The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) November

Wednesday 6th November, 09:00h-12:00h

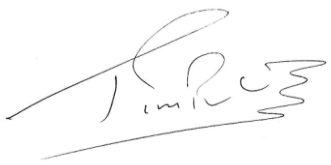
Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 6 November 2024

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 6 November 2024, in the Boardroom, Trust HQ commencing at **09:00.**

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

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



Tim Pile
Chair

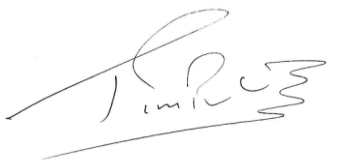
31 October 2024

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, 6 November 2024:

Meeting	Timing
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Public Board meeting – Boardroom, Trust HQ	09:00 – 12:00
Lunch	12:00 – 12:30
Private Board Meeting – Boardroom, Trust HQ	12:30 – 15:00

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** 6 November 2024: 09:00h – 12:00h

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)
Mr Simon Page	Non Executive Director	(SP)
Mr Matthew Hartland	Interim Chief Executive	(MH)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Rachel Richards	Clinical Service Manager – Private Patient Services	(RR)	[Item 1]
Falon Paris-Caines	Communications & Engagement Manager	(FPC)	[Item 1]
Mr Jamie McKenzie	Guardian of Safe Working	(JMK)	[Item 8]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
09:00	1	Patient Story: Woodlands Suite	Presentation	RR/FPC
09:20	2	Apologies:	Verbal	Chair
	3	Declarations of Interest	ROHTB (11/24) 001	Chair
	4	Minutes of Board Meeting held in Public on 2nd October 2024: *for approval*	ROHTB (10/24) 018	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (10/24) 018 (a)	SGL
09:25	6	Questions from members of the public	Verbal	Chair

09:26	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (11/24) 002 ROHTB (11/24) 002 (a)	MH/TP
09:40	8	Guardian of Safeworking Update: *for assurance*	ROHTB (11/24) 003	JMK
09:55	9	WRES/WDES Update: *for assurance*	ROHTB (11/24) 004 ROHTB (11/24) 004 (a) ROHTB (11/24) 004 (b) ROHTB (11/24) 004 (c)	SM
10:15	10	National CQC Inpatient Survey Results: *for assurance*	ROHTB (11/24) 005 ROHTB (11/24) 005 (a)	NB
10:30	**BREAK**			
	GOVERNANCE AND COMPLIANCE			
10:45	11	Corporate Risks Review Progress Update: *for assurance*	ROHTB (11/24) 006	SGL
10:55	12	Safeguarding Annual Report: *for assurance*	ROHTB (11/24) 007 ROHTB (11/24) 007 (a)	NB
11:10	13	Annual Statement of Compliance - Medical Staff Revalidation & Appraisal: *for assurance*	ROHTB (11/24) 008 ROHTB (11/24) 008 (a)	MR
	MATTER TO BE APPROVED IN THE ROLE OF CORPORATE CHARITY TRUSTEE			
11:25	14	Eveson Trust Fund – Application for Ultrasound Machine: *for approval*	ROHTB (11/24) 009 ROHTB (11/24) 009 (a)	MP
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
11:35	15	Upward reports from the Board Committees: • Finance & Performance Committee • Staff Experience & OD Committee	ROHTB (11/24) 010 ROHTB (11/24) 011	LW SJ
11:55	**MATTERS TO BE TAKEN BY EXCEPTION**			
	16	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report c) Workforce Report	ROHTB (11/24) 012 ROHTB (11/24) 013 ROHTB (11/24) 013 (a) ROHTB (11/24) 014	
	17	Any Other Business	Verbal	All
12:30	**CONFIDENTIAL SESSION**			

Date of next meeting: Wednesday, 4 December 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	✓	✓	A					
Gianjeet Hunjan	✓	✓	A	✓	✓	✓					
Ayodele Ajose	✓	✓	✓	✓	✓	✓					
Les Williams	✓	✓	✓	✓	✓	✓					
Simon Page	✓	✓	✓	A	A	A					
Jenny Belza	✓	✓	✓	A	✓	✓					
Jan Teo	✓	✓	✓	✓	✓	✓					
Jo Williams	✓	✓	✓	✓	✓						
Matthew Revell	✓	✓	✓	✓	✓	✓					
Nikki Brockie	✓	✓	✓	✓	✓	A					
Marie Peplow	A	✓	✓	✓	✓	✓					
Stephen Washbourne	✓	A	✓	✓	✓	✓					
Sharon Malhi	✓	✓	✓	✓	✓	A					
Simon Grainger-Lloyd	✓	✓	✓	✓	A	✓					

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
Matthew Hartland **Interim Chief Executive**	• Governor, Shrewsbury Colleges Group	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 • Trustee, Sandwell Leisure Trust	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

Name	Interest	Voting Member
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
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**	• Legal Consultant to Law Firm Addleshaw Goddard LLP – Currently Assigned Full-Time to Group Lotus	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	Yes

Name	Interest	Voting Member
	substantive post at Milton Keynes University Hospital (0.4 WTE secondment) as of 15 April 2024 for six months.	
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**	• 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** 2 October 2024: 1300h - 1500h

Members attending:

Mr Tim Pile	Chair	(TP)
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)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance & Acting Chief Executive Officer	(SGL)

In attendance:

Mr Rob Carter	Business Intelligence System Manager	(RC)	[Item 13]
Mrs Claudette Jones	Freedom to Speak Up Guardian	(CJ)	[Item 20]
Mrs Joanna Thomas	Associate Medical Director	(JT)	[Item 21]
Mrs Emma Steele	Deputy Chief Nurse	(ES)	
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

IN PUBLIC SESSION	
13 Staff Story (RC)	**Presentation**
Rob Carter (RC), Business Intelligence System Manager, was welcomed to the meeting. RC presented his story to the Board: • RC started his career working at Kays Catalogue working in the warehouse, working a variety of shift patterns. • Completed a City & Guilds course in Computing and became an IT Trainer and then completed a degree whilst working full time.	

- Joined the NHS following redundancy. Became an IT Trainer for the roll out of a version of the Patient Administration System.
- Worked a number of roles across a variety of NHS Trusts and during this time began developing database software.
- An opportunity came up at ROH and RC joined the Trust 17 years ago.
- RC felt like he belonged here from the day he started.
- The team which RC works in have all been in the team for a long time.
- RC has undertaken a number of roles within the Business Intelligence team.

The Board was invited to comment and ask questions.

The key points to note are highlighted as follows:

- TP questioned how can we get better. RC explained we are using the power BI tool more effectively but there is opportunity for so much more.
    - SW explained that development within the BI Team over the past few years has meant clinical colleagues are now able to access information they couldn't before.
- GH questioned over the years what changes in the cultural of the Trust has RC experienced. RC explained over the past 8 to 10 years there has been far more focus on colleague wellbeing. There is more interaction now with all the different elements of the Trust, no more 'them and us' feeling.
- RL enquired what opportunities has RC had to give support to others. RC explained that he has been working collaboratively with the IT team. He has run training courses with Medical Secretaries and Executives on using the BI systems.
- AA questioned what the most significant challenges RC faces are and what would he do to improve it. RC explained the sheer amount of work that comes in, as it is all moving very quickly. In comparison to other similar Trust, we are the ones that they come to for help.
- TP enquired what relationship do we have with Aston University or University of Birmingham in order to develop our workforce. SW explained that we have had Graduates, and this is something we could look to expand on in the future.
- MP enquired how can RC be supported. RC explained that there are people in the Trust who are keen to learn more about the data and sharing the knowledge.
- JT questioned are there any understandings/learnings from experience and knowledge that we could use to improve. RC explained that there is data that can be accessed to review deprivation, and this is something that is being

developed that could be invaluable to us. TP thanked RC for sharing his story.	
14 Apologies: (Chair)	**Verbal**
Apologies were received and accepted from Simon Page, Nikki Brockie, Sharon Malhi, and Simone Jordan. Welcome to Rob Rowberry, Public Governor who joined the meeting as an observer.	
15 Declarations of Interest (chair)	**ROHTB (10/24) 008**
There are two new declarations to be included: • SW who is now a Trustee at Sandwell Leisure Trust. • AA will undertake this role alongside a full-time role with a non-NHS organisation.	
16 Minutes of the previous meeting in public held on 4 September 2024 : *for approval* (chair)	**ROHTB (9/24) 030**
The minutes of the meeting held in public on 4th September 2024 were accepted and approved by the board.	
17 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (9/24) 030 (a)**
SGL provided an update on the following action: • ROHTBACT.262 – WRES/WDES Update. The detailed action plan will be shared at Staff Experience and OD Committee in October, then presented to Trust Board at the November meeting. All actions proposed for closure were accepted.	
18 Questions from members of the public (Chair)	**Verbal**
There are no questions received ahead of the meeting.	
19 Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	**ROHTB (10/24) 009** **ROHTB (10/24) 009 (a)**
SGL presented the Chief Executive Update and highlighted the following: • Healthwatch Visit. The Trust welcome the Chair and Chief Executive of Healthwatch Birmingham (HwB). The visit was arranged to share with HwB the key priorities of the ROH and describe to them the future plans. A tour of the ROH was also provided.	

- The Trust will welcome our CQC Relationship Managers on 9th October, this is not an inspection but an opportunity to show our regulators what we do and showcase the outstanding care that we deliver each and every day.
- The Trusts financial position remains challenging, and focus is on developing a recovery plan to deliver a breakeven plan.
- Operational performance remains strong, and we have met our 65-week target. Thank you and congratulations to all those involved.
- On 19 September, the Trust underwent a peer review of our Teenage and Young Adult cancer service. The purpose of the visit was to gain a view from a series of regional visits of the impact of the lack of funding for teenage cancer nationally. The final report will be received shortly however the verbal feedback was very positive.
- The Trust is looking forward to welcoming Matthew Hartland joining the as the Interim Chief Executive on 14th October.
- The Staff survey has been launched from today (2nd October).
- The Trust is working with RSM UK to carry out the RACE Equality Code assessment. Following the initial Trust Board session the next phase to adopt the RACE Equality Code has commenced with workshop sessions arranged for Trust Board members to attend.
- Plans are underway, in collaboration with colleagues across the Birmingham and Solihull ICS to develop a strategic framework and action plan for women's health.
- Conversations are taking place to arrange a Community Roadshow for MSK.
- A 'Community Appointment Day' is being arranged with colleagues from University Hospital Birmingham which will be run by the Physiotherapy Department.
- The Rt Hon. Professor of the Lord Darzi of Denham report has been published since the Board last met and shared with members.
- On Thursday 26th September the Trust experience extreme flooding due to the unprecedented rainfall. It was acknowledged that the response to the Floods last week was exceptional, and the Trust were pleased to report that it made minimal impact on operations due to the management of the situation. Thanks to all those involved in dealing with all this at the time.

The Board was invited to comment and ask questions.

The following points were highlighted:

- JB queried the ICS Beyond Limits and question how many individuals have applied from ROH. SGL confirmed we can find out that information.

• TP encouraged all Non-Executives to complete the RACE Code questionnaire as soon as possible. Chair Update TP provided a Chair Update and highlighted the following: • Since the last Trust Board TP has visited the new Oncology department and the MDT room is being used by a number of colleagues across the Trust, and not just Oncology. • Vaccinations are a hot topic currently and should be seen as a preventative measure. We need to do everything we possibly can to actively encourage people to have their vaccinations and this includes ourselves. TP emphasised the need for us all to be role models and encourage our colleagues to do the same.	
19.1 Council of Governors Update: *for assurance* (TP)	**Verbal**
TP provided an update on the Council of Governors meeting that took place on 18th September and highlighted the following: • Good attendance with representation from across the public, stakeholder and staff Governors. • The Governors received updates on MSK Transformation, People Promise, Volunteer Annual Report and Sexual Safety Charter and these presentations were all well received. Thank you to all those that presented these updates.	
20 Freedom To Speak Up Update: *for assurance* (TP)	**ROHTB (10/24) 010** **ROHTB (10/24) 010 (a)**
Claudette Jones (CJ), Freedom to Speak Up Guardian, joined the Board and presented the Freedom to Speak Up Update. The papers were taken as read. The key highlights are as follows: • Biggest achievement the Trust now has 10 Freedom to Speak Up Champions. It was noted that nationally it is a struggle to recruit a variety of representatives, but we have successfully recruited people from different backgrounds, different roles, etc. • There has been a variety of cases, none have been anonymous. • People still remain worried to speak up as they are concerned about the outcome. • There has been work from the National Guardian Office and a supporting document, 'Disadvantageous and Demeaning Treatment', has been produced;	

this has been rolled out across the Trust to all support workers and managers. • A planning and reflection tool has recently been completed with the audit team and we are awaiting the outcomes from this to create an action plan of next steps. • During the FTSU walkabouts emphasis is on completing the Freedom to Speak up modules. This is not currently mandated at this Trust, but colleagues are being encouraged to complete. • National Guardian Office are undertaking work on the barriers for overseas-trained workers with a focus on improving the 'speak-up' culture among overseas-trained workers. The Board was invited to comment and ask questions. The following key points are of particular note: • TP questioned what the Board can do to help. CJ asked that during walkabouts they talk about and share what Freedom to Speak Up is about. • JT queried how do we ensure that if something is raised and then withdrawn, we make sure we that we still do something about it. CJ explained that the process of escalation is always explained and many of the issues come to FTSU because it has been raised elsewhere but it is not moving quick enough for it to be resolved. MH agreed with JT that even if the issue is withdrawn it should be raised to the Executive team so that they can focus on ensuring there is nothing of concern that should be resolved/dealt with. • JB queried whether the data cut could be broken down even further. CJ explained that the data is available and using the planning and reflection tool will help identify the gaps we have. • JB queried whether there is a plan to make the Freedom to Speak Up training mandatory. CJ explained that it is being considered but not deemed urgent currently. SGL explained that we are seen as a Trust with a good engagement with Freedom to Speak Up. • AA queried the reduction of number of concerns raised. CJ explained that the initiatives in the Trust are having an impact, the correct HR processes are being used, so the most appropriate action is now being taken compared to previously. • SGL explained that the data matches to our incidents also. TP thanked CJ for sharing the update.	
21 Women in Orthopaedics: *for assurance* (JTh)	**Presentation**
Joanna Thomas (JTh), Associate Medical Director, joined the meeting to present an	

update on Women in Orthopaedics. The following key points were highlighted: • 14.7% of consultants are women in the UK. • The West Midlands region is below average in the number of women consultants in post. • High number of surgical trainees have been at ROH over the past 12 months. The feedback was positive on their experience at the ROH. • There are areas to improve, in particular for maternity returners. We had one who was unable to express milk whilst breast feeding. This has been addressed and there is a room now available for this to take place. • 'Women in Orthopaedics Forum' was established, and this has been evolved into the Diversity in Orthopaedics Forum which focuses on equity. The Board was invited to ask questions and comment on the presentation. • JB queried what do we with regards to flexibility and childcare. JTh confirmed for trainees they do not need to be here before 8am. There are options for trainees to speak up if they have any issues. There is flexibility with how they can work to ensure they can fulfil their trainee programme. • IR enquired how do anaesthetists achieved flexibility so well. JTh explained they have more shift pattern working. Surgeons are more specialist, and no one can just step in to cover. • MR thanked JT for the work leading on this. • TP queried previous issues raised on the clothing, ill-fitting shoes, etc. JT confirmed that this has been addressed. • JT queried do male surgeons know how to promote female surgeons. JTh confirmed that in Oncology and Spinal they are actively promoting but there is more that can be done. JT offered to support with sharing previous experience. **ACTION: Trainee Surgeon to come to a future Trust Board as a Staff Story. MR/JTh**	
22 Service Accreditation Update*: for assurance* (ES)	**ROHTB (10/24) 011** **ROHTB (10/24) 011 (a)**
ES presented the Service Accreditation Update, and the paper was taken as read. The key points to highlight include: • This is an update on the Service Accreditation programme that has previously been presented to Trust Board. • The group were challenged to be more ambitious, and the roadmap has been accelerated.	

• A pilot has been undertaken and this took place in September. • The Service Accreditation has been included in the AMaT audit programme and means the audit can be completed live. • There will be a web page on the intranet on Service Accreditation. • Next Steps will be to review the pilot feedback. Focus is now on phase 2 standards as it will be different for places like College Green. • IR explained that this has been through Quality & Safety Committee and was well received. The Board was invited to comment and questions: • SGL suggested that this process is detailed in our recruitment processes. • A discussion around sharing this widely took place amongst Board members and ES explained this has been discussed with the patient representative in the group, they recommended we do not share in public. The engagement will be through the teams. • GH queried the peer review assessment and questioned what are the plans with this. ES explained that this is something that will be considered in the future. TP thanked ES for the update.	
GOVERNANCE AND COMPLIANCE	
23 Corporate Risks Review Update: *for discussion* (SGL)	**ROHTB (10/24) 012**
SGL presented the update on Corporate Risks Review. The key points to highlight include: • There is evidence in Sub Board Committees minutes that discussions are taking place on the corporate risk reviews, and the priority where they sit on the agenda will be moved in some Committee. • Staff Experience &OD Committee meet in October, and then Audit in November so an interim update will be provided at the Board meeting in November followed by a final report to the December Trust Board.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
24 Upward reports from the Board Committees: • **Finance & Performance Committee** • **Quality & Safety Committee**	**ROHTB (10/24) 013** **ROHTB (10/24) 014**

Finance and Performance Committee – LW LW highlighted the following points from the Finance and Performance Committee that took place on Tuesday 24th September: • The focus of the meeting was discussing productivity measures and the urgent need for a financial recovery plan to achieve a breakeven, or better, by year end. • An update was received on the deep dive into Spinal Services that is currently taking place and the early indications of issues that are being explored. • The Committee supported the Ambulatory Care Unit business case be considered at the Trust Board meeting. **Quality & Safety Committee – IR** IR highlighted the following points from the Quality & Safety Committee that was held on Wednesday 25th September: • A deep dive into Surgical Site Infections (SSIs) is taking place to identify whether there are improvements needed to be made to help improve the Trust's results. • The Committee received an update on the Service Accreditation work taking place. • The Medicines Safety Officer Annual Report was presented to the Committee by the Chief Pharmacist and was positively received. • It has been confirmed by the Royal College of Surgeons that they will undertake an independent review of the Trusts Endoscopic Spinal Surgery. • CQC Inpatient survey results were discussed and focus how we improve our patient experience.	
MATTERS TO BE TAKEN BY EXCEPTION	
25 Performance Reports: *for assurance* • **Finance & Performance** • **Quality Report**	**ROHTB (10/24) 015** **ROHTB (10/24) 016**
The reports were taken as read.	
26 Flu Vaccination Update: *for assurance*	**ROHTB (10/24) 017** **ROHTB (10/24) 017 (a)** **ROHTB (10/24) 017 (b)**
The paper was taken as read.	

27 Any Other Business	**Verbal**
There was no other business to discuss.	
28 Meeting Effectiveness	**Verbal**
No comments were offered.	
Date of next meeting: Wednesday, 6 November 2024 @ 0900h	

PUBLIC SESSION

Next Meeting: 6 November 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 21 October 2024

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
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.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.266	Women in Orthopaedics	Presentation	02/10/2024	Invite a Trainee Female Surgeon to a future Trust Board meeting and share their story as part of the Staff Story agenda item.	MR	04-Dec-24	**ACTION NOT YET DUE**	
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	**Details of assurance - positive and negative are now routinely included in the cover sheets for each paper**	
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	~~02/10/2024~~ 06/11/2024	**Item to be deferred to November Trust Board so that it can be shared at SE&OD Committee first.** **Updated at SE&OD and included on Agenda.** **Propose Closure.**	

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Interim Chief Executive**
AUTHOR:	**Matthew Hartland, Interim Chief Executive**
DATE OF MEETING:	**6 November 2024**

EXECUTIVE SUMMARY:

This report is the first presented by the new Interim Chief Executive and summarises his activities since taking up most in mid October.

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

REPORT RECOMMENDATION:

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

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, 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

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board (in Public) on 6 November 2024

1. INTRODUCTION

1.1 This is my first report since commencing as Interim Chief Executive Officer on 14 October 2024.

1.2 I am exceptionally proud to be the Chief Executive of such a well-regarded and highly performing Trust, and am so pleased with the welcome I have received from the Trust Board, Executives, staff and system partners.

1.3 This paper identifies some of my key activities since starting at the Trust, some of the most noteworthy events and updates for the Trust since the last Board meeting and updates from the Birmingham and Solihull system and relevant wider.

2 CHIEF EXECUTIVE ACTIVITIES

2.1 Wellbeing Week

On my very first day at the Trust, I was privileged to able to participate in Wellbeing Week. I had the pleasure of visiting wards and departments with the Chair and colleagues providing hot and cold drinks, fruit and snacks. It was first-hand experience of the exceptional staff working at the Trust and I could not have asked for a better experience at the start of my time at the ROH.

2.2 Care Quality Commission visit

We welcomed the CQC on 9 October. It was unfortunate that only one CQC relationship manager could attend due to illness, but it was great to show our regulators what we do and showcase the outstanding care that we deliver each and every day. In addition to our service leads leading a tour of our facilities, we showcased our work on the Patient Safety Incident Response Framework, our Service Accreditation framework and 'Get You Better' initiatives. The visit went very well, with excellent feedback received. It is not yet clear, however, when we will next be inspected.

2.3 'New Staff Offer' event

I, alongside members of the Executive Team, attended the launch of our Integrated Care System's 'New Staff Offer' on 3 October. It was a great opportunity for me to understand the new support offer for staff, but also to see the work the ROH are leading

on behalf of the system. The offer includes a development programme to improve the identification, engagement, and retention of colleagues from diverse backgrounds and has now been launched for staff across Birmingham and Solihull. Possibilities Beyond Limits (PBL) is open to all at middle management level aiming for senior roles and particularly for BME and disabled/neurodiverse colleagues who continue to be underrepresented at senior levels. Applications are open now until the 28th October and ROH staff have been encouraged to apply.

2.4 Health and care leadership summit

On the 18th October an event was held on for Chief Executives and Executive Teams from BSOL NHS organisations. The agenda for the event was the strategic direction for the system in anticipation of the launch of the NHS 10-year plan, the system response to winter and a presentation on the Federated Data Platform. Further detail is included later in the paper on the 10-year plan.

2.5 Birmingham Health Partners

The ROH is a member of Birmingham Health Partners, a clinical academic alliance for Birmingham and Solihull. I attended BHP with the Chair where we discussed the annual report for the partnership for 2023/24 and the ambition for the partnership for the medium term.

2.6 Race Equality Code

I, alongside members of the Board, attended the second of three sessions on our journey to adopt the Race Equality Code. The Code aims to promote equality and inclusion within organisations by assessing current practices and identifying areas for improvement. The output from the final session will be a co-produced action plan for adoption by the Board.

2.7 ICB Board / Finance Committee

I was invited to an Integrated Care System Board workshop on 14 October where topics included system priorities for health inequalities and the system financial position. It is pleasing that the ROH's Health Inequalities plan is reflective of the discussion and we will continue to contribute to the wider system agenda. I have also been invited to be a member of the ICS Finance and Performance Committee and attended my first meeting in October.

2.8 Visits

I've enjoyed being able to take time to visit colleagues throughout the Trust which has allowed me to meet staff, see the great work they do and give them an opportunity to share any issues they may have. A cup of hot chocolate with the volunteer gardeners has been a highlight so far..

3. ROH UPDATE

3.1 Financial position

The Trust delivered a deficit in month of £111k against a planned deficit of £38k, generating an adverse £82k variance. The year-to-date deficit is now £1,981k against a deficit plan of £75k, generating an adverse £1,906k variance.

Agency expenditure continues to fall within the 3.2% target, whilst Bank expenditure reduced by £100k in month (this is a key focus for the remainder of the year). There continues to be risk relating to ERF income, which is not included within the reported position, although NHSE values for M1-3 have been confirmed as being more than previously expected. If this trend is confirmed for Q2, the gap would reduce further. We are currently working with the Commissioning Support Unit to validate and reconcile the performance for M1-6 in lieu of more timely information from NHSE.

Attention is focussed on delivery of the recovery trajectory to being us back to a break-even position.

3.2 Activity & Performance

Activity in September 2024 delivered 1,270, against a plan of 1,312. Year to date the Trust is 20 cases ahead of plan. Theatre session utilisation was at 83.6% against a target of 85%, ensuring the ROH remain in the top quartile on the Model Hospital dataset .

Operational performance targets performed well with no patients waiting over 65 weeks. Operational focus continues to reduce waiting times further to deliver a reduction in all patients over 52 weeks with an aspiration to have no patients waiting over 52 weeks by April 2025.

The Trust was compliant with all 3 national cancer standards with 93.7% of patients treated within less than 62 days, 100% compliance for patients on the 31-day treatment pathway and faster diagnostic standards achieving 87.2%. The diagnostic standard of 99% was achieved in month (99.8%).

The private patient's prospective income target was exceeded in September by £76k as the team continues to work through actions agreed at June 2024 Trust Board to support the Trust in maintaining financial stability. New business service opportunities are in place to support expansion such as developing an injection suite service and a sports medicine service is currently being scoped. The new BUPA contract went live on the 16th of September in line with the trust private patient strategy.

Outpatient transformation continues at pace maximising the digital opportunities to improve patient experience and support the productivity agenda , these include digitisation of the Patient initiated follow up initiative (PIFU) where the ROH is currently an exemplar site. The stage 2 NHS way finder app has also gone live in September .

3.3 Staff Survey

The national staff survey opened on 2 October, and we welcome comments from all of our colleagues throughout the Trust. We only learn from feedback, and I encourage all staff to complete the survey by the deadline of 29 November.

3.4 National Outcomes Framework segmentation

We have recently received confirmation from Birmingham and Solihull ICB that we remain in NOF segment 2 for Quarter 1 2024/25. We expect the outcome for Quarter 2 very soon.

3.5 Preceptorship Programme

Since October Board we celebrated the completion of cohort 1 of the Preceptorship programme followed by the commencement of cohort 2. This is a multi-disciplinary programme that runs over 12 months for all new qualified and internationally trained staff. This was supported by the International Nursing Bureau being on-site over the month to support our Internally Educated Nurses and encourage them to reach out for support in their career progression.

3.7 New Governors

The elections to the Council of Governors concluded on 4 October and we are pleased to welcome Gareth Yeomans, public governor, Jack Ellis, clinical staff governor and Izzy Munford, non-clinical staff governor, to the Council. Many congratulations are also offered to Arthur Hughes, who was re-elected for a further term to his role as a public governor for the Rest of England & Wales constituency.

3.8 Freedom to Speak Up

October was Freedom to Speak Up month and Claudette Jones, FTSU Guardian and the FTSU champions, organised a programme of events to mark this. Staff were invited to wear green to show their commitment to speaking up, a stand was in place outside Café Royale, providing staff with an opportunity to learn more about FTSU and a listening event was held in theatres. Thanks to all staff for their engagement and support to the speaking up agenda.

3.9 Strategy Unit collaboration

Matt Revell, Medical Director, co-presented the case for quality driven commissioning with the Midlands and Lancashire CSU Strategy Unit on 3rd October. This was very well received and shows the reach and expertise of the ROH to inform national policy.

3.9 MSK Community Appointment Day

On 22nd October 2024 ROH, University Hospitals Birmingham (UHB) and College Green Medical practice hosted their first Community Appointment Day (CAD) at Cocks Moors Woods Leisure Centre in Kings Heath. This is an innovative approach to providing support to patients on our waiting lists for physiotherapy by inviting them to a central location in the community for an opportunity to connect with a variety of clinical and voluntary sector support services. The focus is on holistic care and overall well-being, using a "What Matters to You" personalised care approach. Benefits include a collaborative way of working across BSOL, along with upskilling of existing staff with new working methods that can be carried forward into their daily practice.

We were delighted to collaborate with 13 community partners from a variety of sectors with around 260 patients attending. All patients were given the opportunity to speak with a physiotherapist for exercise advice and assessments where clinically appropriate. In total 20 clinical staff attended from ROH supported by around 40 staff from UHB and other community partners including Versus Arthritis, Age UK and Healthy Minds (Birmingham). Initial feedback from patients and staff was extremely positive and further evaluation of clinical outcomes and patient satisfaction will follow, along with cost/benefit analysis as part of the ongoing MSK programme.

4. NATIONAL UPDATE

4.1 NHS 10-Year Plan

In September, the Rt Hon. Lord Darzi published the findings of his investigation of the NHS in England. Government has previously announced that a 10-year plan for the NHS will be published in Spring 2025 and it is expected to respond to the challenges outlined by Lord Darzi.

We received correspondence from NHSE on 21 October regarding 'Change the NHS' – the public consultation to support the production of the Plan. A national portal has been established at change.nhs.uk where the public can share experiences and ideas.

We at the ROH will also be hosting events with the public, staff and stakeholders. Further detail is expected from NHSE in due course.

4.2 Government Budget

At the time of writing the Government has just presented the Autumn Budget, which included an announcement of additional capital and revenue funding for the NHS. Further details on the impact for the ROH will be shared with Board when known.

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, the following corporate policies have been approved by the Chief Executive on the advice of the Executive Team:

- Personal Protective Equipment policy

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.

Matthew Hartland
Interim Chief Executive
October 2024

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Update from the Guardian of Safe Working – Report for November 2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive Officer (interim Matthew Hartland)**
AUTHOR:	**Jamie McKenzie, Guardian for Safe Working**
DATE OF MEETING:	**6th November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Guardian for Safe Working has confirmed no concerns for the last quarter with respect to the safety of resident doctors.

The document describes the team overseeing resident doctors' working and the current work in progress to improve both patient and employee experience.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• No concerns identified	• Improvements in theatre changing provision

REPORT RECOMMENDATION:

The BOARD is asked to: receive and note the update

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

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

Comments:

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

Care	x	**Community**	
Expertise	x	**Services**	x
People	x	**Collaboration**	

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

This is a report from a statutory function in the Trust

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

Nothing specifically

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

Not applicable
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
April 2024

FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – 6th November 2024

1.0 Situation

1.0.1 The Guardian for Safe Working is required to raise concerns about Safe Working for resident doctors by exception. Exception reports are the mechanism by which resident doctors record unscheduled episodes of work outside their normal working pattern. As of 30th October 2024, there have been no exception reports raised in the last quarter.

1.0.2 Doctors in training, or in non-consultant posts, have requested via the BMA, to be referred to as 'Resident Doctors'.

1.1 Wellbeing

1.1.1 There is a well-documented crisis in the workforce generally. (https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis) This is complex and multifactorial. Resident doctors are campaigning to improve conditions. Their pay dispute has been resolved for the time being.

1.1.2 '**Embedding cultures which make healthcare professionals feel valued is vital, not only to doctors' wellbeing and patient care, but also to the future of the health service.**'

1.1.3 Organisations like the ROH can make a difference to PG graduate doctors' autonomy, self-worth and value.
https://www.som.org.uk/sites/som.org.uk/files/LTF_SOM_mental_health_of_doctors.pdf

1.1.4 The NHS constitution states: All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress.

1.1.5 Successful programmes like the Welldoctor project focus on issues like respect, resting/recharging opportunities etc.

1.1.6 The ROH has appointed Dr James Brunning as Wellbeing lead for medical staff.

2.0 Background

2.1 Leadership Team

The current team looking after middle grade doctors has input from the clinical service managers.

2.1.1 Clinical rotas are prepared by the Administrative Specialist Registrar (SpR), nominated 6-monthly, currently Mr Ahmed Saad. Mr Jones and Mr Politis support the Admin SpR balancing the educational and training opportunities with the service requirement of the organisation. Through regular contact and meetings with trainees and management, the leadership team ensure safe, effective and rewarding postgraduate training. This is monitored by the leadership team and a rapid and effective response is ensured when concerns, challenges and opportunities are identified. Formal feedback via anonymous surveys including the GMC trainee-satisfaction survey and the Job Evaluation Survey Tool (JEST) (now NETS – National Education and Training Survey) is similarly monitored and responded to.

2.1.2 The current consultant staff post holders are:

Mr Morgan Jones	Post Graduate Clinical Tutor	All postgraduate medical and surgical trainees (ST1+) at the Royal Orthopaedic Hospital
Dr James Brunning	Wellbeing Lead and Tutor	Anaesthetics
Mr Angelos Politis	Clinical Lead for Mid-Level Care Providers	Locum doctors & Fellows
Mr Jamie McKenzie	Guardian for Safe Working	Safe working conditions of resident doctors
Mr Khalid Baloch	Director of Medical Education	DME
Mr Matthew Revell	Medical Director	

2.1.3 There are regular medical workforce meetings arranged as part of normal operations.
In addition, there is a regular Resident doctors' forum attended by the leadership team and all resident doctors are invited.

2.1.4 The Post Graduate Clinical Tutor, Medical Director and Safeguarding lead provide input to the doctors' induction meetings. The Medical Director and Post Graduate Clinical Tutor each have 2-monthly meetings with the GP trainees and contribute to the training programme as speakers and medical educators.

2.1.5 All clinical supervisors and allocated educational supervisors are accredited as per the GMC and Academy of Medical Educators directive. Maintenance of accreditation is appraisee-led and recorded via the annual appraisal process. Consultants are currently supported in providing evidence of accreditation to their appraisers. This process is changing under the guidance of the new director of medical education (DME).

2.1.5 The post of ROH Director of Medical Education (DME) has been established recently. Mr Baloch's role as Training Programme Director has been taken over by a consultant colleague from Wolverhampton Hospital, Mr Shree Deshpande.

3.0 Junior Doctor Establishment

3.1 *Specialist Registrars (SpRs) and Fellows Training in Orthopaedic Surgery*

3.1.1 There is presently a combination of Specialist Registrars and Fellows on the Royal Orthopaedic Hospital roster. All contribute significantly to the safe working of the Trust on a day-to-day basis, being timetabled for ward-round cover, theatres and outpatient clinics, as well as on-calls. Fellows do not normally take part in the on-call rota.

3.1.2 New SpR trainees started in August 2024. Face to face teaching is on-going on Fridays.

3.1.3 The GMC National Training Survey (NTS) 2024 results are regularly discussed at high level in the trust. The latest results are good and show improvements over the last few years. Sexual safety is an issue that is being actively addressed at a national level. Sexual safety is specifically discussed at induction and the comms team are regularly addressing this with advice and information. For 'adequate experience' and 'out of hours supervision' our NTS results were just below average. Khalid Baloch (DME) has made an action plan to address these issues, and this has been circulated to consultant body. This action plan is being escalated independently to other committees including the Trust Board.

3.1.4 No significant payroll issues. A backpay discussion due to overtime is being amicably addressed.

3.1.5 On call rooms are limited. There is no room for junior doctors when not officially on call which is a shame as they have requested somewhere to rest that is more than just a lounge. On call rooms allow them to catch some proper rest and have showers etc. There is no provision for consultants who are on call and stay late.

3.1.6 SAS doctors have recently set up an updated teaching programme for their needs.

3.2 *GP Trainees*

3.2.1 There are a variable number of GP trainees at the ROH (1-10). There are currently two. Only one is due in December and next April. There are 5 planned in August 2025. There is on-going work

with the GP dean to ensure GP trainees are encouraged to choose the ROH and it is acknowledged that they receive excellent education when here. Morgan Jones is working hard to improve their ROH experience.

3.2.2 Remaining posts at Senior House Officer level are filled with locums or, more preferably, substantive mid-level care providers (MLCPs) where possible. The aim is to reduce the reliance on locum cover by appointing doctors into 2-year fixed appointments when possible. A new policy on mid-level providers has been produced. Jo Thomas, associate medical director, is examining these issues to try to reduce locum cover. International research fellows have been appointed by Prof Gardiner.

3.3 *FY2 Doctors*

3.3.1 The ROH had requested a FY2 doctor to join the trust. This has not been possible on this rotation, but discussions will continue with the Foundation Director and UHB.

3.4 *International Doctors, inc. junior research fellows*

3.4.1 Concerns have been raised about this new cohort of resident doctors. There is an induction booklet designed specifically for them and their induction process is being developed with a 4-6 week period of special supervision. Pastoral support is a concern as they are often younger doctors and this is often their first post overseas. Clinical governance framework, combining research and clinical factors is being addressed.

4.0 Resident Doctors' Forum (formerly *Postgraduate* Doctors' Forum)

4.1 The resident doctors' forum meetings provide an opportunity for the leadership team, including management, to discuss and plan improvements. Encouraging trainees and other medics to attend is a priority.

4.2 Wellbeing has been raised as an important issue. This is being addressed in several fora, including at every induction for all medical staff, with Angelos Politis as lead. There is a suggestion box in the junior doctors' lounge and requests continue to be acted on in the main. Additionally, wellbeing packs are available in the postgraduate doctors' lounge and there is a freezer providing ready meals.

4.3 The induction process is constantly being improved, often due to direct input at the resident doctors' forum. The induction handbook has undergone some improvements in collaboration with the trainee doctors themselves. Overseas medical graduates have a separate induction process.

4.4 Those resident doctors that work regularly in theatres have brought up time and again that there is little or no space to store their clothes in the locker rooms. There are not enough lockers, even

for consultants. Visiting surgeons often comment on the state of the theatre changing rooms as shocking in an otherwise exemplary hospital. The board is asked to specifically consider the needs of resident doctors when further changes are made to theatres or further expansion is planned. This issue is still outstanding. The Guardian has acquired two lockers for resident's use, but more are required.

5.0 About the Guardian for Safe Working Role

5.1 During negotiations on the junior (now resident) doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for resident doctors.

5.2 The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the resident doctors employed by it. It should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into resident doctor forums.

5.3 The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The post holder is to identify and either resolve or escalate problems, and act as a champion of safe working hours for resident doctors.

5.4 The guardian provides assurance to the employer or host organisation, that issues of compliance with safe working hours will be addressed, as they arise.

5.5 The guardian is accountable to the board and should not hold any other role within the management structure of the employer. The line management arrangements for the guardian should be independent of the medical director and other medical managers to ensure appropriate independence.

5.6 The guardian has a page on the ROH external website with contact details and a description of the role. The role is explained at resident doctors' induction and leaflets are distributed with further details. The guardian attends the resident doctors' forum meetings, and they are easily and frequently contacted.
https://roh.nhs.uk/about-us/corporate-information/guardian-of-safe-working

6.0 Recommendations and Ongoing Work

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report
SUPPORT the following intentions:

- To provide continued support for the key individuals working to support resident doctors' working conditions, especially those involved directly in health and wellbeing.

- Improving working conditions and wellbeing for resident doctors as a priority for the trust.
- Ensure that when changes occur that impact doctors, the doctors are involved in those changes and the doctors' concerns are addressed.

Jamie McKenzie, Guardian for Safe Working
30th October 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Workforce Disability Equality Standard (WDES) update**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Executive Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**6th November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Background:

This the final update on the Workforce Disability Equality Standard (WDES) report. This report will be published on the ROH website by 31st October as part of NHSE requirements. The report must also be sent to the EDI Lead at BSOL ICB for compliance.

The WDES standard consist of a number of indicators linked to:

- 3 metrics that focus on workforce data
- 6 are based on questions from the NHS Staff Survey
- 1 metric focuses on disability representation on boards1
- 1 metric (metric 9b) focuses on the voices of Disabled staff (information will be included in the National WDES report)

This reports gives an overview of the latest data on the WDES indicators for 2024. The data was submitted to NHSE in May 2024 and is presented in chart form. The report also:

- Highlights areas of change from last year's results
- Compares initial information with average Specialist Acute data and BSol ICS data where available
- Reviews areas where the Trust has made progress over the last twelve months
- Outlines an updated WDES action plan

Next steps

- Update any final information for the WDES action plan
- Publish on ROH website

ASSURANCE PROVIDED BY THE REPORT:

POSITIVES	GAPS IN ASSURANCE/RISKS TO ESCALATE
- There has been a positive increase or stayed the same for 9 out of 11 of the WDES indicators - The ABLE network continues to support and contribute to WDES work and actions to ensure progress is made in partnership	- There are only two indicators that have seen a decline since last year and work will be completed to address this. Indicator 1 which looks at % of disabled staff did see a decline but has since seen an increase in this figure to 8.3%

	Indicator 2 for recruitment has seen a decline but this still shows an equal score for disabled and non disabled staff - Some actions have been carried forward from last year due to team resourcing issues but new dates have been set to ensure the work is completed in a timely manner - Ensuring the correct forums are in place at the Trust to hear the voices and concerns of staff members for ongoing progress of WDES work with support from the ABLE network

REPORT RECOMMENDATION:

To review the reports for approval to be published on the ROH website

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

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

Comments:

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

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

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

People Priorities

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

ICS Inclusion work

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

National WDES indicator data
Specialist Acute Trust and indicator results

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

People and OD Group – June 2024
Staff Experience and OD – June 2024
Trust Board – July 2024
People and OD Group September and October 2024
Staff Experience & OD – October 2024

NHS Workforce Disability Equality Standard (WDES)

Update Report – October 2024

Royal Orthopaedic Hospital Workforce Disability Equality Standard (WDES)

Background

This is the sixth year that NHS organisations are required to report on WDES data. The standard was introduced to enable employees with disabilities to have equal access to career opportunities and receive fair treatment in the workplace.

WDES Data

Staff data was collected and submitted to NHS England in May 2024. The data period is 1st April 2023 to 31st March 2024 and is formulated into ten WDES Indicators.

These 11 WDES indicators aims to compare the workplace and career experiences of disabled and non-disabled staff members. The ten indicators include:

- 3 metrics that focus on workforce data
- 6 are based on questions from the NHS Staff Survey
- 1 metric focuses on disability representation on boards1
- 1 metric (metric 9b) focuses on the voices of Disabled staff (information will be included in the National WDES report)

An additional question is included for WDES, compared to Workforce Race Equality Standard (WRES) around reasonable adjustments for staff members.

All NHS Trusts are required to collate and publish this information on their website by October 31st each year.

This report show some Specialist Acute Trust, BSol ICS and national comparison information particularly around the staff survey results. The completion rate for the staff survey overall was 60% which equates to 793 colleagues. For disabled staff the percentage was 20.1% which equates to 164 colleagues – this was an increase from 134 in the previous year.

This report gives an overview of the latest data on the metrics for 2024. It also:

- Highlights areas of change from last year's results
- Compares initial information with average Specialist Acute data where this is available
- Reviews areas where the Trust has made progress
- Updated WDES action plan published in October 2023

Table One below shows ROH WDES Performance Data. Indicators 4 – 8 is collated from the National Staff Survey (NSS) results which staff completed between 4th October and 25th November 2023.

The WDES action plan and approach forms part of the work completed under the ROH Inclusion Strategy. The ABLE Chair and network members have co created the work on this report.

Progress made in the last 12 months

- With support from the ABLE network, the Trust secured funding from the national WDES team to introduce a staff health passport for disabilities. This document produced in an easy ready format has been completed and is designed for staff members who may find it difficult to share personal information regarding their disability or health condition. It facilitates easier conversations about the support an individual may need in the workplace (including reasonable adjustments). This is the first phase of the work - see action plan for next steps

- The new disability leave procedure and statement has been approved as part of the Managing Attendance policy and this is currently being rolled out across the Trust. This work was supported by the ABLE network and was identified as a key action due to varying experiences of network members. The procedure provides clearer information and guidance for individuals and manager. The HR team will start to review the impact of this new procedure through a feedback mechanism.

- The Workforce and OD team have worked with Jade Cotton, a disability advocate on the inclusive recruitment project. Jade originally joined the Trust as a bank staff member and has provided insight into the employee journey at the ROH for an individual with complex medical conditions. She will continue to support with the inclusive recruitment project as highlighted in the action plan.

- The evaluation report for the 'Seeing Beyond the Stigma' is now completed and has been shared across the Trust. The reports outlines the impact of the exhibition on the participants and staff members, to raise awareness of disability and the importance of belonging. There are also a number of recommendations for supporting staff members with disabilities in the future. The report evaluation was undertaken by University of Canterbury and this team will share this work across their networks, particularly around the theme of storytelling. See action plan for next steps.

- Launch of leaflet produced by the ABLE network to highlight reasonable adjustments for staff members. In the staff survey from 2022 to 2023 there was a positive increase from 67% to 75% in the number of staff with long term health conditions who said that reasonable adjustments had been put in place. This percentage will be reviewed again when the staff survey results are available in 2025.

***Please note that some of the work listed above is ongoing and more detail on timelines is shown in the action plan at the end of this report**

Table 1: Overview of WDES Indicators

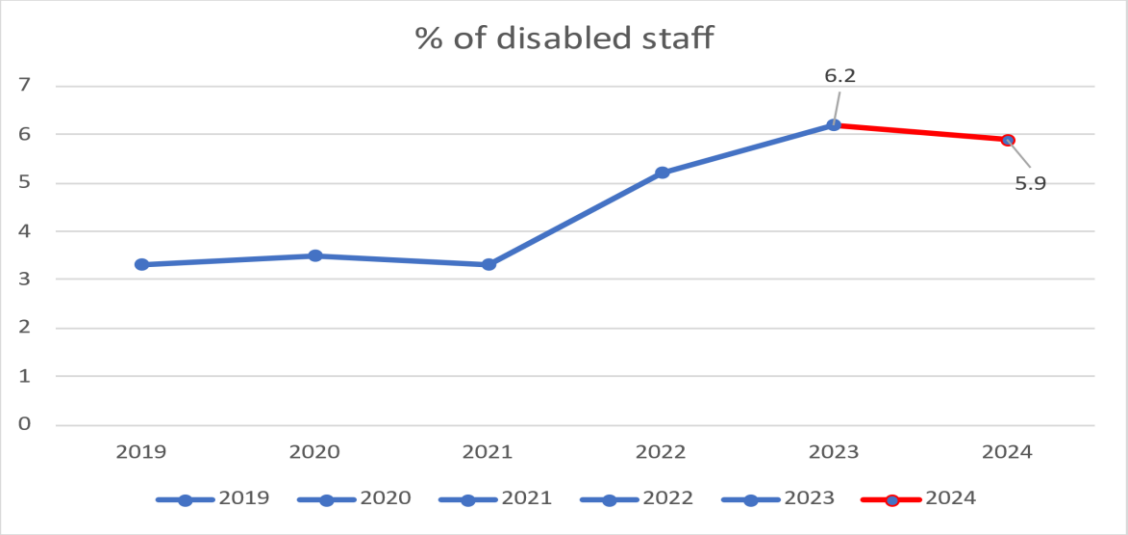
Further information on the WDES indicators

It is positive to see that there has been an improvement or no change in nine out of eleven of the indicators. From the indicators where there has been a decline, it should be noted that:

- Indicator 1 which looks at % of disabled staff has since seen an increase in this figure to 8.3%
- Indicator 2 for recruitment has seen a decline but this still shows an equal score for disabled and non disabled staff

Again, any actions mentioned in this section on indicators are summarised at the end of the document in the action plan.

WDES indicator 1



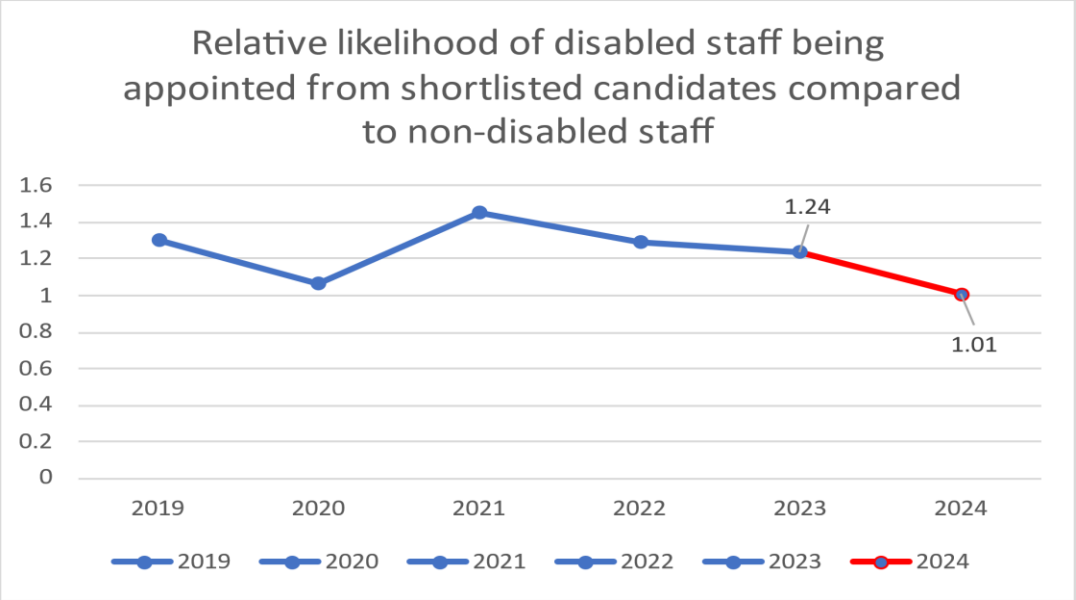
Percentage of staff members with a disability

- There has been a slight change to staff members with a disability declaration rate moving from 6.2% to 5.9%.
- The current ROH rate is 8.3. The average score across the ICS for WDES 2023 when the data was collected w 6% and this figure will be updated once the National WDES 2024 data is available.
- There was a negative change in the figures at the time of reporting due to leavers and new starters.
- The disability declaration for non clinical was 8.3% with 12.3% non disclosed. For clinical staff, the declaration rate was 5.1% with 8.8% unknown.
- The staff grouping with the highest disability declaration is clinical Band 8C or above with a declaration rate of 20% and 20% non disclosed.

Based on this information, the ESR team and ABLE network will continue to support staff members to feel confident to update their disability declaration information by explaining how to easily access

the fields on ESR and the positive reasons for completing the update. This will be done through awareness sessions, discussion at the ABLE network and comms sent out to staff members as noted in action plan below

WDES indicator 2



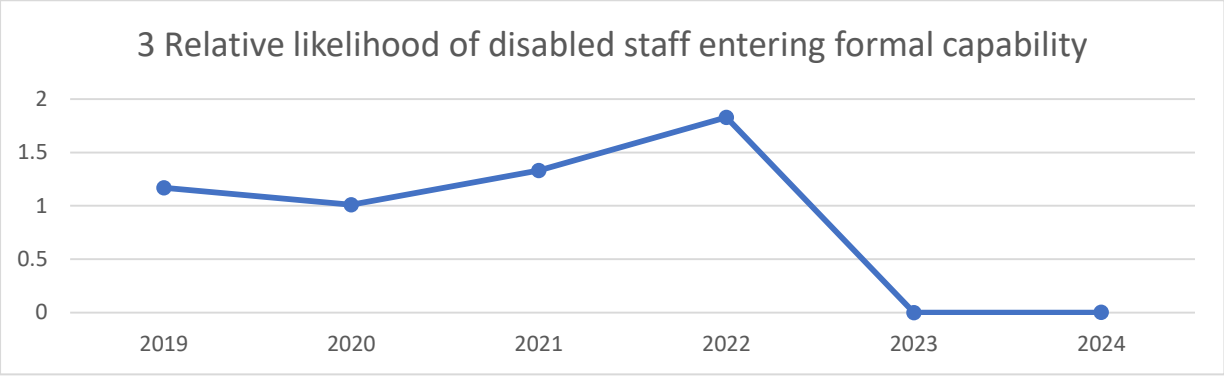
The relative likelihood of disabled applicants being appointed from shortlisting compared to non disabled applicants

For 2024, the ROH has seen a change from 1.24 to 1.01. This is not seen as a concern with the work planned in the next 12 months to review and improve inclusive recruitment practices.

One key initiative to mention is the joint training programme by the HR and OD and Inclusion team to upskill managers for inclusive recruitment practices.

This programme was originally run for nursing managers but will be rolled out further across the Trust starting in January 2025 As part of this work, the team is also supported by Comms to look at different ways to promote the Trust to attract a wider and more diverse audience.

WDES indicator 3

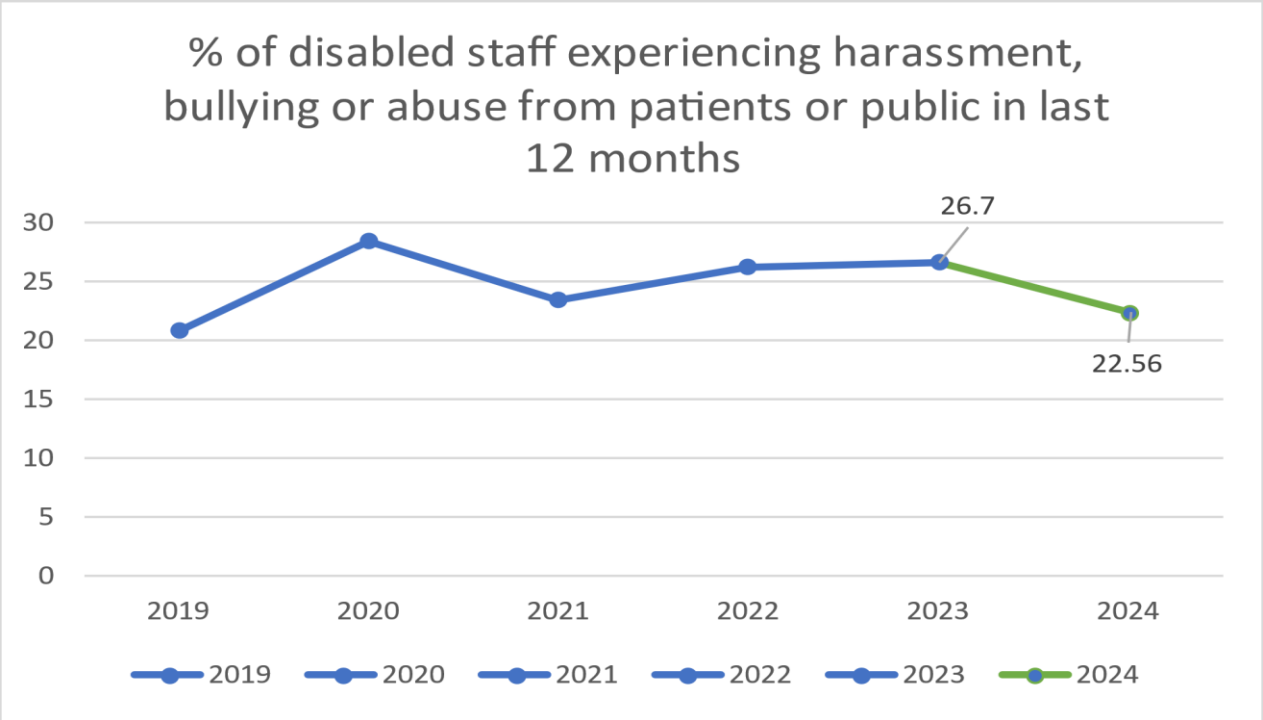


The relative likelihood of disabled staff entering the formal capability process compared to non disabled staff

For 2024, the ROH metric has remained at 0, which is a two year rolling figure. It should be noted that the Trust continues to have a low number of capability cases across all staff groups.

In line with the Trust's ongoing work on case reviews and Civility and Respect, any further cases will be reviewed for fairness and equality. The implementation of the staff passport project (funded by NHS WDES Innovation Fund) will also allow more transparency and support for staff members where issues arise.

WDES Indicator 4



Percentage of disabled staff experiencing harassment, bullying or abuse from patients in the last 12 months

It is positive to see a further reduction in this indicator from 26.7% to 22.56%.

The ROH figure is slightly lower than the average figure across Specialist Acute Trusts which is 23%.

The figure for non disabled staff is 14.12% which has been reviewed by the ABLE network and it is recognised that more support is need for disabled staff to be able to ask for support. The new staff passport will aid in helping staff member to access the correct support their need for their role and their wellbeing.

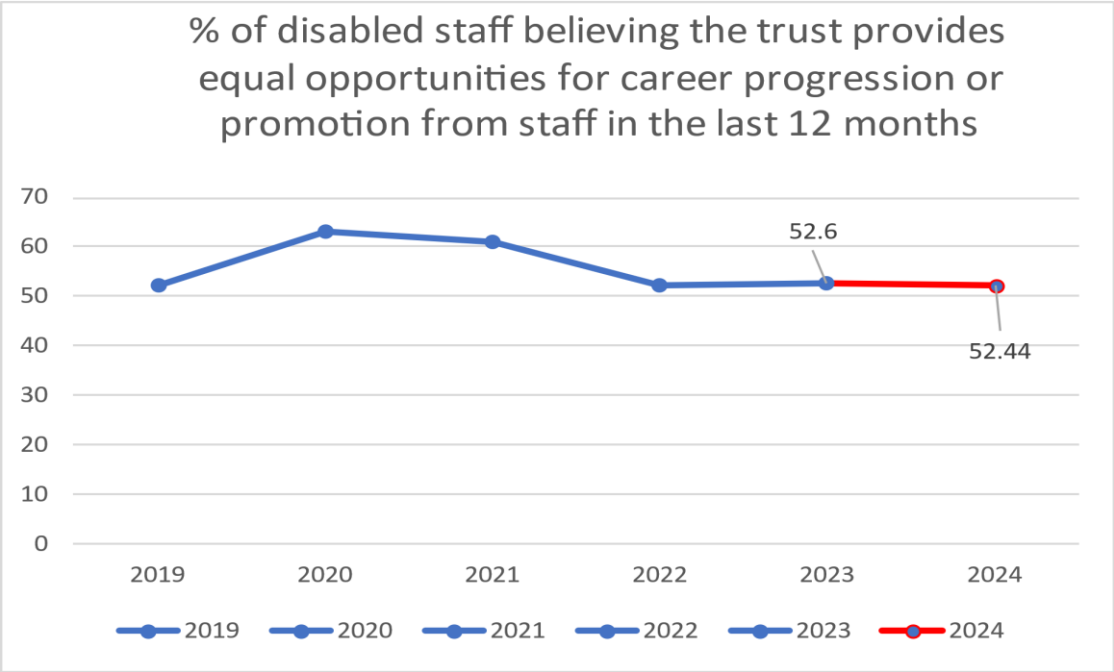
WDES indicator 4a

Percentage of disabled staff experiencing harassment, bullying or abuse from staff in the last 12 months

- There has been no change to this figure which is 23.1%.
- It should be noted that the figure for non disabled staff has actually increased from 14.6% to 17.45%.
- The average figure across Specialist Acute Trusts is 21.83%.

The actions highlighted in this report and also the Civility and Respect project will help to make improvements for all staff groups. In addition, work continues with the Freedom to Speak Up champions and the Sexual safety charter.

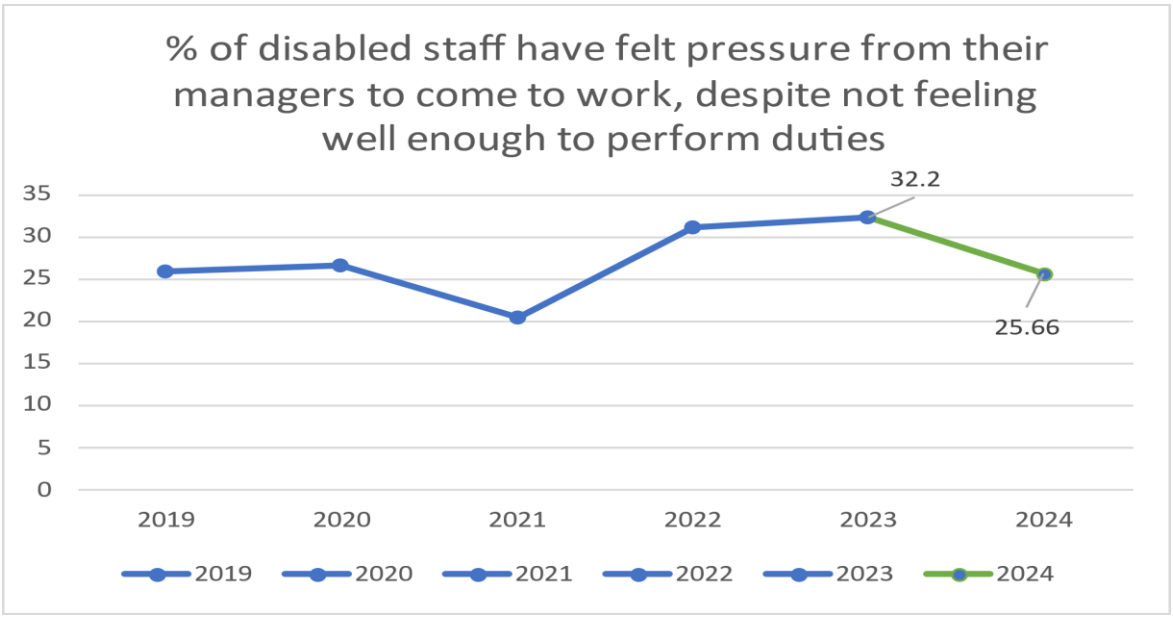
WDES indicator 5



Percentage of disabled staff believing the trust provides equal opportunities for career progression or promotion in the last 12 months

- There has been a very slight change to this indicator from 52.6% to 52.44%.
- The average figure across Specialist Acute Trusts was 51.9% which was lower than the Trust.
- The ABLE network is looking at barriers that may get in the way for network colleagues and will actively support with the mentoring programme which is noted in the
- Recent diversity data from the ROH apprenticeship programme has shown that there is an increasing number of students enrolling on to course with a disability. The latest figure is 11% which is higher than the disability declaration rate.

WDES indicator 6

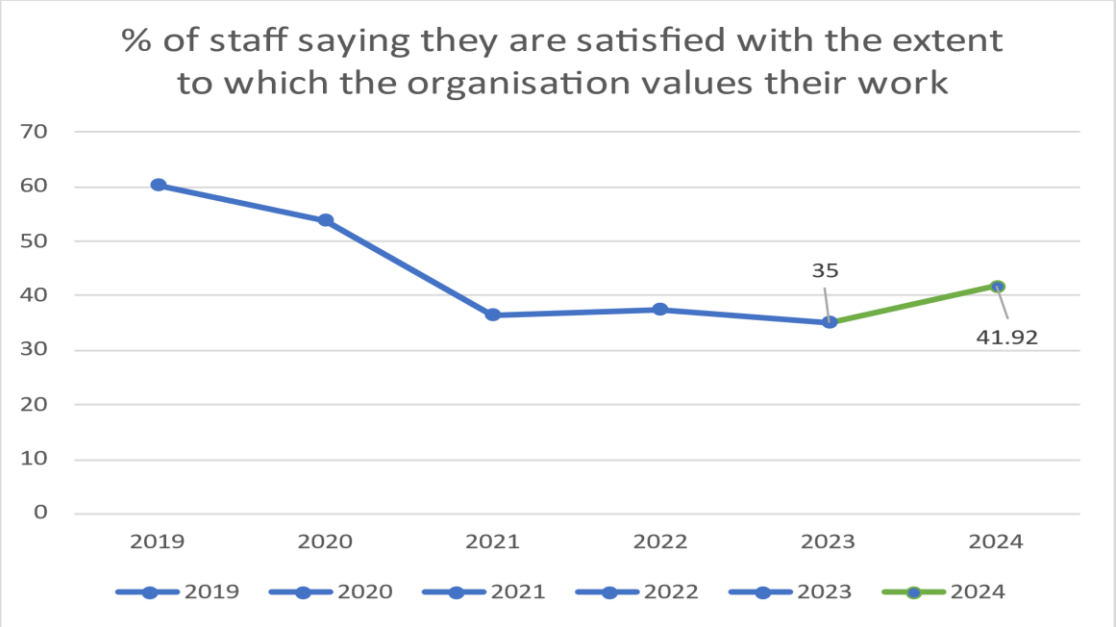


Percentage of disabled staff have felt pressure from their managers to come to work, despite not feeling well enough to perform duties

- There has been a positive change in this metric from 32.2% to 25.66%.
- This is compared to a decline in non disabled staff members which has moved from 17.6% to 18.84%.
- The average figure across Specialist Acute Trusts was 17.67%

Again, the staff passport work and continued rollout of the wellbeing conversation training will help to further improve this figure as managers are upskilled to have supportive conversations. In addition there has also recently been managers training on the sickness policy to upskill managers in having supportive conversations with colleagues.

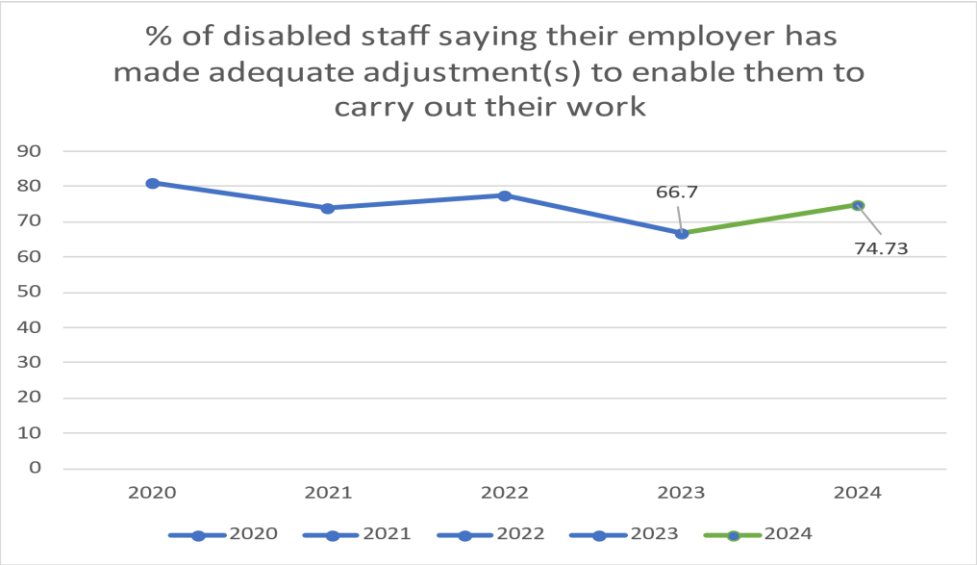
WDES indicator 7



Percentage of disabled staff saying they are satisfied with the extent to which the organisation values their work

- There has been a positive increase in this metric from 35.0% to 41.92% which is encouraging.
- The figure for non disabled staff has also increased from 51.03% to 53.7%
- The average figure across Specialist Acute Trusts was 40.56%.

