NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

AGENDA
TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters **Date** 5 February 2025: 13:45h – 16:00h

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)
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

Ms Sharon Latham	Head of Patient Experience	(SL)	[Item 16]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
13:45	16	Patient Story: Elliot	ROHTB (2/25) 026	SL
14:05	17	Apologies: Jan Teo	Verbal	Chair
	18	Declarations of Interest	ROHTB (2/25) 010	Chair
	19	Minutes of Board Meeting held in Public on 4th December 2024: *for approval*	ROHTB (12/24) 022	Chair
	20	Actions from previous meetings in public: *for assurance*	ROHTB (12/24) 022 (a)	SGL
14:10	21	Questions from members of the public	Verbal	Chair
14:11	22	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (2/25) 011 ROHTB (2/25) 011 (a)	MH/TP

14:25	22.1	Council of Governors Update: *for assurance*	Verbal	SGL
14:30	22.2	Update from Non Executive/Executive Walkabouts: *for assurance*	Verbal	SGL/SJ
14:35	23	Infection Control Annual Report: *for assurance*	ROHTB (2/25) 012 ROHTB (2/25) 012 (a)	NB
14:40	24	Emergency Preparedness, Resilience & Response (EPRR) Update, including Adverse Weather Debrief: *for assurance*	ROHTB (2/25) 013 ROHTB (2/25) 013 (a) ROHTB (2/25) 013 (b) ROHTB (2/25) 013 (c)	SW
14:50	25	Radiation Safety Update: *for assurance*	ROHTB (2/25) 014 ROHTB (2/25) 014 (a)	MP
15:00	26	Safer Staffing Report: *for assurance*	ROHTB (2/25) 015 ROHTB (2/25) 015 (a)	NB
15:10	**BREAK**			
	GOVERNANCE AND COMPLIANCE			
15:15	27	Learning from Deaths: *for assurance*	ROHTB (2/25) 016 ROHTB (2/25) 016 (a)	MR
15:25	28	CQC Well Led Self-Assessment & Action Plan: *for assurance*	ROHTB (2/25) 017 ROHTB (2/25) 017 (a)	SGL
15:35	29	BAF & Risk Update: *for assurance*	ROHTB (2/25) 018 ROHTB (2/25) 018 (a-f)	SGL
15:40	30	Insightful Provider Board: *for discussion*	ROHTB (2/25) 019 ROHTB (2/25) 019 (a) ROHTB (2/25) 019 (b) ROHTB (2/25) 019 (c)	SGL
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
15:45	31	Upward reports from the Board Committees: Finance & Performance Committee Audit Committee Quality & Safety Committe	ROHTB (2/25) 020 ROHTB (2/25) 021 ROHTB (2/25) 022	LW GH IR
15:55	**MATTERS TO BE TAKEN BY EXCEPTION**			
	32	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report	ROHTB (2/25) 023 ROHTB (2/25) 024	

		c) Workforce Report	ROHTB (2/25) 025	
	33	Any Other Business	Verbal	All
	34	Meeting Effectiveness	Verbal	All
16:00	**CLOSE: Date of next meeting: Wednesday, 5 March 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 DECEMBER 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	✓	✓	✓	✓	✓	✓	✓	A			
Simone Jordan	A	✓	A	✓	✓	A	✓	✓			
Gianjeet Hunjan	✓	✓	A	✓	✓	✓	✓	✓			
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓			
Les Williams	✓	✓	✓	✓	✓	✓	✓	✓			
Simon Page	✓	✓	✓	A	A	A	✓	A			
Jenny Belza	✓	✓	✓	A	✓	✓	✓	✓			
Jan Teo	✓	✓	✓	✓	✓	✓	✓	A			
Jo Williams	✓	✓	✓	✓	✓						
Matthew Hartland						✓	✓	✓			
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓			
Nikki Brockie	✓	✓	✓	✓	✓	A	✓	✓			
Marie Peplow	A	✓	✓	✓	✓	✓	✓	✓			
Stephen Washbourne	✓	A	✓	✓	✓	✓	✓	✓			
Sharon Malhi	✓	✓	✓	✓	✓	A	✓	✓			
Simon Grainger-Lloyd	✓	✓	✓	✓	A	✓	✓	✓			

KEY:

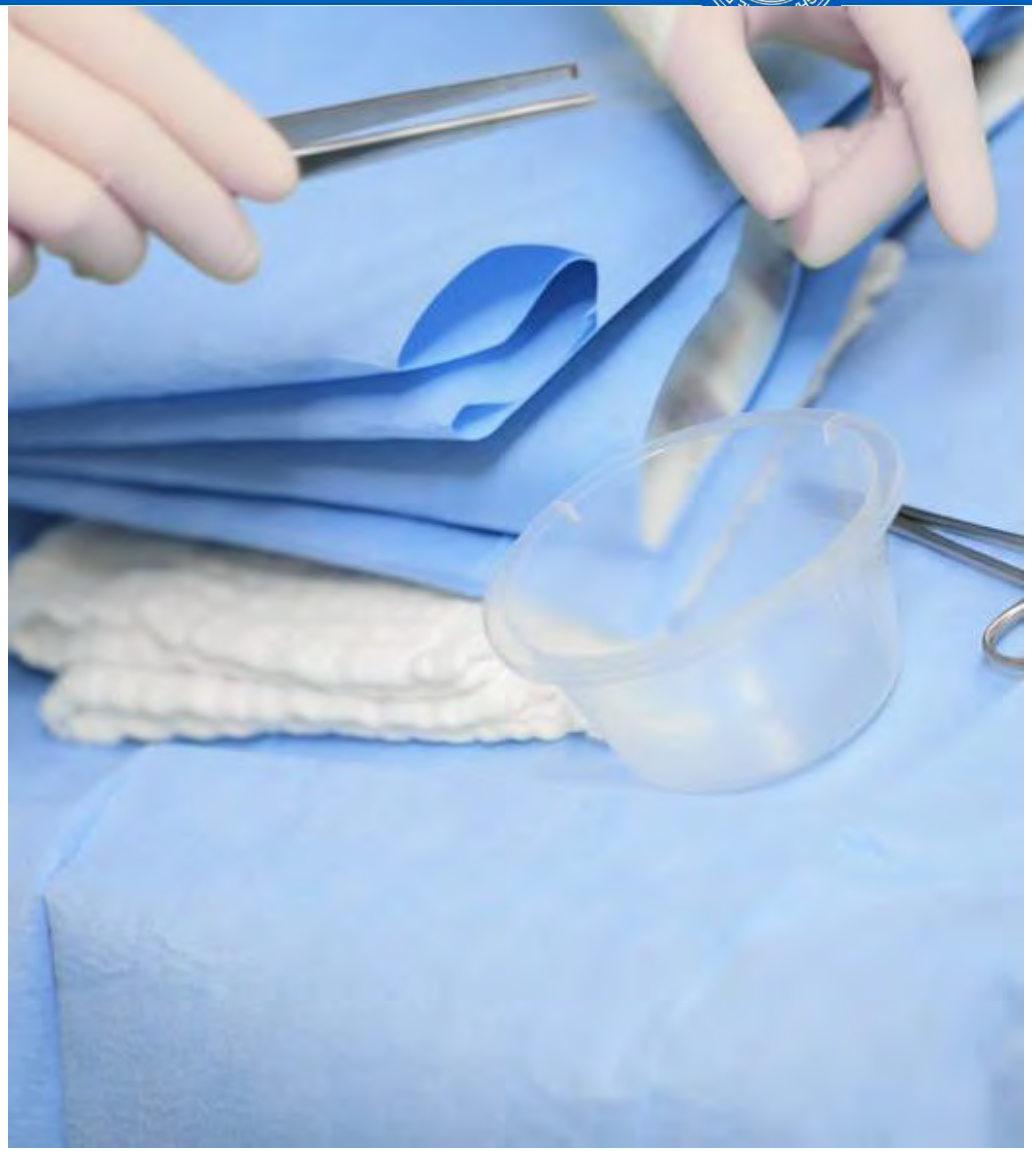
✓	Attended	**A**	Apologies tendered
	Not in post or not required to attend		

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

ELLIOTTS STORY

The Royal Orthopaedic Hospital
Trust Board Patient Story January 2025

Patient



After his time as an inpatient Elliot moved on to a residential rehabilitation placement to continue his recovery and the progress he made at the ROH

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** 4 December 2024: 1130h - 1400h

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)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mrs Jenny Belza	Non Executive Director	(JB)
Mr Matthew Hartland	Interim Chief Executive	MH)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Sharon Malhi	Executive Chief People Officer	(NB)
Mr Simon Grainger-Lloyd	Executive Director of Governance & Acting Chief Executive Officer	(SGL)

In attendance:

Ms Charlotte Murphy	Registered Nurse Associate	(CM)	[Item 15]
Ms Chelsea Lee	Registered Nurse Associate	(CL)	[Item 15]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

IN PUBLIC SESSION	
15 Staff Story (CM)	**Presentation**
NB introduced Chelsea Lee (CL) and Charlotte Murphy (CM) who were new to care and progressing through to degree apprenticeship colleagues. CM worked on ward 2 and is currently on the registered nurse degree programme. Started in 2016 as Bank Healthcare Assistant whilst supporting her teaching degree. After working a number of block booked contracts CM decided she wanted to change career direction after completing her degree and teaching for six months. She applied to the Nurse Associate Programme and has now been qualified for 3	

years as a Registered Nurse Associate. CM was keen to top up her qualification to become a Registered Nurse and NB supported to get onto the Registered Nurse Degree Programme. Chelsea Lee (CL), joined at the same time as CM. Worked on Ward 1 as a Registered Nurse Associate after starting at the Trust as a Healthcare Assistant. CM did not intend to pursue a career in healthcare but after working on the ward was encouraged to move forward with her career. CL applied for the apprenticeship and was successfully appointed. Qualified as a Nurse Associate and now on the top to become a Registered Nurse. CM praised the ROH for the support and was extremely complimentary to Karen Hughes, Head of Nursing Division 1, for her support and encouragement to progress. NB explained the programme is one day at university which is in partnership University College Birmingham. CM explained that it is sometimes difficult to switch to being a Registered Nurse Associate and then the next day a student. TP thanked CM and CL for sharing their story and invited the Board to ask questions and comment. The Board was invited to comment and ask questions. The following key points were of particular note: JB questioned is there anything we could do differently for future students. CM explained currently placements are outside of usual placements, but next placements they will be back on places where they undertake Bank work. CM suggested that maybe a 'this is what can and can't be done' document is shared with all areas to make clear of the scope of the work that can be done, with reasons why they are not able to always do what they always do when they are in student uniform. NB will take this away and ensure this communicated. AA suggested that CM and CL should share their story with others considering this career approach. SM raised how it would be good to use their experience to communicate to people outside of the Trust who may not have considered a career in healthcare. TP praised CM and CL and thanked them for attending the Board meeting today.	
16 Apologies: (Chair)	**Verbal**
Apologies were received and accepted from Ian Reckless, Jan Teo and Simon Page	

17 Declarations of Interest (chair)	**ROHTB (12/24) 011**
There were no new declarations to record to what has been published.	
18 Minutes of the previous meeting in public held on 6 November 2024: *for approval* (chair)	**ROHTB (11/24) 022**
The minutes of the meeting held in private on 6 November 2024 were accepted and **approved** by the board.	
19 Actions from previous meetings in public: *for assurance* (SGL*)*	**ROHTB (11/24) 022 (a)**
SGL confirmed all actions are on schedule.	
20 Questions from members of the public (Chair)	**Verbal**
There are no questions received ahead of the meeting.	
21 Chair's and Chief Executive's update: *for information and assurance* (TP/MH)	**ROHTB (12/24) 012** **ROHTB (12/24) 012 (a)**
MH presented the Chief Executive Update, and the paper was taken as read. The following key points were highlighted: Inclusive Company Awards. Following an awards ceremony on Thursday 28th November it was announced ROH is ranked 8th in the Inclusive Companies listings. Jo Williams was also awarded Chief Executive of Year. NHS Providers Conference. MR and MH both attended the NHS Providers Conference. There were presentations from both Amanda Pritchard, Chief Executive of NHS England and Wes Streeting, Secretary of Health and Social Care. Further detail is expected detailing the new approach for the NHS once regional and local discussions have taken place. NHS 10 Year Plan. An individual response from the ROH has been submitted and we have also been included in the response from the Federation of Specialist Hospitals. This will be circulated to Board members outside of the meeting. Robert Jones & Agnes Hunt (RJAH) Visit. MH visited the RJAH Trust on Monday 2nd December and it was clear from this visit the collaboration work that can be undertaken and is taking place already in some areas. The Board was invited to comment and question. NB and MP explained that collaboration with Robert Jones and Agnes Hunt has developed substantially over the past year.	

Chair Update TP emphasised the focus of the Trust must be on what we can control. TP thanked all those that attended the AGM, and to those who presented. BSOL/Non-Executive Meeting is scheduled to take place this evening (Wednesday 4th December). GH confirmed she will be attending.	
21.1 Council of Governors Update: *for assurance* (SGL)	**Verbal**
SGL provided an update on the Council of Governors meeting held on 20th November 2024. The key points to highlight are: Good attendance from all Governors. A number of new Governors joined the meeting for the first time, two new Staff Governors and a new Public Governor. Updates were given on Freedom to Speak Up, CQC inpatient survey and financial sustainability. The Governors have been undertaking a number of walkabouts across the Trust and provided an update on their experiences at the meeting. The Board was invited to comment and ask questions. TP queried the reporting structure for Freedom to Speak Up. SGL explained that it would feed into Staff Experience & OD Committee but more recently it has come straight to Board. The Board agree that this would be the correct reporting route going forward.	
LUNCH	
22 Complaints Annual Report: *for assurance* (NB)	**ROHTB (12/24) 013** **ROHTB (12/24) 013 (a)**
NB presented the Complaints Annual Report. The paper was taken as read. The following key points were highlighted: The reporting period for this annual report is covering 1st April 2023 to 31st March 2024. There was a reduction in complaints of six compared to the previous year. The internal KPIs for both PALS and Complaints cases were not met in 2023/24 and this continues into this year. Focus on the compliments received this year are also going to be included. The next steps are to focus on the 'you said, we did' and pull out the feedback	

from the Coffee Catch Up. Ensuring this is all encompassed into the report produced for 2024/25. The Board was invited to comment and ask questions. The following points were of particular note: TP praised the report and commented it covered the essential items. JB confirmed this had been discussed at Quality & Safety Committee and feedback given was to see more of the improvements that have been made based on the patient feedback. GH queried the reporting of the private patient complaints. NB explained they are now managed in the same way as all complaints that are received. SJ requested that comparative data that is used is detailed as the scale/size of the comparator. NB explained the Board are requested to approve the publication of the document presented today. The Board **approved** the publication of the Complaints Annual Report for 2023/2024.	
GOVERNANCE AND COMPLIANCE	
23 Corporate Risks Review – Progress Update: *for discussion* (SGL)	**ROHTB (12/24) 014**
SGL provided an update on the Corporate Risks Review. The papers were taken as read. The following key points were highlighted: Since the last Board meeting a further two Board committees have been held. Both Committees received excerpt of the Corporate Risk Registers and Board Assurance Framework (BAF) which included risks pertinent to the remit of the Committee. Meetings have taken place with three out of the four Committee Chairs with the Associate Director of Governance. All Chairs agreed that the current iteration of the Corporate Risk Register does articulate the current risks. An Executive Team session is planned for 17th December 2024 to finalise the document. The final document will be shared at the Board meeting in February 2025.	
24 Board Walkabouts: *for information* (SGL)	**ROHTB (12/24) 015** **ROHTB (12/24) 015 (a)** **ROHTB (12/24) 015 (b)**

SGL provided an update on the Board Walkabout plans. The paper was taken as read. The following key points were highlighted: The schedule to the end of March has been produced. Summary of the walkabouts have been included in the paper. The walkabouts will follow the 'Chat and Check' process but will reframe some of the questions to ensure questions about productivity and sustainability are encourage. RL suggested that the plan is reviewed to enable Non-Executives to attend improvement huddles when undertaking the visits. RL will share the dates of the improvement huddles across the Trust.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
25 Upward reports from the Board Committees: **Finance & Performance Committee** **Quality & Safety Committee** **Audit Committee** **Charitable Funds Committee**	**ROHTB (10/24) 016** **ROHTB (10/24) 017** **ROHTB (12/24) 018** **ROHTB (12/24) 019**
Finance and Performance Committee – LW Deficit year to date has increased due to the inclusion of £1m provision for the Elective Recovery Fund (ERF) but when excluded is pleasing to see a surplus of £500k in month. Deficit year to date is now at £2.4m which poses a significant challenge to the Trust. It was noted the outstanding progress on the control of agency spends is to be commended. There was a continuing positive performance in many areas, including over 65 weeks waits, increased outpatient activity, diagnostics, cancer waits and several other areas. Excellent deep dive presented by the Deputy Chief Operating Officer on Spinal Deformity services, including many proposed actions to improve productivity. **Quality & Safety Committee – JB** There have been two Never Events incidents. They are unrelated and a full investigation is underway.	

Flu vaccinations are only at 35%. We are not the only organisation with these figures, it is a pattern seen across the country. NB explained that there is a big push planned in the lead up to Christmas to encourage uptake in the vaccination.

Two additional risks have been added to the risk register.

An update was received on the learning disability standards and the action plan that supports the changes.

The Spinal Endoscopy Review is underway currently.

Audit Committee – GH

GH thanked SP for attending the meeting in the absence of JB and LW due to the need to reschedule the meeting.

Staff retention audit was presented to the Committee, and it was reassuring to see that it reported significant assurance with minor improvement opportunities.

Freedom to Speak Up audit was also presented to the Committee which rated as significant assurance with minor improvement opportunities. The biggest issue was the access of the training material. SGL provided assurance this matter is being addressed with the Learning & Development Team.

It was noted the hospitality register is not at the level we need it to be, in particular with clinical colleagues not completing it when necessary. More push is required to adherence to declarations of hospitality. The register has significantly improved though.

Charitable Funds Committee – AA

The Charitable Funds met on 21st November 2024.

Key concern to raise to the Board to is the financial sustainability and the investment of funds. A meeting has been arranged with Cazenove to discuss further.

Health Hack Workshop update was warmly received. It is a fantastic initiative that is linking in with the community and supporting the work of the ROH.

- Resus training was supported to purchase diverse mannequins. This project funded by Royal Orthopaedic Charity (ROC), has significantly enhanced diversity in resuscitation training at the ROH.

MATTERS TO BE TAKEN BY EXCEPTION

26 Performance Reports: *for assurance*

Finance & Performance Quality Report	**ROHTB (12/24) 020 ROHTB (12/24) 021**
The reports were taken as read.	
27 Any Other Business	**Verbal**
There was no other business raised.	
28 Meeting Effectiveness	**Verbal**
Date of next meeting: Wednesday, 5 February 2025 @ 0900h	

PUBLIC SESSION

Next Meeting: 4 December 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 30 January 2025

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.267	Chair's and Chief Executive's Update	ROHTB (11/24) 002 ROHTB (11/24) 002 (a)	06/11/2024	Share the plan for the underutlisied area of the Estate with the Board.	SW	~~05/02/2025~~ 05/03/2025	**Item deferred to March meeting.**	
ROHTBACT.268	WRES/WDES Update	ROHTB (11/24) 004 ROHTB (11/24) 004 (a) ROHTB (11/24) 004 (b) ROHTB (11/24) 004 (C)	06/11/2024	Provide an update on the Recruit and Retain programme of work being undertaken at system level to SE&OD Committee in December.	NB	~~18/12/2024~~ 26/02/2025	**Committee postponed to February, item deferred to next SE&OD meeting.**	
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	05-Mar-25	**Updated to March due to availability of Trainee. ACTION NOT DUE**	
ROHTBACT.269	WRES/WDES Update	ROHTB (11/24) 004 ROHTB (11/24) 004 (a) ROHTB (11/24) 004 (b) ROHTB (11/24) 004 (C)	06/11/2024	Deep dive on the WRES/WDES data, particularly around bullying and harrassment to understand what is driving the results. Report to shared with Staff Experience and OD Committee in February.	SM	26-Feb-24	**ACTION NOT DUE**	

KEY:

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

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Interim Chief Executive**
AUTHOR:	**Matthew Hartland, Interim Chief Executive**
DATE OF MEETING:	**5 February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
N/A	N/A

REPORT RECOMMENDATION:

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

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

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

Comments:

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

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

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

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

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

N/A

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

N/A

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

N/A

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**2023/24 IPC Annual Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nurse, and Director of IPC (DIPC)**
AUTHOR:	**Victoria Clewer, Infection Prevention and Control Lead Nurse**
DATE OF MEETING:	**5 February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The ROH Infection Prevention and Control annual report for 2023/24 is presented for information.

Within this report is a full and detailed description of activities undertaken by the IPC team during 2023/24, key success, challenges and operational aspirations for 2024/25.

It is a requirement set out in the HaSCA that all Trusts must produce an annual IPC report and make this publicly accessible.

An executive summary detailing key successes and challenges can be found on page 6.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Compliance with contract reporting requirements. Alignment with the HaSCA.	None.

REPORT RECOMMENDATION:

The Board is asked to note the report.

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

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

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:

The contents of this report align to the:
Health and Adult Social Care Act (HaSCA); code of practice on the prevention and control of infections and related guidance (DH 2012), available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
This report identifies how ROH contributes to the BSOL ICB shared objective 'Protect people from harm'. The contents of this report are shared at ICB IPC committee meetings and operational groups.
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
Details are included in the reports where required.
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Quality & Safety Committee January 2025

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2023/24

INFECTION PREVENTION AND CONTROL
PREVENTING HARM FROM INFECTION

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Foreword

Infection Prevention and Control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare-associated Infections (HCAI) can cause significant harm to those infected. As a result, IPC remains a key priority for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH).

I am proud to be able to present the IPC annual report for 2023/24.

The National Health Service (NHS) continues to experience unprecedented challenges clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centred and safety-focused.

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using services at ROH receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The IPC agenda has continued to be strengthened with a highly visible IPC team.

This report summarises the combined activities, commitment and hard work of the IPC team, clinical and operational staff, board colleagues, governors, and volunteers across ROH in relation to the prevention of HCAIs.

I would like to take the opportunity to thank the IPC team and staff at all levels of our organisation for their continued efforts to reduce the risk from infectious diseases in our patients, and for optimising the use of antimicrobial agents.

Nicola Brockie

Executive Chief Nurse and Director of Infection Prevention and Control (DIPC)

Contents **Page**

Abbreviations

AMS	Antimicrobial stewardship
BAF	Board assurance framework
BSI	Bloodstream infection
BSOL	Birmingham and Solihull
CPE	Carbapenemase-producing Enterobacterales
CQUIN	Commissioning for quality and innovation
CVAD	Central venous access device
DIPC	Director of infection prevention and control
HCAI	Healthcare associated infection
HCAI DCS	Healthcare associated infections data capture system
HDU	High dependency unit
ICB	Integrated Care Board
IPC	Infection prevention and control
MDR	Multidrug-resistant
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-susceptible *Staphylococcus aureus*
NHSE	National Health Service England
NIPCM	National infection prevention & control manual
PIVC	Peripherally inserted venous catheter
PPE	Personal protective equipment
PSIRF	Patient safety incident response framework
PSIRP	Patient safety incident response plan
RCN	Royal College of Nursing
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RNOH	Royal National Orthopaedic Hospital NHS Trust
ROH	Royal Orthopaedic Hospital NHS Foundation Trust
RSV	Respiratory Syncytial Virus
SSI	Surgical site infection
SSIS	Surgical site infection surveillance
UC	Urinary catheter
UHB	University Hospitals Birmingham
UKHSA	UK Health Security Agency
UTI	Urinary tract infections
VAD	Vascular access device
VRE	Vancomycin-resistant *enterococci*

Executive summary

ROH ended 2023/24 below their NHS England threshold for healthcare associated *Clostridioides difficile* (*C. difficile*) *infections*, and bloodstream infections (BSI) attributable to *Klebsiella species* and *Pseudomonas aeruginosa*. However, above their NHS England threshold for BSI attributable to *Escherichia coli* (*E.coli*) and Methicillin-sensitive *Staphylococcus aureus* (MSSA).

The Trust reported zero bloodstream infections attributable to Methicillin-resistant *Staphylococcus aureus* (MRSA). No MRSA BSI have been reported by ROH for the last 12 years.

The number of Carbapenemase-producing Enterobacterales (CPE) positive cases identified prior to or on admission increased as enhanced screening practices were embedded and effectively carried out.

When compared with national data for participating hospitals, the ROH surgical site infection (SSI) risk rate for total knee replacement and spinal surgery was identified as a 'higher outlier' during Q4 2023 (October to December) and Q1 2024 (January to March).

The number of COVID-19 cases and associated outbreaks dramatically decreased during 2023/24.

A review and update of the MRSA policy pre-operative screening guidance was implemented, reducing delays to surgery and short notice cancellations.

28 new respirator hoods were procured and distributed across the Trust, further supporting access to personal protective equipment for clinical staff.

Launched the 'gloves off' campaign which educates staff on the appropriate selection and use of none-sterile gloves to minimise the impact incorrect use has on the transmission of infections and waste leading to wider environmental impacts. Since implementation, ROH has used 343,000 less non-sterile gloves which has contributed to a carbon footprint reduction of 8,928kg of CO2e.

Undertook a gap analysis review of existing IPC polices against the NHS England National IPC Manual to ensure they are aligned.

During November 2023, implemented the NHS England Patient Safety Incident Response Framework (PSIRF) and developed an ROH IPC Patient Safety Incident Response Plan (PSIRP). Process aligned with the wider West Midlands IPC teams approach.

The Trust IPC study day was held in November 2023, which involved internal and external speakers. The day was well attended and evaluated positively by attendees.

Organised and celebrated several key events in the IPC calendar across ROH, this included World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2023.

Recruited 1 whole-time equivalent (WTE) full-time band 6 IPC nurse with IPC experience and 1 WTE band 3 SSI coordinator further supporting our ability to deliver the IPC and SSI programme.

Continued to deliver and innovate services in relation to decontamination, water, and ventilation safety.

Strengthened governance and assurance arrangements to ensure compliance with contractual requirements.

This report includes a summary of the IPC annual business plan and programme of work for 2024/25.

About The Royal Orthopaedic Hospital NHS Foundation Trust

The ROH is one of the largest providers of elective orthopaedic surgery in the UK and is one of five specialist orthopaedic centres. It offers three tiers of service:

Routine orthopaedic operations for a local population of 4 million people in Birmingham and North Worcestershire;
Specialist services such as spinal surgery to 5 million people who live in greater Birmingham and the West Midlands;
and Diagnosis and treatment of malignant bone tumours.

The Trust has fourteen operating theatres, six wards and 117 beds, including eight beds for private treatment and six being on a High Dependency Unit. Of these, 56 are single occupancy rooms with en-suite and 3 are single occupancy rooms without en-suite. The Trust employs in excess of 1,200 staff. Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; the core business of the ROH is elective surgery. The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery.

We are guided by our values in everything we do and reflect the diversity, opportunity and ambition of our communities and the people we serve.

ROH IPC Vision:

Preventing harm from infection by delivering clean, safe care.

ROH IPC Mission:

To deliver a patient focused, expert infection prevention service that supports and empowers staff and patients through education, innovation, and role modelling, to ensure harm free care for all.

Healthcare-associated infection (HCAI) surveillance

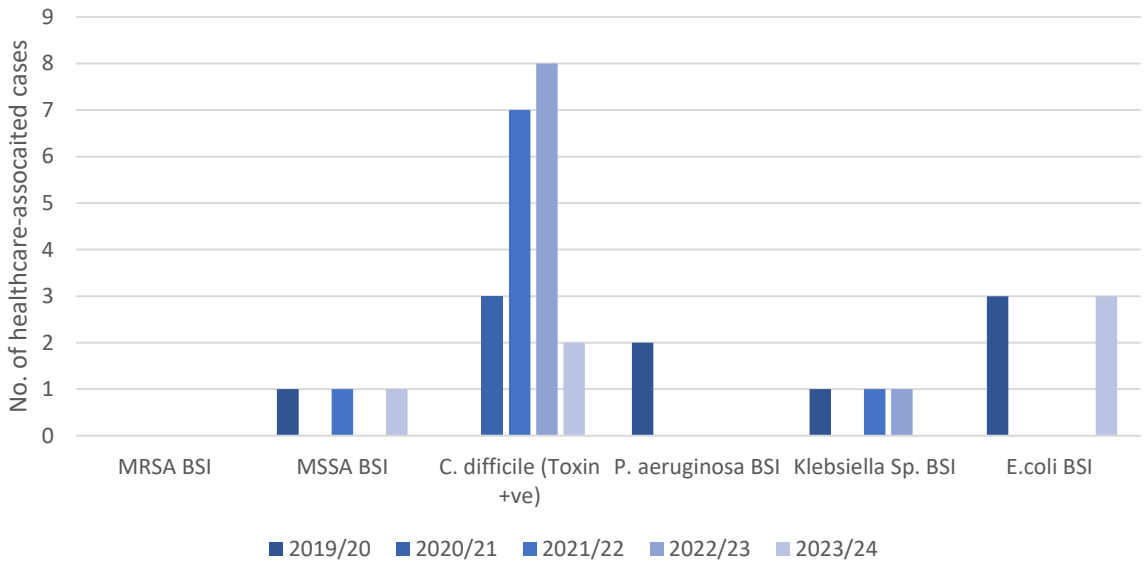
The Trust participates in the mandatory HCAI surveillance programme facilitated by the UK Health Security Agency (UKHSA) including:

Clostridioides difficile infection (CDI) – toxin positive cases
Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia
Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
Escherichia coli (*E. coli*) bacteraemia
Klebsiella species bacteraemia
Pseudomonas aeruginosa (*P. aeruginosa*) bacteraemia
Quarterly Mandatory Laboratory Return (QMLR)

Performance is monitored by Birmingham and Solihull Integrated Care Board (BSOL ICB).

The NHS Standard Contract includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both *C. difficile* and of Gram-negative bloodstream infections to threshold levels set by NHS England. Objectives have been set for five of the six HCAI included in mandatory surveillance. MSSA is the only HCAI without a national objective.

Trust-wide mandatory healthcare-associated surveillance case numbers over the last five financial years:



***Clostridioides difficile* infection**

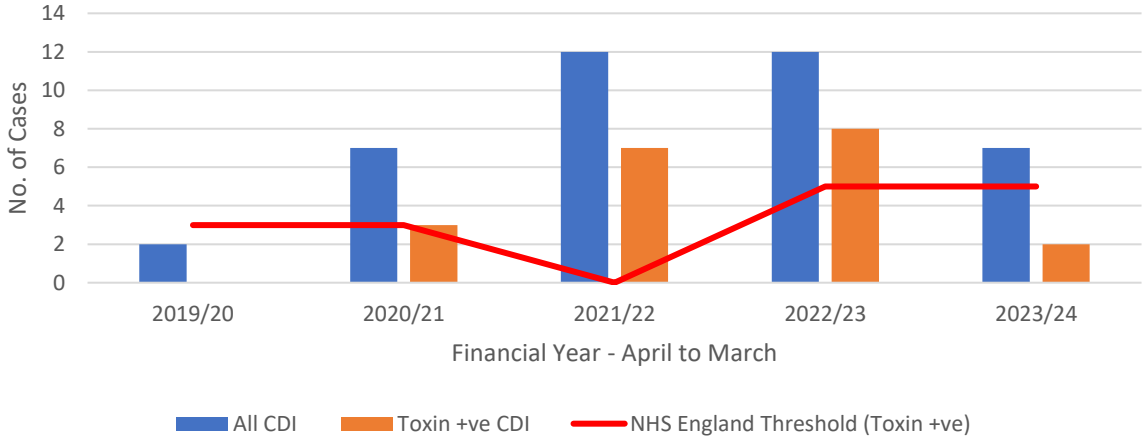
During 2023/24 there were 2 healthcare-associated *C.difficile* toxin-positive (reportable) cases, against the NHS England threshold of 5 cases.

There has been a 75% decrease in toxin positive cases and a 42% decrease in all cases since 2022/23.

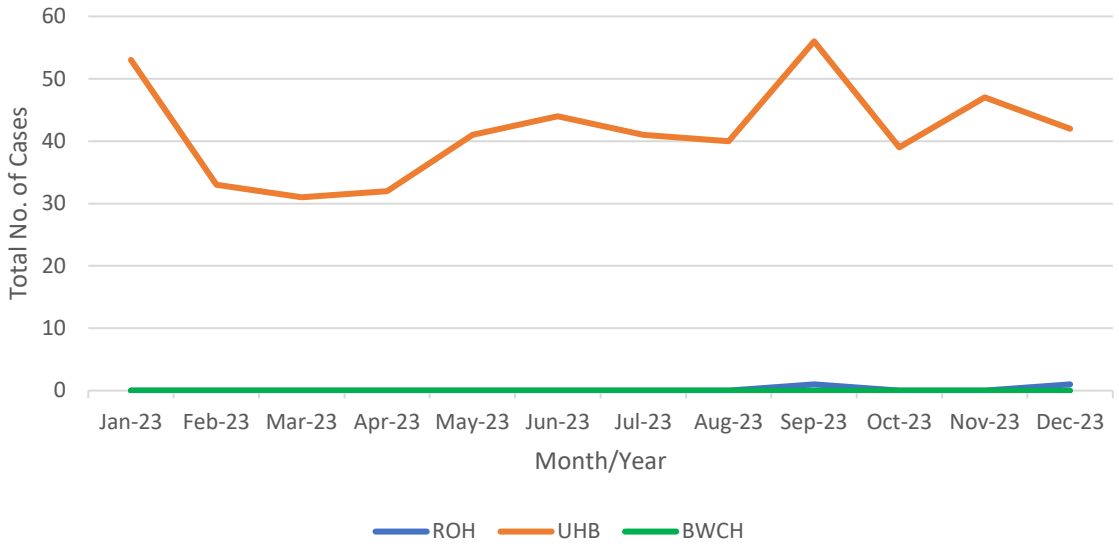
A post infection review (PIR) is undertaken for each healthcare-associated reportable infection; no lapse in care or quality due to cross-transmission or antibiotic choices were identified.

ROH contributes relatively few cases of *C. difficile* to the overall Birmingham and Solihull (BSOL) system totals.

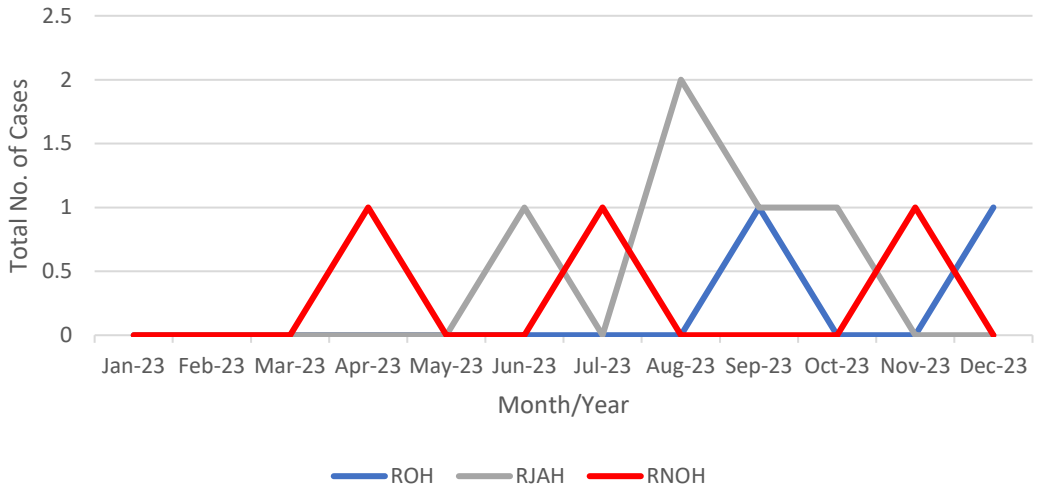
Total number of *C. difficile* cases reported by ROH annually:



Total number of *C.difficile* cases reported by trusts within the BSOL system during 2023/24*:



Total number of *C.difficile* cases reported by specialist orthopaedic trusts during 2023/24*:



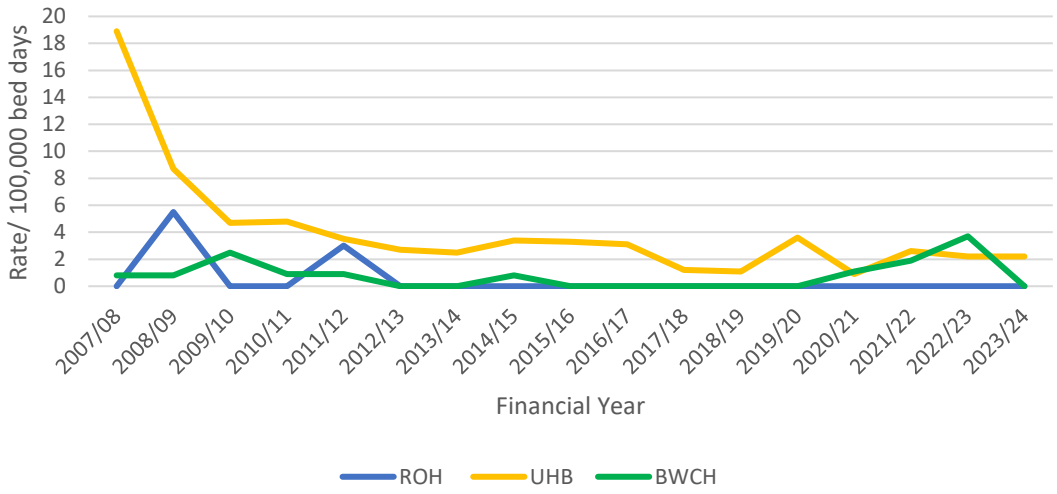
*data obtained from C. difficile infection (CDI): monthly data by prior trust exposure - GOV.UK.

Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections

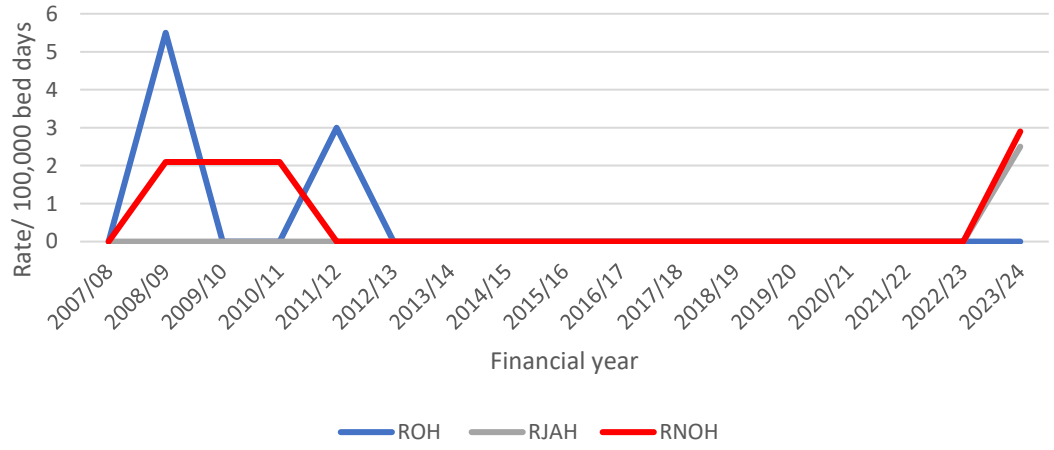
During 2023/24 there were no cases of MRSA BSI. There remains a zero tolerance for MRSA BSIs nationally.

ROH have not reported an MRSA BSI for the last 12 years (last case reported during 2011/12).

Annual MRSA BSI rates per 100,00 bed days for trusts within the BSOL system*:



Annual MRSA BSI rates per 100,00 bed days for specialist orthopaedic trusts*:



*data obtained from MRSA bacteraemia: annual data - GOV.UK.

Methicillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

During 2023/24 there was 1 healthcare associated MSSA BSI; there is currently no national threshold provided by NHS England.

There has been a 100% increase in cases since 2022/23 (1 case), however, ROH has the lowest rate of MSSA BSI per 100,000 bed days within the BSOL system.

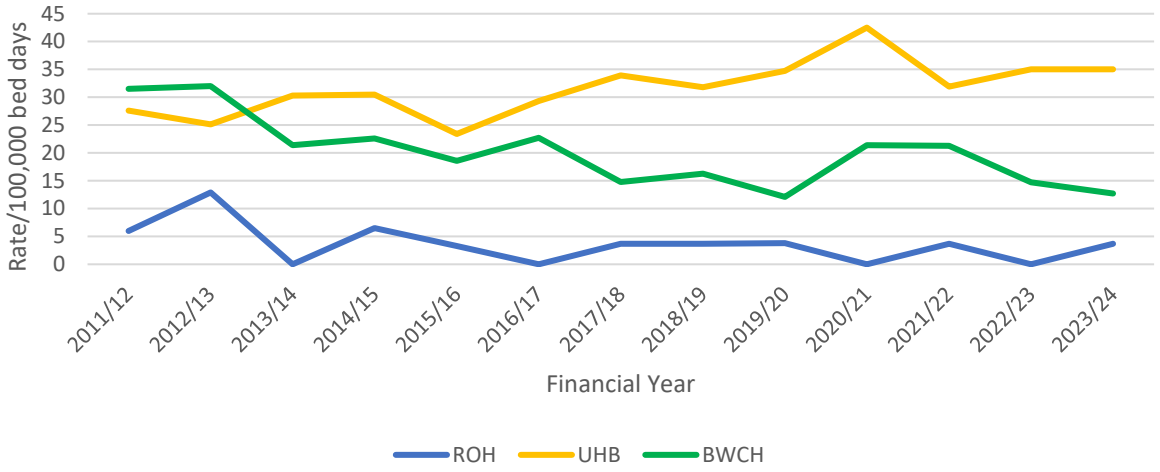
A post infection review was undertaken which found this BSI to be related to the insertion and ongoing care of a peripherally inserted venous catheter (PIVC). Lapse in care identified following investigation which related to the inconsistent documentation of device insertion and ongoing care as well as visual infusion phlebitis (VIP) score.

As a result of this, a short life vascular access device group was set up to review PIVC, central venous access devices (CVAD) insertion and ongoing care practices and address areas that are commonly reported as non-compliant from high impact interventions. This group completed its work during March 2024 and achieved the following:

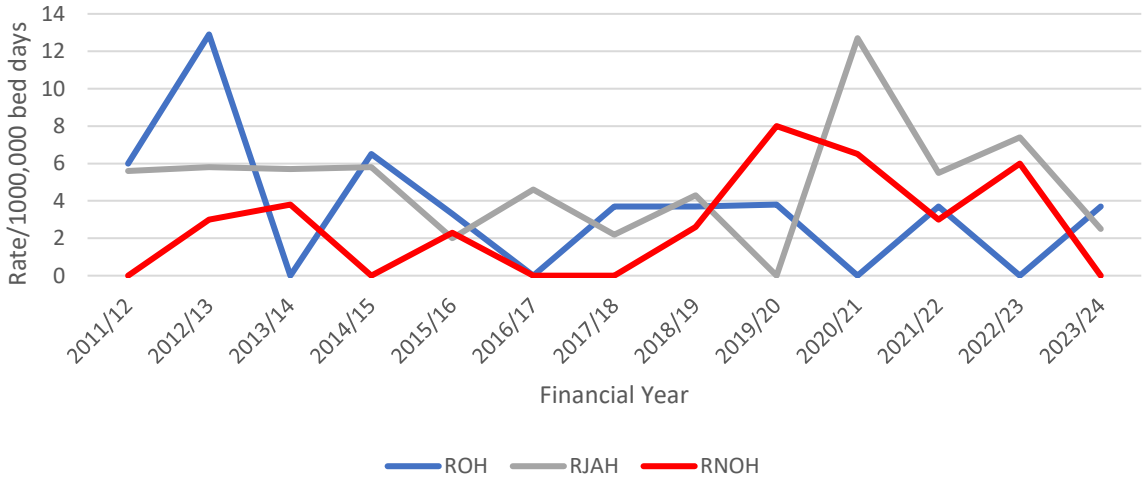
- Reintroduction and training of staff in the use of needle free connectors.

