by CFO: The Trust has recently submitted a £2m deficit plan as part of a system wide deficit of £71m for 24/25. A final plan is required by 2nd May, and there is an expectation that the Trust and sytsem will be required to submit balance financial plan. Internally the Trust is developing an organsiation wide sustainability plan to identify key schemes to deliver a break even position.	Ongoing	3	4	12	Apr-24

Risk Reference	Date risk opened	Accountable Exec Lead	Overnight Committee	Risk Owner	Risk Summary	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Likelihood	Severity	Residual risk rating	Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Likelihood	Severity	Target Risk Rating	Review date
1423	02.05.2022	Chief People Officer	SE & OD Committee	Chief People Officer	There is a risk that current lack of strategic workforce planning capability within the Trust will lead to higher vacancy rates, longer recruitment gaps and a negative impact on staff morale subsequently adversely affecting the delivery of safe and effective care. This is caused by there being multiple and differing versions of staffing establishment data within the workforce and finance teams and there being manual systems in local areas for workforce planning. In addition this has created inconsistent data across teams within the Trust.	5	4	20	There is now a better understanding of development and employment routes. Routine Workforce Performance Data scrutinised at various levels within the Trust. Clinical staff now excluded from the need for Certificates of Sponsorship quotas, and the decision by the NMC to lower the overseas English language pass mark slightly does open up potential additional nursing staff supply from the Philippines. New governance structure with increased focus on attraction, recruitment and retention of clinical staff.nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Overseas recruitment group meets monthly to consider opportunities for overseas recruitment. Additional countries being explored to increase opportunity. Healthy Staff qualified nursing bank to which staff are recruited regularly. Finance and HR currently scoping system wide and trust level workforce planning solutions. Work is now underway to match and map accurate establishment figures on ESR to ensure vacancy gaps can be identified and addressed. Implementation of TRAC will enable better reporting ability to accurately reflect the amount of recruitment activity underway and completed.	3	4	12	↔	January 2024 updated by Human Resources Team: There are various external changes occurring which may further impact this risk, such as the atypical worker regulations, which is pending employer guidance from ACAS. This will need continuous monitoring and a working group to enable adaptation. Current risk score was reduced to 12 (3Lx4C) in August to reflect work underway to develop plan.	Monthly review	3	2	6	Jan-24
27	11.04.2014	Chief Operating Officer	Finance & Performance Committee	Chief Operating Officer	There is a risk to patient safety if there is insufficient cover on Wards due to reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	5	4	20	Since the introduction of e-rostering the forensic oversight and forward planning of nursing rotas have led to a significant and sustained reduction in the use of agency staff. Recurrent use of agency staff is now limited to specialist areas such as Paediatrics, HDU and theatres, all of which are areas influenced by national shortages. Aiming to reduce a further 2 locums by Feb 2021; as we envisage the recruitment of the Research fellow and additional GPST's. Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. Mid Level provider strategic group to be revisited in line with the strategy for the development of the middle grade workforce is now in development. A rota co-ordinator is in place and focuses on weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is monitored by the Clinical Service Managers and reported to a monthly meeting to monitor spend. Locum spend has reduced since January 2020 due to a reduction in 2 locums and further 1 from August 2020 Additionally we have removed 3 locums off the on-call roster which would have further contributed positively to Trust expenditure. We currently have locums with further plans for reduction in February 2021. Trajectories have been developed for all services as part of the restoration and recovery work being undertaken post COVID to meet 18 week RTT. A recovery trajectory is in place to achieve 92% by April 2021 providing we can continue to increase and maintain our elective operating and outpatient capacity A rota co-ordinator is now in place and manages the junior doctors rota on a daily basis to ensure use of agency/ locum expenditure is kept to a minimum. The use of locum costs has reduced significantly due to the increase in allocated GP trainees within the organisation. Increase from 3-5 in Aug 2019 and again increase from 5-7 in Feb 2020. This has allowed the reduction in locum support by 2 posts delivering improved continuity and associated efficiency savings. The appointment of x2 Junior research fellows in January will release an additional locum when they commence in post.(Date TBC.) The Mid level Provider group is planned to meet in April 2021, to continue the transformation of the mid level provision. August 2021: Advert placed to recruit to vacant FY2 posts working with Clinical Lead (Dr Politis) - interim solution locums in place to mitigate any clinical risk.	3	4	12	↔	January 2024 Chief Operating Officer update: Junior Doctor rota reliant on Locum coverage due to reduced number of GPs that have been allocated to ROH on the Deanery - over the last 2 years the quota has reduced from 6 GPs to 2. The Trust has employed more Junior Research Fellows which has offset x2 Locum SHOs, however the Trust will still rely on Locum support in order to maintain safe ward coverage.	Mar-21	1	4	4	Jan-24
770	26.11.2014	Executive Director of Finance and Performance	Divisional Management Board	Deputy Director of Delivery	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant operational impact on clinical services	4	5	20	Continued undertaking of maintenance where possible. Phase 1 and 2 of the theatre expansion programme has been handed over, the Trust have four additional operating theatres however activity is planned to increase beyond the current 12 theatre utilisation.	3	4	12	↔	April 2024 update: risk reviewed by Exec Lead. Boilers in Knowledge Hub and Theatres on capital plan 2024/25, currently going through approval process. Current risk score was reduced in January 2023 to reflect work carried out to date to control the risk.	Nov-23	1	5	5	Apr-24
1425 WF3	Feb-20	Chief Executive	People Committee/SE & OD Committee	Chief People Officer	Due to the high number of days lost due to stress and anxiety and MSK there is a risk that there may be operational disruption and reliance on temporary staffing creating poor patient experience and a financial pressure on the Trust.	5	4	20	Attendance Policy including management guidance. Health and safety policies for stress and manual handling. MHFA training available to staff including access to Mental Health First Aiders Occupational Health and Staff counselling services in place via Birmingham Counselling and Psychotherapy and VIVUP EAP with the option of direct referrals for staff to address any reluctance to access Sickness absence training being rolled out to managers Wellbeing support reiterated through Team Briefs, various network meetings including Schwartz rounds etc , wellbeing intranet pages and support webinars for managers and staff 25.03.2021 SMal update: Health and Wellbeing being prioritised as part of recovery programme at organisational and system level Health and wellbeing conversations have been launched to proactively support staff wellbeing HRM team working with managers to practically manage absences. Funding received to develop wellbeing hubs for staff wellbeing, completed by August 2021. Further embedding of staff requirement to take leave for rest and recuperation. Human Resources and OD teams working on action plan to address high level of health related absences. BSOL looking to getting recurrent funding to keep making recurrent offer to staff. Meeting being scheduled with the system Wellbeing Lead. Regular reporting will ensure this is maintained as a high level risk to the Trust Particular targeted work at improving mental health related absence. Work commenced to start looking at how we provide staff with specific MSK related health issues Wellbeing diagnostic work being undertaken.	4	3	12	↔	December 2023 Human Resources Team Update: Mental health related absence has increased within the Trust since the last review, which has subsequently caused an increase in overall absence. Controls to be reviewed as part of a working group in early 2024. Current risk score reduced from 15 (5Lx3C) to 12 (4Lx3C) in June 2023.	Dec-20	2	3	6	Dec-23

Risk Reference	Date risk opened	Accountable Exec Lead	Overnight Committee	Risk Owner	Risk Summary	Likelihood	Severity	Risk Rating (LS)	Summary of Risk Controls and Treatment Plan	Likelihood	Severity	Residual risk rating	Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Likelihood	Severity	Target Risk Rating	Review Date
1181	2009.2017 (escalated to CR August 2021)	Chief Nurse	Safeguarding Committee	Chief Nurse	IT systems alerts and flagging Potential risk to patient care - information not easily accessible for sharing and several stand alone IT systems. Risk of not being able to easily flag and identify patients with a safeguarding concern/alert Risk of patient information not being shared as required Information about patients known to be at risk is not identified by other professionals Timely manual updates have to take place.	5	3	15	Staff are requested to email leads in the areas with separate IT data base systems i.e. Oncology ONKOS, X-Ray CRIS and PACS and Therapies - TIRIA as these systems do not pull alerts from PAS Lorenzo system IT team have put a guide to adding alert onto PAS/Lorenzo system. Staff when seeking support are offered guidance and encouraged to use guide produced The email address for leads in all areas have been included in every purple folder to ensure staff can communicate alerts required to the correct areas Learning Disability Notification in place via intranet where staff share patient needs and adjustments required. Inadequacies in current patient administrative systems PAS/Lorenzo raised with IM&t board and company. Trust is awaiting upgrade and requests for improvement in alerts and flagging have been requested Flow chart made to explain to staff how to add information under patient needs tab on PAS/ Lorenzo. LD Nurse has regular email contact with the lead within the ICB who is leading on the reasonable adjustment flag programme for NHS digital. LD Nurse has linked up the ROH digital programme manager with ICB project lead to share information. Forward looking document utilised for appointments and admissions using information from PAS LD Nurse meets regularly with the AIS group to discuss flagging and sharing of need	4	3	12	↔	December 2023 Deputy Chief Nurse update: IT have been working with individual teams to develop team databases. However, flagging remains a manual task that will only be resolved by a PICS update. There remains no timescale for this to occur.	Jan-22	2	3	6	Dec-23
MD1	Jun-23	Medical Director	Q&S Committee & Trust Board	Medical Director	If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	3	5	15	Patients are screened prior to admission: Emergencies undergo a boarding card process. Elective cases run through POAC and start a consent process at the time of listing. Staff are aware of the isolated site and of the need to ensure that patients who may encounter a ceiling on care are treated elsewhere or consented appropriately. Deteriorating ward patients are identified and managed by a coordinated rota of clinical, nursing and rapid response team staff. The Trust has a Level 2 critical care facility with excellent outcomes audited through the national network. It is possible to provide ventilation support on site for required periods if necessary. Through a combination of ICS partnerships, custom and practice and partner SLAs, staff are able to call assistance to the ROH site if appropriate or transfer patients out of the Trust to partner organisations where necessary. There is a clear escalation policy. Synopsis electronic pre-operative assessment has gone live April 2023 improving pre-operative process reproducibility and process The Trust has recruited two established / experienced consultants this year with ITU backgrounds. The Trust is working to provide more consultant physician time on the site to improve the resilience around the management of more chronic medical conditions. Acute medical conditions are managed through the above pathways.	2	5	10	↔	April 2024 Medical Director update: Appointment of a new HDU lead consultant with a background of ITU and cardiac. Appointment of a resus officer and planned in house provision of in house ALS training.		1	5	5	Apr-24



TRUST BOARD

DOCUMENT TITLE:	Health & Safety annual report
SPONSOR (EXECUTIVE DIRECTOR):	Simon Grainger-Lloyd, Director of Governance
AUTHOR:	Carl Measey, Health & Safety Adviser Simon Grainger-Lloyd, Director of Governance
PRESENTED BY:	Simon Grainger-Lloyd, Director of Governance
DATE OF MEETING:	5 June 2024

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	X	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	
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EXECUTIVE SUMMARY:

Please find enclosed the annual report on Health & Safety for 2023/24.

The report covers the key matters of note from a Health & Safety perspective during the year and also details work of the Health & Safety Group, the key body overseeing compliance with H&S guidance.

The content will be included within the overall Trust annual report for 2023/24.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
<ul style="list-style-type: none"> Improved oversight by H&SG 	<ul style="list-style-type: none"> Fire safety training uptake is below target

REPORT RECOMMENDATION:

The Committee is asked to RECEIVE and ACCEPT the report for assurance

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Area	X	Area	X	Area	X
Financial	X	Environmental	X	Communications & Media	X
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	X
Inequalities		Integrated Care		Continuous Improvement	

Comments:

ALIGNMENT TO TRUST STRATEGY *(Indicate with 'x' all those that apply):*

Area	X	Area	X
Care	X	Community	
Expertise	X	Services	
People	X	Collaboration	

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

National Workplace Health & Safety Standards

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:

ICB Objectives: • Protect people from harm

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE):*

None

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date):*

Health & Safety Group on 9 May 2024, Quality & Safety Executive on 14 May 2024 and Quality & Safety Committee on 22 May 2024.



HEALTH & SAFETY ANNUAL REPORT 2023/24

REPORT TO TRUST BOARD – 5 JUNE 2024

1.0 INTRODUCTION

- 1.1 The purpose of the report is to formally report to the Trust Board on the key matters of note from the perspective of health & safety at the ROH for the year 2023/24. The report also provides some detail on the operation of the Health & Safety Group, the operational body overseeing compliance with the health & safety framework at the Trust.

2.0 HEALTH & SAFETY GROUP

- 2.1 The Health & Safety Group reports upwardly to the Quality & Safety Committee after each meeting using the 'quadrant' format, highlighting key risks, decisions made, work commissioned & positive assurances.
- 2.2 The Group reviewed its Terms of Reference in October 2023, which were subsequently approved by the Quality & Safety Committee. The changes mainly concerned revisions to the membership of the Group, ensuring that the members reflected the most appropriate attendees. The Terms of Reference also reflect the changes to the secretariat for the Committee.
- 2.3 The responsibility for the Chairmanship of the Group moved from the Executive Director of Strategy & Delivery portfolio when the incumbent retired in March 2023. This was moved to the remit of Simon Grainger-Lloyd, the Executive Director of Governance from 1 April 2023.
- 2.4 The Group met three times during 2023/24 – 21 June 23, 26 October 23 and 8 February 2024. A quorum was present for each meeting.

3.0 OCCUPATIONAL HEALTH AND HEALTH AND SAFETY PERFORMANCE

- 3.1 Significant progress has been made during the year with ensuring the Trust, so far as is reasonably practicable, complies with the 'Workplace Health and Safety Standards' developed by the NHS Staff Council's 'Health, Safety and Wellbeing Group'. The Health and Safety Executive (HSE) is a key member of this Group.
- 3.2 The standards pull together legal requirements and guidance to help healthcare organisations comply with goal-setting legislation. They provide practical pointers and

signposting for meeting appropriate standards in key areas of workforce health and safety. The standards were updated in 2022.

3.3 Standards are aimed at directors and managers with health and safety responsibilities, health and safety professionals and trade union safety representatives. The standards ensure individual healthcare providers have adequate arrangements in place - i.e. polices/procedures/training/systems for monitoring effectiveness etc. The standards include:

- Provision of an occupational health service (OHS)
- Slips and trips
- Musculoskeletal disorders/manual handling
- Electric profiling beds
- Violence and aggression/challenging behaviour
- Lone working
- Work-related stress
- Bullying and harassment
- Hazardous substances
- Management of sharps
- Work equipment
- Provision and use of work and lifting equipment
- Display screen equipment
- Legionella
- Asbestos Containing Materials (ACMs)
- Temperature
- Workplace transport
- Electricity
- Noise
- Contractors and subcontractors
- Radiation
- First aid
- Working Time Directive
- New and expectant mothers
- Ligatures
- Pandemic and Worker Health and Safety

3.4 During the year, a self-assessment was undertaken against these standards was undertaken which showed a high degree of compliance. The matters below were highlighted as areas where there was lack of compliance or areas for improvement, all of which have either now been addressed or are in hand:

- Strengthening reporting of health and safety matters at Board level, including introduction of an annual report
- Clarifying health & safety responsibilities in job descriptions of those responsible for oversight
- Trustwide communications around health & safety to be improved and details of health & safety group to be included on the inter/intranet

- Streamlining attendance at Health & Safety Group meetings and ensuring there is appropriate representation
- Undertaking of formal qualification in Health & Safety by the Director of Governance
- Improvements in performance against the Occupational Health Service Level Agreement
- Introduction of a Work Equipment Policy and policy for managing contractors
- Refresh of the policy referencing indoor temperature management

4.0 POLICIES AND PROCEDURES

- 4.1 A suite of Trust policies and procedures are in place and meets the guidance published in the Workplace Standards. The most recent of which is the new Contractors Policy and the Work Equipment Policy.
- 4.2 The Violence and Aggression Policy has been reviewed and now incorporates a 'strategy' to better align itself with NHS England's Violence Prevention and Reduction Strategy. HR will be monitoring disparity trends in relation to victims of violence who have protected characteristics.

5.0 CAS ALERTS

- 5.1 The ROH is a recipient of patient safety alerts issued via the Central Alerting System (CAS). The Trust has a robust governance structure for the management of patient safety alerts. The Trust's Health and Safety Adviser acts as the Central Alerting System Liaison Officer (CASLO). The CASLO is responsible for monitoring the CAS system and the dissemination of CAS alerts to the Medical Device Safety Officer (MDSO) for review. The MDSO will nominate a subject matter expert for each alert who is responsible for undertaking any actions required. The CAS system is continuously updated evidencing the progress for each alert until all actions required have been completed. Only then will the MDSO give authority to close each alert. Patient Safety Alerts are overseen by clinical members of the Executive Team. During the period 1 Apr 23 -31 Mar 24 the Trust received a total of 18 patient safety alerts; all but one met the timeframe for completion - NatPSA/2023/010/MHRA. As at 31 March 2024, this particular alert requires further work ensuring all actions required are implemented.

Reference	Alert Title	Response	Deadline
NatPSA/2024/003	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials.	Actions completed	08 Mar24
CEM/CMO/2024/001	Valproate: important new regulatory measures for oversight of prescribing to new patients and existing female patients.	Response not required	n/a

Reference	Alert Title	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.	Assessed - relevant to organisation's services	31 Jan 25
NatPSA/2024/001/DHSC	Shortage of GLP-1 receptor agonists (GLP-1 RA) update.	Assessed - not relevant to organisation's services	28 Mar24
CEM/CMO/2023/003	Influenza Season 2023/24: Use of antiviral medicines.	Response not Required	n/a
NatPSA/2023/016/DHSC	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba) products.	Actions completed	22 Dec 23
NatPSA/2023/015/UKHSA	Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia - measures to reduce patient risk.	Actions Completed	17 Dec 23
NatPSA/2023/014/NHSPS	Identified safety risks with the Euroking maternity information system.	Assessed - not relevant to organisation's services	07 Jun 24
NatPSA/2023/013/MHRA	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	Response Not Required	n/a
NatPSA/2023/012/DHSC	Shortage of verteporfin 15mg powder for solution for injection.	Assessed - not relevant to organisation's services	20 Oct 23

Reference	Alert Title	Response	Deadline
NatPSA/2023/011/DHSC	Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets.	Assessed - not relevant to organisation's services	11 Oct 23
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.	Acknowledged	01 Mar24
NatPSA/2023/009/OHID	Potent synthetic opioids implicated in heroin overdoses and deaths.	Action Completed	04 Aug 23
NatPSA/2023/008/DHSC	Shortage of GLP-1 receptor agonists.	Assessed - not relevant to organisation's services	18 Oct 23
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia.	Action Completed	01 Dec 23
NatPSA/2023/006/DHSC	Shortage of pyridostigmine 60mg tablets.	Assessed - not relevant to organisation's services	26 May 23
NatPSA/2023/005/MHRA	Removal of Philips Health Systems V60 and V60 Plus ventilators from service - potential unexpected shutdown leading to complete loss of ventilation.	Assessed - not relevant to organisation's services	02 Oct 23
NatPSA/2023/004/MHRA	Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors, due to the potential for device failure.	Assessed - not relevant to organisation's services	12 May 23

In all cases, aside from the alert NatPSA/2023/010/MHRA, the deadline for closure was met. Further work continues into 2024/25 to address the specific requirements of the outstanding alert.

6.0 CORE MANDATORY TRAINING COMPLIANCE (H&S/FIRE)

6.1 Staff attendance figures for H&S mandatory training has been consistently high - above 90%. This figure is encouraging and helped by the fact staff are only required to undertake H&S training once every 3 years.

6.2 Conversely, staff attendance figures for fire training are much lower - hovering around 75% during much of the reporting period. The reason is clear - staff must undertake fire training much more frequently - every 12 months. Learning and Development staff intend to consult with the Trust's Fire Safety Adviser/Authorised Person (Fire), with the aim of organising additional training opportunities over the coming year to achieve a figure in excess of 90%.

Number of Accidents by Category. 1 Apr 2023 - 31 Mar 24. (Employees/Visitors/Contractors)

Accident Category	Apr 23	May 23	Jun 23	Jul 23	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 24	Feb 24	Mar 24	Total
Manual Handling Injuries	0	0	2	1	0	0	1	2	1	0	0	0	7
Burns / Scalds	0	0	0	0	0	0	0	0	0	0	0	0	0
Contact with hazardous substances (COSHH)	0	0	0	0	0	0	0	0	1	0	0	2	3
Road traffic accident/ incident	0	0	0	0	0	0	0	0	0	1	0	0	1
Sharps injuries	0	1	3	2	0	1	1	2	3	1	1	0	15
Slips, trips, and falls (staff, visitors & contractors)	1	1	2	1	1	0	2	0	2	0	1	0	11
Impact Injury (with static or moving object)	2	0	1	0	1	2	2	1	0	0	2	3	14
Electric shock	0	0	0	0	0	0	0	0	0	0	0	0	0
Total figure for each month	= 3	= 2	= 8	= 4	= 2	= 3	= 6	= 5	= 7	= 2	= 4	= 5	51

7.0 REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS (RIDDOR)

7.1 It is a statutory legal requirement to report specified injuries, diseases, deaths, and dangerous occurrences to the HSE. During the reporting period four RIDDOR reportable incidents were submitted, details of which are overleaf.

Date of Incident	Summary of incident	Date RIDDOR Report submitted to HSE
28 Aug 23	<p>RIDDOR Notification No: 111F6808F1</p> <p>'Nurse cleaning patient bedside tables in preparation for re-opening of ward. Experienced a back injury leading to over 7-day incapacitation.</p>	13 Sep 23
31 Oct 23	<p>RIDDOR Notification No: 15CFB85176</p> <p>Employee walking along outside footpath on hospital Property experienced a slip/trip accident.</p>	20 Dec 23
8 Jan 24	<p>RIDDOR Notification No: BE88118151</p> <p>Hospital porter driving electric waste tug 'clipped' post causing steering wheel to suddenly spin in her hands resulting in a fractured wrist.</p>	24 Jan 24
7 July 23	<p>RIDDOR Notification No: AA161D517C</p> <p>Waste porter wheeling a large plastic waste bin allegedly containing 80-120 kg of pharmaceutical waste. Porter pushed bin up ramp to load onto trailer. In doing so suffered a back injury. Over 7-day incapacitation of a worker due to back pain.</p>	28 Aug 23

8.0 STAFF TRAINING

8.1 For the reporting period 1 Apr 23 -31 Mar 24, the following H&S training sessions were delivered:

- x9 Mandatory training sessions: 5 Apr, 3 May, 7 Jun, 5 Jul, 9 Aug, 4 Oct, 6 Dec, 3 Jan, 14 Feb.
- x1 HCA training sessions: 9 Jan 23, 12 Mar, 11 Jul.
- x1 Stress Awareness Training for AHPs: 25 Apr.
- x COSHH training sessions: 23 Aug, 22 Sep, 28 Sep, 21 Nov, 30 Nov, 12 Dec, 5 Jan, 16 Feb, 5 Mar, 14 Mar, 21 Mar.

9.0 VIOLENCE PREVENTION AND REDUCTION STANDARDS (VPRS)

9.1 The NHS England violence prevention and reduction standard was published in December 2020.

9.2 It provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

9.3 The standard employs a Plan, Do, Check, Act approach, an iterative four-step management method to validate, control and achieve continuous improvement of processes.

9.4 A self-assessment against the standard was completed during the year and considered by the Health & Safety Group and subsequently by the Quality & Safety Committee and Trust Board. On the basis that there was a small number of non-compliances identified, the self-assessment was rated 'Partially Compliant'.

9.5 Work continues to address the areas of non-compliance, with the next update due to the Health & Safety Group in September 2024.

10.0 RISKS

10.1 During the year, some work has been undertaken in conjunction with the corporate governance team to review and refresh the Health & Safety risk register. The latest version was presented to the Health & Safety Group in February 2024 and it will be further refined ready for the September 2024 meeting to ensure that the risk comprehensively captures key Health & Safety risks across the Trust.

11.0 RECOMMENDATION

11.1 The Trust Board is asked to:

RECEIVE and NOTE the annual report and assurances contained within

Simon Grainger-Lloyd
Executive Director of Governance

May 2024



UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 28 May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was noted that there had been a slight deterioration against the 18 weeks Referral to Treatment Time target. This is due to the focus on those waiting longest, particularly within the spinal services speciality.
- Length of stay was reported to have deteriorated, mainly due to the complexity of patients being treated, with many having co-morbidities.
- Private Patient activity was below plan due to difficulties with covering some weekend lists during the month.
- In terms of finances, it was reported that a deficit of £440k had been realised against a plan of £136k deficit.
- There continues to be work to identify the full quantum of the Cost Improvement Programme – the Committee noted the risk associated with the high target set for the year.
- There was noted to be a mismatch between the Elective Recovery Fund (ERF) targets phasing based on the current year's activity plan and the NHSE baseline profile based on the 2019/20 position. This creates a level of risk related to income for the year, although the Committee agreed that this was likely to be a future risk rather than current. Value weighted activity considerations were noted to be important so that there is a clear view of likely contribution for different procedures over the year.
- Performance against mandatory training targets was noted to be poor at present at 68.33%.
- There was reported to have been an increase in short term sickness absence.
- The Committee reviewed the capital budget and plan for 2024/25, noting that there was little scope to undertake a significant number of schemes and the risks associated with this. It was agreed that

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Report back at the next meeting on the impact on flow of some patients being delayed for discharge as a result of social care issues.
- Share definitions and discussions around productivity led by NHS England and the Integrated Care Board when possible.
- All to provide comments to the Committee chair's request for views on how the subject of productivity be given best oversight by the Finance & Performance Committee.
- Circulate the internal audit advisory report on performance reporting.
- All to offer views on the Private Patient update ahead of the Trust Board meeting.



there needed to be further consideration of the capital programme in the context of the Trust's strategic plan which would be discussed at the next Trust Board meeting. It was agreed that the capital works needed to be focussed on improving patient experience and maximising productivity.

POSITIVE ASSURANCES TO PROVIDE

- There was reported to have been an improvement in the level of people waiting 52 weeks or more for treatment.
- A reduction in the number of patients who 'Did Not Attend' was reported.
- Good performance was reported against the cancer and diagnostics targets.
- Agency spend continued to reduce and there had been some periods during the month when there had been no requirement to use agency staffing in theatres.
- The Committee reviewed the estates plan in terms of delivery for 2023/24 and the proposed schemes for 2024/25. A major piece of work for the coming year is the redevelopment of the former physiotherapy area.
- The Committee received the upward report from the Service Improvement Board and noted that the financial sustainability discussions would be built into the remit of the Board going forward.
- The Committee received an update from the Temporary Workforce Group and agreed to continue receiving the report at each meeting.

DECISIONS MADE

- The Committee approved the start point budgets and agreed that they should move forward for Board consideration on 5 June 2024.
- The proposed changes to the Corporate Risk Register were approved.

Chair's comments on the effectiveness of the meeting: The Committee formally welcomed Ms Jan Teo as a new member. It was agreed that despite the complexity of the agenda and topics, that the meeting had been well managed and had run to time.



UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 29 APRIL 2024

<p style="text-align: center;">MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none"> It was noted that the advisory internal audit review of performance reporting suggested that there was more work that could be done to reframe some of the performance information that is considered by the Board and its Committees. The use of an integrated dashboard, as used elsewhere including other members of the National Orthopaedic Alliance, was suggested which includes a number of ‘watch’ indicators. It was noted that there were some minor actions to take to improve the effectiveness of the Audit Committee including induction and standardising the format of the cover sheets used. 	<p style="text-align: center;">MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</p> <ul style="list-style-type: none"> It was agreed that a separate briefing would be arranged to update Committee members on the work to create a contracts database (Atamis) and provide an overview of the new national procurement regulations. Provide assurance to the Committee that the long standing contracts that had been extended continue to deliver value for money. Action plan to address the recommendations of the Audit Committee self-assessment to be considered at the July 2024 meeting.
<p style="text-align: center;">POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none"> The Committee welcomed Simon Stanyer, new Local Counter Fraud Specialist who presented the proposed areas of focus for the coming year, which included improving the awareness of fraud, reviewing the declarations process and increasing the level of referrals, particularly around secondary employment. Some of the work would be undertaken in conjunction with HR and Freedom to Speak Up colleagues. The Committee thanked RSM Counter Fraud Team for their contribution and hard work over the last 5 years. It was reported that the internal audit review of Outpatient Bookings gave an opinion of Significant Assurance, with minor areas of improvement identified. It was noted that the introduction of the Electronic Patient Record would further streamline processes. The Committee was presented with the draft Annual Governance Statement which provided a view that the Internal Control system at the Trust was sound and had improved since the previous year due to various developments and strengthened processes. 	<p style="text-align: center;">DECISIONS MADE</p> <ul style="list-style-type: none"> It was agreed that the Internal Audit plan that the Committee approved should be presented to the Trust Board.



- The Committee received the draft annual accounts which had been circulated separately to the main pack of papers.
- It was noted that the draft Head of Internal Audit Opinion was positive, this being subject to the final work to close the 2023/24 plan.
- The Committee was pleased to be advised that the Counter Fraud Functional Standards Return had been rated green. Some individual elements were rated as amber as some audits could not be undertaken or due to the low fraud awareness survey responses, which will be picked up as part of the 2024/25 plan.
- It was reported that the annual external audit plan was progressing as planned, including the Value for Money work.
- The Committee was joined by the Deputy Chief Nurse who reported on progress with delivery of the annual Quality Priorities for 2023/24. It was noted that of the five, two would be carried forward to 2024/25: optimisation of patients prior to surgery; and improving quality of communication for our patients.
- It was noted that the declarations of interest register was now more comprehensive although some further work was needed to ensure a declaration was submitted by all those who were required to. The outstanding medical staff would be picked up by the Medical Director.
- The Committee was pleased to see the latest iteration of the Board Assurance Framework and the summarised version that had been developed alongside the detail.
- The Committee received and accepted to Audit Committee Annual Report for 2023/24.
- The self-assessment of effectiveness of the Audit Committee was considered which presented a positive picture.
-

Chair's comments on the effectiveness of the meeting: It was agreed that receipt of the draft annual accounts for the meeting had been helpful and the finance team was thanked for expediting making these available. There was agreement that a separate meeting with the auditors was not required after the main meeting.



AUDIT COMMITTEE ANNUAL REPORT 2023/24

1.0 Introduction

- 1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Audit Committee during 2023/24 and indicate its work plan for the financial year 2024/25.
- 1.2 The report ensures that that Trust conforms to best practice as recommended in the NHS Audit Committee Handbook (HMFA, 2018) and the Audit Committee Handbook (HM Treasury, 2016).
- 1.3 The Audit Committee reviewed its Terms of Reference in October 2023 and minor changes were proposed to reflect that the Quality Account is no longer considered as part of the Trust's Annual Report, the secretariat of the Committee has changed and to update the role title of the Chief Finance Officer.
- 1.4 During the year, the Chair of the Audit Committee was Gianjeet Hunjan, a Non Executive Director with a professional background in finance and accountancy.

2.0 Meetings

- 2.1 During 2023/24, the Audit Committee met on five formal occasions.
- 2.2 The attendance at these meetings is as below:

MEMBER	MEETING DATE					TOTAL
	28/04/23	26/06/23	21/07/23	20/10/23	19/01/24	
Gianjeet Hunjan (Ch)	✓	✓	✓	✓	✓	5/5
Les Williams	✓	✓	✓	✓	✓	5/5
Christine Fearn	✓	A	A			1/3
<i>Executive Directors in attendance</i>						
Steve Washbourne	✓	✓	✓	✓	✓	5/5
Matthew Revell	A	A	✓	✓	✓	3/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	5/5
KEY:						
✓	Attended	A	Apologies tendered			

- 2.3 During the year, Non Executive representation from the Quality & Safety Committee was from Chris Fearn, although she stood down as a Non Executive in September 2023, therefore for most of the year, the Committee operated without representation from a Non Executive member of the Quality & Safety Committee.
- 2.4 Meetings were also attended routinely by representatives from the Trust's provider of External Audit and Internal Audit (to include Counter Fraud) services. During the year, the Audit Committee invited a number of guests to present progress on actions arising from some Internal Audit reviews.
- 2.5 Prior to or after each meeting, the auditors were offered a meeting in private with the members of the Audit Committee to discuss any matters or raise concerns where required, without any members of the Executive Team or guests present.
- 2.6 The Audit Committee's minutes were submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions at the meeting, matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2023/24

The Committee dealt with the following key matters:

Routine Work

The Committee:

- Reviewed and approved the Annual Report and Accounts for 2022/23 (in June 2023), together with the Head of Internal Audit's report, Going Concern statement and Annual Governance Statement (and other disclosures) contained within.
- Received the 2022/23 Audit report from the External Auditors.
- Improved the focus on clearing outstanding audit recommendations, resulting in a review of all outstanding recommendations and an improvement in the closure of actions including those raised by the prior Internal Audit function.
- Continued to strengthen a supportive working relationship with the Quality & Safety Committee (QSC). A Non Executive member of the Quality & Safety Committee is included within the membership of the Audit Committee which provided the link between the Committee and the work of the Quality & Safety Committee and its sub-groups. The Executive Medical Director is also a regular attendee at the meeting. The Audit Committee chair is also a member of the Quality & Safety Committee.
- Received the Deloitte audit planning report highlighting the key risks they had considered in planning their audit work.
- Received a report detailing the outcome of the Value for Money assessment undertaken by Deloitte.
- Received from Counter Fraud (RSM) updates on the counter fraud programme for 2023/24.

ROHTB (6/24) 008 (a)

- Received a benchmarking report of anti-fraud, which presented a positive picture of the robust control environment in respect of fraud in the Trust compared to elsewhere.
- Reviewed and approved the Internal Audit charter.
- Received regular update reports from Internal Audit (KPMG) and reviewed all significant internal audit reports. The internal audit plan remained on schedule during the year.
- Received regular updates on the tracking of implementation of all internal and external audit recommendations.
- Reviewed and approved the proposed internal audit plan for 2023/24. This plan had been aligned to the Board Assurance Framework (BAF) and other risk mechanisms within the organisation.
- Received regular updates on the BAF. The Committee was also updated on the work undertaken to restructure the BAF to align it to the new five-year strategy and to take into account best practice suggestions seen elsewhere by Internal Audit.
- Received routine updates on payments made for losses or compensation and waivers & breaches of Standing Financial Instructions. The Committee challenged when needed, the use of single tenders, given that the use of these had the potential to compromise best Value for Money.
- Received updates on the statutory registers, concerning hospitality and declarations of interest and urged that staff be encouraged to make comprehensive and timely declarations when needed.
- Received an update on the Trust's accounting policies and approved some minor amendments to them to ensure that they remained consistent with the NHS Group Accounting Manual.
- Received routine updates on the work to achieve compliance with the requirements of the Data Security and Protection Toolkit.
- Approved its revised workplan for 2024/25.