WDES indicator 8



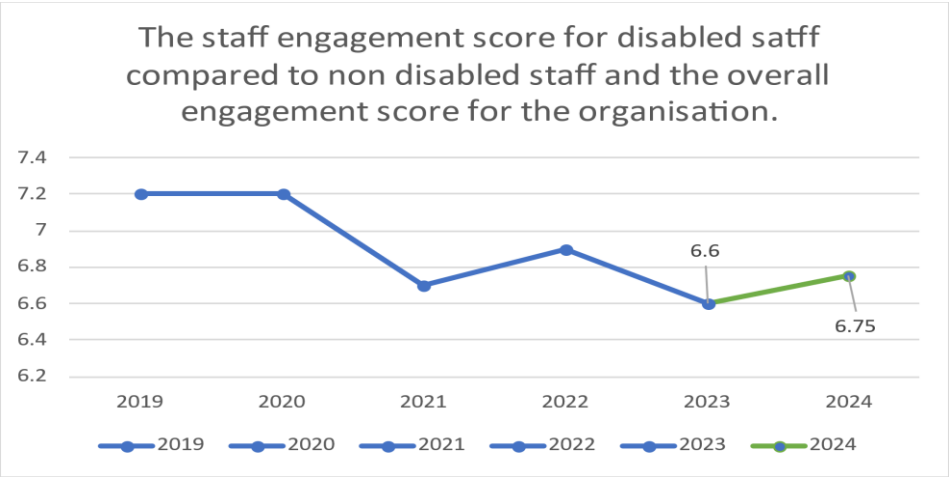
Percentage of disabled staff saying their employer has made adequate adjustments to enable them to carry out their work

- There has been a positive increase to this metric from 66.7% to 74.73%
- The average figure across Specialist Acute Trusts was 74%.

The staff passport is designed to ensure conversations take place on a regular basis between managers and staff members. Wellbeing conversations training is also upskilling managers to have a positive conversation with staff on their individual needs.

Other work to support further improvements includes upskilling managers to understand the services provided with Access to Work through ABLE awareness sessions and the importance on starting supportive conversations during 100 days with new staff members.

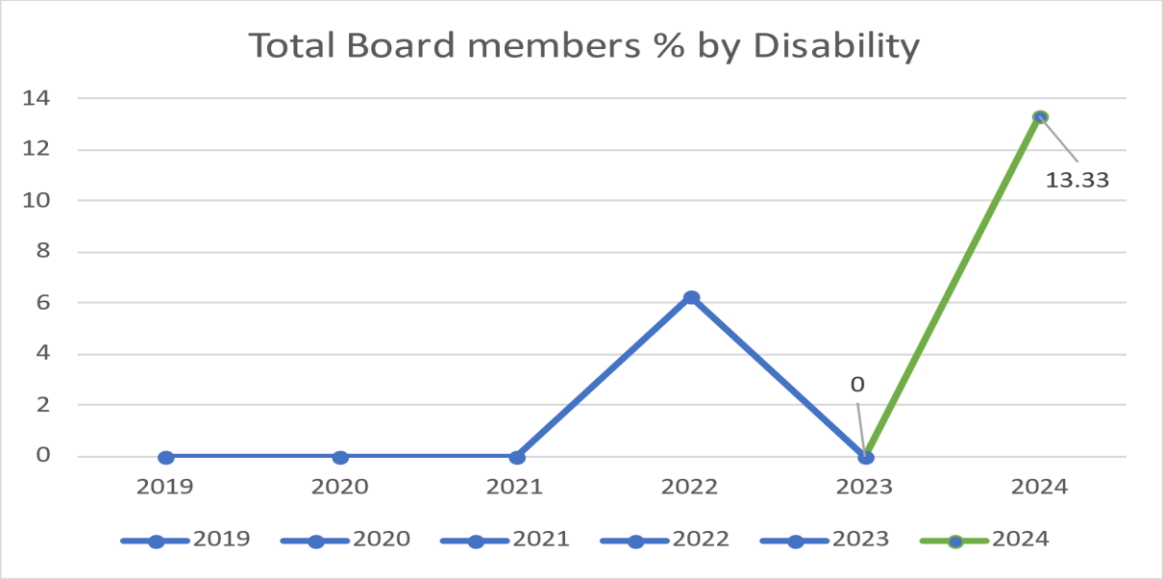
WDES indicator 9



The staff engagement score for disabled staff compared to non disabled staff and the overall engagement score for organisation.

- The engagement score has increased from 6.6% to 6.75%
- The ABLE network will continue to work with staff members to understand why this figure is lower than for non disabled staff which is 7.25%
- The average figure across Specialist Acute Trust was 6.99% which is slightly more positive than the ROH figure.

WDES indicator 10



Percentage of the full board identifying as Disabled

There has been positive change from 0% to 13% for full board members. It should be noted that this figure is higher than the average figure across BSol ICS for 2022/2023 which was 3%

WDES Comparison Data

WDES Indicator	Indicator Definition	Royal National Orthopaedic	Robert Jones	Liverpool and Heart	ICB	BWC	Birmingham Community	BMHT	UHB	ROH
4	% of disabled staff experiencing harassment, bullying or abuse from patients or public in last 12 months	26.76 (17.58)	19.52 (12.98)	13.80 (12.90)	24.05 (6.16)	27.37 (20.13)	27.74 (20.07)	36.08 (29.22)	28.72 (23.00)	22.56
4a	% of disabled staff experiencing harassment, bullying or abuse from staff in last 12 months	21.83 (18.53)	21.80 (14.18)	20.69 (11.21)	22.78 (17.28)	25.39 (14.92)	22.93 (14.66)	24.14 (15.86)	29.60 (19.19)	23.1
5	% of disabled staff believing the trust provides equal opportunities for Career progression or promotion from staff in the last 12 months	48.95 (53.82)	59.24 (59.85)	62.96 (67.14)	40.00 (44.57)	54.04 (58.32)	46.95 (53.32)	50.28 (55.93)	41.87 (52.17)	52.44
6	% of disabled staff have felt pressure from their managers to come to work, despite not feeling well enough to perform duties	24.00 (17.28)	22.06 (14.75)	26.14 (14.04)	15.22 (18.88)	27.06 (16.35)	25.97 (16.01)	20.97 (12.75)	32.23 (19.89)	25.66
7	% of staff saying they are satisfied with the extent to which the organisation values their work	40.56 (53.18)	39.71 (48.75)	53.47 (62.12)	41.98 (45.49)	36.86 (43.88)	33.15 (45.98)	41.55 (52.25)	28.06 (40.82)	41.92
8	% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	76.32	82.91	81.62	82.00	73.45	77.58	76.87	69.27	74.73
9	The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation	7.21 (7.51)	7.15 (7.42)	7.48 (7.82)	6.19 (6.58)	6.65 (7.15)	6.46 (7.03)	6.56 (7.23)	5.96 (6.74)	6.75

*Text highlighted shows the highest scores across the different NHS Trusts

() indicators soccer for other staff

ROH WDES Action plan: 2024 - 2025

This plan gives an overview of the key areas of work that will be undertaken in 2024 – 2025 in line with the NHS WDES standard. The actions set in October 2024 are aligned to the six impact areas in the ROH Inclusion strategy. See table below with the list of WDES indicators)

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
	Impact area: Ambassadors					
Indicator 1- % staff Indicators 4,4a,8 Treatment of staff	Embed Buddy scheme as part of the WDES Innovation Fund	**Campaign to support and raise awareness** To set up buddy programme based MMEG mentoring framework Share information from WDES Evaluation project Share education material for Disability awareness Promote new WDES staff passport	December 2024		ABLE network OD and Inclusion Team	Identified as a key action by the ABLE Network to support speaking up Delayed due to changes in team but this work will be included in the launch of the new staff passport funded by WDES Key focus around International Day of Disabilities **Impact** Improved declaration rate to 10% (including further improvement with Trust Board members) and improved indicators for

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
						treatment of staff by 10% on staff survey
	Impact area: Culture					
Indicator 2 Recruitment	Inclusive approach to attracting, recruiting, and retaining staff	**Inclusive recruitment project** • New bank of inclusive questions to be added to recruitment • Review options for a diverse interview panel model and feedback from candidates • Upskilling managers in inclusive recruitment • Review data set for shortlisted to appointment to identify of key areas of focus • Work to be underpinned by Restorative Just Learning Culture (RJLC) project including for workforce policies • Work will also be incorporated into future	November 2024 Dec 2024 April 2025 Dec 2024 March 2025 March 2025		Workforce and OD Team Support from the staff networks	**Impact** Improved recruitment indicator to 1.2

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
		Trust Board recruitment practices • Reaccreditation for Disability Confident - Leader	April 2025			
	Impact area: Staff and patient voice					
Indicators 4,4a,8 Treatment of staff	Increased participation of staff networks across all departments	• Work with line managers to ensure that staff are able to attend ABLE network when required	March 2025		OD and Inclusion Team Network chair	Work continues to ensure there is full management commitment to networks, encouraging and allowing their team time to attend. Membership numbers have increased – still more progress required on attendance at network meeting **Impact** 20% increase in ABLE network members Deputy ABLE Chair recruited to support network

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
Indicator 1- % staff	Improvement of declaration rates	With support from staff networks encouraging staff to declare diversity information. This will enable better engagement and support from staff from diverse backgrounds ICS project to promote declaration rates through awareness sessions including Wellbeing week	January 2025 January 2025		Clare Mair ESR Team ABLE network	Disability network to run promotion campaign at Wellbeing Week and on International Day of Persons with Disabilities 2024 **Impact** As above - Improved declaration rate to 10% (including improvement to Trust Board members rate)
Indicator 5 – Opportunities Indicator 7 – Value work	Increased number of staff sharing diverse information and lived experience stories	Case studies are being completed by ABLE network members	February 2025		ABLE network Clare Mair	Carried forward Delayed due to changes in team but this work will continue with the staff passport launch **Impact** Further improvement in Indicator 5 and 7 by 10% from the staff survey

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
	Impact area: Education					
Indicator 5 – Opportunities	Implement education programmes and tools to ensure staff at all levels have an awareness	• Develop and delivery modules on autism and neurodiversity with support from Genius Within • Upskill and discuss Oliver McGowan work at Network meeting	March 2025		Laura Tilley-Hood Alex Gilder	**Impact** Pilot completed with 10% managers and 80% positive evaluation from training programmes
Indicator 7 – Engagement	Inclusion calendar updated and used to inform network sessions	• Calendar communicated annually to show key dates recognised in celebrating Diversity, Belonging and Inclusion • Action plan in place to highlight specific dates	January 2025		OD and Inclusion administrator Network Chairs	**Impact** 10% improvement of overall engagement score on Staff survey
	Impact area: Best practice					

Indicators	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
Indicator 7 – Engagement	Promotion of evaluation project for Seeing Beyond the Stigma	Information to be shared through ABLE awareness session	December 2024		OD and Inclusion Team Network chairs	**Impact** Improved declaration rate to 10% (including improvement to Trust Board members rate)
	Impact area: Data Metrics					
All indicators	Embedded approach to Equality impact Assessments (EQIA) across all departments.	Recommended work to include documentation, guidance, monitoring, and training is embedded and understood within the Trust Complete quality review on new approach	January 2024 July 2024		OD and Inclusion Team Governance Team	**Impact** Improvement in quality of completed EQIA for defined time period (criteria to be scoped)

The action plan has been confirmed with support from the ABLE network chair – Alex Gilder

WDES Indicators

Indicator	Descriptor
1	Percentage of staff members with a disability
2	The relative likelihood of disabled applicants being appointed from shortlisting compared to non disabled applicants
3	The relative likelihood of disabled staff entering the formal disciplinary process compared to non disabled staff
4	Percentage of staff experiencing harassment, bullying or abuse from patient and public in the last 12 months
4a	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
5	Percentage of disabled staff believing the trust provides equal opportunities for career progression or promotion
6	Percentage of disabled staff have felt under pressure from their managers to come to work, despite not feeling well enough to perform duties
7	Percentage of disabled staff saying they are satisfied with the extent to which the organisation values their work
8	Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work
9	The staff engagement score for disabled staff
10	Percentage of the full board members with a Disability

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Workforce Race Equality Standard (WRES) update**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**6th November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Background:

This the final update on the Workforce Race Equality Standard (WRES) report. This report will be published on the ROH website by 31st October as part of NHSE requirements. The report must also be sent to the EDI Lead at BSOL ICB for compliance.

The WRES standard consist of a number of indicators linked to:

- 3 metrics that focus on workforce data
- 5 are based on questions from the NHS Staff Survey
- 1 metric focuses on BME representation on Trust Board

This reports gives an overview of the latest data on the WRES indicators for 2024. The data was submitted to NHSE in May 2024 and is presented in chart form. The report also:

- Highlights areas of change from last year's results
- Compares initial information with average Specialist Acute data and BSol ICS data where available
- Reviews areas where the Trust has made progress over the last twelve months
- Outlines an updated WRES action plan

Next steps

- Update any final information for the WRES action plan
- Publish on ROH website

ASSURANCE PROVIDED BY THE REPORT:

POSITIVES	GAPS IN ASSURANCE/RISKS TO ESCALATE
- There has been an increase in three indicators for % BME staff, training and recruitment and more work will be undertaken to improve further particularly around recruitment - The MMEG network continues to support and contribute to WRES work and actions to ensure progress is made, in partnership	- Across the 10 indicators there has been a decline in six out of the 10 WRES indicators in the areas that are focussed around staff treatment, career progression and Board diversity. This includes all three indicators on staff treatment - - Some actions have been carried forward from last year due to team resourcing issues but new

- Recruitment for the new MMEG network chair is underway and will be completed by early November	dates have been set to ensure the work is completed in a timely manner - Ensuring the correct forums are in place at the Trust to hear the voices and concerns of BME staff members for ongoing progress, particularly when considering recent events including riots

REPORT RECOMMENDATION:

To review the reports for approval to be published on the ROH website

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

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

Comments:

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

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

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

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

ICS Inclusion work

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

National WRES indicator data
Specialist Acute Trust and indicator results

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

People and OD Group – June 2024
Staff Experience and OD – June 2024
Trust Board – July 2024
People and OD Group September and October 2024
Staff Experience & OD – October 2024

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

NHS Workforce Race Equality Standard (WRES)

Update Report - October 2024

MMEG
MULTI MINORITY ETHNIC GROUP

Royal Orthopaedic Hospital Workforce Race Equality Standard (WRES)

Background

The Workforce Race Equality Standard (WRES) was introduced in 2015 to enable employees from Black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace.

There are nine WRES indicators that cover:

- Workforce data
- Results from the NHS Staff Survey

This report gives an overview of the latest data on the WRES metrics for 2024. It also:

- Highlights areas of change from last year's results
- Compares initial information with key Specialist Acute data and ICS BSol data, where available
- Reviews areas where the Trust has made progress over the last twelve months
- Outlines the updated WRES action plan

WRES Data

Staff data and relevant staff survey results was collected and submitted to NHS England in May 2024. The data period is 1st April 2023 to 31st March 2024 and is formulated into the nine WRES Indicators. All NHS Trusts are required to collate and publish this information on their website by October 31st annually.

Table 1 below shows ROH (Royal Orthopaedic Hospital) WRES Performance Data for all indicators across the time period of 2016 – 2024.

Data for Indicators 5 – 8 is collated from the National Staff Survey (NSS) results which staff completed between 2nd October 2023 and 24th November 2023. The completion rate for the survey across the Trust was 60% and 25% for BME staff members

National data for this year's submission is currently not available as a comparison for the ESR data metrics (1-4 and 9). However, this report does show average Specialist Acute comparisons and BSol ICS comparisons for the indicators 5-8 linked to the National staff survey 2023.

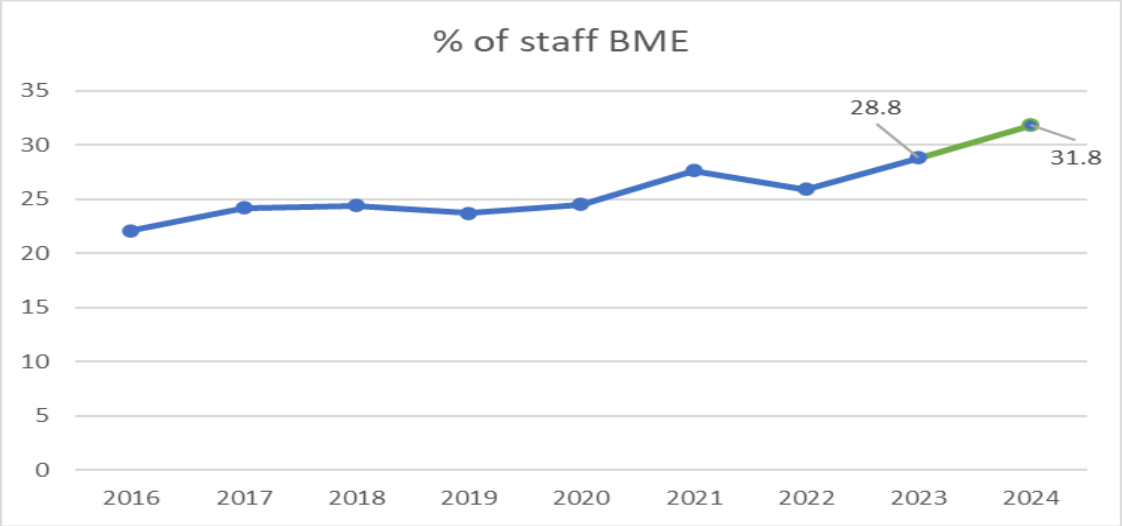
Table 1: Overview of WRES indicators

Further information on the indicators

Across the 10 indicators there has been a decline in six out of the 10 indicators focussed around how staff are treated, career progression and Board diversity.

There has been an increase in three indicators for % BME staff, training and recruitment.

WRES indicator 1

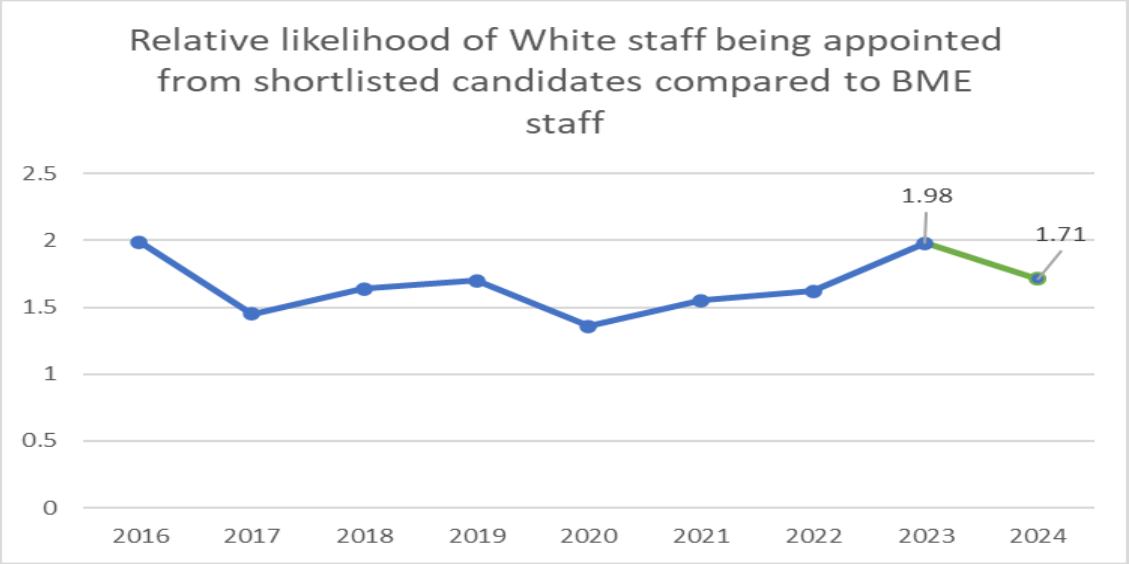


Percentage of staff members from a BME background

- There has been a positive increase in staff members from a BME background at the Trust from 28.8% to 31.8%.
- For non-clinical roles, the largest number of BME staff members is at Band 2 with 35 staff members
- Compared to clinical roles were there are 115 staff members at Band 5 and then at Band 6, it is 72 staff members.

More analysis will be undertaken on this data as part of the Inclusive recruitment work, highlighted in the action plan below

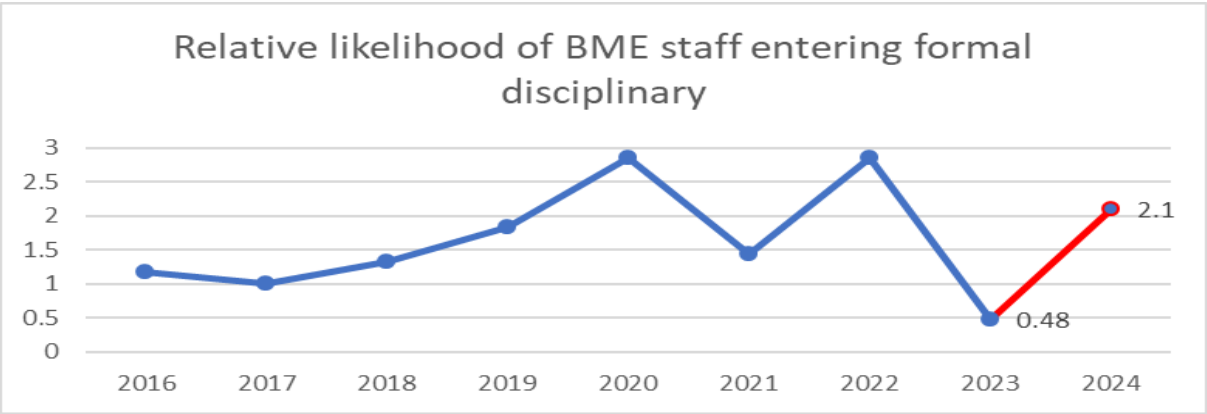
WRES indicator 2



The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

- The National WRES 2023 report (published in March 2024) noted that for 76% of NHS trusts, white applicants were significantly more likely than BME applicants to be appointed from shortlisting, an increase from 71% last year
- The report also stated that recruitment from interview metric remains the most difficult to change with the national likelihood ratio remaining broadly unchanged since the inception of the WRES in 2015/16.
- The ROH has seen an improvement from 1.98 to 1.71 which is positive however taking in account the ethnic diversity across the Birmingham areas, there needs to be more improvements achieved on this indicator
- The Trust is positive that the actions on the WRES action plan shown below will enable further progress to be made.
- As part of the inclusive recruitment work, initial sessions for nursing managers have been run jointly by HR and OD and Inclusion team, with support from the Deputy Chief Nurse. These sessions will be further rolled out across the Trust in 2025 (see action plan below).

WRES indicator 3



The relative likelihood of BME staff entering the formal disciplinary process compared to white staff

- Again, noting the National WRES 2023 report, in 46% of NHS trusts BME staff were over 1.25 times more likely than white staff to enter the formal disciplinary process, a modest improvement from 47% last year. The London region performed persistently worst on this indicator, although improvements have been made over the past two years.

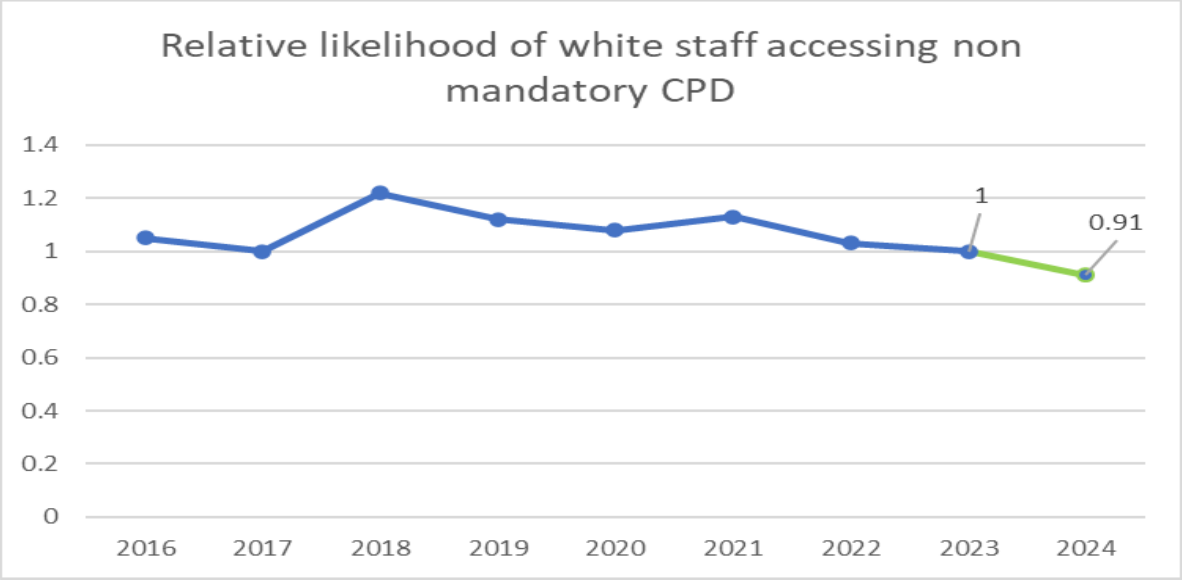
- For 2024, the ROH metric has declined from 2023 at 0.48 to 2.1. This data is from a total of 12 cases across the 12-month period

- Case reviews are undertaken for all disciplinary cases to evaluate proportionality and consistency

- The change from 0.48 to 2.1 may be partly attributed to the increase in cases associated with medical staff which is a more ethnically diverse workforce than other staff groups

- Case assessment panels are to be piloted in 2025 which may help to remove impartiality in the assessment of whether a member of staff enters a formal disciplinary process.

WRES indicator 4



The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

There has been no significant changes to the indicator and work on new appraisal approach will further enhance staff members having equal access to career conversations and training opportunities.

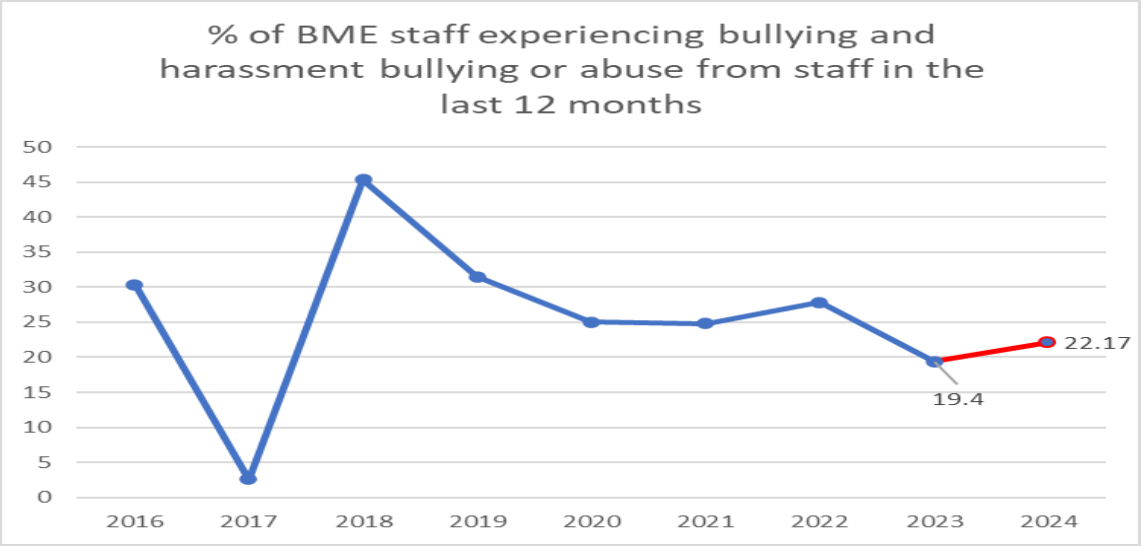
Statistics from the apprenticeship programme show that 35% of learner on the programme are from a BME background and personal development courses continue to be offered to all staff members regardless of staff group. All staff members are also able to attend staff network and other development opportunities.

WRES Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients in the last 12 months

- It is positive to see a further reduction in this indicator to 11.4% which is lower than the figure for white staff at 17.99%
- This is also lower than the average for Specialist Acute Trusts at 18.54%
- This improvement is reflective of the work undertaken, in part by the Nursing Directorate, to support staff against any issues from patients.

WRES indicator 6



Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

- There has been a decline in this figure at the Trust from 19.4% to 22.17%. This is also a decline in the figure than for white staff which is 20.99%.
- It is however more positive than the average figures across Specialist Acute Trust which is 24.23%.

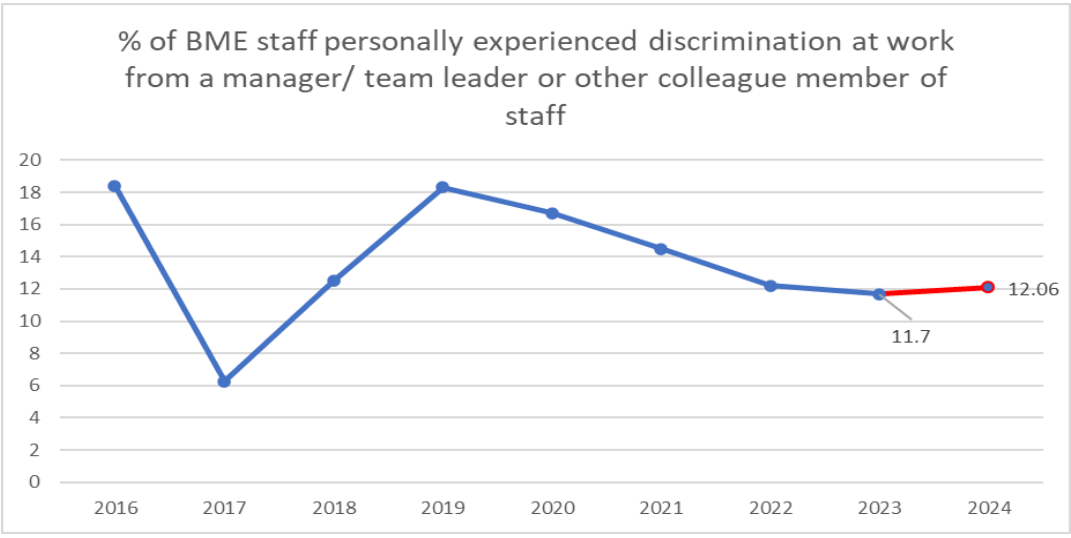
Work will continue to ensure there can be improvements made to this indicator. Examples of this work include the Freedom to Speak Up champions and the Sexual safety charter. This will be supported by work being run within the BSol ICS and the ICS EDI Leads initiatives.

WRES indicator 7

Percentage of BME staff believing the trust provides equal opportunities for career progression or promotion

- There has again been a decline in this indicator to 45.54% (compared to white staff at 62.01%). This is also a slightly lower than the average across Specialist Acute Trusts which is 46.44%.
- It is recognised at the Trust and across BSol ICS that work needs to be concentrated on career progression. An example of this is the ICS coaching and mentoring programme and the ROH is supporting this project team.

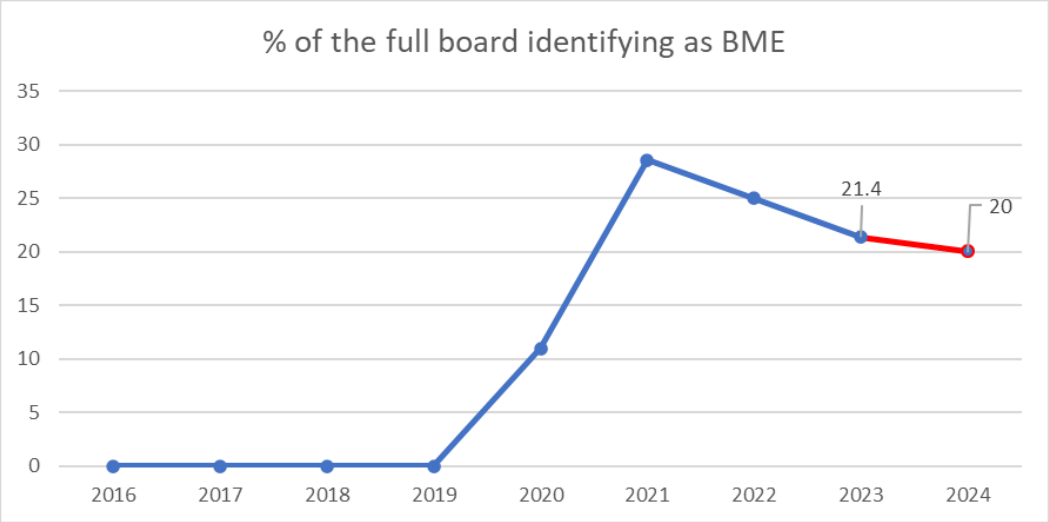
WRES indicator 8



Percentage of BME staff personally experienced discrimination at work from a manager /team leader or other colleague member of staff

- There has been a slight decline in this indicator at 12.06% from 11.72% in the previous year
- This is still more positive than the average of 15.32% across Specialist acute Trusts.
- Two key initiatives to support improvements in this area include the civility and respect work as part of the People Promise programme and also a new suite of management programmes (these will support the WRES action plan)

WRES indicator 9



Percentage of the full board identifying as BME

- There has been a slight decline from 21.4% to 20% for full board members.
- This figure will change in the next reporting year due to recent recruitment onto Trust Board. It should be noted that this figure is still be lower than the average figure across BSol ICS for 2022/2023 which is 29%.

Update on projects

The WRES action plan and approach forms part of the work completed under the Multi Minority Ethnicity staff network and Equality and Diversity network. The key actions achieved over the last twelve months have included:

- Listening sessions to hear the views of different diverse groups where staff have feedback on key concerns around career progression which has helped to inform the WRES actions action
- Celebration of awareness events such as Black History Month
- Hosting the Caribbean Nurses and Midwife association which focussed on the ‘Future of Global workforce’

- Representation at regional events including the REACH super network to ensure networking and support is available for staff
- Support on 10k Black Intern programme with the Trust hosting our third intern
- Continued support for the Birmingham and Lewisham African and Caribbean Health and Inequalities Review (BLACHIR) project group
- Work to support the Race Equality code has started with an initial session for Trust Board members
- New bank of inclusive questions to be added to recruitment
- Enhanced network of Freedom to Speak up champions

***Please note that some of the work listed above is ongoing and more detail on timelines is shown in the action plan at the end of this report**

Comparison data for WRES Indicators

*Text highlighted shows the best score across the different NHS Trusts

() indicators soccer for other staff

WRES Indicator	Indicator Definition	Royal National Orthopaedic	Robert Jones and Agnes Hunt	Liverpool and Heart	BSol ICB	Birmingham Women and Children's	Birmingham Community Health Trust	Birmingham Mental Health Trust	UHB	ROH2024	ROH Change since 2023
5	% of BME staff experiencing harassment, bullying or abuse from patients or public in last 12 months	19.46 (19.73)	17.46 (13.87)	19.70 (11.69)	10.07 (9.95)	18.75 (23.57)	22.60 (21.37)	34.99 (29.0)	23.63 (24.94)	11.44 (17.99)	
6	% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	24.62 (22.13)	30.16 (19.59)	15.67 (16.37)	28.99 (26.42)	22.83 (21.48)	23.70 (19.31)	23.36 (21.99)	29.66 (27.03)	22.17 (20.9)	
7	% of BME staff believing the trust provides equal opportunities for career progression or promotion	45.65 (60.55)	41.27 (61.50)	58.67 (68.19)	32.37 (51.66)	45.34 (62.0)	44.26 (55.93)	52.05 (56.39)	43.23 (52.29)	45.54 (62.01)	
8	% of BME staff personally experienced discrimination at work from a manager /team leader or other colleague member of staff	15.48 (8.74)	20.97 (4.58)	10.36 (4.04)	13.57 (9.95)	15.00 (6.15)	15.26 (6.15)	12.26 (8.78)	17.83 (9.30)	12.06 (8.04)	

ROH WRES action plan 2024 - 2025

This plan gives an overview of the key areas of work that will be undertaken to support the WRES indicators (see table below with list of indicators). All actions were set in October 2024 and are aligned to the ROH Inclusion Action plan under the six high impact areas.

Indicator	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments and Updates
	Impact area: Ambassadors					
Indicator 7 Career	Embed an effective Mentoring approach to offer staff from diverse backgrounds support particularly around career development	• Continue work to embed a mentoring approach for colleagues which will be extended to other colleagues • BSOL Coaching and Mentoring Programme	Launch December 2024 Training January 2025		OD and Inclusion Team	Project restarted due to team recruitment completed **Impact** Improvement (to be defined at start of programme) in progression of staff members who are part of the Mentoring programme

	Impact area: Culture					
Indicator 2 Recruitment	Inclusive approach to attracting, recruiting, and retaining staff	**Inclusive recruitment project** • Review options for a diverse interview panel model (Dec 2024) • Guidance for interview panels • Feedback survey from candidates • Internal interview development sessions • Upskilling managers in inclusive recruitment • Work will also be incorporated into future Trust Board recruitment practices • Review data set for shortlisted to appointment to identify of key areas of focus • Work to be underpinned by Restorative Just Learning Culture (RJLC) project including workforce policies	April 2025		Workforce and OD Team Support from the MMEG and other staff networks	Inclusive recruitment training sessions have taken place for nursing colleague and will be extended to other staffing groups with work to start in January 2025 People Promise Manager will be supporting work on Civility and Respect **Impact** 10% improvement in WRES indicator 2 (move to 1.5)

Indicators 5,6,8 Treatment of staff	Launch 'You OK' campaign	Initiative to link with Freedom to Speak up work to support safe conversations	January 2025		MMEG Network OD and Inclusion team Comms Team	**Impact** 10% improvement in WRES indicator 5,6,8
	Impact area: Staff and patient voice					
Indicators 5,6,8 Treatment of staff	Build support for staff networks to include staff, patients, and senior leaders	Interventions to include • Recruitment of MMEG Chair and Deputy Chair • Continue to set up listening session for staff groups supported by Executive sponsors • Support colleagues and managers to ensure individuals can attend networks	December 2024 March 2025		Clare Mair OD and Inclusion Manager MMEG network	Network chair meetings to continue with continuous improvement format **Impact** 20% (on average) attendance at MMEG network meetings
Indicator 1 % staff	Improvement of declaration rates	• With support from staff networks, encourage staff to declare diversity information. • Diversity declaration event at Wellbeing week in line with ICS project			Clare Mair ESR team MMEG and Staff networks	**Impact** 25% improvement in unknown status on ESR diversity data

	Outcome	Action	Target date			Comments
	Impact area: **Education**					
Indicator 4,7 Training and career	Review of new Appraisal approach	• Upskilling managers to adopt new approach with teams • Implementation recommendations from review • To include enhanced career development conversation training with EDI module • Skills development to include civility and respect element	April 2025		Clare Mair	**Impact** 95% completion of appraisal conversations for BME staff with confirmed career conversation undertaken
Indicator 4, 5,6,8 Training and Treatment of staff	Implement education programmes and tools to ensure staff at all levels have an awareness and understanding of EDI topics	Key work to include: • Review Anti-Racist Workshop with launch of ROH Anti Racist statement • Continue to embed EPIC approach • Active Bystander training • Anti racism statement	Feb 2025 May 2025 March 2025 Dec 2025		Michael Hirons Nurse Directorate	Carried forward - Nursing Directorate is leading on Active Bystander training which is due to commence by March 2025 **Impact** 10% in Indicators 5,6 and 8

		• Update Mandatory training slides to support work on RACE Equality Code work				
Indicator 5,6,8 Treatment (and engagement of staff)	Inclusion calendar updated and used to inform network sessions	• Calendar communicated annually to show key dates recognised in celebrating Diversity, Belonging and Inclusion • Action plan in place to highlight specific dates	January 2025		OD and Inclusion administrator Network Chairs	**Impact** 5% improvement of overall engagement score on Staff survey for BME staff
	Impact area: Best practice					
Indicator 1,2,3,4 % staff, recruitment, disciplinary and training General across all indicators	Establishment of links with regional and national NHS colleagues to share best practice	• Working with the organisations above in the partners' section • Leading on regional and national projects where appropriate linked to People Promise • Support on Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR)	April 2024		Workforce and OD team	Workforce and OD colleagues link in with regional colleagues to work on joint projects, including Black History Month and East & Southeast Asian Heritage month **Impact** Good level of engagement from ROH staff as defined on each project Feedback

	Outcome	Action	Target date			Comments
	Impact area: Data and metrics					
Indicator 5,6,8 Treatment of staff	Developing further NHS compliance data in user friendly format	• Ensure NHS WRES metrics and analysis is made visible and engaging for all staff • Reports show clear progress and future areas of focus	November 2024		OD and Inclusion team Comms team MMEG network	Work undertaken with support from MMEG network Communication to be in line with reports being published at the end of October 2024 **Impact** ROH Staff understand and engage with WRES work and 10% increase in attendance at MMEG network
All indicators	Embedded approach to Equality impact Assessments (EQIA) across all departments.	Recommended work to include documentation, guidance, monitoring, and training is embedded and understood within the Trust Complete quality review on new approach	January 2024 July 2024		OD and Inclusion Team Governance Team	**Impact** Improvement in quality of completed EQIA for defined time period

All indicators	Race Equality Code implementation (ICS project)	• Diagnostic review • Senior Leader sessions • Analysis of Trust information and Action plan • Sharing of information on the Race code across the Trust to ensure all staff are involved	March 2025		OD and Inclusion Team Trust Board External provider	This project is being run with other Trusts across the ICS, supporting by RSM UK consulting **Impact** 10% improvements across Indicators 5-8 in the staff survey

This work will also be supported by the NHS EDI Improvement plan which includes six High Impact Actions

WRES Indicators

Indicator	Descriptor
1	Percentage of staff members from a BME background
2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants
3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff
5	Percentage of staff experiencing harassment, bullying or abuse from patients in the last 12 months
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
7	Percentage of BME staff believing the trust provides equal opportunities for career progression or promotion
8	Percentage of BME staff personally experienced discrimination at work from a manager /team leader or other colleague member of staff
9	Percentage of the full board identifying as BME

REPORT REF:

TRUST BOARD

DOCUMENT TITLE:	**CQC In-patient survey 2023**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Nicola Brockie, Executive Chief Nurse & Sharon Latham, Head of Patient Experience**
PRESENTED BY:	**Nicola Brockie, Executive Chief Nurse**
DATE OF MEETING:	**6 November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The purpose of this paper is to provide an overview of the CQC In-patient survey results for 2023 and provide assurance of actions taken to address areas of improvement. In the 2023, survey 162,492 people nationally were invited to take part, the national response rate was 41.7% (adjusted). However, the Trust response rate for 2023 improved from 57% in the previous year to 60%.

National results show that patient care has deteriorated since 2020. However, the Trust has continued to make improvements and is ranked 9th in the '***Much better than expected***' category for the second consecutive year.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Overview of the in-patient services: 9.0 /10.0 'Much better than expected'. • Trust ranked 9th in 'Much better than expected' results. • Our strategic objective: Care. Outlined the intention to achieve 85% by 2028. This years results are: 84.6%. Work continues to achieve the target.	• Three areas identified requiring improvement. Action plan included.

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: note and accept.

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	**x**
Clinical	**x**	Equality and Diversity	**x**	Workforce	
Inequalities		Integrated care		Continuous Improvement	**x**
Comments:					

ALIGNMENT TO TRUST STRATEGY, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Trust Strategy 2023-2024, CQC In-patient CQC survey 2022.
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
None specifically
PREVIOUS CONSIDERATION:
CQC In-patient CQC survey 2022.

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

CQC In-Patient Survey results 2023

CQC In-patient survey - Background

- The CQC In-Patient Survey was established in 2002 to capture the lived experiences of our patients.
- Nationally, 162,492 people were invited to take part in the In-Patient Survey in 2023. Completed responses were received from 63,573 patients, giving an adjusted national response rate of 41.7%. The Trust response rate for 2023 improved from 57% in the previous year to **60%.**
- National results show that patient care has deteriorated since 2020. However, the Trust has made improvements and continues to perform '**Much better than expected**' for the second consecutive year.
- The results show that in three questions, the Trust scored lower than last year. However, the decrease was 1% or less, and despite this still shows the Trust is scoring above the national average.
- It should be noted that the Trust's programme of continuous improvement has already actioned the majority of concerns raised in 2023 which should be reflected in the 2024 survey results.
- This year's CQC in-patient survey will commence in November 2024.

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

1250 invited to take part

734 completed

4% urgent/emergency admission

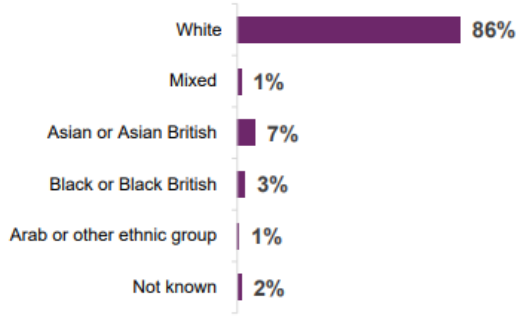
96% planned admission

60% response rate

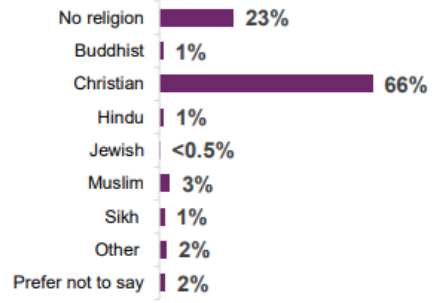
42% average response rate for all trusts

57% response rate for your trust last year

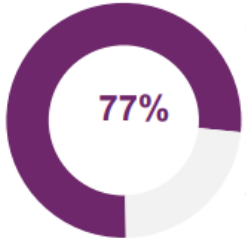
Ethnicity



Religion



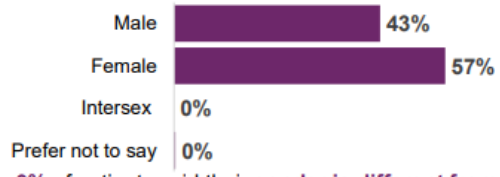
Long-term conditions



of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

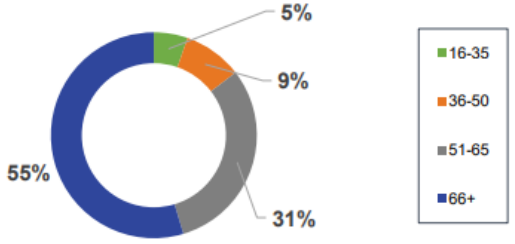
Sex

At birth were you assigned as…



0% of patients said their **gender is different from the sex they were registered with at birth.**

Age



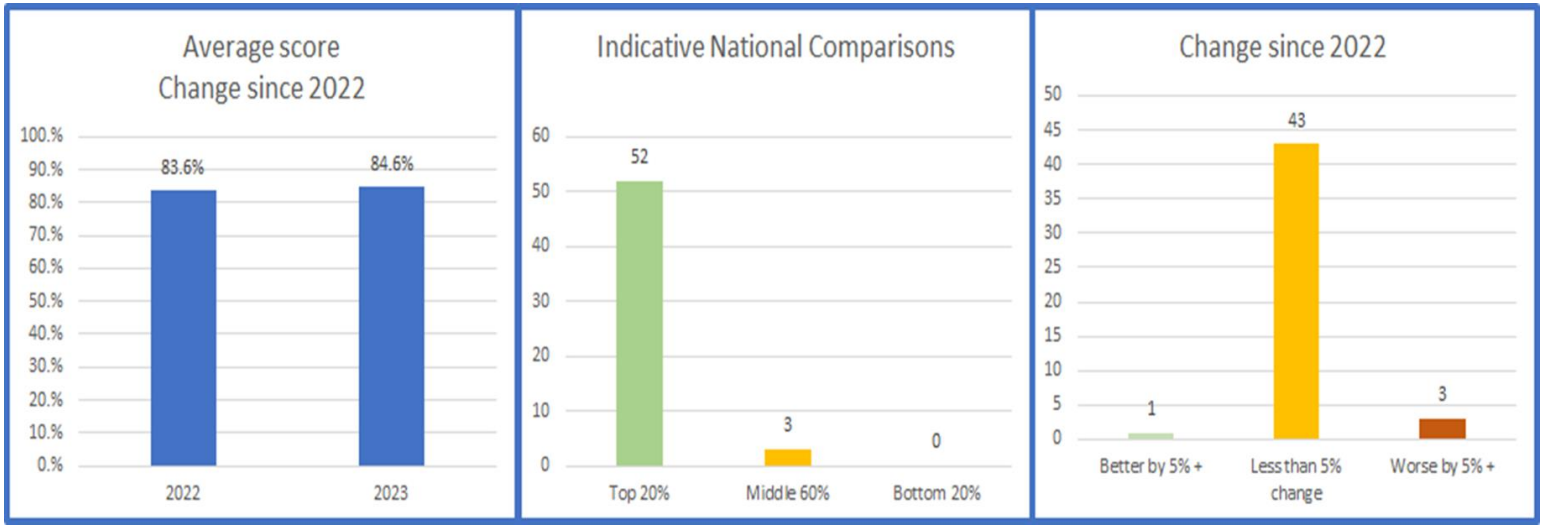
Demographic

- Overall, the demographics remain consistent with those from 2023, with only a slight change in the response rate from ethnicities with no significant fluctuations.

OUR STRATEGIC OBJECTIVES: CARE

Deliver outstanding care that is safe, seamless and patient-centred

Where are we now	Where will we be by 2028
Inpatient survey score: 78% positive	85% positive



Benchmarking

Trusts achieving 'much better than expected' results

Nine trusts were classed as 'much better than expected' in 2023.

	Historic results			Overall results				Core service		Overall CQC rating
	2020	2021	2022	2023	Most Positive (%)	Middle (%)[d]	Most Negative (%)	Medical care	Surgical	
Trust average					65	22	13			
Liverpool Heart and Chest Hospital NHS Foundation Trust	B	MB	MB	MB	77	16	7	MB	B	O
The Christie NHS Foundation Trust	MB	MB	MB	MB	77	17	6	MB	B	G
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	MB	MB	77	17	6	MB	N/A	G
The Walton Centre NHS Foundation Trust	B	B	B	MB	74	18	8	MB	S	O
Royal Papworth Hospital NHS Foundation Trust	MB	MB	MB	MB	78	16	6	MB	B	O
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	MB	MB	79	14	7	B	MB	G
Queen Victoria Hospital NHS Foundation Trust	MB	MB	MB	MB	84	11	5	MB	MB	G
The Royal Marsden NHS Foundation Trust	MB	MB	MB	MB	78	15	7	MB	MB	O
The Royal Orthopaedic Hospital NHS Foundation Trust	S	MB	MB	MB	74	18	8	N/A	B	G

Key: Trust performance: About the same (**S**); Better (**B**); Much better (**MB**)

CQC rating: Inadequate (**I**); Requires Improvement (**RI**); Good (**G**); Outstanding (**O**)

How did we perform?

Overall view of inpatient services
9.0 / 10.0
Much better than expected

Admission to hospital
8.0 / 10.0
Much better than expected

Doctors
9.3 / 10.0
Much better than expected

Nurses
9.0/10.0
Better than expected

Care and treatment
8.7 / 10.0
Better than expected

Operations and procedures
8.2 /10.0
Better than expected

Leaving hospital
7.7 / 10.0
Much better than expected

Feedback on care
5.4 /10.0
Better than expected

Kindness and compassion
9.4 / 10.0
Somewhat better than expected

Respect and dignity
9.4 /10.0
About the same

Areas requiring improvement

Question	R.O.H Score in 2022	R.O.H Score in 2023	National Average 2023
Q11. *If you brought medication with you to hospital were you able to take it when you needed to?*	8.8	8.1	8.0
Q16. *During your period in hospital, did you get enough to drink?*	9.9	9.6	9.4
Q41. 4 *Thinking about any medication you were given to take home were you given any of the following? Written Information about your medicine.*	6.1	5.1	4.3

CQC In Patient Survey 2023 Action plan

Survey issue and Score	Action	Responsibility	Timescale	Progress
Q11. If you brought medication with you to hospital were you able to take it when you needed to? **SCORE OUT OF 10 -8.1**	• Pharmacy are piloting a service in POAC to ensure patients medicines including over the counter and herbal medicines are discussed and captured prior to coming in for surgery. • OTC medications to be accurately prescribed on PICs.	Pharmacy Team: Anisa Jabeen Sulthana Begum	December 2024	Complete
Q16. During your period in hospital, did you get enough to drink? **SCORE OUT OF 10 - 9.6**	• Volunteers to be recruited to provide additional support to ward staff in provision of drinks during the day. • Matron and ward manager to ensure patients have access to water and regular drinks rounds.	Patient Experience Sharon Latham Mirranda Taylor & HON Div 1. Karen Hughes, Matron for wards Laura Clinton	December 2024	Recruitment complete and placements now commencing
Q41.4 Thinking about any medication you were given to take home were you given any of the following? Written information about your medicine **SCORE OUT OF 10- 5.1**	• To review discharge leaflets from discharge lounge and update. • Pharmacy to develop a video around TTOs and key points around discharges. • Pharmacy to develop a counselling point crib sheet or equivalent for the ward teams.	Pharmacy Team Anisa Jabeen Sulthana Begum	January 2025	Action planning and implementation ongoing

What we did well.....

This is the cleanest, friendliest and most well organised hospital from all departments that I have come into contact with	My stay at the Royal Orthopaedic was very good. My surgeon is amazing, and everyone is brilliant.	Excellent care on the ward after my operation. Excellent professionalism by a really good hospital. Caring, clean and great clinicians and other staff.
The staff including the volunteers were brilliant	Fantastic hospital, brilliant staff, nurses that paid attention to my needs.	It was a very gratifying experience. I felt included in every aspect of the stay.
The food was always of a decent portion and tasty, I did not have a bad meal at the hospital.	First Class Care from start to finish!	Whenever engaging with a member of staff they were always polite and willing to answer questions.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Top Risks update**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**6 November 2024**

EXECUTIVE SUMMARY:

Following discussions at the September meeting of the Trust Board around the top risks to the organisation, there was agreement that further consideration of the key risks was needed at Committee-level.

The Board was updated on the discussions at the September meetings of the Quality & Safety Committee and the Finance & Performance Committee at the last meeting of the Trust Board.

Since the last update, two more Board committee meetings have been held: Finance & Performance has sat again and Staff Experience & OD Committee has also met. Both Committees received in papers, and excerpt of the Corporate Risk Register and Board Assurance Framework (BAF) which included risks pertinent to the remit of the Committee.

Discussions around risk at the Finance & Performance Committee on 29 October were moved to the front of the main agenda and there was good debate around the information provided. It was agreed, as a result of the 'check and challenge' of the members, that two additional risks be added to the finance & operational elements of the Corporate Risk Register: one around productivity of theatres & the implications of not achieving a higher level of throughput; and another risk around achievement of the financial recovery plan. It was also agreed that the risk around theatre staffing be strengthened to reflect the timescales and impact of any difficulties with recruitment. It was agreed that the residual risk score of Risk 770 (aged theatre estates & plant), be increased to more accurately reflect the significant impact of any failure. Assurance ratings on the BAF risks was also tested and agreed that given the visibility of the work underway to mitigate the risks, the assurance rating was High.

The discussion around the risk register & BAF extract was equally extensive at the Staff Experience & OD Committee meeting and there was good challenge around some of the revised risk scores. The Committee was satisfied that the risks proposed to be those most significant from a workforce point of view were appropriate, although agreed that two new risks be added: an explicit risk around productivity from a workforce perspective; and the risks to the implementation of seven day working.

The Finance & Performance Committee and the Quality & Safety Committee will meet in November and again, discussion of risk features high up the agenda, with the committees being given an opportunity to consider whether the list of risks presented are appropriate and whether scoring and mitigations are adequate.

The Audit Committee will also meet in November and, as outlined at the last meeting, it is proposed that the process for risk management & review be considered again at this meeting, alongside the progress against the recommendations from the 2023/2024 internal audit into the BAF and risk management.

It is proposed for the December meeting of the Trust Board that, given all Committee would then have met, that the discussion around the top organisation risks be reconsidered, informed by the views of the Board committees.

REPORT RECOMMENDATION:

The Board is asked to note the contents of this report and support the plans for further review of risks.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

Comments: [*elaborate on the impact suggested above*]

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

Risk management and BAF processes.

PREVIOUS CONSIDERATION:

October 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Trust Safeguarding Annual Report -2023-2024 for Children and Adults**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nurse (Safeguarding Executive Lead)**
AUTHOR:	**Rebecca Furnival , Senior Named Nurse Safeguarding & Domestic Abuse Lead** **Evelyn O'Kane , Safeguarding Lead Nurse**
DATE OF MEETING:	**6 November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Annual Safeguarding Report for the year April 2023- March 2024 - 'Safeguarding is Everyone's Responsibility'.

Report this year has been drafted by the Senior Named Nurse . It has been shared with the Trusts Safeguarding Committee members in July 2024, to gain feedback and review. All feedback has been incorporated into the attached report.

The report is a requirement under contractual requirement and in line with best practice , also that we are meeting our statutory requirements of the Children's Act (2004), the Care Act (2014) including the NHS England 'Accountability and Assurance Framework' for safeguarding.

There has been an increase in internal safeguarding notifications received from the previous year of 952 to 1122 this year. 597 were adults' concerns and 525 for children.

Internal reporting database system was changed to the new system phase one of Aurora (cloud based system), in December 2023. This system when fully completed with allow the team to provide data; that is required to be provided both internally and externally. Also allow the team to analyse the data ,and record information more securely.

The report demonstrates the Trust ensures that practice in relation to safeguarding adult, children and young people is person centred and outcome focussed, we work collaboratively with our partner agencies to prevent abuse and neglect. Setting out the priorities for 2024-2025 on page 30 for adults and children for the Trust that will be focused on.

The report once approved by CQ+S Committee will be shared with the communications department for
Then uploaded onto the Trust internet and intranet site so it is accessible to staff and the public as required.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Support provided by the Board the development of the team with three new starters , these include safeguarding nurses , named nurse and administrator.	• Training compliance with mandatory safeguarding training. • The safeguarding and vulnerabilities internal reporting system Aurora has yet to be finalised.

• Patient voice and experience being evidenced as part of the safeguarding care provided. To ensure the voice of the adults, young people and children is heard. • Recognition by the local boards in terms of the Domestic Abuse care pathway and resources for patients and staff. • Engagement from staff in events, including roadshows , champions training. • Teams organisational , operational advice support and input provided over the year. • Local Partnership working with the ICB and the Adult, Board and Children's partnership. • The Safeguarding Team provide a safeguarding quality report which is reviewed at Safeguarding Committee. The quality report aims to provide a Trust-wide overview and assurance relating to bi-monthly safeguarding activity at the Trust. • Key areas of safeguarding adults and children were audited to gain assurance against key safeguarding documents and standards of practice.	• The safeguarding team have yet to source a professional to provide restorative supervision. • Named Doctor for children replacement commencing in post June 2024.

REPORT RECOMMENDATION:

The Board is asked to:
To accept and agree to publication on the Trust website.

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	X	Equality and Diversity		Workforce	
Inequalities		Integrated Care		Continuous Improvement	
Comments:					

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

Care	x	**Community**	
Expertise		**Services**	x
People	x	**Collaboration**	

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

National Safeguarding framework

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

Protect people from harm, Be there across the life course

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

None

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

Annual report FY22/23,

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT 2023-2024

SG

Foreword

The Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements in 2023-2024.

This report provides the Trust and our partners with an overview of how we have fulfilled our safeguarding statutory requirements, our contributions across Birmingham and surrounding areas to the Safeguarding Children Partnerships and Adult Boards arrangements and our collaboration with system colleagues.

We continue to make good progress in relation to our 7 safeguarding priorities as set out in our Trust in 2021-2025. Our focus is always to work in partnership to make a difference the lives of our service users, to promote autonomy, inclusion, and ultimately better health outcomes.

Safeguarding is complex and challenging and our plans for the year ahead are achievable and underpinned by the Royal Orthopaedic Hospitals Core values Respect, Compassion, Excellence, Openness, Pride, and Innovation.

Safeguarding Annual Report 2023-2024

Introduction

This annual safeguarding report for The Royal Orthopaedic Hospital NHS Foundation Trust includes both children and adult safeguarding and covers the period from 1st April 2023 to 31st March 2024. The report aims to provide an insight into safeguarding context at The Royal Orthopaedic Hospital (ROH) whilst providing assurance that we are meeting statutory responsibilities for safeguarding.

2023-2024 has seen significant changes within the safeguarding team at ROH. We welcomed new starters in the following roles:

- Named Nurse for children, young people, and adults.
- Two Safeguarding Nurses (one new post)
- Safeguarding Administrator (New Post)

At the time of writing this report our previous Named Doctor for children resigned and a new Named Doctor for children and adults was sourced and due to start their role in June 2024.

The Chief Nurse is the executive lead for safeguarding and represents the Trust externally at Birmingham Safeguarding Adults Board development group and Birmingham Safeguarding Children's Partnership Strategic Meetings.

The Safeguarding Lead Nurse provides strategic assurance for safeguarding adults and children and supports the Chief Nurse in the executive role and upwardly reporting. The Safeguarding Lead Nurse also acts as Named Senior Officer for allegations made against staff this role also includes ensuring all duties are fulfilled by the staff within the Trust. The Safeguarding Lead Nurse attends partnership meetings for Children and Adults, BSAB Quality and Performance Meetings. Safeguarding Adults National Network (SANN). BSoL ICB LPS and MCA meeting (SWING), Regional MCA LPS Group. The Safeguarding Lead Nurse ensures that development of appropriate systems including audit, governance of policies and procedures to ensure safe practice in relation to the delivery of an effective safeguarding service across the Trust. The Safeguarding Lead Nurse sets out the Trusts Safeguarding Strategy and sets objectives to encourage continuous improvement compliance with national and local policies. Developing and implementing systems for quality monitoring that are robust, auditable, and effective and raising the awareness of safeguarding making it 'everyone's business.

The Safeguarding Lead and Senior Named Nurse actively contribute to Adult Safeguarding Reviews (SARs), Domestic Homicide Reviews (DHR); and Child Safeguarding Practice Reviews (CSPRs) formally Safeguarding Child Reviews (SCR's), both in terms of scoping and when required Individual Management Reviews.

The Senior Named Nurse for children and adults is the Domestic Abuse Lead for the Trust. Provides the organisation with operational advice, support, and input. Is responsible for reviewing safeguarding training ensuring that the Trust is in line with the Intercollegiate Document (2018). The Senior Named Nurse reviews and implements all internal guidance and policies for safeguarding children, adults, and domestic abuse. Ensures annual audits for safeguarding children, adults, and domestic abuse are completed, and duties disseminated across the team. The Senior Named Nurse is supported by the Named Nurse and Safeguarding Nurses, who provide advice, support, and delivery of training to all staff within the Trust. The Senior Named Nurse attends Birmingham Safeguarding Children's Partnership and Birmingham Safeguarding Adults Board meetings and is a core member of the Exploitation Health Reduction Group, Regional Domestic Abuse Whole Health Project,

Domestic Abuse Strategic Partnership Board, Serious Violence Duty Steering Group and National Named Nurse meetings. The Senior Named Nurse oversees safeguarding supervision across the Trust ensuring that staff receive appropriate regular supervision dependant on their roles.

The Named Nurse and Safeguarding Nurses facilitate safeguarding training sessions across the hospital to ensure that learning, skills set, and knowledge of staff is provided as per statutory and mandatory training requirements. The Named Nurse and Safeguarding Nurses are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes. They provide visible and professional safeguarding leadership for all aspects of safeguarding adults, children, and young people to ensure that day to day advice, support and expertise is available to all staff in the hospital.

The safeguarding administrators provide general assistance and support to the teams daily, including the management of and handling of sensitive, emotive, and confidential information.

Local Partnership Arrangements

The Royal Orthopaedic Hospitals safeguarding team contribute to the local Safeguarding Partnership/Boards arrangements representing the Trust on a range of groups and committees.

- Birmingham Safeguarding Adults Board (BSAB)
- Safeguarding Children's Partnership (BSCP)
- Birmingham and Solihull Integrated Care Board (BSoL ICB)

In 2023 BSOL ICB Designate Nurse for Safeguarding completed a safeguarding assurance visit to our Trust. The formal report and feedback shared which was positive and no significant learning or actions identified.

Birmingham Safeguarding Adults Board (BSAB)

The Trust is represented on Birmingham Safeguarding Adults Board (BSAB) by the Chief Nurse and Safeguarding Lead Nurse who ensures the priorities of the Board are reflected in the Trust safeguarding adult's agenda.

BSAB "*Our ambitions and priorities the Strategy have been developed by our citizens and our partner organisations, with a key focus on preventative interventions that minimise the risk of abuse and neglect*". BSAB plan is based around four key priorities, and to ensure that, wherever possible, safeguarding responsibilities across the city are delivered in a way that empowers individuals and communities, that supports defensible decision making and that continues to have 'Making Safeguarding Personal' (MSP) at its heart.