- Human factors review of accessibility to invasive device ongoing care documentation and relocation of nursing care plans (putting back at the bedside to encourage completion as care takes place).
- Turbo tutorials in clinical departments around device care and targeted training for post-graduate doctors and the critical care outreach team who insert the majority of PIVCs within the clinical departments (outside of theatre).

Annual MSSA BSI rates per 100,00 bed days for trusts within the BSOL system*:



Annual MSSA BSI rates per 100,00 bed days for specialist orthopaedic trusts*:



*data obtained from MSSA bacteraemia: annual data - GOV.UK.

Gram-negative bloodstream infections

Gram-negative bacteria such as *E. coli*, *Klebsiella sp.,* and *P. aeruginosa* are the leading causes of healthcare-associated BSI. Each healthcare-associated Gram-negative associated BSI is individually reviewed to identify source (if possible), risk and contributing factors.

***Escherichia coli* bloodstream infections**

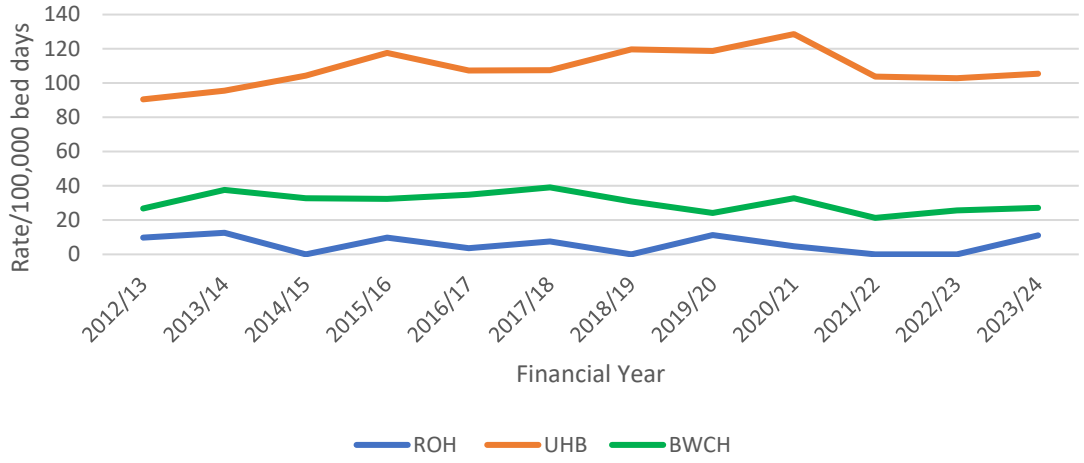
During 2023/24 there were 3 healthcare-associated *E.coli* BSI, against the NHS England threshold of 0.

There has been a 300% increase in cases reported during 2023/24 (3 cases), compared to 2022/23 (0 cases), however, ROH has the lowest rate of *E.coli* BSI per 100,000 bed days within the BSOL system and the second lowest of the three specialist orthopaedic trusts.

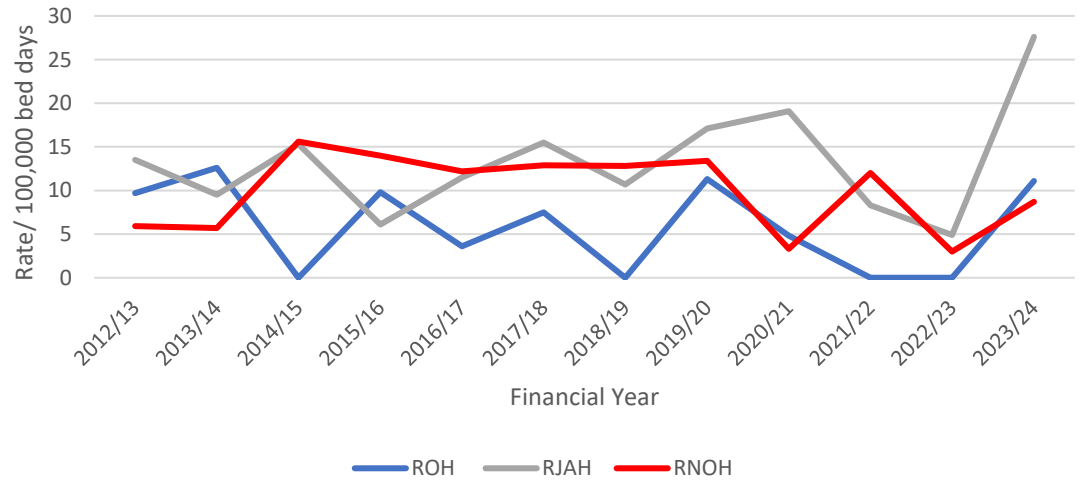
2 of the 3 cases had a urinary source, with both patients also having a UTI. Post infection reviews into cases highlighted similar issues relating to adequate patient hydration which is known to be an influencing factor in the development of UTI.

Revisiting the fundamentals of care in regard to hydration, mobility and good oral care is a priority for the 2024/25 IPC programme of work to address Gram-negative organisms.

Annual *E.coli* BSI rates per 100,00 bed days for trusts within the BSOL system*:



Annual *E.coli* BSI rates per 100,00 bed days for specialist orthopaedic trusts*:



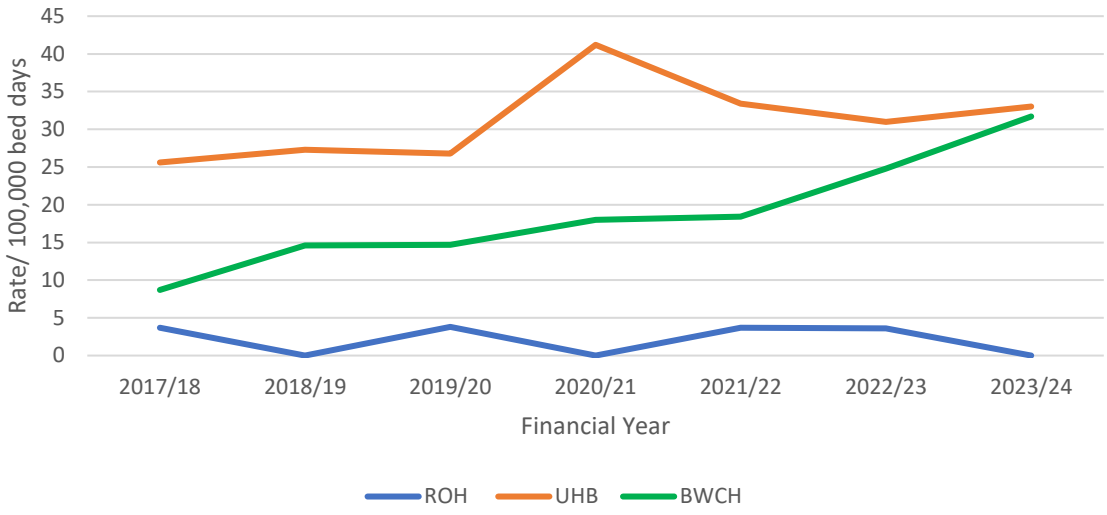
*data obtained from Escherichia coli bacteraemia: annual data - GOV.UK.

***Klebsiella species* blood stream infections**

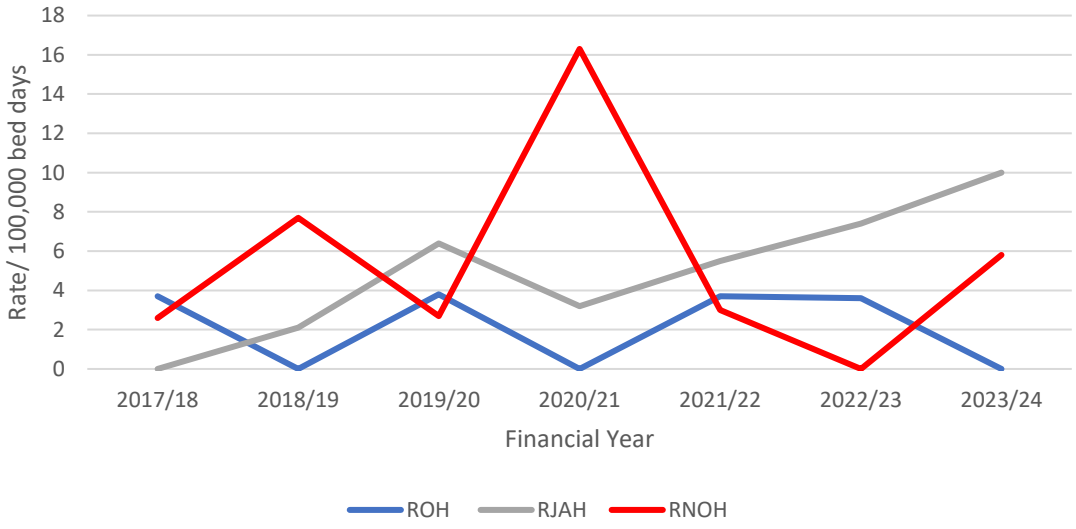
During 2023/24 there were 0 healthcare associated *Klebsiella sp.* BSI, against the NHS England threshold of 1.

There has been a 100% decrease in cases reported during 2023/24 (0 cases) compared to 2022/23 (1 case). ROH has the lowest rate of *Klebsiella sp.* BSI per 1000,000 bed days within the BSOL system and of the three specialist orthopaedic trusts.

Annual *Klebsiella Sp.* BSI rates per 100,00 bed days for trusts within the BSOL system*:



Annual *Klebsiella Sp.* BSI rates per 100,00 bed days for specialist orthopaedic trusts*:



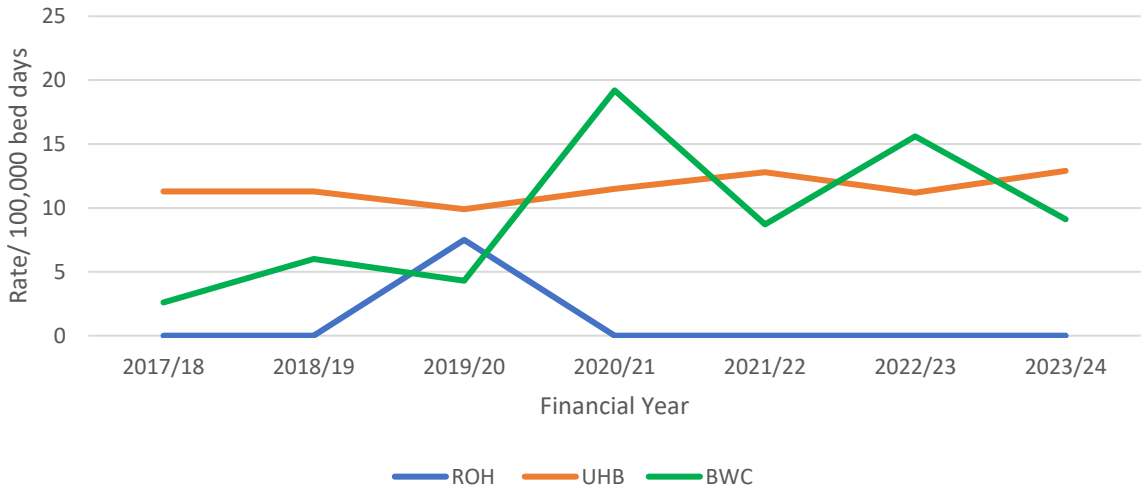
*data obtained from Klebsiella species bacteraemia: annual data - GOV.UK.

***Pseudomonas aeruginosa* bloodstream infections**

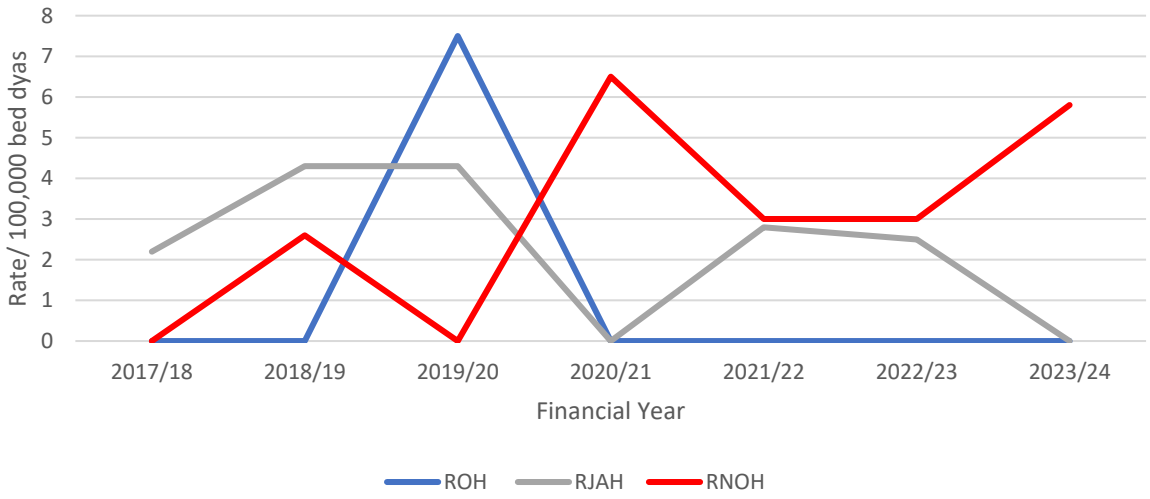
During 2023/24 there were 0 healthcare-associated *P. aeruginosa* BSI, against the NHS England threshold of 0.

This is equal to the number of cases reported during 2022/23 (0 cases). ROH has the lowest rate of *P. aeruginosa* BSI per 1000,000 bed days within the BSOL system and of the three specialist orthopaedic trusts.

Annual *Pseudomonas aeruginosa* BSI rates per 100,00 bed days for trusts within the BSOL system*:



Annual *Pseudomonas aeruginosa* BSI rates per 100,00 bed days for specialist orthopaedic trusts*:



*data obtained from Pseudomonas aeruginosa bacteraemia: annual data - GOV.UK.

Carbapenemase-producing Enterobacterales (CPE)

CPE is considered a high-risk transmission hazard and in healthcare settings can lead to poor clinical outcomes due to limited therapeutic options. Increased incidence of CPE has significant cost and operational implications for healthcare providers. The Trust closely monitor for CPE by undertaking screening based on risk factors to promptly identify and isolate patients who are colonised with the organism. During 2022/23, ROH CPE screening guidance was updated to reflect changes to the national CPE screening guidance as described in Framework of actions to contain Carbapenemase-producing Enterobacterales (UKHSA, 2022).

During 2023/24, A total of 6 CPE cases were identified compared to 2 in 2022/23.

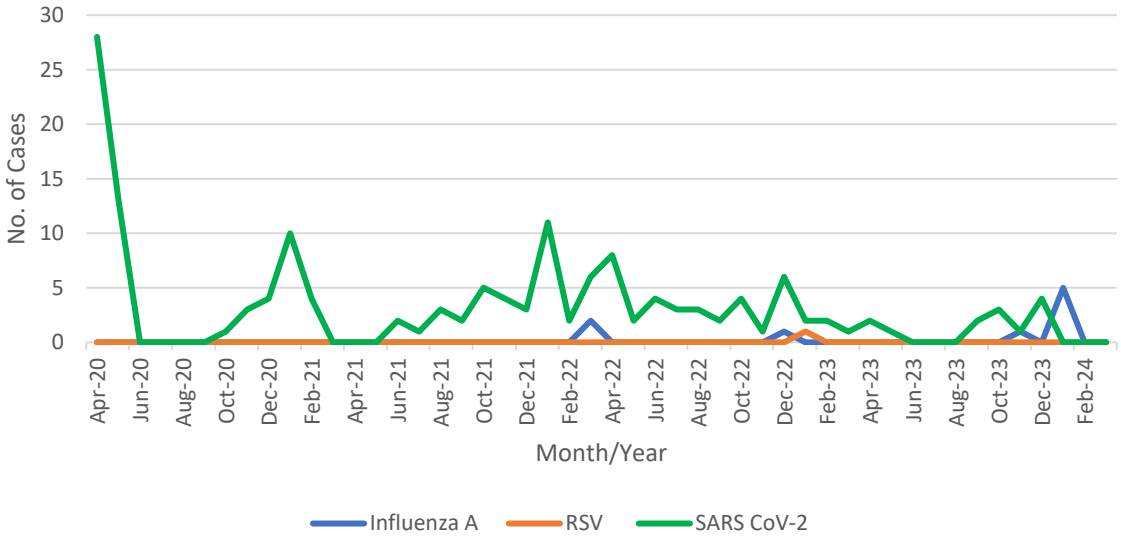
4 of the cases were identified prior to admission, from pre-admission screening. 2 cases were identified on admission following transfer from another acute NHS Trust.

Respiratory Virus Infections

Respiratory viral infections such as Influenza and Respiratory Syncytial Virus (RSV) typically peak during the winter months, however, cases can arise throughout the year depending upon community prevalence.

During 2023/24, a total of 6 Influenza A, 0 RSV and 13 SARS CoV-2 cases were identified, compared to 1 Influenza A, 1 RSV and 38 SARS CoV-2 cases identified in 2022/23.

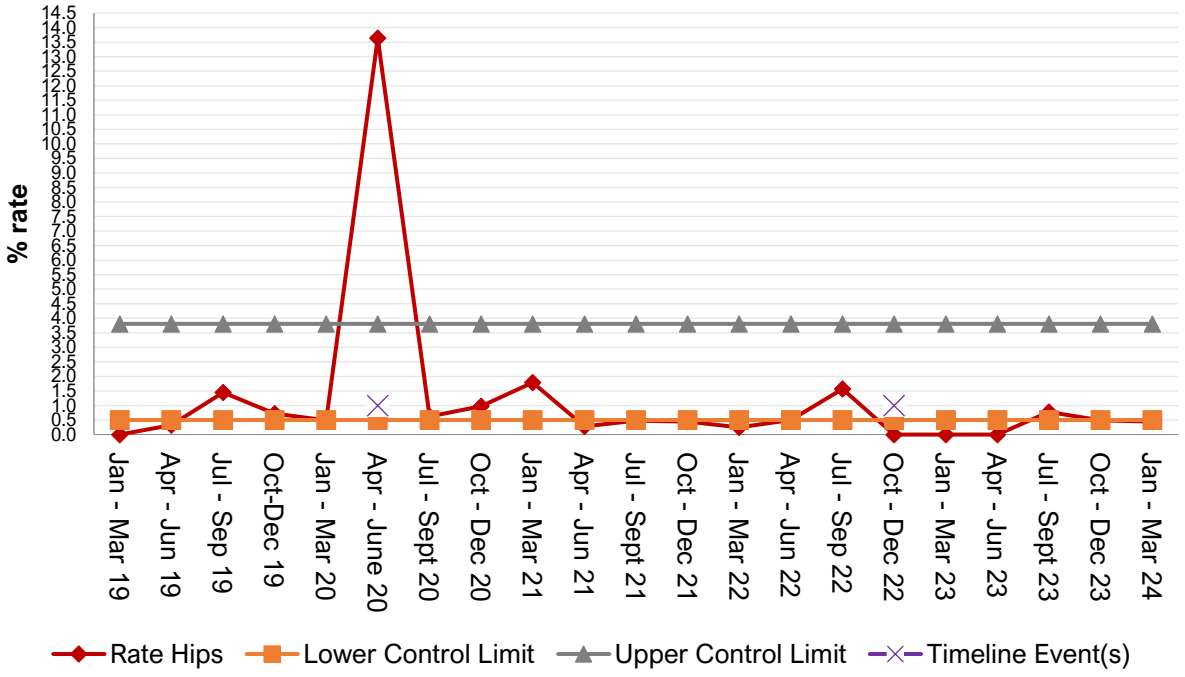
Total number of respiratory viral infections identified prior to, on and during admission to ROH:



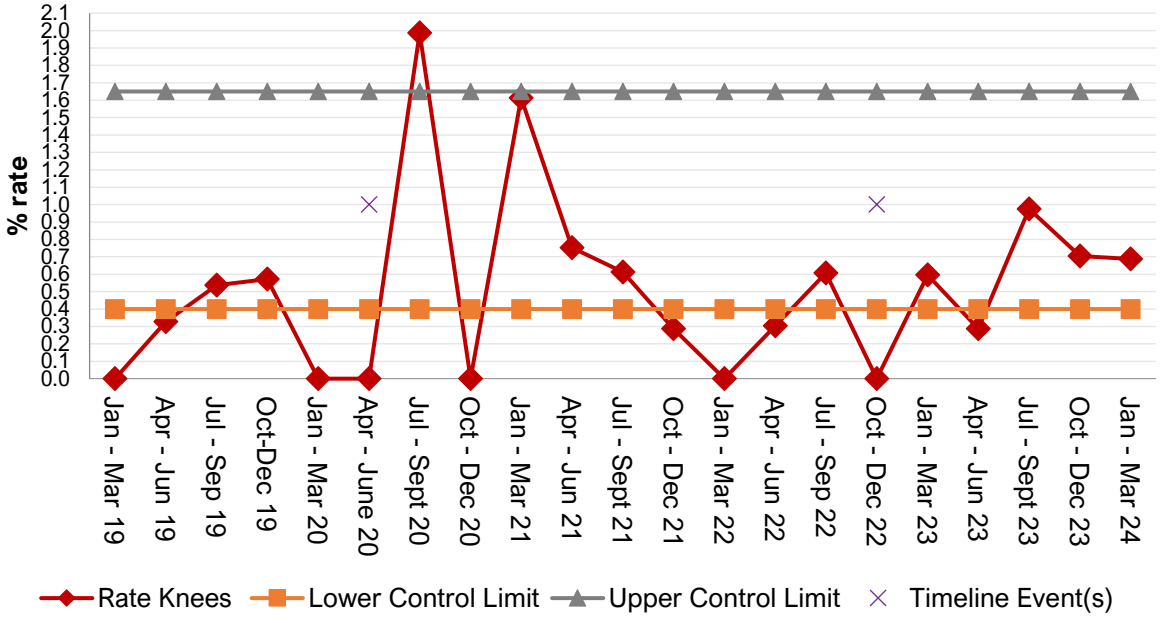
Surgical Site Infection Surveillance (SSIS)

Rates of SSI are monitored by dedicated coordinators within the IPC team for arthroplasty surgery (total hip and knee replacement – mandatory) and spinal surgery (voluntary).
During May 2023 we recruited an additional band 3 SSI coordinator to support surveillance data collection and administration. This enabled us to continue undertaking prospective and continuous surveillance.
When compared with national data for participating hospitals, the ROH SSI risk rate for total knee replacement and spinal surgery was identified as a 'higher outlier' during Q4 2023 (October to December) and Q1 2024 (January to March). A thematic review was undertaken to identify common SSI risk or contributing factors and make recommendations for improvements where required. This was overseen and reviewed by the theatre focus group.
The 'theatre focus group' is attended by key surgical, nursing, and allied health professional stakeholders to review current practice against evidence-based guidance (NICE NG125 SSI prevention and treatment), and identify actions and interventions to help minimise the risk of SSI.
Post infection reviews are completed for all confirmed deep and organ/space SSI to monitor adherence to evidence-based practices to minimise risk of SSI as well as identify contributing factors.
The reduction of SSI risk rate for total knee replacement and spinal surgery was made a Trust quality priority for 2024/25.

Rates of total hip replacement surgery SSI, identified from inpatients or on readmission per quarter – January 2019 to March 2024:

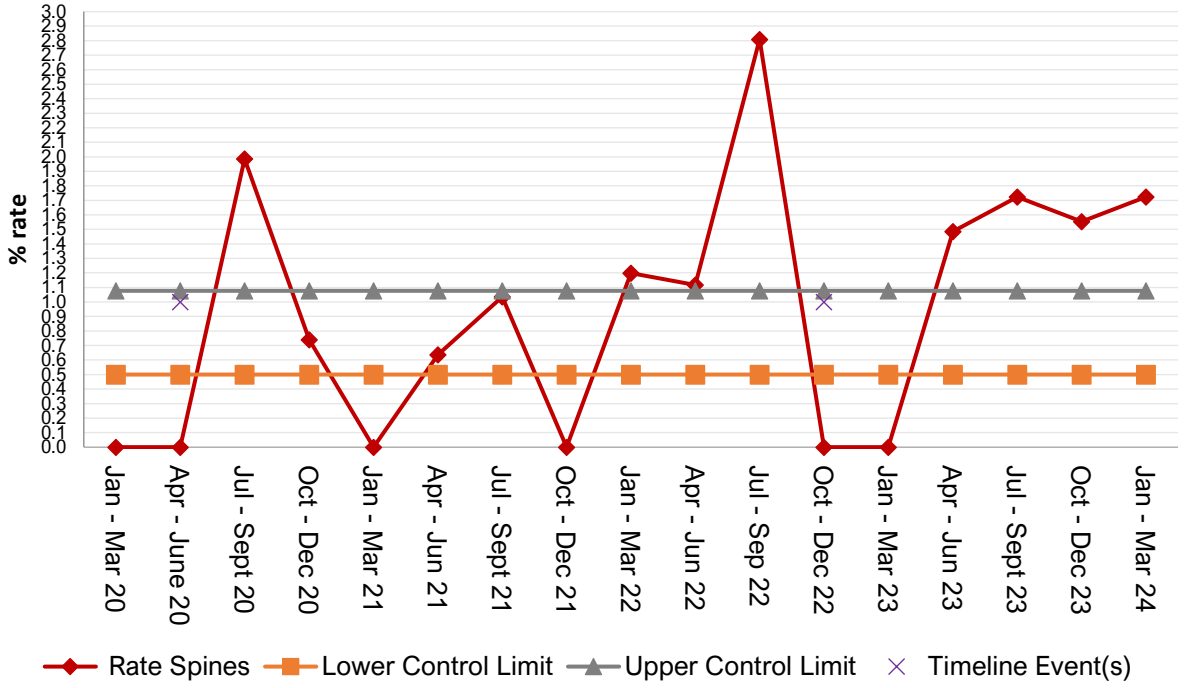


Rates of total knee replacement surgery SSI, identified from inpatients or on readmission per quarter – January to March 2024:



Rates of spinal surgery, identified from inpatients or on readmission SSI per quarter – January 2020 – March 2024.

Spinal surgery SSI surveillance was implemented at ROH from the beginning of April 2020.



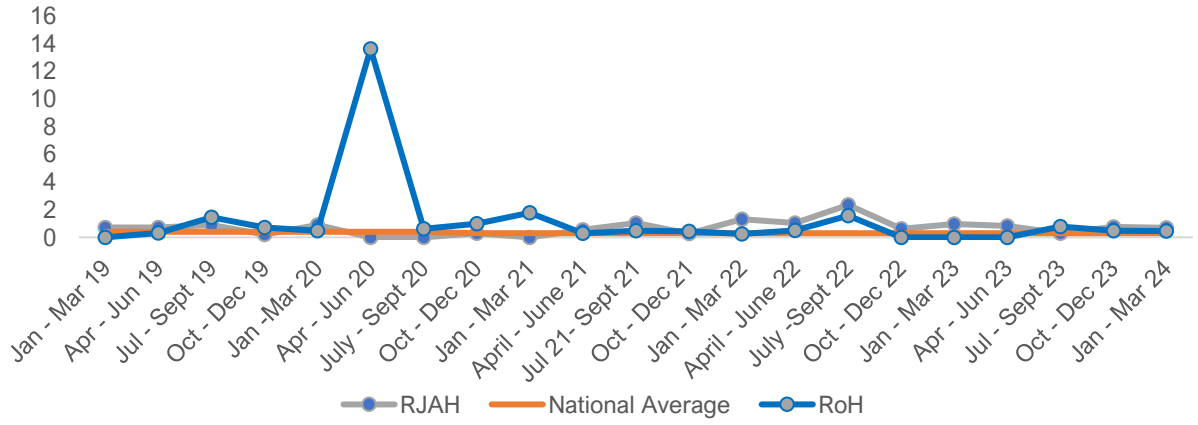
X -April – June 2020 – Reduced number of operations due to the COVID-19 pandemic.

X - Oct – Dec 2022 – Withdrew from UKHSA SSIS data collection and submission due to absence of trained SSI surveillance staff. Theatre focus group also set up to monitor improvement work dedicated to reducing risk rate for SSI.

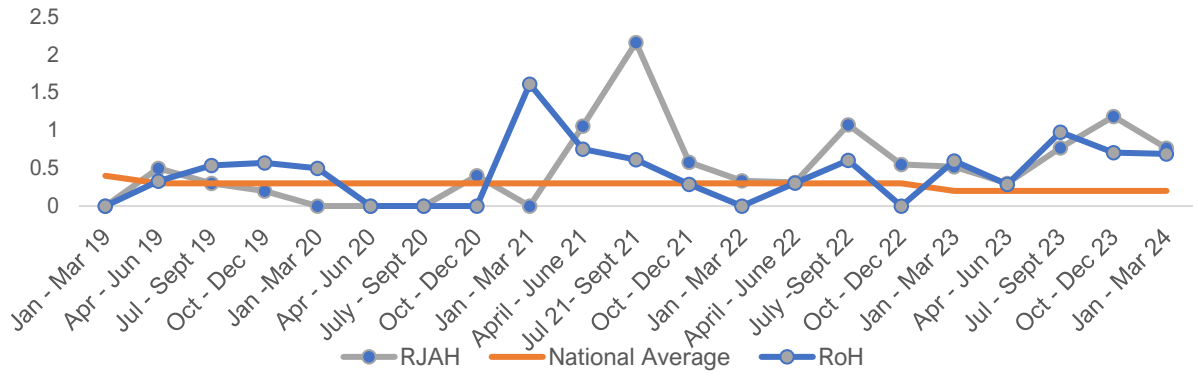
Inpatients and readmission SSI rates benchmarked with other specialist orthopaedic trusts:

Only data from The Robert Jones and Agnes Hunt Orthopaedic Hospital was shared.

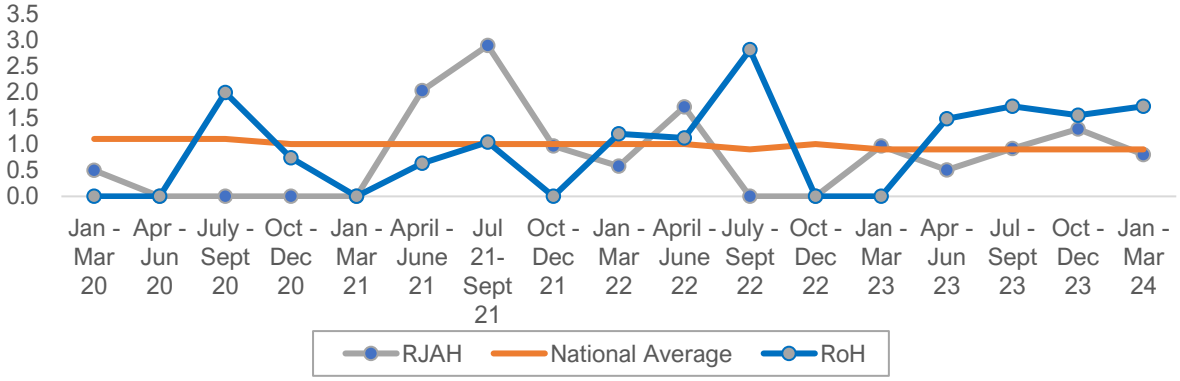
Total hip replacement:



Total knee replacement:



Spinal surgery:



Clinical Activity and Incidents

The IPC team continues to support the development of guidance for managing the risk of infectious diseases that are updated in response to changes in local prevalence and national guidance.

Incidents:

During 2023/24, the number of SARS CoV-2 cases decreased across the organisation and the number of outbreaks related to COVID-19 dramatically decreased.
During January 2024, an influenza A outbreak was declared on ward 2 involving 4 patients. The outbreak was recognised and responded to efficiently, minimising the impact and duration of the outbreak. Peer reviews of the Trust response by UKHSA and ICB IPC team reported that the response to the outbreak was comprehensive.
In response to increased prevalence in local community measles cases, a triage assessment and policy were created and implemented, to guide clinical staff in the prompt identification and management of suspected cases.

Clinical activity:

Review of MRSA policy and updated pre-operative screening guidance, aiming to prevent unnecessary delays to surgery.

28 new respirator hoods were procured and distributed across the Trust, further supporting access to personal protective equipment for clinical staff.

Launched the 'gloves off' campaign which aims to educated staff on the appropriate selection and use of none-sterile gloves to minimise the impact incorrect use has on the transmission of infections and waste leading to wider environmental impacts. Since implementation, ROH has used 343,000 less non-sterile gloves which has contributed to a carbon footprint reduction of 8,928kg of CO2e.

Undertook a gap analysis review of existing IPC polices against the NHS England National IPC Manual to ensure they are aligned.

During November 2023, implemented the NHS England Patient Safety Incident Response Framework (PSIRF) and developed an ROH IPC Patient Safety Incident Response Plan (PSIRP). Process aligned with the wider West Midlands IPC teams approach.

Reviewed all IPC related patient information leaflets to ensure they are up to date and accurate. Ongoing process to ensure this information is fully accessible to all.

The Trust IPC study day was held in November 2023, which involved internal and external speakers. The day was well attended and evaluated positively by attendees.

Antimicrobial Stewardship Programme

The Trust Antimicrobial Stewardship Group (AMSG) continues to meet quarterly and includes representatives from pharmacy, microbiology, nursing, and medical staff. This group produces and manages policies regarding AMS and responds to concerns in this area. The group produces upward reports and escalates concerns via the Drugs and Therapeutics Committee (DTC) and IPCC. The Trust's Antimicrobial Pharmacist reports quarterly antimicrobial consumption which is then reported at DTC and IPCC.

Antimicrobial Consumption Report 2023/24

Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Antimicrobial Pharmacist. The audits outlined above were conducted during 2023-24 for oversight on antimicrobial stewardship activities.

Since 2019 the NHS Standard Contract, set out by NHSE has contained a requirement on trusts to make 1% year-on-year reductions in their rate of total antibiotic usage per 1000 admissions – in accordance with the direction set in the UK's five-year national action plan (NAP) tackling antimicrobial resistance 2019-2024.

ROH antimicrobial baseline data for the year 2018/19:

2018/19 Baseline Data	Total DDD	42008
	DDD / 1000 patients	3239
NHSE target (2022/23)	Target DDD / 1000 patients	3093

DDD = Defined daily doses

The pharmacy team continue to undertake interventions relating to inappropriate antibiotic usage with prescribing teams to maintain good antimicrobial stewardship. Total antibiotic usage is monitored quarterly and ROH continues to maintain usage below the England average.

All antibiotics

Total Antibiotic consumption data in defined daily doses (DDDs) and DDD per 1000 admissions compared to the 2018 reference year (Jan to Dec) for all antibiotics including those prescribed by the Bone Infection Service (BIS):

All antibiotics including BIS Abx

Year (calendar year)	2019/20	2020/21	2021/22	2022/23	2023/24
Total Antimicrobial consumption (DDD)	48607	39194	50179	54639	53814
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2

Year (calendar year)	2019/20	2020/21	2021/22	2022/23	2023/24
Antimicrobial consumption Per 1000 admission	3719	5518	3947	4114	3892
Target DDD/ 1000	3206	3206	3206	3093	2915

All antibiotics excluding BIU Abx

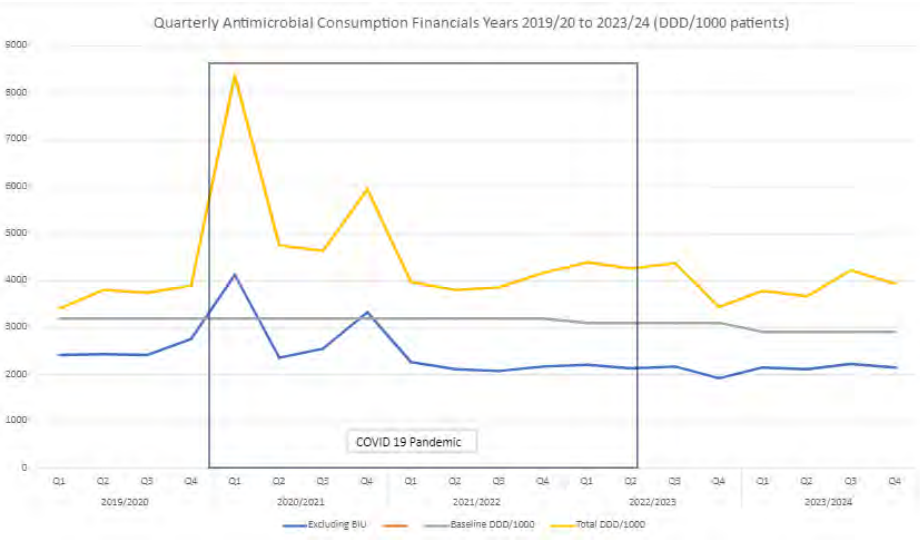
Year (calendar year)	2019/20	2020/21	2021/22	2022/23	2023/24
Total Antimicrobial consumption (DDD)	27647	20549	27400	27984	29813
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2

Year (calendar year)	2019/20	2020/21	2021/22	2022/23	2023/24
Antimicrobial consumption Per 1000 admission	2115	2894	2159	2107	2156
Target DDD/ 1000	3206	3206	3206	3093	2915

Total antimicrobial consumption (DDD) 2019/20 to 2023/24

The tables above provide a breakdown of the overall antimicrobial consumption for each financial year since 2019/20. The data shows that the overall consumption has seen a decline in 2023/24 compared to the previous year. However, if we exclude the antibiotics used for the Bone Infection Service, we are below the NHSE targets.

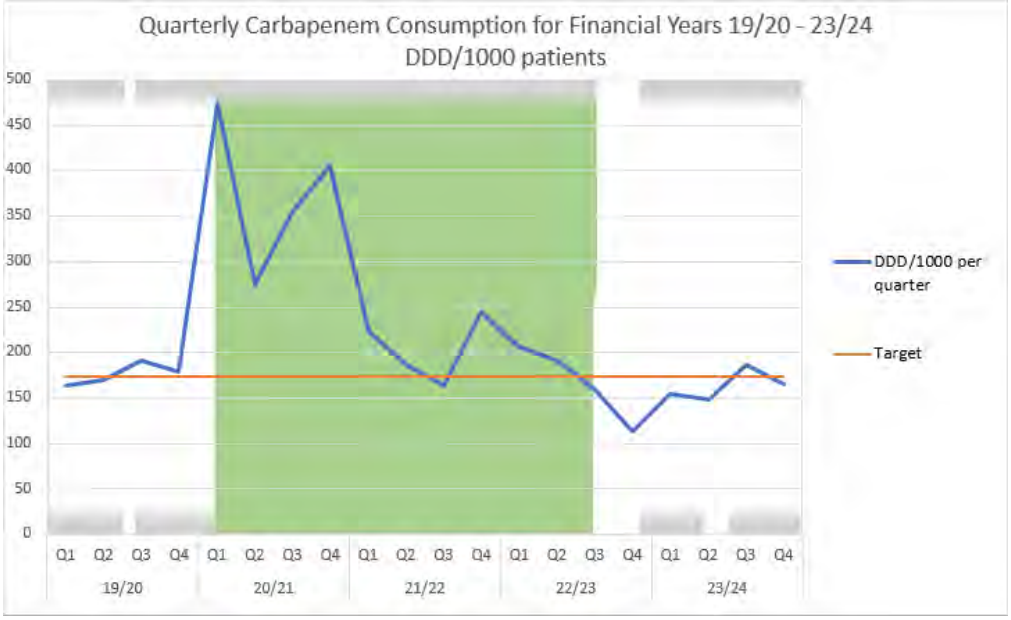
Total antimicrobial consumption (DDD) 2019/20 to 2023/24:



Carbapenem Usage

Total Carbapenem consumption data in DDDs and DDD per 1000 admissions compared to the 2018 reference year:

Year (Calendar Year)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Carbapenem consumption (DDD)	2420.8	2300.5	2548.8	2586	2202	2258
Carbapenem consumption (DDD Per 1000 admission)	177.5	176.01	358.9	204	166	163
Target DDD/ 1000		173.9	173.9	173.9	173.9	173.9



The graph above shows quarterly carbapenem usage has increased over the 2023/24 financial year but has improved to below the target set by NHSE in the final quarter.

Yearly usage of antimicrobials within the WHO "Access" category of the AWaRe list financial years 2019/20 – 2023/24:

Antimicrobial Usage	2019/20	2020/21	2021/22	2022/23	2023/24
Antibiotic consumption within the "Access" category of the AWaRe list	1847 (52%)	2394 (43%)	2054 (52%)	2350 (57%)	2044 (59%)
Antibiotic consumption within the "Watch" category of the AWaRe list	1547 (42%)	2534 (46%)	1546 (39%)	1408 (34%)	1186 (34%)
Antibiotic consumption within the "Reserve" category of the AWaRe list	325 (9%)	594 (11%)	335 (9%)	358 (8%)	263 (8%)

The percentage of antibiotics within the Access group category has been steady between 43-53% for the past 3 financial years, however, there has been a slight increase in the percentage of Access group antibiotics (59%) and a stable consumption within the Reserve category.

It is important to note antibiotics routinely used for BIS MDT are mostly found within either the Reserve or Watch categories; therefore, as activity remains high for BIS Outpatients then this impacts on the percentage consumption of Access antibiotics. Excluding BIS antibiotics causes the Trust to comfortably achieve the CQUIN targets as evidenced below:

Excluding BIS:

Antimicrobial Usage	2019/20	2020/21	2021/22	2022/23	2023/24
Antibiotic consumption within the "Access" category of the AWaRe list	1500 (71%)	1794 (62%)	1534 (71%)	1545 (73%)	1482 (73%)
Antibiotic consumption within the "Watch" category of the AWaRe list	438 (21%)	734 (25%)	416 (19%)	393 (19%)	401 (20%)
Antibiotic consumption within the "Reserve" category of the AWaRe list	177 (8%)	367 (13%)	209 (10%)	170 (8%)	137 (7%)

Care and Management of the Healthcare Environmental and Equipment

Decontamination

No decontamination of critical devices is undertaken onsite at ROH. This is contracted out to BBraun, who deliver an accredited decontamination service and oversee the process and management of all decontamination of surgical instruments. No other equipment used onsite or offsite as part of ROH services requires sterile decontamination.

As set out in Health Technical Memorandum (HTM) 01-01, which offers best practice guidance on the whole decontamination cycle including the management and decontamination of surgical instruments used in acute care, ROH have an appointed Sterile Services Manager (SSM) who takes responsibility for coordinating activity between the theatre, decontamination, and supply/purchase teams. They ensure that the inventory of surgical instruments is proactively reviewed and managed in accordance with national and local guidance, clinical requirements, and industry best practice.

The SSM reports to the Trust's Decontamination lead. In the absence of a formal Decontamination Lead, this responsibility is held by the DIPC. The SSM provides an upward report on decontamination at the IPC committee.

Water

The Water Safety Group (WSG) continues to meet bi-monthly and reports upwardly to the IPC committee. The group is chaired by the Deputy Director of Delivery (Estates). The Trust continues to monitor and review work and actions undertaken toward the water safety plan (WSP). The plan was developed based on the peer review and reflects the status and identified risks of the Trust's water systems. This is monitored at the WSG.

The Estates department carried out planned preventive maintenance in accordance with the relevant water safety guidance documentation. Every two years the Trust commissions an independent Legionella risk assessment to be completed across the site, the outcome/actions from the assessment are discussed at the WSG.

Six monthly Legionella water sampling to several fixed and random points was undertaken. Following an in-depth *Pseudomonas aeruginosa* risk assessment, from January 2024, this also

included testing for *P. aeruginosa* in 'higher risk' areas which include ward 1, ward 3 and HDU. The results are reported through the WSG.

The water quality in our hydrotherapy pool is tested on a weekly basis, the tests are undertaken and monitored by our hydrotherapy staff and exceptions are reported to the WSG.

Ventilation

The ventilation safety group (VSG) continues to meet bi-monthly and reports via upward report to the IPC committee. The DIPC is responsible for reporting on activities and recommendations of the VSG to the Quality and Safety Committee which feeds into Trust Board.

As per the requirements set out in HTM 03:01 specialised ventilation for healthcare premises, the VSG is a multidisciplinary group whose remit is to assess all aspects of ventilation safety and resilience required for the safe development and operation of the ROH healthcare premises.

Estate

The IPCT continue to advise and support estates with refurbishments and new building projects within the Trust. This has required attendance at key design and planning meetings and the review of plans and minimum build standards.

