The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) September

4th September 2024, 12:45h-16:15h

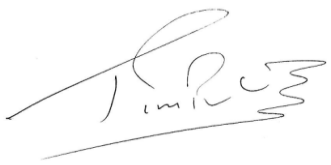
Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 4 September 2024

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 4th September 2024, in the Boardroom, Trust HQ commencing at **12:45.**

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

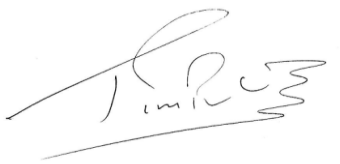
29 August 2024

Notice of a meeting of the Board of Directors

Notice is hereby given to all the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held in the Boardroom, Trust HQ on Wednesday, 4 September 2024:

Meeting	**Timing**
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Private Board meeting – Boardroom, Trust HQ	09:00 – 12:10
Lunch	12:10 – 12:45
Public Board Meeting – Boardroom, Trust HQ	12:45 – 16:15

The business to be transacted is provided on the private and public agendas enclosed or attached with this letter.



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD

Venue Boardroom, Trust Headquarters **Date** 4 September 2024: 12:45h – 16:15h

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)
Mrs Jenny Belza	Non Executive Director	(JB)
Miss 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)

In attendance

Mrs Sharon Latham	Head of Patient Experience	(SL)	[Item 17]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AR)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
12:45	17	Patient Story	Presentation	SL
13:05	18	Apologies: Simon Grainger-Lloyd, Simon Page	Verbal	Chair
	19	Declarations of Interest	ROHTB (9/24) 013	Chair
	20	Minutes of Board Meeting held in Public on 3rd July 2024: *for approval*	ROHTB (7/24) 025	Chair
	21	Actions from previous meetings in public: *for assurance*	ROHTB (7/24) 025 (a)	TF
	22	Questions from members of the public	Verbal	Chair
13:10	23	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (9/24) 014 ROHTB (9/24) 014 (a)	TP/JW
13:30	23.1	Council of Governors update: *for assurance*	Verbal	TP

13:35	23.2	Fit and Proper Person Assurance Report: *for assurance*	ROHTB (9/24) 016 ROHTB (9/24) 016 (a)	TP
13:40	24	EPRR Position Statement update: *for assurance*	ROHTB (9/24) 017 ROHTB (9/24) 017 (a)	SW
14:00	25	Health Inequalities Plan update: *for assurance*	ROHTB (9/24) 018 ROHTB (9/24) 018 (a)	NB
14:20	26	Signage Refresh Plan and Wayfinding: *for assurance*	ROHTB (9/24) 019 ROHTB (9/24) 019 (a)	SW/RL
14:35	**BREAK**			
	GOVERNANCE AND COMPLIANCE			
14:45	27	Corporate Risks Review: *for discussion*	ROHTB (9/24) 020 ROHTB (9/24) 020 (a) ROHTB (9/24) 020 (b) ROHTB (9/24) 020 (c)	AR
15:30	28	Patient Safety Incident Reporting Framework (PSIRF): *for assurance*	ROHTB (9/24) 021	AR
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
15:40	29	Upward reports from the Board Committees: • Finance & Performance Committee • Audit Committee • Quality & Safety Committee ○ IPC BAF Risk Update • Staff Experience & OD Committee	ROHTB (9/24) 022 ROHTB (9/24) 023 ROHTB (9/24) 024 ROHTB (9/24) 024 (a) ROHTB (9/24) 025	LW GH IR SJ
16:00	**MATTERS TO BE TAKEN BY EXCEPTION**			
	30	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report c) Workforce	ROHTB (9/24) 026 ROHTB (9/24) 027 ROHTB (9/24) 028	
	31	Learning from Deaths Update: *for assurance*	ROHTB (9/24) 029 ROHTB (9/24) 029 (a)	
	32	Any Other Business	Verbal	All
	33	Meeting effectiveness	Verbal	All
16:15	**CLOSE: Date of next meeting: Wednesday, 2 October 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

MEMBER	ATTENDANCE										TOTAL
	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	
Tim Pile (Ch)	✓	✓	✓	✓							
Ian Reckless	✓	✓	✓	✓							
Simone Jordan	A	✓	A	✓							
Gianjeet Hunjan	✓	✓	A	✓							
Ayodele Ajose	✓	✓	✓	✓							
Les Williams	✓	✓	✓	✓							
Simon Page	✓	✓	✓	**A**							
Jenny Belza	✓	✓	✓	**A**							
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**	• Council Member, Aston University	Yes
Jo Williams **Chief Executive**	• Trustee, Versus Arthritis	Yes
Simon Grainger-Lloyd **Director of Governance**	• Foundation Governor, Ombersley Endowed First School (4 Year Term of Office from June 2024)	Yes
Steve Washbourne **Chief Finance Officer**	• Governor at University of Birmingham School • Independent Member of the Audit Committee at Aston University	Yes
Marie Peplow **Chief Operating Officer**	• None declared	Yes
Matthew Revell **Medical Director**	• 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**	• None declared	Yes
Sharon Malhi **Chief People Officer**	• Trustee, Victoria Academies Trust	Yes
Simone Jordan **Non Executive Director & Vice Chair**	• Managing Director, Simone Jordan & Associates Limited • Non Executive Director, George Eliot Hospital NHS Trust • Member of the Chartered Institute of Personnel and Development • Vice Chair & Non Executive Director, Leicestershire & Rutland Integrated Care Board (LLR ICB).	Yes
Les Williams **Non Executive Director**	• None declared	Yes

Name	Interest	Voting Member
Gianjeet Hunjan **Non Executive Director**	• 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**	• None declared	Yes
Ian Reckless **Non Executive Director**	• 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**	• Deputy Chair, South Warwickshire NHS Foundation Trust (SWFT) • Owner, Weathervane Consultancy	Yes
Jenny Belza **Non Executive Director**	• Vice Chair and Non Executive Director, Birmingham Community Healthcare Trust • Governor, University College Birmingham	Yes
Jan Teo **Non Executive Director**	• 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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board – PUBLIC DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 3 July 2024: 0900h - 1500h

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)
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:

Mrs Sharon Latham	Head of Patient Experience	(SL)	[Item 1]
Mr David Hinton	Volunteer	(DH)	[Item 1]
Mrs Rebecca Crowther	Deputy Chief People Officer	(RC)	[Item 9]
Miss Hannah Washbourne	Public Observer	(HW)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

1 Staff story (SL/DH)	**Presentation**
TP welcomed Sharon Latham, (SL), Head of Patient Experience, and David Hinton (DH), Volunteer, to the Trust Board. DH joined the meeting to tell his story of how he joined the Trust as a Volunteer. DH was originally a patient, and his most recent operation was in January 2024. DH expressed how he had met some wonderful people over his time as a patient. During his inpatient stay he met a volunteer called John who shared his story. Once DH had recovered, he applied for a Volunteer position and the process was extremely quick. DH emphasised what a great experience it had been, and it has given him an opportunity to still feel he is still able to do something to give back to the Trust.	

DH described how the other volunteers have helped him settle into the role and the knowledge of the other volunteers is amazing. TP thanked DH for sharing his story and thanked the volunteers for their contributions. NB thanked DH for his contribution to the organisation. NB highlighted we have seen a drop in volunteer numbers and wondered if DH had any suggestions on how we can attract more people. DH explained he is actively trying to recruit on behalf of the Trust. JW thanked DH for speaking so highly of ROH. JW enquired whether volunteers are given the mechanism to raise patient concerns as it is felt they are more likely to raise these to our volunteers while in hospital rather than through other routes. DH explained that he had witnessed a great example of seeing how a complaint was dealt with to keep the patients happy. AA enquired whether there is anything we could do more to improve our volunteer service. DH didn't feel there is anything to do differently from his experience so far. It has been a great experience. TP queried if there is any other experience we could give with regards to training, for instance. DH felt the whole induction was great. JW also thanked SL for her role of Head of Patient Experience, and the transformation she has undertaken in interacting with patients. TP thanked DH for sharing his story today and for all the work he is doing for the Trust.	
1.1 Volunteer Annual Report (NB/SL)	**ROHTB (7/24) 001** **ROHTB (7/24) 001 (a)**
SL presented to the Board the Volunteer Annual Report. SL highlighted the following key points: • The reduction in numbers is due to cleansing that has taken place. The team has taken the time to ensure the numbers are accurate and the volunteer figure reflects the number of people who are actively volunteering. • SL provided assurance that active recruitment is taking place in a more targeted way. SL explained we run recruitment in line with the national guidelines. Detail is put on the website explaining the roles that are available and people can apply for a specific role. • The age criteria of 18 years and over has been set and we are getting a number of enquiries. IR queried the over 18 years and asked what we do for those under this age who	

want work experience. NB explained that we still provide those opportunities in a more controlled way. TP enquired what the % of volunteers are ex-patients and ex-staff. SL explained approximately 80% fall into this bracket. Breaking that down further, 4 are ex staff, the rest are all patients. Those that are not patients tend to be relatives or friends of patients. TP raised the charity function would benefit this type of role. SL confirmed this is something we are actively recruiting to, and DH is our first one who applied for that target role. AA queried whether volunteers are rotated between posts, and this is an opportunity available to them. SL explained this is available to them and the volunteers are able to choose where they like to go. SL explained we make clear to the volunteers what is available for them to do. MP enquired if there is an opportunity to market before patients leave. SL explained not at the moment but there is a future plan. TP suggested that being more proactive in our targeting would be the right direction to take. JW explained that a current focus was on the reception area, which could include a charity area. TP enquired whether there is an opportunity for volunteers to support us but not having to be on site. SL thanked TP for the idea and agreed this would be something we need to consider. TP explained they could be marketing the ROH in the area in which they live. GH suggested that this also be shared with schools and universities so this age could also be targeted. NB explained that we also have the Children and Young Persons group – 'Young Voices', who could be help us in this area. TP thanked SL for her report.	
2 Corporate Services Lookback 2023/24 & Forward Plan (RL)	**ROHTB (7/24) 002** **ROHTB (7/24) 002 (a)**
NB – this item was taken after the formal opening of the meeting. RL presented to the Board the key points of her report: • There are 21 corporate services. Half of these have attended Board over the past 6 months to provide updates. • Individual meetings have taken place for business planning. • Key learning from these sessions is that corporate teams do not tend to talk about their achievements.	

- The first Corporate Services reviews took place this week and are now more performance metric based. Feedback is we need clearly defined metrics to be able to make a judgement about corporate performance.
- Link to Business Planning and appraisals is crucial. Work has taken place to make it clear how objective settings needs to link back to the plans. The training is now in place to ensure this is cascaded through the teams in their objectives.
- The full plans are available to be shared with Board members.
- RL acknowledged the work the placement graduate from University of Birmingham has undertaken, which has been instrumental in the work on the corporate services business planning.

TP thanked RL for the detailed summary. TP emphasised how pleasing it is to see the link to delivering objectives and contributions.

LW queried the key achievements and the introduction of the Trustwide performance dashboard and would like to understand how this links to the work the F&P Committee are looking at. LW challenged that there is no mention of the productivity objectives.

SW explained that the dashboard described is the informatics dashboard that can only be accessed when logged into the Trust network. SW highlighted that discussions are taking place with Business Intelligence (BI) about how we build the dashboard. TP requested that the language used needs to make this clear when we are talking about this.

RL responded to the query with regards to the productivity and explained that the previous year this was not the highlight but agreed that this year this should be clear. RL will review the documents to ensure these feeds through in the language to show what we are doing to improve productivity.

SM explained that to provide assurance in committees this is in the discussions that take place that we link productivity to our performance metrics.

AA was keen to read about the community work that has taken place. AA queried how do the community appointments reach those most deprived. RL explained that we are looking at community and faith-based venues to host the events so that we are linking to the health inequalities action plan. Physiotherapy are going to run these events. There is work to look at our waiting lists and identifying where are these people living that are waiting. RL explained an update will come later in the year to the Board.

SJ suggested that some of the objectives needed more detail and an explanation of the 'so what' as many of these are about improving productivity and efficiency but we need to be more explicit. SJ gave an example of the statement that 'by 2027 we will have 'X' number of consultants', so the challenge would be so what would

this deliver if we did this. TP challenged that for each business plan can the leads be asked to detail what the metric will be, what this will show and articulate what the purpose is for measuring this. SW explained that performance reviews have commenced, and the conversations were around the next steps, what the outcome is and what the specific measurements are to show the success of the outcome. TP queried whether it felt the people in those meetings understand what they need to deliver. SW explained that this is the first time we have got this team people of together so is immature at the moment, but the attendees do get what their role is and what they need to do deliver it. JW gave examples of how the teams at these meetings shared how they are making a difference to help deliver the business plans.	
3 Apologies (chair)	**verbal**
Apologies were received and accepted from Simon Page and Jenny Belza. Welcome to Hannah Washbourne, who joins today as a public observer today whilst on work experience with us.	
4 Declarations of Interest (chair)	**ROHTB (7/24) 003**
It was noted that there was a new declaration, around SG-L undertaking a school governor role and the register had been updated to reflect that SJ was no longer the acting chair of the LLR ICB.	
5 Minutes of Board Meeting held in Public on 5 June 2024: ***for approval*** **(chair)**	**ROHTB (6/24) 021**
The minutes of the meeting held in public on 5th June 2024 were **approved** by the board subject to the following changes: LW confirmed it was agreed that the balanced scorecard example needs to be updated to September. SG-L noted that this revised timetable was reflected in the action log which would be considered next.	
6 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (6/24) 021 (a)**
SGL provided the following updates to the actions: • ROHTBACT – 243 'Flu Campaign – The date has been updated for completion to align with the national timetable. Update will now be in September.	

MR requested action ROHTBACT.254 is closed as this updated was provided in June. The Board agreed with the closure of this action.	
7 Questions from members of the public (chair)	**verbal**
No questions were received in advance of the meeting	
8 Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	**ROHTB (7/24) 004** **ROHTB (7/24) 004 (a)**
Chief Executive Update JW highlighted the following: • Thanks to the Communication Team for sharing the patients' stories. • Performance activity was strong, and we continue to have no patients waiting over 78 or 104 weeks. • Junior Doctor Industrial action has just taken place but thankfully caused minimal disruption to our patients. • The annual Blue Heart Awards took place on 7th June where 190 staff members from across the Trust were welcomed. Thanks to the Communications Team for all the work to make this a very special event. • A number of celebrations have been recognised across the Trust including Windrush Day, the anniversary of the D-Day landings, the NHS 76th Birthday and Armed Forces Week. • Thanks to the funding support from the ROH Charity, the community initiative called Health Hacks is underway, starting at Bournville Primary School. We now need to look to accelerate this. The one-hour sessions aim to promote good musculoskeletal health and empower families with essential well-being skills. • The first phase of the Oncology refurbishment has been handed over to the Team and furniture is being delivered today. • Covid is on the increase and some acute trusts are returning to mask wearing. GH queried whether there was any opportunity for Health Innovation West Midlands to fund anything here. JW explained we have extended an invitation to them to show what we can do. GH congratulated JW on the award of Honorary Doctorate from Aston University. TP congratulated the Finance Team on the Level 2 Finance Accreditation award. **Chair Update** TP raised how we use charitable funds should be looked at in more detail by the	

Board and would like to have a focus on this topic at future Board meetings. **ACTION: TF to schedule** Long Service Awards were a great success and the atmosphere and positivity in the room was heartfelt. TP has recently met with Jonathan Pearson, Chair of Birmingham Health Partnership. Brian Toner, Lead Governor, attended the last Board meeting and feedback how positive the Board meeting was that he attended. Challenge was given on the timings of the meeting however, to ensure that the Board prioritises what is important and focuses energy on the items that are critical. TP thanked the team for the time taken to input into the Chair appraisal.	
8.1 Check and Chat Update: *for assurance* (SGL)	**ROHTB (7/24) 005** **ROHTB (7/24) 005 (a)**

SGL provided an update to the Board on the Check and Chat Update.
 	
SGL explained this was introduced in 2021 and highlighted the key points from the report:
• The purpose of the check and chat is to hold informal conversations with staff from across the Trust to understand their experience of working at the ROH and to provide an opportunity for a review of the physical environment in which our teams are working.
• The visits are held 6 weekly and cover clinical and non-clinical areas.
• They are unannounced and last approx. 1.5 hours.
• Discussions with staff are informal but four questions are considered:
  ○ What single word would you use to describe the ROH?
  ○ What can we do to improve your experience at work?
  ○ How can we improve the experience for our patients?
  ○ What do you want to see happen in the next year?
 	
SGL highlighted some of the key themes that have emerged from these sessions:
• Staff talk about working here as being a family, supportive and welcoming.
• When asked how to make things better the responses include more resource both staff and equipment. They also regular mention lack of meeting rooms and car parking.
• How we make experience for patients better – way finding and signage, risk of digital inequalities.	

- How corporate teams link/contribute to care of patients – staff are now able to identify how they contribute.
- Clear desire by staff to remain as a unique entity in the BSol system.

Next steps are to continue with the visits on a 6-weekly basis and to consider formalising the process to include the Non-Executive Directors.

JW detailed how on a recent visit the feedback is no longer about pay and conditions but how they can help patients and what those barriers are.

AA questioned how long this has been running for and have there been any major changes from this. SGL explained this is not an action-based initiative but a triangulation tool back to the business plans. JW explained as a group the Executives come back together to discuss what has been seen, and work together to take the feedback, and make any changes that might be needed. JW emphasised this is an opportunity for staff to feel safe to speak up and share their thoughts.

NB raised that from feedback there has been instrumental change with the salad bar in Café Royal. NB explained that using the feedback and triangulation back to staff survey, for instance. the teams are able to take action on the areas that need attention.

JT highlighted the 'You Said, We Did' is quite powerful, and questioned if this is used. SGL explained that at the Team Brief the key messages are shared in this way.

SJ requested a specific action and timeframe of when Non Executives will be included in this process. SGL confirmed this can be created swiftly and suggested that by the end of July seemed realistic.

ACTION: SGL to define the Chat and Check Process to include Non Executive Directors.

TP queried who is responsible for signage. SW explained it sits with both the Communications function and him. TP underlined the importance of getting the way finding signage right and this needs some immediate focus. JW explained this has been picked up as part of an action from Charitable Funds Committee.

TP questioned what is the improved communication that colleagues are looking for. SGL explained that colleagues feel they sometimes want more access to senior managers and work is taking place to address this.

GH requested a timescale to sort signage. RL explained we have a recommendation report completed but SW raised that there are more than just signs as it is our overall communication. RL felt that an update could be provided within the next month.

ACTION: RL/SW to provide an update to Trust Board in September on the plan to

improve signage across the Trust.	
9 People Promise Update: *for assurance* (RC)	**ROHTB (7/24) 006** **ROHTB (7/24) 006 (a)**
TP welcomed RC to the Trust Board. SM explained that following funding made available we have been able to invest in embedding areas of the People Promise, which included recruiting a People Promise Manager. RC provided an overview of how we secured the funding for the role of the People Promise Manager, and following a self-assessment explained we are focusing on four key areas. Donna McMahon has been recruited as People Promise Manager on a 12-month fixed term contract to help us embed the four areas we know we need to focus on. RC explained the next step is to ensure we use the People Promise language. RC provided assurance that we have a good governance structure in place as this reports into People & OD Committee, and Staff Experience & OD committee, as well as our Staff Networks. RC explained that we feed into the national system as well as the BSol system. RC explained that Donna McMahon role is to help with the delivery by supporting teams as a programme lead. Civility and respect being led by MR and work is already underway. Flexible Working being led by NB. RC emphasised this is a cultural piece of work and therefore there is not an instant change, and the actions carry across through to Quarter 4. TP queried if this has been to Staff Experience & OD Committee - SJ confirmed this has been through the committee. SJ raised we have work to do to ensure the connections to how these all help us deliver the patient care is important and we need to show the links to how these initiatives are helping improve what we do. JW agreed with SJ that much of this is already in place and we need to translate this in everything we do. SM raised that the self-assessment provided assurance that much of our own People Plan already identifies these areas and we are already focussed on; we just need to accelerate this now. JT sought assurance on how the People Promise Manager will be supported to deliver the actions. MR provided assurance by explaining there are Executive SROs to all the focus areas, metrics are being put in place to these to these and we are	

having those conversations. TP queried how are we making sure the system is aligned. RC explained that it is aligned and is reported back on a monthly basis at system level. MP noted that much of this is business as usual and with Donna's role as coordinator of it, asked what our exit plan was from this support, given that Donna's role is time limited. TP agreed that Donna's role is to ensure this is business as usual and measured by the time she lives the role. TP thanked RC for the update.	
10 WRES/WDES Update: *for assurance* (SM)	**ROHTB (7/24) 007** **ROHTB (7/24) 007 (a)** **ROHTB (7/24) 007 (b)** **ROHTB (7/24) 007 (c)**
SM provided an update on the WRES/WDES information that has been circulated to the Board and provided the following highlights: • This is a yearly update that is shared with the Trust Board. • SM explained that going forward the data will move to SPC charts. • There have been some declines, and this is due to an increase in a number of those reporting. • There are areas of concerns, and these remain a focus. • Staff Experience &OD Committee raised concerns about the increase in bullying and harassment. SM explained this is a concern, as any increase is disappointing, but what is pleasing is people feel comfortable to speak up. • Work has taken place around culture and therefore we may see an increase of people speaking up as they feel safe to do that. JT questioned how we measured the effect of this on patients. SM explained that incident reports and complaints have been reviewed, and more work is needed on how we report and give assurance. This is the next step as we have good mechanism in place to ensure we are talking about these incidents and sharing the information so that more targeted approach can take place. SW queried where metrics are asked for what is the response rate. SM advised that the WRES information was taken directly from the staff survey. She explained we would have to do manual calculations. SW raised it would be key to see the numbers to ensure we know how many people this is affecting. GH queried how do the Freedom to Speak Up (FTSU) champions support this work. SM explained that the role of FTSU Champion is a huge role as we talk about FTSU right from Trust induction. We have a number of these concerns raised coming through this channel. SM also raised we need to work with Staff Side more as well. GH queried would encouraging completion of the three FTSU training modules be something that could support. It was agreed that this would be a useful step. GH suggested that line managers particularly should be encouraged to complete the FTSU training.	

GH questioned how does this link with the work the Equality, Diversity and Inclusion Leads are doing. SM explained that an update would come to a future Board meeting on this to show how we are aligned. SM explained we do have an action plan but the link that is missing is the line manager experience, as the intervention piece is where our managers are not experienced. JW explained following JT query that we review the data based on both staff and patients. JW highlighted that the work linked to the Race Code as well as it is clear we need to undertake some training for our line managers. MP agreed that we have created an open culture now where people do feel they can speak up and tell us, so this is positive. NB explained that the human factors training has been taking place over the past two years which may have also impacted this data as people feel comfortable to raise their voice. GH requested clarification on the BSol work and what is the ROH role in that, GH queried will there be a timescale to deliver. SM confirmed that this will be provided and as EDI Lead for the BSol system this will be linked to our work. TP highlighted the disappointing figure across the Trust for bullying and harassment. As a Trust we need to make sure we have clear actions on how we will improve this. TP raised we have zero tolerance to this behaviour. **ACTION: SM to provide a detailed action plan on how improvement in data will be addressed so that we are confident our colleagues feel safe at work.**	
11 Sexual Safety Charter*: for assurance* **(NB)**	**ROHTB (7/24) 008** **ROHTB (7/24) 008 (a)** **ROHTB (7/24) 008 (b)**
NB provided an update on the Sexual Safety Charter and highlighted the following: • The staff survey in 2023/24 included three questions relating to sexual trust and as a trust we are an outlier in the results. • There is concern about what is happening in the workplace and all incidents have been reviewed over the year. 55 people in the Trust felt they had been a victim. • An action plan against the 10 principles has been devised but the national policy has yet to be released due to currently being in purdah therefore the policies have not been published. • Work has taken place with HR and Communications to signpost people where to go if they need to raise anything.	

- There is a regular communication plan.
- Positive feedback has been given on the action Line Managers have taken to support.
- It is included in all our induction process.
- Our Safeguarding lead is planning to introduce the Domestic Abuse & Sexual Violence Advocate (DASVA) post that has been supported through charity funding.

TP queried what involvement Executives have with dealing with cases. NB provided assurance that Executives are made aware, they do get involved in dealing with the cases when needed, and there are consequences to actions.

NB highlighted the next step is to work on upskilling our Line Managers and actively working to put Bystander training in place.

IR queried what are the interventions, and asked whether we encourage senior colleagues to challenge poor behaviour and whether our policies detail what zero tolerance looks like and how this translates to gross misconduct.

JT sought assurance that anything that is a criminal act has been dealt with appropriately. NB/SM both confirmed this is absolutely the case.

JT queried the data and felt that rather than % figure it should be absolute numbers. TP challenged that the data that is being shared in the public domain needs to be clear. SM explained that this is national data. TP requested that before these are published further that they are translated into figures that are easier to understand.

ACTION: SM/NB to refine the data as a number rather than % to ensure the figures being shared clearly explain the impact and reshare the information.

JW provided assurance we have a mechanism in the Trust to ensure our colleagues feel safe to speak up and feel they can raise any issues. This behaviour is unacceptable and will be dealt with.

SM explained the process that takes place should any concern be raised. SM detailed that the Safeguarding Team are informed, and it is dealt with in a multi professional process.

NB, as Safeguarding Lead, is in a position of Trust and is informed on all cases.

TP thanked NB for the report and enquired what the next steps are.

NB highlighted that an update will be provided bi-annually through Staff Experience & OD Committee first.

UPWARD REPORTS FROM THE BOARD COMMITTEES	
12 Upward reports from the Board Committees: (cttee chairs) **a) Finance & Performance Committee** **b) Staff Experience & OD Committee** **c) Charitable Funds Committee**	 **ROHTB (7/24) 010** **ROHTB (7/24) 011** **ROHTB (7/24) 012**

Finance & Performance Committee - LW
 	
The F&P Committee upward report was taken as read, noting that there would be a more detailed discussed on finance and operations in the confidential section of the agenda.
 	
Staff Experience & OD Committee – SJ
 	
SJ highlighted the key points from the upward report:
• Risk to be added to the risk register on productivity.
• A robust meeting that enabled good discussions on the agenda items.
• A Staff story from one of the University of Birmingham Placement Graduate was warmly received.
 	
TP queried the risk rating on assurance levels that were discussed and asked are these documented in the meeting. The Board agreed that assurance ratings would be worthwhile to include.
 	
ACTION: SGL/TF to include assurance ratings on agenda items.
 	
Charitable Funds Committee – AA
 	
AA highlighted the key points from the upward report:
• Key risk is the performance of the investment portfolio, and a meeting is being arranged with Cazenove to discuss.
• Investments showed a positive increase since the last meeting.
• The first Health Hack Workshop was delivered too Bournville Village Primary School which was a huge success.
• Three bids were approved to be supported by the Charity:
  ○ Improving Diversity within the Resuscitation Training
  ○ Accessible site navigation
  ○ Domestic Abuse & Sexual Violence Advocate
 	
In addition, it was recognised the Audit Committee has completed a great amount	

of work outside of the usual Committee schedule and TP praised the Committee for submission of the Annual Report and Annual Accounts.	
Performance Reports	
13 Performance Reports: *for assurance* • **Finance & Performance** • **Workforce**	**ROHTB (7/24) 013** **ROHTB (7/24) 015**
The reports were taken as read.	
14 National Food Standards Update: *for assurance*	**ROHTB (7/24) 009** **ROHTB (7/24) 009 (a)**
NB provided an update to the Board on the National Food Standards action plan and provided the following highlights: • The team has continued to deliver high standards to our patients and staff, despite a challenging workforce. • Challenges include not having a designated Dietician, but we do now have a service level agreement worked up with Birmingham Community Hospital Trust and this will be one of our priorities to refresh our menu. • A piece of work is underway to ensure we are as sustainable as possible. • Food waste is a key focus for the team. • Development of the team is a priority for the next year, and we have some specific roles we now need to focus on. • The Board was invited to sample the patient food, which is also a requirement of the national standard. AA queried the action which states no more than 1500 calories is what we need to provide and questioned whether we have exceptions to this. NB assured the Board that we are able to adapt to the needs of the patient and all menus include calories. SM queried if there had been any development with partnering with the British Dietetic Association. NB explained that work is taking place in looking to work with Birmingham City University who are training the future Dieticians. JT queried there is little mention of allergies. NB explained this takes place at clinical interface and forms part of the safety huddle. There is a display in Café Royale that details all allergens. SGL queried the reporting route on progress with the work and questioned whether this take place to take Clinical Quality Group. NB confirmed this is the case.	

The Board was then invited to sample and provide feedback on the patient food.	
Date of next meeting: Wednesday, 4 September @ 0900h	

PUBLIC SESSION

Next Meeting: 4 September 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 6 August 2024

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.254	Patient Story - BOOM	Presentation	05/06/2024	Provide an update on what the plan is to share the work more widely.	MR	04-Sep-24	**Verbal Update to be given at the meeting.**	
ROHTBACT.243	Flu Vaccination Update	ROHTB (4/24) 007 ROHTB (4/24) 007 (a)	10/04/2024	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 as campaign work will not commence until August/September time. Schedule for Q&S Committee in September. Update to Trust Board in October.**	
ROHTBACT.245	Freedom to Speak Up Assurance Report	ROHTB (4/24) 010 ROHTB (4/24) 010 (a)	10/04/2024	Invite FTSU Guardian to the September Trust Board to provide an update on the national changes.	SGL	~~04/09/2024~~ 02/10/2024	**Deferred to October Board Meeting.**	
ROHTBACT.242	Service Accreditation	ROHTB (4/24) 006 ROHTB (4/24) 006 (a)	10/04/2024	Provide an update on progress at the May Quality & Safety Committee and September Board Meeting.	NB	~~04/09/2024~~ 02/10/2024	**Item deferred to September Q&S Committee and October Trust Board.**	
ROHTBACT.232	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	07/03/2024	Provide a preceptorship update via a staff story in approx 8 months.	NB	04-Dec-24	**ACTION NOT YET DUE**	
ROHTBACT.241	Guardian of Safe Working Update	ROHTB (4/24) 002 ROHTB (4/24) 002 (a)	10/04/2024	Invite Joanne Thomas, Associate Medical Director to give an update on Women in Orthopaedics.	MR	02-Oct-24	**ACTION NOT YET DUE**	

ROHTBACT.259	Chair's and Chief Executive's Update	ROHTB (7/24) 004 ROHTB (7/24) 004 (a)	03/07/2024	Schedule Charitable Funds as an agenda item at a future Board meeting to discuss how funds are used.	TF	04-Dec-24	**ACTION NOT YET DUE**	
ROHTBACT.260	Check and Check Update	ROHTB (7/24) 005 ROHTB (7/24) 005 (a)	03/07/2024	Define the Chat and Check process to include Non Executive Directors.	SGL	02-Oct-24	**ACTION NOT YET DUE**	
ROHTBACT.262	WRES/WDES Update	ROHTB (7/24) 007 ROHTB (7/24) 007 (a) ROHTB (7/24) 007 (b) ROHTB (7/24) 007 (c)	03/07/2024	Provide a detailed action plan on how improvement in data will be addressed so that the Board are confident colleagues feel safe at work.	SM	02-Oct-24	**ACTION NOT YET DUE**	
ROHTBACT.263	Sexual Safety Charter	ROHTB (7/24) 008 ROHTB (7/24) 008 (a) ROHTB (7/24) 008 (b)	03/07/2024	Refine the data presented as a number rather than % to ensure the figure being shared clearly explains the impact and reshare the information	SM/NB	04-Sep-24		
ROHTBACT.264	Upward Reports to Board Committee - Finance & Performance	ROHTB (7/24) 010 ROHTB (7/24) 011 ROHTB (7/24) 012	03/07/2024	On all future agendas include the assurance ratings for each item listed.	SGL/TF	06-Nov-24	**ACTION NOT YET DUE**	
ROHTBACT.255	Patient Story - BOOM	Presentation	05/06/2024	Detail the financial contribution the Oncology service provides as a Board level summary.	SW	04-Sep-24	**Included in CFO report. Propose Closure**	
ROHTBACT.238	EPRR Position Statement	ROHTB (2/24) 010 ROHTB (2/24) 010 (a)	06/02/2024	Provide an update on the EPRR Position Statement following the next assessment	SW	04-Sep-24	**Item included on September agenda. Propose Closure.**	

ROHTBACT.256	Health Inequalities	ROHTB (6/24) 004 ROHTB (6/24) 004 (a)	05/06/2024	Provide an update health inequalities plan with clear measures of success to September Trust Board	NB	04-Sep-24	**Included on September Agenda. Propose Closure.**	
ROHTBACT.257	Corporate Risk Register Review	ROHTB (6/24) 005 ROHTB (6/24) 005 (a)	05/06/2024	Arrange a board session to concentrate on Corporate Risks at the September Board meeting to allow for a Non Executive v Executive comparison on risk rating	SGL	04-Sep-24	**Included on September Agenda. Propose Closure.**	
ROHTBACT.258	Corporate Risk Register Review	ROHTB (6/24) 005 ROHTB (6/24) 005 (a)	05/06/2024	Provide a visualised report showing corporate risks on one page each month.	SGL	04-Sep-24	**Included on September Agenda. Propose Closure.**	
ROHTBACT.261	Check and Check Update	ROHTB (7/24) 005 ROHTB (7/24) 005 (a)	03/07/2024	Provide an update at the Board Meeting in September on the plan to improve signage across the Trust.	RL/SW	04-Sep-24	**Item included on September agenda. Propose Closure.**	
ROHTBACT.254	Upward Reports to Board Committee - Finance & Performance	ROHTB (6/24) 007	05/06/2024	Share the Balance Scorecard samples at the Board meeting in September.	LW/SW	04-Sep-24	**To be included on the September Board agenda with a discussion at Finance & Performance Committee beforehand.**	

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive Officer**
AUTHOR:	**Jo Williams, Chief Executive Officer**
DATE OF MEETING:	**4 September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**X**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

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
• N/A	• N/A

REPORT RECOMMENDATION:

The BOARD is asked to: receive and note the contents of this report.

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

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

Comments:

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

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

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

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

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

N/A

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

N/A

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

N/A

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Public Trust Board (in Public) on 4 September 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 3 July 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

On 21 August, the CQC released their Adult inpatient survey 2023 results. The ROH has been identified as performing 'much better than expected'. This is because the proportion of respondents who answered positively to questions about their care, across the entire survey, was significantly above the trust average. This is an incredible achievement and a testament to the hard work, compassion, and unwavering commitment to excellence that defines the Royal Orthopaedic Hospital. Every patient interaction, every procedure, and every act of care contributes to this outstanding outcome. This achievement is a clear indication of our values and standards.

I want to take this opportunity to thank all our amazing colleagues for their invaluable contributions. Whether on the front lines providing direct care or supporting our operations behind the scenes, everyone's role is crucial in creating a positive and

reassuring experience for our patients. Their dedication has made a significant impact, and it has been recognised at the highest levels.

2.2 Our Services

2024/25 financial year continues to have a greater focus on productivity, efficiency and expenditure to deliver our ambitious plan of breakeven. The Trust delivered a deficit position in July of £266k against a planned surplus of £174k. Year to date deficit totals £1,629k against a surplus plan of £122k, generating an adverse £1,751k variance.

Pay expenditure is overspent in month by £170k and year to date by £270k. Agency spend has been a little higher this month due to holiday cover but is largely in line on a percentage basis with last month at 3.7% of paybill (3.6% prior month) which demonstrates considerable progress made to date.

Activity in July 2024 was very strong, delivering 1348, which is 36 cases over our ambitious plan of 1312. Theatre session utilisation at 89.2% against a target of 85%.

The private patients target was exceeded in the month as the team continues to work through several actions which were agreed at June 2024 Trust Board.

Operational performance targets performed well with 18 patients waiting over 65 weeks; this has decreased from 35 with the remaining patients predominately in Spinal Services. The Trust has no patients waiting over 78 or 104 weeks. Our focus continues to be on clearing the number of patients waiting over 65weeks ahead of the national target of September 2024.

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.

NHS England specialised commissioning Quality and Nursing Team (QNT) who facilitated a peer review of our Primary Bone service on the 4 July 2024, has provided their initial feedback. The team started their feedback with "congratulations for delivering a 'remarkable service with extremely high standards' they also said, "it's extremely difficult to find any areas for improvement**".** We are very proud of our collaboration with Birmingham Women's and Children's NHSFT (BWC), and we continue to champion how we have come together to make a difference for patients and families.

On 31 July we had our annual accreditation review meeting with the National Team for our Elective Hub. Congratulations to all the team – we passed with flying colours and the team was very complimentary about the progress you have made to date.

2.3 Our People

2.3.1 On 5 August, as part of my weekly briefing I issued a statement called **"**Standing Together in the Face of Tragedy". In summary, like so many people, I was deeply saddened by the tragic events that took place nationwide since the horrific incident in Southport on the 29 July.

The surge in racism and hate crimes we witnessed were heartbreaking and goes against the core values we uphold. Now, more than ever, we must stand together in solidarity and support one another.

Across those days we saw an alarming instances of violence, including attacks on individuals, businesses destroyed, and buildings set alight. We also know that these events left many feeling afraid and uncertain about their safety, including the fear of leaving home and coming to work.

I reiterated that we will not tolerate any discriminatory comments, abuse or violence towards our staff, patients, and volunteers. Any verbal, physical or discriminatory abuse must be reported, and it will be investigated.

We remain committed to providing a safe and inclusive environment for everyone and we will continue to work together fostering an environment of understanding and mutual respect for all.

2.3.2 The NMC commissioned Nazir Afzal OBE to carry out an independent review of the NMC's culture, after concerns were raised about the organisation's culture, including racism and fear of speaking up. The report was published in July 2024.

The NMC is the world's largest regulator for nurses, midwives and nursing associates, with over 808,000 professionals registered. The review was commissioned following a series of disclosures by a whistle-blower in 2023, claiming there was a "deep seated toxic culture" which was leading to skewed and failed investigation.

Attached as **Appendix A** to this report is a briefing paper prepared by Nikki Brockie, our Chief Nurse, on the findings of the review in more detail and the actions underway at the ROH as a result of this.

2.4 Our Collaboration

I am delighted to confirm that our finance team has achieved Level 2 accreditation in the Future Focused Finance Framework. The accreditation is designed to give recognition to NHS organisations that have the very best finance skills development culture and practices in place.

I want to add my congratulations alongside Steve Washbourne, Chief Financial Officer, to say that we are incredibly proud of the team in achieving Level 2

Accreditation – not only does it demonstrate the level of excellence and focus on improvement that we now have within the finance department, but it is also reflective of the relationships, partnerships, and collaborations we have across the Trust."

2.5 Our Community

Over the coming months we look forward to welcoming to our Trust our newly elected MPs: Alistair Cairns, Parliamentary Under Secretary (Minister of Defence) (Minster for Veterans) for Birmingham Selly Oak and Laurence Turner MP for Birmingham Northfield.

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 9 September 2024.

4. THANK YOU

4.1 On 12 August 2024, I shared with the Trust that I had been asked by NHS England to support The Shrewsbury and Telford Hospitals (SaTH) NHS Trust in an interim capacity, as their Chief Executive Officer. This is a short-term appointment which means I will be leaving the Royal Orthopaedic Hospital on 6 September and returning early 2025.

I accepted this request after some serious thought. The Royal Orthopaedic Hospital is in a strong position. Our stability and success are the reason NHS England is confident in asking me to support SaTH. It is also the main reason I have accepted – because I know that ROH is in an excellent position and will continue to make progress.

I understand that changes in leadership can bring about uncertainty, but I want to reassure you that our hospital remains in very capable hands. While we have not yet finalised the arrangements to cover the Chief Executive role in my absence, I am confident that our Executive Team will continue to lead and support you, ensuring that we remain productive and stable. We are lucky as they are an amazing team.

It is important to me that you know this decision was not made lightly. I have complete confidence in the continued success of the ROH. We have always been a resilient, innovative, and compassionate team, and I know that you will continue to deliver the exceptional care and support that our patients and their families rely on.

I will remain connected and engaged with the hospital during this period, and I am confident that together, we will navigate this transition smoothly.

Thank you for your ongoing dedication and hard work and for everything you do. I have been heartened by your messages of good luck. I will miss you all whilst I am away, but I look forward to seeing how much progress you have continued to make when I return early 2025. Thank you to our Chair, the Non-Executives and our Lead Governor who have been incredibly supportive and enabled me to accept this position. The ROH is an incredible organisation, and I am extremely proud of everything you do each day for our patients.

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

28 August 2024

FOR INFORMATION

APPENDIX A

The Royal Orthopaedic Hospital NHS Foundation Trust

NMC Culture Report - Briefing paper

Report to Trust Board on 4 September 2024

1 EXECUTIVE SUMMARY

1.1 The NMC commissioned Nazir Afzal OBE to carry out an independent review of the NMC's culture, after concerns were raised about the organisation's culture, including racism and fear of speaking up. The report was published in July 2024.

1.2 The NMC is the world's largest regulator for nurses, midwives and nursing associates, with over 808,000 professionals registered. The review was commissioned following a series of disclosures by a whistle-blower in 2023, claiming there was a "deep seated toxic culture" which was leading to skewed and failed investigation.

2 Background / Review

2.1 Over the last decade, a series of reports and investigations have highlighted a growing concern with the fabric of the NMC. In 2012, a strategic review of the NMC for the Council for Healthcare Regulatory Excellence, found weakness in the governance, leadership, decision making and operational management. A year later the Francis Report (2023) also highlighted concerns relating to the NMC during the Mid Staffordshire NHS Foundation Trust review.

2.2 Then between 2016 – 2019 a range of audits, reviews and reports further raised concerns. This included the handling of documentation with a timely and appropriate level of care and compassion, and one which normalised a tolerance of race inequalities.

2.3 The Nazir Afzal independent review focused on engaging with staff, reaching 85% of the workforce, with many sharing that they felt frustrated that previous reviews had failed to drive change and that their voices have been overlooked.

3.0 Overview of key finding

3.1 The review highlighted the current issues at the NMC are as follows:

Organisational and operational dysfunction

- Huge backlog of fitness to practice caseload (6,000 cases)
- All cases taking too long for decisions to be taken and delays having serious impact on those that have been referred.

- In the worst cases, nurse have taken their own lives during investigation for Fitness to Practice. In the last year, there have been six suicides of nurses undergoing the fitness to practice process and some have been waiting for four to five years.

- Some nurses have been waiting for 10 years in the fitness to practice process.

- The screening is incredibly slow with insufficient tuning to differentiate between serious and minor issues.

3.2 Key findings in the report:

- Staff feel trapped within the toxic culture, who feel frustrated and upset in their role.
- Claims of racism, people being afraid to speak up and nurses accused of serious sexual, physical and racial abuse, being allowed to keep working on wards were all reported by the staff. (The report outlined: '*Evidence suggests that the previous reports that showed a long-standing culture of toxicity have been validated from the findings throughout the review, more concerningly whilst they have previously been well-contained, there is a concern there are much more widespread.')*
- The impact on staff at the NMC was outlined*: increased sickness associated with stress, anxiety and depression, staff deeply unhappy in their jobs, with over 30% signalling that they felt emotionally drained from their work.*
- Evidence of a blame culture, impeding confidence to speak up and clearly demonstrating there is an openly toxic culture, that previously was more hidden.
- The report highlighted some evidence of risk to public safety due to the strains and pressures to NMC staff, impacting on the registrants.
- A complex governance process that led to mistrust, with little faith in decision making and the duty of candour responsibility for healthcare professionals to be honest when things go wrong.

3.3 The NMC has responding by accepting the findings in the report and the recommendations with a view that this is a turning point.

4 Actions taken:

4.1 In March this year, the NMC agreed to invest £30m into an 18-month plan to improve fitness-to-practice. Prior to this in February 24, they strengthened the guidance to make decisions on concerns about sexual misconduct and other forms of abuse outside professional practice.

4.2 Further recommendations have also been taken:

- Appointing an equality, diversity and inclusion (EDI) advisor to the Executive Board to support decision making.
- Work to increase the diversity of the Executive Board.
- The Freedom to Speak Up Guardian is now available to colleagues to raise concerns and get independent support.

- Listening circles, facilitated by trained professionals for all colleagues to openly discuss issues raised in the report.
- Invested in a partner to improve psychological safety in teams, starting in Professional Regulation directorate which includes fitness to practise, and registration and revalidation.
- Decompression support to colleagues working on sensitive casework, professional counselling from a trained psychologist.
- Doubling the amount spent on learning and development. An external EDI partner is undertaking a review of the EDI learning and making further recommendations to improve mandatory training.
- Actively working on a new behavioural framework to support recruitment, development, career progression and performance management, for launch in September.

5 What actions are being taken at the ROH in light of this report?

- A letter has gone out to all Trust nursing registrants, acknowledging the review and the actions that have been agreed by the NMC.
- Two open forums are planned in the coming months to allow nurses to share their concerns with the Chief Nurse and Deputy Chief Nurse.
- The review is agenda to be discussed at the Nursing Council and at a Band 7 meeting chaired by the Chief Nurse.
- ROH is developing, with the support of HR, a list of all referrals going back three years to track any concerns. At this point there are no concerns highlighted in our referral practice.
- The Chief Nurse has joined the regional NMC Task and finish group to support the improvement work.

Nicola Brockie
Chief Nurse
August 24

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Fit and Proper Persons Test update**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
PRESENTED BY:	**Tim Pile, Trust Chair**
DATE OF MEETING:	**4 September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**X**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

Board members will recall that new and revised Fit and Proper Persons Test regulations were introduced in 2023, following the review by Tom Kark KC.

These new regulations required a more detailed review of the fitness of new individuals to serve on the Board of an NHS organisation, including a more robust reference process and additional external checks including social media and a check against the register of disqualified charity trustees. There was also a requirement to complete a Board member reference template for those leaving the organisation and to hold this on file pending a request from any other NHS organisation to which the individual may be appointed. Finally, there was a requirement introduced to ensure that all Board members completed a self-attestation document to self-declare that they are fit to serve as a Board member.

This is to provide assurance to the Trust Board, that the ROH has complied with the requirements of the new Fit and Proper Persons regulations since it was introduced. Key pieces of work to support this include:

- Completion of a Board member reference template for Richard Phillips, who left the ROH as a Non Executive on 31 January 2024
- Completion of a Board member reference template for Jenny Belza, Jan Teo and Simon Page who joined the Board earlier in 2024
- Enhanced series of pre-employment checks undertaken for the above including social media and disqualified trustee register, in addition to the standard checks against the disqualified directors register and the register of bankruptsy
- All Board members have completed their annual self-attestation
- Sign off of the self-attestation statements by the Chair (and for the Chair by the Vice Chair)
- Submission of the summary of FPPT compliance to NHS England by 30 June as required (as attached)

Although all Board members have undergone a DBS check, a small number of the Board are due to renew their DBS checks, a process which will be undertaken during the autumn 2024.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Compliance with the new FPPT regulations • No issues of concern raised as part of the FPPT checks have been identified	• None

REPORT RECOMMENDATION:

The Trust Board is asked to RECEIVE and ACCEPT the report for assurance.

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

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

Comments:

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

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

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

Good governance and adhere to requirements in the FPPT regulations.

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

None specifically.

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

None

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

Council of Governors 31 July 2024.

NHS England

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
The Royal Orthopaedic Hospital NHSFT	Tim Pile	September 2023 – June 2024

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	1 + 7	X		None	1	One
Executive board members (*including Acting COO and Deputy Director of Strategy)	9*	X		None		
Partner members (ICBs)	N/A					
Total						

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC		None		
Other, e.g., internal audit, review board, etc.		None		

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR THE ROYAL ORTHOAPEDIC HOSPITAL NHSFT 2024				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director and Vice Chair	Simone Jordan	25/6/2024	Yes
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
	Yes			
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:		
	No			
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:				
Date signed:	26.06.24.			
For the regional director to complete:				
Name:				
Signature:				
Date:				

For the regional director to complete:	
Name:	Dale Bywater
Signature:	
Date:	18th July 2024

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TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2024 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer, AEO SIRO**
AUTHOR:	**Stuart Lovack, Deputy Director of Delivery**
DATE OF MEETING:	**4th September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**X**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

The NHS needs to plan for and respond to a wide range of emergencies that could affect health and patient safety. As part of the Civil Contingencies Act (2004) the Royal Orthopaedic Hospital NHS Foundation Trust has reviewed its Emergency Preparedness, Resilience and Response (EPRR) using the 2024 NHS Core Standards profile.

The Trust has self-assessment against the Core Standards and identified areas of partial compliance however a period of 'Check & Challenge' with the ICB/Regional Team is to be undertaken within the next two months.

The 11 areas of partial compliance against the 2024 EPRR core standards are:

- Duty to maintain plans - New and Emerging Pandemics
- Duty to maintain plans – Counter Measures
- Training & Exercising – Responder Training
- Warning & Informing – Incident Communication Plan
- Warning & Informing – Media Strategy
- Business Continuity – Business Continuity Management Systems (BCMS) scope & objectives
- Business Continuity – BCMS Monitoring & Evaluation
- Business Continuity – BCMS Continuous Improvement Process
- Business Continuity – Assurance of Commissioned Providers / suppliers BCP's
- Hazmat/CBRN – Hazmat/CBRN Risk Assessments
- Hazmat/CBRN – Hazmat/CBRN Planning Arrangements

In relation to the 'Deep Dive Cyber Security' the areas of partial compliance are:

- Cyber Security – DD4 Media Strategy
- Cyber Security – DD6 Continuous Improvement
- Cyber Security – DD7 Training Needs Analysis
- Cyber Security – DD9 Business Impact Assessments
- Cyber Security – DD10 Business Continuity Management System
- Cyber Security – DD11 Business Continuity Arrangements

Through the EPRR Core Standards process the Local Health Resilience Partnership (LHRP) which includes Birmingham & Solihull ICB and Black Country ICB will review all Trust's within the region and report at a future date on the overall rating.

Due to the specialist Orthopaedic nature of the Trust, there will be areas listed above where the Trust will be challenged in achieving full compliance, these will be discussed with the ICB/Regional Team throughout 2024. The areas of partial compliance listed above form part of the Trust's 'action plan', addressing these issues will move the Trust towards better compliance with the EPRR Core Standards.
The overall timescale identified for completion of these areas (where achievable) is six months; a project lead has been identified.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Self-Assessment (Partial Compliance) shows an improved position from position last year (Not Compliant).	• Still 11 areas which we have self-assessed as partial compliance, most of which remain difficult to achieve full compliance given the nature of the Trust

REPORT RECOMMENDATION:

The BOARD is asked to: note the content of this report which has been assessed against the 2024 NHS Core Standards, noting the actions being taken to address the areas where EPRR compliance needs to be strengthened.

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

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

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

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

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

Safe, efficient processes that are patient centred.

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

None specifically.

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

None specifically.

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

Annual consideration by the Trust Board

Completion guidance

- Action plan status
  - On track: expect to complete all actions by the submission of the EPRR assurance 2024
  - Slippage: expect to complete majority of actions by the assurance submission deadline, some approvals will go beyond 30th August
  - Major slippage: Approximately 50% of actions have been delayed and will remain incomplete by 30th August
  - Delayed: No progress has been made on actions from the EPRR assurance 2023

- Plans consulted upon – number seen by ICB, NHSE will also confirm.

- Applicable standards
  - Specialist – 59

The Royal Orthopaedic Hospital NHS FT

NHS England Midlands

Specialist Trust (59) Core Standard Grouping	Action plan status	Number of standards to be progress as of 2023	Number Standards addressed	Number of standards to be progress in 2024/25	2023 position	Likely 2024 position
Governance (6)	On track	2 (3,6)	2	0	Partial	Compliant
Risk (2)	On track	0	0	0	Compliant	Compliant
Duty to Maintain (11)	On track	6 (9,12,13,14,15,19)	4	2 (13,14)	Non	Partial
Command & Control (2)	On track	1 (21)	1	0	Partial	Compliant
Training & Exercising (4)	On track	2 (23,24)	1	1 (24)	Partial	Partial
Response (6)	On track	3 (28,30,31)	3	0	Non	Compliant
Warning & Informing (4)	On track	3 (33,34,36)	1	2 (34,36)	Non	Partial
Co-operation (4)	On track	1 (43)	1	0	Non	Compliant
Business Continuity (10)	Slippage	7 (45,48,49,50,51,52,53)	3	4 (45,50,52,53)	Non	Partial
CBRN (10)	Slippage	7 (56,58,60,61,63,64)	5	2 (56,58)	Non	Partial
Overall Position					Non	Partial

Overall self assesment rating:									
Ref	**Domain**	**Standard name**	**Standard Detail**	**Supporting Information - including examples of evidence**	**Organisational Evidence**	**Self assessment RAG** **Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.** **Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.** **Green (fully compliant) = Fully compliant with core standard.**	**Action to be taken**	**Lead**	**Timescale**
Domain 1 - Governance Domain 2 - Duty to risk assess Domain 3 - Duty to maintain Plans									
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	COVID-19 is now 'business as usual' and incorporated into the relevant polices such as the Isolation Policy. The IPC Team regularly meet with system and regional partners to monitor regional and national rates of HCAI and new and emerging pathogens. IPC Plans in place. The Trust's role in a Pandemic outbreak is under review with ICB and National Team.	Partially compliant	BS to embed Pandemics in to IRP. BS to work with IPC to develop a new plan for new and emerging pandemics.	Stuart Lovack/Bernie Sheridan	Six months
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	The Trust during the COVID-19 outbreak have worked with our neighbouring hospital to provide step down orthoapedic care for trauma pateints. The ROH have partnered with our neighbouring Trust and provided access to our theatres and supported the transfer of clinical staff between sites. We are not a receiving hospital; the Trust are aware of NHS England's Guidance for the requesting and receipt of countermeasures. We continue to review national and regional guidance to support countermeasure deployment.	Partially compliant	Awaiting ICB and national guidance. BS to review Trust role in counyermeasure s in different types of incidents.	Stuart Lovack/Bernie Sheridan	Six months
Domain 4 - Command and control Domain 5 - Training and exercising									
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Business continuity training delivered to staff. Strategic command training delivered to staff. Principles of Health Command Training completed by Senior staff. JESIP training completed by EPO Lead on 18th June 2024.	Partially compliant	Review training needs analysis and embed this into the response plan. Develop training standards for key staff.	Stuart Lovack/Bernie Sheridan	Six months
Domain 6 - Response Domain 7 - Warning and informing									
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Trust has an active Media Policy. The Incident Response Plan incorporates an action card for the 'Communications Manager'. EPO to work with Trust's Communication Department to develop a crisis management communication plan. Crisis communication plan in development.	Partially compliant	Develop a Crisis Communicaiton Plan.	Stuart Lovack/Bernie Sheridan	Six months
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust's 'Media Policy' also covers its communication strategy and intervention/links with the general public/media. EPO working with Trust's Communication Department to review their plans.	Partially compliant	Update Media Policy.	Stuart Lovack/Bernie Sheridan	Six months
Domain 8 - Cooperation Domain 9 - Business Continuity									
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objec	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Business Continuity Recovery Plan incorporates scope, objectives and details a risk management approach. The information is disseminated throughout the organisation. Review the Trust's Business Continuity Management Systems.	Partially compliant	Develop a Business Continuity SOP.	Stuart Lovack/Bernie Sheridan	Six months

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The Emergency Preparedness, Resilience and Response Group monitors our Business Continuity Management Systems. The TOR's for the group include Business Continuity plans as a key objective. The group reports upwardly to the Health & Safety Group which reports through to the Quality Safety Committee and through to the Trust Board. Key Performance Indicators to be developed.	Partially compliant	Maintain EPRR reports and develop KPI's.	Stuart Lovack/Bernie Sheridan	Six months
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Business Continuity systems are reveiwed Bi-annually, lessons learnt are incorporated into further planning to foster a system of continuous improvement. All department have been re-assessed in 2023. The BCMS continuous improvement process is under development. After action review forms in circulation.	Partially compliant	Develop a BCMS and review bi-annually.	Stuart Lovack/Bernie Sheridan	Six months
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Trust gains assurance through the Procurement Hub who have processes in place to ensure key suppliers to have Business Continuity systems in place. It is written within procurement specifications/documentation that Business Continuity Planning is essential to ensure continuity of services. National and regional framework agreements are in place. Check and challenge processes are in place for critical suppliers. Procruement assurance process for commissioned providers/suppliers in relation to BC plans to be reviewed..	Partially compliant	Review the assurance process for commissioned providers and suppliers in relatino to Business Continuity Plans.	Stuart Lovack/Bernie Sheridan	Six months
Domain 10 - CBRN									
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	The Trust is not a receiving hospital however, it has a CBRN Plan in place and the 'Planning for the management fo self presenting patients in healthcare settings' NHSE guidance document is available on our Trust intranet site. JESIP Document availabe. On scene risk assessment available. Develop an IOR based on our Trust.	Partially compliant	Develop CBRN self presenters plan.	Stuart Lovack/Bernie Sheridan	Six months

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	As a Specialist Trust we do not have an Emergency Department however we have appropirate 'Personal Protective Equipment' (PPE) to ensure safe delivery of care to potentially contaminated persons. We have CBRN Plan and the Public Health England documentation 'Chemical, biological, radiological and nuclear incidents: clinical management and health protection' available in our emergency planning documentation. The CBRN Plan is based on the guidance from the 'Planning for the management of self-presenting patients in healthcare settings'. FFP3 Fit Testing Programme in place. Training package under review.	Partially compliant	Establish who can deliver regional CRBN training and cascade to Trust staff.	Stuart Lovack/Bernie Sheridan	Six months
Deep Dive - Cyber Security and IT relatec	0	0	0	0					
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	Media Policy to be updated.	Partially compliant	Media Policy to be updated.	Ray Mian	Six months
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	IT Department use 'After Action Review Forms'. Tracker schedule to be developed.	Partially compliant	Tracker scheduled to be developed.	Ray Mian	Six months
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	TNA's to be developed.	Partially compliant	TNA's to be developed.	Ray Mian	Six months
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	Cyber security BIA's to be reviewed and embedded into EPRR.	Partially compliant	Cyber secuirty plans to be reviewed and embedded into EPRR.	Ray Mian	Six months
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	Business continuity SOP to be developed.	Partially compliant	Business continuity SOP to be developed.	Ray Mian	Six months
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Cyber secuirty Business continuity plan in development.	Partially compliant	Cyber secuirty plans to be reviewed and embedded into EPRR.	Ray Mian	Six months

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TRUST BOARD

DOCUMENT TITLE:	**Health Inequalities update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, COE**
AUTHOR:	**Nicola Brockie, Chief Nurse and Rebecca Llyod, Deputy Director of Strategy**
DATE OF MEETING:	**4 September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE		**FOR INFORMATION ONLY**	x	**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

In May 24, the health inequalities action plan outlining five key workstreams was presented to Trust Board. The plan outlined actions panned for 2024/25, while a more detailed three / four-year plan is developed in line with national and regional strategies.

Actions have been undertaken against the five key workstream described below:

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

The action plan outlines that three out of the five actions are on target; however, 2 actions (Data and insight and improvement interventions) require further focus to ensure delivery against plan.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Health Inequalities lead nominated as Paul Athey. First meeting is being planned. • CNO & CPO are attending Executive level Health Inequalities training with NHS Conf over the coming year. • Health inequalities training is being uploaded to ESR and will be available mid-September 2204 • MSK Health Prevention Programme -Health Hacks is underway and going well. • Worked in collaboration with ICB to submit £500k bid to DWP for dedicated Employment Advisers for MSK patients. • Community Appointment Day held (May 2022) with over 300 patients attending (Solihull) - ROH & QE planned 22/10/2024	• Waiting list profile for Total Knee Replacement being analysed as part of Masters level research (within Digital Team) - final data analysis expected September 24 • Dataset delayed – expected September 2024. Focus on waiting list profile agreed. Linking in with proposal to implement HEART clinical tool across system.

REPORT RECOMMENDATION:

The Board is asked to: note and accept.

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	**xx**	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	**x**	**Services**	
People	**x**	**Collaboration**	

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:

Contribute to the wider determinants of health.

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

N/A

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

Health Inequalities paper in May 24

HEALTH INEQUALITIES PLAN 2023 - 2028

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

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 leaderhsip, capacity, support and resources to deliver our health inequalities agenda.