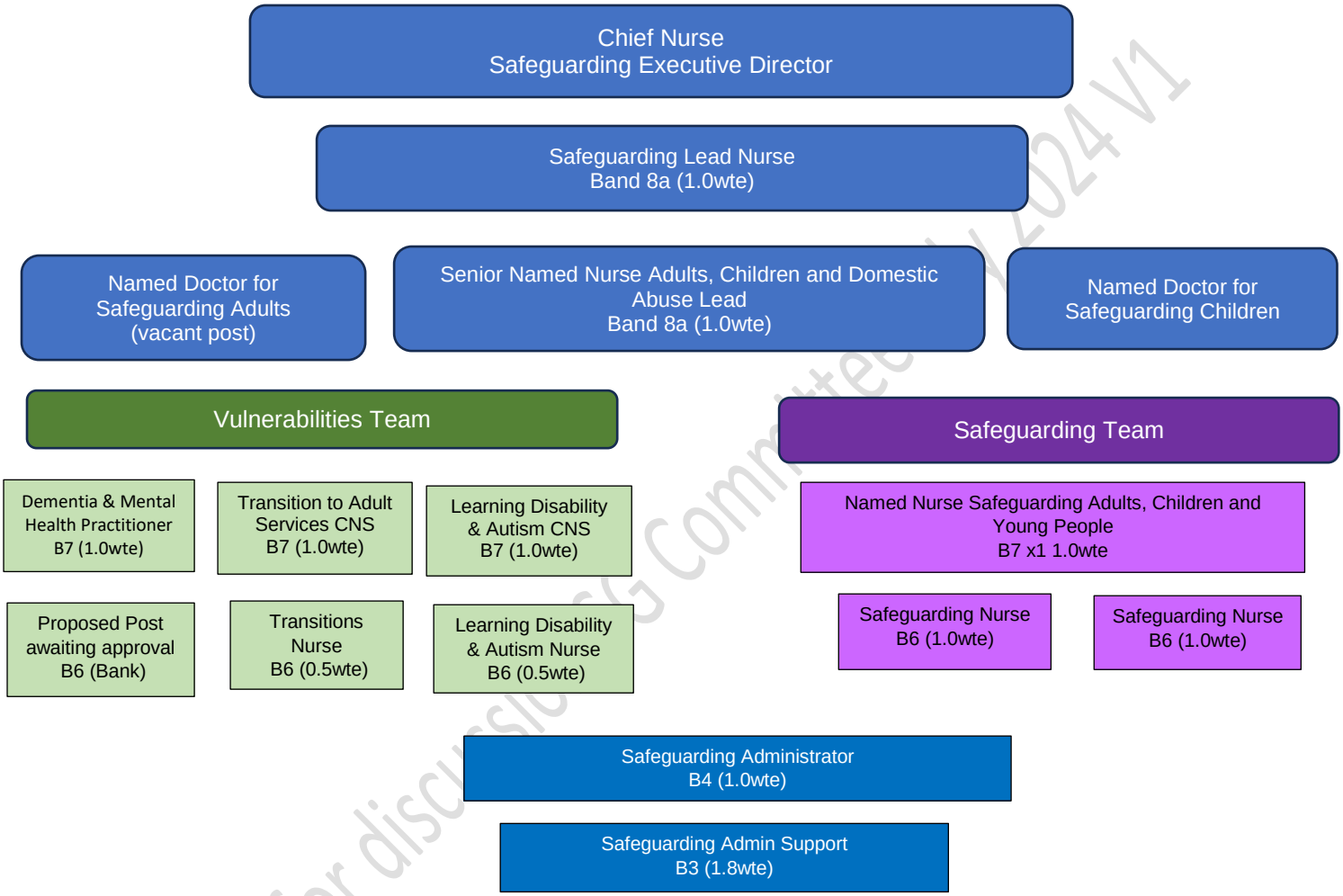
Birmingham Safeguarding Children's Partnership (BSCP)

The BSCP is led by the three statutory partners (Birmingham Council, Birmingham, and Solihull integrated Care Board (BSOL ICB) and West Midlands Police. The partnership enables local organisations and agencies to work together to safeguard and protect children.

The Trust is represented at the Birmingham Safeguarding Children's Partnership by the Chief Nurse, Safeguarding Lead and Senior Named Nurse.

Birmingham Children's Trust visions and Values are to build a Trust that provides excellent social work and family support for the city's most vulnerable children, young people, and families.

At the Royal Orthopaedic Hospital, the Safeguarding Team also includes the Vulnerabilities Team. Although, our team work closely together ensuring health inequalities and risks of harm are reduced we all have distinctive roles within the organisation which enhances patient care and provides strategic assurance.



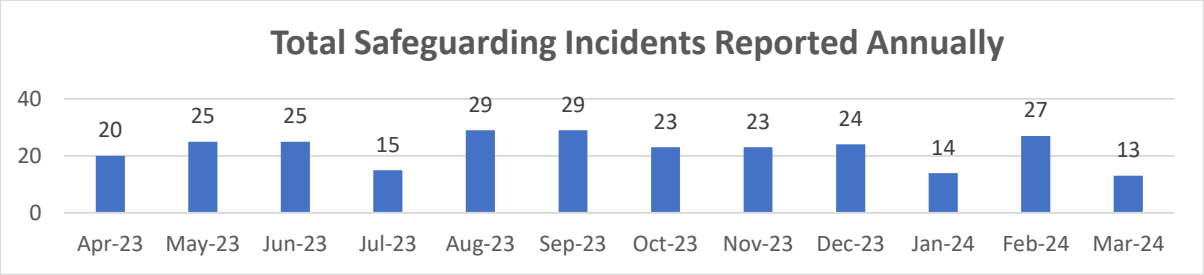
Safeguarding Governance and Partnership Working

The Royal Orthopaedic Hospital is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act (2004), the Care Act (2014) and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' (2019). The Trust is statutorily required to maintain certain posts and roles within safeguarding teams.

The Trust Safeguarding Committee is attended by ward and departmental managers and senior leaders for the Trust whose role is to offer reporting, scrutiny, challenge, and cascade

learning to their areas. The Safeguarding Team provide a monthly safeguarding quality report which is reviewed at Safeguarding Committee. The quality report aims to provide a Trust-wide overview and assurance relating to bi-monthly safeguarding activity at The Royal Orthopaedic Hospital NHS Trust (ROH).

Safeguarding incidents in the Trust are monitored by the safeguarding team. Alerts for safeguarding incidents are generated via the Trusts electronic reporting system. The majority of incidents are managed at departmental level by the Department Lead however, some are more complex and require additional oversight within the Trusts governance meetings. The incidents are analysed to detect trends and themes and to improve safeguarding within the Trust reporting to Quality and Safety Committee.



The safeguarding and vulnerabilities team risk register is reviewed bi-monthly by the Safeguarding Lead Nurse and the Risk and Policy Officer for the Trust. Each risk is recorded using the risk matrix. The risk register is shared with safeguarding committee members and discussed.

The Trusts intranet page provides staff with safeguarding policies, procedures, and guidance. The intranet is regularly reviewed and updated by the Senior Named Nurse, Safeguarding Lead, and the Communications Team. The Trusts external website provides the public with information in relation to safeguarding and signposts to other support services available in the community. The internal and external sites have been updated this year. All risks on the Safeguarding risk register are in date and reviewed at each committee meeting.

The Safeguarding team are represented and contribute to several Trust internal governance processes including Quality and Safety Group, Nursing Council, Human Resources (HR) liaison meetings, Ward and Departmental Mangers meeting and Children and Young Persons Board.

Achievements and Challenges

ROH safeguarding team can provide assurance on their progression with last year's priorities and continue to influence safeguarding practice from a health perspective within the Trust and as a wider members of partnership meetings, which will be evidenced throughout this report.

To achieve our key priorities an action plan has been developed by the Safeguarding Lead Nurse. The Trusts Safeguarding Committee will monitor, review progress and will report to the Quality and Safety Committee which is a subcommittee of the Trust Board. This will be reviewed and updated quarterly.

Safeguarding priorities for Adults and Children outlined in last years annual report:

To hear the voice of adults, young people and children

- The safeguarding team continued to raise awareness across the Trust regarding the importance of recognising and responding to indicators of neglect following the local Child Safeguarding Practice Review Hakeem. This was achieved through; safeguarding champions day, Birmingham Safeguarding Childrens Partnership (BSCP)Neglect Lead attended and delivered a session to all champions, internal neglect guidance launched in line with the BSCP's neglect procedures, sharing Hakeems story at the Executive Board, Clinical Audit meetings with Clinicians, Safeguarding supervision and the first standalone neglect audit completed in April 2024.
- The safeguarding team completed a documentation audit in February 2024 which reviewed nursing, Allied Health Professionals and Medical Staffs documentation evidencing the child/adults voice being recorded throughout their consultation, admission, or appointments.

Challenges - The findings from the audit highlighted areas of improvement are required in evidencing the child/adult's voice within documentation.

To make safeguarding a priority

- Safeguarding Supervision has been embedded throughout the Trust over the last two years. Safeguarding supervision is delivered face to face monthly, bi-monthly, or quarterly depending on the health practitioner's roles and responsibilities. Generally, supervision is delivered in groups. This year a safeguarding supervision audit was completed by the senior named nurse. The positive feedback 97% of staff would recommend safeguarding supervision to a colleague.
- The safeguarding team have continued to spread awareness across the Trust through the quarterly safeguarding purple paper, which provides all staff with internal, local, national safeguarding updates and training opportunities. Roadshows domestic abuse, adult safeguarding, and neglect.
- All internal safeguarding policies have been reviewed and amended inline with Working Together to Safeguard Child (2023) and Domestic Abuse Act (2021).
- The safeguarding team continue to be a visible presence around the Trust, offering face to face support to high-risk patients and staff, reviewing mental capacity assessments and Deprivation of Liberty Safeguards applications.

Challenges – Over reliance on the safeguarding team to attend ward or departmental areas to have "difficult" conversations with high-risk patients due to time constraints for clinical staff.

To improve awareness and practice

- Core mandatory safeguarding level two and three training has been reviewed and amended in line with local and national changes by the senior named nurse. The training is delivered face to face by a member of the safeguarding team, and it provides group work and DASH training. The training now includes a Child Safeguarding Practice Reviews (CSPR) for child C recommendations adultification and intersectionality. Local CSPRs are discussed such as Hakeem and Arthur. The safeguarding team now deliver additional training on the care certificate training at the Trust.

- Each clinical department/area across the Trust has at least one safeguarding champion. All safeguarding champions receive additional quarterly training delivered by the safeguarding team on champions days. The safeguarding champions days are planned throughout the year and external speakers deliver presentations to enhance learning.
- Currently there are 52 clinical and non-clinical Domestic Abuse Champions across the Trust. All domestic abuse champions are required to attend at least on annual training session delivered by the senior named nurse who is the domestic abuse lead.
- The senior named nurse worked closely with the Trusts communications team towards the end of the year in developing a level 3 safeguarding training booklet that staff could use as guidance following training. The training booklet is due to be finalised and published in 2024.
- The senior named nurse developed safeguarding leaflets to be provided to parents and or carers. The leaflets will assist parents and or carers in understanding internal safeguarding procedures and staff responsibilities around the following subjects: lateral checks, suspected non-accidental injuries, home schooling/ missing in education and children in care. The communications team are currently working on the designs and formatting and the leaflets be finalised in 2024.
- The safeguarding team completed eight out of the ten annual audits this year, the two outstanding audits are Prevent and Person in Position of Trust (PiPoT) which will be completed by the end of 2024. All audits where shared at the safeguarding committee for wider learning.

Challenges – ensuring all local and national safeguarding recommendations are included within training and policies. The pressure on the safeguarding team to deliver mandatory safeguarding training, champions day training and domestic abuse champions training to meet compliance.

Mental Capacity Act (MCA), Deprivation of Liberty Protection Safeguards (DoLS)

- The safeguarding team continue to provide support and advice to clinicians and staff on how to complete mental capacity assessments and best interest meetings.
- The safeguarding team review all mental capacity assessments and DoLS applications.
- The safeguarding team and safeguarding lead nurse have continued to support the Trust to meet its statutory obligations in respect of the implementation of the forthcoming Liberty Protection Safeguards (LPS), despite the government's announcement to postpone implementation.

Challenges – Over reliance on the safeguarding team to arrange and take part in best interest meetings. Staff understanding the importance of evidencing decision making and care/treatment for a person who lacks capacity.

To work in partnership

- The Safeguarding team continued to support the Local Safeguarding Adult and Children Partnerships/Boards, attending subgroups, and participating in child and adult reviews this year.
- The Safeguarding Lead Nurse and Senior Named Nurse are key members at local sub group meetings which include; Domestic Abuse Strategic Partnership

Board, Domestic Abuse Whole Health Project Regional Meeting, Exploitation Health Reduction Group, National Named Nurse Meeting, Birmingham Against Female Genital Mutilation, Birmingham Safeguarding Adults Board Quality and performance Group, Heads of Safeguarding meeting, Safeguarding Adults National Network (SAAN), Midlands MCA/LPS Forum and Provider meeting with the ICB.

- The safeguarding team work closely with external partners to reduce the risk of harm for patients and staff. These would include the Local Authorities, Police, ICB, Education, Primary Care Services, third sector organisations.
- The safeguarding teamwork ibn partnership with Birmingham Women's and Children's Hospital (BWCH) safeguarding team to support staff and patients who work and attend across site.

Challenges – Time constraints in attending internal and external meetings for the safeguarding lead and senior named nurse.

To have a safe and effective reporting workforce

- The safeguarding team provide upward reporting to internal and external boards/partnerships to provide assurance in relation to safeguarding activity and standards of practice.
- Safeguarding Lead and Senior Named Nurse ensured their functions, and services that are contracted to other organisations/business, are discharged having regard to the need to safeguard and promote the welfare of children in line with Section 11(4).
- Key areas of safeguarding adults and children were audited to gain assurance against key safeguarding documents and standards of practice.
- Audit and monitoring of safeguarding practices, policies, training, and compliance.
- Supporting staff to identify, support and refer adults and children at risk of harm, and ensure concerns are reported appropriately.
- The safeguarding team continued to report risks associated with patients and staff and escalate matters of concerns to senior managements (transparency).
- Support from IT in building a safe and effective Safeguarding and Vulnerabilities internal database to assist accurate reporting and internal and external auditing.
- Safeguarding Lead Nurse and safeguarding team to regularly review risk register and update actions to reduce risks.
- Safeguarding team to be provided with regular access to restorative supervision.
- The safeguarding team to access internal and external training opportunities throughout the year which is relevant to their roles within the organisation.

Challenges – Training compliance with mandatory safeguarding training. The safeguarding and vulnerabilities internal reporting system Aurora has yet to be finalised. The safeguarding team have yet to source a professional to provide restorative supervision.

To ensure a focus on Transition from adult services

The safeguarding team continued to work closely with the Transition to Adult Services Clinical Nurse Specialist to improve the safeguarding response to young people recognising their developmental needs.

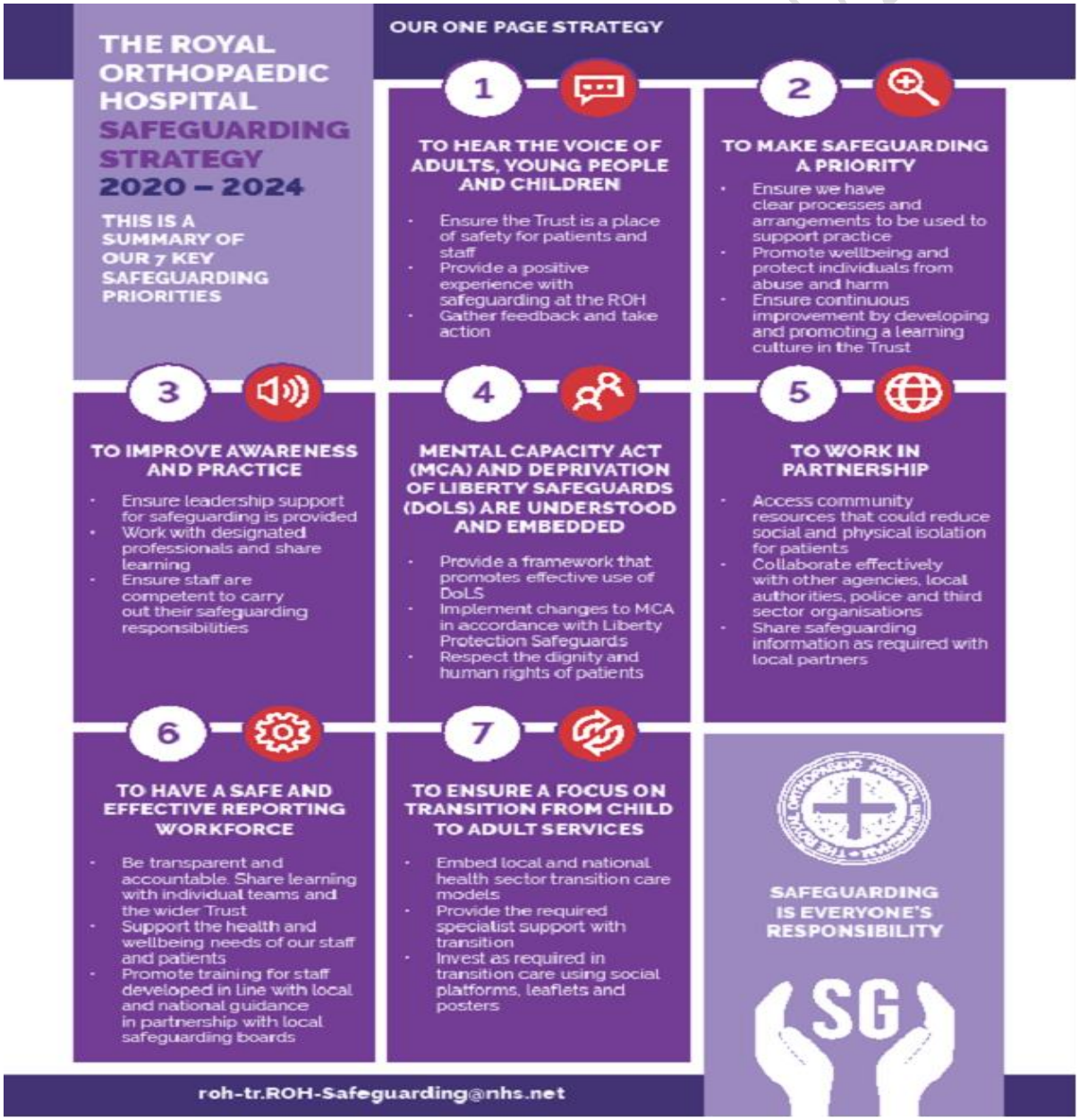
The safeguarding team provided support to the vulnerable young people who access our services in terms of the notable difference between thresholds and criteria when transitioning from children to adult services.

Challenges - Transitions to adult services Clinical Nurse Specialist vacant post from March 2024. Staff ensuring that young people who are seen in adult environments are provided with additional support.

Safeguarding strategy

The Trust Safeguarding strategy is aligned with Trust objectives and values, and those of the local Safeguarding Boards BSAB and the BSCP. The strategy encompasses key legislation, guidance including local and national themes and recommendations.

The staff are provided with the safeguarding strategy on induction to ensure they are aware of their responsibilities and the Trusts responsibilities to protect patients, staff, and visitors from harm.



Safeguarding Training

The Trusts mandatory safeguarding training is reviewed annually to ensure it is in line with local and national safeguarding themes, priorities, and statutory training requirements within Skills for Health Core Skills Training Framework (2018) and Intercollegiate Document for Children RCPCH (2019) and the Adults Intercollegiate NHS England (2018).

The training provides staff with the knowledge and skills to identify a concern, be professionally curious, share information between key professionals and immediately escalate and respond to potential risks or harm to adults, young people and or children.

The level 2 and 3 training was reviewed and amended in September 2023 by the senior named nurse. The level three training now includes a CSPR's for child C recommendations adultification and intersectionality. Local CSPRs are discussed such as Hakeem and Arthur. The safeguarding team now deliver additional safeguarding training on the care certificate training at the Trust.

The level two and three safeguarding training is delivered face to face monthly by members of the safeguarding team.

All staff members are required to receive basic awareness Prevent training which staff access via e-learning. The PREVENT level three WRAP training is delivered by the Safeguarding Lead Nurse who is the PREVENT lead for the Trust.

All staff including students and volunteers receive level one safeguarding basic awareness and PREVENT via the Trust Safeguarding booklet, this is available in electronic and hard copy version.

All named professionals receive Level 4 training which includes the Chief Nurse, Safeguarding Lead Nurse, Senior Safeguarding Named Nurse, Named Nurse, and Named Doctor.

Training compliances are reported externally as a key performance indicator to the ICB as part of contractual arrangements and are requires as assurance against statutory safeguarding requirements for the safeguarding boards/partnerships.

	April 2023	May 2023	June 2023	July 2023	August 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024
Adult Level 2	82.27%	83.12%	84.68%	86.22%	86.18%	85.48%	86.86%	87.26%	88.70%	88.97%	89.03	88.55
Adult Level 3	77.84%	80.15%	83.02%	83.11%	82.06%	83.15%	83.83%	85.37%	86.03%	84.11%	83.99	82.68
Level 4	80%	80%	80%	100%	100%	100%	80%	80%	80%	80%	60	75
Child Level 2	82.18%	82.86%	84.68%	86.14%	86.10%	85.23%	86.70%	87.01%	88.46%	88.89%	88.89	88.40
Child Level 3	78.03%	80.15%	82.82%	83.11%	81.68%	82.80%	83.46%	85.19%	85.54%	83.96%	84.03	82.68
Mental Capacity Act (MCA)	82.44%	83.21%	84.85%	86.39%	86.35%	85.88%	87.11%	87.09%	88.62%	88.97%	89.19	88.55
Deprivation of Liberty Safeguards (DoLS)	82.09%	82.95%	84.68%	86.22%	86.27%	85.63%	86.95%	87.01%	88.54%	88.89%	89.12	88.48
Prevent Awareness	90.14%	89.86%	90.49%	91.24%	91.32%	89.98%	94.48%	89.84%	91.38%	90.33%	89.35	87.70
WRAP 3	82.19%	83.89%	85.68%	87.89%	87.41%	86.15%	85.51%	86.17%	86.25%	85.22%	81.21	82.71

There is an annual review of the Safeguarding Training Needs Analysis. Additionally, the Safeguarding Lead Nurse provides a monthly compliance quarterly report to the Trusts

Assistant Director of Governance and Risk and shared with the ICB, divisional DMB meeting, Quality and Safety meeting and the Trusts Team Brief.

The safeguarding team added additional level three mandatory training sessions in 2023 due to staff compliance. The safeguarding team continue to encourage attendance to the mandatory training to ensure training compliance is met.

The safeguarding team receive positive feedback in relation to mandatory training see below:

- "*Answered all our questions, sharing information, great pace of delivery and very informative".*
- *"Early Help and Right Help Right Time and the booklet provided for reference".*
- *"The group work and the examples/illustrations provided".*
- *"Both presenters were /are excellent "," extremely knowledgeable and speakers' passion from them really shows".*
- *"The group breakouts for discussions and case studies "*
- *"Contextual safeguarding and breast ironing not heard of these before".*

Safeguarding Activity 2023-2024

All NHS agencies and organisations are requested to participate in a statutory review. The input and involvement required will be discussed and agreed if the person is known to the Trust. Generally, this will involve evidence of contribution. Statutory reviews are processes for learning and improvement and all health providers are required to provide and share information relevant to any statutory review process. Safeguarding Adult Reviews (SAR), Child Safeguarding Practice Reviews (CSPRs) and Domestic Homicide Reviews (DHR) form an essential part of the multi-agency partnerships safeguarding strategies.

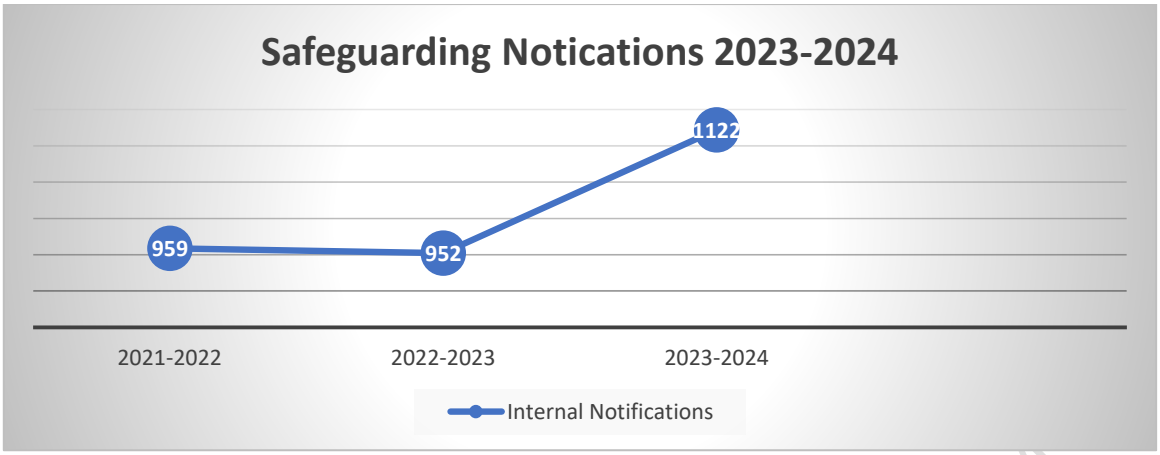
Serious Adult Reviews (SARs), Child Safeguarding Practice Reviews (CSPR's) and Domestic Homicide Reviews (DHR) as outlined within legislation including the Care Act (2014), The Children and Social Work Act (2017) and Domestic Violence, Crime and Victims Act (2004).

The Police, Crime, Sentencing and Courts Act received Royal Ascent in April 2022. The Serious Violence Duty (SVD) requirements came into effect in January 2023, introduced a new statutory duty for specified authorities in a locality to collaborate to prevent and reduce serious violence which includes scoping for Offensive Weapon Homicide Review (OWHR).

Between 2023 and 2024 the Safeguarding team received the following scoping requests:

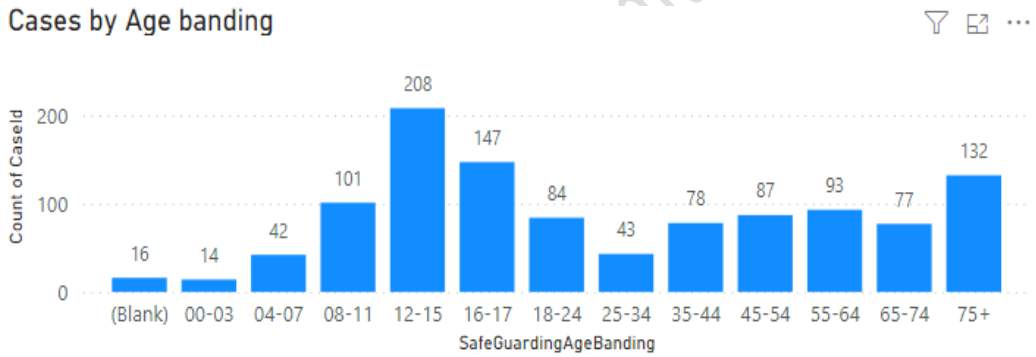
CSPRs	8
SARs	3
DHRs	7
OWHR	7
Missing Persons	2

Between 31st March 2023 – 1st April 2024 the safeguarding team received 1122 internal safeguarding notifications.



Out of the 1122 notifications received a total of 597 Adult safeguarding concerns and 525 safeguarding concerns for children. The internal notifications are forwarded to the safeguarding team's central email and reviewed daily by the safeguarding team.

The largest age range of concerns reported were between 12-15 years old. This further evidences the need for early support during in the period of transitioning between child to adult services.



In February was the highest reporting month with 117 notifications. This could be due to the impact of services during the festive period such as reduction in clinics and temporary closures of services.

The internal notifications provide the safeguarding team with a list of concerns that staff have observed or that has been disclosed including what action has been taken. All high-risk safeguarding concerns that require support from external services such as social care or MARAC are also reported through the Trusts incident reporting system Ulysses.

In December 2023 the previous safeguarding reporting database was changed to a new system called Aurora. This system allows the safeguarding team to analyse data and record information securely.

Adult Safeguarding

The Care Act 2014 emphasises that a personal approach to safeguarding is essential for making our service users feel they are the focus and have control over the safeguarding process. Making Safeguarding Personal has been a driver since the Care Act 2014.

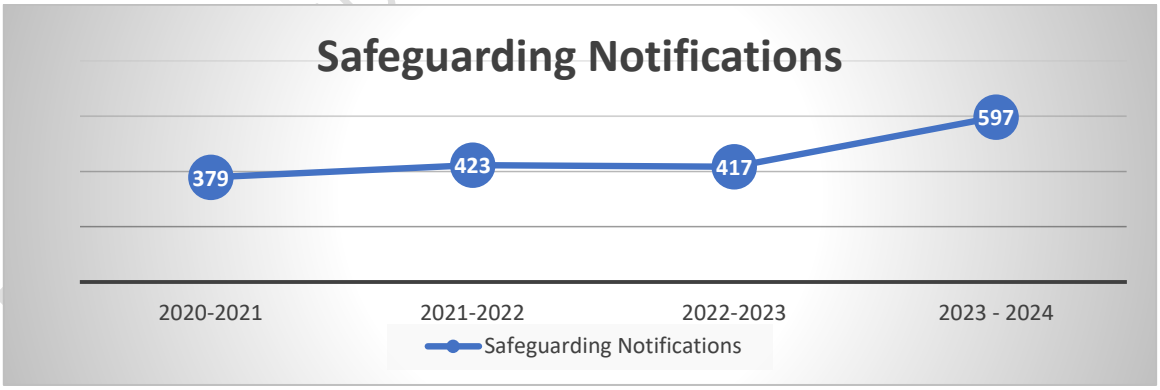
Safeguarding Adults is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system. This requires all staff to recognise their individual responsibility to safeguard and promote the welfare of adults and are equipped to fulfil this task, and the Trust is committed to support them in this. NHS trusts must assure that adult safeguarding is embedded at every level in their organisations.

The Royal Orthopaedic Hospital ensures that practice in relation to safeguarding adults is person centred and outcome focussed, we work collaboratively with our partner agencies to prevent abuse and neglect.

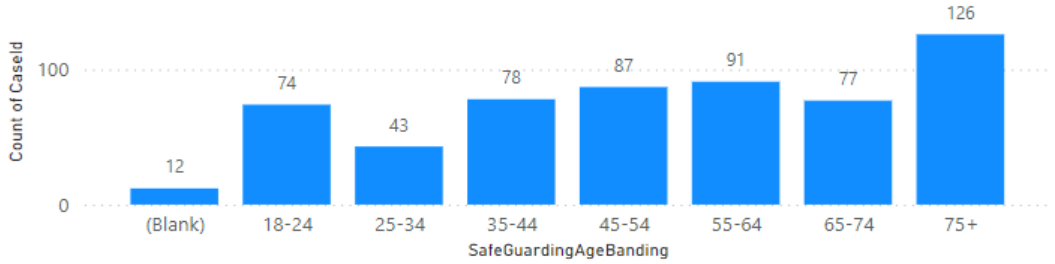
The safeguarding team work together to:

- Ensure the Trust has safeguarding arrangements in place as defined by the Care Act (2014)
- Ensure that the process of protecting adults with care and support needs is integral to all health care provision within the Trust.
- Ensure that 'making safeguarding personal' is central to the way staff respond to people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others.
- Implement national and local guidance to safeguard adults and play an integral part in the Birmingham Safeguarding Adults' Boards subgroups and meetings.

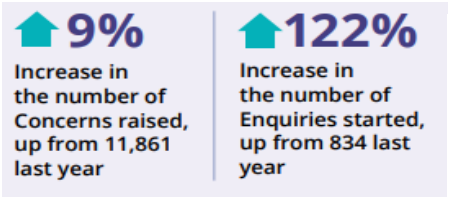
In 2023-2024 the safeguarding team received 597 adult safeguarding notifications. The largest single category for adult safeguarding notifications received this year is for domestic abuse. The second highest notifications were categorised as risks identified. Risks identified generally means that several concerns or risks have been observed, disclosed, or identified.



The largest age cohort of safeguarding cases reported were 75 years and over. This is most likely due to the vulnerabilities faced with the ageing population and care/support needs identified.



Adult social care referrals completed by the safeguarding team increased by 51% this year. A total of 41 referrals sent to the vulnerable persons Local Authority.



Birmingham City Council

The majority of referrals made to adult social care by ROH was due to the vulnerable adult being identified as having care and support needs and requiring intervention to reduce risks.

The safeguarding team have highlighted on-going concerns regarding community support for high-risk complex discharges, particularly relating to institutional neglect, self-neglect and poorly engaged vulnerable adults. Frequently these are patients for whom assessment of their mental capacity is complex and may fluctuate. Considerable support and supervision are often needed in Deprivation of Liberty decision making. Other components of this complexity have been mental health concerns, domestic abuse, and substance misuse within the context of the safeguarding risk.

The safeguarding team over the last year have been working with staff across the Trust to raise awareness of neglect and self-neglect including hoarding in adults, new internal neglect guidance was launched to support staff. The guidance encourages staff to use their professional curiosity to gain insight into the adult's daily activities and support within the community.

Adult Safeguarding making safeguarding personal ROH case example.

Patient T is unable to communicate verbally and deemed as a vulnerable adult with care and support needs in the community. Patient T who was admitted to ROH for a planned surgery. During admission, staff and patients' family raised concerns regarding the care and support Patient T was receiving in the community by a care agency in there own home. The concerns were around financial abuse and neglect. The Senior Named Nurse and Named Nurse liaised with multiple external professionals and patients family to gather an insight into Patients T's needs and wishes and completed an adult social care referral based on the risks and concerns voiced by those involved in Patient T's life. Adult Social Care launched a section 42 enquiry and Patient T was discharged to a place of safety where all care and support needs could be met.

19 Female Genital Mutilation (FGM) referrals were made to Summerfield FGM specialist support clinic in Birmingham, following disclosure by adults during pre-screening that they had been victims of FGM in childhood and are still experiencing health implications. The

Named Nurse attends Birmingham Against Female Genital Mutilation (BAGFM) subgroup which provides local and national information.

This year 65 Deprivation of Liberty Safeguards applications (DoLS) and 40 Mental Capacitiy Assessments (MCA) completed without initial DoLS restrictions.

External Learning

Throughout the year the safeguarding team are encouraged to attend external learning events to enhance their knowledge and skills. The new safeguarding nurses completed their Safeguarding Supervision training and attended multiple learning events by BSCP. The Named Nurse completed a master's module for safeguarding at Birmingham City University. The Safeguarding Lead Nurse and Senior Named Nurse attended the BSOL level 4 safeguarding training and Safeguarding supervision refresher two-day course.

Safeguarding Children

Safeguarding children, young people and families is the action the Trust take to promote the welfare of children and to protect them from harm. The Child's Voice underpins all safeguarding work and should be reflected in referrals and documentation throughout the Trust. The Trusts safeguarding duties are guided by core Child Protection Legislation and policy such as: The Children Act 1989, The Human Rights Act 1998, The United Nations Convention for the Rights of the Child (UNCRC) and Working Together to Safeguard Children (2023).

Section 11(4) of the Children Act 2004 places duties on a range of organisations, agencies, and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. NHS organisations and agencies are subject to the Section 11 duties. The Safeguarding Lead Nurse and Senior Named Nurse complete the annual Section 11 audit to provide Local Safeguarding Boards/Partnerships assurance.

All children and young people under the age of eighteen are required to complete an internal first contact form with support of parents/caregivers if required. This form enables staff to identify any health concerns, vulnerabilities, and safeguarding concerns. This includes home educated/missing in education, previously or currently known to social care and other organisations such as mental health. A Registered Nurse (RN) reviews all first contact forms and if safeguarding concerns are identified uses their professional curiosity to gather further information. All safeguarding concerns/risks highlighted staff gain consent from parents/caregiver and or child/young persons to commence lateral checks with key agencies such as Education, Social Services and GP.

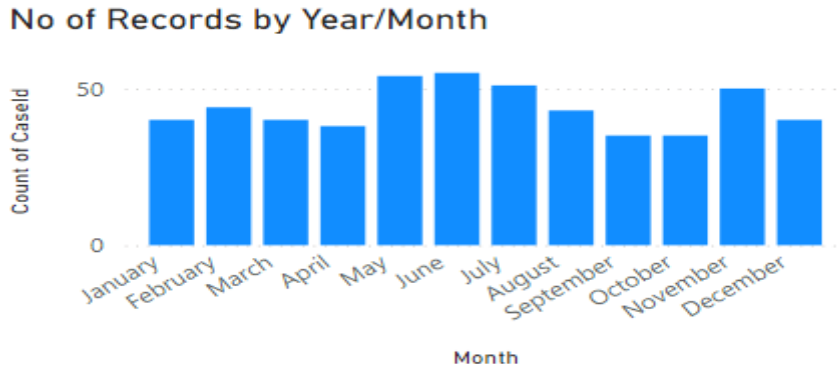
This year a total of 525 internal safeguarding notification were received. The majority of concerns raised were under the category of risks identified (167) or was not brought (WNB) (151).

For children not being brought to their appointments could result in health needs be unmet, but there may also be safeguarding concerns. Missing appointments for some children may be an indicator that they are at an increased risk of abuse. There are many reasons why children miss appointments, but numerous studies have shown that missing healthcare appointments is a feature in many CSPRs.

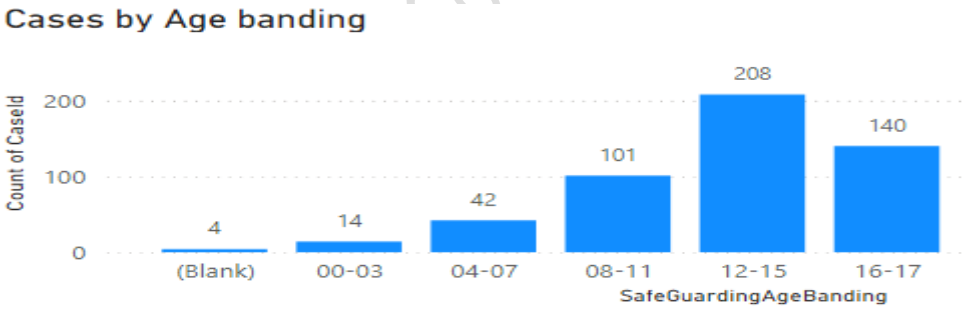
There has been a focus on the impact of social deprivation with the cost of living significantly rising this year and the safeguarding team have encouraged staff to report concerns if

parents/carers report that they are unable to bring their child due to travel costs. A focus in 2024 is to work alongside national express to try and seek support for vulnerable families.

The largest safeguarding reporting months for children were May and June, it is unknown why but, it has been acknowledged by the safeguarding team that due to half term and pending summer holidays this can cause delays in receiving outcomes from external professionals when completing lateral checks.

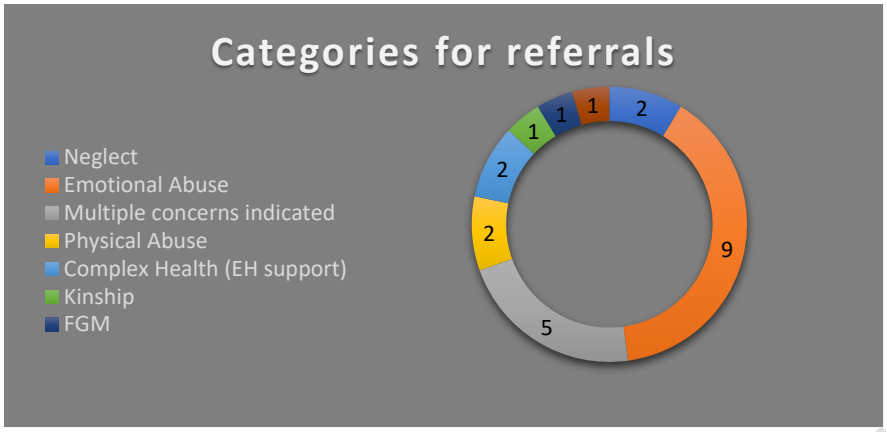


As previously acknowledged in this report the largest reported age range is between 12-15 years old. At ROH if a child under 16 years old requires Orthopaedic surgery our medical staff and Clinical Nurse Specialists cross site work at Birmingham Women's and Childrens Hospital (BWCH) where the surgery is completed. This poses an increase in demand for our staff and the safeguarding team to ensure all safeguarding information is collated prior to surgery and shared with BWCH to ensure support is in place to reduce risks of harm.



Safeguarding Children case example ROH response to "think family"

Patient T (mother) was admitted for day surgery and disclosed using substances to alleviate pain. Staff reported the concerns to the safeguarding team who attended the ward area and initiated a conversation with Patient T using professional curiosity, it was identified Patient T had dependants, a previous history of involvement from children's services, and a kinship placement that social services where unaware of. Consent was gained for a children's services referral to be completed, a referral to a third sector organisation who support adults who have substance misuse concerns was offered but this was declined, information was shared with the patient's GP for a follow up post discharge.



The largest category for social services referrals completed at ROH are for emotional abuse. Nationally Neglect is the leading category for children being referred to social care with concerns that they are at risk of significant harm. However, in 2023 Birmingham was identified as the only city where emotional abuse was identified as the largest reported concern. This is further evidenced by ROH data with emotional abuse as the biggest referring category for social care support.

The referrals completed for emotional abuse by ROH were following a disclosure from the child's parents that they are victims of domestic abuse. The recent amendment to the Domestic Abuse Act in 2021 place responsibility for staff to report concerns as children are now recognised as victims.

The safeguarding team attended 48 Local Authority meetings which included Child in Care reviews, Child in Need Meetings and Child protection meetings. Generally, the safeguarding team will only attend these meeting if the child has a complex health plan which requires specialist input. The safeguarding team attended 10 strategy discussions as requested by the muti-agency Safeguarding Hub (MASH). In 2023 GOV.UK reported that there was a 0.3% decline for children placed on child protection plans nationally**.**

The Named Nurse published internal neglect recognition and response guidance for staff to follow and arranged for the Neglect Lead within Birmingham Childrens Safeguarding Partnership to present at the Champions Day in September 2023. Neglect impacts babies, young children, and adolescents. The impact of Neglect is predicted to rise following the cost-of-living crisis.

The safeguarding team continued to encourage staff to complete an internal notification for any children in care who access our services. This year 60 child in care notifications were received. This will enable the safeguarding team to gather a better insight into the child's lived experience and plan of care including any vulnerabilities or risks associated. The Senior Named Nurse has requested for the Safeguarding Nurses and Learning Disability Nurse to attend external training in April 2024 by People in Partnership which is focused on children in care. Safeguarding Champions Day in June 2024 will also focus on children in care.

The senior named nurse developed safeguarding leaflets to be provided to parents and or carers. The leaflets will assist parents and or carers in understanding internal safeguarding procedures and staff responsibilities around the following subjects: lateral checks, suspected non-accidental injuries, home schooling/ missing in education and children in care. The communications team are currently working on the designs and formatting and the leaflets be finalised in June 2024.

Local and national Child Safeguarding Practice Reviews are shared Trust wide. The safeguarding team disseminate learning and recommendations within training, supervision, bespoke events (champions day), road shows and Trust wide communications.

Domestic abuse

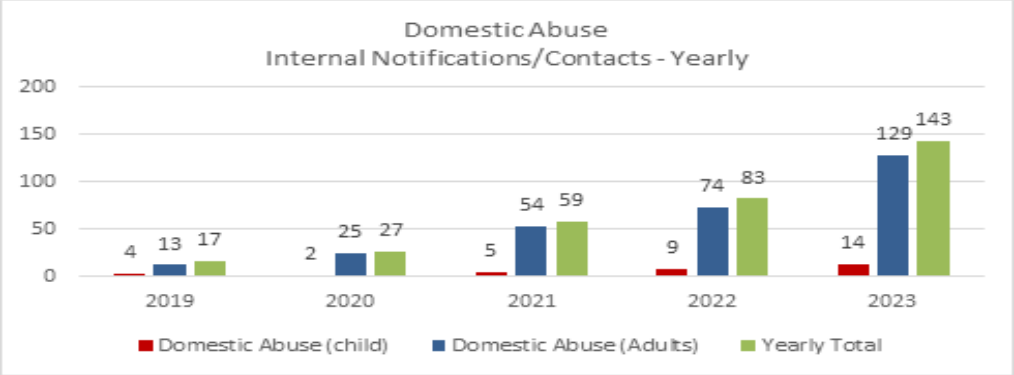
The Domestic Abuse Act (2021) provides further protection to victims of domestic abuse and strengthen measures to tackle perpetrators. There is now a wide-ranging legal definition of domestic abuse which incorporates a range of abuse beyond physical violence, including emotional, coercive, or controlling behaviour and economic abuse. Under the Act, Police have also been given new powers including Domestic Abuse Protection Notices, providing victims with immediate protection from abusers, whilst Courts can now issue Domestic Violence Protection Orders to help prevent offending by enforcing perpetrators to engage in support. The Government have also added in new measures to further strengthen the law including creating a new offence of non-fatal strangulation and threats to disclose intimate images. Other measures in the Act include extending the controlling or coercive behaviour offence to cover post separation abuse. Explicitly recognising children as victims if they see, hear, or experience the effects of abuse and establishing in law the office of Domestic Abuse Commissioner and set out its functions and powers.

The Senior Named Nurse is the Domestic Abuse Lead for the Trust and is supported by the Safeguarding Lead who the Senior Named Nurse is accountable to provide assurance to. The Senior Named Nurse accesses regular external training in relation to Domestic Abuse and has built close working relationships with external professionals who work for domestic abuse services.

The Senior Named Nurse/Domestic Abuse Lead was asked to present and share our Trusts domestic abuse procedures and support pathway at The Whole Health Regional Domestic Abuse Project by Crossing Pathways. The work within the domestic abuse field at ROH has been recognised locally and national and multiple Trusts and organisations have requested to use and adapt ROH domestic abuse guidance within their own services. Birmingham City Council City Wide Domestic Abuse Strategy have included ROHs data within their report to be published in 2024.

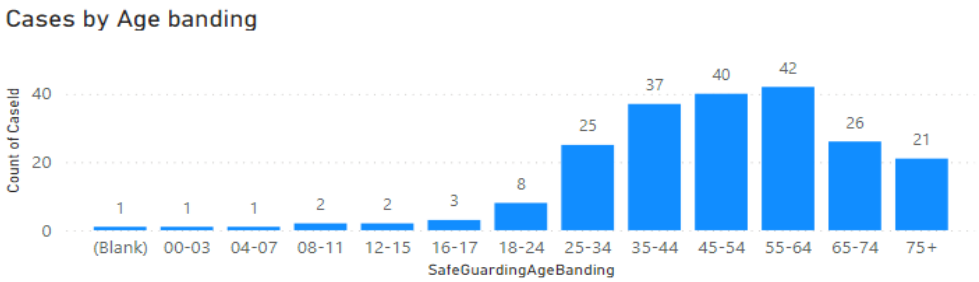
Our Trust is committed to ensuring that victims and survivors of domestic abuse receive a high standard of care irrespective of age, race, culture, sexuality, religion, or ability. This includes those outside the trust that we become aware of who could also be at risk. To improve our response to survivors of domestic abuse it is essential that our staff feel adequately informed to make routine enquiries and are equipped to respond to disclosure.

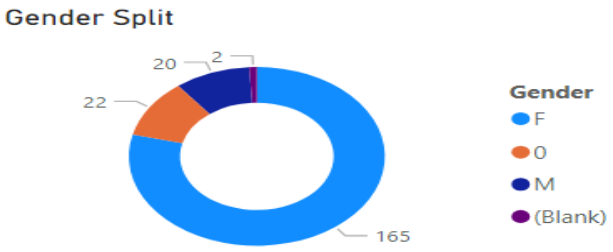
Over the last three years since the launch of the routine enquiry (domestic abuse question), our Trust has received a significant increase in domestic abuse disclosures. Patient domestic abuse disclosures have increased by 411% since 2020 and staff disclosures have increased by 150% since 2019.



The above graphs data is between 1st January and 31st December.

This year reporting has further increased from staff and patients between 31st March 2023 to 1st April 2024 a total of 209 safeguarding notification were received under the category of domestic abuse.





Adult/Child	Domestic Abuse	Total
⊞ Adult	197	197
⊞ Child	12	12
Total	209	209

Example of ROH domestic abuse response

Patient A was seen in outpatient's clinic for an appointment, where it was observed by staff the patient had significant bruising and a healing pelvic fracture following an Xray. The staff asked Patient A the direct domestic abuse question and Patient A disclosed they are a victim of domestic abuse, the safeguarding team were called as Patient A was feared to be high risk. Patient A was reviewed by the Named Safeguarding Nurse, information gathered, and risks shared with relevant professionals. A MARAC referral was made where it was identified the patient was a repeated victim of domestic abuse. Patient A received sign posting and safety planning by the Named Nurse and a GP request was made for a medical follow up of injuries in the community. The Safeguarding team would like to thank the OPD team for their swift actions taken to support Patient A.

Due to the significant increase of disclosures, the senior named nurse completed a business case for a Domestic Abuse and Sexual Violence Advocate with the support of the Safeguarding Lead and Chief Nurse. The case will be presented to the Executive Board in a request for additional funding, this role will provide further support following the Trust signing to the NHS Sexual Safety Charter in 2023. The DASVA will be part of the Safeguarding Team working alongside partner agencies to support victims of domestic abuse and or sexual violence. The role of the DASVA is to work on the front line to provide face to face support for victims, survivors, families, and staff which includes safety planning and advice in line with the Domestic Abuse Act (2021), Governments Strategy for tackling violence against women and girls (2021) and the NHS England Sexual Safety in Healthcare Charter (2023). At the time of writing this report the new role had been approved as a band 5 at the ROH banding panel and funding is awaiting to be approved at ROH charities on a fixed term contract.

Safeguarding and Domestic Abuse Champions

Safeguarding Champions

The Trusts aim is to have a at least one safeguarding champion in their departmental area. Safeguarding champions are the first point of contact for staff in their departmental area for advice or support. The safeguarding champions will guide staff on where or how to access policies, procedures, or guidance to support their decision making when safeguarding patients. The safeguarding champions are required to attend at least two out of four quarterly safeguarding champions days annually. Attendance is reviewed by Safeguarding Administrators, Safeguarding Lead and Senior Named Nurse.

Over the last year the safeguarding team have provided three out of four champions days for the safeguarding champions across the Trust between 2023-2024. The fourth champions day was for the vulnerabilities team. The safeguarding champions days focused on the themes delivered throughout the year are; Neglect, Child Exploitation, Honor Based Abuse and Forced Marriage, Female Genital Mutilation, Self-Neglect and Hoarding and findings/learning from internal safeguarding audits. Safeguarding champions are encouraged to take part in safeguarding audits within their own ward or departmental area.

Examples of feedback following domestic abuse champion training:

- “Better understanding of hoarding following training”.
- “I enjoyed the substance misuse training”.
- “I’m looking forward to the next champions day as I really enjoyed this training”.

Domestic Abuse Champions

Domestic abuse champions are clinical and non-clinical staff, this year we have 52 trained to support staff and patients. Domestic abuse champion training started in 2021 due to the launch of the internal Domestic Abuse policy and Staff Domestic Abuse Policy by the Senior Named Nurse/Domestic Abuse Lead.

The Senior Named Nurse provides domestic abuse champions with external training opportunities shared through local safeguarding boards/partnerships and provides an annual internal domestic abuse champions training day. Annual refresher training was completed in July 2023 and September 2023. We would like to thank BSoL ICB Interpersonal Violence team in delivering a presentation at our Trusts domestic abuse champion training.

The champions are required to evidence annual training attended which is reviewed by the Senior Named Nurse. Attendance is monitored by Safeguarding Administrators.

Examples of feedback following domestic abuse champion training:

"I enjoyed real life stories being shared".
"The interactive nature of the training was great".
"I enjoyed the group work".
"Really good and informative session"
"Understanding different ways perpetrators display power and control".

Domestic abuse champions are required to disseminate learning within their ward or departmental areas, which is monitored with safeguarding supervision.

Safeguarding Supervision

Safeguarding supervision is an accountable process which supports, assures, and develops the knowledge, skills, and values of an individual, group or team. It provides the opportunity for staff to:

• Reflect and review their practice
• Discuss individual cases in depth
• Change or modify their practice and identify training and continuing development needs

The safeguarding team use a variety of reflective cycles, it is dependent on the individual and safeguarding case and individuals' wellbeing (restorative).

Safeguarding supervision compliance is monitored through the safeguarding committee bi-monthly.

This year safeguarding group supervision was delivered to the following departments:

- Pre-operative Assessment Clinic (POAC) – Monthly
- Outpatients Department (OPD) – Monthly
- Children and Young Persons Outpatient Department – Monthly
- Admission Day Case Unity (ADCU) – Monthly
- Outpatient Physiotherapy Department (Bi-Monthly)
- In-patient Physiotherapy Department (Bi-Monthly)
- Occupational Therapists (OT) – (Bi-Monthly)
- Imaging Department - (Bi-Monthly)
- (ROCs)- (Bi-Monthly)
- Oncology Clinical Nurse Specialists (CNS)- (Bi-Monthly)
- Advance Nurse Practitioners - (Bi-Monthly)

Individual safeguarding supervision is accessed as and when requested by staff or if the safeguarding team identify that supervision is required for staff members this could be due to complex safeguarding cases or lessons to be learned.

A safeguarding supervision audit was completed by the Senior Named Nurse and Named Nurse and presented to the safeguarding committee in July 2023. This was a qualitative audit based on ten questions. The audit evidenced that 94% of staff report supervision has met their expectations, staff report "*atmosphere which allows everyone to share thoughts without judgement*" "*friendly team, supportive and approachable".* Positive feedback 97% of staff would recommend safeguarding supervision to a colleague.

The Safeguarding Named Nurse and two safeguarding nurses receive quarterly group supervision delivered by BSoL ICB Designate Nurses. The group supervision is provided to all band 6 and band 7s working in the safeguarding across Birmingham and Solihull. Each group averages at around 10 people and is delivered online through MS Team.

The Senior Named Nurse/Domestic Abuse Lead receives quarterly individual supervision delivered by BSoL ICB Designate Nurse for Children. The Safeguarding Lead receives one-one external safeguarding supervision.

The Senior Named Nurse provided bi-monthly supervision to the ICB Domestic Abuse and Serious Violence Nurse within Interpersonal Violence Team between 2023-2024.

An action which has not been met from last years annual report is access for the safeguarding and vulnerabilities team to restorative supervision. This was approved by the Trust board due to the complex, challenging, and emotional issues discussed daily within our team. This will be a priority this year.

Audits

The following audits was completed by the safeguarding team this year:

- Section 42 and 47 referrals audit (December 2023) – Senior Named Nurse
- Safeguarding Documentation Adults and Children audit (April 2023) – Senior Named Nurse and Named Nurse
- Domestic Abuse Awareness audit (February 2024) – Senior Named Nurse
- Domestic Abuse Routine Enquiry documentation audit (July 2023) -Senior Named Nurse
- Section 11 Audit (May 2024)- Safeguarding Lead and Senior Named Nurse
- Mental Capacity and Deprivation of Liberty Safeguards (January 2024) – External MCA and DoLS trainer
- Safeguarding Supervision audit (June 2023) - Senior Named Nurse
- Exploitation awareness audit (August 2023) – Senior Named Nurse

Safeguarding audits are shared with the safeguarding committee members and presented by the author at Safeguarding Committee for comments and feedback. The Quality and Safety committee are provided assurance following the Safeguarding Committee. The Safeguarding Lead Nurse reviews the annual audit schedule with the safeguarding team and plans what internal audits need to be completed in line with legislation and local/national or internal themes.

The audits highlighted good practice shown by staff and provided assurance to committee members. However, further learning was required regarding the safeguarding documentation audit for adults and children, which demonstrated that the adults and child's voice was largely not included within documentation around decision making when addressing safeguarding risks or concerns. The Senior Named Nurse and Named Nurse ensured the learning was shared within supervision and a documentation session was delivered on safeguarding champions day.

Two outstanding audits carried for to be completed by the end of 2024 are PiPoT and Prevent which will be completed by the Safeguarding Lead Nurse.

Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

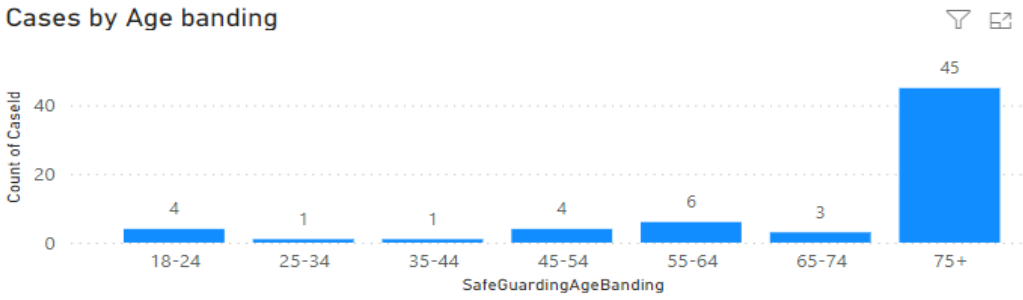
The Mental Capacity Act (MCA) came into force in October 2007. The MCA provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. The MCA applies to everyone working in health and social care providing support, care or treatment to people aged 16 and over who live in England and Wales.

The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

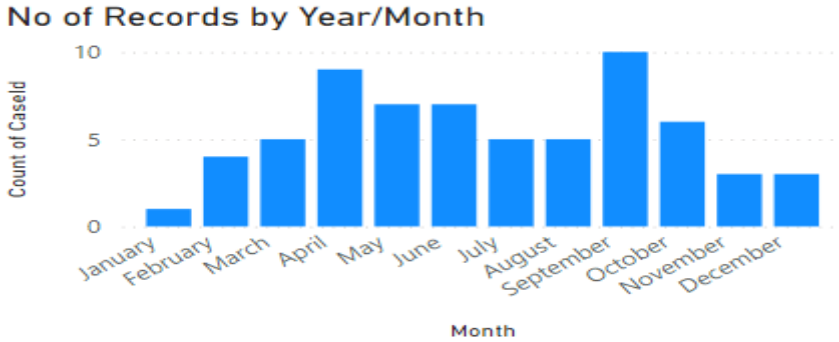
- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process.
- By allowing people to plan for a time in the future when they might lack the capacity

Awareness throughout the Trust has been raised by the Safeguarding Lead Nurse and Safeguarding Team. The Level three safeguarding training incorporates MCA and DoLS face to face training and the level two safeguarding training provides basic awareness. The MCA and DoLS training incorporated within the level three safeguarding training is delivered by an external practitioner. The Safeguarding Lead Nurse provides enhanced MCA and DoLS training bi-monthly.

The largest age range for DoLS applications in 2023-2024 was 75 years old and over.



The safeguarding team received a total of 65 Dols authorisation form requests and an additional 41 notification forms highlight concerns around capacity, these notifications included indication that the patients accessing our services had a diagnosed impairment of the mind or brain or that they may require further assessment and onward referral to one of our partner agencies.



There were a greater number of MCA assessments carried out in February total was 117 compared to every other month.

Males were identified as the largest gender category for MCA assessments and DoLS applications.

The MCA and DoLS audit this year were undertaken by the independent trainer and supported by the Trust Mental Health Practitioner. The purpose of the audit was to update the Safeguarding Committee on overall progress of the quality of mental capacity and deprivation of liberty activity. The Mental Health Practitioner reviewed the Prescribing Information and Communication System (PICS) electronic documentation which had not been included in previous audits; it was however recognised that an increasing amount of documentation is being recorded here therefore was essential for inclusion.

The recommendations from the previous audit were:

Areas of Improvement / Action Required

- Increase evidence of best interest decision
- Increase use of including safeguarding team email on DoLS request forms
- Increase evidence of care and treatment under best interest

Recommendations

The recommendations were:

1. Need to evidence best interest decision on mental capacity assessment form.
2. Need to increase use of safeguarding team email on DoLS request forms
3. Need to increase evidence of care and treatment under best interest.

In 2023-2024 the audit showed some examples of good practice however it does need to be acknowledged that this is less than previous years, overall documentation was inconsistent.

The Safeguarding Committee and Trust Board can gain some level of assurance of mental capacity and deprivation activity although this is overall disappointingly lower than recent years.

Recommendations

The recommendations are:

1. Exclude use of out-of-date mental capacity assessment forms
2. Need to evidence best interest decision on mental capacity assessment form.
3. Need to increase evidence of means of how the patient is being deprived of liberty
4. Need to increase documented evidence of review of restrictions
5. Need to strengthen documentation evidence of cessation of deprivation of liberty.

Following findings from the above audit and action plan for improvement has been agreed with the safeguarding lead, Chief Nurse, and External Trainer provider.

Liberty Protection Safeguards (LPS) following Parliamentary scrutiny and progress through the UK parliament the Mental Capacity Act (amendment) Bill received Royal Assent in May 2019. Deprivation of Liberty Safeguards (DoLS) is replaced with a scheme known as the Liberty Protection Safeguards (LPS). The target date for implementation was 1st October 2020 but due to the Covid-19 pandemic the Government delayed the publication of the Code of Practice until the autumn of 2021 with LPS introduction in April 2022, with a further delay this year until after the next Government elections.
Expected key changes:

- In line with the Law Commission's to start at 16 years old
- There is no statutory definition of a deprivation of liberty beyond that in the Cheshire West and Surrey Supreme Court Judgment of March 2014 – the 'acid test'.
- Deprivations of liberty have to be authorised in advance by the 'responsible body'. For NHS hospitals, the responsible body will be the 'hospital manager'.
- For arrangements under Continuing Health Care outside of a hospital, the 'responsible body' will be their local ICB (or Health Board in Wales).

The implications for the Trust are that the local authority will no longer be the supervisory body for all applications, the hospital will become the responsible body and authorise their own LPS. This will now apply to individuals who are over 16 (previously 18) and deprivations may be transportable between multiple settings. For the Trust to be prepared for this change the MCA/LPS. There will need to be consideration for the referral to Approved Mental Capacity Professional (AMCP) previously known as Best Interest Assessor (BIA). AMCPs when objections occur and Independent Mental Capacity Assessors (IMCA) when no appropriate person is present. Clarification will need to be provided to staff around responsibilities including who will complete the capacity assessments, who will confirm medical diagnosis of cognitive impairment, who will complete the necessary and proportionate restrictive assessment and enhanced observation care plan.

Prevent

Prevent is part of the Government's Counter Terrorism Strategy called "CONTEST". As part of this strategy, all healthcare staff receive mandatory training, and this has to be updated every 3 years (training figures are contained within this report). All staff have a responsibility to raise concerns where they believe that a person is at risk of being drawn into terrorist activity or committing a terrorist act.

Prevent training is delivered to staff in the Trust through e-learning and face to face training .

Prevent WRAP training L3 is delivered face to face , sessions have been provided monthly. Training compliance is reported and monitored at the Safeguarding Committee and upwardly reported to the Quality and Safety Committee. Information on the number of staff booked and those attending is reported in the SG Quality Report monthly.

The Safeguarding Lead Nurse has provided training compliance updates at Divisional Management Meetings , to raise awareness.

Below are the training figures compliance %, for the year

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Prevent Awareness	90.14	89.86	90.49	91.24	91.32	89.98	94.48	89.84	91.38	90.33	89.35	87.70
WRAP L3	82.19	83.89	85.68	87.89	87.41	86.15	85.51	86.17	86.25	85.22	81.21	82.71

National and local updates have been shared with staff via weekly Safeguarding Shout out emails and via Trust SG Quality reports.

Trust has submitted all required external quarterly digital reporting in line with submission deadline. The Safeguarding Lead Nurse maintains contact with regional Prevent Lead.

Person in Position of Trust (PiPoT) Managing Allegations Against Staff

Where allegations are made that a member of staff is unsuitable to work with children or has harmed a child the Trust is required to make a referral to the Local Area Designated Officer. It is a keyway in which we protect children our care by ensuring that we have robust mechanisms to address any risk that may emerge in our workforce. Each month the Safeguarding Lead Nurse meet with HR and discuss cases that have come to the attention of HR and whether they meet the criteria for a referral to the LADO.

Staff of whom the allegation has been made against are offered internal support and signposted to external support through unions. The staffs line manager is required to identify a suitable member of staff to provide regular check ins with the member of staff. This is to ensure that their wellbeing is assessed including Occupational Health referral, and they are given an opportunity to disclose any concerns, whilst the investigation continues.

The Safeguarding Lead reports all PiPoT cases to the Chief Nurse who is the Safeguarding Executive.

This year the Safeguarding Lead Nurse was involved in three cases. All cases are managed on an individual basis, the outcome is dependent on the nature of the allegations and the staff members role. The Lead Nurse works closely with staff members line managers and the Human Resource department on the management of all cases. Ensuring the staff member where allegations are made against are supported and concerns investigated.

The Safeguarding Lead has also undertaken refresher training offered by the local safeguarding partnership.

Safer Recruitment and Disclosure Baring Service (DBS)

Safer Recruitment means thinking about the Safeguarding of Children, Young People and Adults, and promoting their welfare at every stage of the recruitment process.

This is to minimise the risk of employing unsuitable staff to work and care for children, young people and adults at risk who have care and support needs by having robust selection and recruitment procedures in place.

Safer Recruitment forms part of Section 11 of the Children Act 2004 and requires safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check.

• NHS organisations and agencies are subject to the section 11 duties. Health practitioners are in a strong position to identify welfare needs or safeguarding concerns regarding individuals and, where appropriate, provide support. This includes understanding risk factors, communicating and sharing information effectively with children and families, liaising with other organisations and agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

• Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children, young people, and adults at risk, and creating an environment where staff feel able to raise concerns and feel supported in their role

• All staff working in healthcare settings – including those who predominantly treat adults – should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance

• Safer practice in recruitment means giving consideration to safeguarding arrangements at every step of the process

In August 2023 the Trust reviewed and launched safer recruitment training for staff, which is led by Human Resources Team. All line mangers and senior staff attended online and new line managers complete training within their induction.

Safeguarding Policies and Risks

Risks

Safeguarding risks are currently reviewed with the Trusts Risk officer and Safeguarding Lead Nurse. The risks are then shared for comment and feedback at the Trusts bi-monthly Safeguarding Committee meeting. The details of each risk are included in the Risk Register Table and the outstanding actions are completed; the current score will be reviewed by the risk owner to ensure appropriated progress is being made. There are 14 risks on the safeguarding and vulnerabilities risks register, all risk are in date and reviewed at the Safeguarding committee meeting.

Safeguarding policies

The Safeguarding and vulnerabilities team manage, review, and amend 15 policies across the Trust.

The safeguarding Lead Nurse is responsible for:

- Managing Allegations Against Staff (PiPoT) policy
- Missing Patient policy
- Restrictive Interventions policy

- Prevent policy.
- MCA and DoLS policy
- Safeguarding Adults at risk policy

The Senior Named Nurse/Domestic Abuse Lead is responsible for:

- Safeguarding Supervision policy
- Domestic Abuse policy for patients and families
- Staff Domestic Abuse policy
- Safeguarding Children, Young People, and family's policy

The Named Nurse is responsible for:

- Increased therapeutic Observation- Adults policy.