During 2023/24 the IPCT have advised on:

Routine programme of ward and theatre closures to allow routine maintenance and deep cleaning to take place.

Refurbishment of Café Royale, the onsite restaurant for staff, patients, and visitors.

Estate challenges are ongoing throughout the theatre complex and orthotics department. These areas are historic buildings that require investment to ensure prolonged use.

Environmental Hygiene (Cleanliness)

Cleaning and environmental decontamination services provided at ROH are undertaken by an in-house team within the Facilities department. These services are provided by a dedicated team of environmental cleaners and an enhanced cleaning team. Environmental cleaners provide cover in all patient areas from 06:00 to 22:00hrs Monday to Friday and 08:30 to 19:00hrs Saturday & Sunday. The enhanced cleaning team undertake all enhanced cleaning and terminal cleaning requests which includes UV-C & Bioquell between the hours 08:30 to 05:30hrs (split over two long shifts) Monday to Sunday.

Training for domestic staff continues to be provided by the housekeeping coordinators which includes the completion of a training manual.

Environmental cleaners are responsible for ensuring that cleaning methodologies are rigorously applied, and frequencies are maintained. All cleaning staff play an essential role in ensuring that the Trust maintain low incidence of HCAI which helps to promote confidence in patients and visitors.

Facilities audit programme:

<u>Star ratings</u>

Star ratings are displayed to give patients, staff, and the public an easily understood visual score of the standard of cleanliness being met. It reflects the cleanliness of a functional area regardless of which staff group is responsible for cleaning each element. Our star ratings are derived from the original audit score at the time of audit. Scores can only be updated following the next full re-audit.

The monthly star ratings are displayed within all patient facing locations displays. This system enables easier administration and allows monitoring to take place. All areas achieved 5 stars at each audit during 2023/24.

Efficacy audits

Annual efficacy audits are designed to assess the process of cleaning and infection prevention and control practices related to cleaning. The audit is carried out by Facilities Management, Infection Prevention and Control and Clinical teams.

Location	Date performed	Scoring %
Ward 1	Jan 23	96.87
Ward 2	Jun 24	99.98
Ward 3	May 24	97.98
Ward 4	June 24	99.97
Ward 12	May 24	95.65
HDU	Aug 24	99.99
Theatres	Aug 24	99.97

Patient led assessment of the care environment (PLACE)

PLACE assessments assist organisations to understand how well they are meeting the needs of their patients and identify where improvements can be made. Assessments were performed over a one-day period with Trust volunteers and uses information gleaned directly from patient assessors to report how well our trust has performed – in terms of national standards and against other similar trusts. Assessments were undertaken on our wards, clinics, out-patient departments, and public areas.

Discipline	National Average	ROH 2023/24	Comment
Cleanliness	98.01	99.62	Above national average
Food	90.23	94.84	Above national average
Organisational Food	90.23	91.84	Above national average
Ward Food	90.23	95.83	Above national average
Privacy, Dignity	84.08	91.62	Above national average
Condition/Appearance	95.79	98.98	Above national average
Dementia	80.60	89.23	Above national average
Disability	82.49	93.66	Above national average

Successes:

An independent cleanliness peer review was undertaken, from this the following was highlighted:

The National Standards of Healthcare Cleanliness 2021 had been implemented.
Good awareness and understanding of decontamination and discharge cleans which are colour coded.
The Environmental Cleaning Services Team were helpful, enthusiastic, and engaged.
The cleaning team's contribution to the areas they work in was acknowledged.
Training records were available, and training was scheduled and not delivered all at once.
Staff had a thorough working knowledge of the varying requirements of respective areas and ward department needs.

Future Plans:

To explore possible chemical free alternatives to cleaning chemical materials, that has limited or zero impact on the environment.
To increase staff training with the safe use of the decontamination Bioquell system.
Review local cleaning training manual, in collaboration with Infection prevention and control team.
Review Environmental cleanliness policy.

IPC Training and Education

The IPC team deliver training sessions year-round according to a training needs analysis.
Mandatory IPC training continues to be delivered in-person (level 1 – all staff) and online (level 2 – clinical staff). Trust compliance is monitored at the IPC Committee.
Ad-hoc, turbo tutorials are delivered by the IPC team in clinical settings to share updates, important messages, and target education on specific subjects.
There is an active link champion programme in place with good engagement from clinical departments. Quarterly in-person link champion meetings are held by the IPC team.
Engagement and training undertaken by the IPCT during 2023/24:

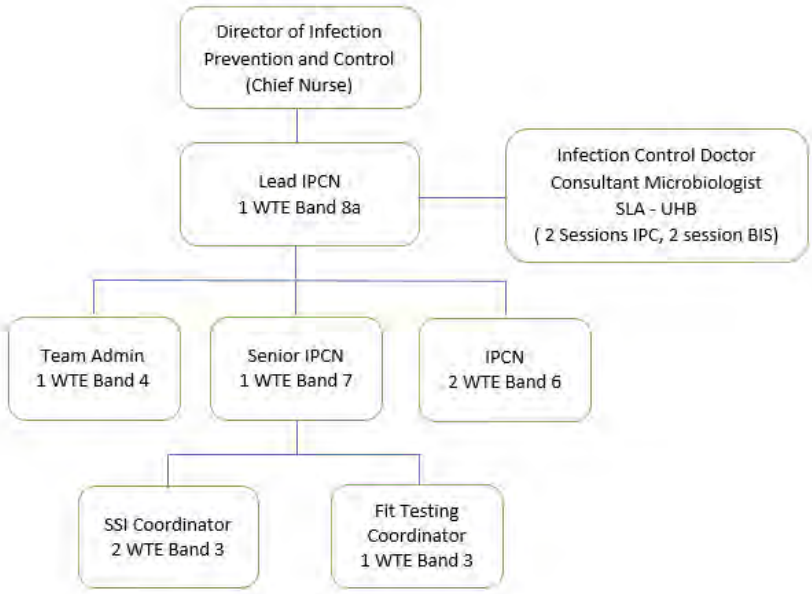
- Facilitated quarterly meetings for IPC link champions (from each ward and department).
- Continued to utilise educational 'grab packs' for hand hygiene, Influenza, MRSA, PPE, and CPE across ROH to support staff with effective application of theory into practice within their areas of work.
- Continued to work collaboratively with suppliers, estates, and facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment, or processes.
- Continued to facilitate communication of key messages via several media methodologies including social network, newsletters, and emails.
- Facilitated the national antibiotic awareness and hand hygiene days across ROH.

Governance and Assurance Arrangements

The IPC team support the Trust in meeting its obligations under the Health and Social Care Act 2008 code of practice for prevention and control of infections and related guidance and other relevant legislation and guidance from, for example, the Department of Health and Social Care, UKHSA, and the Care Quality Commission. The service is led by the Lead Specialist IPC Nurse, (holding a formal qualification in IPC) with the Chief Nurse as director of IPC (DIPC) and executive lead.

The team operates between the hours of 08:30 and 16:30hrs Monday to Friday (except bank holidays). The Trust has 24-hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospitals Birmingham (UHB).
A Consultant Microbiologist is the designated Infection Prevention and Control Doctor (IPCD) which is also provided via an SLA with UHB. This allows for the weekly allocation of 2 programmed activities (PAs) of Infection Control Doctor time. Cover for leave of absence of the IPCT and out of hours service is provided by the on-call Microbiology team at UHB which is covered in the SLA.
ROH do not have access to an onsite laboratory. Laboratory services are provided by UHB which has purpose-built laboratories onsite at both The Queen Elizabeth Hospital and Heartlands Hospital where ROH samples are processed. The UHB microbiology laboratory has full (UKAS)

accreditation ISO Standard 15189. ROH has electronic access to microbiology results to facilitate prompt identification and response.
Occupational Health services are provided via an SLA by UHB. Occupational Health (OH) staff from UHB provide one session (1 day) per week to support the OH requirements of ROH staff. The OH team carry out preplacement health assessment and immunisation needs, skin health surveillance (from referral) and management of inoculation injuries.
The IPC service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients, and visitors. The main objective of the annual programme is to maintain the high standards already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPC committee.



During 2023/24, the IPC team took part in the following development opportunities:

Lead IPC Nurse began a master's course in IPC at Dundee University.
Lead IPC Nurse began a DIPC development course.
Senior IPC began the internal nurse leaders development programme.
An away day to review previous year's performance and plan for the year ahead.
Several Infection Prevention Society study days attended focusing on key topics that benefit service provision at ROH.
SSI team undertook annual SSI surveillance training refresher provided by UKHSA.
During February 2024, the whole IPC team participated in a day's Water Safety Training, facilitated by the water authorised engineer.
Instigated monthly journal clubs to discuss new and emerging research, evidence related to IPC to inform continuous improvement.

Governance

A bi-monthly Trust Infection Prevention and Control Committee (IPCC) is chaired by the Chief Nurse and reports to the Trust Board. It receives regular reports and updates from each Clinical Group and the following sub-committees:

- Water Safety Group
- Ventilation Safety Group
- Antimicrobial Stewardship Group
- Surgical Site Infection Surveillance Group

The IPCC also receives updates from our regional UKHSA Advanced Health Protection Nurse, Integrated Care Board IPC lead, estates, facilities, and UHB Occupational Health team.

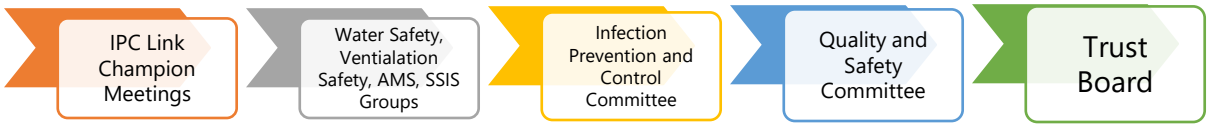
Assurances associated to Trust IPC matters is provided three times a year by the DIPC to the Quality and Safety committee, which reports directly to Trust Board. Any interim exceptional reporting to the Trust board is undertaken via existing reports from the Chief Nurse's Office.

To keep IPC high on the agenda the IPCT regularly attend and champion IPC at relevant groups, committees, and forums.

Improved communication and patient flow lead to positive outcomes for patients and their families when the system works together. The IPCT have been actively engaged in maintaining and expanding networks locally, regionally, and nationally. This has included:

- Regional and national meetings with NHS England.
- Birmingham and Solihull system IPC Meetings.

No external reviews of IPC practice were undertaken during 2023/24.



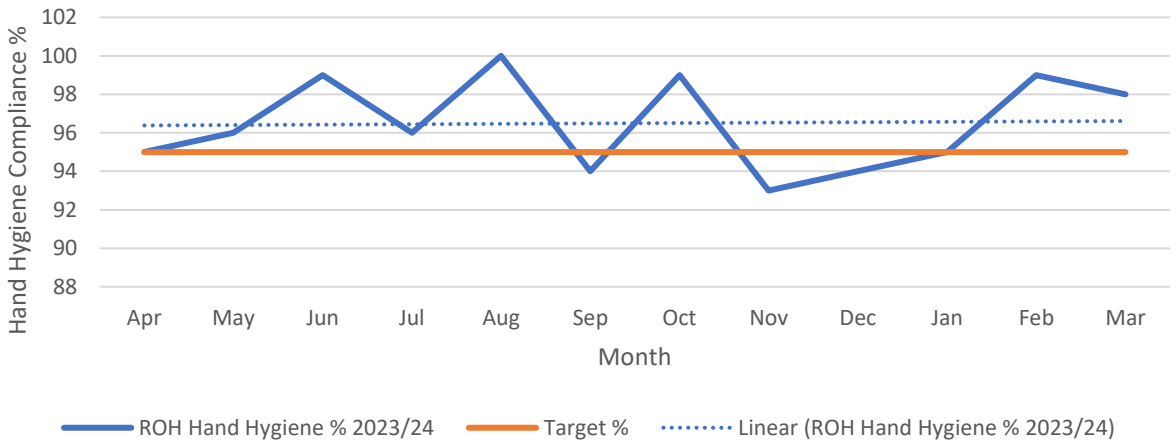
Assurance

The IPC audit programme demonstrates compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. Audits are undertaken by both clinical teams, as self-assessments and the IPCT, as assurance of practice and data validation. Where additional risks are identified or upon the declaration of a period of increased incidence/outbreak, the IPCT undertake additional audits, outside of the routine programme, in accordance with risk requirement.

Action plans are devised by the departments where issues are highlighted, and completion of these are monitored within the responsible division and reported on at fortnightly divisional governance meetings. Details of audits undertaken by clinical areas and associated actions are upwardly reported by the divisional Head of Nursing to IPCC by exception or to champion good practice. Details of audits undertaken by the IPCT are included in the IPC summary report provided by the Lead IPC Nurse at the IPCC.

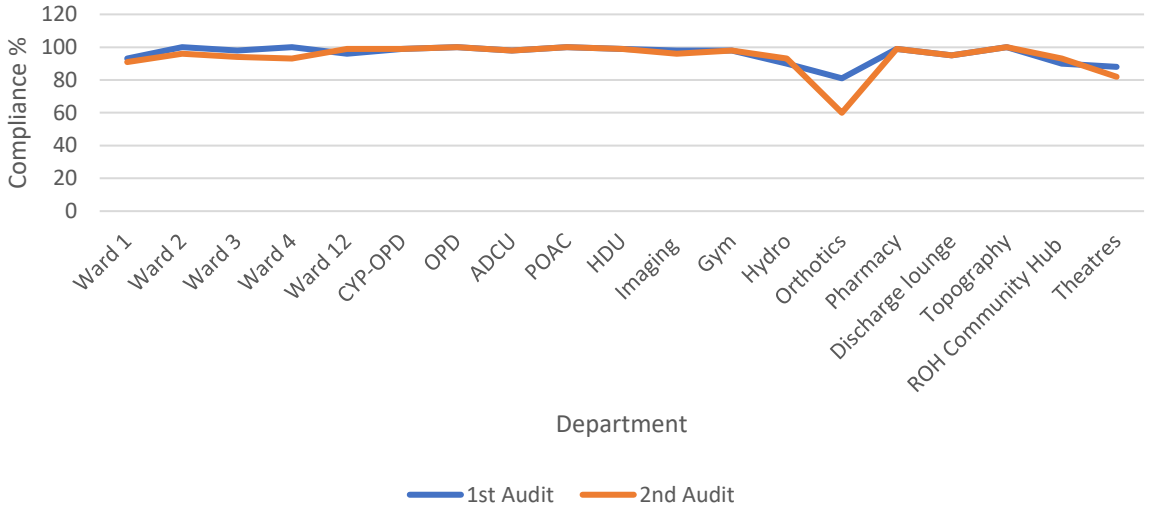
Hand hygiene (inc. bare below the elbows) and Personal Protective Equipment:

Overall compliance from hand hygiene auditing was 96%, this is a 2% reduction from 2022/23. Audits undertaken by IPC nurses showed a lower level of overall compliance rate at 90%. This is in part due to the competence of those undertaking the audit and audit bias (observation, observer, and selection bias). Overall compliance from PPE audits undertaken by the IPC team was 91%. Work to address hand hygiene and PPE compliance is a 2024/25 priority for the IPC team, with the intention of introducing formal hand hygiene and PPE training for all staff and audit training for link champions.



IPC Practice Audit:

All clinical areas are audited by the IPCT in conjunction with facilities and estates every 6 months. A RAG based scoring system is used and a formal process for audit escalation followed should an audit fail. This involves escalation to senior management within the division, re-audit within a specified time frame (dependent upon severity of findings) and feedback of corrective actions/measures taken to address issues. All audits that fail (<95%) have improvement recommendations made and are re-audited until compliance achieved, however re-audit figures are not included in the chart below. There are ongoing estates issues within the theatre and orthotics departments that continue to bring down the departments IPC audit compliance scores.



Policy

All IPC policies, guidelines and standard operating procedures are available for staff to view via the Trust intranet. There is a formal governance structure in place for reviewing and ratifying such documents within the Trust and the corporate governance team produce a directory of documents alerting lead authors when policies are due for review. Policies are also updated prior to review date if national guidance or evidence base is updated/changed. All polices are agreed and approved for use at the IPCC (if minor or no change) or Quality and Safety Committee (if the changes are major or introduction of new policy).

The Trust has adopted the new NHS England National Infection Prevention and Control Manual (NIPCM) to guide its policies and procedures.

During 2023/24 the IPCT reviewed and/or updated the following polices:

MRSA Policy
Chickenpox and Shingles Policy
Staff Immunisation Policy

The following polices/documents were removed as they were deemed no longer relevant or included within existing polices:

Transfer of infected patients policy
HCAI incident reporting and management SOP (replaced by PSIRF)

Risk

The IPC board assurance framework has been updated throughout 2023/24. Actions arising from the framework are monitored via the IPC committee.
IPC risks are included on a risk register which is reviewed bi-monthly at the IPC committee.
Three risks were closed during 2023/24:

- May 2023 – risk relating to the lack of capacity within the IPC team to undertake SSI surveillance. This was closed as the vacant roles were fully recruited to and staff trained to undertake surveillance.
- May 2023 – Risk relating to lack of access to adequate respirator protection was closed as the Trust procured 28 respirator hoods.
- December 2023 – risk relating to IPC team IT Issues and inability to access the UKHSA HCAI data capture system was closed as IT has fixed a long-standing issues which meant the IPC team can log reportable infections with ease and on time.

Two new risks were added to the IPC risk register:

- January 2024 - risk relating to the lack of staff immunisation policy and assurance of staff immunisation status. The IPC team created an immunisation policy that was approved and signed off at the IPC committee. Ongoing work with the occupational health team improved communication and working process to ensure the sharing of information when required. Risk mitigated at present.
- January 2024 - risk relating to an increasing number of 'missing' specimens or lack of results. No formal process in place for tracking clinical specimens from department to lab. Head of Facilities looking into this to identify as possible solution.

Annual Plan

Operational priorities for the IPC service over: 2023-2026:

Innovation and patient safety

Review and refresh the infection prevention and control training programme to ensure it remains responsive to both national and local requirements.
Ensure that a robust infection prevention and control audit programme is in place which has the ability to measure infection prevention and control practice in all clinical settings.
We will explore opportunities to participate in quality improvement initiatives to underpin IPC related practice and improve patient experience.

Be committed to the identification, implementations and promotion of innovations which drive forward improvements in infection prevention practices.

Optimising antimicrobial treatment

Produce and implement an educational programme to engage the workforce in AMS.
Ensure prescribers have access to up-to-date user-friendly Trust antimicrobial guidelines.
Create educational materials for patients to raise awareness on AMS.

Providing a clean, safe care environment

Ensure all parts of the premises are suitable for their intended purpose, kept clean and maintained in good physical repair and condition.
Ensure environmental cleaning is carried out and maintained in accordance with the National Cleaning Standards.
Ensure water safety is embedded and all necessary risk assessments are reviewed annually.
Explore the use of technology to assist with cleaning assurance processes.

Collaborative working

Receive consistently positive patient feedback relating to IPC and cleanliness standards.
Continue to share learning with regional partners and learn from others by the continued attendance at BSOL ICB and West Midlands NHSE meetings.
Contribute to regional and national IPC collaborative workstreams, working alongside local Trusts and commissioners to improve and align IPC services.
Develop a communications plan for the IPC service collaboratively with the Trust communications team.
Explore ways to diversify the way we communicate with staff.

IPC buisness plan (planned activities that will form the annual programme of work) for 2024/25, mapped against our Trust strategic objectives:

Strategic objectives	Quality / service improvement
Care	Develop a ROH specific SSI prevention bundle – six key priorities to promote and support the adoption of best practice to prevent SSI throughout the patient's surgical journey.
	Revisit fundamentals of care – linked to ward accreditation on the following topics: Mouthcare Hydration
Expertise	Full review of IPC related training and education in line with the NHS England IPC Education Framework, developing innovative ways to deliver IPC training.
	Participate in IPC related quality improvement projects and share finding at regional and national events.
People	Invest in the development of the IPC team, to provide an expert service to the ROH.
Community	Work closely with patient engagement services to identify patients views of IPC within the Trust and utilise their feedback to inform future practice/priorities and identify better ways to engage with them to share IPC related information.
	Promotion of vaccination campaigns to our local communities.
Services	Develop surveillance methods and databases to track HCAI trends and themes.
	Be an integral member of the Trust Green Forum and advise on projects involving IPC that can contribute to sustainability. Reducing negative environmental impact from IPC related practices. Review and reduce the need for single use plastics and single-use items where safe to do so. Explore opportunities to reuse items and identify eco and staff/patient health friendly alternatives for cleaning products currently used.
Collaboration	Set up an IPC collaborative group with Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) to share practices, provide peer support, peer review capabilities and sharing of learning/best practice.

Conclusion

Overall, our success is measured by our compliance with the Health and Social Care Act 2008 code of practice for the prevention and control of infections, which encompasses all aspects of infection prevention and control, including management systems, environment, cleaning, training, and policies to protect patients and staff.

During 2023/24 the IPC team has continued to lead and innovate, successfully delivering the IPC programme to reduce HCAIs, with an improved recruitment position compared to 2022/23.

The focus for the IPCT and the Trust remains on improving and maintaining infection prevention and control practices, supporting patient care pathways across the health economy, and enhancing and improving clinical practice. The IPCT will continue to undertake robust reviews and scrutiny of each case of infection, working with colleagues and clinicians, to identify learning and ensure the continued high standard of patient care.

It is clear IPC specialists lead the way in ensuring our staff and patients safety. We must continue to evaluate and consider each step to ensure that patient safety remains at the forefront, as well as the wellbeing of our staff, who continue to rise to the challenge.

Related Documents

Department of Health (DOH) The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance. The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (publishing.service.gov.uk)

WHO access, watch, reserve, classification of antibiotics for evaluation and monitoring of use. 2021 AWaRe classification (who.int)

Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan. Tackling antimicrobial resistance 2019 to 2024 (publishing.service.gov.uk)

Protocol for the Surveillance of Surgical Site Infection Surgical Site Infection Surveillance Service Version 6 (June 2013) Protocol for the Surveillance of Surgical Site Infection version 6 (publishing.service.gov.uk)

NHS England (2022) National Infection Prevention and Control Manual for England. NHS England » National infection prevention and control manual (NIPCM) for England

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2024 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Stephen Washbourne, Chief Finance Officer, AEO SIRO**
AUTHOR:	**Mr Stuart Lovack, Deputy Director of Delivery**
DATE OF MEETING:	**5th February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

The Trust through the 'Self-assessment' and 'Check & Challenge' process reviewed itself against the Core Standards (CS) and identified 33 areas of partial compliance.

The 33 areas of partial compliance against the 2024 EPRR core standards relate to:

Governance – CS3 & CS5
Risk – CS7
Duty To Maintain – CS13, CS14, CS17 & CS18
Command & Control – CS20 & CS21
Training & Exercising – CS22, CS23 & CS24
Warning & Informing – CS34, CS35 & CS36
Co-operation – CS39
Business Continuity – CS44, CS45, CS47, CS48, CS49, CS50, CS51, CS52 & CS53
CBRN – CS55, CS56, CS57, CS58, CS61, CS63, CS64 & CS68

This year the deep dive focussed on 'Cyber Security' the 11 areas of partial compliance identified were:

D01 Incident Preparedness
D02 Incident response arrangements
D03 Resilient Communication
D04 Media Strategy
D05 Testing & Exercising
D06 Continuous Improvement
D07 Training Needs Analysis
D08 EPRR Training
D09 Business Impact Assessments
D010 Business Continuity Management System
D011 Business Continuity Arrangements

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

Due to the specialist Orthopaedic nature of the Trust, there will be areas listed above where the Trust will be challenged in achieving full compliance, these will be discussed with the ICB/Regional Team throughout 2025.
The areas of partial compliance listed above form part of the Trust's 'action plan', addressing these issues will move the Trust towards better compliance with the EPRR Core Standards. The key focus for 2025 will be Governance, Warning & informing, Business Continuity and CBRN compliance.
The overall timescale identified for completion of these areas (where achievable) is six months; a project lead has been identified.

Flood Post Incident Report

Additionally the September Flood post incident report is attached for your information

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Trust action plan in place to address the issues identified. The key focus for 2025 will be Governance, Warning & Informing, Business Continuity and CBRN compliance.	The Trust has 33 areas of partial compliance, most of which remain difficult to achieve full compliance given the nature of the Trust.

REPORT RECOMMENDATION:

The BOARD is asked to: note the content of this report which has been assessed against the 2024 NHS Core Standards through the 'Self-Assessment' and 'Check & Challenge' process, noting the actions being taken to address the areas where EPRR compliance and Cyber Security compliance needs to be strengthened.

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

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

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

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

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

Safe, efficient processes that are patient centred.

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

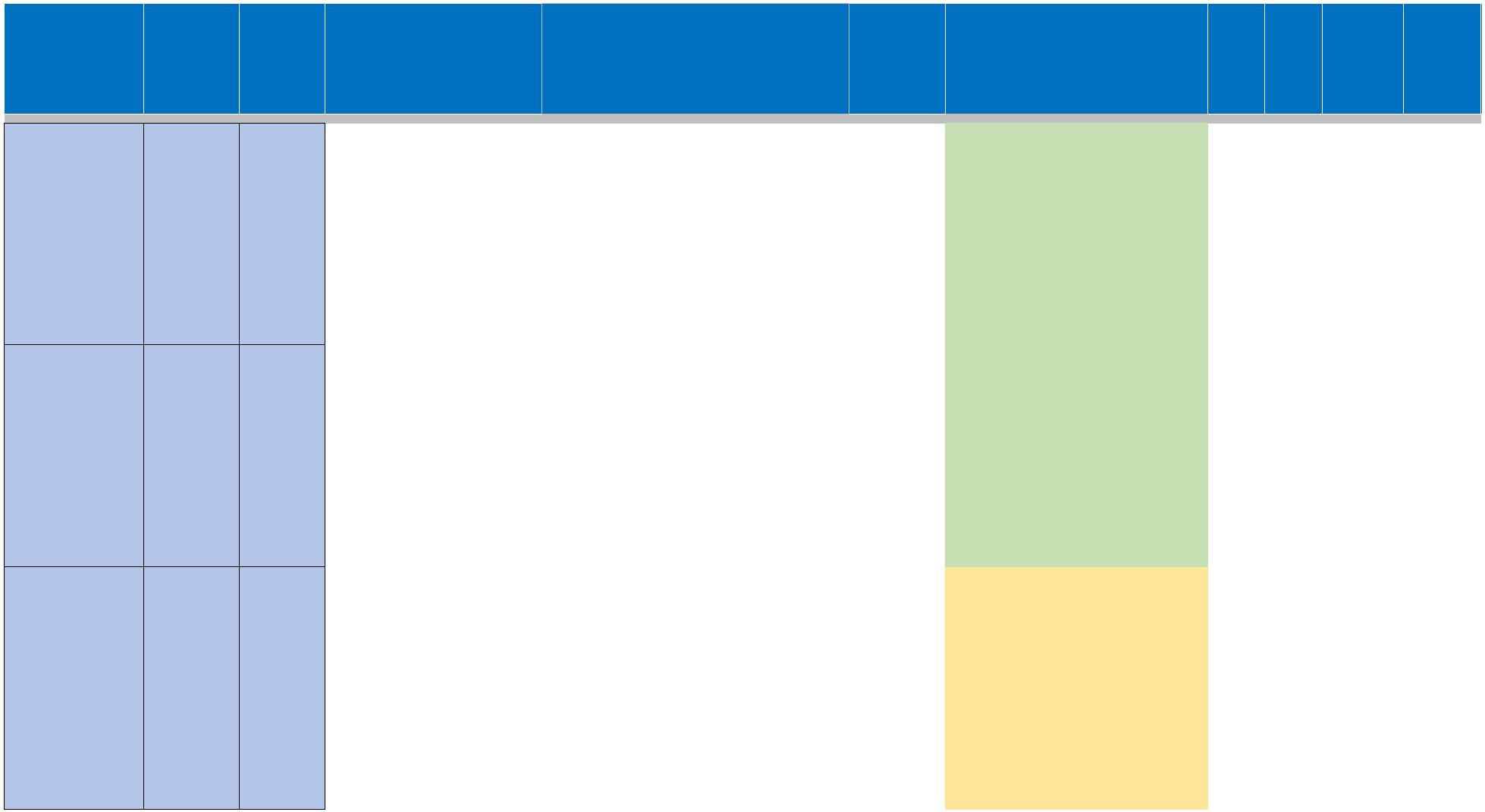
None specifically.

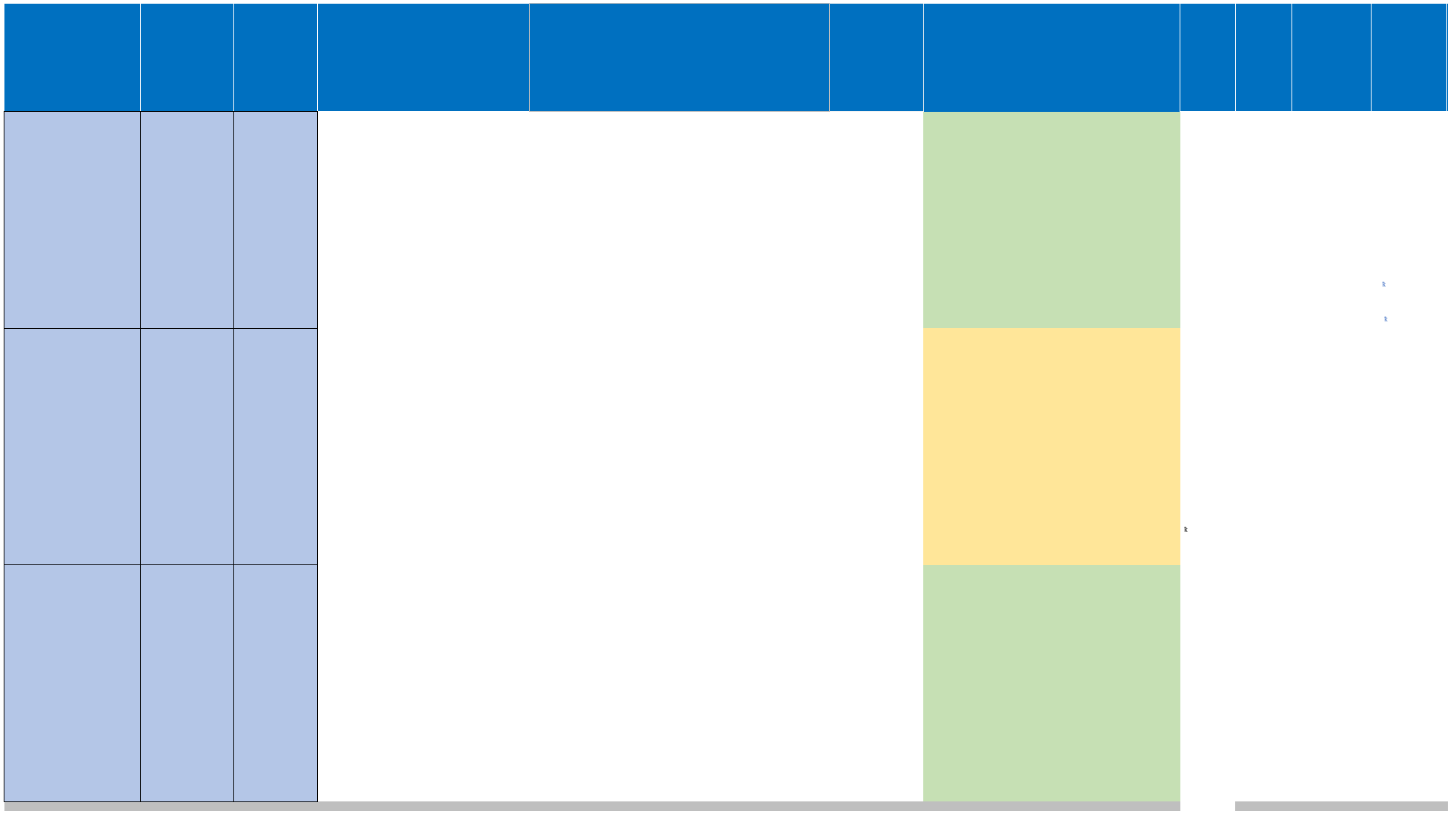
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**

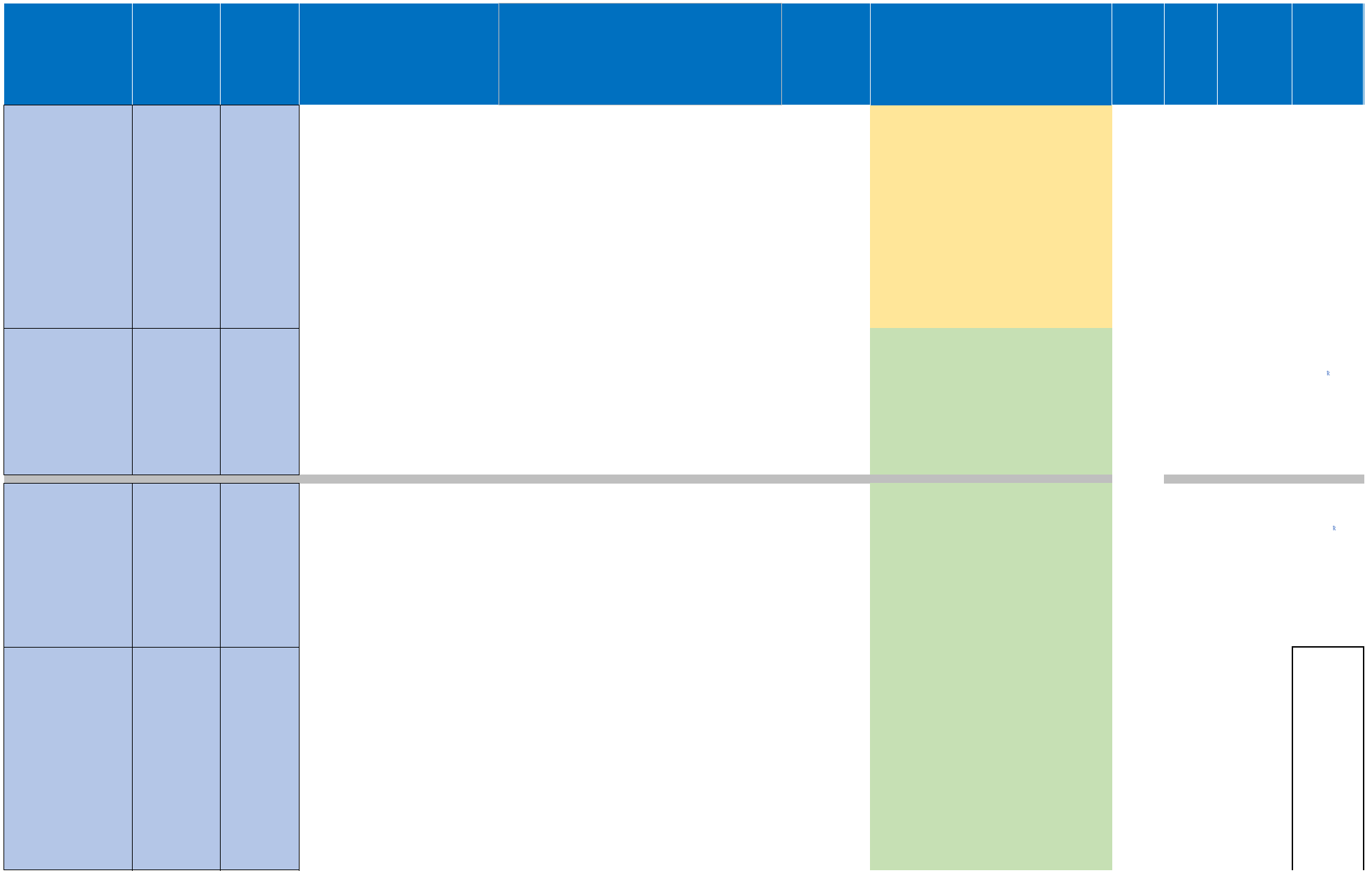
None specifically.

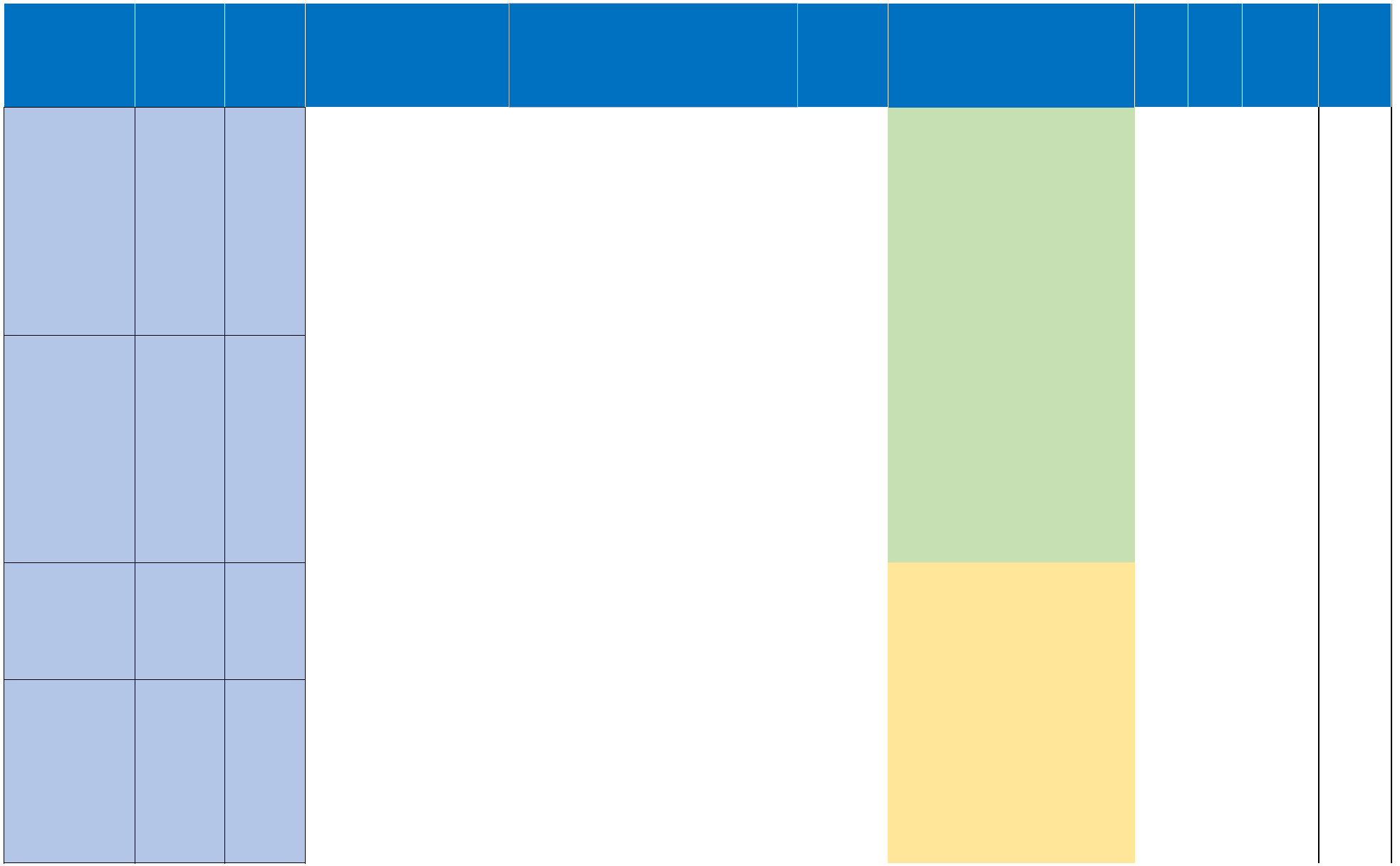
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**