IMPROVEMENT INTERVENTIONS

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

	What are we trying to deliver?	Quarter 1 (2024-25) actions	Update	RAG rating
Data & Insight	Introduce a **clear framework** for collecting health inequalities (HL) data and create a **dashboard** to support insight and improvement	• Patient progress dashboard update to Q&SC • Business Intelligence team building v1 of Health Inequalities dataset. • Data Quality Group – to scope & agree KPI'S • System to support with benchmarked data	• Medical Director leading wider stakeholder engagement on patient progress dashboard • Dataset delayed – expected September 2024. Focus on waiting list profile agreed. Linking in with proposal to implement HEART clinical tool across system • Health Inequalities lead nominated as Paul Athey. First meeting is being planned.	Behind target
Governance & Monitoring	Ensure that our governance supports **consistent monitoring of health inequalities data** to enable improvement.	• Refine ROH Health Inequalities Plan • Reporting structure agreed - QSE then direct to Board. • BAF updated to highlight Health Inequalities	• Health Inequalities Plan due at QSC in November 24 for approval. • Reporting structure embedded. • BAF work completed and incorporated Health Inequalities • Reporting against Trust Strategy will include Critical Success Metric and improvement targets around health inequalities	On track
System Alignment	Ensure that the data we collect and actions we take, aligns with the **strategic approach of BSol ICS** in tackling health inequality	• 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	• Working in partnership with VA to promote MSK education sessions to primary care colleagues • 'I Can' approach has been embed into ROH, with entry level roles being fielded through the team. The work is expanding to included universal carers • Worked in collaboration with ICB to submit £500k bid to DWP for dedicated Employment Advisers for MSK patients • Community Appointment Day held (May 2022) with over 300 patients attending (Solihull) - ROH & QE planned 22/10/2024	On track

	What are we trying to deliver?	Quarter 1 (2024-25) actions	Update	RAG rating
Capacity & Support	Build **adequate leadership, capacity, support and resources** to deliver our health inequalities agenda.	• Finalise Health Inequalities training offer for staff (Health disparities & Health inequalities module on e-learning)	• CNO & CPO are attending Executive level Health Inequalities training with NHS Conf over the coming year. • Health inequalities training is being uploaded to ESR and will be available mid-September 2204 for staff to undertake. Communication team to roll out information on training.	On track
Improvement Interventions	Create a **high impact action plan** that prioritises **measurable improvement interventions** that reduce health inequality	• 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. • LD & Autism Strategy	• MSK Health Prevention Programme -Health Hacks is underway and going well. • Quality priority 2 (Patient Information) - focusing on easy read material. This work is progressing. Digital team are now supporting. • Waiting list profile for Total Knee Replacement being analysed as part of Masters level research (within Digital Team) - final data analysis expected September 24 • LD & Autism Strategy update due at SG committee and QSC in November 24.	Behind target

Focus for remainder of Quarter 2:

- Confirm rolling programme of MSK community education/roadshow events (ROH bus – linking with ICB teams who are currently piloting this in Cancer services)
- Finalise Health Inequalities dataset and reporting
- Promotion of Health Inequalities training (and evaluation)
- Incorporate all Board feedback into revised Health Inequalities Plan – succinct, measurable plan that articulates smaller number of priorities for ROH to focus on

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TRUST BOARD

DOCUMENT TITLE:	**Signage refresh plan and wayfinding**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne – Executive Chief Finance Officer**
AUTHOR:	**Rebecca Lloyd – Deputy Director of Strategy**
DATE OF MEETING:	**4 September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**X**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

This paper provides an update on the work of the Signage Improvement Group and plans to refresh Trust signage and wayfinding, incorporating feedback from patients, staff and volunteers.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Updated Trust site map published and will be printed on all patient letters by early September 2024 • AccessAble planned visit in September 2024 to evaluate access (including signage and wayfinding) • Alternative signage quotes sought as well as scoping of digital wayfinding solutions	• Full signage refresh costs and timeline not yet known

REPORT RECOMMENDATION:

The Board is asked to receive this report for assurance.

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

Financial	X	Environmental	X	Communications & Media	X
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	
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:

Patient experience

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

N/A

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
N/A

Signage update

Trust Board | September 2024

1. Introduction

Over the past few years, the ROH site has undergone significant redevelopment which has involved the relocation of departments such as the Pre-Operative Assessment Centre (POAC), Physiotherapy and Ward 4. Unfortunately, the signage and wayfinding systems (e.g. hospital maps and letters including locations of departments) have not been updated in line with these changes resulting in inaccurate or misleading signage across the site. The effect of this is evident when walking through the hospital, and there are many examples of staff being stopped by patients to help navigate them to their desired location, as well as new members of staff finding it difficult to navigate around the hospital whilst they familiarise themselves with the layout of the site.

2. Patient & visitor feedback

It is essential that feedback from patients, staff and visitors is reviewed and incorporated into any planned improvements to Trust signage. Feedback and suggested improvements have been provided by John, one of the ROH volunteers who provides an exceptional wayfinding service from main Outpatients. **Appendix A** includes a summary of his themed recommendations for improvements to signage based on his daily interactions with visitors to the site.

3. Project Group

A dedicated project group has been established to a) review previous patient feedback (over 200 responses) about Trust signage and b) identifying a series of short and medium-term plans to improve signage and wayfinding. The group includes representation from Nursing, Safeguarding, Operations, Estates, Patient Experience, Communications and Service Improvement.

The project group are focusing on three components:

1. Way finding
2. Trust signage
3. Gate A signage

Progress to date is summarised below:

Date/Time Period	Actions Taken	Current Status
July 2024	Signage Improvement Group established	Complete
1st August 2024	Inaugural project group meeting with representation from Nursing, Estates, Patient Experience, Private Patient Suite and Operations	Complete
August 2024	Arranged for AccessAble to visit ROH to conduct a full trust signage review - Sept 2024 (Date TBC)	In Progress
August 2024	In conversation with 4 signage companies to visit and provide packages with different options for the Trust to explore and understand the costs. One company has visited. Awaiting their package and other 3 are currently reviewing site plans	In Progress
19th August 2024	Further project group meeting held - discussed range of ideas we could explore internally whilst we await external quotes	Complete
August 2024	Spoke to Digital Wayfinding Company who produce GPS routed digital maps on apps for hospitals. Exploring potential options and have emailed across the requirements to review most appropriate options for ROH	In Progress
22nd August 2024	Requested feedback from John – Volunteer in Outpatients. He will continue to monitor and report any major patient signage concerns as necessary to patient experience team who feed into the Signage Improvement Group. Incorporate feedback into action plan.	In Progress/Ongoing
August 2024	Agreed to include new Trust map on back of all appointment letters. By 2nd September all letters will have the new map on them.	Partially Completed
27th August 2024	Communications are currently looking into 0-3 months implementations to improve wayfinding and reduce reliance on signage in the short term whilst we work towards a permanent signage solution.	In Progress

4. Way-finding

As alluded to above, work has recently completed on an updated Trust site map (see below) which is now available on the Trust website.

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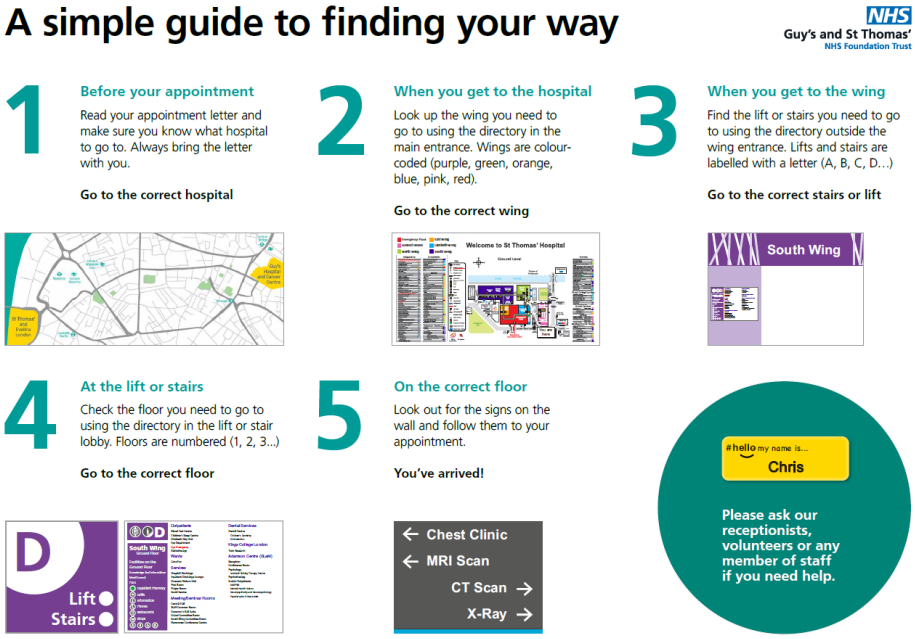
Departments	Area	Floor
Admissions and Day Case Unit (ADCU) (Accessed via the walkway under Ward 12)	12	G
Children and Young People's Outpatients (Accessed via stairs or lifts near the main entrance)	1	1
Discharge Lounge	5	G
High Dependence Unit (HDU)	11	G
Hydrotherapy (Accessed via Cafe Royale entrance)	6	G
M.R.I	3	G
Orthotics (Next to the courtyard entrance)	10	G
Outpatients	1	G,1
Pharmacy (Below Ward 2) (Accessed via Cafe Royale entrance)	7	G
Phlebotomy (Accessed via POAC Entrance)	2	G
Pre-Operative Assessment Clinic (POAC)	2	G
Topography (Accessed via POAC Entrance)	2	G
Ward 1 (Below Ward 2) (Accessed via Courtyard entrance)	7	G
Ward 2 (Accessed via Cafe Royale entrance)	7	1
Ward 3 (Above Ward 2) (Accessed via stairs or lifts near Cafe Royale)	7	2
Ward 4 (Accessed via Cafe Royale entrance)	8	1
Ward 12 (Accessed via Cafe Royale entrance)	10	1
Woodlands Suite (Accessed via Ward 4)	9	1
X-ray	4	G

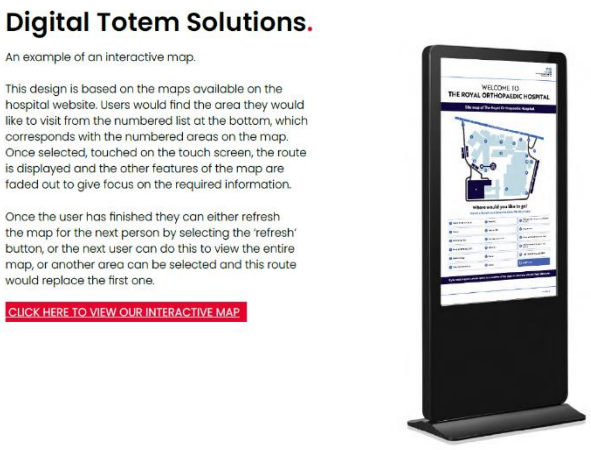
Work is underway to include the new map on the back of patient appointment letters. This has been completed for letters printed via our Patient Administration System (PAS) and will be completed for letters sent digitally via Synertec by 2nd September 2024.

In addition, the Communications team are leading on improving visual Trust map locations across the site, developing wayfinding leaflets between departments (in line with our patient pathways i.e. Outpatients to X Ray) and exploring the possibility of implementing QR code access points.

The project group are exploring best practice examples from other NHS organisations, such as the example from Guys & St Thomas' below:



Digital wayfinding solutions are also being scoped, which would provide an interactive touch screen at main Outpatients and the Cafe Royale Entrance. The example below is included for reference:



4. Trust signage

As the trust has continued to grow over the past 24 months, it would appear the current signage and wayfinding systems are therefore in need of an upgrade, to take into account these new estates redevelopments and to make it as easy as possible for visitors to navigate around the site. This is now even more significant as we continue to outgrow and increase the number of patients visiting our site, thus meaning having clear and effective signage is even more crucial.

The detail provided at Appendix A highlights specific examples of Trust signage that is outdated, and this feedback will be incorporated into any proposed plans and associated quotations from external companies.

The project group have request that AccessAble return to the ROH (following their visit in 2020) to audit the whole site and provide an external independent and transparent view on Trust signage. This visit is planned for September 2024, and the outcome will inform the options pursued.

5. Gate A signage

Currently, signage at Gate A is not fit for purpose. There is lack of clarity of which of the two ground floor entrances (by Cafe Royale or lower ground) patients should use. It leaves clear confusion amongst patients when entering the Trust site, at what can be an anxious time. Gate A is currently where most patients tend to enter from as it is the first entrance from the dual carriageway. The signage board Gate A suggests that it is only for patient drop off and pick up, although there is some patient parking in this area.

The project group are reviewing whether it is necessary to work with the Highway Authority to improve the signage and markings at the U-turn from the northbound carriageway and provide additional directional signage from the southbound carriageway, alongside making internal signage changes inside the entrance gates. Currently there is no signage to indicate which departments are nearest to entrance A in this location. The group are also looking at revising the hospital signage boards so they are easier to read from the carriageway and reinforce the location and distance to the Main Entrance C.

6. Next steps

Quotes to update Trust signage will be reviewed in September 2024 and a final plan for Trust signage will be presented to Trust Board in November 2024 once the AccessAble evaluation has been completed.

Appendix A: Summary of feedback from volunteer in Outpatients

General feedback

- Access to the Trust H.Q. can be problematic e.g. if someone arrives at Gate C for an interview in Trust HQ, they can either be directed to the main entrance to the HQ via the glass doors by café royale but there is no disabled access to Trust HQ. then you have to use a phone to enter which might not get answered. Entrance around the balcony also requires swipe card access to enter.
- It can be difficult for delivery/collection drivers needing to deliver/ collect something from theatre, especially after 4pm where the stores department is generally empty. I can be difficult for them to know what door to go to and where to park.
- There is only a small car park at Gate A, which can make it very difficult for drivers wishing to deliver or collect a patient to and from ADCU. What do you do if there is no parking space? Patients may be disabled and unable to walk far.
- People find it difficult to find Orthotics. Better and more signage is required.

Outpatients

- The self booking in machine in Outpatients has been out of order for months. They have been replaced with new machines but still have out of order sign on them.
- There are usually at least 1 or 2 wheelchairs by the Gate C building exit but not always. What do people do if they arrive with a disabled patient needing a wheelchair if there is no one at welcome desk?

Car Park Signage:

- Longstanding issue with the two parking machines at the Outpatients entrance (Gate C)
- Occasionally the parking ticket machine issues a void ticket once patients have paid. It needs to be clearer that that a void parking ticket is still accepted as patients are getting confused and paying for additional parking ticket.
- Many people do not know that parking is free for blue badge holders. Better signage is required.
- It is also not clear that you pay on arrival rather than on leaving. People coming to the Trust do not know how long to pay for and they are worried they will get a parking fine if the ticket runs out – solution is modern registration tracked site leaving parking system. Popular example is Queen Elizabeth Hospital.
- Appointment letter says you have to pay £3.80 if you have a blue badge.

Corridor Signage

- X – ray signage on the wall near outpatients above the welcome desk looks as if the X-Ray department is on 1st floor.
- MRI entrance door is always locked and there is no adequate signage to explain people must press buzzer to gain access. Both doors must be kept unlocked as it's difficult for someone on wheelchair to enter with only one door opening.
- Years ago the hospital use to have coloured strips on the floor (e.g. blue to x-ray) to help guide people around the hospital. Is there a possibility to review this?
- Hydrotherapy has a sign over the actual doorway but no sign leading to it on the corridor. It is poorly sign-posted elsewhere.
- Patients are told to go to discharge lounge to pick someone up but you can only get in using a swipe card. Any other instructions for getting in are not clear.
- Still signs around the site direction people to physio, despite the fact that it is no longer on the main trust site (one near the Café Royale)
- There are a number of issues about the woodlands suite; it is sometimes spelt 'Woodlands' and sometimes 'Woodland'.
- Patients coming for an outpatients consultation often think that they have to go the Woodlands Suite itself, but in nearly all cases they will be seen in the Outpatients department. I think that confusion arises from what it says either in their letter or in a telephone call.
- If you come from Gate C end of the hospital and you want to go either to Ward 2 or the prayer + meditation room, it is not at all easy to see the signs for them on the ground level until you are practically there.
- Are there any plans to introduce signposting in another language or languages including Braille? Other hospitals manage this to some extent.

Appointment Letter Issues

- Each week a number of people come to the hospital itself, although their letter does say that they need to go to ROH Hub in Griffins Brook Lane. The letters need to be updated. Patients are spending money on parking before they enter the hospital and find out they are on the wrong site. If they are travelling by bus or taxi, they don't know how to get to the Hub afterwards.

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TRUST BOARD

DOCUMENT TITLE:	**Top Corporate Risks**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**All Board members**
PRESENTED BY:	**Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**4 September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE		**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**	**X**	**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

The Board will recall that at the June meeting, the outcome of the Executive 'check and challenge' exercise of the Corporate Risk Register was presented. The exercise had required the Executives to challenge each other around the scoring, relativities and mitigations in place to control the risks. It was resulted in agreement on the ten risks that were the most critical to the organisation from the perspective of the Executives.

As a reminder, the following risks had been offered as the most significant to the Trust, these being 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 qualitied 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)

The detail of the Corporate Risks discussed at the June meeting is reattached for reference as **Appendix A.**

At the June Board meeting, it was agreed that a similar exercise be organised to allow the Non Executives to offer their perspective, with a view to considering both sets of risks at the September Board meeting, so that the Board as a whole, could alight on what it saw as the overall top risks for the organisation. The outcome of the Non Executive exercise is attached as **Appendix B.**

This exercise at Board today links to the work to refresh the Board Assurance Framework and decide whether any of the top risks agreed by the Board should feature on the BAF or replace those risks currently featured. The latest version of the BAF is provided as **Appendix C** for reference.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Positive discussions and challenge by the Executive Team and Board to date. • 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.	• 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:

- DISCUSS the sets of risks offered by both the Executive and Non Executive cadres of the Board and agree their top set of most significance.
- AGREE whether any of the risks replace or add to the risks currently featured on the Board Assurance Framework.

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

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 ***(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:

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

None

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

Executive Team in May 2024 and Trust Board in June 2024.

Corporate Risk Register - May 2024

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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 dleivering a longer term sustainable position for the the Trust. Specific schemes are being identified as part of the wider organsistaional sustainability plan as discussed in CE! 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 prepartion for the production of a case-for change document. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity, efficiency an sustainablity, 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 finanical 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	Oversight Committee	Risk Owner	Risk Summary	Likelihood	Severity	Risk Rating (L&S)	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 Englsh language pass mark slightly does open up potential additional nursing staff supply from the Philippines. New governace 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 oversees 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 unsufficient 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 influences 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	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
1181	20.09.2017 (escalated to CRR 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 be 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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**PSIRF Update – August 2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Executive Chief Nurse & Simon Grainger—Lloyd, Executive Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**4th September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**x**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

Summary and updates on implementation of PSIRF

The Trust went fully live with PSIRF in November 2023. The PSIRF Response plan and the new PSIRF investigation methodologies are becoming well embedded into our governance practices.

The principles of PSIRF, as well as knowledge and awareness of wider quality improvement work, are being factored into our decision-making processes to good effect.

As evidence of the new PSIRF investigation methodologies becoming well embedded into our governance practice and the Quality & Safety Committee has received examples of completed investigation reports to demonstrate the quality of the analysis and identification of learning.

There remains further work to be done to evolve and ever continue to improve our application of PSIRF. Key highlights of the remaining work are included below:-

<u>Duty of Candour (DoC)</u>

A review of our DoC process, policy and templates is underway, with the aim of ensuring we conduct DoC in a more compassionate and patient centred way, as per one of the key principles of PSIRF. It is important we review our DoC process to ensure that the patient (and/or their family) are better afforded the opportunity to engage in the patient safety incident management process in a way that offers them the best chance to contribute, have a voice and seek the assurances they need.

Update – advice/input from BSOL ICB and other providers within the system is to be sought on DoC. The wording of the DoC regulations is strongly aligned to the definitions of harm, with the trigger for the statutory DoC process being moderate or severe harm incidents. The trigger for DoC being based on moderate harm does not easily correlate or align with PSIRF and its focus on learning rather than level of harm. This poses questions as to which patient safety incidents we should be following DoC for.

Discussion around DoC and the problems outlined above have begun at monthly BSOL ICB PSIRF meetings.

VTE & Tissue Viability Investigation Templates

The previous templates used as 'mini-RCA' templates in relation to VTE and Tissue Viability/Pressure Sore related incidents have been reviewed by the PSIRF Project Leads. It is proposed to amend the templates for use as 'triage' style review templates, as opposed to a full investigation being required for every incident, that when completed will give a quick and clear indication as to whether further investigation is required to identify learning and opportunities for improvement. This work is aimed at increasing the efficiency and proportionality of our responses to these types of patient safety incident. Speciality teams will be consulted on the proposed new templates and the intention is to trial use of new templates to gauge effectiveness.

Update - Trials are currently underway on live incidents, and we await feedback and revised templates from specialty leads.

Patient Safety Incident Investigation Training

Update - Several providers of training on new PSIRF investigation methodologies have been approached for quotes and details of availability.

As an alternative, enquires have also been made with Heath Innovation West Midlands (HIWM) to ascertain whether they would be willing and able to facilitate incident investigation training. HIWM have been providing support and expertise to BSOL ICB since the beginning of the planning and implementation of PSIRF, so they would have helpful insight and continuity from supporting the Trust and therefore be well placed to help support our training needs.

We would also like to utilise the training and approach it from a train the trainer basis. A key cohort of staff would attend and would then be able to share knowledge and learning via in-house training and support moving forwards.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Good evidence of embedding of PSIRF principles in governance processes and the management and investigation of patient safety incidents.	Duty of Candour, as detailed above. Training on patient safety incident investigations.

REPORT RECOMMENDATION:

The Board is asked to: receive this update as assurance of the ongoing work to embed PSIRF within the Trust.

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

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

ALIGNMENT TO TRUST STRATEGY *(Indicate with 'x' all those that apply):*			
Care	x	**Community**	
Expertise		**Services**	
People		**Collaboration**	

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Aligned to clinical risks on BAF, CRR and Divisional level
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
Aligned to BSOL ICB Quality objectives, CRM review meetings and PSIRF working group.
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Q&S Committee July 2024 & Trust Board June 2024

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The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 30 July 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that according to benchmarking data, productivity was below expectations. An agreed set of metrics is being devised to help focus and drive productivity upwards. • It was noted in-session theatre utilisation is below target. Some of this is due to patients cancelling appointments. Work is taking place with Division 2 to ensure patients are fully optimised and prepared to prevent last minute cancellations. • The Histopathology services remains fragile; this is recorded on the risk register and reflects the national shortage of Pathologists. The Trust is working with UHB closely to ensure the service is available when needed.	• A breakdown of productivity, to also include the waterfall depiction of data over the past five to seven years, showing activity, infrastructure, and cost to be provided for the next meeting in September. • The Ambulatory Care business case to come to Finance and Performance Committee in September and then to Trust Board in October.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee held a focussed session on productivity and reviewed how this will be measured and reported going forward. • Agency spend continues to show improvements. • The vacancy position has stabilised, and the Nursing vacancies are at its lowest level for a number of years. • There has been a significant reduction in non-pay, particular in Theatre spends. • Unidentified cost improvement programmes (CIP) have reduced to £582k. • During July there have been 1362 cases in Theatres; this is the highest since COVID, and 50 more than planned for July. • Work is taking place to reconfigure wards to enable the Trust to have a day case ward. • The Committee was assured that the length of stay is a focus, with a direct focus on Spinal currently as there is opportunity here to reduce length of stay.	• The Committee accepted the metric tool presented at the meeting. • The Committee will meet in September to discuss the high-level productivity measures that the Executive Team has prepared and discuss what is required to produce the Balanced Scorecard, which will be presented at the October Trust Board. • The Committee supported the development of the Ambulatory Care Unit business case.

• Private Patient Oversight Group has held its first meeting. Mr Mehta, as Clinical Service Lead, is making a positive impact. • The Primary Care Interface Group is being scoped and will meet in September. This group will look at how we work with GP practices, etc. to help promote the work the ROH undertakes. • The Committee was presented with an update on the plans for the Ambulatory Care Unit. • The Board Assurance Framework (BAF) and Corporate Risk Register will be reviewed considering the recent cyber security outage issue across the world.	

Chair's comments on the effectiveness of the meeting: The agenda for the meeting focused on the metrics it was felt should be provided to demonstrate how efficient the Trust is with productivity. This gave the Committee the opportunity to discuss and challenge what information needs to be provided around productivity, efficiency, and how that revised reporting should look. It was agreed that at the Finance and Performance Committee in September the agenda will focus on high level productivity. It was felt by the Committee that this style of meeting provided a good opportunity to have an open discussion.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 19 JULY 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that that there is further work with GenMed planned to address the issues highlighted with the yearly stocktake to understand any issues prior to the end of each financial year. • The Committee was interested to understand how we might embrace the use of Artificial Intelligence. Further work is required and Shakeel Sabir, Chief Digital Information Officer, will take the lead on this work. • There are a number of recommendations following the DSPT audit that require attention. The gaps identified will be added to the risk register.	• The Charity audit will be taking place over the coming months. • An update on the DSPT actions and progress being made will be included on future agendas of the Audit Committee as a standing item. • There will be a Board session at the September Trust Board to review the BAF and Corporate Risks. • The breaches and waivers report is to be reviewed and more detail to be provided to the Audit Committee to give more visibility of issues.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Jenny Belza, Non-Executive Director, was welcomed officially as part of the Audit Committee. Jenny has a clinical background and is a welcome addition to the Committee. • The annual accounts and report documentation was submitted in time to meet the deadline. • The Committee received a comprehensive update on three areas from internal audit: Cyber and DSPT, BAF & risk management and data quality. • Shakeel Sabir, Chief Digital Information Officer, and Calvin Worthington, Deputy Head of Cyber Security joined the meeting to provide assurance around the work being undertaken to address the recommendations raised in the DSPT audit. • The Committee was provided with an update on the BAF & risk management audit which provided significant assurance. • The Committee was assured that the Trust has a robust data validation process in place. • It was confirmed that all Clerical and Admin staff, who require it, have had training on the Referral to Treatment Time processes.	• It was agreed that the Value for Money assessment should be shared with the wider Trust Board members.

• The Committee was provided with assurance by Rachel Matthews, Clinical Support Services Manager, that the recommendations identified in the RTT audit were being worked on and strengthened. • The Committee received a positive update from the Local Counter Fraud Specialist, and discussions took place on the counter fraud work plan.	

Chair's comments on the effectiveness of the meeting: There was noted to be good attendance and healthy level of challenge around some of the areas of underperformance and the improvement required.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 24 July 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the CAS alert relating to bed rails remains outstanding, but the Committee was assured that all the actions relevant to ROH are in place. A further update will be provided in September. • It was noted that the response times to PALs & complaints had deteriorated and there had been an increase in the amount being received. A review is taking place to understand what improvements can be made and to identify key themes. • It was noted that we are an outlier on Surgical Site Infection (SSI) data. The Committee was provided with an update on how the Trust is working with peer organisations to understand what our issues are and what improvements are needed.	• Reopened complaints detail to be shared to allow for understanding as to why they have reopened. • A further update to be provided to the Committee on conclusion of the coroner's investigation. • An update is to be provided on readmissions linked to surgical site infections to the next Quality & Safety meeting. • An annual report on radiation safety to be produced and included on the Committee workplan. • The Governance Team to share with the Committee the reports being produced on low and no harm incidents for Ward Managers.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Trust has recruited into the Band 7 Practitioner role who will oversee our blood transfusions which will reduce the risk currently documented. • Following feedback, the Quality Report now includes visualisation of the various incident investigations. • The Patient Safety team has established a working group looking at how learning from excellence can be replicated across the Trust. • A review is currently taking place with spinal colleagues to understand the issues with RTT, complaints and PALS concerns. • The Committee received an update on the learning that has taken place at the Trust following the recent inpatient deaths. • An update was provided on the Human Tissue Authority inspection, and it was confirmed the Trust is currently working through the action plan. The outcome of the inspection was overriding positive. • An update was provided on safer staffing; we have significantly reduced our vacancies across nursing, and reduced agency spend.	• The Committee agreed that the risk on mutual aid should be reviewed. • The Chief Pharmacist will be invited to a future Quality & Safety Committee meeting to provide an overview of medicine safety in the Trust.

• The Committee received an update to give assurance on the Infection Prevention Control BAF as part of the annual process. • The Committee received a positive update on the use of Patient Safety Incident Reporting Framework (PSIRF) in the Trust. • An update was provided on the recent cancer peer review visit. • The Committee received an update on Radiation Safety in the Trust from the Head of Imaging. • An update was provided on the CQC action plan, and it was confirmed a relationship meeting would be taking place in the autumn.	

Chair's comments on the effectiveness of the meeting: It was noted that there was a good level of healthy challenge and debate at the meeting.

REPORT REF: ROHTB (9-24) 024 (a)

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention and Control Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie – Chief Nurse & DIPC**
AUTHOR:	**Victoria Clewer – Lead IPCN**
PRESENTED BY:	**Emma Steel – Deputy Chief Nurse**
DATE OF MEETING:	**4th September 2024**

PURPOSE OF THE REPORT:

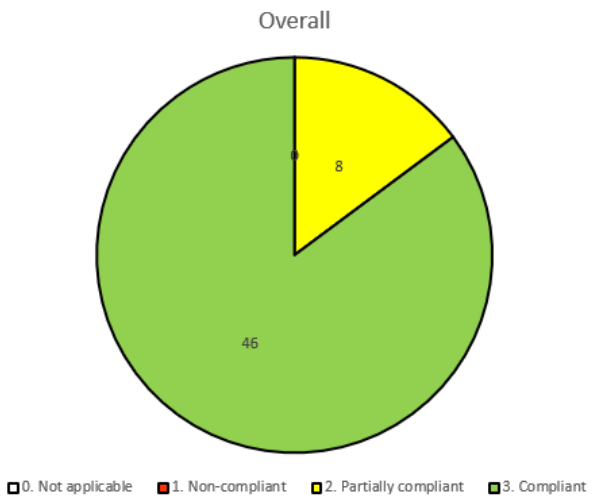
TO PROVIDE ASSURANCE	✓	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**	✓	**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

The National Infection Prevention and Control board assurance framework (IPC BAF) is issued by NHS England. The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures. The ROH IPC Lead Nurse and DIPC meet regularly to review the framework, action plan and outcomes.

A full review of outstanding actions was undertaken prior to this meeting to ensure the actions are well defined to prevent slippage and re-focus work to address compliance.

As of June 2024:



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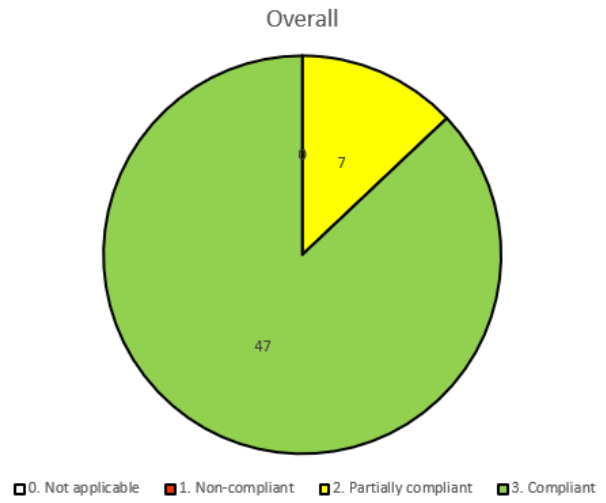

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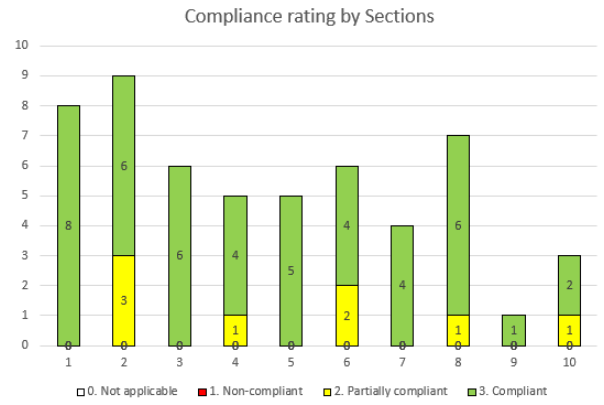

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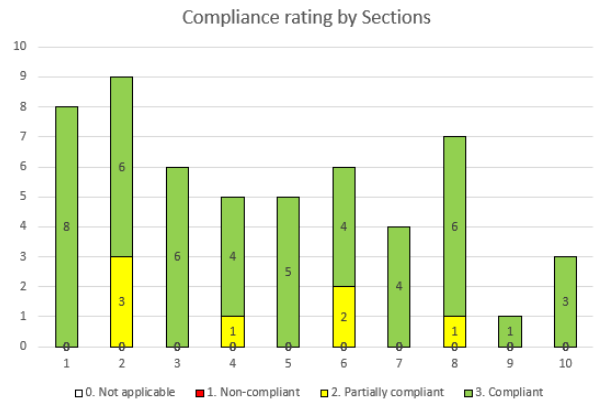


ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
Full assurance of processes in place to show compliance with 6 out of the 10 criterion. This has improved since the last report. Plans in place to address current areas of partial compliance. There are no areas of none-compliance. There is now a better understanding of the Occupational health Service offering and how we can work together to ensure the safety of our staff.	No gaps requiring escalation. Action plan in place to address areas of partial compliance. This is regularly reviewed by the Lead IPCN and DIPC.

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to note and accept the report.

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

Financial		Environmental/Net Zero		Communications & Media	
Business and market share		Legal, Policy & Governance	✓	Patient Experience	✓
Clinical	✓	Equality and Diversity		Workforce	✓
Inequalities		Integrated care	✓	Continuous Improvement	✓

Comments:

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

The contents of this report align to the:

- Health and Adult Social Care Act; code of practice on the prevention and control of infections and related guidance (DH 2012).
- National Infection Prevention and Control Manual.
- Trust KPIs for; MRSA, Clostridioides difficile and Gram-negative blood stream infections.

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

This report identifies how ROH contributes to the BSOL ICB shared objective 'Protect people from harm '. The contents of this report are shared at ICB IPC committee meetings and operational groups.

PREVIOUS CONSIDERATION:

IPC BAF summary report provided to the committee during January 2024.

IPC BAF ACTION PLAN

INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK

Objective:
The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

COMPLETE | ON TRACK | SOME DELAY Expect to complete as planned | SIGNIFICANT DELAY Unlikely to complete as planned | NOT YET COMMENCED | OBJECTIVE REVISED

Objective	Actions	Lead	Progress Update	Date last reviewed	Deadline	Status	Completion Date
2.2	PLACE 2023 report and action plans to be presented.	Steve Harnett	2023 PLACE report to be shared at IPC committee in July 2024 and evidence of report shared and discussed at Execs to be submitted before action can close.	15/07/2024	~~31/03/2024~~ 30/07/2024	On Track	TBC
2.6	Review of ward/dept. storage use to ensure storage of linen complies with section 1.7 of the National IPC Manual.	Matrons and Dept. Managers	All areas have been reviewed by Matrons - storage risk for equipment remains for Ward 1, 12 and 3 and are currently unable to improve further hence the remaining risks. Narrative for why this cannot be improved to be provided. Improved storage of linen within the recovery department has taken place. Ongoing issue within the linen rooms of inpatient areas (ward 1,2,3,12,4) - update required on how this being addressed by inpatient matron. New deadline for work is required as initial deadline has passed.	15/07/2024	31/03/2024	Significant Delay	TBC
2.9	Review the training need analysis for food hygiene training and provide assurance of training completion.	Steve Harnett Himadri Ghosh	13/06/2024 - an action plan is being created to address food standards. To include update on training and competence. From HG - all staff within catering are due refresher training. From KH - The Food Hygiene policy, section 10 details the expected training. Clinical staff handling food complete L1 e-learning 2 yearly-compliance is monitored by the Corporate Nutrition Lead and upward reported at each Clinical Quality Group meeting. New deadline for work is required as initial deadline has passed.	15/07/2024	31/03/2024	Significant Delay	TBC
4.2	To produce IPC related information in formats that are accessible (easy read, other languages etc.)	Communications and Digital Team Karen Hughes	13/06/2024 - This is a quality priority for 2024/25. Update required on progress and how this can link in with IPC information provision.	15/07/2024	~~30/06/2025~~ 31/08/2024	On Track	TBC
6.3	To review IPC training data (level 1/2 mandatory, PPE and fit testing) presented to the IPC committee to ensure this encompasses all staff groups.	Nicola Brockie HoNs	Overall Trust IPC level 1 and level 2 mandatory training is now included in the IPC summary report. This will cover the specific reporting period for each meeting (previous 2 months). Divisional reports to include breakdowns of staff groups to ensure accountability and close monitoring. New deadline for work is required as initial deadline has passed.	15/07/2024	31/03/2004	Significant Delay	TBC
6.4	To review delivery of PPE training, with a view to linking this to level 2 IPC training. To ensure completion can be linked to staff ESR records and monitored from this also.	~~Department Managers~~ IPC Team	PPE training sessions are being held by IPCT, department managers and senior mangers to encourage and support staff to attend. IPCT plan to submit an application to the Training & Development Group to have this matched to level 2 IPC training. This will then allow accurate monitoring of completion and identify areas that need to be targeted for further training opportunities.	15/07/2024	~~30/06/2024~~ 30/092024	On Track	TBC
8.3	To create a trackable process for specimen/samples from ROH to UHB lab.	Steve Harnett	A process and SOP has been created by the Facilities lead to ensure samples sent from ROH are logged prior to being transported to UHB so any discrepancies can be traced. SOP to be approved and implemented. Project led by IT to implementation a specimen tracking system for theatre samples as well as specimens/samples sent from clinical areas.	15/07/2024	30/06/2024	Significant Delay	TBC

Infection Prevention and Control Board Assurance Framework v0.1 - last updated July 2024

Ref.	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	IPCC Committee in place - meets bi-monthly. DIPC reports upwardly on IPC matters to the Quality & Safety Committee which is upwardly reported to Trust Board. QSC Terms of reference & meeting minutes. IPCC terms of reference & meeting minutes IPC Annual Report.	None	N/A	N/A	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Newly identified alert organisms reported via Ulysses. Added to IPC surveillance spreadsheets and monitored for prevalence. Infections investigated as required. Incidence monitored at divisional governance meetings. HCAI figures reported via divisional condition reports and included in the IPC summary report shared at the IPC committee. These are also reported at the QSC.	None	N/A	N/A	3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	IPC PSIRF plan created and implemented. All HOHA & COHA infections are incident reported to allow trends and increased incidence to be monitored. Staff are encouraged to report non-compliance with IPC procedures to monitor trends and identify areas/staff groups who may require additional IPC training and support.	None	N/A	N/A	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	NIPCM gap analysis. All compliant - recommended updates to the scrubbing technique to include use of nail picks - discussed with theatres matron.	None	N/A	N/A	3. Compliant

1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Mandatory surveillance undertaken for: • MRSA BSI • MSSA BSI • Gram Negative BSI (E.coli, Klebsiella, Pseudomonas) • *C. difficile* infections This is completed by the IPCT and submitted to the UKHSA data capture system. UKHSA database 'sign-off' by the 15th of the month by the IPCT. Figures and reports of incidence/outbreaks included in the IPC summary report provided at the IPC committee, and upwardly reported to the QSC by the DIPC. Escalated to Trust board when required (outbreaks, increased prevalence) for oversight and action monitoring.	None	N/A	N/A	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Adherence to IPC principles (SICPs) and standards of practice are monitored via the IPC audit programme which is reported via IPC committee and upward reporting to the Quality and Safety Committee. All clinical areas are required to monitor their own hand hygiene compliance and relevant High Impact Interventions at least monthly and to present data via the quality dashboard and divisional condition reports. Divisional and Trust data is presented and monitored via IPCC. The Trust has an extensive and robust IPC policy framework to ensure full adherence to the IPC Code of Practice and Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.	None	N/A	Vascular Access Device (VAD) group set up to identify common issues and to review. Standardise practice. Action summary created and actions assigned to address issues highlighted from PIRs and audits. Group finished 31/03/2024. Summary of work and achievements provided at IPCC in May 2024. Review High Impact Interventions undertaken at ROH. Review includes areas that may/may not be suitable to undertake the audits (data validity and use of audit data). HII now created in AMaT. Divisional oversight and spot checks by Matrons. VAD audit by external company. VAD group work concluded end of March 2024.	3. Compliant

1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff locally employed by ROH regardless of contract length (permanent, bank, flexible, agency, locum etc.) have access to mandatory training which includes level 1 IPC and level 2 (if clinical). Additional and tailored IPC training is provided to medical staff who work at ROH for short periods (rotations) such as Post graduate Doctors, visiting Fellows etc. Contractors working onsite receive information on IPC principles and ways to ensure the safety of themselves and others whilst working onsite. All employment contracts set out the individuals' responsibilities for upholding the principles of IPC practices throughout their duties. Mandatory training figures (for Nursing staff) are reported to the IPC committee.	None	N/A	IPCT have created 'IPC at ROH' quick reference tools for departments that do not access our mandatory training or need additional support. Undertake a review of workforce IPC training needs analysis. To review training data presented to the IPC committee to ensure this encompasses all staff groups/specialities etc. Full review of IPC training to take place as a priority for 2024/25.	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	IPCT have a strong clinical presence and are available to support risk assessment needs for IPC issues when required. IPC team have created an IPC risk assessment template which can be used by clinical areas to assess specific IPC risks as well as generic IPC practices based on the hierarchy of controls. IPC measures beyond the identified hierarchy of controls for the specific organisms are risk assessed and implemented based on need according to local prevalence data and risk assessments – these are approved through local ROH governance systems. All Trust risk assessments are based on current national best practice and guidance ensuring rapid implementation of control measures to effectively mitigate risk. Risk assessments are based on the hierarchy of controls, ensuring maximum risk mitigation.	None	N/A	This risk assessment process is also utilised to support the local system to effectively control and mitigate risk when supporting patient transfers within Birmingham and further afield. An overarching Trust respiratory viral infection risk assessment has been completed, based on the hierarchy of needs, and identified risks included within the IPC risk register along with current mitigations. This is monitored and reviewed at the IPC committee.	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place).	The Trust has implemented the National Standards of Healthcare Cleanliness (released in April 2021). Reports on the programme implementation and mitigation are provided by the Head of Facilities and presented to the IPC Committee and upwardly reported to the Quality and Safety Committee.	None	N/A	N/A	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Performed annually. A formal summary report and action plan is written and monitored. PLACE last took place in October 2023 - awaiting report and action plans.	PLACE 2023 report and action plans to be presented at IPCC.	PLACE lead requested to share findings and associated actions at the IPCC Committee meeting on 30th July 2024.	PLACE update and feedback from inspection to be given at IPCC committee in July 2024.	2. Partially compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning charters have been implemented in all areas outlining the responsibilities and frequencies of cleaning related to the environment and equipment. These are also clearly defined in the Trusts Decontamination and Cleanliness Policy. Cleanliness and Decontamination Policies dictate the responsibilities, frequency, and products to be used for cleaning and decontamination.	None	N/A	Cleaning schedules and assurances of cleaning are currently being reviewed by the IPCT as part of s sustainability piece of work - looking to remove or at least reduce the use of the plastic 'I am clean' indicator tags that are overused within clinical and non-clinical areas.	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM: 03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM: 04-01.	The Trust have an appointed authorising engineer who provides specialist advice on ventilation. A ventilation safety group in place – which meets bi-monthly and core membership includes DIPC, Director of Estates, Estates managers, IPCT, Microbiologist and ventilation AE. A full ventilation assessment has been completed by an external contractor and recommendations put forward. This has been created into an action plan which is completed and monitored by the VSG and progress reported to the IPC Committee. The Trust have an appointed authorising engineer who provides specialist advice and guidance on water safety. A water safety group in place - meets bi-monthly and core membership includes DIPC, Director of Estates, Estates managers, IPCT, Microbiologist and water AE. Water safety plan in place and Pseudomonas risk assessment completed - reviewed annually. Action plan in place to address any outstanding risks or issues - monitored by the WSG.	None	N/A	N/A	3. Compliant

2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN: 00-09	The Trust uses an electronic system 'Planet FM' to organise its planned preventative maintenance programme, information is available upon request. ROH 'permit to work' policy and procedure followed for all building works that may have IPC implications. Works must be approved by IPC before they can be undertaken and also signed-off by IPC before the areas can be used. A multi-disciplinary team, including an IPC lead in engaged during the planning/development stages of major capital schemes.	None	N/A	N/A	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM: 01-04 and the NIPCM.	Nominated contractor evidences BS EN 14065- through tender exercise – copies are available upon request. Nominated contractor has provided operational laundry procedures detailing temperature washing, and quality safety checks. Policy for the management of laundry and infected linen in place. Clean linen holding areas active. Separate Soiled linen holding area. Removed daily. Annual Duty of care visits scheduled. Bagging procedure/signage adopted -clearly stating how to separate infectious Linen for general soiled linen. Clean and soiled linen deliveries witnessed. Clean linen received into trust via covered/packaged roll cages.	There is limited storage in clinical areas. Linen cupboards are often combined with other storage (clean items). Not all linen cupboards are enclosed/covered - most linen room door remain open. Stock holding shelving not covered. Site Duty of care visit due Jan 24	Review of ward/dept. storage use to ensure storage of linen complies with section 1.7 of the National IPC Manual.	Lack of storage within clinical areas are added to affected department risk registers. A review of storage use and placement of items being undertaken by department managers and divisional senior management. Review of stock ordering (quantities etc.) All areas have been reviewed by Matrons - storage risk for equipment remains for Ward 1, 12 and 3 and are currently unable to improve further hence the remaining risks. Narrative for why this cannot be improved to be provided. Improved storage of linen within the recovery department has taken place. Ongoing issue within the linen rooms of inpatient areas (ward 1,2,3,12,4) - update required on how this being addressed by inpatient matron.	2. Partially compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM: 07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste management policy as been revised and updated to include best practice guidelines outlined within the HTM 07/01 and the NHS clinical waste strategy. Non-infectious waste steam has been implemented to ensure compliant healthcare waste is captured correctly. Designated waste manager appointed.	None	N/A	N/A	3. Compliant

2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM: 01-01, HTM: 01-05, and HTM: 01-06.	The decontamination service is now provided by Steris. (previous contract was provided by BBraun). All surgical instrumentation is processed in accordance with MDA 93/42EEC, now superseded by directive 2007/47/EC .This demonstrates compliance with essential requirement of MDD. The outsourced provider will have a quality system who are independently audited.	None	N/A	Decontamination group due to be reinstated. First group to meet in August 2024. Steris appointed new sterile services contractor. Decontamination contract is managed by Pan Birmingham who provide assurances that all decontamination processes are automated and validated to the MDD standards and comply to the contract . Monthly defect meetings are held to discuss any contractual turnaround failures , wet sets , torn wrap and missing or damaged instrumentation. Regular meetings held with stakeholders to discuss common issues and work collaboratively.	3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Catering staff have all undertaken Level two in food safety – Catering managers have undertaken Level Three food safety. Ward based meal service personnel undertake level 1 food safety awareness training. All food handlers undertake "allergy awareness training.		Review the training need analysis for food hygiene training and provide assurance of training completion for catering/chef staff. Assurance provided for clinical staff by HoN - Division 1.	13/06/2024 - an action plan is being created to address food standards. To include update on training and competence. From HG - all staff within catering are due refresher training. From KH - The Food Hygiene policy, section 10 details the expected training. Clinical staff handling food complete L1 e-learning 2 yearly-compliance is monitored by the Corporate Nutrition Lead and upward reported at each Clinical Quality Group meeting.	2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	The Trust AMS operational plan is incorporated into the wider Trust IPC operational plan and is reported on via the IPC Committee and Quality and Safety Committee. The DIPC has organisational responsibility for AMS and the Trust nominated lead is the Antimicrobial Pharmacist.	None	N/A	N/A	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Annual AMS activities are include in the annual DIPC report which discusses consumption data. Reports on antimicrobial consumption are produced quarterly and presented at The IPC committee, CT and Q&S Committee throughout the year.	None	N/A	N/A	3. Compliant

3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The DIPC has organisational responsibility for AMS.	None	N/A	N/A	3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, Then Focus are followed.	Consumption audits are carried out quarterly to provide assurance on antibiotic usage. Anomalies are investigated and exception reports are provided. Antimicrobial guidelines are in place and are easily accessible via the prescribing system. The Trust uses a electronic prescribing system which reduces inappropriate prescribing by flagging up review notes for antibiotics >72 hours.	None	N/A	N/A	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing. • Broad-spectrum prescribing. • Intravenous route prescribing. • Treatment course length.	Antimicrobial consumption reports produced quarterly providing data on usage including usage of carbapenems and Watch & Reserve antibiotics. Trust completed the national CQUIN03 Iv to Oral switch 2023/24 and findings were presented at the AMS group, Drugs and therapeutics group as well as the IPC committee.	None	N/A	N/A	3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors).	Audit programme in place that is monitored via the AMS group. Antimicrobial prescribing guidelines easily accessible and can be found on Trust website. Antimicrobial pharmacist works alongside IPC team to deliver annual education session. AMS included in the level 2 IPC mandatory training. Antimicrobial pharmacist delivers educational sessions regularly to pharmacy staff.	None	N/A	N/A	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						

4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	All IPC produced information leaflets are submitted to the Patient Engagement Group (PEG) before implementation to allow comments and recommendations to be made on suitability and accessibility. All IPC leaflets reviewed during 2023 to ensure accuracy and relevancy. Leaflets are available to read or download from the external Trust webpage. Copies can be made in alternative languages and formats on request by the comms department.	None	N/A	N/A	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	All IPC leaflets reviewed during 2023 to ensure accuracy and relevancy. Leaflets are available to read or download from the external Trust webpage. Copies can be made in alternative languages on request by the comms department.	Protected characteristics. Easy read materials - LD and autism. Trust comms strategy required.	To produce IPC related information in formats that are accessible.	A working group is being sent up by the LD nurse and comms, reviewing all information leaflets and assessing what needs to be created in easy read formats other languages etc. IPC T to support where necessary. This is a Trust quality priority for 2024/25.	2. Partially compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	See 4.1	None	N/A	N/A	3. Compliant

4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Personal responsibilities in regard to IPC are explained in appointment letters, pre-operative information, and discharge information. Provision of IPC advice and information is available in various formats throughout the Trust, these include; •Patient information leaflets •IPC information posters •IPC information page via external website There are visual prompts situated throughout the hospital reminding staff, patients, and visitors of the principles of IPC and their responsibilities in upholding these. IPCT produce a quarterly newsletter discussing key topics, learning from practice and incidents etc. Monthly focus training materials and supplementary material such as leaflets, posters 'bug boards' are created and shared across the Trust to educate staff, patients and visitors.	None	N/A	N/A	3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Details of any known infections are expected to be provided during handover between organisations and included within the patients discharge documentation. Where required, catheter passports are available for use to facilitate a safe transition of care for the invasive device.	None	N/A	N/A	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Robust systems and processes have been embedded across the Trust to ensure prompt identification of people who have or are at risk of developing an infection, ensuring they receive timely, appropriate treatment to reduce the risk of transmitting infection. Pre-operative screening and triage questions asked at the '72-hour call' help to identify potentially symptomatic and infectious patients as early as possible so that the urgency of their procedure vs the risk associated with operating can be assessed and timely plans made.	None	N/A	N/A	3. Compliant

5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Pre-operative screening and triage questions asked at the '72-hour call' help to identify potentially symptomatic and infectious patients as early as possible so that the urgency of their procedure vs the risk associated with operating can be assessed and timely plans made. Patients are assessed again upon admission and Priority for single room isolation is assessed according to the 'priority for isolation' chart specified in the Trusts Isolation Policy. Daily review of inpatients is undertaken by clinical teams in conjunction with the IPCT to ensure appropriate placements and best utilisation of single rooms.	None	N/A	N/A	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	If known or if suspected to have an infection, details of this is to be included in the discharge documentation (along with details of outstanding screens/swabs etc.) The same details are to be verbally discussed during hand over and notification made to any patient transport or ambulance services which may be required.	None	N/A	N/A	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Implementation of consistent triage questions across all services, ensuring infection risk is promptly identified and appropriately managed. All correspondence provided to patients and visitors prior to attendance (clinic and appointment letters, external internet, and telephone messages) inform them not to attend if they are symptomatic or unwell - they are directed to call into the department they will be due to attend to obtain further guidance. Targeted questioning is used during the preoperative assessment to identify patients who are at risk of infection or may be admitted with a history of infection prior to their admission date. This information is used to inform the procedure they will be having, any special precautions required such as changes to prophylactic antimicrobials, isolation provision and discharge planning.	None	N/A	N/A	3. Compliant

5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	UKHSA agreed outbreak definitions were adopted and this is written into the Trusts outbreak policy along with associated actions for the incident management group and reporting – dependent upon the organism, number of affected cases and operational impact (bed closures/empty closed beds etc.) Details of ongoing outbreaks are shared via the daily Sit-reps and communicated to system partners.	None	N/A	N/A	3. Compliant
6.5	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC training delivered at ROH meets the required specifications as set out in the Core Skills Framework for IPC mandatory training. This includes training on SICPs and TBP for level 1 and level 2. During 2023 the ROH IPC mandatory training was reviewed for accuracy. Level 1 can be accessed as an online module via Elfh or face to face and level 2 is accessed via Elfh only.	None	N/A	A further review of IPC education is planned when NHS England release further guidance on the new IPC education Framework.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	As above. The Trust has developed robust systems and processes to ensure compliance with health and safety legislation to assure safety in the workplace.	None	N/A	N/A	3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Assurance mechanisms include monitoring of mandatory training compliance (including IPC Level 1 and Level 2), PPE training and fit testing. Records are kept via ESR or health roster and reports provided to the IPC Committee and Quality and Safety Committee. Divisional leads monitor training compliance within their areas.	Reporting of training completed per staff group needs to be strengthened as currently not assured all areas are bine monitored.	To review IPC training data (level 1/2 mandatory, PPE and fit testing) presented to the IPC committee to ensure this encompasses all staff groups.	Overall Trust IPC level 1 and level 2 mandatory training is now included in the IPC summary report. This will cover the specific reporting period for each meeting (previous 2 months). Divisional reports to include breakdowns of staff groups to ensure accountability and close monitoring.	2. Partially compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	An extensive range of training resources have been developed to ensure staff are competent in correct donning/doffing techniques and selection of PPE. The IPCT provide PPE training which currently has received poor attendance as not currently deemed mandatory.	Poor attendance at PPE training. PPE training is not mandated by the Trust, unable to ensure all required staff are trained.	To review delviery of PPE training, with a view to linking this to level 2 IPC training. To ensure completion can be linked to staff ESR records and monitored from this also.	Fit testing compliance has improved significantly. PPE training sessions are being held by IPCT, department managers and senior mangers to encourage and support staff to attend. IPCT plan to submit an application to the Training & Development Group to have this matched to level 2 IPC training. This will then allow accurate monitoring of completion and identify areas that need to be targeted for further training opportunities.	2. Partially compliant

6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff who are/may be required to wear a FFP3 respirator to deliver clinical care, have been identified and required to undergo fit testing against a range of RPE (disposable FFP3 respirators). Fit testing records are held by the individual members of staff and also uploaded as a 'skill' on HealthRoster. Reports of fit testing uptake and pass/failures are given by divisional leads at IPCC, CQG and Q&SC.			In-house fit testing programme now in place. 19 staff trained to use the PortaCount equipment to deliver fit testing. Permanent band 3 fit testing coordinator recruited . Continuous reminders provided to all line managers to record fit testing records correctly onto HealthRoster/ fit testing spreadsheet. A guide to entering fit testing records onto Health Roster has been created and disseminated to all line managers to encourage the correct entry of data. Fit testing data reported on via divisional IPC reports at the IPC committee.	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Training of specific skills and procedures undertaken by the Trust Learning & Development/Clinical Education teams. Training records are held locally for staff trained in additional skills that require proof of competency. Records are also held via the ESR system.	N/A	N/A	N/A	3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Pre-operative screening and triage questions asked at the '72-hour call' help to identify potentially symptomatic and infectious patients as early as possible so that the urgency of their procedure vs the risk associated with operating can be assessed and timely plans made. Patients with suspected or known infections (where treatment cannot be deferred) are prioritised for single room isolation and transmission-based precautions are implemented from the point of admission. This is reflected in all relevant clinical documentation to facilitate accurate handovers between departments/services.	None	N/A	N/A	3. Compliant

7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Pre-operative screening and triage questions asked at the '72-hour call' help to identify potentially symptomatic and infectious patients as early as possible so that the urgency of their procedure vs the risk associated with operating can be assessed and timely plans made. Patients are assessed again upon admission and Priority for single room isolation is assessed according to the 'priority for isolation' chart specified in the Trusts Isolation Policy. Where single room provision does not meet the needs for isolation purposes, where possible, following risk assessment by the IPCT (or on-call Microbiologist) patients may be cohorted in a multi-occupancy bay. For infections spread via the droplet or aerosol route, patients are advised to wear a fluid resistant surgical mask at all times (where this does not impede clinical care or is detrimental to patient health).	None	N/A	N/A	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Standard infection control precautions are the minimum IPC precautions practiced by all clinical staff at all times throughout the Trust. This is specified in the SICPs Policy. Transmission based precautions are applied as required according to the transmission and virulence factors of the organism present and as advised by the IPCT. Arrangements for this is evidenced in the PPE and Isolation Policies. These recommendations align with guidance set out in the NIPCM manual.	None	N/A	N/A	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Details of any known infections are expected to be provided during handover between organisations and included within the patients discharge documentation. Where required, catheter passports are available for use to facilitate a safe transition of care for the invasive device.	None	N/A	N/A	3. Compliant
8.2 Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						

8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Staff receive training as part of local competencies in swabbing/sampling and are supported to achieve the correct technique and competency. The Trust has in place guidance for the correct swabbing/sampling procedures required to test for infectious organisms. ROH protocols for pre-operative and inpatient testing adhere to national guidance which is implemented following local risk assessment based on patient type, risk of infection and risk of onward transmission. The swabbing/sampling required, how to undertake this and how to send the specimen to the laboratory are covered in the corresponding policy e.g., MRSA, C. difficle, CPE etc.	None	N/A	N/A	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	There is robust local guidance in place which emphasises treating patients based on symptoms of infection. Where inpatients develop symptoms, they are isolated and tested (what for is dependant upon the symptoms present and suspected diagnosis following clinical assessment). This is evident in the HCAI organism specific polices and isolation policy. Results are communicated directly to the clinical area sending the sample and to the ROH IPCT for follow up. IPCT communicate these results with the relevant individuals and instigate IPC precautions, offer advice and guidance on management etc.	None	N/A	N/A	3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	ROH Microbiology laboratory services are provided via SLA with University Hospitals Birmingham – which is UKAS accredited. Testing turnaround times are monitored by both the laboratory and also the ROH IPCT. Any issues are promptly escalated which is supported by the IPC Doctor who is based at UHB.	Issue noted with 'missing samples' - reported via risk register.	To create a trackable process for specimen/samples from ROH to UHB lab.	A process and SOP has been created by the Facilities lead to ensure samples sent from ROH are logged prior to being transported to UHB so any discrepancies can be traced. Work being led by IT into the implementation of a specimen tracking system for theatre samples as well as specimens/samples sent from clinical areas.	2. Partially compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	ROH protocols for pre-operative and inpatient testing adhere to national guidance which is implemented following local risk assessment based on patient type, risk of infection and risk of onward transmission.	None	N/A	N/A	3. Compliant

8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	There is robust local guidance in place which emphasises treating patients based on symptoms of infection. Where inpatients develop symptoms, they are isolated and tested (what for is dependant upon the symptoms present and suspected diagnosis following clinical assessment). This is evident in the HCAI organism specific polices and isolation policy.	None	N/A	N/A	3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Clear communication between ROH and UHB laboratory in the event of a period of increased incidence or outbreak that would necessitate increased screening/swabbing - prior notification is important to ensure there is capacity within the lab to process the swabs. Process covered in the Major Outbreak Policy.	None	N/A	N/A	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Transport of specimens is handled via a dedicated specimen delivery driver operating between ROH and UHB. Policy for the use of this service is in place.	None	N/A	N/A	3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	The Trust has an extensive and robust IPC policy framework to ensure full adherence to the IPC Code of Practice and Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. Monitoring adherence to IPC practices and policy is achieved via an IPC audit programme. At present audit results are monitored via several governance channels which include condition reporting, IPC committee and the sub board quality and safety committee. All IPC audits are in the process of being registered and entered onto AMaT. The ROH has in place a 'Outbreak policy' which details the practices required to identify, manage and reporting of HCAI outbreaks.	None	N/A	The list of IPC policies in place at ROH are subject to an annual comprehensive review and updated accordingly to accommodate changes to the national IPC manual and any changes to evidence-based practice/guidance. IPC policy gap analysis undertaken during July 2024 - minor outstanding gaps which have been discussed at IPC committee.	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						

10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	During pre-employment OH clearance, staff are risk assessed by the OHD, any considered to be 'high-risk' are offered the necessary vaccinations etc. Communication between OHD and the recruiting line manager state the need for further role and duty risk assessments to be carried out by the line manager, as well as any recommended restrictions on practice (e.g. exposure prone procedures) and further vaccinations required, as well as when. Staff at risk of complications from infection due to pregnancy are escalated to OH through line manager referral.	None	N/A	Meeting held with OHD to gain a better understanding of the services provided. OH SLA provided by UHB. This is currently a 12 month contract, to be reviewed. Measles risk assessment for ROH staff was shared by the OHD.	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Sharps/Slash exposure procedure in place which details the actions to take in the event of an exposure incident. Exposure events monitored at the Health and Safety Group. Annual occupational dermatitis checks implemented - monitored by line managers.	N/A	N/A	N/A	3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	This service is provided by the OH team at UHB (OH services SLA). There is a system in place to advise managers of immunity status post clearance and no EPP workers are cleared without the appropriate bloods being taken prior to clearance. Regular reporting provided for assurance at IPCC.			Staff immunisation policy now in place.	3. Compliant

PAPER REFERENCE: ROHTB (9/24) 025

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 28 August 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was reported that the workforce risks had been restructured in line with the national People Promise.
- Sickness absence and particularly short term absence, was noted to have increased. Turnover had also increased slightly.
- It was noted that there remains a concern over the uptake of Mandatory Training which was below the desired level at present. It was suggested that where there was a lacklustre uptake with no perceivable barriers to completing the training, then the performance management procedures should be applied.
- An overview of payroll errors was presented. It was noted that recovery of overpayments was more successful for those staff still in post than for those staff who had left the organisation.
- An overview of the position concerning the Band 2 to 3 changes for Healthcare Support Workers was presented. This had the potential to create a significant financial liability for the Trust, although work was underway across the System to understand the implications. It was agreed that the matter should be added to the Corporate Risk Register.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- A consultation exercise on 7 day working in theatres is underway, with the outcome expected in the autumn 2024.
- An overview of the skills gaps being addressed by the apprentices was requested, alongside an update on the apprentice pipeline into the Trust.
- Add a risk to the workforce risk register concerning productivity.
- Recruitment into the workforce planning role was reported to be underway.
- Update on payroll errors to be presented twice per year.
- Update on training themes raised as a consequence of the new appraisal approach to be presented at the next meeting.