As of 1st April 2023 two policies was outstanding for review in March 2024 which are:

- Restrictive Interventions policy
- MCA and DoLS policy

Safeguarding Priorities for Adults and Children for 2024-2025

Last year's priorities were:

Safeguarding adult's priorities 2023-2024

- Focus on reducing the implications for patients experiencing neglect including self-neglect.
- The voice of the adult (making safeguarding personal) to be included within care planning, risk assessments, safeguarding referrals, and documentation.
- A consistent clear application of the principles of MCA when undertaking assessments throughout the Trust.
- To improve mandatory training compliance across the Trust.

Safeguarding Children priorities 2023-2024

- Focus on reducing the implications for children and young people experiencing neglect.
- To improve information sharing with parents and care givers when completing safeguarding duties.
- To reduce health inequalities for children in care who access our services. The safeguarding team to work alongside social services, foster parents, children in care nurses to ensure that the child in care has appropriate support in place to facilitate their needs.
- To improve mandatory training compliance across the Trust.

As evidenced throughout this report, the safeguarding team provided multiple resources, bespoke training, external training opportunities and supervision sessions to ensure staff have the knowledge and skills to meet last years priorities. It has been acknowledged that there have been challenges which have resulted in further work required to gain assurance. Therefore, additional work will be undertaken this year on last years priorities which include, safeguarding documentation evidencing the adults and child's voice, mandatory training

compliance particularly focusing on the medical team and bank staff. A review of MCA and DoLS training and embedding the action plan following this year's audit.

This year the senior named nurse has set the following priorities which is overseen by the safeguarding lead:

Safeguarding adult's priorities 2024-2025

- The voice of the adult (making safeguarding personal) to be included within care planning, risk assessments, safeguarding referrals, and documentation.
- Staff taking accountability with documentation in evidencing decision making, care/treatment and review using mental capacity assessment forms.
- Focus on the safeguarding team's responsibilities with the implementation of the Domestic Abuse and Sexual safety charter.
- To improve mandatory training compliance.
- Safeguarding team improving staff awareness around serious violence and local/national reporting/response responsibilities.

Safeguarding Children priorities 2024-2025

- Reducing vulnerabilities and health inequalities for children in care
- Increasing staff's knowledge and skills in understanding the importance of early recognition and response - Early Help
- Increasing staff's knowledge regarding serious youth violence and supporting young people who are currently at risk.
- To improve mandatory training compliance.
- Continue to reduce the implications for children and young people experiencing neglect.

Conclusion

The Royal Orthopaedic Hospitals safeguarding team are committed to ensuring that the Trust effectively executes its duties and responsibilities for safeguarding. The Team adopts a whole systems approach to its work across acute and community boundaries. This annual report demonstrates safe and effective practice in relation to our statutory and regulatory agenda, with overall good compliance to internal and external safeguarding standards. The team will continue to build on existing work to ensure the Trusts safeguarding processes are robust and effective and remain aligned with core Trust values.

The Safeguarding Team wishes to thank all our dedicated staff, our supportive partners, external trainers, the Executive Team, and the Trust Board who continue to work so positively with us to ensure 'Safeguarding is Everyone's Responsibility'.

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

SG

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Designated Body Annual Report October 2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Matthew Revell (Medical Director)**
AUTHOR:	**Angharad MacGregor, Medical Directorate Manager** **Alison Newman, Revalidation Support Assistant**
DATE OF MEETING:	**6 November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The report is the annual submission for medical appraisal and revalidation for 2023/2024.
The questions and format are mandated by NHS England.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Actions identified in the previous annual report were completed, new appraisers have been identified and trained and the Professional Practice Advisory Group has been strengthened in terms of membership, agenda, and reports.	There is a resource pressure within the medical directorate team and a business case is planned for additional support from April 2025. In addition, new appraisers are needed to cover the increase in demand plus some appraisers retiring

REPORT RECOMMENDATION:

The Board is asked to:
Approve this report for submission to NHS England revalidation team

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	x	Equality and Diversity		Workforce	
Inequalities		Integrated Care		Continuous Improvement	
Comments:					

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

Care	x	**Community**	
Expertise	x	**Services**	x
People	x	**Collaboration**	x

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

Aligned to the performance metrics for annual appraisal

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)*:
Staff Experience & OD Committee in October 2024. Reported at Trust Board annually

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Royal Orthopaedic Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No action
Comments:	The current Responsible Officer has been in post since February 2019.
Action for next year:	Continued attendance at the Responsible Officer Network Meetings.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	No

Action from last year:	To review the ongoing resource
Comments:	The number of prescribed connections has increased by 16% from 108 to 125 connections. The supporting resource has been diluted due to the Medical Directorate Team expansion. Therefore, there is a need for an additional supporting resource. A business case will be compiled for additional resource from April 2025.
Action for next year:	Compile business case to fund additional supporting resource for medical appraisal and revalidation

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No action
Comments:	Yes, the information is triangulated with the Trust's electronic appraisal system, Electronic Staff Record and GMC Connect.
Action for next year: a.	NA

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	No action
Comments:	Appropriate policies to support medical revalidation are in place and are reviewed by the Responsible Officer when required. The revalidation policy was reviewed in 2024.
Action for next year:	NA

b. 1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Approach to Robert Jones and Agnes Hunt NHS Trust for peer review to take place before the end of the year
Comments:	Robert Jones and Agnes Hunt unable to support peer review request last year due to staffing vacancy. Further request has been made to Robert Jones and Agnes Hunt to support peer review.
Action for next year:	Request peer review from similar sized Trusts

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	No action
Comments:	Locum Consultant and Clinical Fellows will be supported through a specialty structure by the Clinical Service Lead and Clinical Service Manager. Locally employed doctors will have an identified academic tutor. Agency ward doctors meet bi-weekly with a senior consultant to review issues/development needs. Professional support is provided by a dedicated Clinical Lead
Action for next year	Further development of a locally employed doctors induction programme.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	No actions
Comments:	Annual appraisal covers whole practice and doctors must include information from work undertaken outside of the Trust, such as other NHS providers, private practice and voluntary roles. Appraisal documentation must include information regarding complaints and significant events and doctors need to provide data from national outcome registries where appropriate such as National Joint Registry/PROMS data.
Action for next year:	NA

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	No actions
Comments:	The Appraisal Lead, Directorate Manager and Revalidation Support Assistant meet on a monthly basis to review appraisal figures and plan action for overdue appraisals. Escalation process is via the Associate Medical Directors and the Professional Practice Advisory Group.
Action for next year:	Formalise the escalation pathways and add to the revalidation policy.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Review the policy
Comments:	There is an Appraisal and Revalidation Policy in place which was reviewed in 2024.
Action for next year:	No actions

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	New question
Comments:	18 Appraisers for the 125 prescribed connections is approximately 7 appraisals each. However, there is a steady turnover of appraisers as staff retire, therefore a presentation is planned for the October 2024 Clinical Audit meeting with the purpose of recruiting new appraisers.
Action for next year:	New appraisers are to be identified and trained in the next 12 months.

II.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No actions
Comments:	The Appraisal Lead holds meetings with all appraisers and offers individual support to appraisers if required. Refresher training and networking is encouraged. Appraisal reports are reviewed and scored as part of ongoing audit process. Feedback is given at meetings and individually when required.
Action for next year:	Appraiser refresher training to be arranged for early 2025 Deliver annual presentation in the October Medical Audit and Governance meeting about appraisals and quality.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	**No actions**
Comments:	The PreP appraisal system is now established and the reporting route is through the Professional Practice Advisory Group meeting. The appraisal outputs are qualitatively reviewed within the PreP software and feedback is given to appraisers and presented at audit.
Action for next year:	**No action**

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	No actions
Comments:	Recommendations to the GMC are made in a timely manner. No issues have been identified by the GMC Liaison Officer as part of quarterly meetings with the Trust.
Action for next year:	No actions

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	**No actions**
Comments:	All revalidation recommendations made to the GMC, including reasons for deferral, are recorded by the Trust.
Action for next year:	**No action**

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	**No actions**
Comments:	Serious incidents, complaints, learning from deaths and key risks are discussed at the fortnightly Executive Triumvirate Governance meetings and monthly Executive Quality and Safety Meetings. There is a monthly Clinical Audit meeting and data is also reviewed as part of the Model Hospital Club and AQILA (Audit, Quality Improvement, Learning and Analysis Group) meetings. Governance have introduced Patient Safety Incident Response and Freedom to Speak Up frameworks
Action for next year:	**No actions**

a. 1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	**No actions**
Comments:	Appraisal packs are issued to doctors which include information regarding activity data, incidents and complaints. Conduct and performance is monitored via the Professional Practice Group meeting and Partnership Assurance Group (with other Trusts).
Action for next year:	The Partnership Assurance Group is currently under review and we will support the new iteration.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	**No action**
Comments:	Standardised appraisal information packs are provided to Trust doctors for information that they cannot access themselves. Doctors are expected to provide external information such as PROMS data.
Action for next year:	**No Action**

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	**No Action**

Comments:	MHPS Policy is in place. A Professional Practice Advisory Group meeting now meets quarterly. The Trust has a GMC Liaison advisor who we can discuss issues with. Plus, a contact within NHS resolution who supports us.
Action for next year:	**No Action**

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	**No Action**
Comments:	The Professional Practice Advisory Group (PPAG) includes representation from Human Resources, meets quarterly by default and meetings added according to need. An upward report is submitted to the Executive Quality and Safety Group meeting by the Responsible Officer.
Action for next year:	**No Action**

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	**No Action**
Comments:	There is direct contact with Responsible Officers at other Providers to discuss concerns. Information is shared with NHS trust via MPIT forms when doctors move organisations or if there is an issue.
Action for next year:	**No actions**

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	**No Action**
Comments:	The Head of Human Resources and Business Partnering is now a member of the Professional Practice Advisory Group. Doctors can raise issues via the Freedom to Speak up Process and Guardian of Safe Working Good industrial relations with BMA via Joint Local Negotiating Committee and in the context of case management
Action for next year:	**No Action**

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	**New question**
Comments:	NICE Guidance and National Audit reports are reviewed as part of the AQILA meeting and recommendations discussed at the appropriate forum. Learning is also shared via the Clinical Newsletter. The Health and Safety committee reviews CAS alerts, which are triaged and circulated as appropriate. Pharmacy reviews medicines safety alerts which are discussed via the Medicines Safety Committee.
Action for next year:	**No actions**

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	**New question**

Comments:	A number of leadership development initiatives are underway: New Consultant Development Programme Development of Trust Leadership Charter Good Medical Practice – circulated via the Medical Director and an article published in the ROH clinical News. Physician Associates are awaiting national Standards New appraisal process for non-medics Leadership programme for executive directors and senior staff Management development programmes established within our People Promise Work Streams
Action for next year:	**No actions**

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	**New Question**
Comments:	The Head of Human Resources has reviewed the medical staff recruitment process. Pre-employment checks for locum staff are carried out by locum agencies which are part of the NHS Framework. Trust requirements for locum staff are overseen by a consultant lead.
Action for next year:	**No actions**

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	**New Question**

Comments:	Professional standards are central to learning from incidents. The PSIRF framework is used to review incidents. Learning from incidents is within the Clinical Audit and Divisional Governance meetings. A Continuous Improvement Triage Group has been established with medical representation Implementation of the AMAT system to support clinical audit cycle.
Action for next year:	**No actions**

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	**New Question**
Comments:	Compassion, fairness, respect, diversity and inclusivity are embedded within the Trust Values, which form the basis of the Trust strategy, specialty business planning and personal development plans. In addition, a priority project within the People Promise Workstream is the implementation of the Civility Saves Lives Initiative across the Trust with a focus on the medical staff. Staff Networks are active within the Trust to support inclusivity and diversity at all levels.
Action for next year:	**No Actions**

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	**New question**
Comments:	Dedicated Non-Executive Director for Freedom to speak up. Freedom to Speak Up and Guardian of Safe Working roles are actively promoted within the Trust and regular update reports are submitted to the Trust Board.
Action for next year:	**No Action**

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	**New Question**
Comments:	Feedback is encouraged through HR, Freedom to Speak up and directly to the Medical Director. Feedback from BMA representative at JLNC There is a grievance process in place for connected doctors
Action for next year:	**No actions**

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	**New question**
Comments:	This is monitored by the Human Resources Team
Action for next year:	Use of a monitoring proforma for cases discussed at the Professional Practice Advisory Group (PPAG) meeting Equality and diversity section added to PPAG agenda for HR to report into

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

b.

Action from last year:	**New Question**
Comments:	Responsible Officer attendance at Regional Higher Level RO Meetings Attendance at MMC Partnership Assurance Group meeting led by UHB Participation in GMC Responsible Officer Reference Events

Action for next year:	**No action**

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	112

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	85
Total number of appraisals approved missed	21
Total number of unapproved missed	6

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	20
Total number of late recommendations	0
Total number of positive recommendations	14
Total number of deferrals made	6

Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	6

2D – Governance

Total number of trained case investigators	**4**
Total number of trained case managers	**3**
Total number of new concerns registered	3
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March	151
Median duration of concerns processes closed	115
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	56 (includes training doctors on rotation)
Number of new employment checks completed before commencement of employment	56

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0

Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
• Review the revalidation and Appraisal Policy • Explored a peer review but this has not happened due to resources in identified Trust. • Recruited new appraisers and new appraiser/refresher training has taken place. Professional Practice Advisory Group has been strengthened this year including membership, agenda and reports.
Actions still outstanding
• Require a peer review, potentially ask Trusts in the local region. • Appraiser refresher training planned for early 2025. Recruitment for new appraisers to replace planned retirements and resignations from the appraiser role.
Current issues
Increased number of overseas fellows – no previous appraisals, therefore there will be a period of time when they do not have an appraisal. • Resources for the Revalidation and Appraisal Portfolio have been diluted and require support. Recruitment for new appraisers to replace planned retirements and resignations from the appraiser role.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- PPAG to be moved to monthly.
- Compile business case to fund additional supporting resource for medical appraisal and revalidation.
- Development of locally employed doctors' induction programme
- Formalise the escalation pathways for appraisal and revalidation and add to the revalidation policy.
- Recruit new appraisers.
- Appraiser refresher training to be held in 2025 onsite.
- Appraisal presentation to be delivered in October 2024 audit meeting, identifying areas of concern and improvements, also calling for volunteers to become appraisers.
- Continue the development of the new consultant leadership programme.

    c. Use of a monitoring proforma for cases discussed at the Professional Practice Advisory Group meeting

    d. Equality and diversity section added to PPAG agenda for HR to report into

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The ROH has delivered the appraisal and revalidation portfolio within 2023/24 and is currently working towards improvements to enhance the quality of the internal processes to maintain effectiveness.

This will be supported via the strengthening of PPAG and an increased number of appraisers.

It is hoped that a peer review will be undertaken in 2025 to enable external scrutiny of our systems and processes.

Section 4 – Statement of Compliance

The Board/Executive Management Team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	The Royal Orthopaedic Hospital NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Charitable Funds Bid – Ultrasound Machine for Imaging**
SPONSOR (EXECUTIVE DIRECTOR):	**Marie Peplow, Chief Operating Officer**
AUTHOR:	**Ruth Hughes, Charity Manager**
DATE OF MEETING:	**6 November 2024**

EXECUTIVE SUMMARY:

Royal Orthopaedic Charity (ROC) is currently applying for grants for a variety of projects.

One grant identified is for a large capital application supported by the Eveson Trust for a contribution to the purchase of an Ultrasound machine for Imaging. Replacement of an Ultrasound Machine is listed as part of capital spend that cannot be funded 24/25. The Eveson fund will be a maximum of £50K and it was felt that an equipment ask that could be covered in its entirety was the best option for this application.

The Trust Board, in its capacity as the Corporate Trustee of the Charity, is asked to give its support to the application for a grant to the Eveson Trust. The Eveson Trust requires written evidence that the bid will be supported from the Trust Board.

REPORT RECOMMENDATION:

The Board, is in its capacity as the Charity's Corporate Trustee, to approve the application to the Eveson Trust.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

Comments: [*elaborate on the impact suggested above*]

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

Capital programme for 2024/25

PREVIOUS CONSIDERATION:

Executive Team in October 2024.

Request for funds form

Section 1: About you

Name	Ruth Hughes/Sharon McGarry
Email address	ruth.hughes35@nhs.net sharon.mcgarry@nhs.net
Ward / Department	Imaging
Who supports this request? (e.g. line manager, team leader)	Ali Sprason
Executive Director sponsor	Marie Peplow

Section 2: About your request

Reference Number: (the finance team will complete this)	
Amount requested:	

What is the name of the project/item/service you are requesting funds for? *Provide a short title that we can use to describe your request for our records*	
(In principle) Board approval of a new ultrasound machine for Imaging *NB: This is for grant application needs only and there is no guarantee that the grants/money will be secured, and this bid will progress*	
What will the benefits of this investment be to patients and the public i.e. what difference will it make? Tick all that apply. **Please note: ROC's funds are to be used for purchases that provide added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds.*	
✓	Will enhance the level of care the hospital can give to its patients
✓	Will give staff new skills or knowledge to improve quality of care/service
	Will support orthopaedic research and promote innovation. Please provide evidence of R&D approval *(ISAP committee approval and HRA approval is applicable).*
	Will improve the public's experience of the hospital surroundings through major development
	Will improve the publics' experience of an existing NHS service
Over time, ultrasound modality in imaging has become more complex. Newer ultrasound technology produces images with much higher resolution than before. This new comprehensive ultrasound solution will aid our Consultant Radiologists/ Sonographers in the increased accuracy of ultrasound-guided core needle biopsies for the diagnosis of tumours for our patients on an urgent cancer pathway.	

Describe your idea, and which parts of it you need funding for. *Describe what you plan to do, how you will do it and the activities, events or items you want to spend charitable funding on.*
ROC are currently applying for grants for a variety of projects with the help of Mollie Borg (a freelance grants and trust consultant working for ROC). One grant she has identified for a large capital application is the Eveson Trust. After an initial enquiry to the Eveson Trust they replied with the following: Highlighted in Yellow is the detail we are seeking from Board. *'Thank you for your update. You may apply for a contribution towards the ultrasound machine once you have received quotes to give an indication of the price. Please ensure that the project budget in the application reflects all costs associated with the project including decommissioning of the old machine, installation and set up of the new machine and staff training.* ***Before considering an application, we need to be assured that the NHS Trust is committed to the project and that it will definitely happen. We have awarded grants to several NHS projects which have then been cancelled or severely delayed. So, your application should include an extract of the Trust's board minutes approving the purchase of a new ultrasound machine.***
How did you identify the need and this solution? *Details of any consultations with patients, service users or other sources of insight or evidence.*
Replacement of Ultrasound Machine is listed as part of capital spend that cannot be funded 24/25. The Eveson fund will be a maximum of £50K and it was felt that an equipment ask that could be covered in its entirety was the best option for this application.
When will your project start and end?
TBC depending on success of grant application and appropriate procurement.
Who will manage the process of implementing your idea?
Elizabeth Loach, Head of Imaging

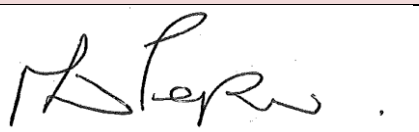
Section 3: Finance

Value requested
£50,000
Is this a one-off request or will there be recurrent costs? *If there are recurrent costs, how will these be funded?*
N/A
Have you confirmed with the finance team that there is funding available to support your request and that the expenditure is in line with purpose of the fund?
ROC would be reimbursed if the grant application was successful.
Which charitable fund should be used? Please request fund code from the finance team

General
Has the procurement team been involved in selecting the item and getting best value for money?
Sharon McGarry (Consultant Sonographer) has received 3 quotes for the machine needed working with the system procurement hub

Section 4: Sign off

	Research bids only I confirm I have provided evidence of ISAP committee and HRA approval *Tick box*

Applicant		
Name	Signature	Date
Elizabeth Loach		15/10/2024
Fund holder/Executive Director/Charity Manager Signature		
Name	Signature	Date
Marie Peplow		28/10/2024
Trustee sponsor (if applicable):		
Name	Signature	Date
(Alternatively, please provide an email showing the support of a Trustee)		

**Please note that the approval process depends on the amount requested*

Return completed forms to roc@nhs.net

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 29 October 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was suggested and agreed that two new risks be added to the Corporate Risk Register, one around productivity of theatres & the implications of not achieving a higher level of throughput; and another risk around achievement of the financial recovery plan. It was agreed that the risk around theatre staffing be strengthened to reflect the timescales and impact of any difficulties with recruitment. • The Trust delivered a deficit in month of £111k against a planned deficit of £37k, generating an adverse £74k variance. Year to date deficit totals £1,981k deficit against a deficit plan of £75k, generating an adverse £1,906k variance. • There remains a risk to the achievement of the Elective Recovery Fund and the delivery of the forecast activity plan. Total number of cases is on plan, however the case mix means that there is underperformance on elective cases and overperformance against day case activity. There would be an enhanced focus on elective recovery over the next two quarters of the year. • It was reported that there was a close focus on staff turnover given that there had been a rise and a 'deep dive' into short term sickness absence would be considered by the Staff Experience & OD Committee in December.	• Update the financial & operational elements of the Corporate Risk Register in line with suggestions. • Update on information from PLICS be considered on a quarterly basis. • Share the latest letter from the Integrated Care Board on the recent NHSE classification. • Provide an update at the next meeting on forecast recovery of disputed debt. • Share additional Cost Improvement Programme/Financial Recovery Schemes by mid-November.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee discussed the need for a series of 'deep dives' which would be presented over coming months. These were suggested to be: theatre productivity and seven-day operating; casemix & complexity of procedures; potential efficiencies in terms of Length of Stay and discharge; the hand service overview; procedures which could be converted from an Inpatient case to a day case; arthroplasty service overview; and outpatient transformation and Primary Care liaison.	• Committee agreed that the residual risk score of Risk 770 (aged theatre estates & plant) be increased to more accurately reflect the significant impact on levels of activity and income of any failure.

• The most appropriate metrics to measure productivity changes were discussed and it was agreed that the NHSE headline productivity metrics included in the draft Integrated Performance dashboard be used as the primary set of indicators, supplemented by a range of internal operational and financial measures, which would be included in a dynamic dashboard available from Spring 2025, although shadow monitoring would be introduced during the final quarter of 2024/25. • The Committee received a presentation on the PLICS (Patient Level Information and Costing System). It was noted how the system could be used to identify variability of cost/procedure between similar cases and individual surgeons. It could also be used to identify the relative contributions made by standard procedures, but this needed to be discussed at individual clinician and team level, which was underway. • It was reported that due to a close focus on the use of bank staff, there had been an in-month reduction, including across administration areas. • The Trust's performance against the range of operational measures, including constitutional standards, remains good. • The Trust continues to maintain its position in terms of avoiding having any patients waiting in excess of 65 weeks for treatment, agreed to be an excellent performance compared to the overwhelming majority of trusts; the next area of focus is to eliminate any cases waiting in excess of 52 weeks. • It was noted that the Trust is the best organisation in the country for on time theatre list starts. • Income from patients treated on a private patient contract was reported to be higher than planned in month and additional controls are being put in place to improve the efficiency of invoicing, with the service expected to achieve its financial end of year target. • The Committee received assurance reports from the Service Improvement Board and the Temporary Workforce Group.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting had included some useful discussions and that further time would be dedicated to the operational elements of the monthly report at the next meeting.

PAPER REFERENCE: ROHTB (11/24) 011

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 24 October 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was requested that two new risks be added to the workforce risk register: one around productivity and another to reflect the 7 day working plans. • There was reported to have been an increase in turnover, although a degree of this reflected staff who had retired but had returned. It was noted that there was more work to do to develop the flexible working offering to staff, which may lead to a decrease in turnover. • There was reported to have been an increase in the number of employment relation cases and grievances. It was noted that there was more work to do to embed conflict resolution practices which may help to prevent formal cases being raised in future. • Temporary staffing was reported to be higher than desired, namely the use of bank staff. Work is underway to review all posts filled by bank staffing to understand where the position could be addressed. • Sickness absence remains high in some areas and various measures are being used to improve this. • The overall Mandatory Training position was noted to be below expectations, particularly for those modules which require annual renewal. A trajectory for the recovery of the resuscitation training compliance by Christmas was reported to have been developed.	• The Race Code action plan was reported to be under development, following the recent workshop with RSM UK. • It was reported that following the publication of a new national framework around productivity, plans would be developed to align the improvement work at the ROH to this. The overall plan would be shared in November. • It was agreed that a summary of the key elements and impact of the new Employment Rights Bill would be presented at the next meeting. • It was suggested that work be undertaken to define a set of metrics that the Committee could monitor to identify key risks and define the pace of change. • Update on plans to address sickness absence at the next meeting. • Present the plan to address medical staffing vacancies at the next meeting. • Further work is underway to improve the disability declaration rates. • It was agreed that further work was required to clarify the actions within the WRES and WDES action plans.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
➢ The Committee welcomed the ward manger of the Admissions and Day Case Unit who described her experience of working at the ROH. She was pleased at how the Trust had supported her development over the years, but highlighted how further work could be done to advance the uptake of Professional Nurse Advocate training. She also highlighted the opportunities she saw with improving the efficiency and productivity of the organisation through better patient flow and theatre utilisation.	• The Committee approved the proposed changes to the workforce risk register.

➢ It was reported that a new HR Business Partner had joined, this being a new role for the ROH. A new workforce planner would also start shortly. ➢ The consultation on 7 day working in theatres had concluded and had been a positive experience. ➢ A management development training plan was reported to be under construction which would provide accreditation to those participating. It was suggested that this needed to be linked to the 7 day working and productivity work. ➢ Time to Hire had reduced to 55 days from a high of 85 days. ➢ A strengthened process for vacancy approvals was reported to have been implemented including the requirement for a quality impact assessment, Executive sign off and where the seniority of the role requires it, System approval. ➢ The Trust received assurances that there was compliance with the medical revalidation requirements and that there was a plan to create a specific resource to support the revalidation work. ➢ An update on violence and aggression incidents was presented, which highlighted that the Trust complied with its legal requirements to protects staff and patients from harm. It was noted that violence and aggression incidents were low risk at the Trust given its elective nature. ➢ The Committee received a positive update on the work completed and impact created by the University of Birmingham student placements. Funding is being sourced for four placements for the current year. ➢ A positive update was received on the work to recruit and develop apprentices within the organisation. 27 apprentices are currently in post, with plans to recruit a further set over coming months. ➢ An update on the position against the Workplace Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) was presented which overall showed a positive position. ➢ It was reported that Uzo Ehiogu had been appointed as the programme lead for the MSK academy.	

Chair's comments on the effectiveness of the meeting: The Committee agreed that the face to face meeting had been helpful and noted that the reports provided a high level of assurance on workforce matters which could be offered upwards to the Trust Board. Jane Teo was welcomed as a new member of the Committee.

Finance and Performance Report

Month 6

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.

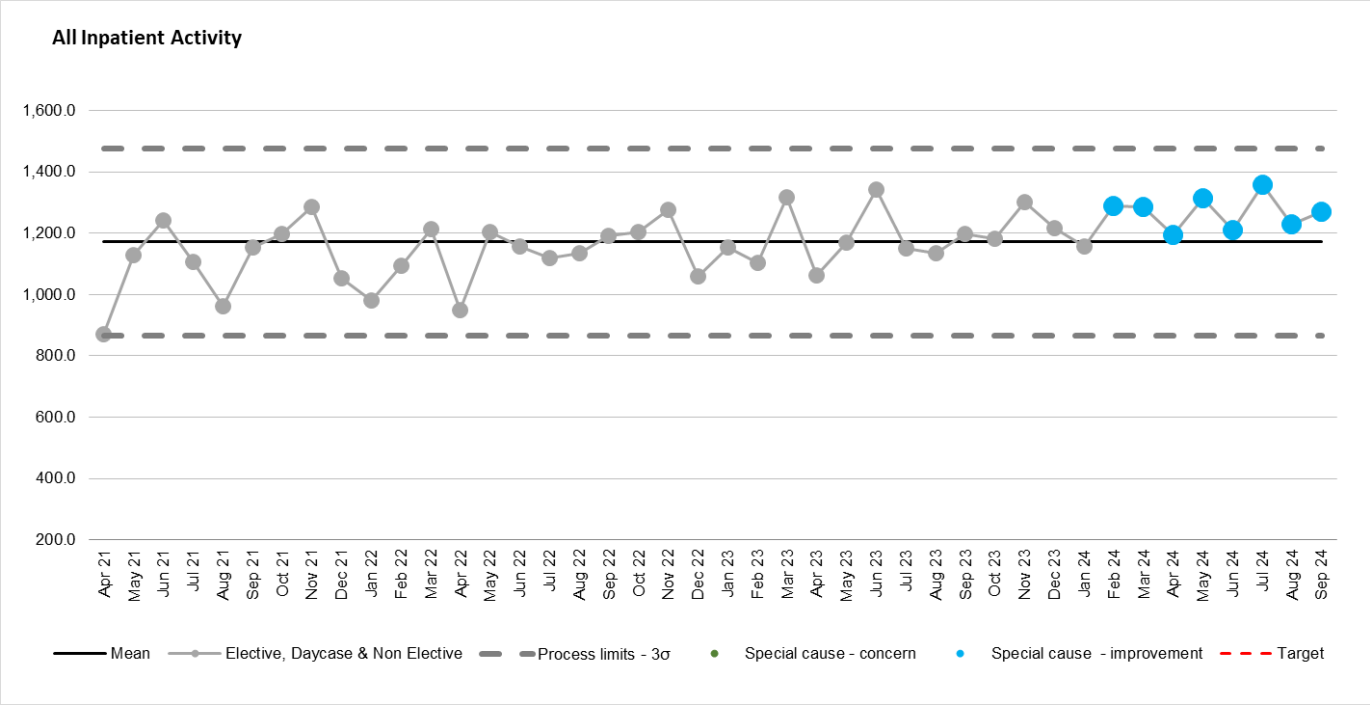
Operational Performance Summary

Performance to end September 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	52.90%	53.36%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	0	9	0		
52 week waits (52 – 64 Weeks)	641	590	0		
All activity YTD (compared to plan)	7,576	6,307	7,556		
Outpatient activity YTD (compared to plan)	35,646 109.7% Cumulative	29,750 111.3% Cumulative	32,491 YTD Target		
Outpatient Did Not Attend (YTD)	7.9%	7.7%	8%		
PIFU (trajectory to 5% target)	566 10.01%	507 9.43%	425 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.0%	11.0%	19%		
FUP attendances(compared to 19/20)	99.4%	100.3%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	114.0%	115.7%	120%		
Diagnostics volume YTD (compared to plan)	13,131 Cumulative	11,007 Cumulative	13,171 YTD Target		
Diagnostics 6 week target	99.8%	99.9%	99%		

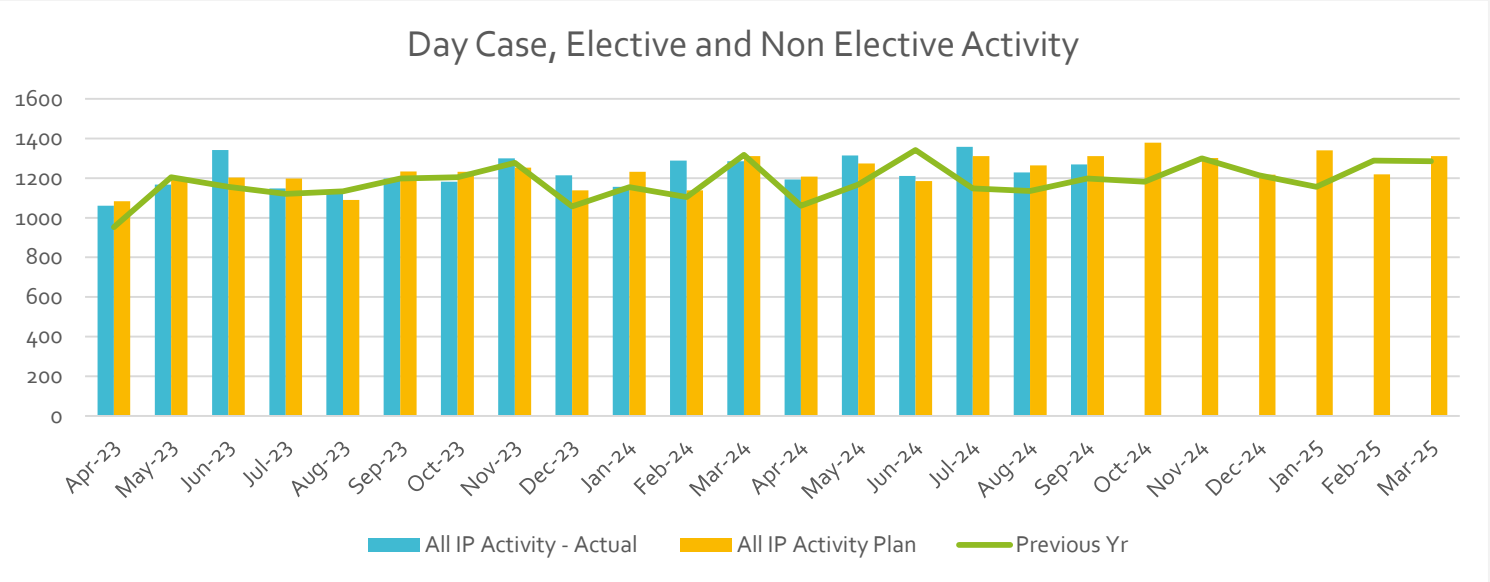
Operational Performance Summary

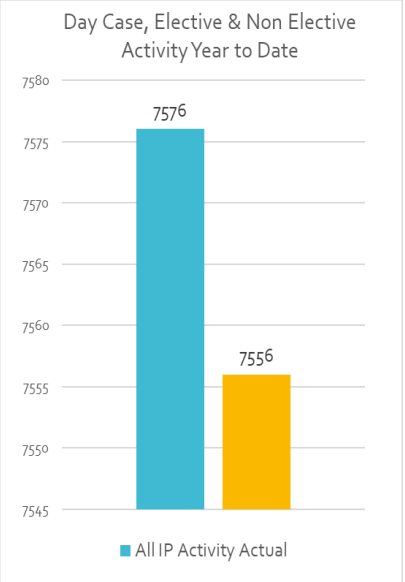
Performance to end September 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	86.5%	83.2%	85%		
Theatre In Session Utilisation (Uncapped)	83.6%	81.3%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	93.7%	82.3%	70% Nat 85% Trust		
28 day FDS	87.2%	81.8%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	12,977	10,867 Cumulative	11,335 Cumulative		
Bed Occupancy (excluding CYP and HDU)	72.5%	67.2%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.13	3.69	n/a		
LOS - elective primary hip	3.1	2.8	2.7		
LOS - elective primary knee	3.0	3.3	2.7		
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Jun 24	61.30%	59.70%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar'24)	36.3%	-	-		

1. Activity Summary



1. Activity Summary - New slides





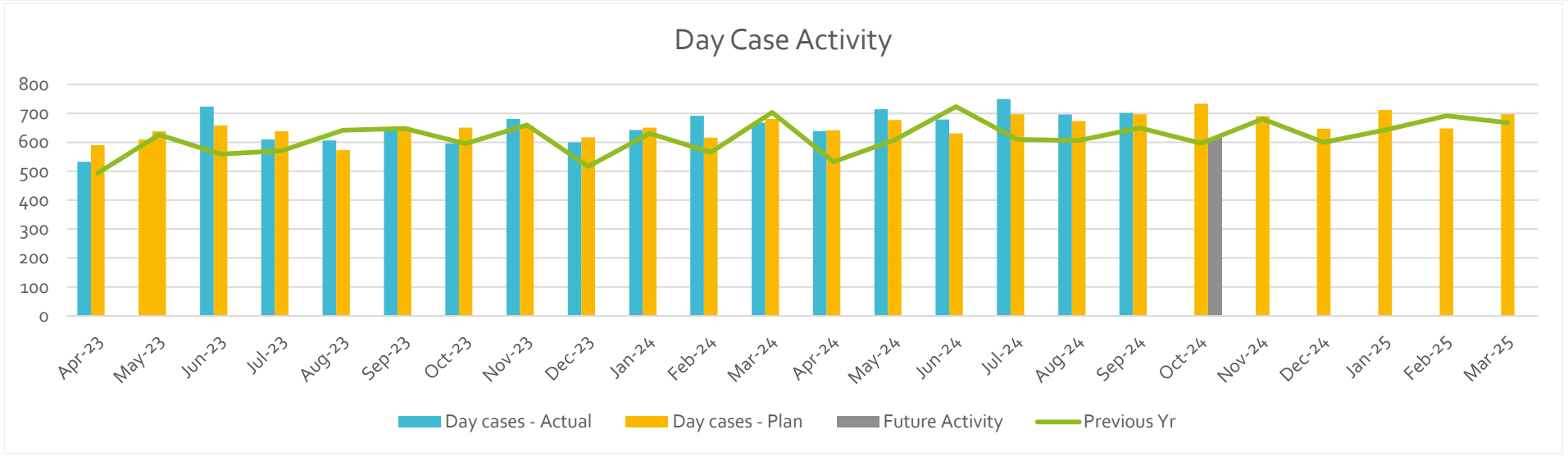
	Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	554	584	542	602	580	602	632	598	560	614	560	602	3464	3285	95%	-179
	Daycase	642	677	631	697	673	697	733	691	647	712	648	697	4017	4180	104%	163
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	75	111	148%	36
	All Activity	**1208**	**1274**	**1186**	**1312**	**1264**	**1312**	**1379**	**1302**	**1218**	**1340**	**1219**	**1312**	**7556**	**7576**	**100%**	**20**

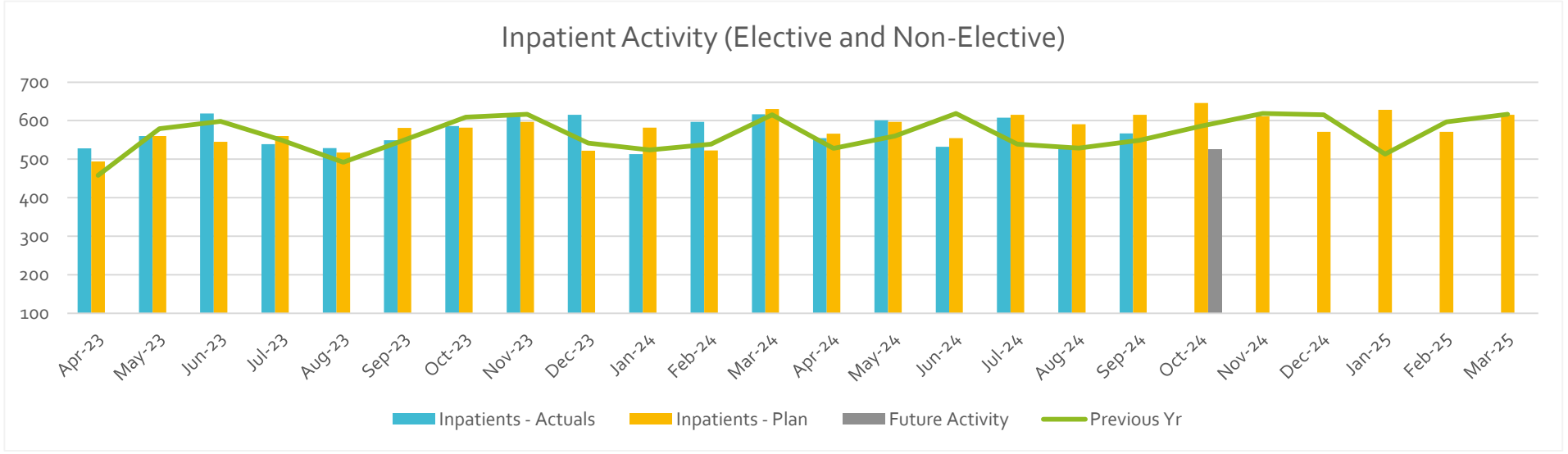
September 2024

Figures include BCH activity from April 2024
In month performance: Actual activity was 1270/1312 (-42 cases behind the stretch activity target).
Year to Date the Trust remains 20 cases ahead of the annual activity plan.

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

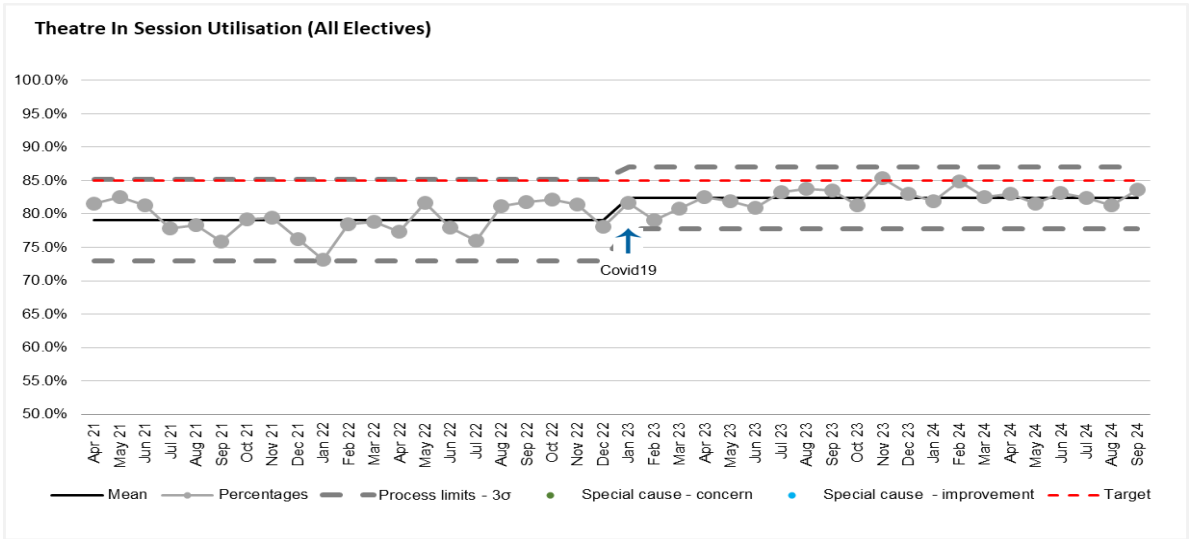
1. Activity Summary

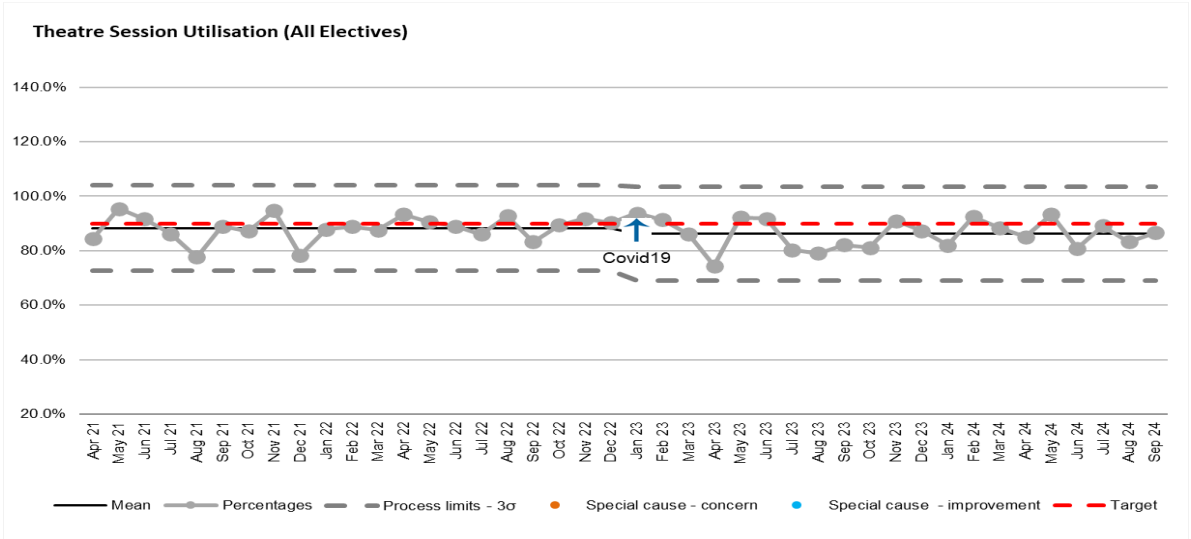




2. Theatre Utilisation

DATA QUALITY KITEMARK

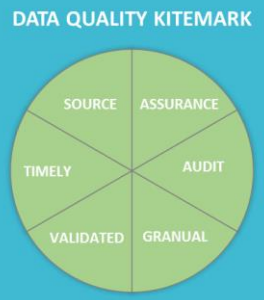




Elective Session Utilisation (September 2024)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	507	435	72	85.80%
UHB	42	40	2	95.24%
Totals	**549**	**475**	**74**	**86.52%**

Elective In Session Utilisation (September 2024)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1891	1584	307	83.76%
UHB	181	148	33	81.80%
Totals	**2071**	**1731**	**340**	**83.59%**

2. Theatre Utilisation



SUMMARY

Overall theatre session utilisation for September was **86.52%.**

The overall in-session utilisation for September was **83.59%.**

Cancellations on the day, as detailed in the next 2 slides impacted on ROH Utilisation in month.

AREAS FOR IMPROVEMENT

BI colleagues are adding turnaround times as a metric to the theatre dashboard so that baseline data can be collected. The Theatre Improvement Group has now established a working group to focus on this with the GIRFT Theatre Specialist also attending. The aim is to improve theatre efficiency by addressing theatre turnaround times, late starts and unplanned overruns to help reduce delays and maximise resources.

The standby/contingency patient process has been rolled out to Hands; Mr. Brewster has identified patients although there hasn't been a requirement to use the standby process at this time. Discussions have taken place with Spinal and Arthroplasty to ensure a full rollout by the end of November.

A virtual standby theatre has also been set up in TheatreMan so that when patients are identified they can be recorded appropriately.

• RISKS / ISSUES

- UHB have confirmed retention of 3 theatre days per week. Recruitment to vacant consultant posts will offset the reduction in UHB activity.
- A review has taken place of demand and capacity data to ensure that consultant recruitment delivers 50 weeks in line with specialty backlogs.
- The table below includes the latest recruitment position by specialty:

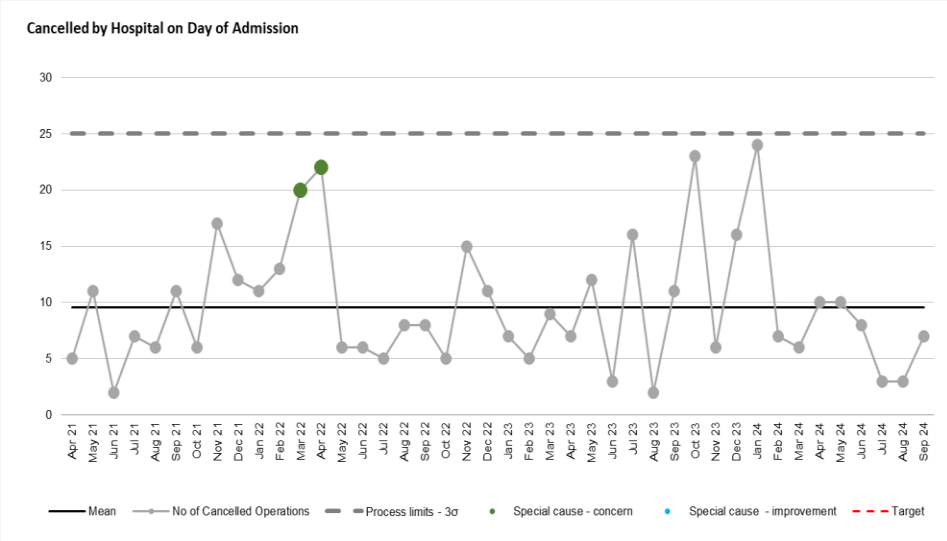
Specialty	Progress
Spinal	1 x Oncology post – interviews 26.11.24 / 1 x Degenerative post starts 04.11.24 / 1 x Spinal Deformity – Approved by Royal college – to advertise with interviews on 12.12.24
Arthroplasty	2 posts with the Royal College of Surgeons for JD review – will be advertised early Nov 24
Hands	2 posts with Royal College of surgeons for JD approval – will be advertised early Nov 24
Arthroscopy	1 commenced in post Mid-August 24

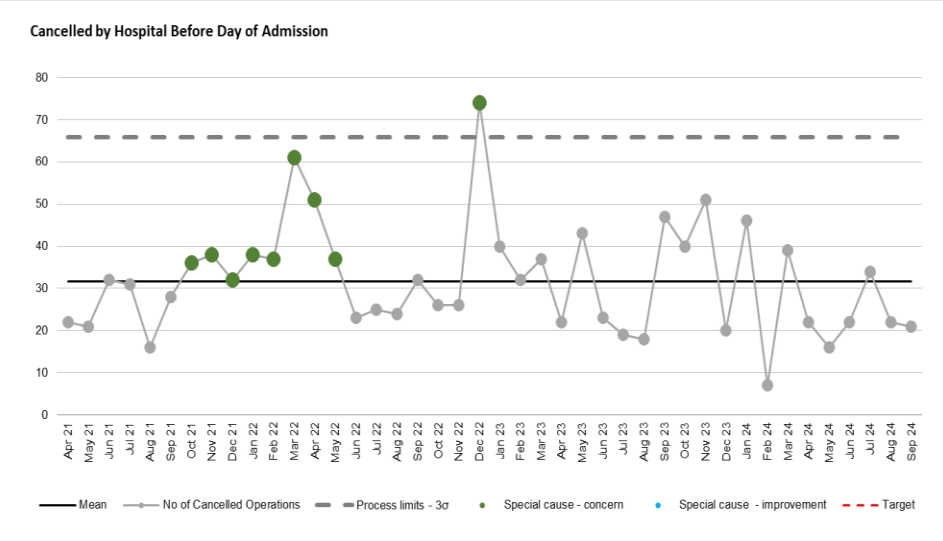
2. Theatre Utilisation - Seamless Surgery Update

SEAMLESS SURGERY ACTION PLAN

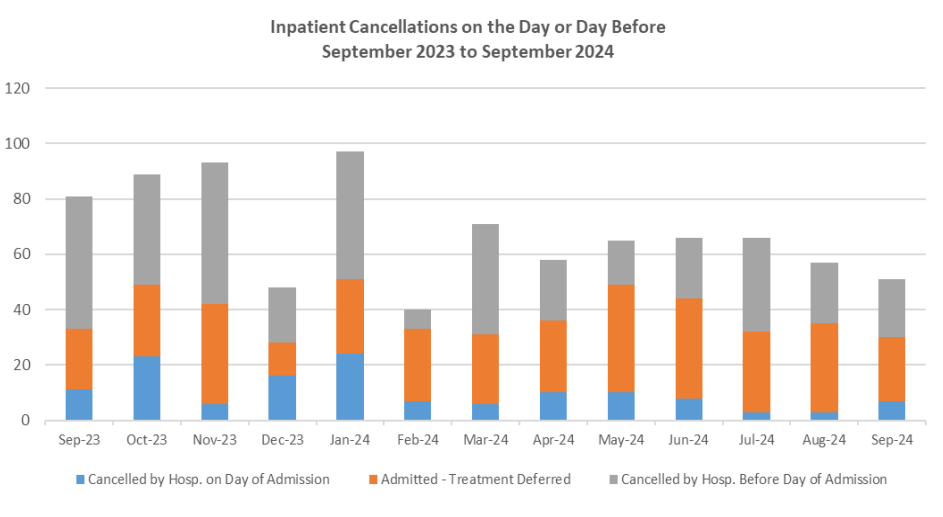
1. Instrument Integrity – 20 power tools have been delivered into theatres for use.
2. Theatre maintenance programme agreed for the next 3 years that includes repairing the HDU corridor in December 24.
3. 7 day working consultation for theatre staff has concluded with themes and feedback provided to staff.
4. 6 Image Intensifiers have been delivered and are now in use in theatres.
5. IPC and Senior Leadership Team regularly review the theatre environment.
6. Theatre male changing room currently being timetabled in to minimise impact on activity.
7. Capital agreed for Spinal Microscope with Procurement underway.
8. Staggered admissions have been reviewed for all specialities with 2 times standardised.
9. Additional afternoon huddle still in place to forward plan the theatre preparation for the next day to prevent any last-minute cancellations.
10. Standby patient process has started in Hands and is being rolled out across other specialities.

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
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
Aug-24	3	32	22	57	0
Sep-24	7	23	21	51	0
Total	**134**	**359**	**389**	**882**	**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 September24:

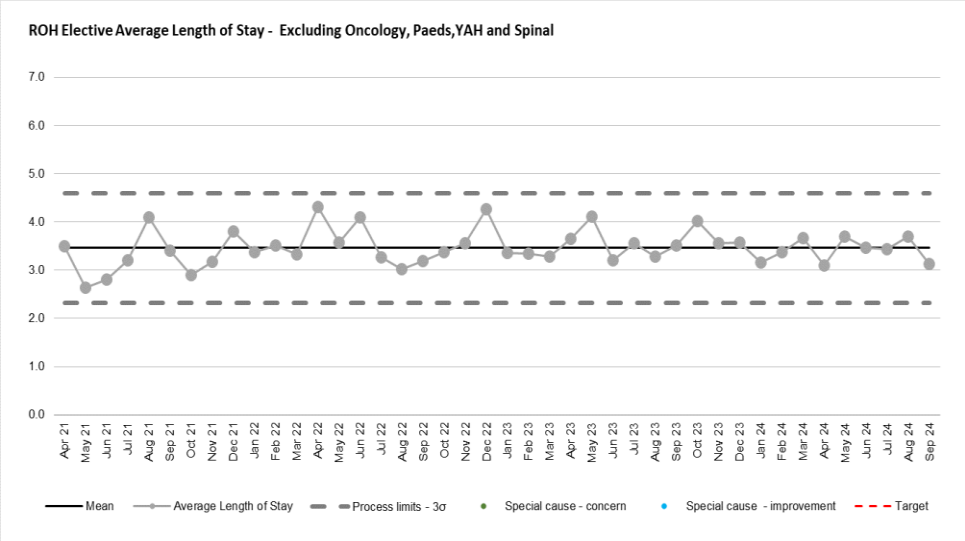
Patients cancelled on the day x 7	Patients admitted and had treatment deferred x 23	Patients cancelled by the hospital the day before the date of admission x 21
Clinical 1 x Consultant unavailable/un-well 3 x Patient self-cancelled / unwell /change in plan / pt declined procedure 1 x Replaced by more urgent case Non-Clinical 1 x Equipment failure - unable to proceed 1 x Lack of theatre time – due to complex cases	Clinical 2 x Medically unfit / not stopped meds 3 x Skin integrity - insect bites/dog bites/ulcer etc. 4 x Patient self-cancelled / unwell / Change in plan / pt declined procedure Non-Clinical 1 x Lack of equipment – Surgical tray required in another theatre 6 x Lack of theatre time – due to complex cases 7 x Consultant unavailable/un-well/staffing skill mix	Clinical 6 x Medically unfit. 3 x Replaced by more urgent case 8 x TCI date not convenient for patient/change in TCI date Non-Clinical 3 x Consultant unavailable/un-well 1 x Ambulance Service unable to transport patient

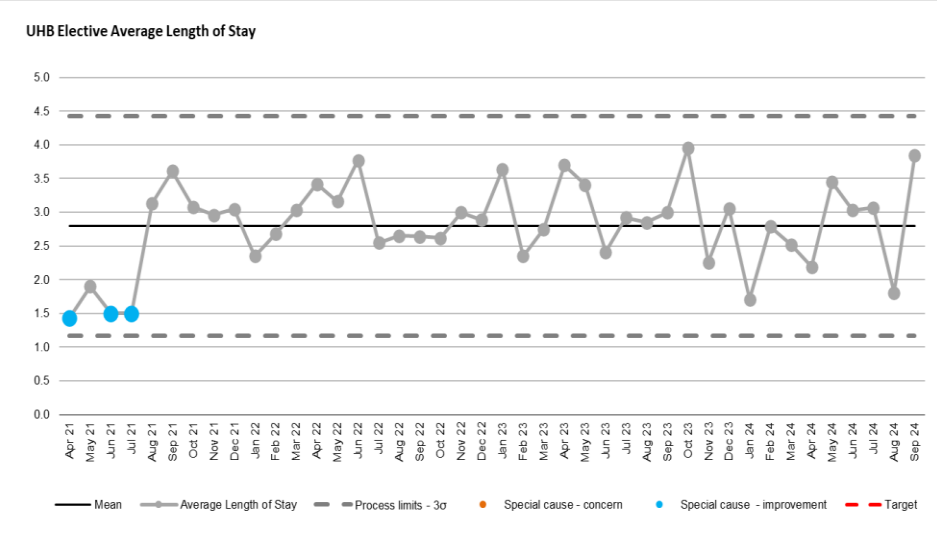
AREAS FOR IMPROVEMENT/ RISKS/ISSUES

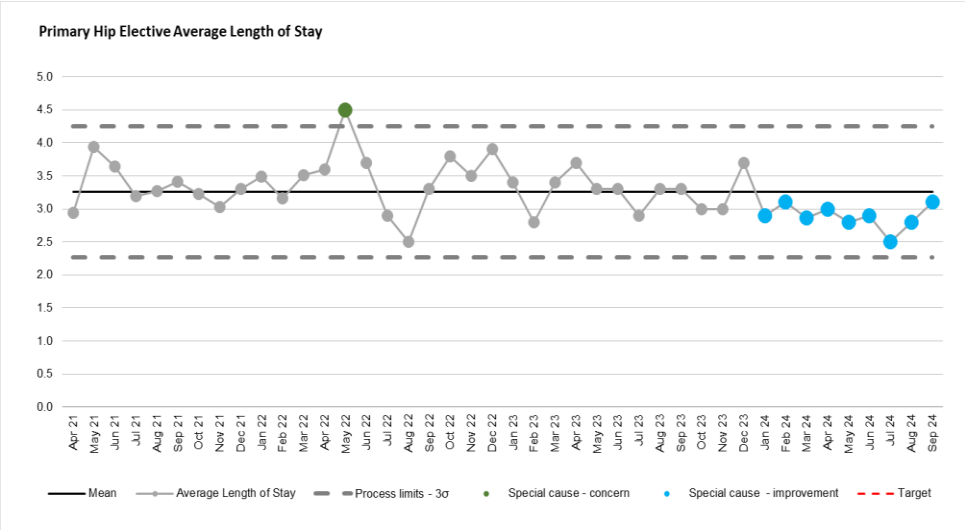
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

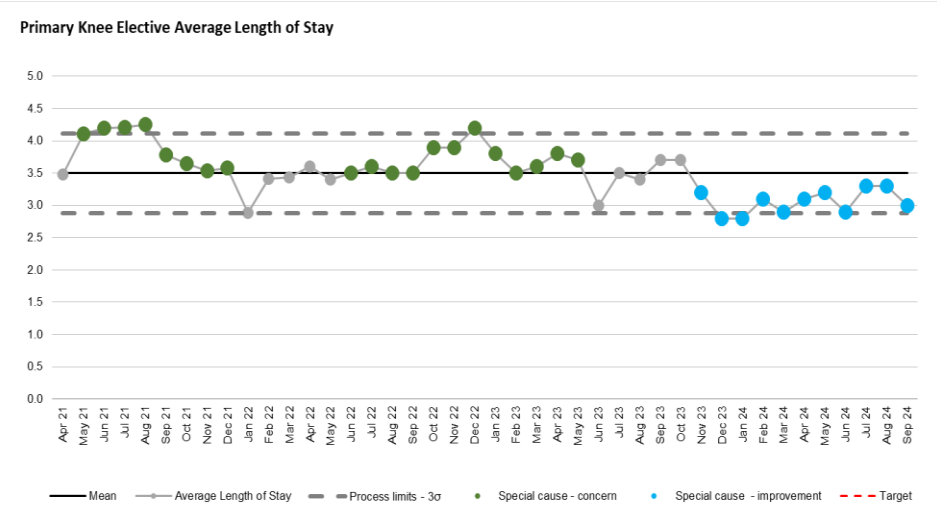
Pilot for 7-10 day pharmacy calls to be carried out in POAC commenced w/c 07/10/24 for 2 weeks with the aim to reduce the number of cancellations. An audit of the pilot will be compiled and reviewed to inform improvements in processes. Early feedback has been very positive from patients who have appreciated the contacts to remind them of the stopping/starting medicines instructions.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips increased to 3.1 days (2.8 days August 24) and primary Knees has decreased at 3.0 days (3.3 days August 24).

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.13 days** (3.69 days August 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 9 (5 Aug), 6 arthroplasty and 3 Oncology arthroplasty. 2 had an ASA score of 3 (Severe systemic disease), 6 had an ASA score of 2 (mild systemic disease).1 had an ASA score of 1 (normal healthy patient). This patient's LOS was 9 days due to physio need. On review of clinical noting LOS for other 8 was due to on-going therapy (OT or Physio), clinical care needs or social care needs.

A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 26 (28 Aug).
13 were Oncology Arthroplasty, and 13 were Arthroplasty.

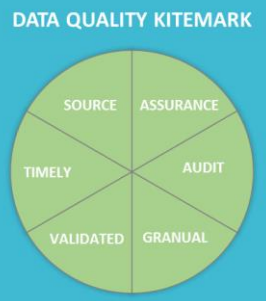
Review of the 6 long stay patients >15 days (12 Aug) 3 were Oncology Arthroplasty, 3 was Arthroplasty. Longest stay 54 days (42 days Aug), complex Oncology Arthroplasty/plastics with clinical and bone infection needs.

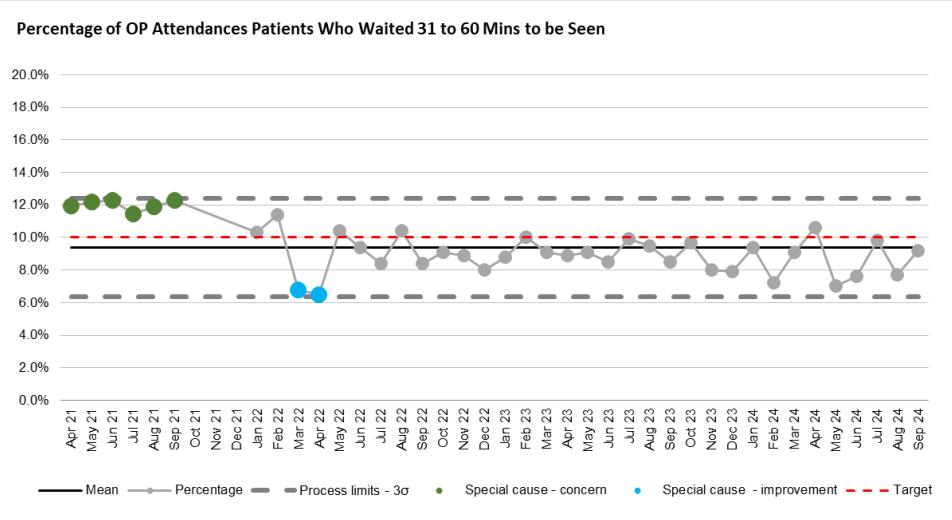
All stays >15 days reviewed on PICS appeared appropriate, were either complex surgery/ clinical needs/co-morbidities or discharge planning.

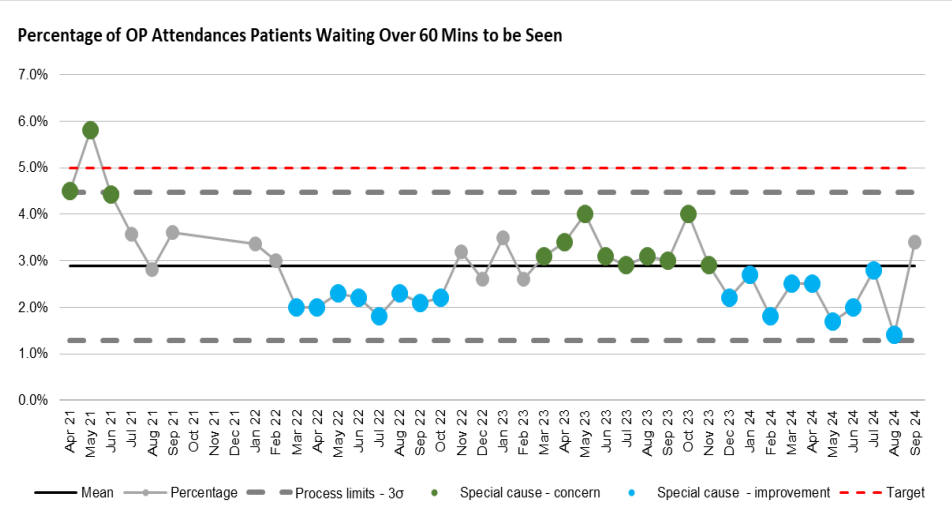
AREAS FOR IMPROVEMENT / ACTION PLAN

- Social care capacity-delays, particularly out of area. Daily monitoring and escalation process is in place.
- Bone infection and MRC patients – review taking place of discharge/repatriation process.
- Number of patients converting from day case to overnight stay for non-clinical reasons. Review under way by Division 2 awaiting outcome.
- Alignment of support services to 7 day working.
- Renewed focus on BADS data reporting to SIB following changes to dataset.