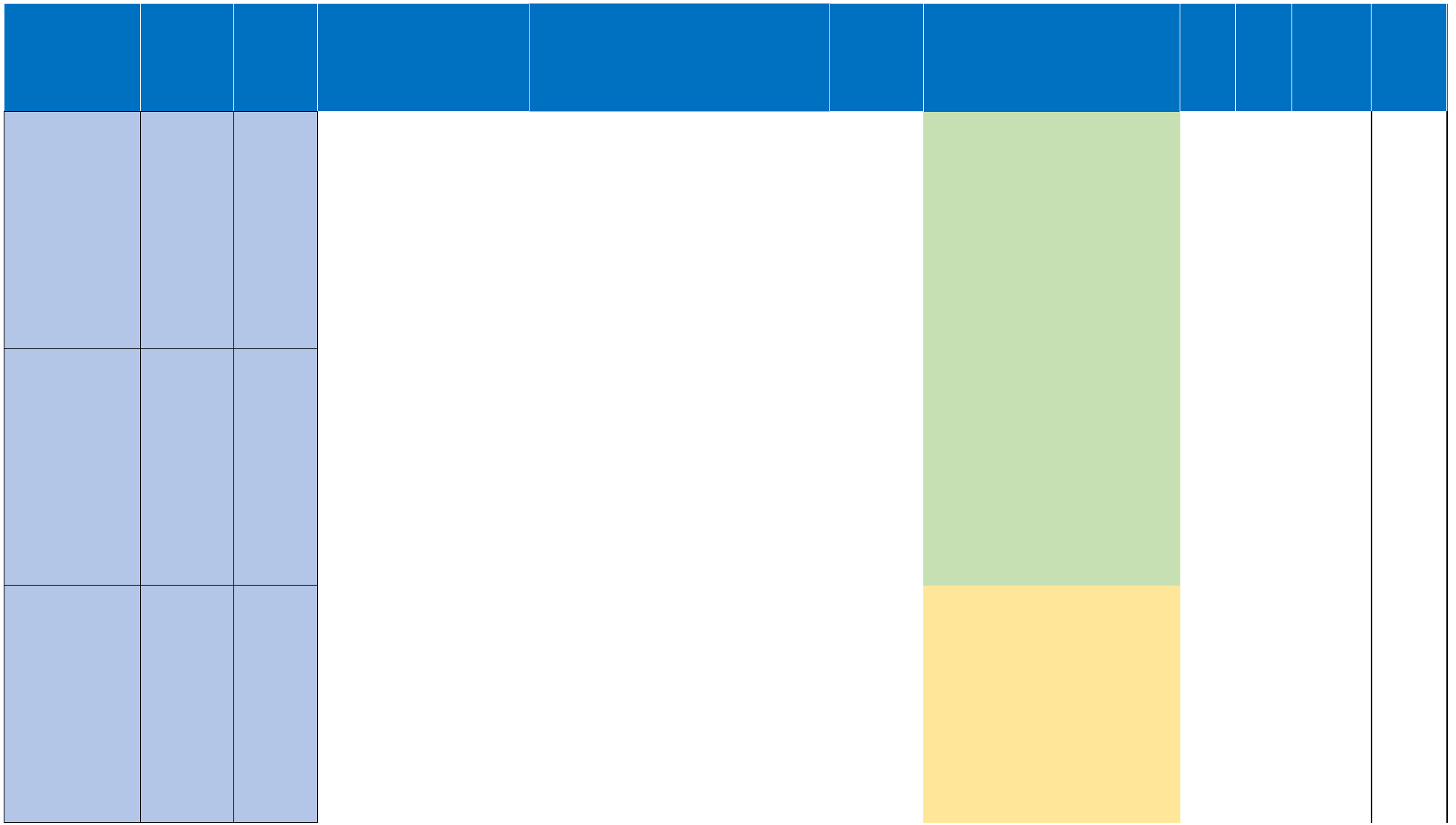
Trust Board Meeting September 2024

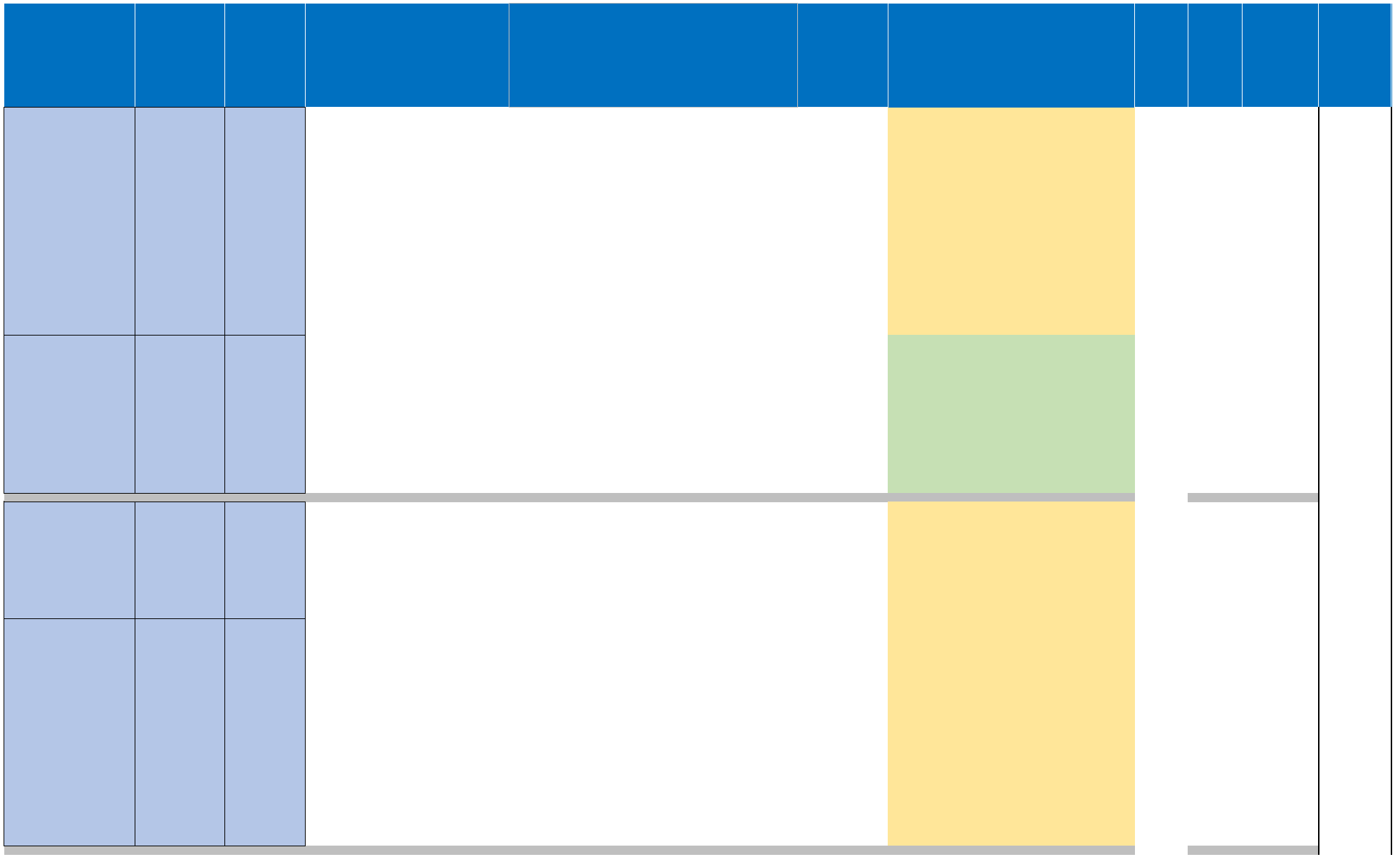


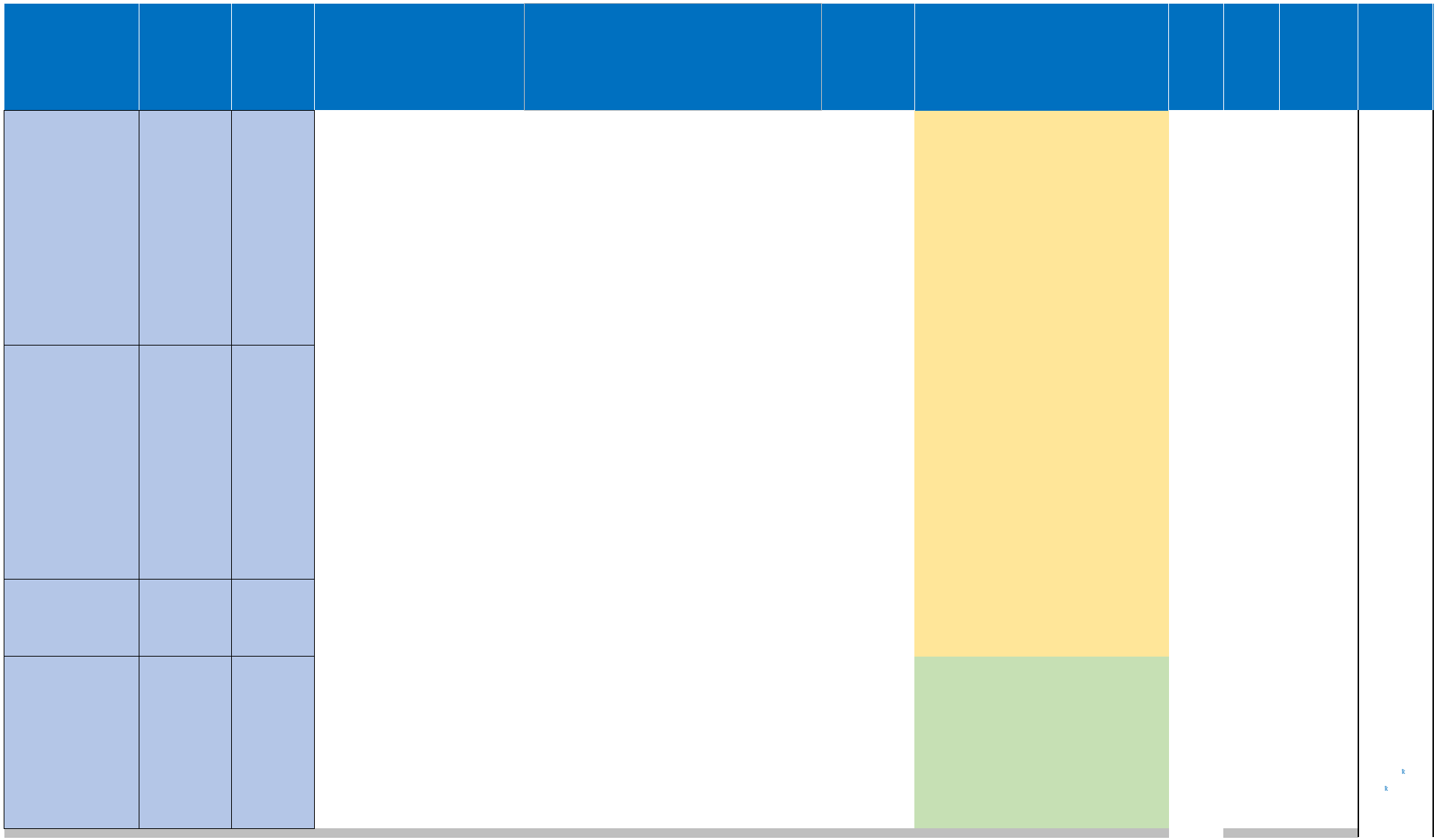


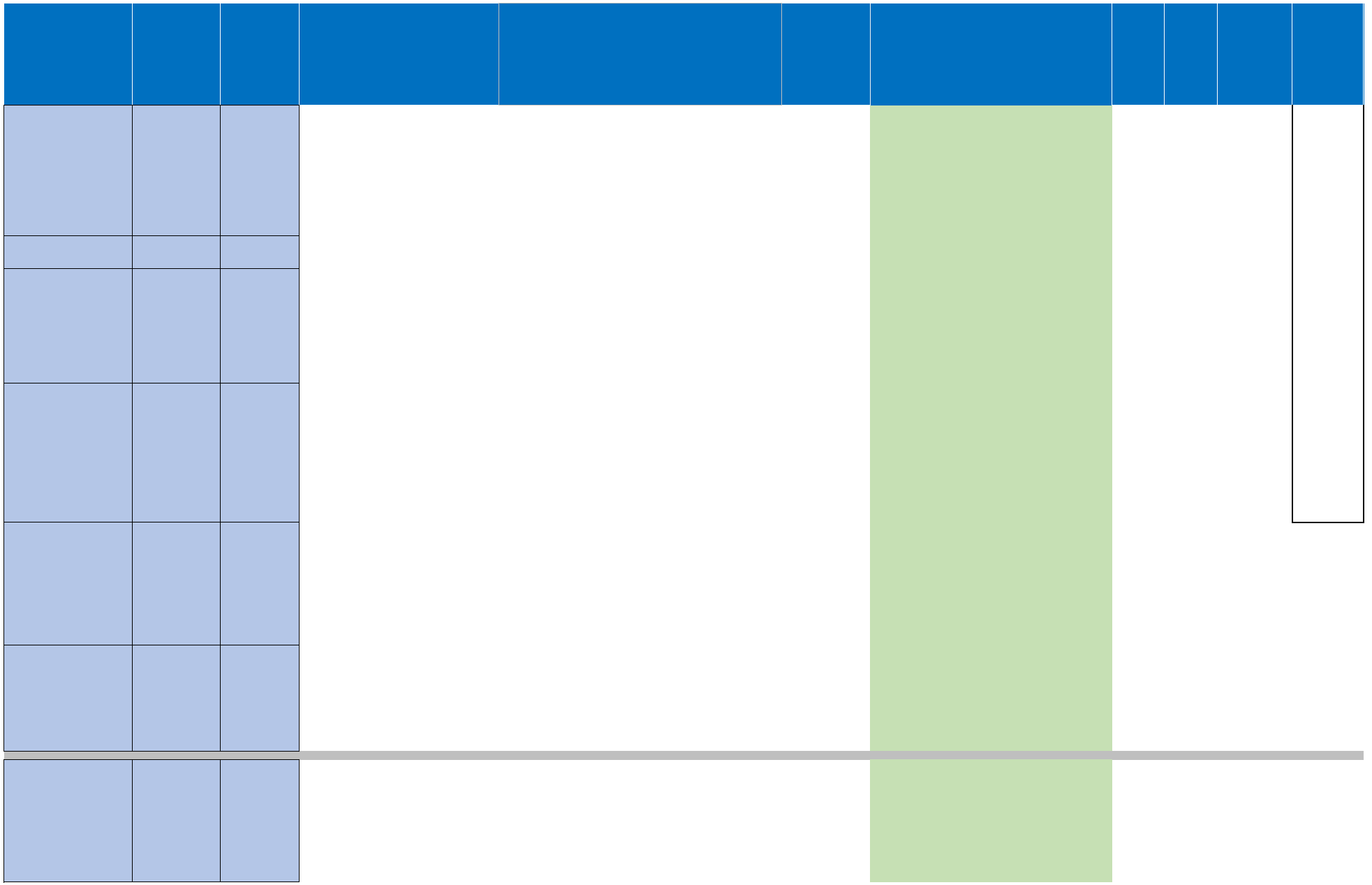


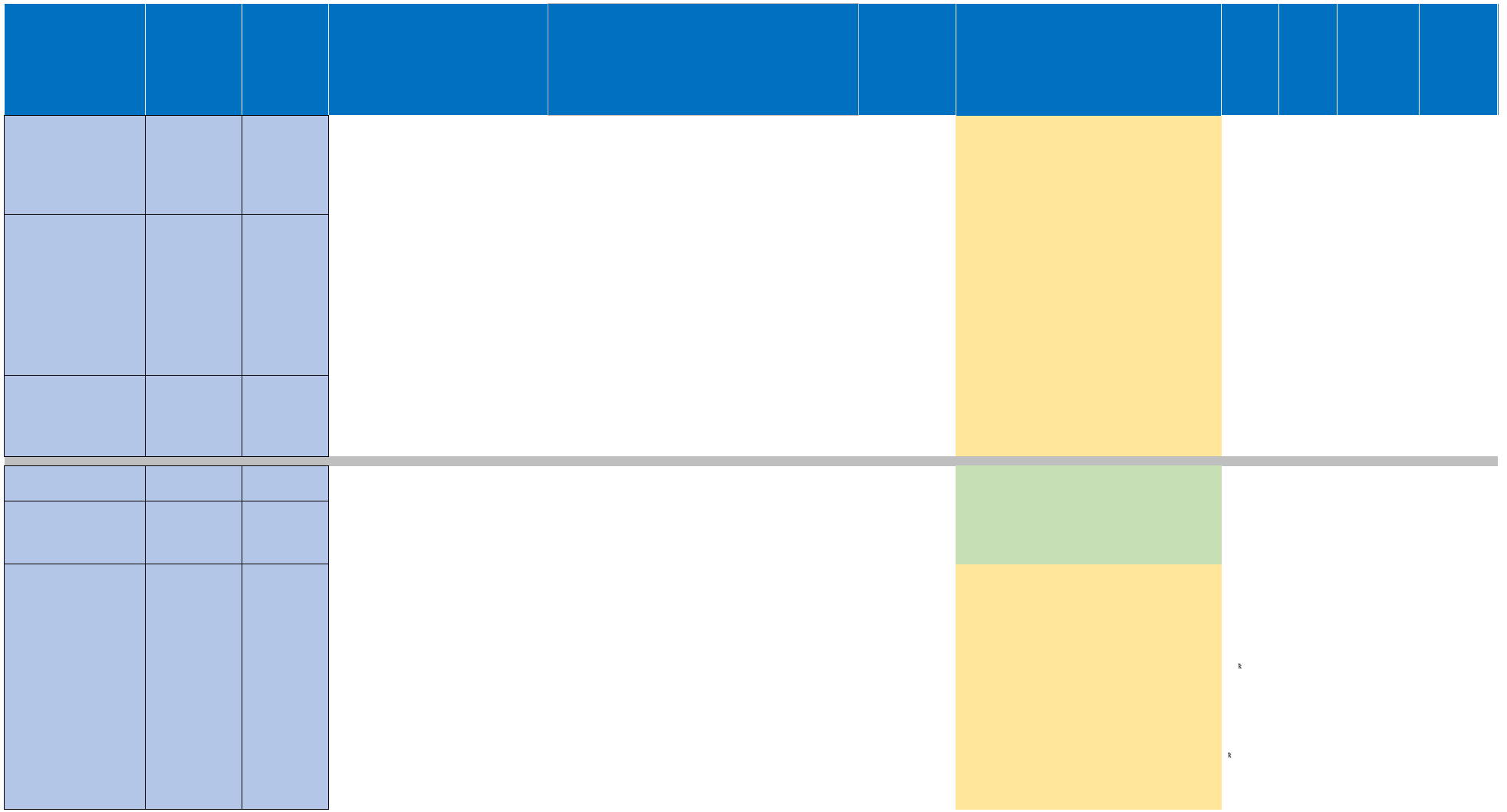


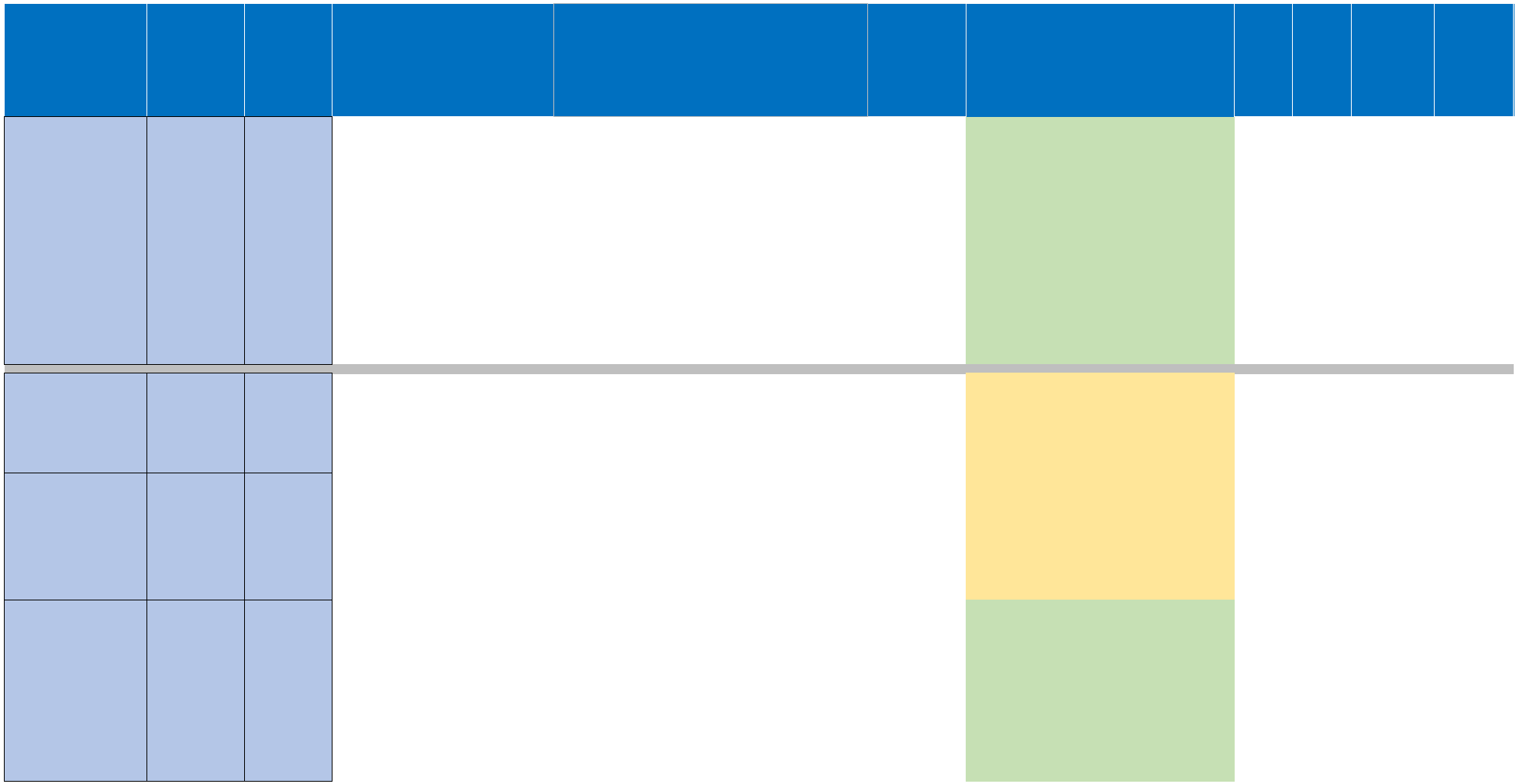


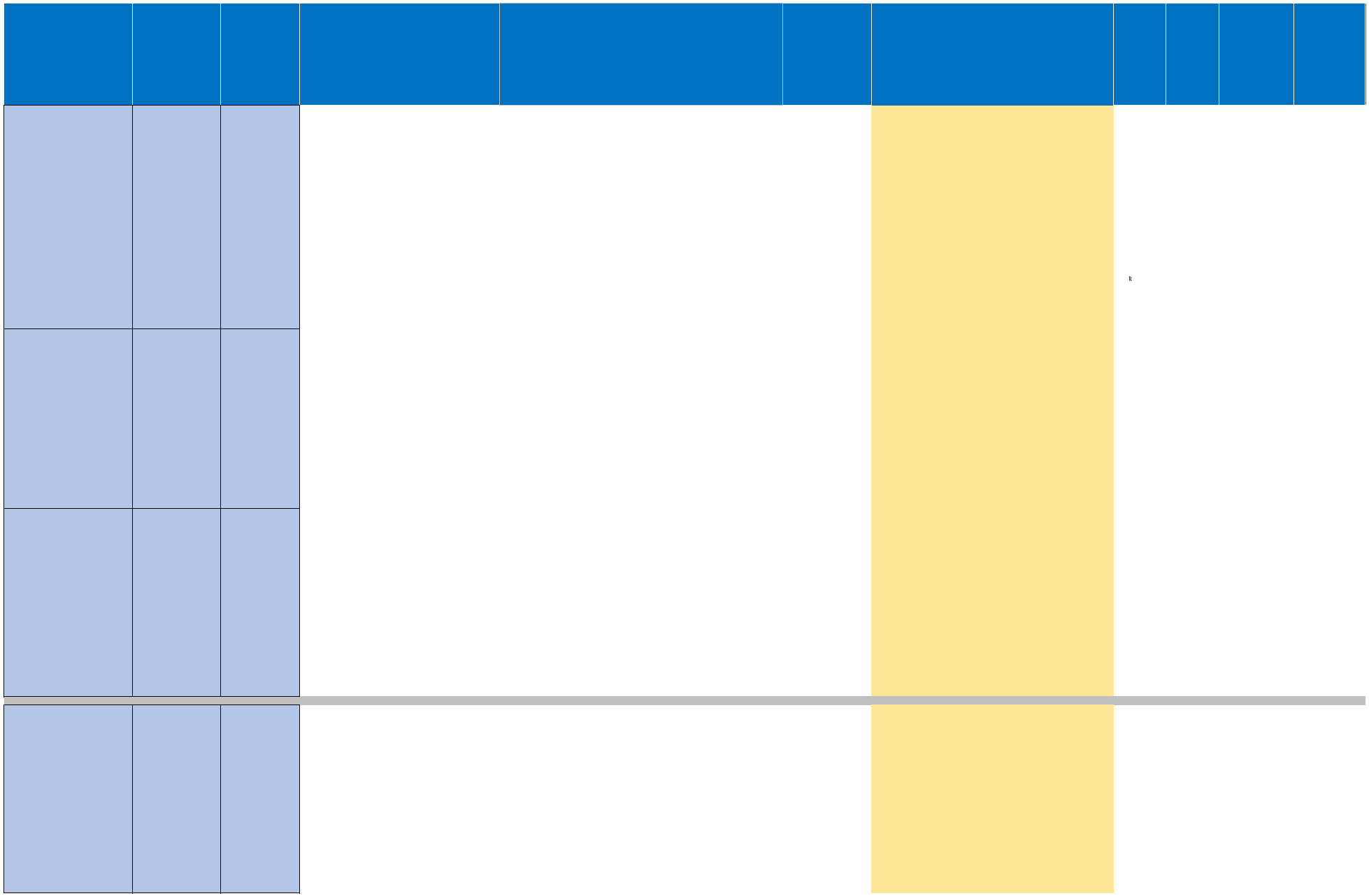


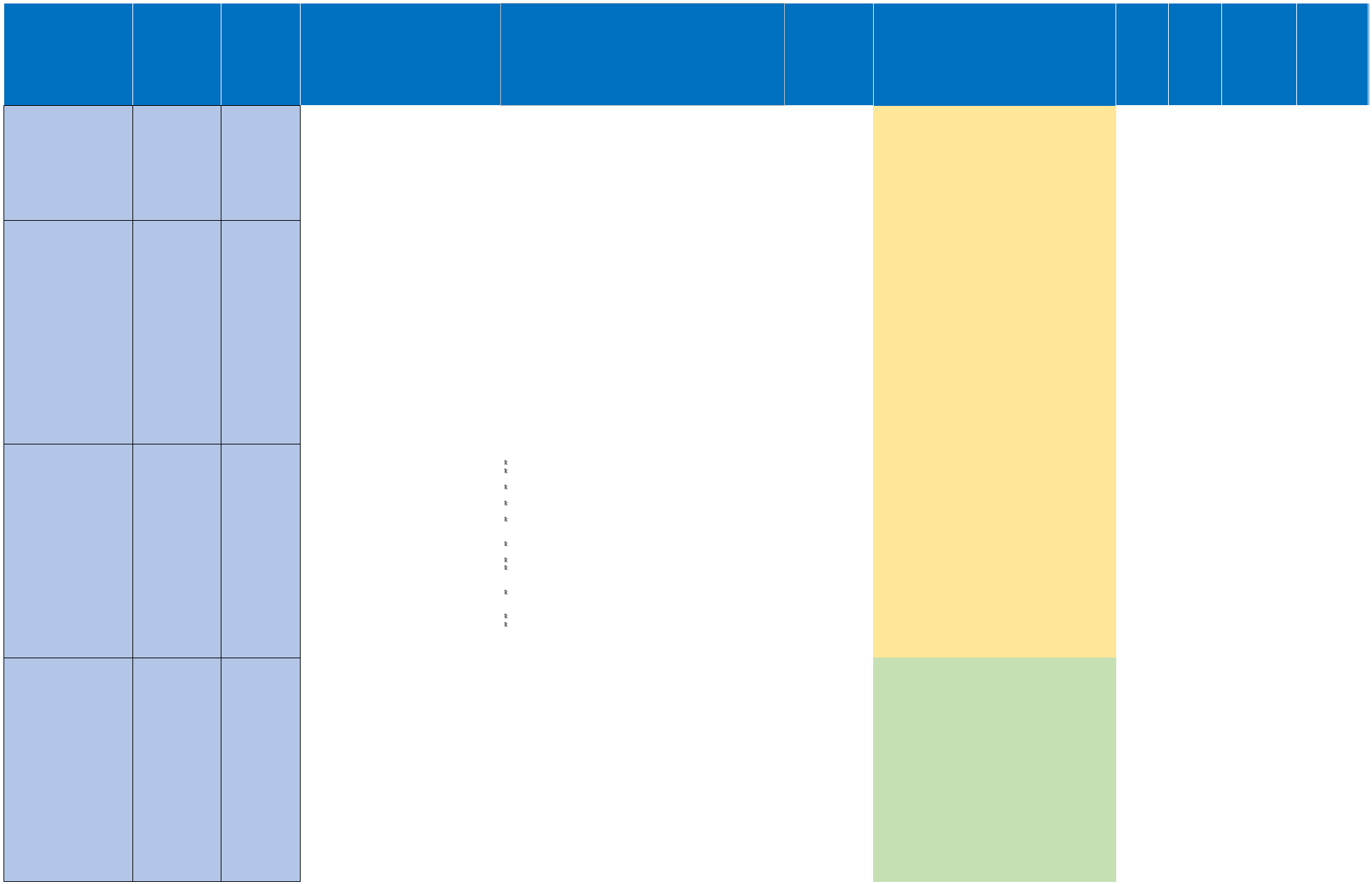


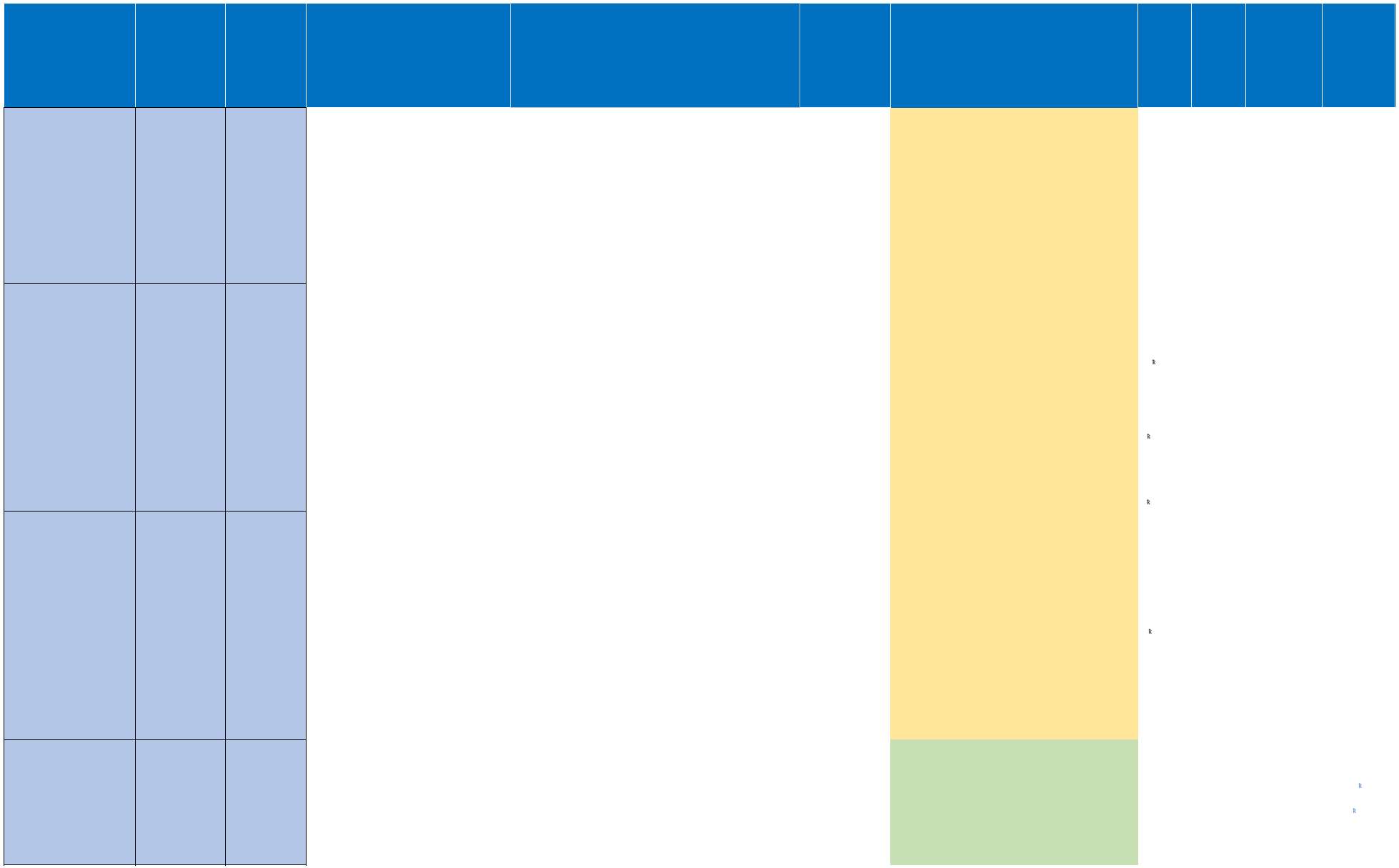












NHS England Midlands

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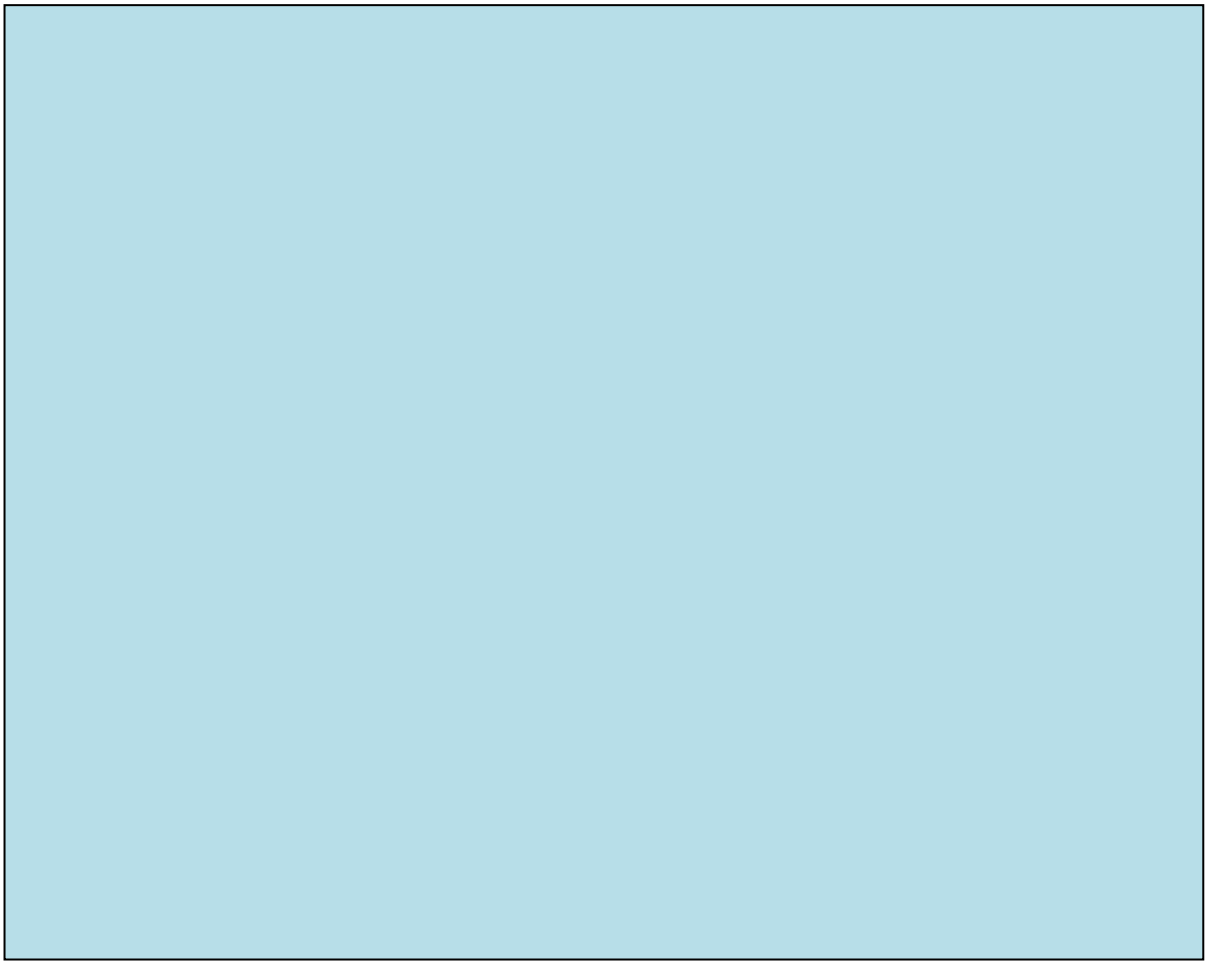

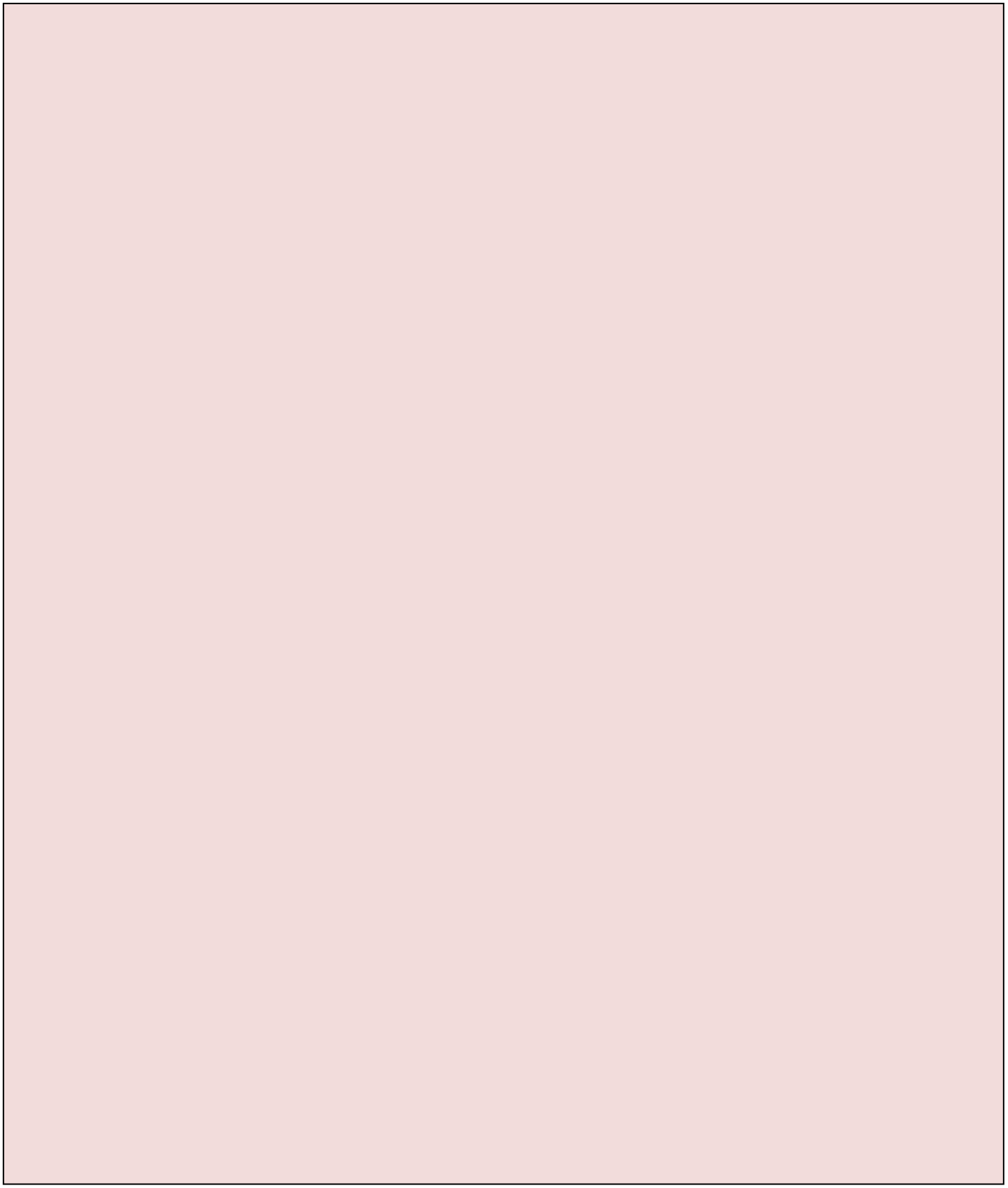

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NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Imaging and radiation safety report**
SPONSOR (EXECUTIVE DIRECTOR):	**Marie Peplow, Executive Chief Operating Officer**
AUTHOR:	**Liz Loach, Head of Imaging**
DATE OF MEETING:	**5 February 2025**

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 give assurance that Radiation safety remains a priority within the Imaging Department and that it is committed to keeping exposure to ionising radiation as low as reasonably practicable. The paper will also update the committee on the service status in imaging and includes matters relating to patient and staff safety and experience in imaging.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Continue to meet internal and national performance targets – DM01 consistently above 99% Staff and Environmental monitoring are compliant against national standards Policies reviewed and up to date	Consultant radiologist vacancies Radiographer vacancies Ageing equipment

REPORT RECOMMENDATION:

The Board is asked to:
Be assured that all Imaging equipment is serviced and maintained to Equipment manufacturers specifications and radiation safety checks are completed by RRPPS. When errors occur, RRPPS are informed and provide dose assessments with recommendations if error is reportable externally. There is shared learning within the imaging team to prevent re-occurrence when radiation issues arise.

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**	

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

1841 - CT replacement is on Divisional and Local Risk registers, X-ray rooms (2020,2080) and portable equipment (2081) on Local Risk register with monthly reviews. Oncology Risk 2015 and Imaging Risk 2082 - Radiologist Shortage.

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**
RRPPS gave assurance that radiation incidents at the ROH do not exceed numbers of other hospitals within their jurisdiction (most of the West Midlands hospitals) and that the Imaging Team are responsive when issues occur.
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**
Quality & Safety Committee January 2025

IMAGING AND RADIATION REPORT

Data Jul 2024 - Dec 2024

Liz Loach
Head of Imaging

CONTENTS

Introduction

The purpose of this paper is to give assurance that Radiation safety remains a priority within the Trust and that the Imaging Department it is committed to keeping exposure to ionising radiation as low as reasonably practicable. The paper will also update the Committee on the service status in Imaging and includes matters relating to patient and staff safety and experience in Imaging.

The guiding principle of radiation safety is "ALARA," which stands for "as low as reasonably achievable". This means that if there is no direct benefit from receiving radiation, even a small dose should be avoided.

1.0 Radiation safety, Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiations Regulations 2017 (IRR17)

1.1 Radiation Protection Adviser (RPA)

It is essential that the Trust consults an RPA on matters relating to IRR17. Local rules (Appendix A) have been prepared to satisfy the IRR17 regulations. The RRPPS provides this service, and our RPA is currently Mrs E Larkin.

1.2 Radiation Protection Supervisor (RPS)

As service lead, Liz Loach has been appointed as the lead Radiation Protection Supervisor, alongside the X-ray/CT Team Leader after completing training in October 2024. As the Lead RPS she will monitor compliance with IRR17.

1.3 Radiation Safety Advisory Group

Meetings are held bi-annually with RRPPS. The last Radiation Safety Advisory Group (RSAG) meeting was July 2024. This provided assurance that all equipment is being checked and any identified issues are actioned in accordance with ionising and non-ionising regulations.

1.4 Staff monitoring

All clinical staff working in x-ray and the injections suite are monitored. During this reporting period (July – December 2024) no members of staff have received an unintentional dose reading outside of national guidance. A report has been implemented internally for the ease of Dose Monitoring results sent from RRPPS which allows the RPS to keep track of any doses for each member of staff.

1.5 Environmental Monitoring

All x-ray rooms should be monitored intermittently for dose assessment. The latest room to be monitored was CT which covered the period June-October 2024. This showed a projected Annual Dose of <0.1 mSv (recommended is <0.3 mSv), therefore no concerns have been identified and demonstrates compliance against national standards. All other rooms are compliant and have been monitored as per RRPPS schedule.

1.6 IR(ME)R 2017

As a result of amendments to IR(ME)R 2017 which came in to force from October 2024, the following changes were made:

a new requirement for co-operation between employers when there are multiple employers involved in the delivery of exposure to an individual

strengthened employers' responsibilities regarding general procedures and protocols, clinical audit, and accidental or unintended exposures to safeguard patient safety

updates to definitions of commonly used terms to minimise confusion and resolve any potential ambiguity in interpretation

clarifications regarding consent for individuals lacking capacity or competence

The above amendments have been updated in the local rules. There are new processes regarding Comforters and Carers being implemented following amendments from regulation 2. Guidance has been provided from RRPPS in respect of these amendments to support any changes. RRPPS have advised that they will provide templates, and these will be populated as soon as they are received.

1.7 Policies

Local Rules: reviewed and updated in October 2024.
Radiation Safety Policy: Implemented in June 2023 and due for review in June 2025.

1.8 Audit

A radiation review audit by RRPPS was undertaken in October 2024 to ensure all documentation with regards to IRR17 and IR(ME)R 2017 meet the required standards.
To date a formal report has not been received from RRPPS, however informal feedback has been received which has not highlighted any significant concerns. The department continues to work closely with RRPPS to ensure all standards are met and maintained. This will be discussed at the next RSAG meeting in February 2025, following receipt of formal audit feedback.

2.0 MRI

2.1 MRI Safety

MRI Safety is a priority therefore understanding risks is essential. All MRI Staff have completed the eLearning for Health (eLFH) MRI Safety Training and receive refresher training annually. To add resilience to the team, an MRI Radiographer attended the internationally recognised Magnetic Resonance Safety Officer (MRSO) course in June 2024. This enhances the understanding of scanning implants and interpreting the MRI conditions. Along with the MRI Team Leader they can support and guide front line staff on MRI safety matters.
RRPPS also support MRI with a Medical Physics Expert (MPE) as required.

2.2 Policies

Local Rules: reviewed and updated in September 2024
MRI Safety Policy: Implemented in February 2023 and due for review in February 2025.

3.0 Incidents/Patient Experience

3.1 Incidents

All incidents are logged on Ulysses. Incidents of concern and any associated with potential harm are also discussed at the Divisional Governance Meetings.
The most common categories of incident for Imaging are:

Clinic Delays – Additional unplanned imaging required in theatres results in additional staff having to be sent to theatres, this can result in x-ray being short staffed which in turn increases the waiting times for patients having x-rays and this sometimes incurs delays in clinic. Weekly scheduling meetings by the imaging team is now in place to forward look and pre-empt any potential issues and identify solutions pro-actively.

Communication Issues – Examples of this are when imaging has not been requested in advance to support theatre lists. Imaging Clinical Services Support Manager (CSSM) will now carry out a forward look of future theatre bookings, to avoid theatre cancellations.

Medical Devices – These incidents relate to the 5 image intensifier equipment (Arcadis Varic Image Intensifiers) regularly breaking down due to their age. These were replaced in October 2024 via the Trust capital programme to mitigate this risk.

Staffing – Incident forms have been submitted as a result of vacancies within the workforce and the additional workforce pressures this has on existing staff and their wellbeing. However, we have had successful recruitment to ease pressures and ongoing recruitment. See section 6.4 regarding current vacancies and the workforce planning that is in progress.

Radiation Incidents – All radiation incidents are submitted to RRPPS for a Dose Assessment and, where advised, the CQC are notified either voluntarily or as a Clinically Significant Accidental or Unintended Exposure (CSAUE).