POSITIVE ASSURANCES TO PROVIDE

- A positive staff story was received from a Digital Programme Manager who had joined the Trust in 2023. He described how the team and the organisation was supportive, but highlighted the opportunity in his view, to streamline the governance framework of the Trust. He celebrated the Tech Bar initiative which had been used to raise the profile of the digital team.
- The NHS staff survey will be launched at the ROH on 2 October 2024.
- National NHS payrises agreed by the Government, are due to be awarded in October 2024, backdated to 1 April 2024.
- It was reported that the overall vacancy gap at the Trust had reduced and the speed of recruitment had increased.

DECISIONS MADE

- The risk concerning the Band 2/3 Healthcare Support Workers situation to be presented to the Trust Board at the next meeting.

• The time to handle employment relations cases has reduced. • There was noted to have been a positive improvement in the level of staff declaring their protected characteristics. • The new appraisal framework was noted to have been implemented successfully, with an overall 93% compliance rate at present. The level of appraisals completed within the 'window' was at 79% vs. a target of 80%. • A positive reduction in the use of agency staffing was reported, with no agency now used to support ward staffing unless in an exceptional circumstance. Any further reduction was noted to be dependent on changing the model of the mid level medical cover. • Good progress was reported to be being made around the workforce planning actions. It was noted however, that the areas of delay were associated with the decisions and actions needed to be taken at System level. This would be raised at the next meeting of the System Chief People Officers. • An evaluation of the 'Beyond the Sigma' initiative was presented which was noted to be very positive. Consideration was being given as to how the legacy of this work would be captured and harnessed.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting had been productive and there was a good level of assurance provided by the papers. Jo Williams was thanked for her support as Chief Executive, to the work to improve the culture of the organisation and she was wished well for her secondment to Shrewsbury & Telford Hospitals NHS Trust.

Finance and Performance Report

Month 4

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 execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

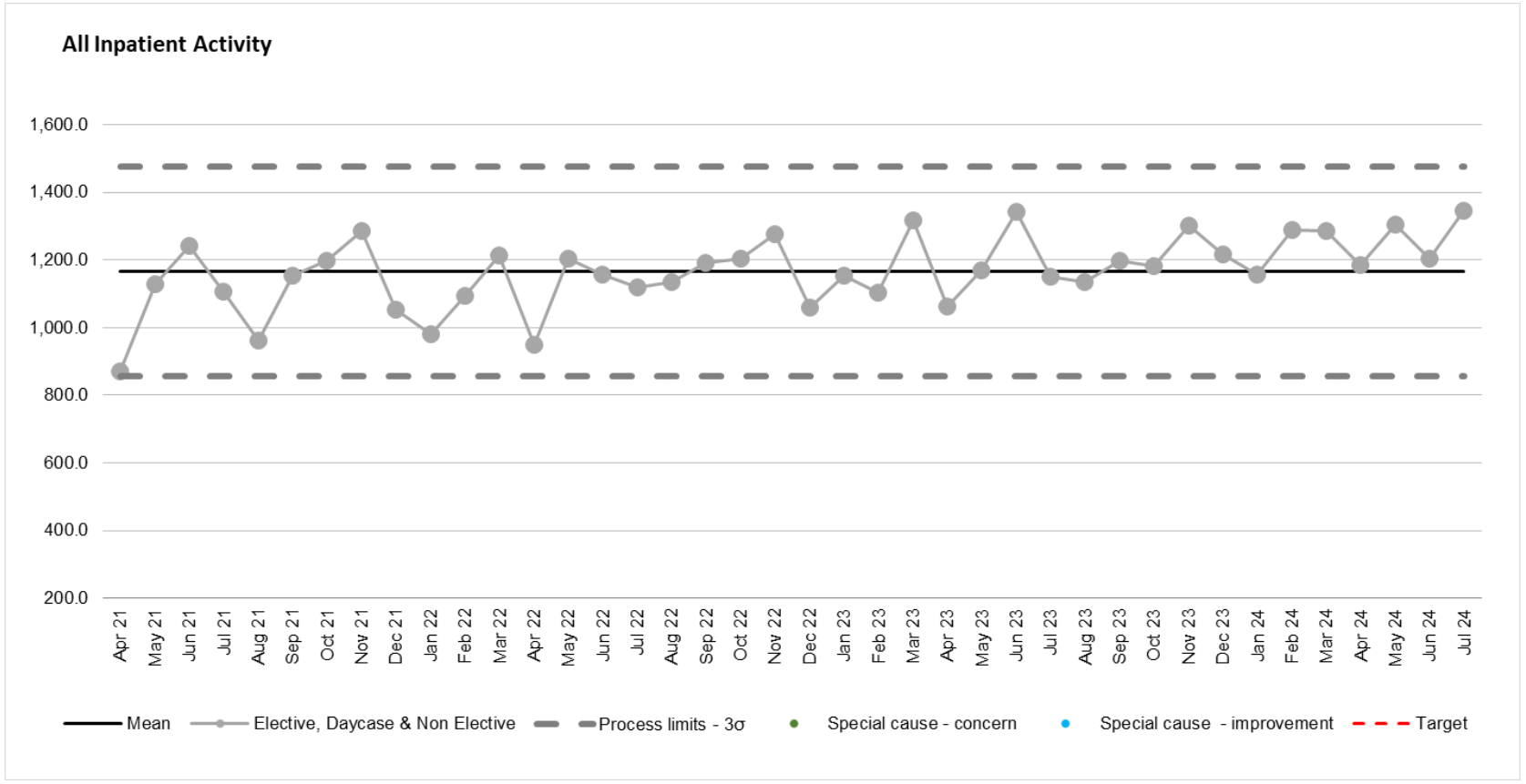
Operational Performance Summary

Performance to end July 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	52.58%	50.75%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	18	35	0	L	F
52 week waits (52 – 64 Weeks)	560	541	0	H	F
All activity YTD (compared to plan)	5,038	3,694	4,980		P
Outpatient activity YTD (compared to plan)	24,101 104.4% Cumulative	17,666 105.8% Cumulative	23,078 YTD Target		P
Outpatient Missed Appointments (YTD)	6.9%	6.8%	8%		P
PIFU (trajectory to 5% target)	657 10.67%	472 8.6%	470 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	11.2%	10.8%	19%		F
FUP attendances(compared to 19/20)	100.9%	100.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	114.6%	114.0%	N/A		F
Diagnostics volume YTD (compared to plan)	8,832 Cumulative	6,584 Cumulative	9,355 YTD Target		F
Diagnostics 6 week target	100%	100%	99%		P

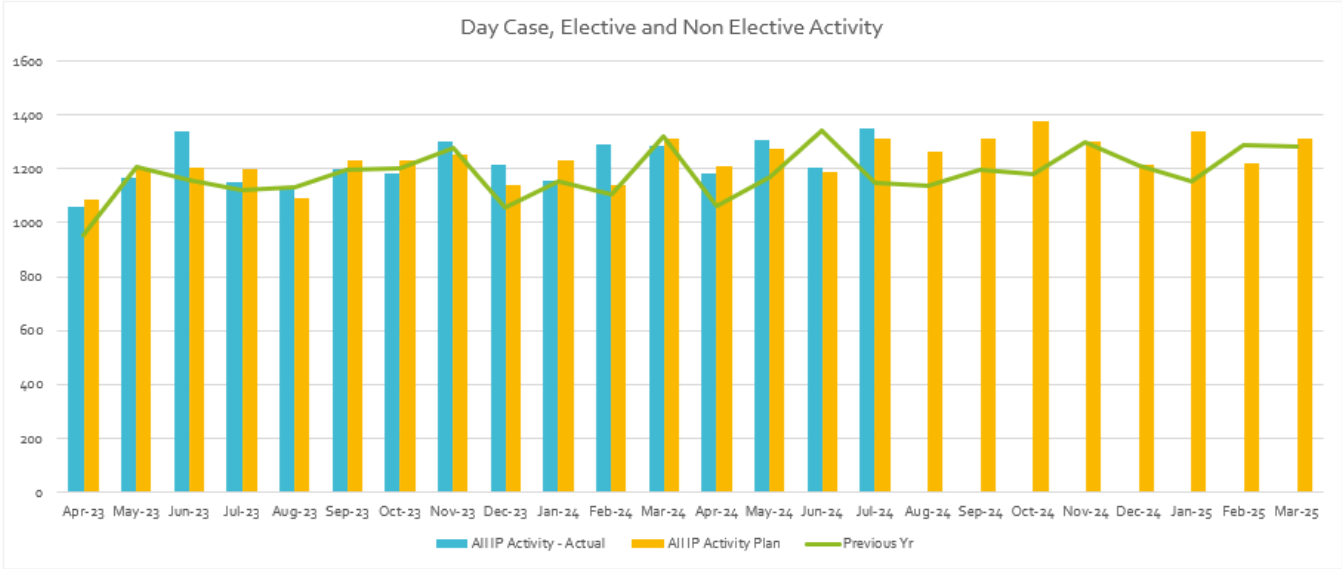
Operational Performance Summary

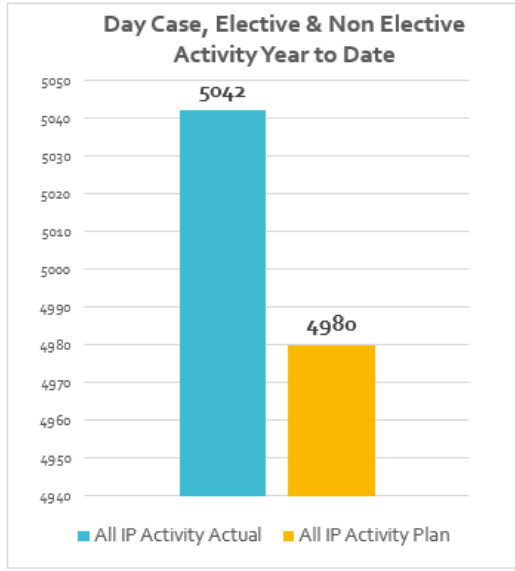
Performance to end July 24	In month	Previous month	Target	Variation	Assurance
Theatre Session Utilisation (Uncapped)	89.2%	80.8%	85%		
Theatre In Session Utilisation (Uncapped)	82.4%	83.17%	85%		
Cancer - 31 day to treatment	94.74%	100%	96%		
Cancer - 62 day standard	66.67%	85.7%	70% Nat 85% Trust		
28 day FDS	78.72%	75.3%	75%		
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	8,762 Cumulative	6,613 Cumulative	7,712 Cumulative		
Bed Occupancy (excluding CYP and HDU)	71.6%	70.1%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.43	3.47	n/a		No Target
LOS - elective primary hip	2.5	2.9	2.7		
LOS - elective primary knee	3.3	2.9	2.7		
BADS Daycase rate (Note: due to time lag in month is Mar'24)	75.0%	75.0%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar'24)	36.3%	36.9%	-		No Target

1. Activity Summary



1. Activity Summary - New slides





	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	554	584	542	602	580	602	632	598	560	614	560	602	2282	2200	96%	-82
	Daycase	642	677	631	697	673	697	733	691	647	712	648	697	2647	2767	105%	120
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	51	71	139%	20
	All Activity	**1208**	**1274**	**1186**	**1312**	**1264**	**1312**	**1379**	**1302**	**1218**	**1340**	**1219**	**1312**	**4980**	**5038**	**101%**	**58**

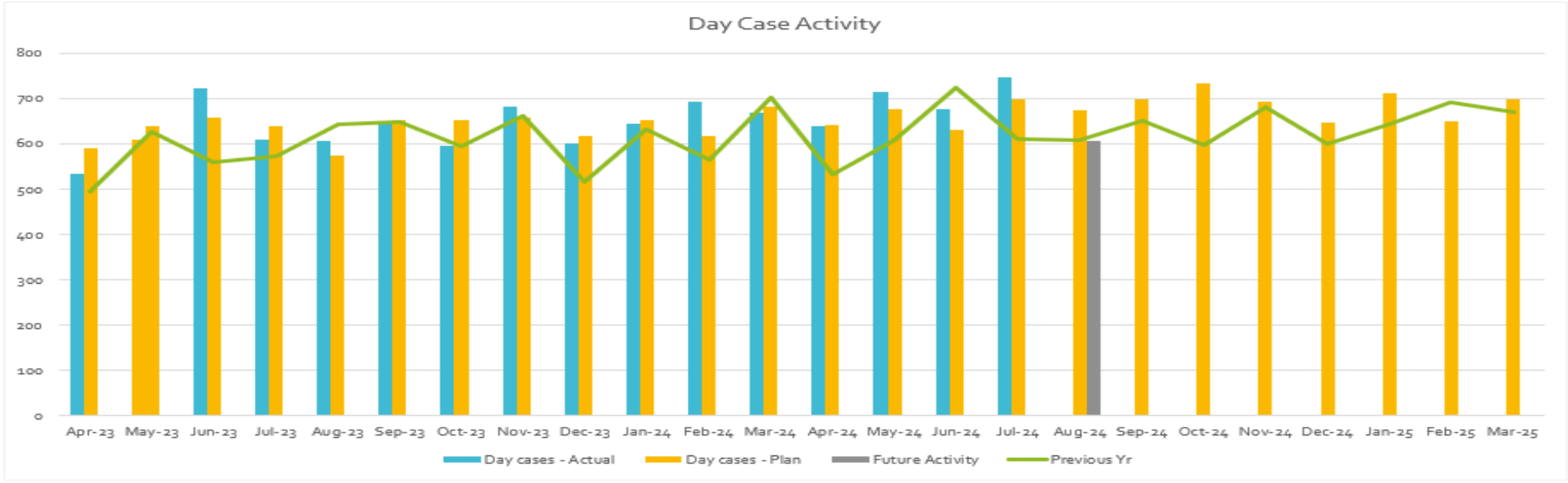
July 2024

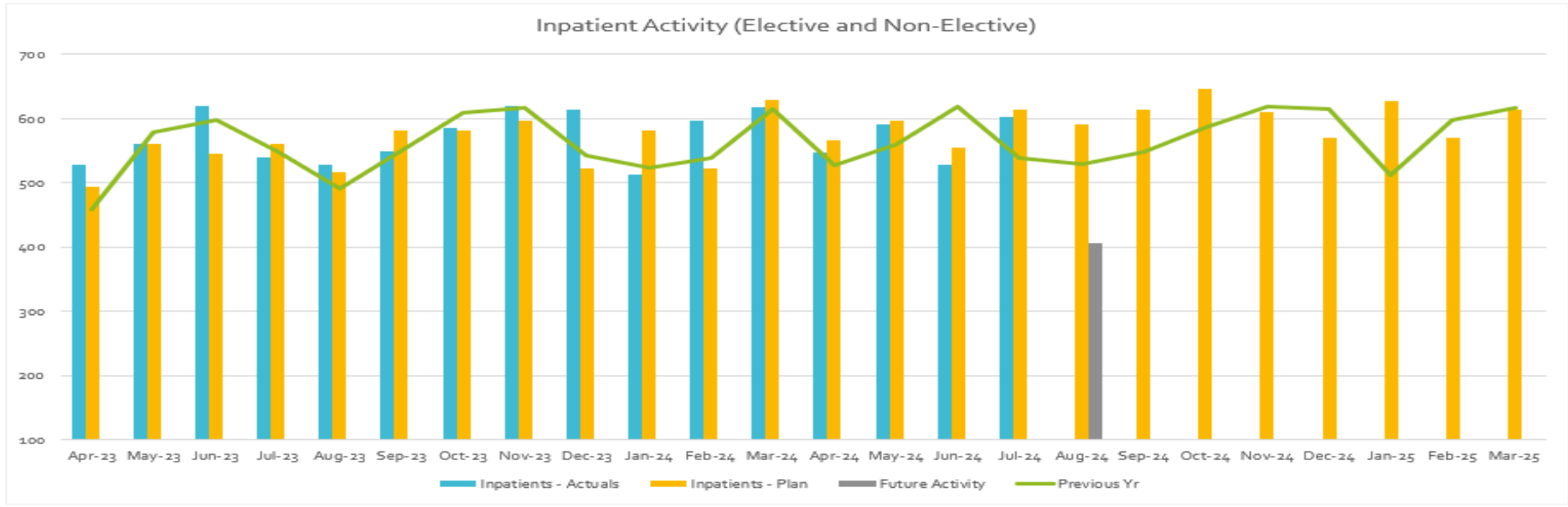
In month performance, Trust delivered 36 cases above for the activity trajectory.

- YTD is 58 ahead of Plan

The original system plan of 4% has been amended to 15,326 reflecting the agreed 6% uplift on last year's activity plan.

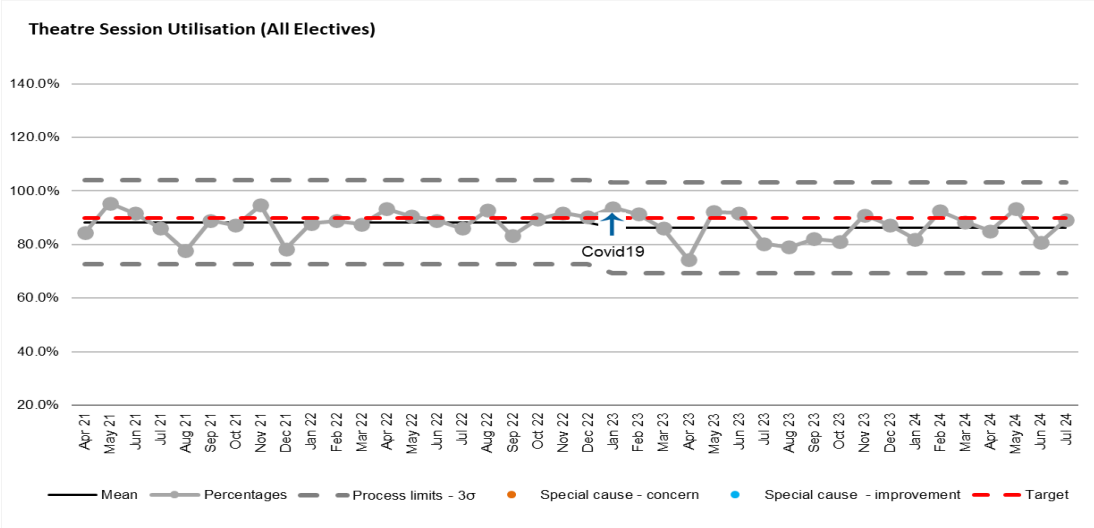
1. Activity Summary

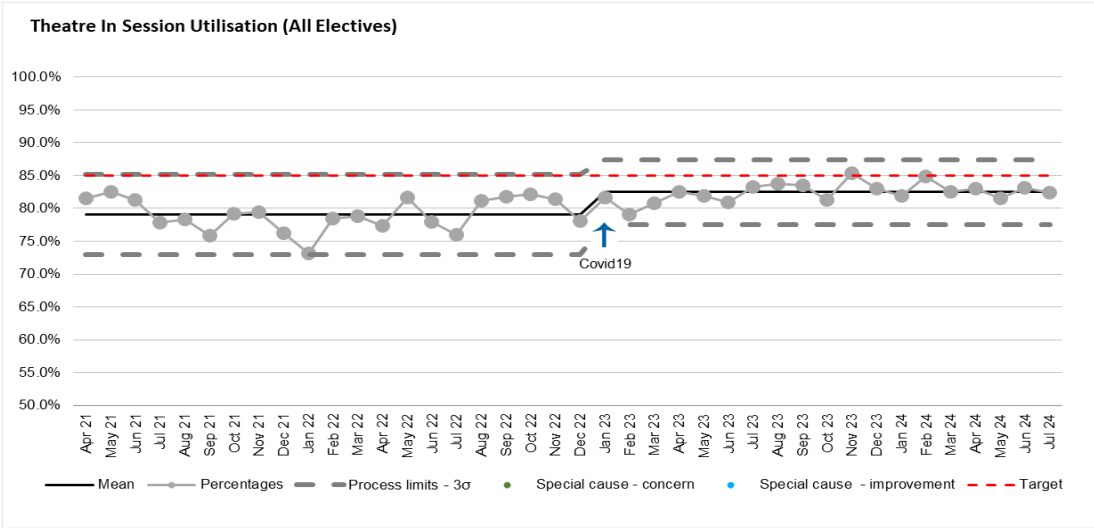




2. Theatre Utilisation

DATA QUALITY KITEMARK





Elective Session Utilisation (July 2024)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	545	489	56	89.72%
UHB	65	55	10	84.62%
Totals	**610**	**544**	**66**	**89.18%**

Elective In Session Utilisation (July 2024)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	2132	1776	356	83.32%
UHB	246	182	64	73.98%
Totals	**2378**	**1958**	**420**	**82.35%**

2. Theatre Utilisation

DATA QUALITY KITEMARK

SUMMARY

Overall theatre session utilisation for July was **89.18%** which was above the Trust target of **85%.**

The overall in-session utilisation for July was **82.35%**.

UHB in-session utilisation at 73.98% due to sickness in the admin team leading to ineffective booking of lists.
Cancellations on the day as detailed on a later slide impacted on ROH Utilisation in month.

AREAS FOR IMPROVEMENT

Working groups with project support have been identified to pilot theatre turnaround times within a specific speciality effective from September 24.

Ongoing work with POAC to ensure specialities have a list of optimised short notice patients who can be contacted at short notice to backfill cancellations

Early starts have shown improvement and positive outcomes collaborating with colleagues in Division 1 to ensure that lists are optimised to reduce early finishes. The number of theatres starting on time is now recorded on the daily SITREP.

The current protocol for emergency patients is being reviewed by the theatre triumvirate team in the event that the emergency theatre is already in use.

RISKS / ISSUES

UHB have confirmed intentions to retain up to 1 theatre and session allocations have been agreed post September 24. Administrative and operational resources will be required to support this activity managed by ROH to ensure productivity is maximised. During the SLA negotiation, we have requested that the UHB remaining sessions are provided for 50 weeks of the year.

Recruitment to vacant consultant posts will offset the reduction in UHB activity. This is on a 42 weeks basis.

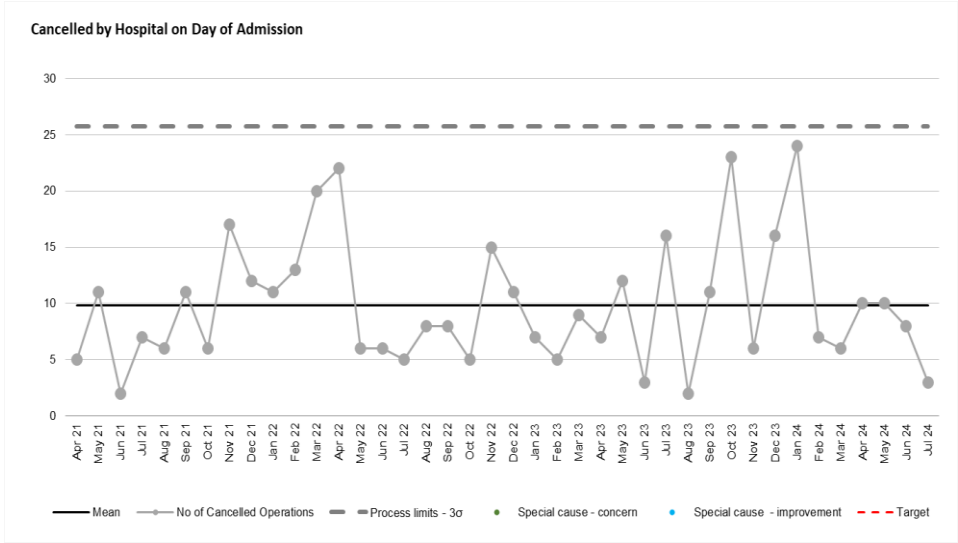
A review has taken place of demand and capacity data to ensure that consultant recruitment delivers 50 weeks in line with specialty backlogs.
Recruitment is ongoing with adverts out; interviews planned and start dates in place. A new Arthroscopy consultant commenced in August 24 and Spinal have recruited to 1 vacancy with the individual due to commence in post in September 24. Arthroplasty, Spinal Deformity and Hands posts are going through the recruitment process. Admin and operational resource will be needed to support the delivery of 50 weeks.

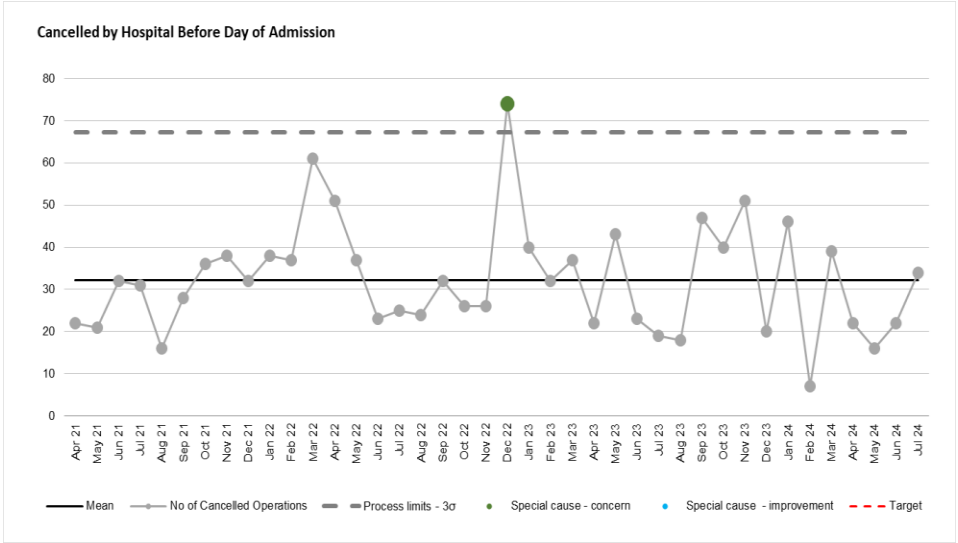
2. Theatre Utilisation - Seamless Surgery Update

SEAMLESS SURGERY ACTION PLAN

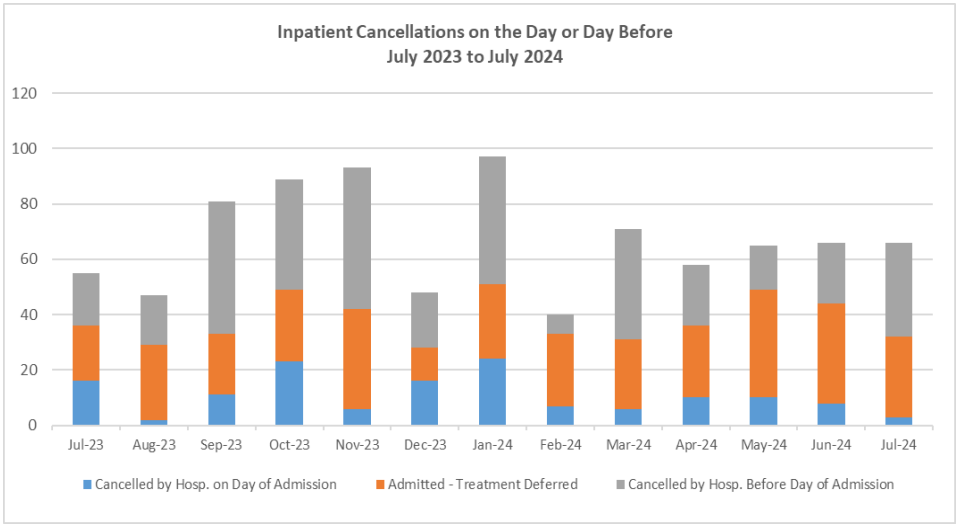
1. "You said, we did" - actions completed for recovery and fed back to the recovery team.
2. Instrument Integrity – 20 power tools have been ordered and delivery is commencing in batches following feedback on equipment availability and integrity.
3. Theatre maintenance programme agreed for the next 2 years that includes repairing the HDU corridor discussed with 2 Non-Executive Directors on theatre visit.
4. 7 day working consultation for theatre staff commenced on 05.08.2024.
5. 6 Image Intensifiers have been ordered with delivery scheduled for the beginning of October 2024. The team managed to obtain 6 for the original capital allocation agreed for 5. This will provide additional resilience and avoid cancellations due to faulty imaging equipment.
6. IPC and Senior Leadership Team regular review of theatre environment.
7. Theatre male changing room expansion needs to be timetabled to minimise impact on activity.
8. Capital agreed for Spinal Microscope with Procurement underway.
9. Staggered admissions have been reviewed for all specialities with 2 times standardised.
10. Additional afternoon huddle still in place to prevent any last-minute cancellations.
11. Standby patient process to roll out in September 2024.

2. Theatre Utilisation/ Hospital Led Cancellations





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
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
May-24	10	39	16	65	0
Jun-24	8	36	22	66	0
Jul-24	3	29	34	66	0
Total	**142**	**351**	**383**	**876**	**0**



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 July 24:

Patients cancelled on the day x 3	Patients admitted and had treatment deferred x 29	Patients cancelled by the hospital the day before the date of admission x 34
2 x Patient declined surgery. 1 x Lack of equipment – Metal allergy	15 x Medically unfit / not stopped meds 3 x Change in plan / pt declined procedure 2 x Lack of equipment – Metal allergy / Kit used for an emergency. 2 x Lack of theatre time – due to complex cases 1 x Patient arrived on incorrect TCI date 2 x Procedure abandoned – pt couldn't tolerate injection / exploratory surgery explained in advance to patient may not be able to proceed to full surgery. 2 x Blood antibodies not requested by haematologist 2 x Lack of a HDU bed – HDU bed not pre-booked and patients were prioritised based on clinical need.	11 x Medically unfit. 10 x Replaced by more urgent case 9 x TCI date not convenient/change in TCI date 2 x Lack of equipment – Imaging intensifier breakdown 1 x Case unsuitable to be carried out at ROH (UHB) 1 x Change in clinical plan

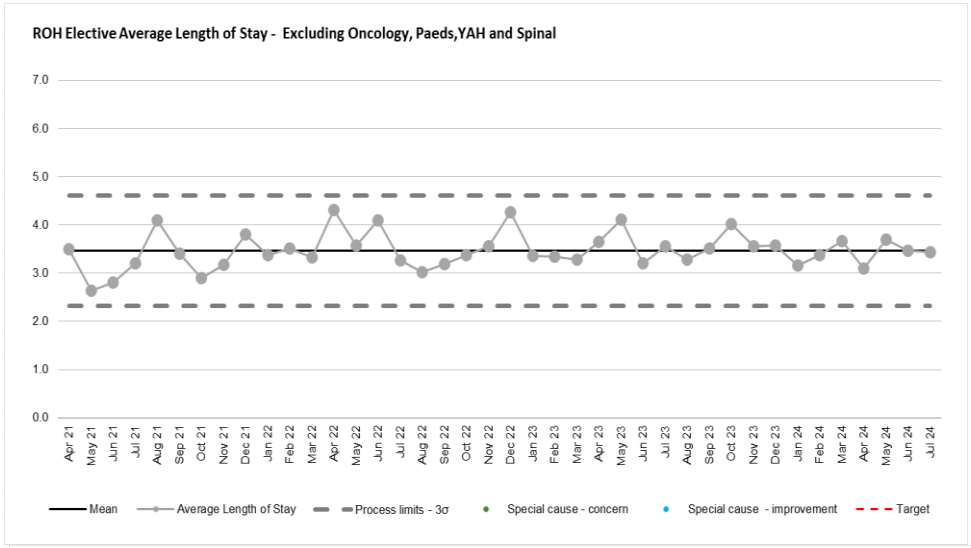
AREAS FOR IMPROVEMENT/ RISKS/ISSUES

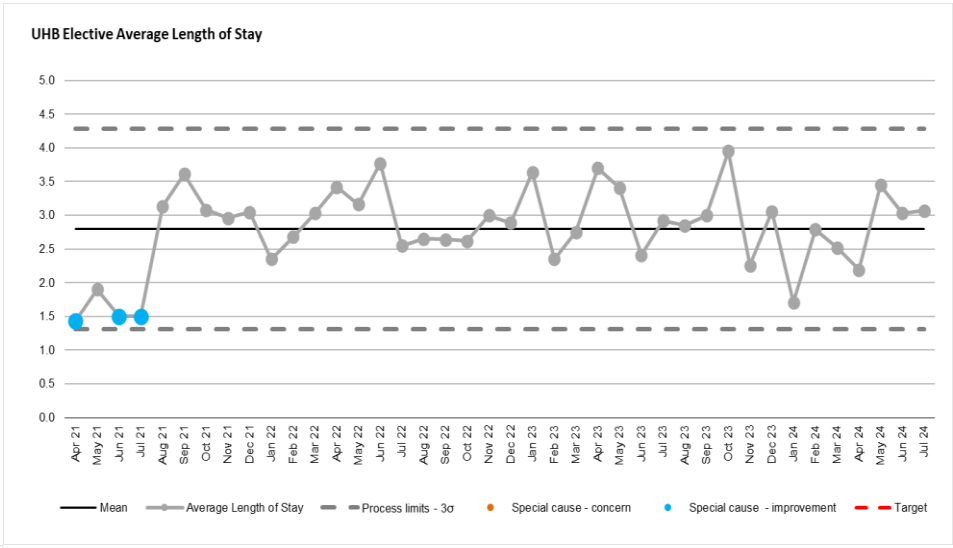
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

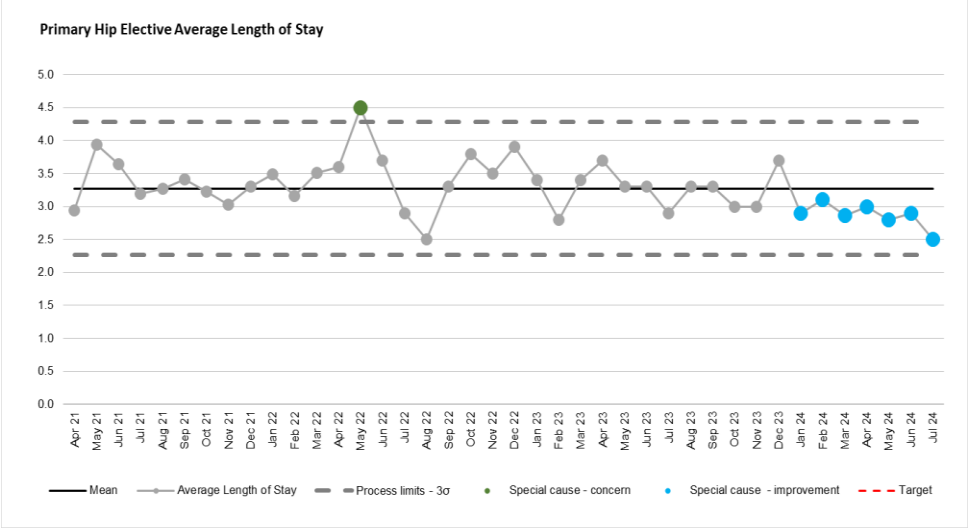
Theatre lookback meeting continues to review short notice cancellations with a view to identify opportunities to improve. Medical review to be carried out for cancellations due to 'medically unfit' to identify themes. Metal allergies process is being reviewed by Associate Director of Operations.

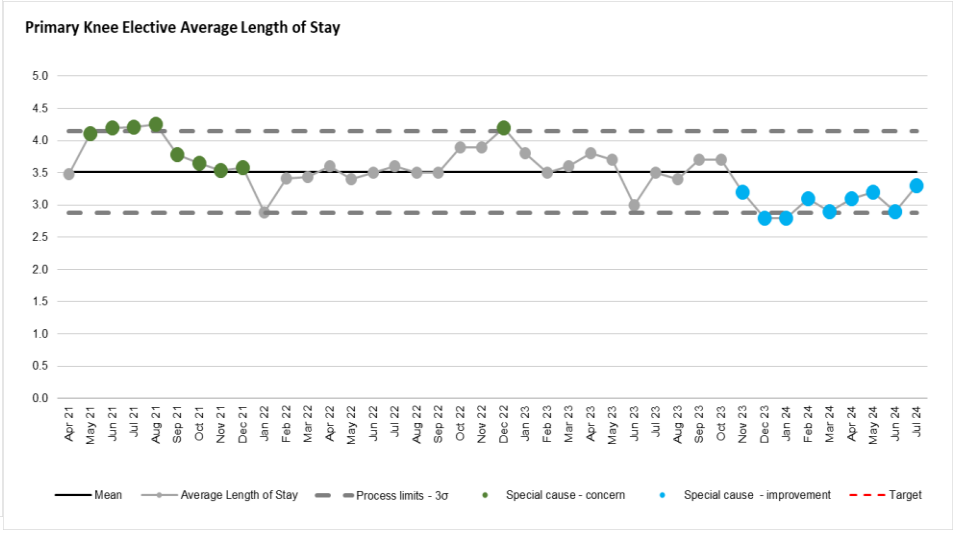
Standby/Contingency patient process to be rolled out in September 2024 starting with Spinal and Arthroplasty.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips decreased to 2.5 days (2.9 days June 24) and primary Knees has increased slightly to 3.3 days (2.9 days June 24).

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.43 days** (3.47 days June 24).

A review of the ROH data for arthroplasty and oncology arthroplasty primary hips and knees identifies the number of patients with LOS >/= to 8 days as 5 (3 June), 3 arthroplasty and 2 Oncology arthroplasty. 1 had an ASA score of 3 (Severe systemic disease), 4 had an ASA score of 2 (mild systemic disease). On review of clinical noting LOS for all 5 was due to on-going therapy or clinical care needs.

A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 28 (25 June).
17 were Oncology Arthroplasty, and 8 were Arthroplasty.

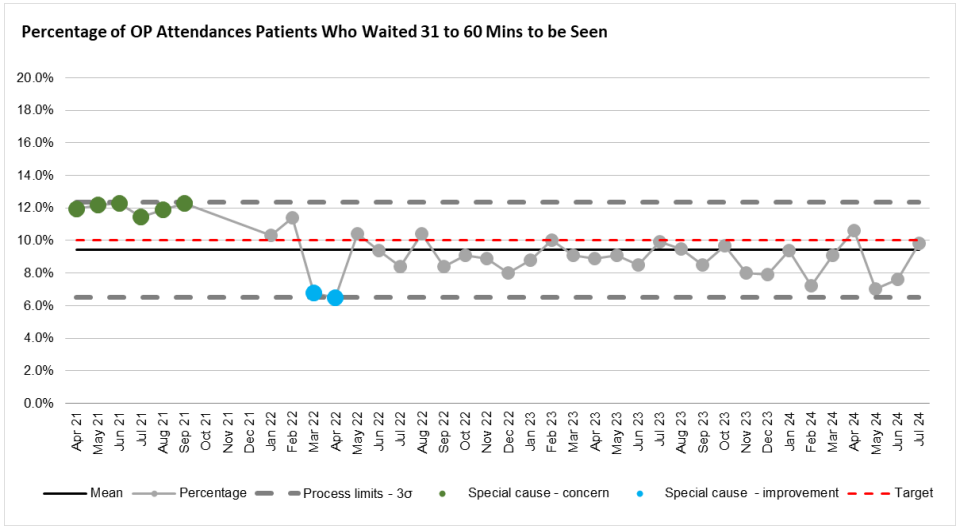
Review of these long stay patients >15 days (4) 3 were Oncology Arthroplasty, 1 was Arthroplasty. Longest stay 25 days (78 days June), complex Oncology Arthroplasty with therapy requirements. All long stays reviewed on PICS appeared appropriate, were either complex surgery/ clinical needs/co-morbidities or discharge planning.

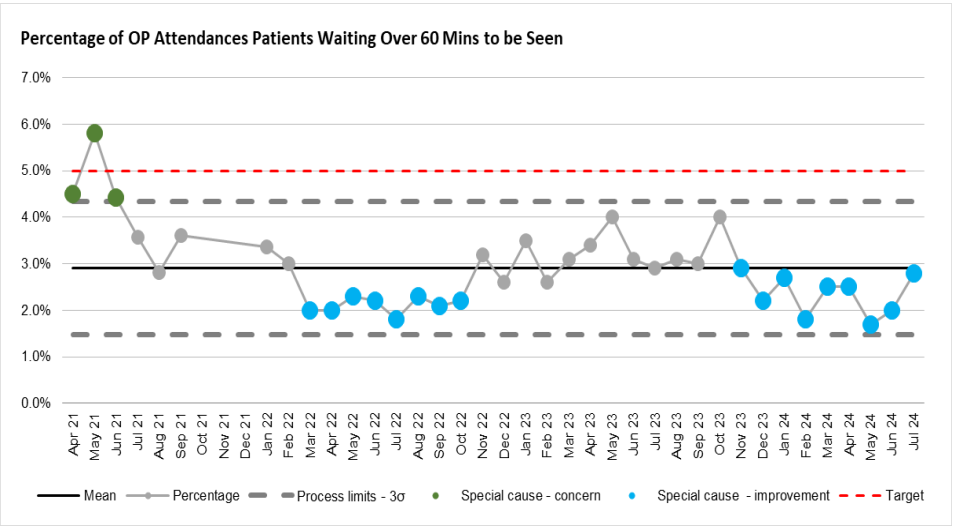
AREAS FOR IMPROVEMENT / ACTION PLAN

- Social care capacity-delays, particularly out of area. Daily monitoring and escalation process is in place.
- Out of area transport delays-productive meeting with Non-Emergency Patient Transport (NEPT) 01/07/24. Awaiting escalation process which is being agreed by NEPT.
- Number of patients converting from day case to overnight stay for non-clinical reasons. Review under way by Division 2
- OT capacity if increase in number of patients requiring in-put-risk insufficient to see all patients
- Saturday arthroplasty lists- potential missed opportunities for day case, 1-day discharges due to unavailability of support services i.e. Imaging and Pharmacy, reduced Physio cover.

4. Outpatient efficiency

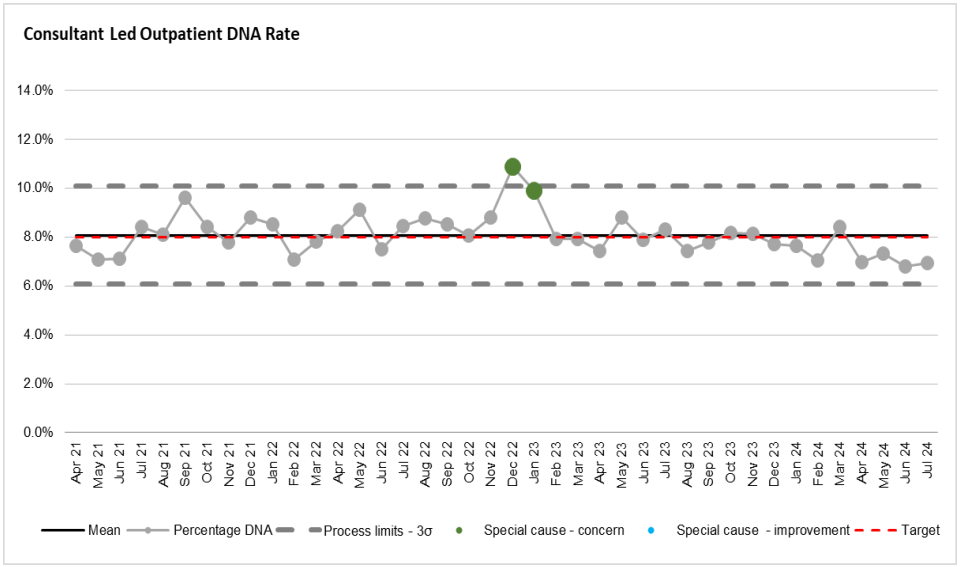
DATA QUALITY KITEMARK

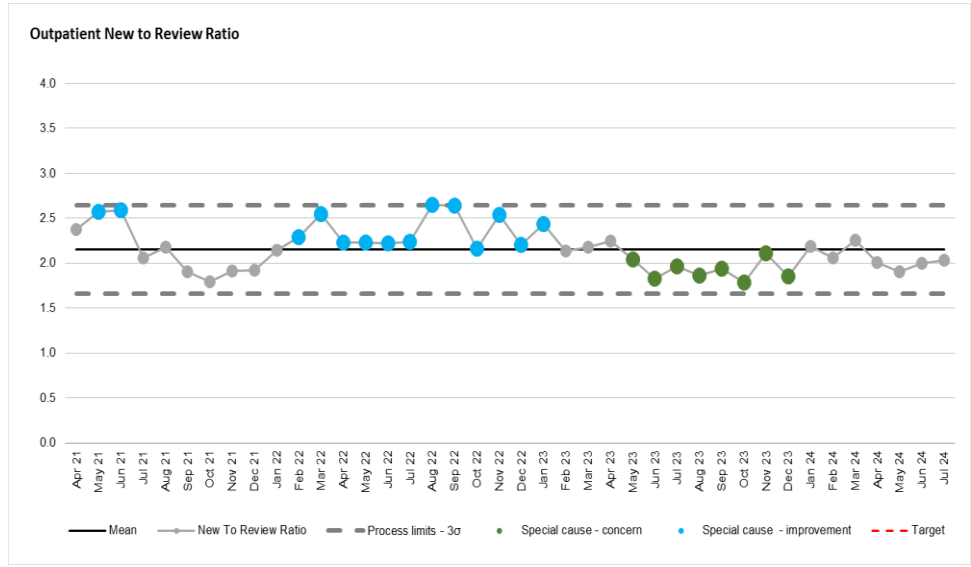


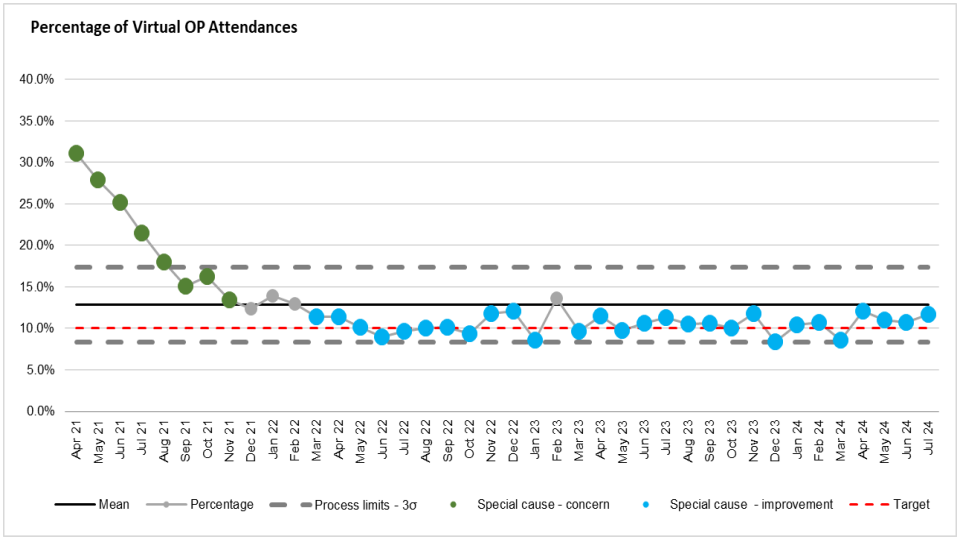


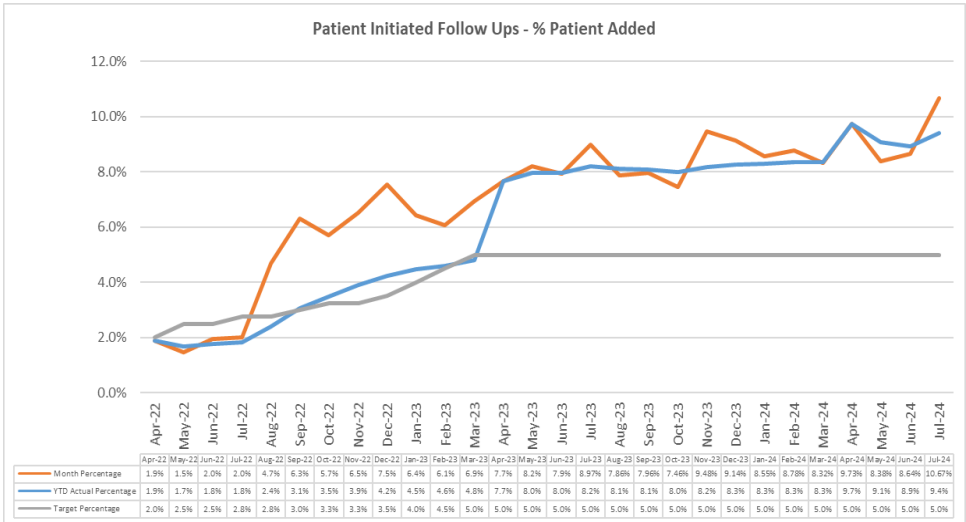
4. Outpatient efficiency

DATA QUALITY KITEMARK



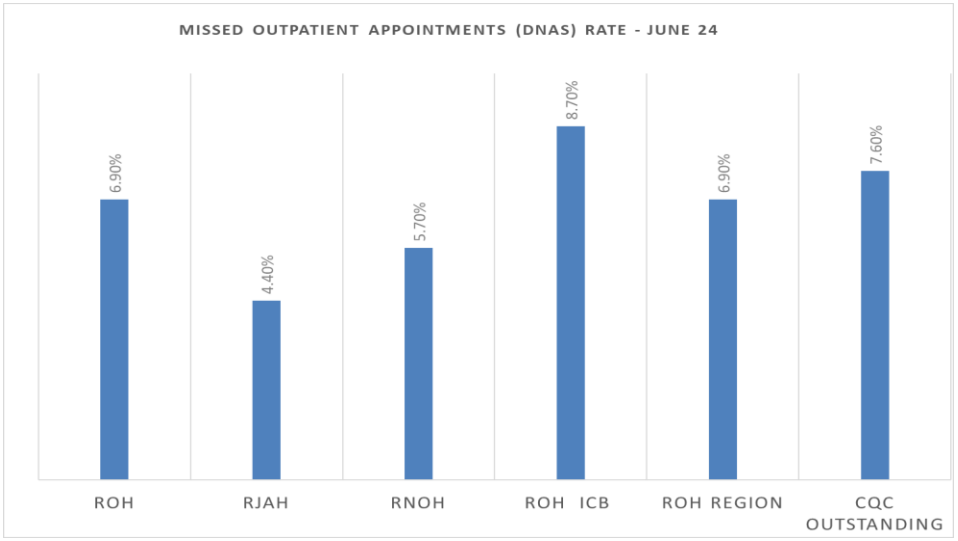


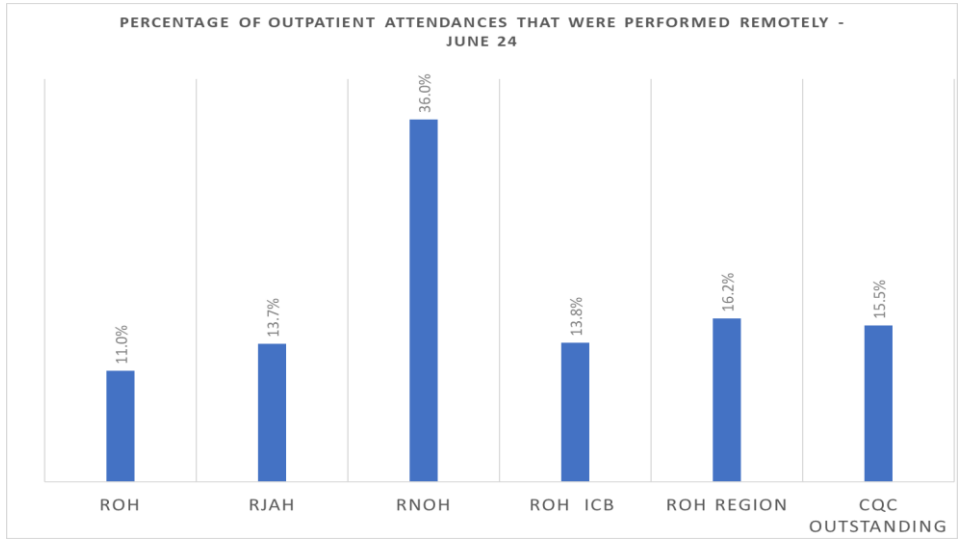


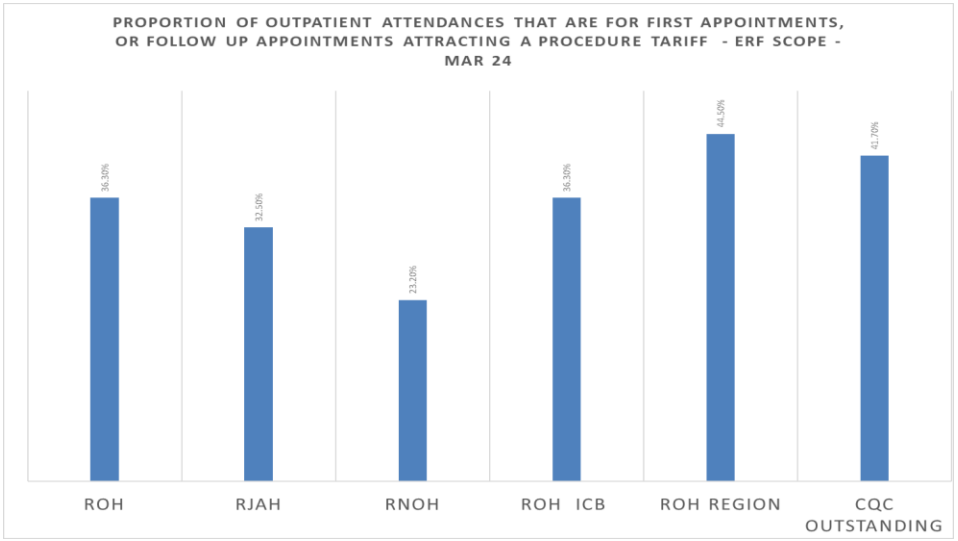


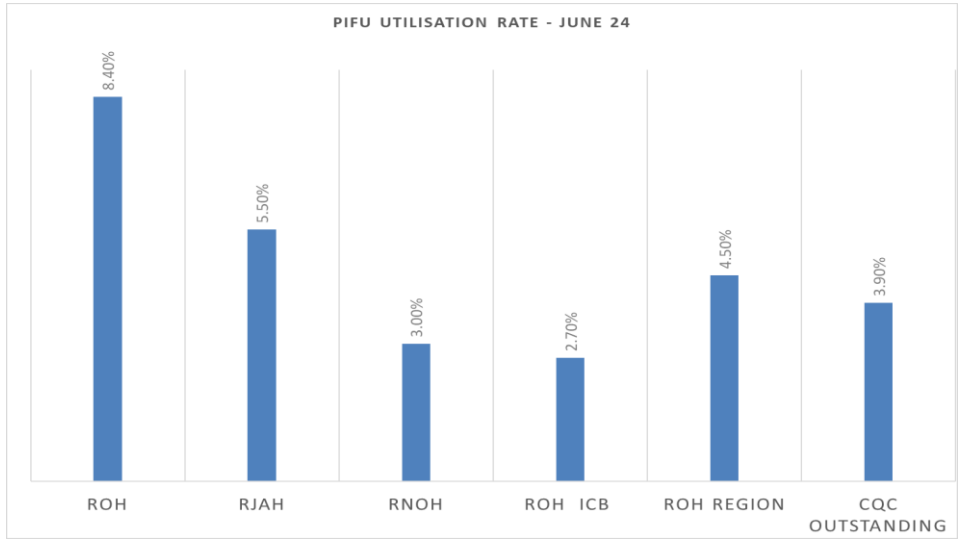
4. Outpatient efficiency

DATA QUALITY KITEMARK

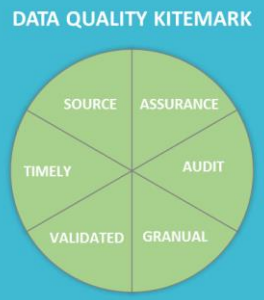








4. Outpatient efficiency



SUMMARY

July 2024 performance is as follows:

- 5,716 face to face and 719 virtual appointments
- 11.17% virtual in total.
- 10.6% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 9.4%.
- 6.92% Missed Appointment (DNA) rate – lower than the Trust target of 8%

- **Clinic Waiting Times**
- 30-minute delays – meeting Trust Target at 9.8% **(Target 10%)**
- 60-minute delays – meeting trust target at 2.8% **(Target 5%)**

AREAS OF IMPROVEMENT

Outpatient Utilisation

We have seen an increase overall with outpatient appointments. The focus remains on clinic utilisation, rooms bookings and clinic numbers measured through the 6-4-3 specialty scheduling meetings that remain well attended.

MA data, specialty follow up waiting lists, PIFU and RMS triage numbers, continue as part of the agenda. We identify key areas of concern with continued escalation

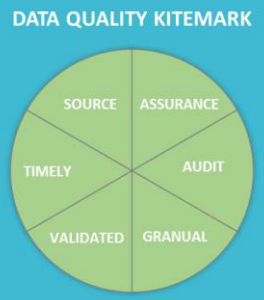
Friday outpatient check and challenge meetings with specialty leads, Outpatient Nursing team and appointments managers are on-going. Actions are reviewed from specialty scheduling meetings, and a look back at the previous week's activity highlighting areas of concern.

Missed Appointments (MA)
MA monthly meetings continue with a review of ICB MA toolkit, monitoring of Dr Doctor text messaging and MA prediction tool.

Appointments
KPI data is monitored weekly by the Div 1 ADOPs. KPI's also discussed at weekly Ops meeting on a Monday. Exceptions are escalated to the Deputy COO. Weekly specialty scheduling meetings are continuing with focus on clinic utilisation.

Digital
Business case being drafted for the upgrade of Flow Manager to enable implementation of the electronic outcome form and electronic room booking system.

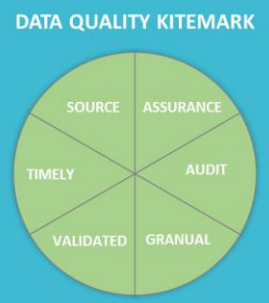
4. Outpatient Transformation



SPECIALTY PRIORITY UPDATES / HIGHLIGHTS

PIFU (8.6%)	Missed Appointments (6.7%)	Reduction in Follow Ups	Clinical Pathways (e.g. Specialist Advice)	Productivity & Efficiency
Oncology is carrying out an evidence-based review of pathways to introduce PIFU for long term condition management. PIFU rates continue to be in line with overall outpatient activity levels.	Configuration continues for TIARA appointments to receive reminders for appointments. Scoping for Pre-op Assessment to take place The Dr Doctor contract has been renewed to include direct messaging.	A further waiting list validation exercise has taken place to support the Spinal waiting list position.	Associate Medical Director for Division 1 is supporting the ongoing Clinical Pathways project. The aim of this programme is to improve referral criteria and service provision details to referrers in Primary Care. A primary care interface group is being established for September 2024	A business case for Vital Hub (formerly Intouch) is to be submitted by September 2024 to upgrade the system and include e outcomes and improved clinic management. The system is going to be increasing focus on the GIRFT further faster programme that ROH are already implementing.

5. Referral to Treatment



SUMMARY

The Referral To Treatment (RTT) position for July was **52.58%** against the National Constitutional Target of 92%. This represents a 1.83% increase compared to the June reported position of **50.75%** that includes patients transferred from other providers**.** The LUNA report for data quality validation is consistently above 98%.

There were **578** patients waiting over 52 weeks in July, an increase from the trust wide position in June which was **576** 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 July 24, ROH received 2,851 referrals (105.44%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

The trust validation team are continuing to validate all patients over 18 weeks to support the improving RTT position and manage patients through their pathway. The Team are working closely with the specialities to manage any potential delays.

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 Trust target is to have 0 x 65 weeks by the end of August 24 with the exception of clinically unfit / patient choice.