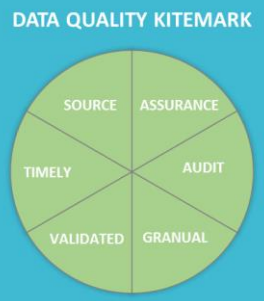
4. Outpatient efficiency

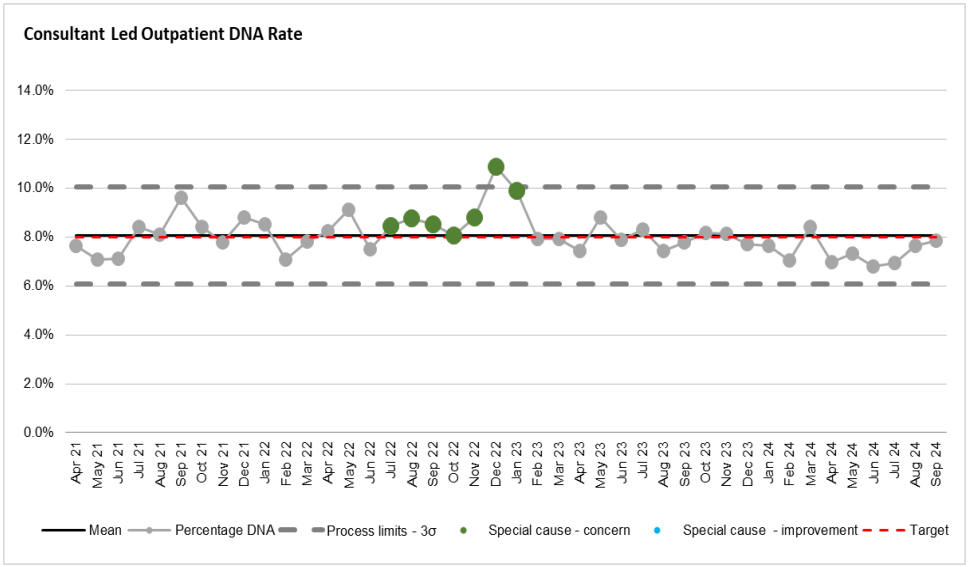


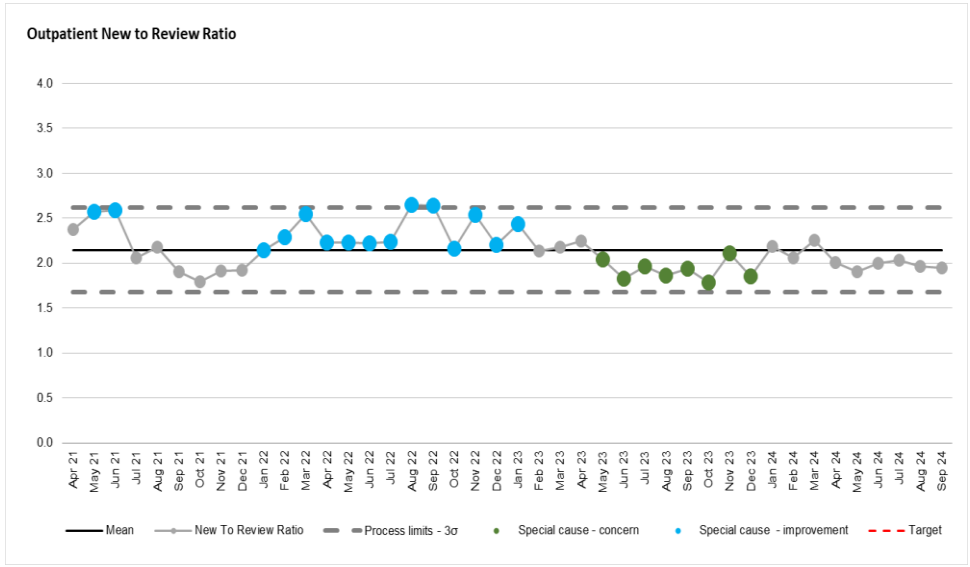


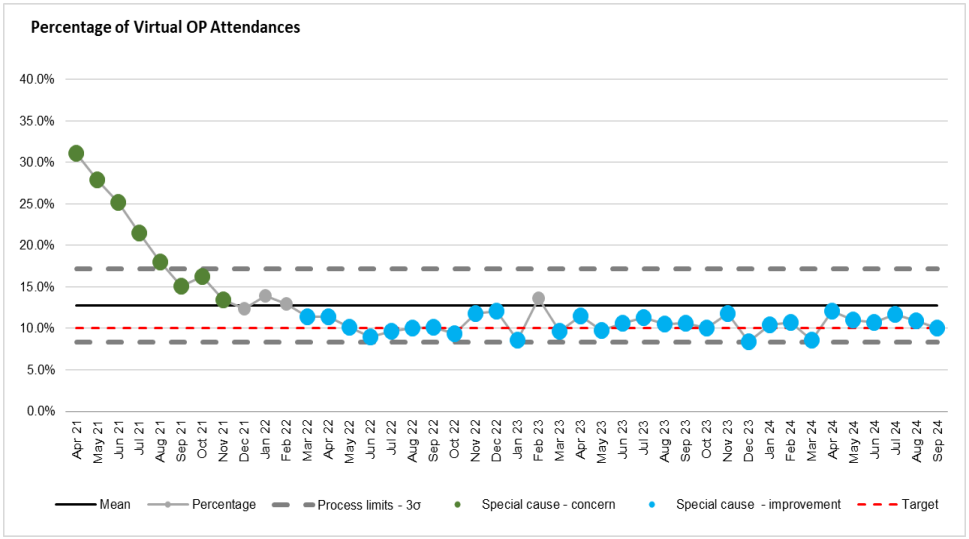


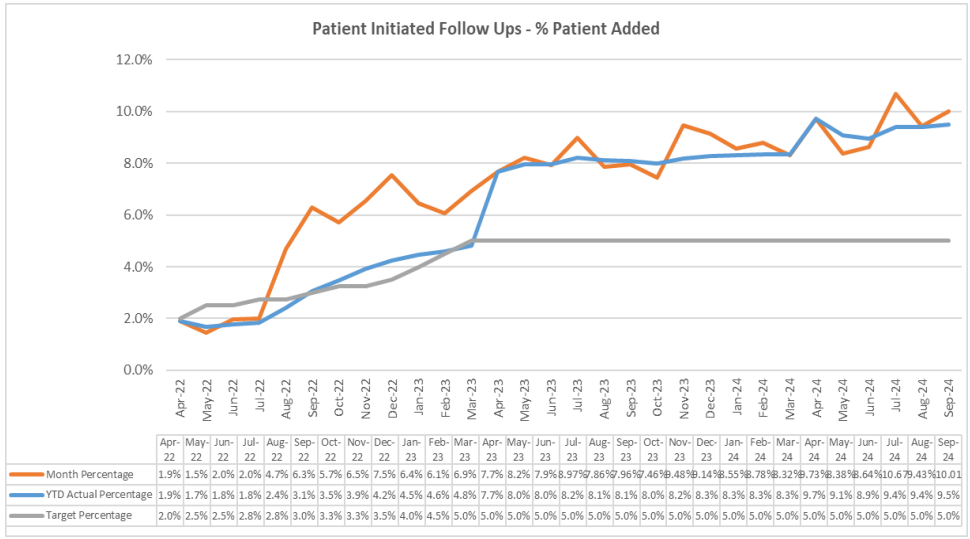
4. Outpatient efficiency







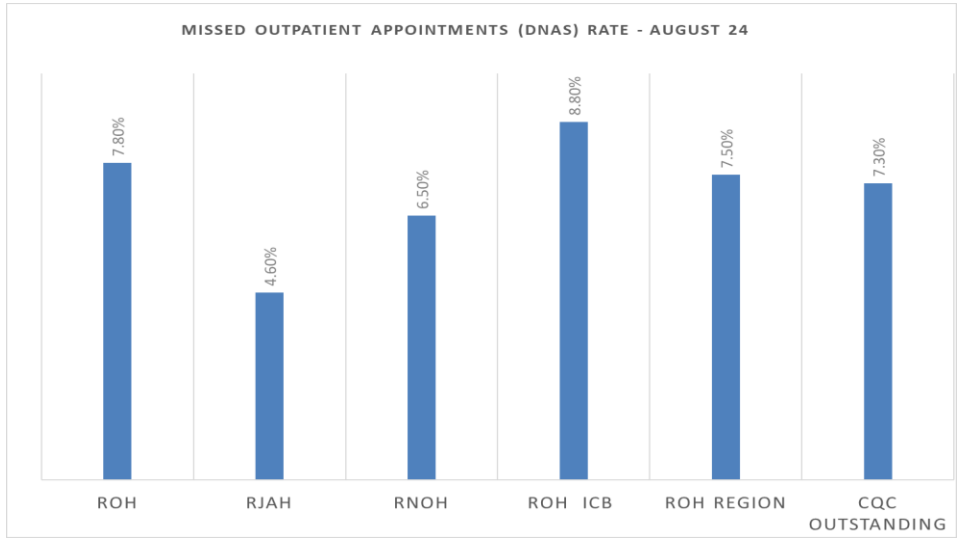


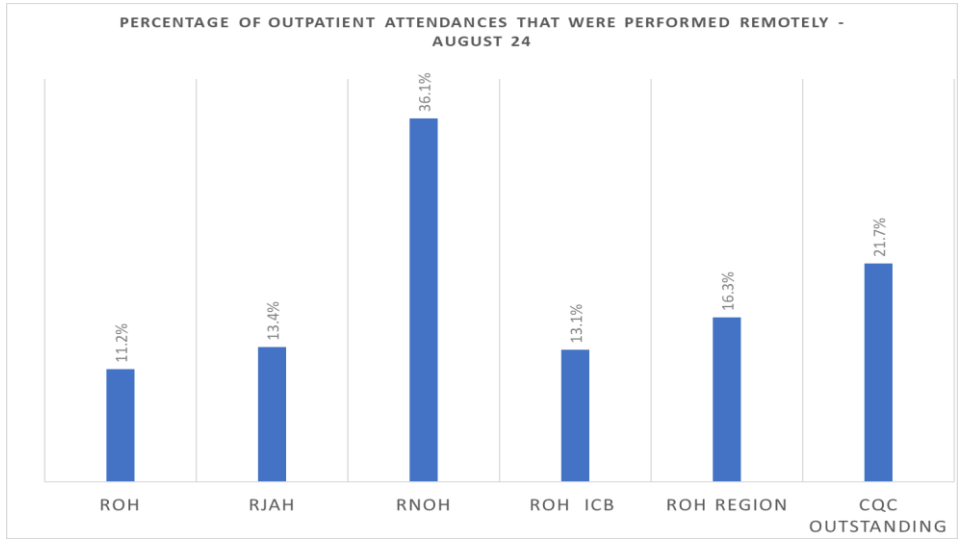


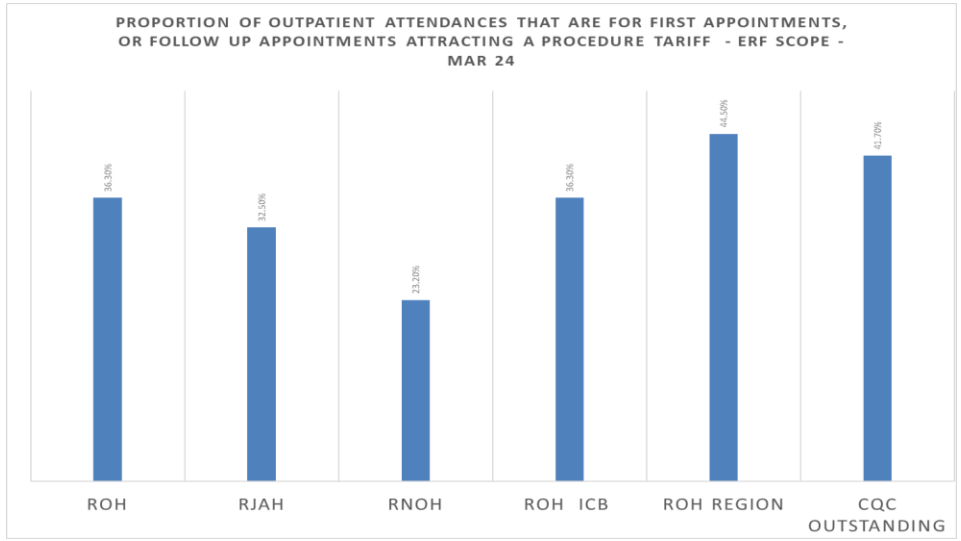
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Month Percentage	1.9%	1.5%	2.0%	2.0%	4.7%	6.3%	5.7%	6.5%	7.5%	6.4%	6.1%	6.9%	7.7%	8.2%	7.9%	8.97%	7.86%	7.96%	7.46%	8.48%	8.14%	8.55%	8.78%	8.32%	8.73%	8.38%	8.64%	10.67	9.43%	10.01
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%	8.0%	8.2%	8.3%	8.3%	8.3%	8.3%	9.7%	9.1%	8.9%	9.4%	9.4%	9.5%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

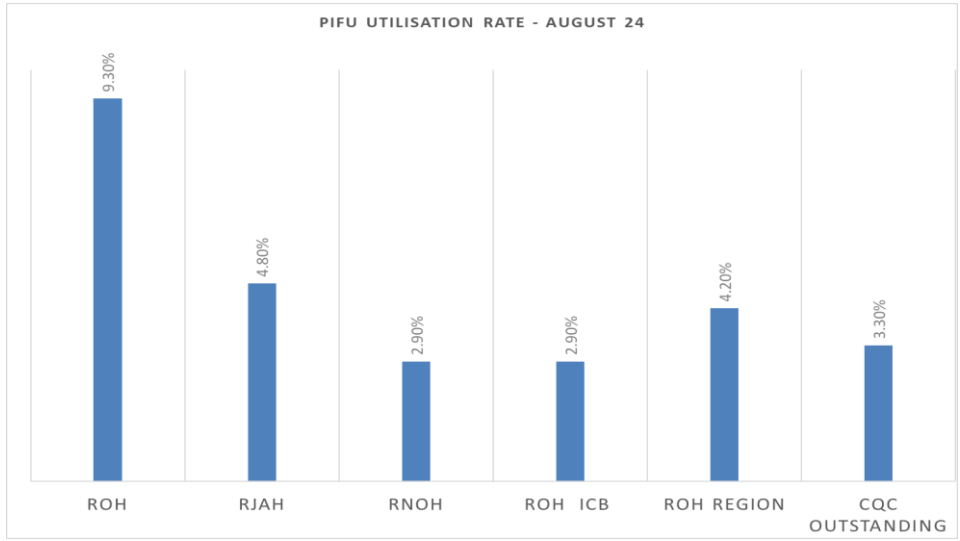
4. Outpatient efficiency

DATA QUALITY KITEMARK









4. Outpatient efficiency

DATA QUALITY KITEMARK

SUMMARY

September 2024 performance is as follows:

- 5,305 face to face and 591 virtual appointments
- 10.02% virtual in total.
- 10.01% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 9.5%.
- 7.85% Missed Appointment (DNA) rate – lower than the Trust target of 8%

- **Clinic Waiting Times**
- 30-minute delays – meeting Trust Target at 9.2% **(Target 10%)**
- 60-minute delays – meeting trust target at 3.4% **(Target 5%)**

AREAS OF IMPROVEMENT

Outpatient Utilisation

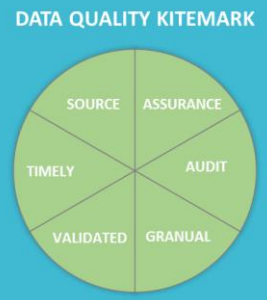
We have seen an increase overall with new outpatient appointments year to date. The team remain focused on clinic utilisation, monitoring room usage, numbers of patients booked. Specialty scheduling meetings (6-4-3) are well attended by all specialties and the booking coordinators. The Friday check and Challenge/Look Back meeting provides added assurance and interaction between the operational and nursing team.

Review of KPI's also form the agenda of these meetings, items for discussion and action are follow up waiting lists, PIFU and RMS triage numbers, un-booked urgent patients and missed appointment numbers. Any areas of concern identified are escalated accordingly to Divisional Associate Director of Operations and specialty manager via the Monday divisional operational meeting. Un-booked capacity is also discussed and challenged at this meeting.

Missed Appointments (MA)
MA monthly meetings continue with a review of ICB MA toolkit, monitoring of Dr Doctor text messaging and MA prediction tool. Further development of the Dr Doctor system are underway which will provide additional functionality for patients to book, cancel and reschedule their appointments.

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 a focus on clinic utilisation and run by the booking coordinators and overseen by the appointments manager / CSSM. There is also a staffing review being undertaken to ensure that the appointments team have sufficient resource to meet the demand.

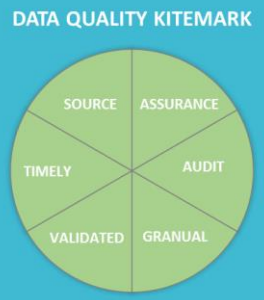
4. Outpatient Transformation



SPECIALTY PRIORITY UPDATES / HIGHLIGHTS

PIFU	Missed Appointments	Reduction in Follow Ups	Clinical Pathways (e.g. Specialist Advice)	Productivity & Efficiency
The ROH continues to be a national exemplar for PIFU (6th nationally and top of peer group). Coding is being scoped for the Dr Doctor PIFU module to automate validation of the waiting list and create a record for patient requests to be seen.	**Configuration for TIARA has been delayed due to difficulty with coding.** NHS Wayfinder has gone live for stage 2. E-meet and greet module in Dr Doctor being explored. Arthroplasty continues to show best practice with a 4.9% MA rate.	Continue to follow GIRFT best practice. Business intelligence request to support GIRFT pathways and identify variance.	Referral criteria needs to be confirmed for Primary Care. Activity has been confirmed for A&G via national reporting team.	Dr Doctor bid sent to ICB. Development in scope for digital PIFU and e meet and greet commenced. We are creating outpatient metrics for in session utilisation in line with theatre productivity monitoring.

5. Referral to Treatment



SUMMARY

The Referral To Treatment (RTT) position for September was 52.90% against the National Constitutional Target of 92%. This represents a 0.46% decrease compared to the August reported position of 53.36% that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

There were 0 patients over 65 weeks and 641 patients waiting over 52 weeks in September, an increase from the trust wide position in August which was 599 patients. Majority of the patients sit within the Spinal Service, and we are currently triaging referrals and scoping support from MSK.

During September 24, ROH received 2,301 referrals (85.10%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

The trust validation team are completing an enhanced validation on all Patients pathways that are due to breach 52 weeks up until March 2025 to allow additional focus on ensuring the delivery of zero 52 week waits.

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. Due to the increase in the Trust's total waiting list size, a business case is in progress to support the growth of the Validation team to ensure that the team can maintain a comprehensive Validation. The deficit is currently being provided by Bank following the change to validation numbers stipulated by NHSE in September 2023.

New reporting on our 52 week breach cohort is being introduced within the business intelligence department to support the specialties.

RISKS / ISSUES

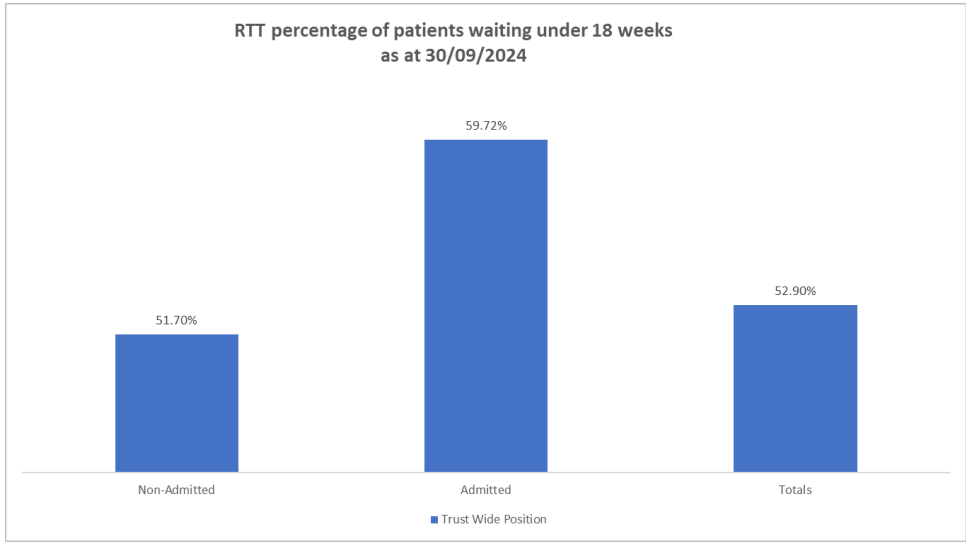
Spinal backlogs continue to be a concern with the team focussing on managing all patients currently over 60 weeks and preventing tip ins. Spinal is to be prioritised with the roll out of GIRFT follow up recommendations. Deputy COO is providing specific support to the Spinal team reviewing processes and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

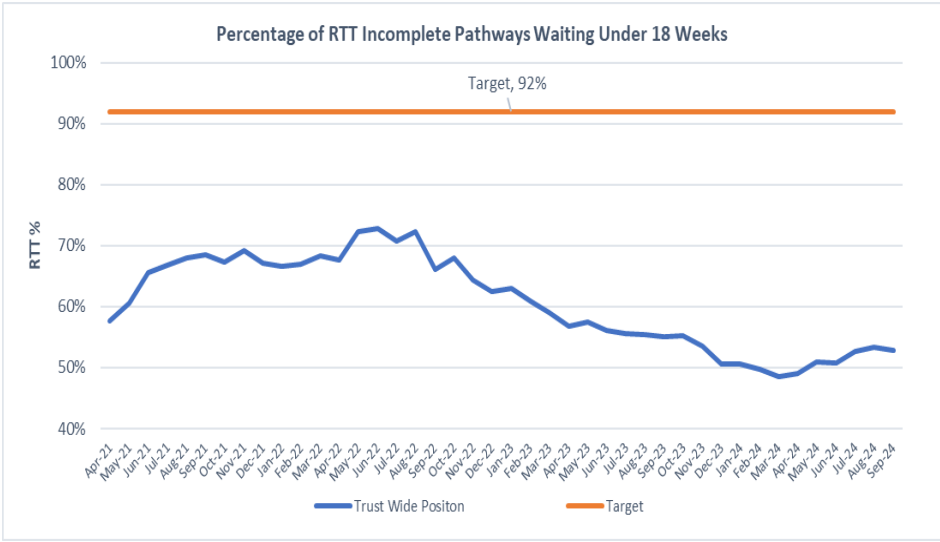
5. Referral to Treatment

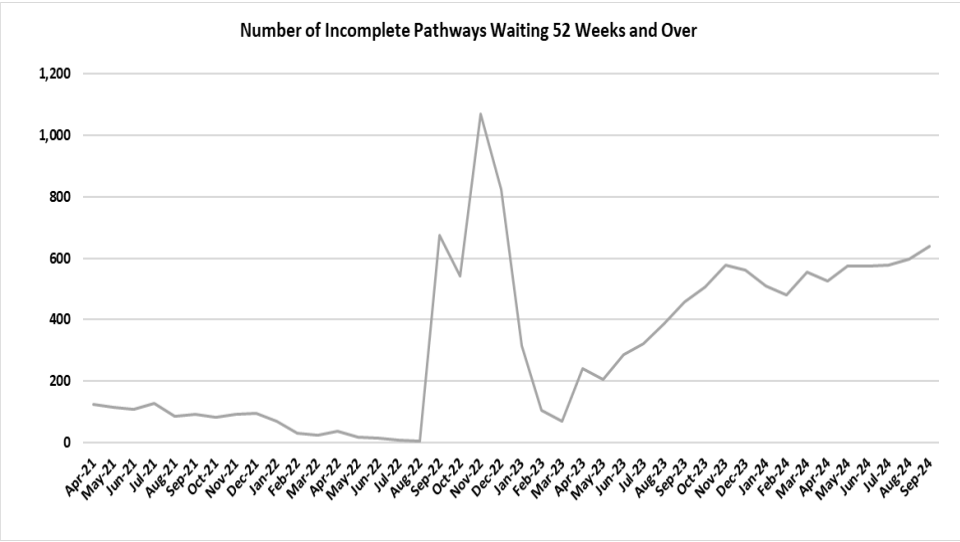
DATA QUALITY KITEMARK

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,989	616	3,605
7-13	2,565	523	3,088
14-17	1,066	213	1,279
18-26	2,090	387	2,477
27-39	2,075	331	2,406
40-47	1,031	99	1,130
48-51	409	34	443
52 weeks and over	580	61	641
Total	12,805	2,264	15,069

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,620	1,352	7,972
18 and over	6,185	912	7,097
Month End RTT %	**51.70%**	**59.72%**	**52.90%**



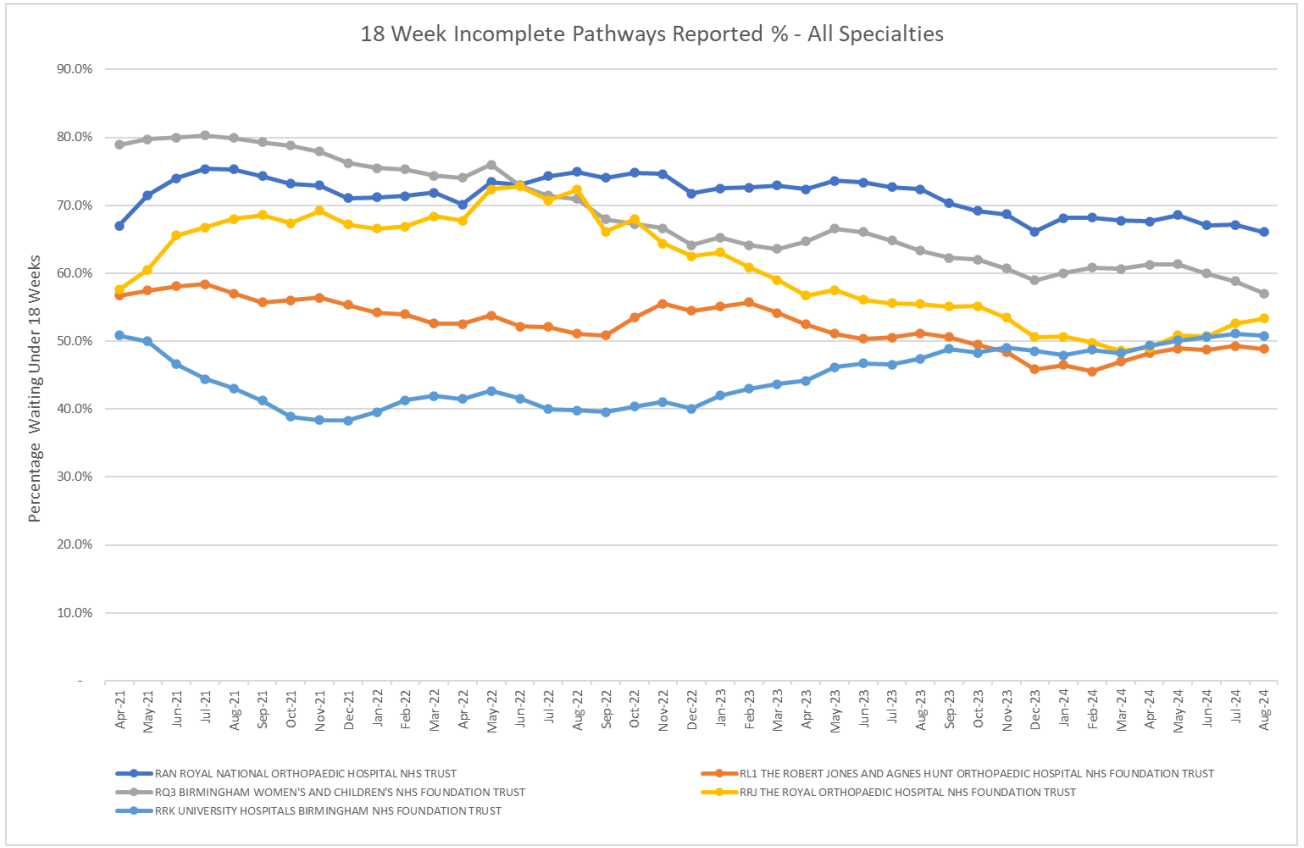




5. Referral to Treatment

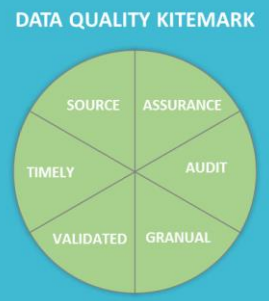
DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:

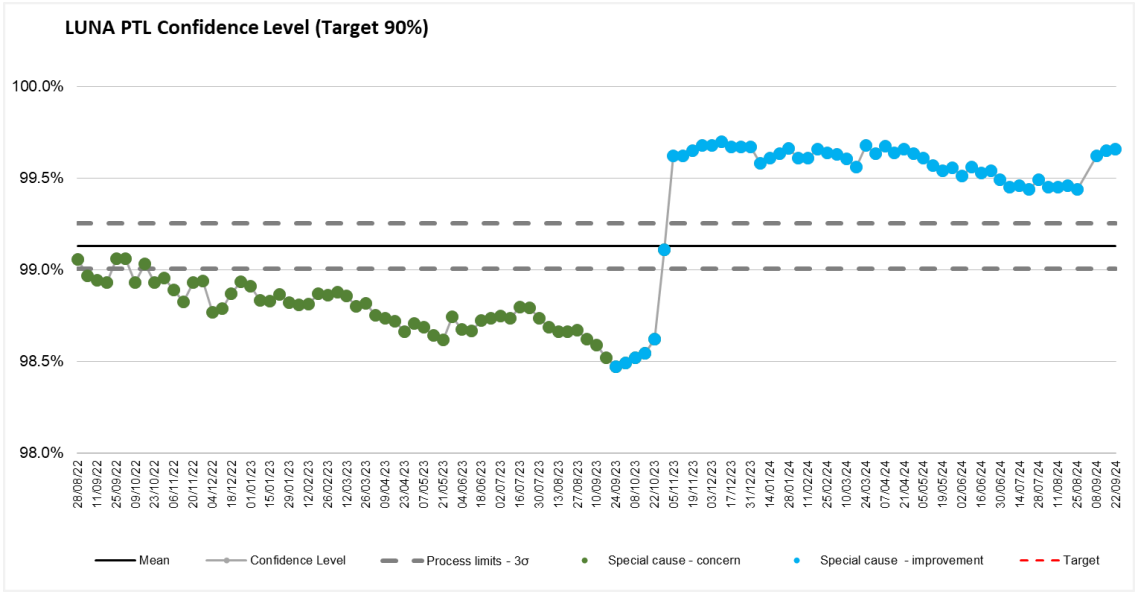


5. Referral to Treatment

Luna Data



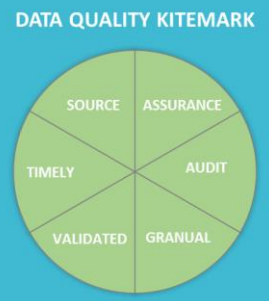
The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with 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.

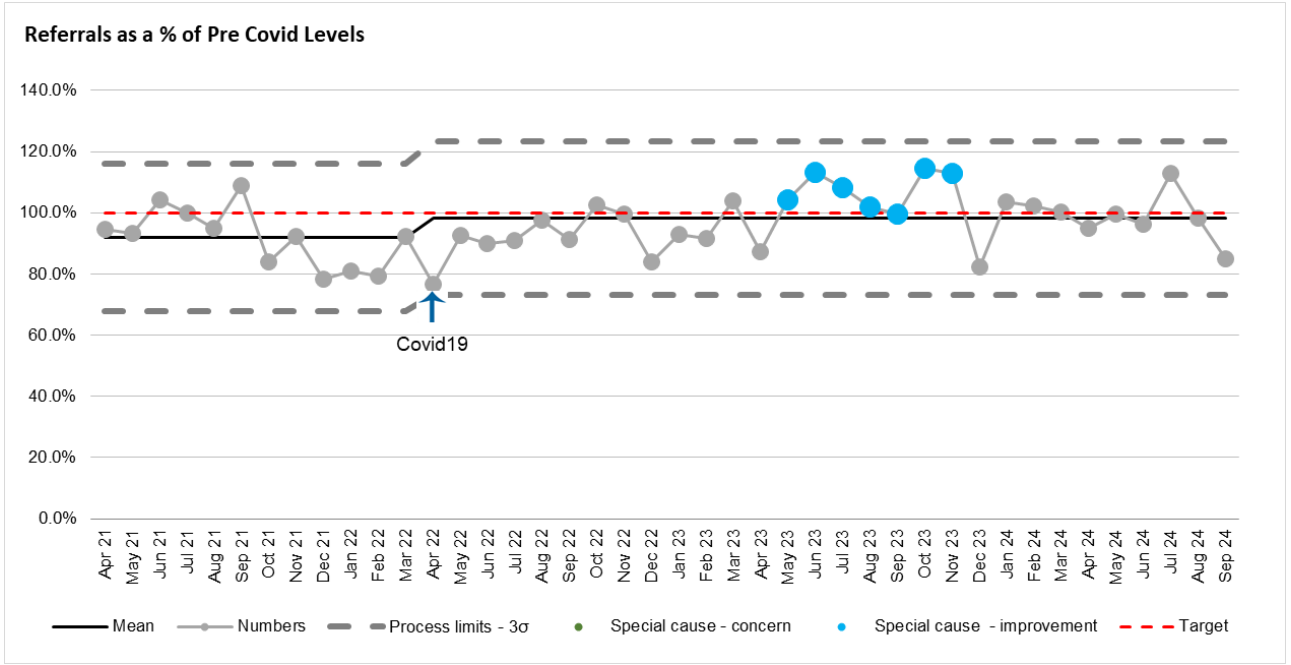


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

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





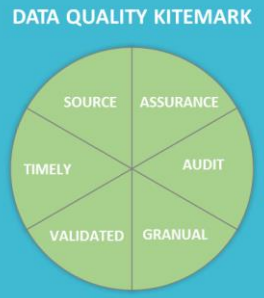
Pre Covid Level	2704

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	2566	2695	2606	3051	2653	2301						
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%	94.90%	99.67%	96.38%	112.83%	98.11%	85.10%						

5. Referral to Treatment

Specialty Breakdown



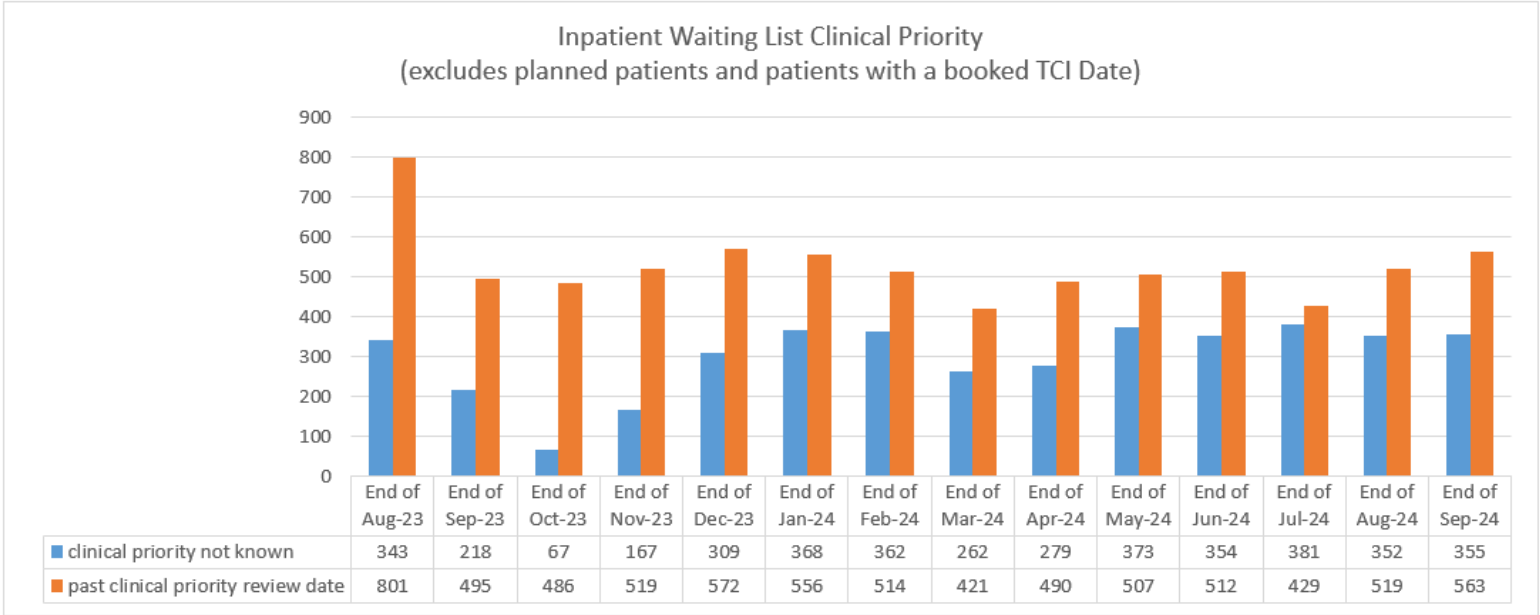
The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention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

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 16.09.24	RTT % as of 14.10.24	Difference
Arthroplasty	2	68.1%	71.00%	2.9%
Arthroscopy	38	49.4%	51.1%	1.7%
Clinical Support	5	66.5%	58.6%	-7.9%
Foot and Ankle	34	47.3%	47.1%	-0.2%
Hands	56	45.1%	42.5%	-2.6%
Oncology	0	84.7%	84.6%	-0.1%
Oncology Arthroplasty	0	77%	72.4%	-4.6%
Spinal	288	31.8%	30.1%	-1.7%
Spinal Deformity	332	28.9%	27.3%	-1.6%
Young Adult Hips	3	69%	69.5%	0.5%

5. Referral to Treatment

DATA QUALITY KITEMARK

Overdue Clinical Priority:



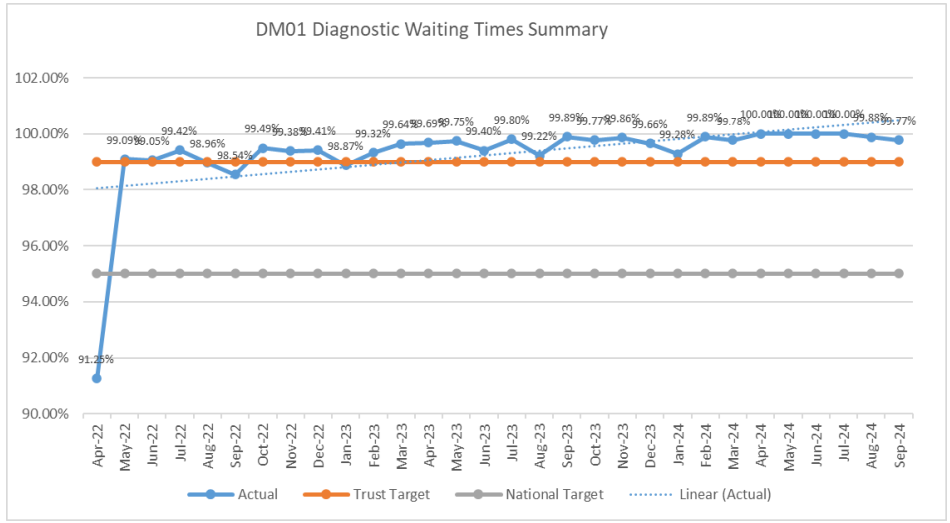
	End of Aug-23	End of Sep-23	End of Oct-23	End of Nov-23	End of Dec-23	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24
clinical priority not known	343	218	67	167	309	368	362	262	279	373	354	381	352	355
past clinical priority review date	801	495	486	519	572	556	514	421	490	507	512	429	519	563

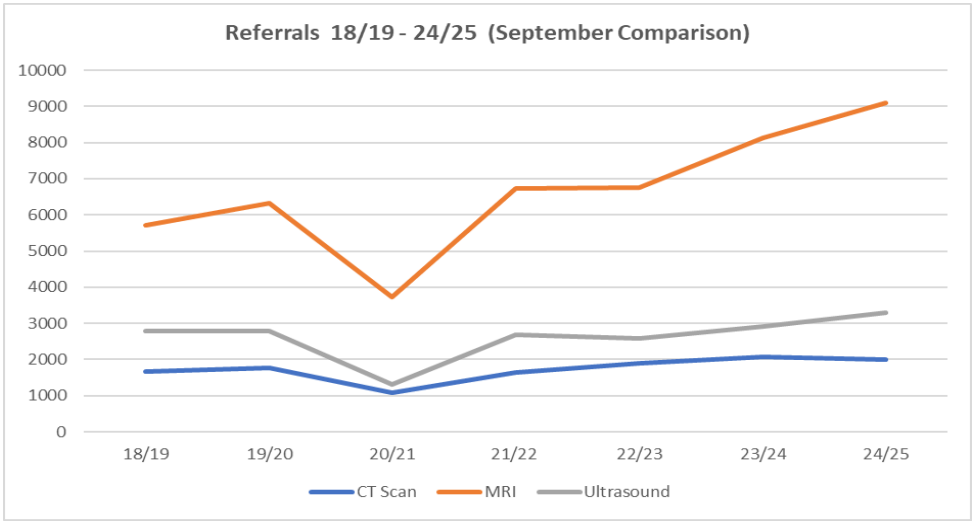
The number of patients with an unknown clinical priority has increased by 27 patients, however, the numbers that have past the clinical priority review date has reduced by 93 patients. The information continues to be shared on a monthly basis with individual services and clinicians to manage individual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

The clinical priority mechanism was discussed at the clinical service leads meeting, and it was indicated that the priority unknown following an audit in arthroplasty are most likely non urgent P4 patients. A sample audit will be taken across all other specialities to confirm that this is the case and update will be provided in the November 24 pack.

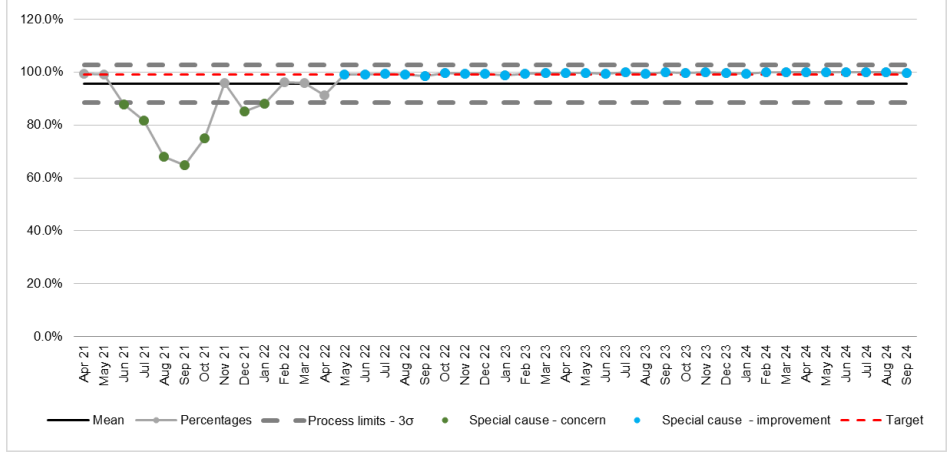
6. Diagnostic Performance

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

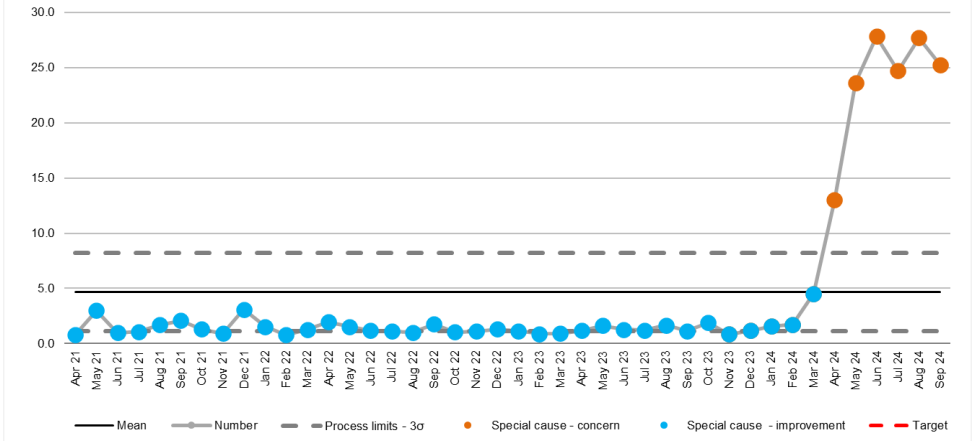




Diagnostics: Percentage of Patients Waiting Under Six Weeks



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



7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in September 2024 closing the month at 99.77%

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

AREAS FOR IMPROVEMENT

Radiology Reporting- Outsourcing commenced on 08/08/2024. All MRI's to 03/09/24 have been outsourced and will be reported within 7 days. All Oncology and non-medical referrer x-rays continue to be prioritised.

Dictation has significantly improved with backlogs all cleared.

Voice recognition is currently being tested in imaging via the TPro solution. Testing will continue to the end of October 24 with more testers being included.

Adjustment of Consultant job plans to maximise clinical duties and capacity in both CT and ultrasound to support Oncology services is underway with a further review of capacity and demand modelling also being undertaken.

Implementing electronic letters being sent via Dr Doctor – testing took place last week; minor adjustments need to be made so now anticipate to go live by end of October 2024.

Extension of the BWCH SLA, which is providing MRI capacity to support gynae waiting lists, has been extended to the 31st December.

RISKS

There is a current risk with Consultant Radiologist workforce vacancies. The previous advert failed to attract suitable candidates for shortlisting. The vacancy has been readvertised with a closing date of 31/10/2024.

Support to the Oncology service is continuing but with reduced Interventional lists and MDT support. Mutual Aid scoped but no availability from RJAH or Oxford Orthopaedic. Discussions regarding job plans taking place to allow maximum support.

8. Cancer Performance

Summary Performance Figures – October 24 (August 2024 Submission)

		August 24 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	17.0	0.0	17.0
62 day RTT to treatment	70%	93.7%	7.5	0.5	8.0
28 day FDS REPORTED	75%	87.2%	82.0	12.0	94
Patients over 104 days (62 day standard)				1	

Performance

The trust was compliant against all 3 cancer waiting time targets for August 24.

The 62-day metric was achieved at 93.7%. A total of 8 treatments were applicable to the trust, 7.5 of those were compliant and the remaining 0.5 patients breached.

The root cause of the delays for the 62-day breach were due to complex diagnostics and surgical planning as follows:

- 0.5 shared breach; This patient was a late tertiary referral into ROH on day 60. This was a complex surgical planning case that required vascular support at UHB and therefore we was unable to meet the 24 day target.

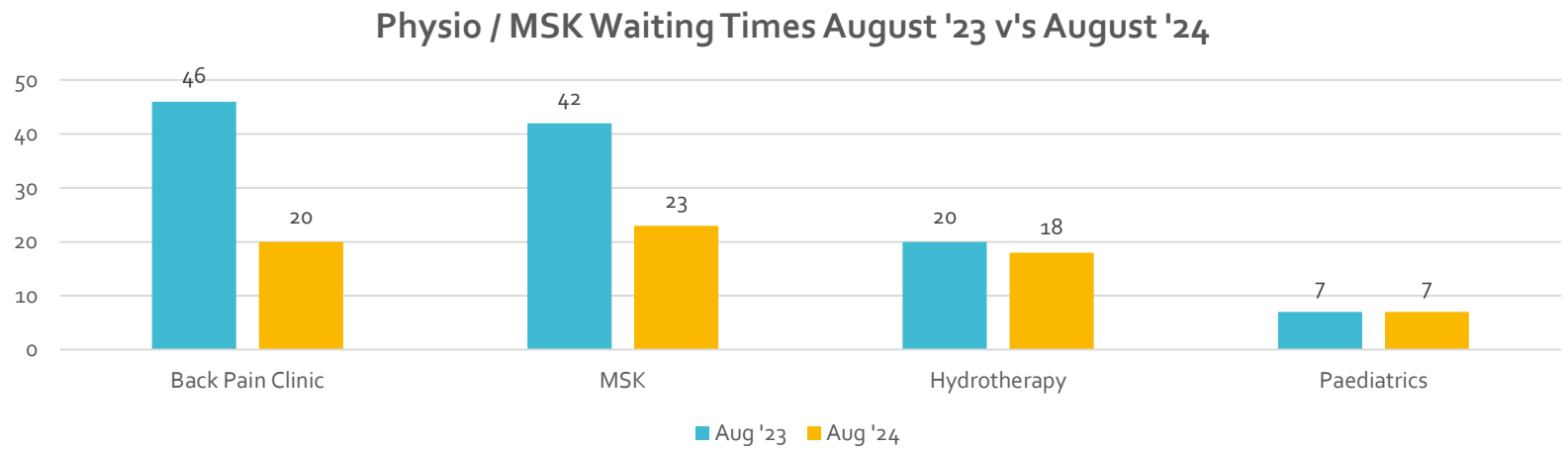
Risks /actions ongoing

The weekly cancer PTL and System Oversight Group continues to oversee performance. 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 and there has been a positive improvement in August performance for FDS from 76% to 87%. There are also positive improvements in scheduling pelvic cases within 62 days which has a improved 62 day performance to 93% by having a 5th pelvic surgeon trained. Workforce challenges in Radiology are being mitigated through communication and early escalation between oncology and radiology. Any risk to pathways are escalated to Deputy COO.

A business case is currently being developed for approval of an SLA expansion to address joint plastic surgery capacity throughout the week.

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 a £5m turnover planned for this year with a stretch target of an additional £500k
- The service exceeded its September income target by £76k.
- The service is running at £55k behind plan with plans to reach breakeven by November 24
- The service expects to exceed the income plan in the last quarter of the year.
- BUPA contract went live 16th September
- Imaging invoicing backlog is being worked through. Income has been invoiced from February to August at a value of £36k.

24-25 summary	M1	M2	M3	M4	M5	M6	YTD
Income Plan (£000)	425	425	425	407	255	383	2320
Income to be collected (£000)	375	384	241	474	332	459	2265
Variance	-50	-41	-184	67	77	76	-55

***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) Communications plan is in development to support roll out of the BUPA contract with a focus on consultant and secretary comms and promotion on website and marketing collateral. BUPA finder will need to be updated, and consultants may require support with this. Consultant profiles on ROH private website will be linked with BUPA finder to increase SEO opportunity.

2. New business and services to support income target;

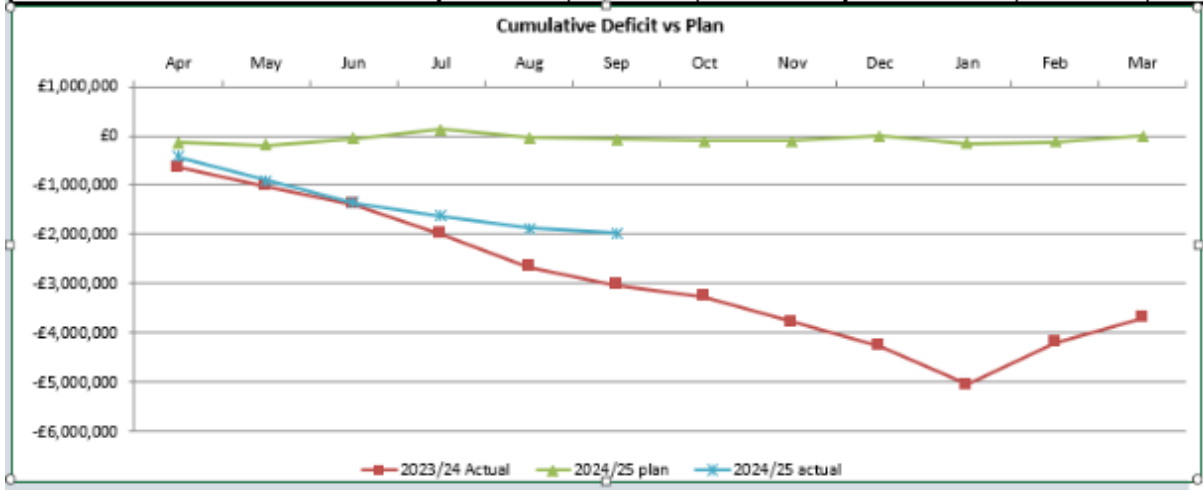
- Ballet school imaging agreement approx. £20k per year
- Joining BUPA imaging network
- Injection suite service
- Aviva contract continuation (new contract November)
- Vitality contract renewal – negotiations ongoing
- Sports medicine service model under discussion via CSL

8. Finance on a Page

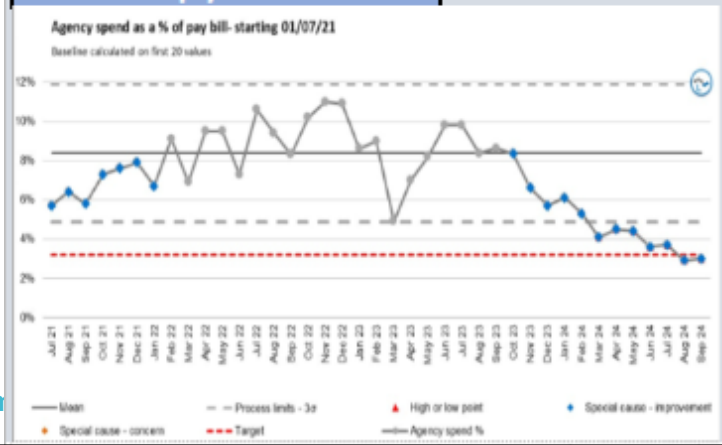
Month 5

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	£11,051	£10,898	-£153	£65,762	£65,309	-£453	£131,973	£131,186	-£787
Other income	£541	£491	-£50	£3,212	£2,910	-£302	£6,432	£6,262	-£170
Pay	-£6,584	-£6,341	£243	-£38,499	-£38,490	£9	-£78,370	-£76,302	£2,068
Non Pay	-£4,936	-£5,082	-£146	-£29,883	-£31,240	-£1,357	-£58,691	-£60,186	-£1,495
Non operating costs	-£119	-£84	£35	-£713	-£515	£198	-£1,436	-£1,052	£384
Remove capital donations	£8	£8	£0	£46	£46	£0	£92	£92	£0
TOTAL	-£39	-£110	-£71	-£75	-£1,980	-£1,905	£0	£0	£0



Agency as a % of paybill =3%



Efficiencies	YTD	Forecast
Plan	£2,691	£6,484
Actual	£2,606	£8,220
Variance	-£85	£0

Capital	YTD	Forecast
Plan (exc IFRS16)	£2,289	£4,400
Actual	£964	£4,400
IFRS 16	£0	£756
Variance	£1,325	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	82.9%	81.9%
By Value	87.6%	87.8%
NHS		
By number	53.5%	53.5%
By number	20.7%	19.8%
Total		
By number	82.2%	81.3%
By Value	82.0%	81.1%

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £111k against a planned deficit of £37k, generating an adverse £74k variance. Year to date deficit totals £1,981k deficit against a deficit plan of £75k, generating an adverse £1,906k variance.

Income year to date under performed by £755k. This relates to a £111k underperformance in Private patient income, underperformance in education income of £177k, commercial income £125k and a £398k provision for 24/25 convergence and growth adjustment for commissioners.

Pay expenditure is underspent in month by £196k with a year to date overspend of £8k. Agency spend reduced to 2.9% of paybill in month and a year to date underspend of £136k.

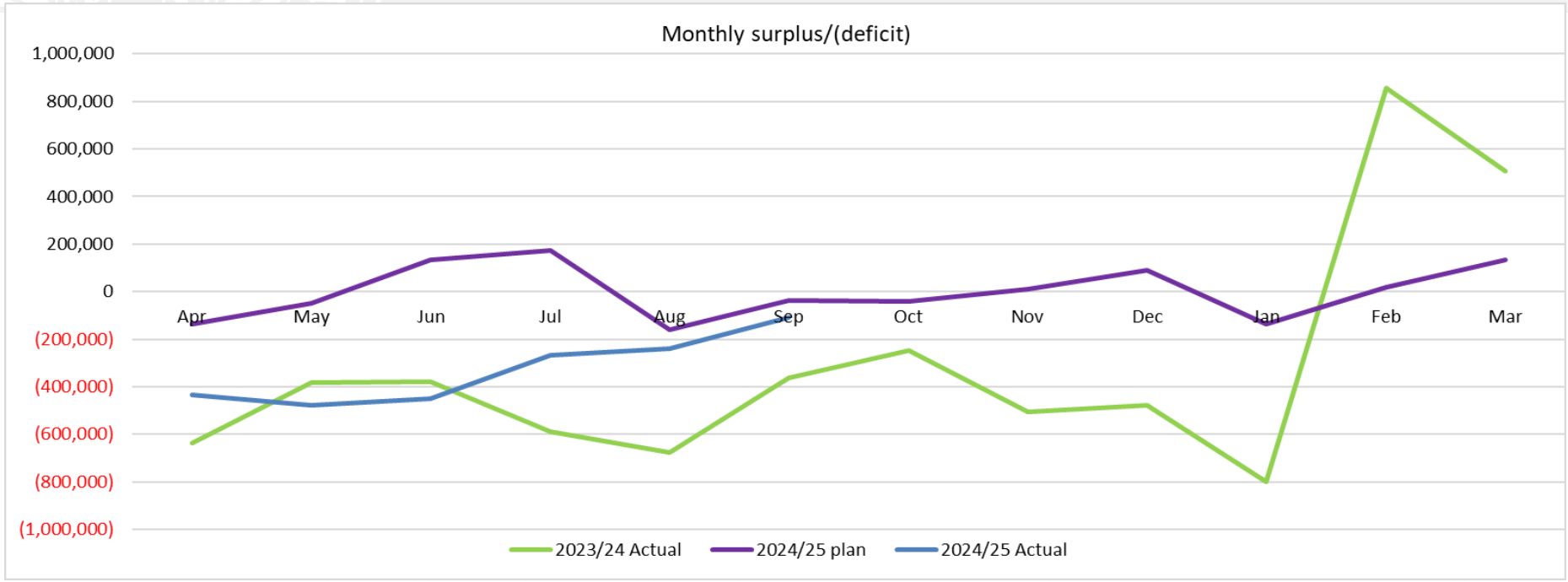
Non pay expenditure overspent in month by £185k and year to date adverse variance of £1,357k. This is primarily driven as a result of LLP expenditure above plan and unidentified CIP not yet identified.

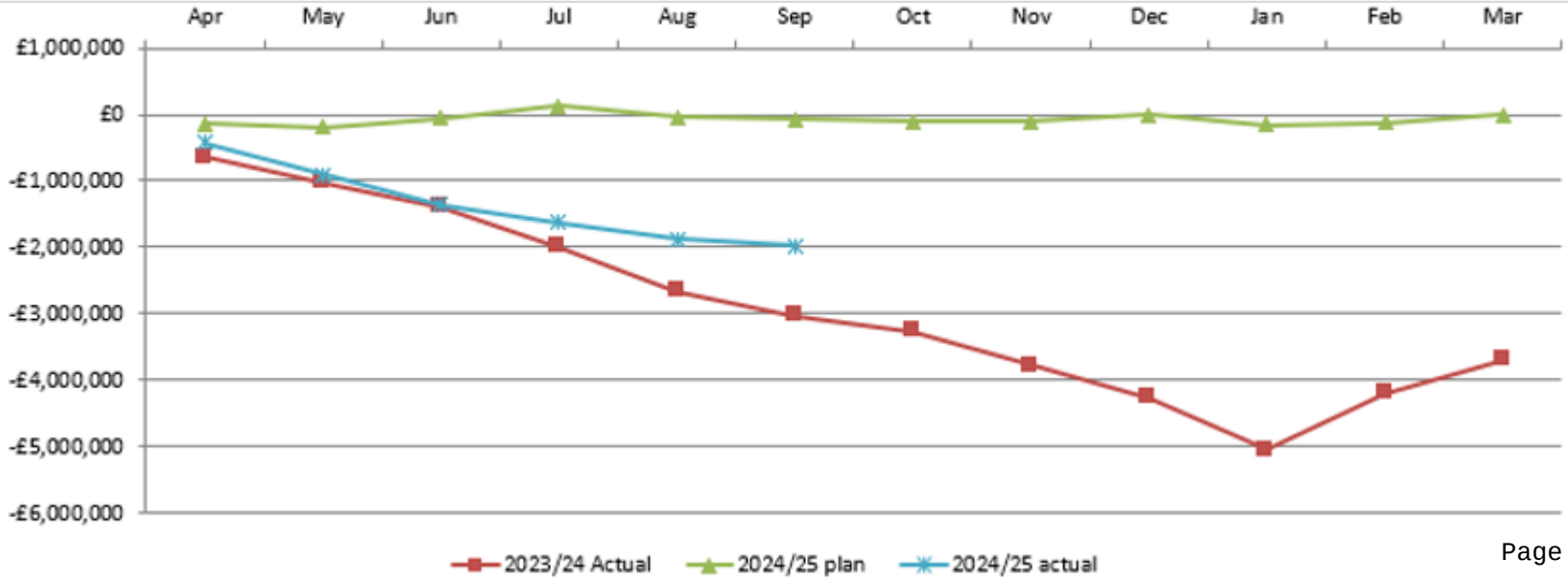
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(755)	8	(1,357)	198	(1,906)
Year to date plan	68,974	(38,499)	(29,883)	(667)	(75)
Year to date actual	68,219	(38,490)	(31,240)	(470)	(1,981)
Variance compared previous month	↑	↓	↓	↑	↓

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	65,762	65,309	(454)
Other Operating Income (Excluding top up)	3,212	2,910	(302)
Employee Expenses (inc. Agency)	(38,499)	(38,490)	8
Other operating expenses	(29,883)	(31,240)	(1,357)
Operating Surplus	**592**	**(1,511)**	**(2,104)**
Net Finance Costs	(713)	(515)	198
Net surplus/(deficit)	**(121)**	**(2,026)**	**(1,905)**
Remove donated asset I&E impact	46	46	-
Adjusted financial performance	**(75)**	**(1,981)**	**(1,906)**

9. Overall Financial Performance





10. Income

SUMMARY

Income year to date under performed by £755k. This relates to a £111k underperformance in Private patient income, underperformance in education income of £177k, commercial income £125k and a £398k provision for 24/25 convergence and growth adjustment for commissioners.

Elective Recovery Fund (ERF) income performance is an underperformance against NHSE target of £464k year to date and underperformance of £2.9m against the adjusted ERF target. The adjusted ERF target includes the additional activity performance included within the route to breakeven plan. 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.

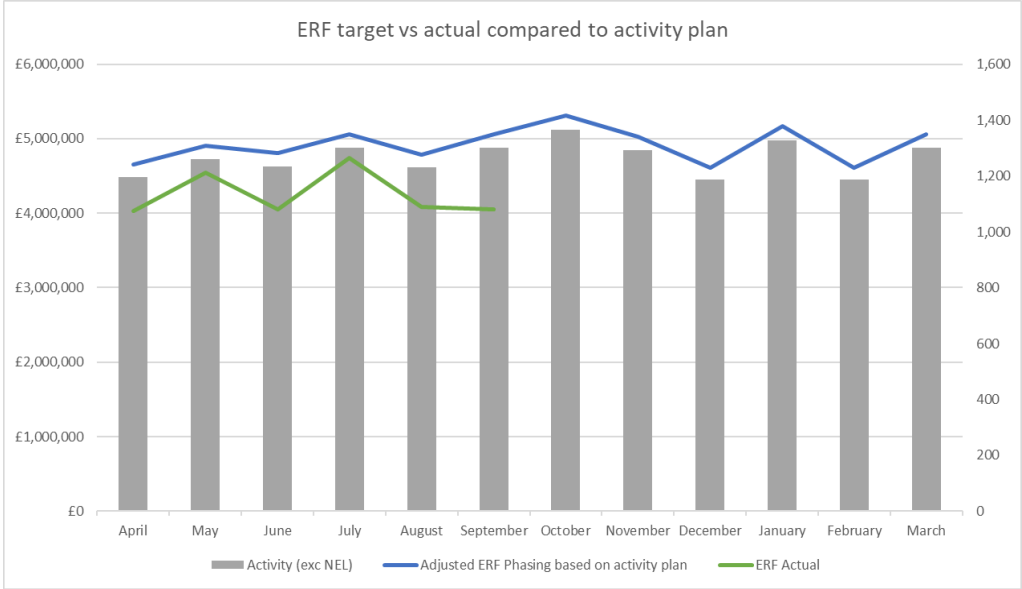
ERF target baseline phasing does not align to the Trusts activity plan with significant increase in ERF target set by NHSE in Q4.

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 underperformance against NHSE target of £464k year to date and underperformance of £3.3m against the adjusted ERF target. The adjusted ERF target includes the additional activity performance included within the route to breakeven plan.