Ad hoc matters

- The Committee received updates on the work to strengthen the Contracts Database such that there was a clear view of spend and ownerships of each of the contracts.
- An update on the work to improve the risk management framework in the organisation was received at the October 2023 meeting which was presented by the Assistant Director of Governance & Risk.
- During the year, the Council of Governors was asked to approve the extension of the contract for the provision of services by Deloitte as the Trust's External Auditors. Approval was gained for this proposal.
- A procurement exercise was undertaken to select a provider for the provision of Counter Fraud Advisory Services and KPMG was successful in being awarded this contract.
- The Committee received an overview of the work being led by the Chief Nurse to address health inequalities by the Trust and within the Birmingham and Solihull Integrated Care System.

4.0 Work Plan 2024/25

ROHTB (6/24) 008 (a)

- 4.1 For 2024/25, the Audit Committee will continue with its routine work as well as to deal with ad hoc requirements that will emerge from time to time.
- 4.2 The Committee has set expectations that the process for ensuring that decision-making staff adhere closely to the requirements of the Trust's Conflicts of Interest policy is strengthened.
- 4.3 The Committee will retain a close oversight of the progress with minimising cybersecurity risks and achieving compliance with the DPST.
- 4.4 Given the ongoing financial pressures at a national level and on the organisation, close scrutiny of the Trust's Going Concern status will remain also an area of prime focus during the year.

5.0 Audit Committee Effectiveness

- 5.1 In 2023/24, the Committee undertook a review of its effectiveness. Members and regular attendees of the Audit Committee were issued with a questionnaire over winter 2023, asking them to provide a view of the strength of the Committee's arrangements in respect of a number of measures covering seven domains:
 - Creating an effective Audit Committee
 - Running an effective Audit Committee
 - Professional Development
 - Overseeing financial reporting
 - Overseeing risk management and internal control
 - Overseeing external audit
 - Overseeing internal audit
- 5.2 The Methodology and questionnaire used were based on approach set out in the Audit Committee Institute Audit Committee Handbook 2014.
- 5.3 The outcome of the effectiveness review will be considered at the April 2024 meeting, which will suggest improvements to the induction of new members to the Committee. The assessment of the audit functions supporting the Trust are noted to be positive.

6.0 Conclusion

- 6.1 The Audit Committee continues to play an important role in the corporate governance framework and continued success of the Trust.

Gianjeet Hunjan
Chair of Audit Committee

April 2024



Internal Audit Plan

Royal Orthopaedic Hospital NHS Foundation Trust

KPMG Governance, Risk & Compliance Services

May 2024

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Distribution list

For action:

Steve Washbourne, Executive Director of Finance and Performance

Simon Grainger-Lloyd, Director of Governance and Data Protection Officer

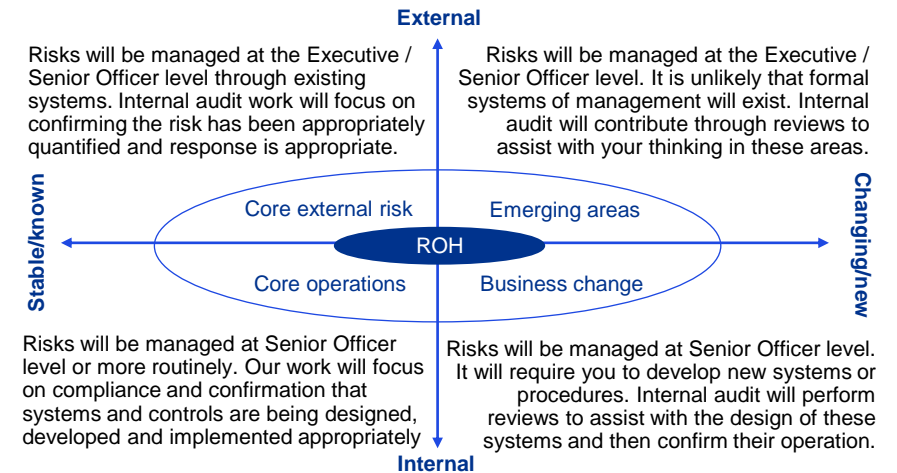
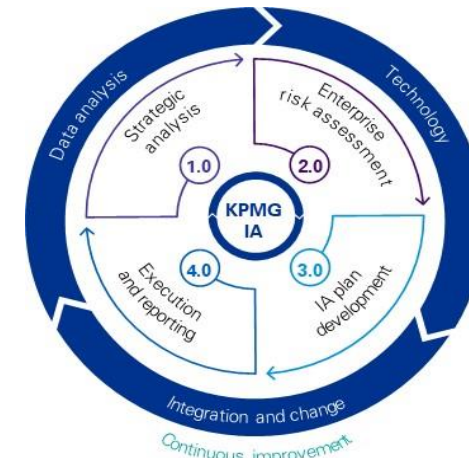
For information:

Audit Committee

01 - How we prepare the Internal Audit plan

Our internal audit plan is devised by understanding the strategy and objectives of Royal Orthopaedic Hospital NHS Foundation Trust, its risk profile (whether strategic, operational, or change risks), considering the other forms of management and independent assurance and, therefore, agreeing what internal audit work is required. In summary:

1. **Strategic analysis** In developing our risk assessment and plan for 2024/25 we:
 - Reviewed the Trust Strategy and Board Assurance Framework;
 - Interviewed members of the executive team;
 - Presented to the executive team and Audit Committee.
2. **Enterprise risk assessment** Drawing on your risk register, our knowledge of the systems you operate, the audit work performed in prior years, and our wider knowledge of the health sector we use the approach shown opposite to categorise your auditable systems.
3. **IA plan development** We have combined our assessment of the overall risks you face with a more traditional internal audit assessment of inherent risk, control risk and materiality to identify the sequence in which we will perform our work. To ensure that we track the type of work we are performing we have identified whether the work is based on a cyclical review of your systems to provide the Head of Internal Audit Opinion.
4. **Execution and reporting** At the conclusion of our planning process we also provide an initial summary of the scope of each review we are proposing and the timing of our work. These details are finalised in advance of the detailed fieldwork being completed as part of the Terms of Reference process we complete with audit sponsors (we have an Executive Sponsor for each review) and auditees (those who will be involved in more detail with our fieldwork).



02 - Summary of the Internal Audit plan 2024/25

We set out below the proposed schedule for delivering the 2024/25 plan. This schedule has been aligned with the planned dates of the Audit Committee to ensure an even flow of reporting throughout the year.

	Review	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
01/24	Right to Speak Up												
02/24	Consultant job planning												
03/24	Operational productivity												
04/24	Key Financial Controls												
05/24	Pre-operative assessment												
06/24	Patient Safety Incident Response Framework												
07/24	BAF and Risk Management												
08/24	DSP Toolkit												

Audit Committee Dates

❖ ❖ ❖ ❖ ❖



03 - Detailed Internal Audit plan 2024/25

We set out below the high level scopes for the 2024/25 internal audit plan. These will be subject to refinement with individual Executive sponsors as part of the scoping process.

#	Name	Rationale for inclusion and scope	Sponsor
01/24	Right to Speak Up	<p>Risk Based Review</p> <p>The need to have an open and supportive culture that encourages staff to raise concerns, for example any issues of patient care quality or safety, is vital for all NHS providers in their work to achieve continuous improvement in service delivery. In the 2023 NHS Staff Survey, 67% of respondents from the Trust said that they feel safe to speak up about anything that concerns them, while 60% felt confident that if they did speak up the organisation would address their concern. The review will consider the processes that the Trust has in place to support the right to speak up, and how the Trust responds to concerns that are raised.</p>	<p>Simon Grainger-Lloyd, Director of Governance and Data Protection Officer</p> <p>Sharon Malhi, Chief People Officer</p>
02/24	Consultant Job Planning	<p>Risk-based review</p> <p>A job plan is a professional agreement which sets out the activities, responsibilities, accountabilities and objectives of the consultant, and the supporting resources required to achieve it. In order to drive improvements in quality, job planning should be based on a partnership approach. It is important that there are appropriate and robust policies and procedures in place to govern the job planning process. As part of this audit, we will review the design and operating effectiveness of the arrangements the Trust has in place regarding consultant job planning, against national guidance.</p>	<p>Matt Revell, Chief Medical Officer</p>
03/24	Operational productivity	<p>Risk Based Review</p> <p>Efficient use of Trust resources is essential as the Trust seeks to reduce the waiting time for patients across the West Midlands. As at January 2024 the Trust was reporting 50.6% against an RTT target of 92%. The Trust's Board reporting notes that the indicator consistently falls short of the target. This review will consider the work that is being done across the Trust to optimise use of resources, as well as considering how productivity data is being calculated and reported across the Trust.</p>	<p>Michelle Hubbard, Interim Chief Operating Officer</p>

03 - Detailed Internal Audit plan 2024/25

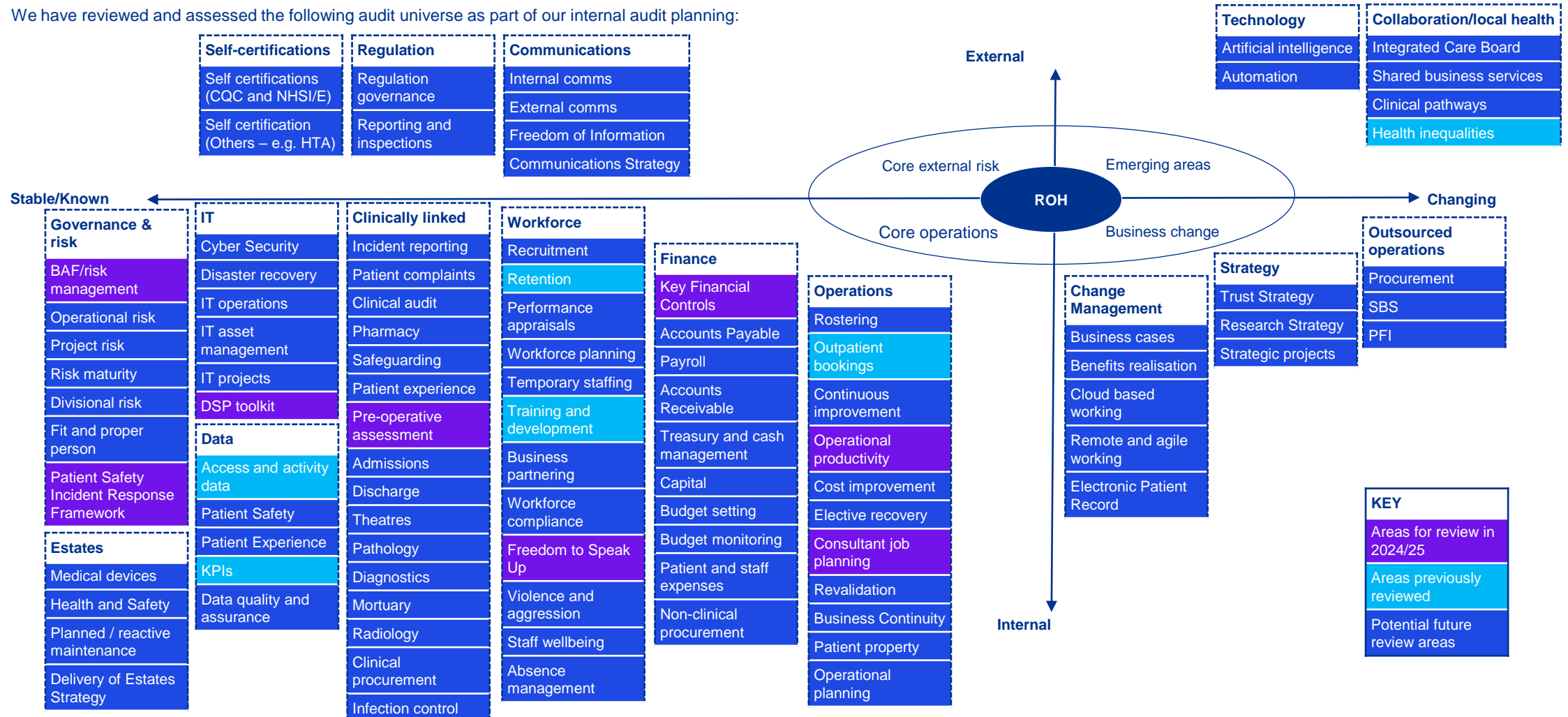
#	Name	Rationale for inclusion and scope	Sponsor
04/24	Key Financial Controls	<p>This is a core review to inform our Head of Internal Audit opinion.</p> <p>We will assess the design of controls in place to support the production of accurate and timely underlying financial records. This will include consideration of financial systems to be agreed with the Executive Director of Finance. Our rolling programme will seek to cover general ledger, treasury management, budgetary control, payroll, income and expenditure, creditors and fixed assets. We will use data analysis techniques to test the operation of key controls over the financial systems. We will also include consideration of agreed actions from prior year reviews within the review.</p>	Steve Washbourne, Executive Director of Finance & Performance
05/24	Pre-operative assessment	<p>Risk-based review</p> <p>Pre-operative assessment is an important step in ensuring patient safety and optimising surgical outcomes. Effective pre-operative assessment can also reduce the need for late cancellations, and in doing so support the Trust's elective recovery plan. This review will assess the design of the pre-operative assessment process as well as carrying out sample testing to consider how the process is operating in practice.</p>	Michelle Hubbard, Interim Chief Operating Officer
06/24	Patient Safety Incident Response Framework	<p>Risk Based Review</p> <p>The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It is a contractual requirement under the NHS Standard Contract and is mandatory for the Trust. The PSIRF was adopted at the Trust in 2023/24, putting in place a PSIRF policy and plan. This review will assess the systems that the Trust has put in place to respond to the PSIRF, and whether they have been successfully embedded across the organisation.</p>	Simon Grainger-Lloyd, Director of Governance and Data Protection Officer

03 - Detailed Internal Audit plan 2024/25

#	Name	Rationale for inclusion and scope	Sponsor
07/24	BAF and Risk Management	<p>This is a core review to inform our Head of Internal Audit opinion.</p> <p>We will review the consistency of BAF and risk documentation, monitoring and reporting across the Trust. Our review will also give consideration to the processes in place for risk management across the Trust by ascertaining the framework in place, reviewing the Trust-wide approach to identifying operational and corporate risks, reviewing and commenting on the risk map, risk management strategy and risk management policies against best practice, and reviewing the arrangements for reporting risk throughout the Trust.</p>	Simon Grainger-Lloyd, Director of Governance and Data Protection Officer
08/24	DSP Toolkit	<p>This is a core review to inform our Head of Internal Audit opinion.</p> <p>We will review the processes for the collation of information from across the organisation for the assessment of the DSPT scores. This review will be in line with the requirements of NHS Digital. Our review will consider the progress made in preparing the evidence for the Toolkit submission to provide assurance that evidence supports the Trust's anticipated level.</p> <p>On the assumption that there are no changes made to the reporting programme by NHS Digital for 2024/25, Royal Orthopaedic Hospital NHS Foundation Trust is required to make a performance update in October 2024, and this will be used as a baseline for our review. The timing of our review is such to allow the Trust ample time to make any refinements required prior to the final submission as at 31 March 2025.</p>	Steve Washbourne, Executive Director of Finance & Performance

04 - Strategic Internal Audit plan 2024-2027

We have reviewed and assessed the following audit universe as part of our internal audit planning:



04 - Strategic Internal Audit plan 2024-2027

Following our identification of the auditable systems and consideration of how these link to your strategy we have then developed our strategic plan to consider the audit risks and therefore the work to be completed within the remaining years of the strategy. We have set this out below:

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Auditable Area		Core	1	Medium	✓				

The first part of our analysis shows which area is being reviewed and identifies past assurance (and the year it was awarded) levels. We have also forecast the expected future assurance level for each area were it to be included in the current year audit plan. The previous assurance allows a judgement to be made on the organisational progress of assurance rating over time, and the level of improvements that have occurred during the audit cycle.

Our forecast assurance rating is based upon our understanding of the operating environment, the controls in place and work completed since the previous audit or discussion which have taken place in formulating the revised strategic plan.

The second part of our analysis assesses audit category; All our audits are undertaken using a systems based audit methodology. However, some of those audits are focused on:

- **Core** content (such as those financial controls, risk management, governance or data control) which we need to undertake to provide a head of internal audit opinion.
- Consideration of value of money (**vf**m) or wider systems, which while a number of such review are required to issue an internal audit opinion a less prescriptive scope can be formulated.

The fourth part of our analysis shows timing of review for individual auditable system within the strategic plan. It shows when systems have previously been reviewed and when they are next expected to be reviewed. The aim of this sequencing is to balance risk of systems, required internal audit standards and flow of work across the five years of the strategic plan.

The third part of our analysis considers our internal audit risk, which is the aggregate of the related material, inherent and control assessments. This risk reflects the internal audit risk and impact of controls, rather than the organisational risk, which is formulated to an alternative assessment of likelihood and impact criteria. We cross refer our operational plan to the Risk Register as part of the formation of that. We have also analysed how many high risk actions we have raised to date as part of our strategic internal audit plan.

04 - Strategic Internal Audit plan 2024-2027

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Core operations									
Key Financial Controls	2023/24	Core, D&A		MEDIUM	✓	✓	✓	✓	✓
BAF and Risk Management	2022/23	Core, D&A		MEDIUM	✓	✓	✓	✓	✓
Data quality: KPI assurance	2022/23	Core, D&A		MEDIUM	✓	✓	✓	✓	✓
General IT Controls	2021/22	Core	1	MEDIUM	✓			✓	✓
DSP Toolkit	2022/23	Core		MEDIUM	✓	✓	✓	✓	✓
Operational risk		Risk Based		MEDIUM					
Project risk		Risk Based		MEDIUM					
Risk maturity		Risk Based		MEDIUM					
Divisional risk		Risk Based		MEDIUM					
Fit and proper person		Risk Based		MEDIUM				✓	
Patient Safety Incident Response Framework		Risk Based		MEDIUM			✓		
Medical devices		Risk Based		MEDIUM					
Health and Safety		Risk Based		MEDIUM					✓
Planned / reactive maintenance		Risk Based		MEDIUM					
Delivery of Estates Strategy		Risk Based		MEDIUM					
Cyber Security		Risk Based		MEDIUM					
Disaster recovery		Risk Based		MEDIUM				✓	
IT operations		Risk Based		MEDIUM					
IT asset management		Risk Based		MEDIUM					
IT projects		Risk Based		MEDIUM					✓



04 - Strategic Internal Audit plan 2024-2027

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Core operations									
Access and activity data		Risk Based		MEDIUM					
Patient Safety		Risk Based		MEDIUM					
KPIs	Advisory	Risk Based		MEDIUM		✓			
Incident reporting		Risk Based		MEDIUM					
Patient complaints		Risk Based		MEDIUM					
Clinical audit	2021/22	Risk Based		MEDIUM				✓	
Pharmacy		Risk Based		MEDIUM					
Safeguarding		Risk Based		MEDIUM					
Patient experience		Risk Based		MEDIUM					✓
Pre-operative assessment		Risk Based		MEDIUM			✓		
Waiting list management	2022/23	Risk Based		MEDIUM					
Discharge		Risk Based		MEDIUM					
Theatres utilisation	2022/23	Risk Based		MEDIUM	✓				
Pathology		Risk Based		LOW					
Diagnostics		Risk Based		MEDIUM					
Mortuary		Risk Based		LOW					
Radiology		Risk Based		MEDIUM					
Clinical procurement		Risk Based		MEDIUM					

04 - Strategic Internal Audit plan 2024-2027

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Core operations									
Recruitment		Risk Based		MEDIUM					
Retention		Risk Based		MEDIUM		✓			
Performance appraisals		Risk Based		MEDIUM					
Workforce planning	2022/23	Risk Based	1	MEDIUM	✓			✓	
Temporary staffing		Risk Based		MEDIUM					✓
Training and development	2023/24	Risk Based		MEDIUM		✓			
Business partnering		Risk Based		MEDIUM					
Workforce compliance		Risk Based		MEDIUM					
Freedom to Speak Up		Risk Based		MEDIUM			✓		
Violence and aggression		Risk Based		MEDIUM					
Staff wellbeing		Risk Based		MEDIUM					
Absence management		Risk Based		MEDIUM					
Patient and staff expenses		Risk Based		MEDIUM					
Non-clinical procurement		Risk Based		MEDIUM					
Rostering		Risk Based		MEDIUM				✓	
Outpatient bookings	2023/24	Risk Based		MEDIUM		✓			
Continuous improvement		Risk Based		MEDIUM					✓
Operational productivity		Risk Based		MEDIUM			✓		

04 - Strategic Internal Audit plan 2024-2027

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Core operations									
Cost improvement		Risk Based		MEDIUM					
Elective recovery	2022/23	Risk Based		MEDIUM	✓				
Consultant job planning		Risk Based		MEDIUM			✓		
Revalidation		Risk Based		MEDIUM					
Business Continuity		Risk Based		MEDIUM				✓	
Patient property		Risk Based		MEDIUM					
Operational planning		Risk Based		MEDIUM					
Core External Risks									
Self certifications (CQC and NHSI/E)		Risk Based		LOW					
Self certification (Others – e.g. HTA)		Risk Based		MEDIUM					
Regulation governance		Risk Based		MEDIUM					
Reporting and inspections		Risk Based		MEDIUM					
Internal comms		Risk Based		MEDIUM					
External comms		Risk Based		LOW					
Freedom of Information		Risk Based		MEDIUM					
Communications Strategy		Risk Based		MEDIUM					
Emerging areas									
Artificial intelligence		Risk Based		LOW					
Automation		Risk Based		LOW					
Integrated Care Board		Risk Based		LOW					✓



04 - Strategic Internal Audit plan 2024-2027

Areas	Previous assurance	Audit type	Past high priority recs	Aggregate risk	2022/23	2023/24	2024/25	2025/26	2026/27
Emerging areas									
Shared business services		Risk Based		LOW					
Clinical pathways		Risk Based		MEDIUM				✓	
Health inequalities	2022/23	Risk Based	1	MEDIUM					
Business change									
Business cases		Risk Based		LOW					
Benefits realisation		Risk Based		MEDIUM				✓	
Cloud based working		Risk Based		MEDIUM					
Remote and agile working		Risk Based		MEDIUM					
Electronic Patient Record		Risk Based		MEDIUM					
Trust Strategy		Risk Based		MEDIUM					✓
Research Strategy		Risk Based		MEDIUM					
Strategic projects		Risk Based		MEDIUM					
Procurement		Risk Based		MEDIUM					
SBS		Risk Based		LOW					
PFI		Risk Based		LOW					
Cost of internal audit reviews								£92,000	
Audit planning								£2,750	
Contract management, progress reports, Audit Committee Attendance								£6,500	
Total cost of internal audit								£101,250	



04 - Strategic Internal Audit plan 2024-2027

We have linked the internal audits to your most recent risk assessment

Strategic risk description	Your risk rating	Planned internal audit report and explanation of timing of coverage	Internal Audit planned response				
			2022/23	2023/24	2024/25	2025/26	2026/27
SR1 Our Care: There is a risk that the Trust will fail to meet its objective of being rated as 'outstanding' by the CQC by 2028.	●	This area is not subject to review in the 2024/25 cycle.				●	
SR2 Our Expertise: There is a risk that the Trust will fail to meet its objective of being kitemarked as a Major Revision Centre and Surgical Elective Hub and will publish 30% more research publications.	●	This area is not subject to review in the 2024/25 cycle.				●	
SR3 Our People: There is a risk that the Trust will fail to meet its objective of being rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey.	●	Planned 2024/25 and rolling coverage: <ul style="list-style-type: none"> Right to Speak Up 		●	●		
SR4 Our Community: There is a risk that the Trust will fail to meet its objective of reducing health inequality by improving access for people in the most deprived 20% of our communities.	●	This area is not subject to review in the 2024/25 cycle. This was the subject of an internal audit in 2023/24.		●			
SR5 Our Services: There is a risk that the Trust will fail to meet its objective to increase the number of people we treat by 20% within our current resources (this figure will be adjusted as resources increase).	●	Planned 2024/25 and rolling coverage: <ul style="list-style-type: none"> Pre-operative assessment Operational productivity Consultant job planning 		●	●		
SR6 Our Collaboration: There is a risk that the Trust will fail to meet its objective of delivering a standardised pathway for elective orthopaedics in Birmingham and Solihull.	●	This area is not subject to review in the 2024/25 cycle					●



Internal Audit Charter

Purpose of this document

A professional, independent and objective internal audit service is one of the key elements of good governance, as recognised throughout the UK public sector.

From 1 April 2017 a common set of Public Sector Internal Audit Standards (PSIAS) were adopted across the public sector. These standards require all internal audit service providers to develop an internal audit charter. This is a formal document that defines the activities, purpose, authority and responsibilities of internal audit. It also ensures the internal audit service we provide to you meets the requirements of both Internal Auditing Standards and KPMG's own Internal Audit Manual.

Approval of this internal audit charter is the responsibility of the Audit Committee on behalf of the Board.

Public Sector Internal Audit Standards

The PSIAS are based on the four mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF):

Definition of Internal Auditing

Internal audit can be defined as *'an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'*.

Compliance with the Code of Ethics

Internal auditors in UK public sector organisations are required to comply with the Code of Ethics set out in PSIAS. This promotes an ethical, professional culture and requires internal auditors to have regard to the Committee on Standards of Public Life's Seven Principles of Public Life. All KPMG staff are required to ensure their compliance with this code, which is consistent with the code of ethics set out by the code of ethics set out by

internal auditors' own professional bodies' and KPMG's own standards in respect of ethics, independence and integrity.

International Standards for the Professional Practice of Internal Auditing

In common with the IIA International Professional Practices Framework, on which they are based, PSIAS comprise Attribute and Performance Standards. The Attribute Standards address the characteristics of organisations and parties performing internal audit activities. The Performance Standards describe the nature of internal audit activities and provide quality criteria against which the performance of these services can be evaluated. The PSIAS apply to all internal audit service providers, whether in-house, shared Services or outsourced.

Core Principles for the Professional Practice of Internal Auditing

In common with the IIA International Professional Practices Framework, on which they are based, PSIAS comprise Core Principles. For an internal audit function to be considered effective, all principles should be operating effectively.

Internal Audit Charter

This Internal Audit Charter is the framework within which the Internal Audit function operates and formalises the arrangements approved by the Audit and Risk for the internal audit service provided by KPMG. As a public sector organisation, you are required to have an internal audit service in place which conforms to the standards set out in PSIAS.

Roles and responsibilities

The objectives of Internal Audit are to assist all levels of your management and the Audit and Risk Committee in the effective discharge of their responsibilities relating to risk management and internal control by providing you with appraisals, management actions, and other relevant information concerning your activities. We also aim to promote effective internal control at a reasonable cost and to facilitate the risk management process throughout your organisation and help embed this process.

Internal Audit Charter

We set out below, both your responsibilities, and those of the Head of Internal audit.

Role and responsibilities of the Head of Internal audit:

The key role of internal audit is to assist the Board in discharging its governance responsibilities. Your Head of Internal Audit will ensure:

- the independence and objectivity of the internal audit service, as well as the individual independence and objectivity of members of the audit team;
- the development of an annual audit plan and three year audit strategy. In conjunction with you we will establish an audit strategy to determine the priorities for internal audit work which are consistent with your goals. From this a risk-based annual internal audit plans will be determined. This will outline the assignments to be carried out in any one year, their respective priorities and the estimated total resources needed. The annual internal audit plan will be flexible and kept up to date with the organisation and its changing risks and priorities. Any changes to the plan will be reported to the Audit Committee for approval;
- internal audits are planned and conducted in a manner designed to fulfil the objectives as approved by the Audit Committee and that high standards and a consistent approach are adopted by internal audit staff. The process for the delivery of individual assignments is set out later in this document;
- all members of the audit team have the skills, experience and competencies needed to deliver an effective internal audit service. This includes the need to ensure the continuing professional development of all members of the team;
- the implementation of KPMG's quality assurance programme, compliance with internal and external assessments, and delivery of arrangements to ensure the continued improvement of the internal audit service;
- compliance with all relevant standards for the professional practice of internal auditing;
- the reporting of key findings and management actions arising following internal audits to the managers responsible for the area being audited, to the Executive Director of Finance and to the Audit Committee;
- regular and appropriate liaison with external audit to ensure optimal coverage;
- assistance in the design of new controls and the understanding of internal control principles by management and other staff, affording regular consideration to the adequacy of internal control processes;
- the delivery of an annual internal audit opinion and report that can be used by you to inform your governance statement. The annual report will incorporate:
 - the Head of Internal Audit opinion;
 - a summary of the work that supports the opinion; and
 - a statement on conformance with the PSIAS and any relevant results of the quality assurance programme.

Your roles and responsibilities

You are responsible for maintaining effective internal audit activity on an ongoing basis. This includes:

- Monitoring and reviewing the effectiveness of the internal audit function;
- Reviewing and assessing the internal audit strategy and annual internal audit plan and its progress;
- Ensuring the internal audit function is adequately resourced, has appropriate reporting lines, and enjoys appropriate standing within the organisation; and
- Consideration of management's response to management actions and progress in their implementation.

Internal Audit Charter

Independence and objectivity

The independence of internal audit is assured by KPMG's Head of Internal Audit by Andrew Bostock reporting to the Chief Executive Officer as necessary with further reporting lines to the Executive Director of Finance.

KPMG's Head of Internal Audit also has direct access to the Chair of the Audit Committee, to whom all significant concerns relating to the adequacy and effectiveness of risk management activities, internal control and governance are reported.

Where independence is impaired in fact or appearance the KPMG's Head of Internal Audit will report the details to the Chair of the Audit Committee and the Executive Director of Finance. The nature of the disclosure will depend upon the impairment. However, it is important that our independence in reporting to the management and the Audit Committee does not appear to be compromised but equally that you should not be deprived of expertise where it is needed and can be leveraged from KPMG.

Fraud and irregularities

It is a management responsibility to maintain systems and to ensure that resources are properly applied in an appropriate manner on approved activities. This includes responsibility for the prevention and detection of fraud and other illegal acts.

Internal audit staff shall have regard to the possibility of such malpractice and should seek to identify serious defects in internal control which might permit the occurrence of such events.

KPMG's Head of Internal Audit should be advised of any discovery or suspicions of malpractice by management or the Audit Committee. Likewise KPMG's Head of Internal Audit is responsible for notifying management, the appointed Local Counter Fraud Specialist or the Audit Committee in the event of internal audit staff discovering evidence or suspicion of malpractice. You shall determine any action to be taken.

Liaison with other auditors

The internal audit function extends to activities which should be of interest and benefit to the external auditors; in particular through the review and evaluation of financial systems and investigations relating to key business risks.

Internal audit plans and assignment reports will be issued to your external auditor via the circulation of the Audit and Risk Committee papers, as your external auditors on a regular basis to actively plan and avoid clashes in visits and duplication of effort.

Periodic meetings can be held between internal audit staff and the external auditors to discuss liaison matters and ensure an appropriate dialogue to identify, and take action on, areas where liaison can achieve time savings or improved performance. External audit should be explicitly requested to review the annual plan and comment thereon formally to the Audit Committee. Internal audit working papers may be made available to external audit for review at mutually convenient times.

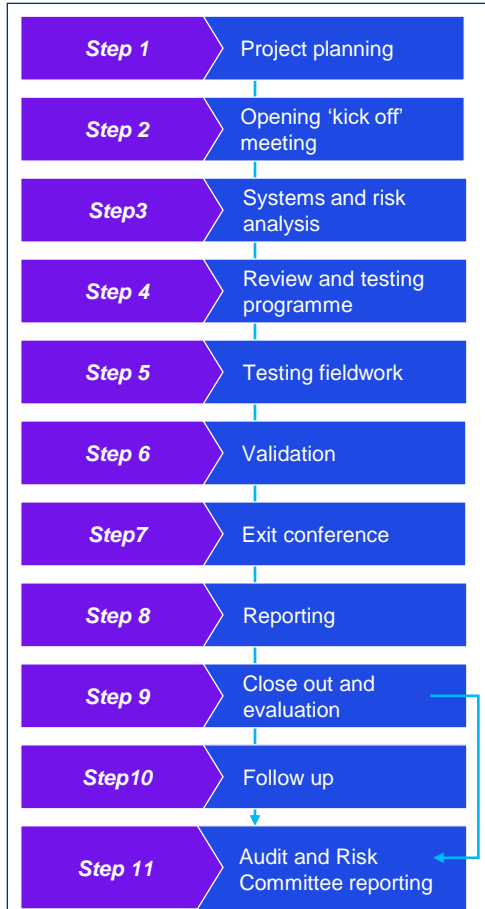
Operating principles – The assignment process

We will utilise a risk-based approach to the individual reviews in line with the KPMG internal audit methodology. This involves:

- identifying the risks that may impact on the systems achieving their objectives;
- identifying and evaluating the systems of internal control designed by management;
- compliance testing of the operation of controls; and
- suggesting appropriate management actions and advising management on how systems of internal control may be streamlined or strengthened.

The different delivery stages of the audit process are shown opposite: our approach to individual reviews recognises that different approaches will be required in different circumstances, for example in some cases as systems are being developed or revised it may be beneficial for us to defer detailed testing until a later date, but instead focus on understanding and contributing to the development of the design of the control framework.

Internal Audit Charter



Reporting

On completion of our individual reviews, we will produce a report for management that will outline the objectives and scope of our work, risks considered during our review, an assessment of the effectiveness of internal controls and considerations for performance improvements. Each report will include an implementation plan.

We undertake follow up work in subsequent periods to track the implementation of agreed management actions. A Progress Report will be presented to each Audit Committee providing a summary internal audit activities and progress on the implementing agreed management actions.

Following our internal audit work for the year we will produce an annual internal audit report. This will summarise the work completed and will provide an overall opinion in respect of risk, control and governance arrangements.

Levels of Assurance

Opposite we show the basis of the levels of assurance that we provide you with for our reports.

Action ratings

Our actions are given the ratings shown on the following page:

Level

Classification

Significant assurance	Means the system is well designed and only minor low priority management actions have been identified related to its operation. Might be indicated by priority three only, or no management actions (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).
Significant assurance with minor improvement opportunities	Means the systems is generally well designed however minor improvements could be made and some exceptions in its operation have been identified. Might be indicated by one or more priority two management actions. (i.e. there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Partial assurance with improvements required	Means both the design of the system and its effective operation need to be addressed by management. Might be indicated by one or more priority one, or a high number of priority two management actions that taken cumulatively suggest a weak control environment. (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
No assurance	Means the system has not been designed effectively and is not operating effectively. Audit work has been limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one management actions and fundamental design or operational weaknesses in the area under review. (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).