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

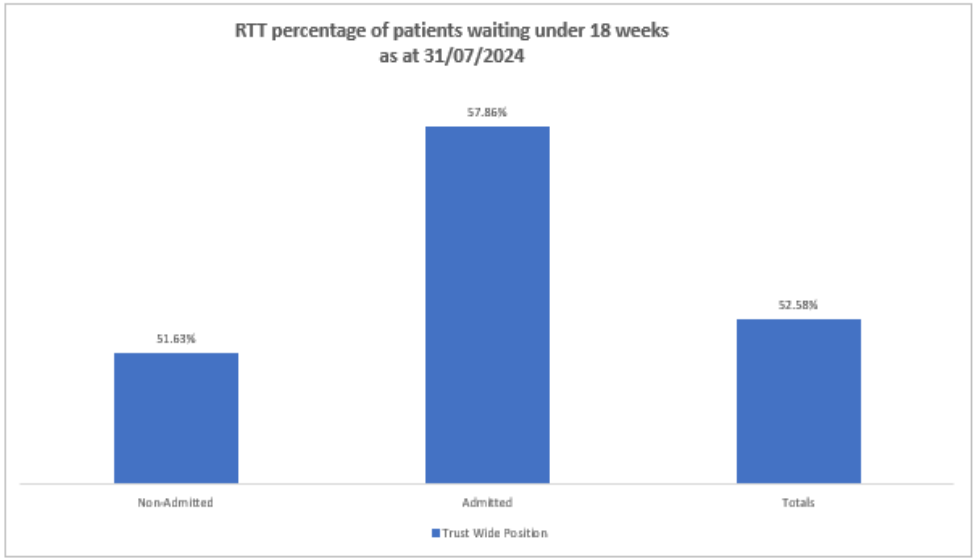
Spinal backlogs continue to be a concern with the team focussing on managing all patients currently over 60 weeks and preventing tip ins. Spinal is to be prioritised with the roll out of GIRFT follow up recommendations. Deputy COO is providing specific support to the Spinal team reviewing processes and pathways and meeting regularly with the consultant body.

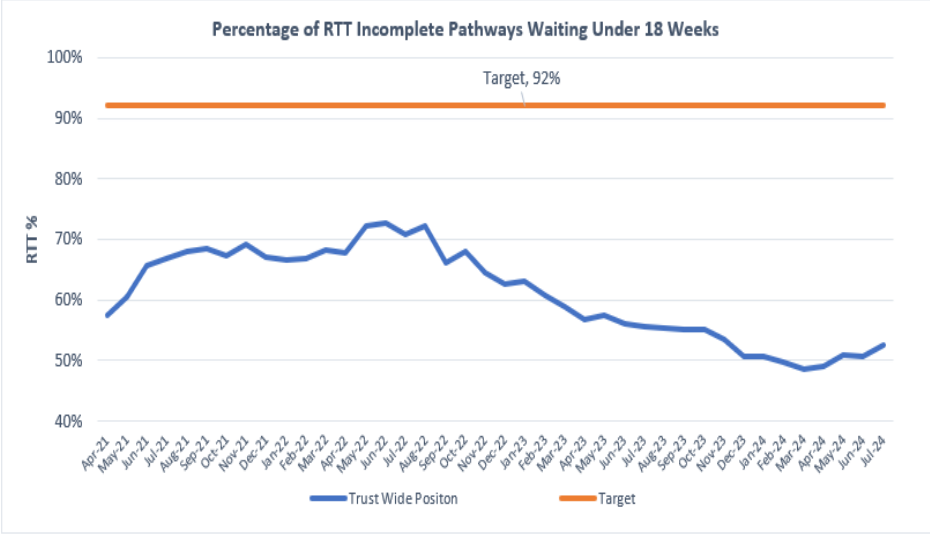
5. Referral to Treatment

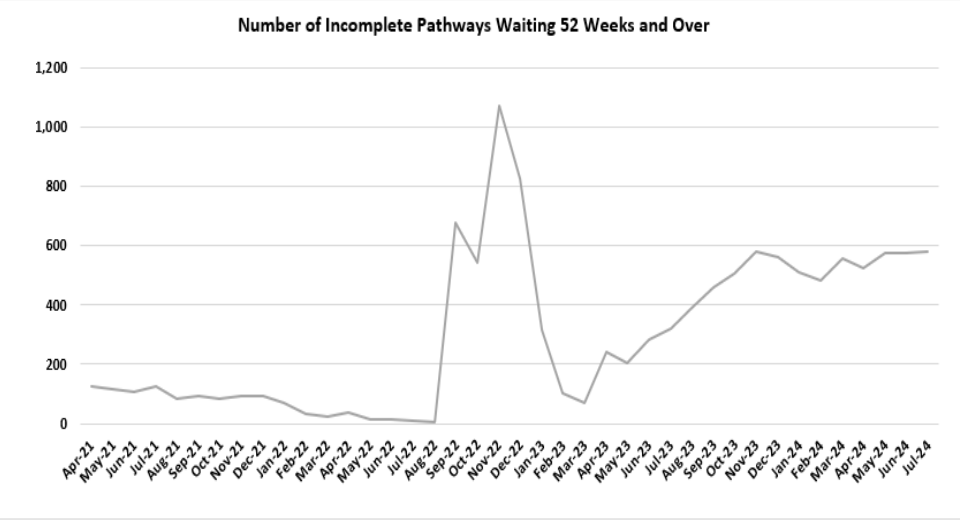
DATA QUALITY KITEMARK

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	3,307	647	3,954
7-13	2,445	484	2,929
14-17	1,025	234	1,259
18-26	2,194	422	2,616
27-39	2,175	335	2,510
40-47	1,136	113	1,249
48-51	347	44	391
52 weeks and over	498	80	578
Total	13,127	2,359	15,486

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,777	1,365	8,142
18 and over	6,350	994	7,344
Month End RTT %	**51.63%**	**57.86%**	**52.58%**



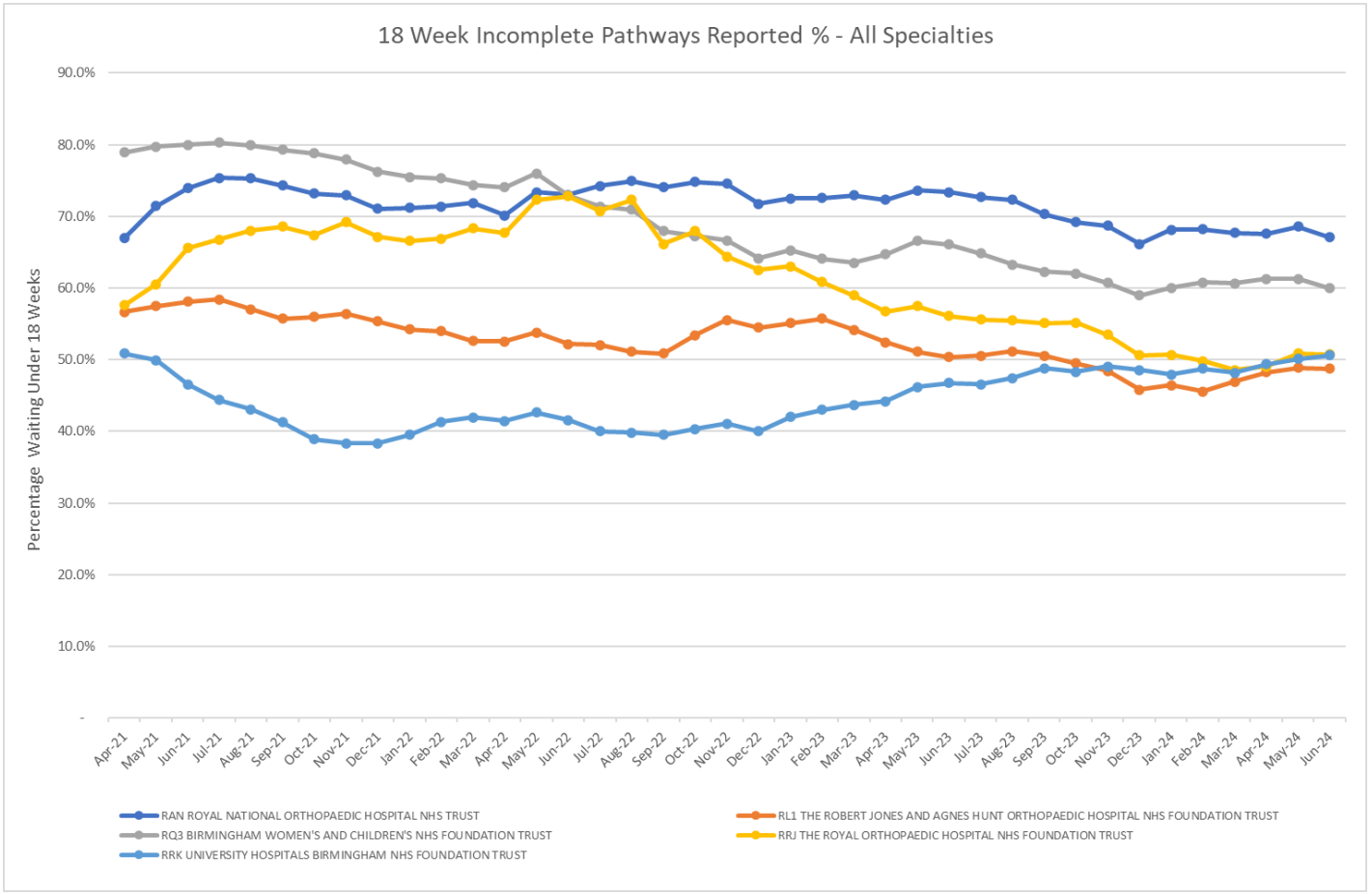




5. Referral to Treatment

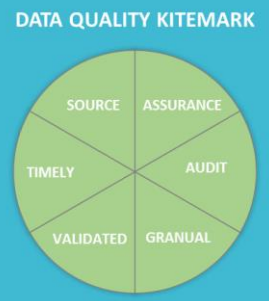
DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:

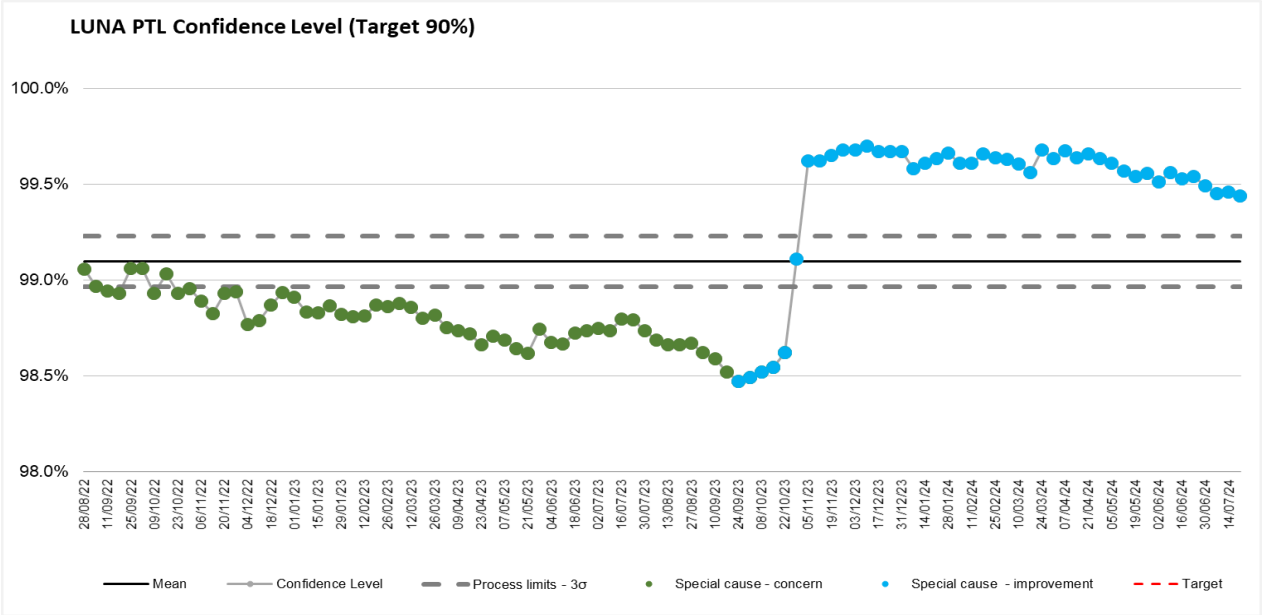


5. Referral to Treatment

Luna Data



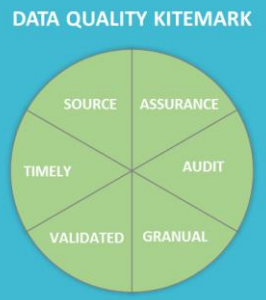
The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with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

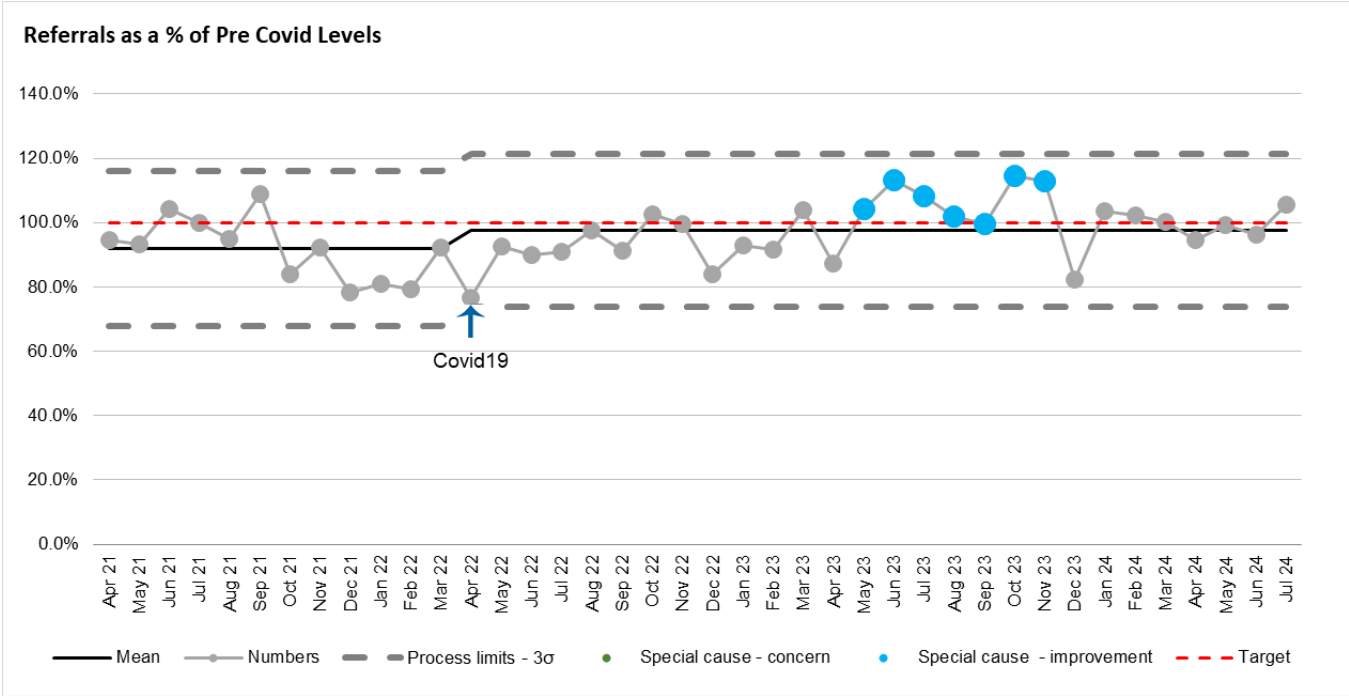


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

KPMG Audit highlights: KPMG provided a rating of significant assurance with minor improvement opportunities. A total of four findings, of which one is medium – a small sample of incorrect clock starts by a few days, and three are of low-level priority as follows: recommends a monthly reconciliation from data sent through to final RTT submission, clock stop times and ensuring maintenance of RTT trainers for new PAS users.

5. Referral to Treatment





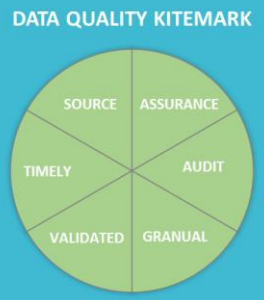
Pre Covid Level	2704

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	2554	2679	2601	2851								
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%	94.45%	99.08%	96.19%	105.44%								

5. Referral to Treatment

Specialty Breakdown



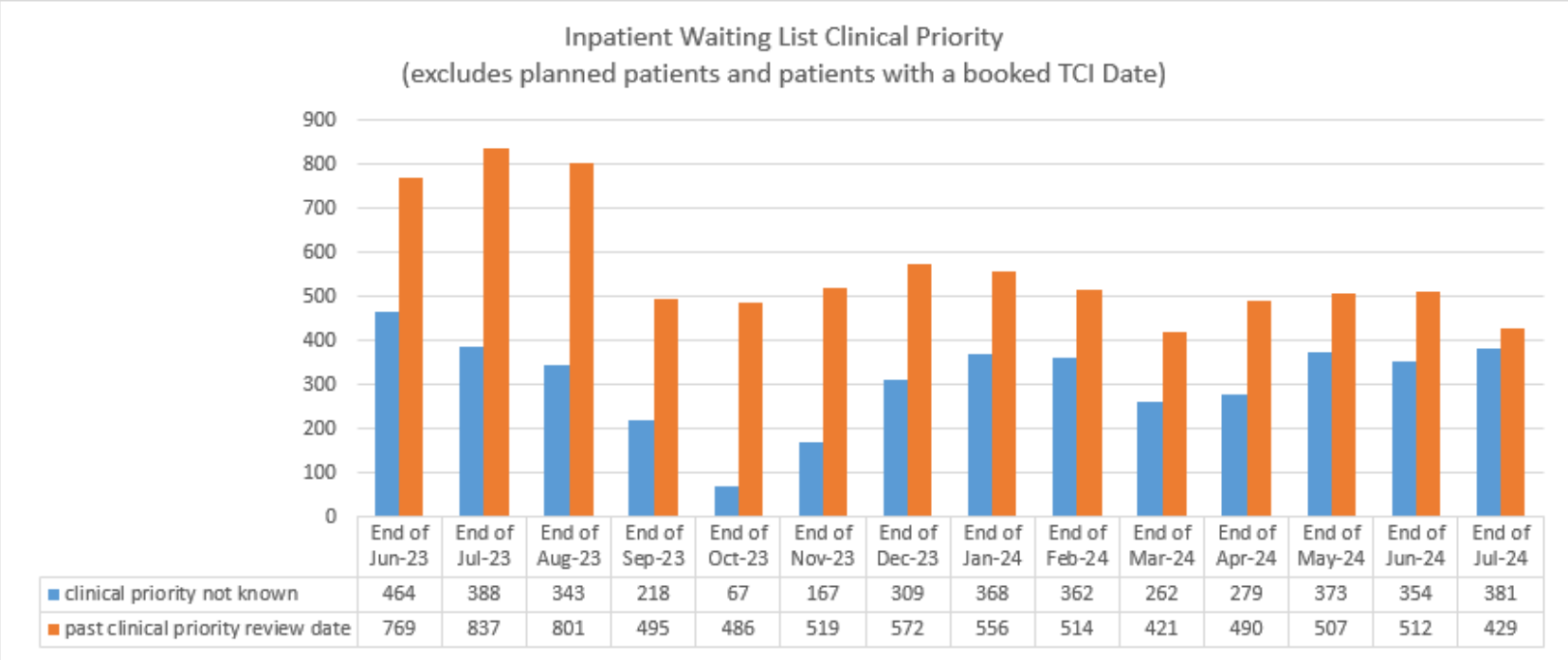
The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention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

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 16.07.24	RTT % as of 16.08.24	Difference
Arthroplasty	10	70.7%	71.1%	0.4%
Arthroscopy	36	45.2%	47.0%	1.8%
Clinical Support	7	58.7%	61.6%	2.9%
Foot and Ankle	34	41.1%	46.2%	5.1%
Hands	75	41.1%	45.6%	4.5%
Oncology	1	85.2%	87.3%	2.1%
Oncology Arthroplasty	1	71.6%	78.5%	6.9%
Spinal	253	31.1%	31.7%	0.6%
Spinal Deformity	185	29.7%	29.5%	-0.2%
Young Adult Hips	3	71.7%	71.2%	-0.5%

5. Referral to Treatment

DATA QUALITY KITEMARK

Overdue Clinical Priority:



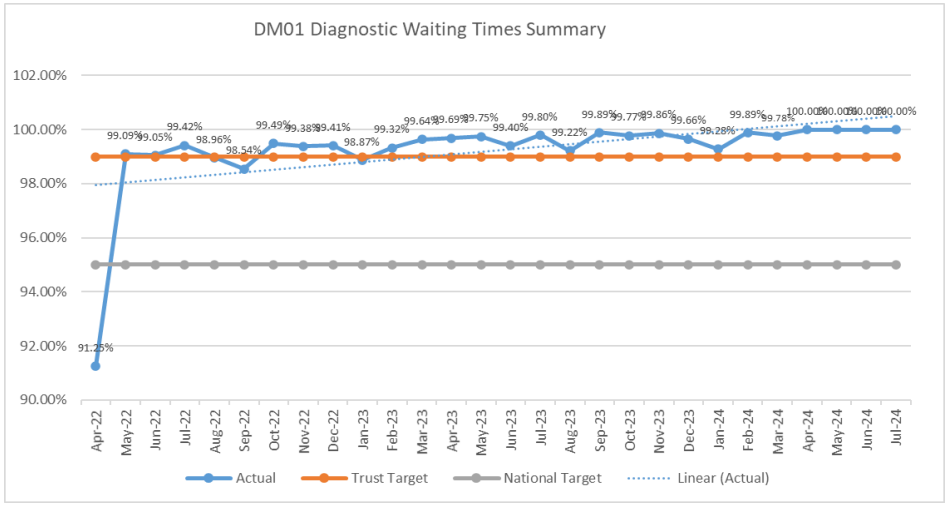
	End of Jun-23	End of Jul-23	End of Aug-23	End of Sep-23	End of Oct-23	End of Nov-23	End of Dec-23	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24
clinical priority not known	464	388	343	218	67	167	309	368	362	262	279	373	354	381
past clinical priority review date	769	837	801	495	486	519	572	556	514	421	490	507	512	429

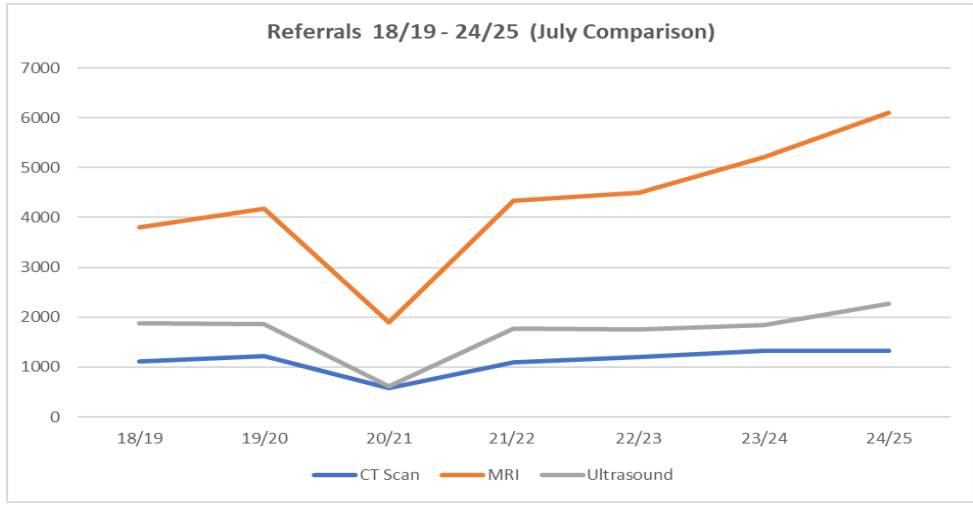
The number of patients with an unknown clinical priority has increased by 27 patients, however, the numbers that have past the clinical priority review date has reduced by 93 patients. The information continues to be shared on a monthly basis with individual services and clinicians to manage individual clinical practice.

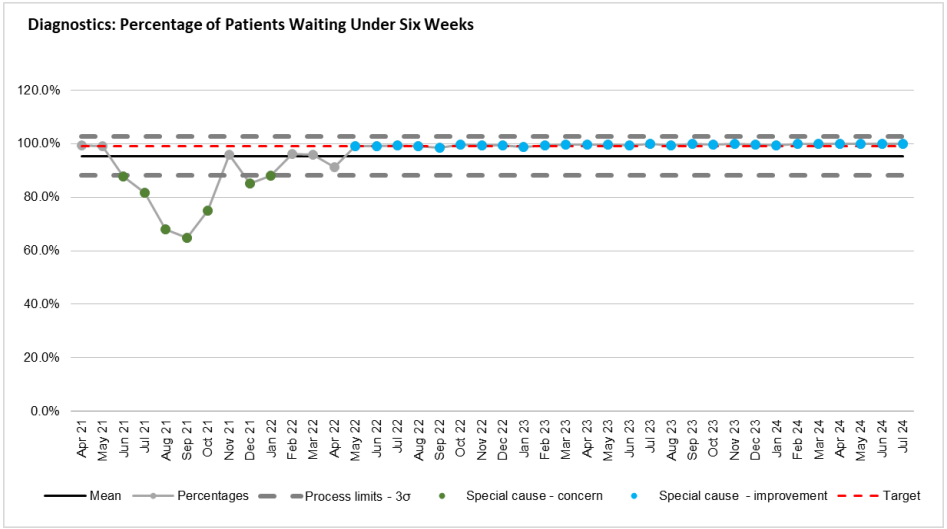
There will be a focus in August 2024 with clinicians and medical secretarial colleagues to update clinical priority records accordingly.

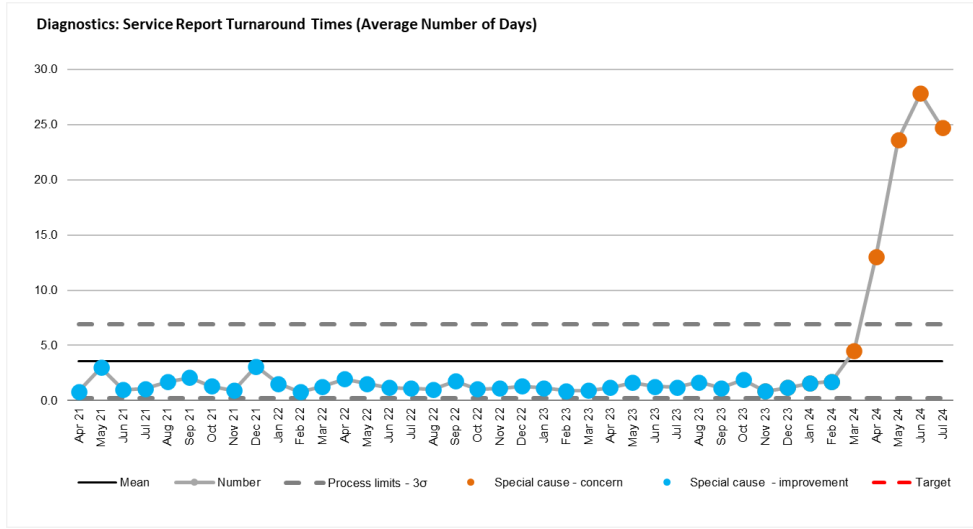
6. Diagnostic Performance

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









7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in July 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

Plan to reduce the typing backlog ongoing with clinical staff supporting. All Oncology imaging continues to be prioritised and typed. July has now been cleared so focus is now on getting August back on track.

Reduction in bank & agency spend due to recruitment into vacancies (MRI, X-ray & admin).

Adjusting Consultant job plans to maximise clinical duties and capacity in both CT and ultrasound to support Oncology services

Implementing electronic letters being sent via Dr Doctor – anticipated go live in August 2024.

Outsourcing of the reporting has commenced,and has started to reduce the reporting turnaround times significantly.
June 24 reporting has been cleared, and July's activity is being processed by the outsourcing provider. We expect to be back on track during September 2024.

RISKS

There is a current risk with Consultant Radiologist workforce vacancies. The previous advert failed to attract suitable candidates for shortlisting. The advert will go out again is September 24.

8. Cancer Performance

Summary Performance Figures – August 24 (June 2024 Submission)

	June Performance				
	Number of patients	Compliant	Breach	Accountable	%
28 days FDS	94	74	20	94	78.72%
31 day to treatment	19	18	1	19	94.74%
62 days	18	10	5	15	66.67%

		June 2024 (Old Standards)			
Target Name	National Standard	%	In target	Breach	Total
2 WW	93%	98.3%	59.0	1.0	60.0
31 First	96%	92.9%	13.0	1.0	14.0
31 day subsequent	94%	100%	5.0	0.0	5.0
62 day Standard	85%	66.7%	2.0	1.0	3.0
62 day (Cons Upgrade)	n/a	66.7%	8.0	4.0	12.0
28 day FDS REPORTED	75%	78.7%	74.0	20.0	94
Patients over 104 days (62 day standard)					0

Performance

The trust was compliant against faster diagnosis standards for June 24 achieving 78.72% against a national target of 75%. Unfortunately, the 31-day target was not met for 1 patient that requiring input from 4 specialities for surgery due to the complexities of the case. The combined reporting improved the overall rating from 92.9% to 94.74% Unfortunately, the 62-day metric was also not achieved at 66.67%. A total of 15 treatments were applicable to the trust, 10 of those were compliant and the remaining 5 patients breached this target due to a requirement for multiple biopsies and complex diagnostic pathways.

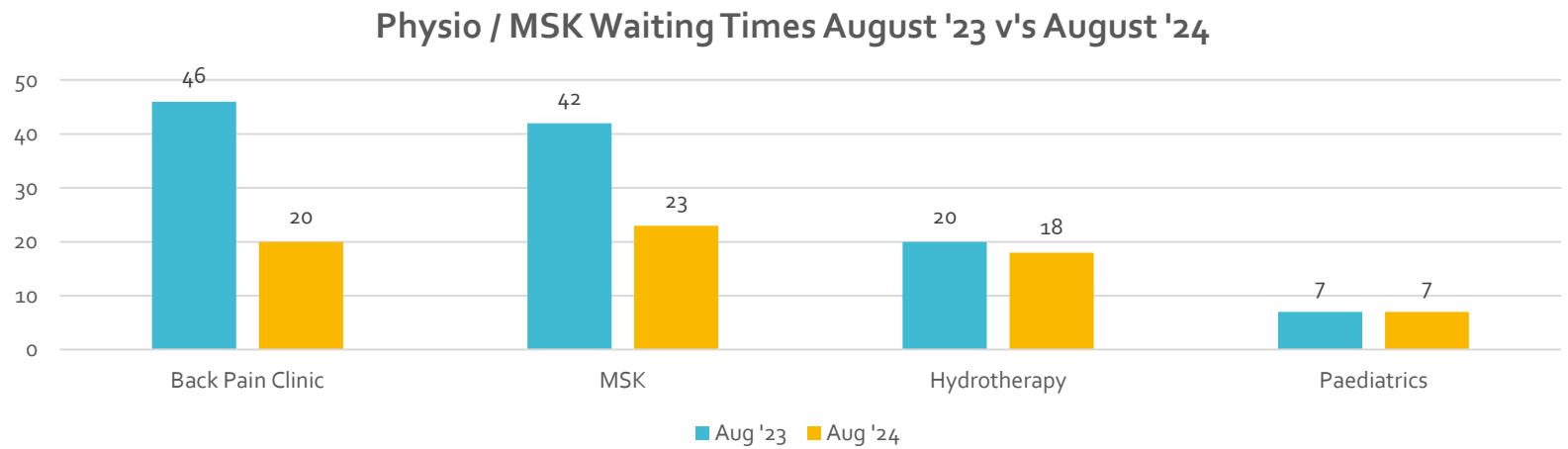
The root cause of the delays for the 62-day breaches was due to complex diagnostics and surgical planning.

- 0.5 shared breach, late tertiary out day 44. Complex surgical planning, patient was for re-section, but pre-op scans showed tumour enlargement. The patient was referred out late for pre-op RT.
- 1 breach, tertiary referral received day 8. Complex diagnostics patient required two repeat biopsies. Patient had 2 repeat biopsies and pathology wait was 20 days for each pathology report. Complex diagnostics.
- 1 full Breach patient was scheduled for surgery within 62 days; however, a further lesion was identified. The TCI was cancelled, and another biopsy performed. The breach was due to the second lesion being identified.
- The remaining two patients breached due to complex surgical planning, both patients had sacrum lesions and required four specialties for operating. Plastics, spinal, pelvic and retroperitoneal were required for surgery therefore unable to schedule within 62 days.

Risks /actions ongoing

The team continues to monitor performance 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. 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. Interventional radiology capacity has been reduced to 3 list a week due reduction in workforce with maternity leave. Positive service development 5th pelvic surgeon now being trained to address one of the key challenge areas for elective capacity and a business case is currently being developed for approval of an SLA expansion to address joint plastic surgery capacity.

9. MSK Waits



Summary – data as per 12/08/24

The chart above shows the significant improvement in therapy waiting times covering the period August 2023 to August 2024. Work continues to ensure clinics are fully maximised to support reducing the waiting times further.

It is therefore recommended that this metric is reported on a quarterly basis or by exception if waiting times deviate off track.

Risks /actions ongoing

- Recruitment continues to be a challenge for physiotherapists, occupational therapists and clinical psychology.
- Waiting times are being managed and reducing steadily.
- Administrative workforce challenges remain in managing a PTL of over 4,500 pts, resource intensive.
- Community appointment day is planned for October 2024 in line with the MSK programme which has produced a waiting list reduction in pilot projects already undertaken within the system (Solihull May 2024).

10. Private Patients

SUMMARY

- The service has ambitions to exceed £5m turnover this financial year.
- The service exceeded its July 24 income target by £67k.
- July has seen the biggest turnover in inpatient income for the service so far.
- The service is running at £208k behind plan.
- August income is expected to exceed plan by circa £50k, bringing the overall YTD position to -£158k
- The service secured continuation of the Aviva hip and knee network contract that will commence in November and BUPA recognition is expected to be agreed in October. The BUPA contract will support business growth and support the service to reach income plan for the year.

24-25 summary	M1	M2	M3	M4	YTD
Income Plan (£000)	425	425	425	407	1682
Income to be collected (£000)	375	384	241	474	1474
Variance	-50	-41	-184	67	-208

***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 the income received ***.

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:

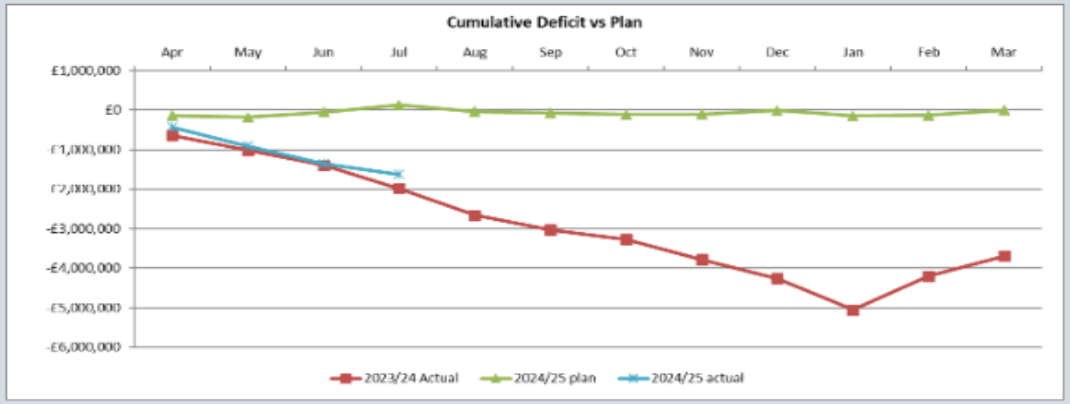
A) Private Practice oversight group meet 29.7.24. Key work programmes include the agreement of process to support outside surgeons to practice at ROH, oversight of private practice privileges
B) CSL to lead communication with surgeons to support increasing their activity
C) Weekend spinal theatre capacity is being well utilised with full lists booked in August and at maximum financial viability.
D) Marketing commenced in July with leafleting drop, website refresh and targeted advertising in regional magazines

8. Finance on a Page

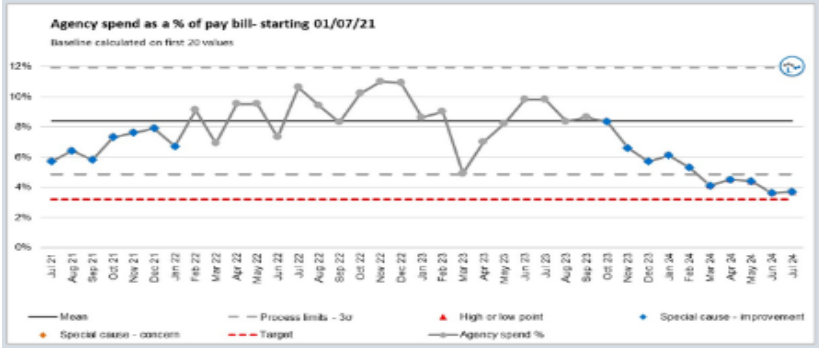
Month 4

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	£10,995	£10,962	-£33	£43,948	£43,595	-£353	£131,973	£131,186	-£787
Other income	£536	£474	-£62	£2,135	£1,915	-£220	£6,432	£6,262	-£170
Pay	-£6,346	-£6,517	-£171	-£25,466	-£25,736	-£270	-£78,370	-£76,302	£2,068
Non Pay	-£4,900	-£5,175	-£275	-£20,050	-£21,083	-£1,033	-£58,691	-£60,186	-£1,495
Non operating costs	-£119	-£18	£101	-£476	-£350	£126	-£1,436	-£1,052	£384
Remove capital donations	£8	£8	£0	£30	£30	£0	£92	£92	£0
TOTAL	£174	-£266	-£440	£121	-£1,629	-£1,750	£0	£0	£0



Agency as a % of paybill =3.7%



Efficiencies	YTD	Forecast
Plan	£1,784	£8,220
Actual	£1,321	£8,220
Variance	-£463	£0

Capital	YTD	Forecast
Plan (exc IFRS16)	£1,224	£4,400
Actual	£248	£4,400
IFRS 16	£0	£756
Variance	£976	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	82.9%	0.3%
By Value	86.1%	1.5%
NHS		
By number	55.3%	4.7%
By number	28.1%	6.0%
Total		
By number	82.3%	0.5%
By Value	81.2%	1.7%

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £266k against a planned surplus of £174k, generating an adverse £440k variance. Year to date deficit totals £1,629k deficit against a surplus plan of £122k, generating an adverse £1,751k variance.

Income year to date under performed by £574k. This relates to a £159k underperformance in Private patient income, a slight underperformance on education income, and a £252k provision for 24/25 convergence and growth adjustment for commissioners.

Pay expenditure is overspent in month by £170k and year to date by £270k. Agency spend has been a little higher this month due to holiday cover, but is largely in line on a percentage basis with last month at 3.7% of paybill (3.6% prior month).

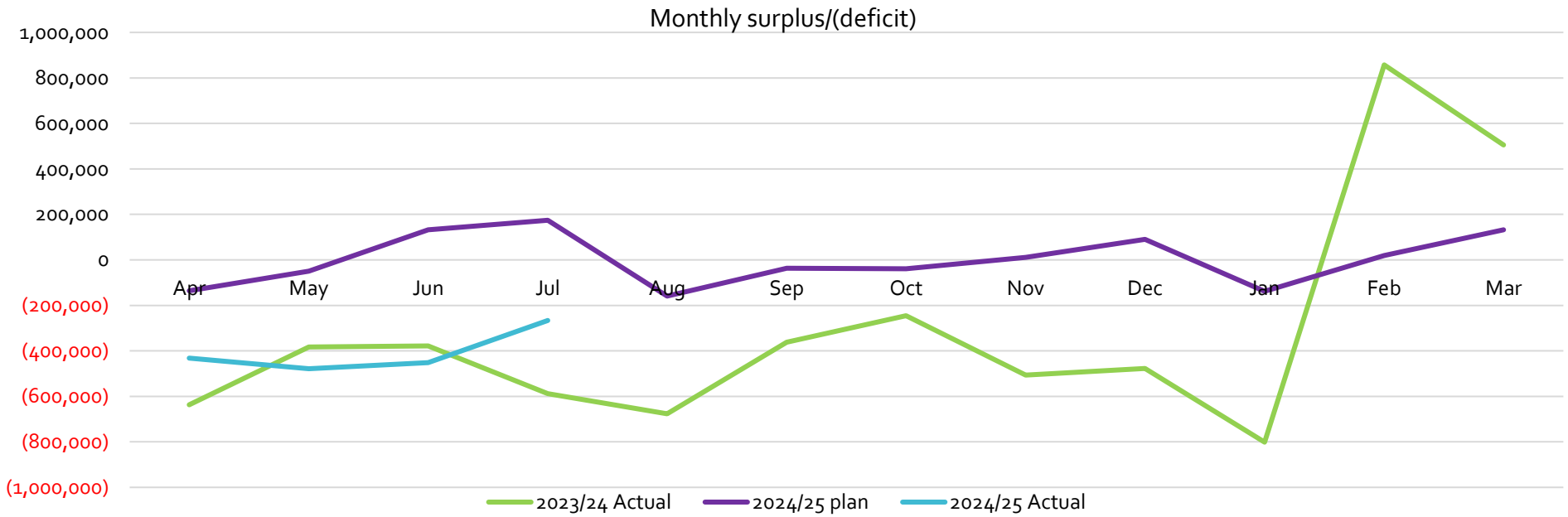
Non pay expenditure overspent in month by £275k and year to date adverse variance of £1,033k. This is primarily driven as a result of LLP expenditure above plan and unidentified CIP not yet identified.

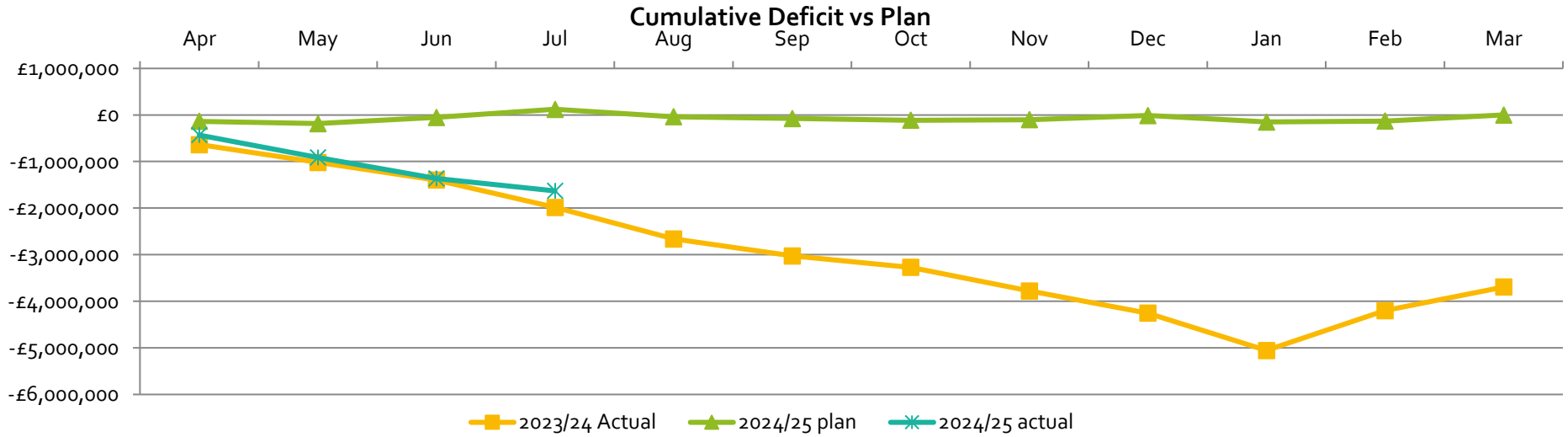
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(574)	(270)	(1,033)	126	(1,751)
Year to date plan	46,084	(25,466)	(20,050)	(446)	122
Year to date actual	45,510	(25,736)	(21,083)	(320)	(1,629)
Variance compared previous month	↓	↓	↓	↑	↓

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	43,948	43,595	(353)
Other Operating Income (Excluding top up)	2,135	1,915	(220)
Employee Expenses (inc. Agency)	(25,466)	(25,736)	(270)
Other operating expenses	(20,050)	(21,083)	(1,033)
Operating Surplus	**567**	**(1,309)**	**(1,876)**
Net Finance Costs	(475)	(350)	125
Net surplus/(deficit)	**92**	**(1,659)**	**(1,751)**
Remove donated asset I&E impact	30	30	0
Adjusted financial performance	**122**	**(1,629)**	**(1,751)**

9. Overall Financial Performance





10. Income

SUMMARY

Income year to date under performed by £574k. This relates to a £159k underperformance in Private patient income, a slight underperformance on education income, and a £252k provision for 24/25 convergence and growth adjustment for commissioners.

Elective Recovery Fund (ERF) income performance is an underperformance against NHSE target of £1.7m year to date and underperformance of £2.5m against the adjusted ERF target. The adjusted ERF target includes the additional activity performance included within the route to breakeven plan. This is not currently accounted for within the income position stated above.

AREAS FOR IMPROVEMENT

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

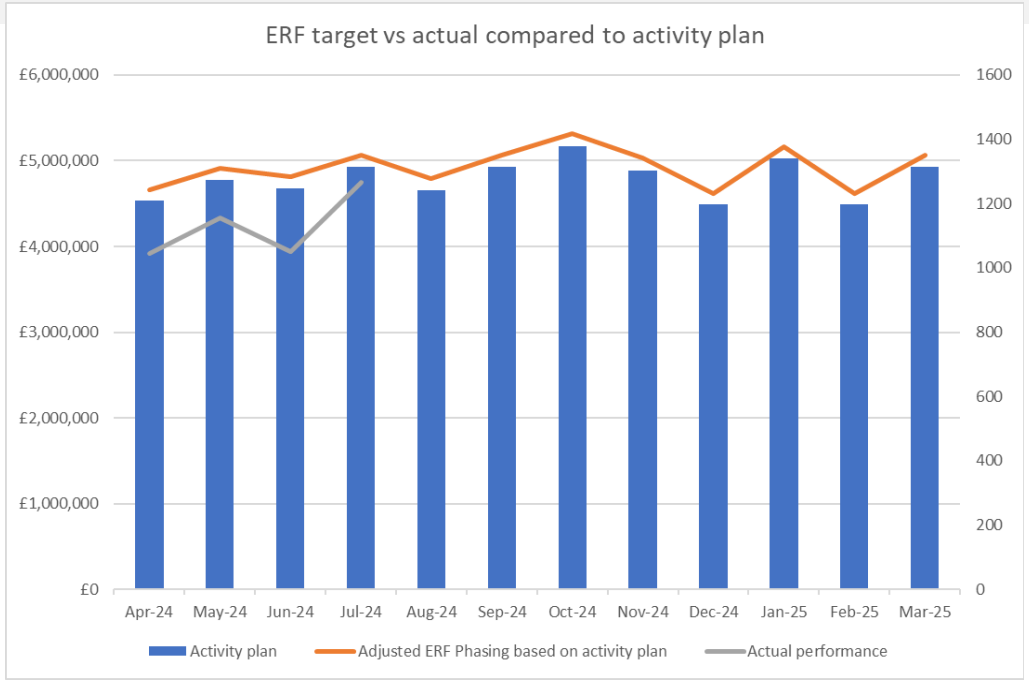
RISKS / ISSUES

Elective recovery target delivery remains a risk. 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 with significant increase in ERF target set by NHSE in Q4.

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

10. Income



Elective Recovery Fund (ERF)

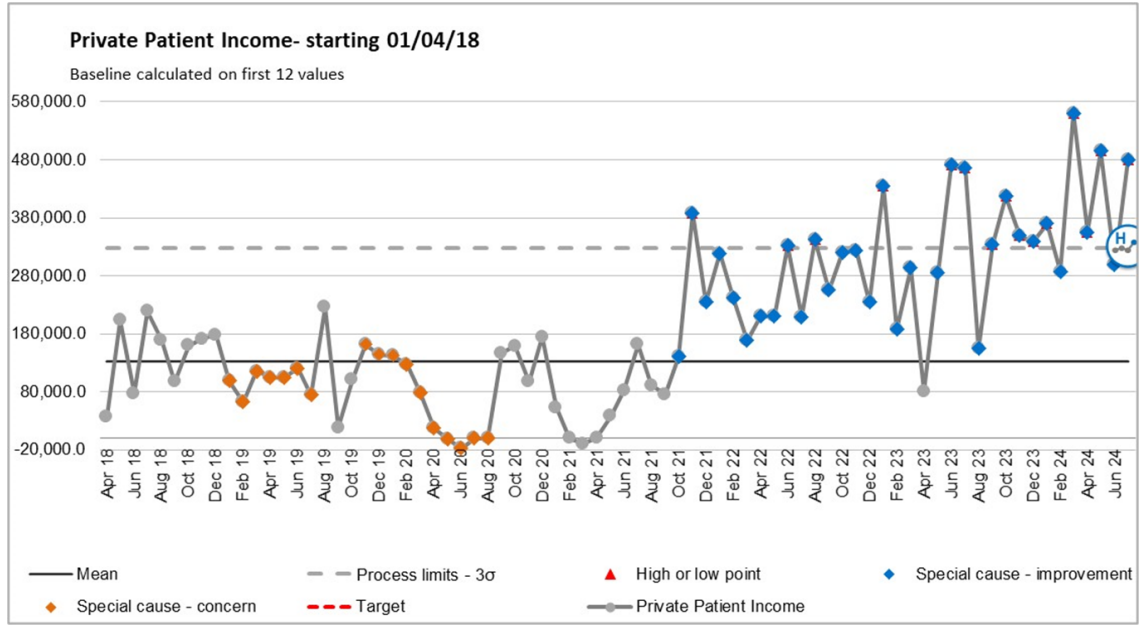
Elective Recovery Fund (ERF) income performance is an underrperformance against NHSE target of £0.8m year to date and underperformance of £2.5m against the adjusted ERF target. The adjusted ERF target includes the additional activity performance included within the route to breakeven plan.

	YTD Target	YTD Actuals	over/(under) performance
NHSE target Elective Recovery Fund	£17,004,082	£16,934,535	-£823,281
Adjusted Elective Recovery Fund (breakeven)	£19,437,086	£16,934,535	-£2,502,551

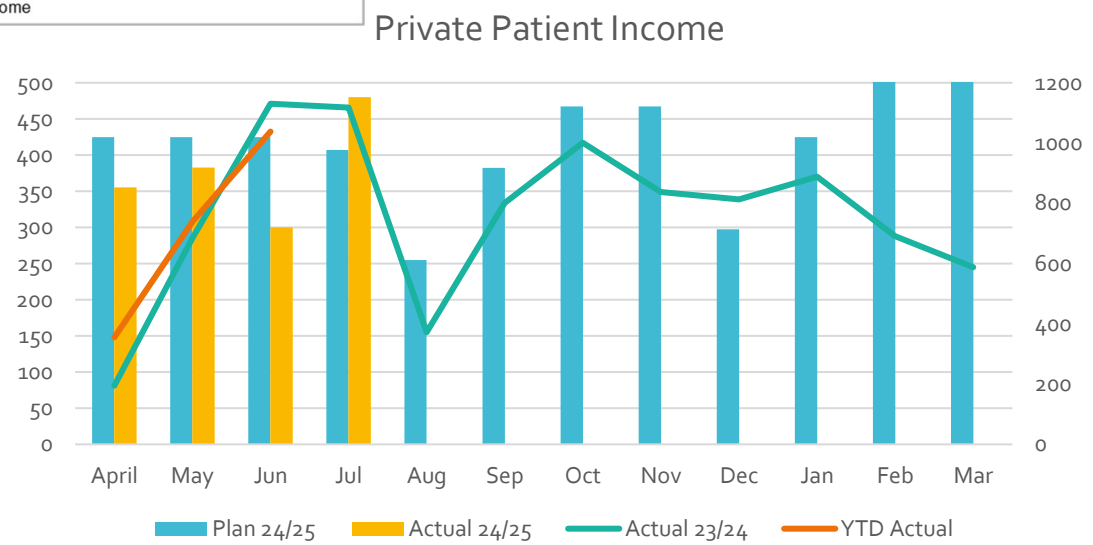
£'000s						
19/20 baseline	Estimated 24/25 target (1.1% net inflation tariff uplift)	Additional income for 4% increase	Additional 2% to breakeven	23/24 underperformance adjustment	Adjusted ERF target	% 19/20 baseline
48,710,331	54,440,185	2,153,914	1,076,957	£1,836,990	59,134,960	121%

10. Income

Private patient income



*note that the private patient income reported is different to the value reported in the operational report. The finance value includes all private patient activities and is based on the same principles of NHS reported income of being accounted for based on discharge date and not TCI



11. Expenditure

SUMMARY

Pay expenditure is overspent in month by £170k and year to date by £270k. Agency spend has been a little higher this month due to holiday cover, but is largely in line on a percentage basis with last month at 3.7% of paybill (3.6% prior month).

Non pay expenditure overspent in month by £275k and year to date adverse variance of £1,033k. This is primarily driven as a result of LLP expenditure above plan and unidentified CIP not yet identified.

Surgical LLP spend year to date is an overspend of £522k with spend of £830k against a plan of £308k.

There continues to be high spend in theatres which is £1.2m overspent YTD. An additional contract performance meeting with Genmed has further strengthened controls and actions to militate further cost increases have been agreed., Additional reporting is now in place, providing more information on which further decisions can be taken

Unidentified CIP now totals £405k year to date. Whilst additional recurrent schemes are being identified the Trust now need to identify non-recurrent schemes which can deliver this.

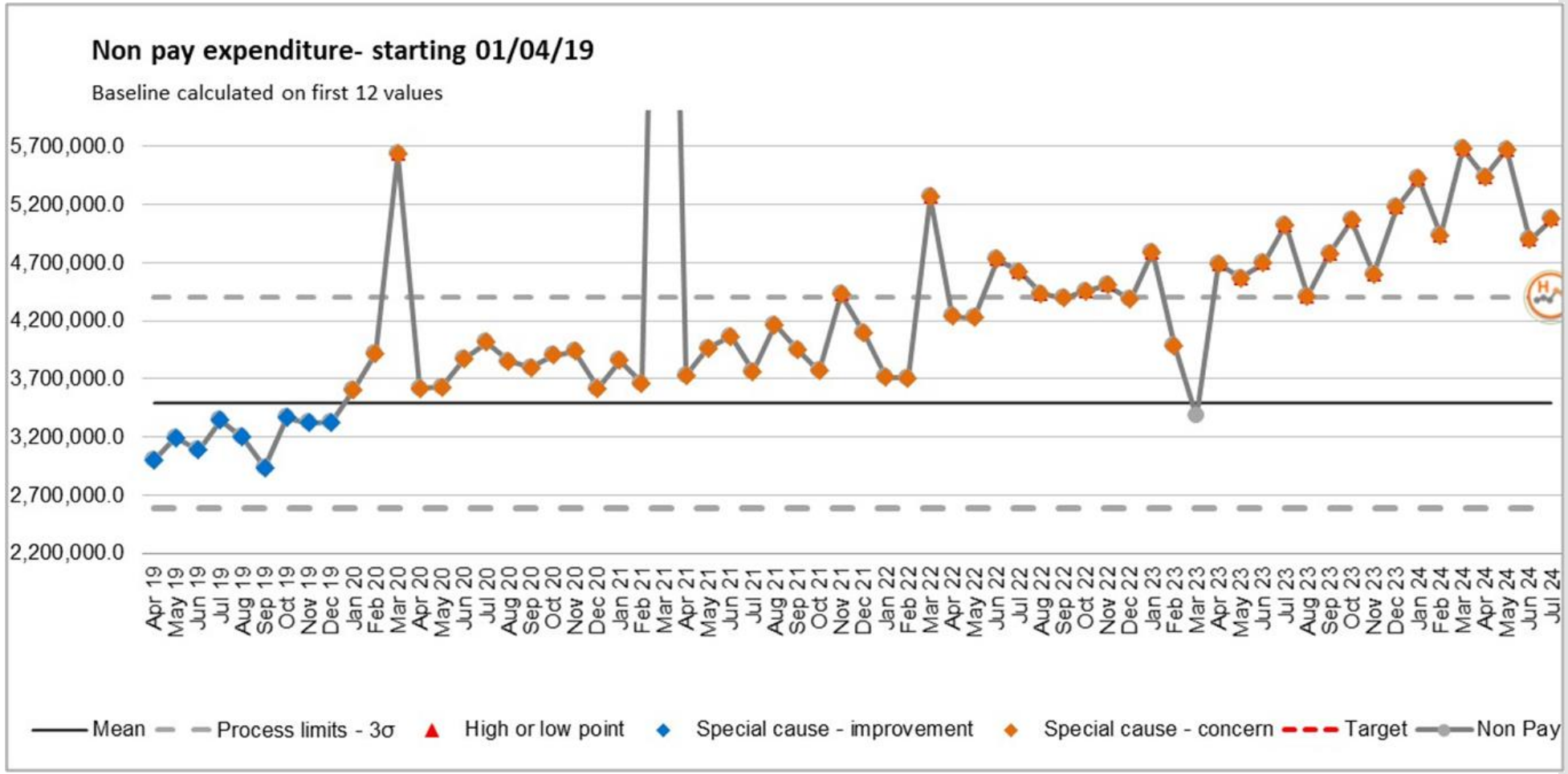
AREAS FOR IMPROVEMENT

- Agency spend is above agency cap as a % of pay bill against a cap of 3.7%.
- Identification of CIP
- Theatre consumable spend reducing to planned levels.
- LLP expenditure reduction.