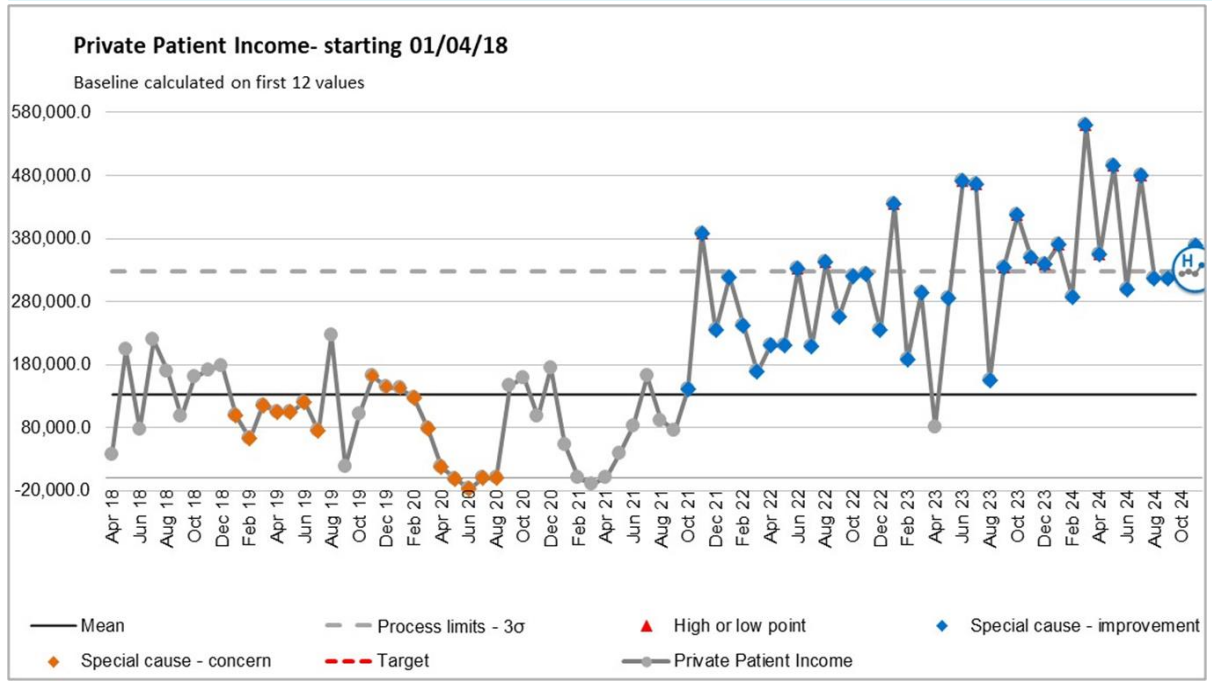


24/25 confirmed target	2% breakeven	Breakeven ERF target	23/24 underperformance to be mitigated	23/24 provision	Total ERF income delivery required for breakeven
£55,387,523	£1,076,957	£56,464,480	£2,440,028	-£1,952,754	£56,951,754

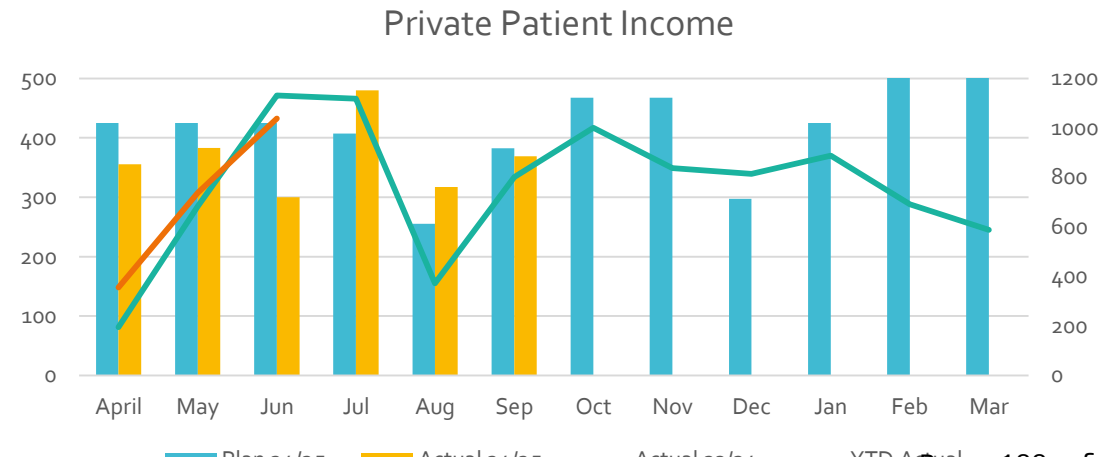
	April	May	June	July	August	September	YTD
NHSE Target	4,249,531	4,564,489	4,398,797	4,595,086	3,821,312	4,335,727	25,964,942
Actual performance	4,030,507	4,544,975	4,050,335	4,741,048	4,079,202	4,054,935	25,501,002
Variance	(219,024)	(19,514)	(348,462)	145,962	257,890	(280,792)	(463,940)
Breakeven Target	4,556,464	4,556,464	4,556,464	5,126,023	4,556,464	5,126,023	28,477,903
Variance	(525,957)	(11,489)	(506,129)	(384,975)	(477,262)	(1,071,088)	(2,976,901)

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 underspent in month by £196k with a year to date overspend of £8k. Agency spend reduced to 2.9% of paybill in month and a year to date underspend of £136k.

Non pay expenditure overspent in month by £185k and year to date adverse variance of £1,357k. 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 £827k with spend of £1,581k.

There continues to be high spend in theatres which is £1.5m 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. Analysis of the Genmed spend patterns has shown an increase in pricing with an impact of c.£1.4m a year above inflation.

Unidentified CIP now totals £602k 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

- LLP expenditure reduction
- Bank expenditure above plan
- Identification of CIP
- Theatre consumable spend reducing to planned levels.

RISKS / ISSUES

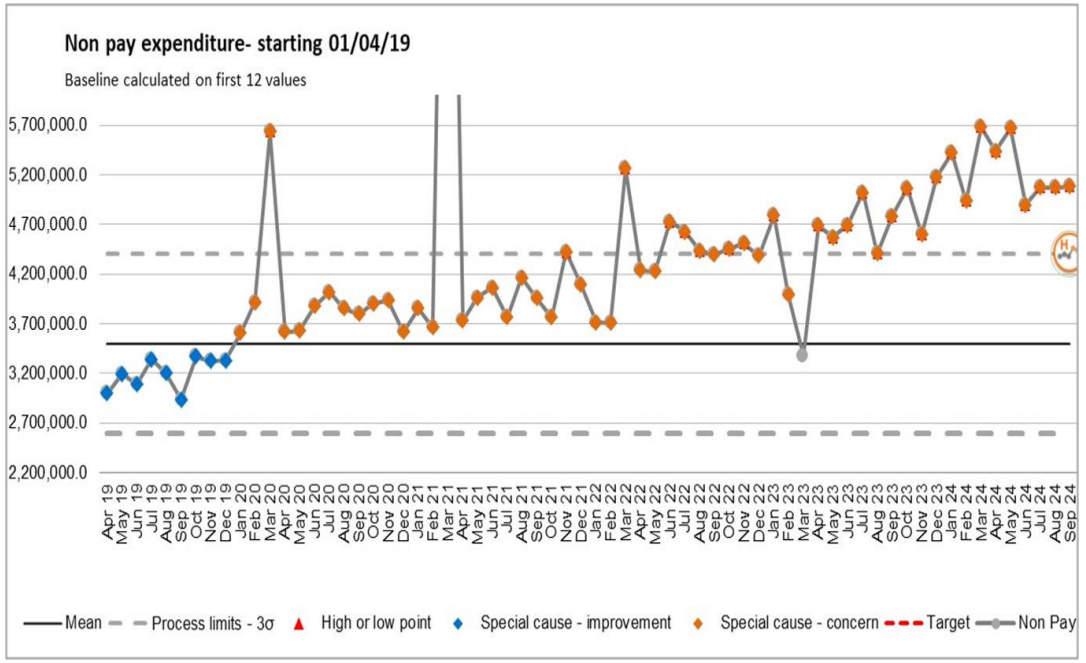
Agency spend remains high causing a cost pressure during the year.

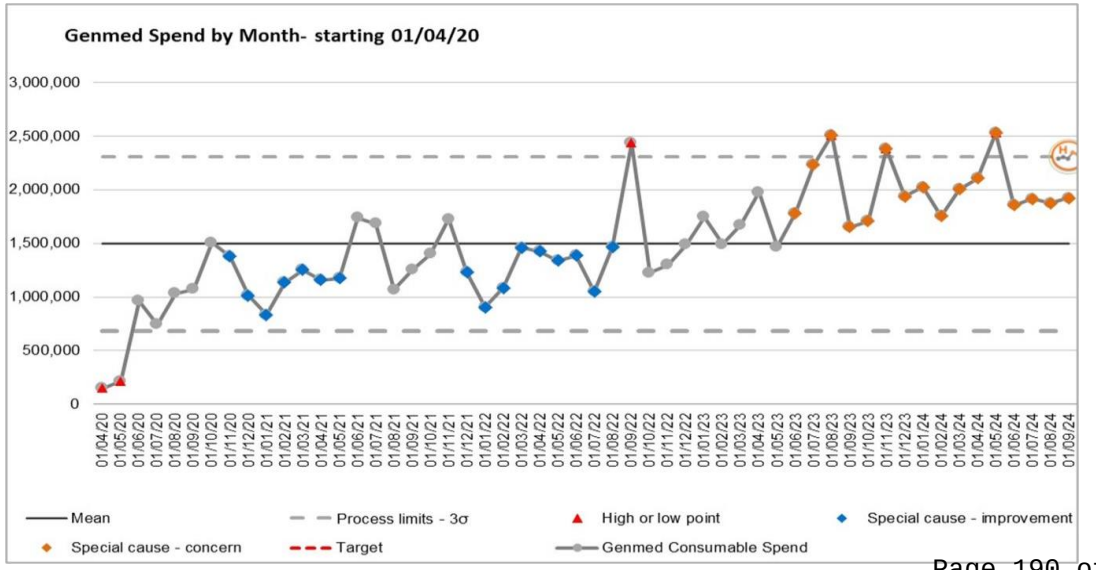
12. Non Pay Expenditure

Genmed spend mirrors closely the overall non-pay spend due to its value proportionally against non-pay spend.
Most other non-pay spend is fairly consistent month on month.

It can be noted however that the additional controls being put in place are beginning to stabilise Genmed spend in comparison to the increases seen previously.

Further work is ongoing to introduce additional controls to further control that spend.





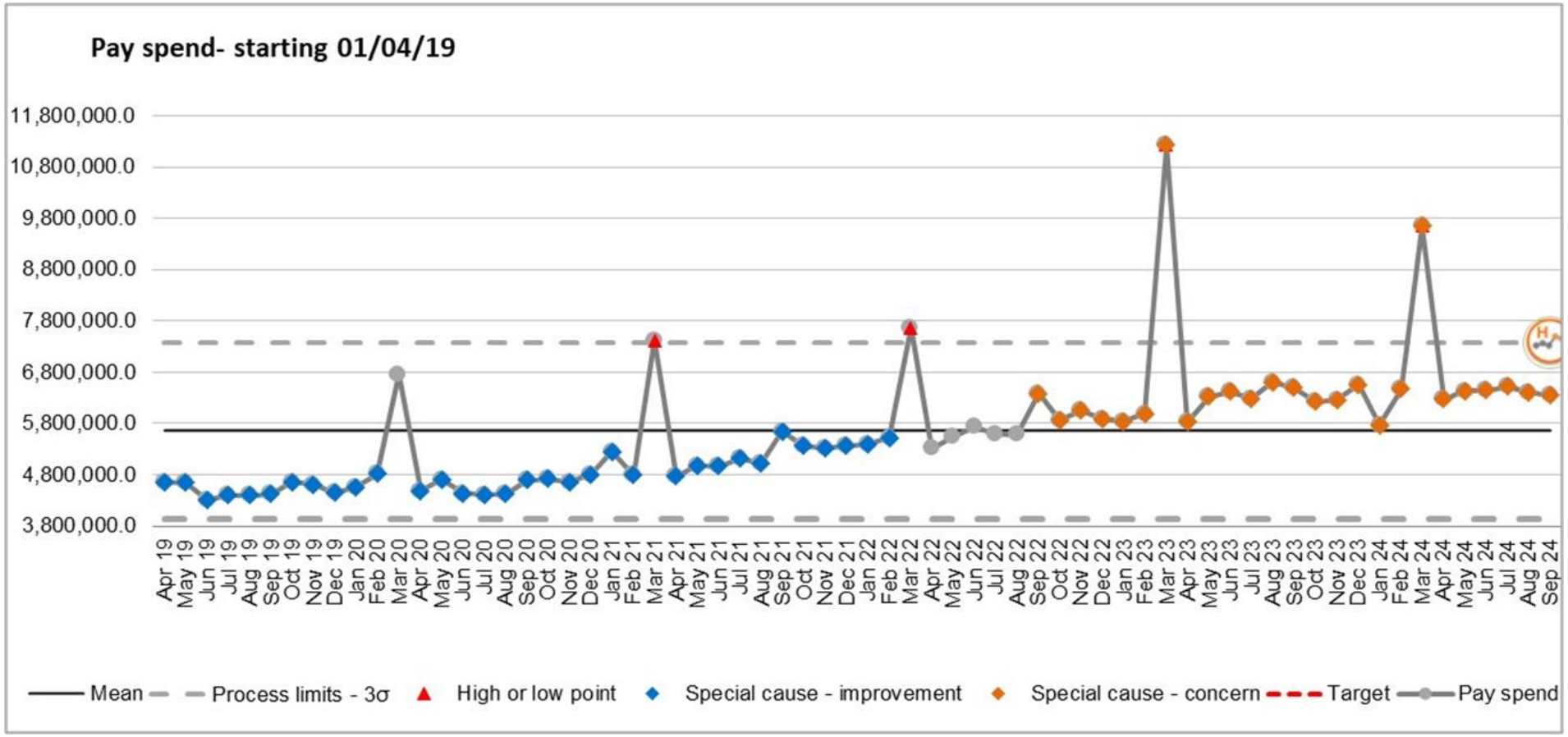
12. Non Pay Expenditure

SUMMARY

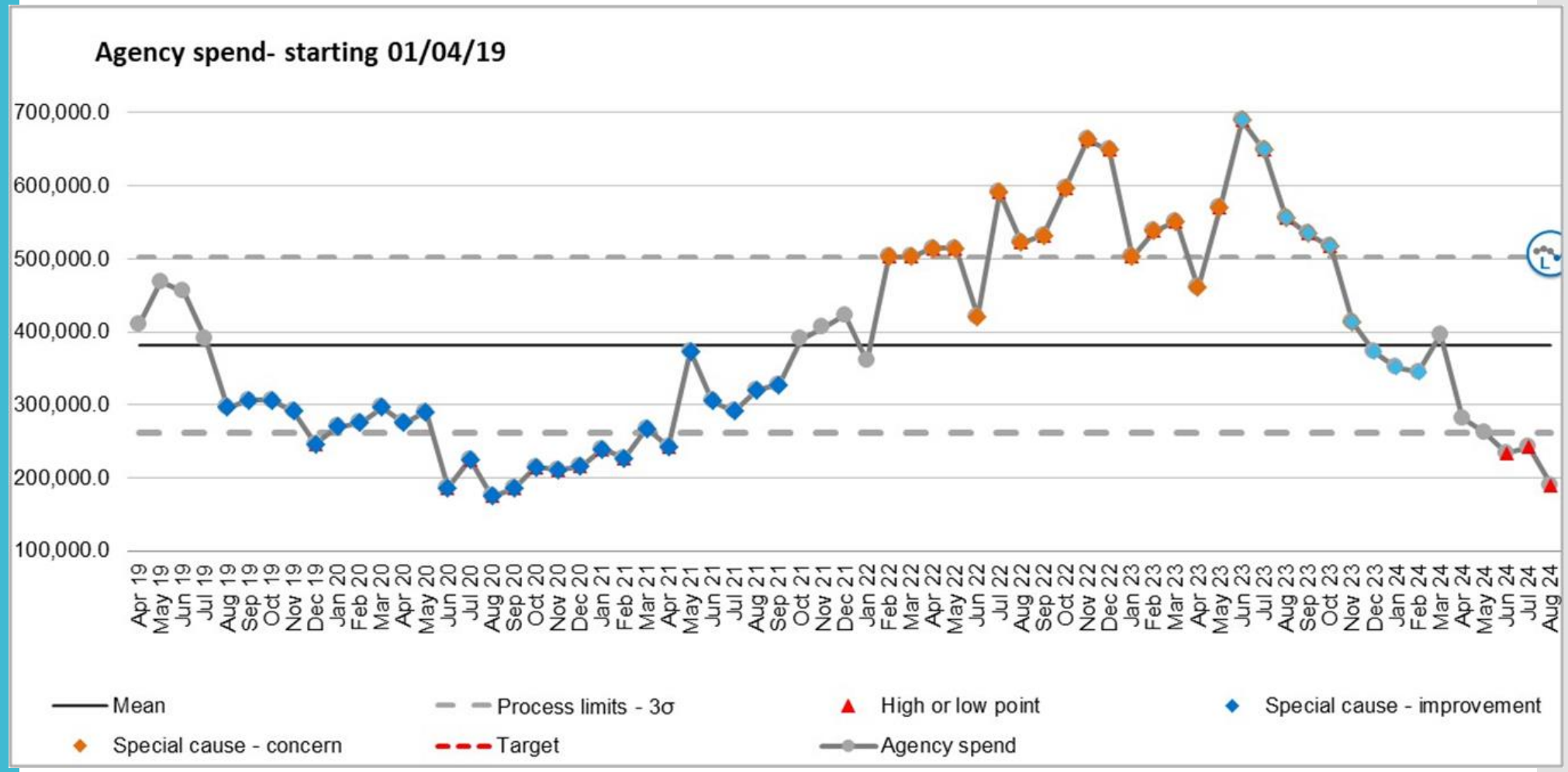
Premium rate additional sessions remain a focus of the financial recovery plan, with a reduction in LLP expenditure planned from October'24 – March'25.

	£'000s			Substantive wte surgeons (excludes anaes and radiologist)
Year	LLP	ADH	Total	
17-18		1,672	1,672	63.28
18-19		1,950	1,950	61.57
19-20	274	1,503	1,777	64.48
20-21	271	432	703	70.22
21-22	1,460	438	1,898	75.58
22-23	1,865	882	2,747	71.66
23-24	3,382	1,067	4,449	70.22
24-25	1,683	707	2,390	73.11

13. Pay Expenditure



14. Agency Expenditure



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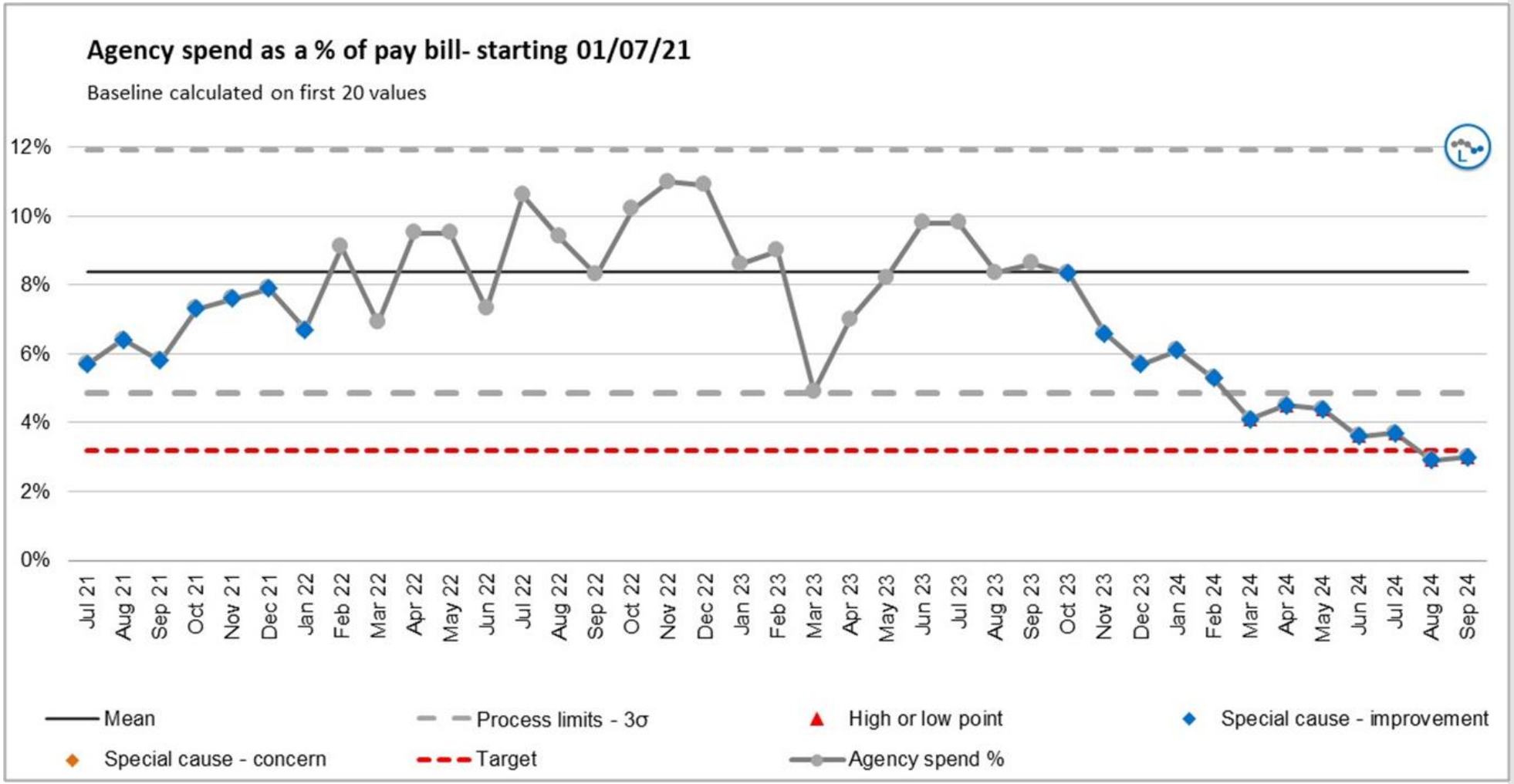
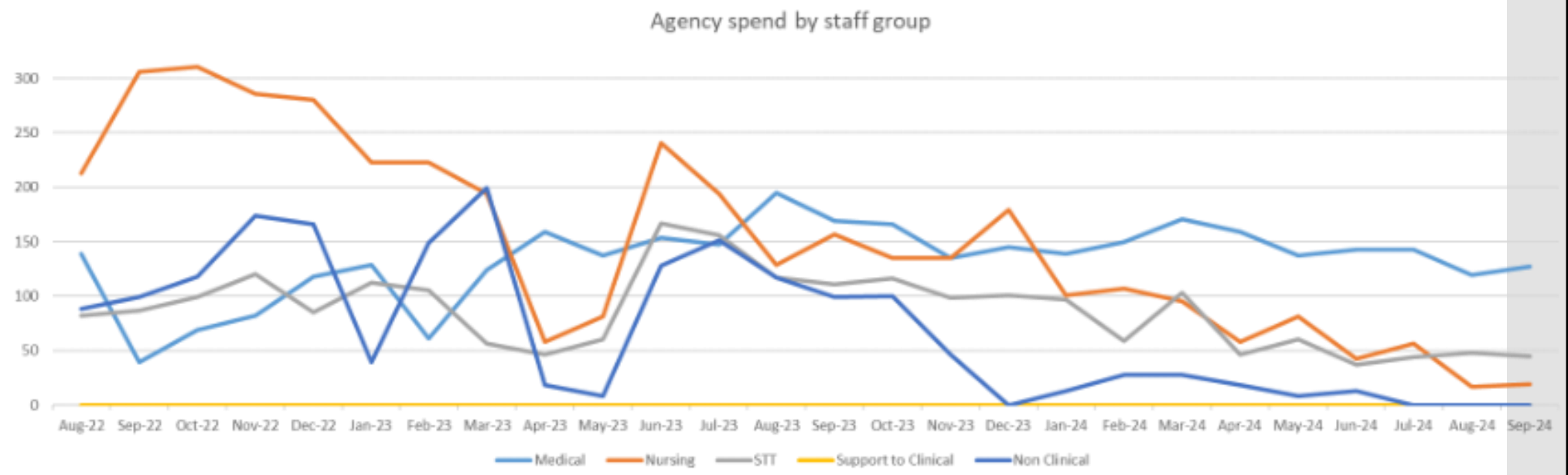
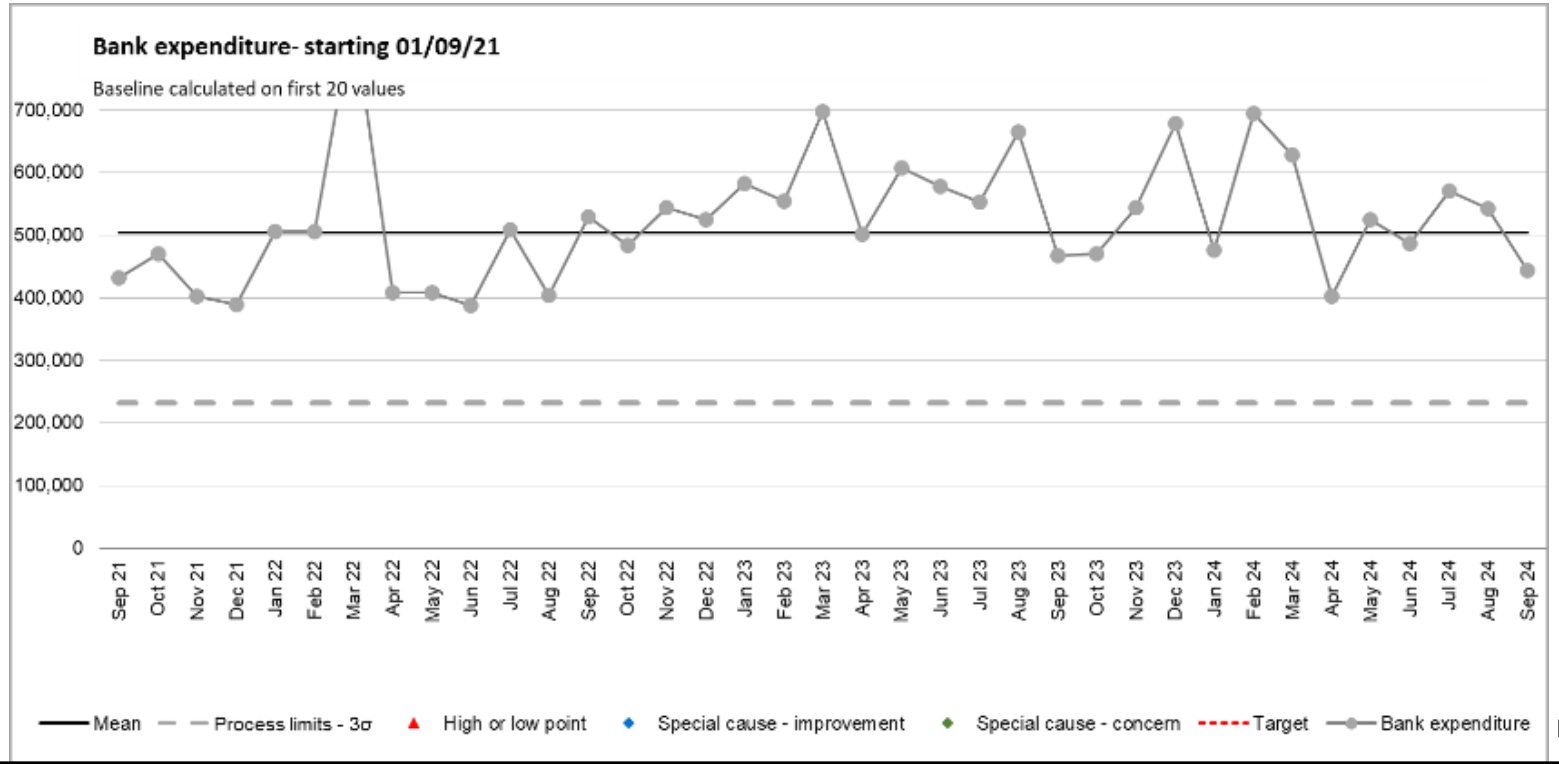


14. Agency Expenditure



14. Bank Expenditure

Bank expenditure	£'000s					
	April	May	June	July	Aug	Sept
Registered nursing, midwifery and health visiting staff	108	122	110	136	116	101
Allied health professionals	26	35	32	47	25	33
Support to clinical	52	70	60	86	78	55
Total medical and dental staff bank	78	162	128	113	124	103
NHS infrastructure support	138	136	155	189	200	151
TOTAL	**402**	**525**	**487**	**570**	**543**	**443**



15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £3,075k have been delivered, against a planned forecast of £4,110k, delivering an adverse variance of £1,035k. Unidentified CIP has contributed to the underperformance year to date. The Financial Sustainability and Improvement Group has given focus to the un-identifed CIP and additional schemes have been identified to reduce this value.

PFR Category	Scheme	Plan total	YTD Plan	YTD Actual	Variance
Non-Pay-other	Discretionary spend hold	750	378	43	(335)
Pay-Agency	Minimise overall agency spend	2904	1,002	1,574	572
Income-Non-Patient Care	commercial income	294	147	0	(147)
Pay-service redesign	POAC redesign nurse led model	115	58	0	(58)
Non-Pay-Medicines efficiencies	Pharmacy - Generic switches	154	77	0	(77)
Pay-corporate service transformation	Non clinical admin, vacancy and bank hold	334	167	0	(167)
Non-pay-Procurement	Procurement - Birmingham Hospital Alliance Collaborative	198	102	119	17
Non-pay-Service redesign	Day case unit - increase to 23 hour	750	275	0	(275)
Non-pay-Procurement	Procurement -ROH	528	254	1,315	1.061
Income-Private Patient	Private patient service expansion	440	304	24	(280)
Pay-E Job Planning	Consultant premium rate working (LLP spend reduction)	564	282	0	(282)
Income-other	ERF additional income	607.2	304	0	(304)
	Scheme total	7638.2	3891	3,075	
	Unidentified	582	291	0	(291)
	TOTAL	8,220	4,110	3,075	-1,035

15. Recovery plan progress

	£'000s							
	Month 6	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Full year**
Recovery plan monthly improvements	0	501	464	464	571	587	594	3180
Year to date deficit (including M6 forecast)	-250							-2030
Current monthly plan		-39.0	11.0	89.0	-139.0	19.0	134.0	75.0
Current CIP monthly plan		-636	-664	-690	-717	-744	-818	-4267.9
Continuation of existing CIP								
Agency reduction		242	269	295	322	350	424	1902.0
Procurement - ROH		44	44	44	44	44	44	264.0
Procurement - BSOL		16	16	16	16	16	16	96.0
Associate bad debt recovery							401.5	401.5
Energy savings							51	51.0
Clinical negligence saving		11	11	11	11	11	11	64.0
Pharmacy savings		13	13	13	13	12	12	76.0
Private patient expansion		36	37	37	37	37	37	221.0
Revised financial plan	**-250**	**187**	**201**	**279**	**157**	**332**	**906**	**33**
Actual	**-110**							
Variance	**140**							

16. Capital summary

SUMMARY

Year to date spend of £910k against planned spend of £2,289k generating an underspend to date of £1,379k. This is due to scheme slippage against the original plan rather than an expected underspend by the end of the year.

Stream	Scheme Name	Plan	YTD Spend	Variance	Forecast	Variance
Strategic Estates	Oncology office refurbishment/relocation	1,196,222	950,041	246,181	1,196,222	0
Strategic Estates	Retention - Relocation of Facilites to the Old Pharmacy building	6,582	(257)	6,839	6,582	0
Strategic Estates	Retention - Replacement for room 3 from a fluoroscopy room to a digital x-ray room	2,771	1,726	1,045	2,771	0
Strategic Estates	Retention - Café Royale Refurbishment	2,000	3,600	(1,600)	2,000	0
Strategic Estates	Replacement boiler knowledge hub	400,000	0	400,000	460,000	(60,000)
Strategic Estates	Replacement boiler theatres	100,000	0	100,000	0	100,000
Strategic Estates	Remote ability to connect to mobile Generator for 2	95,000	0	95,000	95,000	0
Strategic Estates	Roof Replacement inc Large and Small Joint Medical Secretary block / Plaster room / Theatre 3, Hydrotherapy roofs	70,000	0	70,000	86,401	(16,401)
Green estate	Pool allocation for scheme prioritisation by budget holder	50,000	560	49,440	1,000	49,000
Estates Maintenance	Pool allocation for scheme prioritisation by budget holder	150,000	38,594	111,406	150,000	0
Equipment	Pool allocation for scheme prioritisation by budget holder	200,000	94,609	105,391	200,000	0
Equipment	Image intensifiers x 5	804,000	0	804,000	804,000	0
Information Technology	Pool allocation for scheme prioritisation by budget holder	100,000	0	100,000	84,024	15,976
Information Technology	EPR	200,000	65,770	134,230	411,000	(211,000)
Reserve		122,425	(244,879)	367,304	0	122,425
TOTAL		**3,499,000**	**909,763**	**2,589,237**	**3,499,000**	**0**
	Additional System capital allocation (EPR Networking and telephony)	901,000	0	901,000	901,000	0
TOTAL EXCL. IFRS16 ADJ		**4,400,000**	**909,763**	**3,490,237**	**4,400,000**	**0**
	IFRS 16 Adjustment for revaluation of Modular theatres	756,000	0	756,000	756,000	0
TOTAL CDEL		**5,156,000**	**909,763**	**4,246,237**	**5,156,000**	**0**

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.

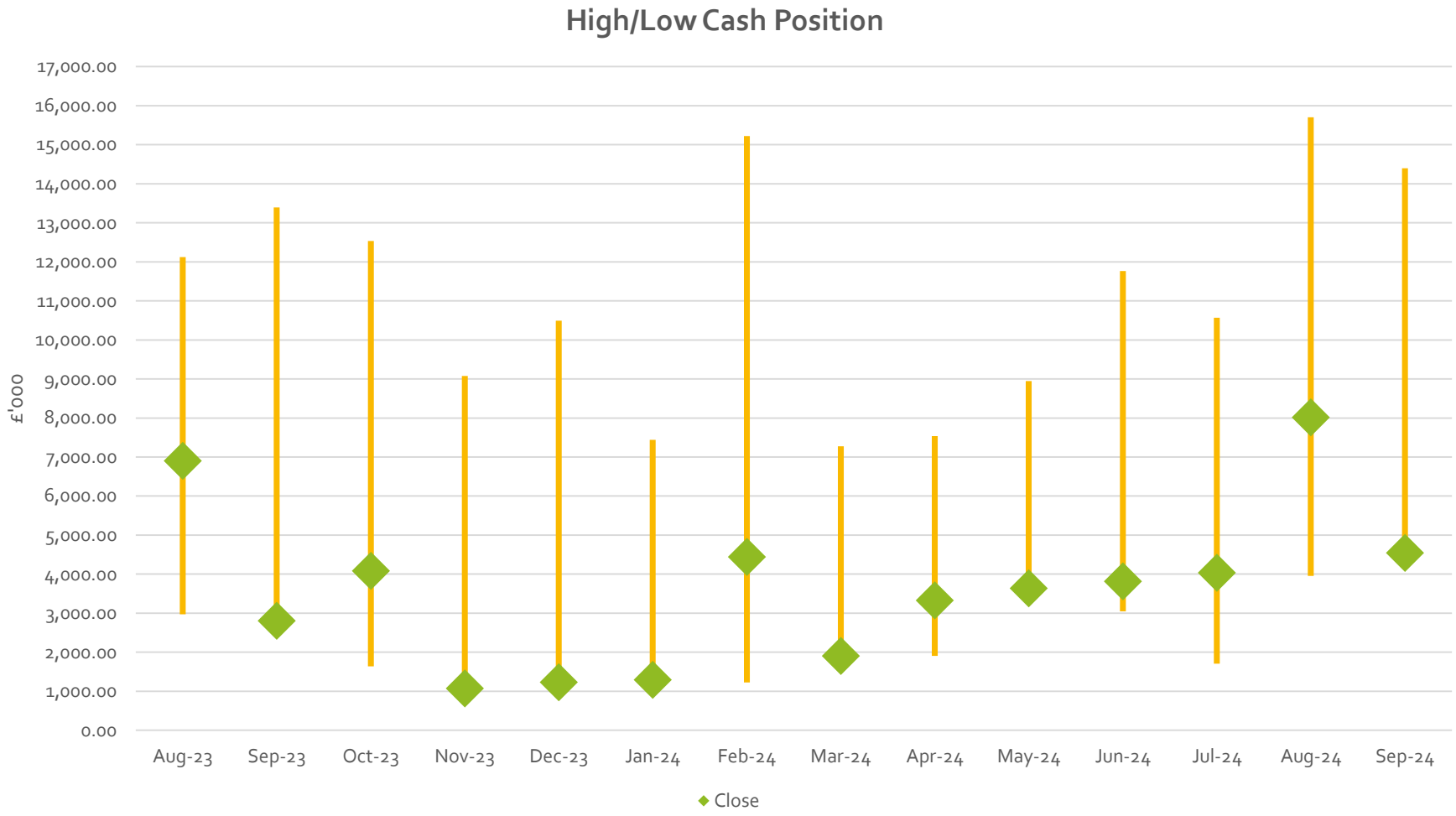
The cash position has eased, but will remain challenging, particularly as the capital slippage is recovered.

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 M6	Movement
		(£'000)	
Intangible Assets	981	822	(159)
Tangible Assets	65,398	63,592	(1,806)
Total Non Current Assets	**66,379**	**64,414**	**(1,965)**
Inventories	1	2	1
Trade and other current assets	8,195	10,291	2,096
Cash	1,698	4,332	2,634
Total Current Assets	**9,893**	**14,625**	**4,732**
Current Liabilities	(18,332)	(21,962)	(3,630)
Non current liabilities	(14,129)	(12,200)	1,929
Total Liabilities	**(32,461)**	**(34,162)**	**(1,701)**
Total Net Assets Employed	**43,811**	**44,877**	**1,066**
Total Taxpayers' and Others' Equity	**43,811**	**44,877**	**1,066**

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.



19. System Position

For the CFOs meeting, the Month 6 draft revenue position is £72.6m deficit, £54m adverse against the YTD plan of £18.6m deficit. Variance has increased by £10.6m in month, predominantly at UHB (£5.9m), ICB (£3.9m) and BWC (£0.9m).

Total Performance	YTD				FOT				Prior Month variance £000s
	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plar £000s	FOT £000s	Variance £000s	
BSOL ICB	2,808	2,808	924	-1,884	11,405	11,405	11,405	0	1,973
BSMHT	1,245	1,245	-61	-1,306	2,069	2,069	2,069	0	-1,247
BCHC	-226	-226	87	313	0	0	0	0	41
BWC	1,500	1,500	-2,899	-4,399	3,000	3,000	3,000	0	-3,455
ROH	-75	-75	-1,981	-1,906	0	0	0	0	-1,833
UHB	-23,832	-23,832	-68,707	-44,875	-16,474	-16,474	-16,474	0	-38,987
Total	-18,580	-18,580	-72,638	-54,058	0	0	1	0	-43,508

Total Variance (per PFRs from last mth & current KDR)	Trend												
	M1 £000s	M2 £000s	M3 £000s	M4 £000s	M5 £000s	M6 £000s	M7 £000s	M8 £000s	M9 £000s	M10 £000s	M11 £000s	M12 £000s	YTD £000s
BSOL ICB	0	-2,613	4,492	582	-488	-3,857							-1,884
BSMHT	-542	92	271	-396	-671	-60							-1,306
BCHC	654	-1,035	258	9	154	272							313
BWC	-1,003	-1,003	-1,003	-187	-258	-944							-4,399
ROH	-297	-429	-585	-440	-82	-73							-1,906
UHB	-8,377	-9,895	-7,692	-6,421	-6,603	-5,888							-44,875
Total	-9,565	-14,883	-4,258	-6,854	-7,947	-10,550	0	0	0	0	0	0	-54,058

Pay	YTD				Forecast			
	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plan £000s	FOT £000s	Variance £000s
BSOL ICB								0
BSMHT	144,304	144,780	141,951	2,829	289,070	290,021	281,831	8,190
BCHC	130,145	130,145	127,114	3,031	257,875	257,875	255,403	2,472
BWC	188,560	188,560	192,737	-4,177	373,384	373,384	384,482	-11,098
ROH	38,469	38,499	38,490	8	78,310	78,370	75,937	2,433
UHB	675,836	679,976	733,044	-53,068	1,345,724	1,350,777	1,422,220	-71,443
Total	1,177,314	1,181,960	1,233,337	-51,377	2,344,363	2,350,427	2,419,873	-69,445

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quality Report - October 2024 (September 2024 Data)**
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:	**6th November 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

DRAFT VERSION

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.

Summary

- 1 Inpatient death
- 1 Avoidable VTE incident
- 0 PSII investigations
- 0 Never events
- 0 Infections reported
- 0 Avoidable category 3 PU incidents
- Improved Safeguarding training compliance
- Increase in incidents reported – likely attributable to higher activity after seasonal reduction in previous month (August 2024)

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• No PSIIs • No Never Events • No Infections reported. • No Category 3 PUs • Improvement in safeguarding training compliance	• Avoidable VTE incident • Inpatient death • Benchmarking data. • WHO data and charts being reviewed – working on development of reports following the move to WHO audits being performed using AMAT system.

REPORT RECOMMENDATION:

The Board is asked to: note and accept this report as 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	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Inequalities		Integrated Care	x	Continuous Improvement	x
Comments:					

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

Care	**x**	**Community**	
Expertise	**x**	**Services**	**x**
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)***:**

Bi-Monthly via Q&S Committee (previously in September 2024) & Clinical Quality Group (October 2024); Monthly via Executive Governance Meeting (October 2024) and Trust Board (October 2024)

Quality Report

October 2024 (September 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.

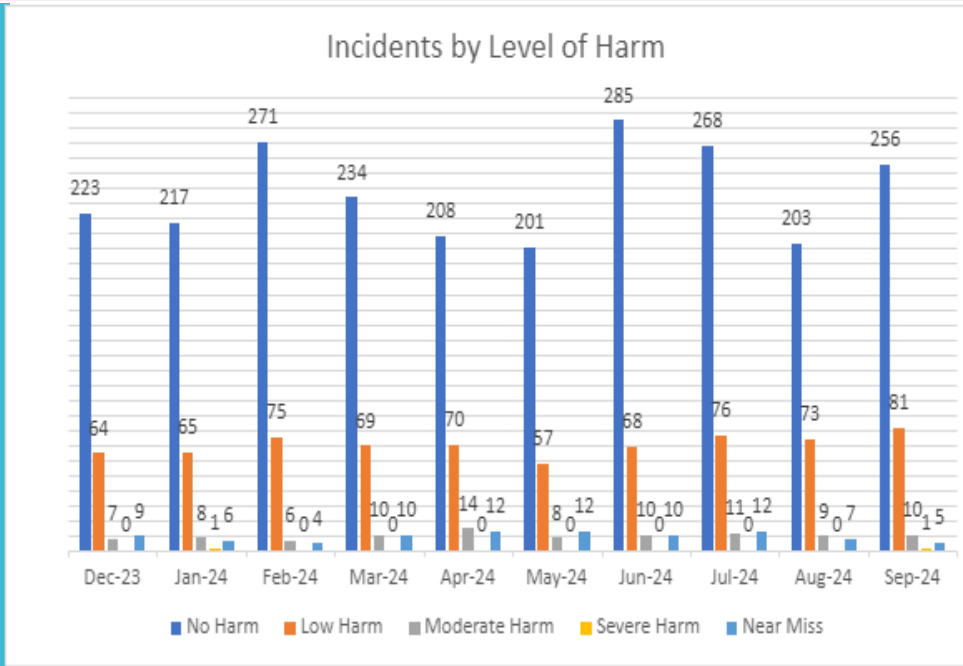
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

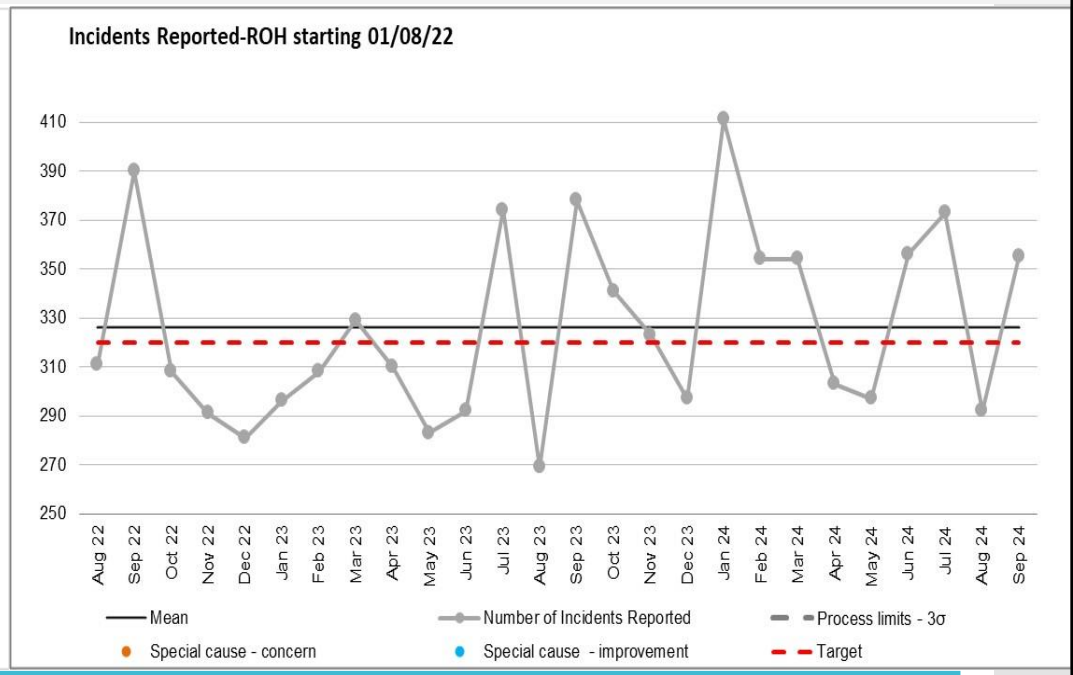
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end September 2024	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	355	292		
Inpatient Deaths	1	0		
PSII's (Patient Safety Incident Investigations)	0	0		
Never Events	0	0		
VTE Incidents (Avoidable)	1	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	1		
Falls (Total No of Inpatient Falls)	5	9		
Infection Incidents (Reportable)	0	0		
Complaints	6	4		
Claims	0	0		
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.

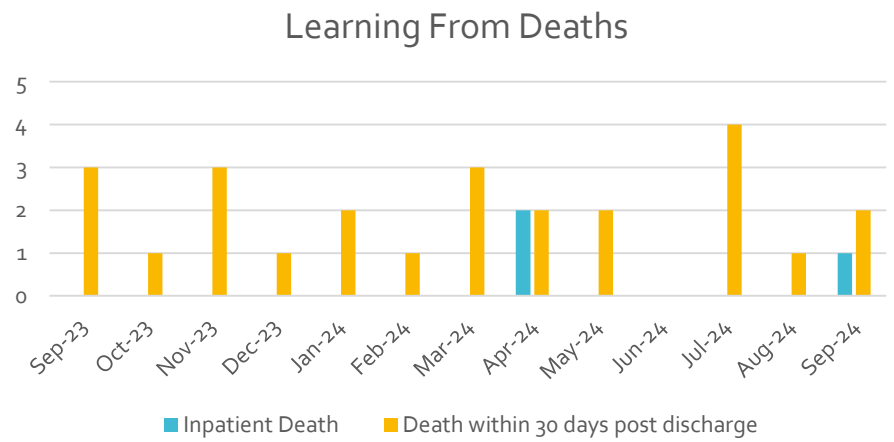
With locally managed incidents the proposed plan is to provide regular reports to local managers on closed incidents that can then be used to feedback to incident reporters on a 1 to 1 basis and also be used to share outcomes wider at local team/department meetings.

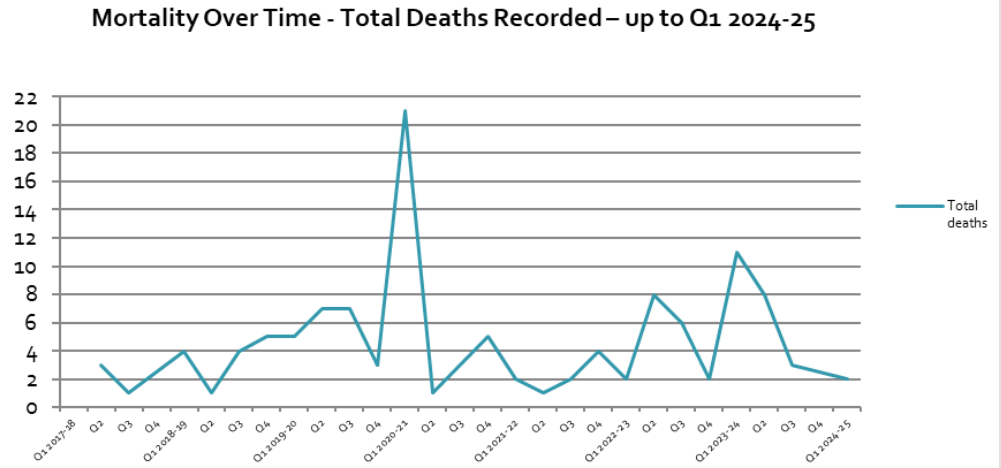
With incidents that are managed and investigated via divisional governance process, we are currently working with the Comms team to devise a format for the wider sharing of patient safety incidents and moreover the sharing of the learning from patient safety incidents that will be disseminated across 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	3	1	14
MDT	0	0	1
Thematic Review	0	1	2

Learning from Deaths





Quality Improvement & Learning

There was 1 inpatient death reported in September 2024.

Inpatient death was reported on Ward 4 on 20.09.2024.

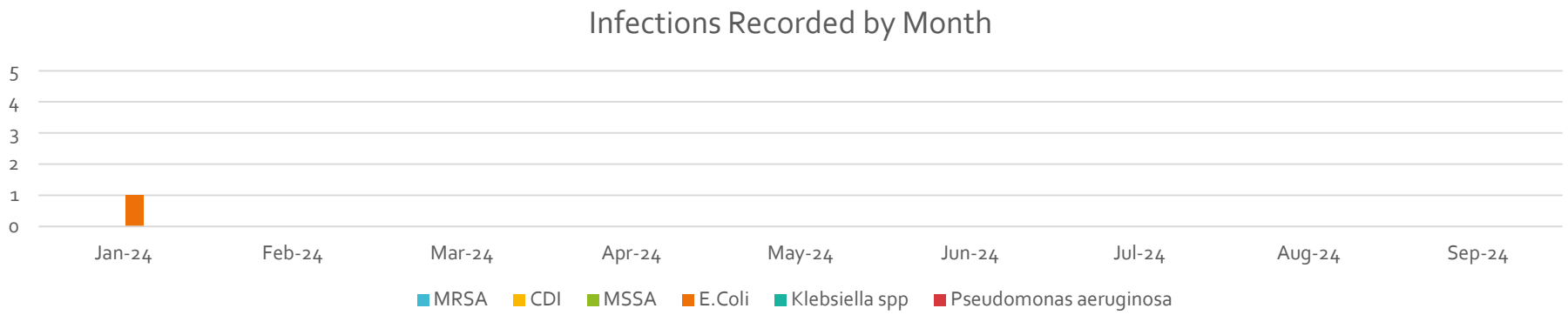
- Provisional SJR has been completed. Death due to the patient's significant comorbidities (metastatic cancer, respiratory failure, cor pulmonale, heart failure, and obesity).
- SJR states that all aspects of care met the required standards, and there were no lapses in care that contributed to the patient's death.

Governance Process: Discussed within divisional governance and will follow the internal LfD process.
Coroneal / ME Process: Death was reported to Medical Examiner as per standard practice. Coroner has open an investigation into the death but has not listed the case for an Inquest hearing

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

Patient was transferred out after intra-operative vascular complications. They returned to the ROH 4 days later. The patient started to feel unwell day 5 following return and died on day 6 (unexpected death)
Governance Process: PSII has been signed off in Exec Governance and shared with Coroner to support with inquest.
Coroneal / ME Process: Confirmation received on 23.08.2024 from Coroner's Office that this will now be an inquest, with hearing listed for Dec 2024. See also p13

Infection Prevention & Control



NHS Standard Contract 2024/25 objectives for minimising Clostridioides difficile infection (CDI) and Gram-negative blood steam infections - ROH thresholds:

	CDI (Toxin +ve)	*E.coli* BSI	*P. aeruginosa* BSI	*Klebsiella* Sp. BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0

Quality Improvement & Learning

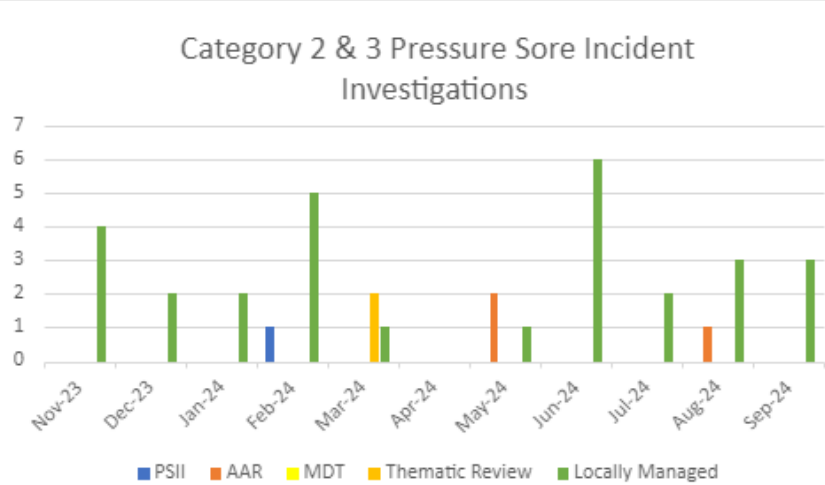
IPC Safety Priorities

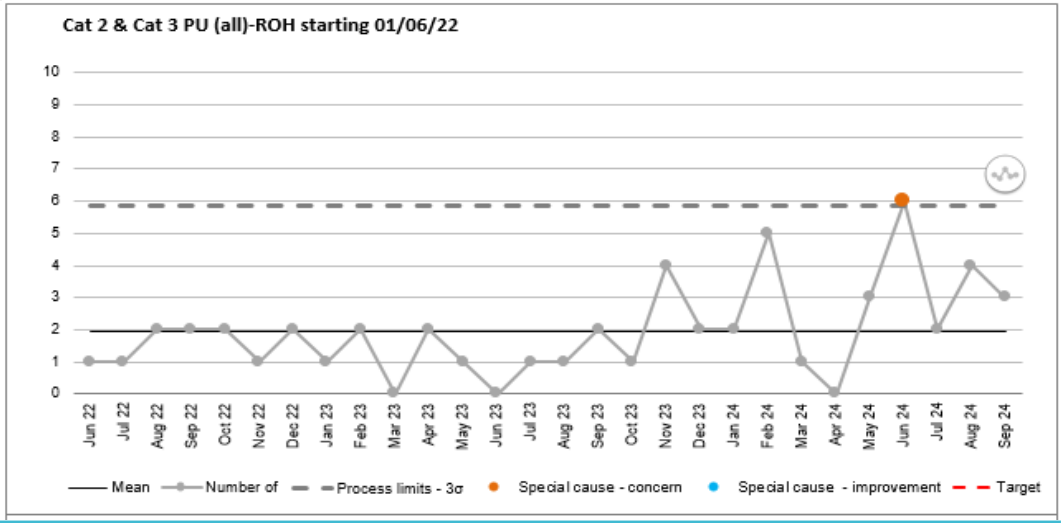
IPC safety priorities for 2024/25 have been identified following a review of all IPC incidents. Further detail of why these have been selected is provided in the Patient Safety Incident Response Plan (PSIRP) for IPC related incidents.

The three areas of focus for Quality Improvement work are:

- Surgical Site Infections
- Invasive Devices
- Antimicrobial Stewardship

Tissue Viability





Quality Improvement & Learning

There were 5 TV incidents reported in September 2024 – all incidents are being managed locally.

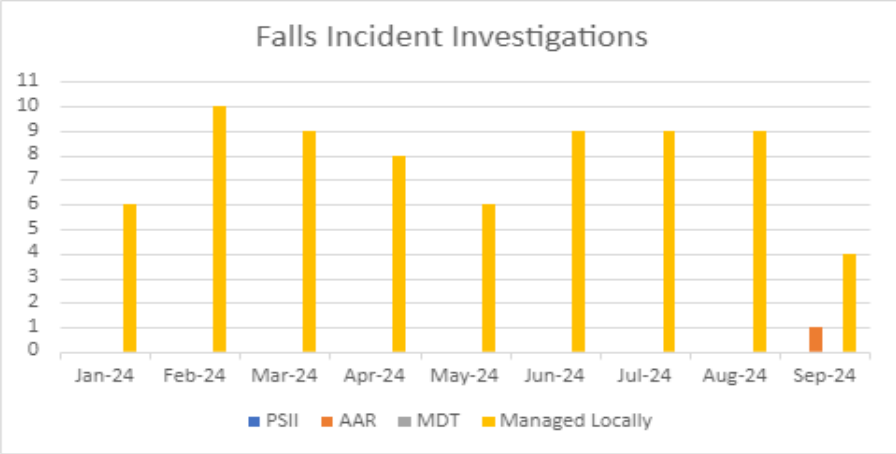
<u>Update on AAR (Reported in August 2024)</u>
AAR completed and signed off in divisional governance on 30.09.2024.
Good practice identified from nursing staff and will be shared in team newsletter.
Areas of improvement:

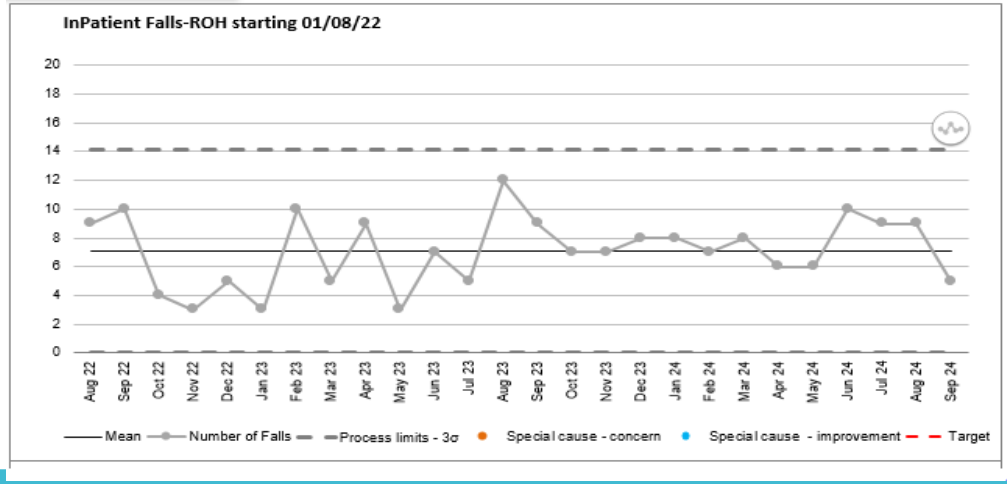
- Closer adherence to the repositioning schedule
- Improve awareness of the mattress pump settings and how to identify when it is on firm mode

<u>Quality Improvement</u>

- Work on-going in relation to the implementation of Purpose T
- Newsletter sent out w/c 14/09/24 – highlighting harms caused by not repositioning patients frequently, nor looking under dressings and bandages, plus ~stop the Pressure Day 2024 – 21/11/24 – join us.

Falls





Quality Improvement & Learning

There were 5 inpatient falls reported in September 2024. 2 incidents were taken through the Trust's divisional governance process:

Inpatient Fall – Ward 3: Confirmed dislocation from the fall. Immediate actions were taken by staff, and patient was moved to a more visible bed space, as he couldn't recall how he had gotten out of bed. Decision taken to not commission an AAR as little opportunity for learning - patient was not considered a fall risk, had bed rails up and is thought to have gotten out of bed whilst sleepwalking.

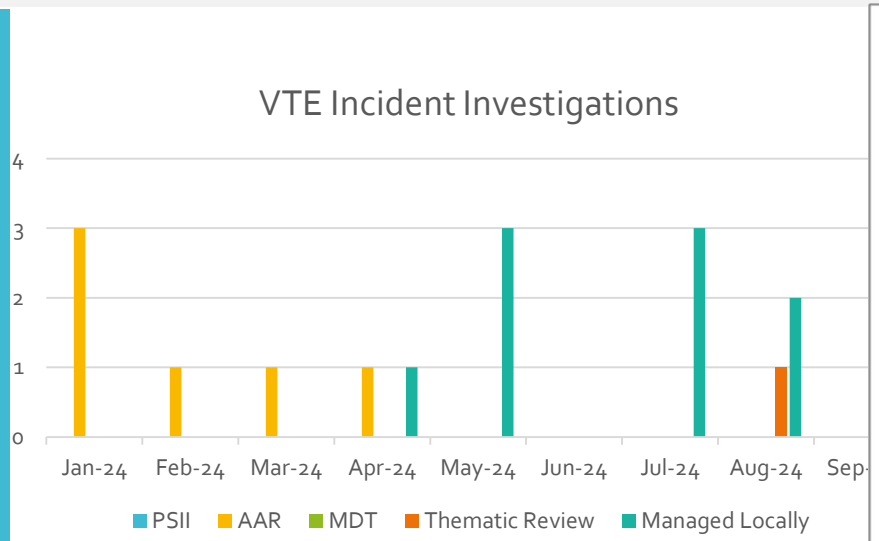
Inpatient Fall – Ward 4: Confirmed fracture from fall. An AAR has been commissioned into this incident due to the potential for learning around a language barrier and communication, with the learning to be shared in a future report.

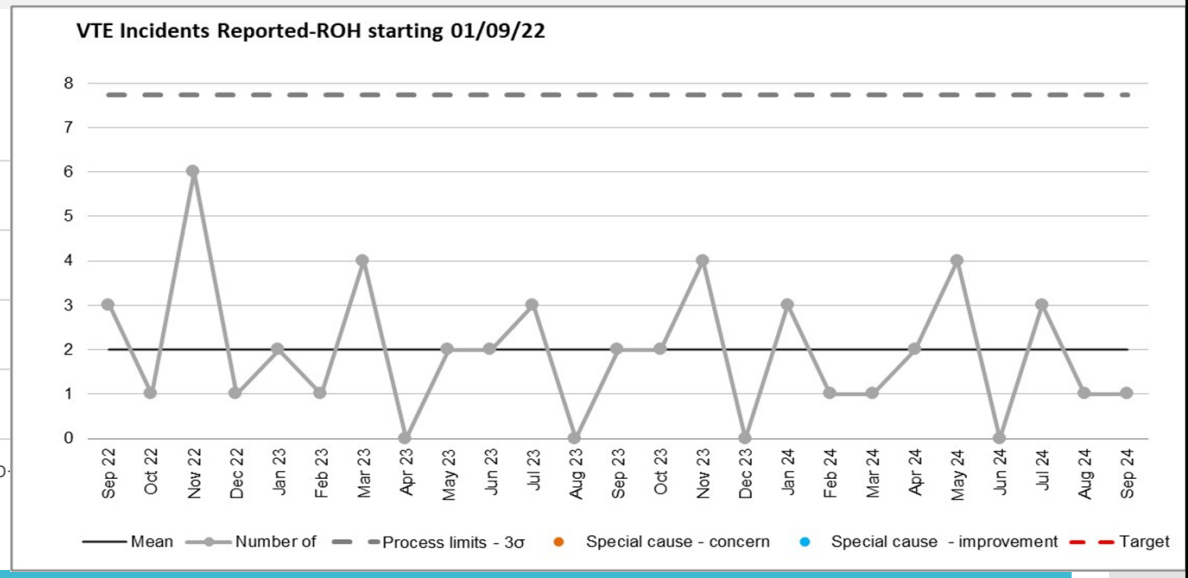
Themes:
All inpatient falls reported were unwitnessed .
2 - of the falls reported were documented as patient mobilised against advice
2 – of the falls have resulted in a fracture
4 - of the falls reported were on Ward 3

<u>Quality and Improvement Work</u>

- Review/walk round of bathrooms on ward 4 to be undertaken with Estates

VTEs





Quality Improvement & Learning

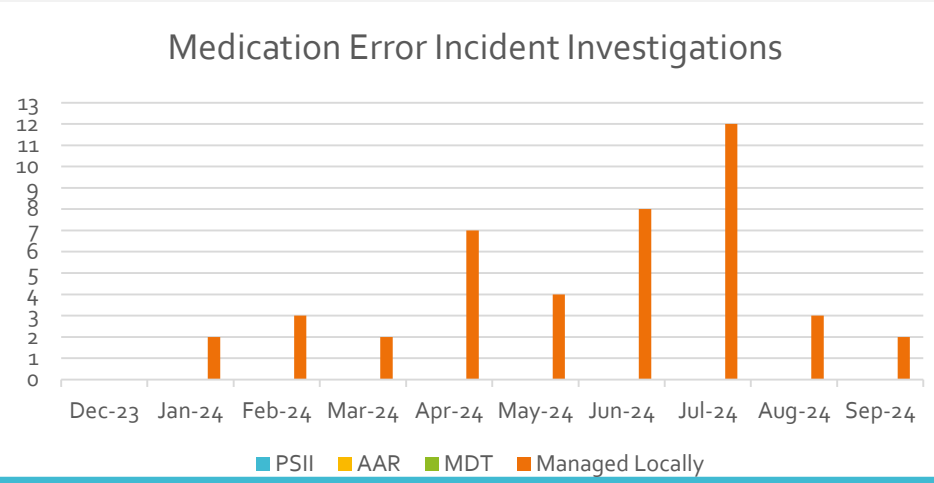
1 VTE incident was reported in September 2024. This incident is being managed locally

<u>VTE On Admission Assessment Compliance</u>
Compliance figure for September 2024: 97.09%

<u>Update on previously reported VTE incident reported in April 2024 (Reported in May 2024 Quality Report)</u>
AAR has been completed and confirmed as an avoidable VTE. Patient was only expected to be a day case patient but due to post op need for additional bed rest and wound review they remained an inpatient for a longer period of time. Therefore, the patient was not flagged as needing a day 1 post operative VTE review post-surgery. The patient was not reviewed from a VTE perspective until day 3.
Areas of improvement from investigation:-

- Reminder that VTE prophylaxis for surgical patients should be prescribed before a patient leaves theatre. Post operative named surgeon accountable for ensuring this is complete
- Safer Surgery Checklist – Effectiveness of VTE prophylaxis question to be reviewed.
- Nursing staff to review and escalate at daily huddles where post-operative instructions are not in place.
- Recovery and ward staff to review post operative instructions and confirm if VTE Prophylaxis is required and ensure this is prescribed prior to patient leaving recovery.

Medication Errors



Quality Improvement & Learning

There were 2 medication error incidents reported in September 2024. 1 incident was regarding the dose of Vancomycin given to the patient. This incident was discussed in divisional governance, as per the agreed actions following the previously reported rise in vancomycin related medication error incidents (reported in August 2024 Quality Report and summarised again below) and remains under review.

Significant reduction in these incidents shows that the governance safeguards and identified learning following the initial review have been effective in resolving the issues.