Since the last report there have been 4 (0.02% of x-rays completed) radiation incidents, all recorded on Ulysees:

02/08/2024	48625	Xray	Wrong Projection performed	Radiographer error in reading clinical indications
02/08/2024	48384	Xray	T/spine requested but clinical information only relating to c spine. C/spine x-rayed, referrer than stated whole spine required instead	Wrong clinical indications for examination required.
21/11/2024	49902	Xray	Incorrect Femur was x-rayed	Radiographer error
22/11/2024	49779	Xray	Xray was performed instead of US	Admin Error/ Radiographer Error

On completion of dose assessments, RRPPS advised none of the above incidents were reportable to the CQC. All these incidents were discussed at divisional governance meeting and learning on one page (LOOPs) completed and shared with staff with the support of the Trust's Clinical Governance team.

There were 3 radiation incidents detailed in the previous QSC report. 2 were reportable to CQC and 1 was reported voluntarily. All 3 have now been closed by CQC without any further investigation being required.

RRPPS have given assurance that radiation incidents at the ROH do not compare adversely with other hospitals within their jurisdiction (most of the West Midlands hospitals) and that the Imaging Team is responsive when issues occur. RRPPS have no concerns with regards to radiation incidents at ROH. Further comparison % data is being actively sought to give further assurance in preparation for a CQC inspection as benchmarking highlighting best practice.

The table below shows the total number of incidents since the last report with regards to level of harm.

Count of Actual Impact							
Row Labels	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
1 - No Harm	**13**	**2**	**12**	**15**	**13**	**12**	**67**
2 - Low Harm	**1**	**2**	**7**	**3**	**1**	**1**	**15**
3 - Moderate Harm	**0**	**0**	**1**	**2**	**0**	**0**	**3**
6 - Near Miss	**0**	**0**	**0**	**0**	**0**	**2**	**2**
Total	**14**	**4**	**20**	**20**	**14**	**15**	**87**

The vast majority of the incidents were categorised as “no harm”.

Moderate Harm:

1 recategorized as “no harm” following review.

Delayed MRI report – Scan took place on 29/08/2024, report was completed on 16/10/2024 (7 weeks). The patient was a spinal patient with incidental finding on Kidney. There were no indications to prioritise report as “urgent”. When the report was completed, the recommendations were flagged to the referrer.

Due to number of Consultant Radiologists vacancies, there is a risk of delays to Radiologist reporting. Outsourcing of reporting has commenced, however oncology, paediatrics and complex spinal MRIs are reported internally due to the complexity of the cases.

Manual handling incident – ward patient for ? dislocation of the hip was transferred onto x-ray table, patient raised concerns regarding method of transfer. This is still under review, jointly with Division 1. Once completed, will be reported via the usual governance channels.

Near Miss:

Incorrect images downloaded to PACS – this incident was redirected and dealt with by I.T. (PACS) as the PACS team transferred from Imaging to I.T. at the beginning of 2024-2025 financial year.

Projectile incident in MRI – This incident is still open and under investigation. Divisional governance advised a Learning On One Page (LOOP), is being completed by the Deputy Head of Imaging and will return this to Divisional Governance to be approved. The Deputy Head of Imaging has also arranged a debrief with all staff present during the incident to discuss learning from the event and changes/actions that can be put in place to avoid this happening again. The MRI Team Leader will also attend.

3.2 Patient Experience

Friends and Family Test (FFT) forms are issued to patients to be completed; and the department routinely receive positive responses with 95% + rating their experience as 5 out of 5.

PALS – There have been 6 x PALS raised since the last report. All cases have been closed.

Complaints – 1 x complaint has been received since the last report. The was related to an appointment booking error. This has been closed.

4.0 Equipment

Current guidance from the European Society of Radiology recommends that assets should be replaced at an interval of 10 years. Equipment downtime and maintenance costs escalate for assets over 10 years old. The National Imaging Data Collection found that significant numbers of CT and MRI scanners in use in the NHS are over 10 years old (>30% of MRI, >15% of CT).

4.1 Current Equipment

Modality	Manufacturer	Model	Manufacturer Date
Digital Radiography (DR)	Philips	Digital Diagnost	12/2015
	Philips	Digital Diagnost	12/2015
	Siemens	Ysio	02/2014

	Philips	Digital Diagnost	05/2023
Image Intensifiers	Siemens	Cios Fusion	04/2021
	Siemens	Cios Spin	04/2022
	Siemens	Cios Flow x6	10/2024
Mobile DR	Philips	Mobile Diagnost	12/2014
	Philips	Mobile Diagnost	02/2015
CT	Siemens	Somatom Definition AS	02/2014
MRI	Siemens	Sola 1.5T	08/2021
	Siemens	VidaFit 3.0T	01/2024
Ultrasound	Siemens	ACUSON S2000	12/2021
	Siemens	ACUSON S2000	04/2022

4.2 Maintenance

- All Imaging equipment is under OEM maintenance contracts through NHSSC and RRPPS review all equipment to ensure it remains within acceptable limits.
- QA is carried out as per manufacturer guidelines and in line with IRMER Legislation by the radiographer led QA team and any variance is actioned.

4.3 Equipment Concerns

As narrated in the table above, the Digital Radiography (DR) equipment and CT Scanner are now 9-10 years old. An end of full support notice has been issued for 1 DR room and 1 mobile DR machine effective from December 2025 as a result of the age of the equipment. This is included on the department's risk register.

This reliance on older equipment brings numerous risks with it. While there are inevitably exceptions, newer equipment is more reliable and less likely to break down – meaning there are fewer unplanned pauses in the imaging schedule. Newer equipment can typically produce the necessary imaging output faster than older machines; it will generally use lower doses of radiation than previous models to achieve the same quality output and will be designed to integrate easily into the department's IT systems. Crucially too, there are some imaging requests that simply cannot be fulfilled using some older equipment, which doesn't work to the resolution or quality required to show small changes or support certain techniques. In short, the use of newer equipment will invariably increase a radiology department's capacity, even if the total number of machines in use is the same.

GIRFT Feedback from February 2022 recommended to seek to establish a formal rolling equipment replacement plan for all imaging equipment, and maybe a staggered approach when items have previously been purchased as a set. Such a plan can help reduce the effort required in each bidding cycle; it means that as well as seeking to secure the timely replacement of ageing systems, trusts can also make a stronger case for expansion – acquiring additional equipment to reflect changing demand. It also gives time to secure the support of other departments, to make provision for recruitment and staff training so that there is no gap between the purchase of new equipment and its usage and align purchases with forthcoming changes in practice.

Capital funding had been allocated to allow the purchase of 6 new Image Intensifiers which were commissioned in October 2024, 5 of which were to replace existing ageing equipment. Furthermore, capital funding has been agreed to purchase 2 Philips Mobile DR units which are expected to be delivered in March 2025.

The CT Scanner and DR Rooms have been added to the Imaging Business Plan for Capital funding in 2025-26.

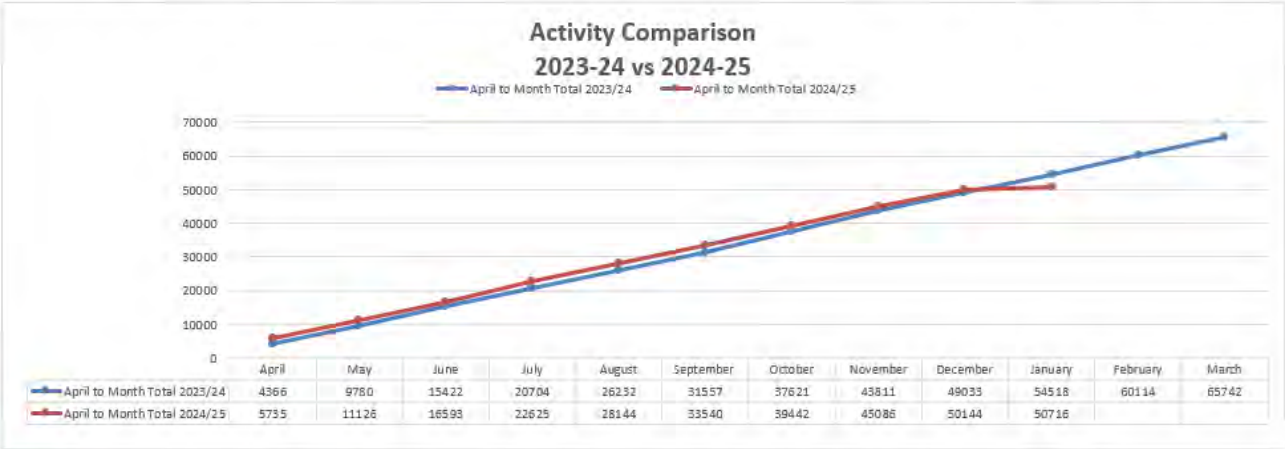
5.0 Performance

5.1 Activity Levels

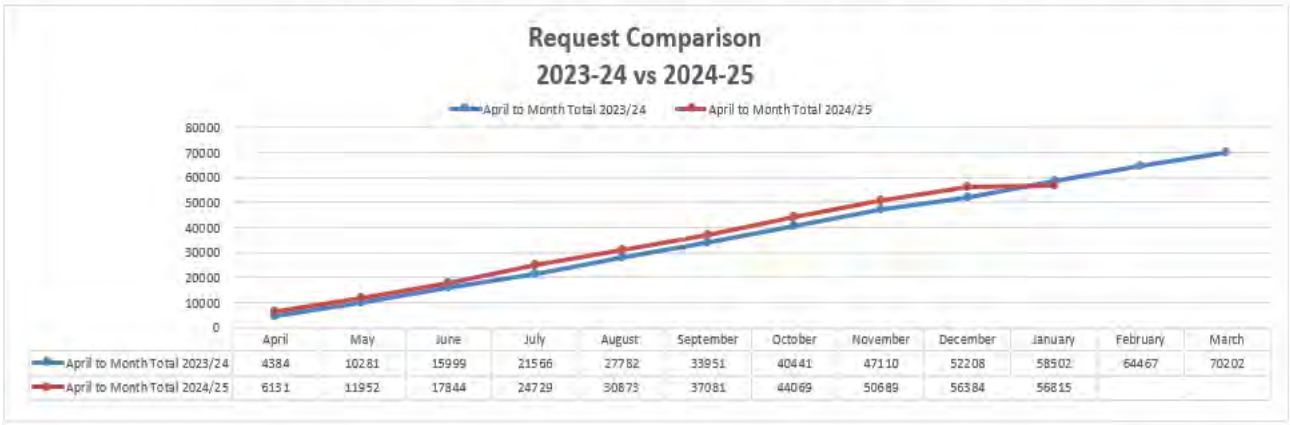
Activity levels have been on the rise consistently, the graphs below show the comparison from 2023/24 to 2024/25 to date:

05/01/2025

	April	May	June	July	August	September	October	November	December	January	February	March
April to Month Total 2023/24	4366	9780	15422	20704	26232	31557	37621	43811	49033	54518	60114	65742
April to Month Total 2024/25	5735	11126	16593	22625	28144	33540	39442	45086	50144	50716		

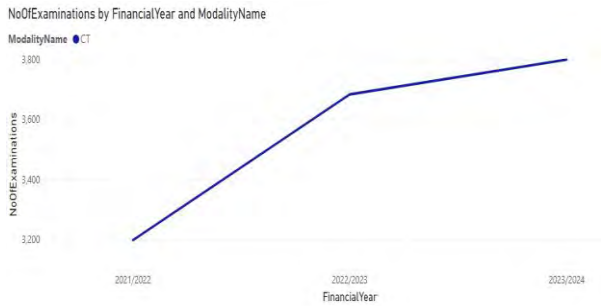


	April	May	June	July	August	September	October	November	December	January	February	March
April to Month Total 2023/24	4384	10281	15999	21566	27782	33951	40441	47110	52208	58502	64467	70202
April to Month Total 2024/25	6131	11952	17844	24729	30873	37081	44069	50689	56384	56815		

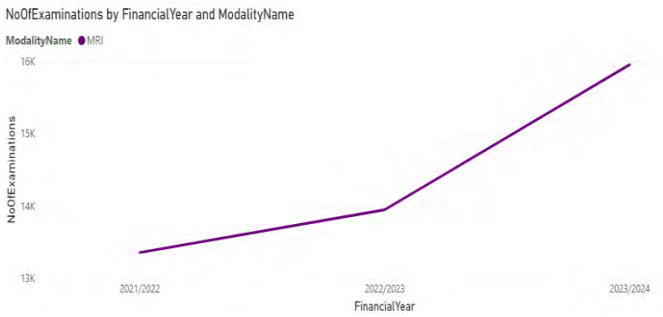


Breaking this down further per modality, it shows an increase in activity across all modalities:

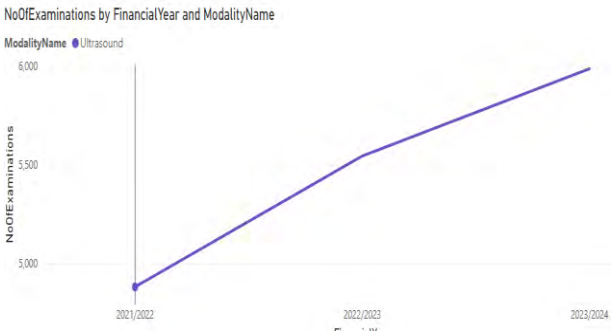
CT



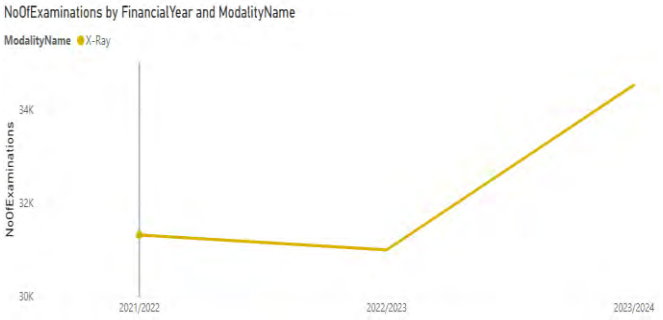
MRI



Ultrasound



X-ray



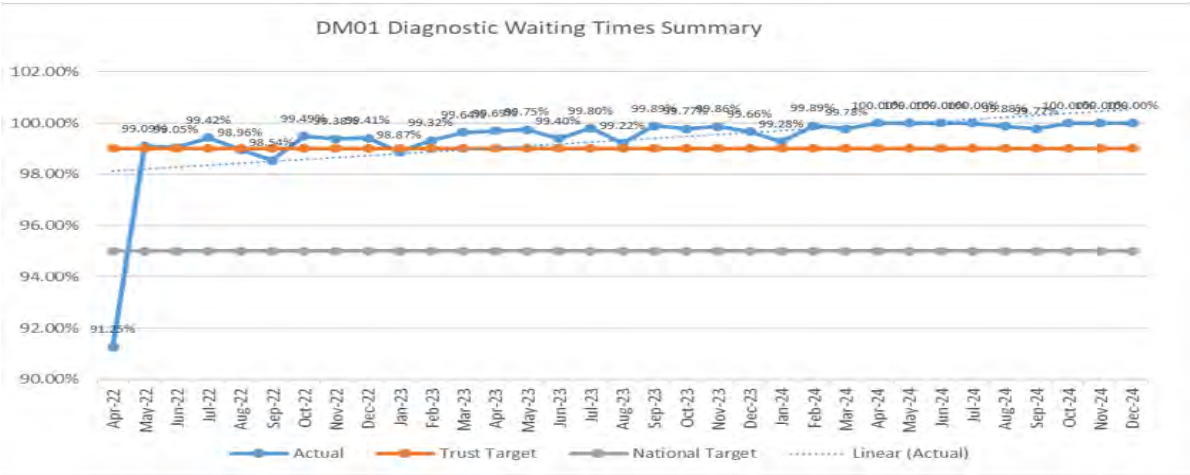
5.2 Diagnostic Waits

Current Waiting Times are as follows:

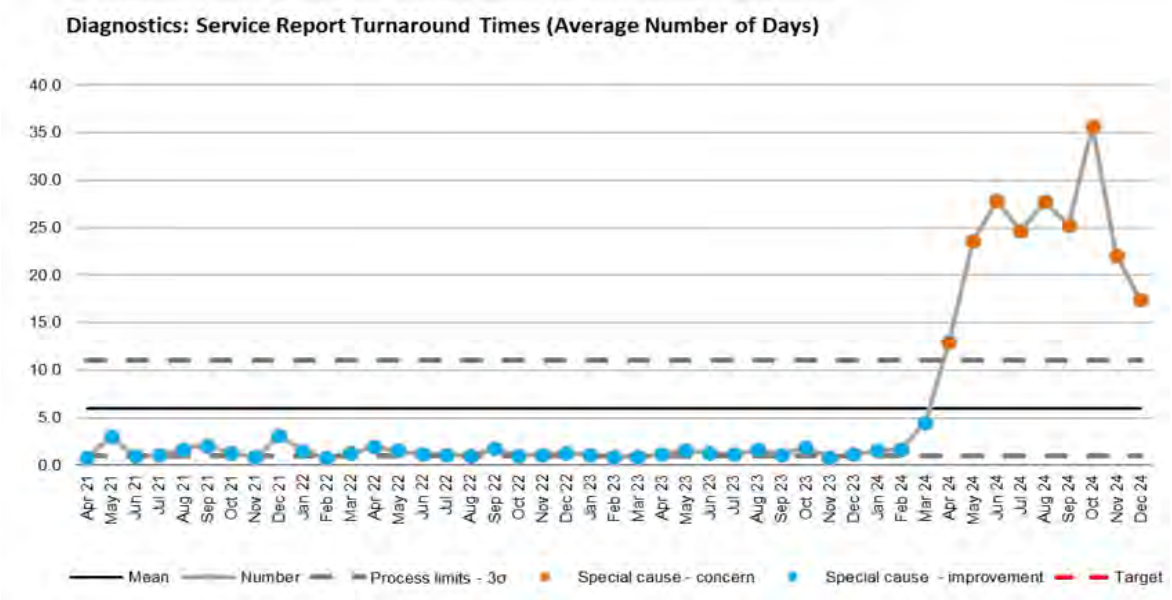
MRI	29 Days
CT	28 Days
Ultrasound	38 Days

The monthly diagnostics waiting times (DM01) and activity return collects data on waiting times and activity for key diagnostic tests and procedures. It is used to measure performance against the operational standard, that less than 5% of patients should wait 6 weeks or more for a diagnostics test.

The National 24/25 operational target remains at 95% which ROH continues to achieve consistently despite reduced capacity in ultrasound.



5.3 Reporting Times



The main reasons for this are as follows:

Radiologist Vacancies (See 6.4)
Increased Activity (See 6.1)
Addition of an acceleration software package on both MRI scanners allowing more patients to be scanned per day therefore increasing total activity delivered.

To support the turnaround times Radiologist team, a proportion of the radiology reporting has been outsourced to an external company. The aim was to reduce the x-ray reporting to within 7 working days and MRI to within 5 working days. The backlog has steadily decreased up to December 2024 and is currently as follows.

Modality	No. of Days
X-Ray	35
MRI	8
CT	1
Ultrasound	1

There are currently 395 x-rays and 143 MRIs with the outsourced company. The turnaround of which is 72 hours for MRI and 7 days for x-ray. Once these are reported, the target turnaround will have been achieved. Therefore, by February 2024 reporting turnaround times will be met and monitored monthly at the Trust Finance and Performance Committee to give assurance.

It was agreed at the Clinical Service Leads meeting in December 2024 that the medically requested x-rays will move to auto-reporting with the exception of Chest and Abdominal X-rays and Paediatrics (under 18). This has not yet been implemented due to clarification required on risk. A paper has been submitted to the executive team for approval and further work has been requested prior to approval.

5.4 Vacancies

Radiographers

The radiology department has a funded establishment of 16 Radiographers. The current workforce is 13.2 WTE. Recruitment has been positive, and the department has recently been able to offer our existing Band 5 Radiographers opportunities for career development to Band 6 alongside external recruits. While this is positive for staff development, the service now has 2.8 WTE vacancies at band 5 to fill, for which recruitment is ongoing.

We are working with new Trust workforce planning lead on capacity and demand modelling within imaging to develop a bottom up refreshed workforce plan as part of business planning for 2025/26.

Radiologists

The Radiology department has a funded establishment of 7 consultants. During 2024, one consultant left to return to their country of origin, a second has taken agreed parental leave and a third will be leaving the trust at the end of February 2025. The current establishment is as follows:

Rad Number	WTE	Comments
1.	0.9	
2.	0.9	
3.	0.6	
4.	1.0	Leaving 28/02/2025
TOTAL	**3.4**	**2.4 WTE from 01/03/2025**

Following the most recent advertisement, there is 1 potential candidate that has been shortlisted for interview in early January 2025. However, if recruitment is successful this will still leave 2.6 WTE vacancies plus 1.0 WTE on parental leave until October 2025 (it is anticipated that they will return a part-time basis).

A Radiology Resilience Plan was written in December 2024 (Appendix 1). This paper outlines the approach taken, the impact of measures that have been put in place and makes a recommendation to the executive team for further mitigation measures.

6.0 Risks

The Imaging risk register is reviewed monthly. The main areas of concern at present are as follows:

Aging equipment – see section 5

Shortage of Radiologists

- Potential delays to diagnosis from delay in reporting of images. Risk of delay to treatment if unsuspected significant findings are discovered on the report. This risk is being managed with the continuation of outsourced reporting until established vacancies are recruited to.
- Reduced capacity for Interventional procedures and DMDT, with limited cross cover available for Annual leave. Imaging admin attendance at DMDT and weekly meetings with Oncology and Imaging to prioritise patients and ensure available lists are booked to full capacity. WLI's have also been offered to existing Radiologists. Mutual aid has been scoped from RJAH and Oxford Orthopaedic Hospital but without success.

7.0 Conclusion

The committee is asked to receive and note the assurances offered by the paper with regard to the safety and management of the imaging service

Appendix A

Local Rules

Imaging%20Department%20Local%20R

Appendix B

Radiology Resilience Plan

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REPORT REF:

EXECUTIVE TEAM

DOCUMENT TITLE:	Radiology Resilience Plan
SPONSOR (EXECUTIVE DIRECTOR):	Executive Medical Director
AUTHOR:	Ben Smith Associate Medical Director (Division 2) Marie Raftery (Operations Director Division 2) John Va Faye Associate Medical Director (Corporate) Vinay Ketkar(CSL) Elizabeth Loach (Head of Imaging)
PRESENTED BY:	Executive Medical Director
DATE OF MEETING:	Dec 24

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The radiology department has a funded establishment of 7 consultants. During 2024, one consultant left to return to their country of origin, a second has taken agreed parental leave and a third will be leaving the trust at the end of February 2025.

As a result of increased activity and reduced workforce, the unit has come under pressure with reporting. The reduced resilience makes the unit more vulnerable to outside shocks.

This paper outlines the approach taken, the impact of measures that have been put in place and makes a recommendation to the executive team for further mitigation measures.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Wide ranging and impactful mitigation plan Maintaining constitutional targets in cancer care	Further consultant leaving 28/02/2025

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board/Committee/Group is asked to: Check & Challenge. Draw assurance and draw attention to areas for improvement.

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

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

Comments:

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

Patients, Best Care
ALIGNMENT TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
PREVIOUS CONSIDERATION:
Executive Team, Divisional Performance meetings

Situation

Establishment

The radiology department has a funded establishment of 7 consultants. During 2024, one consultant left to return to their country of origin, a second has taken agreed parental leave and a third will be leaving the trust at the end of February 2025. The current establishment is as follows:

	WTE	Clinical PA's per week	Comments
AMD	0.9	6.75	
RB	0.9	6.75	
SJ	0.6	4.50	
AP	1.0	7.50	Leaving 28/02/2025
TOTAL	**3.4**	**25.50**	**2.4 WTE from 01/03/2025**

The above figures do not include Annual Leave (AL) and Study Leave(SL) entitlements which will reduce the workforce and capacity on 24 weeks of the year. There is no capacity for cross-cover at times of AL, study leave and shortfall of established

As a result, the unit has come under pressure with reporting and this pressure will increase in the new year. The reduced resilience makes the unit more vulnerable. Both of the MRI scanners have had acceleration software installed which has increased the daily throughput. As well as a year-on-year increase in activity across all modalities.

Typical Weekly Workload (Current)

	Workload	PA'S
X-ray Reporting	670 Patients/825 Areas	10.25
CT Reporting	55 Patients/60 Areas	4.0
MRI Reporting	406 Areas	29.0
CT Interventional	3 Days	7.0
Ultrasound	3 Lists	3.0
MDT	Hours	5.25
	PA's Required	**59.25**

Due to vacancies/parental leave the unit has reduced:

- Interventional sessions from 4 days to 3 days
- Ultrasound sessions from 5 Consultant lists to 3 Consultant Lists
- DMDT from 5 days to 4 days.

Background

The Trust set out a multi-faceted approach to manage through until further consultants could be recruited.

Broadly speaking the approach was to manage demand and to expand capacity.

The mitigation proposals the unit examined are shown in the table below:

Capacity	
a)	Consultant recruitment
b)	Use of fellows for service delivery
c)	Use of locums
d)	Use of a radiology Limited Liability Partnership to support additional work
e)	Exploration of Artificial Intelligence solutions
f)	Home reporting for radiologists
g)	Outsourcing MRI
h)	Rationalise and prioritise MDT meetings
i)	Recruiting radiographer reporters or expediting training of radiographers to report in house in the medium term
Demand	
a)	Reduce the requirement for plain radiograph reporting
b)	Stop reporting images from outside routinely and report by request / exception
c)	Cease reporting unfunded imaging – eg standing CT foot and ankle
d)	Work with requesters to audit and improve the quality of imaging requests. Images without recorded symptoms, clinical signs and a clinical question to be triaged by a radiographer and rejected
e)	In the medium term review the imaging prescribing base and publish indications for images and scans to ensure that pathways and requests are rational and viable

Analysis

Senior Fellows / Consultant Recruitment / Locum Recruitment

Senior fellows are generally able to take up a proportion of consultant caseload after 6 months in post (for the second half of their placement). They also represent the most effective recruitment pool.

The unit have been unsuccessful so far in recruiting back into the vacant posts. Reasons were thought to include national shortages, challenges on recruitment pipeline relating to super specialist work, previous lack of home reporting (now corrected), absence of senior fellows ready for promotion as the unit had until recently been in a relatively strong position looking to recruit a 7th consultant without significant current operating pressure. The 7th consultant post was approved as part of the Business case for the installation of the 2nd MRI scanner and the associated increase in MRI reporting. However, current workload has exceeded what was expected.

The unit reported that they were unable to identify suitably experienced locums. A Locum is likely to be less efficient as high day rate and lower throughput (working to RCR guidelines per session reporting). Therefore, cost per report would be significantly more than outsourcing. A locum would only be beneficial to cover gaps in interventional work/Ultrasound lists or MDT cover but it would be unlikely to find someone with the relevant experience.

The posts have been readvertised but with only one suitable applicant (current radiology fellow) that will be interviewed on 13/01/2025. We have 3 senior fellows but contribution is limited as they have only been in post between 2-3 Months.

Limited Liability Partnership

Contracts have been completed and this is now in place

Artificial Intelligence

The Medical Director has approached Birmingham City University to explore work with the Oncology unit on plain radiography surveillance for cancer, where there is a need to monitor for both local recurrence on limb X-rays and central metastases on chest and abdominal X-rays.

There were no immediate commercial solutions identified. RCR started that much needs to be done to define the appropriate use of AI in the reporting of imaging investigations, setting standards for AI interoperability, testing AI algorithms, as well as addressing regulatory, legal and ethical issues.

Home Reporting

This is now in place for 2 WTE of the current workforce. 1 additional workstation is also available once recruited. Purchase of additional workstations for new consultants has been added to the Business Plan 25/26.

Outsourcing

Outsourcing started on 08/08/2024 and is currently being used for reporting as follows:

MRI – Initially this was agreed at 30 per day but increased to 55 per day from 28/11/24 to reduce the backlog. LLP's have also been used to reduce reporting times.

X-ray – To reduce the backlog when reporting initially stopped from 01/03/2024. On 08/08/2024 the reporting of x-rays was at 99 days. It currently sits at a 19-day turnaround time with a plan to reduce to 7 days with increased throughput from the external reporting service.

Prioritisation of MDT meetings

The unit has worked collaboratively with other units to try to maintain MDT service, with the exception of DMDT on Thursdays and cross-cover during absences.

Radiographer Reporting

Training radiographers in house is currently unfeasible. Training would take 2 years to complete and there is a commitment for Radiologists to support the training for at least 1 day per week. The department could look at recruiting a Band 7 Reporting Radiographer but this would demoralise existing Band 6 staff who would like to be offered the opportunity to develop in to this role. Radiographer reporting is also limited in scope

In many trusts who employ reporting radiographers, it was found that even if there was a dedicated rota for radiographer reporting sessions, radiographers were not always being released from their other clinical duties because they had to cover radiographer vacancies. This meant trained reporting radiographers were required to work in the general department, for example taking X-rays, rather than undertaking their scheduled reporting sessions.

Plain radiograph reporting demand measures

There has been an increase in activity for x-ray examinations. Since April 2022 there has been an increase to 115%.

Source	Annual Workload (Patients/Areas)	Weekly Workload (Patients Areas)	Reporting Time (PA's)
GP Referrals, cancer surveillance and x-rays requested by non-medical practitioners	10,090/12,410	195/238	3.0
Medically requested plain x-rays	24,433/30,052	470/578	7.25

(RCR guidelines suggest that 80 x-rays (areas) can be reported per session)

By stopping reporting or outsourcing the medically requested x-rays, this would produce a time saving of 7.25 PA sessions per week. If all x-ray reporting is outsourced, this would produce a further time saving of 3.0 PA sessions per week. Radiologist skills can then be utilised for other clinical needs. The reporting of Paediatric X-rays will need to continue in-house as the outsourced company does not offer this service.

Outsourcing

Outsourcing Costs – X-ray

Modality	Per Single area	Per additional Area
X-ray	£5.25	£5.25

The current backlog of unreported x-rays sits at 2,408 patients/2,961 areas. This would therefore cost **£15,545** to report.

To maintain a 7-day turnaround for x-ray reports, there would be a weekly cost as follows:

Medically requested plain x-rays	£3034.50
GP Referrals, cancer surveillance and x-rays requested by non-medical practitioners	£1249.50
	£4284.00

Outsourcing Costs – MRI

The plan was to outsource the additional capacity from the 2nd scanner.

Weekly Patients	Cost per area	Total per week
203	£40 (£25 additional areas)	~ £9000 (depending on areas)

In November 2017, NHS England Diagnostic Imaging Dataset Annual Statistical Release 2016/17 stated that 76% of acute NHS trusts were outsourcing at least some of their radiology reporting work to external companies in an effort to keep up with demand.

Auto-reporting X-rays

On the same report it stated all radiology examinations should have a documented report, especially those involving ionising radiation such as plain film X-rays, CT and nuclear medicine, where it is a legal requirement. One way that trusts can manage the radiology reporting workload is to identify which examinations could be reported by non-radiology staff. This process is known as auto-reporting as it involves sending a standard response automatically to referrers, informing them that the examination will not receive a formal radiology report and that it is their responsibility to provide one. There is a potential risk of harm to patients associated with non-radiology staff reporting images that do not receive a separate formal radiology report. This is especially a risk for chest and abdomen X-rays, where general medical training does not constitute adequate training. On the basis that all medical staff have undergone image interpretation as part of their studies and are working under the guidance of a clinical specialist in their field auto-reporting could be implemented. They also stressed that if the medical staff felt that the image was outside of their area of expertise, they could request a radiology report.

Stopping reporting Medically requested plain x-rays (with the exception of Chest and Abdomen) would equate to approximately 7 PA's of Radiologists time or a cost saving of £3034.50 per week from outsourcing costs.

The trust would need to make sure that audits are performed to make sure that the x-ray had been reviewed and the outcome was documented and accurate in the patients' electronic notes.

Discontinue Routine Reporting of Outside X-rays for Referrals

The reporting of outside x-rays equated to approximately 500 per year. The Radiologists feel this is duplication of services and reintroduction would involve a robust criteria and SOP to reintroduce this service.

The standing CT service for Foot/Ankle referrals no longer exits due to the company going into liquidation.

Improve Quality of Requesting / Imaging Indications

Dr Botchu (radiology IR(ME)R Lead) attended the September Audit meeting and delivered a presentation on IR(ME)R. There is an IR(ME)R training module available to all referrers and practitioners on ESR, and clinicians were made aware that this training should be updated every 3 years to ensure referrals are justified and the least possible radiation is given to the patient, hence less risk to the patient. This was also shared in the November issue of ROH clinical news.

All x-ray referrals are vetted by a Radiographer and justified based on clinical information given. Any referrals without recorded symptoms, clinical signs and a clinical question are rejected.

Recommendations

The executive team are asked to:

- Make a decision based on risk, whether all medically requested x-rays need to be reported.
- If the decision is to report on the above x-rays, agree that these x-rays will need to be outsourced with the current staffing levels.
- Agree that the remaining x-rays (GP Referrals, cancer surveillance and x-rays requested by non-medical practitioners) need to be outsourced until sufficient staffing levels enable them to return in-house.
- Agree that all MRI's from the 2nd scanner will be outsourced for reporting until sufficient staffing levels enable them to return in-house.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Bi-annual safer staffing report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Emma Steele, Deputy Chief Nurse**
DATE OF MEETING:	**5 February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018. It is a national requirement for the Board of Directors to receive this report bi-annually to comply with the CQC fundamental standards as outlined in the well-led framework.

This report provides analysis of the Trust's Nursing and AHP (ODP only at this time) workforce position at the end of November 2024.

Nationally the workforce position has seen a change. Data from NHS England show a vacancy rate of 7.8% (32,738) vacancies in June 2024 (updated February 2024) for registered nursing which is a decrease of 2.8% from the same period the previous year when the vacancy rate was 10.7% (43,628) vacancies.

ROH has benefited from a successful recruitment campaign both domestically and via international recruitment. At the end of November 24 there were a total of 3.81 wte registered nurse's vacancies.

Two Degree Nurse Apprentices (top-up) on programme. ROH has down developed a pathway 'new to care' all the way to registered nurse.

ROH is working with 'ican' to support recruitment to entry level posts working as an anchor institute.

ODP continue to have 9 wte vacancies and is recognised as a hard to recruit to post. Theatre department are utilising CDP to support nursing staff to undertake the anaesthetic course to address the gaps in skills. This support the ODP apprenticeship programme that has support 3 ODP's to registration. 12 more on programme.

Long term sickness rates across the 12-months range from 2.01 % to a high of 7.37% in Jan 24. Short term sickness at times appears to mirror the long-term sickness profile. With a peak in January 24 of 7.19% followed by a low of 0.22% in March 24.

Agency has dropped to an all time low of around 20 per month, Bank is decreasing but work is required to continue to drop this lower.

Nurse turnover has improved to 9.98%, with ODP Static.

The total number of international recruited nurses (IR) joining the Trust over the last 18 months is 49 wte. The programme has now stopped.

The Safer Nursing care Tool (SNCT) provides a framework for incorporating professional judgement and assessment of nursing sensitive outcomes as part of a triangulated approach to ensure nursing establishments

reflect patient needs in terms of acuity and dependency. Originated in 2006, the tool was updated in 2013 and further refreshed in 2023. Census will be collected in June 2025.

Ward staffing has consistently remained above 91% of the planned staffing fill rates for registered staff and unregistered staff. The average fill rate against planned shifts in November 2024 was92 % for registered nurses and % for unregistered staff.

Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward based settings since April 2016. CHPPD is a metric to reflect care hours per patient bed day and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The ROH wide average CHPPD level is 8.3 hours per patient against a 9.4 hours per patient of specialist days.

The following actions will be undertaken in the next 6 months:

Undertake the SNCT Census of clinical areas before implementing changes to establishments/budgets.
Complete the OPD establishment review
Continue to work with staff side to complete the Band 2/3 job description review
Roll out of the 7-day working in Theatres
Review headroom for 25/26 in view of current mandatory training requirements.
Review all training plans for 25/26 (clinical)
Review healthroster templates to ensure they are in line with agree establishments
Review AFPP recommendations against current working model in theatre.
Future reports will also include all AHP (Physiotherapy and radiology)
Benchmark against model hospital current baseline

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Current workforce data supports that the wards and departments are safe and providing quality care.	Further workforce reviews are required over the next 6 months. Wider AHP are not at this time included in the paper. This will be under taken in the report.

REPORT RECOMMENDATION:

The Board is asked to:

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical	x	Equality and Diversity		Workforce	xx
Inequalities	x	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:
Trust strategy
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)*:
Safer staffing papers. Quality and Safety Committee January 2025

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Biannual Safe Staffing Report (Nursing)

Quality & Safety Committee Jan 25

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide the Board of Directors with a bi-annual, comprehensive safer staffing report for Nursing and Allied Health Professions (AHP), which outlines staffing capacity and compliance. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[2], published in October 2019.

1.2 This report provides analysis of the Trust's Nursing and AHP workforce position at the end of November 2024. For the purpose of this report AHP'S will only refer to Operating Department Practitioners (OPD). The paper will cover the last 12-months from November 23 until the end of November 24. *However, at times in order to share the wider workforce backdrop the report will pull in later data, as required to provide context.* The Clinical Workforce Group present their workforce positions and plans bi-monthly via the Safer Staffing report to Quality Safety Committee. A summary of these reports is included in this report (Appendices).

2.0 NATIONAL CONTEXT – NURSING

2.1 Nationally, Nursing workforce supply and demand remains a well-recognised challenge within NHS Trusts. Dynamic initiatives in bridging the vacancy gap by the government through increased funding to recruit and train more nurses has been instrumental in changing the nursing workforce landscape both nationally and locally over the last 12-18 months. However, NHS England demonstrates an improving landscape with August 24 data reporting a sustained growth in nursing workforce in the NHS[3].

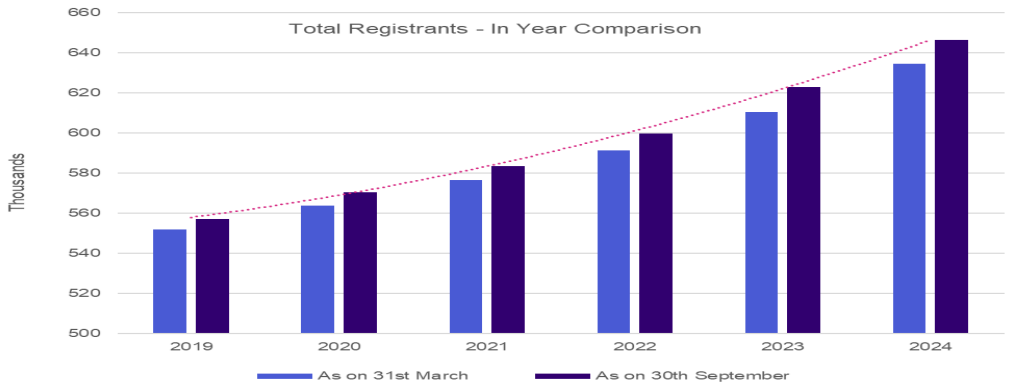
2.2 Data from NHS England[4] show a vacancy rate of 7.8% (32,738 vacancies) in June 2024 (updated February 2024) for registered nursing, which is a decrease of 2.8% from the same period the previous year when the vacancy rate was 10.7% (43,628) vacancies. Birmingham and Solihull (BSOL) Integrated Care System (ICS) have reported an improved

[1] NHS England (2016) National Quality Board guidance on safer staffing
[2] NHS England (2018) Developing Workforce Safeguards
[3] NHS Workforce Statistics, August 2024 England and Organisation.xlsx
[4] NHS England (2024) Vacancy statistic June 2024

position over the last 12 months, with an increase of 19.40%[5] in nursing and midwifery across the five providers. All providers are now reporting improved vacancy positions of between 4 – 11%, which is a significant improvement on the previous year.

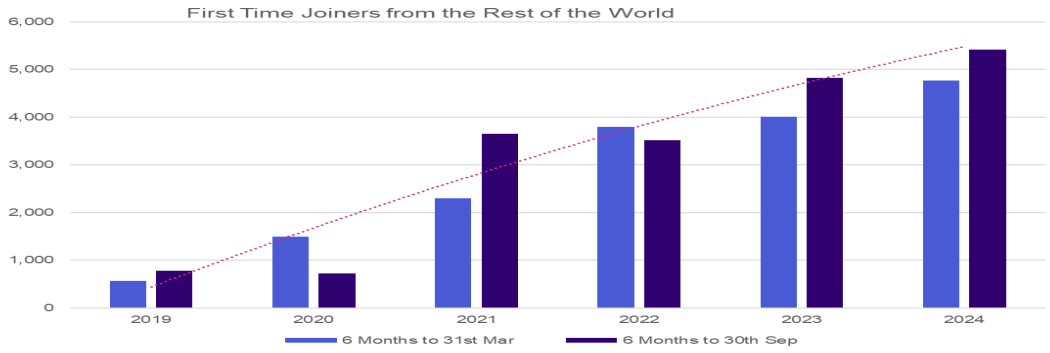
2.3 The NMC Register Mid-Year Data Report (March 2024) showed a record 634,440 nurses, midwives, and nursing associates registered with the NMC in England, which is an increase of 24,060 (3.9%) in 12 months from March 2023 in England.

2.4 Graph 1. Illustrates a 15% growth of registrants over the last five years. Within this data one of the most notably improvements is a 16.5% increase in Nursing Associates over the last 12 months. There are now 10,816 Nursing Associate registered in England.



Graph 1. Five-year comparison in registrants (Graph supplied by NMC)

2.5 The NMC continues to report the biggest growth in registrants is from international educated professionals joining the register in England in the last year. In total there were 9,903 international joiners as depicted in Graph2. The data shared by the NMC outlines that the rest of the world recruitment has increased but EU recruitment has continued to drop over the last five years. It is anticipated through this financial year these rates will slow significantly given the reduction in international recruitment programmes across each NHS organisation which is reflected locally in BSOL.



Graph 2. Demonstrated the growth in register from the rest of the world

[5] Workforce update nursing & midwifery system monthly report (Jan 25).

2.6 Despite these improvements to the registration, there continues to be challenges with supply and demand both nationally and locally in specific roles. Within ROH below outlines the current challenges:

NHS staff retirement. Resulting in a loss of experience, knowledge and specific skills, often replaced with less skilled and experience staff.
NHS Maternity leave.
Challenges to manage finances while protecting safety.
An increase in nursing workload due to aging population with increased acuity, dependency, and comorbidities.
Long- and short-term staff sickness absence accounts for a loss of 900k per month, with anxiety, stress & depression the highest reason in nursing referenced in the SE&OD November 24 deep dive.
Time taken to training and upskill staff.
National mandatory training requirements and the impact on team to support the release of staff.

2.7 The outlined factors compound the reliance and usage of temporary staffing to ensure minimum safe staffing levels are met through the organisation. Recent financial reports from NHS England (2024) shows YTD spend for bank and agency staff at 4.83m[6].

2.8 In 2023, the NHS Long Term Workforce Plan[7] (LTWP) sets out the case for change, taking a more strategic and long-term approach to improving the workforce position, and proposes actions to be taken locally, regionally, and nationally in the short to medium term to address current and future workforce challenges. The LTWP recognised the rising demographic pressures, changing burden of disease, high number of vacancies across the NHS workforce, and the NHS's firm reliance on temporary staffing and international recruitment to fill service gaps to ensure safe staffing levels.

2.9 The LTWP – Implementation update [8](Dec 2023) identifies three key priority areas; Train, Retain and Reform:

Train – increasing the number of students and trainees across every professional group and across every region was a key aspiration. Nurse education training places aim to increase by 34% to 40,000 by 2028/29 and by 80% to over 53,500 by 2031/32. The aim of the plan is to have 28% of registered nurses training through degree level apprenticeships. The ROH has successfully recruited two Degree Nurse Apprentices (Top-Up from Nursing Associates), who have commenced their course in October 2024.

[6] NHS England » Financial performance report 2023/24: Quarter 2
[7] NHS England » NHS Long Term Workforce Plan
[8] NHS England » Long term workforce plan – implementation update

Retain – intentions to reduce the leaver rate from 9.1% in 2022 to between 7.4% and 8.2% over the next 15 years[9].

Reform – improving productivity by embracing technology and increasing the breadth of multidisciplinary teams by broadening the roles.