Internal Audit Charter

Priority	Description
Red – priority 1	A significant weakness in the system or process which is putting you at serious risk of not achieving its strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any management actions in this category would require immediate attention.
Amber – priority 2	A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.
Green – priority 3	Management actions which could improve the efficiency and / or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

Internal auditors in the public sector must conform to the Code of Ethics. These are:

1. Integrity Principle: The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement. Internal auditors:

- 1.1 Shall perform their work with honesty, diligence and responsibility;
- 1.2 Shall observe the law and make disclosures expected by the law and the profession;
- 1.3 Shall not knowingly be a party to any illegal activity, or engage in acts that are discreditable to the profession of internal auditing or to the organisation; and
- 1.4 Shall respect and contribute to the legitimate and ethical objectives of the organisation.

2. Objectivity Principle: Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant

circumstances and are not unduly influenced by their own interests or by others in forming judgements. Internal auditors:

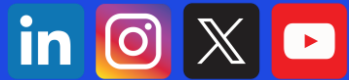
- 2.1 Shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation;
- 2.2 Shall not accept anything that may impair or be presumed to impair their professional judgement; and
- 2.3 Shall disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review.

3. Confidentiality Principle: Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so. Internal auditors:

- 3.1 Shall be prudent in the use and protection of information acquired in the course of their duties; and
- 3.2 Shall not use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the organisation.

4. Competency Principle: Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services. Internal auditors:

- 4.1 Shall engage only in those services for which they have the necessary knowledge, skills and experience;
- 4.2 Shall perform internal auditing services in accordance with the International Standards for the Professional Practice of Internal Auditing; and
- 4.3 Shall continually improve their proficiency and effectiveness and quality of their services.



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This plan is provided pursuant to the terms of our engagement letter. Nothing in this terms of reference constitutes a valuation or legal advice. We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in our engagement letter. This terms of reference is for the sole benefit of the Royal Orthopaedic Hospital NHS Foundation Trust. In preparing this terms of reference we have not taken into account the interests, needs or circumstances of anyone apart from the Royal Orthopaedic Hospital NHS Foundation Trust, even though we may have been aware that others might read this plan. This plan is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Royal Orthopaedic Hospital NHS Foundation Trust) for any purpose or in any context. Any party other than the Royal Orthopaedic Hospital NHS Foundation Trust that obtains access to this terms of reference or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through the Royal Orthopaedic Hospital NHS Foundation Trust Publication Scheme or otherwise) and chooses to rely on this plan (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this plan to any party other than the Royal Orthopaedic Hospital NHS Foundation Trust. Any disclosure of this plan beyond what is permitted under our engagement letter may prejudice substantially our commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If Royal Orthopaedic Hospital NHS Foundation Trust receives a request for disclosure of the product of our work or this terms of reference under the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2002, having regard to these actionable disclosure restrictions the Royal Orthopaedic Hospital NHS Foundation Trust should let us know and should not make a disclosure in response to any such request without first consulting KPMG LLP and taking into account any representations that KPMG LLP might make.

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UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 22 May 2024

<p style="text-align: center;">MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none"> • It was noted within the Health & Safety annual report that fire safety training uptake remained below the level required but further work was being undertaken to refine the course and delivery methods which should improve the position. • It was noted that there had been two inpatient deaths over the last month – both had been referred to the Coroner and appropriate internal investigations were being undertaken. • It was noted that the CQUINs regarding ‘flu vaccination and the documentation and assessment of pressure ulcer risks were not achieved in 2023/24. 	<p style="text-align: center;">MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</p> <ul style="list-style-type: none"> • Circulate the full Quality Account to the Committee when available. • Revise the Quality Report to include further detail around PSIRF investigations and incident handling including numbers of After Action Reviews (AARs), Patient Safety Incident Investigations (PSII) and hot debriefs. • It was agreed that the detail of actions taken in response to the findings of the CQC inpatient survey would be useful to include in the next overall Patient Experience update.
<p style="text-align: center;">POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none"> • An update on the position regarding incidents related to appointments was reported which highlighted a significant reduction compared to the situation reported previously – this was associated with more streamlined outpatient appointments and gaps in staffing having been filled. • The Committee received a positive update on the JointCare ‘Coffee Catch Up’ sessions which demonstrated a very clear link between feedback received at the sessions and the quality improvement work at the ROH. There were some clear examples provided of where the treatment received at the Trust had delivered a life changing experience for patients. • The Committee received the draft nursing plan – it was agreed that some further metrics would be useful to include within this and the articulation as to how the plan contributed to the delivery of the Trust’s central strategy. • An update on the outcome of the recent inspection by the Human Tissue Authority was received, which showed that no major actions had been raised as a result of the inspection, with three minor 	<p style="text-align: center;">DECISIONS MADE</p> <ul style="list-style-type: none"> • Agreed the closure of a number of actions on the Committee’s log, including that related to benchmarking, given that work had been undertaken to source this and it was included in papers where available. • The proposed changes to the Corporate Risk Register were approved and also suggested that it would be helpful to see an overview of risk score movement over the financial year for those risks within the remit of the Committee. • The Committee approved the list of quality priorities for 2024/25 and would recommend their adoption to the Trust Board when the full Quality Account was presented for approval at the end of June 24. • Subject to comments made, the Committee approved the presentation of the Nursing Plan to the Trust Board. • The Committee approved the presentation of the Health & Safety annual report to the Trust Board at its next meeting.



actions and three advisory recommendations offered. These mainly related to the Spherox pathway and documentation.

- An update on the position regarding claims being handled by the Trust was received, which highlighted that there had been fewer claims received in 2023/24 compared to previous financial years and that claims continued to be settled either at or below the worst case financial scenario.
- An update on the Trust's implementation of the Patient Safety Incident Response Framework was provided which gave assurance that the Trust was managing its incidents in line with the principles of the new framework. The Committee expressed a wish to see more detail to provide ongoing assurance that this was the case within the Quality Report. It was also agreed that the feedback from patients involved in the investigation process would be useful to include.
- The Committee received an update on the outcome of the CQC national inpatient survey results for 2022. The overall outcome was positive with the Trust rated as performing 'Much Better than Expected' in comparison to other organisations.
- An overview of access to care from a health inequalities perspective was considered, which suggested that based on an analysis of patients receiving hip and knee replacements, that the Trust provides good access for the deprived, ethnic minority groups and patients with co-morbidities, particularly those with obesity. The Committee discussed the need for a System-wide approach to be taken to addressing health inequalities and the benefits of viewing demographic and access information across the region.
- CQUINs concerning switching of intravenous antimicrobial treatment to the oral route and communication of changes to medicines were achieved.

Chair's comments on the effectiveness of the meeting: It was noted that a walkabout had been undertaken prior to the meeting which had visited theatres and clinical Non Executives had joined the morning huddle. The need to replace a section of flooring outside of the High Dependency Unit as a priority was noted. The Committee meeting was held in person which was welcomed and agreed should be held in this way for each alternate meeting. There was good challenge and productive discussions across the agenda. Following the meeting, the Non Executives visited the Patient Experience team.

Finance and Performance Report

Month 1

Introduction

The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues that are being highlighted.

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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



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



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



A grey graph icon tells us the variation is common cause, and there has been no significant change.
For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



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

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



Operational Performance Summary

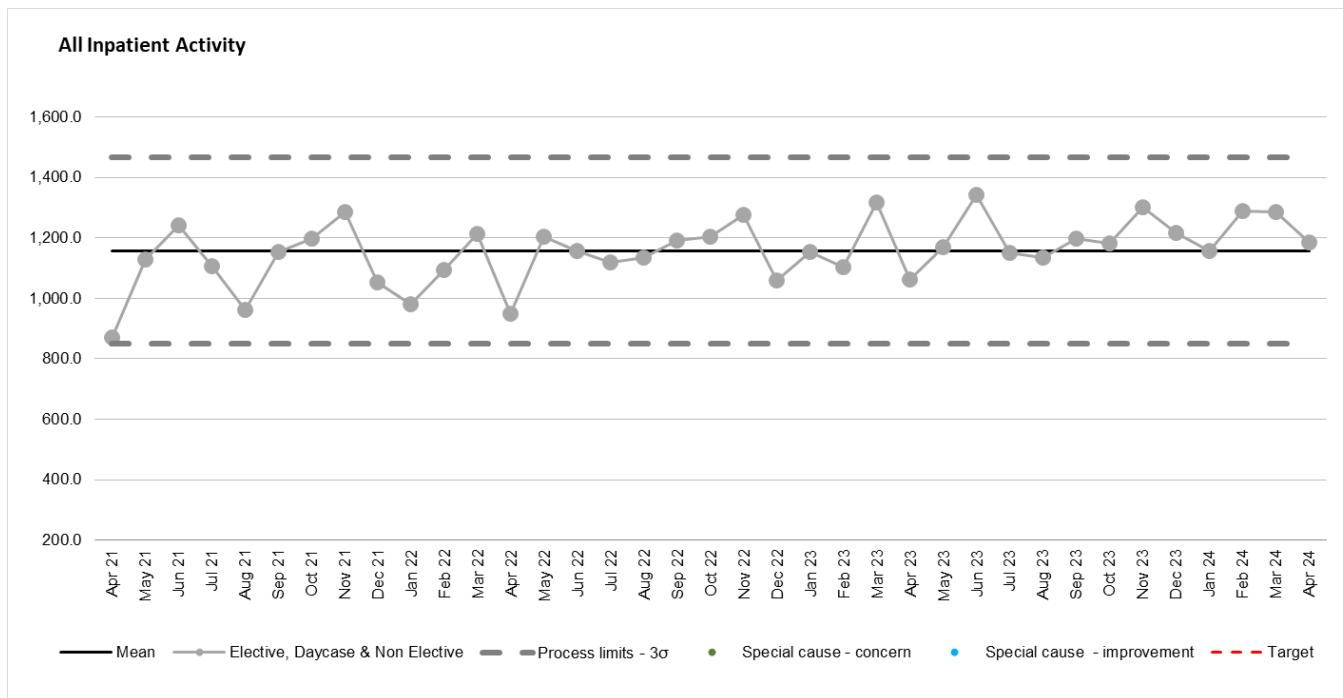
Performance to end April 24	In month	Previous month / Year end	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	49.05%	49.58%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	36	39	0		
52 week waits (52 – 64 Weeks)	490	517	0		
All activity YTD (compared to plan)	1,185	14,481	1,185		
Outpatient activity YTD (compared to plan)	6,034 110.4% Cumulative	66,066 99.8% Cumulative	5,466 YTD Target		
Outpatient Did Not Attend (YTD)	7.0%	8.4%	8%		
PIFU (trajectory to 5% target)	571 9.7%	416 8.3%	403 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	12.1%	8.5%	19%		
FUP attendances(compared to 19/20)	102.4%	92.6%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	121.5%	110.1%	120%		
Diagnostics volume YTD (compared to plan)	2,320 Cumulative	25,498 Cumulative	2,216 YTD Target		
Diagnostics 6 week target	100%	99.8%	99%		



Operational Performance Summary

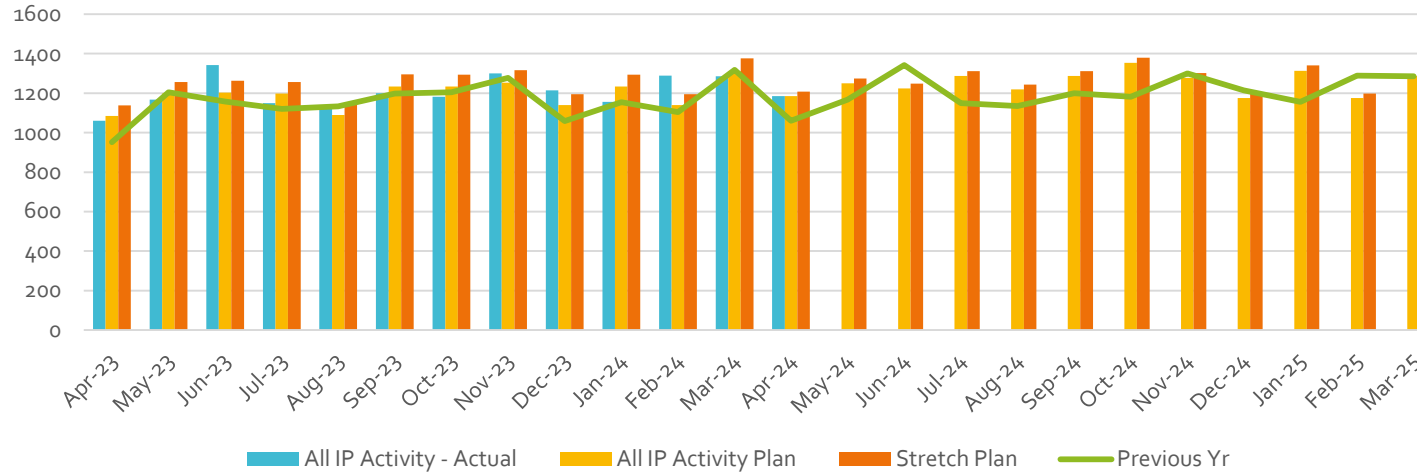
Performance to end April 24	In month	Previous month/ year end	Target	Variation	Assurance
Theatre Session Utilisation	85.04%	89.42%	85% stretch is 95%		
Theatre Insession Utilisation (Uncapped)	83.04%	82.58%	85% stretch is 90%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	85.7%	59.1%	85%		
28 day FDS	82.8%	82.8%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	2,329 Cumulative	25,552 Cumulative	1,765 Cumulative		
Bed Occupancy (excluding CYP and HDU)	70.5%	69.7%	82-85%		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.09	3.66	n/a		
LOS - elective primary hip	3.00	2.90	2.7		
LOS - elective primary knee	3.10	2.90	2.7		
BADS Daycase rate (Note: due to time lag in month is Jan'24)	72.2%	72.90%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff	35.90%	-	-		

1. Activity Summary

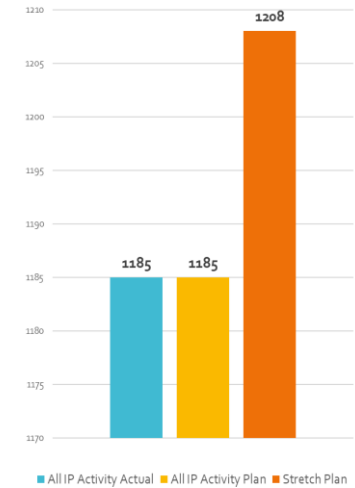


1. Activity Summary

Day Case, Elective and Non Elective Activity



Day Case, Elective & Non Elective Activity Year to Date

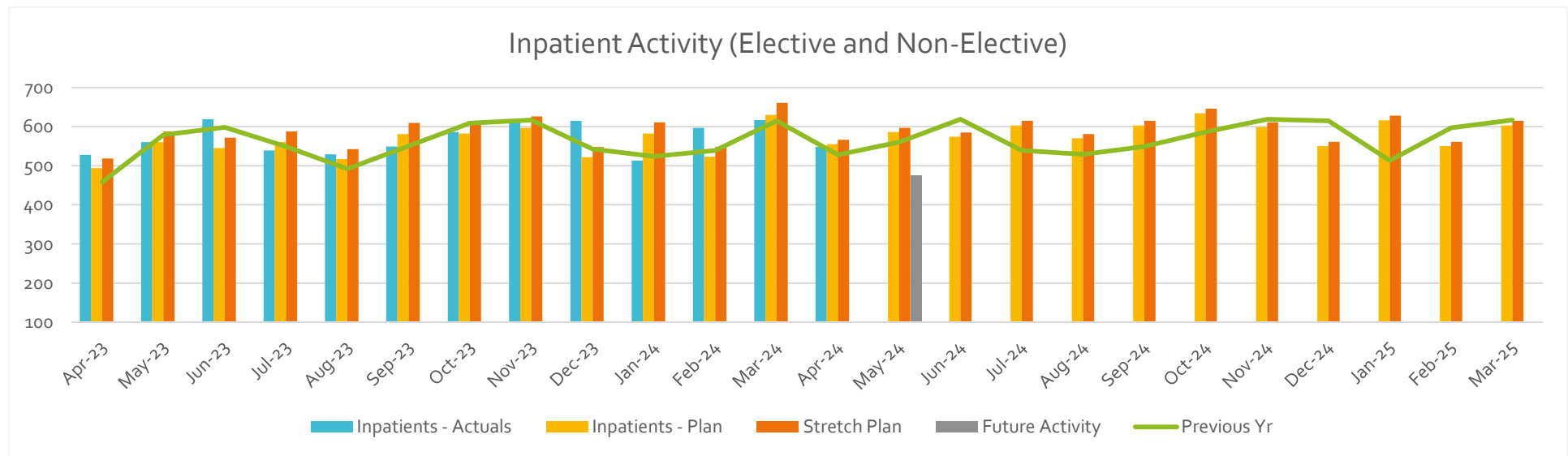
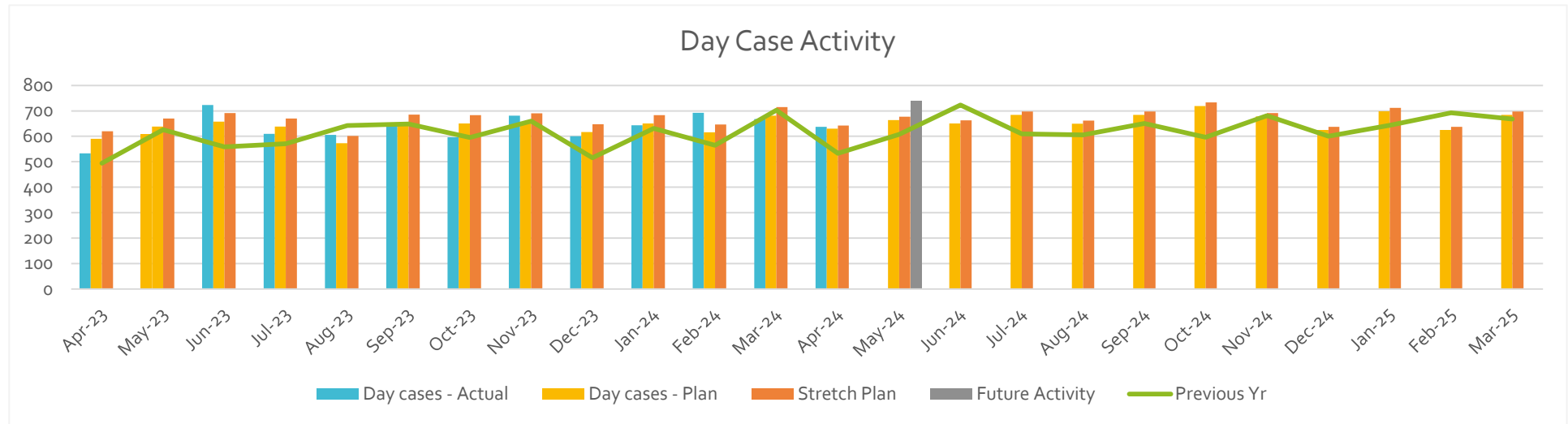


		Plan												Plan	Actual	% Achieved	Variance
Activity Type		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	543	573	561	590	559	590	620	586	539	602	539	590	543	528	97%	-15
	Daycase	630	664	650	684	649	684	719	678	625	698	625	684	630	637	101%	7
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	12	20	167%	8
	All Activity	1185	1250	1224	1287	1219	1287	1353	1277	1175	1314	1175	1287	1185	1185	100%	0
Stretch Plan	Inpatient	554	584	572	602	570	602	632	598	550	614	550	602	554	528	95%	-26
	Daycase	642	677	663	697	662	697	733	691	637	712	637	697	642	637	99%	-5
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	12	20	167%	8
	All Activity	1208	1274	1248	1312	1243	1312	1379	1302	1198	1340	1198	1312	1208	1185	98%	-23

April 2024

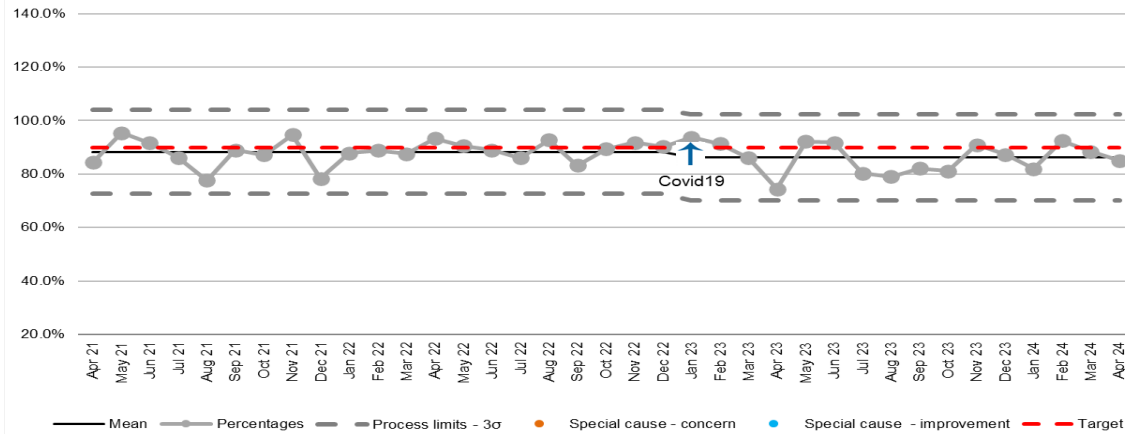
Actual Monthly 1185 vs 1185 Trust Monthly Plan. The April plan was still set at the 23/24 system plan due to a delay in operational planning guidance.

1. Activity Summary

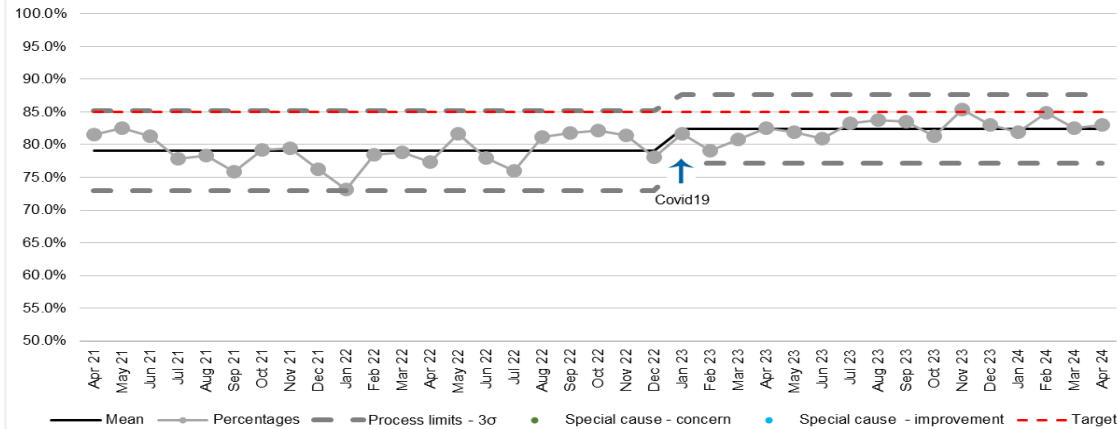


2. Theatre Utilisation

Theatre Session Utilisation (All Electives)



Theatre In Session Utilisation (All Electives)



Elective Session Utilisation (April 2024)

Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	474	404	70	85.23%
UHB	74	62	12	83.78%
Totals	548	466	82	85.04%

Elective In Session Utilisation (April 2024)

Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1771	1500	271	84.70%
UHB	274	198	76	72.28%
Totals	2044	1697	347	83.04%

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for April was **85.04%** which was above the Trust target of **85%**.

The overall in-session utilisation for April 24 was **83.04%**.

AREAS FOR IMPROVEMENT

Theatres carried out a Seamless Surgery Event during the week of the 29th April 24 which identified themes where a review of current processes will be undertaken for example, the process of listing patients (staggered admissions), theatre utilisation, standby patient process etc. An action plan will be compiled along with a 'you said we did' communication following review of over 40 suggestion forms completed by theatre staff, and both consultant surgeons and anaesthetists, which demonstrates the level of engagement from staff.

A review of POAC processes/pathways has been undertaken, supported by the GIRFT Pre-operative Lead. A preoperative process project group chaired by the divisional HoN, supported by the AMD has been established to develop an action plan with next steps to be consolidated

Ongoing close monitoring of UHB theatre utilisation continues with Interim COO oversight.

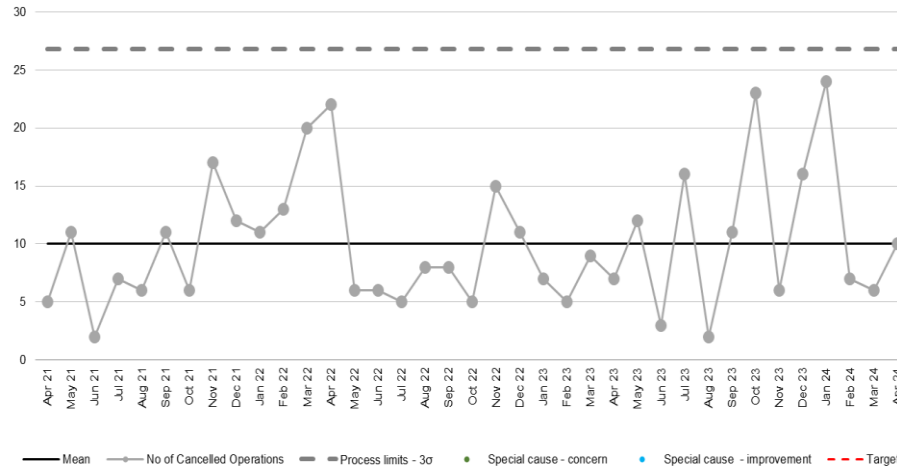
RISKS / ISSUES

UHB have confirmed intentions to retain up to 1 theatre. The team are working with UHB to confirm the surgeons remaining and to agree the process going forward. Martin Richardson Exec lead has been informed that lists that remain need to be owned and managed by ROH. This will require admin and Ops resource to oversee. This has been provided by UHB to date. The other theatres will be covered by consultants that lost capacity due to UHB's arrival and recruitment to vacant posts scheduled to fall in line with UHB's exit.

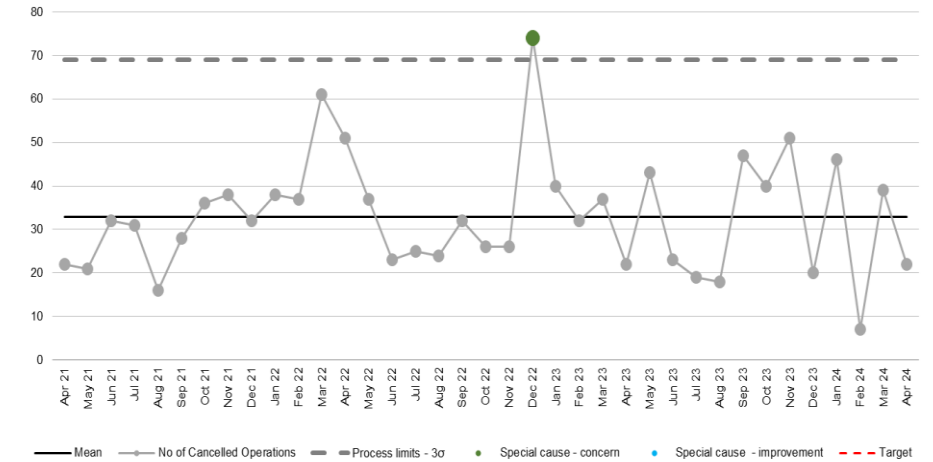
Reviewing demand and capacity data to ensure that consultant recruitment delivers 50 weeks in line with specialty backlogs.

2. Theatre Utilisation/ Hospital Led Cancellations

Cancelled by Hospital on Day of Admission

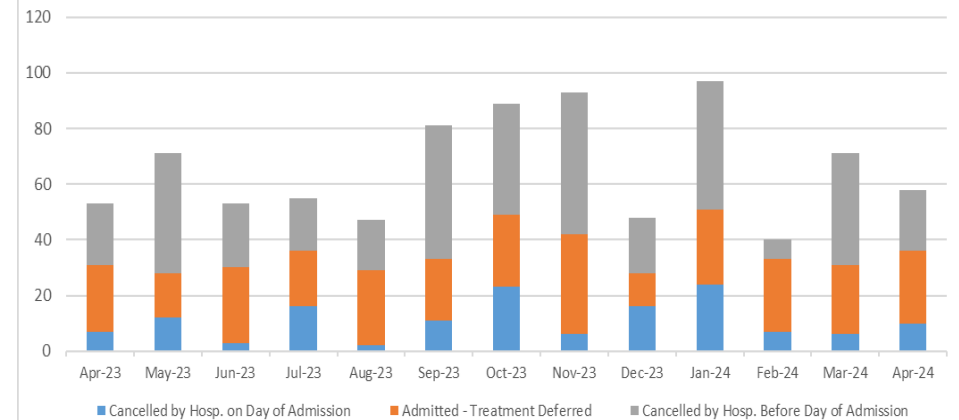


Cancelled by Hospital Before Day of Admission



Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Apr-23	7	24	22	53	0
May-23	12	16	43	71	0
Jun-23	3	27	23	53	0
Jul-23	16	20	19	55	0
Aug-23	2	27	18	47	0
Sep-23	11	22	48	81	0
Oct-23	23	26	40	89	0
Nov-23	6	36	51	93	0
Dec-23	16	12	20	48	0
Jan-24	24	27	46	97	0
Feb-24	7	26	7	40	0
Mar-24	6	25	40	71	0
Apr-24	10	26	22	58	0
Total	143	314	399	856	0

Inpatient Cancellations on the day or day before April 2023 to April 2024



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases. These cases are more difficult to avoid due to very short notice bookings. The table below provides details of the cancellations for April 24. The overall number of cancellations reduced by 13 patients in April 24:

Patients cancelled on the day x 10	Patients admitted and had treatment deferred x 26	Patients cancelled by the hospital the day before the date of admission x 22
6 x Surgeon/Anaesthetist unavailable 3 x Medically unfit /change in clinical condition / further tests required 1 x replaced by emergency case	18 x Medically unfit /change in clinical condition / not stopped meds 3 x Surgeon/Anaesthetist unavailable 2 x Change in plan / pt no longer wanted the procedure 1 x Lack of theatre time – due to complex cases 1 x Interpreter unavailable 1 x Procedure abandoned	10 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds 5 x TCI date not convenient/unable to contact patient 3 x Surgeon unavailable 2 x Pre-op assessment not carried out/abandoned 1 x Replaced by more urgent case 1 x No HDU bed

AREAS FOR IMPROVEMENT/ RISKS/ISSUES

Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

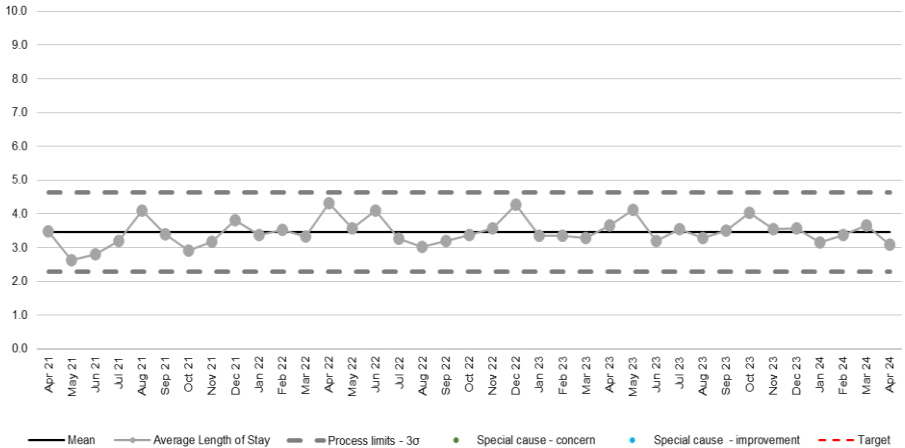
Theatre lookback meeting continues to review short notice cancellations with a view to identify opportunities to improve.

GIRFT are supporting with the standby patient process and will share evidence of good practice from other Trusts. The spinal services intend to support this process starting with Spinal Degenerative patients under Mr. Hughes.

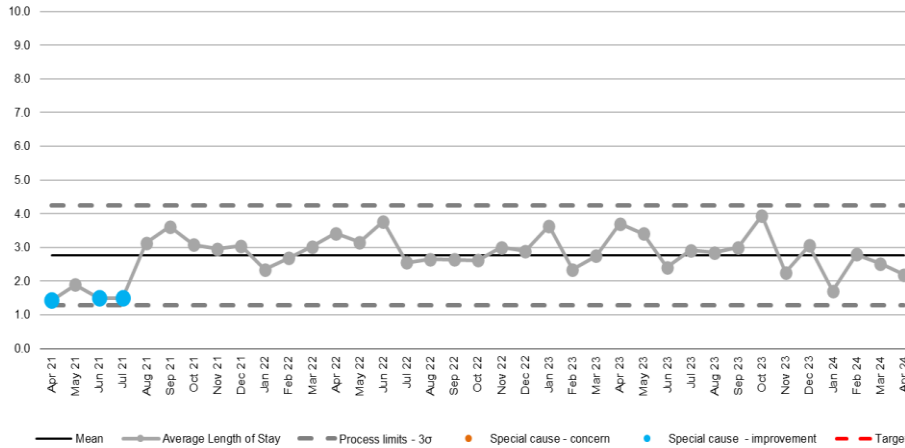
Following the seamless surgery week a review of admission times was carried out and it identified that standardising to just two admission times (7am & 11am) would be instigated to support improvements in flows and will be kept under review.