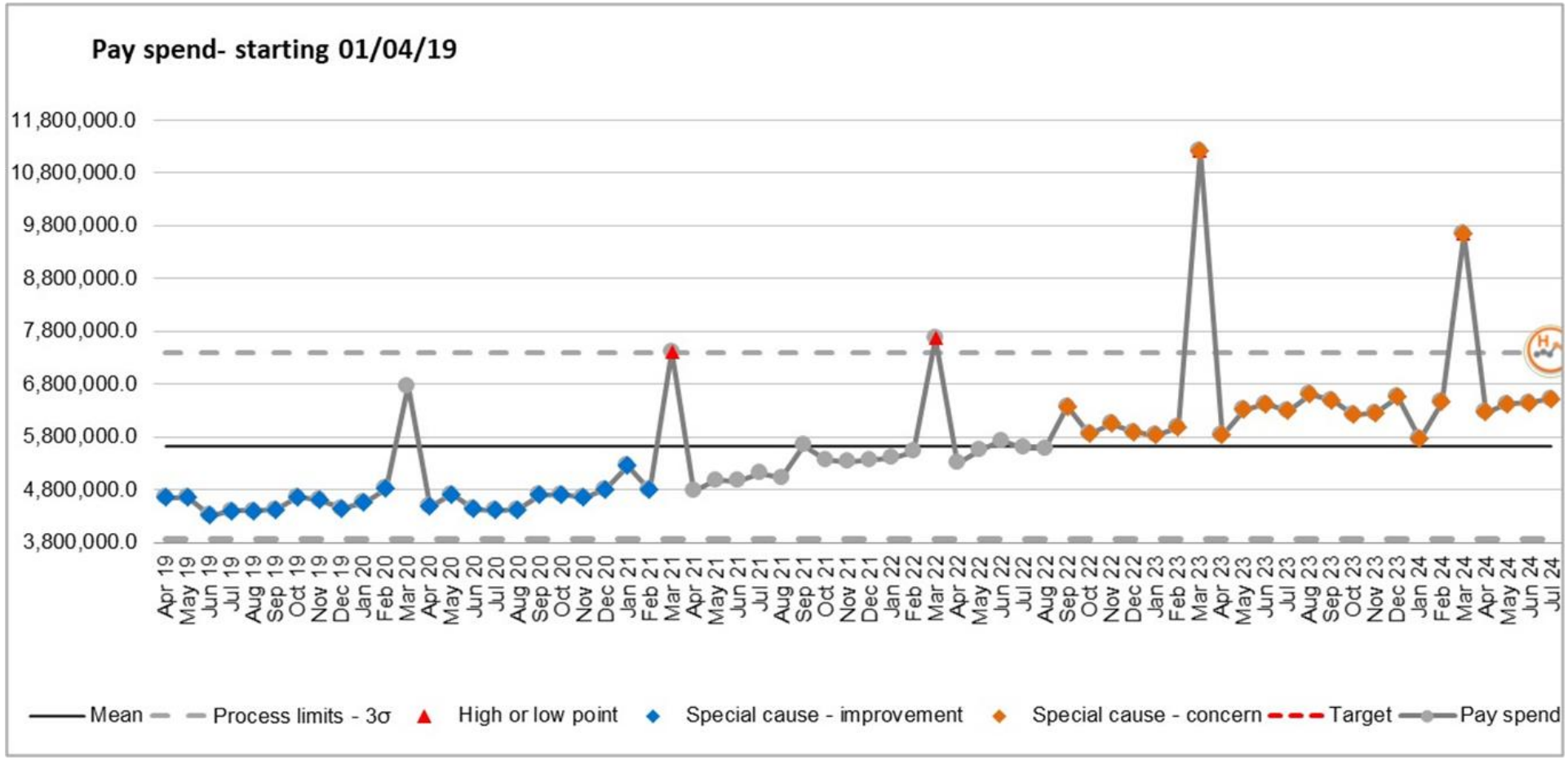
RISKS / ISSUES

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

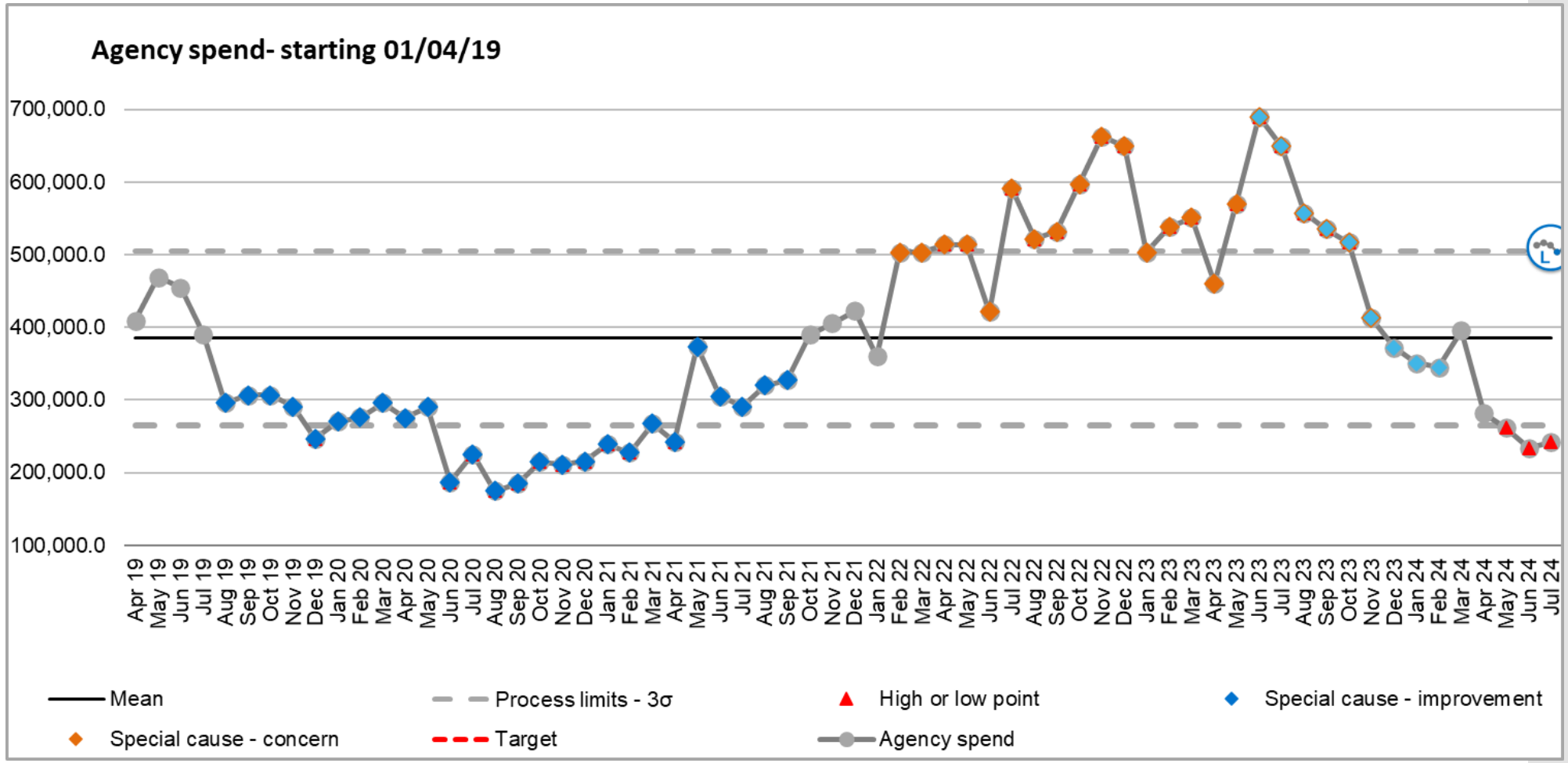
12. Non Pay Expenditure



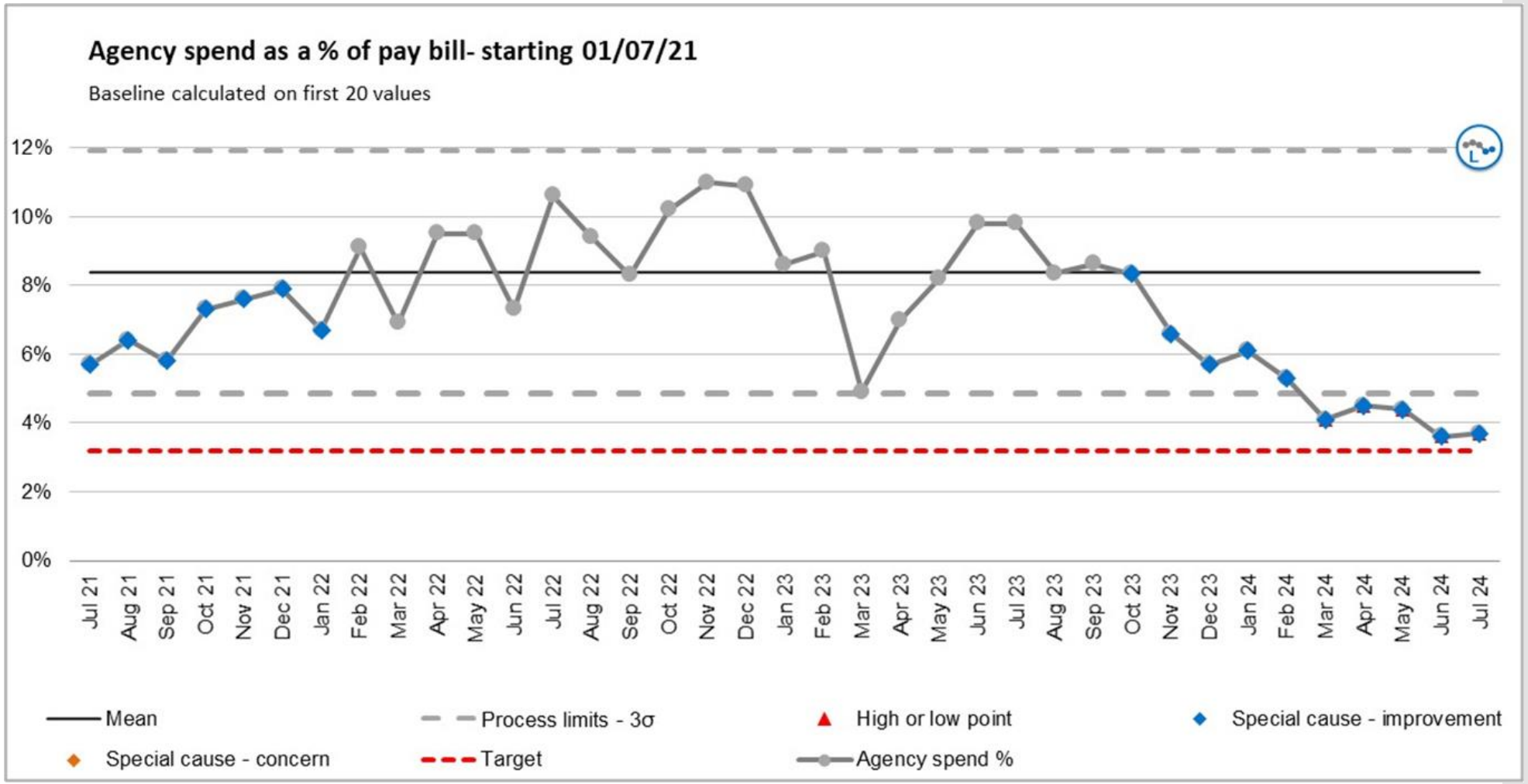
13. Pay Expenditure



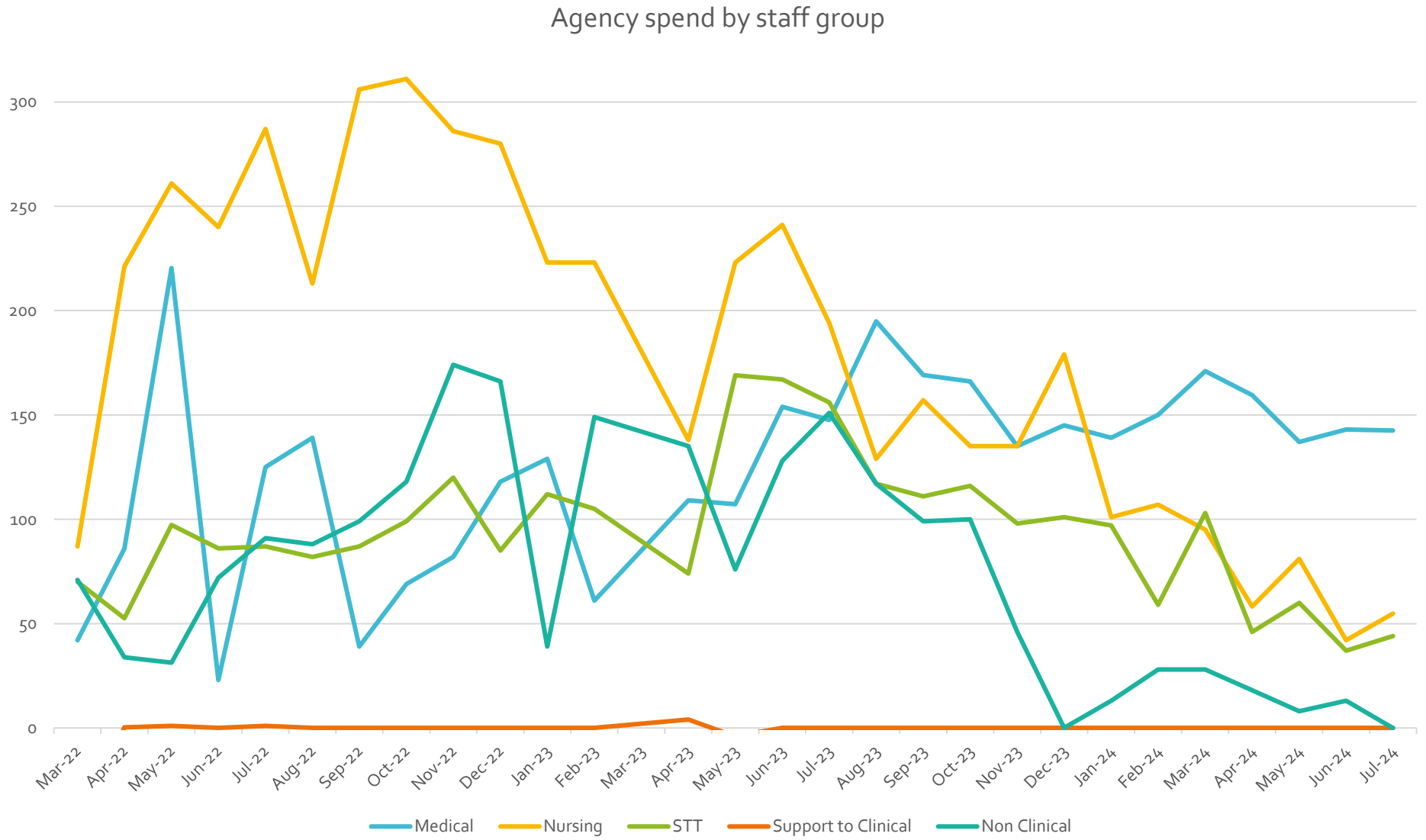
14. Agency Expenditure



14. Agency Expenditure



14. Agency Expenditure



15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £1,321k have been delivered, against a plan of £1,784k, delivering an adverse variance of £463k. Unidentified CIP has contributed to the underperformance year to date. The Financial Sustainability and Improvement Group has given focus to the unidentifed CIP and additional schemes have been identified to reduce this value.

PFR Catergory	Scheme	Plan TOTAL
Non-Pay-other	Discretionary spend hold	750
Pay-Agency	Minimisation of overall agency spend	2904
Income-Non-Patient Care	commercial income	294
Pay-service redesign	POAC redesign nurse led model	115
Non-Pay-Medicines effiecincies	Pharmacy - Generic switches	154
Pay-corporate service transformation	Non clinical admin, vacancy and bank hold	334
Non-pay-Procurement	Procurement - Birmingham Hospital Alliance Collaborative	198
Non-pay-Service redesign	Day case unit - increase to 23 hour days	750
Non-pay-Procurement	Procurement -ROH	528
Income-Private Patient	Private patient service expansion	440
Pay-E Job Planning	Consultant premium rate working (LLP spend reduction)	564
Income-other	ERF additional income	607.2
	Scheme total	7638.2
	Unidentified	582
	TOTAL	8,220

15. Route to breakeven progress

	Proposed opportunity	Proposed implementation	24/25 opportunity		QIA Assessment: Patient Experience	QIA Assessment: Patient Safety	QIA Assessment: Clinical Effectiveness	Exec Lead	Progress: Monitoring forum	Progress: June'24	Progress: July'25	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	Increase of non clinical posts by £18k from M12 23/24	Reduction in month of £41k	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	Year to date u/spend £38,354	Year to date u/spend £49,223	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	Year to date u/spend £6,041	Year to date u/spend £3,923	Comparison against 24/25 plan
Consultancy	£92,827	April	£92,827	50% reduction on consultancy support				Steve Washbourne	Non clinical procurement group	Year to date o/spend of £8,500	Year to date u/spend £2.989	Comparison against 24/25 plan
Agency				Already ambitious target within financial plan to reduce to 3.2% target				Matt Revell	Temporary workforce working group	Reduction in agency usage of £52k in nursing and AHPs, Medic agency spend has remained the same.	Year to date u/spend £65k	Comparison against 24/25 plan
Elective Activity	£500,000	May	£458,333	2% Productivity in addition to 4%				Michelle Hubbard	OMB	Underperforming against ERF target	Underperforming against ERF t	Activity against ERF target
Outpatient Activity	£200,000	June	£150,000	4% Productivity in outpatients				Michelle Hubbard	OMB	Overperforming against outpatient plan by 568 cost analysis to be undertaken to calculate if delivered through productivity	Underperforming against ERF t	Activity against plan
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	Overspent against surgical LLP to date by £522k with £830k spent YTD. Anaesthetic LLP spend i sbelow plan by £21k	Overspent against total LLP to date by £501k with £1.003m spent YTD.	LLP spend
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	Physio agency and bank spend contunues in month with £19,950 spent in month 3 and £55,819 spent year to date.	Physio agency and bank spend contunues in month with £114,611 spent year to date.	Comparison against M12 23/24
Non ERF activity reduction; Outpatient follow up activity				Needs further consideration to ensure it won't imapct on ERF with current conversion rates				Michelle Hubbard	TBC	Overperforming against outpatient follow up activity by 392 patients YTD, no additional income is received for this activity	Overperforming against outpatient follow up activity by 1614 patients YTD, no additional income is received for this activity	Activity against plan
Increase prices in commercial income generation				Difficult to model with impact on demand by price adjustment				Steve Washbourne	FSIG	Underperforming year to date of £54k	Underperforming year to date	Commercial income generated
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	SIB			
Nurse led Pre operative assessment	£138,934	Sept	£81,045	Including budget + agency spend on medical staff				Nickie Brockie	SIB	Pay budget o/spent year to date by £28,958		Year to date spend
Admin bank controls	£120,000	May	£110,000	Cease all premium rate bank working with admin bank only wokred within core hours				Steve Washbourne	Temporary workforce working group	Spend continues to increase with an increase from M3 to M4 by £34k	Spend increased in M3 from M2 by £19,328, which is an increase in monthly spend from M1 of £54k	Comparison against M12 23/24

16. Capital summary

SUMMARY

Year to date spend of £248k against planned spend of £1,224k generating an underspend to date of £976k. This is due to scheme slippage against the original plan rather than an expected underspend by the end of the year.

Stream	Scheme Name	FYE 24/25	YTD Actual	Risk Score
Strategic Estates	Oncology office refurbishment/relocation	1,196	158	
Strategic Estates	Retention - Relocation of Facilites to the Old Pharmacy building	6		
Strategic Estates	Retention - Replacement for room 3 from a fluoroscopy room to a digital x-ray room	2	2	
Strategic Estates	Retention - Café Royale Refurbishment	2		
Strategic Estates	Replacement boiler knowledge hub	400		76
Strategic Estates	Replacement boiler theatres	100		76
Strategic Estates	Remote ability to connect to mobile Generator for 1,2 &3	95		76
Strategic Estates	Roof Replacement inc Large and Small Joint Medical Secretary block / Plaster room / Theatre 3 Hydrotherapy roofs	70		84
Green estate	Pool allocation for scheme prioritisation by budget holder	50	1	
Estates Maintenance	Pool allocation for scheme prioritisation by budget holder	150	1	
Equipment	Pool allocation for scheme prioritisation by budget holder	200	32	
Equipment	CT Scanner replacement			
Equipment	Image intensifiers x 5	804		101
Information Technology	Pool allocation for scheme prioritisation by budget holder	100		
Information Technology	EPR	200	44	
Reserve		122	10	
TOTAL		**3,499**	248	
Year to date plan			1,224	
Variance			976	

17. Statement of Financial Position

SUMMARY

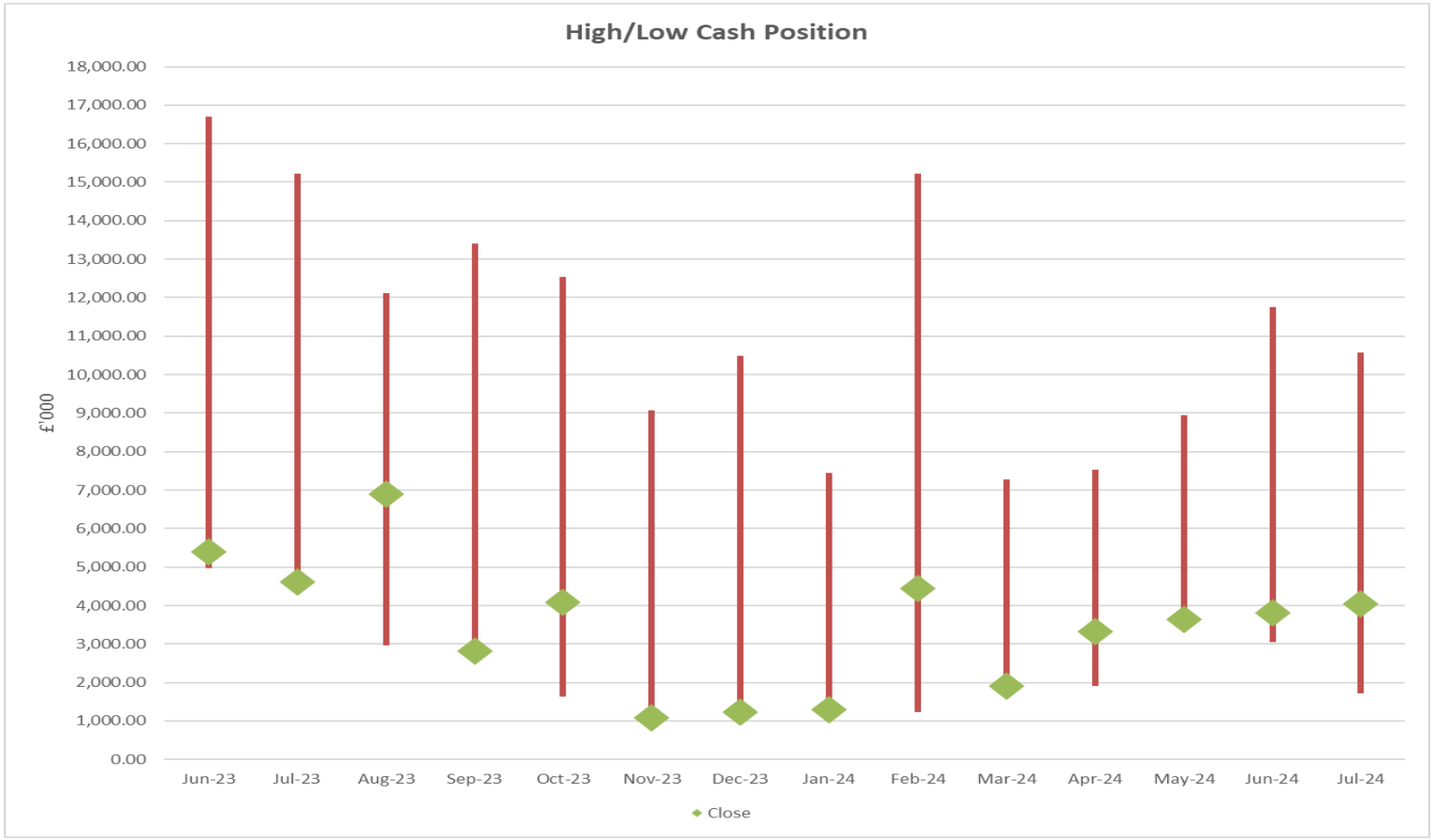
The main movements in the balance sheet have been in relation to the increase in cash and PDC following the support payment received from the Department of Health.

The cash position has eased, but 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 places on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.

	2023/24 M12	2024/25 M4	Movement
		(£'000)	
Intangible Assets	981	875	(106)
Tangible Assets	65,398	63,801	(1,597)
Total Non Current Assets	**66,379**	**64,676**	**(1,703)**
Inventories	1	1	-
Trade and other current assets	8,195	9,416	1,221
Cash	1,698	4,070	2,372
Total Current Assets	**9,893**	**13,487**	**3,593**
Current Liabilities	(18,332)	(19,075)	(743)
Non current liabilities	(14,129)	(12,401)	1,728
Total Liabilities	**(32,461)**	**(31,476)**	**985**
Total Net Assets Employed	**43,811**	**46,687**	**2,876**
Total Taxpayers' and Others' Equity	**43,811**	**46,687**	**2,876**

18. 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 places 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 June for £877k of Provider Revenue Support for Q2 (£742k in July and £135k in August), although only the July drawdown was needed, so the August draw down was not taken.



19. System Position

The headline performance at Month 4 is a deficit of £51.4m, a £35.5m adverse variance to the planned £15m adverse plan.

Month	4							
	YTD				FOT			
Total Performance	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plan £000s	FOT £000s	Variance £000s
BSOL ICB	78	78	2,539	2,461	11,405	11,405	11,405	0
BSMHT	759	759	184	-575	2,069	2,069	2,069	0
BCHC	-351	-351	-464	-113	0	0	0	0
BWC	1,000	1,000	-2,197	-3,197	3,000	3,000	3,000	0
ROH	121	122	-1,629	-1,751	0	0	0	0
UHB	-17,453	-17,453	-49,839	-32,386	-16,474	-16,474	-16,474	0
Total	-15,846	-15,845	-51,407	-35,562	0	0	0	0

20. Workforce

Summary / Highlights

- Sickness absence increased but has remained below the percentage it has been at this month in previous years.
- Appraisals made good progress towards Trust target
- Mandatory training has made small progress
- The occupied establishment has increased beyond 90% for the first time in a number of years

Risks / Issues

- Sickness absence rates are high and one of the highest in the system.
- Mandatory training progress is sow

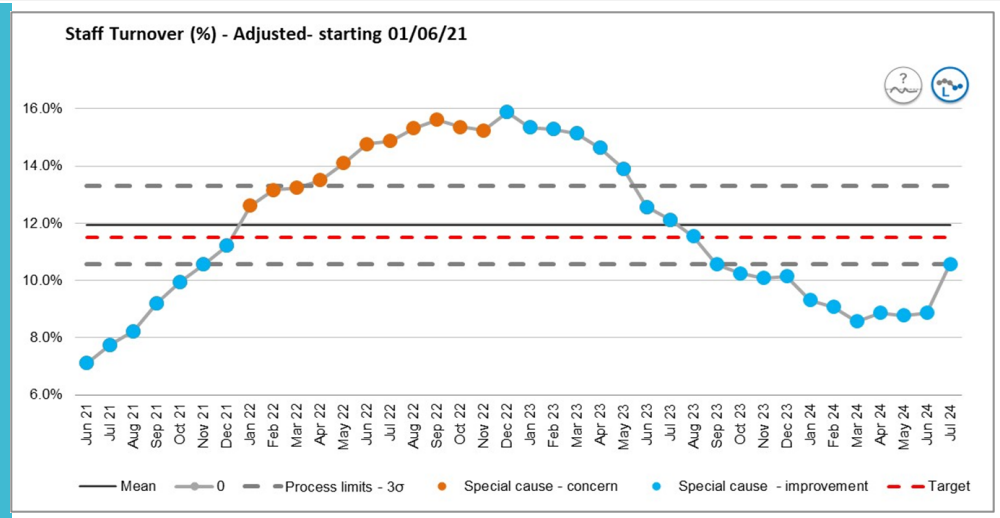
Actions

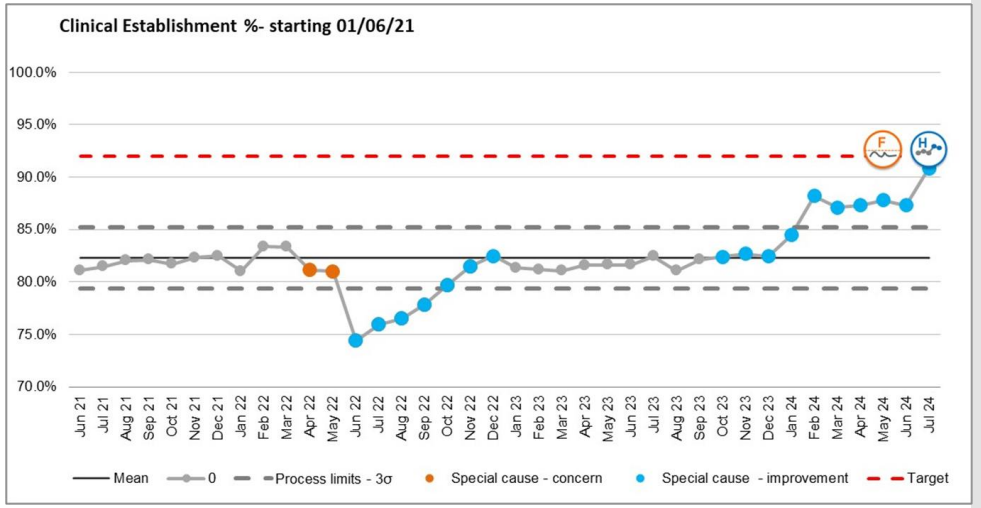
- HR team will continue with the new approach around sickness absence in supporting more directly and helping to embed the new policy and practice.
- Monitoring of turnover to continue.
- Work is ongoing with the resus lead on improving training for resuscitation. There is also a big focus on fire safety, IG and Cyber training.

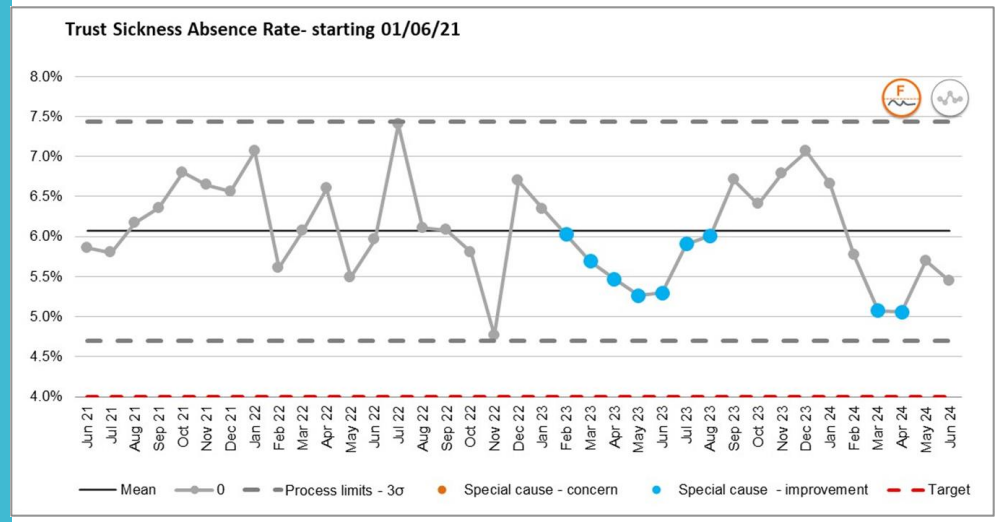
20. Workforce

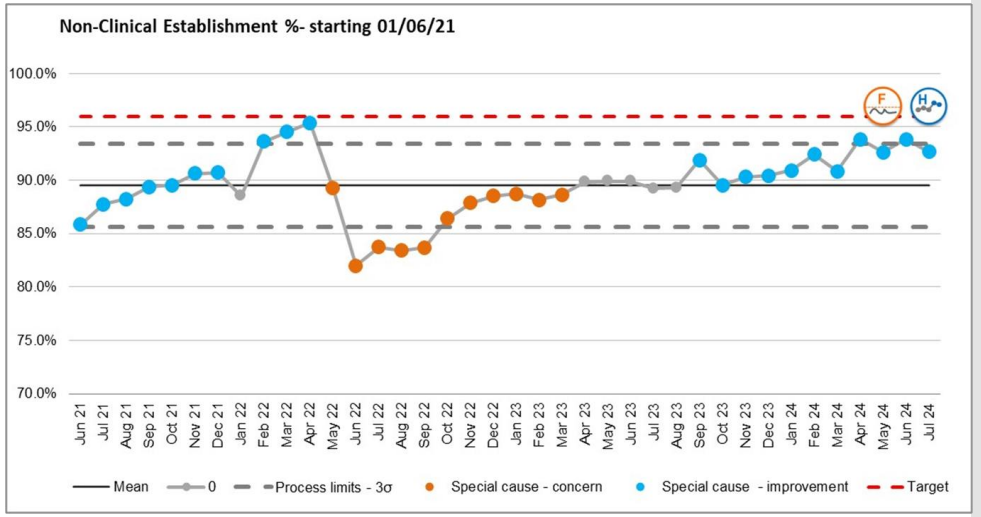
Trust Workforce Metrics	Jun-24	Jul-24	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1455	1451	-4	-	-
Staff In Post - Full Time Equivalent	1288.65	1284.57	-4.08	-	-
Staf Turnover % - Unadjusted	13.93%	14.55%	0.62%		<=11.5%
Staf Turnover % - Adjusted	8.87%	10.58%	1.71%		<=11.5%
Total WTE Employed as % of Establishment	89.67%	91.38%	1.71%		>=93%
Total WTE Employed as % of Establishment - Clinical	87.32%	90.85%	3.53%		>=92%
Total WTE Employed as % of Establishment - Non-Clinical	93.83%	92.64%	-1.19%		>=96%
% Of Attendance	94.56%	94.14%	-0.42%		>=96.3%
% Of 12 mth MAA Attendance	93.96%	93.97%	0.01%		>=96.3%
% Staff received mandatory training last 12 months	78.31%	79.62%	1.31%		>=93%
% Staff received formal PDR/appraisal last 12 months	66.76%	90.58%	23.82%		>=95%
% of Sickness - Trust wide Long-term	3.91%	3.86%	-0.05%		-
% of Sickness - Trust wide Short-term	2.13%	2.17%	0.04%		-
Return To Work Completion %	65.28%	63.08%	-2.20%		>=80%

20. Workforce

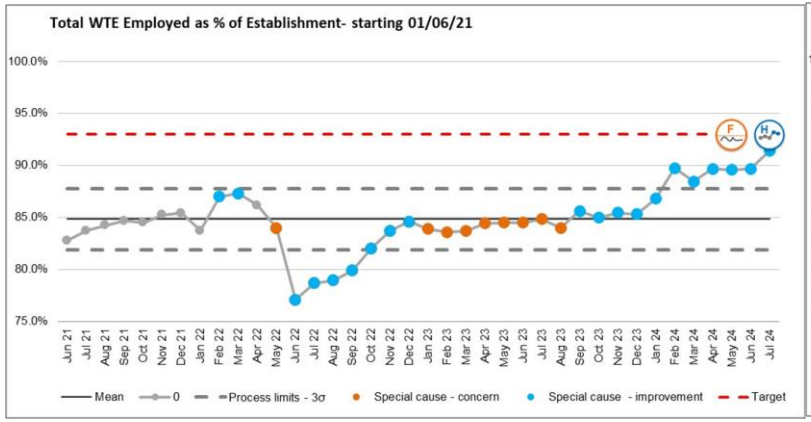


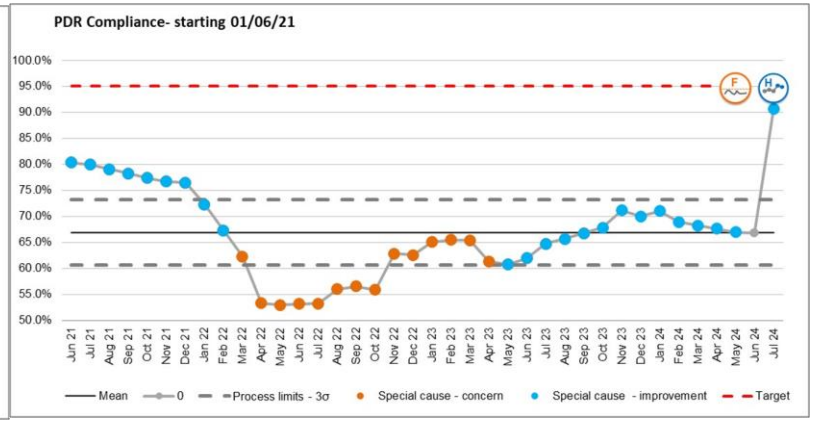


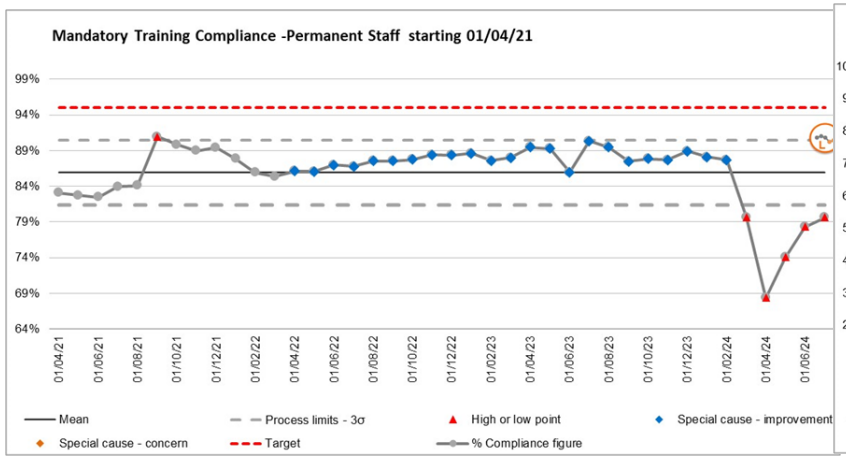


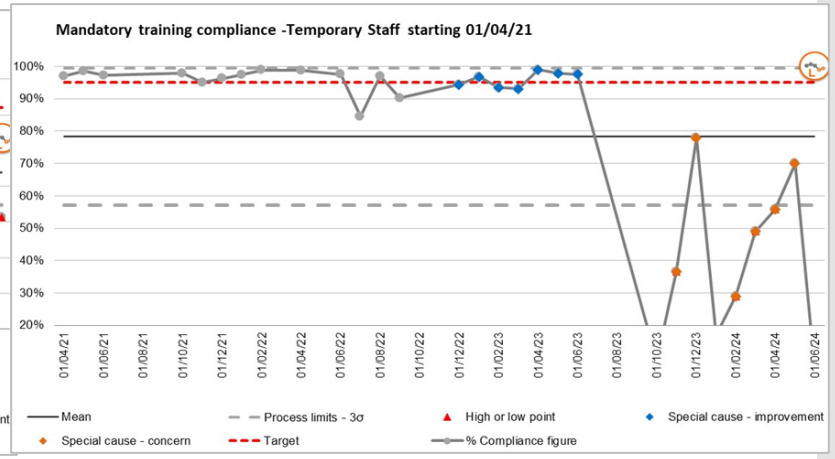


20. Workfo


Total WTE Employed as % of Establishment- starting 01/06/21
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


PDR Compliance- starting 01/06/21
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Mandatory Training Compliance -Permanent Staff starting 01/04/21
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Mandatory training compliance -Temporary Staff starting 01/04/21
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure

Quality Report

August 2024 (July 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 execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

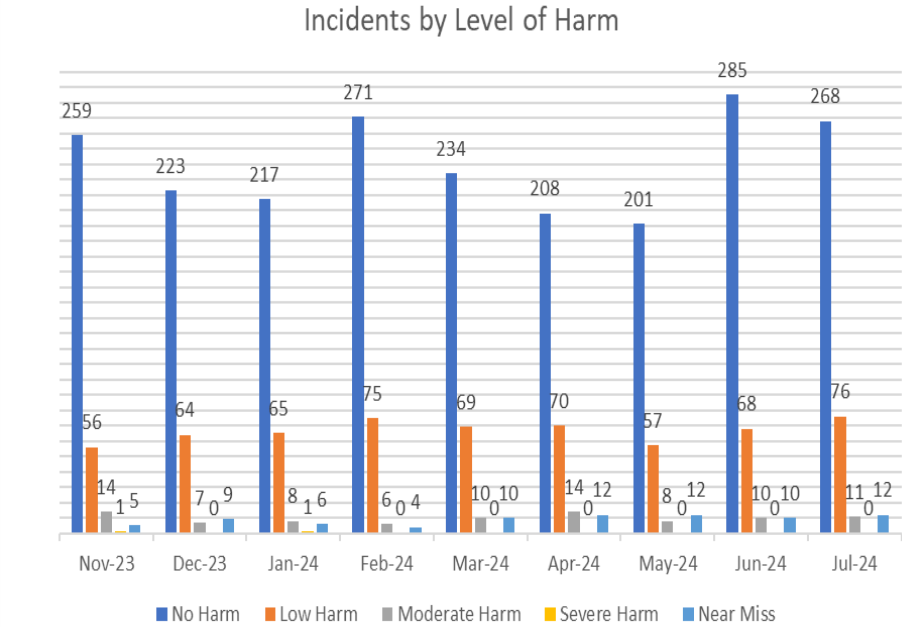
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

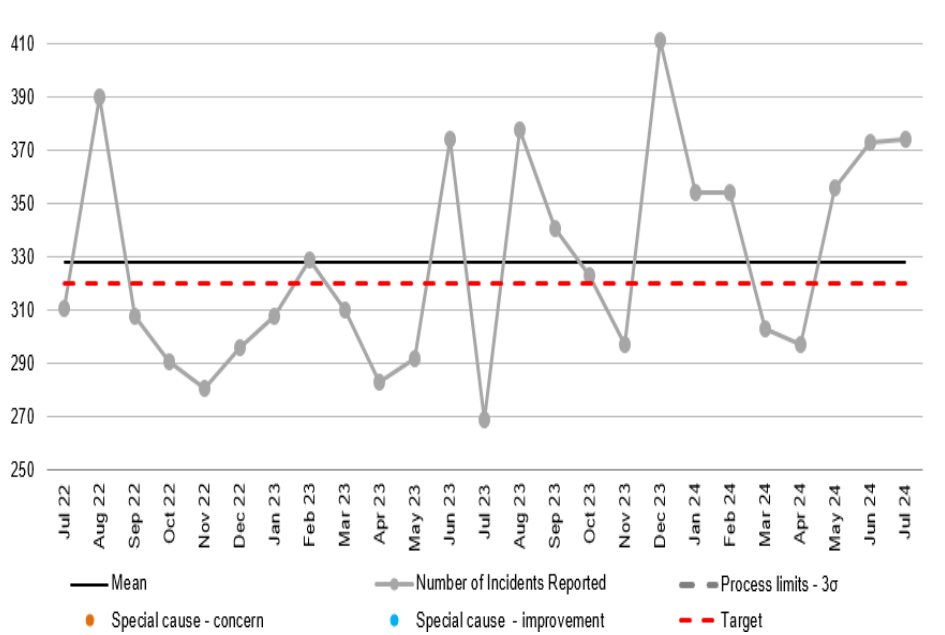
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end July 2024	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	374	373		
Inpatient Deaths	0	0		
PSII's (Patient Safety Incident Investigations)	0	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)	9	9		
Infection Incidents (Reportable)	0	0		
Complaints	10	7		
Claims	0	1		
Inquest	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.

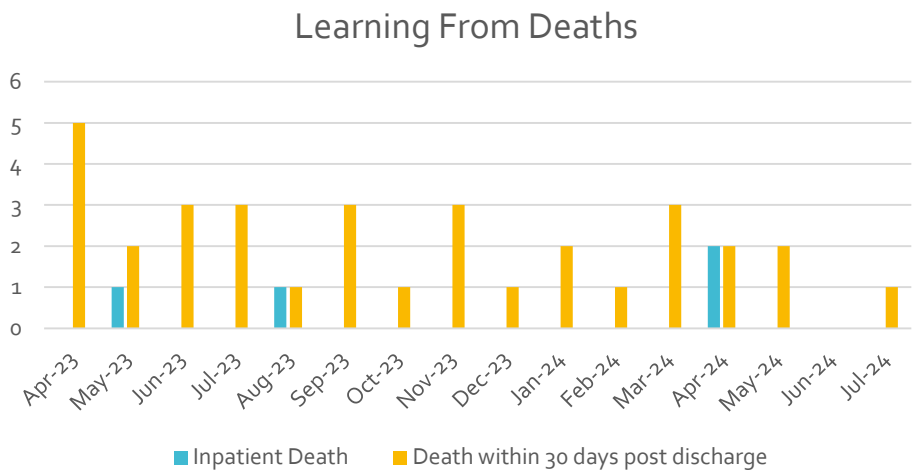
With locally managed incidents the proposed plan is to provide regular reports to local managers on closed incidents that can then be used to feedback to incident reporters on a 1 to 1 basis and also be used to share outcomes wider at local team/department meetings.

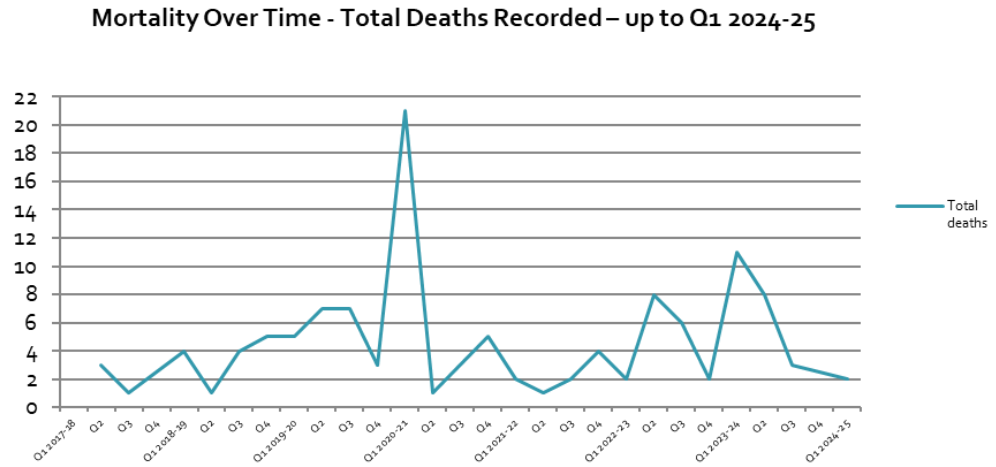
With incidents that are managed and investigated via divisional governance process, we are currently working with the Comms team to devise a format for the wider sharing of patient safety incidents and moreover the sharing of the learning from patient safety incidents that will be disseminated across the whole trust on a periodic basis. It is also planned to include a regular governance section to the monthly electronic bulletin aimed at clinical staff entitled 'Clinical News'.

Incidents Reported... (continued)

PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	0	0	1
AAR	1	1	10
MDT	0	0	1
Thematic Review	0	0	1

Learning from Deaths





Quality Improvement & Learning

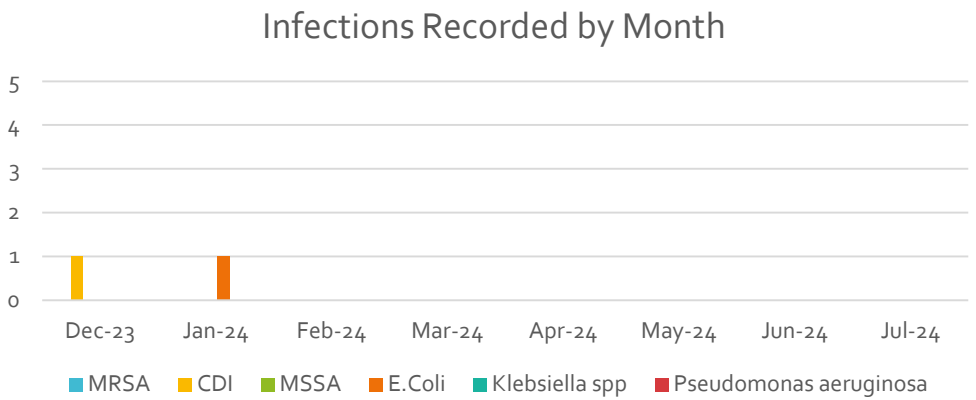
There were no inpatient deaths reported in July 2024.
There was 1 patient death within 30 days of discharge reported in July 2024. This death was reported at UHB after a planned transfer from ROH for ongoing care.

<u>Update on inpatient deaths reported in April 2024 (May 2024 Quality Report)</u>

Case A - Patient was transferred out after intra-operative vascular complications and died subsequently.
Governance Process: PSII has been signed off in divisional governance and was also signed off by the Executive Governance Meeting scheduled held on 28.08.2024
Coroneal / ME Process: Coroner has listed this for an inquest, the outcome of which will be reported subsequently.

Case B – Arrest during bone implant cementation
Governance Process: Trust learning from deaths process completed. SJR found no lapses in care and no learning. Good practice was identified with staff being praised for the level of care by the family.
Coroneal / ME Process: Inquest hearing scheduled for Sept 24 stood down as coroner concluded as an Inquest in writing. Conclusion was accidental death with coroner noting the deceased died as a result of a complication of surgery. No further action required. This case will be closed from a learning from deaths perspective, awaiting confirmation of presentation at clinical audit.

Infection Prevention & Control



Quality Improvement & Learning

Antimicrobial Stewardship

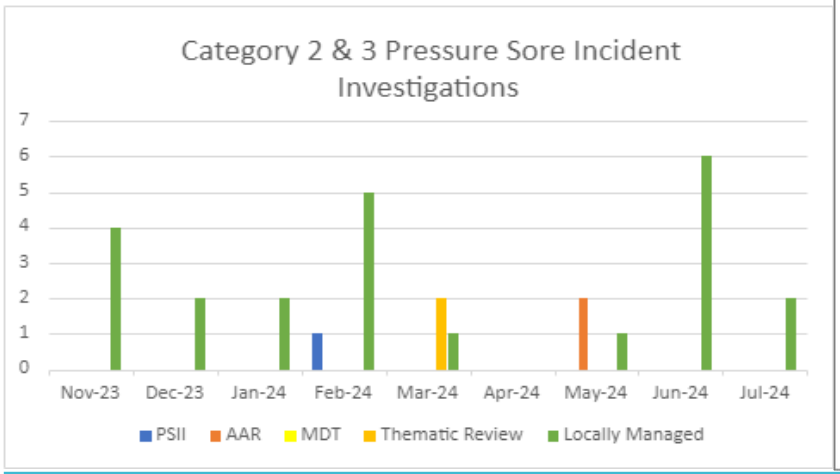
Much work has been undertaken to review surgical prophylaxis as has been described under the SSI IPC priority.

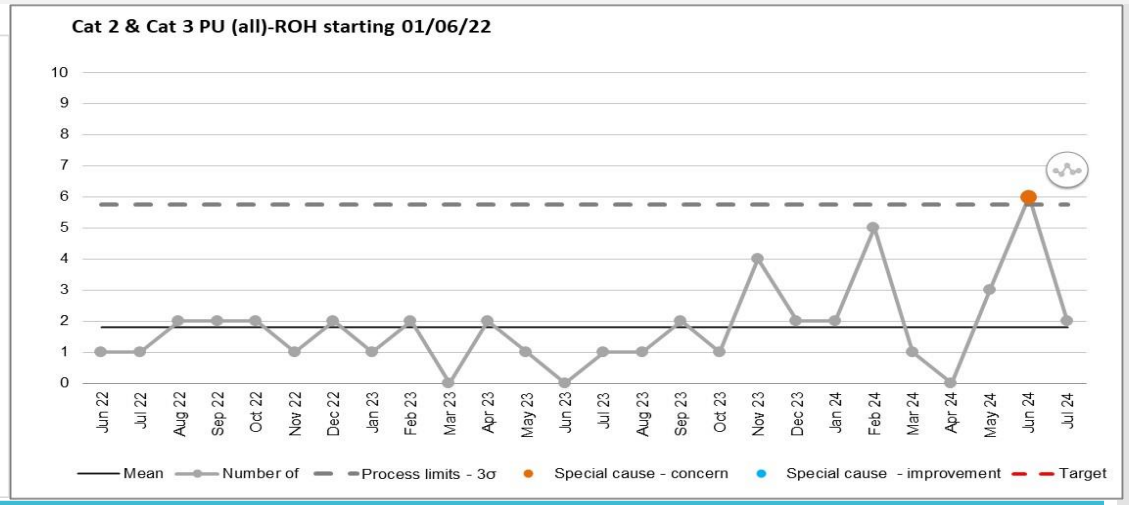
In addition to this, there is a focus on the judicious use of antimicrobials, monitoring consumption and prescribing practices. This is actioned through:

- AMS training and education for prescribers and Nurses.
- Implementing AMS ward rounds.
- Ensuring up to date and accessible information and guidance on antibiotics for staff and patients.

Antimicrobial stewardship is included in the IPC operational plan and annual programme of work. Quality improvement initiatives and programme of work is monitored via the antimicrobial stewardship group, chaired by the Antimicrobial Pharmacist. A four-box report is submitted to the IPCC for review and information. New Antimicrobial Pharmacist in post, working collaboratively with IPC to address objectives.

Tissue Viability





Quality Improvement & Learning

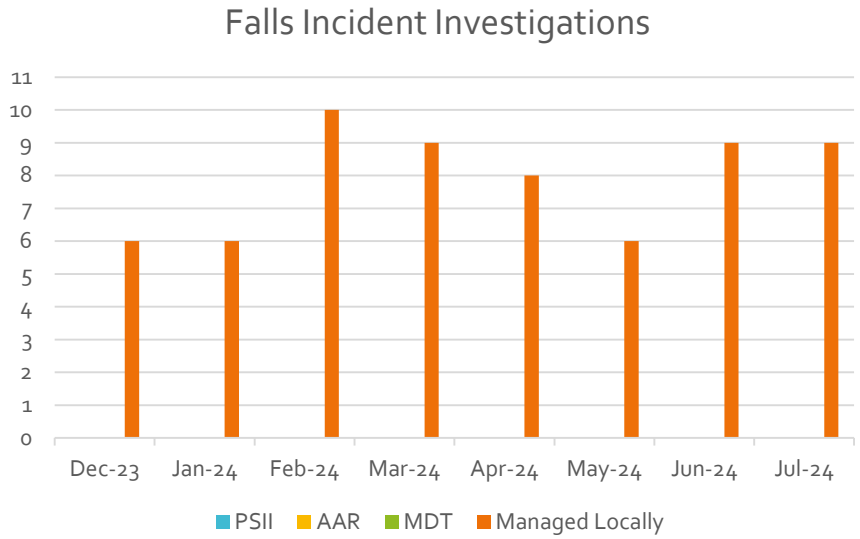
<u>Learning from AAR Category 3 Pressure Ulcer reported in May 2024 (June 2024 Quality Report)</u>
Summary of findings and areas of improvement include:

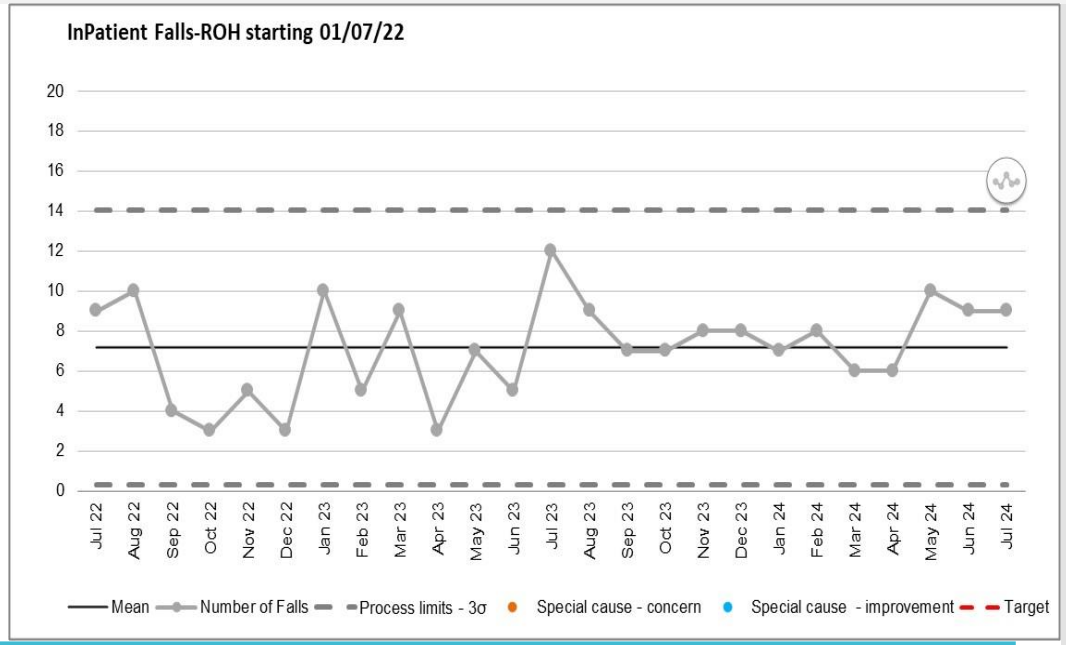
- All staff are to ensure timely referral to the TV Team
- Multiple missed opportunities for patient to be transferred to IQ matress
- Identify high risk patients at start of every night shift and make repositioning plans/times for each of them
- Pressure area care not recorded as having been given on PICS even though it was for hygiene needs, on multiple occasions.

<u>Quality Improvement</u>

Increase in blisters being reported under post – op dressings. TV team are undertaking a robust investigation – initial review has discovered that certain Consultants are using a different dissolvable suture and large steristrips over the wound which is causing increased skin tension and subsequent skin damage. Conversations have been had by TV team with consultants to discourage this practice.

Falls





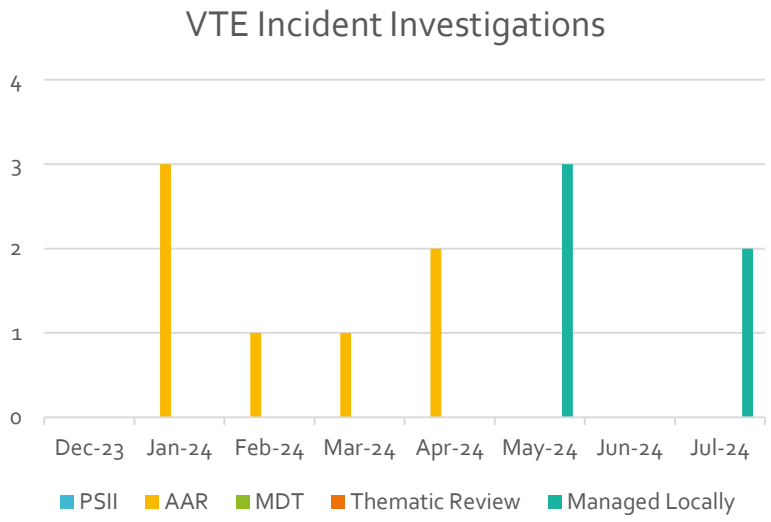
Quality Improvement & Learning

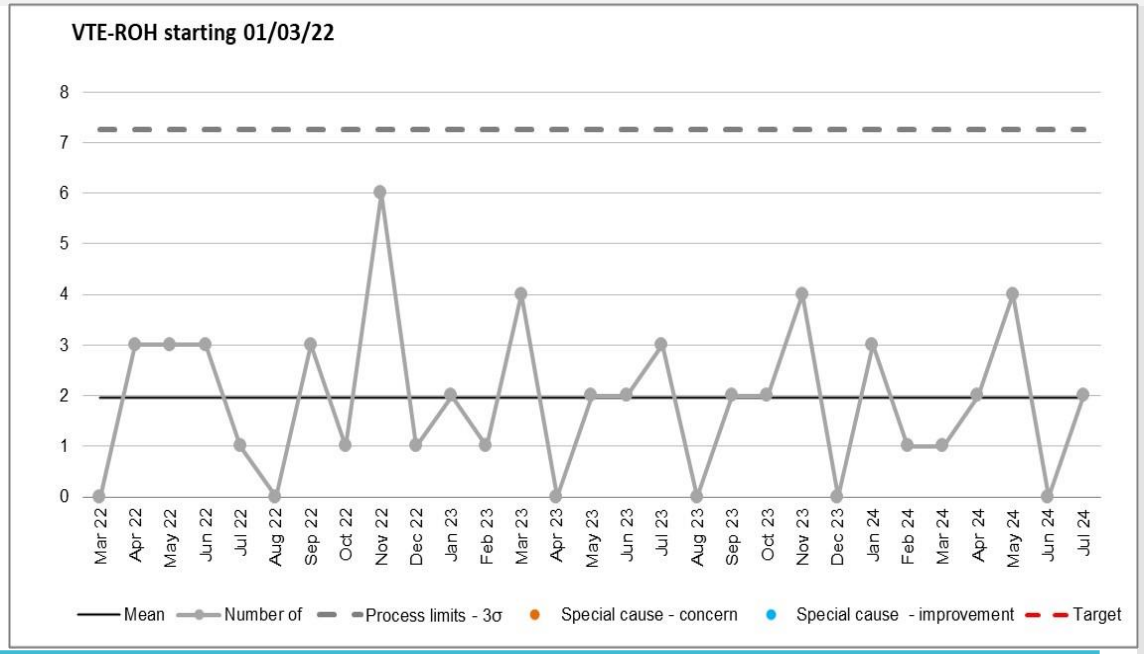
There remains a consistent number of falls this month. All falls have been graded as no or low harm, with no injuries reported resulting from a fall. Theme of incidents relate to patients using the bathroom when falls occurred. Patients had all been seen by physio and deemed able to mobilise to support recovery.

<u>Quality Improvement Work</u>

- New & updated falls risk assessment tool on PICS for use across all inpatient areas – still awaited
- Drafting mini audit questionnaire for use with patients that have fallen after mobilising against advice to see if any themes.
- Work also underway to reduce the risk of patient's falling when pressing the bin peddle on the bins located in the bathrooms.

VTEs





Quality Improvement & Learning

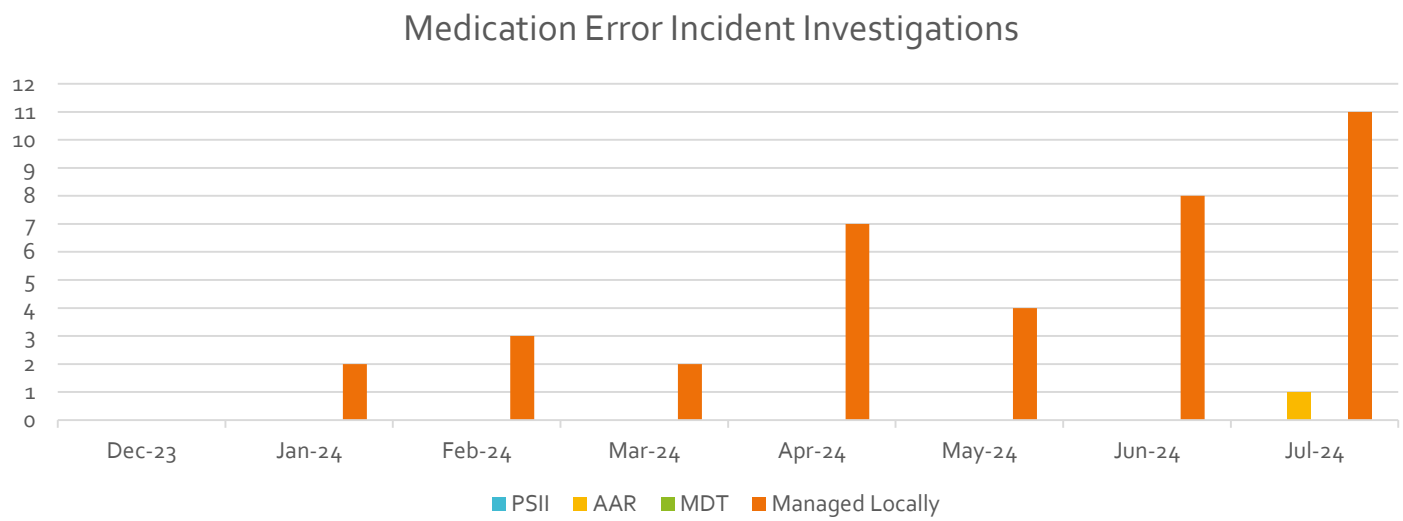
2 VTE incidents reported in July 2024.