2.10 Staff retention programmes across England have seen a steady improvement in retention rates. The national all-staff leaver rate continues to decrease, now down to 7.7% in June 2024, and the overall nursing and midwifery leaver rate in June 2024 was 5.8%, lowest level since pre-2020. Leavers rates for staff under the age of 55 years has remained at a similar level throughout ranging from current low of 5.0% from the peak of 6.6% last year. The leaver rate for over 55 years has significantly decreased in the last two years from high of 14.5% to 9.7% in June 2024.

2.11 This national decreasing trend has been reflected within ROH nursing teams, with the current leaves rate down to 9.98% in November 24 from a high of 13.38% in December

REGIONAL & SYSTEM CONTEXT

2.12 At the same time as NHS England launched the LTWP, BSOL ICS undertook a workforce review led by Jo Lenahan. The review identified four key workstreams which align to the LTWP. They are outlined below:

Reconnect – this was supported with a system wide listening event which resulted in the BSOL new staff offer.

Recruit, Retain & Train – Oversee early careers opportunities for the local population all the way to 'Registrant', working towards the five providers being anchor institutes and feeding into the BSOL health inequalities strategy. Furthermore, the group also oversee the 'Education Collaborative' working with our Higher Educational Instities to shape the workforce and ensure the training needs of our workforce.

Resilience – Exploring a system wide approach to reduce reliance on temporary workforce.

Reform – improving how we embrace new approaches to care in the future.

3.0 Undergraduate Nursing and AHP (OPD) Pre-Registration Education Pipeline

3.1 There has been considerable engagement with the local Universities to ensure the nursing and AHP pipeline remains viable. However, in 2023 Birmingham City University (BCU) was issued with an improvement notice by the NMC. This followed concerns raised due to the university's use of simulated training hours to meet the clinical practice hours requirements for student to gain registration. The Chief Nursing Officers across the system

[9] NHS England » Support available to improve staff retention

have supported BCU to complete the action plan, by providing additional placement capacity for students affected by this.

Undergraduate Nursing Education Pipeline.

3.2 Overall, the number of applications to nursing programmes nationally has continued to fall as described in the University and Colleges Admissions Service (UCAS)[10] end of cycle 2024 report. The report highlights that in 2024 there were 41,520 nursing applications to UK universities, this represents a 5.5% decrease from 2023 and is at the lowest level in five years. However, locally, Birmingham universities have reported good numbers of candidates and have successfully recruited to bi-annual programmes.

3.3 Annually ROH support students from across the BSOL universities and receives positive feedback. The Clinical Education Team lead attend the Education Collaborative and is part for the Placement Group workstream, designed to ensure placements for students.

Nursing apprenticeship

3.4 ROH have historically supported a total of 20 apprentice nursing associates to complete their programme since 2020. However, currently there are only 2 student nursing associates (SNA) in theatres undertaking their training through the apprenticeship route. Two nursing associates have gone onto complete further training to top-up their degree to a registered nurse.

International Nurse recruitment programme.

3.5 The BSOL International Recruitment Bureau since 2022 until early 2024 has supported 1077 nurses into posts across the system. In addition, 118 AHP have been recruited. At ROH we have welcomed 49 international trained Nurses and 4 radiographers. This work is now complete, and the Bureau will be stood down in January 2025. Over the last 6 month the focus of the Bureau has been on retention and pastoral care to ensure the staff stay and thrive.

4.0 Allied Health Professionals

4.1 Since the publication of Health Care Professional Council (HCPC) report "Retention rates of first time HCPC registrants'[11], in January 2023. ROH has update its preceptorship programme to ensure internationally trained and newly registered AHP staff can access the programme.

4.2 The national context for AHP has slightly improved over the last six months, with NHS England in August 2024 reporting 172,165[12] registered AHPs were working in the NHS in England. However, locally ROH continues to struggle to recruit Operating Department Practitioners (ODP) reporting a current vacancy of 9.36 wte. This position has slight

[10] Data and Analysis | Business | UCAS
[11] The HCPC publishes analysis of retention rates among registrants who joined the HCPC Register via the international registration route | The HCPC
[12] NHS Workforce Statistics, August 2024 England and Organisation.xlsx

deteriorated in position of 1wte over the last 12 months. However, as it has been difficult to recruit to these positions, the theatre team have recruited nurse, with a view to exploring post-graduate anaesthetic programmes.

4.3 The Health & Care Professions Council (HCPC) reported on the 1 December 2024, that there were 15,616 ODP's registered in the UK[13]. However, that was a decrease of over 500[14] registered OPD's on the previous month.

4.4 Over the last 4-years ROH has supported an apprenticeship programme to grow our own OPD's, to date this has resulted in following apprentices commencing the programme:

Year commenced course	Numbers	Date to complete course
2022/2023	2	2025
2023 / 2024	4	2026
April 25	2	2027

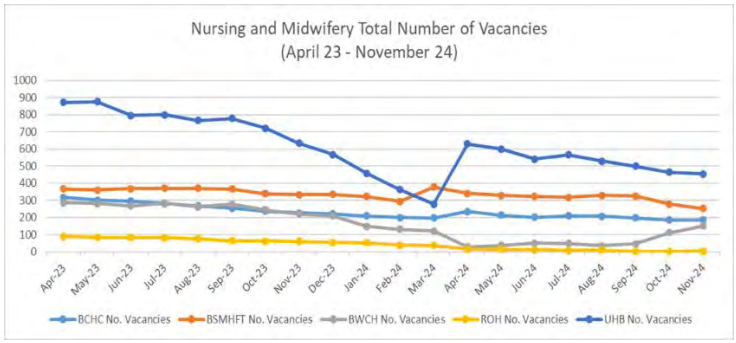
4.5 The ROH OPD apprenticeship has been established for 4 years and has successfully supported three candidates to registration. All three candidates are now established members of the team. There are two more apprentices due to qualify in April 25 who will take up full time posts.

4.6 There is no equivalent to the Safer Nursing Care Tool for AHPs to determine optimal staffing levels, however there is guidance for ensuring 'Staffing for Patients in the Perioperative Setting' by AFPP[15] last updated 2022. ROH currently works within the AFPP recommendations thereby meeting best practice and ensuring patient safety.

5.0 ROH Workforce Position Nursing Vacancies

5.1 BSOL nursing vacancy position as been an improving picture over the last 2 years following the introduction of, the system International Nursing Bureau and the recruitment programme. This programme was supported by NHSE funding scheme, which has now stopped. The International Bureau has now been stood down and will stop operating in March 25. Graph 3. Demonstrates the improving system landscape and how the bureau and domestic pipelines have supported recruitment.

[13] Registrant snapshot - 1 December 2024 | The HCPC
[14] Registrant snapshot - 1 November 2024 | The HCPC
[15] Home - The Association for Perioperative Practice



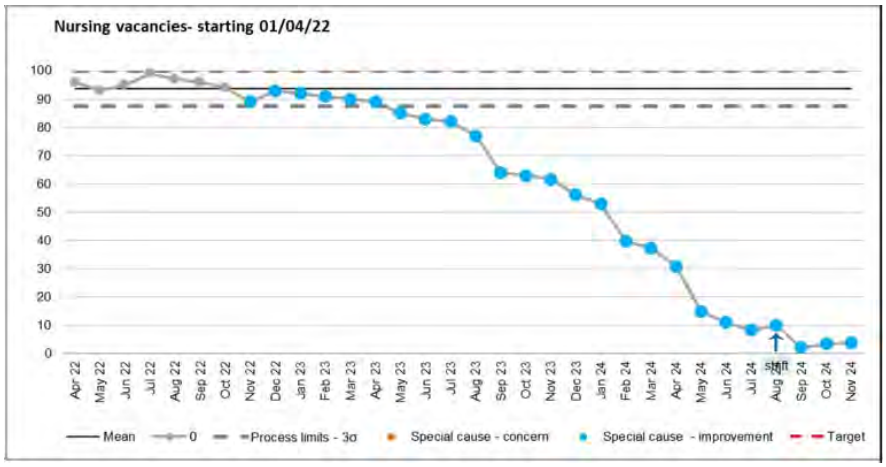
Graph 3. BSOL nursing and midwifery vacancies

5.2 The Trust has continued to benefit from successful nurse recruitment programmes. Although our international recruitment programme was extremely successful it has stopped at this time, with no current plans to continue to utilise this pipeline. The nursing teams continue to recruit to posts through normal NHS recruitment pathways.

5.2 In October 2023 Nursing Vacancy Confirm and challenge meetings were introduced and chaired by the Deputy Chief Nurse and supported by colleagues in Finance and recruitment to drive efficient recruitment and reduce reliance on temporary staffing. Due to the reduction in vacancies and reduced use of Temporary staffing these were stood down in October 2024. Nursing Vacancies are reviewed at the monthly Nursing Workforce and Education meeting and captured in the Safe Staffing reports which are presented to Quality and Safety Executive.

5.3 The ROH nursing establishment is 329.98 wte, in post at the end of November 24 were 326.17 wte giving the trust an overall nursing vacancy rate of (1.15%). This is significantly lower than the national rate of (7.8%)[16], and the Midlands vacancy rate of (6.4%)[17].

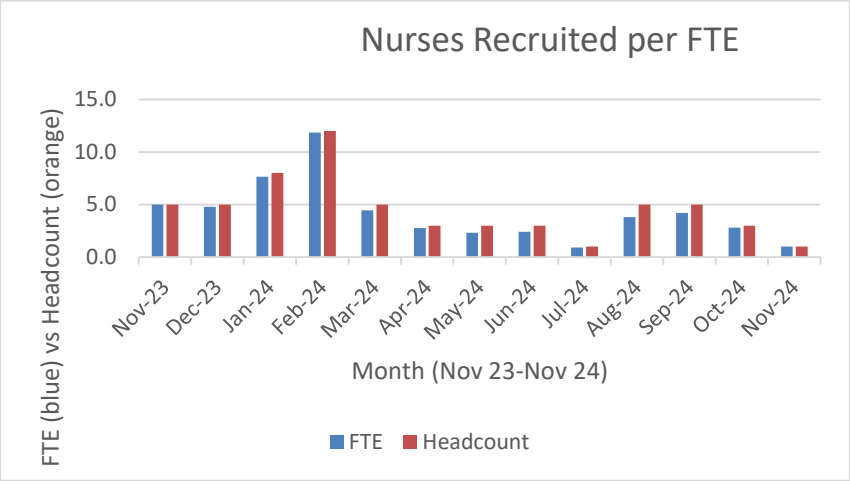
5.4 At the end of November 2024 there were a total of 3.81 wte registered nursing vacancies across the Trust as demonstrated in Graph 4.



[16] NHS Vacancy Statistics England, April 2015 - June 2024, Experimental Statistics - NHS England Digital
[17] NHS Vacancy Statistics England, April 2015 - June 2024, Experimental Statistics - NHS England Digital

Graph 4. Nurse vacancy

5.5 Recruitment over the last 12 months has been steady as demonstrated in Graph 3. Recruitment has been a combination of domestic and international pipelines, with some specialist hard to fill roles being successfully recruited into such as infection prevention and control nurses, Safeguarding team and critical care outreach team.



Graph 4. demonstrates the recruitment of nurses over 12 months

Unregistered workforce

5.6 At the end of November 24, the Band 2 workforce was a stable with 19.21wte vacancies across Trust. The establishment is set at 163.78wte and in post was 141.37, however Division 1. is undertaking a review of HCA's and is currently holding several vacancies. This work is due to complete shortly.

5.7 Nationally, a significant number of NHS organisations in England have been challenged by the unions to undertake a review of their band 2 Job descriptions. This has resulted ROH reviewing the current job description against the national band 2 / 3 job profiles. Work remains on-going at this time.

5.8 ROH are committing to engaging with the BSol 'ICan' project to recruit to entry level roles including Healthcare support workers and Theatre assistants. The project provides dedicated support and training, bespoke to individuals needs to help find the best role for candidates who may otherwise struggle to gain employment.

6.0 Safe Staffing National Guidance

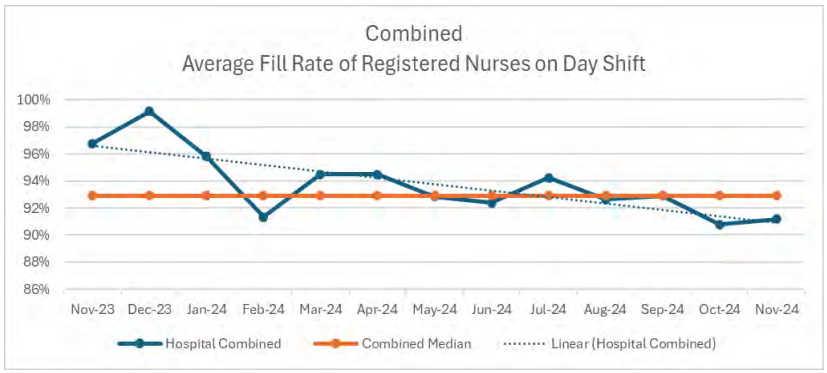
6.1 Recommendations set out in the Developing Workforce Safeguards Report 2018 focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance states organisations must demonstrate compliance with the key principles of safe staffing, supporting a triangulated approach to decide staffing requirements combining evidence-based tools such as Safer Nursing Care

Tool (SNCT)[18] data to measure patient acuity and dependency, professional judgement, patient quality outcomes, accreditation, and harm.

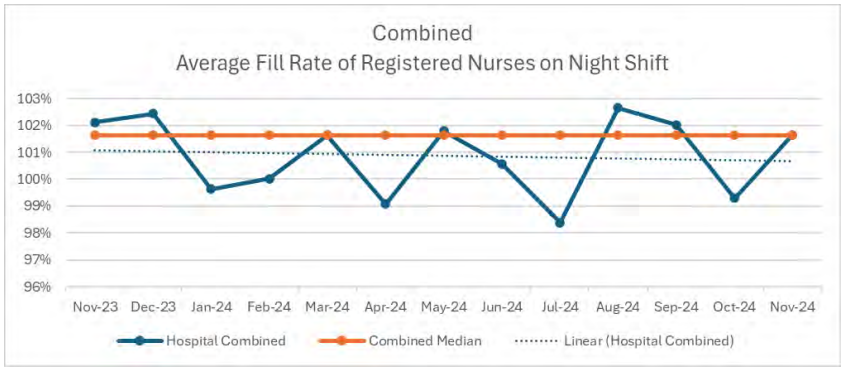
6.2 The Trust is currently reviewing the current safer staffing requirements in line with the changes to the safer staffing tools set out by the Shelford Group Safer Nursing Care Tool Steering Committee in 2024. The Workforce & Education Lead undertook the two-day Chief Nursing Officer for England Safer Staffing course, designed to ensure all organisations have a baseline in the safer staffing tool. The Trust also uses an e-rostering system tool Allocate, which has the Safer staffing nursing tool embedded.

Registered Nurse & un-registered nursing fill rates

6.3 The Trust is required to submit a monthly Safe Staffing Unify Report[19] to NHSI detailing actual registered nurse staffing levels as a percentage against those that were planned. The average fill rate against planned shifts in October 2024 was 91% for registered nurses and 92% for unregistered staff. In comparison, the fill rate in March 2024 was 92% and 103%. It is important to note that these fill rates are based on the commissioned bed base, therefore it important to note that due to reduced activity over holiday periods, the bed bases management has been agile around activity. This has allowed the clinical teams to flex beds as required.

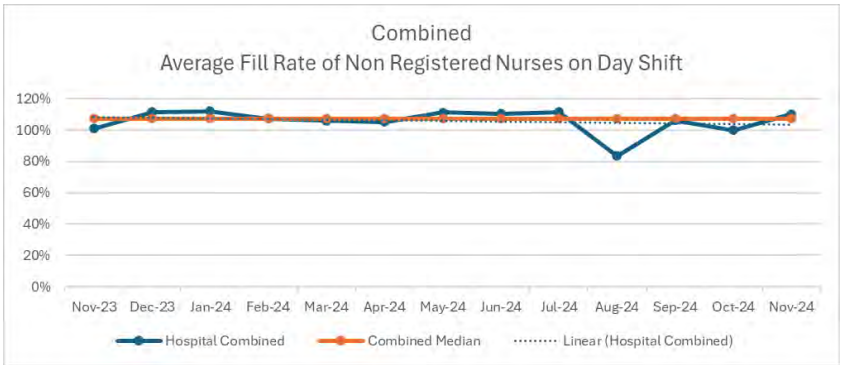


Graph 5. of average fill rates for registered nurses on day shift

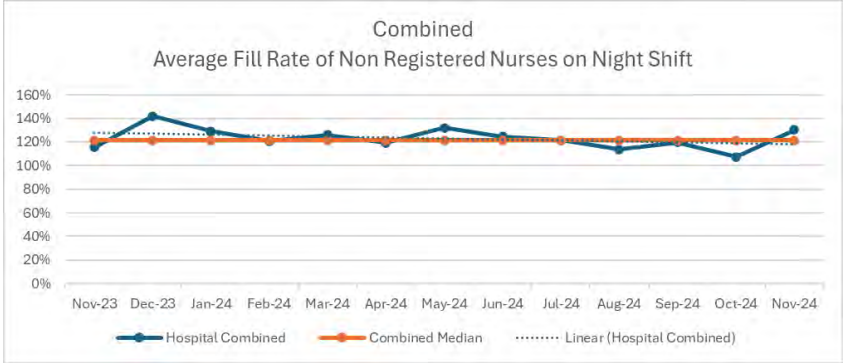


Graph 6. Of average fill rates for registered nurses on night shift

[18] NHS England » Safer nursing care tool
[19] NHS England » Freedom of Information: UNIFY return



Graph 7. Of average fill rates for un-registered nurse on day shift



Graph 8. Of average fill rates for unregistered nurses on night shift

6.4 Fill rates for un-registered nurse on night shifts average 123%, which is higher than the planned rates. Themes identified as to explain the high fill rates are enhanced observations, patients on Deprivation of Liberty requiring enhanced care needs. Nationally, it has been noted that there has been an increase in enhanced observation. Therefore, NHSE have established a working group to review and explore enhanced hours. ROH will be engaging with this work and exploring alternative approaches to ensuring patient safety.

Care Hours Per Patient Bed Days (CHPPD)

6.5 Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward-based settings since April 2016. CHPPD is a metric to reflect care hours per patient bed day and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight. CHPPD is not indicative of the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive, therefore must be considered in conjunction with measures of safety and quality and using professional judgement. CHPPD relates to hospital inpatient wards only where patients stay overnight.

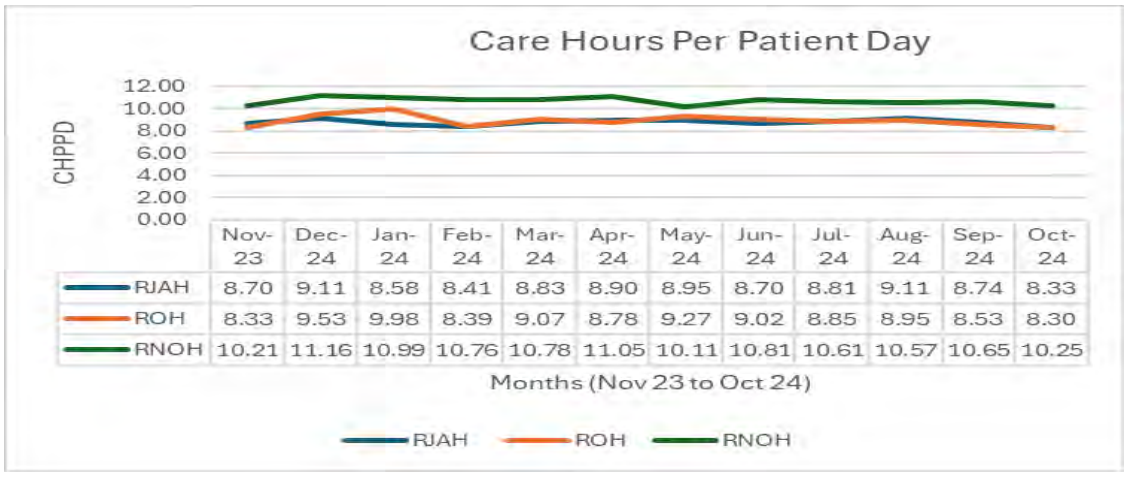
6.6 CHPPD is calculated using the data supplied to NHS England via a monthly nurse staffing return known as the "Hard Truths" report (Department of Health 2014)[20], NHS

[20] NHS England » Care hours per patient day (CHPPD) data

England “Model Hospital” is used as a data platform to view productivity and CHPPD from across NHS providers in England.

6.7 CHPPD can be viewed for each professional group that deliver care in a ward-based setting or as a combined total for benchmarking productivity against regional providers or national peers. This ensures skill-mix is well-described and the nurse-to-patient ratio is considered when deploying the clinical professionals to provide the planned care, reflected alongside an aggregated overall actual CHPPD.

6.8 There is no national target for CHPPD, however NHSI publish the data on the NHSI Model Hospital. Graph 9. illustrates the recent Trust CHPPD data against the median for specialist hospitals. The ROH average CHPPD level is 8.4 hours per patient against an average of 9.4 hours against the three specialist trusts, suggesting that the Trust staffing levels result in a CHPPD level aligned with the other two trusts.



	Nov-23	Dec-24	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
RJAH	8.70	9.11	8.58	8.41	8.83	8.90	8.95	8.70	8.81	9.11	8.74	8.33
ROH	8.33	9.53	9.98	8.39	9.07	8.78	9.27	9.02	8.85	8.95	8.53	8.30
RNOH	10.21	11.16	10.99	10.76	10.78	11.05	10.11	10.81	10.61	10.57	10.65	10.25

Graph 9. CHHPD benchmarking against specialist hospitals

6.9 The lack of national CHPPD targets limits the validity and use of this data to inform safer staffing decisions although it is recommended that benchmarking against other organisations is considered when undertaking a workforce review.

6.10 SNCT provides a recommended number of staff (measured as whole-time equivalents) and does not differentiate between unregistered and registered staff, and CHPPD can be a useful indicator used alongside the SNCT audit to assess productivity and skill mix as it differentiates between registered and unregistered staff.

Controls

6.11 All wards and departments use Allocate Healthroster and the rosters are aligned with agreed establishments that are reviewed every 6 months. Ward/Department managers are responsible and accountable for the provision of safe staffing levels to meet patient needs by preparing and managing the roster. Matrons are responsible and accountable for reviewing, overseeing and approving the roster. This is completed following a ‘Confirm and Challenge’ meeting where checks are made regarding appropriate annual leave, study leave etc.

6.12 Rosters are built and published 6 weeks in advance and capture staff flexible working

6.13 Nurse staffing levels are reviewed daily and then weekly in real time and monitored through the 'staffing meeting' to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. The review includes level of staffing requirements including bed occupancy, planned v's actual staffing. Planned v's actual staffing numbers are displayed visually outside each in-patient ward and on the Trust website. The daily staffing levels are viewed along with reported outcome measures to provide safe and effective patient care. Professional judgment in managing unplanned absences or increased demand, alongside the skill mix and competences is paramount to provide the safest care possible across the trust. The process informs identification of the staffing escalation position and the identification of any red flag staffing events.

7.0 Retention

Retention of our people is a key national priority, as outlined in the People Plan, The NHS Long Term Plan and the NHS Long Term Workforce Plan.

7.1 The plan also includes "Our People Promise" which sets out practical actions that employers and systems should take, as well as the actions that NHSEI and HEE will take. It focuses on:

Looking after our people – with quality and wellbeing for everyone.
Belonging in the NHS – with a particular focus on the discrimination that some staff face.
New ways of working – capturing innovation, much of it led by our NHS People.
Growing for the future- How we recruit, train, and keep our people, and welcome back colleagues that want to return.

7.2 The NHS People Plan[21] highlights the importance of looking after our people to support and grow the future NHS workforce. The plan focuses on NHSE's targeted workforce retention actions which are most likely to have the greatest impact on job satisfaction and retention of NMAHP. These include flexible working and retirement options, benefits, and rewards, developing a menopause strategy, implementation of the national preceptorship framework and legacy mentoring schemes.

7.3 ROH received one year funding in March 2024 for a People Promise Manager[22], who is focusing on staff retention across the Trust. There are four People Promise Managers across BSOL and all are working to improve retention and staff experience. One key aspect of the work has been to explore flexibility.

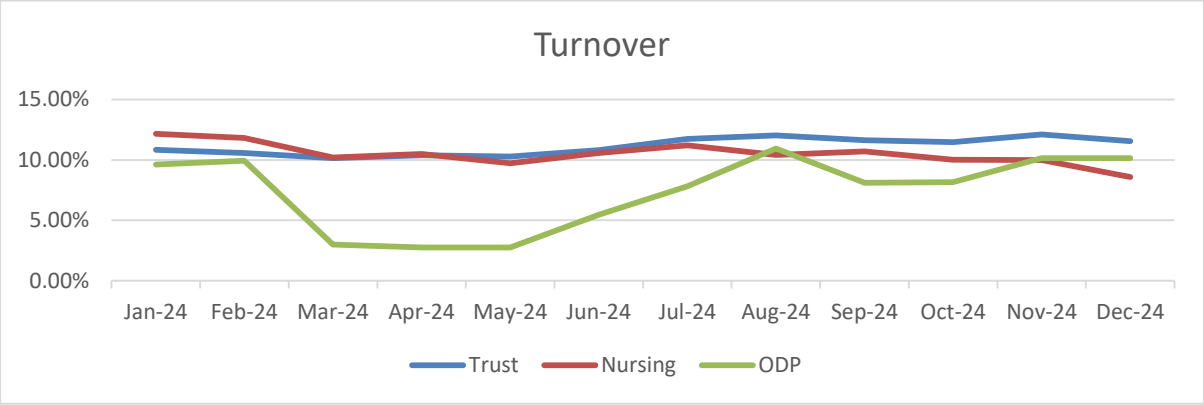
7.4 A retention action plan was developed and commencing in early 2023 following the 2022/23 staff survey results. The plan was implemented by the Heads of Nursing for Division

[21] NHS England » Our NHS People
[22] NHS England » Our NHS People Promise

1 and 2 will a clear focus on improving the nursing workforce retention. The plan focussed on:

Encouraging feedback and conversation – use of exit interviews and access to the Freedom to speak up guardian. Stay conversations and flexible working requests
Engaging with new appraisal process
Sharing of WRES and WDES data
Introduction of Quality Improvement nurse to help teams share ideas and embrace continuous improvement
Leadership programmes – new leadership forum launched and well attended, and a new Leadership programme has commenced

7.5 In light of the retention action plan, there has been a reduction in nursing turnover to 9.98%. However, Graph 10. highlights a static landscape within the ODP workforce, therefore following this review work will be undertaken to improve retention in the ODP workforce.



Graph 10. Turnover

8.0 Nurse and AHP sickness

8.1 Long term sickness rates across the 12-months range from 2.01 % to a high of 7.37% in Jan 24. The HR team have been supporting the divisions to robustly manage long terms sickness across the year. This management is also reflected in the ODP workforce, were they reported a high of 9.32% long term sickness in the same months as nursing.

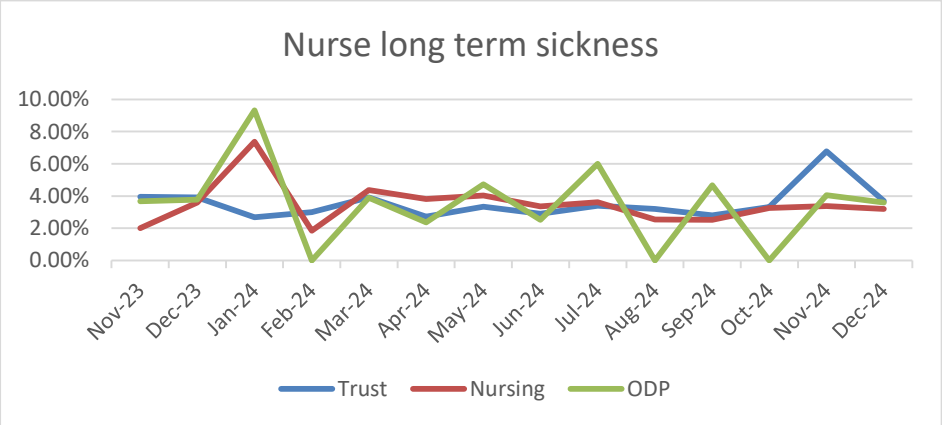


Table 1. Long term sickness

8.2 Short term sickness at times appears to mirror the long-term sickness profile. With a peak in January 24 of 7.19% followed by a low of 0.22% in March 24. Line managers and Divisional leads monitor sickness and ensure adherence to the local policy. During the 12 months, the trust absence policy changed and at times the team reported some confusion with management robustly sickness. The HR team advised and supported in all cases.

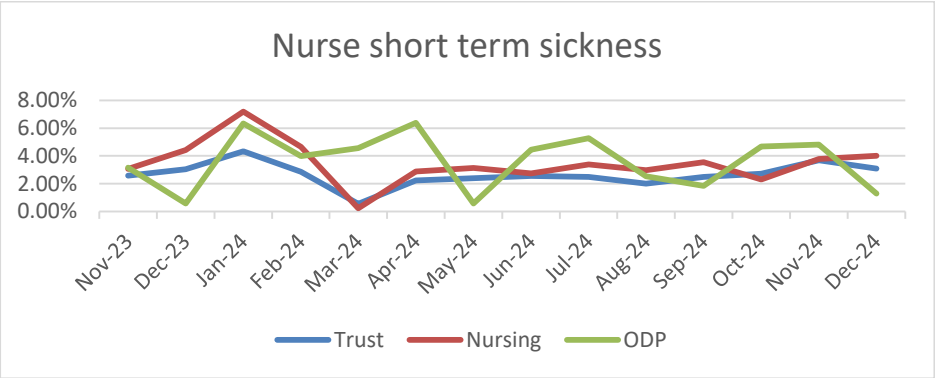


Table 2. Short term sickness

8.3 Targeted initiatives to reduce sickness have been introduced to key area with high sickness levels across the trusts, as described in the HR operational plan.

8.4 Benchmarking sickness data across the three specialist hospitals as described in table 3. (caveat that this data is all staff groups), places ROH with the highest sickness rates.

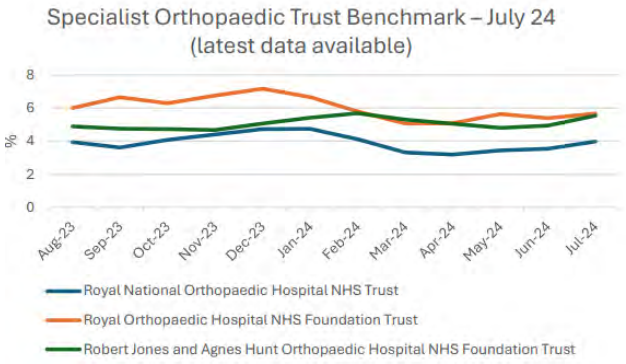


Table 3. Benchmarked sickness rates.

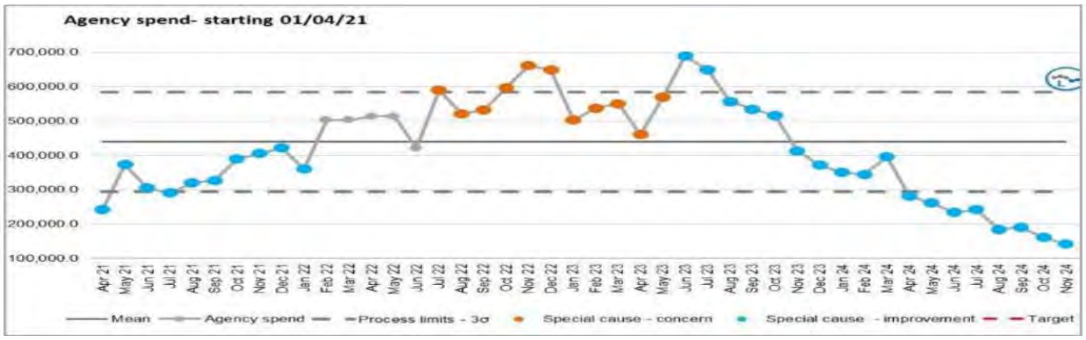
9.0 Temporary workforce

9.1 In October 2023, NHSE[23] outlined the following '*At month 5 2023/24, Midlands' systems have spent £805m on bank and agency staff, £176m more than it had planned to do at this point in the year and these costs account for 13% of total workforce costs'*. NHSE at this point set a national agency reduction target, with all system expected to develop agency reduction plans.

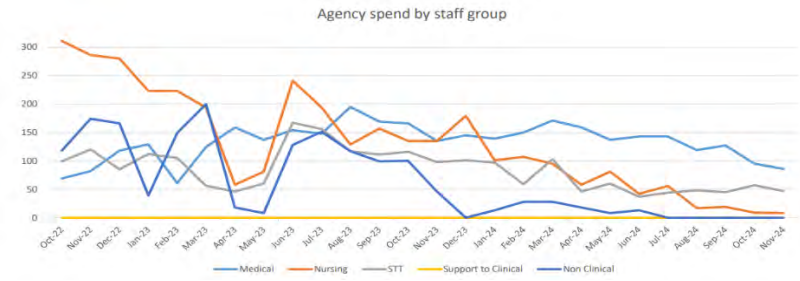
[23] NHS England » Agency rules

9.2 Shortly after this, BSOL ICS wrote to all providers outlining the current predicted system monthly agency position (*monthly agency spend increasing from £7.5m a month in 22/23 to £10m a month in 23/24 despite an overall increase in substantive and bank workforce*). In response to this letter, the Chief Nurse for ROH supported the 'BSOL Agency Reduction Meeting', with a clear system target of '*agency costs should not exceed 3.7% of total pay costs'*. The working group had clear objectives to focus on reducing overall agency costs, ensuring all agency rates were within cap, stopping using of framework agency and explore a system bank model. This working group fed into the Workforce Programme Board as outlined in section 2.12.

9.3 Agency (all ROH) spend across the year has continued to decrease from a high of £700k per month in July 23, to a current low position of £150K month in November 24 (across the trust). As demonstrated in graph 11 & 12.



Graph 11. Agency cost



Graph 12. Agency spends across all workforces

9.4 However, further drill down into nursing by shift demonstrates that nursing use of agency has dropped by shift to an all times low of 20 shift per month as demonstrated in graph 12.

Graph 13. Agency shift per month

Temporary staffing Controls

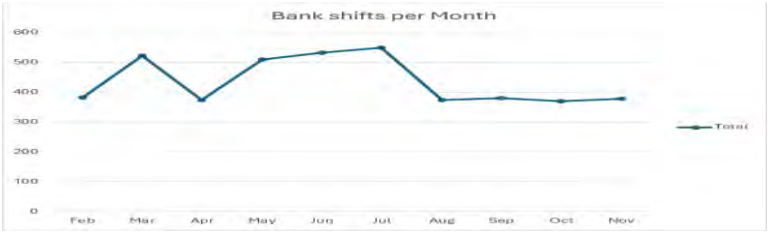
9.5 Temporary staffing has continued to be utilised to support staffing levels throughout the Trust. ROH has continued to focus on removal of nursing agency for the wards and the

Temporary staffing team have worked with the agencies to bring the pay rates under cap. The Temporary staffing team have reviewed all workforce to determine training and competencies. Those who are not up to date with mandatory training within the agreed timeframe or who have not worked shifts within 6 months have been terminated.

9.6 The Heads of Nursing and Matrons are committed to reducing the use of temporary staffing within their areas and are responsible for reviewing and authorising both Agency and bank requests. A Confirm and challenge process is followed before rosters are signed off which supports reduced reliance on temporary staffing.

9.7 Use of Temporary staffing is closely monitored by the Chief Nurse and the Deputy Chief Nurse. As vacancies have reduced, so has the use of temporary staffing as seen below.

9.8 However, additional is required in nursing over the coming months to continue to decrease bank shifts as demonstrated in graph 14.



Graph 14. Bank shifts

10.0 Quality Metrics (support safe staffing triangulation)

10.1 Safer staffing recommends that organisations triangulate safer staffing data with staffing incidents; there is an expectation that these incidents are reviewed, and action taken at divisional quality groups level prior to review at corporate nursing level and report to Board

10.2 The monthly Safer Staffing reports provide a comparison of Nursing workforce and safe staffing data against quality outcomes. On review of the planned staffing fill rate, there is no direct correlation found between wards with a lower fill rate and nurse sensitive indicators including patient falls, pressure ulcers and medication errors

Graph 15. Staffing incidents from April 2024-September 2024

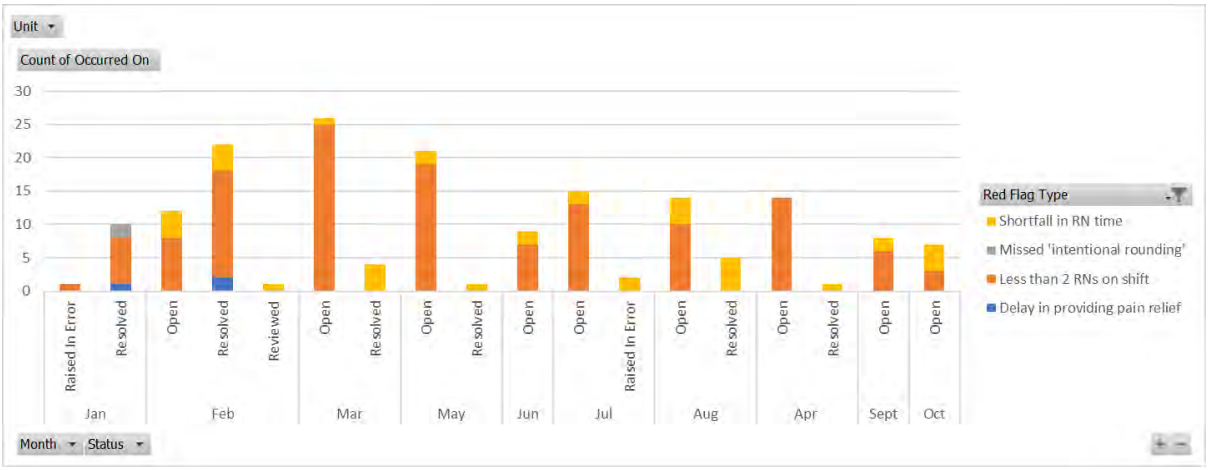
10.3 Staffing incident themes.

The themes identified are:

Lack of suitably trained staff due to staff illness/absence
Shortages on in-patient wards resulting in inability to provide escort for patients
Pressures in Theatre to manage lists with appropriate staff

Red Flags

10.4 Red Flags as Identified by NICE (2014): NICE (2014, 2018a, 2018b)[24] recommend the use of red flag events to support daily staffing decisions. A red flag event needs to be raised in the event there are indicators that the number of planned, required and available nursing hours on a ward is insufficient and present a clinical risk to patient care. This should prompt an immediate response by the registered nurse in charge of the department and Matron. Locally, red flags are designed to be an integral feature within Safe Care and Ulysses and should be reviewed daily as part of the daily staffing oversight. Any decision to resolve a red flag should not result in a red flag in another ward/area. Headings for the red flags are under review to tailor for all departments. Any red flag escalations are recorded within safecare and reviewed and manged by Matron.



Graph 16. Red Flag data January 2024 – October 2024

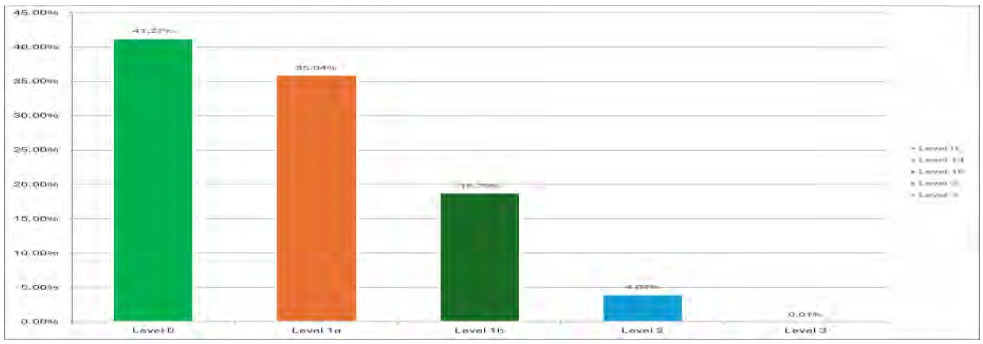
10.5 The monthly Safer Staffing reports provide a comparison of Nursing workforce and safe staffing data against quality outcomes. On review of the planned staffing fill rate, there is no direct correlation found between wards with a lower fill rate and nurse sensitive indicators including patient falls, pressure ulcers and medication errors.

Accuity

10.6 The overall average percentage of data for adult ward acuity demonstrates that the highest proportion of patients are stable, and dependent on nursing care with (18.79%) of level 1b patients. This level indicates a patient is requiring a high level of nursing time and

[24] Recommendations | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE

support. Significant proportion of the patients (41.27%) are level 0 patients (Table 4). As expected, there are a low number of level 3 patients (0.01%). All level 3 patients are transferred to critical care units within the BSOL system. It is expected that enhanced observation has increased marginally, and this will be captured in the planned census.



Graph 17. Accuity scores (average across the year)

10.7 Services Accreditation was undertaken in 6 clinical areas in November 24, 3 areas achieved silver, and three areas achieved Gold. Phase 2 will be rolled out in April 25 to included HDU and other clinical areas.

11.0 Divisional safe staffing reports

Division 1

In-Patient wards - The In-patient wards establishment reviews have been completed; the main action was an uplift to the health care assistant workforce on ward 3 (Oncology) which had been proposed following review and monitoring of dependency and acuity data via safecare.

Out-patient department (ODP) – main out-patient nursing establishment review completed in January 2025 in conjunction with Consultant Job plans and clinic templates. Children and Young Adult Out-patients (CYP OPD) review will be completed once job plans and clinic templates are finalised. CYP ODP have created a Developmental Band 6 post and looked at ways for staff to maintain skills to promote retention.

Royal Orthopaedic Community Service (ROCS) have recruited to a long-standing Physiotherapy role and have support workers who have commenced on Lead Practitioner Healthcare apprenticeships at Level 4.

Training and Development –

- Two registered Nurse Associates commenced their Registered Nurse Conversion training in October 2024.
- There has been career progression for internal staff who have been successfully appointed from band 5 to band 6.
- An Outpatient nurse has completed a secondment to a specialist Geonomics role in the research team and a CYP nurse has seconded to the Oncology Macmillan team to support reasonable adjustments.
- There are currently 9 Registered Nurse Associates within Division 1.

Division 2

Theatres – An establishment review is underway following the 7-day working consultation.

Admissions Day Case Unit (ADCU) – The establishment review has been completed with no changes proposed. A future development is to work on a Nurse Led Iron clinic.

Pre-operative Assessment Centre (POAC) – Workforce review and services redevelopment programme is underway. Aim is to implement a Nurse Led protocols to maximise efficiency, reduce unnecessary tests and improve patient experience. Competencies have been developed and training will commence.

High Dependency Unit (HDU) – The establishment review has been completed with no changes proposed. Focus on training with 1 member of the team on the Critical Care course and 2 more to enrol in September 2025. To support and help nurses achieve and maintain level 3 competencies, 1 member of staff a week completes a shift on Trauma Critical Care at Queen Elizabeth Hospital. This also promotes system working and networking.

Critical Care Outreach Team (CCOT) The team have increased their establishment to by 3 WTE in July 24, to allow the services to expand 24/7 to meet the national drive to implement Maratha's rule. Currently the team are reviewing the Job Description for the Band 6 role with support from Union representatives and HR.

7 day working consultation

11.1 During 2023, the Getting it right first-time team (GIRFT) awarded accreditation status to the Trust. However, one of their key recommendations was to pursue the formalisation of theatres working 6 days to ensure full maximisation of theatre capacity. Formalised 6-day working would also allow the teams to plan lists in advance and improve compliance with the Trust's 6-4-2 process.

11.2 In August 2024, employees on agenda for change (AfC) terms and conditions within the Theatre team were consulted to support 7 days operating. The consultation was concluded for a 6-week process, and it was agreed that a change to contracts would be implemented in March 2025. Following this changes to rosters will be implemented to support four lists on a Saturday and one list on a Sunday. A workforce establishment review is current underway to support this change.