3. Length of Stay

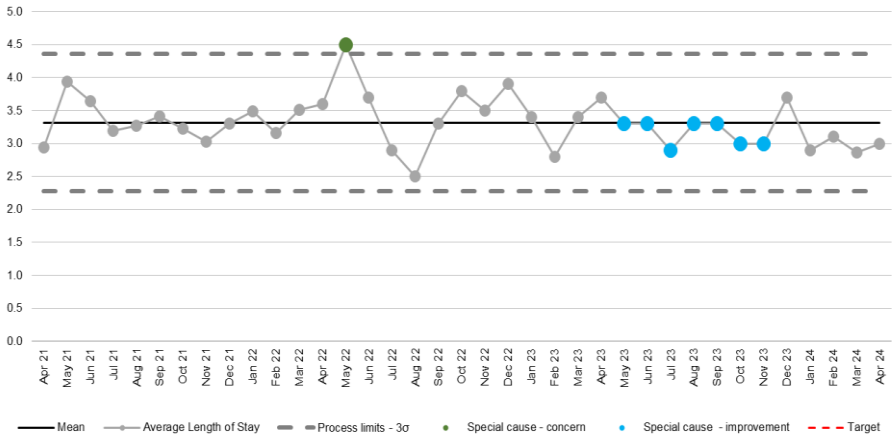
ROH Elective Average Length of Stay - Excluding Oncology, Paeds, YAH and Spinal



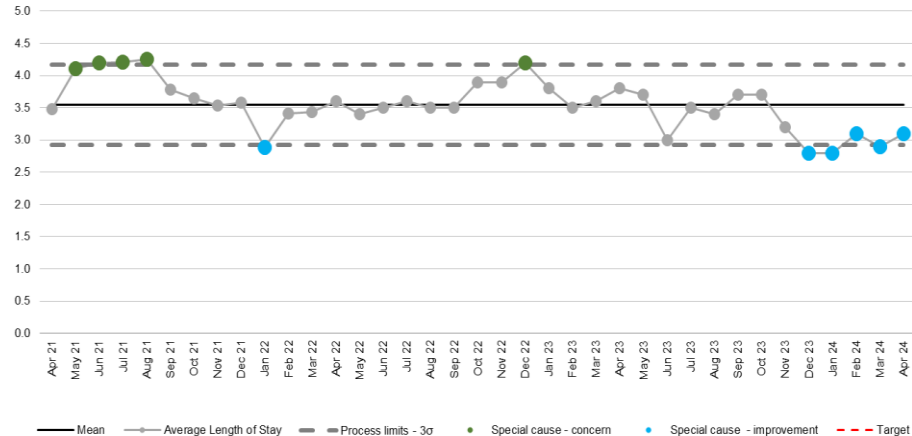
UHB Elective Average Length of Stay



Primary Hip Elective Average Length of Stay



Primary Knee Elective Average Length of Stay



3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips increased slightly to 3.0 days (2.9 days March 24) and primary Knees has increased to 3.1 days (2.9 days March 24).

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.09 days** (3.66 March).

A review of the ROH data for arthroplasty and oncology arthroplasty primary hips and knees identifies the number of patients with LOS \geq to 8 days as 8 (2 March), 7 arthroplasty and 1 Oncology arthroplasty. 4 had an ASA score of 3 (Severe systemic disease), 4 had an ASA score of 2 (mild systemic disease) Of the longest length of stay patients 3 had an ASA score of 3. On review of clinical noting most were delayed due to complex discharge needs including Package of Care.

A review of **all** arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS \geq to 8 days as 23 (24 March). 8 were Oncology Arthroplasty, and the other 15 were Arthroplasty.

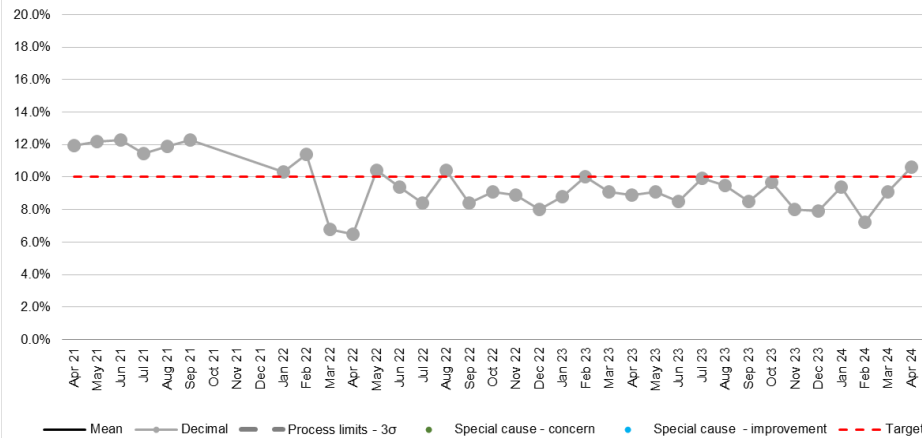
Review of these long stay patients: 2 longest stay of 25 days both complex Oncology Arthroplasty. All were either complex primary arthroplasty patients due to nature of surgery or co-morbidities and/or there were clinical or complex discharge planning needs. Noted that some patients declined arranged discharges packages.

AREAS FOR IMPROVEMENT / ACTION PLAN

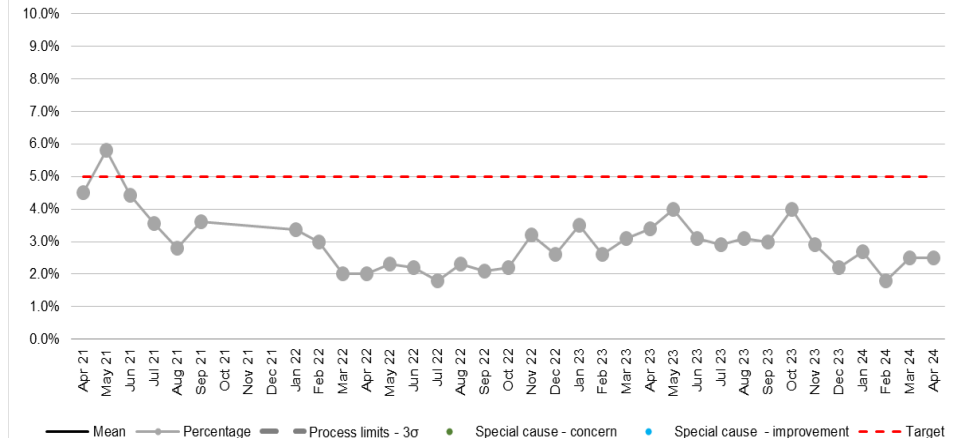
- Social care capacity-delays, particularly out of area. Monitoring and escalation process in place with support from the ICB.
- Repatriation- need agreed policies and process regarding repatriation back to local acute Trust -Consider for BIS, MRC and spinal particularly.
- Finalise process/pathway for default to day case primary hip/knee procedure and how information is captured.
- Following meeting with Head of Nursing Div 1, Consultant Physician and Discharge Nurse a series of meetings and sessions being planned with Medical, Nursing and Therapies colleagues to raise awareness of discharge pathways, processes, expectations to ensure accurate and consistent communication to patients and families.
- Review of themes regarding why patients convert from day case to overnight.
- Consolidate the learning from GIRFT visits of other sites.

4. Outpatient efficiency

Percentage of OP Attendances Patients Who Waited 31 to 60 Mins to be Seen

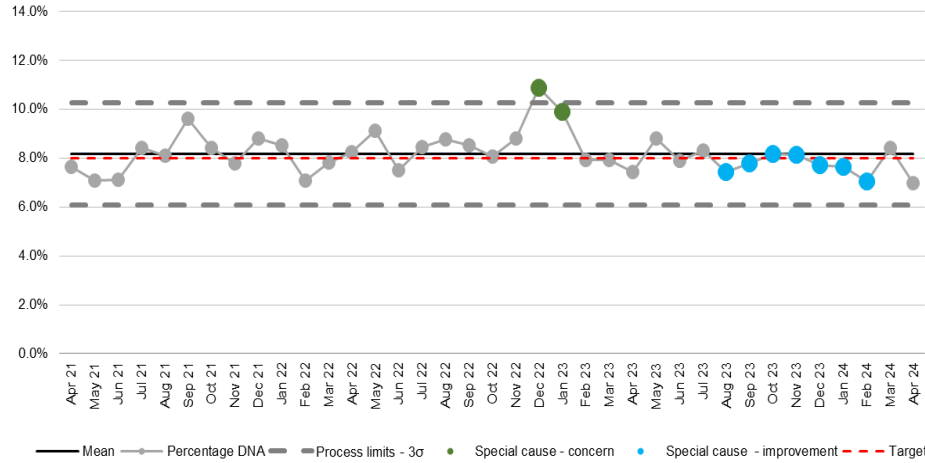


Percentage of OP Attendances Patients Waiting Over 60 Mins to be Seen

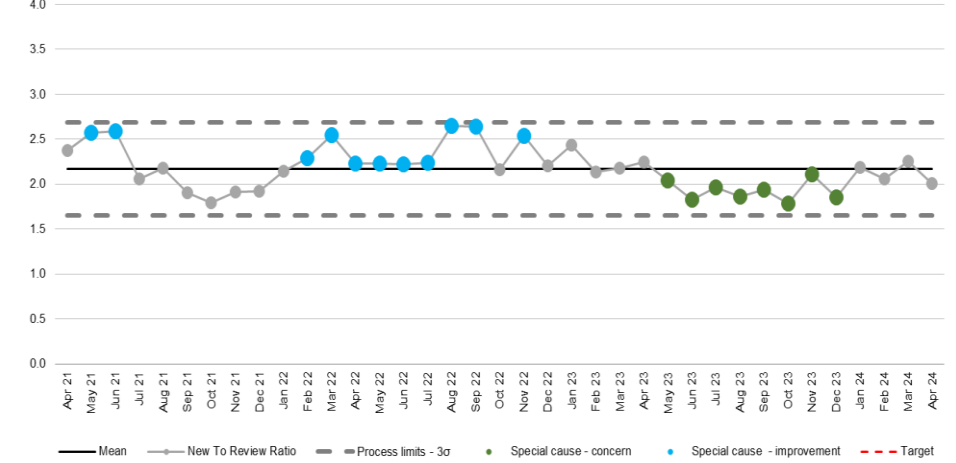


4. Outpatient efficiency

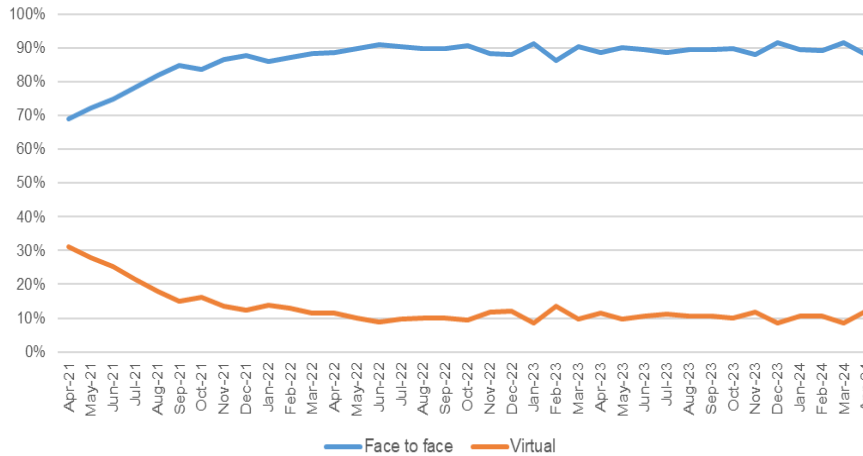
Consultant Led Outpatient DNA Rate



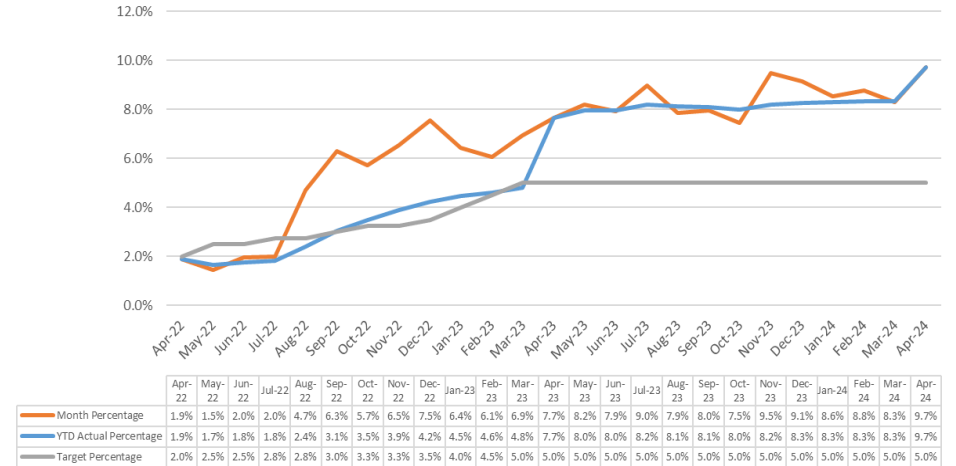
Outpatient New to Review Ratio



Outpatient Activity Split by Type



Patient Initiated Follow Ups - % Patient Added



4. Outpatient efficiency

SUMMARY

April 2024 performance is as follows:

Overall Outpatient activity was +11% variance against the Trust trajectory with April delivering 6047 (New and Review) episodes.

- 5,291 face to face and 727 virtual appointments
- 12.08% virtual in total.
- 9.7% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 9.7%.
- 6.96% Missed Appointment (DNA) rate – lower than the Trust target of 8% and higher than the national standard of 6%
- Imaging DNA rates have improved significantly, reporting an average of 3.92% in March
- **Clinic Waiting Times**
- 30-minute delays – slightly over the Trust Target at 10.6% this is due to the increase in activity (**Target 10%**)
- 60-minute delays – within trust target at 2.5% (**Target 5%**)

AREAS OF IMPROVEMENT

Outpatient Utilisation

We continue to focus on productivity, with a Model Hospital review having taken place and presented at Model Hospital Club in April 2024. Enhanced focus on outpatient utilisation and efficiency is taking place, supported by business intelligence. Outpatient productivity is now a topic for the weekly ICB chaired System Oversight Group.

Missed Appointments

The Missed Appointments group is using a previous patient audit which took place in Quarter 4 of 2023/24 to further identify opportunities to improve clinic attendance.

Appointments

Outpatient and Appointment KPIs are monitored with weekly oversight to the Acting Chief Operating Officer. Weekly scheduling meetings are functioning well with gains evidenced through improved utilisation and activity levels.

Digital

E-outcome forms are being reviewed on the InTouch system to improve the workflow for outpatient appointments. Work continues as part of the transition to TPro with clinicians and administrative staff. A pilot is being agreed with Young Adult Hip to use a document viewer for finalised documentation to streamline processes.

4. Outpatient Transformation

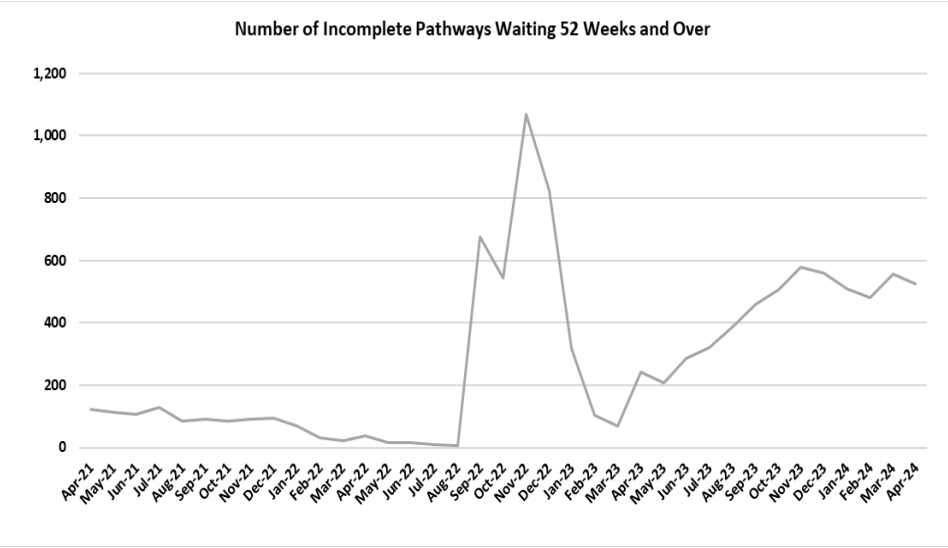
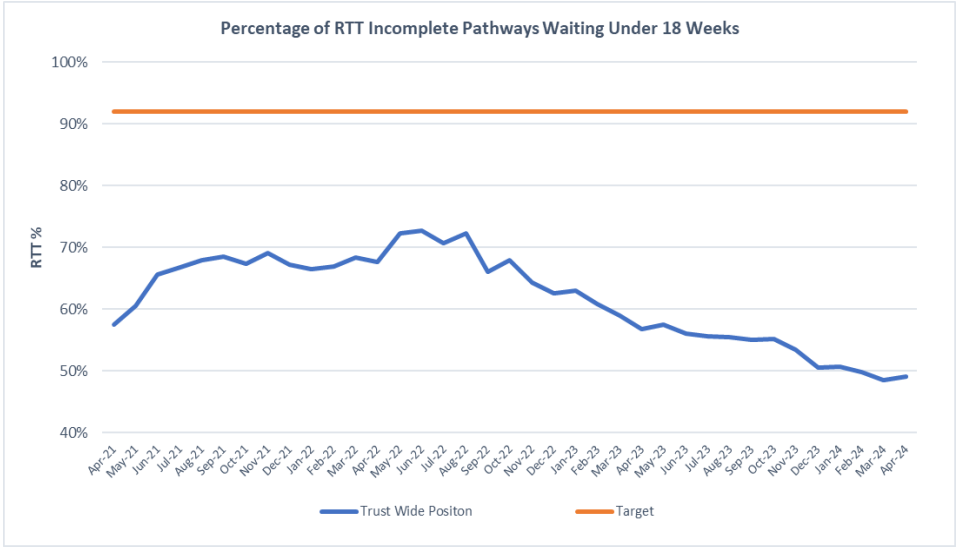
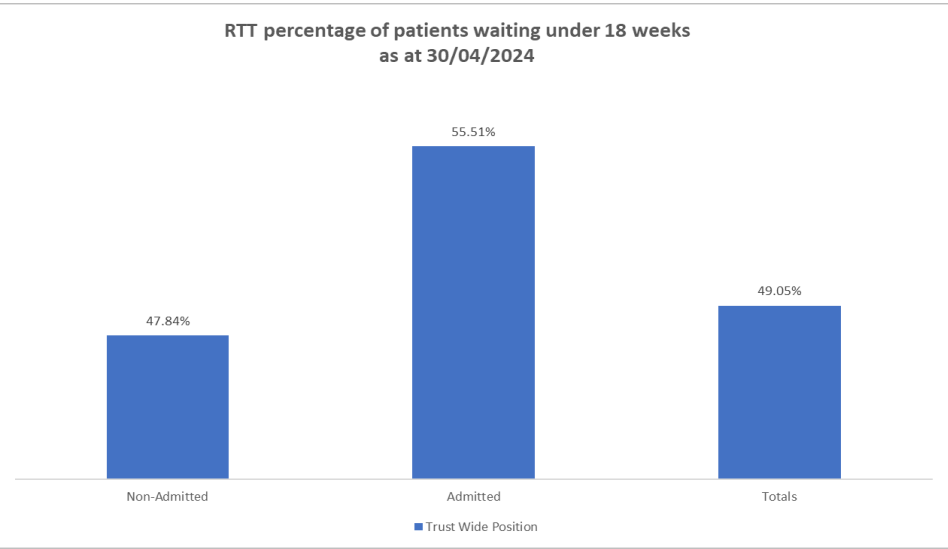
Specialty Priority Updates / Highlights

PIFU	Missed Appointments	Reduction in Follow Ups	Clinical Pathways (e.g. Specialist Advice)	Productivity & Efficiency
<p>Oncology are exploring the potential to use PIFU and virtual pathways to reduce travel for long-distance patients and improve the experience of patients under long-term surveillance.</p> <p>The PIFU module development on Dr Doctor is paused while TIARA configuration is prioritised for MA reduction.</p>	<p>Configuration continues for TIARA appointments to receive reminders for appointments.</p> <p>Benchmarking has taken place through GIRFT further faster network and joint work is taking place with RJAH who have achieved radical improvements in 2023.</p> <p>The ICB is working on a missed appointment toolkit to support Trusts.</p>	<p>Supported by other workstreams.</p> <p>The Outpatient CSSM is reviewing the follow up waiting list by specialty and will lead a discussion at the outpatient transformation group in April 24.</p> <p>Oncology are reviewing the follow up patient pathway</p>	<p>Meetings are to be coordinated with the ICB lead.</p> <p>Meeting attended in Arthroplasty to discuss options for changing pathways to improve referrals into the Trust.</p>	<p>The KPMG audit has been completed.</p> <p>6-4-3 model is now established for Outpatients with positive feedback.</p>

5. Referral to Treatment

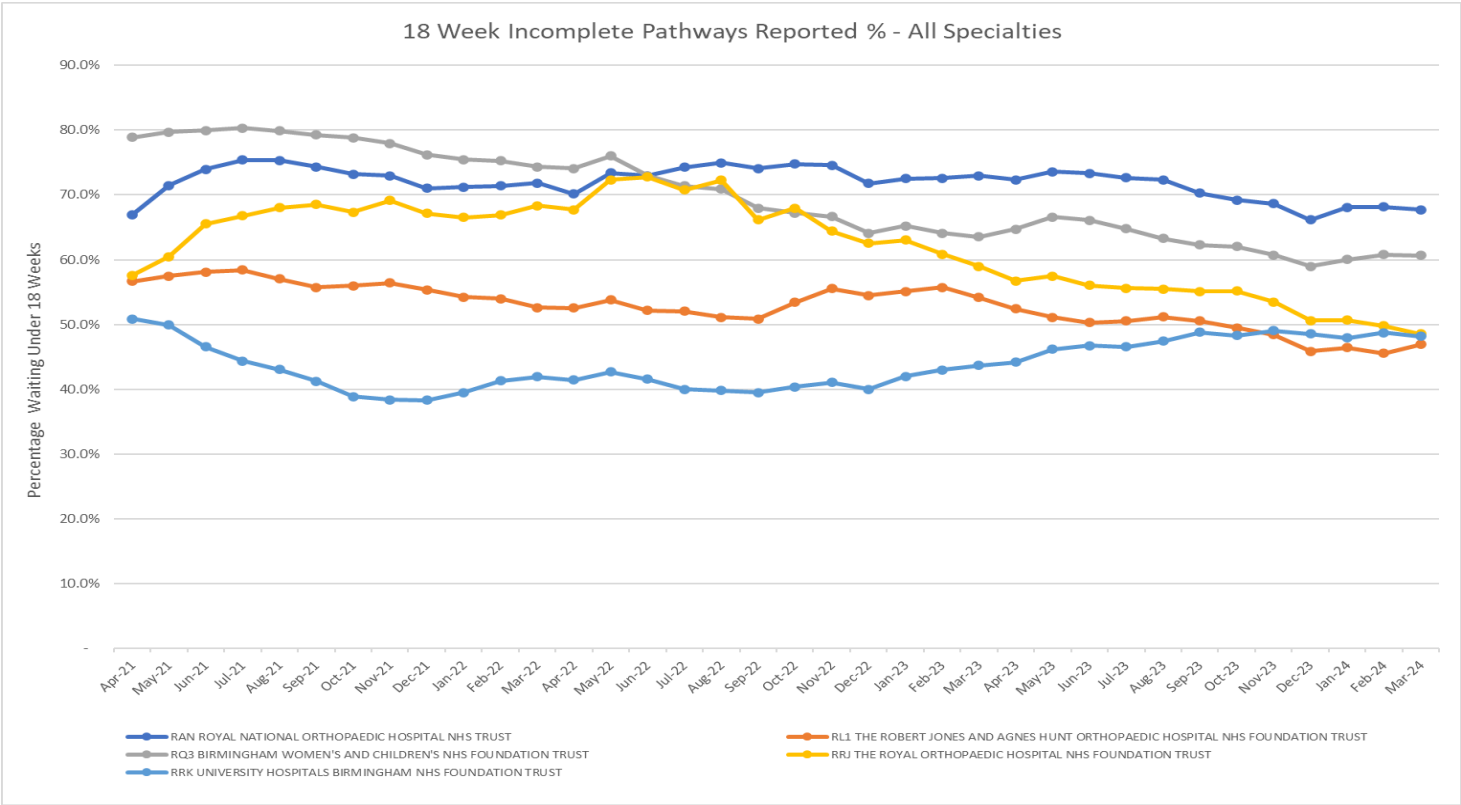
Trust Wide Position			
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,940	656	3,596
7-13	2,471	531	3,002
14-17	934	193	1,127
18-26	2,312	410	2,722
27-39	2,676	401	3,077
40-47	1,176	122	1,298
48-51	358	44	402
52 weeks and over	397	129	526
Total	13,264	2,486	15,750

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,345	1,380	7,725
18 and over	6,919	1,106	8,025
Month End RTT %	47.84%	55.51%	49.05%



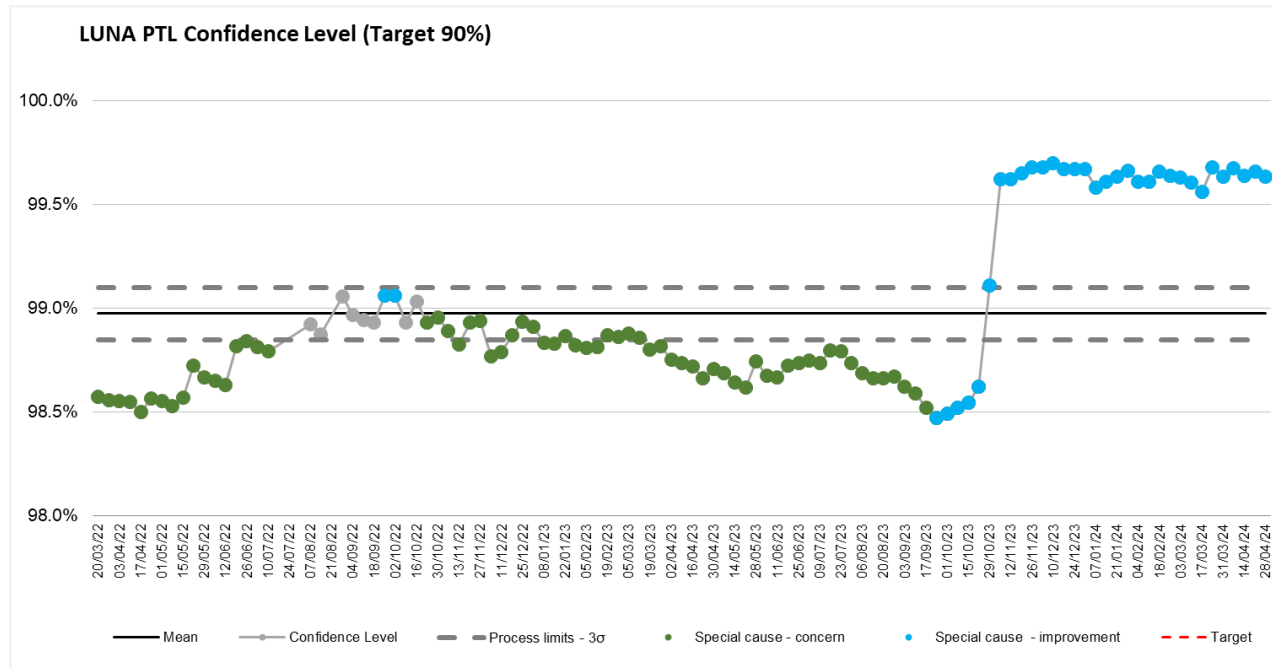
5. Referral to Treatment

18 weeks Incomplete pathways Benchmarking against other providers:



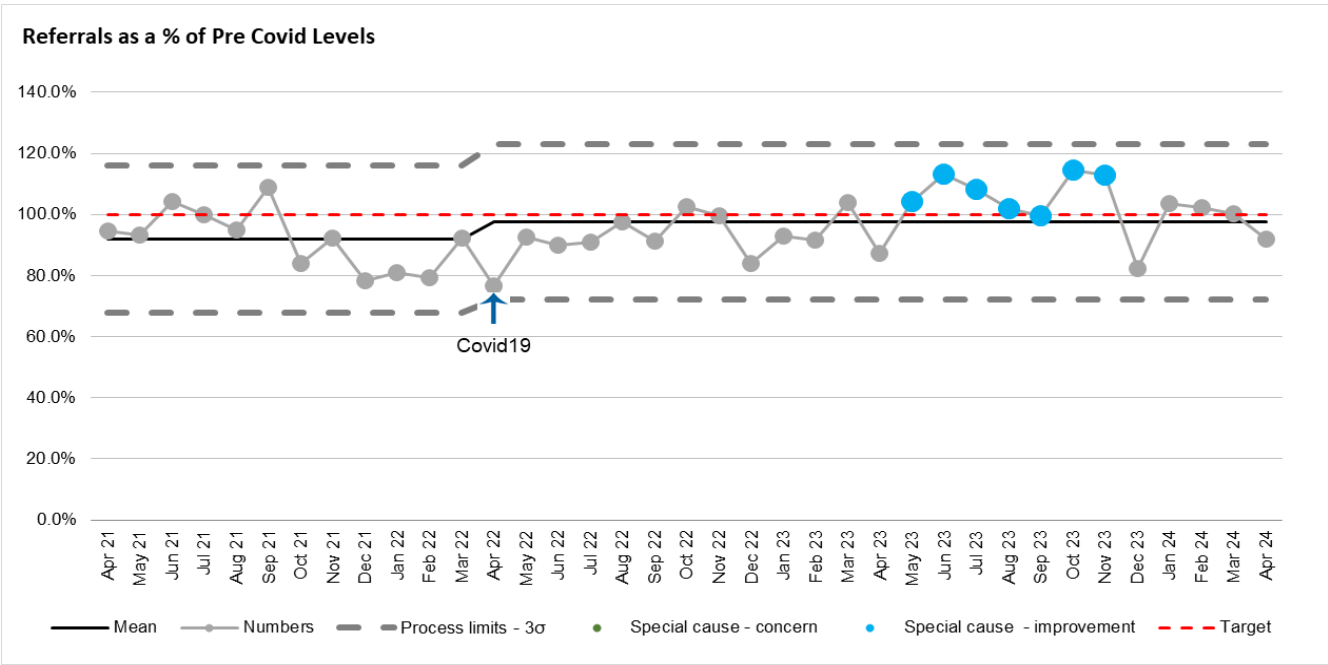
5. Referral to Treatment Luna Data

The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with no areas of concern highlighted. In the last 2 weeks we have had a focus on the technical pathway inconsistencies, which has demonstrated a further improvement of our waiting list data quality.



It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

5. Referral to Treatment



Pre Covid Level	2704
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Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of Referrals	2557	2521	2815	2704	2567	2941	2273	2495	2113	2236	2249	2516	2082	2522	2479	2573	2681	2515	2820	2728	2282	2532	2513	2835
Referrals as a % of Pre Covid Levels	94.56%	93.23%	104.11%	100.00%	94.93%	108.76%	84.06%	92.27%	78.14%	82.69%	83.17%	93.05%	77.00%	93.27%	91.68%	95.16%	99.15%	93.01%	104.29%	100.89%	84.39%	93.64%	92.94%	104.84%

Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707	2485											
Referrals as a % of Pre Covid Levels	87.39%	104.22%	113.13%	108.21%	101.78%	99.59%	114.39%	113.02%	82.25%	103.62%	102.07%	100.11%	91.90%											

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for April was **49.05%** against the National Constitutional Target of 92%. This represents a 0.47% decrease compared to the March reported position of **49.58%** that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

There were **526** patients waiting over 52 weeks in April, a decrease from the trust wide position in March which was **556** patients. Most patients waiting over 52 weeks are Spinal Adults. The Team continue to work in partnership with regional providers to support orthopaedic recovery. Long waiters added to the PTL have been prioritised leading to the number of shorter waits growing impacting on the overall RTT position, as well as the reduction in capacity due to industrial action. Extra capacity is based on the specialty backlog clearance required to support the national delivery of zero 65-week waiters by March 2024.

During April 24, ROH received 2,485 referrals (91.90%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

The trust validation team plays a pivotal primary role to ensure the trust have accurate reported numbers of patients who are waiting over 18 weeks for treatment. By Dec-2023, the trust had 7,914 patients waiting over 18 weeks for treatment; representing a 466% increase since 2019/20. Thus, a business case is in progress to request an expansion of the validation team to allow for greater resource to be in place to address the expansion of the Trust waiting list. For April 2024, the service will continue to focus on initiatives already in place to mitigate the risk of increasing volumes of RTT validation include, Validating up to 10 working days after month end, reducing duplicate validations on pathways who have been previously validated in last 60 days and staff working additional hours to address the increase.

Weekly specialty meetings chaired by the Performance lead focus on our longest waiting patients and achieving the 0 x 65 weeks national target. NHSE is extending the deadline to 30.09.24, however, the system is still pushing for achievement by 31.05.24 with the exclusion of Spinal and complex soft tissue cases.

All Patient waiting over 12 weeks on an RTT pathway have been sent a text message to determine whether they wish to remain on the waiting list in line with national guidance.

RISKS / ISSUES

Spinal backlog continues to be a concern with the team focussing on managing all patients currently over 60 weeks and preventing tip ins. Spinal is to be prioritised with the roll out of GIRFT follow up recommendations. The Validation team continue to provide extra support to Spinal services to help manage patients through their pathway.