<u>VTE On Admission Assessment Compliance</u>
Compliance figure for July 2024 = 97.84%

<u>Update on previously reported VTE incidents:</u>
May 2024: There were 3 VTE incidents reported, all have been triaged using the new PSIRF VTE triage forms and found to be unavoidable.

Further amendments and improvements being made to positive VTE triage PSIRF form in response to the trial.
Arthroplasty DVT diagnosis pathway trial has been extended and will upward report to the next VTE Advisory Group meeting.

Medication Errors



Quality Improvement & Learning

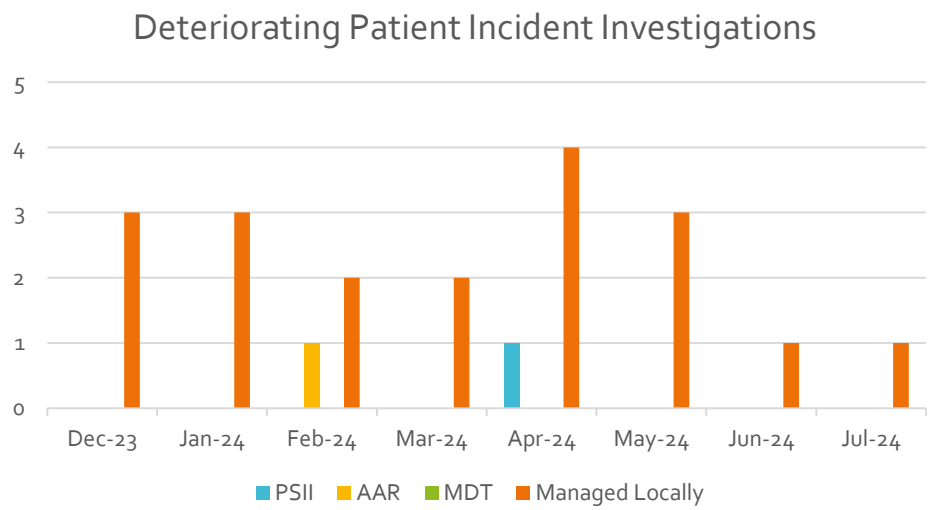
There were 12 medication error incidents reported in July 2024. This is in addition to the increase reported in June 2024.

Incident reports have highlighted that there was an emerging trend in increased incidents relating to medication errors, particularly errors in the prescribing of vancomycin. This information was included on the agenda for the most recent Division 2 governance meeting (held on the 19.08.2024) for review. The committee discussed an update to guidance on prescribing vancomycin which was published in May 24. Following discussion there were some areas of practice which identified that staff were continuing to follow the previous guidance or only partially following the new guidance.

Following learning and improvement actions that were agreed following discussion are as below;

- The pharmacy team are updating prescribers through bespoke training.
- Resources are being printed out and displayed in prominent places in the clinical areas.
- A consultant anaesthetist will include an update on the revised guidance at the audit meeting due to take place on the 23rd August.
- The ARR originally commissioned for the first vancomycin incident will be stood down in lieu of the planned actions.
- The Clinical Governance Facilitators will update the bi-weekly incident report submitted to Division 2 governance meeting to include a section focusing on medication incidents for the next 3-6 months. If the incidents continue, the committee will review the need for additional actions or reviews.

Deteriorating Patients



Quality Improvement & Learning

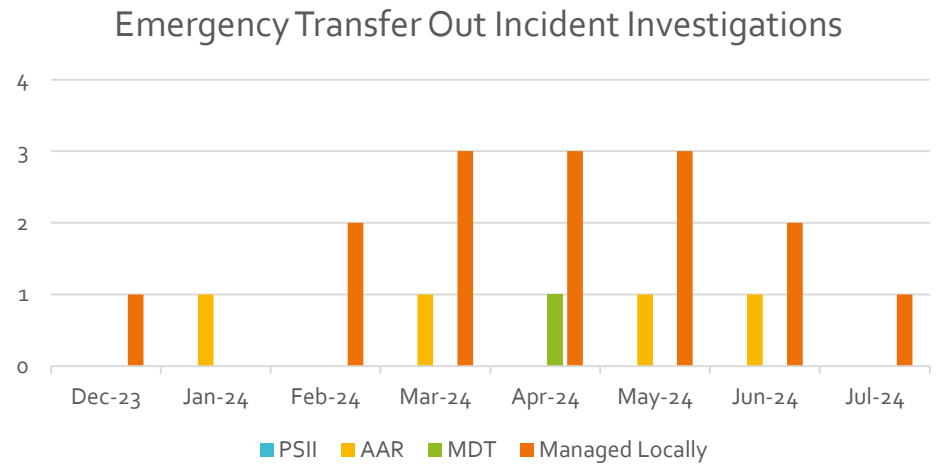
There was 1 deteriorating patient incident reported in July 2024, this incident is being managed locally.

<u>Update on Case A as reported in May 2024 Quality Report</u>
Patient was transferred out after intra-operative vascular complications and died subsequently.

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.

The PSII report has been signed off at Division 1 governance meeting was signed off at the Executive Governance Meeting scheduled for 27.08.2024. See also p7

Emergency Transfers Out



Quality Improvement & Learning

There was 1 emergency transfer out incident reported in July 2024.

Update on Case A as reported in May 2024 Quality Report
AAR due for sign off in next divisional governance meeting.

Complaints

Complaint Information

The Trust received **10** complaints in July 2024

Below are the departments that received complaints in June 2024

- Ward 2
- MSK x2
- Theatres
- Spinal Paediatrics x2
- ADCU/Patient Experience
- Spinal
- Private Suite x2

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

At the time of producing this report, (05/08/2024) we currently have **18** open formal complaints. **2** complaints are Private Suite Complaints.
4 complainants have requested a complaint resolution meeting

Departments that have open complaints at the time of writing report

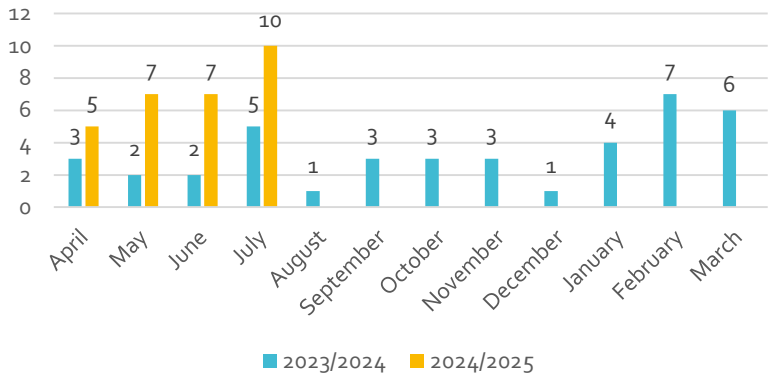
- Oncology
- Large Joints x3
- Spinal x4
- Inpatient Services
- MSK x2
- Theatres
- ADCU
- Private Suite x2
- Spinal Paediatrics x2

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 July 2024 the Trust received **4 requests for a resolution meeting.**

Complaints Recieved, 2023/2024 Vs 2024/2025



Complaints KPI's

KPI0	Complaints %
April 2024	100%
May 2024	57%
June 2024	0%
July 2024	50%

0%-79%
80%-90%
91%-100%

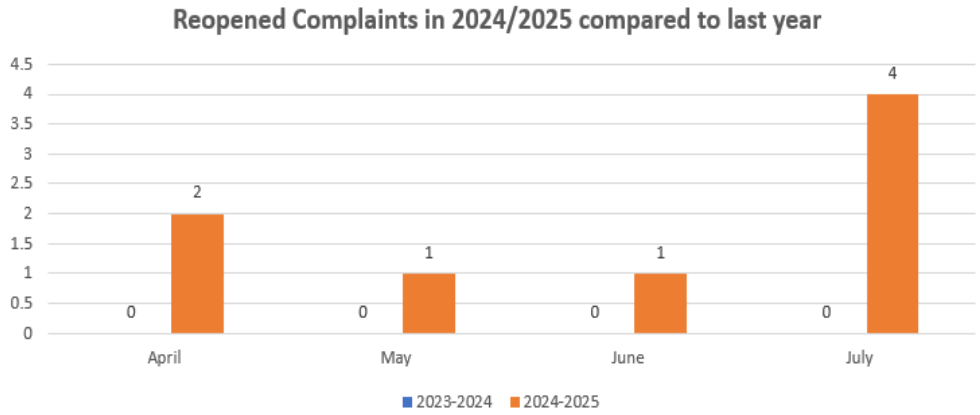
KPI for July is 50% as 2 Complaints Cases out of 4 breached the timeframe in July 2024

Complaint Year Totals	
April 2023 - March 2024	42
April – July 2024	26

Actions from Complaints

In July 2024 5 actions were identified. These actions remain open at this time.

Complaint Themes



Reopened complaints

The Trust received 1 request to reopen a complaint in June 2024. This is due to the complainant not being satisfied with the response. A complaint resolution meeting is due to be arranged for this complainant

PHSO Cases

The Trust currently has no PHSO complaints cases open.

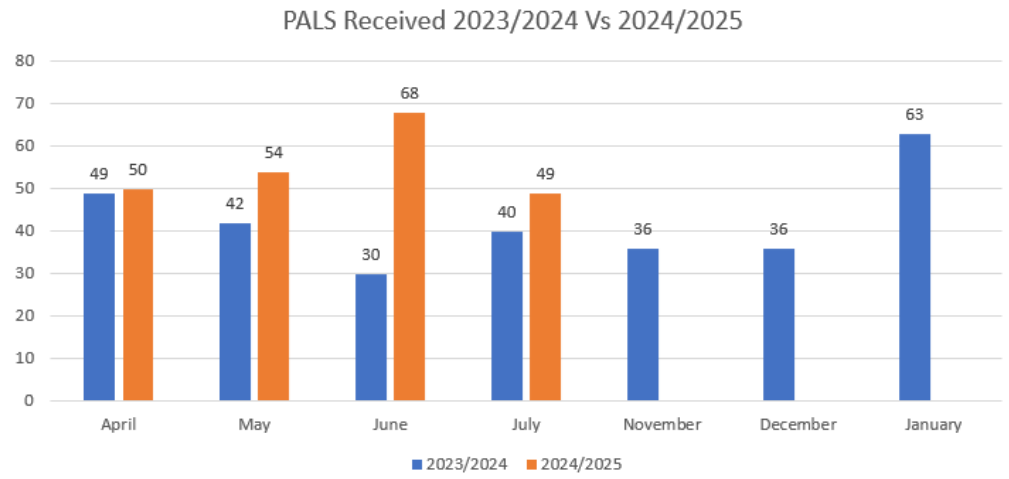
Themes

1. Care Received
2. Unsatisfactory Care and Behaviours
3. Communication

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 and entered to Ulysses.
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 is making it more clear which cases they have resolved before reaching the divisions.

Patient Advice and Liaison Service – PALS



PALS KPI's

KPI	PALS Contacts %58%
April 2024	34%
May 2024	48%
June 2024	58%
July 2024	86%

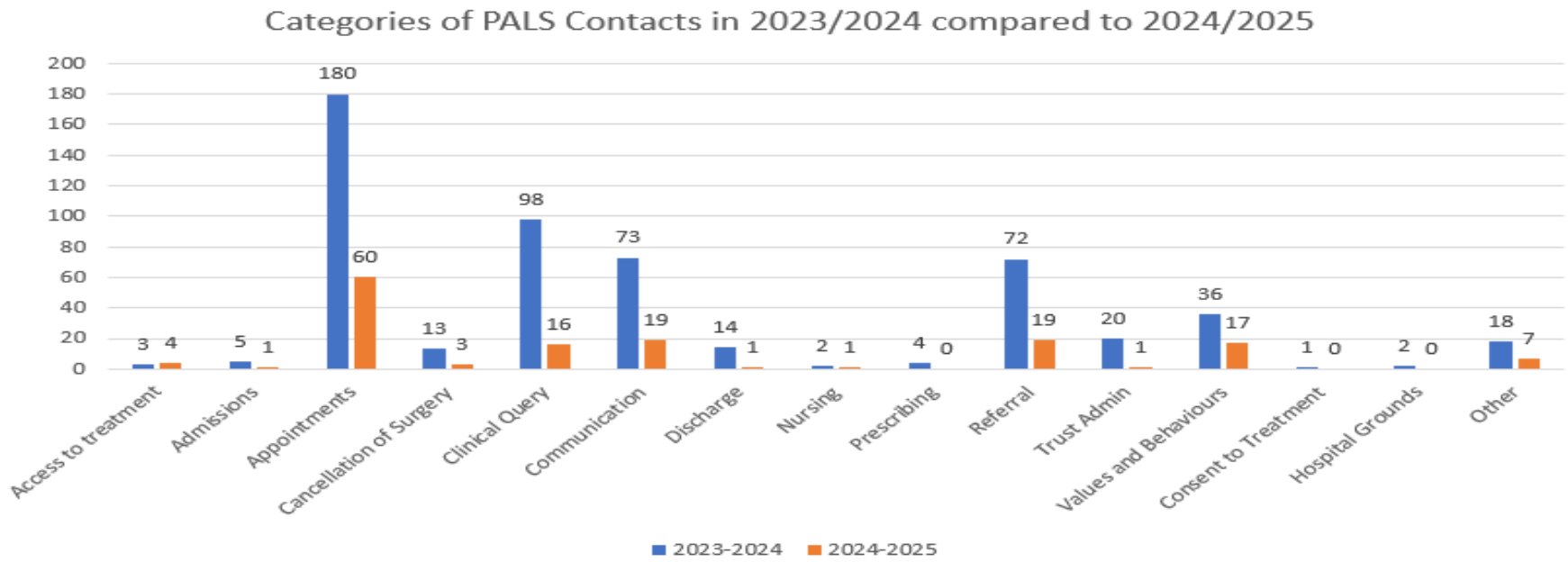
0%-79%
80%-90%
91%-100%

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.

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

7 PALS Cases breached in July 2024
The KPI for PALS Contacts was met for July 2024

PALS Themes



What we have done

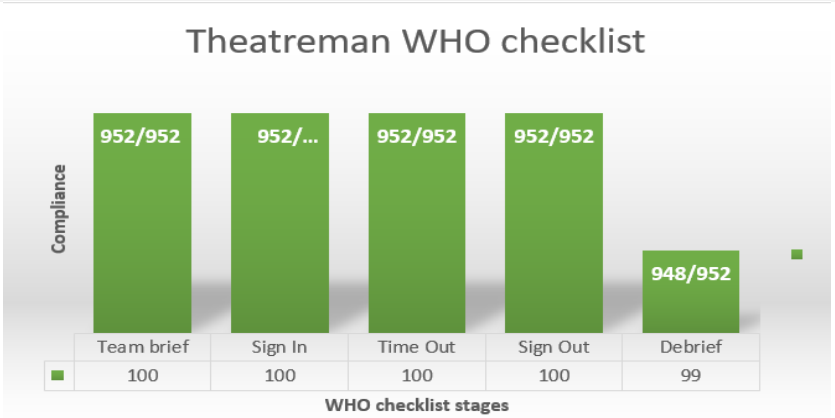
Tracked in Executive Governance Meetings
Raised in Governance meetings and with departmental managers.
Escalation to ensure PALS cases are responded too.
Head of Patient Experience sending out individual reminders on outstanding PALS. PALS are dealing with PALS contact within their remit.

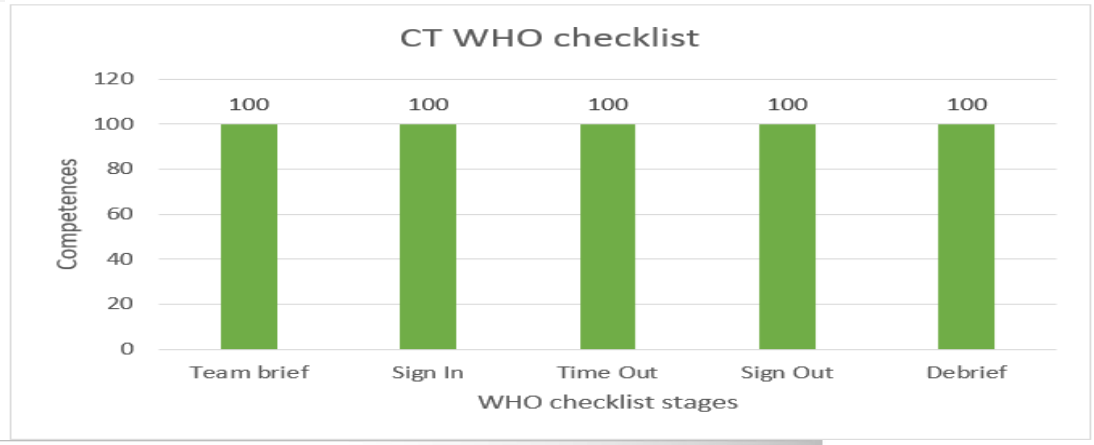
Themes

Appointments – 15 out of 49 received
Specifically: Appointments Cancelled and failure to follow up.

Clinical Query – 9 out of 49 Received
Attitude of medical staff and nursing.

WHO Audits





Quality Improvement & Learning

WHO checklist audits included on AMAT. The baseline number of WHO checklist audits set on AMAT is 10 operating lists. The number of patients on the list varies from 1 to 7 patients. All the 5 WHO checklist steps captured per audit.
Theatres 3, 5,7, 8 and 12 did not submit 10 audits set on AMAT.

Action plan : Email sent to cluster leads to ensure that visual WHO audits are completed and recorded on AMAT in a timely manner.
Work in Progress – Waiting date for the next meeting with the Patient Safety specialist to review the current WHO checklist form and incorporating NatSSIPs 2.

CAS Alerts – New

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/009/DHSC	Shortage of Human Albumin 4.5% and 5% dose vials. There will be limited stock of Human Albumin from July 2024 until at least December 2024. Resolution date for a resumption of full market coverage is still to be confirmed. The supply disruption is caused by a combination of increased global demand for Human Albumin resulting in one supplier being unable to bring in sufficient stock and a sustained overall increase in demand for the product. Volumes of Human Albumin 20% remain available but cannot support an uplift to meet the additional demand from the 4.5% and 5% preparations. Human Albumin is licensed for restoration and maintenance of circulating blood volume where volume deficiency has been demonstrated, and use of a colloid is appropriate. However, in practice it is used extensively for: Plasma expansion after paracentesis Plasma exchange in neuroinflammatory crises Treatment of hepatorenal failure in association with terlipressin. Remaining volumes of Human Albumin should be prioritised for patients that clinical leads have indicated are critical.	National Patient Safety Alert - DHSC	30-Jul-24	**Chief Pharmacist:** *We do use Albumin 5%. There's been a shortage for a couple of months. We have sufficient stock for the next 2 months based on current use'.* **MDSO:** *Only used in HDU. Before this is closed, we need to confirm what it's used for. Awaiting response from clinician's (Benjamin Smith & Tosh William)* On-going….	7 Aug 24 On-going…

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/008/DHSC	Shortage of Kay-Cee-L (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup. Kay-Cee-L (potassium chloride 5mmol/5ml) syrup will be out of stock from late September 2024. The resupply date is to be confirmed. The supply disruption is caused by an amendment to the manufacturing process, requiring re-formulation, and revalidation of the product. Sando-K (potassium bicarbonate 400mg and potassium chloride 600mg) effervescent tablets remain available and can support a full increase in demand. One effervescent tablet contains 12mmol potassium. Unlicensed potassium chloride oral solutions manufactured within the UK are available via Specials manufacturers. Remaining supplies of Kay-Cee-L syrup should be prioritised for patients requiring doses of less than 12mmol of potassium and where other preparations are not suitable (see Notes). Care is needed to ensure selection of the most appropriate oral potassium supplement and delivery of the correct dosage.	National Patient Safety Alert - DHSC	26-Jul-24	**Chief Pharmacist:** *'Sufficient stocks held'.*	Action Completed

CAS Alerts – Open alerts from previous months

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks. 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 NRFit connectors for all intrathecal and epidural procedures, and delivery of regional blocks by 31 January 2025.	National Patient Safety Alert	31-Jan-24	Assessing relevance. **16 Apr:** **Email from MDSO**: *'Alert to remain open until all relevant devices transferred over.* *Mtg to be arranged with T. Sutherland to discuss'.* On-going...	31 Jan 25 On-going…

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/004/MHRA	Reducing risks for transfusion-associated circulatory overload. Transfusion-associated circulatory overload (TACO) is defined as acute or worsening respiratory compromise and/or acute or worsening pulmonary oedema during or up to 12 hours after transfusion, with additional features including cardiovascular system changes not explained by the patient's underlying medical condition, evidence of fluid overload and a relevant biomarker. TACO is one of the most common causes of transfusion related deaths in the UK and cases have increased substantially in recent years. Identifying risk factors for TACO prior to transfusion allows initiation of appropriate mitigating measures. This National Patient Safety Alert contains further information and action for providers to reduce risks for patients.	National Patient Safety Alert	4 Apr 24	**MDSO:** *'This alert is relevant to the ROH so needs to stay open. I will discuss with Emma Steele as to who might be best to lead on it'.* On-going…	4 Oct 24 On-going…

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. 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. This National Patient Safety Alert provides further background and clinical information and actions for providers.	MHRA	31 Aug 23	**11 April 2024: Email from MDSO:** *'National issues are preventing closure of this alert. Working with BSol and Birmingham Citywide to address issues. Alert on risk register and discussed at divisional governance'.* **Estates:** Beds tagged to aid compilation of Estates inventory. Beds & bedrails now to be serviced by our in-house engineers jaw Arjo's service schedule.	1 Mar 2024. On-going...

Safeguarding Training Compliance

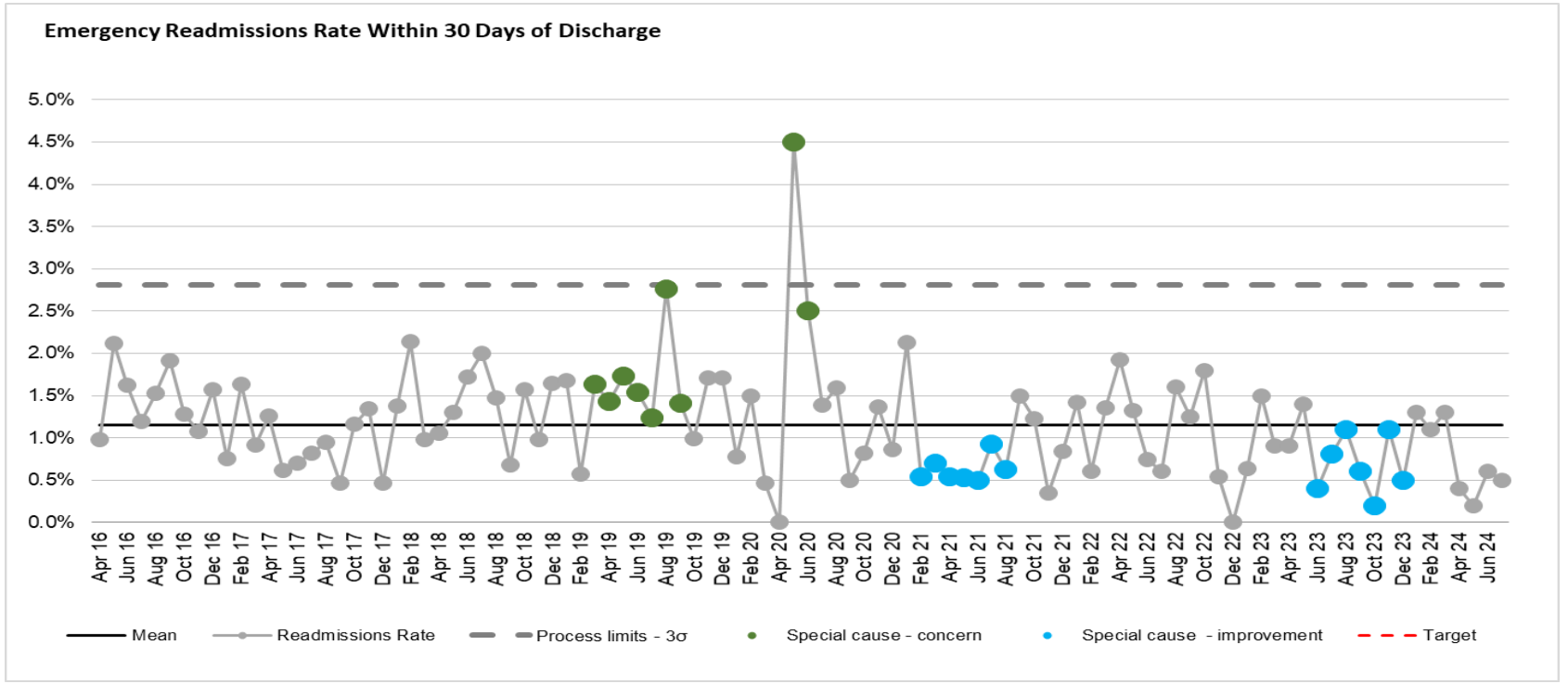
KPI	July 2024
Safeguarding Adult Notifications	60
Safeguarding Children and Young People Notifications	47
Adults Level 1- Target 90%	84.81%
Adult Level 2 -Target 85%	91.81%
Adult Level 3- Target 85%	86.11%
Level 4- Target 90%	100.0%
Child Level 1 -Target 90%	84.28%
Child Level 2- Target 85%	91.27%
Child Level 3- Target 85%	85.99%
Mental Capacity Act MCA- Target 85%	91.73%
Deprivation of Liberty Safeguards DoLs	91.65%
Prevent Awareness- Target 95%	88.99%
WRAP (prevent level 3)- Target 90%	85.86%
FGM	1
DOLS	2
MCA	7
PIPOT cases	0
PREVENT Notifications	0

Safeguarding Training dates has been shared via Communications Team, Safeguarding Purple News, within Safeguarding Supervision and Leaders forum to encourage staff across the Trust to attend. Safeguarding level 1 training is delivered via booklet which is provided by the Learning and Development team during Trust induction. If staff have completed Level 2 training, they will be compliant with Level 1 as Level 2 training has met compliance the level 1 training recording of data may need to be reviewed.

The Safeguarding Lead Nurse has encouraged staff across the Trust to attend Prevent training and offering monthly face to face sessions as well e-learning modules.

The Safeguarding Lead Nurse met with staff bank manager to discuss low training compliance in relation to bank staff. The safeguarding team will continue to encourage attendance across the Trust throughout the year.

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
No of Readmissions	5	3	1	6	3	6	6	7	2	1	3	3
Denominator	469	492	543	553	559	462	546	548	491	529	470	559
% Readmissions	1.1%	0.6%	0.2%	1.1%	0.5%	1.3%	1.1%	1.3%	0.4%	0.2%	0.6%	0.5%

There is a standalone paper due for submission to Q&S committee in September 2024 covering readmissions to any Trust

Freedom to Speak Up

July 2024 data not available at time of submission:-

Quality Improvements & Learning

Rolling out of the Sexual Charter and the work currently being undertaken in the Trust will enforce a zero-tolerance approach to any unwanted, inappropriate and or harmful sexual behaviour within the Trust. Staff were made aware of this and how to escalate.

Awareness was also raised, and Information shared regarding Disadvantageous and Demeaning Treatment (previously called detriment) (The National Guardian Office has advised that this document should be attached to the FTSU Policy to support staff). This Document was shared at the Ward Manager meeting in June to support learning and raise awareness. Further work will be done by the FTSUG in the coming months to imbed this process to support workers and cultural improvement.

Two new FTSU Champion were inducted to the FTSU Team bringing the total number to 10. Their Bespoke induction was conducted by Simon Grainger-Lloyd Executive Director and Lead for FTSU, Gianjeet Hunjan, Non-Executive director and lead for FTSU, and Claudette Jones FTSU Guardian. Several of the FTSU Champions also attended, they shared their stories and welcomed the new Champions to the Team. The Champions also had their Team 1:1 wellbeing meeting with Simon and Gianjeet this was found to be useful and supportive.

FTSU survey done on 02Jul2024 to benchmark the work of the FTSU team and to assess strength, weakness, and gap; data to be analysed and shared.

FTSU Newsletter will be coming out soon to provide updates and share the work of the FTSU Team.

The FTSU Guardian is now distributing Thank you Cards to people who are speaking up, as suggested by the NGO. The Thank You Cards were designed by the FTSU Team.

Operational Performance Summary

Performance to end July 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	52.58	50.75%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	18	35	0	L	F
52 week waits (52 – 64 Weeks)	560	541	0	H	F
All activity YTD (compared to plan)	5,038	3,694	4,980		P
Outpatient activity YTD (compared to plan)	24,101 104.4% Cumulative	17,666 105.8% Cumulative	23,078 YTD Target		P
Outpatient Did Not Attend (YTD)	6.9%	6.8%	8%		P
PIFU (trajectory to 5% target)	657 10.67%	472 8.6%	470 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	11.2%	10.8%	19%		F
FUP attendances(compared to 19/20)	100.9%	100.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	114.6%	114.0%	120%		F
Diagnostics volume YTD (compared to plan)	8,832 Cumulative	6,584 Cumulative	9,355 YTD Target		F
Diagnostics 6 week target	100%	100%	99%		P

Operational Performance Summary

Performance to end July 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	89.2%	80.8%	85%		P
Theatre In Session Utilisation (Uncapped)	82.4%	83.17%	85%		F
Cancer - 31 day first treatment	78.7%	100%	96%		P
Cancer - 62 day (traditional)	94.7%	85.7%	85%		P
28 day FDS	66.7%	75.3%	75%		P
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	8,762 Cumulative	6,613 Cumulative	7,712 Cumulative		P
Bed Occupancy (excluding CYP and HDU)	71.6%	70.1%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.43	3.47	n/a		No Target
LOS - elective primary hip	2.5	2.9	2.7		P
LOS - elective primary knee	3.3	2.9	2.7		F
BADS Daycase rate (Note: due to time lag in month is Mar'24)	75.0%	75.0%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar'24)	36.3%	36.9%	-		No Target

Workforce Performance Report

Prepared by:
Matt Dingle, Head of Human Resources
Claire Felkin, Training and Development Manager
Clare Mair, Head of Organisational Development
Ref: Aug, 2024/ HR&OPS

Scorecard

Topic	KPI	July – 2024	TREND
Occupied Establishment	93%	91.38%	↑
Turnover (adjusted)	10.5%	10.58%	↑
Staff in post - FTE	N/A	1284.57	↑
Sickness absence	4%	5.86%	↑
Appraisals	95%	91%	↑
Disability declaration rate	7.5%	8.5%	↑
Workforce Wellbeing – A/Leave	N/A		N/A
Mandatory Training	93%	79.62%	↑

Section One:

HR Operations Team

Prepared by: Matt Dingle, Head of Human Resources

Presented by: Matt Dingle, Head of Human Resources

Ref: Aug, 2024/HR&OPS

HR Operations

Summary:

July proved a challenging month for sickness absence although sickness has regularly been higher at this point of the year, in the previous years.
Turnover made an increase and will be monitored accordingly.
The establishment grew to over 90% for the first time in a number of years and we are recruiting faster than we have before.

Areas for Improvement:

Sickness absence management remains high priority for the HR & OD teams. The current rate is one of the highest in the system.

Risks / Issues:

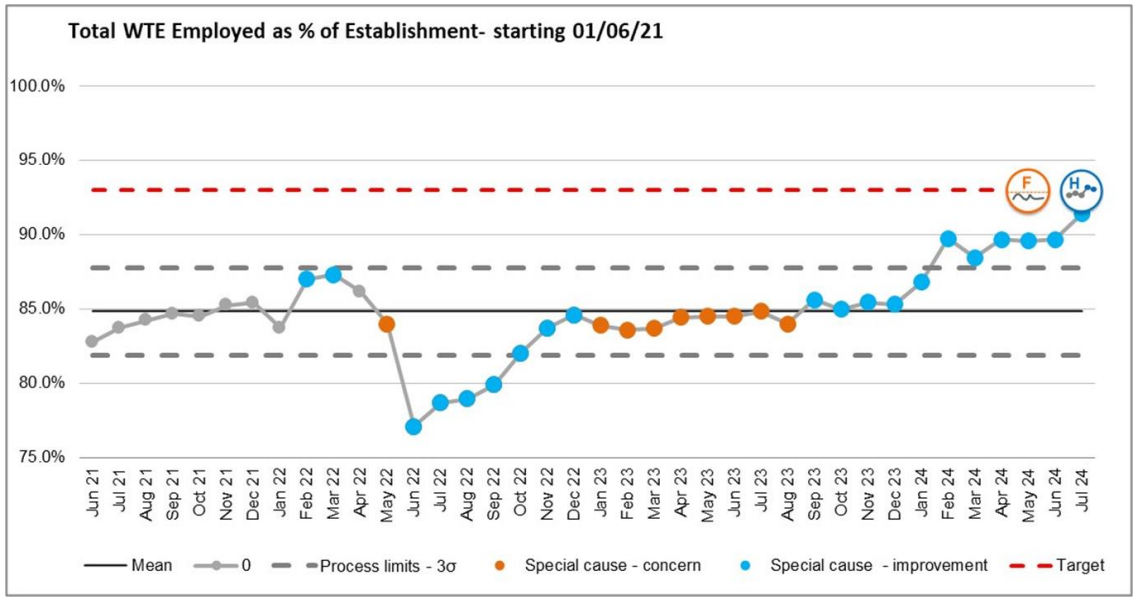
High absence rates can lead to lower productivity, staffing issues and increased bank/agency spend.

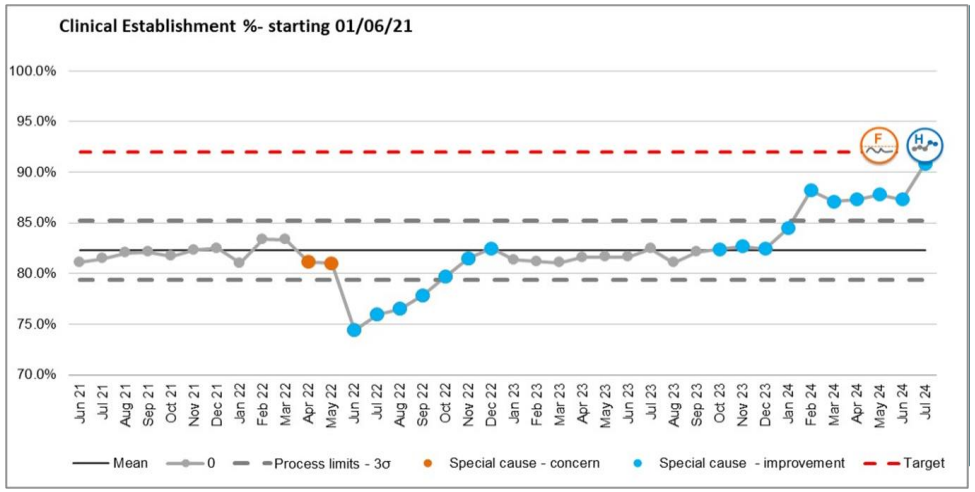
Action Plan:

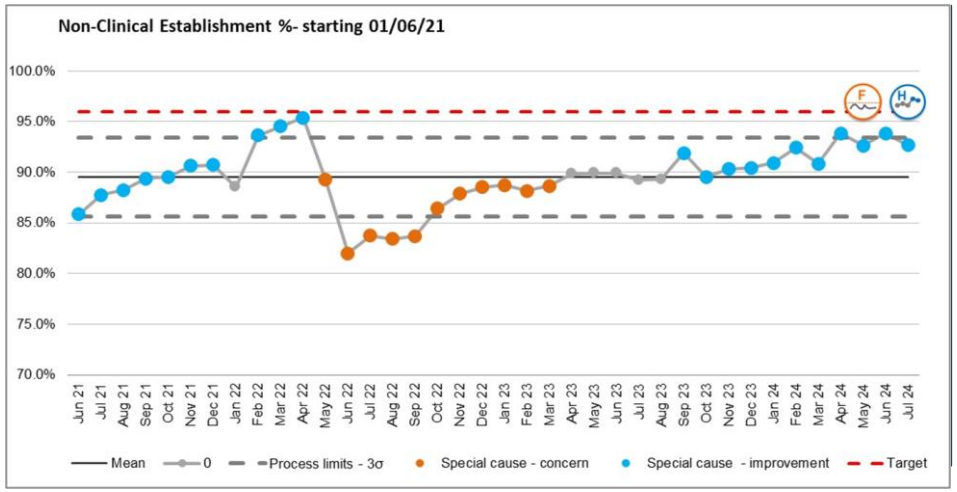
- HR team will continue with the new approach around sickness absence in supporting more directly and helping to embed the new policy and practice.
- Monitoring of turnover to continue.
- Casework levels are stable and informal approaches will support this continuation.

Occupied Establishment

KPI	93%
July 2024	91.38%
Trend	↑







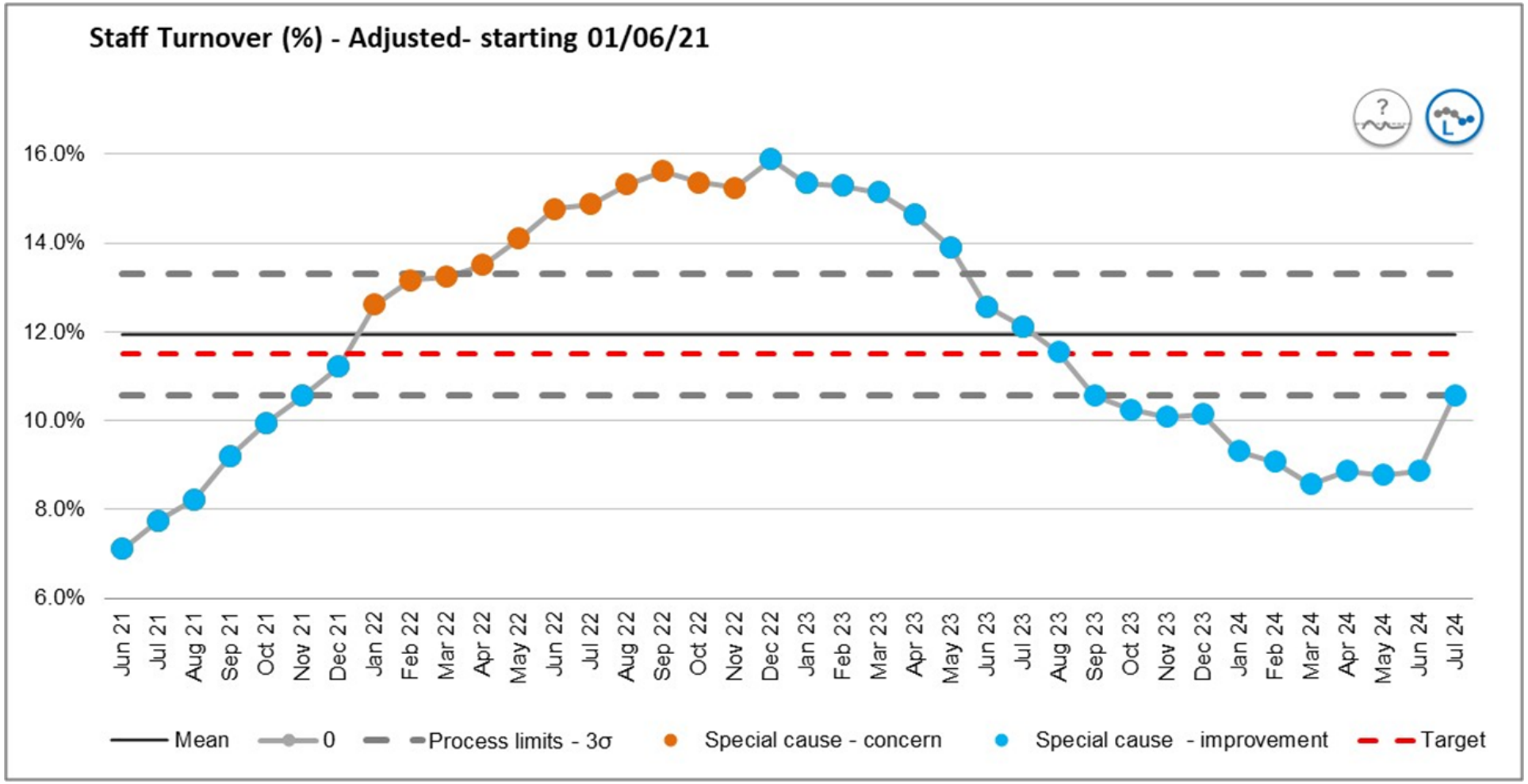
Turnover (adjusted)

KPI	10%
July 2024	10.58%
Trend	↑

Adjusted turnover *is all turnover minus:*

- *Junior doctor rotation*
- *Flexible retirement*
- *End of FTC*

Adjusting turnover provides more meaningful data around Trust performance



July 2024 leavers

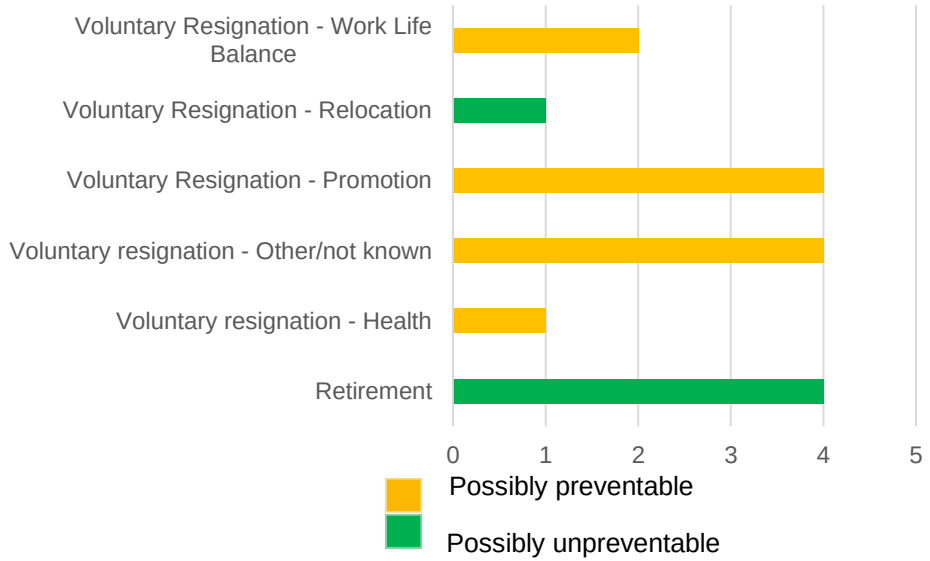
Impact:

In July, more staff left the Trust than normal, albeit this remained at a reasonable level and just above target.

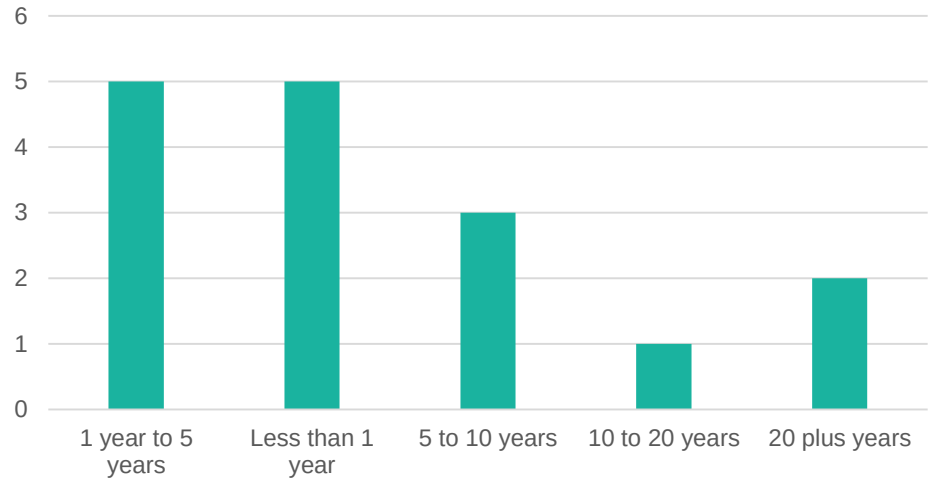
There is some concern that we have lost 5 staff this month who had less than 1 years service. However, the data doesn't suggest a pattern around why staff with less service are leaving.

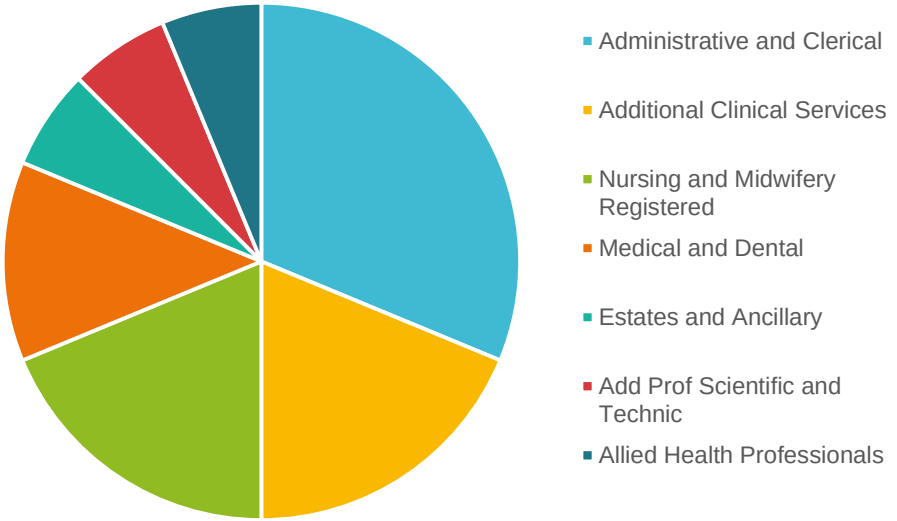
Of the 4 staff who retired in July,
2 have returned

Reason for leaving by headcount



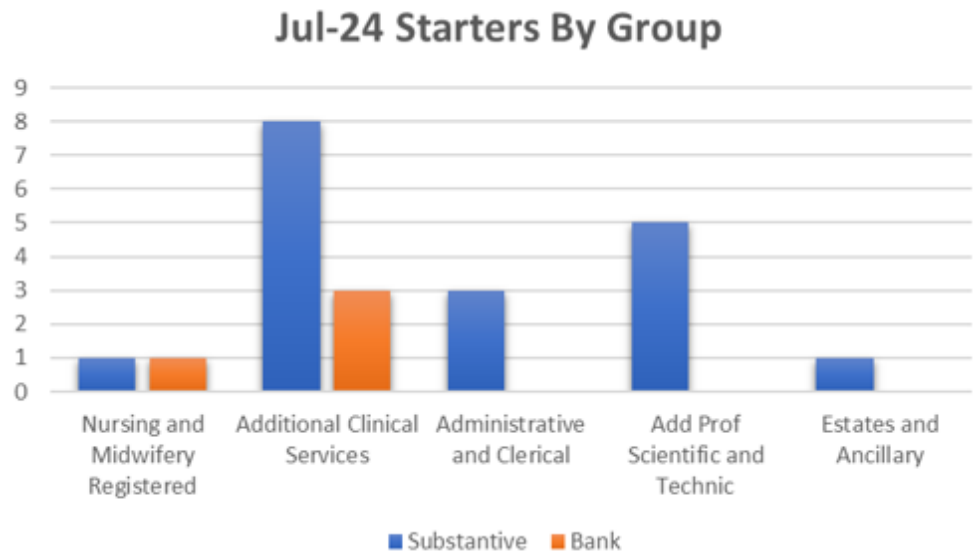
Average length of service of leavers

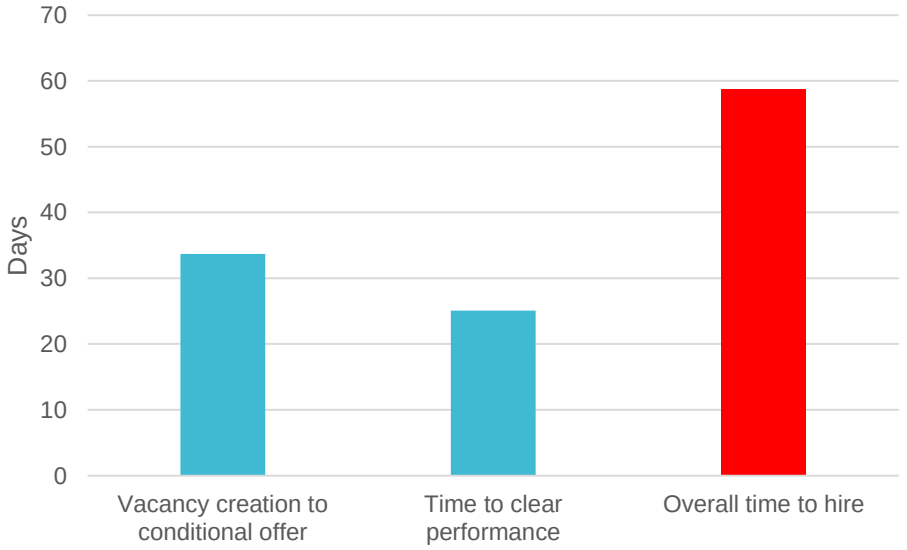


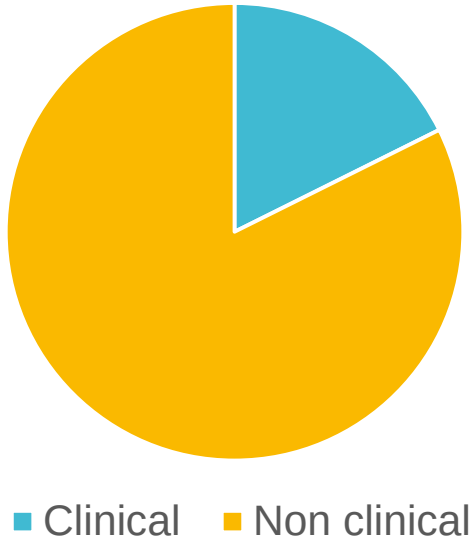


Starters – July 2024

Impact:
Recruitment is faster than it has been before, although less staff started in July than all other months. There are a higher number of staff in process and so it is expected to increase in August.







A reasonable time for recruitment could be:
Time to approve – 7 days
Advertisement – 14 days
Shortlisting – 7 days
Interview – 7 days
Clearances – 20 – 30 days (depends on role)
Total = 55 to 65 days

Employee Relations

Impact:
Handling cases informally (where possible) is helping us to keep casework low and the impact is naturally reduced.

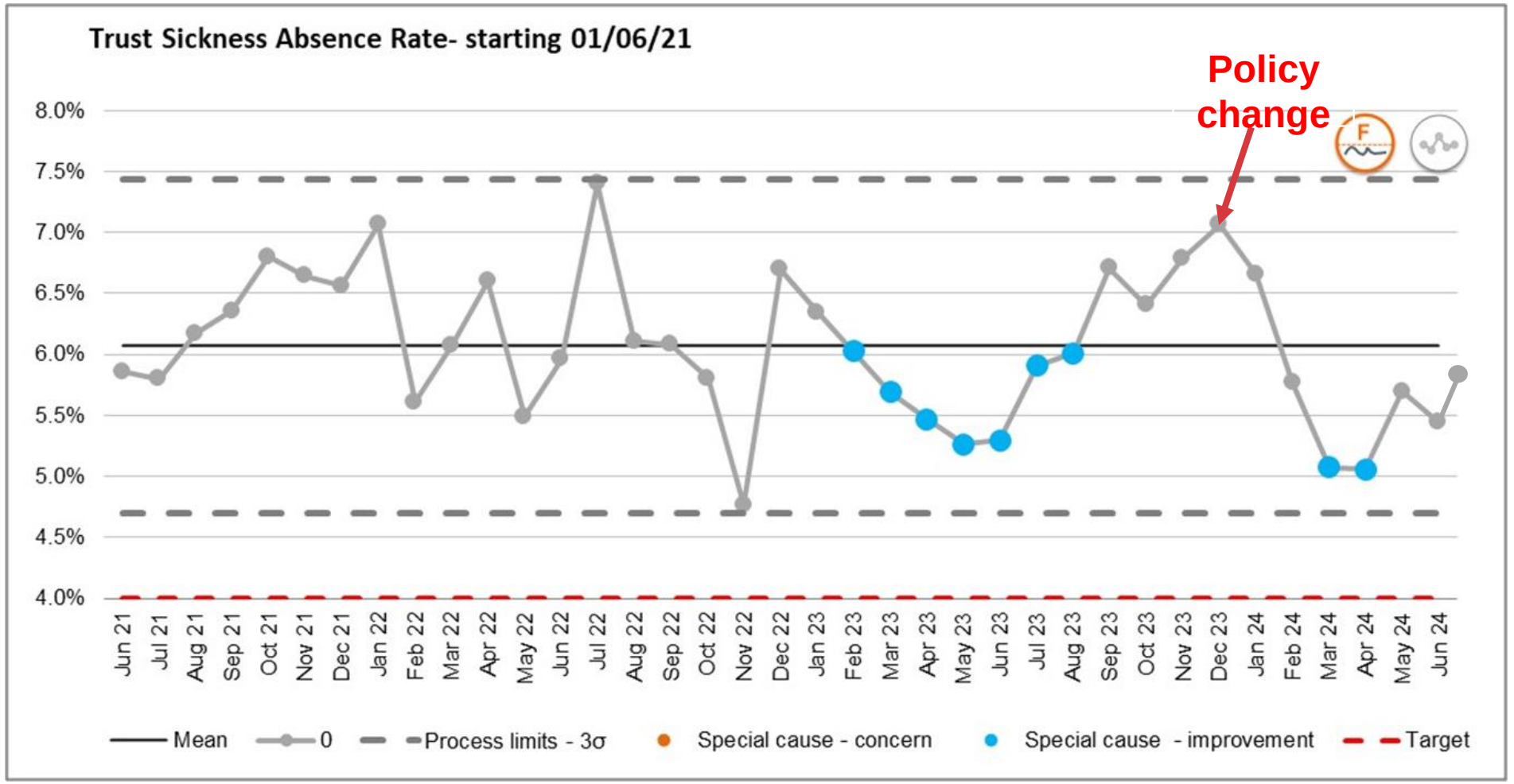
Case Type	Cases open	Suspended/ Excluded	Cases Concluded May/June
Disciplinary	3	1	4
Grievance	2	0	1
Formal Capability	0	0	0
Formal Capability (absence related)	5	0	0
MHPS	0	0	0

Key Themes:
Cases are relatively light at present and there are efforts to support staff and managers in handling matters informally which tends to have a better outcome.