14.0 Health and Wellbeing of Nursing and AHP Workforce

14.1 The health and wellbeing of the Nursing and AHP workforce remains a key priority with initiatives across each Division to ensure staff are supported whilst at work and links with the trust's retention strategy.

14.2 Professional Nurse Advocate

14.3 The Professional Nurse Advocate (PNA) programme was launched by England's Chief Nursing Officer (CNO) in 2021 in response to the pandemic recovery to support the wellbeing of our nursing workforce. The PNA supports staff through restorative clinical supervision (RCS) with a recommended target of 1:20 PNA to registered nurse ratio by 2025.

14.4 To meet this ratio, and to ensure all registered nurses have access to a PNA, a minimum of 13 PNAs are required across the organisation. Currently 4 registered nurses have completed the PNA programme by November 2024, with a further 3 undertaking training taking us to 53% of the target.

14.5 Data in relation to the number of restorative supervision sessions, career conversations and improvement projects supported by PNAs is reported monthly to NHSE. Themes raised from restorative clinical supervision are:

Workload and Staff Shortages
Emotional Resilience and Well-being
Career Development and Recognition
Interpersonal Challenges
Need for Psychological Safety
Transition Support for New Staff and International Recruits
Reflective Practices and Patient-Centred Care

14.6 This feedback is now being triangulated with retention data to inform the trust nursing retention plan. Restorative Clinical Supervision addresses the emotional needs of staff. It provides "thinking space", which reduces stress and burnout and in turn improves staff retention.

14.7 In Late 2023, NHS England funding was released specifically for critical care staff, designed to ensure they have access to PNA support, training and well-being initiatives. The majority of the funding allocated to ROH was used to support the PNA training and Critical care training to meet the requirements within HDU. Additionally a small proportion was used to create a reflection room based within HDU for staff to be able to reflect and relax while on shift to help reduce the risk of burnout and work-related stress absence.

14.7 Preceptorship Accreditation

14.8 The Clinical Education Team developed a 12-month rolling preceptorship programme, designed to allow staff to 'step on' and 'off' as they require. This programme was awarded the interim Quality Award[25] in 2024. The trust is now supporting the 3rd cohort, with positive feedback from staff, having support 48 staff to attend the protected programme.

14.9 Continuing Professional Development (CPD)

[25] National Preceptorship Interim Quality Mark - National Workforce Skills Development Unit

14.10 In September 2023, the Trust undertook a review and relaunch of our continuing professional development (CPD) programme designed to support nursing, nursing associate and AHPs.

14.11 CPD has funded externally academic programmes such as the Orthopaedic Course delivered by Rober Jones and Agnes Hunt. Several master's programmes designed to develop experts within teams, such as the Infection Prevention Control (IPC) Lead undertaking a IPC masters.

14.12 The funding has also been used to target specific training needs, targeting a wider audience. Such as the Human Factor programme, Mental health training and face-to-face dementia training over the last 12-months. Funding has also been used to develop a leadership programme for senior nurse and AHP leaders. With all theatre band 7's commencing the programme in October 24.

14.13 Recognising the challenges outlined in section 4. Associated with the recruitment of ODP's. The theatre department have utilised CPD funds support nurses to undertake the anaesthetic course. Currently two nurses have completed the course and are consolidating their skills. Three more are currently awaiting results at the time of the report. With one more nurse due to commence the programme in March 25.

15.0 RECOMMENDATION(S)

15.1 The following outlined below are the intended actions to be undertaken over the next six months, with a view to presenting the findings to the board in October 25, as part of the bi-annual reporting cycle.

Undertake the SNCT Census of clinical areas before implementing changes to establishments/budgets.
Complete the OPD establishment review
Continue to work with staff side to complete the Band 2/3 job description review
Roll out of the 7-day working in Theatres
Review headroom for 25/26 in view of current mandatory training requirements.
Review all training plans for 25/26 (clinical)
Review healthroster templates to ensure they are in line with agree establishments
Review AFPP recommendations against current working model in theatre.
Future reports will also include all AHP (Physiotherapy and radiology)
Benchmark against model hospital current baseline

16. Conclusion

16.1 The Board of Directors are asked to receive this paper and note the current position and planned work to be undertaken in the preceding 6 months and the following recommendations.

16.2 Safer Staffing reports for Nursing and AHP, will be presented on a bi-annual basis.

16.3 Conduct a further SNCT Census of clinical areas before implementing changes to establishments/budgets in quarter 4.

Nicola Brockie & Emma Steele
Chief Nurse & Deputy Chief Nurse
January 2025

APPENDICES:

Appendix 1 – AFFP link.

AFPP updated (2022)Staffing for Patients in the Perioperative Setting – Staffing for Patients in the Perioperative Setting - Fourth Edition - The Association for Perioperative Practice

TRUST BOARD

DOCUMENT TITLE:	**Learning from Deaths Summary**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revell, Executive Medical Director** **Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**5 February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

A detailed Learning from Deaths was presented at Quality and Safety Committee in January 2025 as part of the regular reporting cycle.

This included a qualitative review and a quantitative review

Qualitative Review

Case 1: Update on Hemipelvectomy (hind quarter amputation) Death

This case has been the subject of a regulation 28 notice from the coroner and was discussed in detail

Case 2: Cardiac related death post spinal surgery

Quantitative Review

This regular part of the report indicates a stable position overall against historical and peer controls.

The Governance department maintain a learning from deaths tracker

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Stable position on qualitative review and temporal clustering of peri-operative deaths earlier in the year does not appear to have been a sustained pattern of increased peri-operative deaths Detailed and thorough governance review No criticism of the clinical care itself in the coroners concerns	Documentation in the operation note was incomplete and will form the basis of the next health records documentation quality audit, building on some work in 2023 around operation note quality after the move to PICS operation noting. The Trust Clinical Governance Team is clear how similar complex cases will be unified and presented in future.

REPORT RECOMMENDATION:

The Board is asked to: Accept the report for assurance.

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	**X**	Environmental		Communications & Media	**X**
Business and market share		Legal & Policy	**X**	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		**Services**	
People		**Collaboration**	

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

BAF Risk SR1: Our Care.

MD1: Isolated Site

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

Learning from Deaths and System Quality Meetings

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

HED Data

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

Regular report to the Quality and Safety Committee.

Case Outline

1. The absence of documentation of the peritoneal defect and its repair in the operative note.
2. The limited scope of the PSII investigation, which focused on resuscitation but did not address the root cause of the death (the peritoneal defect and subsequent herniation).

These points were framed as evidence that the trust needs to strengthen its learning culture and investigative processes.

The Trust has responded formally to the coroner and is liaising with the CQC.

The case and the regulation 28 notice have been presented in full to the clinical body and the importance of accurate documentation emphasised. Health Records committee will be auditing operation notes specifically to ensure that the Trust maintains its focus.

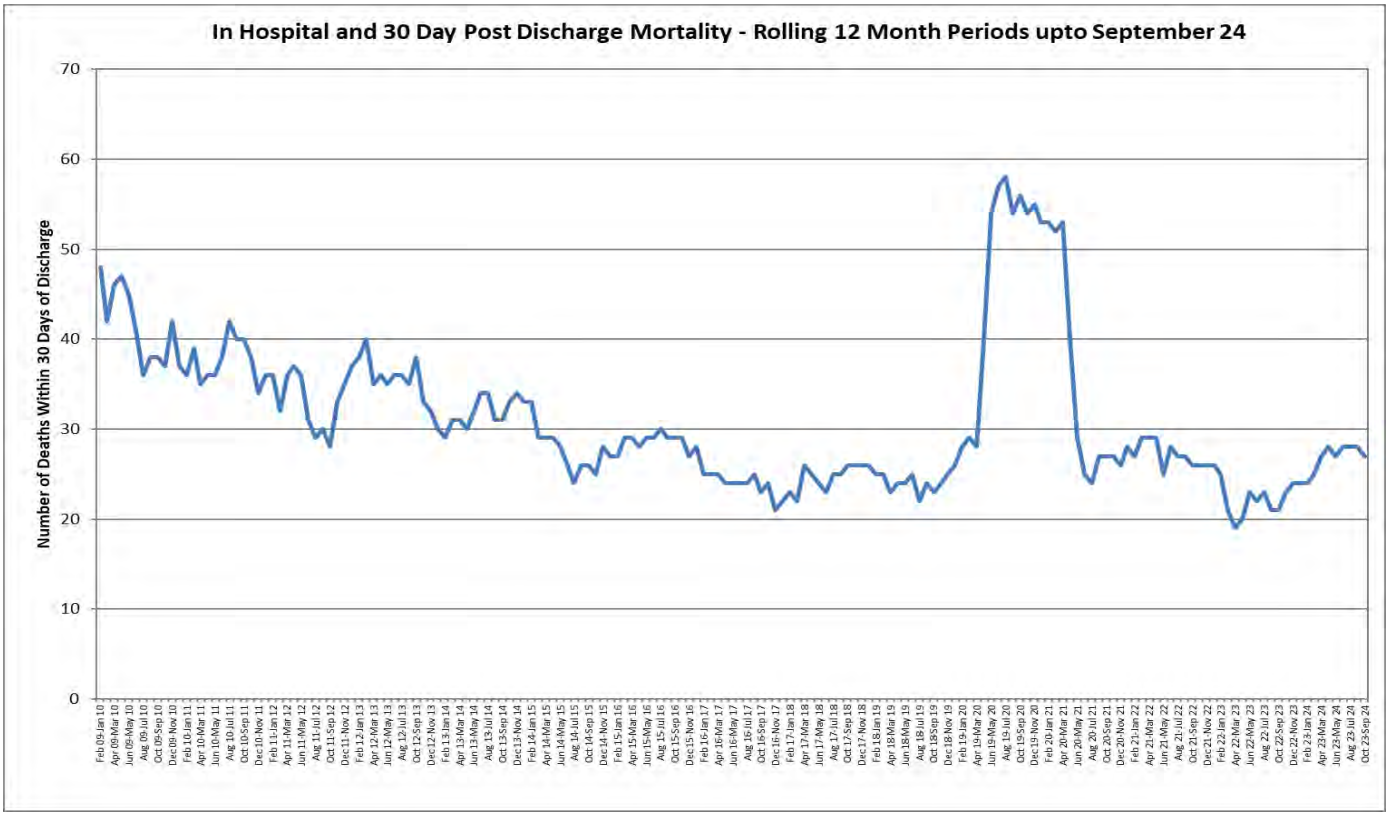
The case and the Regulation 28 notice have also been presented in detail to the BSol Quality and Safety Committee.

The Trust also engaged with internal and external stakeholders to confirm that PSIRF was applied in the spirit in which it was intended to this case, and generated a proposal as to how the evidence of the investigations and learning are best presented to the Coroner in future.

A second death in spinal surgery was included in the detailed report and learning points identified.

Mortality is reviewed quantitatively every month at AQILA, and the latest reviews (November 2024 and December 2024) indicated no breach of control limits and a benchmark position in line with other stand-alone orthopaedic Trusts.

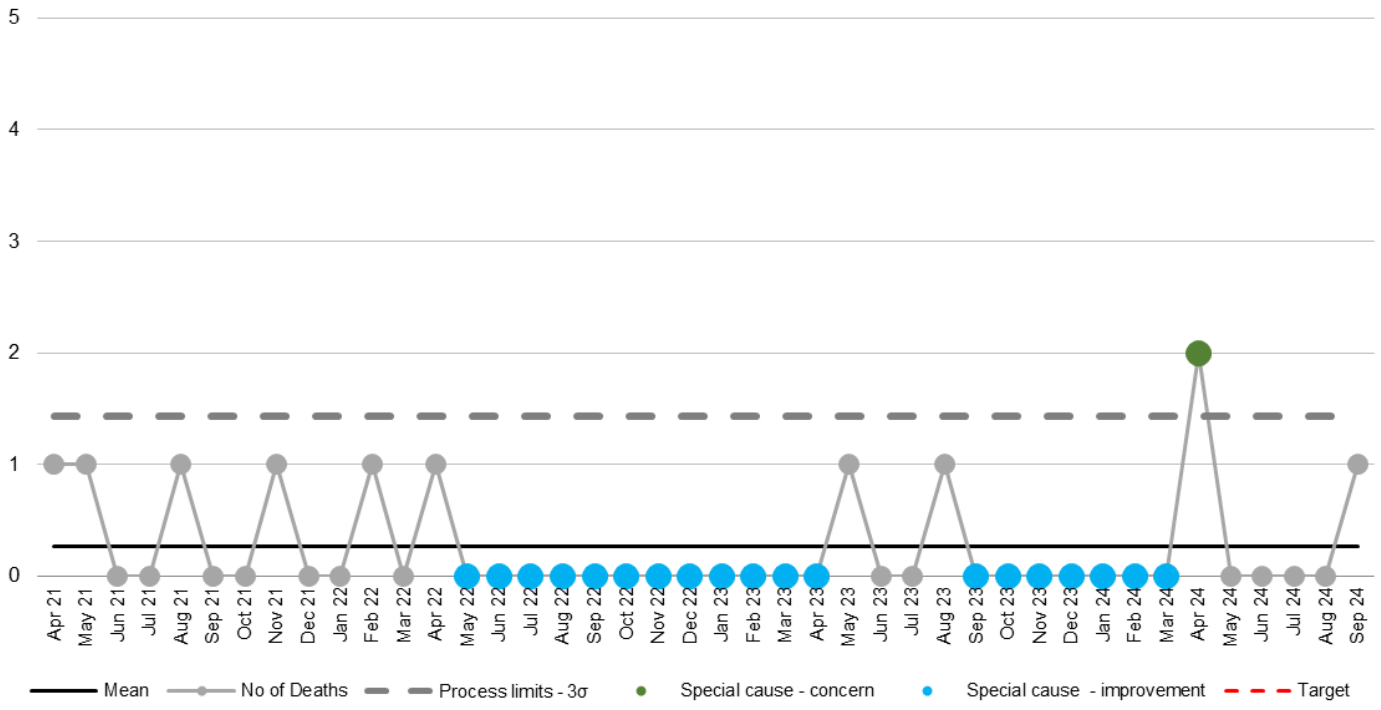
Quality and Safety Committee received a detailed analysis and the main trackers are included in appendix 1. There are no clear adverse trends and a numerical rise in oncology related deaths is being monitored.



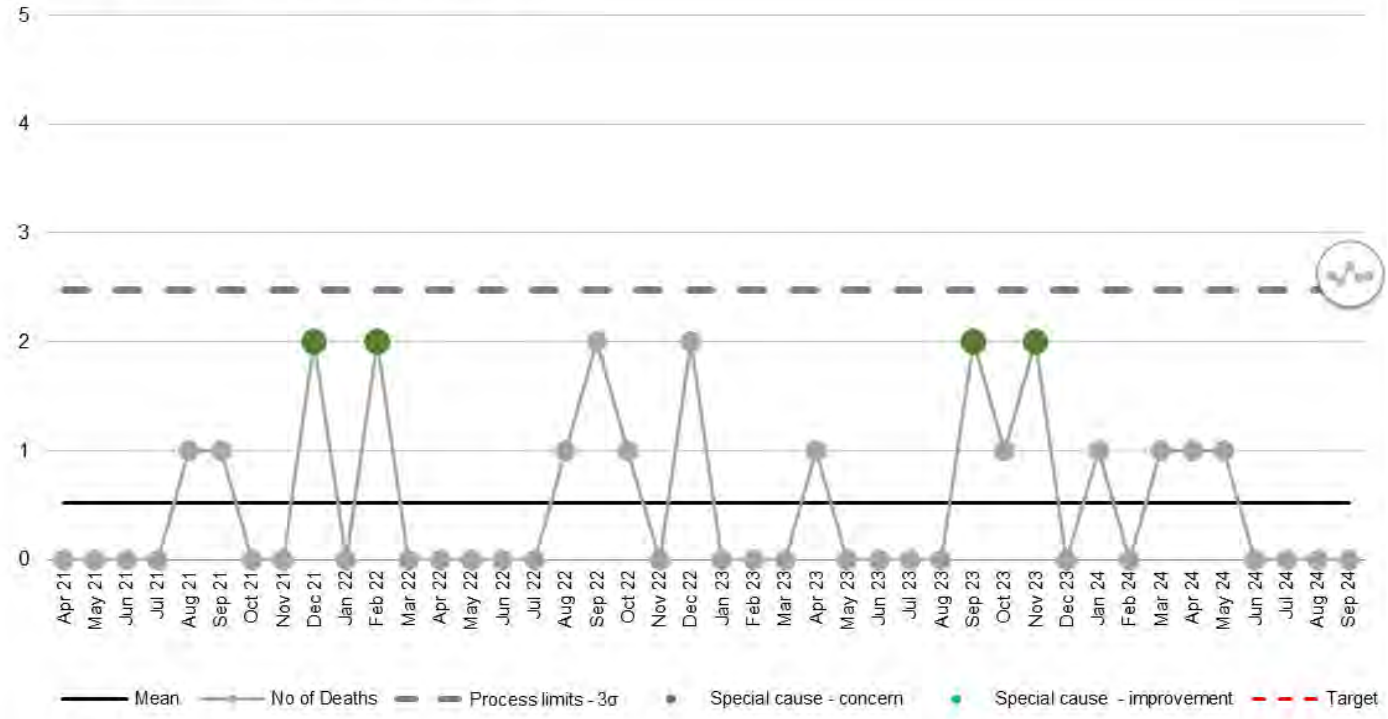
Mortality Outcome	CCS Code	Cause of Death Description	Total
DEATHS IN HOSPITAL	238 - Complications of surgical procedures or medical care	Not Recorded	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Not Recorded	1
	21 - Cancer of bone and connective tissue	Not Recorded	1
1-7 DAYS	238 - Complications of surgical procedures or medical care	Not Recorded	1

	205 - Spondylosis; intervertebral disc disorders; other back problems	Congestive heart failure	1
	237 - Complication of device; implant or graft	Chronic obstructive pulmonary disease with acute lower respiratory infection	1
	42 - Secondary malignancies	Malignant neoplasm: Bone and articular cartilage, unspecified	1
		Malignant neoplasm: Connective and soft tissue of lower limb, including hip	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Chronic obstructive pulmonary disease with acute lower respiratory infection	1
	21 - Cancer of bone and connective tissue	Not Recorded	1
8-30 DAYS	**203 - Osteoarthritis**	Chronic ischaemic heart disease, unspecified	1
		Intracerebral haemorrhage, unspecified	1
		Rheumatoid arthritis, unspecified	1
	238 - Complications of surgical procedures or medical care	Malignant neoplasm: Connective and soft tissue of lower limb, including hip	1
	205 - Spondylosis; intervertebral disc disorders; other back problems	Acute myocardial infarction, unspecified	1
	237 - Complication of device; implant or graft	Chronic ischaemic heart disease, unspecified	1
		Urinary tract infection, site not specified	1
	42 - Secondary malignancies	Chronic obstructive pulmonary disease with acute exacerbation, unspecified	1
		Malignant neoplasm: Endometrium	1
		Malignant neoplasm: Intestinal tract, part unspecified	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Malignant neoplasm, primary site unknown, so stated	2
	21 - Cancer of bone and connective tissue	Malignant neoplasm, unspecified	1
		Malignant neoplasm: Bone and articular cartilage, unspecified	2
		Malignant neoplasm: Connective and soft tissue, unspecified	1
	82 - Paralysis	Cerebral palsy, unspecified	1
Grand Total			**27**

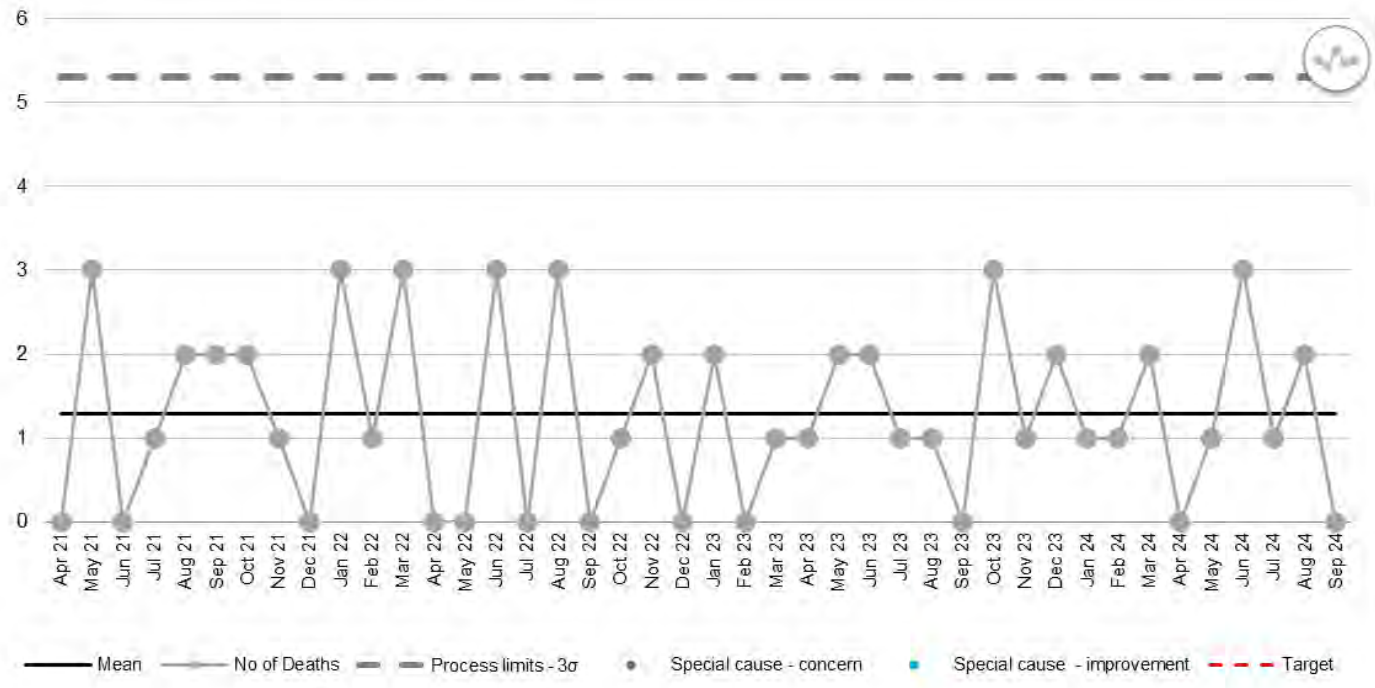
Number of In Hospital Deaths



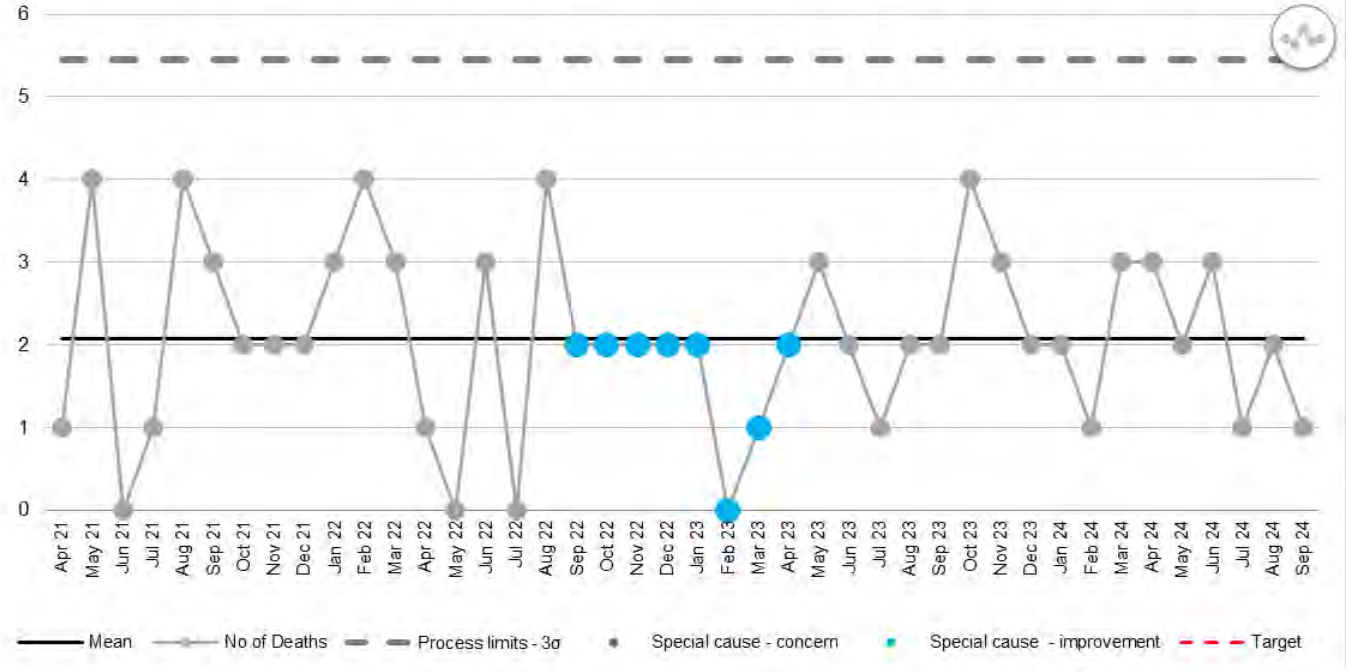
Number of Deaths 1-7 Days Post Discharge



Number of Deaths 8-30 Days Post Discharge

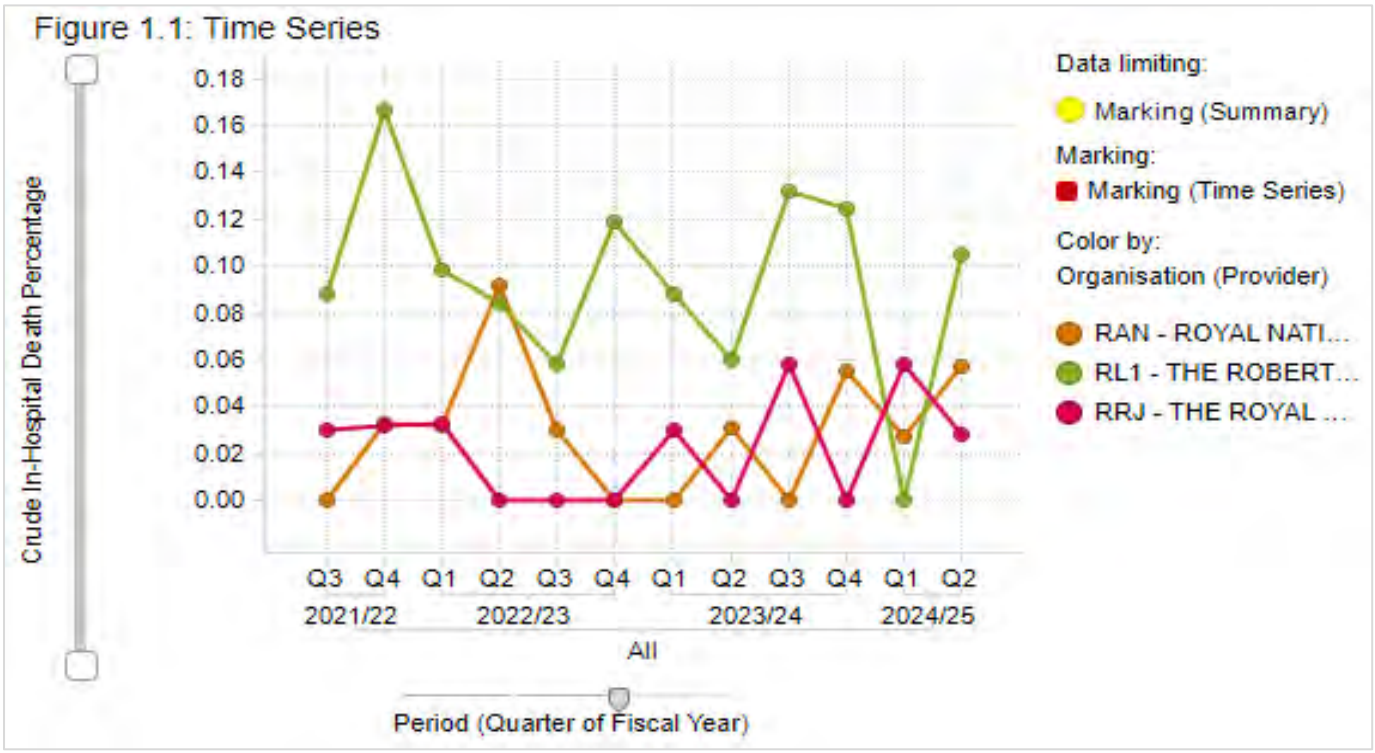


Number of Deaths Within 30 Days Discharge (Including In Hospital Deaths)



October 21 – September 24

Crude In-Hospital Death Rate (number of in hospital deaths in period/number of discharges in period)



NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Well Led self-assessment & action plan - updated**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**5 February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

As part of the CQC preparedness plans, self-assessments against all domains of the CQC Single Assessment Framework (SAF) have been completed.

Priority has been given to the self-assessment of the Well Led domain, given that under the new SAF it is clear that this assessment is considered primarily, given the assertion that if an organisation is Well Led, then it is likely to be Effective, Responsive, Caring and Safe.

The attached provides an updated version of Well Led self-assessment which was last considered by the Board in April 2024. It provides a positive position, with additional pieces of evidence to offer as assurance. Where there are identified gaps or improvements required, these have been entered into an action plan which can be found in the last pages of the document.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Good overall compliance with the CQC well led domain and many areas of good practice which may be regarded as 'Outstanding'.	Gaps in compliance or areas requiring improvement included in an action plan.

REPORT RECOMMENDATION:

The Board is asked to:

note and accept this report as assurance

agree that monitoring of the action plan be delegated to the Staff Experience & OD Committee

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

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

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

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

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

Compliance with CQC Single Assessment Framework

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

None specifically

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

Not applicable

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

April 2024 Trust Board. Updated version considered by Executive Team in January 2025.

CQC Well led domain – self-assessment

Overall assessment of: whether there is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities

There are effective governance and management systems. Information about risks, performance and outcomes is used effectively to improve care

SHARED DIRECTION AND CULTURE		
QUALITY STATEMENT: *We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them	Board Approved strategy – June 2023 Slides from strategy launch – 2 November 2023 Updates from Strategy Review Group including proposed refresh plans Agenda for Board strategy session on 5 February 2025 Plans on a Page Strategy section of 100 days induction Value cards Recruitment material	Strategy personalised for teams Job descriptions do not always articulate how the role contributes to the delivery of patient care Complete the strategy refresh
Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners	Strategy update to Board – November 2022 and April 2023 Updates from Strategy Review Group Section in strategy detailing engagement on strategy Slides from Board session in October 2022 Strategy section of 100 days induction National staff survey results around vision	
Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement	CQC National Inpatient Survey results Compliments Complaints responses Meetings with complainants ~~RCAs shared with patients involved in an incident~~	~~Developing PSIRF approach~~

	PSIRF policy and plan describing patient involvement in investigations Duty of Candour cases Learning on One Page examples Patient Engagement and Experience ~~Forum~~ Group papers Chat & Check Continuous Improvement and Quality Improvement methodology Service accreditation Wellbeing offering Values cards HERO awards	
Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care	Equality & diversity staff network Other staff networks WRES and WDES updates to Staff Experience & OD Committee FTSU updates to Trust Board Staff and patient stories e.g. neurodiversity Inclusive Companies awards Thrive at Work accreditation Disability Confident accreditation Veteran Aware status E & D mandatory training 100 days induction slides on equality & diversity	Composite networks update to Staff Experience & OD Committee Reported poor attendance at some staff network meetings ~~Resignation of~~ ManKind network to be reinstated ~~chair~~
Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action is taken to address these	100 days induction slides on equality & diversity and staff networks Staff survey results – compassionate & inclusive domain	

	Benchmarking work across BSol to ensure that staff grades are comparable	
Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plans	Realigned Board Assurance Framework Financial Recovery Board updates ~~sustainability plan~~ Upward reports from Board committees to Trust Board	Quarterly updates to Trust Board on delivery of strategy not yet started Revised BAF still undergoing final iterations Corporate Risk Register to be cleansed
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
~~Further embed PSIRF~~ Complete the strategy refresh Updates on strategy delivery to be systematised Further refine BAF Encourage better attendance at staff networks		
PROPOSED 'OUTSTANDING' EVIDENCE		
Trustwide strategy session – 2 November 2023 Strategy Review Group Strategy animation Staff networks Chat & Check 100 Day Induction Service Accreditation National Accreditation & Awards		

SUBTOPICS THIS QUALITY STATEMENT COVERS

Strategy and vision

Organisational culture

Values

Addressing social impact

CAPABLE, COMPASSIONATE AND INCLUSIVE LEADERS		
QUALITY STATEMENT: *We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered and risks are well managed	Executive and Non Executive appraisals Executive portfolio summary Organisational chart CVs of Board members Board members' objectives Nominations & Remuneration Committee papers FPPT updates to Trust Board Recruitment material for SP, JB and JT	Fit and Proper Persons Test policy currently being updated
Leaders at every level are visible and lead by example, modelling inclusive behaviours	Chat & Check QA walkabouts Chair's visits CEO and Chair updates to Board 100 day induction and reunion ~~events~~ feedback Governor engagement plan Team Brief Staff network structure showing Executive sponsorship	Non Executive walkabouts to ~~commence~~ embed ~~Visibility of sub-Board posts to be confirmed~~ Feedback gained through Quality Walkabouts suggests poor understanding of the role & visibility of NEDs Posters of Board members to be prepared and displayed
High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning	Workforce updates to Staff Experience & OD Committee Non Executive recruitment material Recruitment material for ~~Chief Nurse and Chief Finance Officer~~ Board members Board structure showing deputies	No formal succession or talent development process in place No clear succession plan for Chief Executive or Director of Governance posts

Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role	Team Brief Senior Leadership Team development programme Executive Team development programme New appraisal process Trust Management Group Terms of Reference	'We are Learning' scores in National Staff Survey are suboptimal
Leaders are alerted to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly	FTSU framework and updates to Trust Board Health & Safety Group papers Violence Prevention & Reduction standards updates to Trust Board and Staff Experience & OD Committee Staff stories Complaints sign off process Incident reporting and management framework Divisional performance review papers Board walkabouts	'You Said, We Did' to be developed for FTSU concerns and incidents

KEY ACTIONS REQUIRED TO ADDRESS GAPS

~~Strengthen attendance at~~ Revise 100 day reunion process
Progress and implement succession and talent management approach
Develop various means of sharing learning and action taken in respect of FTSU concerns and incidents
~~Implement~~ Embed non-executive walkabouts

PROPOSED 'OUTSTANDING' EVIDENCE

100 day induction ~~and reunion~~ process
Appraisal process

SUBTOPICS THIS QUALITY STATEMENT COVERS

Leadership competency, support and development

Safe recruitment of leaders/FPPR

Compassionate and capable leaders

Roles and accountability

Succession planning/talent management

FREEDOM TO SPEAK UP		
QUALITY STATEMENT: *We foster a positive culture where people feel that they can speak up and that their voice will be heard*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders act with openness, honesty and transparency	FTSU updates to Trust Board Details of FTSU week – October 2023~~4~~ Team Brief slides ~~Slides for session held to outline Trust financial challenges~~ Speaking Up update to Trust Board following Lucy Letby judgement Trust values 100 day induction slides Annual self-attestations for Board members	
Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard	Team Brief slides Continuous Improvement and Quality Improvement framework 100 day induction slides QSIR updates Coffee Catch up methodology Chat & Check	~~Speaking up scores in National Staff survey have dipped but remain good compared to other NHS organisations~~
There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on	Confidential concerns paper to Trust Board – February 2024 Notes from CQC engagement meetings Staff survey results FTSU updates to Trust Board Oncology culture review FTSU internal audit New detriment addition to FTSU policy	Feedback from those raising concerns to be developed You Said, We Did to be developed for FTSU concerns

When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again	Complaints responses Apologies issued in response to legal claims ~~RCAs shared with those involved in an incident~~ PSIRF policy and plan describing patient involvement in investigations Shared decision-making material Duty of Candour policy Evidence of meeting with patients as part of resolving a complaint	Incident reports to be developed for those which are managed locally and shared with ward managers LOOP to be more fully embedded and systematic lessons learned dissemination process to be developed Patient safety bulletin to be devised
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
Improved feedback loops for FTSU and incidents		
PROPOSED 'OUTSTANDING' EVIDENCE		
FTSU week FTSU framework Shared decision-making		

SUBTOPICS THIS QUALITY STATEMENT COVERS

Speaking up culture

Freedom to speak up guardian

Whistleblowing

Closed cultures

WORKFORCE EQUALITY, DIVERSITY AND INCLUSION		
QUALITY STATEMENT: *We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion	Adoption of Race Code Race Equality Code workshops with RSM WRES and WDES updates to Staff Experience & OD Committee Equality & diversity annual reports Development and refresh of plans for those with learning disabilities, vulnerable adults and safeguarding Learning disabilities, vulnerable adults and safeguarding annual reports MMEG exhibition 'Behind the Stigma' exhibition Inclusion of an equality objective in appraisals Hardship fund	
Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact	Summary of work to improve Women in Orthopaedics experience Staff story from female registrar at Staff Experience & OD Committee and actions taken since the story Staff networks WRES and WDES updates to Staff Experience & OD Committee Sexual Safety Charter Gender pay gap action plan	~~Development of a sexual safety policy~~ No evaluation of wellbeing offering at present

	Wellbeing offerings and updates to SE&ODC and Trust Board Menopause work and network Sexual safety policy	
Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all	Summary of work to improve Women in Orthopaedics experience Equality Impact Assessments for policies WRES/WDES updates Equality & Diversity annual report EDS2 updates Updated FTSU policy Action plans from annual staff survey Information submitted to Inclusive Companies	
Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups	FTSU reports and FTSU framework Zero tolerance posters Violence Prevention and Reduction Standards action plan and progress reports Workforce performance report CQC concerns update to Trust Board in February 24 HR documentation of employee relations cases	
Leaders make reasonable adjustments to support disabled staff to carry out their roles well	Workplace risk assessments Disabled staff profile Improved declarations rates Staff stories to SE&ODC and Trust Board Health & Safety updates Risk assessments	

Leaders take active steps to ensure staff and leaders are representative of the population of people using the service	Gender pay gap report to SE&ODC in March 24 EDS2 updates Reports demonstrating improved declarations rates Data Quality group material highlighting work underway to improve collection of patient demographic information Recruitment material promoting equality of opportunity Trust Board diversity profile Health Inequalities action plan Consultant recruitment panel compositions	
Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation	FTSU information showing that staff from a range of ethnicities speak out FTSU internal audit report Staff networks Organisation is third highest rated specialist trust for Staff believing that their concerns will be acted on if they speak up Multidisciplinary approach to shared governance and continuous improvement Chat and Check to all areas of the Trust to hear the staff voice Staff stories from a range of staff groups People Pulse results 100 day ~~reunion events~~ follow up process	Staff survey results suggest that staff are not aware of changes made as a result of incident reporting or speaking up
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
~~Development of a Sexual Safety policy~~		

Range of communication methods to be developed to ensure that staff are aware of changes made as a result of them speaking up or reporting incidents Undertake an evaluation of wellbeing offering to understand impact and take up
PROPOSED 'OUTSTANDING' EVIDENCE
Inclusive Companies awards Staff survey results re: confidence in speaking up MMEG and Behind the Sigma campaigns Hardship fund Reasonable adjustments for those experiencing the menopause Wellbeing Offering to all staff 100 day ~~reunion events~~ process

SUBTOPICS THIS QUALITY STATEMENT COVERS

Fair and equitable treatment of staff

Staff human rights

Well-being of workforce

Gender pay gap

Workforce diversity

Flexible working arrangements

WRES and WDES

GOVERNANCE, MANAGEMENT AND SUSTAINABILITY		
QUALITY STATEMENT: *We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff	Trust Board and committee structure Governance framework showing reporting lines between corporate bodies Organisation chart showing structure of each directorate ~~Leadership charter~~ Role descriptions New appraisal framework Divisional performance review material Divisional governance meetings Divisional management board meetings 100 day induction Staff survey results Senior Leadership Team educational programme Executive and Non Executive appraisals Local induction material Mandatory training updates Appraisal rate updates	Audit of governance framework to understand effectiveness of corporate groups and areas of duplication Poor mandatory training ~~and appraisal~~ rates
The systems to manage current and future performance and risks to the quality of the service take a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service	Corporate, divisional and local risk registers Board Assurance Framework Upward reports from Board committees and corporate governance groups Research & Development annual report	

	Quality Impact Assessments when new services introduced QSIR methodology Continuous improvement and Quality Improvement frameworks ~~Financial sustainability updates and plans~~ Strategic Oversight Board and subgroup updates Officers' reports to Board Workforce planning role recruited ~~updates from CSU~~ Workforce planning internal audit Quality Assurance walkabouts EPRR framework	
Data or notifications are consistently submitted to external organisations as required	CAS alerts updates NICE guidance reports Updates from AQILA Finance returns to NHSE Annual report Communications with ICB Serious Incident reports Preventing Future Deaths response Response to complaints received through CQC Notifications to Health & Safety Executive Updates provided as a result of requests through the local and regional ICC National Joint Registry updates CQUIN updates Green Board updates	

	Safeguarding updates Radiation Safety updates	
There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care	Information Governance Group material Health Records Group material IG incidents and investigations Data Quality Group information Health Inequalities plan ~~summary to Trust Board in March 24~~ EPR updates to Trust Board DPST updates to IGG and Audit Committee	Absence of EPR means that there remain disparate systems Partial compliance with requirements of DPST
Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities	Health Inequalities plan ~~summary to Trust Board in March 24~~ Inequalities internal audit report PSIRF updates PROMS updates Annual quality priorities updates Quality Account	~~Development of a Health Inequalities action plan~~
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
Implementation of an EPR ~~Implementation and roll out of~~ Evidence of embeddedness of leadership charter Improve MT ~~and appraisal rates~~ Undertake comprehensive audit of governance framework Business continuity arrangements to be tested		
PROPOSED 'OUTSTANDING' EVIDENCE		
QSIR approach 100 day induction process Upward reporting process ~~Leadership Charter~~		

SUBTOPICS THIS QUALITY STATEMENT COVERS

Roles, responsibilities and accountability

Governance, quality assurance and management

Cyber security and data security and protection toolkit (DSPT)

Emergency preparedness, including climate events

Sustainability, including financial and workforce

Data security/data protection

Statutory and regulatory requirements

Workforce planning

External recommendations, for example safety alerts

Records/digital records

PARTNERSHIPS AND COMMUNITIES		
QUALITY STATEMENT: *We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies	National Orthopaedic Alliance Birmingham Health Partners ICB framework Mutual aid CQC engagement meeting material Appointed governors from universities and local institutions Model Hospital Group material Joint working update to QSC Strategic partnership update JLR visit update Acute Provider Collaborative Community Care Collaborative	
Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care	UHB theatre utilisation and partnership working SLAs with BSol providers Mutual aid PSIRF BSol event material Osseointegration updates ROH leadership of BSol workforce initiatives Robotics updates Private patient updates MSK academy development MSK transformation programme Community Appointment Days	GP liaison plans to be progressed Fragility of support arrangements for some clinical services

Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people	Complaints responses Claims and litigation updates Shared decision making approach Patient Experience & Engagement Group Plans to involve patients and carers in the investigations under PSIRF Health Inequalities updates Roving governor walkabouts Coffee catch up meetings Acute Provider Collaborative Community Care Collaborative Quality meetings with ICB	

KEY ACTIONS REQUIRED TO ADDRESS GAPS
Development and implementation of GP liaison plans

PROPOSED 'OUTSTANDING' EVIDENCE
Shared decision making Osseointegration Coffee Catch up meetings MSK transformation

SUBTOPICS THIS QUALITY STATEMENT COVERS

Sharing good practice and learning

Integration health and social care

Partnership working and collaboration

LEARNING, IMPROVEMENT AND INNOVATION		
QUALITY STATEMENT: *We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact	QSIR methodology Continuous Improvement and Quality Improvement framework Lessons learned framework Quality Priority updates 100 day induction slides Quality Improvement updates Service/ward accreditation Learning from Deaths updates AMaT AQILA	
Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives	Coffee Catch up meetings Complaint responses and meetings Patient stories to Trust Board 100-day video showing impact of Joint Care NJR updates PROMS updates Patient Engagement and Experience Group updates Membership surveys Shared decision-making approach ~~Sharing of RCAs with~~ Involvement of patients in PSIRF investigations	
There are processes to ensure that learning happens when things go wrong, and from	~~RCA reports~~ PSIRF policy & process PSIRF investigations	Further work to do to ensure that staff understand what actions have been taken

examples of good practice. Leaders encourage reflection and collective problem-solving	Executive Governance papers PSIRF updates LOOP reports Clinical audit day material Divisional governance board material Round Table material Human Factors training Restorative supervision plans Plans to implement LFPSE	in the event of an incident being reported or a FTSU concern being raised
Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives	QSIR training Management Skills Programme material Senior Leadership programme Quality Improvement updates Continuous Improvement framework Service Improvement Board material Research and Development annual report AQILA updates AMaT update Underpinning plans to overall Trust strategy Details of visit to Jaguar Land Rover	Embryonic continuous improvement methodology
Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff	Research and Development annual report ~~Corporate Transformation Business Planning Workshop~~ Business Planning framework Presentation on QI project at Trust Board in March (Tissue Viability) FTSU framework Continuous Improvement framework Continuous Improvement week	

	Temperature Check discussions Chat & Check	
The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation	Birmingham Health Partners National Orthopaedic Alliance Research & Development programme Dubrowsky laboratory activity Osseointegration University placements Chair of Orthopaedics Undergraduate and post graduate medical staff framework and support BOOM conference - international bone oncology consensus meeting Oncology research audit by Jonathan Stevenson Jaguar Land Rover linkages	

KEY ACTIONS REQUIRED TO ADDRESS GAPS

~~Develop and formalise~~ Further embed the continuous improvement framework and evidence its impact
Develop a range of tools to communicate action taken with incidents are reported or FTSU concern raised

PROPOSED 'OUTSTANDING' EVIDENCE

BOOM conference
Osseointegration
QI project (tissue viability)

SUBTOPICS THIS QUALITY STATEMENT COVERS

Innovation

Learning and improvement

Research

Learning from deaths

ENVIRONMENTAL SUSTAINABILITY – SUSTAINABLE DEVELOPMENT		
QUALITY STATEMENT: *We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population	Green Board material Green Board upward reports to Finance & Performance Committee Work of waste management officer Estates plan Trust's net zero strategy update to Trust Board	Poor engagement with the Green Board No defined programme setting out ambitions and actions to reduce carbon footprint of the Trust
Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity	Net zero updates to Trust Board and Finance & Performance Committee Continuous improvement framework Reduction in use of disposable containers in Café Royale Use of Board Effect to reduce use of paper Board packs Use of electric vehicles for blood and specimen management Flexible working approach to reduce travel to site Car sharing schemes	
Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others	BSol inequalities strategy BSol Green Plan to FPC in February 2024 Prevention element of inequalities work	

Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible	Solar panels installation Ward refurbishments with low-wattage LEDs Recycling introduced as routine across Trust Efforts to reduce food wastage Virtual consultations	
Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time	Move to text reminders Digital, data and technology strategy EPR updates to Trust Board Estates plan Capital plans	
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
Improve engagement with the Green Board Refresh and re-energise the Trust's Net Zero plan		
PROPOSED 'OUTSTANDING' EVIDENCE		
None		

SUBTOPICS THIS QUALITY STATEMENT COVERS

Staff awareness and education

Carbon reduction. For example, within travel and transport, medicines, and supply chain

Health promotion and prevention

Estates and Facilities. For example, energy saving measures, lower carbon options and waste reduction including recycling

Efficient service delivery with resource optimisation

Well Led Domain – Action Plan

REF.	ACTION	RESPONSIBLE	COMPLETION DATE	PROGRESS	STATUS
WLQS1.1	Complete the strategy refresh	RL	30 March 2025	Strategy refresh underway overseen by Strategy Review Group	
WLQS1.2	Systematise the updates to the Board on the delivery of the Trust strategy	RL/SGL	1 April 2025	To be built into the Board workplan for 2025/26 on a quarterly basis	
WLQS1.3	Complete the Board Assurance Framework refresh	SGL	30 March 2025	BAF updated for Board in February and further update planned to align with strategy refresh for March 2025 Board meeting.	
WLQS1.4	Refresh communications around staff networks to encourage better attendance	SM	28 February 2025		
WLQS2.1	Complete refresh of Fit and Proper Persons Test policy	SM	1 March 2025	Policy refresh underway	
WLQS2.2	Develop succession and talent management approach	SM	1 May 2025	Linked to new Management Development Programme	
WLQS2.3	Develop various means of sharing learning and action taken in respect of FTSU concerns and incidents	SGL	30 April 2025	LOOP documents already widely used. Approach to be adopted by FTSU.	
WLQS2.4	Embed the NED/ED walkabouts	SGL	30 March 2025	First walkabout completed with further scheduled	
WLQS2.5	Develop & implement a patient safety bulletin	SGL	30 April 2025		
WLQS3.1	Undertake an evaluation of wellbeing offering to understand impact and take up	SM	30 March 2025		

REF.	ACTION	RESPONSIBLE	COMPLETION DATE	PROGRESS	STATUS
WLQS4.1	Implement EPR	SW	FY 2026/27		
WLQS4.2	Evidence embeddedness of leadership charter	SM	30 March 2025	To be tested with Senior Leadership Team	
WLQS4.3	Improve Mandatory Training rates	ALL	31 May 2025		
WLQS4.4	Undertake comprehensive audit of governance framework	SGL	1 May 2025	Initial governance review plan considered by Executive Team in January 2025	
WLQS4.5	Arrange for business continuity arrangements to be 'stress tested'	SW/MP	30 April 2025		
WLQS5.1	Develop GP liaison plans	MP/RL	1 May 2025	Part of strategic partnership work underway	
WLQS6.1	Further embed the continuous improvement framework and evidence its impact	RL	31 May 2025	Presentation to Executive Team in January 2025	
WLQS7.1	Improve engagement with the Green Board	SW	30 April 2025		
WLQS7.2	Refresh and re-energise the Trust's Net Zero plan	SW	30 April 2025		

KEY

RL	Rebecca Lloyd, Director of Strategy
SGL	Simon Grainger-Lloyd, Director of Governance
SW	Steve Washbourne, Chief Finance Officer
SM	Sharon Malhi, Chief People Officer
MP	Marie Peplow, Chief Operating Officer
	Not yet started
	On track for delivery as planned
	Delay but progressing
	Significant delay and risks to completion
	Completed

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Risks update**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**5th February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Following discussions at the October 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 and Executive level.