5. Referral to Treatment

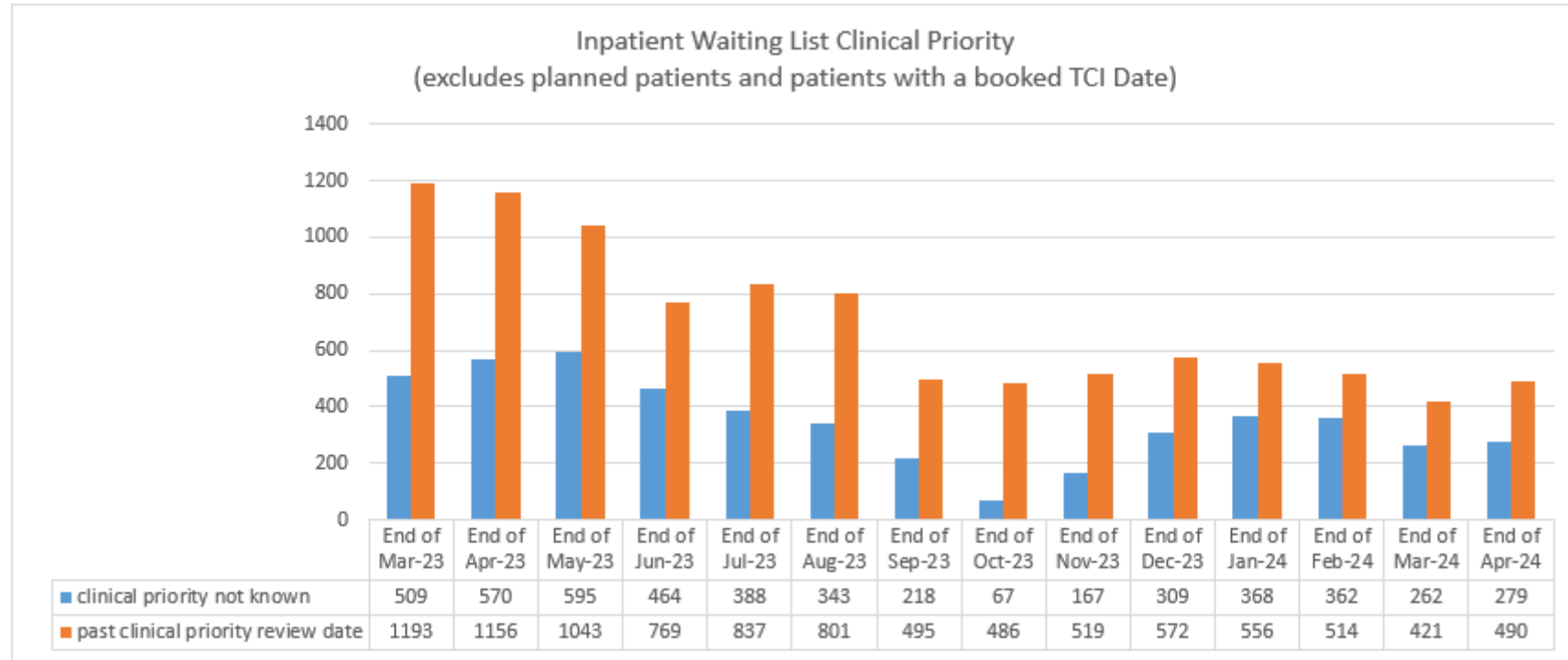
Specialty Breakdown

The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention going forward:

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 16.05.24	RTT % as of 16.04.24	Difference
Arthroplasty	2	74.3%	70.5%	3.8%
Arthroscopy	55	42.7%	43.0%	-0.3%
Clinical Support	7	56.4%	51.8%	4.6%
Foot and Ankle	2	41.4%	40.0%	1.4%
Hands	65	39.2%	35.4%	4.8%
Oncology	1	80.6%	76.8%	3.8%
Oncology Arthroplasty	1	53.7%	47.4%	6.1%
Paediatrics	1	69.1%	60.0%	9.1%
Spinal	273	30.8%	26.1%	4.7%
Spinal Deformity	133	32.8%	29.8%	3%
Young Adult Hips	1	71.3%	64.2%	7.1%

5. Referral to Treatment

Overdue Clinical Priority:

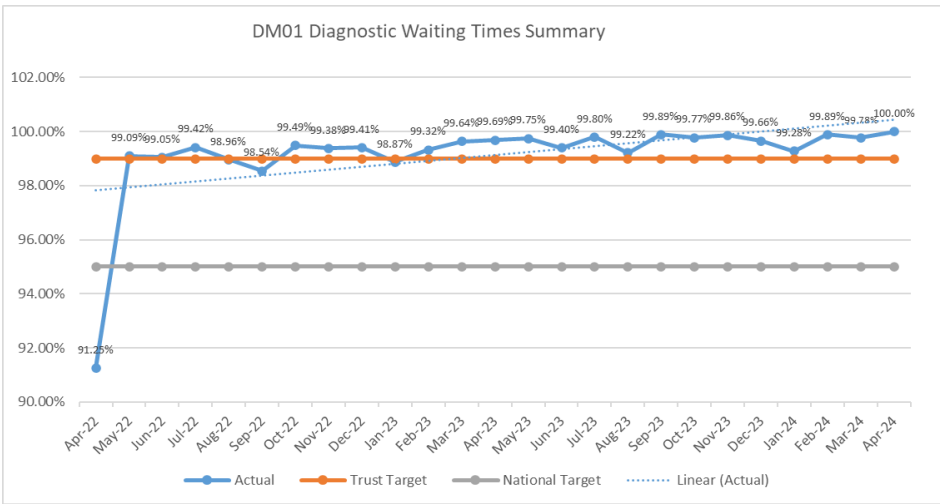


The numbers have increased during April 24 and have been shared with all CSLs to review and make improvements.

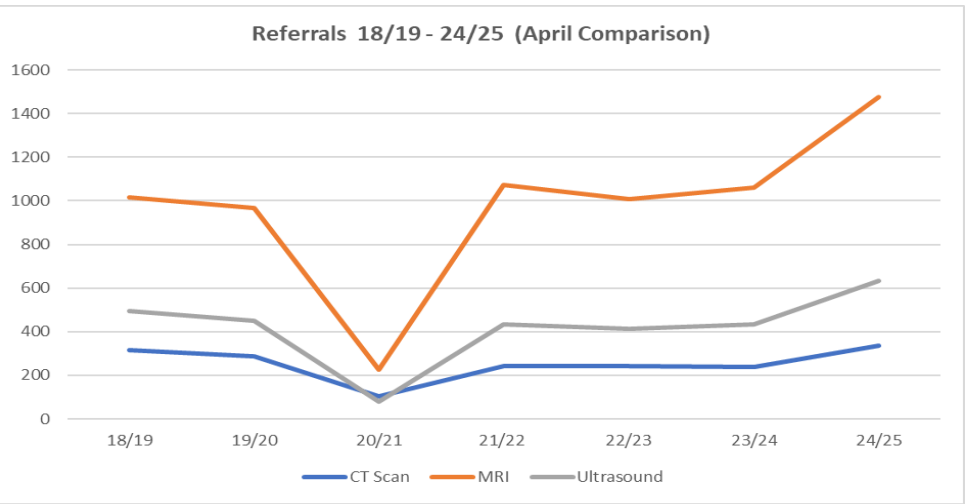
All patient lists have been shared with the clinical teams to review the patients that are currently have an overdue clinical priority flag. Arthroplasty service and Prof. Ed Davis are piloting a process to monitor the 'overdue clinical priority' waiting list with an objective to streamline to reduce the number of patients on the overdue priority list. Outcomes will be shared with all services following the audit.

6. Diagnostic Performance

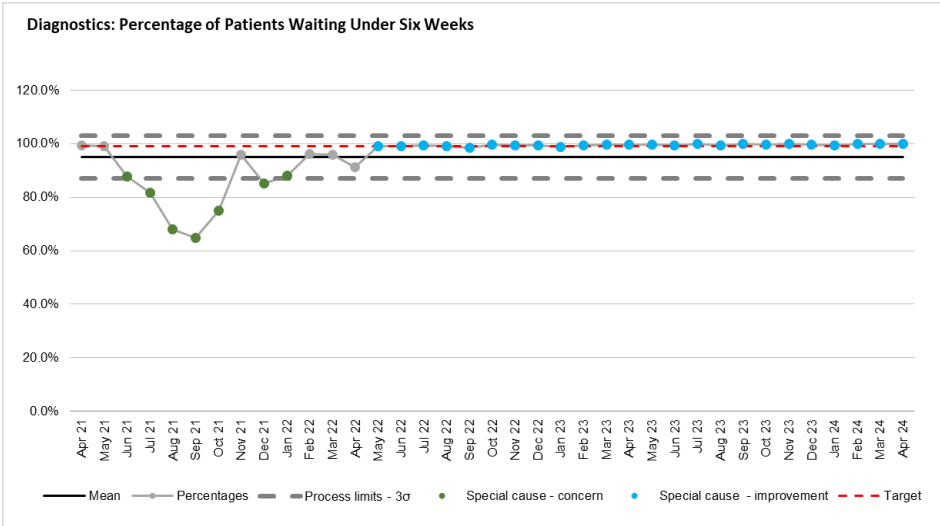
% of Patients Waiting <6 Weeks for Diagnostic Test - National Standard is 99%



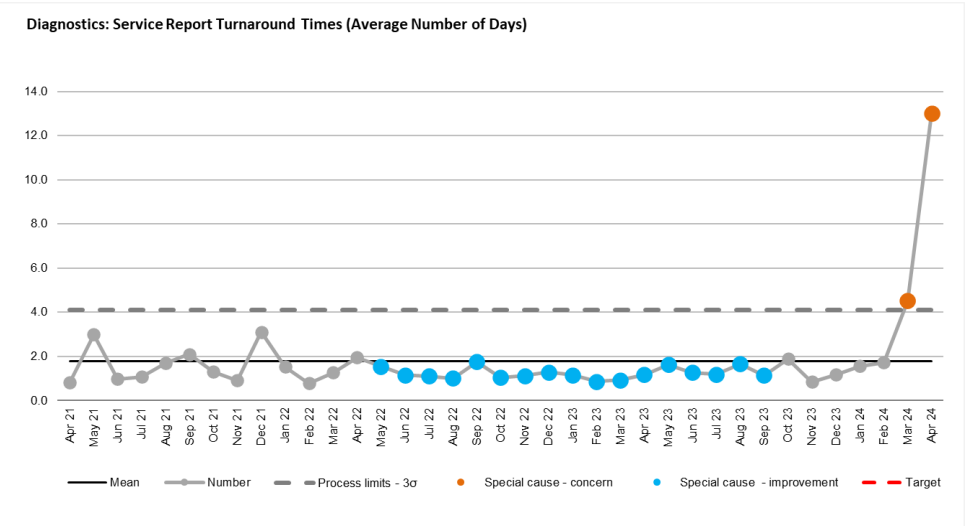
Referrals 18/19 - 24/25 (April Comparison)



Diagnostics: Percentage of Patients Waiting Under Six Weeks



Diagnostics: Service Report Turnaround Times (Average Number of Days)



7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in April 2024 closing the month at 100% with no diagnostic imaging waiting over 6 weeks.

The National 24/25 operational target remains at 95% which ROH continues to achieve consistently.

AREAS FOR IMPROVEMENT

Ensuring that all capacity is fully utilised and minimise missed appointments supported using Dr Doctor text messaging at 1 week and 48 hours prior to appointments; improvements in missed appointments.

Plan to reduce the typing backlog, all Oncology imaging continues to be prioritised and typed.

RISKS / ISSUES

Following a Consultant Radiologist relocating back home, there is a backlog in MRI reporting which is partially due to an increase in capacity from acceleration software on the 2 MRI scanners, PACS workstations failing, and Consultants planned leave. This has significantly increased report turnaround times and some outsourcing of MRI & x-ray reports is underway. There is a regulatory issue for some non-medical referrers not receiving an x-ray report, and there is a plan in place to outsource this work that will be offset by the vacancies.

Referral rates are increasing for all modalities and the reduction in missed appointment allows capacity to be maintained – referral rate is 132% on the same period as last year with activity at 122% of 23/24 .

Failure of aging image intensifiers requires significant capital expenditure and has been escalated to the Divisional risk register – lack of equipment will have a significant impact on Theatre activity with some days requiring more Imaging than intensifiers. This is being managed and mitigated via the 6-4-2 process.

Summary Performance Figures – February 24 (April 2024 Submission)

Target Name	National Standard	March 24 (complete)				March 2024 (Old Standards)					
		%	In target	Breach	Total	%	In target	Breach	Total		
31 DTTD to Treatment	96%	100%	16.0	0.0	16.0	93%	97.6%	80.0	2.0	82.0	
62 day RTT to treatment	85%	85.7%	9	1.5	10.5	96%	100%	7.0	0.0	7.0	
28 day FDS REPORTED	75%	82.8%	72.0	15.0	87	94%	100%	6.0	0.0	6.0	
Patients over 104 days (62 day standard)	0	0	0	0	0	85%	85.7%	3.0	0.5	3.5	
						62 day (Cons Upgrade)	n/a	85.7%	6.0	1.0	7.0
						28 day FDS REPORTED	75%	82.8%	72.0	15.0	87.0
						Patients over 104 days (62 day standard)	0	0	0	0	0

8. Cancer Performance

Performance

The trust was compliant against all three metrics for March Performance. The trust was compliant with the 28 days FDS standard achieving 82.8% against a target of 75% and 100% compliance against the 31-day metric. The 62-day metric was achieved at 85.7%. A total of 11 treatments were applicable to the trust, 9 of those were compliant and the remaining 1.5 patients breached this target due to multiple biopsies required and complex diagnostic pathways.

The root cause of the delays for the 62-day breaches were due to complex diagnostics and surgical planning.

- 0.5 Shared Breach, IPT received day 51 into the ROH, Spinal surgery patient confirmed chordoma needed joint surgery with 2 spinal surgeons and retroperitoneal team from UHB therefore surgical planning was very complex and not able to be scheduled within the 24 day target.

-0.5 Shared breach, Direct 2ww into ROH complex diagnosis patient had 3 repeat biopsies due to differential between Sarcoma and metastatic carcinoma, patient required multiple imaging as primary site could not be identified patient was then not referred out locally for chemotherapy until day 64 and treated on day 102.

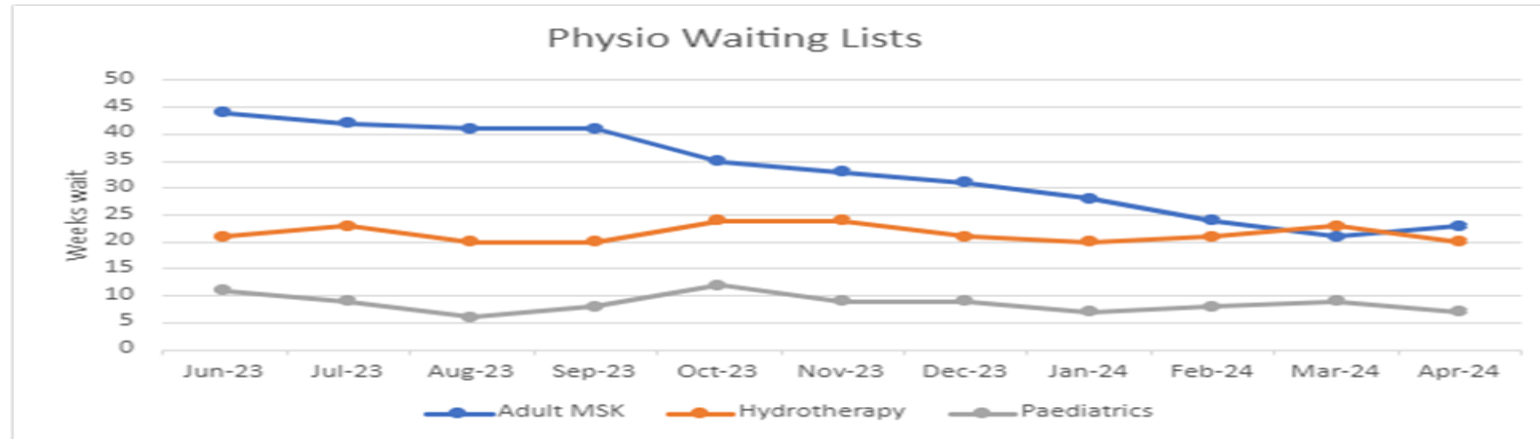
-0.5 Shared breach, Patient Referred out day 64 for oncological treatment, due to complex diagnostics, patient required 2 repeat biopsies under image guided and one open biopsy. The patient was unable to commence chemotherapy until full diagnosis was reached.

Risks /actions ongoing

ROH continues to monitor performance twice weekly at the cancer PTL meetings, actively participating and engaging with the weekly System Oversight Group for cancer recovery and receives positive feedback against overall performance standards. Ongoing concerns regarding histological reporting resulting in delays in patient pathways which are under current analysis/review. Pathology delays have been raised at the System Oversight Group, as an area of concern. Histology delays continue to be escalated to UHB DOP for an expedited resolution. Positive service development 5th pelvic surgeon now being trained to address one of the key challenge areas for elective capacity.

9. MSK Waits

Physio Wait Comparison April 22 vs April 24 (as at 15th)



Summary – data as per 15/04/24

Paediatric Physio waits continue to be maintained below 12 weeks with the April position currently at 7 weeks. Hydrotherapy waits are at 20 weeks.

Adult physio waiting times have reduced from 44 weeks in June/July to 23 weeks as of 15th April 24.

Back Pain waiting times reduced from 39 weeks in Sept 23 to 22 weeks as of 15th April 24.

Plans are being developed to support the hydrotherapy waiting times with resources from the adult MSK team

The Community Appointment Day planning meeting took place at the beginning of April 24. Several workstreams will commence to manage the project, aiming to run a day in September to allow for learning from a Solihull based day taking place in May 24.

Risks /actions ongoing

- A comprehensive action plan had been produced to address the long waits associated with Adult MSK Routine appointments and as a result the Trust has seen a positive reduction in the waiting list.
- New starters have also helped with the improved position

10. Private Patients

SUMMARY

- There were 46 inpatients treated privately in April. This was 4 patients under plan. There were 13 inpatients cancelled this month.
- The service fell short of its income April target by £50k – the value of the 13 cancellations was £93k.
- May activity is predicted to meet the activity target with 41 patients booked vs a plan of 50 patients.
- There is no outpatient target, however there were 133 private outpatient appointments in April 24 compared with 78 in April 23

24-25 summary	M1	
Income Plan	425000	
Activity Plan	50	
Income to be collected	375000	Medical reasons cancellation prior to the day x2
Activity actual	46	Medical reasons cancellation on the day x2
Cancelled cases	13	Long haul flight x1 Patient choice x5
Cancelled income	93000	No theatre staff x3

The above figures are based on activity and income through the service which may not have been invoiced yet. This does not include income for private imaging. Finance figures are based on what has been invoiced.

AREAS FOR IMPROVEMENT

To support additional income and activity generation to support the Trust position in 24/25 and assure the committee that key actions from the strategic plan are being delivered, the following actions are being undertaken:

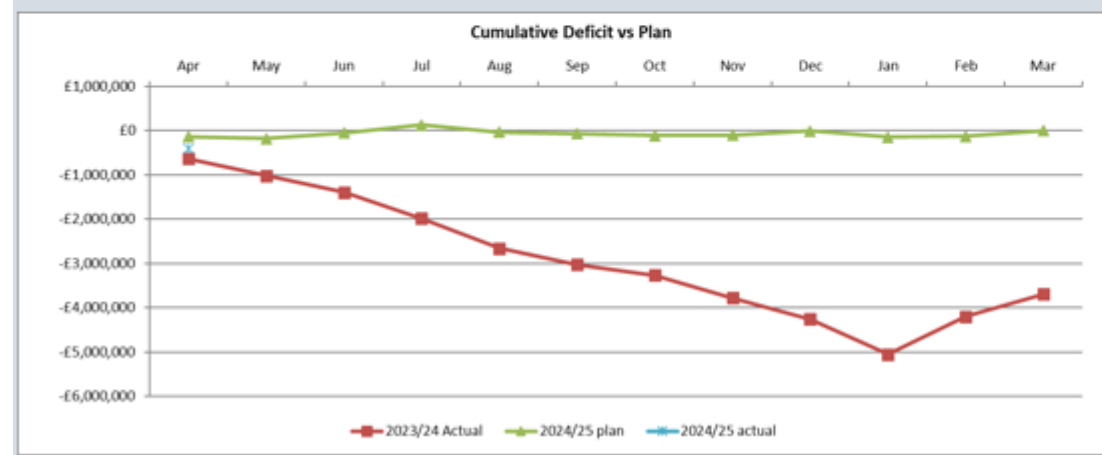
- Addendum to 3 year strategic plan is being developed for Trust Board June 2024 by the SRO
- Negotiations remain ongoing with AXA
- BUPA recognition process has started with the aim to complete by autumn
- Work ongoing to rebrand ward 4 as Woodlands Suite in its entirety to support patient and staff experience
- Business case for dedicated finance band 4 and 3 to support a robust invoicing process has been approved and is being recruited to.

8. Finance on a Page

Month 1

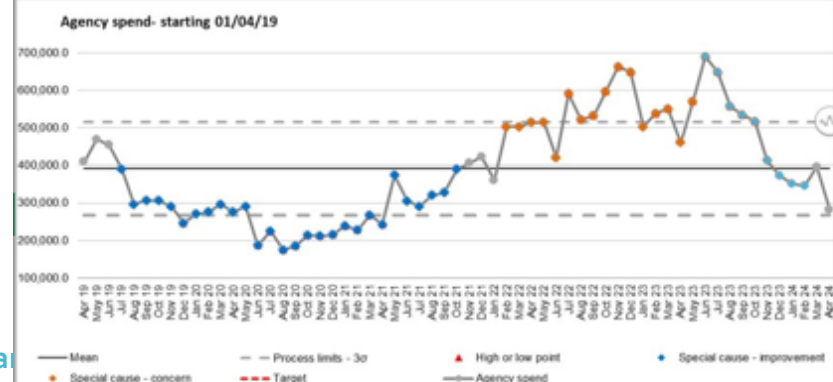
FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income from patient care activities	£10,941	£10,901	-£40	£10,941	£10,901	-£40	£131,912	£131,912	£0
Other income	£526	£460	-£66	£526	£460	-£66	£6,432	£6,432	£0
Pay	-£6,413	-£6,347	£66	-£6,413	-£6,347	£66	-£78,310	-£78,310	£0
Non Pay	-£5,078	-£5,341	-£263	-£5,078	-£5,341	-£263	-£58,691	-£58,691	£0
Non operating costs	-£118	-£114	£4	-£143	-£114	£29	-£1,435	-£1,435	£0
Remove capital donations	£7	£0	-£7	£7	£0	-£7	£92	£92	£0
TOTAL	-£136	-£440	-£304	-£136	-£440	-£304	£0	£0	£0



Agency as a % of paybill = 4.4 %

Recurrent efficiency % of forecast = 100%



Efficiencies	YTD	Forecast
Plan	£288	£8,220
Actual	£185	£8,220
Variance	-£103	£0

Capital	YTD	Forecast
Plan (exc IFRS16)	£118	£3,499
Actual	£51	£3,499
IFRS 16	£0	£756
Variance	-£67	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	81.0%	-7.0%
By Value	80.6%	80.6%-90.7%
NHS		
By number	48.9%	-51.1%
By number	66.4%	-33.6%
Total		
By number	79.7%	-8.3%
By Value	79.6%	-11.2%

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £440k against a planned deficit of £136k, generating an adverse £304k variance.

Income year to date under performed by £106k. £70k underperformance in Private patient income, a slight underperformance on other commercial income, and £65k provision for 24/25 convergence and growth adjustment for commissioners.

Pay expenditure is underspent by £66k with continued good progress in reducing agency spend.

Non pay expenditure overspent against plan with an adverse variance of £264k. This includes £50k costs relating to MRI quench costs, LLP expenditure above plan and unidentified CIP..

Agency spend reduced as a percentage of pay bill to 4.4% against 24/25 target of 3.2%,

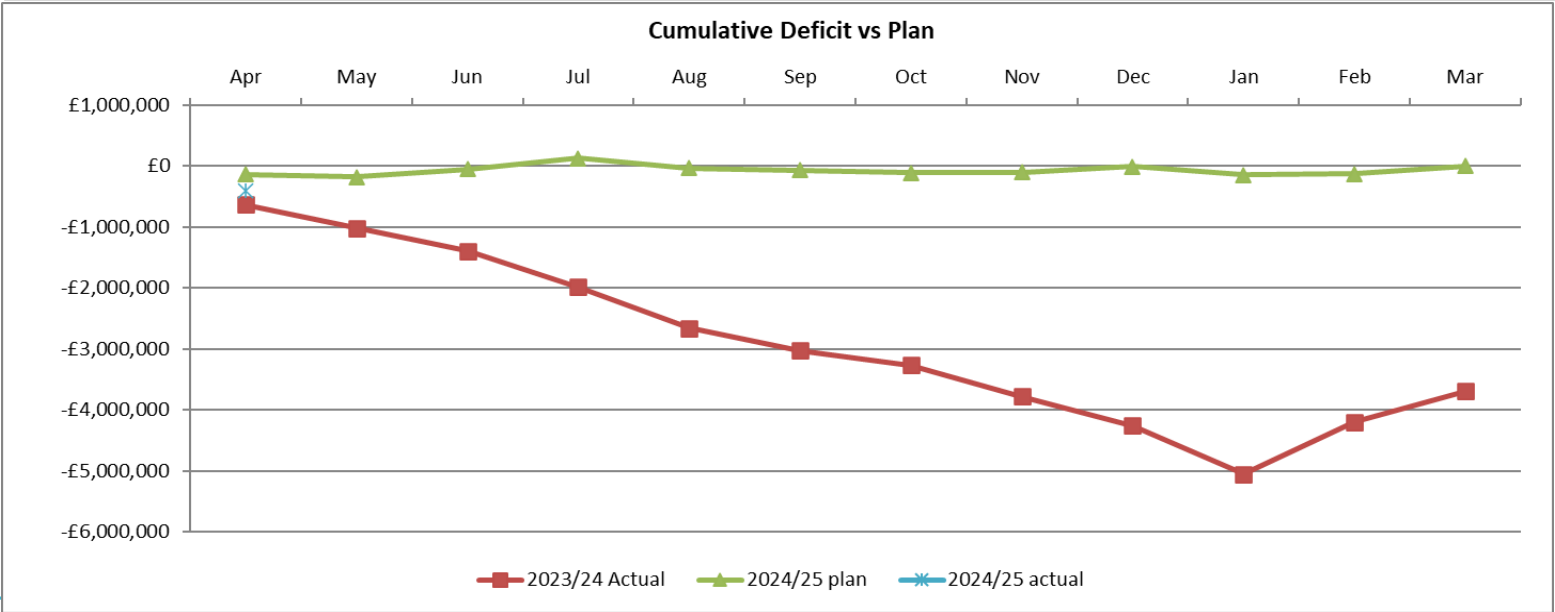
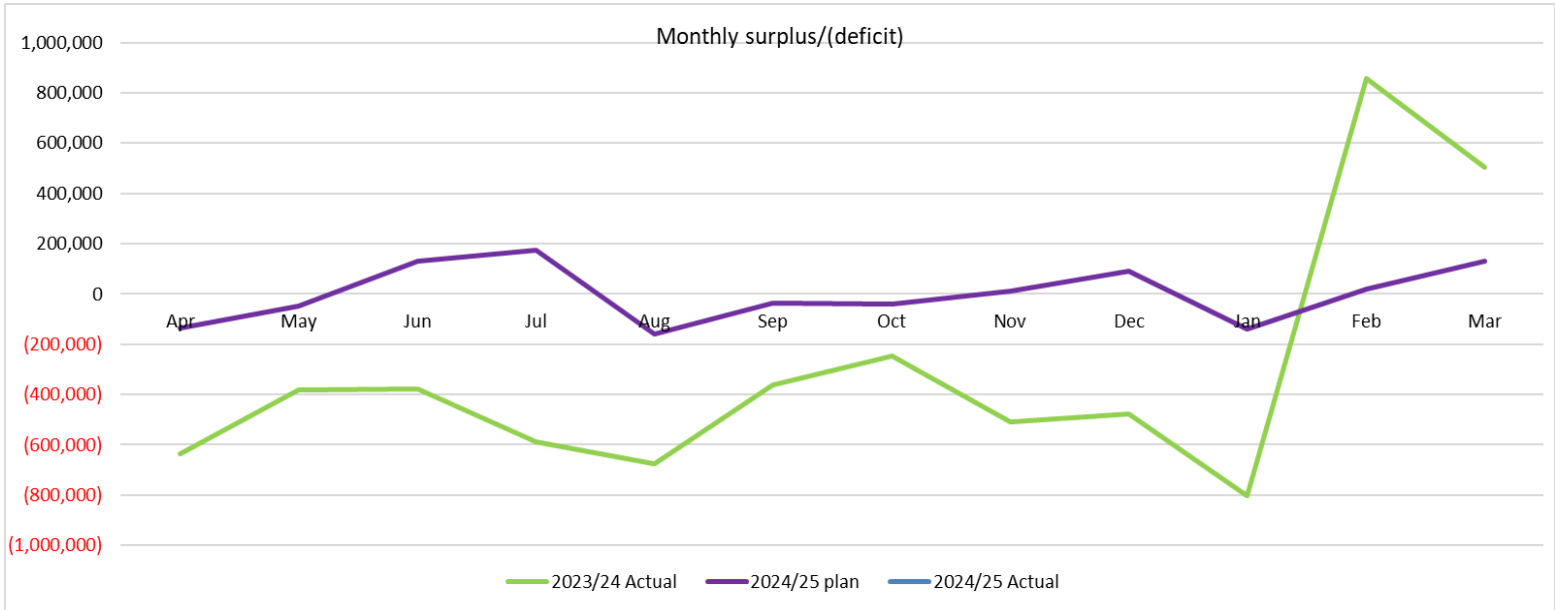
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(106)	66	(263)	(3)	(304)
Year to date plan	(106)	66	(263)	(3)	(304)
Year to date actual	11,361	(6,347)	(5,341)	(114)	(440)
Variance compared previous month					



9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	10,941	10,901	(40)
Other Operating Income (Excluding top up)	526	460	(66)
Employee Expenses (inc. Agency)	(6,413)	(6,347)	66
Other operating expenses	(5,078)	(5,341)	(263)
Operating Surplus	(24)	(326)	(302)
Net Finance Costs	(118)	(114)	29
Net surplus/(deficit)	(143)	(440)	(304)
Remove donated asset I&E impact	7	0	0
Adjusted financial performance	(136)	(440)	(304)

9. Overall Financial Performance



10. Income

SUMMARY

Income in month underperformed by £106k. Associate ICB convergence and growth has not been resolved with an in month provision of £65k.

Elective Recovery Fund (ERF) income performance is an overperformance against estimated NHSE target of £358k but an underperformance of £747k against an adjusted ERF target. The adjusted ERF target includes the additional activity performance included within the route to breakeven plan.

Private patient income underperformed against plan with an adverse variance of £70k..

AREAS FOR IMPROVEMENT

Elective recovery target delivery during the year to maximise income generation.

RISKS / ISSUES

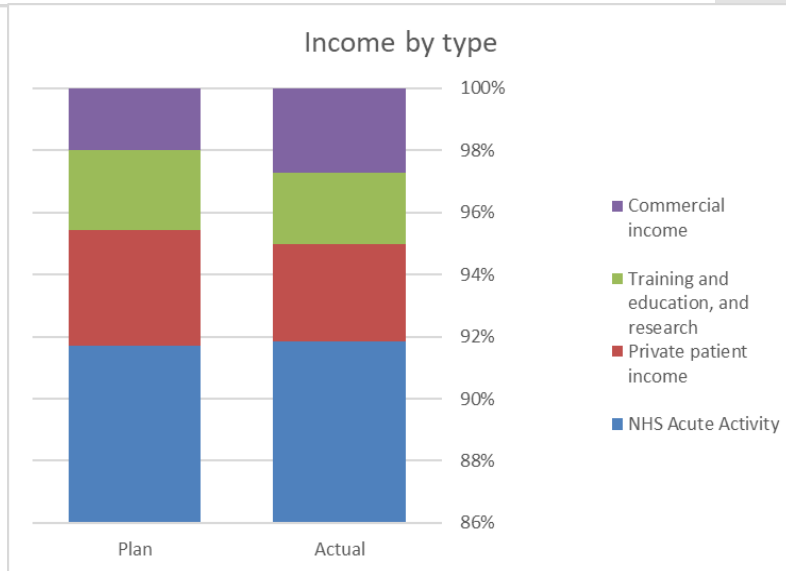
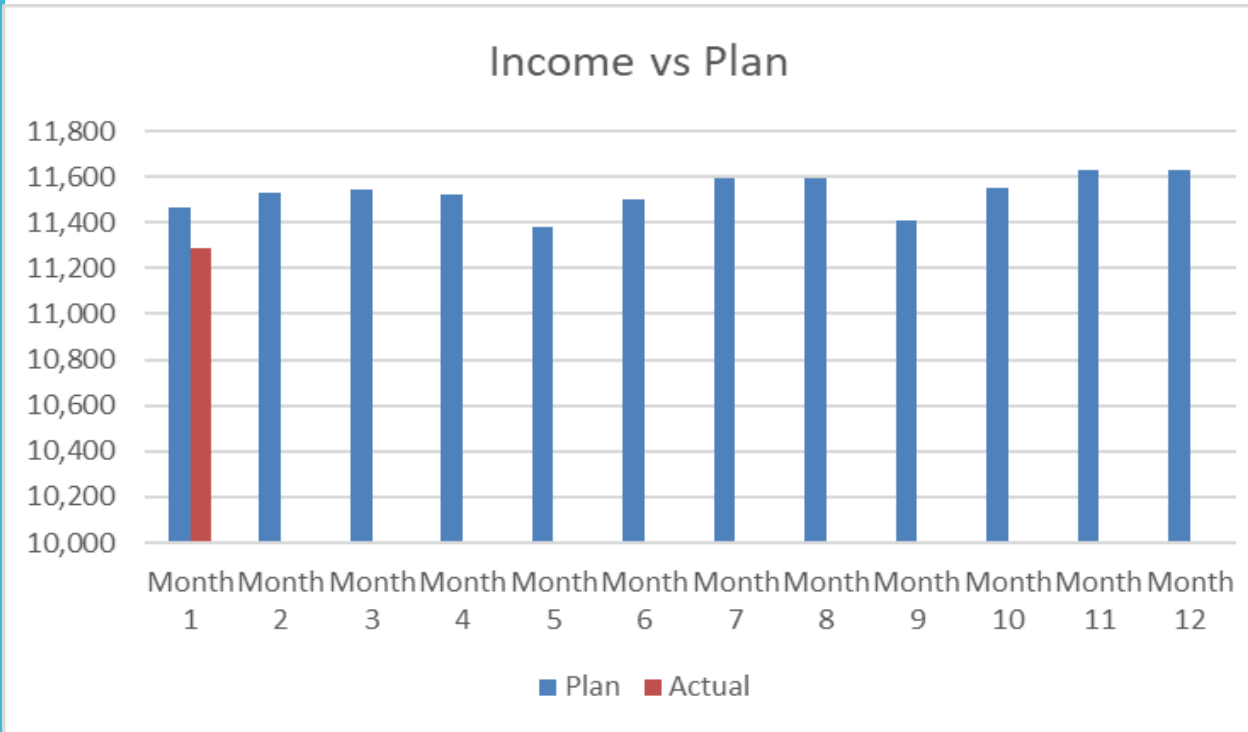
Elective recovery target delivery remains a risk. The provider targets have not yet been released, so monitoring performance is currently done against an estimated target.

Discrepancies between NHS England published ERF performance and application of the ERF rules by commissioner has been varied.

ERF target baseline phasing does not align to the Trusts activity plan.

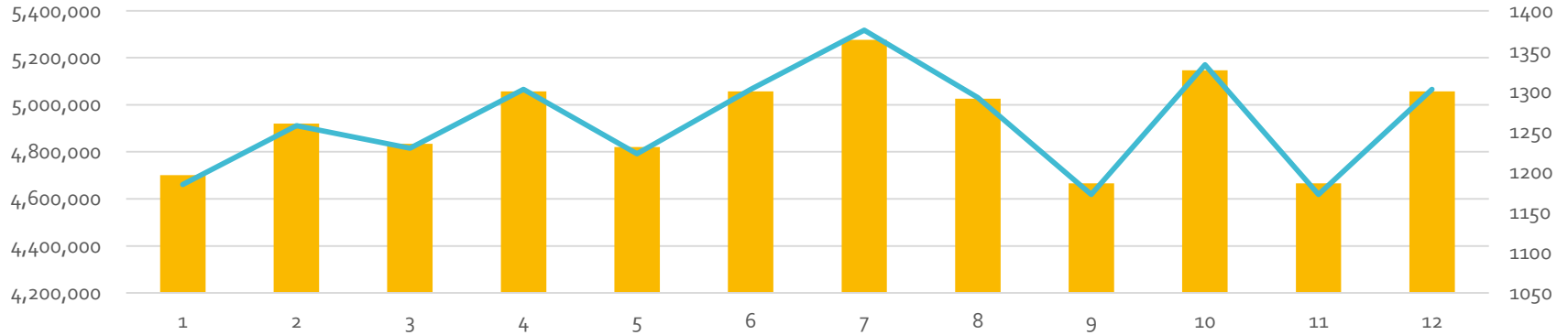
Non recurrent funding has been included within plans for 2024/35, generating an underlying financial risk for 2024/25 and beyond.