Of the cases that are in hand themes are as follows:

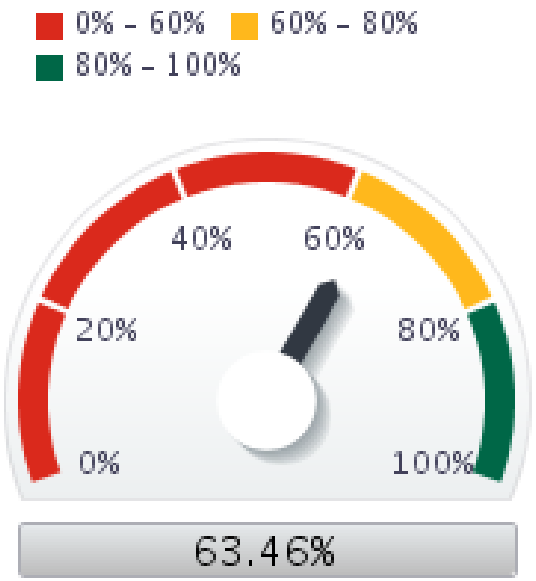
- Bullying and harassment (Grievance)
- Concerns around how incapability (performance) is being addressed (Grievance)
- Minor level fraudulent activity (Disciplinary)
- Professional misconduct (Disciplinary – fair blame)
- Bullying and not performing duties (Disciplinary)

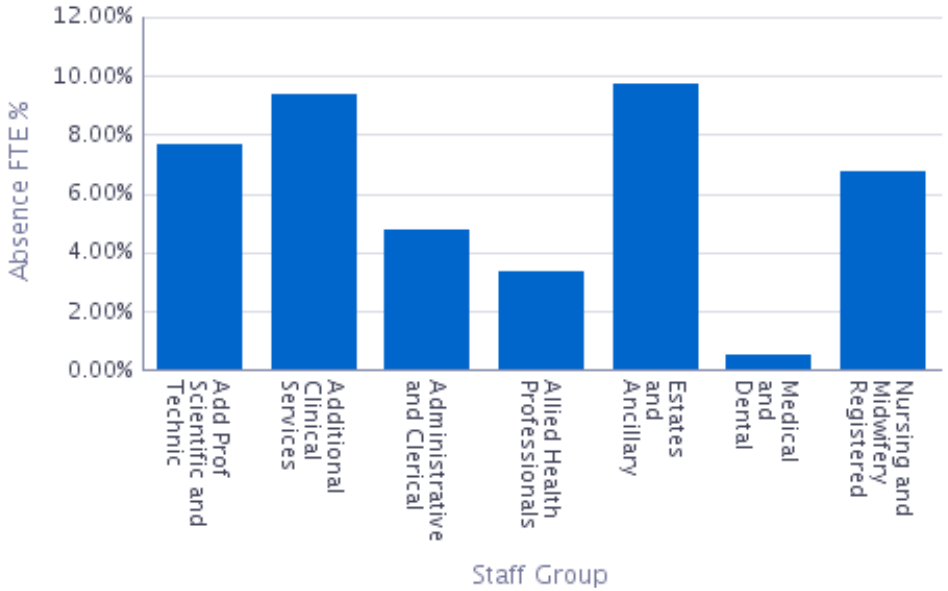
Sickness	
KPI	4%
July 2024	5.86%
Trend	↑

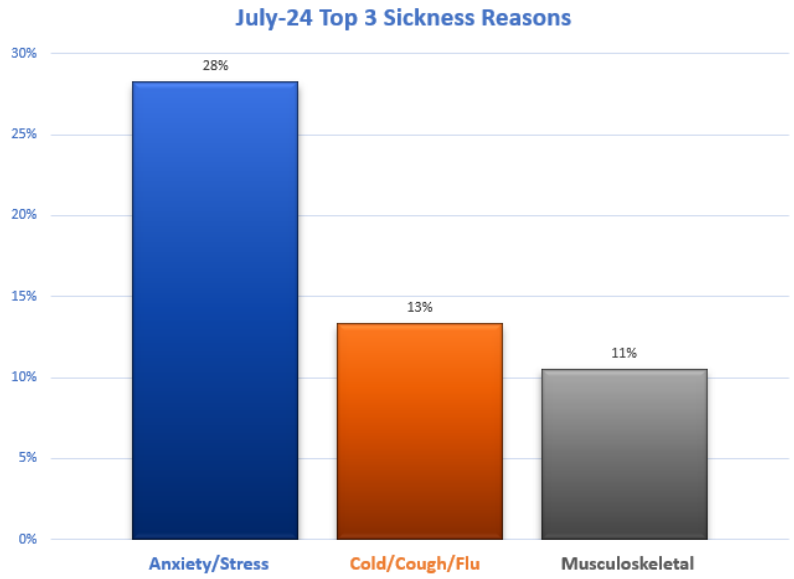


Sickness Continued

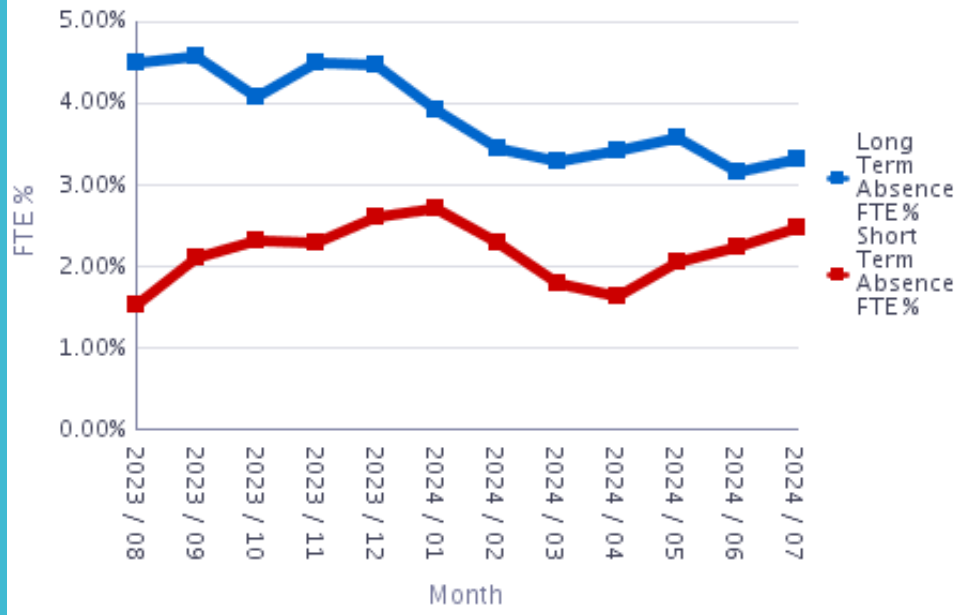
Return to work compliance (logged on ESR)

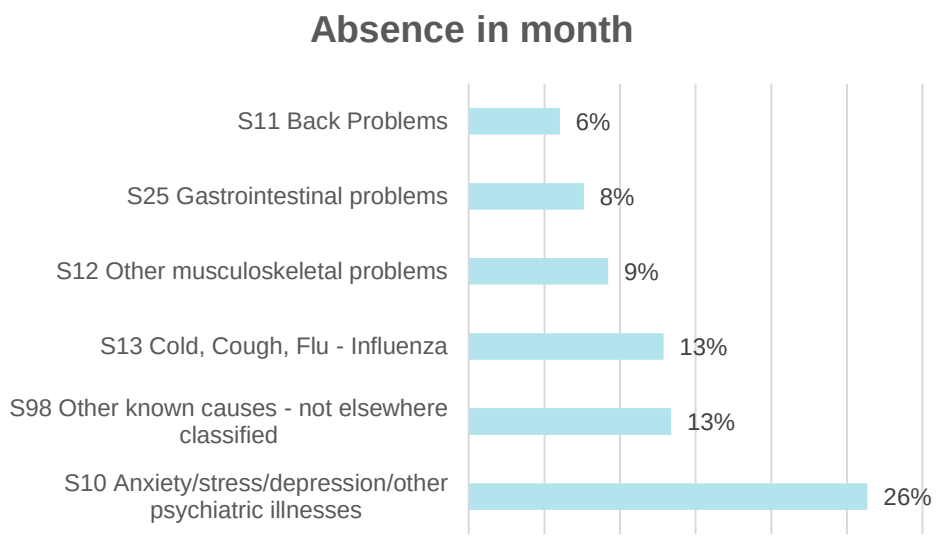


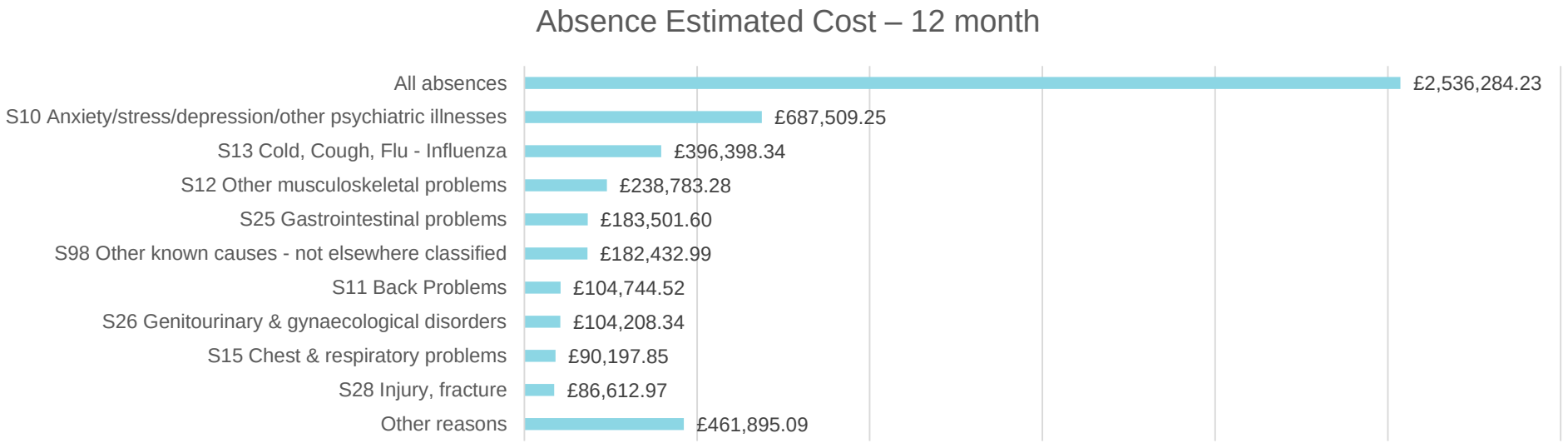




Sickness - continued

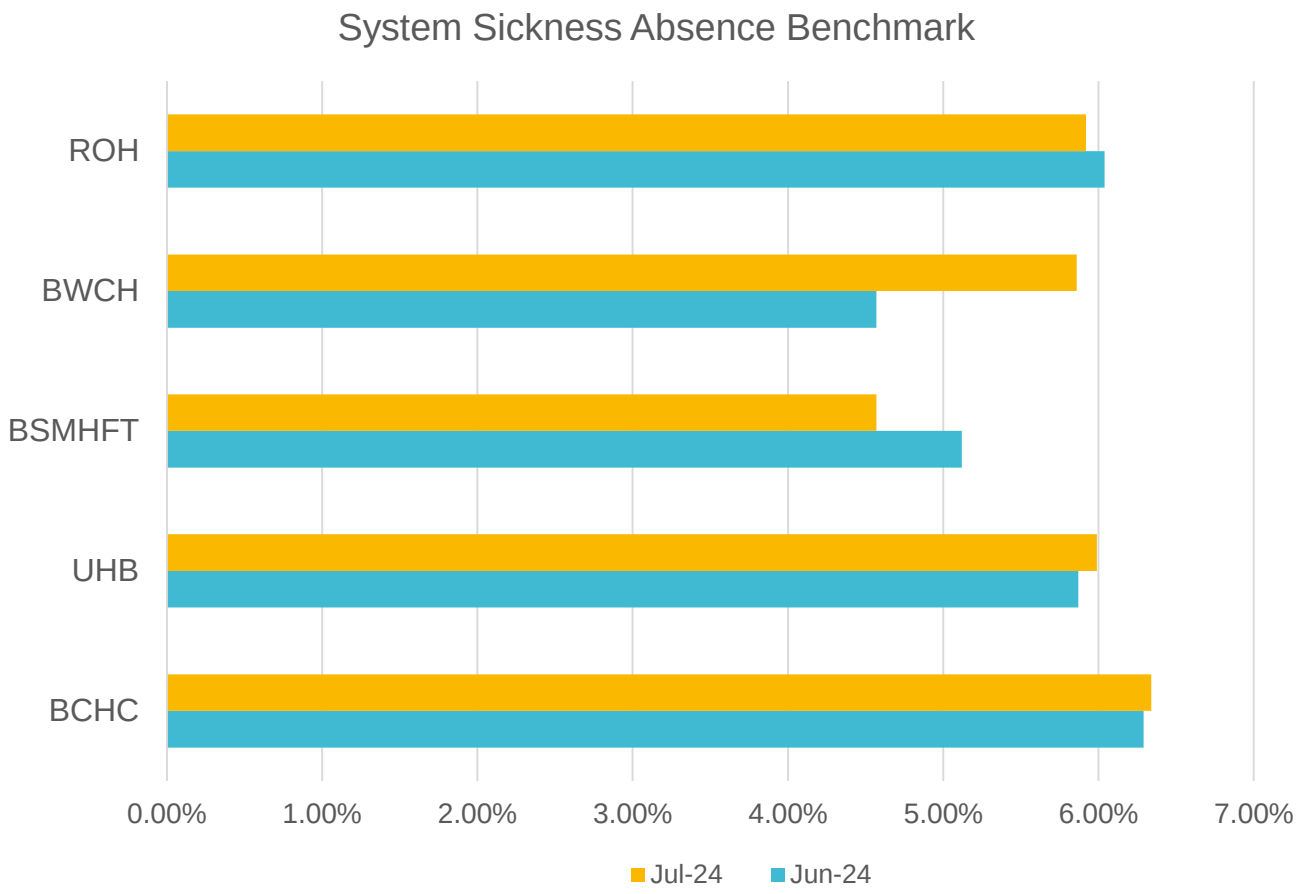






Sickness - continued

Insights:
Sickness increased this month, both in terms of long and short term. There are some very long term sensitive sickness cases coming to a close.



Section Two:

Education and Training

Prepared by: Claire Felkin, Training & Development Manager

Presented by: Claire Felkin, Training & Development Manager

Ref: Aug, 2024/HR&OPS

Education and Training

Summary:

We are not seeing the improvements we expected to see. We are well below the target of 93% overall. The annual renewal modules are falling well short and bringing the average compliance figure down. For example Fire is at 75.63% and Cyber at 51.39% whereas the average figure for the 3 yearly modules is 88%
In July there was a focus on Resus Level 1 activity and saw an increase of and this increase of 8%

Apprenticeship numbers are currently at 13/33 and current Apprenticeship Levy spend is at 56.46% which has increased. People are showing an interest so this figure should increase and we should achieve target.

Areas for Improvement:

- Cyber and IG and Resus has seen a reduction in compliance this month, we are working with the Resus Lead on increasing this.

Risks / Issues:

- Problems accessing Cyber ad IG as its through Metacompliance and not via ESR.
- Training & Development Advisor is taking a Career Break of 6 months for personal reasons this could have a potential impact on apprenticeship activity although the T&D Team have implemented plans to minimise this risk.

Action Plan:

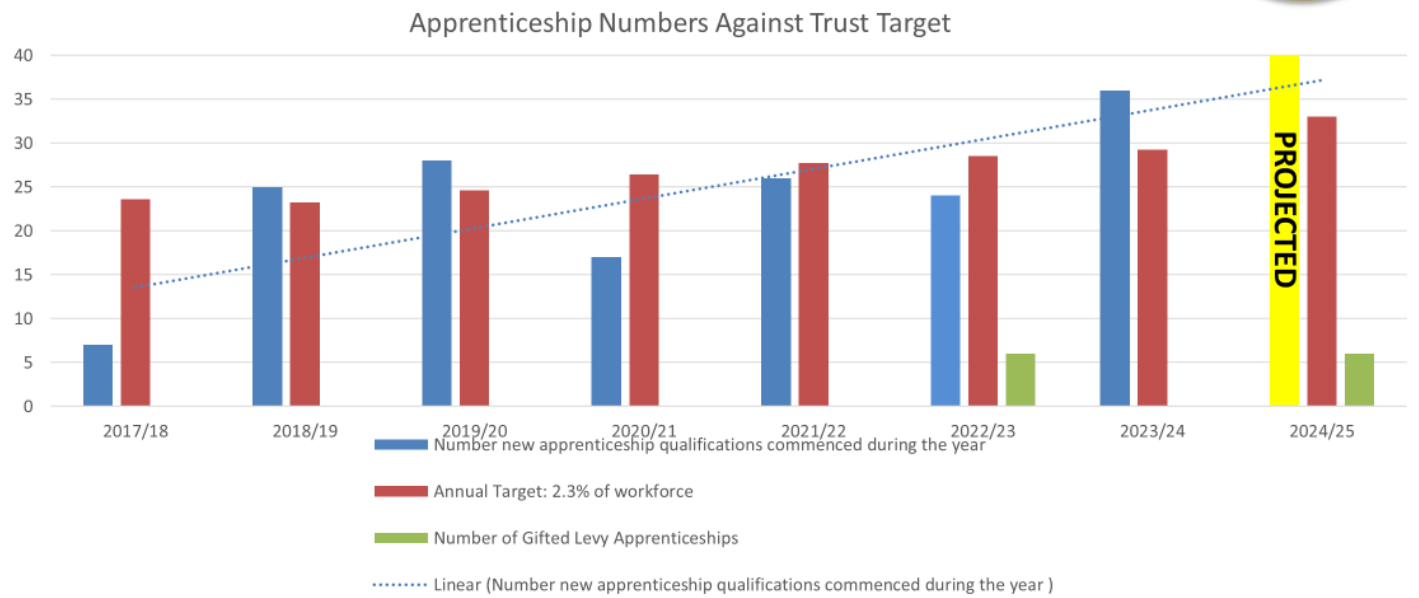
- In August there was a focus on Safeguarding Level 1 on request of Evelyn O'Kane.
- There has also been a focus on Fire Safety also so hope to see increase for next month's figures.

Apprenticeship Activity	
KPI	33
Current YTD	13/33
2023/24	36/29
2022/23	24/28

ROHSE (01-18) Workforce Performance Report

Apprenticeship Levy and Qualifications (2.3% of workforce)

2	Apprenticeship Qualifications Progress Summary
2b	Apprenticeship Commencements per year against Trust Local Target in numbers.



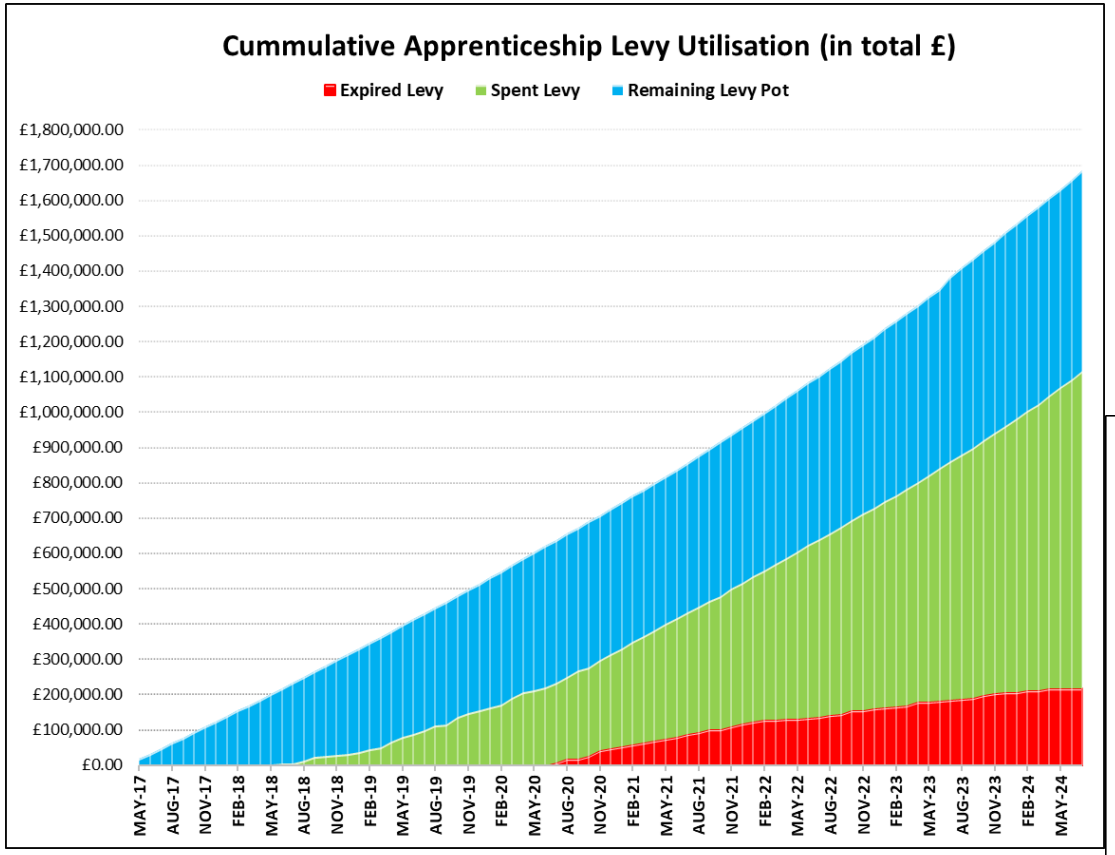
Achievement toward annual target:

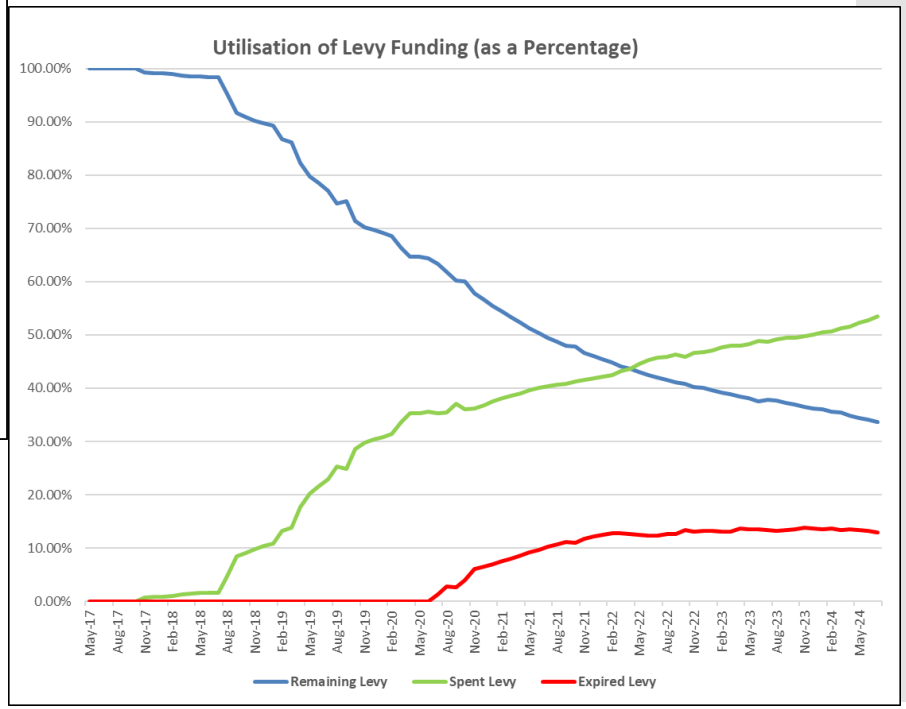
- This graph shows the number of new apprenticeship qualifications commenced in each year against the annual local trust target for that year. The impact of the pandemic on apprenticeship numbers can still be clearly seen during 20/21, and a positive increase back to our target levels in the years following. For 2023/24 we worked towards a projected number of 31/32 apprenticeship new starts and achieved 36. The Trust also gifted levy funding to support 6 apprenticeships in 2022/23, and has supported 6 this year to date.
- For 2024/25, we are making significant progress towards our national target (33) as detailed in the previous slide. And we have set a projected target of 40 new apprenticeship starts by 31st March 2025.

3

Apprenticeship Levy Funding

Spent	53.46%
Expired	12.94%
Unused	33.60%
Trend	





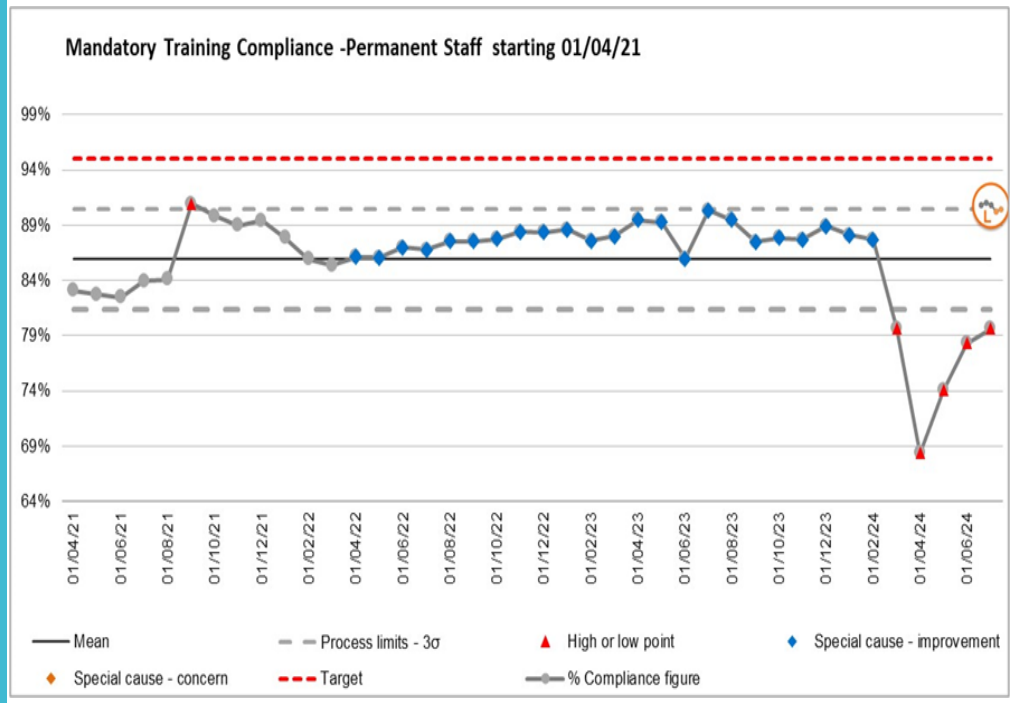
Mandatory Training

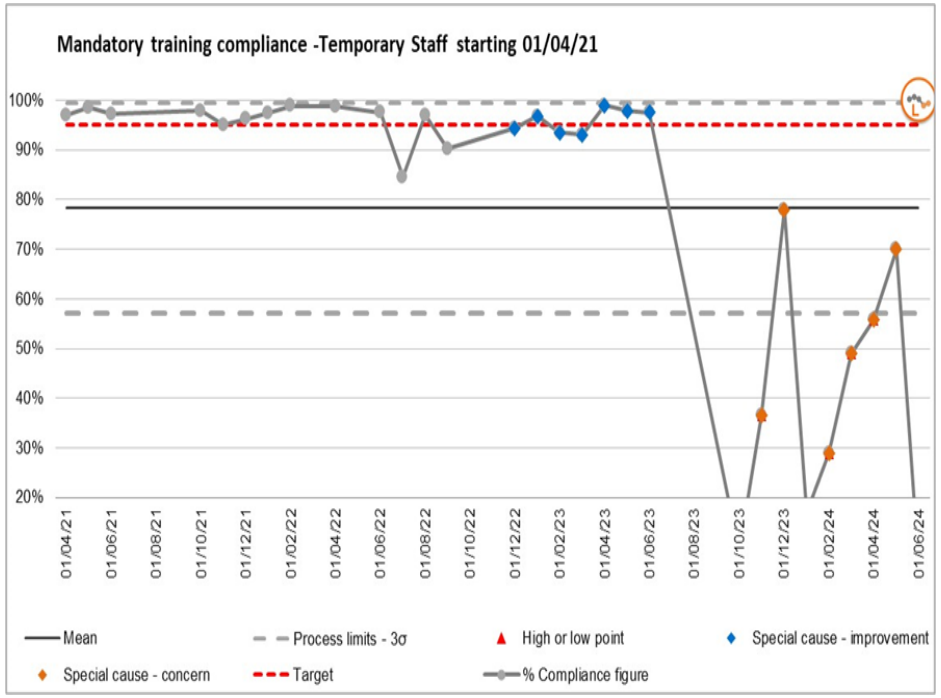
KPI	93%
July 2024	79.62%
TREND	

Training compliance summary – 31st July 2024

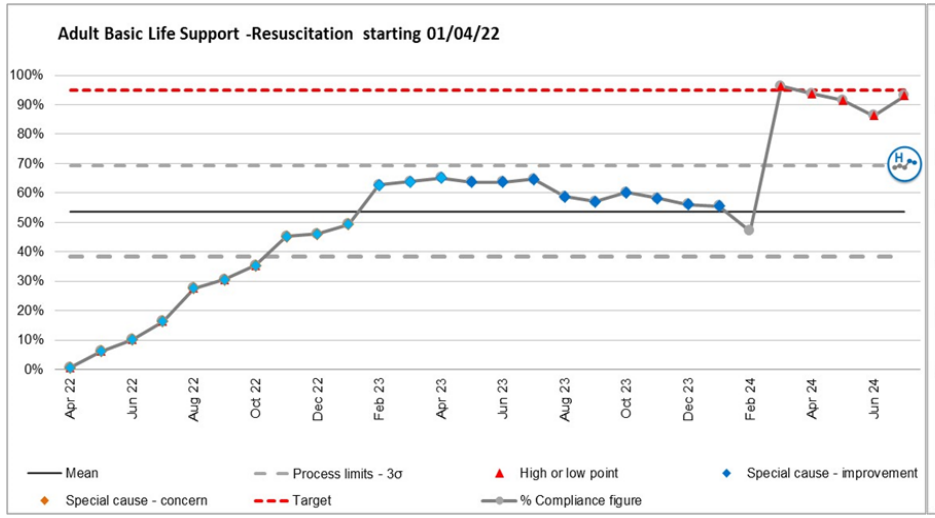
Pg.	COURSE	Compliance %age	COMMENTS	TREND
3	Core Mandatory Training – Permanent Staff	79.62%	Compliance is improving. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). % decrease due to Cyber and IG	
3	Core Mandatory Training – Temporary Staff	56%	Based on staff working on the Bank who are **compliant** with training	
5	Cyber	51.39%	Slight increase this month as monitoring via ESR has commenced	
5	IG	49.62%	Slight increase this month as monitoring via ESR has commenced	
7	Basic Life Support – Level 1	93.01%	Following direct mail chasing completions this has vastly improved. Target audience – non clinical.	
7	Hospital Life Support – Level 2	76.41%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	
8	Immediate Life Support	62.68%	We have now stopped working with HEST and our Resus Officer is now supporting additional sessions to improve compliance.	
8	Advanced Life Support	95.12%	4 identified as Out of date (1 to be removed, two new starters to be confirmed, and one with date confirmed in July)	
9	Paediatric Immediate Life Support	47%	Target achieved earlier this year, a few out of date and training planned in July.	
10	Patient Handling	82.85%	Good progress overall this year but less stable during the last few months; need to sustain improvement.	
10	Conflict Resolution	52.08%	Large decrease this month due to the change in compliance frequency to 3 yearly instead of once only from 1st May Should bounce back up within 3 months providing staff are supported to complete this elearning.	
11	NEWS2	97.92%	Consistently achieving over 95% compliance since June 2022.	
11	Safe use of Insulin	85.76%	Staying the same over the last few months.	
11	VTE	91.69%	Stayed the same over the last few months.	
12	CONSENT	79.76%	Slight decrease on last months, accessed via BMJ.	
12	IPC2	81.70%	Continual increase during the last few months.	
12	Food Hygiene	93.16%	Slight increase on last month	

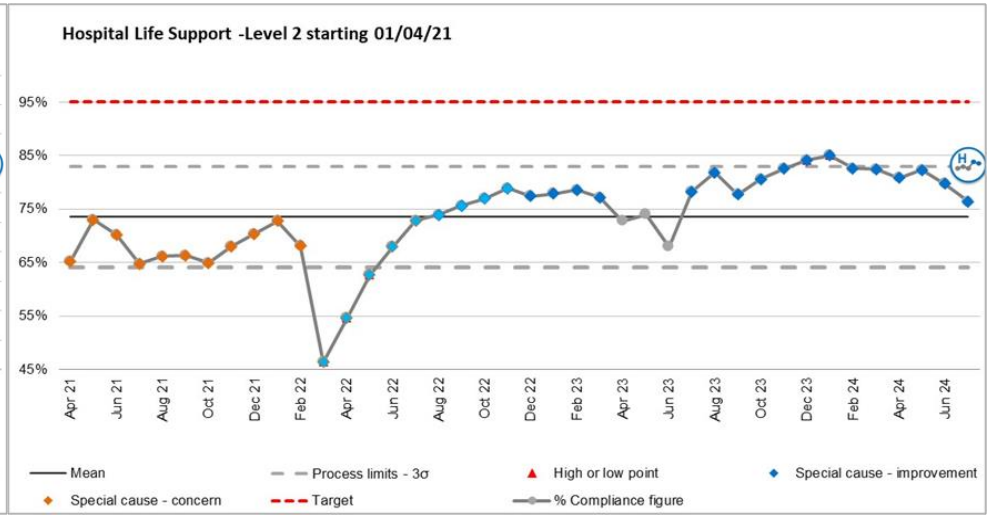
Core Mandatory Training: Permanent and Temporary Staff

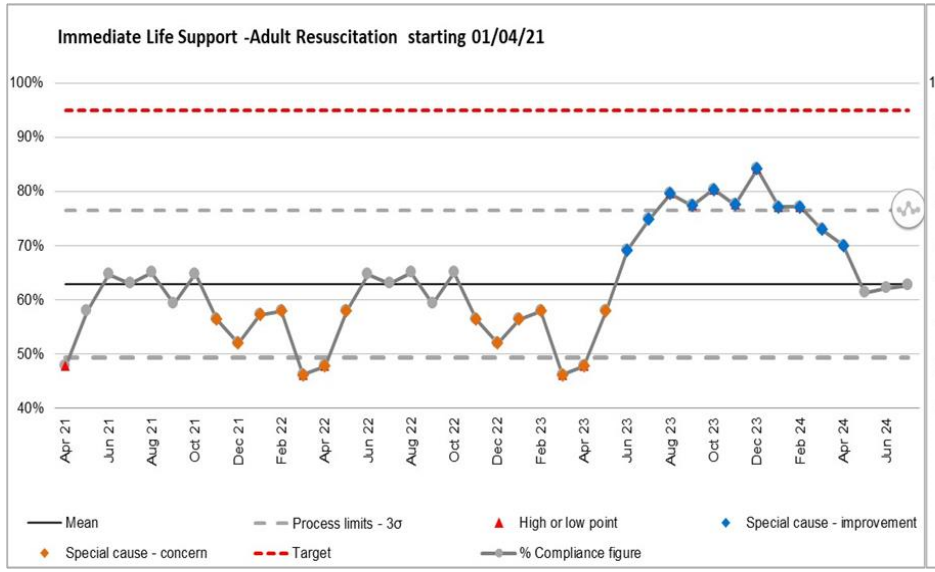


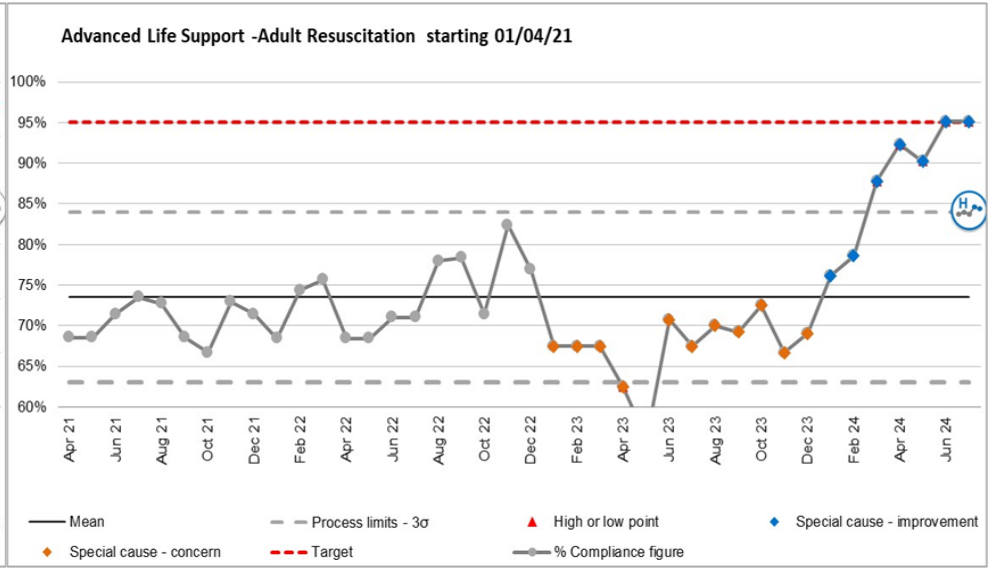


Resuscitation Training: Adult

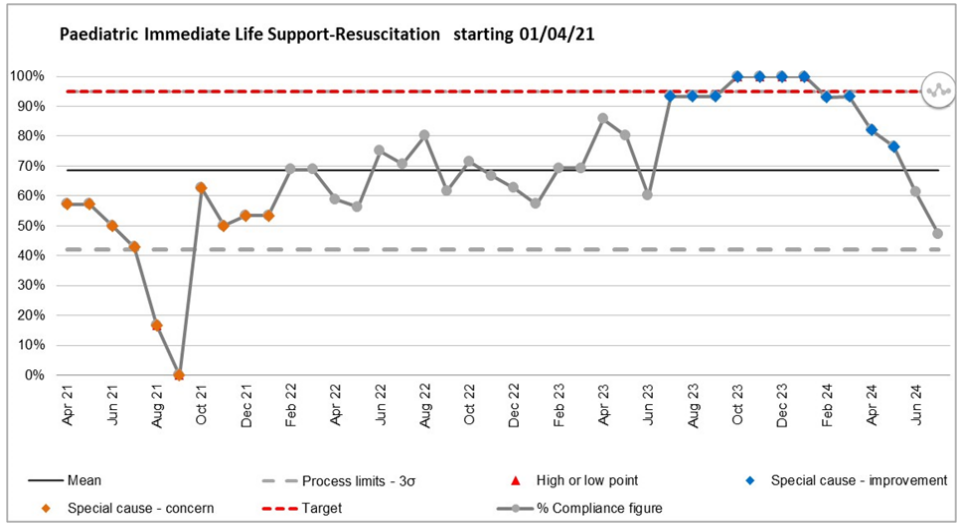


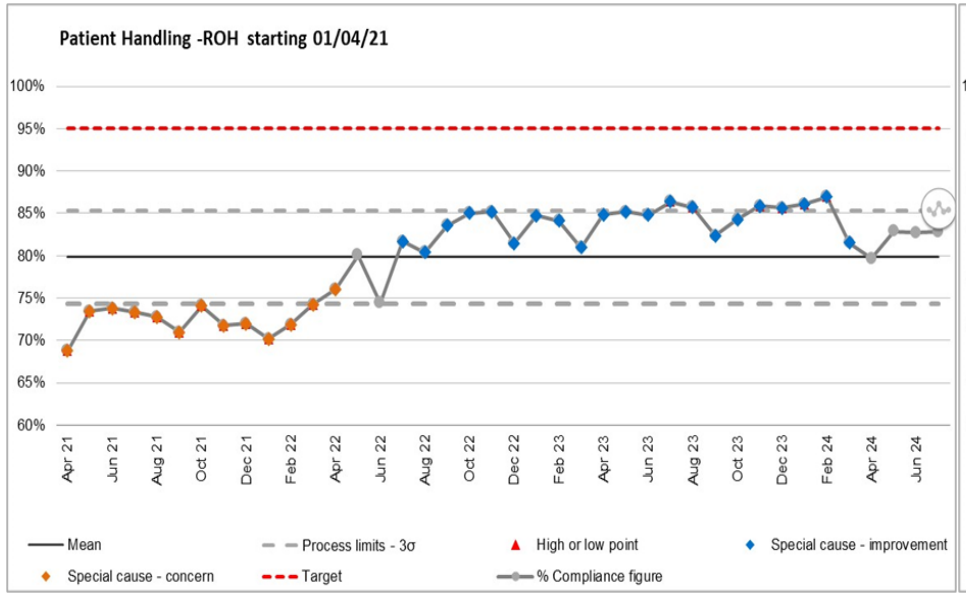


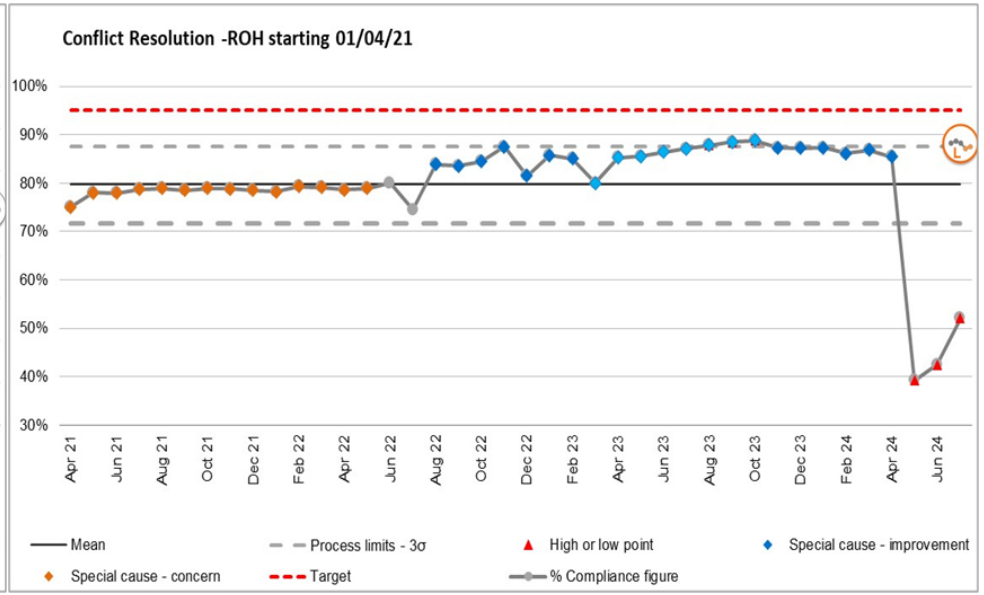




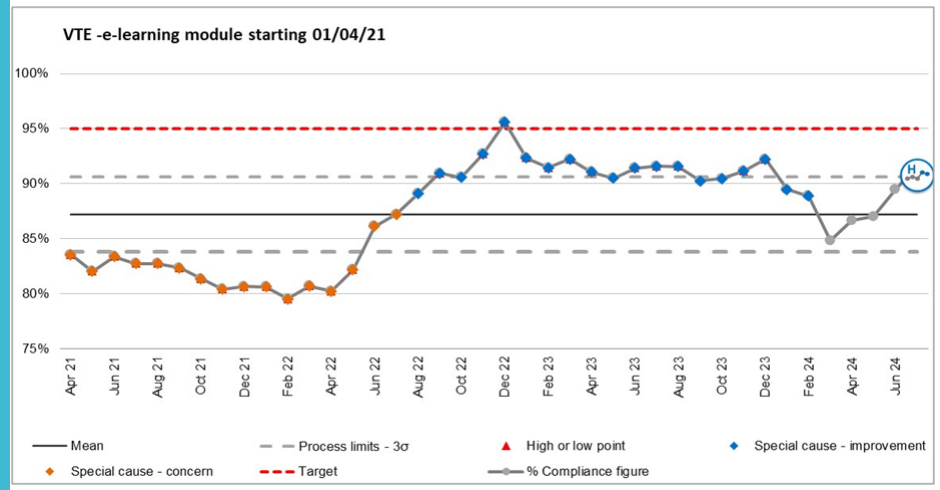
PILS, Conflict Resolution Patient Handling

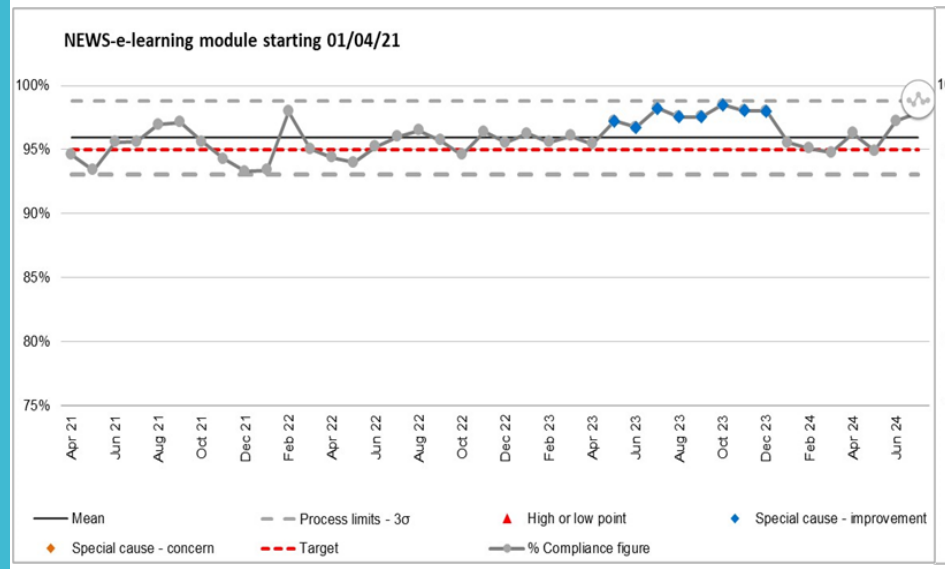


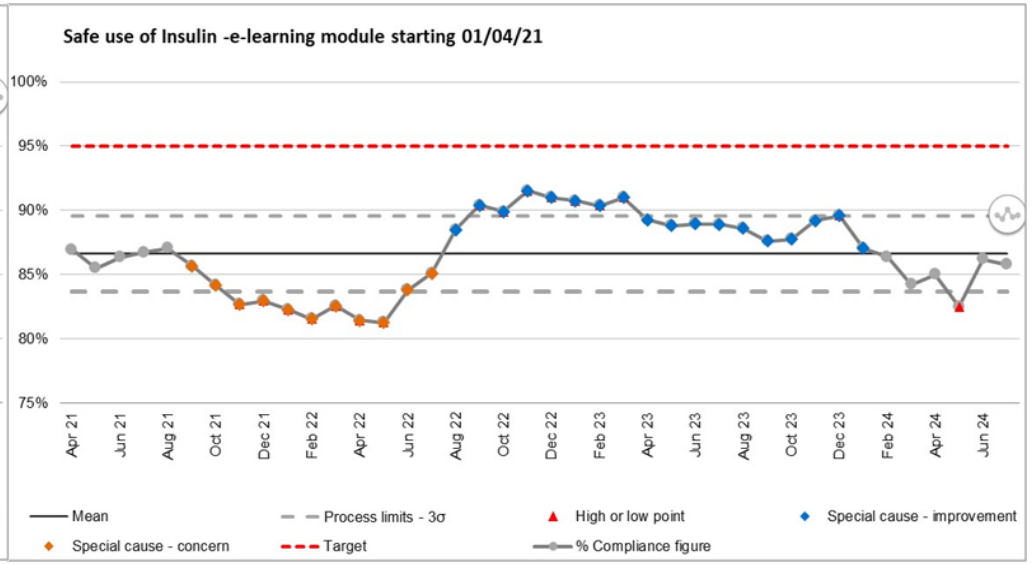




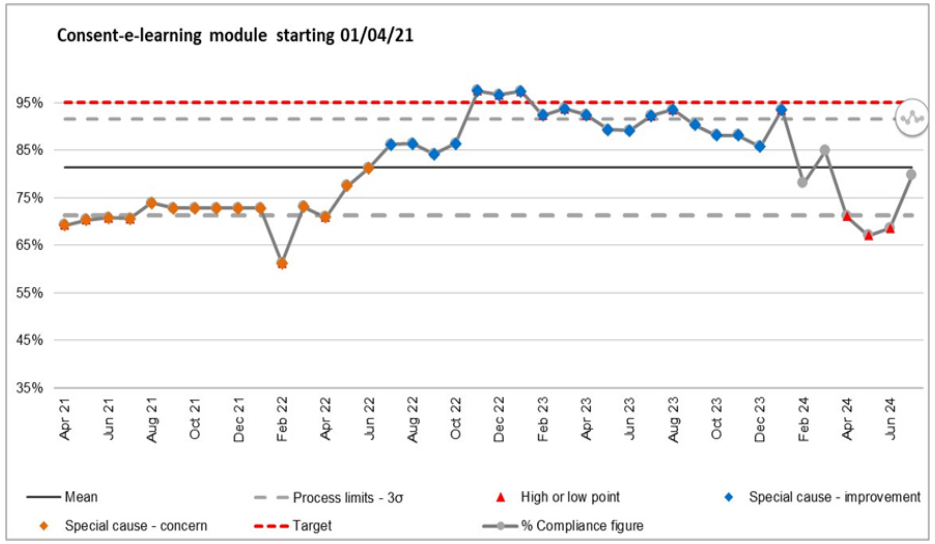
VTE, Safe use of Insulin, NEWS2

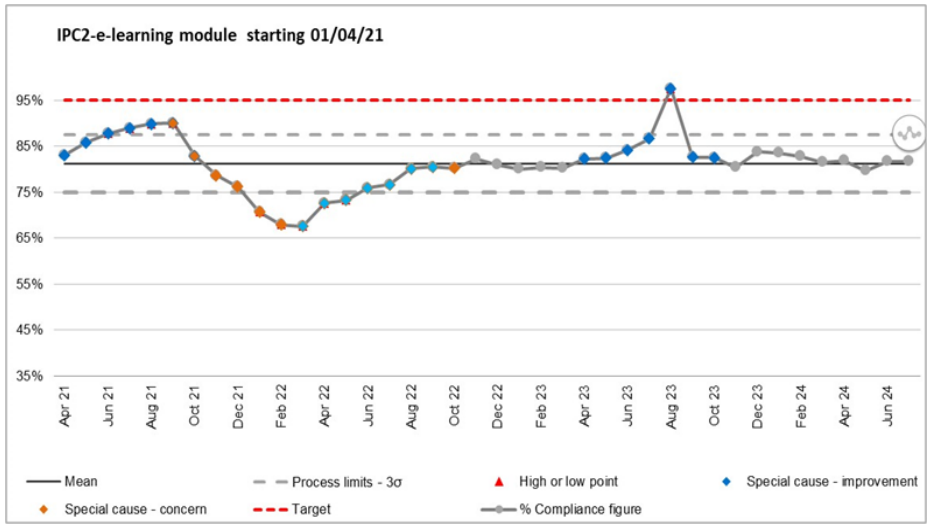


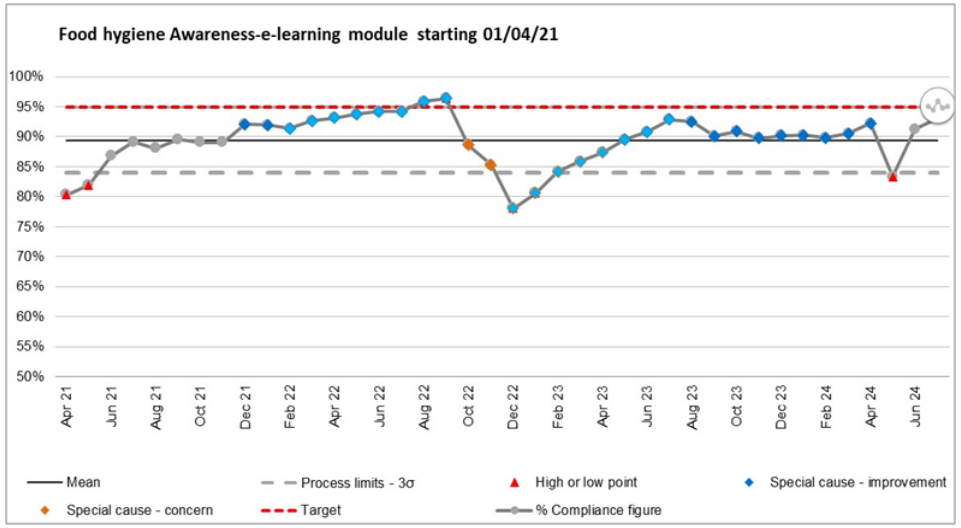




IPC Level 2, Food Hygiene Consent







Section Three:

Organisational Development Team

Prepared by: Clare Mair, Head of OD & Inclusion

Presented by: Clare Mair, Head of OD & Inclusion

Ref: Aug, 2024 /HR&OPS

Organisational Development

Summary:

- Key focus area of work has been around the New Appraisal Window approach which ran between 1st April and July 31st. There has been a positive increase to the first phase of the project which included manager training and awareness and completion of appraisal conversations
- Work progresses with the 4 well-being priorities
- Inclusive companies application submitted with support from colleagues across the Trust
- Team is working with colleagues across the ICS to improve the quality of diversity data
- Michael Hirons, the new OD and Inclusion Manager started at the Trust in mid August

Action Plan:

- Complete appraisal survey and quality review
- Complete final comms for National staff survey 2023
- Confirm plans for National staff survey 2024
- Support implementation of Race Equality code
- Planning for October Wellbeing week

• Areas for Improvement:

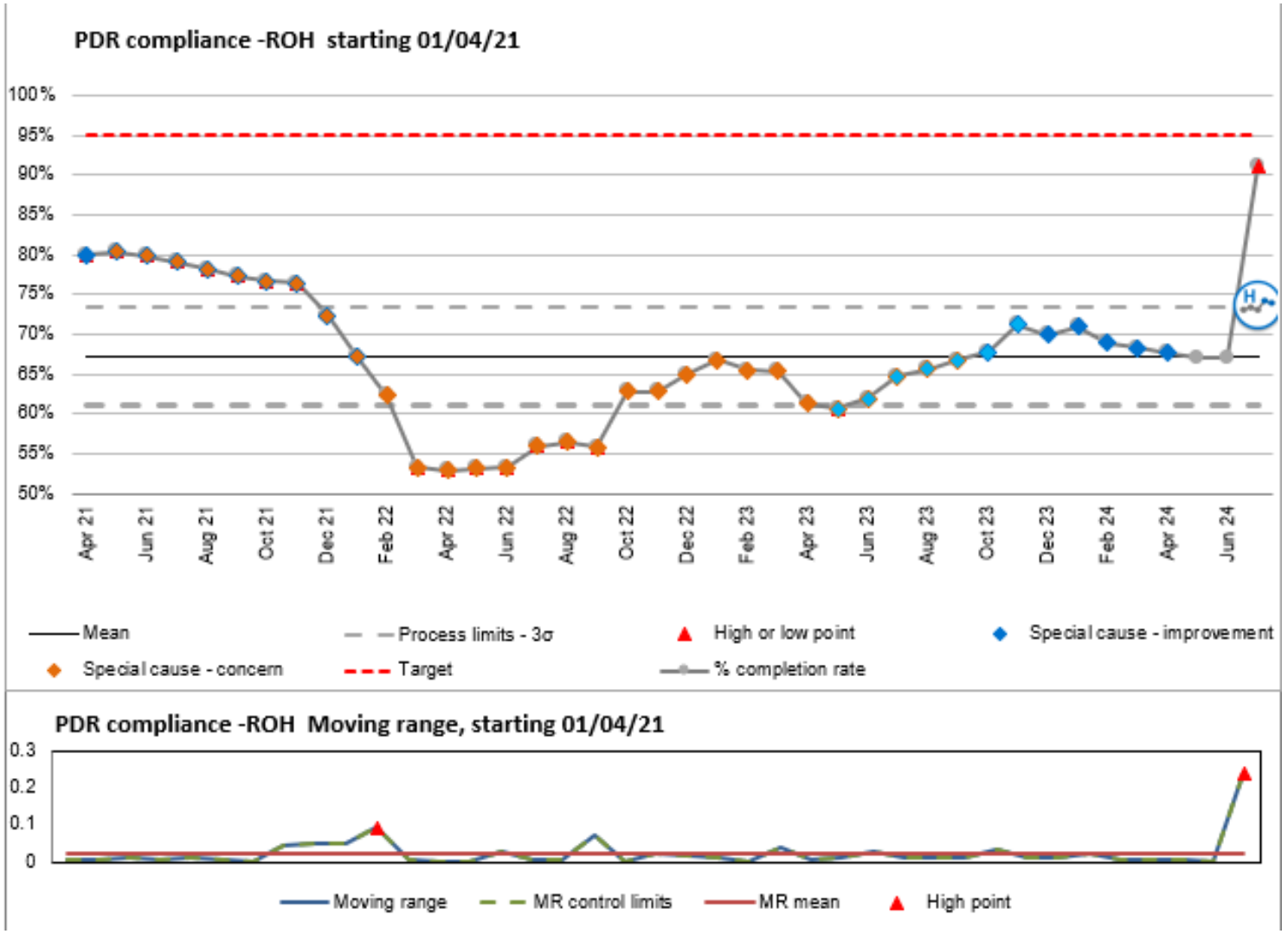
- Uptake on Wellbeing conversation training for managers
- Recruitment of network chairs to support staff voice
- Activity to improve engagement on staff survey for 2025

Risks / Issues:

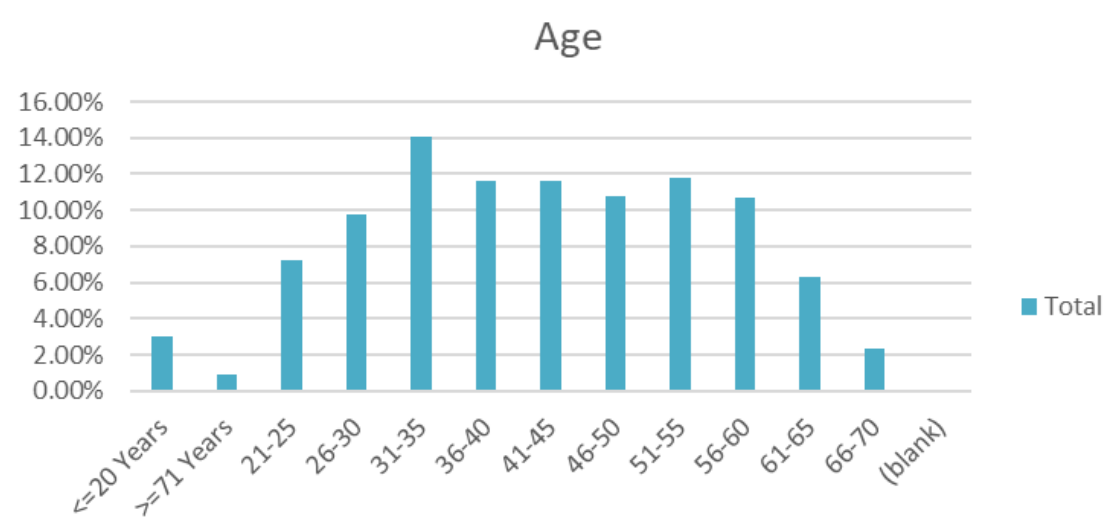
- Ensuring managers are equipped to support their teams with current challenges

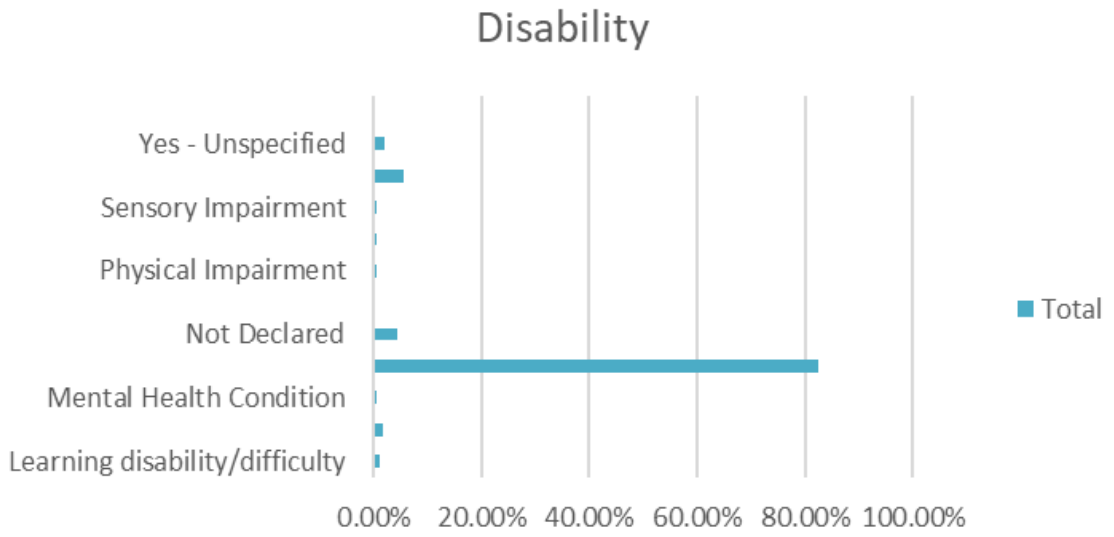
Performance & Development Reviews

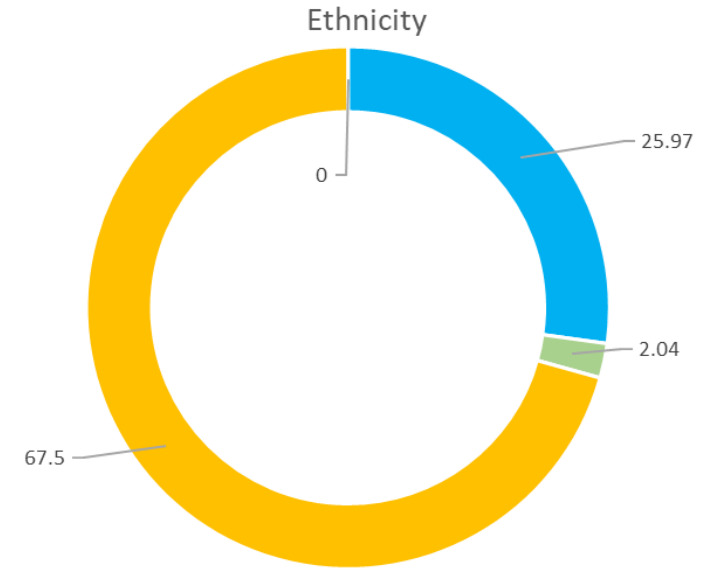
KPI	95%
July, 2024	91%
Trend	↑

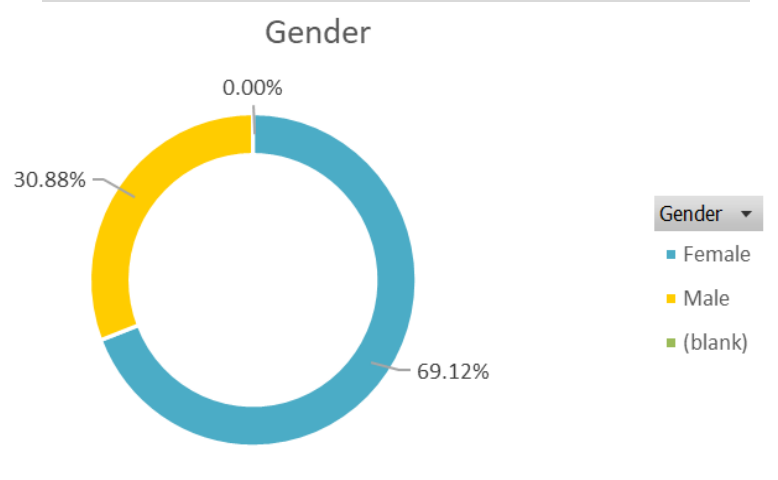


Workforce Demographics

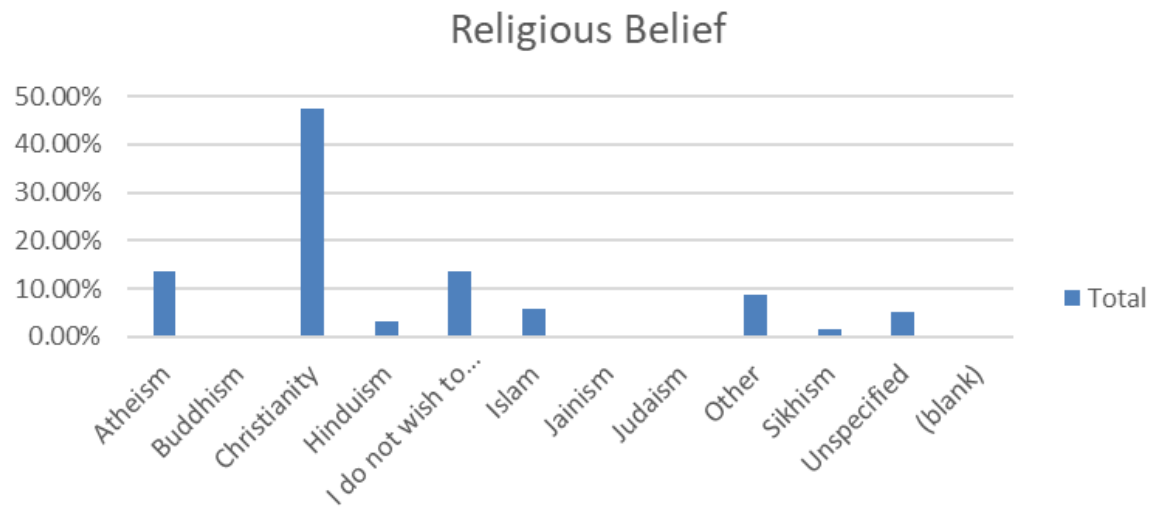


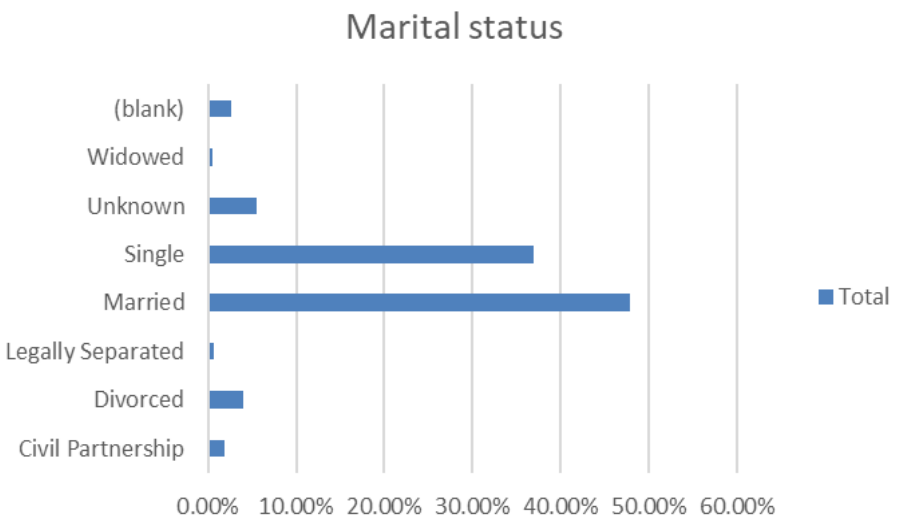


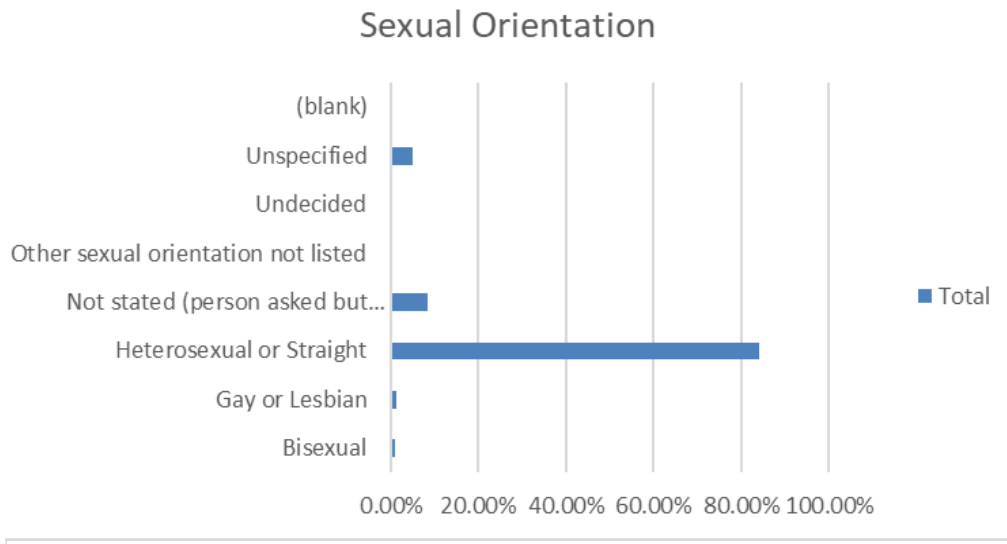




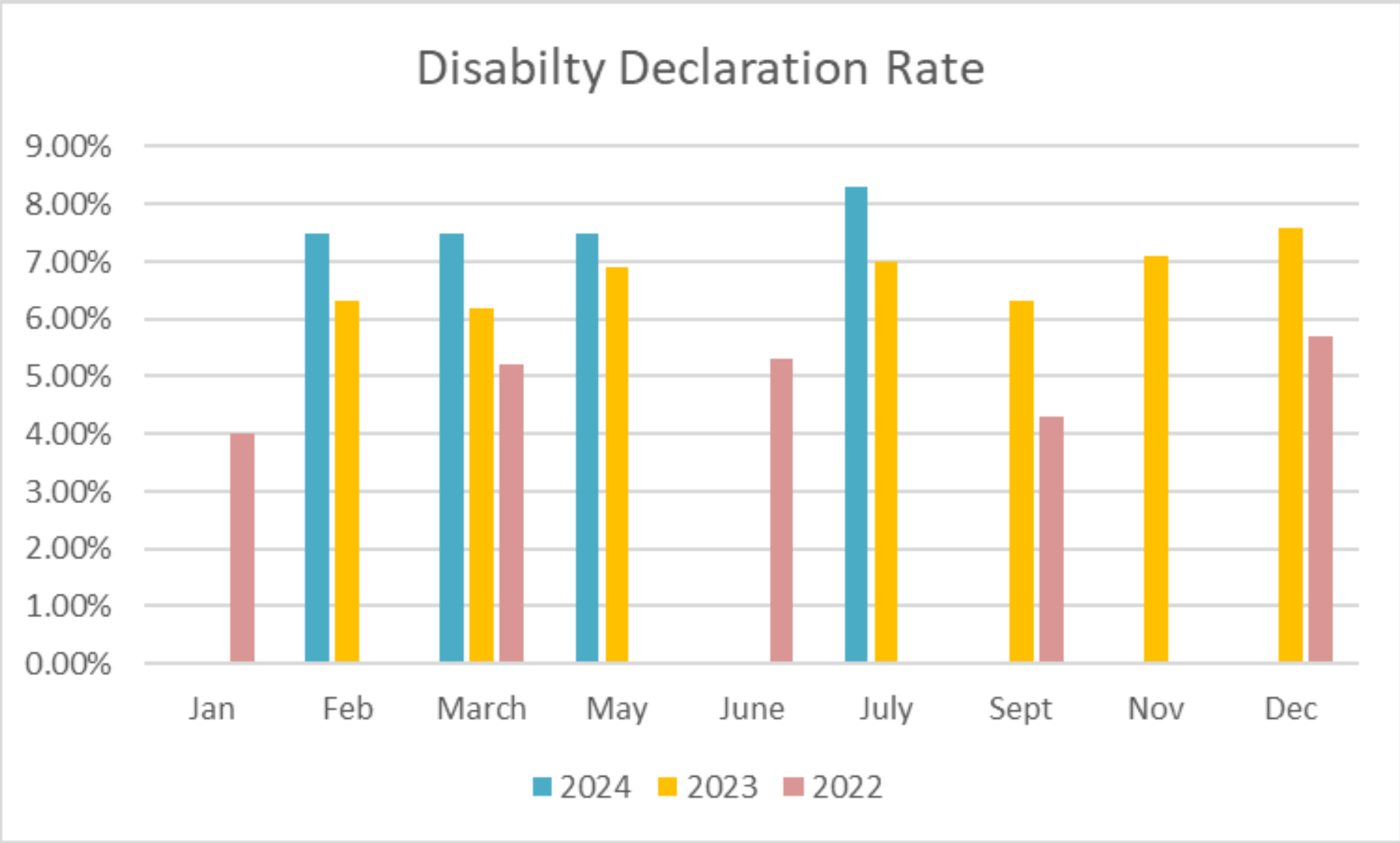
Workforce Demographics







Workforce Experience	
KPI	7.5%
July 2024	8.2%
Trend	↑



Workforce Wellbeing: Annual Leave Current percentage and Target

Division	% Annual Leave Taken
303 Corporate Directorate	18.11%
303 Division 1 – Patient Services	32.07%
303 Division 2 – Patient Support	39.91%
303 Division 4 – Estates and Facilities	9.90%

Staff Group	% Annual Leave Taken
Add Prof scientific and technic	6.01%
Additional Clinical Services	18.06%
Administrative and Clerical	33.94%
Allied Health Professionals	6.69%
Estates and Ancillary	8.57%
Nursing and Midwifery Registered	26.44%

Workforce Demographics

Initiative	December	February	April	June	August
Number of members of staff network meetings – (All members of all staff networks – from June)	296	301	291	302	299
Number of attendees at staff network meetings	25	21	19	26	21
Number of hits on Staff Networks intranet site – (**Viewers** – how many individual staff members have viewed site/ **Views** – number of people visiting site more than once from July)	21 Viewers	40 Viewers	101 Viewers	59 Viewers	41 Viewers
	174 Views	48 Views	147 Views	79 Views	54 Views
Number of hits on Health & wellbeing intranet site (**Viewers** – how many individual staff members **Views** – number of people visiting site more than once)	54 Viewers	51 Viewers	82 Viewers	Viewers	191 Viewers
	108 Views	85 Views	125 Views	Views	224 Views

Workforce Demographics

Initiative	December	February	April	June	August
OD intranet sites – Appraisals / Training dates	-	-	-	237 Viewers	241 Viewers
	-	-	-	464 Views	514 Views
Workshop attendance OD	121	28	110	39	47
Workshop attendance Health & Wellbeing	83	tbc	69 Trust Tea Trolleys	183	48
Entrance swipe to Wellbeing room / Dome (from July)	351/82	122/45	288 / 174	240 /142	205 /109

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Learning from Deaths and Mortality Review**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**John Va Faye – Associate Medical Director** **Adam Roberts – Assistant Director of Governance** **Hayley Phillips - Informatics Analyst** **Sally Breecher – Clinical Governance Lead** **Matt Revell - Executive Medical Director**
DATE OF MEETING:	**4th September 2024**

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	**X**	**FOR INFORMATION ONLY**		**TO CREATE DISCUSSION**		**TO SEEK APPROVAL**	

EXECUTIVE SUMMARY:

The Learning from Deaths (LfD) report provided is a quarterly report that has been previously shared at the Quality & Safety Committee in July 2024.