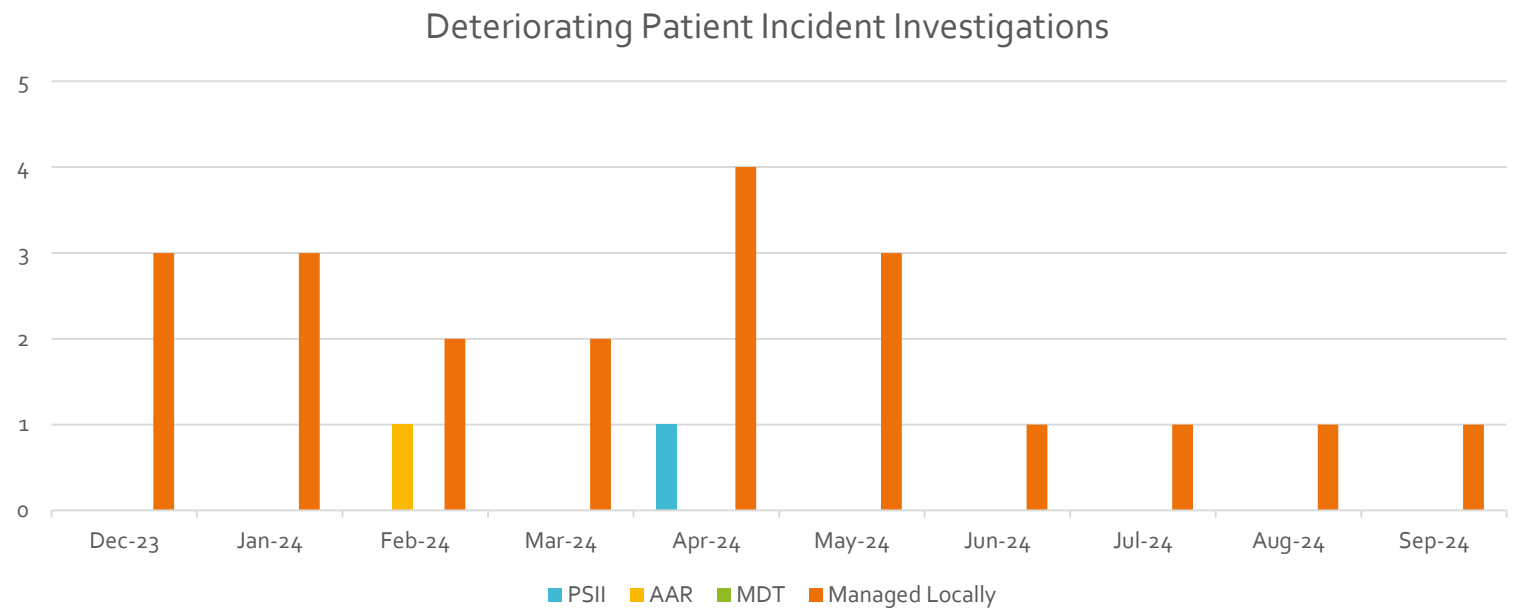
<u>Vancomycin Medication Error Incidents</u>

An emerging trend was identified in August 2024 regarding an increase in medication errors, particularly errors in the prescribing of vancomycin. Following discussion at Divisional governance meeting, there were some areas of practice which identified that staff were continuing to follow the previous guidance or only partially following new guidance.

The following learning and improvement actions were agreed

- The pharmacy team are updating prescribers through bespoke training.
- Resources have been printed out and displayed in prominent places in the clinical areas.
- Consultant anesthetist included an update on the revised vancomycin guidance at the August Clinical Audit meeting
- The ARR originally commissioned for the first vancomycin incident was stood down in lieu of the themed review and planned actions.
- The Clinical Governance Facilitators have been updating the bi-weekly incident report submitted to Division 2 governance meeting to include a section

Deteriorating Patients

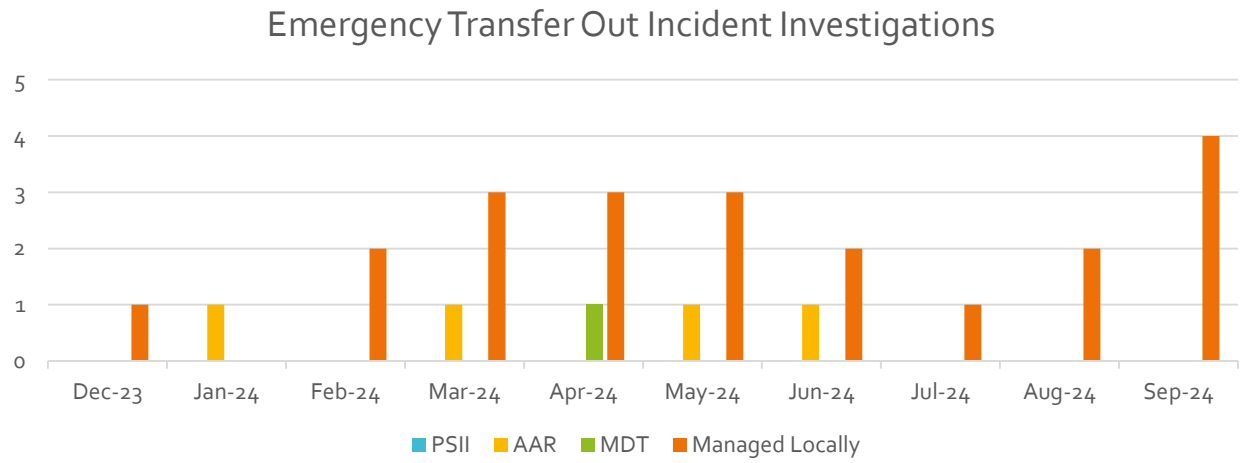


Quality Improvement & Learning

There was 1 deteriorating patient incident reported in September 2024.

Patient was transferred from the ward to HDU for closer monitoring. Discussed in divisional governance - probable cause of deterioration documented as hyponatremia. Reported as severe harm, incident and severity remains under review via trust governance process. An update will be provided in a future report

Emergency Transfers Out



Quality Improvement & Learning

There were 4 emergency transfer out incidents reported in September 2024. All incidents have been discussed within divisional governance and are being managed locally.

No themes or trends or key areas of learning were identified.

<u>Update on Case A as reported in May 2024 Quality Report</u>
AAR identified good ROH practice. No key learning identified

<u>Update on Case B as reported in June 2024 Quality Report</u>
AAR awaiting sign off via divisional governance process – update to follow in a future report.

Complaints

Complaint Information

The Trust received **6** complaints in September 2024

Below are the departments that received complaints in September 2024

- Spinal x3
- Ward 2
- Ward 4
- HDU

In September 2024, the complaints team closed **4** formal complaints. 3 complaints breached the timeframe agreed with the complainant and 2 of those were private suite complaints. **KPI = 50%**
At the time of producing this report, (10/10/2024) we currently have **17** open formal complaints.
1 complaint is currently paused due to awaiting consent form from the patient

Departments that have open complaints at the time of writing report

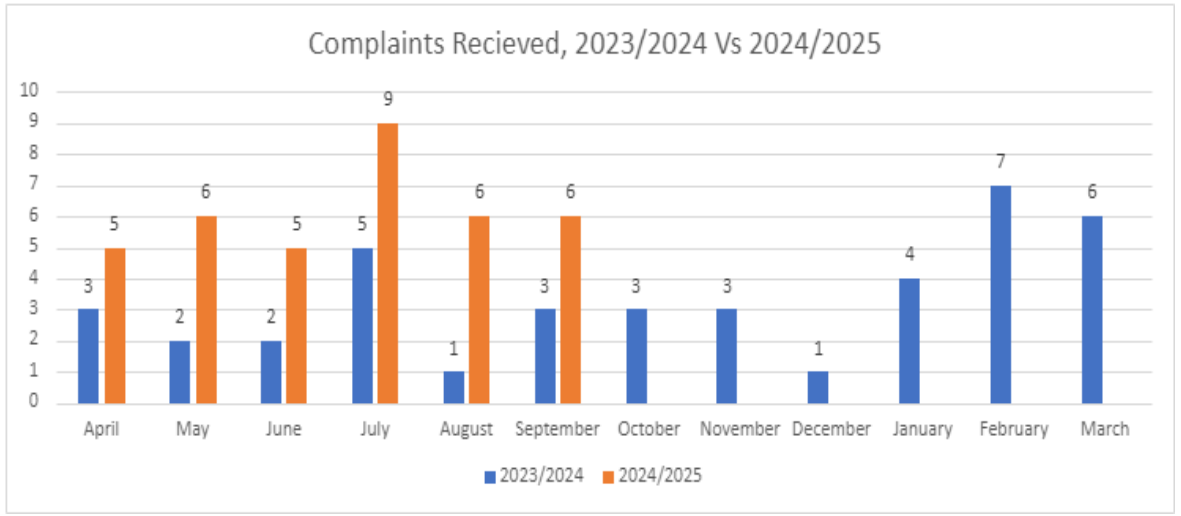
- Large Joints x2
- Spinal x7
- Oncology x2
- Ward 2 x1
- Ward 4 x1
- HDU x1
- Imaging x1
- MSK x1

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 September 2024 the Trust received **1 requests for a resolution meeting.**

Complaints



KPI's

KPI0	Complaints %
April 2024	100%
May 2024	57%
June 2024	0%
July 2024	50%
August 2024	40%
September 2024	50%

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

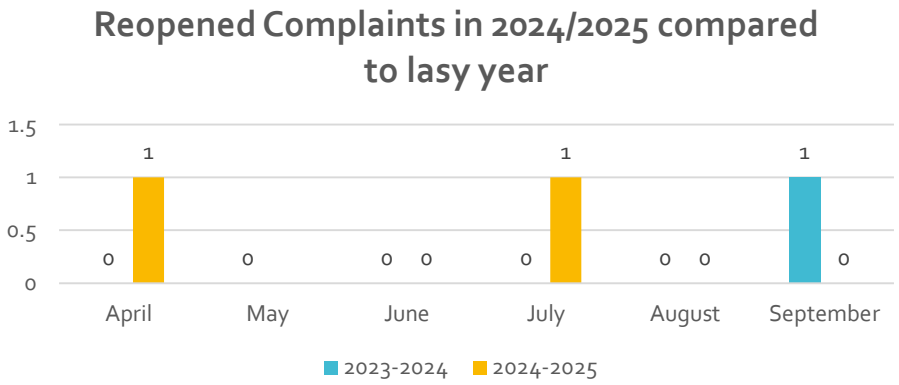
Complaint Year Totals	
April 2023 - March 2024	42
April – September 2024	37

KPI is 40% due to 1 complaint out of the 2 NHS complaints breaching the agreed timeframe

Actions rom Complaints

From the complaints closed in September 2024 3 actions were identified and these actions have been closed

Complaint Themes



Reopened complaints

The Trust received 0 request to reopen a complaint in September 2024.

The Trust currently has no PHSO complaints cases open.

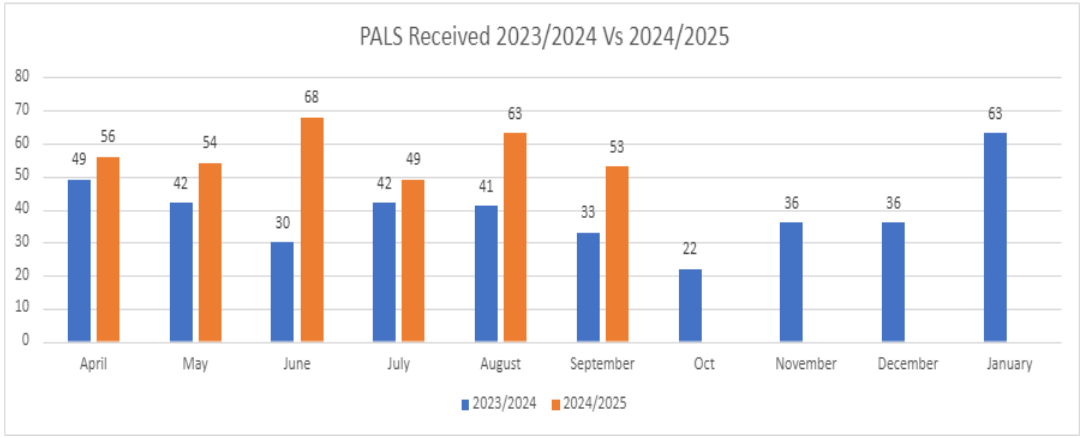
Themes of complaints currently open

1. Unsatisfactory care
2. Lack of follow-up care
3. Miscommunication
4. Delays in treatment
5. Values & Behaviour

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 and action plans.
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



KPI's

KPI	PALS Contacts %
April 2024	34%
May 2024	48%
June 2024	58%
July 2024	86%
August 2024	76%
September 2024	59%

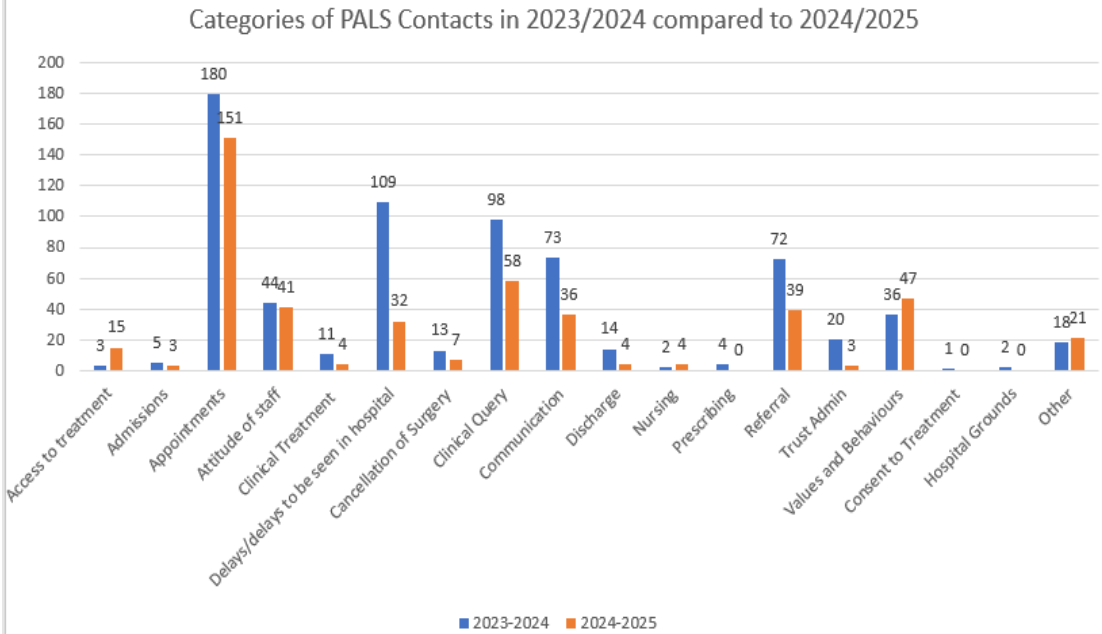
0%-30%
31%-79%
80%-100%

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.

12 PALS Cases breached in September 2024
The KPI for PALS Contacts was not met for September

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

PALS Themes



Themes

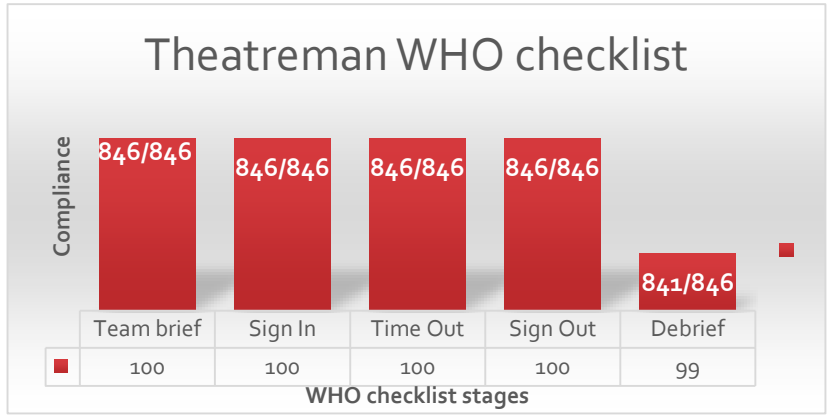
Appointments – 25 out of 53 received
Specifically: Appointments Cancelled and Failure to provide follow up

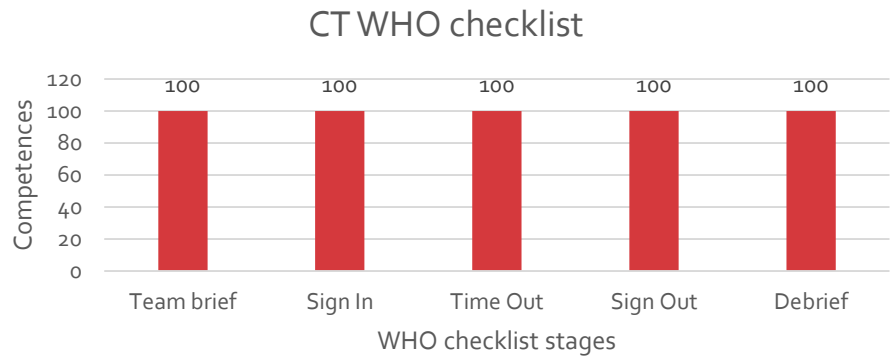
Referral– 8 out of 53 Received
Specifically: Disagreement of referral/referral not actioned

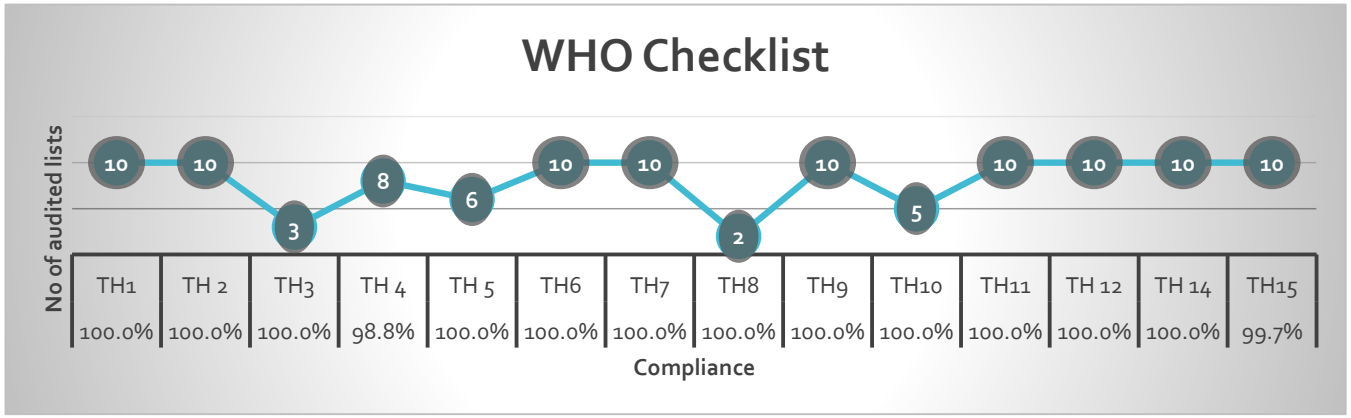
What we have done:

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

WHO Audits







Quality Improvement & Learning

Work in Progress – Safer surgery report with recommendations received. Meeting to be arranged with theatre leads and quality improvement lead to discuss the following:

- Establishing a Trust NatSSIPs steering group.
- Introduction of planned interdepartmental WHO audit process.
- Updating ROH Safe Surgery Policy
- Reviewing Safer Surgery Checklist
- Scrutinising and reviewing
- WHO audit tools

CAS Alerts – September 2024

CAS ALERTS 1-30 SEP 2024

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/010/NHSPS	Risk of oxytocin overdose during labour and childbirth. This National Patient Safety Alert, issued by the NHS England National Patient Safety Team and endorsed by the Royal College of Obstetricians & Gynaecologists, Royal College of Midwives and Royal College of Anaesthetists, instructs all relevant NHS funded maternity care providers to cease pre-preparing oxytocin infusions at ward level in all clinical areas. All actions should be completed by 31 March 2025.	National Patient Safety Alert - NHS England Patient Safety	24-Sep-24	Assessed - not relevant to organisation's services	31 Mar 25

CAS Alerts – Open alerts from previous months

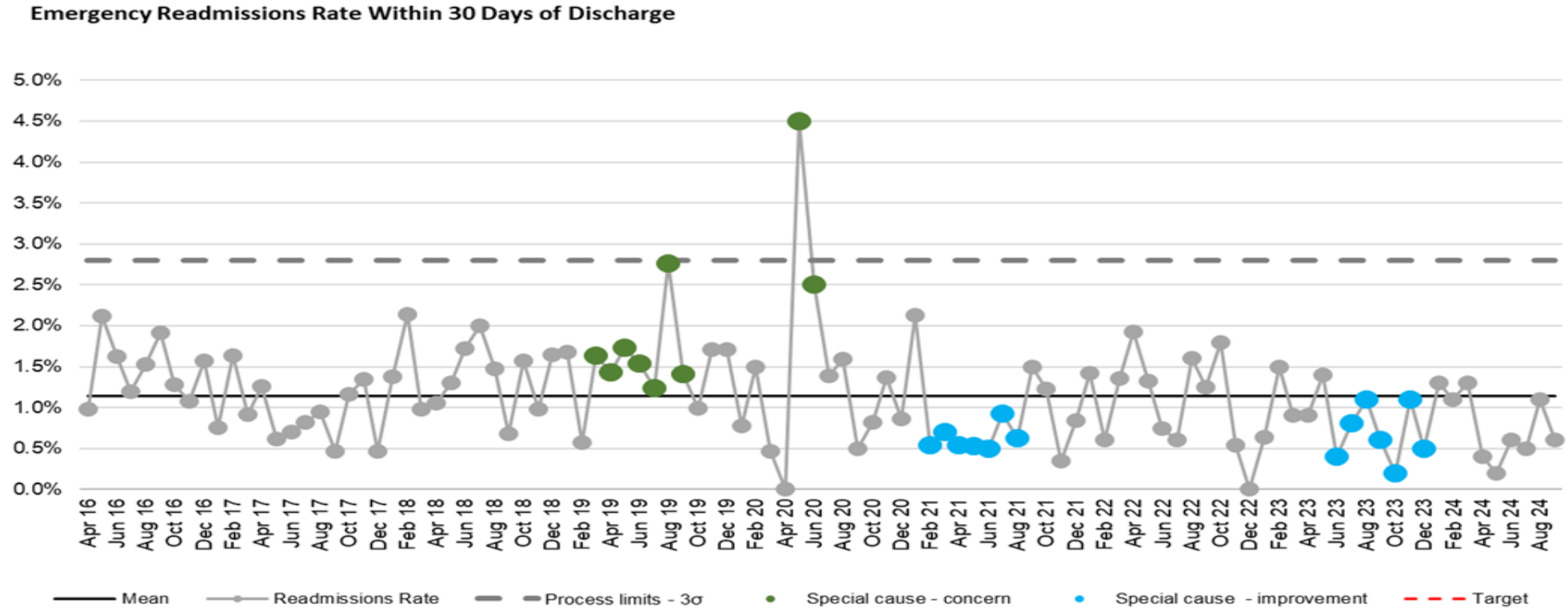
Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks. This National Patient Safety Alert, issued by the NHS England National Patient Safety Team, and co-badged 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/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 iaw Arjo's service schedule. On-going…	1 Mar 2024. On-going…

Safeguarding Training Compliance

KPI	Sept 2024
Safeguarding Adult Notifications	40
Safeguarding Children and Young People Notifications	54
Adults Level 1- Target 90%	99.77%
Adult Level 2 -Target 85%	93.10%
Adult Level 3- Target 85%	88.37%
Level 4- Target 90%	100.0%
Child Level 1 -Target 90%	99.16%
Child Level 2- Target 85%	92.56%
Child Level 3- Target 85%	87.73%
Mental Capacity Act MCA- Target 85%	92.79%
Deprivation of Liberty Safeguards DoLs	92.79%
Prevent Awareness- Target 95%	90.74%
WRAP (prevent level 3)- Target 90%	87.18%
FGM	0
DOLS	3
MCA	5
PIPOT cases	0
PREVENT Notifications	0

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
No of Readmissions	1	6	3	6	6	7	2	1	3	3	5	3
Denominator	543	553	559	462	546	548	495	534	473	562	461	508
% Readmissions	0.2%	1.1%	0.5%	1.3%	1.1%	1.3%	0.4%	0.2%	0.6%	0.5%	1.1%	0.6%

Freedom to Speak Up

There were 5 concerns raised to FTSU in September.

The themes from concerns raised were:

- lack of managerial support
- delay in managers dealing with escalated concerns
- Escalated concerns not being taken seriously by managers

Quality Improvements & Learning

Learning and Outcome: Awareness raised on Disadvantageous and Demeaning Treatment supporting Document and Trust wide encouragement to complete FTSU Modules – Freedom to Speak Up, Freedom to Listen Up and Freedom to Follow Up. These tools are available to support the speaking up culture.

OCTOBER IS FTSU MONTH

October FTSU awareness and celebration is in full swing. The Theme this year is **Listening with Compassion** – please take this opportunity to give a values card to someone who supports you.
Our First Awareness Stand was on 14/10/24 working in collaboration with the Wellbeing Team.
Staff are being encouraged to wear something Green on Wednesdays to show support for FTSU.
Please come and get involve, we are **LISTNING**. We will be in Theatre on the 29/10 with our grand finale and a listening session.

Workforce Performance Report

Prepared by:
Matt Dingle, Head of Human Resources
David Richardson, Head of Education and Training
Clare Mair, Head of OD & Inclusion

Ref: October, 2024/ HR&OPS

Scorecard

Topic	KPI	September 24	TREND
Occupied Establishment	93%	89.67%	↑
Turnover (adjusted)	10.5%	11.07%	↑
Staff in post - FTE	N/A	1286.93	
Sickness absence	4%	5.28%	↓
Performance & Development Reviews	95%	91.30%	↑
Disability declaration rate	7.5%	8.34%	↑
Workforce Wellbeing – A/Leave	N/A	49.3%	N/A
Mandatory Training	93%	85.89%	↑

Section One:

HR Operations Team

Prepared by: Matt Dingle, Head of HR

Presented by: Matt Dingle, Head of HR

Ref: <Month, Year>/HR&OPS

HR Operations

Summary:

The Trust are reporting positive improvements in the sickness absence rate, for the month of September and from assessing yearly data between January and September. Turnover rate increased slightly this month but monitoring suggests this isn't cause for concern.

Areas for Improvement:

Despite improvements, sickness absence remains above target. Achieving the 4% target would provide significant gains for the Trust. The Trust is also reporting a high rate of grievances, which most have accompanied a long-term absence. Finding ways to enable positive working relationships and early interventions when relationships turn negative is key.

Risks / Issues:

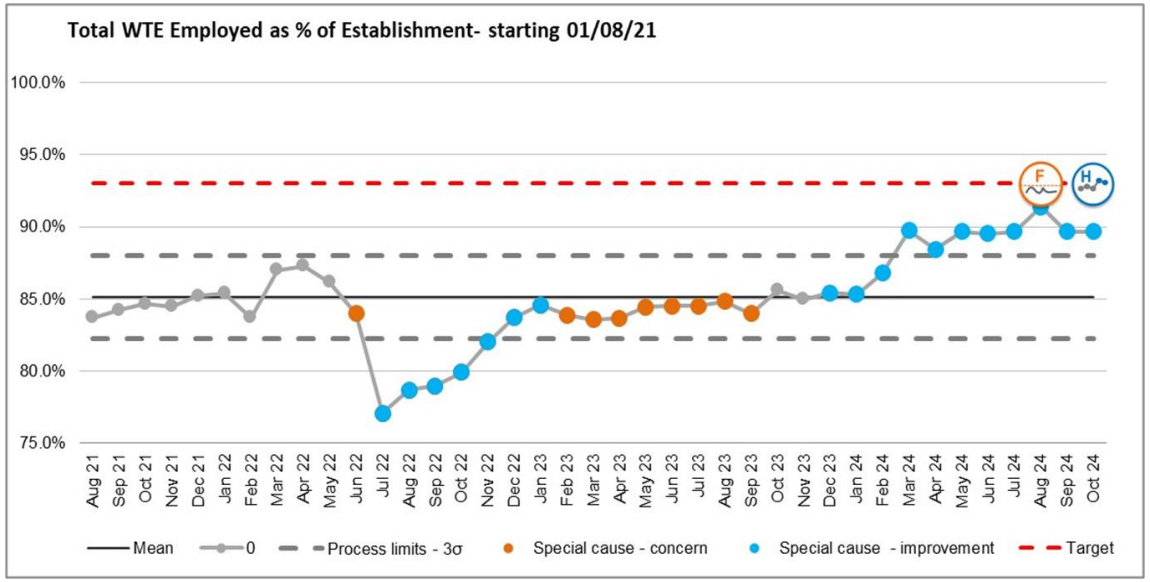
Conflict has an obvious impact within the Trust that requires intervention when it becomes unhealthy. The manager/employee relationship requires improvement in isolated cases.

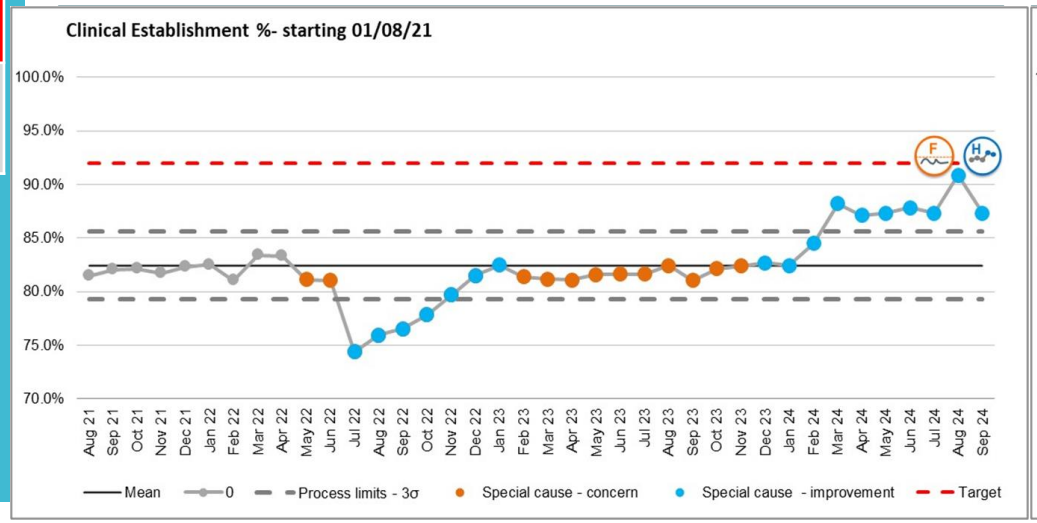
Action Plan:

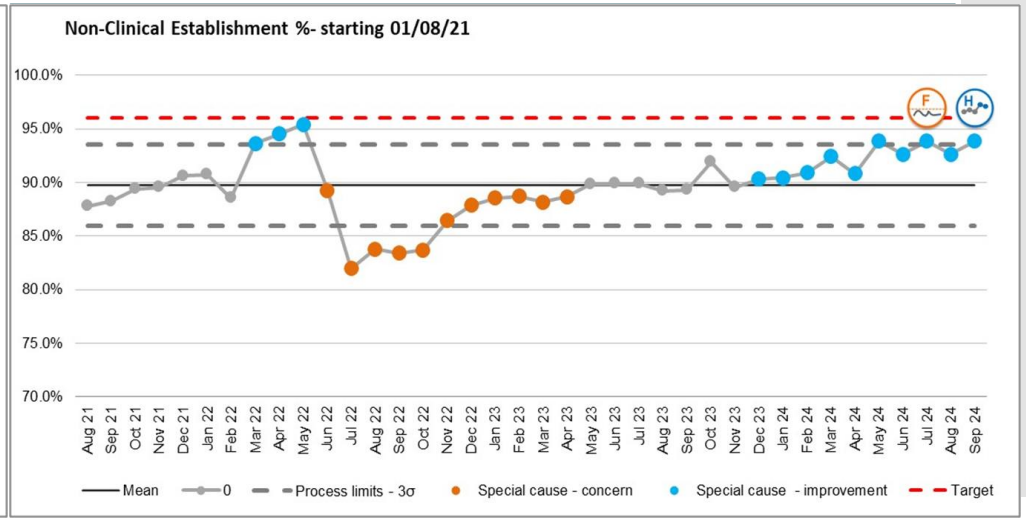
We have piloted conflict sessions and are looking to role these out in the Me as Manager programme in 2025.
Sickness absence target in hotspot areas continues
Turnover will continue to be closely monitored.

Occupied Establishment

KPI	93%
Sept 2024	89.67%
Trend	↑







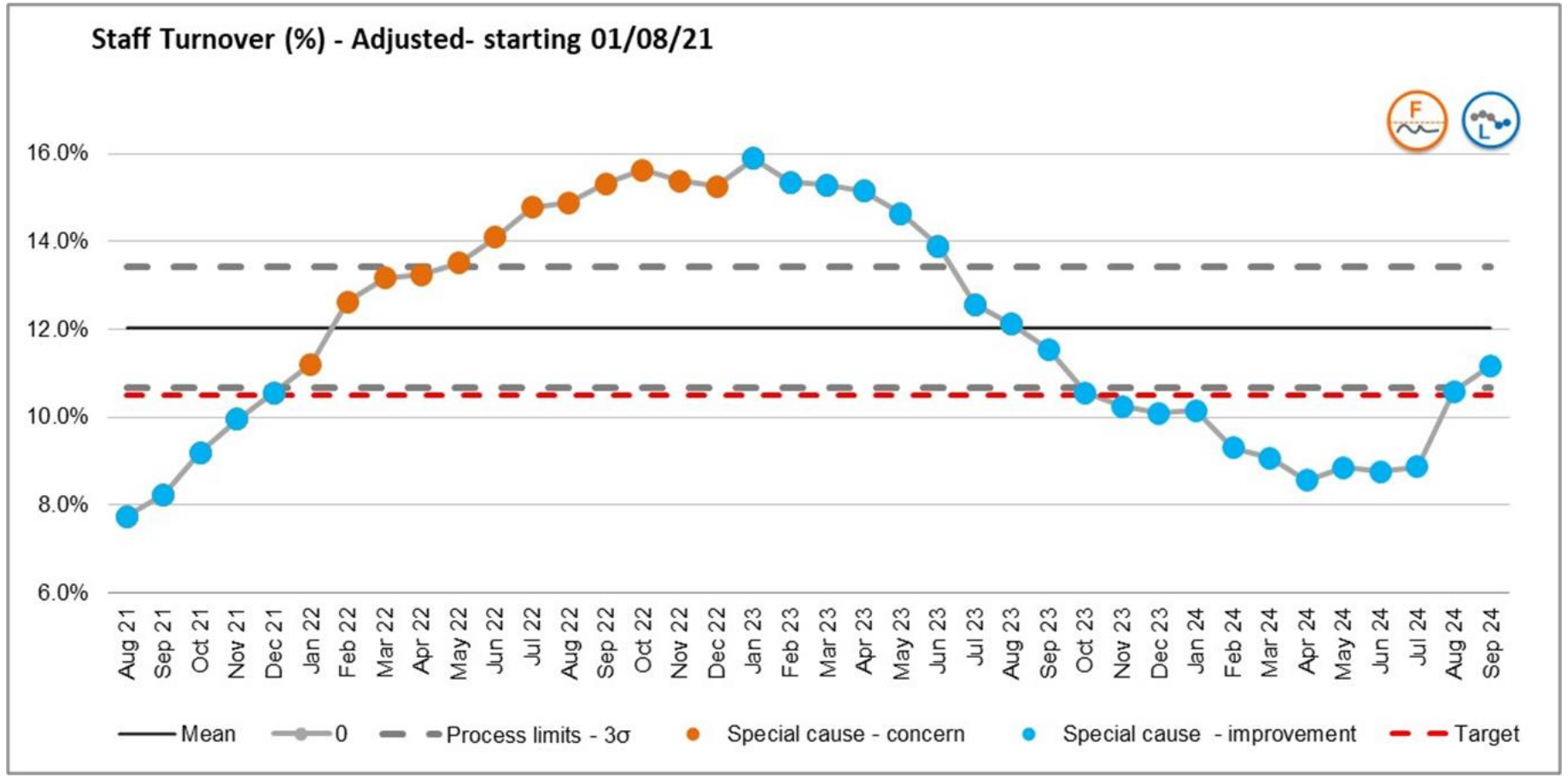
Turnover (adjusted)

KPI	10.5%
Sept 2024	11.07%
Trend	▲

Adjusted turnover *is all turnover minus:*

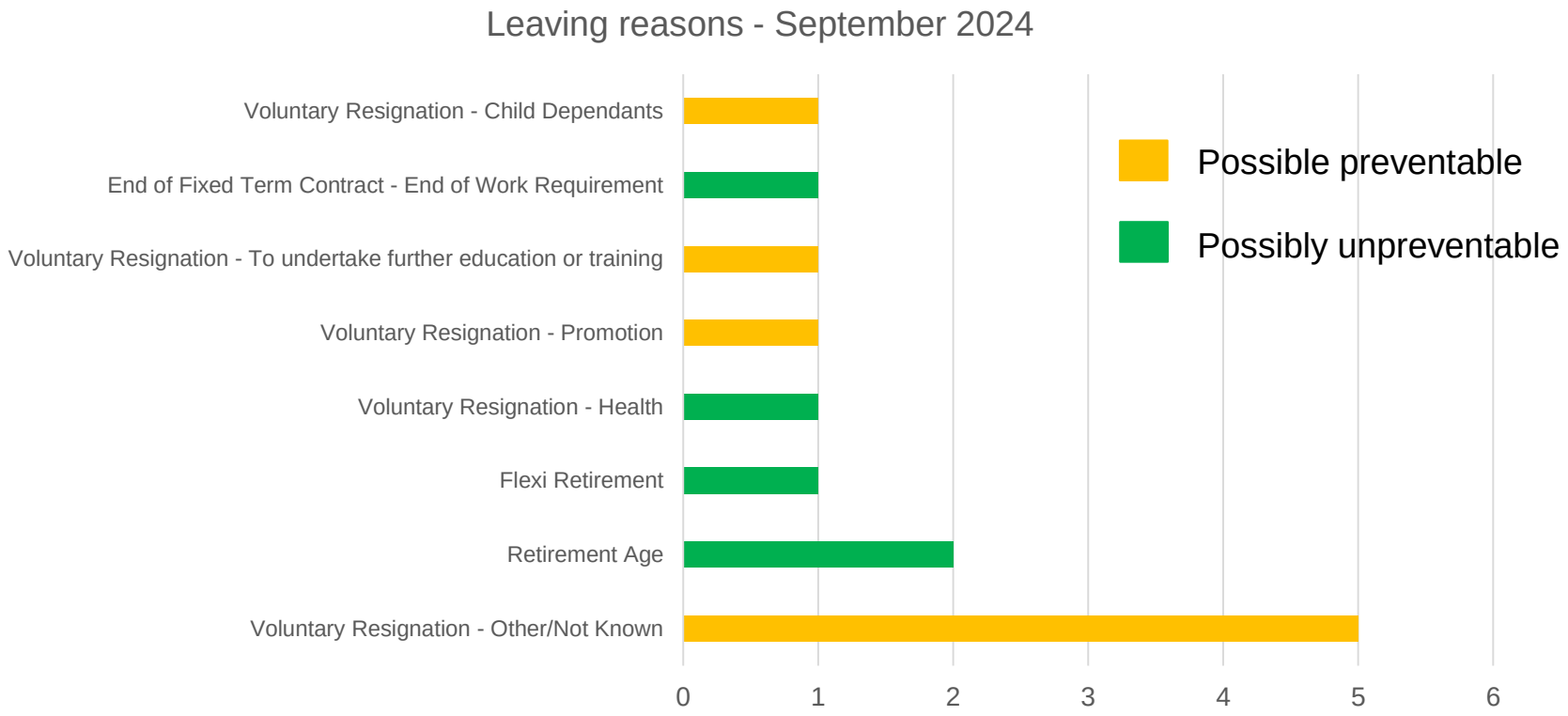
- *Junior doctor rotation*
- *Flexible retirement*
- *End of FTC*

Adjusting turnover provides more meaningful data around Trust performance



Sept 2024 leavers

Of the three staff members that retired, two returned

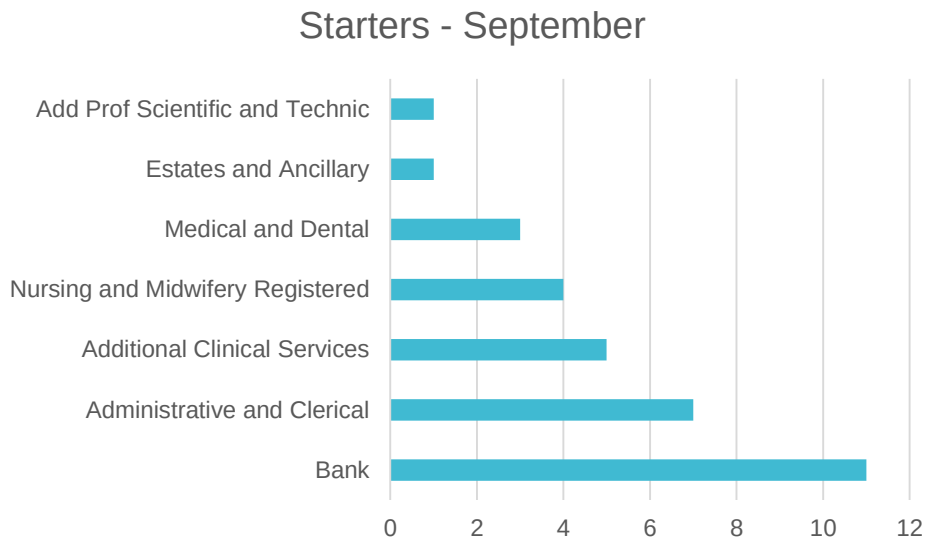


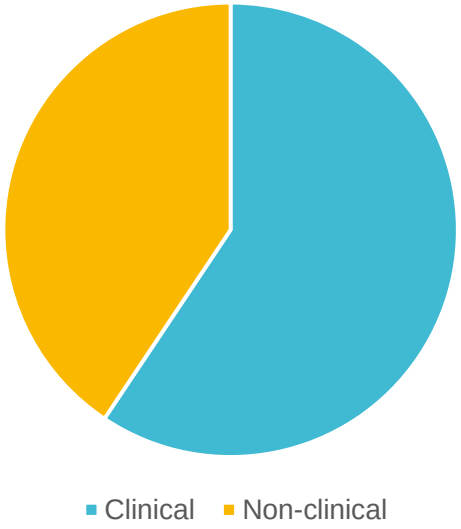
Impact:

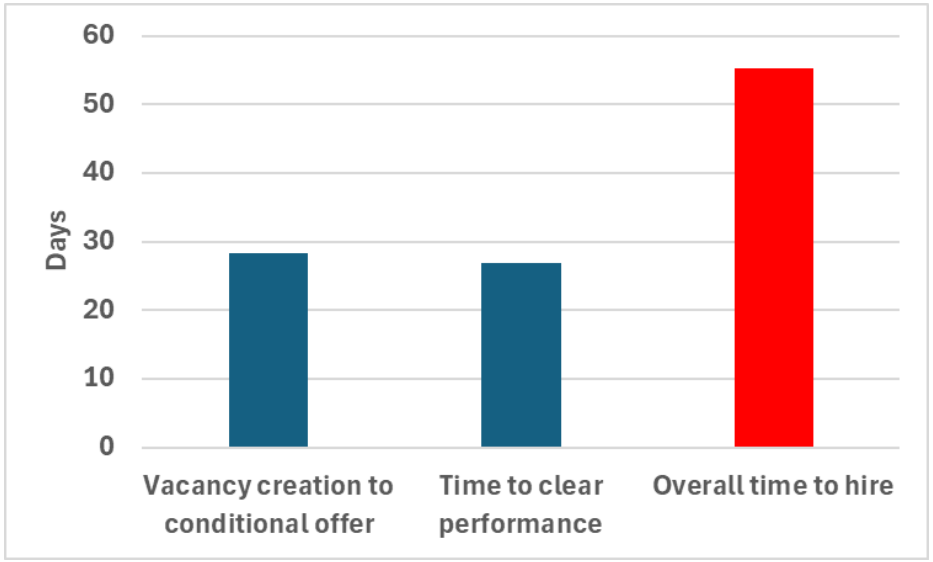
We had a slightly higher than normal turnover rate in September, however reviewing the nature of the turnover, if the retiree who returned were taken out of the figures, it would have resulted in a decrease in percentage just above target

Starters – Sept 2024

Impact:
Recruitment times are comfortably within a reasonable timescale and improving.







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:

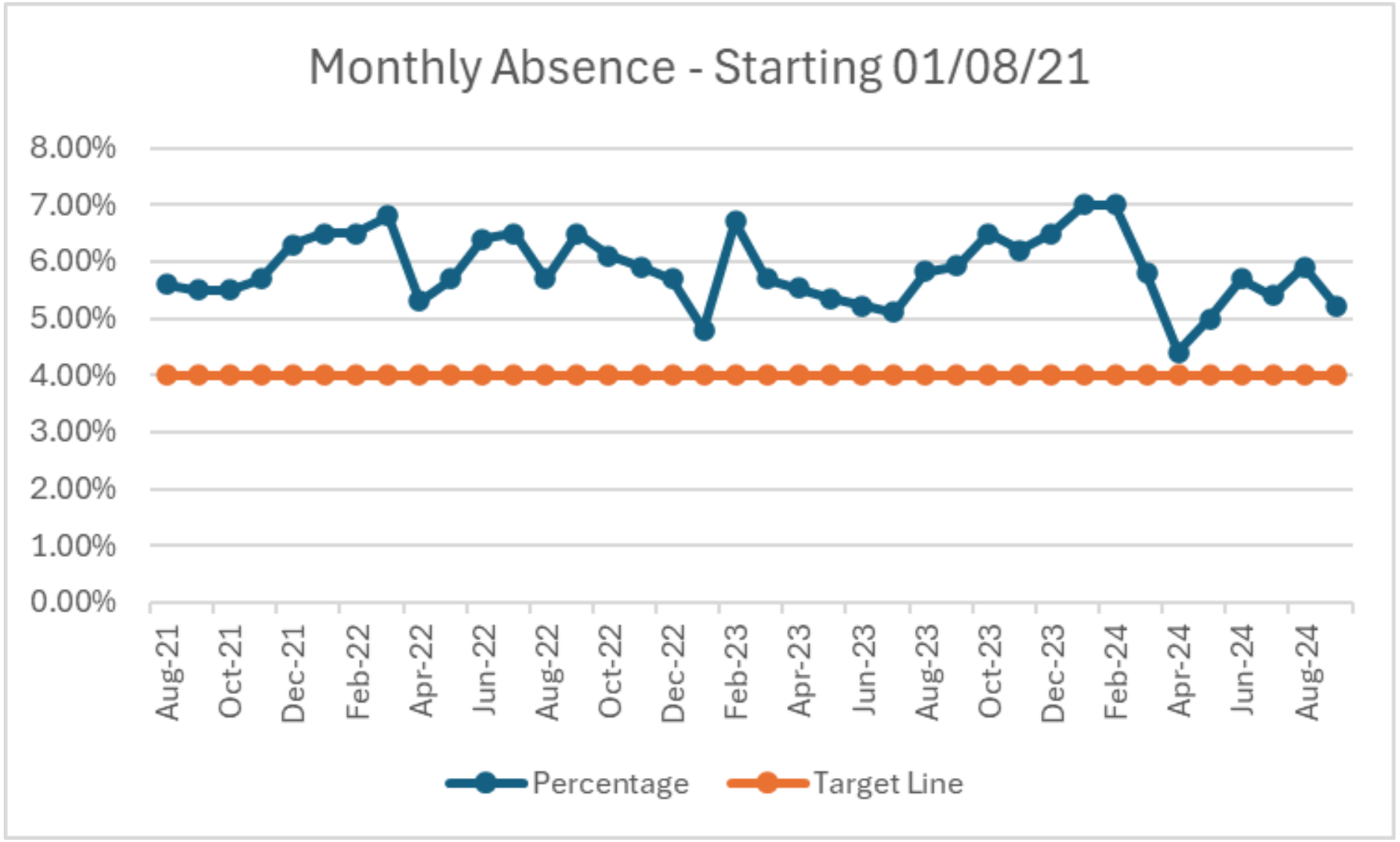
- 5 out of the 6 grievances have resulted in long term sickness for the complainant.
- Alongside the suspensions, impact on the Trust has been significant

Case Type	Cases open	Suspended/ Excluded	Cases Closed / Concluded in Aug/Sept
Disciplinary	3	2	2
Grievance	6	N/A	
Formal Capability	1	0	0
MHPS	1	1 (restricted)	0
Final Stage Sickness	5	N/A	2

Key Themes:

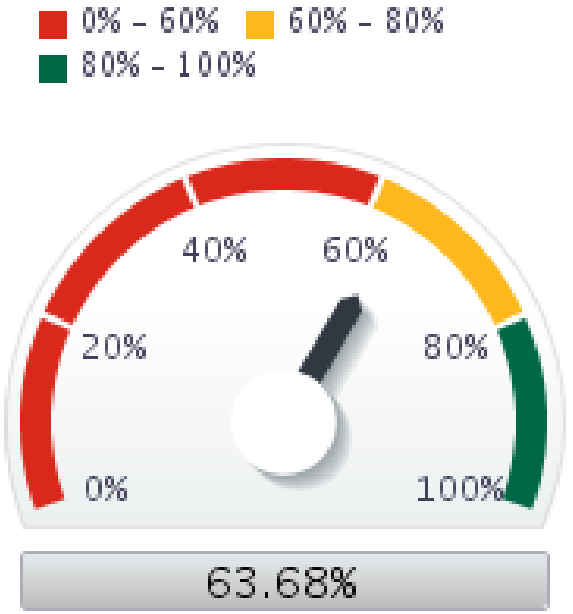
- Grievances all follow the same trend, which is concerns around management behaviours.
- Three of which are related to perceived treatment in response to management processes (e.g. conduct, capability).
- All cases were opened in the last two months other than one Grievance which has been a long-term ongoing case, due for conclusion at appeal in November.
- Suspensions are regularly reviewed and scrutinised.

Sickness	
KPI	4%
Sep 24	5.2%
Trend	↑

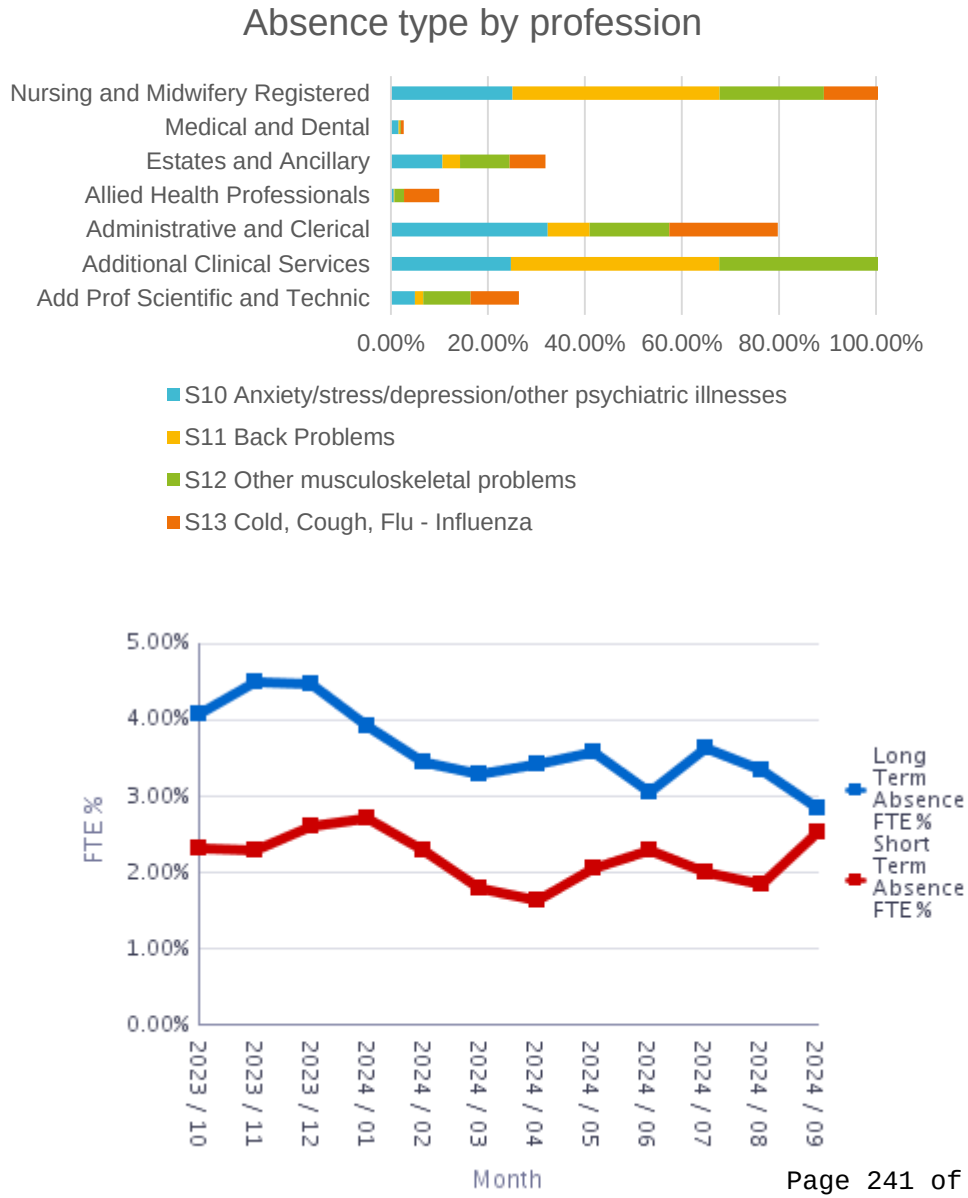


Sickness Continued

Return to work compliance (logged on ESR)

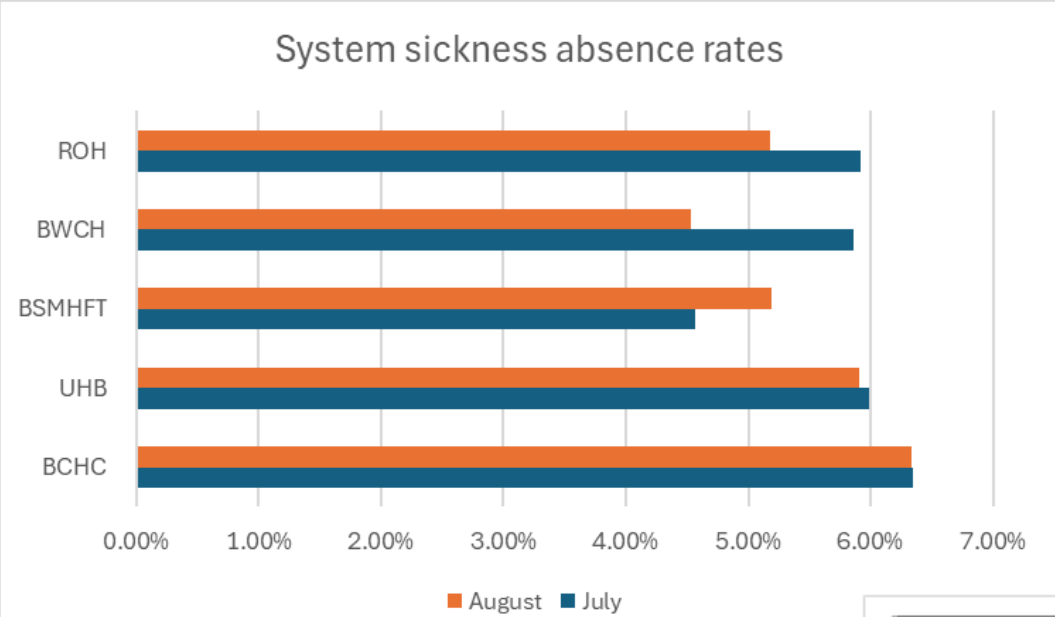


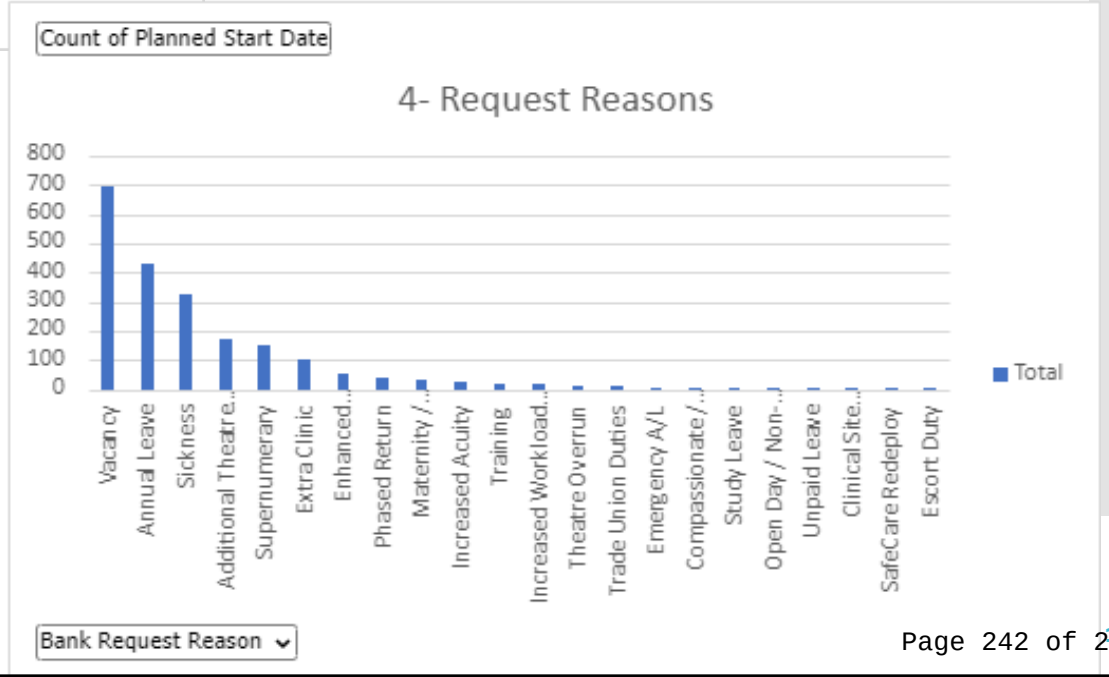
Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	26.5
S13 Cold, Cough, Flu - Influenza	13.4
S12 Other musculoskeletal problems	10.5



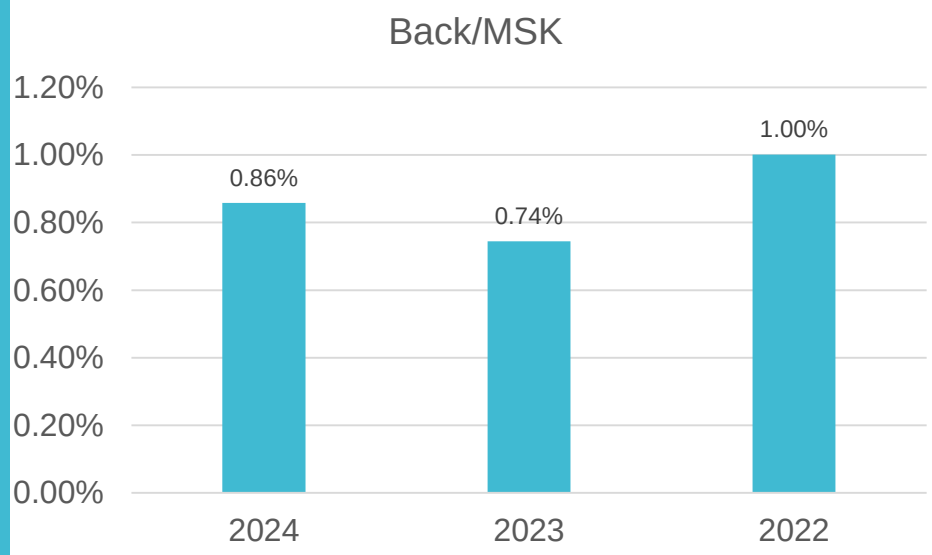
Sickness - continued

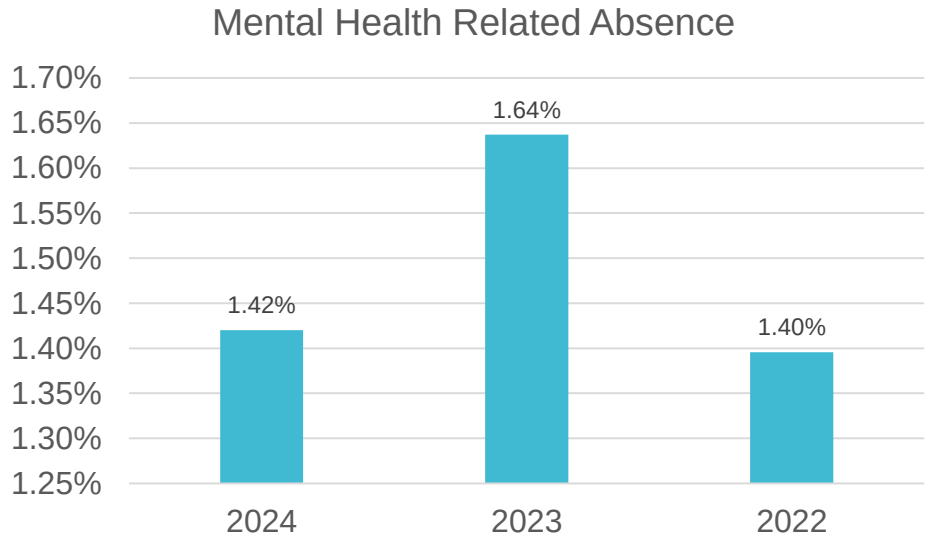
Insights:
The Trust has improved in September to have the second lowest sickness absence rate in the system

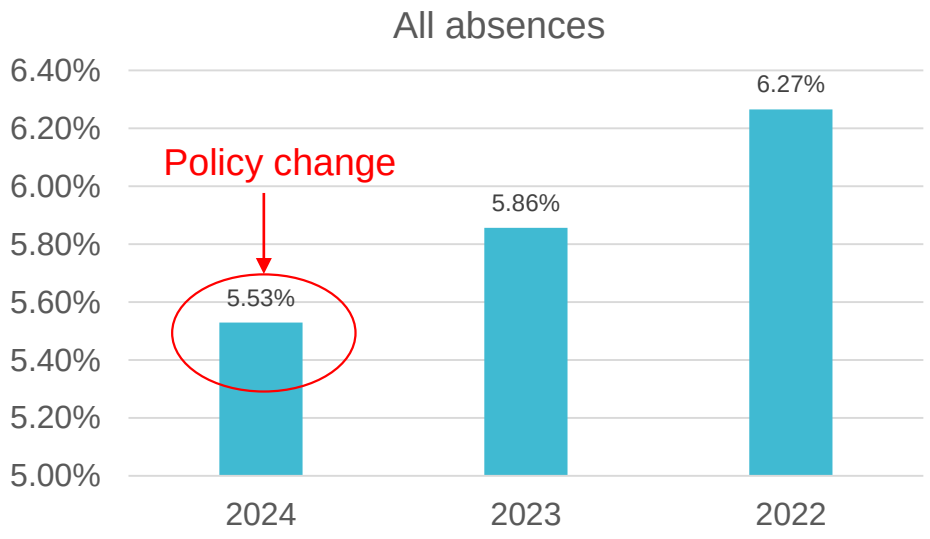


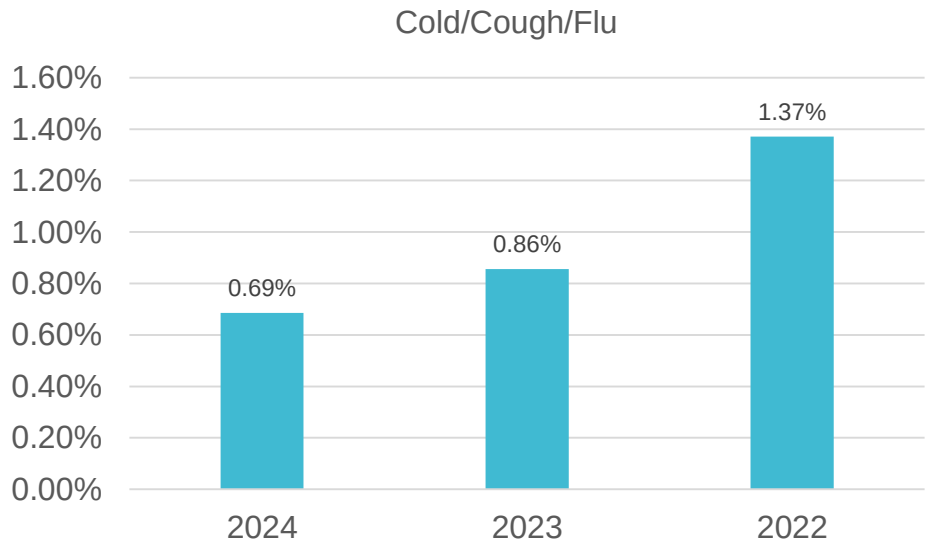


Sickness Analysis – January to September



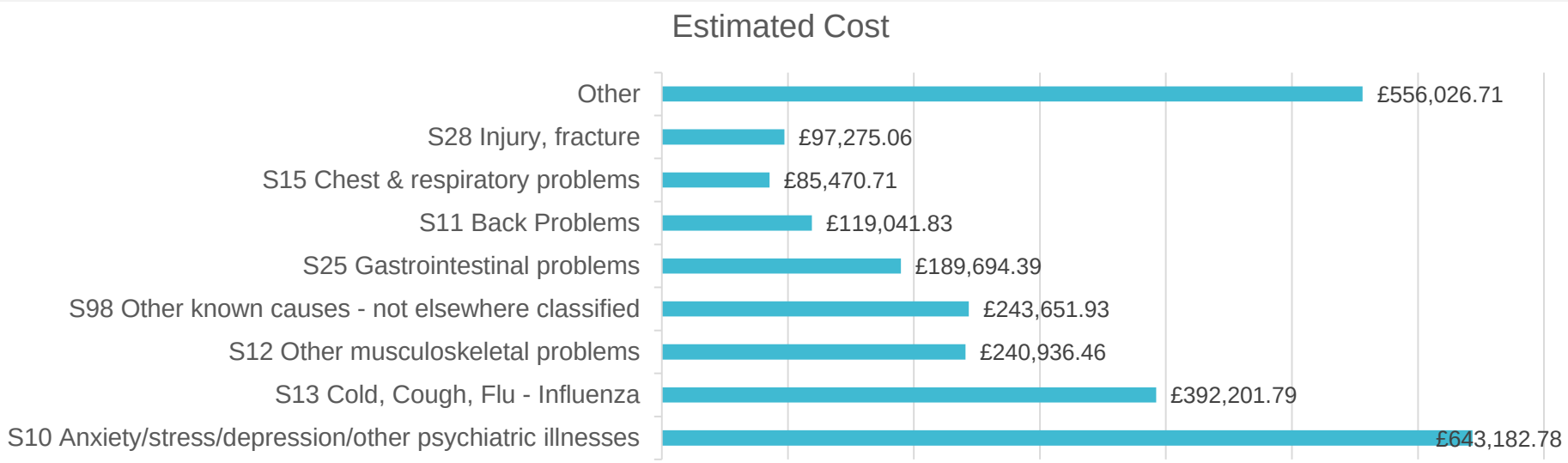


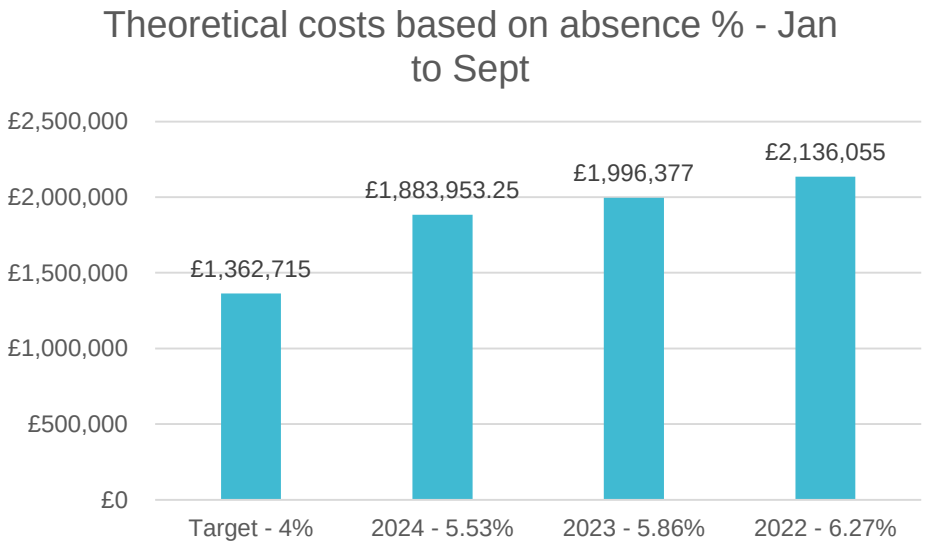


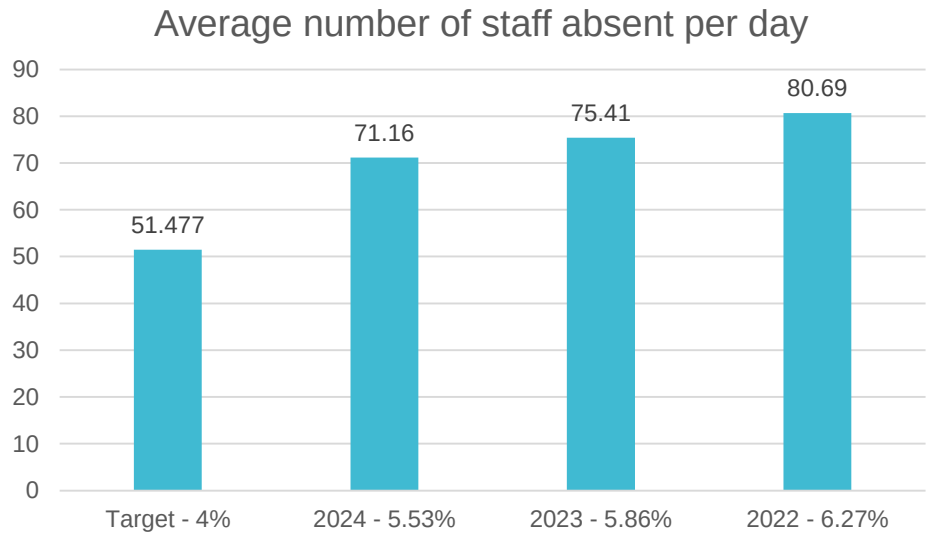


Estimated Cost

Insights:
As a result of the lower sickness rate in 2024, it is estimated this has saved the Trust £112,424 (excludes cost of replacement) and 4.25 more staff are in work per day







Section Two:

Education and Training

Prepared by: Sharon Thornton, E-learning and Compliance Training Facilitator

Claire Felkin, Training & Development Manager

Presented by: David Richardson, Head of Education and Training

Ref: Sept. 2024/HR&OPS

Education and Training

Summary:

In September we have not seen the improvement we were expected to see. We continue to be well below the target of 93% overall. The modules which require an annual renewal are falling well short and bringing the average compliance figure down. For example Fire is at 77.32% and Cyber at 79.32% whereas the average figure for the 3 yearly modules is at 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 27/33 and current Apprenticeship Levy spend is at 54.62% which has increased. People are showing an interest so this figure should increase and we should achieve target.