10. Income



10. Income

Adjusted ERF target with stretch activity plan



Elective Recovery Fund (ERF) ■ Total (excluding NEL) — Adjusted ERF Phasing based on activity plan

ERF targets for providers have now been released which for the ROH is £56.224m. An adjusted ERF target then been calculated to account for the additional activity performance included within the route to breakeven plan. This gives an adjusted activity target for the ROH of £59.6m. However, the ERF target is profiled in the same way as 19/20. Because we had the impact of additional capacity in Q4, this therefore means that we are still expected to deliver c28.5% of our activity in Q4 (it would only be 25% if we assumed pro-rata and our plan assumes 25.12%). Conversely it only assumes we would deliver 6.88% of our activity in month 1 (our plan assumes 7.88%). This is shown overleaf. Therefore it would be more prudent to internally rephase our ERF target based on the phasing of the agreed activity plan.

Based on what we believe the value of activity in month 1 to be, this gives the following performance. Note no adjustments have been made to reflect this in month 1.

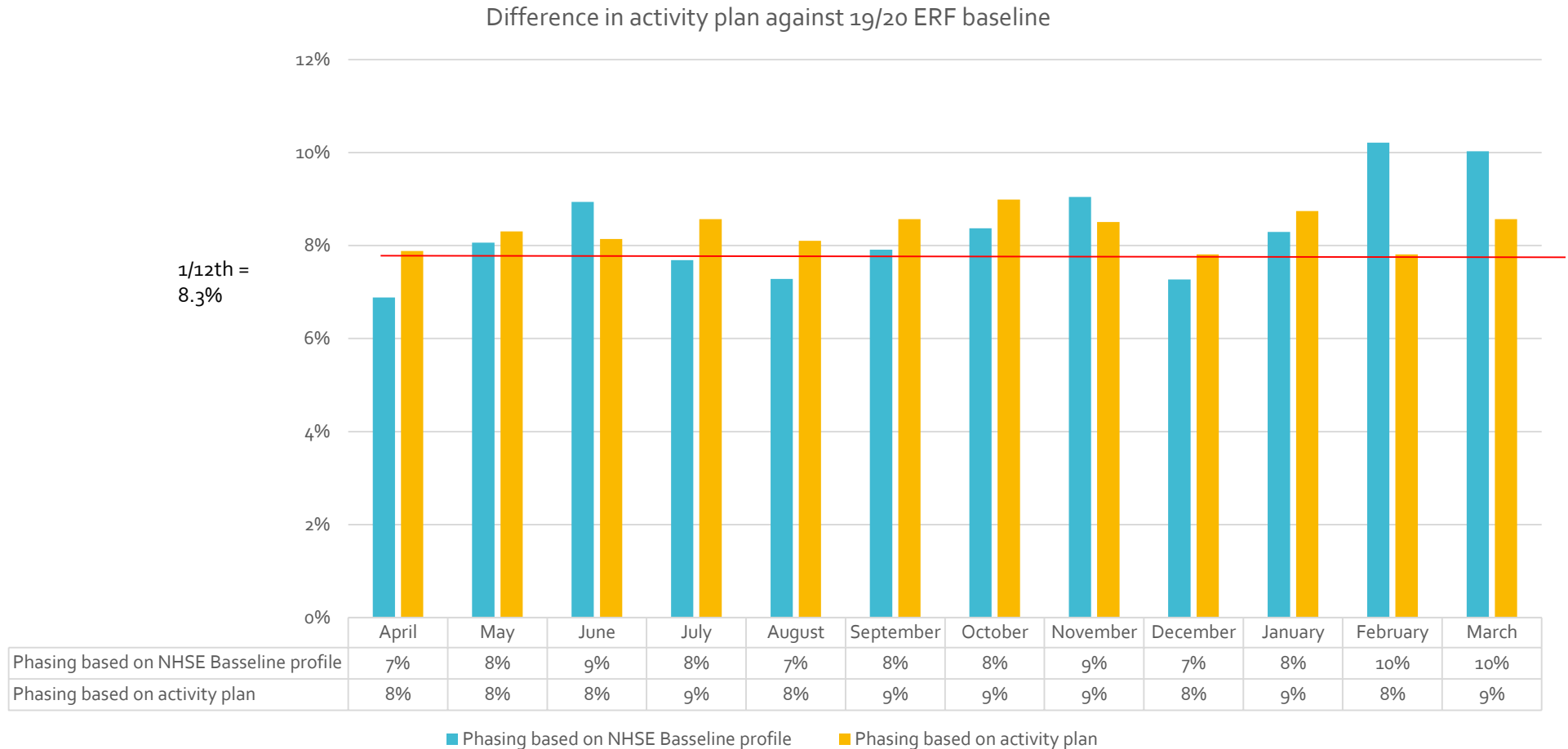
	M1 Target	YTD 24/25 Actuals	Over/ (under)
Unadjusted NHSE ERF Target	£3,868,244	£3,913,994	£45,750
Adjusted / Reprofiled Break-even ERF Target	£4,616,522	£3,913,994	(£702,528)

£'000s					
19/20 baseline	Estimated 24/25 target (1.1% net inflation tariff uplift)	Additional income for 4% increase	Additional 2% to breakeven	Adjusted ERF target	% 19/20 baseline
50,115,289	56,224,481	2,248,979	1,124,490	59,597,950	119%

10. Income

Elective Recovery Fund (ERF)

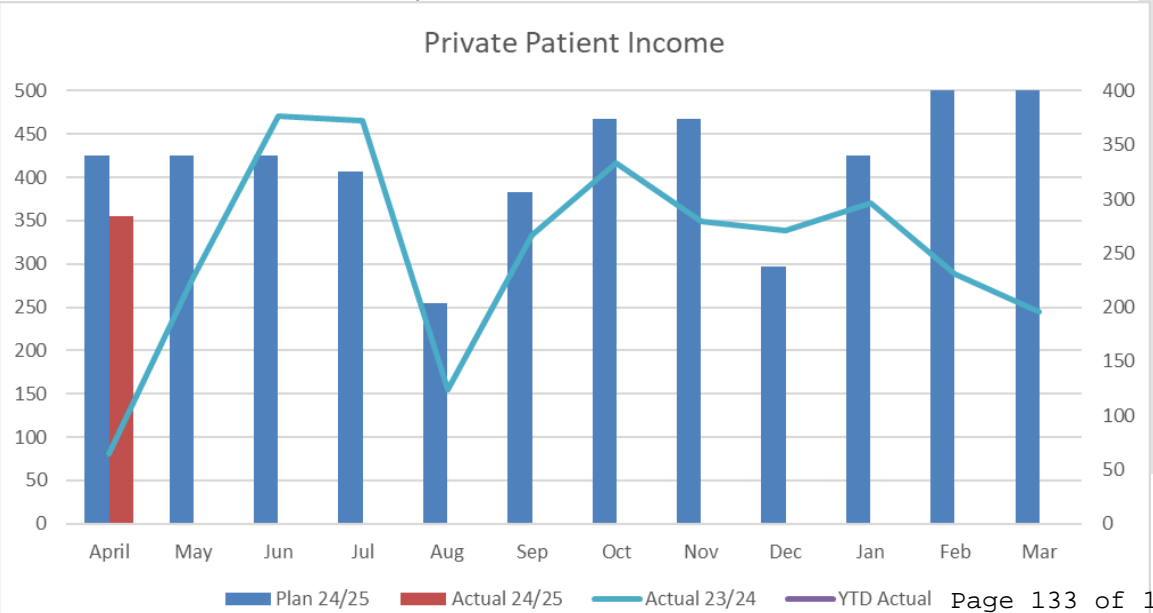
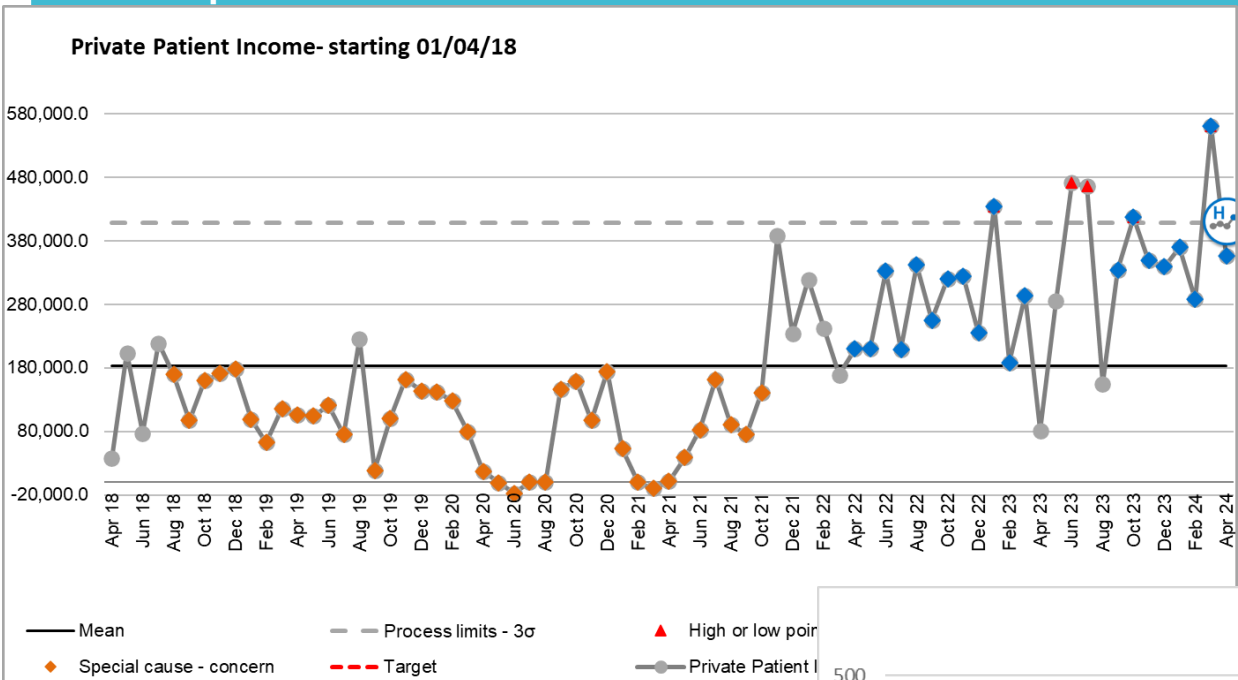
The phasing of the ERF target compared to the activity plan has been shown below to demonstrate how the ERF target has a significant increase in target for Months 11 and 12. The ERF target baseline set by NHSE is based on 19/20 profile and cannot be amended.



1/12th =
8.3%

10. Income

Private patient income



11. Expenditure

SUMMARY

Pay expenditure is underspent by £66k with continued good progress in reducing agency spend.

Non pay expenditure overspent against plan with an adverse variance of £264k. This includes £50k costs relating to MRI quench costs, LLP expenditure above plan and unidentified CIP. There continues to be high consumable spend in theatres, and above inflationary pressures particularly with regards to estates spend

Agency spend reduced as a percentage of pay bill to 4.4% against 24/25 target of 3.2%,

AREAS FOR IMPROVEMENT

Agency spend is above agency cap as a % of pay bill against a cap of 3.7%.

Theatre consumable spend reducing to planned levels.

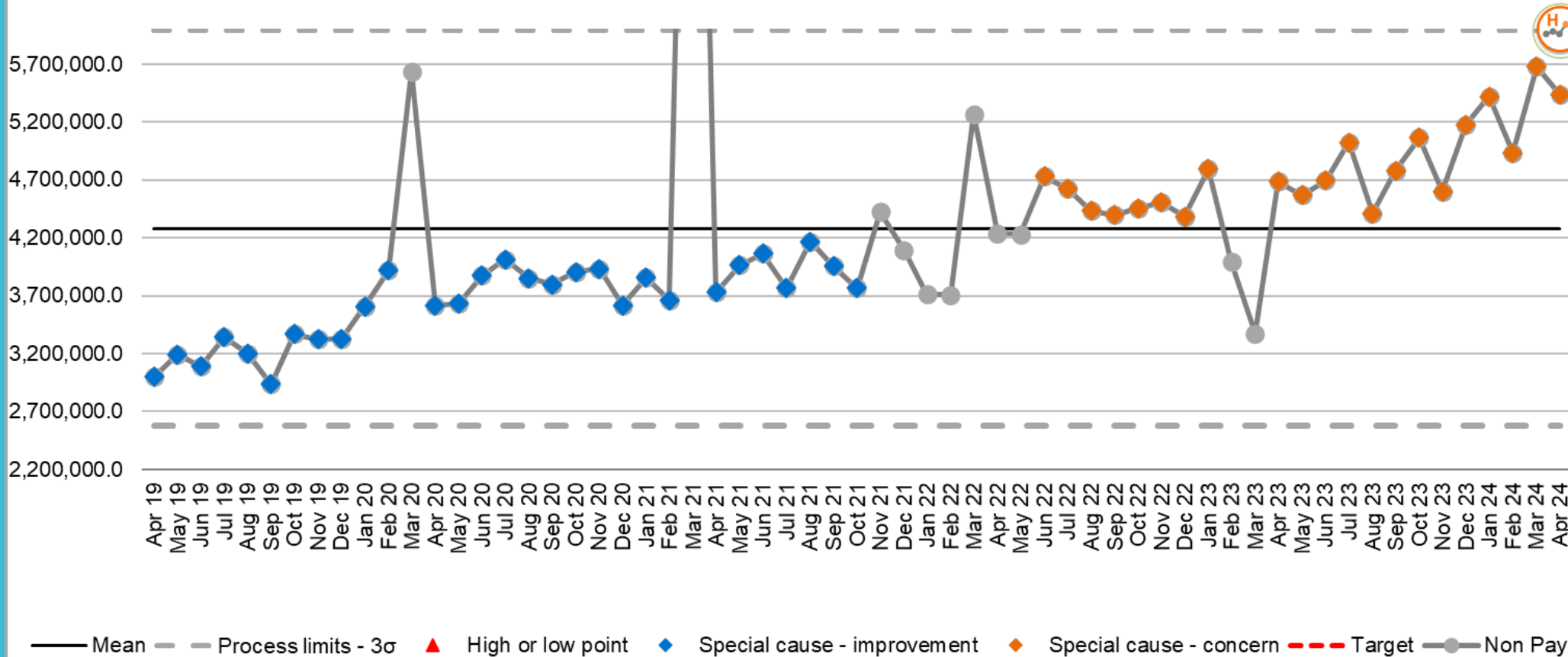
LLP expenditure reduction.

RISKS / ISSUES

Agency spend remains high causing a cost pressure during the year.

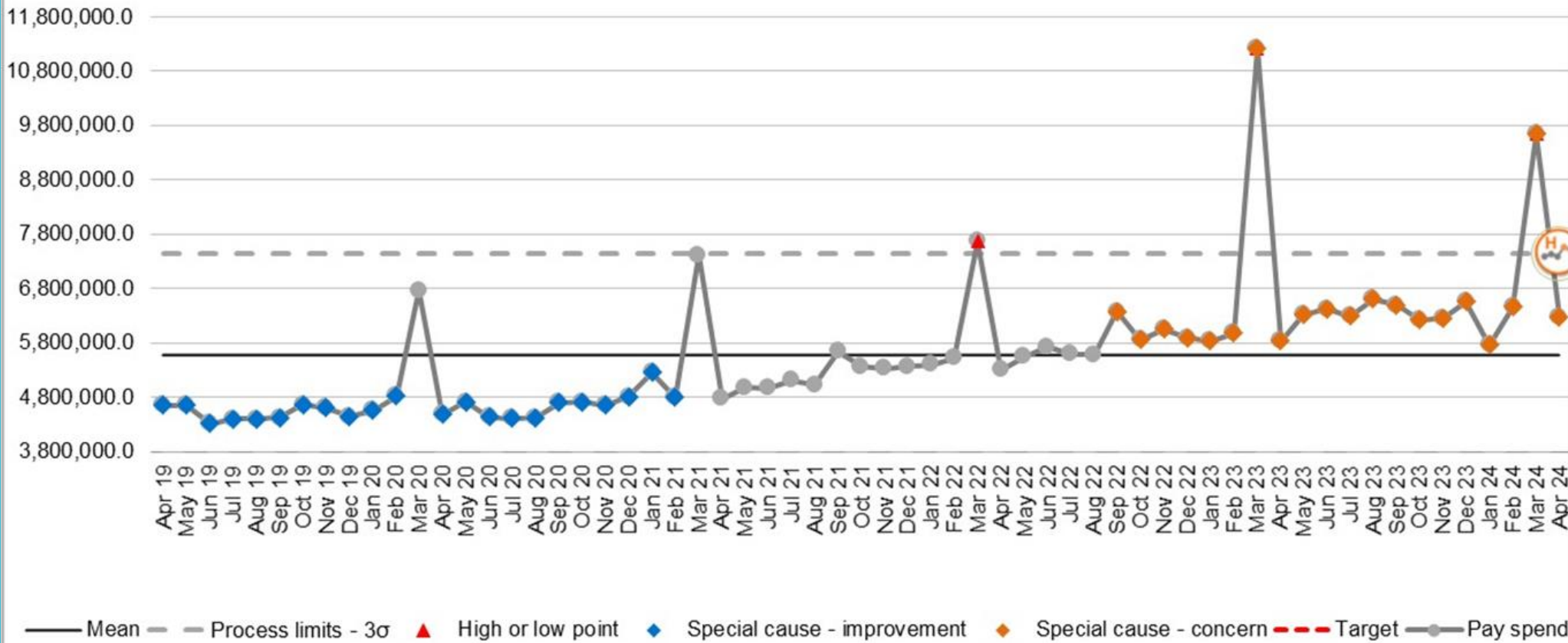
12. Non Pay Expenditure

Non pay expenditure- starting 01/04/19



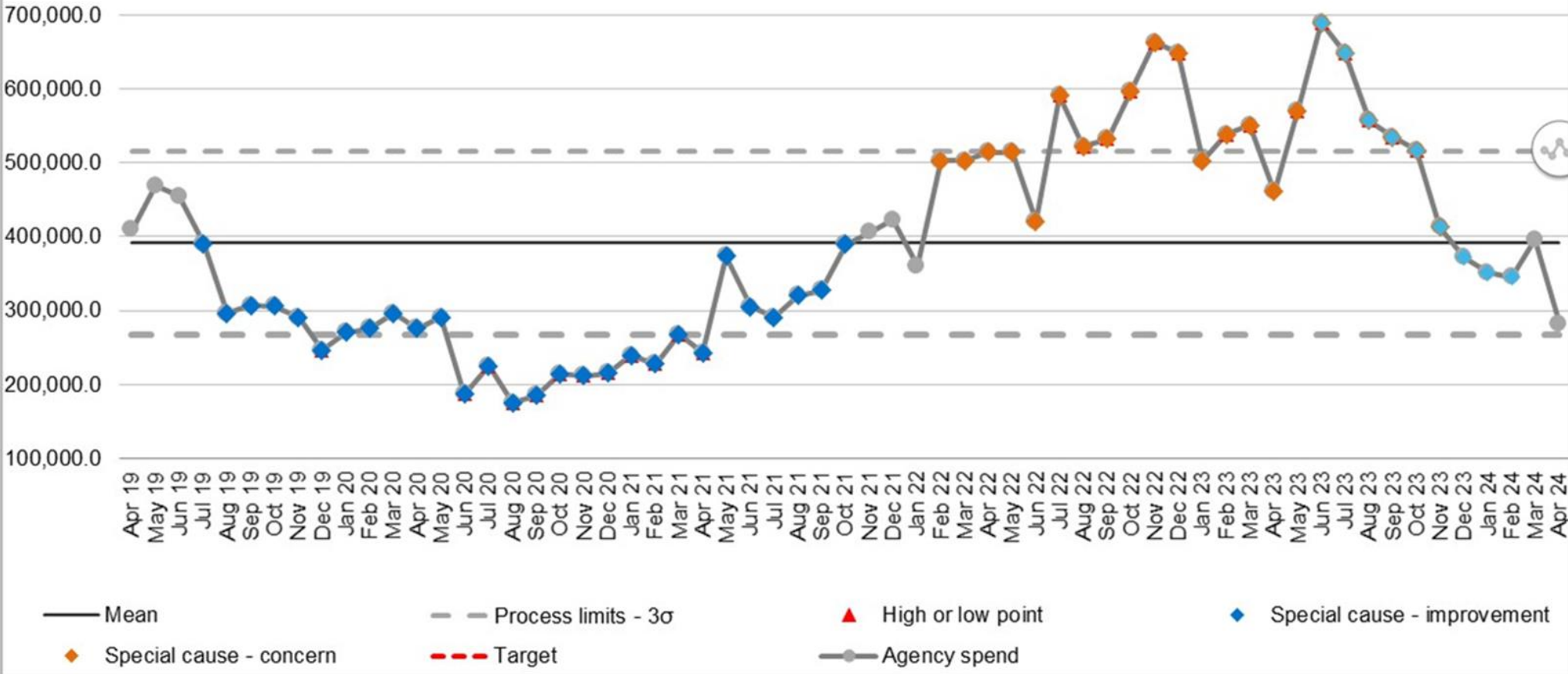
13. Pay Expenditure

Pay spend- starting 01/04/19



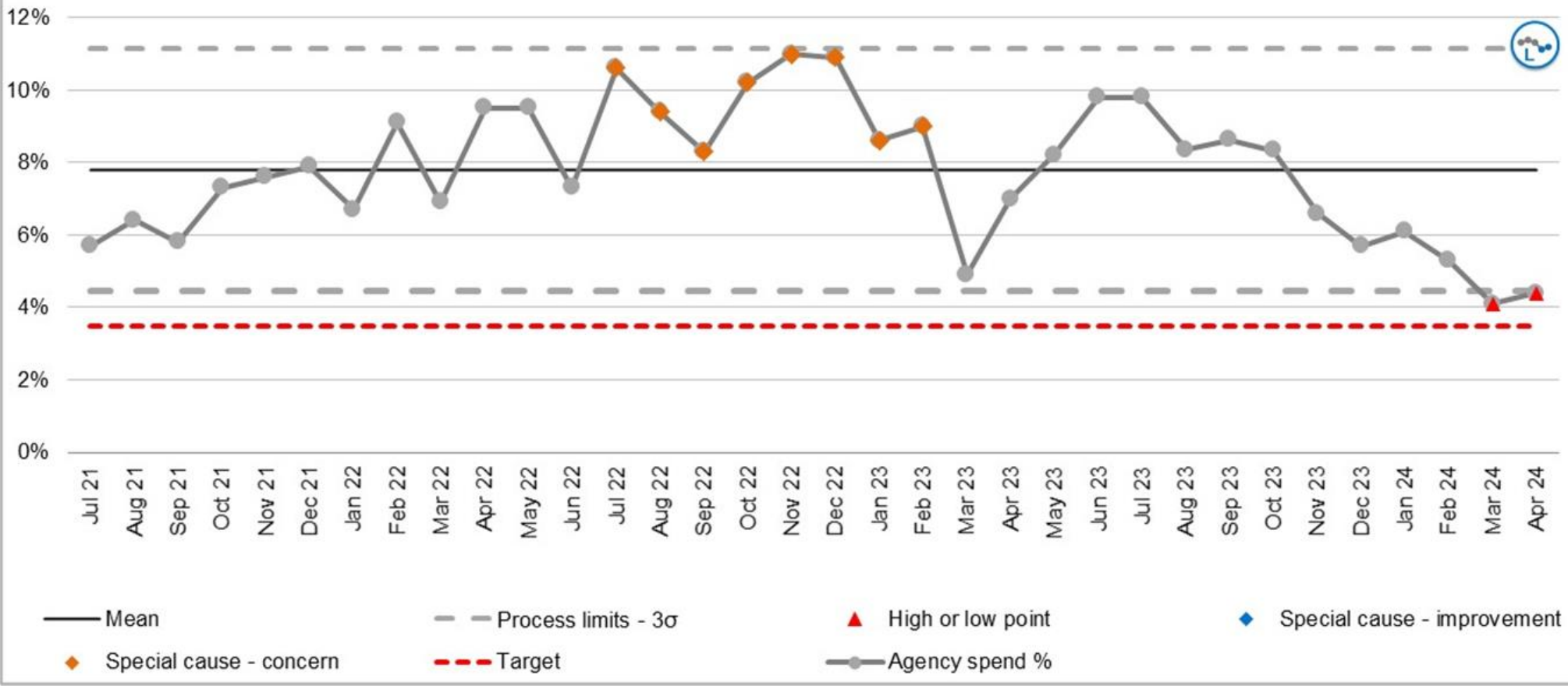
14. Agency Expenditure

Agency spend- starting 01/04/19

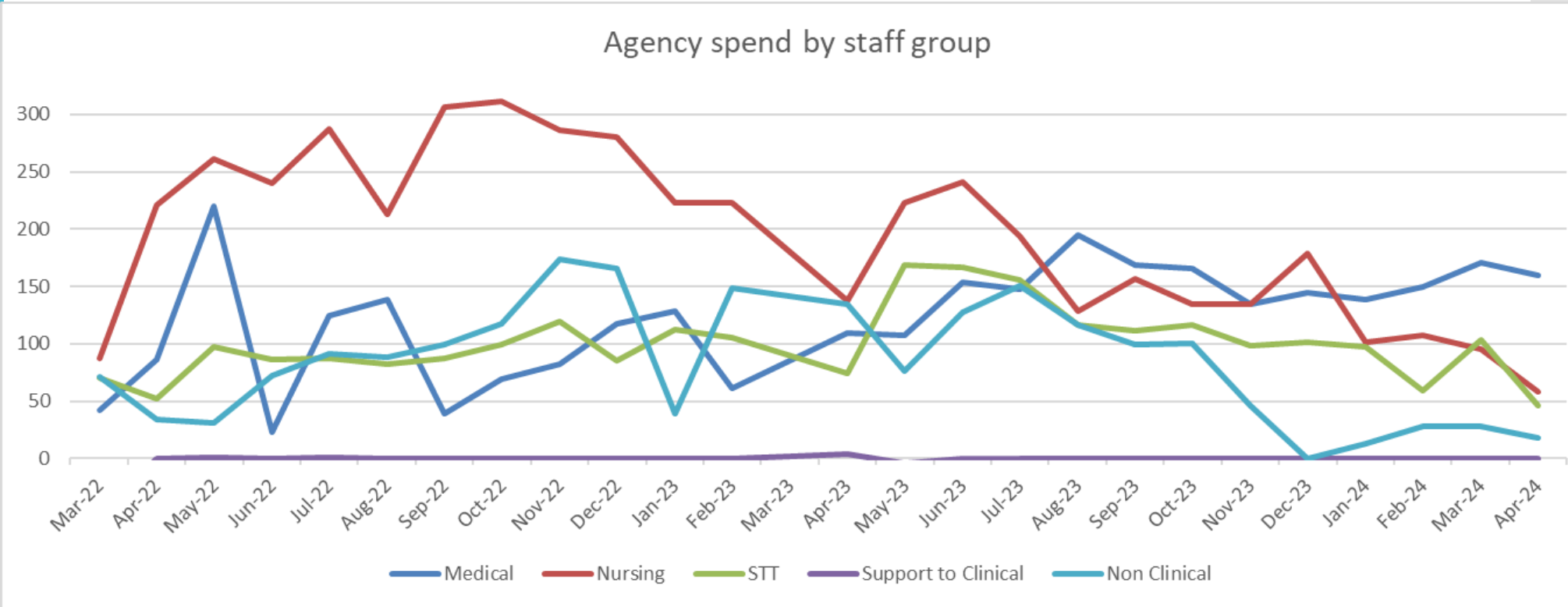


14. Agency Expenditure

Agency spend as a % of pay bill- starting 01/07/21



14. Agency Expenditure



15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £185k have been delivered, against a plan of £288k, delivering an adverse variance of £103k. The Financial Sustainability and Improvement Group continued this month, with good engagement across the organisation. Work is ongoing to identify recurrent plans for the unidentified element of the target.

Scheme	Value £000s	Recurrent / Non-recurrent	Developed Status	Risk
Commercial income - Private patient income	440	Recurrent	Fully Developed	Low Risk
Commercial income - Research and Development, catering, car park and accommodation	294	Recurrent	Opportunity	Medium Risk
Pharmacy - generic switches	154	Recurrent	Plans in Progress	Medium Risk
Procurement – BSOL procurement schemes identified	198	Recurrent	Plans in Progress	Low Risk
Procurement - ROH schemes identified	528	Recurrent	Opportunity	Medium Risk
Workforce improvements - reduction to 3.2% agency target	2,904	Recurrent	Plans in Progress	Medium Risk
Pathway redesign - day case pathways with reduced bank and agency through reduced bed occupancy	750	Recurrent	Opportunity	High Risk
Non clinical admin vacancy hold	224	Non-recurrent	Plans in Progress	Medium Risk
Discretionary spend hold	212	Non-recurrent	Plans in Progress	Medium Risk
Pathway redesign - Pre operative assessment staffing model	115	Non-recurrent	Plans in Progress	Medium Risk
Admin and clerical bank hold	110	Non-recurrent	Plans in Progress	Medium Risk
Reducing consultant premium rate working	564	Recurrent	Plans in Progress	High Risk
Additional ERF income delivery (elective and outpatient)	608	Recurrent	Plans in Progress	High Risk
Unidentified	1,119	Non-recurrent	Opportunity	High Risk
	8,220			

15. Route to breakeven progress

	Proposed opportunity	Proposed implementation	24/25 opportunity		QIA Assessment			Exec Lead	Progress		
					Patient Experience	Patient Safety	Clinical Effectiveness		Monitoring forum	April'24	Data source
Recruitment hold on non clinical vacancies	£224,538	May	£205,827	25% hold on posts at an average yearly cost of c£23k				Sharon Malhi	Vacancy panel	-£30,316	Comparison of substantive pay spend in M1 compared with M12 23/24
Training and education	£83,253	May	£76,315	25% reduction on current training and education budgets				Sharon Malhi	Non clinical procurement group	£10,911	Comparison against 24/25 plan
Room hire and hospitality	£37,056	May	£33,968	50% reduction on external room hire and hospitality				Rebecca Lloyd	Non clinical procurement group	£1,338	Comparison against 24/25 plan
Consultancy	£92,827	April	£92,827	50% reduction on consultancy support				Steve Washbourne	Non clinical procurement group	£2,670	Comparison against 24/25 plan
Agency				Already ambitious target within financial plan to reduce to 3.2% target				Matt Revell	Temporary workforce working group	£9,295	Comparison against 24/25 plan
Elective Activity	£500,000	May	£458,333	2% Productivity in addition to 4%				Michelle Hubbard	TBC		
OP Activity	£200,000	June	£150,000	4% Productivity in outpatients				Michelle Hubbard	TBC		
Activity delivery – reducing premium rate working	£753,108	July	£564,831	LLP Reduction. Productivity gain of delivering additional activity within job planned core hours				Michelle Hubbard	FSIG		
Non ERF activity reduction; Physiotherapy	£40,788	June	£30,591	Reduce waiting list reduction rate with significant reduction in agency expenditure				Michelle Hubbard	Temporary workforce working group	£10,163	Comparison against M12 23/24
Non ERF activity reduction; Outpatients				Needs further consideration to ensure it won't impact on ERF with current conversion rates				Michelle Hubbard	TBC		
Increase prices in commercial income generation				Difficult to model with impact on demand by price adjustment				Steve Washbourne	FSIG		
Ward closures	£323,706	July	£242,780	Accelerate reduction in length of stay initiatives and remodel a ward to a 5 day ward				Nickie Brockie	TBC		
Nurse led Pre operative assessment	£138,934	Sept	£81,045	Including budget + agency spend on medical staff				Nickie Brockie	TBC		
Admin bank controls	£120,000	May	£110,000	Cease all premium rate bank working with admin bank only worked within core hours				Steve Washbourne	Temporary workforce working group	£62,563	Comparison against M12 23/24
	£2,514,210		£2,046,516							£66,624	

Plan £7,736
Variance to plan £58,888

16. Statement of Financial Position

SUMMARY

The main movements in the balance sheet have been in relation to the increase in cash and borrowings following the support payment received from the Department of Health. Debtors has increased in month as a result of BSOL ICB reverting back to paying mandates at the start of the month and the previous 23/24 month 12 position with no payment received in March.