Governance Update:

The governance team have started to move the LfD process onto the Trust Audit Management and Tracking Tool (AMaT), a transition which is expected to complete Autumn 2024. This initiative will improve workflows and make analysis easier.

The Trust maintains a high profile in the regional review of deaths; the Associate Medical Director and Assistant Director of Governance participate in the BSol Learning from Deaths Committee, returning with key insights to be integrated into our trust processes. This ensures alignment with regional practice.

Qualitative Analysis: Key Learning from this reporting interval

Three cases are discussed in detail in this paper. Both cases found good or excellent care and are awaiting final discussion at the next trust wide audit:

- UHB foot and ankle patient readmitted to UHB after previous surgery at ROH
- In-patient death due to cement reaction
- End of surgery in theatre oncology death

Quantitative Analysis:

Our review of the in-hospital death rate from April 2023 to March 2024 suggests a small potential increase in mortality rate, but it remains within historical statistical control limits. Benchmarking against other specialist orthopaedic hospitals also confirms our rates are within comparable ranges to similar Trusts.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Mortality rate remains low overall and within historical control limits. LfD team have in general found good to excellent care of the patients. No major evident care deficiencies or	Data note: Monitoring all 30-day deaths within and outside the hospital requires several informatics feeds. These include one for out of hospital deaths. There can be unavoidable delays in reporting,

issues with decision making were identified in the last quarter. The Trust has identified key learning points and the actions arising have clear owners. Close working with the external medical examiner has continued and new national rules have been disseminated to all consultants. ROH continues to attend and contribute to regional BSol LfD meetings and processes. The pre-operative assessment development team have taken account of the LfD analysis around complex cases and multi-morbidity patients. As resources reconfigure around new triage pathways over the autumn a High-Risk Panel is planned within current resources to review such cases.	clustering of incident reports and minor variability in the timing of various data feeds. The team monitor to ensure that this does not distort objective interpretation of the data. As the LfD process is transferred to the AMaT system, there is a small risk of delays as processes transfer and the new system embeds. It is anticipated that both process and analysis will be more streamlined than current manual tracking.

REPORT RECOMMENDATION:

The Board is asked to:
Note and accept the sources of assurance.

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

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

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

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

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

Best Care

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

Keeping patients safe and offering the right care, at the right time, in the right setting.

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

N/A

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

Quality & Safety Committee and Trust Board.

Learning From Deaths

Contents

Introduction

The Learning from Deaths (LfD) framework is an essential part of improving patient care and safety. The process supplements normal divisional governance and seeks to enhance learning from cases where the patient has died in our care.

Most Trusts use the Structured Judgement Review (SJR) to triage in hospital deaths and identify cases where there would be benefit in a closer examination and review of care. At our Trust, all deaths within 30 days of discharge are reported and then triaged so that: cases where care was evidently good palliative end of life care throughout can be de-escalated and all others going on to have a detailed supplementary review.

In line with the national approach, the Governance Team maintain the Trust's dedicated tracker and dashboard and are responsible for making it available on the Trust website. Clinical oversight is by the Associate Medical Director (Corporate). They and the Associate Director of Governance, also play an active role in the regional Learning from Deaths forum.

The Audit Quality Improvement Learning and Analysis group (AQILA) receives LfD reports and monitors mortality data monthly.

Qualitative Review: Learning from Deaths

Case 1: UHB Foot and Ankle Procedure

Case outline

A patient under the care of the University Hospitals Birmingham surgical team, underwent a complex foot and ankle procedure at ROH. The patient had been identified prospectively as high risk due to significant comorbidities.

The patient experienced an oxygen desaturation event in the operating theatre, largely relating to a pre-existing lung condition. There was clinical escalation and support from multiple consultants in theatre and the patient was admitted to the High Dependency Unit (HDU) for monitoring and further management. The patient went on to have an uneventful further postoperative recovery and was subsequently discharged from ROH.

After discharge from the ROH, the patient was subsequently readmitted to UHB due to an unrelated complication of a urinary tract infection (UTI) and died.

Learning

The governance team at UHB will also be undertaking a review of this patient's case, focusing on both the clinical and governance aspects. This dual review will provide a more complete understanding of the whole patient spell and will identify any further opportunities for learning and improvement.

Evaluation

Learning from Deaths (LfD) identified excellent clinical management and coordination during surgery and in the immediate postoperative period. The cause of death is believed to be unrelated to care. The case also shows the coordinated approach between ROH and UHB around clinical governance.

Coronial Process

Not applicable

Case 2: Periprosthetic Fracture and Cement Reaction

Case outline

An elderly patient was transferred to ROH from a nearby hospital, after a fall in a care home. The transfer was initially delayed for investigations into possible medical causes of the patient's fall. The patient had sustained a peri-prosthetic fracture and was listed for a distal femoral replacement. The patient died in the operating theatre due to bone cement reaction despite mitigation measures. Cement reaction is a known complication in orthopaedic reconstructive surgery and the surgeon had correctly avoided pressurising the cement in the bone to reduce the risk.

Learning

Throughout the patient's treatment, effective communication was maintained with her family. The medical team provided clear explanations of the risks associated with the fracture and the chosen management through a surgical procedure. The patient's family have subsequently indicated that they had a thorough understanding of the treatment plan and potential outcomes and wrote to thank the team, surgeon in particular, for their care.

The review identified a lack of specific evidence regarding bone cement reactions in endoprosthetic replacements. To address this, a Standard Operating Procedure (SOP) is being developed. This SOP will

integrate best clinical management for future cases. The first draft has been completed, and relevant stakeholders have been identified to contribute to its finalisation.

Evaluation
Our internal review found no evidence of harm attributable to ROH and surgical team practices.
The review identified two learning from excellence themes:

- Effective Communication: Ensuring the family was consistently well-informed at all stages.
- Prioritisation of Patient Needs: Customising the care plan to meet the patient's specific requirements.

Coronial Process
The case is scheduled for a coroner's inquest on 9th September 2024. This was anticipated because the fracture was the result of a fall and the fall had happened during managed care.

Case 3: (Update) End of procedure Complex Oncology (Chondrosarcoma hemipelvectomy) death

Case outline

A older patient under the care of oncology team underwent a complex hemipelvectomy for primary bone cancer. Surgery was uneventful with less than expected blood loss. After the end of procedure upon emergence from anaesthesia, when patient was being turned on the surgical operating table the patient had a sudden cardio-respiratory arrest. The patient was stabilised and transferred to QE where they died subsequently from multi organ failure.

Learning

The learning was that correct procedures were followed, and evidence of particularly good clinical practices were noted in that blood loss was less than expected with immediate recognition of cardiac event and correct and prompt process for patient stabilisation. Consideration is now being given to establishing a high-risk patient panel to further enhance ROH pathways.

Evaluation

Learning from Deaths (LfD) review established that the death was not avoidable. An After-Action Review (AAR) also concluded that established protocols at ROH were followed, there were no obvious pre-optimisation steps in this case which could have been taken that would have changed the outcome.

Coronial Process

Originally a full inquest had been arranged. However, after review of submitted written evidence the coroner decided an Inquest-In-Writing was sufficient. The coroner established that death was due to multiorgan failure as result of a cardiac event, a known complication of necessary surgery for cancer without which the patient would have inevitably died.

Case 4: (Update) Post-discharge death from cardiac causes following a total knee replacement.

Case Outline
This case has been discussed in a previous LfD paper

Learning
The case has now been discussed further at clinical audit with the following outcome from the discussion: mandate to explore a bespoke cardiac optimisation pathway.

Analysis suggests that there has not been a statistically significant increase in ischaemic cardiac deaths in recent months, although numbers did rise a little at the end of calendar year 2023 – see Figure 1. Nevertheless, cardiac related deaths represent numerically the largest diagnostic group for deaths after elective surgery.

The AMD Corporate has therefore undertaken to develop a dedicated model cardiac pre-operative pathway and will oversee discussions with the peri-operative team, supported by the AMD Division 2.

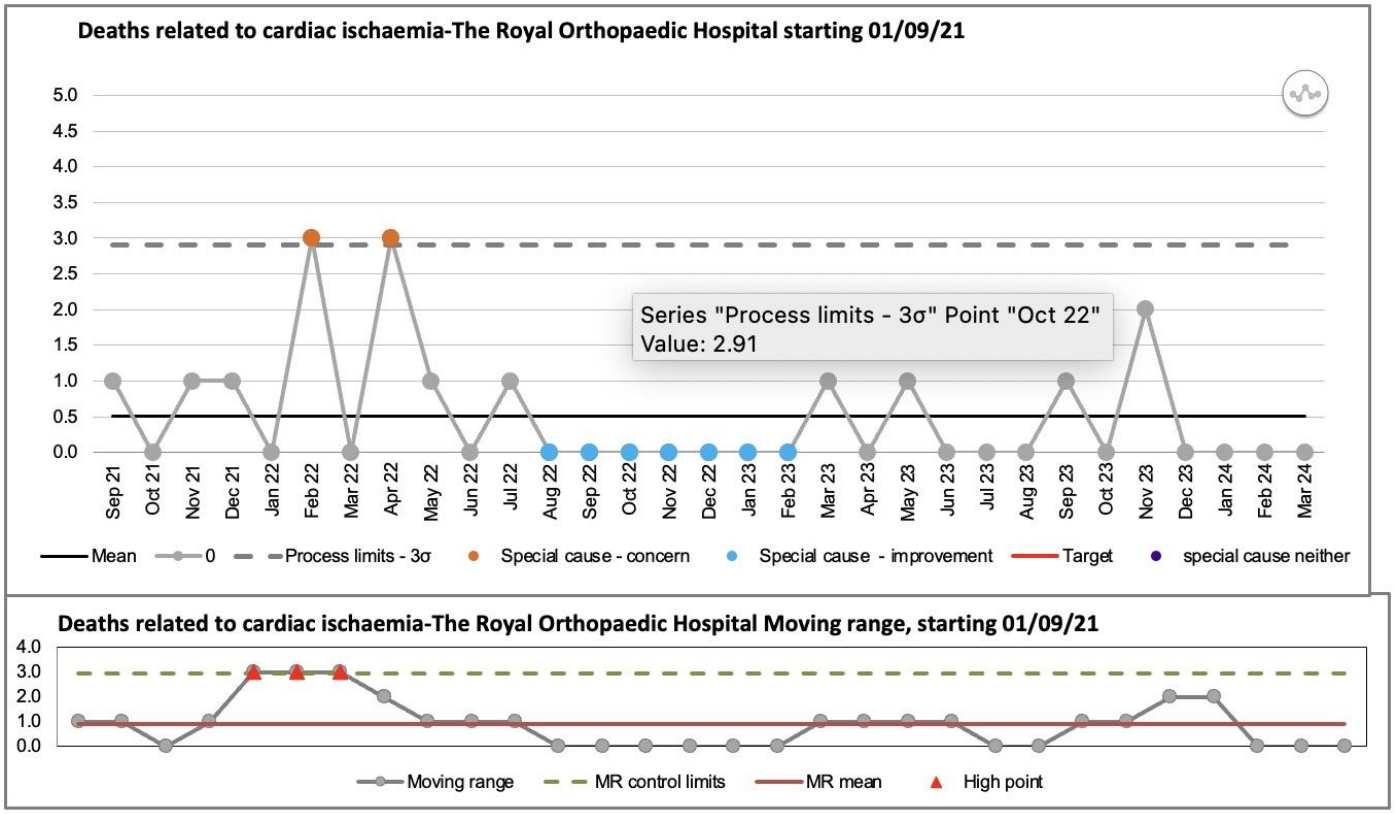


Figure 1 Ischaemic Cardiac Related Deaths at ROH Sept 2021-Mar 2024

Key Recommendations

As a result of LfD the following actions are in progress:

- A standard operating procedure for periprosthetic fracture patients around the hip & knee replacements requiring cementation with mega prosthesis is under development by AMD(Corporate).
- Evolution of a High-Risk Panel potentially drawing learning from Stanmore Royal National Orthopaedic Hospital by our AMDs.
- Exploration of a bespoke cardiac optimisation pathway (AMD corporate)

Quantitative Review

Crude mortality

The crude 30-day mortality is the calculated by adding all deaths within 30 days of discharge within a given time period. Deaths in hospital, 7 day and 30-day mortality are shown in Table 1 and Figures 2-4. Note that, just prior to April 21, there was a surge in mortality associated with Covid. Before this, there had been a gradual decrease in mortality over 10 years (Figure 5).

Deaths remain within historical control limits and comparable with similar stand alone Orthopaedic Trusts (Figure 6 and 7).

Table 1: Number of Deaths within 30 days Apr23-Mar24

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Deaths In Hospital		1					1	1				
1-7 Days from discharge	1					2		1		1		1
8-30 Days from discharge	1	2	2	1	1		3	1	2	1	1	1
Total	**2**	**3**	**2**	**1**	**1**	**2**	**4**	**3**	**2**	**2**	**1**	**2**

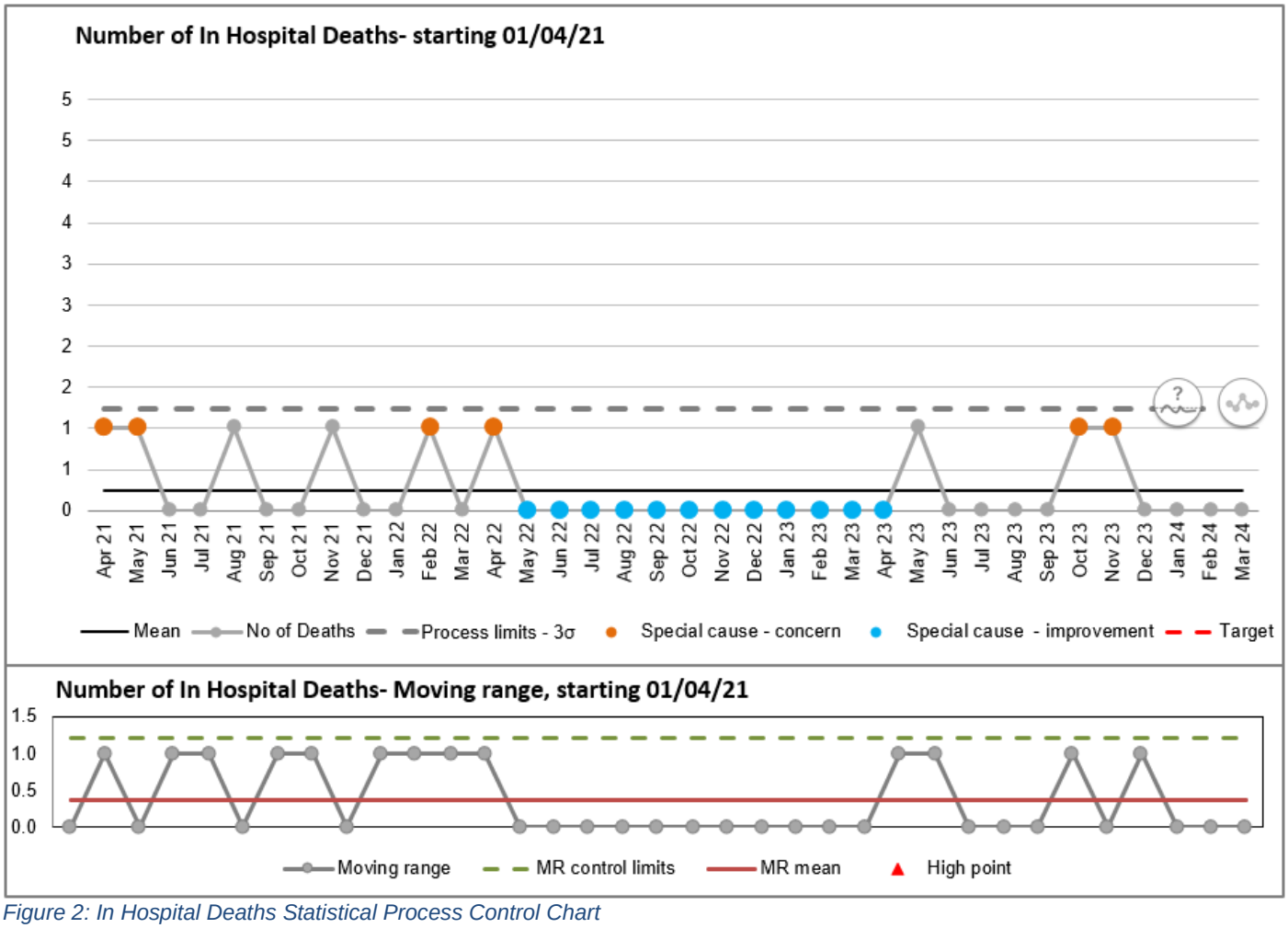


Figure 2: In Hospital Deaths Statistical Process Control Chart

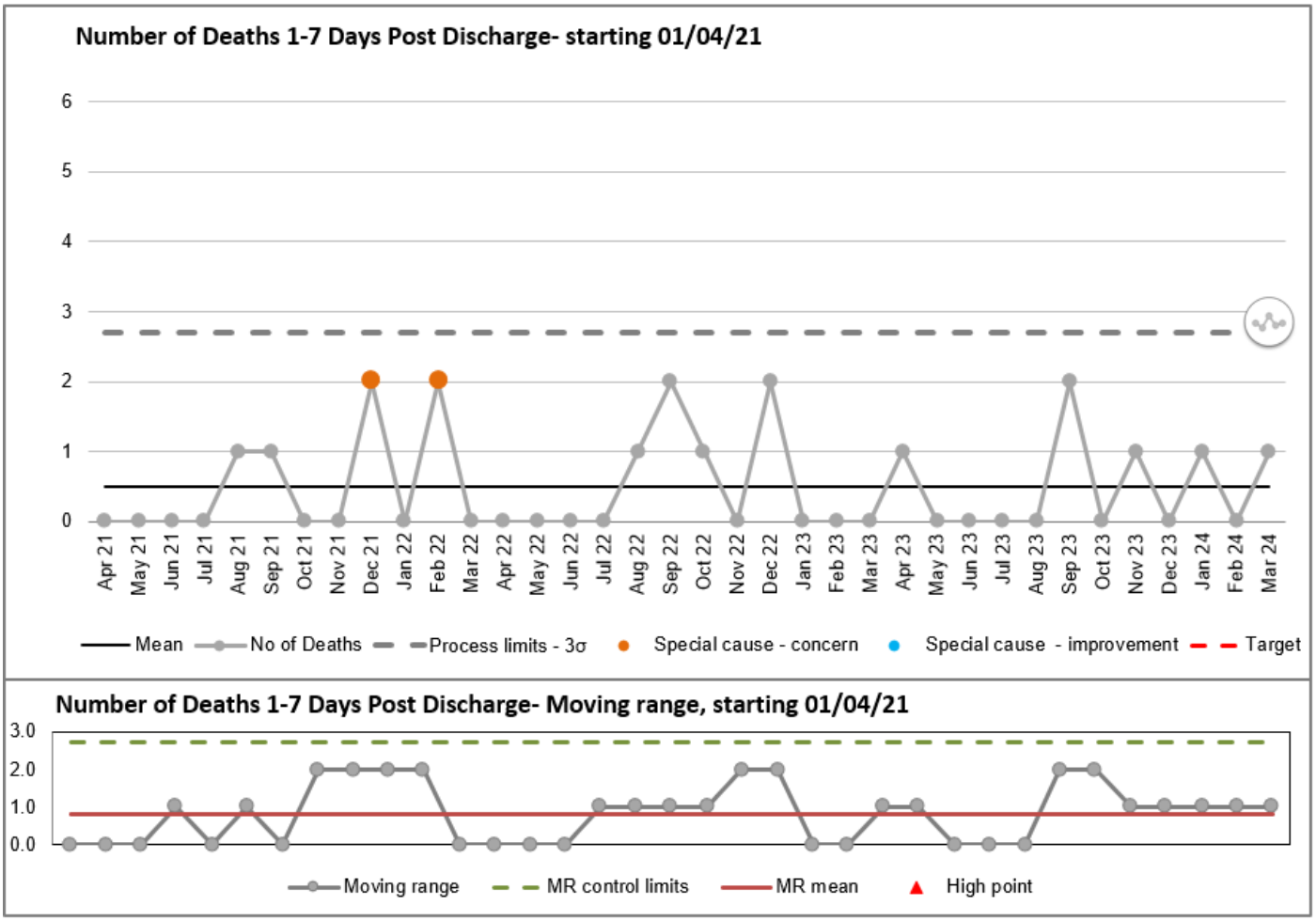


Figure 3 Deaths within 7 Days Statistical Process Control Chart

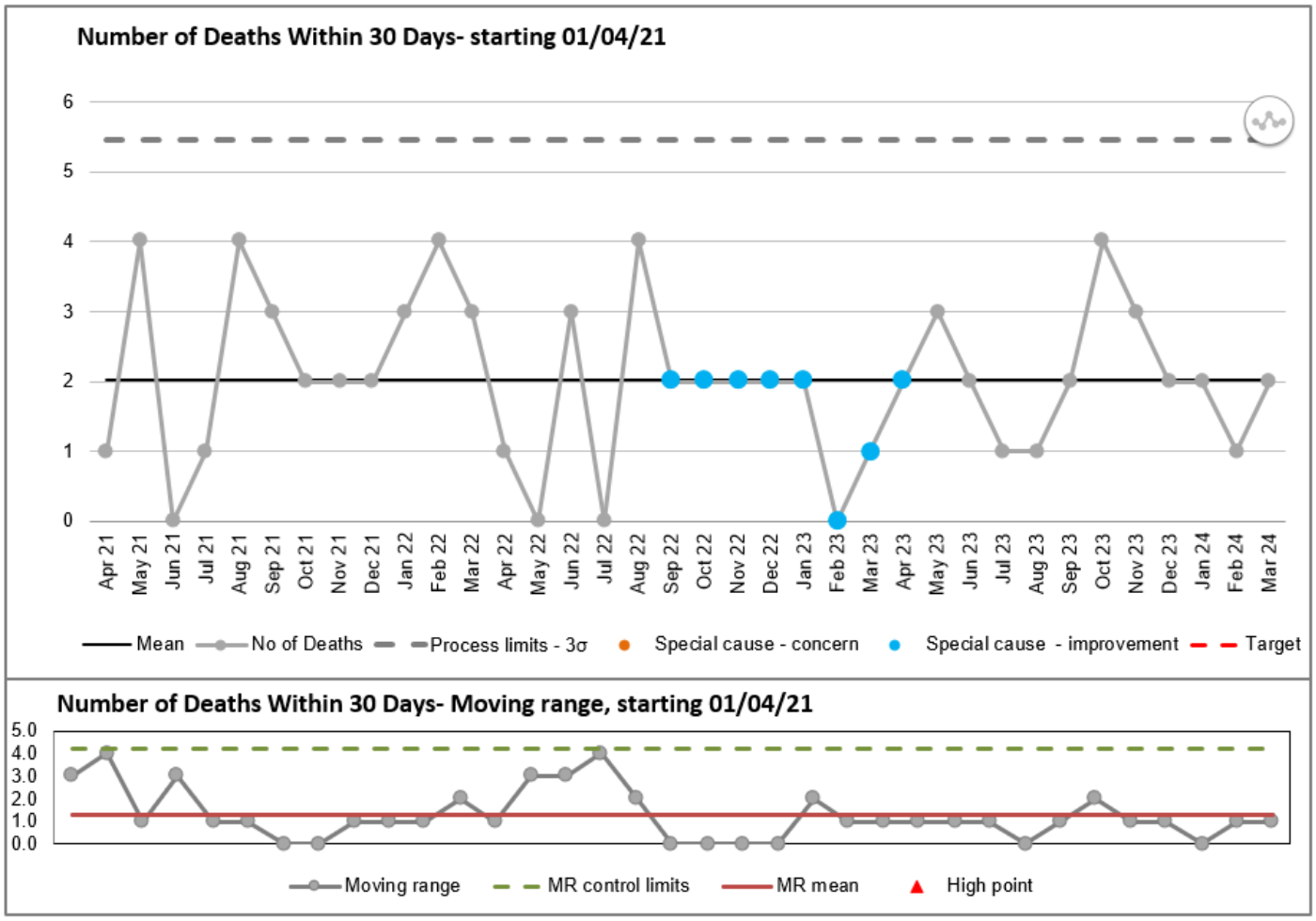


Figure 4 Deaths with 30 days Statistical Process Control chart

Longer term mortality profiling is shown in Figure 5 and suggests that currently the rolling average runs at approximately 25 per year and gives a visualisation of the longer-term trend.

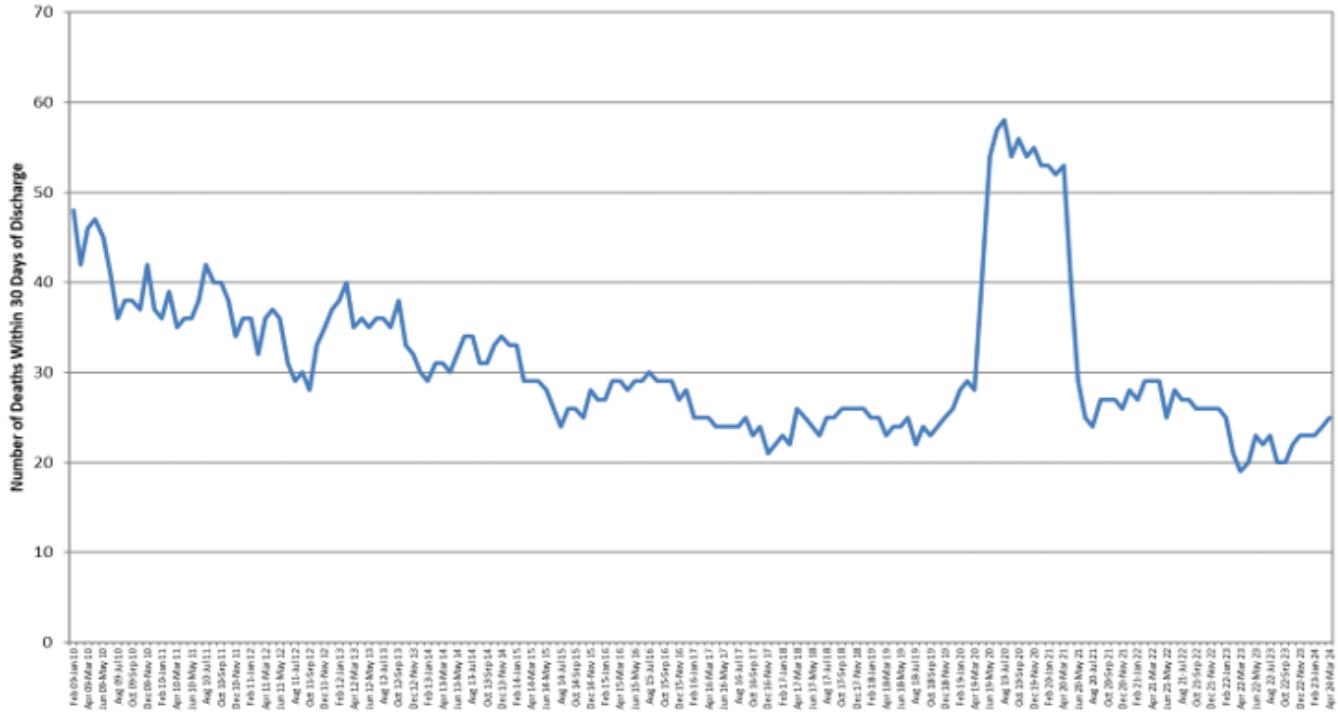


Figure 5: 12 month Rolling Average Deaths within 30 days Feb 10 - Mar 24

The LfD governance dashboard is shown in Appendix 1.

Benchmarking

Crude in-hospital mortality is shown in the figure below:

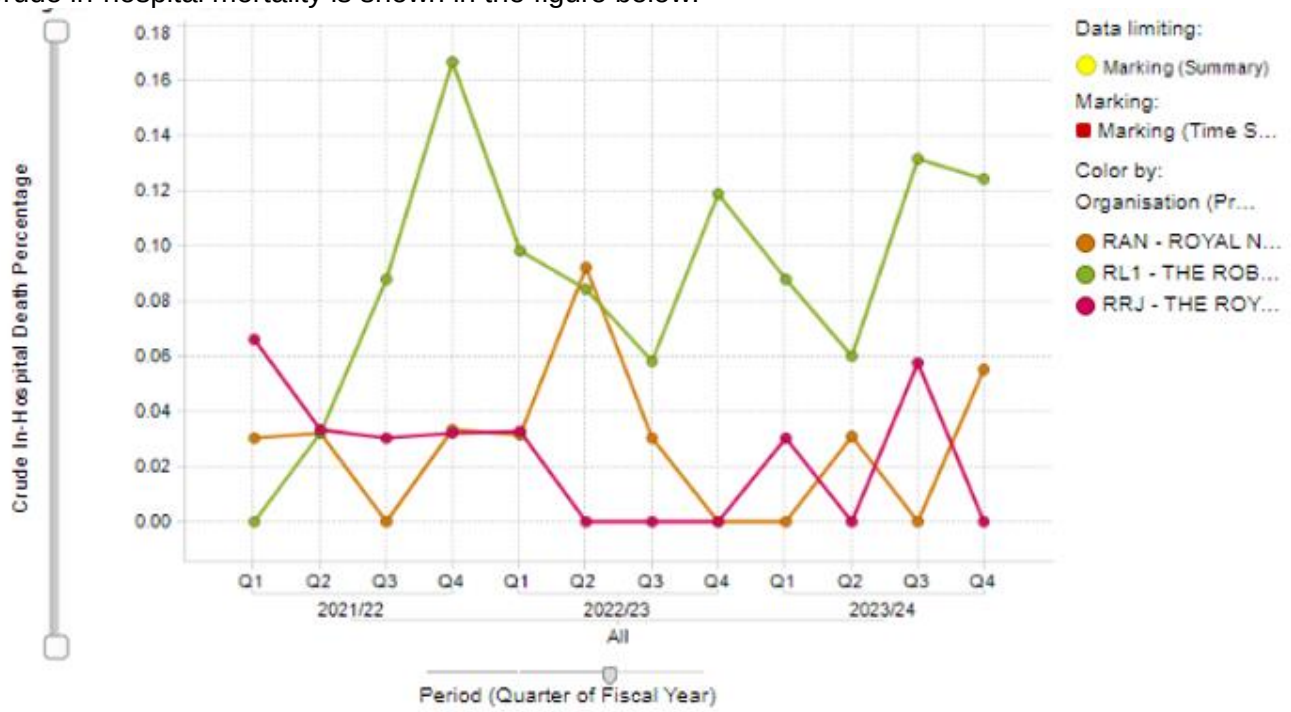


Figure 6 Crude in Hospital Mortality 2021-2024 Compared with other stand-alone Orthopaedic Trusts

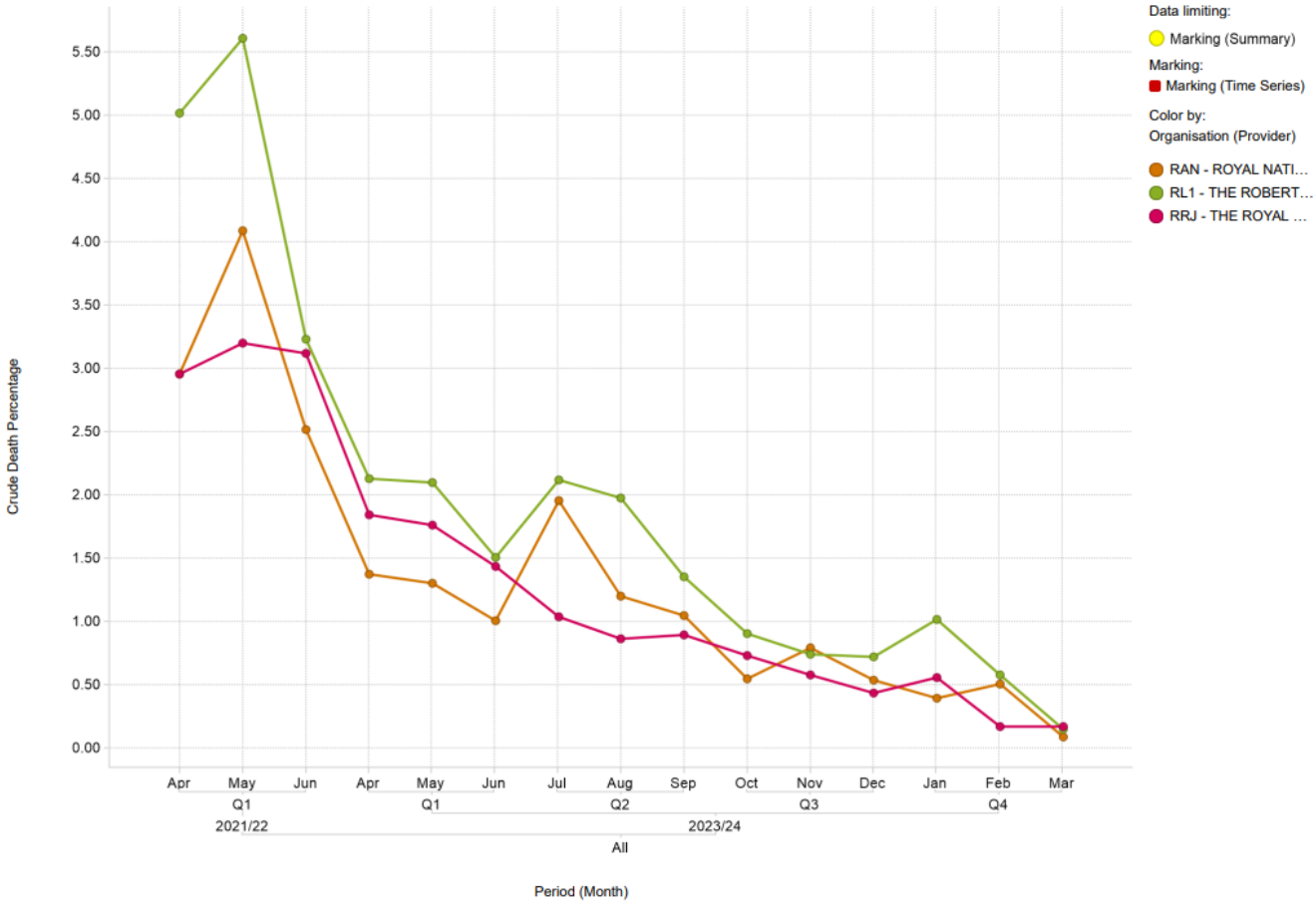


Figure 7 Crude Death Percentage (all deaths of former inpatients at any interval post discharge)

Mortality in Relation to Activity

2022/23

Number of discharges	13890
Total Deaths (inpatient and 30 days post discharge)	18
30 day mortality rate as a percentage of discharges	0.13%

2023/24

Number of discharges	14494
Total Deaths (inpatient and 30 days post discharge)	28
30 day mortality rate as a percentage of discharges	0.19%

Additional Analysis

SJR reviews for the year all graded 5 or 6 (out of 6, with 6 representing the best level of care) indicating no major shortfall in care had been identified.

Appendix 2 includes a number of other mortality measures and confirms that on historical series and benchmarking mortality remains within safe limits.

Appendix 3 includes more demographic and diagnostic detail for deaths within 30 days from April 2021

Conclusions

The governance team continues to enhance the LfD process. The integration of AMaT into our framework is progressing, promising improvements in our workflows and analytical capabilities. The active participation of the Associate Medical Director and Associate Director of Governance in regional committees ensures that insights from region are integrated within the trust.

The qualitative review has showed areas of good and excellent practice and the team have provided assurance around how the learning from deaths process guides organisational learning.

The quantitative review confirms mortality remains with safe limits as compared with historical or specialist orthopaedic Trust controls. Major causes of death included chronic ischaemic heart disease, various malignant neoplasms, and chronic obstructive airways disease.

Appendix 1 – Learning from Deaths Dashboard

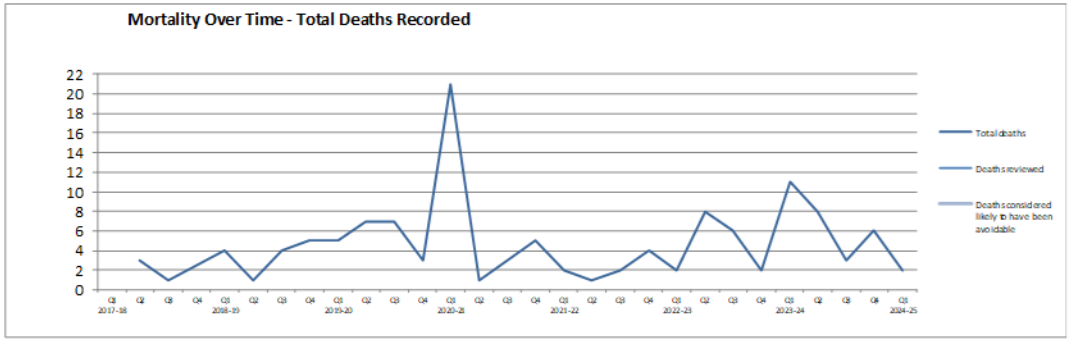
The Royal Orthopaedic NHS Foundation Trust : Learning from Deaths Dashboard - November 2023-24

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	0	1	N/A	0	N/A
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	28	1	27	0	27

Time Series: Start date 2017-18 Q1 End date 2024-25 Q1



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	100.0%
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2024-25 Q1

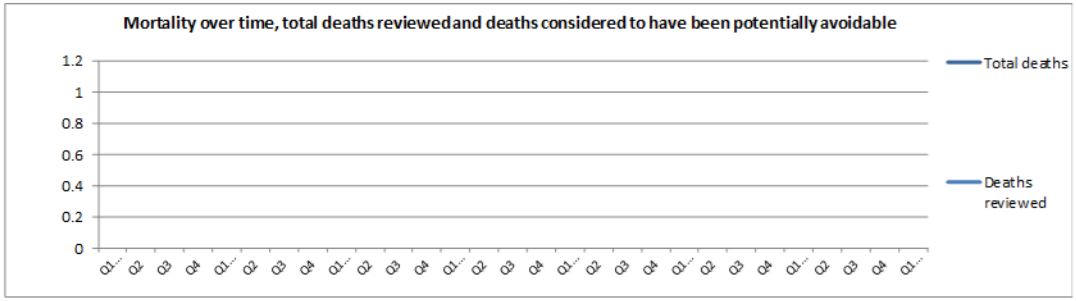


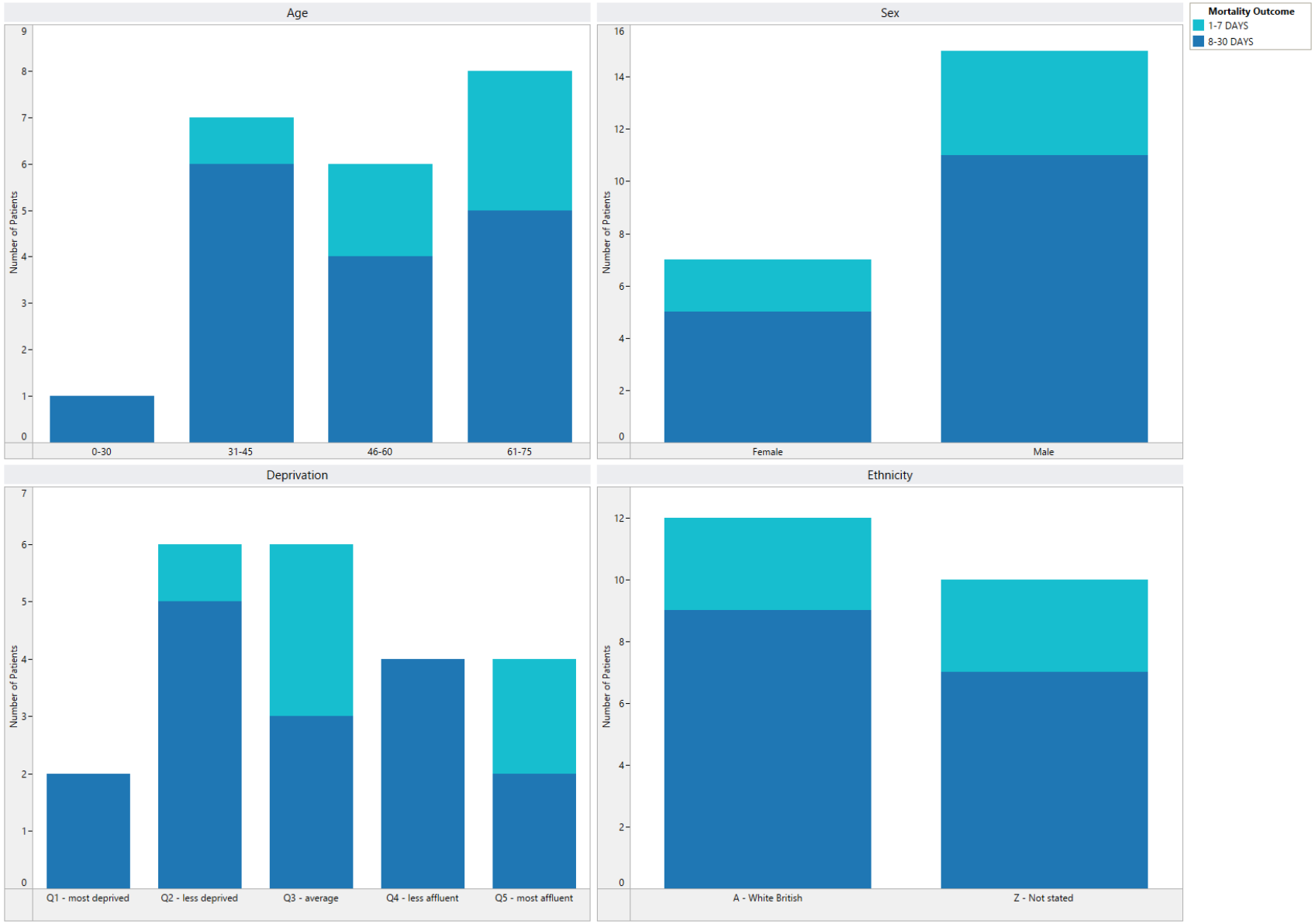
Figure 8Learning from Deaths Dashboard July 2024

Appendix 2 – Additional Mortality Measures

Table 2 Mortality Measured Benchmarked Nationally with Standalone Orthopaedic Trusts as selected Peers – Source Hospital Episode Data (UHB)

Custom Indicator Set: - Mortality Dashboard	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
Number of mortalities (12 mth rolling) HES Inpatients (May 2024)	115 (Apr 2023 - Mar 2024)	128 (Mar 2023 - Feb 2024)	-13 ↓	150*	2,774*	
Number of in-hospital mortalities (12 mth rolling) HES Inpatients (May 2024)	3 (Apr 2023 - Mar 2024)	3 (Mar 2023 - Feb 2024)	No Change	9*	1,335*	
Number of out-of-hospital mortalities (12 mth rolling) HES Inpatients (May 2024)	112 (Apr 2023 - Mar 2024)	125 (Mar 2023 - Feb 2024)	-13 ↓	141*	1,441*	
HSMR (monthly) HES Inpatients (May 2024)	-	-	No Change	-	101.96	Within expected range
HSMR (12 mth rolling) HES Inpatients (May 2024)	48.81 (Apr 2023 - Mar 2024)	48.90 (Mar 2023 - Feb 2024)	-0.09 ↓	102.80	99.92	Within expected range
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (May 2024)	35.23 (Apr 2023 - Mar 2024)	34.61 (Mar 2023 - Feb 2024)	0.62 ↑	71.94	99.82	Low (>95%)
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (May 2024)	63.12 (Apr 2023 - Mar 2024)	65.67 (Mar 2023 - Feb 2024)	-2.55 ↓	93.17	98.63	Within expected range
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (May 2024)	-	0.00 (Mar 2023 - Feb 2024)	No Change	-	103.90	Within expected range
Average co-morbidity score (Diag 2-14) - all conditions (12 mth rolling) HES Inpatients (May 2024)	1.9926 (Apr 2023 - Mar 2024)	1.9886 (Mar 2023 - Feb 2024)	0.004 ↑	2.2255	4.9198	
NRLS - Incidents resulting in severe harm or death (biannual) NRLS (Oct 2022)	0.00 (Oct 2019 - Mar 2020)	0.16 (Apr 2019 - Sep 2019)	-0.16 ↓	0.19	0.23	
Crude mortality rate in low-risk diagnosis groups (12 mth rolling) HES Inpatients (May 2024)	0.01% (Apr 2023 - Mar 2024)	0.01% (Mar 2023 - Feb 2024)	No Change	-	0.04%	Within expected range
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2024)	0.02% (Apr 2023 - Mar 2024)	0.02% (Mar 2023 - Feb 2024)	No Change	0.06%	1.17%	
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2024)	0.85% (Apr 2023 - Mar 2024)	0.95% (Mar 2023 - Feb 2024)	-0.10 ↓	1.06%	2.46%	
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2024)	0.16% (Mar 2024)	0.17% (Feb 2024)	-0.01 ↓	-	1.56%	
Crude out-of-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2024)	0.83% (Apr 2023 - Mar 2024)	0.93% (Mar 2023 - Feb 2024)	-0.10 ↓	0.99%	1.29%	

Appendix 3 – Additional Analysis of ROH Deaths within 30 days of Discharge April 2021 – March 2024



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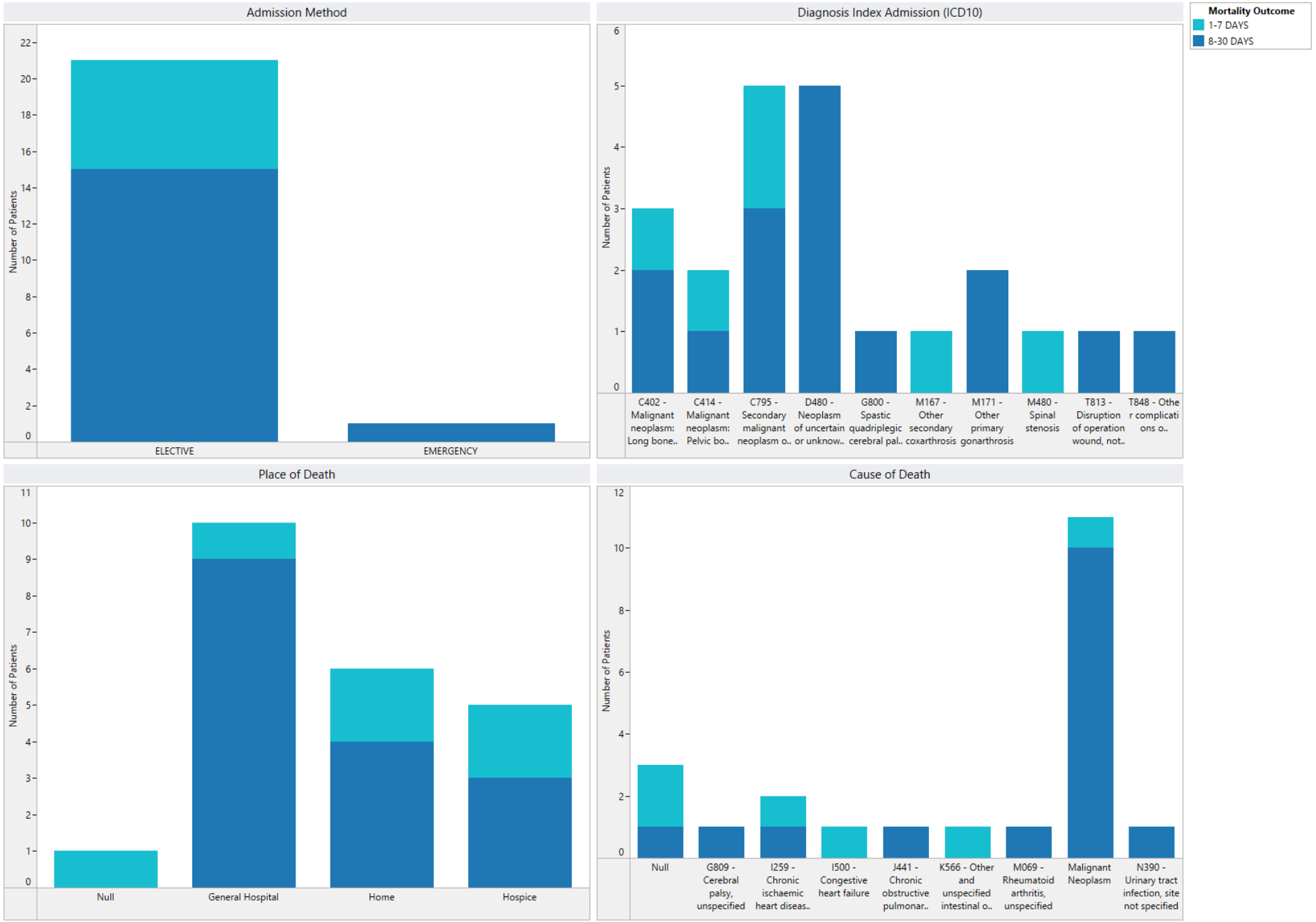
Admission Method
Number of Patients
ELECTIVE
EMERGENCY
Diagnosis Index Admission (ICD10)
Number of Patients
C402 - Malignant neoplasm: Long bone..
C414 - Malignant neoplasm: Pelvic bo..
C795 - Secondary malignant neoplasm o..
D480 - Neoplasm of uncertain or unknow..
G800 - Spastic quadriplegic cerebral pal..
M167 - Other secondary coxarthrosis
M171 - Other primary gonarthrosis
M480 - Spinal stenosis
T813 - Disruption of operation wound, not..
T848 - Other complications o..
Mortality Outcome
1-7 DAYS
8-30 DAYS
Place of Death
Number of Patients
Null
General Hospital
Home
Hospice
Cause of Death
Number of Patients
Null
G809 - Cerebral palsy, unspecified
I259 - Chronic ischaemic heart diseas..
I500 - Congestive heart failure
J441 - Chronic obstructive pulmonar..
K566 - Other and unspecified intestinal o..
M069 - Rheumatoid arthritis, unspecified
Malignant Neoplasm
N390 - Urinary tract infection, site not specified

Cause of Death (ICD10 Diagnosis Code – March 23 – February 24

Cause of death is taken from the death certificate in the ONS data, additional information relating to the table can be provided if required.

Mortality Outcome	CCS Code	Cause of Death Description	Total
DEATHS IN HOSPITAL	203 - Osteoarthritis	Chronic ischaemic heart disease, unspecified	1
	237 - Complication of device; implant or graft	Chronic obstructive pulmonary disease with acute lower respiratory infection	1
	42 - Secondary malignancies	Malignant neoplasm: Bone and articular cartilage, unspecified	1
1-7 DAYS	203 - Osteoarthritis	Chronic ischaemic heart disease, unspecified	1
	205 - Spondylosis; intervertebral disc disorders; other back problems	Congestive heart failure	1
	42 - Secondary malignancies	Malignant neoplasm: Connective and soft tissue of lower limb, including hip	1
		Not Recorded	1
	21 - Cancer of bone and connective tissue	Not Recorded	1
		Other and unspecified intestinal obstruction	1
8-30 DAYS	203 - Osteoarthritis	Chronic ischaemic heart disease, unspecified	1
		Rheumatoid arthritis, unspecified	1
	238 - Complications of surgical procedures or medical care	Malignant neoplasm: Connective and soft tissue of lower limb, including hip	1
	237 - Complication of device; implant or graft	Urinary tract infection, site not specified	1
	42 - Secondary malignancies	Chronic obstructive pulmonary disease with acute exacerbation, unspecified	1
		Malignant neoplasm: Endometrium	1
		Malignant neoplasm: Malignant melanoma of skin, unspecified	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Malignant neoplasm, primary site unknown, so stated	3
		Malignant neoplasm: Bone and articular cartilage, unspecified	1
		Malignant neoplasm: Connective and soft tissue, unspecified	1
	21 - Cancer of bone and connective tissue	Malignant neoplasm: Bone and articular cartilage, unspecified	1
		Malignant neoplasm: Connective and soft tissue, unspecified	1
		Not Recorded	1
	82 - Paralysis	Cerebral palsy, unspecified	1
Grand Total			25

ROH Rolling 12 Month 30 Day Mortality Numbers by Treatment Function Code

Treatment Function	May 22-Apr 23	Jun 22-May 23	Jul 22-Jun 23	Aug 22-Jul 23	Sep 22-Aug 23	Oct 22-Sep 23	Nov 22-Oct 23	Dec 22-Nov 23	Jan 23-Dec 23	Feb 23-Jan 24	Mar 23-Feb 24	Apr 24-Mar 24
T&O	12	14	13	14	12	13	15	15	16	15	15	17
Spinal Surgery	1	1	1	1	1	1	1	2	1	1	1	1
General Medicine	1	1	1	1	1	1	1	1	1	1	1	0
Clinical Oncology	5	6	6	6	6	5	5	5	5	6	7	7
Physiotherapy Service	1	1	1	1	0	0	0	0	0	0	0	0
TOTAL	**20**	**23**	**22**	**23**	**20**	**20**	**22**	**23**	**23**	**23**	**24**	**25**