Areas for Improvement:

- Cyber Security, Information Governance and Fire Safety still require improvement, and Resus training has seen a reduction in compliance this month, we are working with the Resus Lead on increasing this.

Risks / Issues:

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

Action Plan:

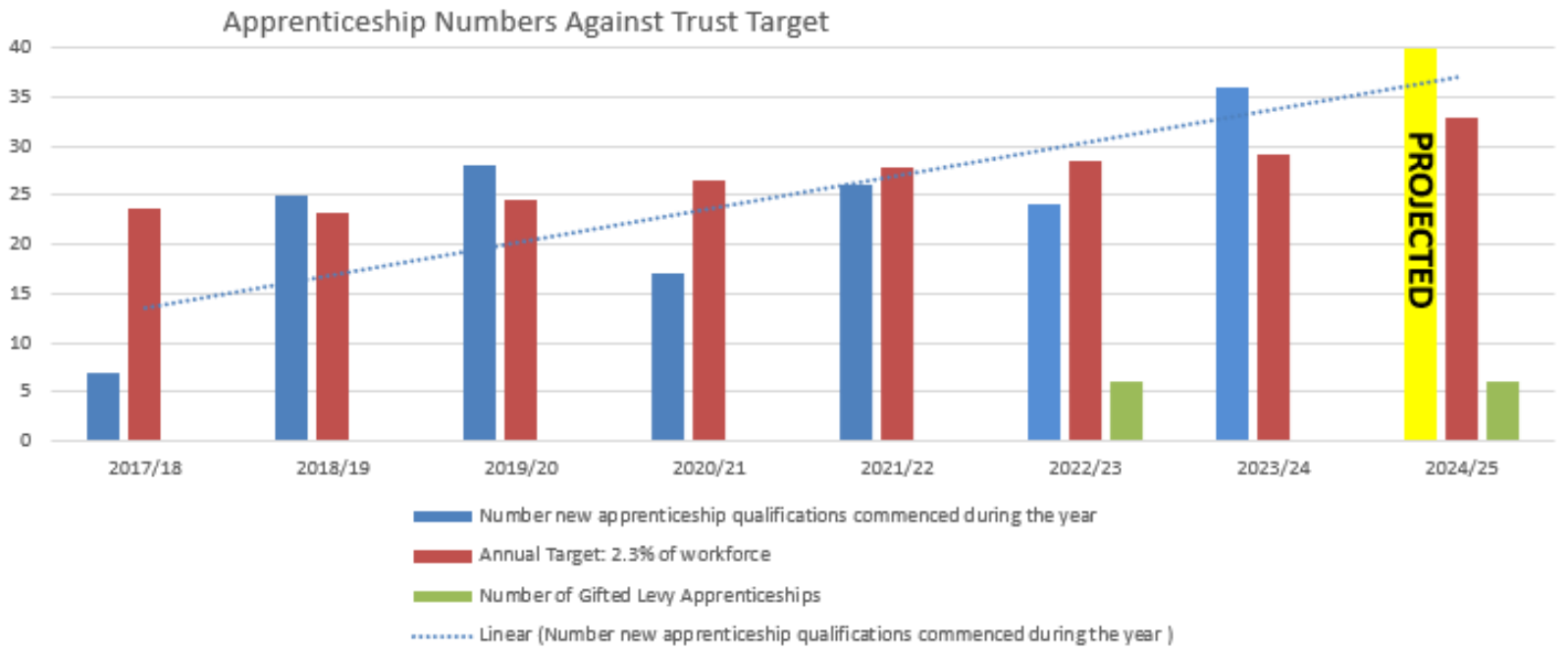
- In August there was a focus on Safeguarding Level 1 on request of Evelyn O'Kane, the Trust safeguarding lead.
- There has also been a focus on Fire Safety also hope to see an improvement next month

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.

Apprenticeship Activity	
KPI	33
Current YTD	27/33
2023/24	36/29
2022/23	24/28

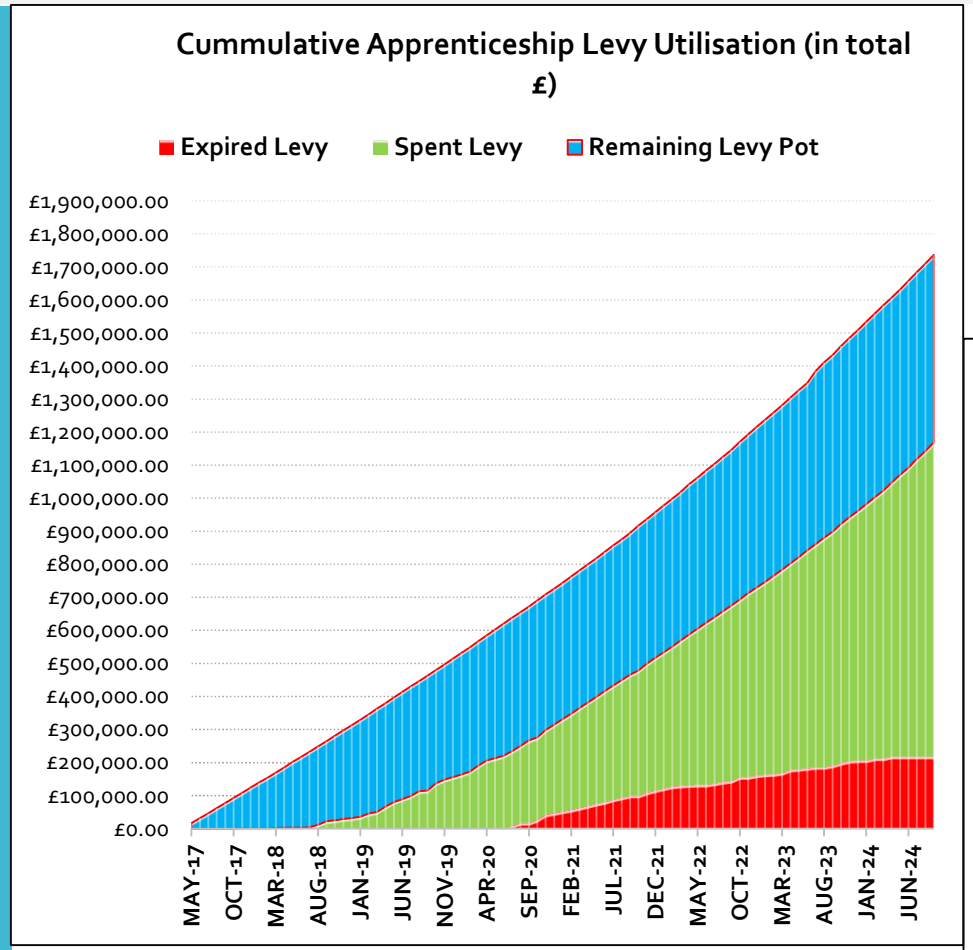


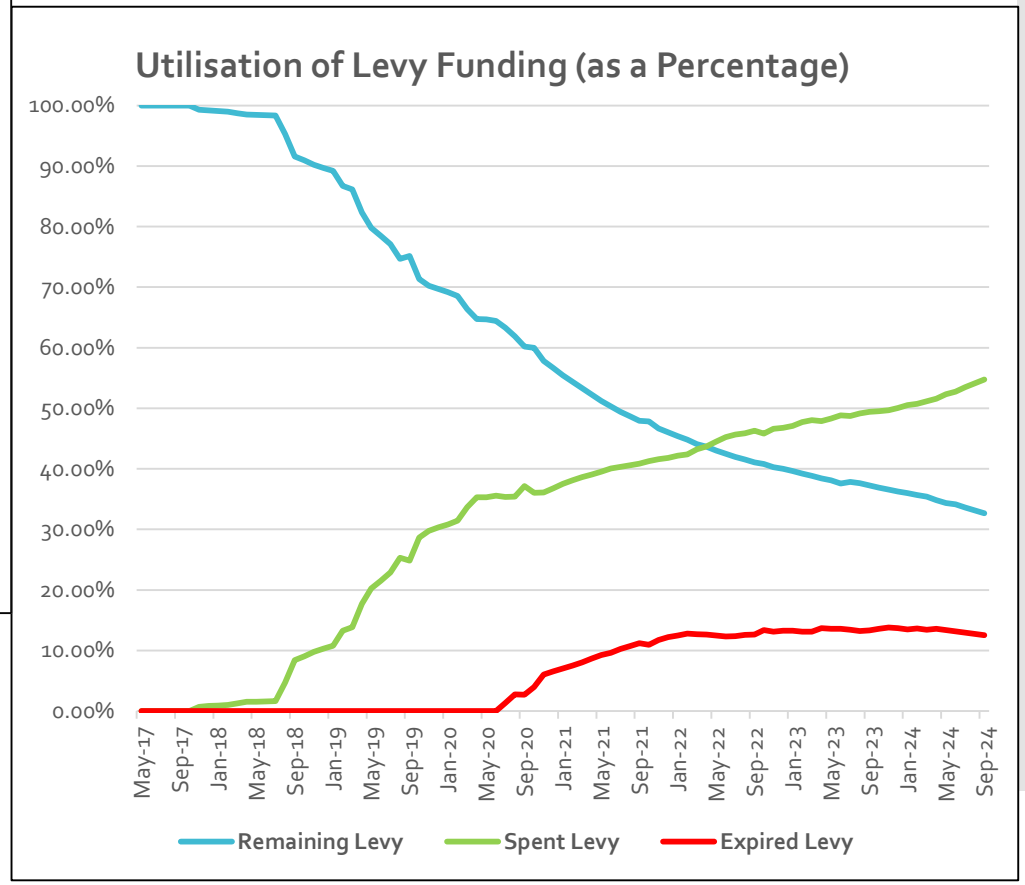
Achievement toward annual target:

- 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 33 apprenticeship new starts and achieved 36. The Trust also gifted levy funding to support 6 apprenticeships in 2022/23. and is supporting 8 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.

Apprenticeship Levy Funding

Spent	54.62%
Expired	12.43%
Unused	32.96%
Trend	↑





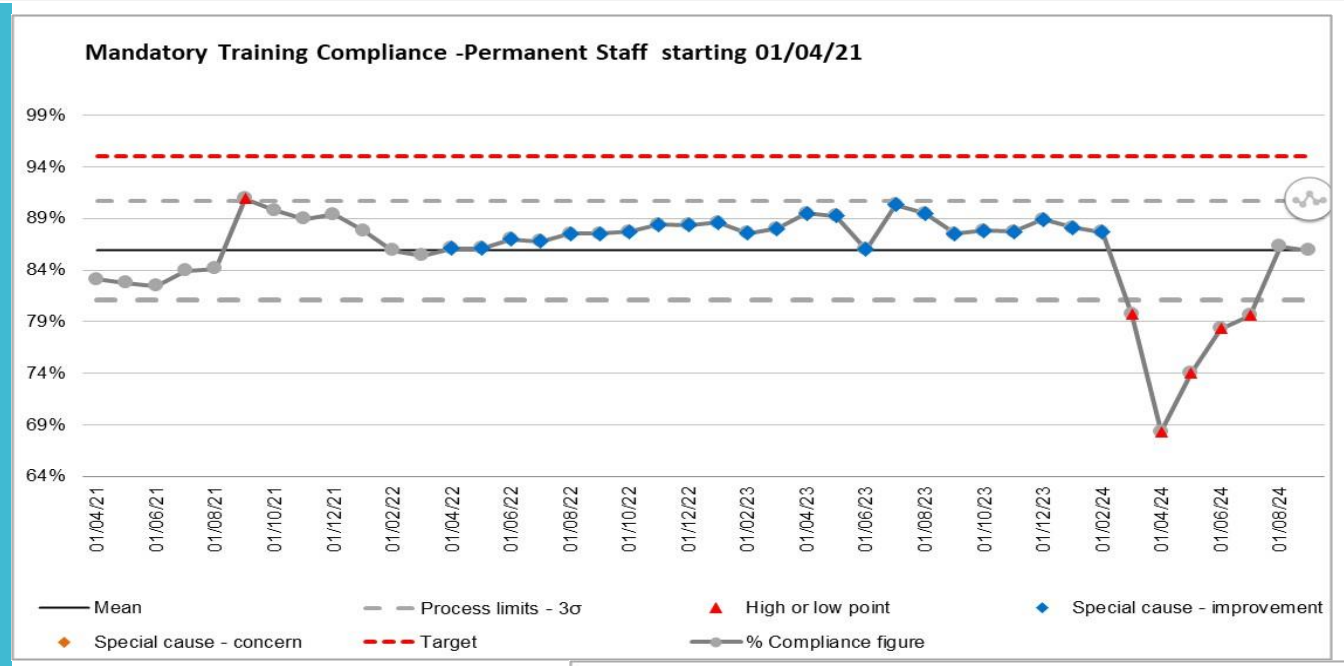
Training compliance summary – 30th September 2024

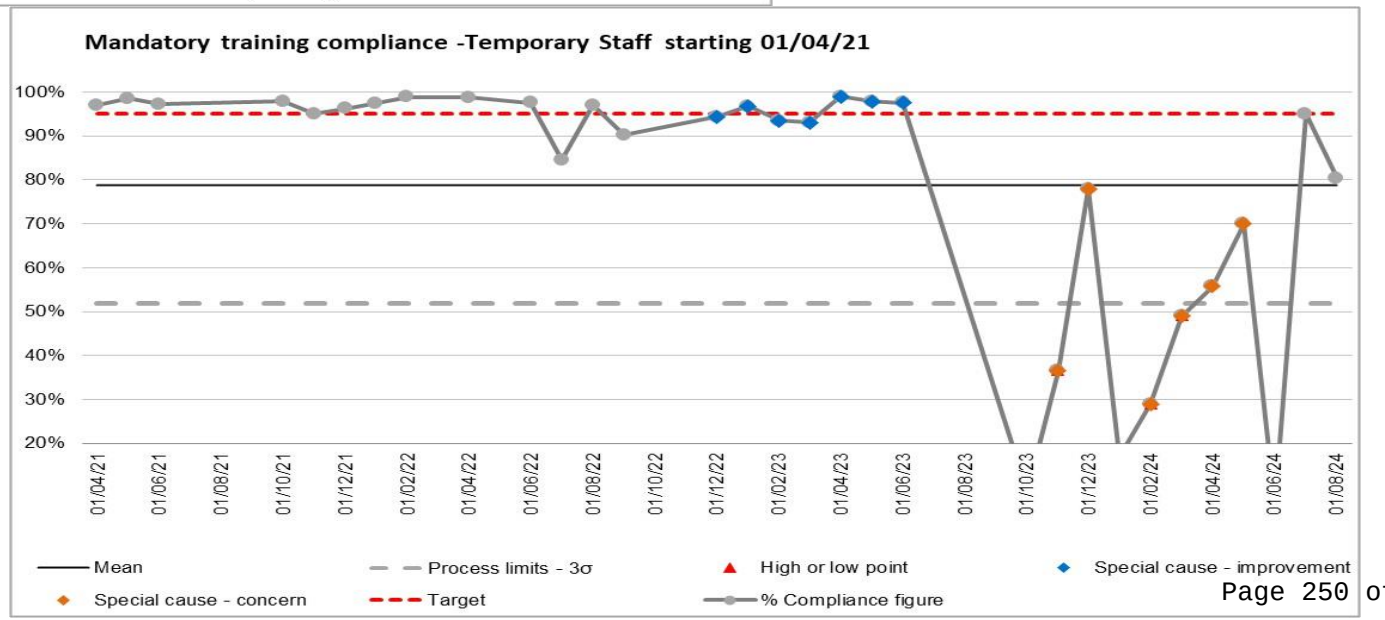
Mandatory Training

KPI	93%
Sept 2024	85.89%
TREND	

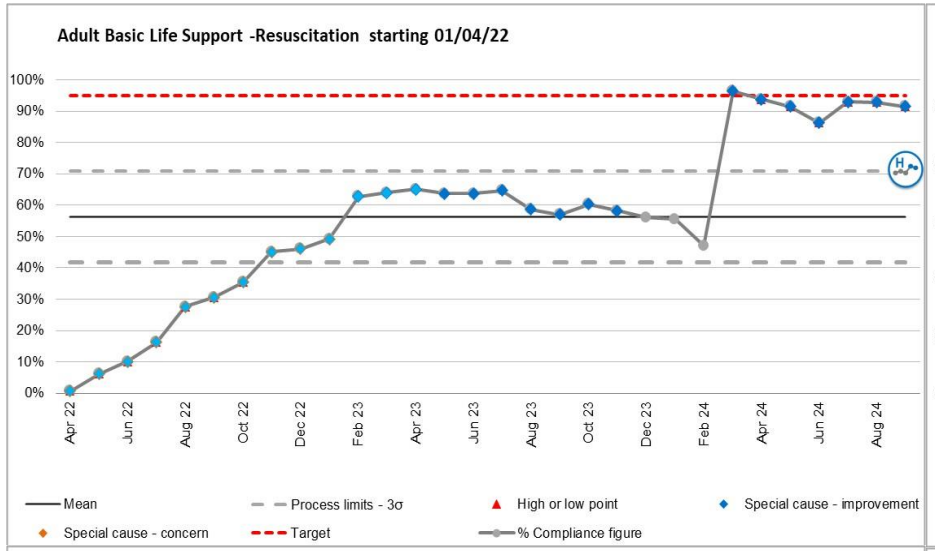
Pg.	COURSE	Compliance %age	COMMENTS	TREND
4	Core Mandatory Training – Permanent Staff	85.89%	Compliance is improving. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). % increase due to Cyber and IG	
4	Core Mandatory Training – Temporary Staff	80.35%	Based on staff working on the Bank who are **compliant** with training	
6	Cyber	79.32%	Large increase this month following Comms referring to lockouts during Sept	
6	IG	77.82%	Large increase this month following Comms referring to lockouts during Sept	
7	Basic Life Support – Level 1	91.49%	Following direct mail chasing completions this has vastly improved. Target audience – non clinical.	
7	Hospital Life Support – Level 2	74.87%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	
8	Immediate Life Support	58.90%	We have now stopped working with HEST and our Resus Officer is now supporting additional sessions to improve compliance.	
8	Advanced Life Support	92.50%	4 identified as Out of date	
9	Paediatric Immediate Life Support	64.71%	Target achieved earlier this year, a few out of date and training planned in July.	
10	Patient Handling	81.47%	Good progress overall this year but less stable during the last few months; need to sustain improvement.	
10	Conflict Resolution	74.79%	Significant increase this month since the competence change.	
11	NEWS2	98.13%	Consistently achieving over 95% compliance since June 2022.	
11	Safe use of Insulin	87.20%	Staying the same over the last few months.	
11	VTE	93.98%	Stayed the same over the last few months.	
12	CONSENT	79.49%	Slight decrease on last months, accessed via BMJ.	
12	IPC2	85.74%	Continual increase during the last few months.	
12	Food Hygiene	91.89%	Slight increase on last month	

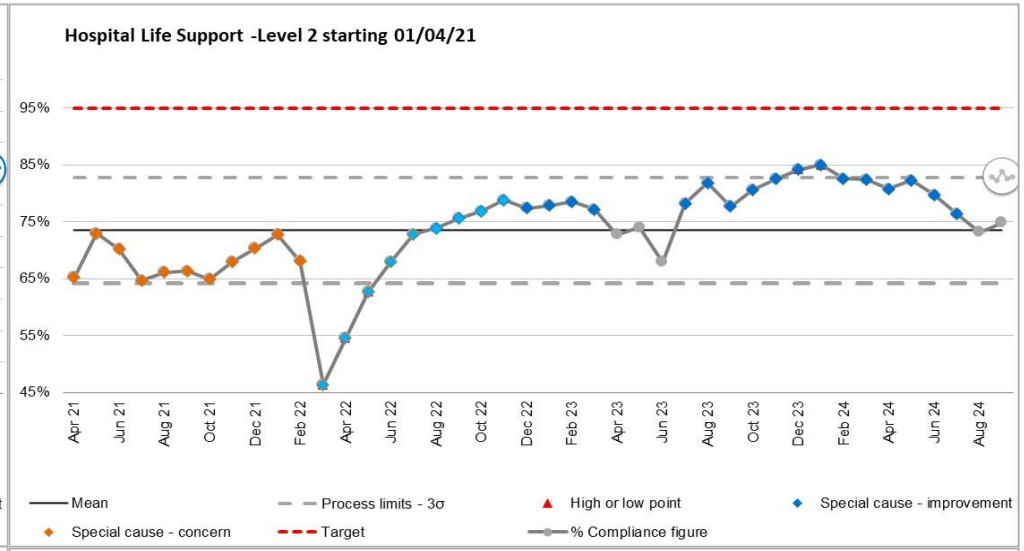
Core Mandatory Training: Permanent and Temporary Staff

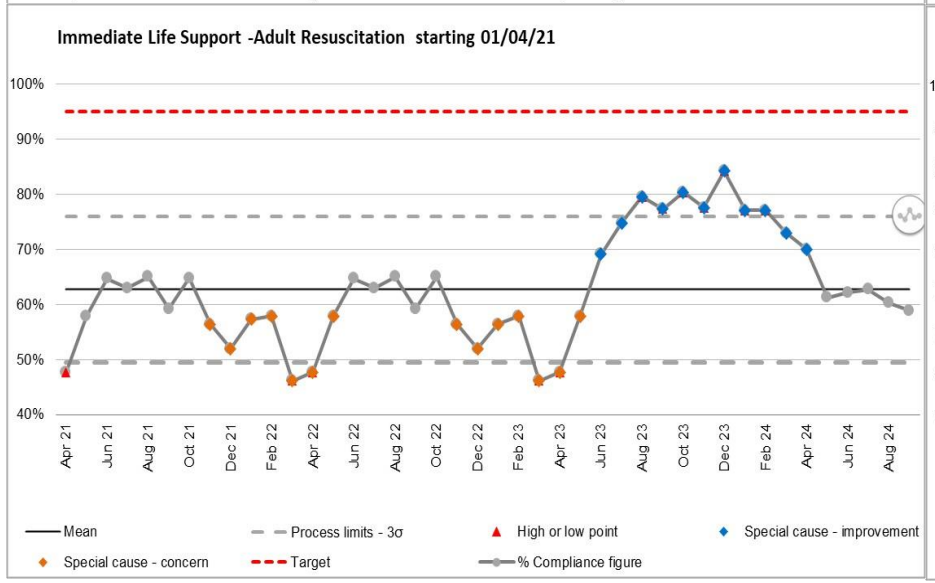


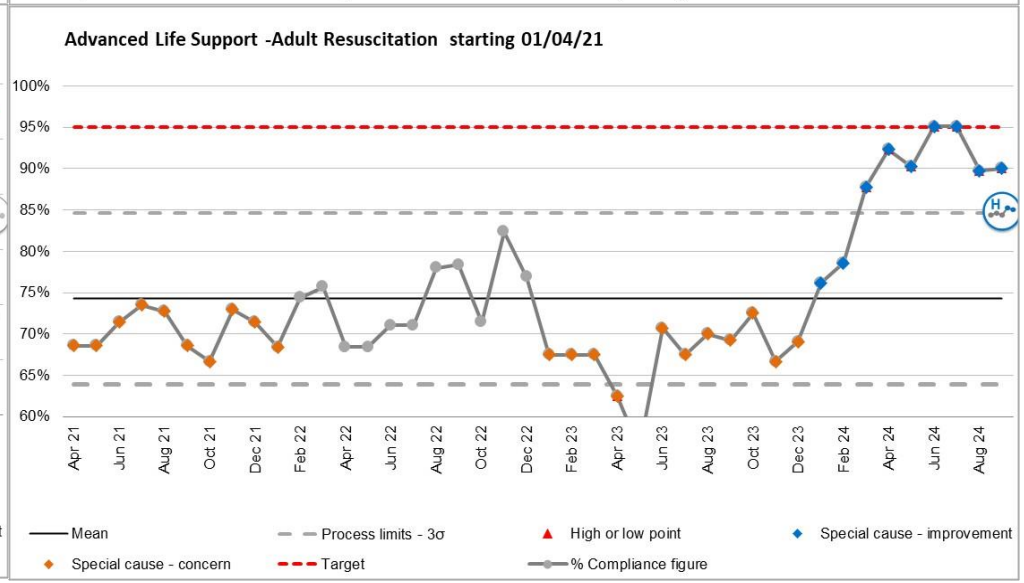


Resuscitation Training: Adult

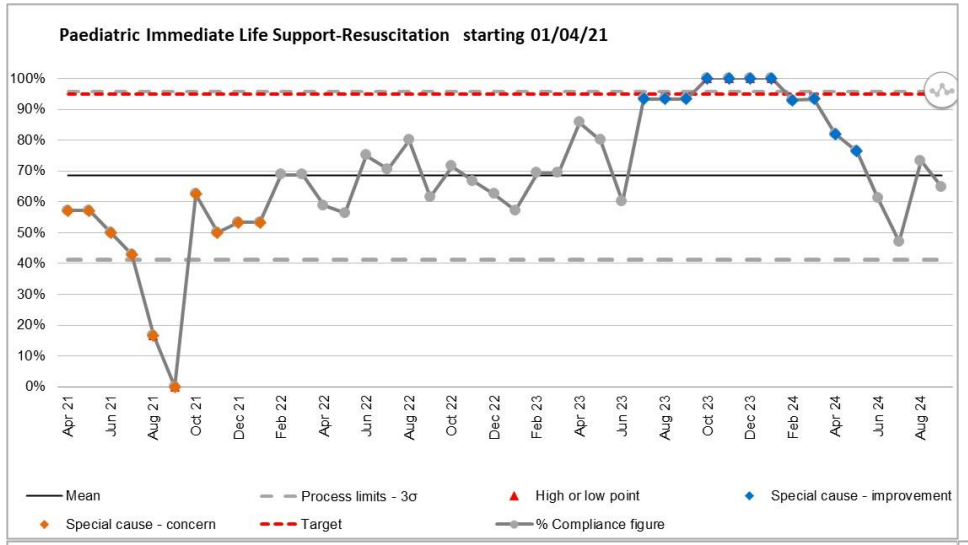


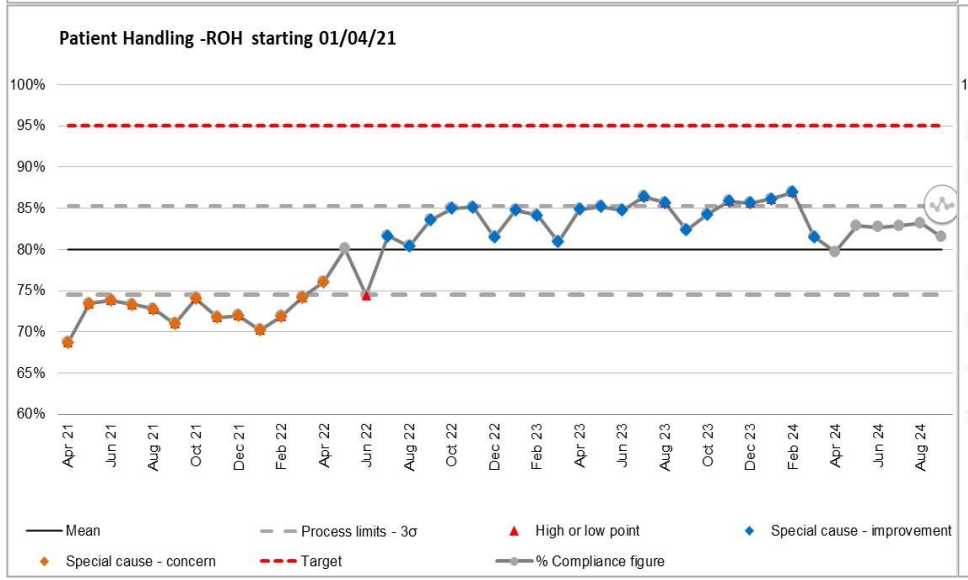


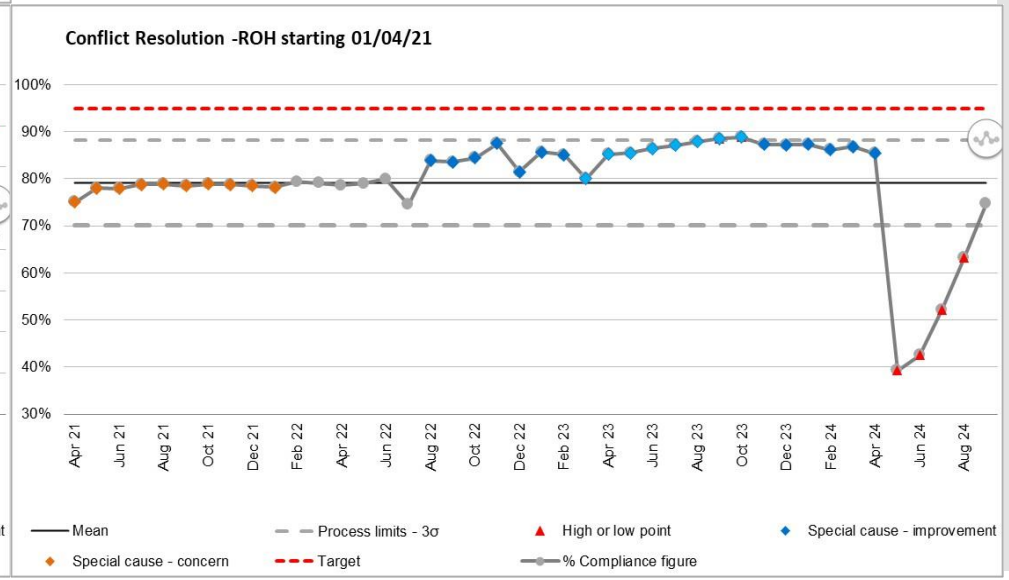




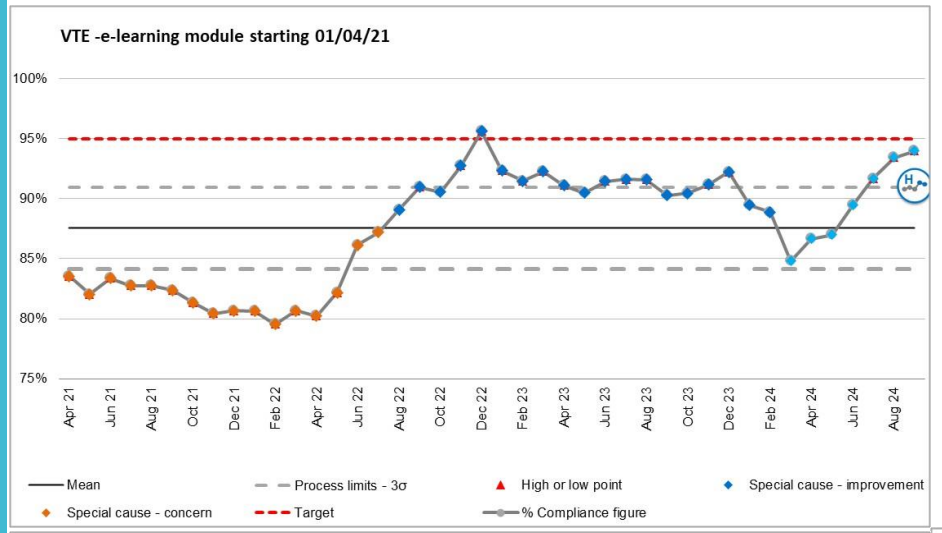
PILS, Conflict Resolution Patient Handling

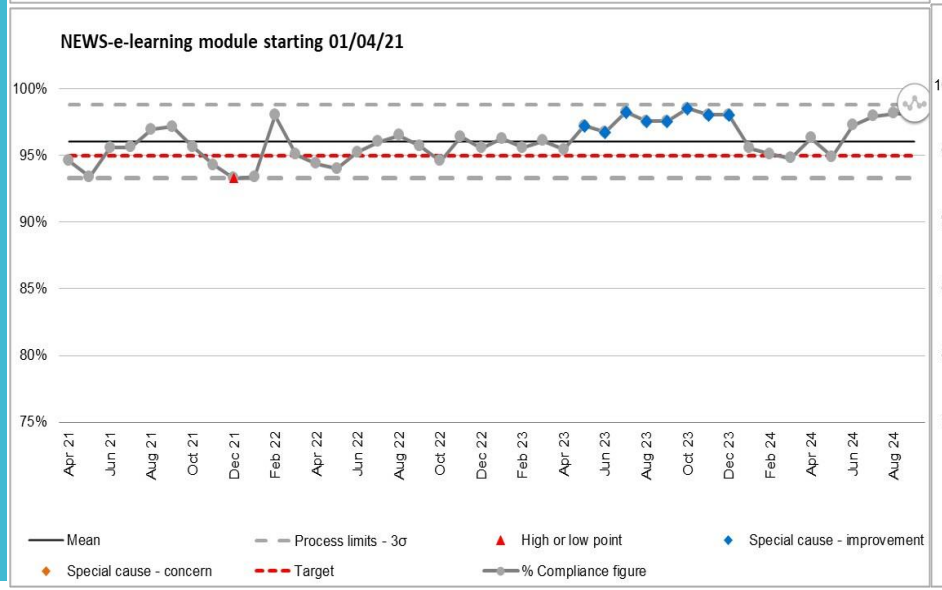


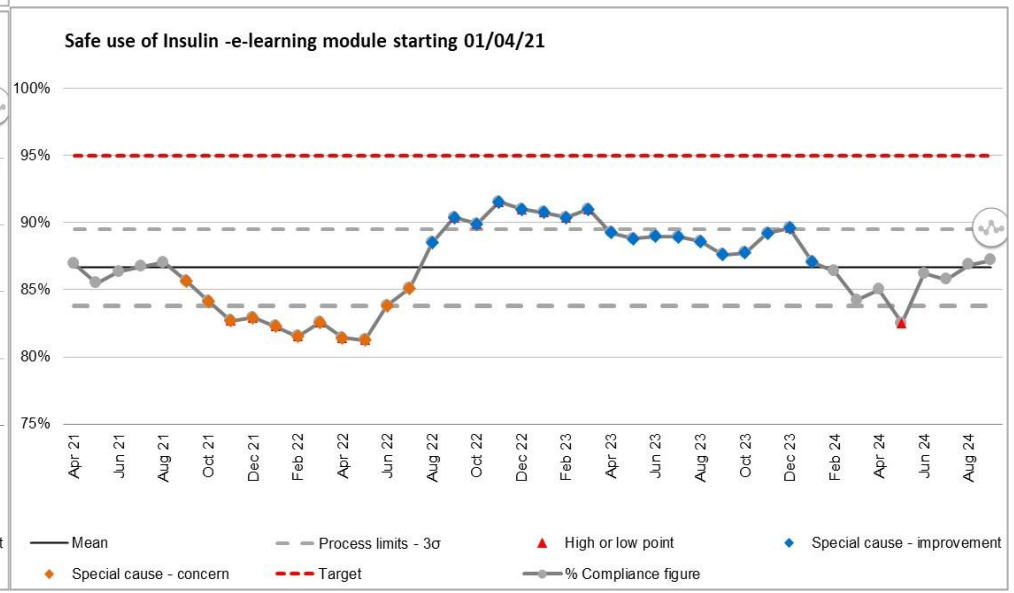




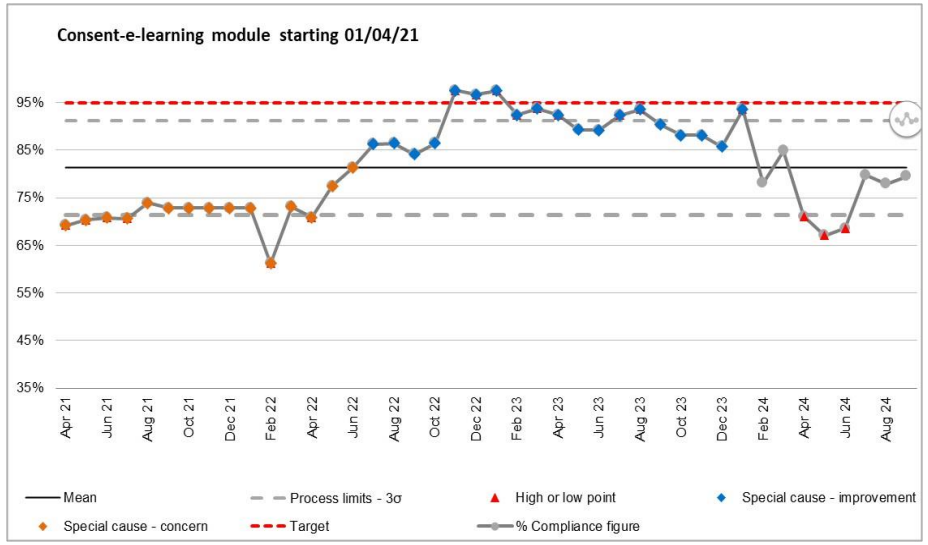
VTE, Safe use of Insulin, NEWS2

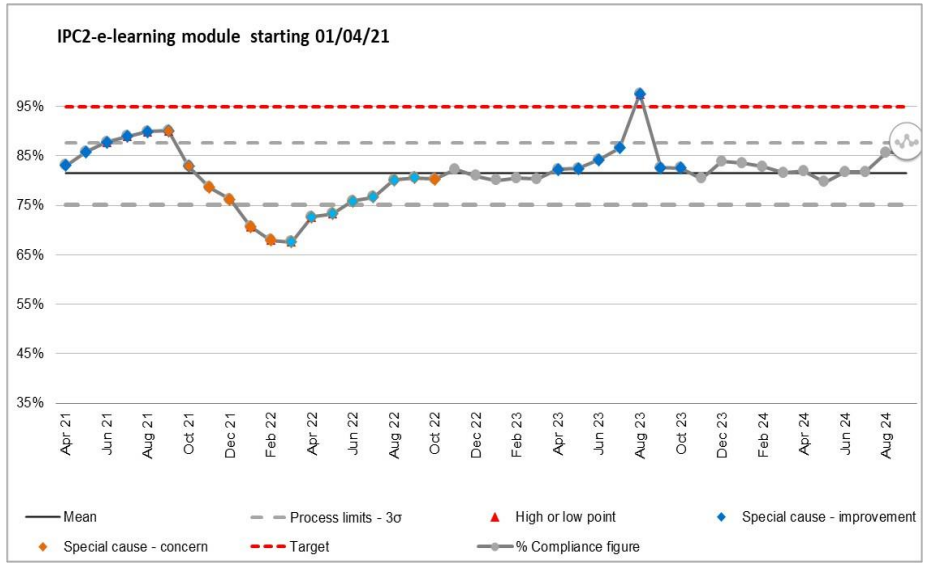


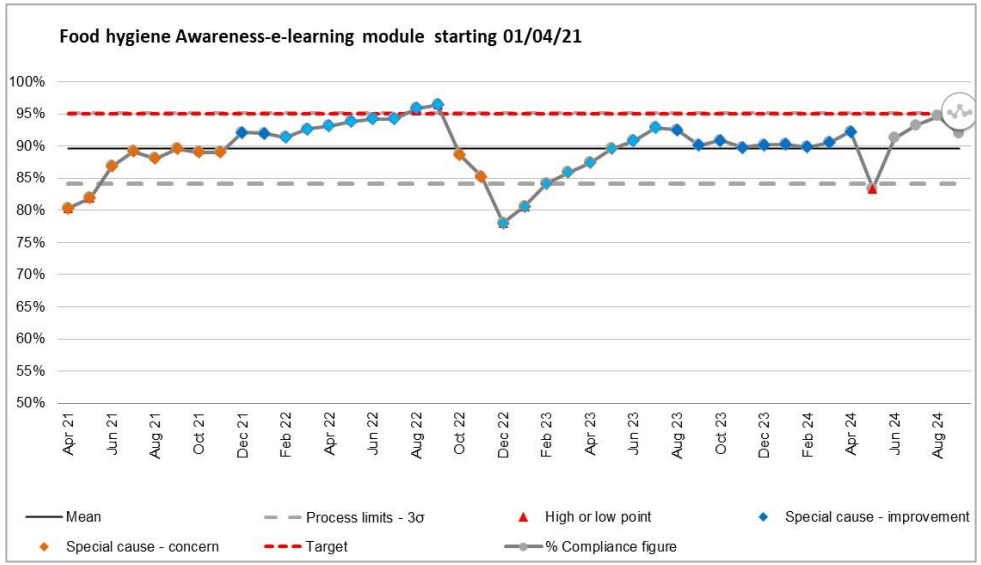




IPC Level 2, Food Hygiene Consent







Section Three:

Organisational Development Team

Prepared by: Clare Mair, Head of OD & Inclusion

Presented by: Clare Mair, Head of OD & Inclusion

Ref: October 2024/HR&OPS

Organisational Development

Summary:

- Staff engagement activity at the Trust is currently concentrated around National staff survey and the results for People Pulse
- The feedback survey for the new appraisal approach has been collated with key information being incorporated into the amendments to training and documentation and to support with the quality review
- The initial work for the RACE Equality code has been undertaken with Trust Board members to assess current status of EDI and race work across the Trust (including a documentation review)
- Wellbeing week took place between 14-18th October with good engagement from staff through awareness stands and activities and Trust Board members visiting department with the Wellbeing trollies

Areas for Improvement:

- The Trust is currently work with ICS colleagues on a programme to improve diversity data. This continues the progress made on the Disability declaration work undertaken by the ESR team and ABLE network

Action Plan:

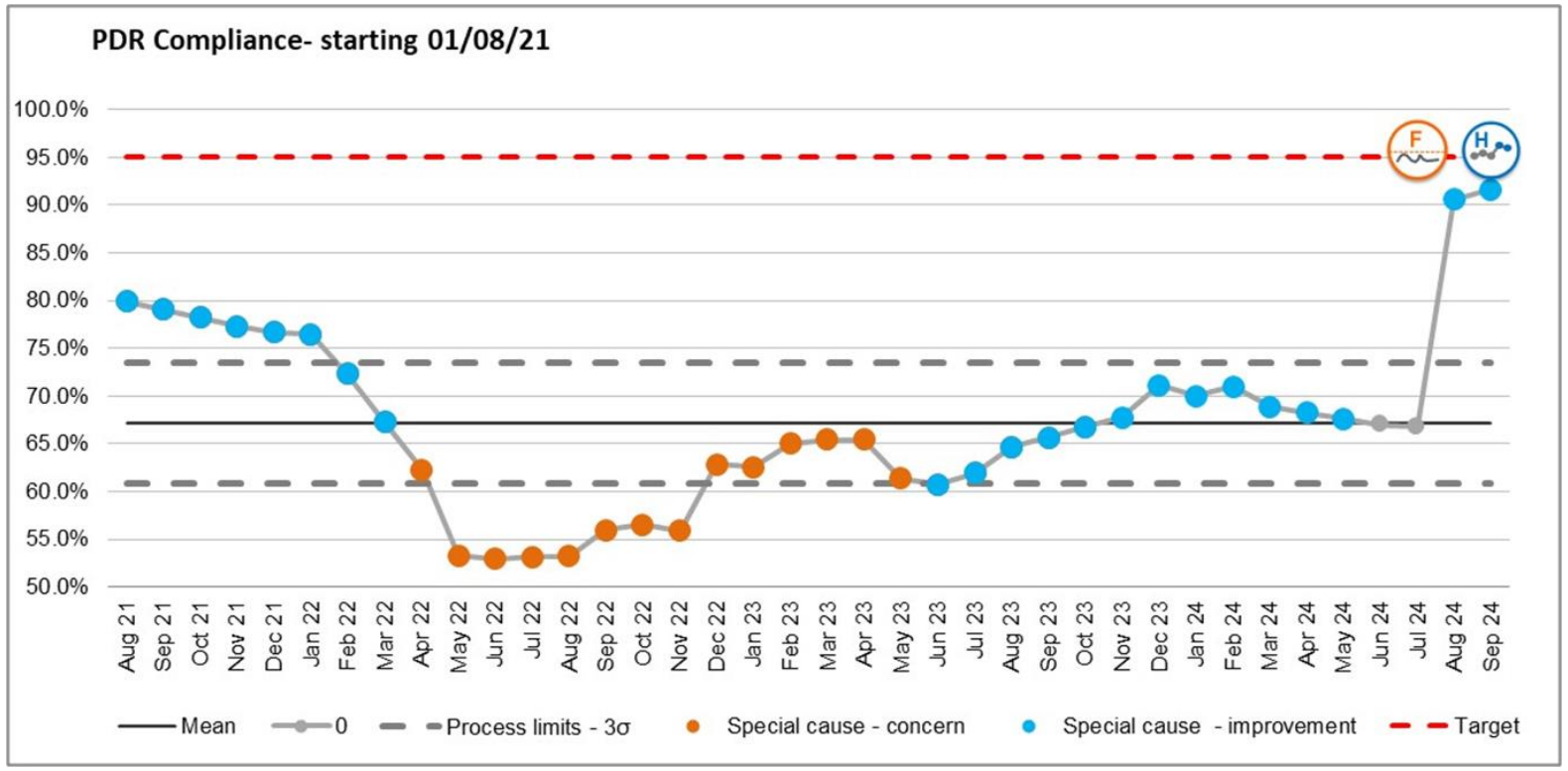
- Work continues on the Equality Delivery System (EDS) 2025 and the three areas have been identified with ICS colleagues for the Patient Domain, in line with Health Inequalities priorities
- The quality review for appraisals will be completed in November in preparation for the planning of the Appraisal window 2025
- The staff survey plan is currently underway and fieldwork started on October 2nd 2025
- Recruitment is now underway for the Mankind and Multi Minority Ethnic Group (MMEG) chair positions to enhance work on Staff Voice and EDI initiatives

Risks / Issues:

- Ensuring actions on the Inclusion work are prioritised to impact change
- Engaging with colleagues to complete the work on the Equality Delivery system (EDS) 2025 submission
- Ensuring staff are supported by managers and given the opportunity to feedback on the staff survey,with current work pressures
- Resourcing issues in the team is limiting the level of work that can be delivered

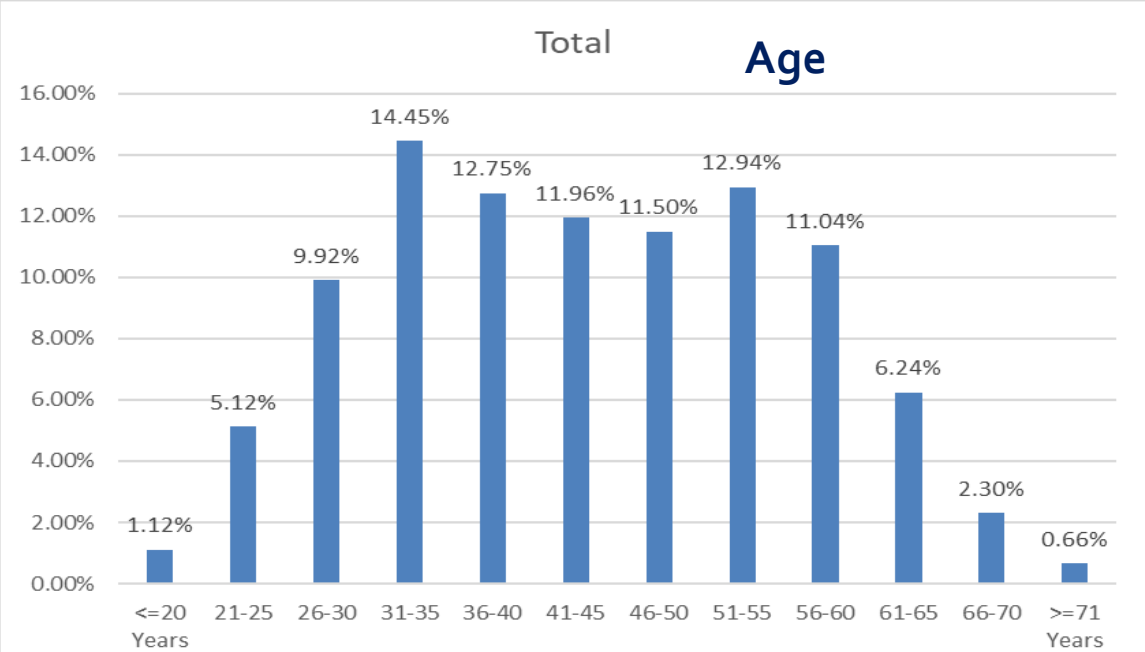
Performance & Development Reviews

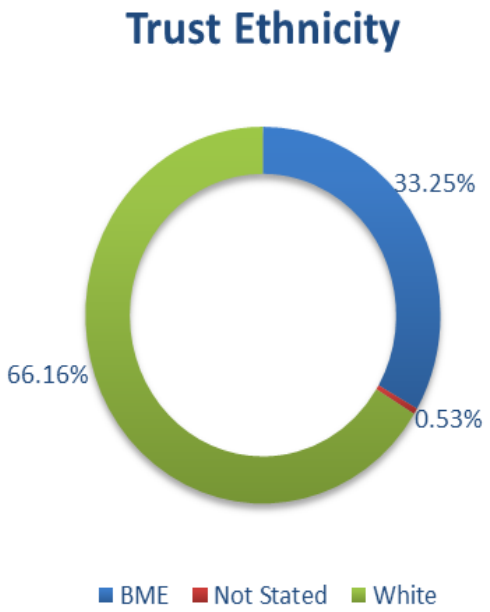
KPI	95%
Sept 2024	92%
Trend	↑

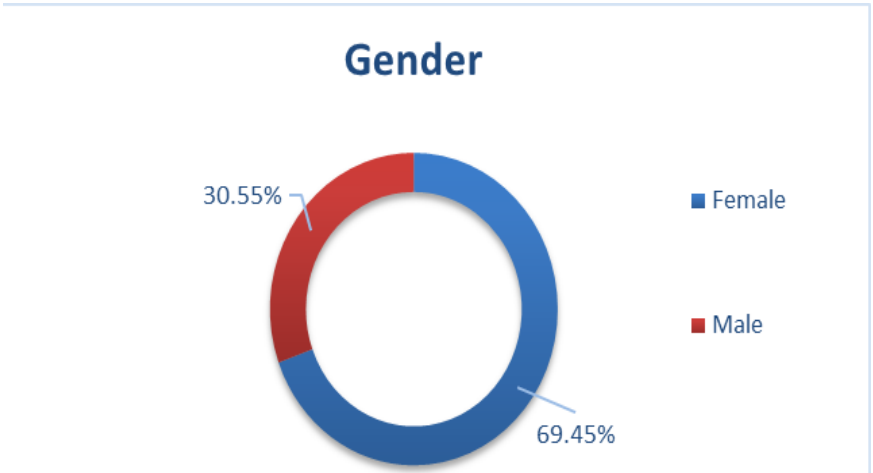


There has been continued work to support with the rollout out of the new appraisal window approach. There has been further improvement in the completion rate since the end of the window at the end of August.
Training continues for new managers and a quality review is underway to look at the improvements needed for next year. Additional support needed in areas is being identified to ensure that KPI figures can achieved

Workforce Demographics



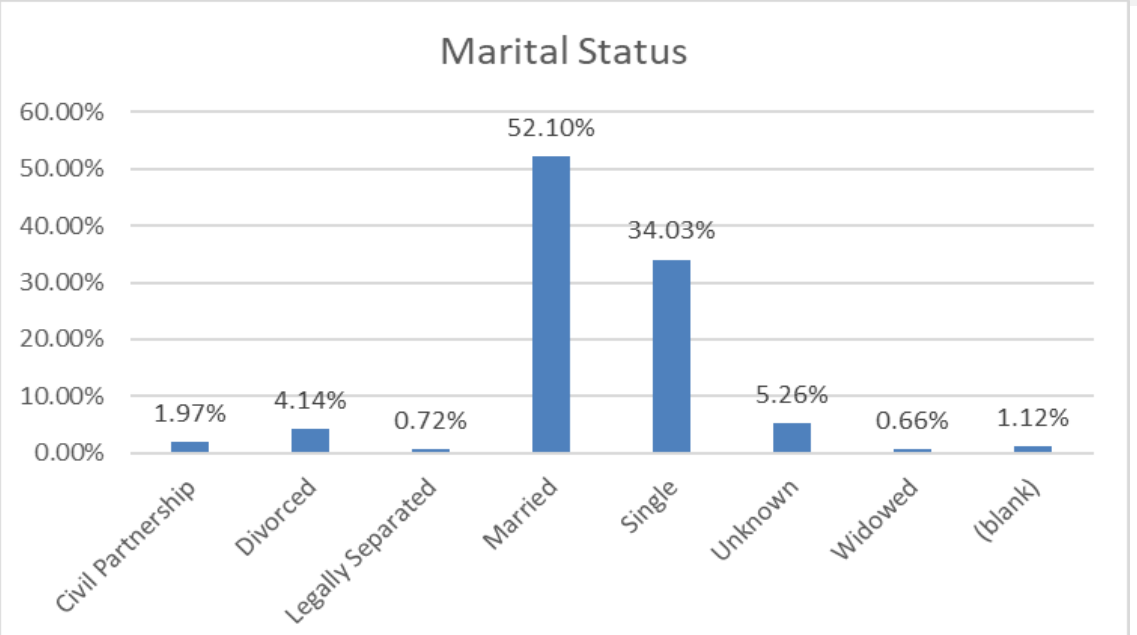


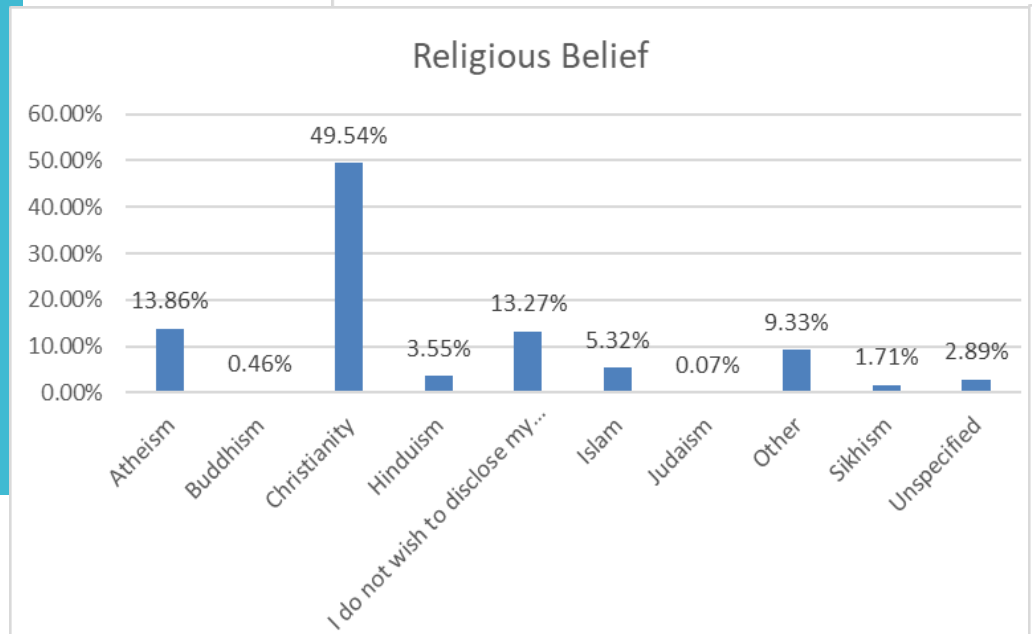


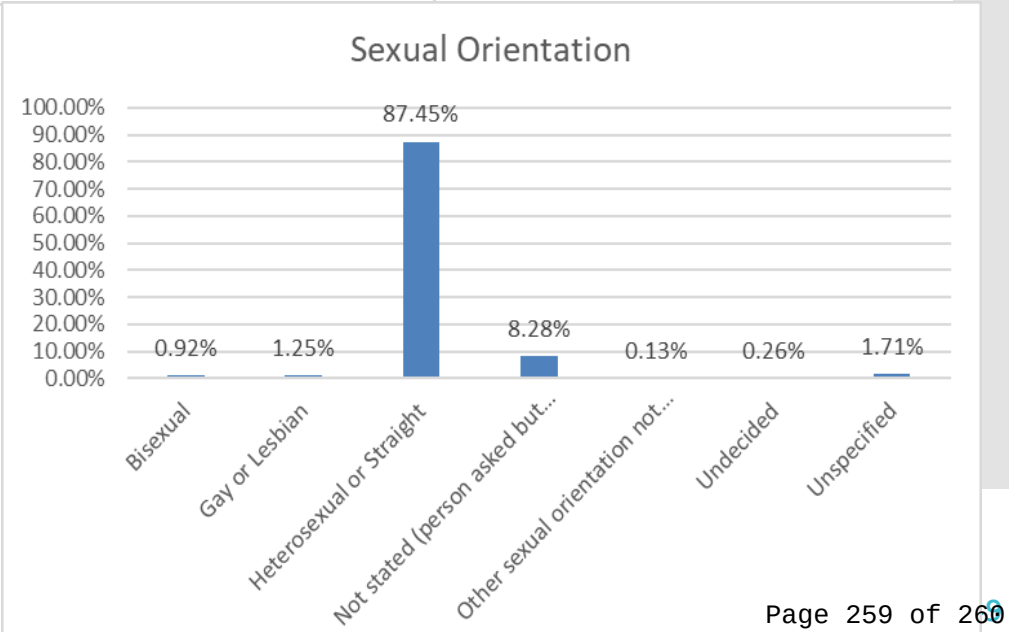
There has been another increase in staff members from an ethnic minority background joining the Trust. In addition there has been a slight decrease in the number of new starters 'not stating' their ethnicity which positive

There has also been a slight decline in the percentage of female colleagues at the Trust

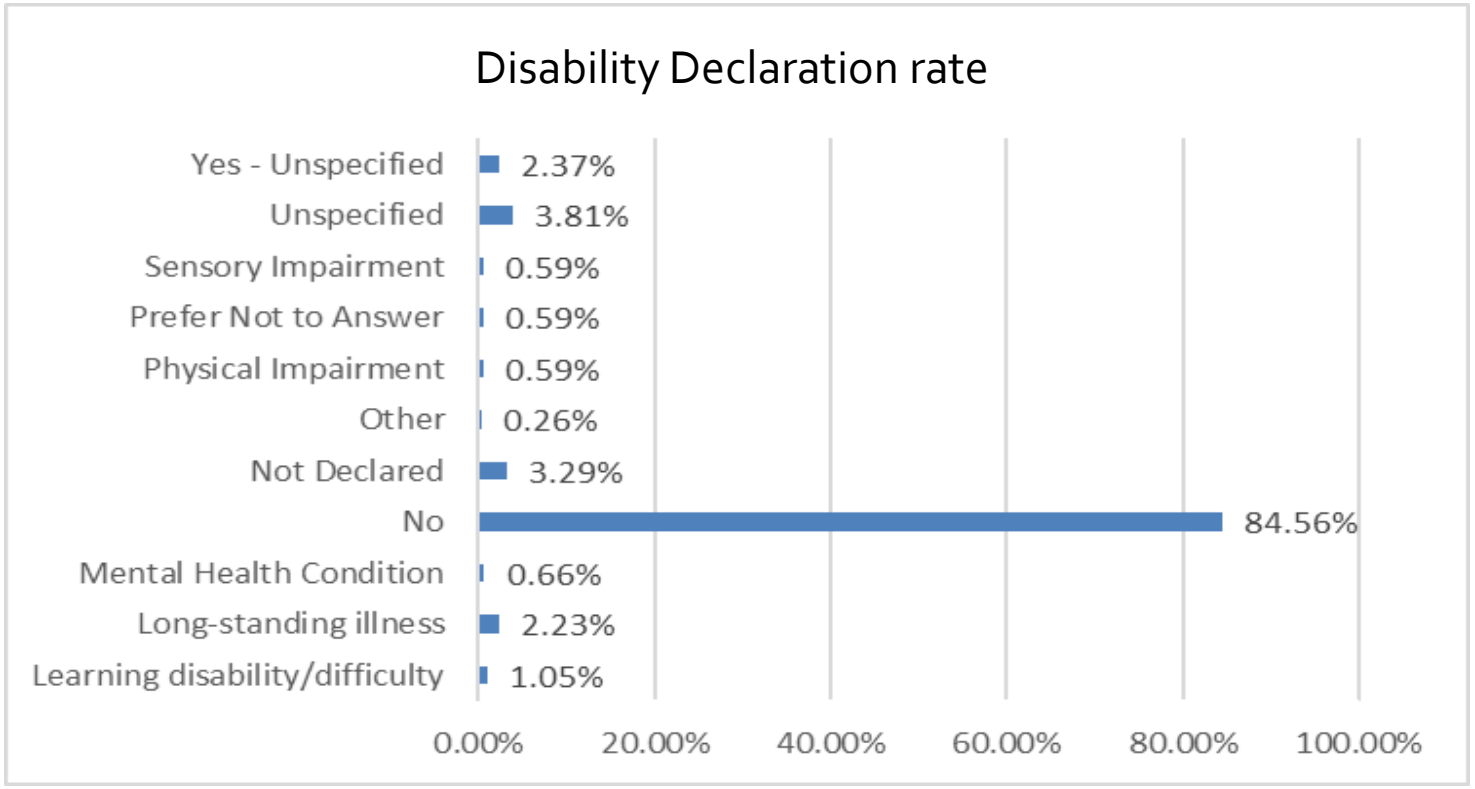
Workforce Demographics







Workforce Experience	
KPI	7.5%
Sept 2024	8.34%
Trend	↑



There has been another increase in the declaration rate to 8.34% which shows a continued confidence with staff sharing their information on disability.
More progress needs to be made in the other protected characteristic declaration rates and a project with the ESR team is current underway to address this