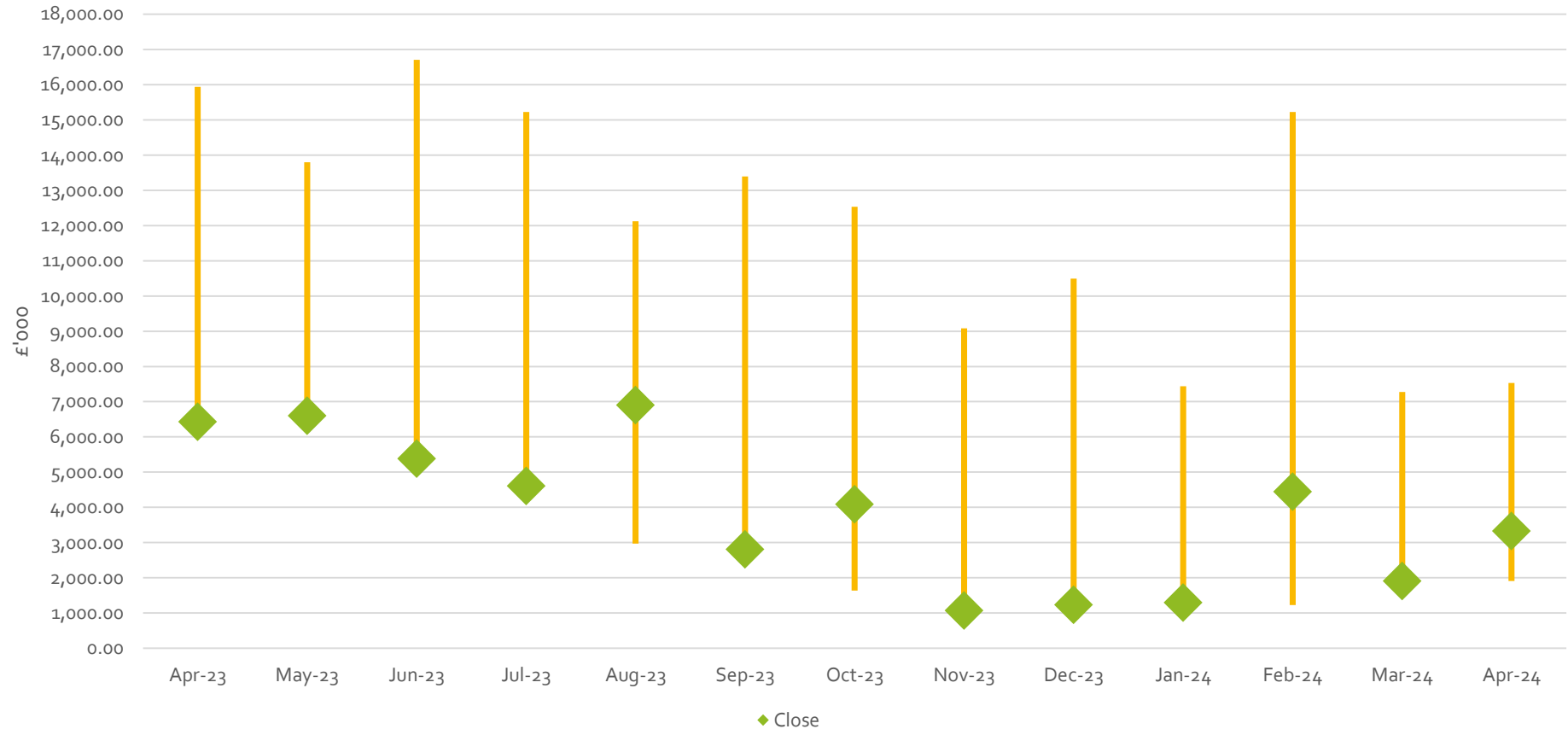
The cash position remains challenging to manage within the in-month peaks and troughs, with BSOL ICS supporting the trust in the short term. Continued focus is being placed on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance. Cash support from NHS England was received during April, improving cash available during April by £3.05m

	2023/24 M12	2024/25 M1	Movement
	(£'000)		
Intangible Assets	981	954	(26)
Tangible Assets	66,219	65,990	(228)
Total Non Current Assets	76,200	66,944	(255)
Inventories	1	1	0
Trade and other current assets	8,299	14,163	5,864
Cash	1,698	3,057	1,359
Total Current Assets	9,998	17,221	2,446
Trade and other payables	(12,999)	(11,911)	1,087
Borrowings	(15,639)	(18,914)	(3,275)
Provisions	(1,187)	(1,186)	1
Other Liabilities	(250)	(0)	(250)
Total Liabilities	(31,564)	(32,012)	(448)
Total Net Assets Employed	45,634	52,153	6,519
Total Taxpayers' and Others' Equity	45,634	52,153	6,519

17. Cash

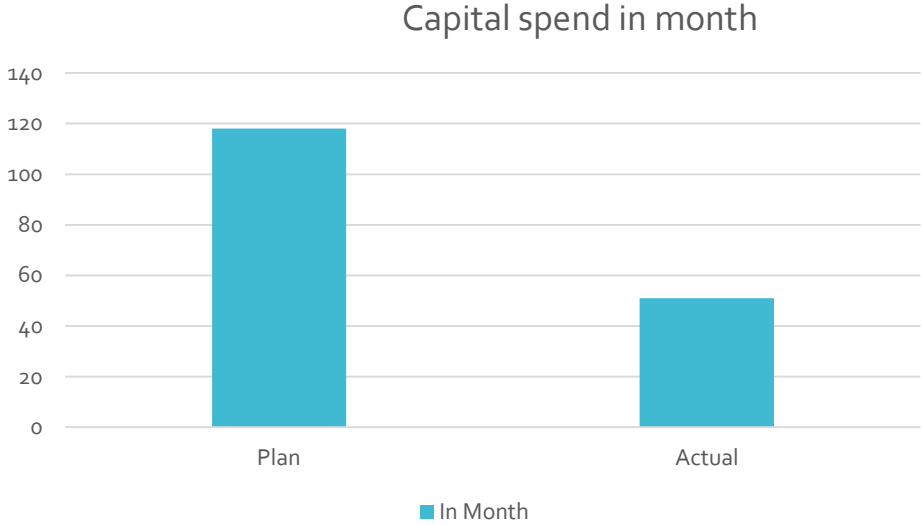
- The cash position remains challenging to manage within the in-month peaks and troughs, with BSOL ICS supporting the trust in the short term.
- Continued focus is being placed on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.
- Cash support from NHS England was requested during March and received during April, improving cash available during April by £3.05m

High/Low Cash Position



18. Capital

- Capital expenditure in month totals £51k against prior committed 2023/24 building schemes.
- A proposed capital plan has been included within a separate report



20. Workforce

Summary / Highlights

- Adjusted turnover remains low and within Trust target
- Establishment improved and we have 18 additional staff in April, compared to May. We are nearly at 90% establishment which was last achieved in 2021.
- Appraisals decreased in April which was expected however we are just now entering the April – July window and compliance is expected to increase in the coming months.

Risks / Issues

- Sickness absence increased, albeit long-term absence reduced. There was an increase in short-term absence in April.
- Mandatory training decreased which was due to the addition of the Information Governance and Cyber Training to ESR. There have been complications with the Meta system that these training sessions are held on.

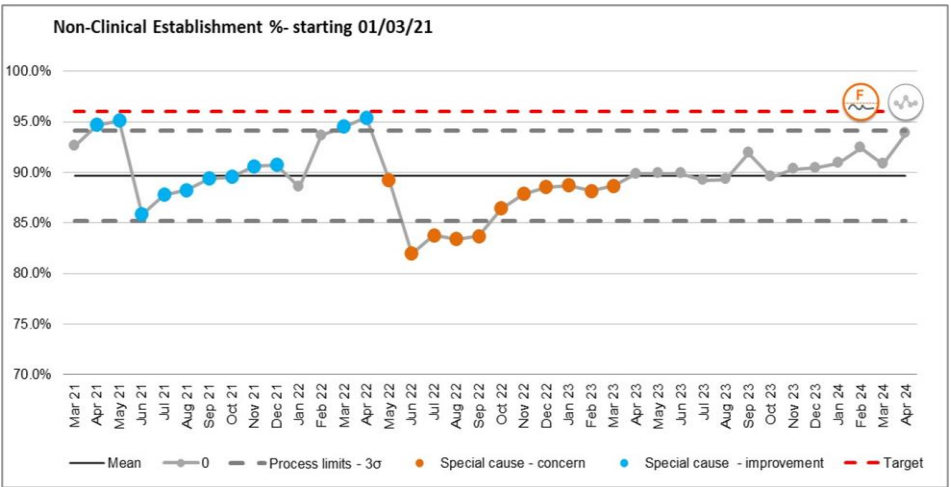
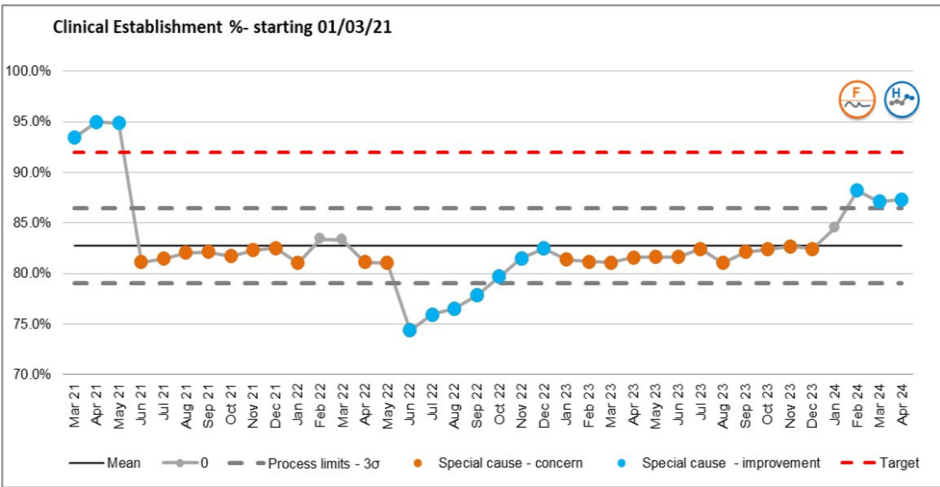
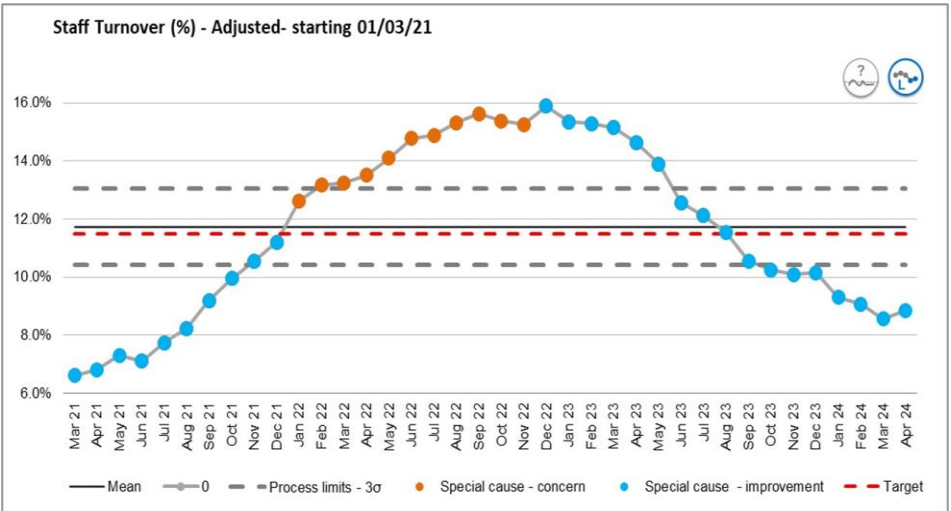
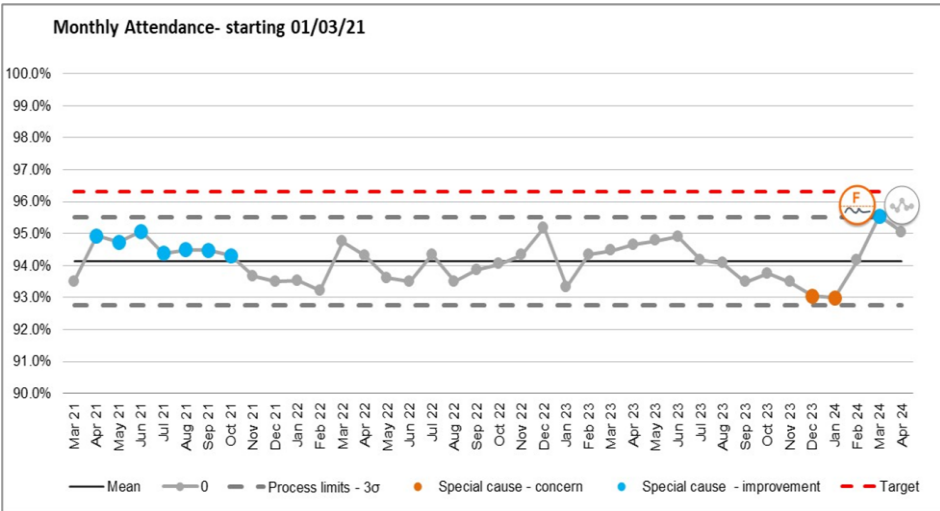
Actions

- We are now in the April – July window for appraisals and will anticipate an increase in the coming months.
- There is work continuing to support sickness absence management, which includes workshops, tailored support for departments with higher absence rates, training and direct support with awareness sessions. 104 line managers have been trained in 2024.
- IT issues concluding will support improvement of IG and Cyber training to recover the overall compliance.

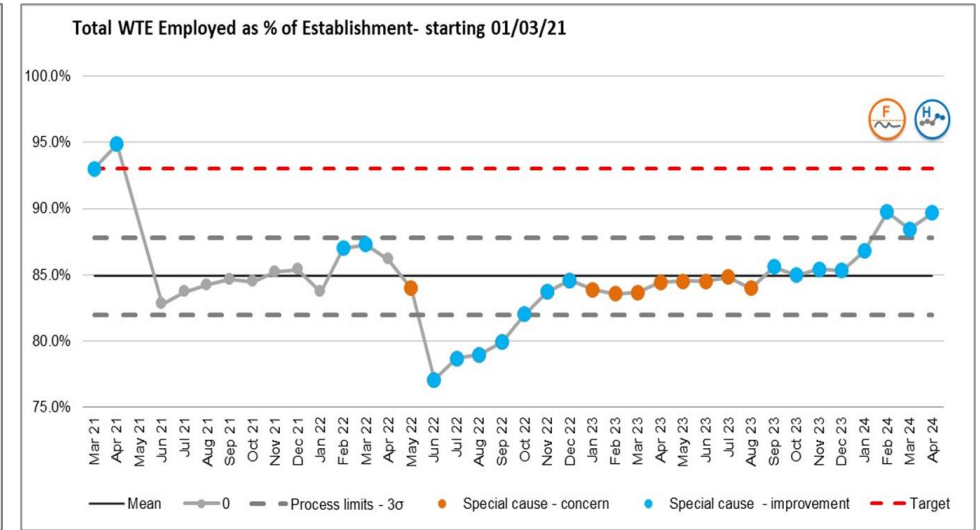
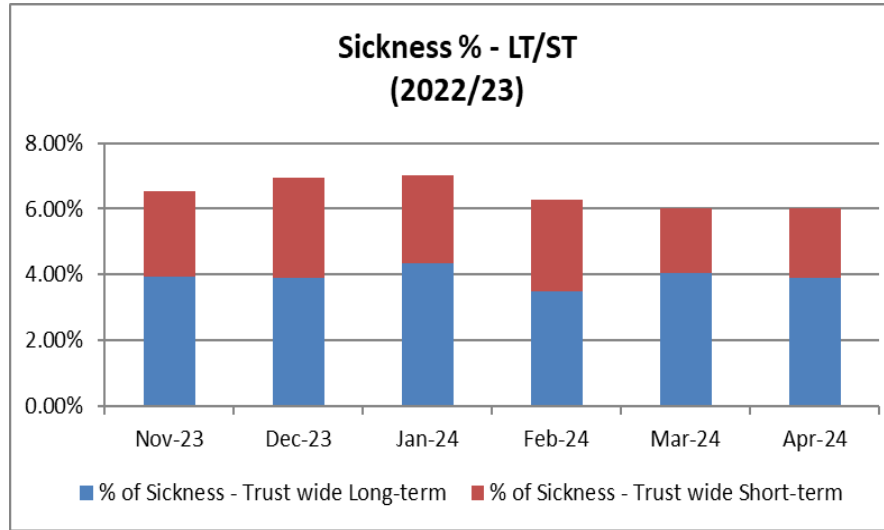
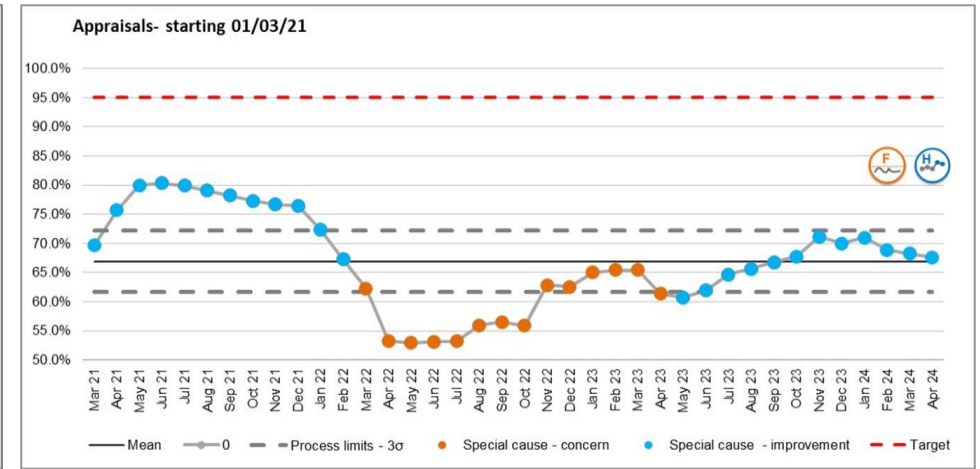
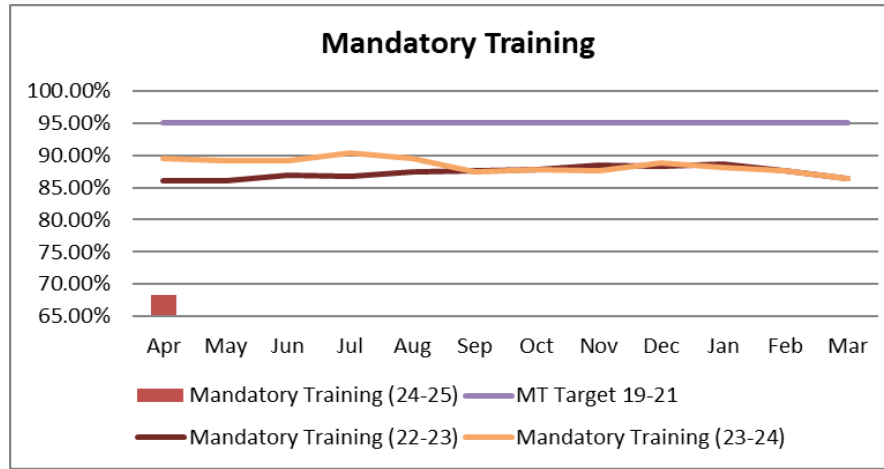
20. Workforce

Trust Workforce Metrics	Mar-24	Apr-24	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1428	1446	18	-	-
Staff In Post - Full Time Equivalent	1264.65	1280.71	16.06	-	-
Staff Turnover % - Unadjusted	13.36%	13.48%	0.12%	↑	<=11.5%
Staff Turnover % - Adjusted	8.57%	8.86%	0.29%	↑	<=11.5%
Total WTE Employed as % of Establishment	88.45%	89.67%	1.22%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	87.11%	87.32%	0.21%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	90.82%	93.83%	3.01%	↑	>=96%
% Of Attendance	95.55%	95.04%	-0.51%	↓	>=96.3%
% Of 12 mth MAA Attendance	93.98%	94.00%	0.02%	↑	>=96.3%
% Staff received mandatory training last 12 months	86.41%	68.33%	-18.08%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	68.24%	67.60%	-0.64%	↓	>=95%
% of Sickness - Trust wide Long-term	4.03%	3.90%	-0.13%	↓	-
% of Sickness - Trust wide Short-term	1.99%	2.10%	0.11%	↑	-
Return To Work Completion %	57.14%	66.09%	8.95%	↑	>=80%

20. Workforce



20. Workforce





Quality Report

May 2024 (April 2024 Data)

Introduction

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Integrated Care System for routine engagement and assurance meetings.

The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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



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



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



A grey graph icon tells us the variation is common cause, and there has been no significant change.
For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



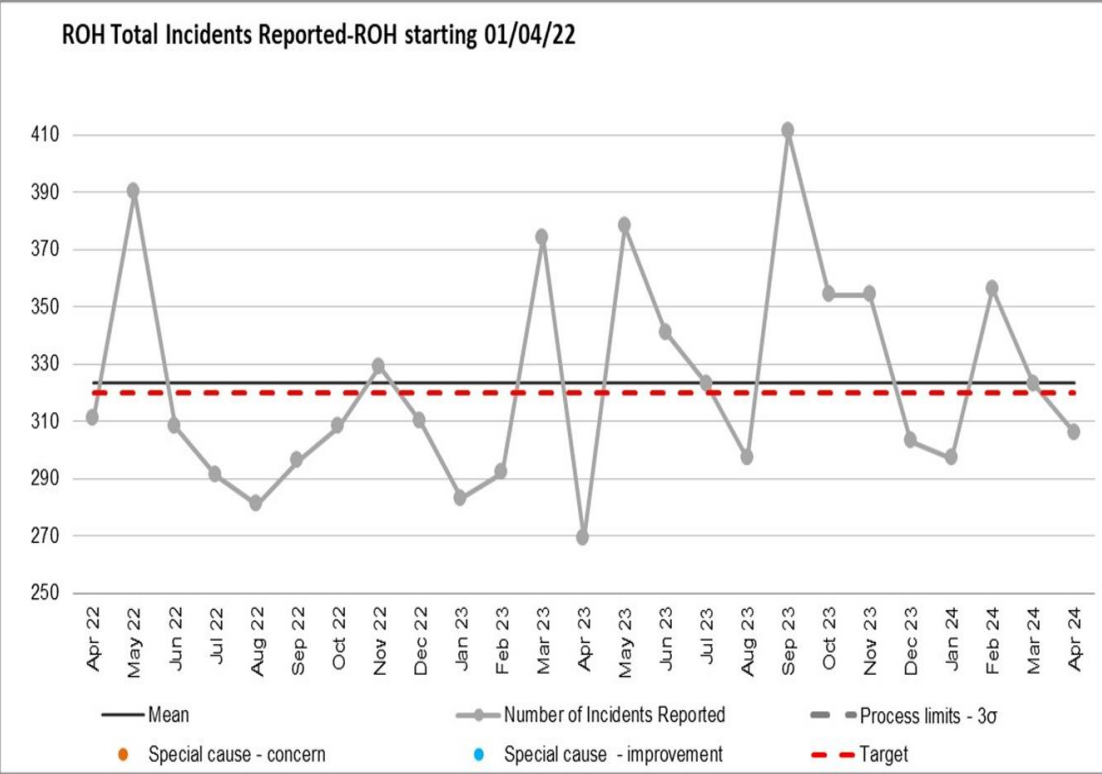
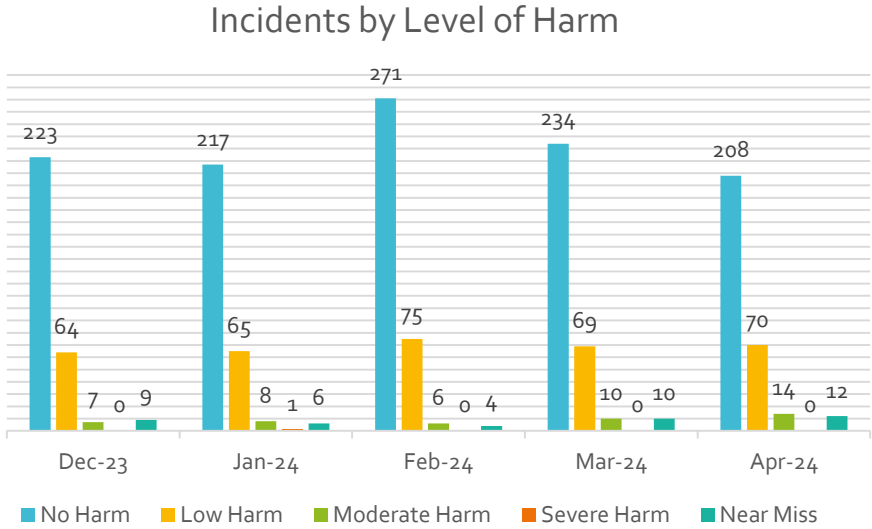
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

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

Governance Performance Summary Dashboard

Performance to end March 2024	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	306	323		
Inpatient Deaths	2	0		
PSII's (Patient Safety Incident Investigations)	1	0		
Never Events	0	0		
VTE Incidents (Avoidable)	0	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0		
Falls (Total No of Inpatient Falls)	8	9		
Infection Incidents (Reportable)	0	0		
Complaints	5	6		
Claims	0	0		
Inquests	0	0		

Incidents Reported



Quality Improvement & Learning

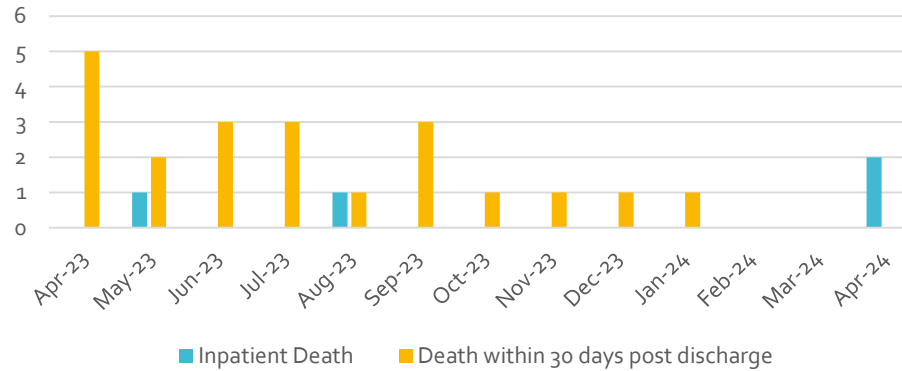
A plan is currently being devised to improve the sharing of the outcome of patient safety incidents, whether the incident is managed locally or whether the incident is taken through the Trusts governance process and managed in accordance with our PSIRF Response Plan.

With locally managed incidents the proposed plan is to provide regular reports to local managers on closed incidents that can then be used to feedback to incident reporters on a 1 to 1 basis and also be used to share outcomes wider at local team/department meetings.

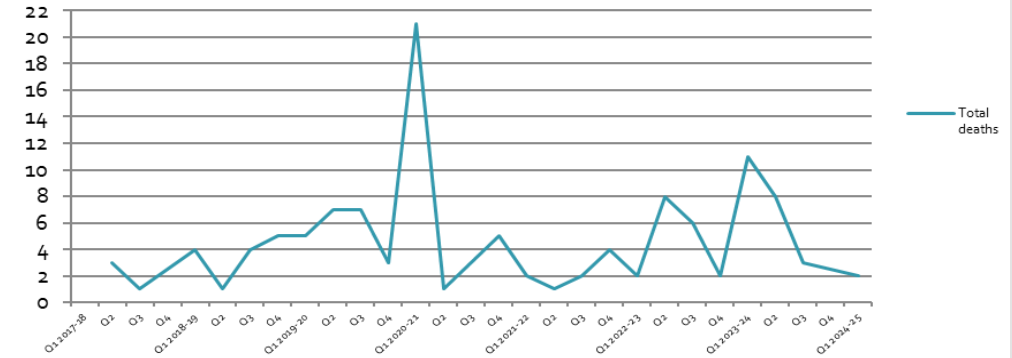
With incidents that are managed and investigated via divisional governance process, we are currently working with the Comms team to devise a format for the wider sharing of patient safety incidents and moreover the sharing of the learning from patient safety incidents that will be disseminated across the whole trust on a periodic basis.

Learning from Deaths

Learning From Deaths



Mortality Over Time - Total Deaths Recorded – up to Q1 2024-25



Quality Improvement & Learning

2 x Inpatient deaths in April 2024 –

Case A - A PSII is being undertaken (see also section relating to Deteriorating Patients p12)

Case B – Divisional governance did not recommend PSII pending feedback from medical examiners and coroner. Trust learning from deaths process will proceed in parallel.

Outcome of Learning From previously notified death Jan 2024 (Feb 24 Quality Report)

During hemipelvectomy surgery to treat a primary bone tumour the patient had a cardiac arrest at the time of turning from lateral to supine position. Despite immediate recognition, successful CPR, treatment of reversible causes, and transfer to a level 3 unit, the patient sadly died a few hours later. As well as reaching out to family, there was an early debrief with considerable emphasis on support for staff.

Early discussions with the medical examiner and tertiary referral receiving centre confirmed cause of death remained uncertain

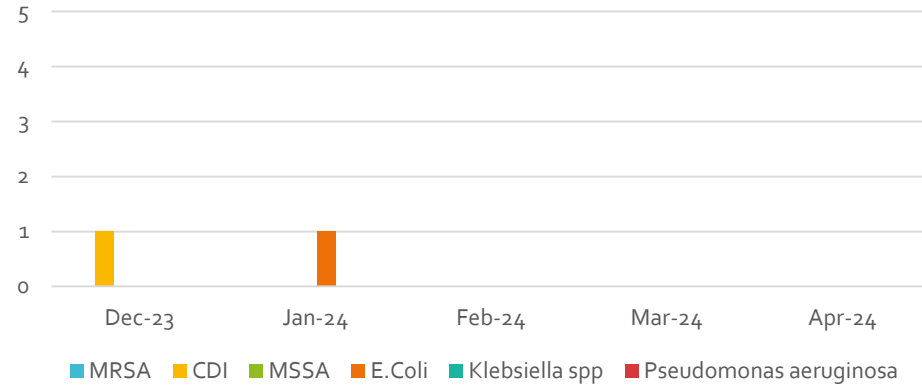
An internal After Action Review identified no major deficiencies in care and the following actions:

- Anaesthetic department to review which consultants undertake pelvic resections to ensure a small group with experience of these cases are assigned - to reflect the scale of the surgery and to mirror surgical practice in this highly specialised area.
- Use of peer consultation to look for ways to optimise pre-operative preparation as well as theatre skill-mix for complex cases
- Review the benefits of introducing cardiac output monitoring for major oncology procedures.

Expected Completion Date of Actions: September 2024.

Infection Prevention & Control

Infections recorded by month



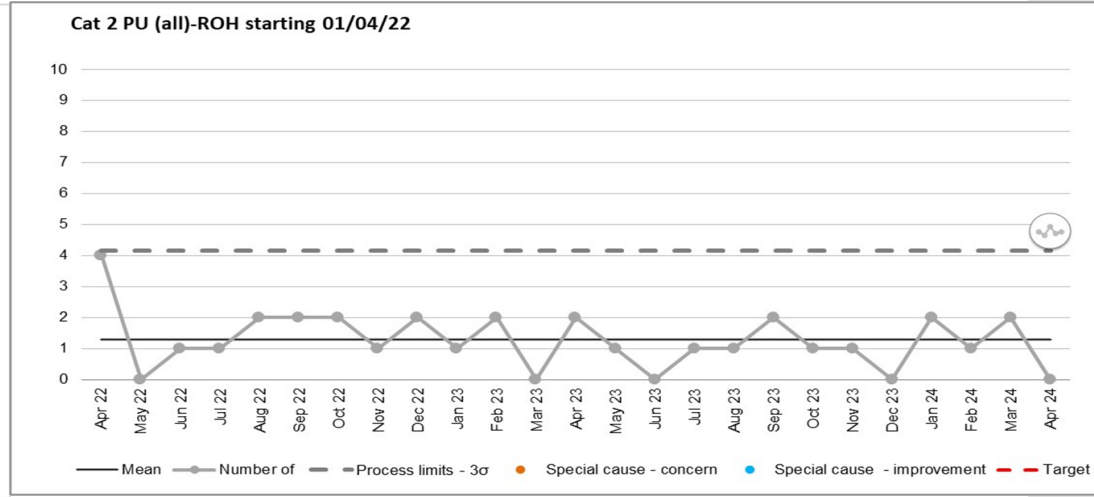
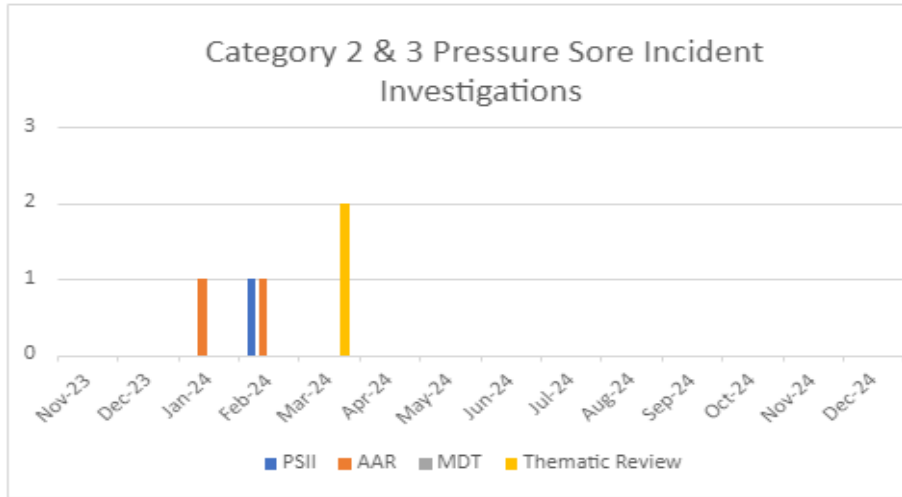
Quality Improvement & Learning

The 2023-2026 IPC operational plan incorporates antimicrobial stewardship and describes the key objectives for the ROH IPC service. The programme of work for 2024/25 will be shared at the IPC committee meeting in May 2024 for information and included in the Quality Report thereafter.

Summary of key achievements from the 2023/24 IPC programme of work:-

- Process for pre-operative MRSA treatment and management reviewed and policy updated.
- Introduced a tailored IPC audit process for theatres.
- Developed CDI severity assessment tools for post-graduate doctors.
- Implemented the 'gloves-off' initiative and updated local policies to reflect this.
- Undertook a review of unnecessary use of 'blue-couch roll' and removed where not required.
- Strengthened governance process around safe management of water systems and undertook a trust wide pseudomonas aeruginosa risk assessment. From this implemented pseudomonas water testing for three high risk areas. Also improved monitoring, reporting and oversight of hydrotherapy pool water management.
- Implemented PSIRF for all IPC incidents.
- Organised and held a well attended IPC study day.
- Strengthened links with Robert Jones and Agnes Jones Hunt (RJAH) Orthopaedic Hospital IPC team to share learning, resources and create a support network.

Tissue Viability



Quality Improvement & Learning

Learning from Previous Incidents

Thematic Review underway in to 2 x Hospital Acquired Category 3 Pressure Sores – feedback on learning to be provided in a future report along with learning from remaining open 2 x AAR and 1 x PSII investigations. The reports are still pending final divisional governance sign off at time of report.

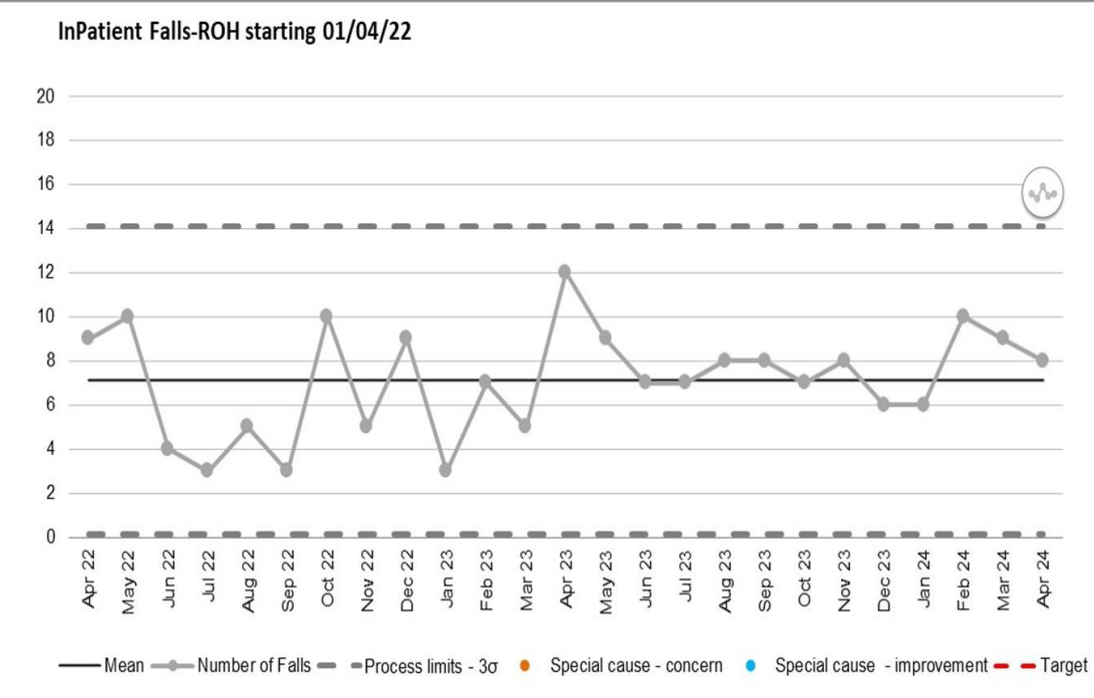
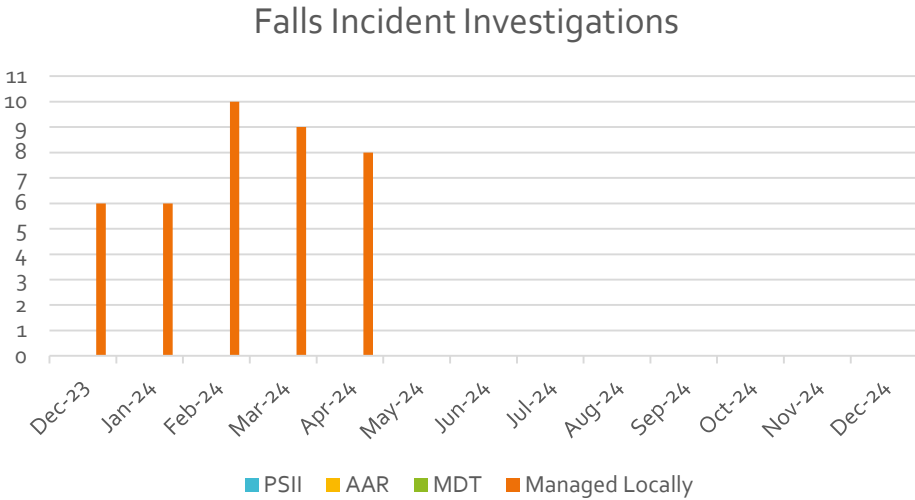
PSIRF Decision Making

Rationale for Thematic Review as opposed to separate AAR or PSII investigations into the two category 3 pressure sores was that both incidents occurred on the same ward and it was felt that a joined-up approach to identifying common themes and learning was a more proportionate and systems-based approach than 2 separate investigations.

Quality Improvement

New NWCSP “Pressure Ulcer Recommendations and Clinical Pathway” guidance has been released. Changes will need to be made to the PU categorisation and reporting process. TVN Lead undertook a gap analysis and sent summary report to Clinical Quality Group on 05/02/24. Task and finish group to be arranged to discuss the new NWCSP “Pressure Ulcer Recommendations and Clinical Pathway” and propose a new pressure ulcer risk assessment tool.

Falls



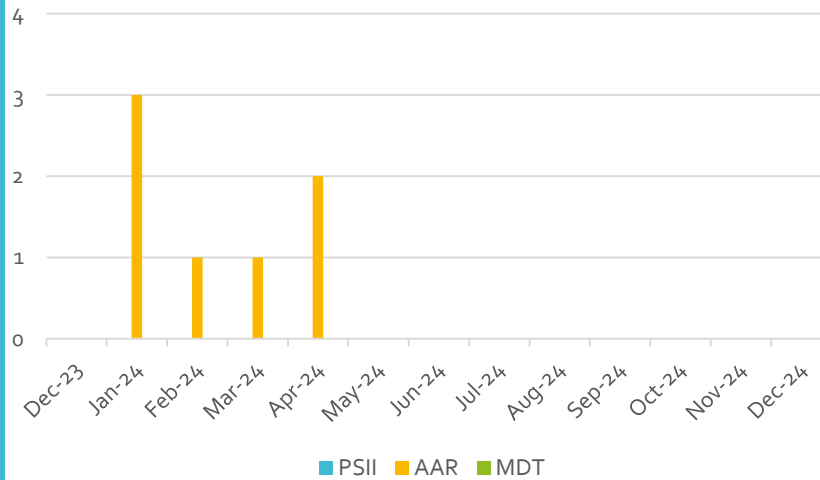
Quality Improvement & Learning

Review of bed rails risk assessment in conjunction with Patient Safety Specialist.

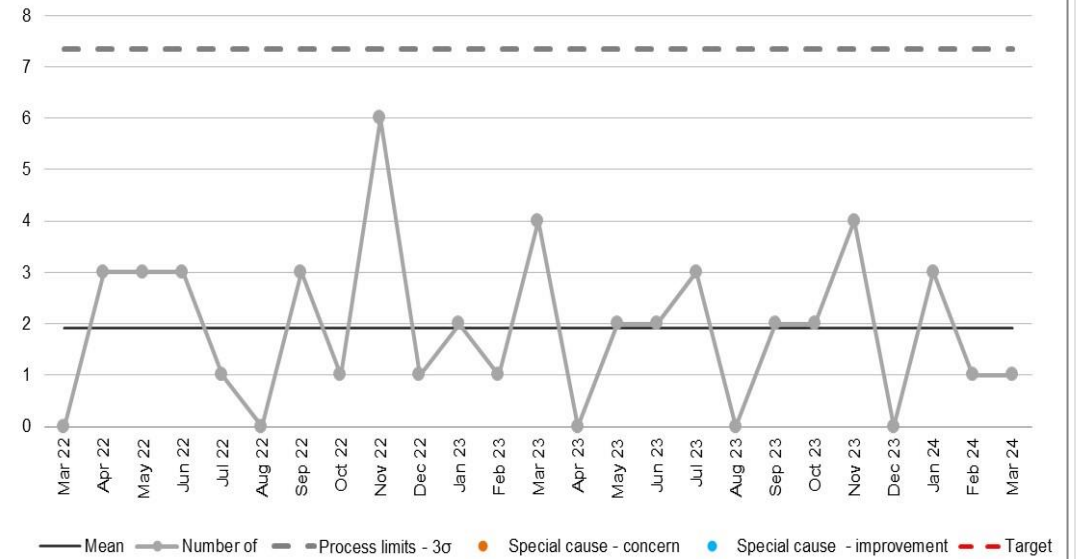
Planned walk round with Estates team to identify outstanding work needed in relation to falls & dementia

VTEs

VTE Incident Investigations



VTE-ROH starting 01/03/22



Quality Improvement & Learning

Learning From Previous AARs

5 VTE AARs have been concluded. All VTEs were deemed unavoidable. Main theme of learning from AARs relates to improved documentation and recording of information in patient records.

VTE On Admission Assessment Compliance

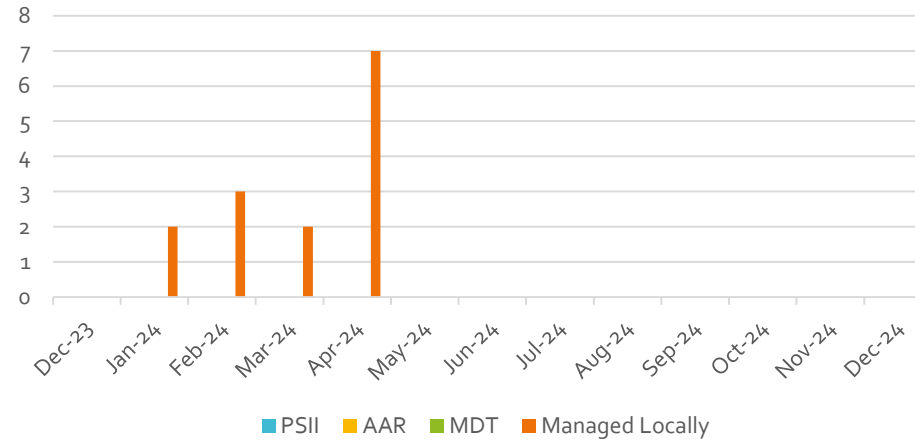
Compliance figure for April 2024 = **95.54%** *This figure is the pre-validated figure and therefore likely to change

Quality Improvement work underway

Latest NICE Guidance relating to VTE management has been reviewed and discussed at VTE Committee – Trust deemed compliant with Guidance – minor amendment to VTE Policy needed to reflect changes for patients with Covid 19 – this work is underway.

Medication Errors

Medication Error Incident Investigations



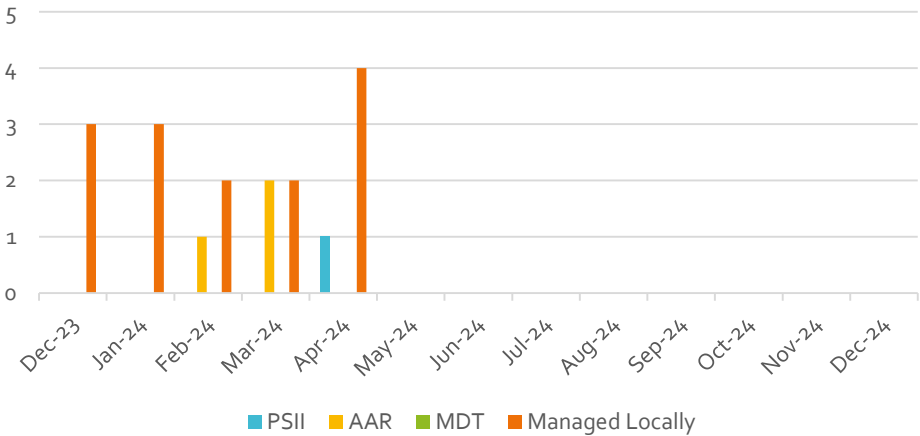
Quality Improvement & Learning

No AAR's, MDT or PSII investigations have been undertaken – all incidents being managed locally.

The increase in medication error incidents in April 24 has been brought to the attention of the Head of Nursing for Division 2, who is going to support the Pharmacy department with looking into the incidents to identify themes and possible opportunities for learning. All incidents reported as low or no harm.

Deteriorating Patients

Deteriorating Patient Incident Investigations



Quality Improvement & Learning

AAR investigations remain underway – awaiting final sign off at Divisional governance

Case A – as per p6 under Learning from Deaths April 2024

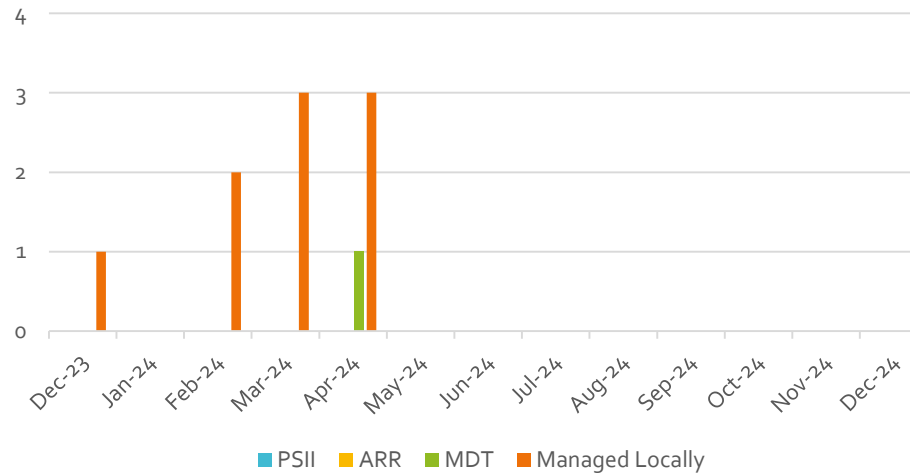
Patient was transferred out after intra-operative vascular complications. They returned to the ROH 4 days later. The patient started to feel unwell day 5 following return and died on day 6 (unexpected death)

A PSII investigations is underway and is informed by 2 elements:

- An MDT review of surgery and theatre aspects of care has taken place (07.05.24) – positive feedback from the partner provider clinicians.
- Review ward care and peri-arrest in progress.

Emergency Transfers Out

Emergency Transfer Out Incident Investigations



Quality Improvement & Learning

Case A - (April 2024) as per p6 and p12.

Note on PSIRF Decision making

Rationale for MDT investigation into surgery and theatre aspects of care, as per the Trusts PSIRF Response Plan, was due to the treatment and care of the patient involving several teams within the Trust, as well as the ACCOTs service and UHB ITU teams. An MDT style meeting with all specialities and the correct expertise around the table to identify the issues and any learning was seen as an effective, proportionate and systems-based approach to responding to this patient safety incident.

Complaints

Complaint Information

The Trust received **5** complaints in April 2024

Below are the departments that received complaints in March 2024

- Imaging
- POAC
- MSK
- Governance
- Spinal

In April 2024, the complaints team closed **4** formal complaints

At the time of producing this report we currently have **9** open formal complaints. **1** complaint is comeback complaint which has request a meeting and **1** is a Private Suite Complaint.

4 formal complaints have breached their timeframe and are still open. (1 PP Complaint, 3 for Spinal)

Below are the departments that have complaints currently open at the time of writing this report

- SpinalX2
- MSK
- POAC
- Private Suite
- Spasticity

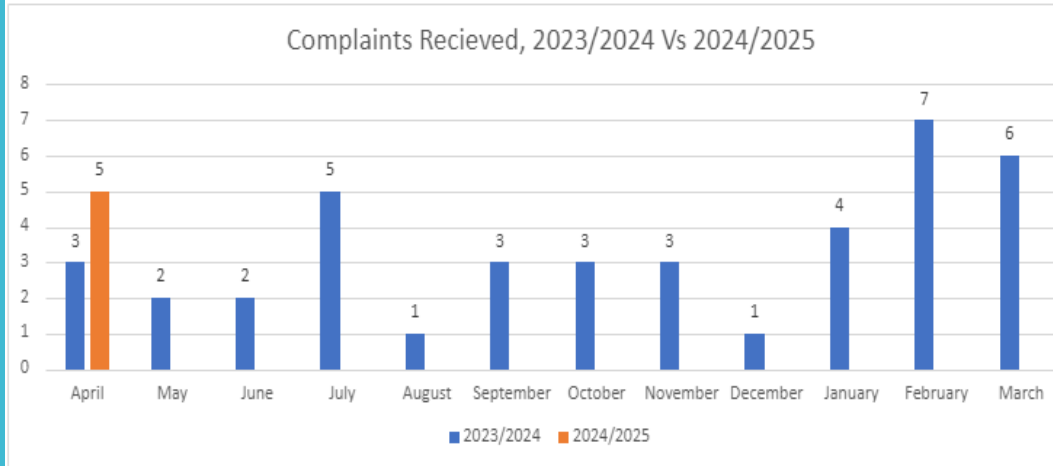
No complaints were received where the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

Complaint Resolution Meetings and Reopened Complaints

The Trust offers meetings to the complainant in both the verbal and written acknowledgement letter and also within the response letter. Where the Trust did not meet the complainant's expectation in the first response or meeting, the Trust encourages complainants to write to us with any additional comments, questions or recommendations that will satisfy the complainant.

In April 2024 the Trust received **2 reopened complaints** and **2 requests for a resolution meeting**.

Complaints KPI's



Complaint Year Totals

April 2023- March 2024	42
April 2024	5

KPI0	Complaints %	Target Range
		0%-79%
		80%-90%
		91%-100%
April 2023	100%	91%-100%
May 2023	67%	0%-79%
June 2023	75%	0%-79%
July 2023	100%	91%-100%
August 2023	0%	0%-79%
September 2023	100%	91%-100%
October 2023	77%	80%-90%
November 2023	100%	91%-100%
December 2023	0%	0%-79%
January 2024	0%	0%-79%
February 2024	100%	91%-100%
March 2024	100%	91%-100%
April 2024	100%	91%-100%

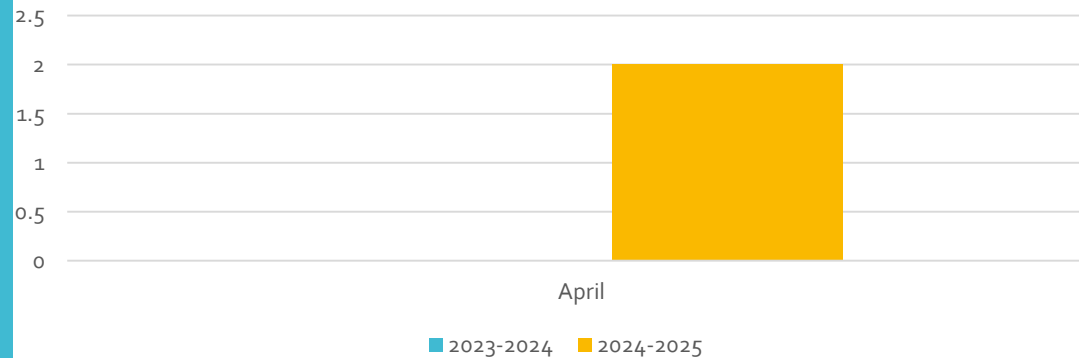
100% of KPI's were met due to all complaints remain open and within timescales

Actions from Complaints

In April 2024 4 actions were identified. 3 for Complaints and 1 for PALS. All of which are still open 2 are for Ward 1, 1 for Spinal Services and 1 for Imaging. These are reviewed and discussed in the bi-weekly governance meetings.

Complaint Themes

Reopened Complaints in 2023/2024 compared to last year



Reopened complaints

The Trust received 2 requests to reopen complaints in April 2024. This can be attributed to the complaints previously resolved being managed to the complainant's satisfaction.

PHSO Cases

The Trust currently has no PHSO complaints cases open.

Themes

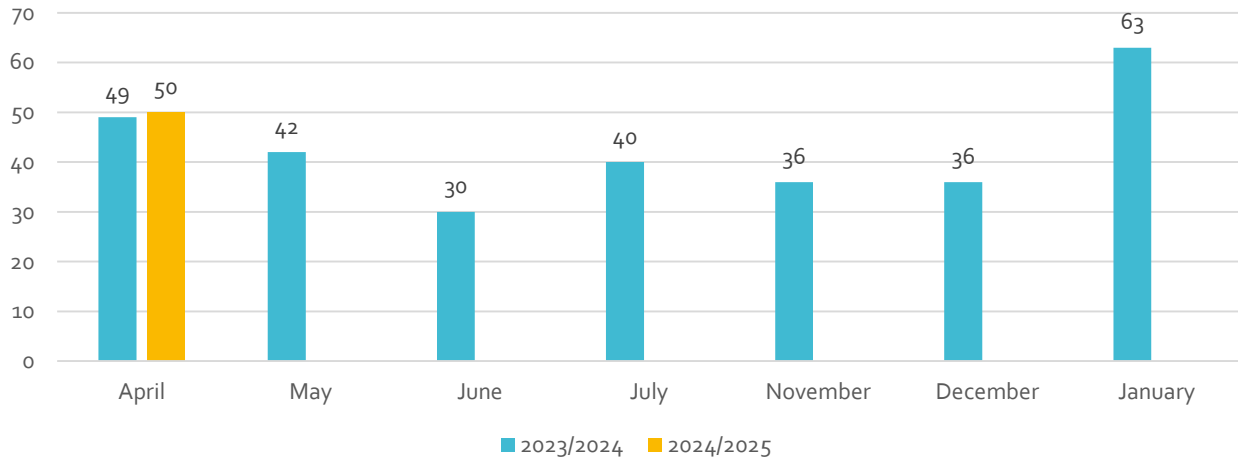
1. Access to treatment or drugs
2. Clinical Query
3. Communication
4. Trust Administration
5. Values & Behaviours

What We Did / Are doing

1. Raised in divisional governance meeting to track themes.
2. Tracked in Executive Governance Meeting
3. Ensuring actions are created
4. Ensuring relevant departments are aware of concerns
5. Requesting updates on outstanding actions in bi-weekly governance meetings
6. HoPE sending out weekly reminders to triumvirate
7. Internal investigations – PALS department are making it more clear which cases they have resolved .

Patient Advice and Liaison Service – PALS

PALS Received 2023/2024 Vs 2024/2025



The above graph shows that this financial year The Trust has received more PALS contacts overall in comparison to last year. PALS Team are now formally documenting cases dealt with within the department on Ulysses to enable them to be reported on to the Divisions they originate from.

3 PALS Cases were received where the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

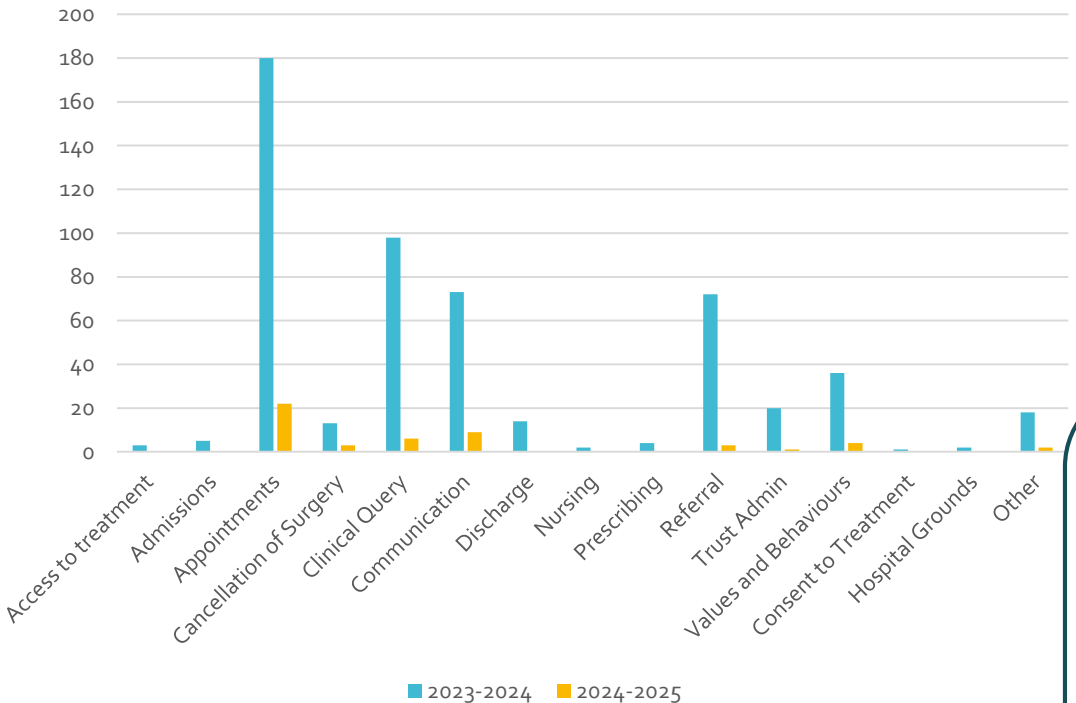
PALS KPI's

KPI	PALS Contacts %	Target Range
		0%-79%
		80%-90%
		91%-100%
April 2023	85%	
May 2023	93%	
June 2023	90%	
July 2023	88%	
August 2023	50%	
September 2023	36%	
October 2023	50%	
November 2023	56%	
December 2023	82%	
January 2024	68%	
February 2024	64%	
March 2024	66%	
April 2024	34%	

The KPI for PALS Contacts have not been met (80%) since December 2023. This is primarily due to the lack of, or delayed responses from the specialities and operational level.

PALS Themes

Categories of PALS Contacts in 2023/2024 compared to 2024/2025



Themes

Communication – 9 out of 50 contacts received

Specifically: Communication/information given to patient

Appointments – 22 out of 50 received

Specifically: Appointments Cancelled

What we have done

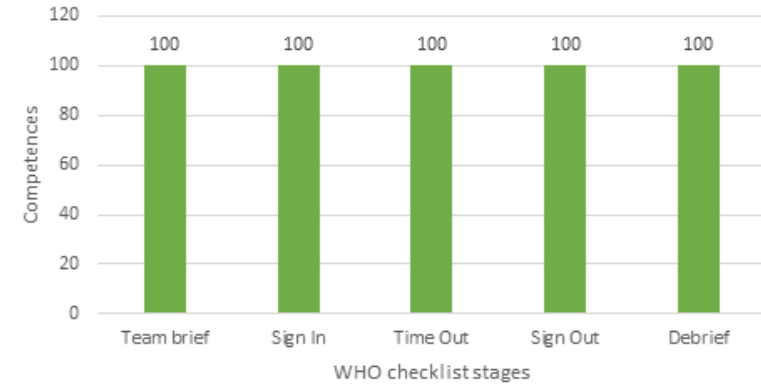
Tracked in Executive Governance Meetings
 Raised in Governance meetings and with departmental managers.
 Escalation to ensure PALS cases are responded too.
 Head of Patient Experience sending out individual reminders on outstanding PALS. PALS are dealing with PALS contact within their remit.

WHO Audits

Theatreman WHO checklist



CT WHO checklist



WHO Checklist



Quality Improvement & Learning

As of 1st April 2024 WHO Audits are completed via AMAT. The baseline number of WHO checklist audits set on AMAT is 10 operating lists.

Action plan : Staff adjusting to the new AMAT system. Cluster leads to ensure that visual WHO audits are completed and recorded on AMAT in a timely manner. Any identified issues to be escalated to matron.

Work in Progress -Meetings with the Patient Safety specialist commenced to review the current WHO checklist form and incorporating NatSSIPs 2.

CAS Alerts – Open alerts from previous months

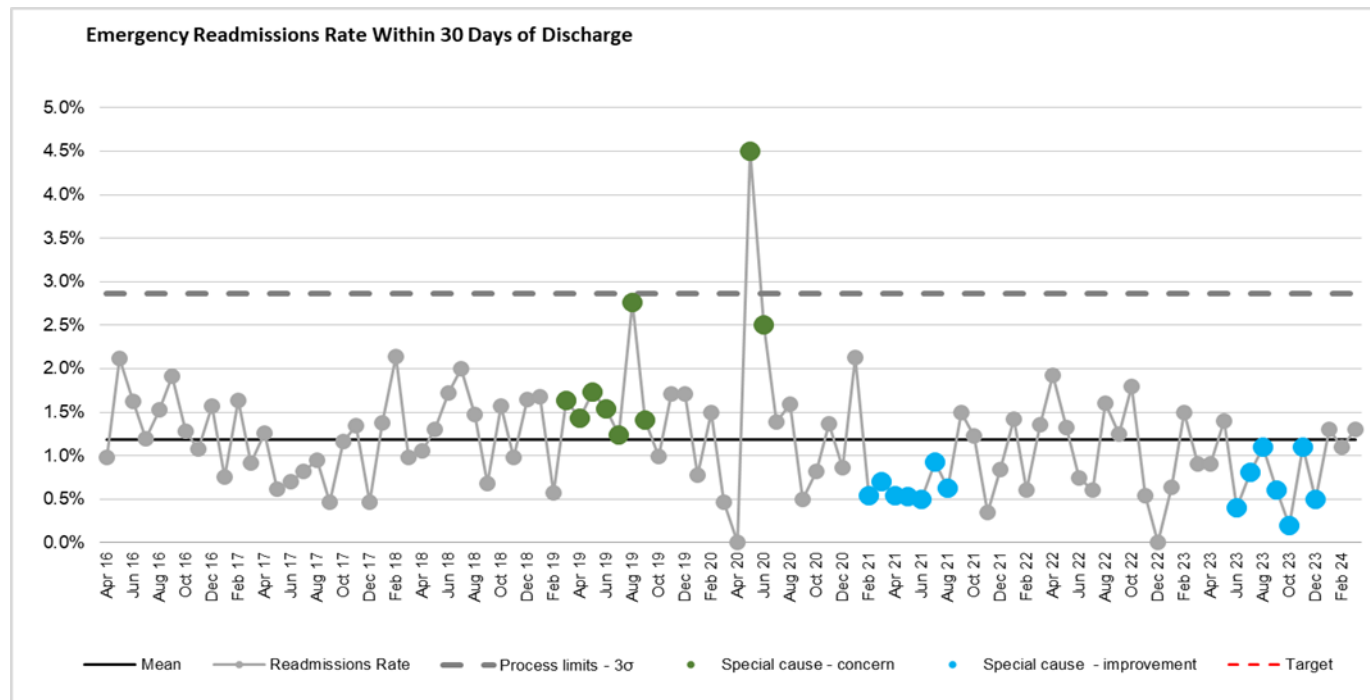
Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	<p>Transition to <u>NRFit</u> connectors for intrathecal and epidural procedures, and delivery of regional blocks.</p> <p>This National Patient Safety Alert, issued by the NHS England National Patient Safety Team, and co-badged by the Association of Anaesthetists, Royal College of Anaesthetists and the Safe Anaesthesia Liaison Group, instructs all relevant NHS funded providers to complete the transition to <u>NRFit</u> connectors for all intrathecal and epidural procedures, and delivery of regional blocks by 31 January 2025.</p>	National Patient Safety Alert - NHS England Patient Safety	31-Jan-24	<p>Assessing relevance.</p> <p>16 Apr 24: Awaiting response from Bill Rea/ Tony Sutherland/ Benjamin Smith.</p> <p>In-going...</p>	<p>31 Jan 25</p> <p>On-going...</p>

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	<p>Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.</p> <p>The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS.</p> <p>This National Patient Safety Alert provides further background and clinical information and actions for providers.</p>	MHRA	31 Aug 23	<p>11 April 2024: Email from MDSO: National issues are preventing closure of this alert. Working with <u>BSol</u> and Birmingham Citywide to address issues. Alert on risk register and discussed at divisional governance.</p> <p>Estates: Beds tagged to aid compilation of Estates inventory. Beds & bedrails now to be serviced by our in-house engineers <u>law Ario's</u> service schedule.</p> <p>On-going...</p>	<p>1 Mar 2024.</p> <p>On-going...</p>

Safeguarding Training Compliance

KPI	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Safeguarding Adult Notifications	17	43	21	44	43	47	37	47	58	65		72	56
Safeguarding Children Notifications	23	37	29	55	51	42	25	35	40	45		45	40
Adult Level 2 - 85%	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)	86.22%	85.48% (↓)	86.86% (↑)	88.7% (↑)	88.97% (↑)		89.03% (↑)	88.55%
Adult Level 3 - 85%	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)	82.06% (↓)	83.15% (↑)	83.83% (↑)	86.03% (↑)	84.11% (↓)		83.99% (↓)	82.68% (↓)
Level 4 - 90%	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)	100% (↑)	100.00%	80% (↓)	80.00%	80.00%		60% (↓)	75% (↑)
Child Level 2 - 85%	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)	86.12% (↓)	85.23% (↓)	86.7% (↑)	88.46% (↑)	88.89% (↑)		88.89%	88.4% (↓)
Child Level 3 - 85%	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)	81.68 (↓)	82.8% (↑)	83.46% (↑)	85.84% (↑)	83.96% (↓)		83.99% (↑)	82.68% (↓)
Mental Capacity Act MCA - 85%	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)	86.35% (↓)	85.88% (↓)	87.11% (↑)	88.62% (↑)	88.97% (↑)		89.19% (↑)	88.55% (↓)
Deprivation of Liberty Safeguards DoLs - 85%	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)	86.27% (↑)	85.63% (↓)	86.95% (↑)	88.54%	88.89% (↑)		89.12% (↑)	88.48% (↓)
Prevent Awareness - 90%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)	91.32% (↑)	89.98% (↓)	94.48% (↑)	91.38%	90.33% (↓)		89.35% (↓)	87.70% (↓)
WRAP (prevent level 3) - 85%	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)	87.41% (↓)	86.15% (↓)	85.51% (↓)	86.25% (↑)	85.22% (↓)		81.21% (↓)	82.71% (↑)
FGM	1	3	0	1	0	5	2	3	1	1		2	1
DOLS	0	7	0	6	4	4	2	5	3	6		5	4
MCA	1	3	4	1	4	2	7	5	6	7		13	6
PIPOT cases	0	0	0	0	1	0	0	0	0	1		0	0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0		0	0

Readmissions



Number of Emergency Readmissions to ROH within 30 Days of Discharge												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
No of Readmissions	4	7	2	4	5	3	1	6	3	6	6	7
Denominator	465	494	554	482	469	492	543	553	559	462	546	548
% Readmissions	0.9%	1.4%	0.4%	0.8%	1.1%	0.6%	0.2%	1.1%	0.5%	1.3%	1.1%	1.3%

There were 6 concerns raised in April 2024 in relation to the following themes

- Patient safety
- Worker's safety and wellbeing
- Attitude and behaviour
- Poor support from manager

Quality Improvements & Learning

FTSU Reflection and Planning tool – The FTSUG is leading a project to help the Trust Board and senior leaders identify strength and weakness within the organisation and at each leadership team level. It will serve to identify any gaps that need working on and set plans, objectives, and learning initiative. It will also reflect on demonstratable improvement.

Triangulation Document- A pilot will start soon in collaboration with FTSUG and Division Leaders – Sharing number of cases and common themes. This will maximise relevant resources with strong focus on the newly launched Leadership Charter and incorporating working with the Improvement and QSIRF Team.

FTUG to hold regular meetings with HR to review gaps in case resolution, learning and development

Freedom to
Speak Up

Operational Performance Summary

Performance to end March 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	49.58%	49.77%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	39	68	0		
52 week waits (52 – 64 Weeks)	517	414	0		
All activity YTD (compared to plan)	14,475	13,196	14,316		
Outpatient activity YTD (compared to plan)	66,066 99.8% Cumulative	60,831 101.2% Cumulative	66,174 YTD Target		
Outpatient Did Not Attend (YTD)	8.4%	7.0%	8%		
PIFU (trajectory to 5% target)	416 8.3%	447 8.8%	211 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	8.5%	10.7%	19%		
FUP attendances(compared to 19/20)	92.6%	90.6%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	110.1%	110.0%	120%		
Diagnostics volume YTD (compared to plan)	25,498 Cumulative	23,114 Cumulative	18,985 YTD Target		
Diagnostics 6 week target	99.8%	99.9%	99%		

Operational Performance Summary

Performance to end March 24	In month	Previous month	Target	Variation	Assurance
Theatre Session Utilisation	89.42%	92.5%	85%		
Theatre In Session utilisation (Uncapped)	82.58%	84.86%	85%		
Cancer - 31 day first treatment	100%	93.7%	96%		
Cancer - 62 day (traditional)	59.1%	85.7%	85%		
28 day FDS	82.8%	87.9%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	25,552 Cumulative	23,415 Cumulative	23,322 Cumulative		
Bed Occupancy (excluding CYP and HDU)	69.7%	73.7%	82-85%		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.66	3.37	n/a		
LOS - elective primary hip	2.90	3.10	2.7		
LOS - elective primary knee	2.90	3.10	2.7		
BADS Daycase rate (Note: due to time lag in month is Dec'23)	72.90%	74.0%	85%		