A summary of those discussions, the decisions reached, and the planned next steps are included below.

The current set of Board Assurance Framework (BAF) risks are enclosed with this report and have been updated to include details of the current priority work streams, which are the key drivers for mitigation of risks to achievement of the strategic priorities. These current workstreams have been born out of the ongoing work to review and refresh the trust's strategic focus and priorities.

A fully revised and refreshed BAF will be provided at Trust Board in March 2025 alongside the revised Trust Strategy.

Discussion with Committee Chairs

Key points of discussion from the meetings between the Assistant Director of Governance & Risk and the chairs of the sub-board committees was around the need to revisit the wording of some of the Corporate Risk Register (CRR) risks to reflect the current position more accurately, especially in light of the recent decision to revisit and reprioritise the strategic focus and strategic workstreams.

Another discussion point was around the current priority issues being intrinsically linked, with resolving workforce and productivity problems being key to improving financial sustainability. There is therefore a view that these revised/new priority issues/risks would lend themselves to more joined up risk articulation, rather than a set of separate risks broken down into ops, finance and workforce. It was also agreed that the BAF needed to be updated to reflect the sustainability risk more fully.

Discussion with CEO and Executive Directors

Following discussion with the chairs of sub-board committees, a proposed new, separate BAF risk relating to financial sustainability and productivity was discussed at the Executive Team meeting on the 21st January

2025. There was a consensus of opinion that the current financial situation and productivity levels are the trust's greatest risks and that the BAF needs to be amended to reflect this position.

As an outcome of the discussion, a decision was reached to remodel the current BAF risk relating to the delivery of the current Services priority (BAF Risk SR 5) into a BAF risk that incorporates financial sustainability and productivity, instead of having a separate standalone BAF risk. This decision was made in light of the proposed plan to realign the current strategic priority relating to services into a priority relating to sustainability.

Next Steps

The revised trust strategy is due to be presented to Trust Board in March 2025. An updated BAF, including an amended version of BAF risk SR 5, will also be presented to ensure the BAF is fully aligned to the new strategic focus and priorities.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Good engagement on risks by Committee chairs and Executive Directors Risk Management review practices that enable evolution of the BAF to reflect the current climate in which the trust operates and is aligned to the strategic direction of the trust	None

REPORT RECOMMENDATION:

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

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

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

Comments:

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

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

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

Risk management and BAF processes.

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

None specifically

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

None specifically

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

December 2024

Board Assurance Framework (BAF): SR1 - OUR CARE - JANUARY 2025

Risk Reference: SR1 - Our Care	Strategic Risk: There is a risk that the Trust will fail to meet its objective of being rated as 'outstanding' by the CQC by 2028.	**Causes**	As a result of the Trust:- Not being able to maintain current standards of service and patient care; Not being able to optimise pathways to ensure they are seamless and patient centred; Not being enabling patient-led booking via implementation of innovative digital technologies; Not having enough staff and resources Not having a suitable physical estate or environment	**Consequence**	With the consequence of detriment to:- Patient safety, The quality of service we provide; and Our reputation and rating as a Trust.	**Priorities**	Achieve a CQC rating of Outstanding Achieve a CQC Inpatient Survey Score of over 85% Reduce RTT waiting times to 12 weeks	**Strategic objective:**	**CARE - By 2028, we will be rated as 'outstanding overall' by our regulators, the Care Quality Commission. This will indicate that we are achieving the highest levels of care and quality.**
Lead Committees	Quality & Safety Committee, SE & OD Committee, Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3IX4c)
Executive Lead:	Chief Nurse & Chief Operations Officer	**Likelihood**	3		1			**April 2024**	12 (3IX4c)
Initial Date of Assessment	January 2024	**Risk Rating**	12		4	TBC		**July 2024**	12 (3IX4c)
Risk appetite Statement	The Trust has a low/no tolerance to risks that have the potential to negatively impact the quality of care we provide and the safety of our patients							**October 2024**	12 (3IX4c)
								January 2025	12 (3IX4c)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
Good oversight of current clinical and operational performance at sub-board committees	Continuously improve our inpatient experience through our Service Accreditation Programme
Maintenance schedule	Embed seamless, connected, efficient processes and pathways in readiness for a fully integrated Electronic Patient Record
Quality & Safety walkabouts	Evolve our JointCare pathway to meet the needs of our joint replacement patients, increasing the number of day case patients we treat
GIRFT accreditation	Mobilise a suite of meaningful outcome targets that are actively used to improve the quality of care we delivery (including PROMS, National Joint Reg
	Implement centralised booking and improved access for patients

Board Assurance Framework (BAF): SR2 - OUR EXPERTISE - JANUARY 2025

Risk Reference: SR2 - Our Expertise	Strategic Risk: OUR EXPERTISE - There is a risk that the Trust will fail to innovate, improve, research and teach to the level requied to achieve its ambition for patients to deliver less pain, more independence and life changing care	**Causes**	Shortfalls in the ability to: Research and innovate, teach and train, continuously improve May have underlying cause in Insufficient capital and/or resource, insufficient infrastructure or resillience, insufficient agility and dynamic capability to adapt to rapid change rapidly enough to keep up with changes in the Trust's external environment	**Consequence**	Consequences include: Failure to keep pace or ahead of technological gains which would benefit patients Failure to teach and train our staff Failure to continuously improve the quality of our work or maintain and monitor standards	**Priorities**	>1000 participants recruited to NIHR funded studies. 30-35% increase in publications (compared with 21/22)	**Strategic objective:**	**OUR EXPERTISE - Innovate, improve, research and teach - By 2028, we will be kitemarked as a Major Revision Centre and Surgical Elective Hub and will publish 30% more research publications. This will indicate our expertise**
Lead Committees	SE & OD Committee, Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	3		3			**January 2024**	9 (3Lx3C)
Executive Lead:	Medical Director	**Likelihood**	3		2			**April 2024**	9 (3Lx3C)
Initial Date of Assessment	Jan-24	**Risk Rating**	9		6	TBC		**July 2024**	9 (3Lx3C)
Risk appetite Statement	The Trust has a higher level of tolerance to risks that involve innovation and service improvement which would enable us to grow and expand our expertise and our reputation as a specialist provider of orthopaedic care. The Trust needs to be brave and at the forefront of change. This has to be balanced with a no/low tolerance of risk to patient harm.							**October 2024**	9 (3Lx3C)
								January 2025	9 (3Lx3C)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
	Building ROH into a leading centre for cutting edge innovation, including robotic assisted surgery, Osseointegration, Metastatic
	Deliver years 3-5 of Research & Development Plan
	Accreditation as a Major Revision Centre
	Growing the ROH MSK Academy, designing and delivering education for NHS colleagues, patients and communities
	Supporting the professional development of ROH staff
	Excellence in HVLC and maintaining GIRFT accreditation
	Leadership in MSK and Orthopaedics (APC/FSH/NOA)

Board Assurance Framework (BAF): SR3 - OUR PEOPLE - JANUARY 2025

Risk Reference: SR3 - Our People	Strategic Risk: OUR PEOPLE - There is a risk that the Trust will fail to meet its objective of being rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey.	**Causes**	As a result of the Trust:- Having difficulties in recruiting and retaining staff at both a trust/local level and is also impacted upon by the difficulties the NHS is experiencing with recruitment and retention at a national level.	**Consequence**	With the consequence of detriment of:- The culture within the Trust and also potential impact on our abilty to deliver large aspects of the Trust's Strategy (for example our ability to provide outstanding care, our ability to continue to provide our current level of service, our abilty to expand and innovate, our inability to addres health inequalities within our region and our ability to collaborate and contribute to wider system work.	**Priorities**	Turnover rate <10% Establishment >90% Specific target for WRES/WDES Reduce the gender pay gap National accreditation	**Strategic objective:**	**OUR PEOPLE - Rated as among the best NHS hospitals to work for by our team - By 2028, we will rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey. This will indicate that we are supporting our most valuable asset; people**
Lead Committees	SE & OD Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**January 2024**	20 (4Lx5C)
Executive Lead:	Chief People Officer	**Likelihood**	4		2			**April 2024**	20 (4Lx5C)
Initial Date of Assessment	Jan-24	**Risk Rating**	20		10	TBC		**July 2024**	20 (4Lx5C)
Risk appetite Statement	The Trust has a low tolerance for risks relating to our people and the recruitment and retention of staff, as being able to attract and retain staff is absolutely essential to not only our abilty to achieve our stategic objectives but also to our continued day to day delivery of services and care.							**October 2024**	20 (4Lx5C)
								January 2025	20 (4Lx5C)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	Success metrics
People Plan	Me As Manager
	Talent & Succession Framework
	Flexible Working
	Performance Management
	Embed Race Equality Code

Board Assurance Framework (BAF): SR4 - OUR COMMUNITY - JANUARY 2025

Risk Reference: SR4 - Our Community	Strategic Risk: There is a risk that the Trust will fail to meet its objective of reducing health inequality by improving access for people in the most deprived 20% of our communities	**Causes**	This could potentially be caused by:- a lack of quality data to help identify this cohort of patients; a lack of a framework for the necessary outreach and engagement work; and a lack of resource to fund the work required to achieve this objective, especially in the current financial situation the Trust and the wider NHS are operating within and an inabilty to work collaboratviely within the BSOL ICB to ensure there is a jointed up system based arrpoach to talking regional health inequalities,.	**Consequence**	This could potentially have the consequence of:- No change or improvement in obtaining access or earlier access to health care for those within our community who would benefit from earlier access to health services, which in turn would help reduce the long term burden and cost to the NHS if treated earlier.	**Priorities**	Improve waiting times for patients in our 20% most deprived communities. Increase the number of people accessing entry level posts through iCAN	**Strategic objective:**	**OUR COMMUNITY - Work with our community to reduce health inequality and support prevention - By 2028, we will be reducing health inequality by improving access for people in the most deprived 20% of our communities. This will indicate that we are reducing health inequality**
Lead Committees	Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3Lx4C)
Executive Lead:	Chief Executive Officer	**Likelihood**	3		2			**April 2024**	12 (3Lx4C)
Initial Date of Assessment	Jan-24	**Risk Rating**	12		8	TBC		**July 2024**	12 (3Lx4C)
Risk appetite Statement	The Trust has a higher tolerance for risk in regards to tackling regional health inequalities. Earlier access to treatment for this cohort of patients is important in terms of reducing health inequalities within the region and thus in turn also helping reduce the long term cost and burden on the NHS. However, it is key to balance this with the reality of the current ecomnomic situation we as a Trust and the wider NHS are operating in and the pressure to prioritise the need to mainatian current levels and standards of service with the same/or less levels of resource and income.							**October 2024**	12 (3Lx4C)
								January 2025	12 (3Lx4C)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
	Deliver our 3 year Health Promotion and Prevention Plan, using our orthopaedic and MSK expertise to build tools and develop services for our partners and communities
	Deliver a rolling programme of Community Appointment Days and Community Roadshows to provide condition and community specific MSK advice & signposting
	Embed engagement and co-production into our services to ensure people help design and deliver the services they need
	Utilise digital technology to optimise how patients access ROH services (Clinical Decision Support, Self-Management, AI, Triage)
	Implemented a new MSK workforce model through the MSK Transformation Programme

Board Assurance Framework (BAF): SR5 - OUR SERVICES - JANUARY 2025

Risk Reference: SR5 - Our Services	Strategic Risk: There is a risk that the Trust will fail to meet its objective to increase the number of people we treat by 20% within our current resources (this figure will be adjusted as resources increase)	**Causes**	As a result of the Trust:- breakdown of aged theatre plant/estates; increased costs associated with staffing and retention levels; mutual aid and collaborative work within the BSOL system to ease waiting list pressure; increased demand for services via health inequality work plans; the risk of breaches of our cyber security defences; further financial controls imposed by BSOL ICB due to current system financial position	**Consequence**	With the consequence of detriment to:- an increase in patient safety incidents as well as financial and reputational loss and poor compliance with national targets.	**Priorities**	Financial target. Activity target. Private Patient target. GIRFT	**Strategic objective:**	**OUR SERVICES - Efficient, effective and sustainable- By 2028, we will have increased the number of people we treat by 20% within our current resources (this figure will be adjusted as resources increase) . This will indicate excellent productivity and support more people to access treatment.**
Lead Committees	Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**January 2024**	15 (5Lx3C)
Executive Lead:	Chief Operating Officer	**Likelihood**	3		1			**April 2024**	15 (5Lx3C)
Initial Date of Assessment	Jan-24	**Risk Rating**	15		5	TBC		**July 2024**	15 (5Lx3C)
Risk appetite Statement	The Trust has a low tolernance for this risk due to the potential negative impact on our activity levels, the quality of our patient care and the financial implications for the Trust both as a standalone legal entity and as part of the wider BSOL ICB system							**October 2024**	15 (5Lx3C)
								January 2025	15 (5Lx3C)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
	Ambulatory Care Unit
	Private Patient growth
	7 day working
	Commercialising innovation
	Specialised service development
	Delivering Elective Reform Plan

Board Assurance Framework (BAF): SR6 - OUR COLLABORATION - JANUARY 2025

Risk Reference: SR6 - Our Collaboration	Strategic Risk: There is a risk that the Trust will fail to meet its objective of delivering a standardised pathway for elective orthopaedics in Birmingham and Solihull	**Causes**	As a result of the system not having the agreed framework for a single point of access for orthopaedic referrals and stanadrdised pathways agreed across ptimary and secondary care. Not having the neccesary capital and/or resource to enable growth, expansion and innovation in terms of our ability to establish the Trust as a Major Revision Centre (MRC) and deliver additional capacity required across the system to suport standardised access in terms of waiting times . Also the logistical and/or political and operational difficulties of trying to embed new pathways and processes across the system	**Consequence**	With the consequence of detriment to:-financial impact and quality differential , as well as a reputational impact in terms of our allignment, position and standing within BSOL ICB	**Priorities**	GIRFT metric. Strategic Partnership Agreements. Commercial income growth.	**Strategic objective:**	**OUR COLLABORATION - Collaborate to support improvement, locally, regionally and nationally - In the next five years, through the Bsol MSK Tranforamtion programme we will help to deliver a standardised pathway for elective orthopaedics in Birmingham and Solihull. This will indicate that our system is transforming for the benefit of patients.**
Lead Committees	Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
Executive Lead:	Chief Operating Officer	**Consequence**	4		4			**January 2024**	12 (3L x 4C)
Initial Date of Assessment	January 2024	**Likelihood**	3		2			**April 2024**	12 (3L x 4C)
Risk appetite Statement	The Trust has a higher tolerance for risk in regards to our ability to engineer improvement to system wide pathways and services and our abilty to influence and have a strong voice within the BSOL ICB system	**Risk Rating**	12		8	TBC		**July 2024**	12 (3L x 4C)
								October 2024	12 (3L x 4C)
								January 2025	12 (3L x 4C)

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
	Healthcare – leading MSK & Orthopaedics as part of Acute Provider Collaborative
	Industry
	R&D
	Academia
	Charity
	VFSCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Insightful Provider Board**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Tammy Ferris, Corporate Services Manager**
DATE OF MEETING:	**5th February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Insightful Provider Board guidance was published to support provider boards and ICB boards to turn data into useful insights. Following the publication of the Darzi report these documents supports the 'system optimisation' piece.

The guidance considers effective governance practice around board reporting and assurance seeking, and contains suggested measures that boards might wish to consider using for planning, monitoring and seeking assurance about progress.

The initial review of the guidance suggests that we run an effective Board, however a full self-assessment is planned and we would also welcome the thoughts of the Board to aid the development of the Board Development Plan that is likely to arise from the work.

The paper attached provides further detail on the guidance and provides the templates that we propose to use to further assess the position and engage the Board with the work.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
It will support the Trust in being able to demonstrate we are a well-led Board. This is an opportunity to reflect on how effective our Board, and Board committees are. It supports the integrated performance approach that we have already start to look at.	No clear gaps against the guidance, however the full self-assessment is likely to suggest areas that could require strengthening or improvement.

REPORT RECOMMENDATION:

The BOARD is asked to:
receive and support the plan to assess to what degree the Trust Board operates in an insightful way
agree to receive a more detailed self-assessment and action plan at the April meeting of the Board

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

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

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

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

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

Code of Governance

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)***:**

Executive Team Meeting – January 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

Insightful Provider Board – February 2025

1. Introduction

1.1 In November 2024, NHS England published the 'Insightful Provider Board' guidance setting out the role of a provider board. The guide aims to help boards consider their approach to handling and acting on the information they receive. It also considers leadership behaviours and culture, and the metrics that can be used to better understand the organisation's performance.

2 The Key Principles

2.1 Active Governance – There should be 'active' governance with scrutiny and challenge that leads to insight and informs decision making, and a 'problem-sensing' approach that involves actively seeking out weaknesses in systems.

2.2 A Unitary Board – It requires all board members to have sufficient understanding of risks and issues across all aspects of the trust's operations to make decisions.

2.3 Committees should be well utilised, looking at more detail prior to the board, and reporting on key messages, updates and actions, in line with agreed delegation, risk and escalation framework.

2.4 Review of governance arrangements – Boards should regularly review their governance arrangements as part of a continuous development ethos and consider what training and other resources they need to have the required skills and expertise.

3 The Board's Key Roles

3.1 The Board has a collective responsibility for:

Ensuring high quality and effective care for all patients and service users.
Setting strategic direction.
Adding value to the success of the organisation and its systems.
Using prudent and effective controls.
Promoting and adhering to the organisation's values.
Ensuring the organisation's obligations and duties are met.

4 Board Oversight Domains

4.1 The guide sets out 6 domains as indicative areas of oversight and details a range of metrics that could be used to support.

1. Strategy
2. Quality
3. People
4. Access and targets
5. Productivity
6. Finance

5 The Information

5.1 An insightful board must consider the following with regards to the information it receives:

Must be meaningful, clearly linked to the strategy and the 6 domains listed above and be framed for the Board's role.
Be reported by exception: the board should not be seeing each indicator at each meeting.
Balance assurance and reassurance, including using integrated reporting and triangulation to provide real assurance.
Focus on outcomes and impact, not just report on processes or progress against a plan.

6 Next steps

6.1 The purpose of the 'Insightful Provider Board' guide is to support boards to reflect and consider whether the leadership, culture, systems and processes that are in place are using information in the best way to lead the organisation effectively. To achieve this, the following needs to take place:

Undertake an initial self-assessment of the information shared at board committee level to ensure the information is providing the assurance and reassurance required, considering the 6 domains and the information available – All Executive Board Members.
Undertake a survey of Board members to gain views around how insightful the Royal Orthopaedic Hospital Trust Board is – All Board Members
Develop a Board Development Plan using the output of the self-assessment - All Board Members

Please see Appendix A enclosed which details the assessment criteria that will be used for the self assessment and Appendix B which is the proposed Board questionnaire to assess members' views.

7 Recommendation

7.1 The Board is asked to:

RECEIVE and SUPPORT the plan to assess to what degree the Trust Board operates in an insightful way

Tammy Ferris
Corporate Services Manager

January 2025

Appendix B

The Royal Orthopaedic Hospital NHS Foundation Trust

Insightful Provider Board Self Assessment 2025

GOVERNANCE & CULTURE					
	1	2	3	4	COMMENT
GOVERNANCE					
Are the chair's role and responsibilities clearly set out?					
Are there rigorous skills-based recruitment and appointment processes for non-executives, and are these independent?					
Does the size of the board, the committee structures and processes reflect the size, services and complexity of the organisation?					
Does the board receive the right information, presented in the right way and at the right time?					
Are there robust internal controls across the trust to support organisation-wide transparency and accountability?					
Are the right structures in place to escalate information through the organisations from the point of care to the board?					
Is the board able to hear patients, services users and staff voices in an authentic way as part of its leadership role?					
Are the roles and responsibilities of the Senior Independent Director clear and agreed by the board (as set out in the Code of governance) ?					

Comments:

Rating	
Strongly Agree	**1**
Agree	**2**
Disagree	**3**
Strongly Disagree	**4**

Appendix B

GOVERNANCE & CULTURE					
	1	2	3	4	COMMENT
CULTURE					
Does the board role-model a culture of open and curious challenge?					
Does the board understand when to seek external review and independent input?					
Is most of the discussion at the public board, and with clear justification for any items discussed in private?					
Are issues appropriately escalated from executives and is information presented transparently					
Does the board balance operational performance with people performance at all levels of the organisation?					
Do all board members undertake 360-degree feedback?					
Does the board proactively seek views, listen to them and demonstrably follow-up, and promote the value of 'speaking up' culture?					
Is Freedom to Speak Up (FTSU) information discussed at the board and is it considered alongside other sources of information on organisational culture?					

Comments:

BOARD COMMITTEES					
	1	2	3	4	COMMENT
BOARD AND COMMITTEES					
Is the role of each board committee clear, including what areas and organisational risks it covers and how it reports into the board?					
Are there areas and functions of your trust's operations that require specific governance groups (for example Mental Health Act)?					
Are board agendas planned in such a way over the year that all relevant areas of the trust's operations get the appropriate scrutiny?					
Is there the right balance between strategy – developing and delivering it – and day-to-day operations?					

Comments:

MEANINGFUL INFORMATION					
	1	2	3	4	COMMENT
INSIGHTFUL INFORMATION					
Is there a clear purpose for why each piece of information is escalated to the board?					
Is information reported in a way that enables the board to see links to strategic objectives and risks?					
Does the board also receive information showing wider system performance across the provider's key operational areas?					
Is the overall volume of information appropriate or is there too much provided in each pack which is preventing the board from seeing the bigger picture?					
Is information streamlined using data tools such as SPC?					
Are actual numbers included or does the pack rely solely on percentages? (either may be appropriate)					
Does information escalated from committees draw out themes and key issues for board consideration?					
Does the board consider an integrated performance report and is this presented in a way which focuses their attention on meaningful data rather than expected variation and statistical 'noise'?					
Does the board's approach allow for information sources to be triangulated, including qualitative and quantitative data as well as soft intelligence to spot warning signals?					
Does the information support the board to ensure a focus on continuous improvement across the organisation?					

Comments:

6 DOMAINS TO CONSIDER					
	1	2	3	4	COMMENT
I. STRATEGY					
Does the organisation's strategy reflect shared priorities across the system and an agreed contribution to the Joint Forward Plan and Capital Plan with ICB and system partners?					
Is the trust working effectively and collaboratively with system partners and its provider collaborative for the overall good of the system and population served?					

Is the board assured that it is overseeing the delivery of its organisational strategy effectively, and that this is responding to the needs of the local system strategy?					
Is the organisation meeting, and it will continue to meet, any regulatory direction placed on it or undertakings?					

Comments:

6 DOMAINS TO CONSIDER					
	1	**2**	**3**	**4**	**COMMENT**
II. QUALITY					
Does the trust have, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients having had regards to relevant NHS England guidance (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt)?					
Are systems in place to monitor patient experience, and are there clear paths to relay safety concerns to the board?					

Comments:

6 DOMAINS TO CONSIDER					
	1	**2**	**3**	**4**	**COMMENT**
III. PEOPLE					
Is staff feedback used to improve the quality of care provided by the trust?					
Do staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels?					
Are staff able to express concerns in an open and constructive environment?					
Are staff metrics used to improve productivity, staff satisfaction and patient care					

Comments:

6 DOMAINS TO CONSIDER					
	1	2	3	4	COMMENT
IV. ACCESS AND TARGETS					
Are plans in place to improve performance against the relevant access and waiting time standards?					
Is the trust able to identify and address inequalities in access and waiting times to NHS services across its patients?					
Have appropriate population health targets been agreed with the Integrated Care Board?					

Comments:

6 DOMAINS TO CONSIDER					
	1	2	3	4	COMMENT
V. PRODUCTIVITY					
Are plans in place to deliver productivity improvements as referenced in, for example, the Model Health System, this guide and other relevant guidance?					

Comments:

6 DOMAINS TO CONSIDER					
	1	2	3	4	COMMENT
VI. FINANCE					
Does the trust have a robust financial governance framework and appropriate contract management arrangements?					
Is financial risk managed effectively, and financial considerations (such as efficiency programmes) do not adversely affect patient care and outcomes?					
Does the trust actively engage with system partners regarding the optimal use of NHS resources and supports the system's delivery of its planned financial out-turn?					

Comments:

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 28 January 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
The Trust risks not achieving the Elective Recovery Fund (ERF) for this year, and the main reason for this has been due to consultant capacity. The Committee was also guided through the latest changes to the ERF allocations for the final quarter of the year and likely impact. It was noted that the Trust is facing ongoing challenges to achieve the financial plan, however there are a number actions taking place to help address this through various working groups. The number of referrals around primary hip and knee are not as high as they were pre-Covid. Work is taking place to address this and influence referrals to be made to the Royal Orthopaedic Hospital. There are currently a number of patients who have now breached the 65-week waiting list. There is a plan in place to rectify this in February. The Trust remains an outlier with sickness absence, and a deep dive has taking place which will be discussed at the next Staff Experience & OD Committee in February and feedback will be shared with Finance & Performance Committee colleagues.	Provide an updated risk register to the Finance & Performance Committee February meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
The Committee received an overview of the work the productivity group has been undertaking. January activity is above plan and private patient income is ahead of target by £46k. The Committee received an update on the work that is taking place to improve the number of referrals to the Royal Orthopaedic Hospital, including the use of community clinics. The Committee was provided with the assurance that there are several support mechanisms in place to help colleagues with mental health disorders.	The Committee approved the Terms of Reference presented at the meeting as part of the annual review.

The Committee was given an overview on the draft planning guidance and the productivity pack that has been published.	

Chair's comments on the effectiveness of the meeting: It was agreed that it was a good meeting that was very focussed, and all items addressed in a timely manner.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 17th January 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
It was noted that it was felt there is not enough knowledge of Artificial Intelligence (AI) and how the Trust intends to progress in this area and an update from the Chief Digital Information Officer would be welcomed.	The Job Planning audit actions will be finalised before the full report is presented to the Audit Committee in April. New global internal audit standards are being adopted that will provide greater alignment between the public and the private sector. This will require joined up working with internal and external audit. A session to be arranged on AI to understand where we are as a Trust and how it can offer benefit in the future. A value for money review will be taking place to look at our legal services and an update will be provided at a future Audit Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
The Committee received a comprehensive update from internal audit, including the review that is underway on Patient Safety Incident Response Framework (PSIRF). It was noted that there is no conflict of interest with regards to the work KMPG is doing with the Trust and the Inspection & Intervention (I&I) work being undertaken in the Birmingham & Solihull ICS. The Committee was provided with an updated Freedom to Speak Up report that now included actions and owners. The Committee was provided with assurance that the work plan with regards to the annual accounts is on track. The Committee was provided with an update on Counter Fraud and the successful awareness session held at the Trust in November 2024. The Committee received a comprehensive update on reporting culture in the Trust following a recent audit that had been undertaken. It was noted that the review identified that the Trust had a strong reporting culture including raising Freedom to Speak Up concerns.	The audit plan will be the final version when it is presented to the Committee in April, and all necessary meetings will have taken place prior to this to gain approval.

The Committee was provided with assurance with regards to the processes that are followed with breaches and waivers of Standing Financial Instructions. The Committee received a comprehensive update on the changes that have take place on the Data Security & Protection Toolkit (DSPT), in particular the updated name to Cyber Assessment Framework (CAF) which is aligned to NHS standards. The Committee was provided with a follow up update on the progress that has been made with risk management. The Committee was assured that an update on risk is provided at each Trust Board meeting now also. The Committee approved the proposed 2025/26 Audit Committee workplan	

Chair's comments on the effectiveness of the meeting: The meeting provided good updates that allowed for members to grow their own understanding, ask questions and provide assurance, with input from all those that attended.

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 22 January 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
It was noted that the turnaround time on complaints still requires improvement but there has been a considerable amount of attention on dealing with the current backlog. It was noted that in December, the Trust reported 13 breaches of 65 week waiting time targets. These are all in spinal services and although reflect the national position are also due to the current capacity pressures within the team. The volume of complaints has increased and is primarily driven by waiting times. It was noted that the Trust is tracking significantly over the national benchmark with regards to surgical site infections and we need to do some work to understand the methodology underpinning quoted national average rates. It was noted that there are significant vacancies within the Radiology Team, however with the outsourcing of the reporting it has meant the Team has been able to focus on the clinical work of seeing patients rather than trying to keep on top of the reporting as well. It was noted the Trust had received a Regulation 28 notice from a recent Coroner's Inquest, to which the Trust has developed a formal response which will be issued shortly.	The PALs and Complaints action plan will be shared at the next Quality & Safety Committee. This will also include a presentation on the actions that has already been taken to address the key points. Provide an opportunity for the Non-Executive Directors to gain understanding of the Bone Infection Unit service model at the ROH. The Safer Staffing update highlighted a number of items that will also need to be shared with the Staff Experience & OD Committee for further oversight.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
The Trust has successfully recruited both a Spinal Deformity Consultant and a Spinal Degenerative Consultant. The Committee received an update on the quarterly performance of PALs and Complaints, and it was noted the improvements in the delivery of KPI which is now sitting at 79% against a target of 80%. The Infection Prevention and Control Annual Report was presented to the Committee and was positively received.	The Committee agreed that the Non-Executive Directors from the Committee will visit the Bone Infection Unit prior to the next Quality & Safety Committee. The Committee agreed that the Safer Staffing Report would be presented to the Trust Board. The Committee agreed that the Infection Prevention and Control Annual Report could be presented to the Trust Board.

The Committee received an update on the work taking place with surgical site infections (SSIs) and the improvement work that is being undertaken. The Committee received a positive safer staffing update which included a position statement of where the Trust is against the national picture. The Committee was provided with assurance from the Head of Imaging that the Trust is compliant with Radiation Safety regulations. The Chief Pharmacist presented the Medicines Optimisation Strategy to the Committee. The Committee received an update on the litigation work that has taken place in the Trust. It was noted that the Clinical Negligence Scheme for Trusts (CNST) premium had reduced for the seventh year in a row, which was reflective of better case handling and clinical engagement. The Committee was provided with assurance that there had been a great deal of work taken on investigating the two recent Never Events and an assurance paper was received to provide an overview of the declarations process.	The Committee agreed that Preventing Future Deaths item should also be shared at Trust Board in February.

Chair's comments on the effectiveness of the meeting: The meeting provided the opportunity to discuss a number of items on the agenda that helped assure the Non-Executive Directors of the work being undertaken.

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.

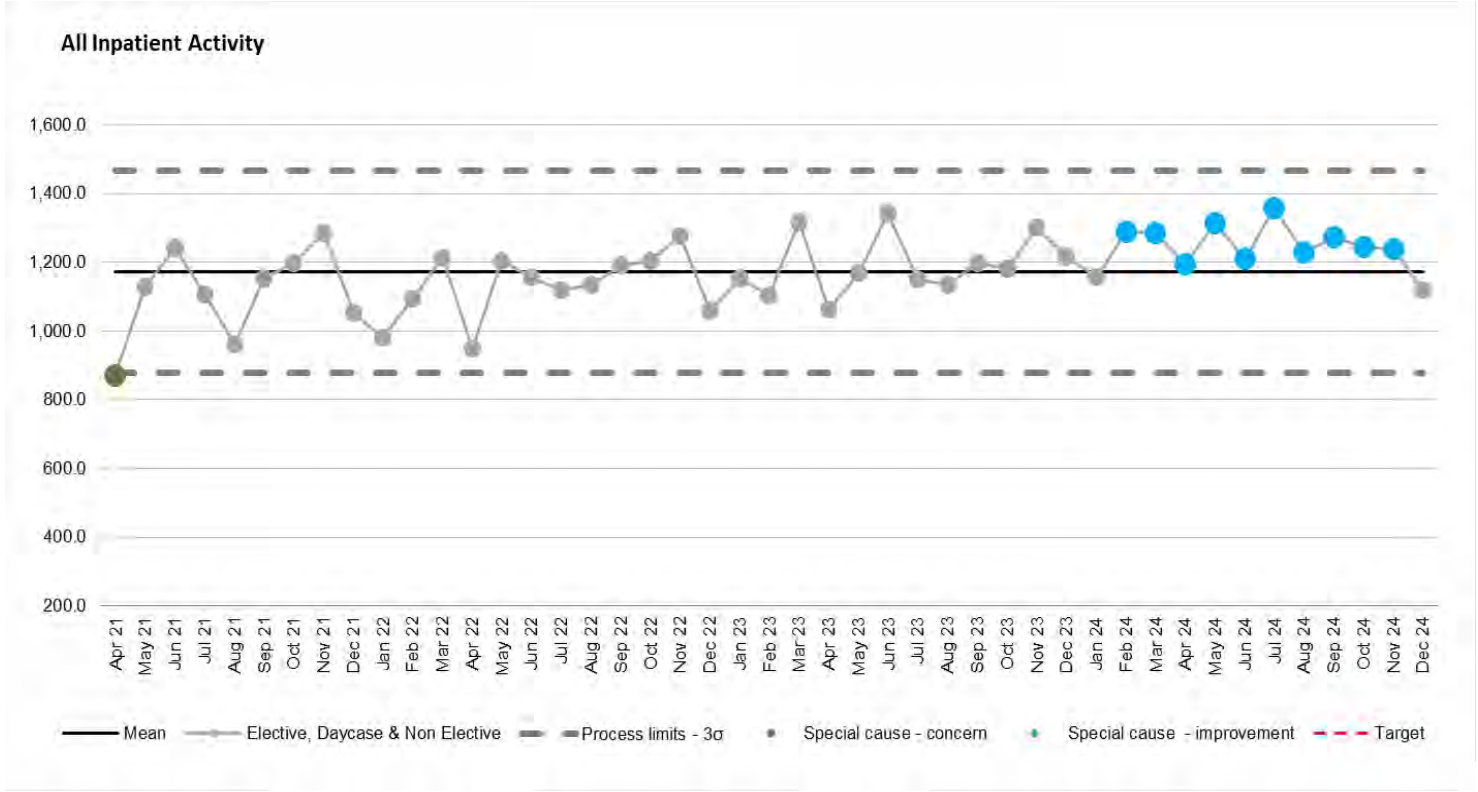
For measures without a target you will instead see the "No Target" icon.

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.

				○	F
				L	P
				L	P
				L	F
				H	F
				○	F
				○	P
				○	F
				H	P
				○	F
				○	P
				○	F
				○	F
				○	P


P
F
P
P
P
No Target
P
F
No Target
F
F
F
No Target


All Inpatient Activity
1,600.0
1,400.0
1,200.0
1,000.0
800.0
600.0
400.0
200.0
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
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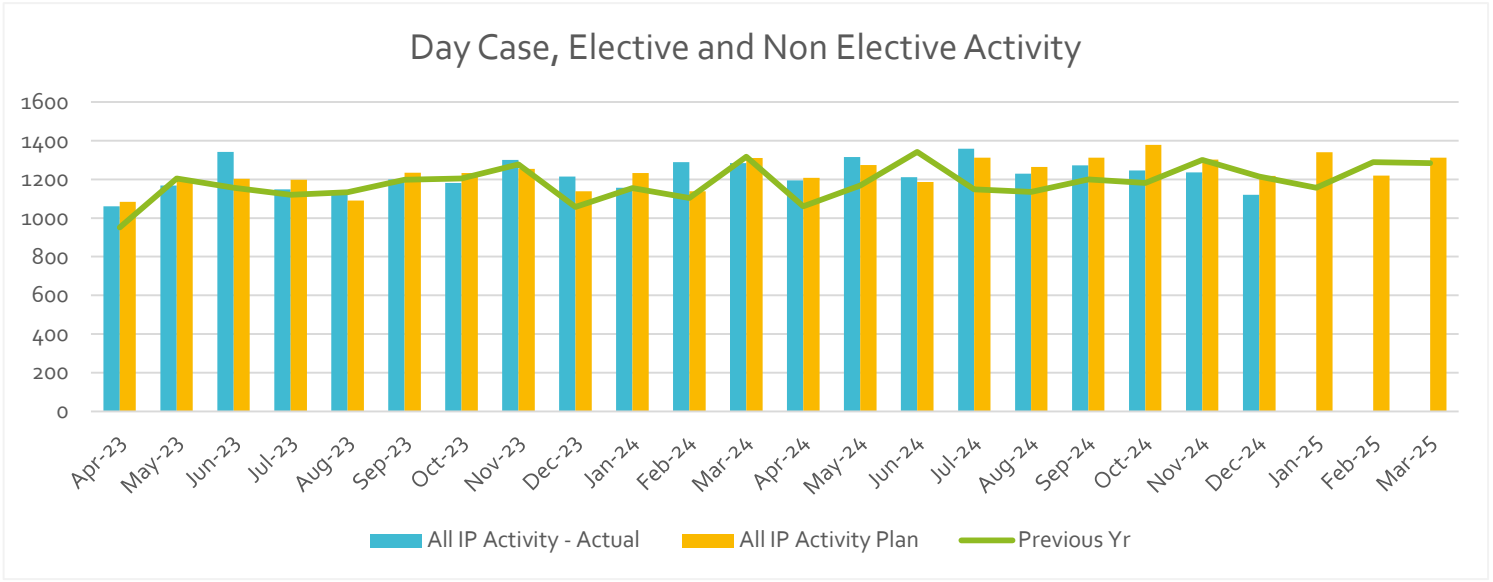
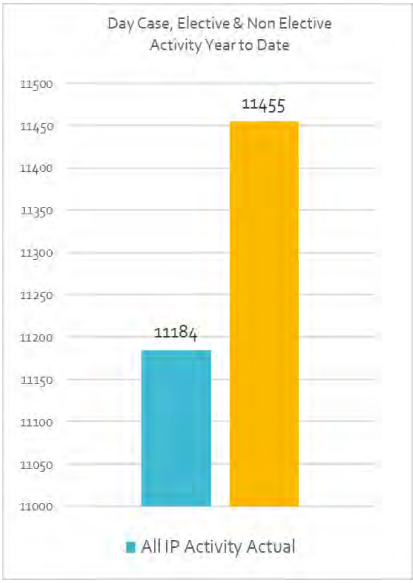
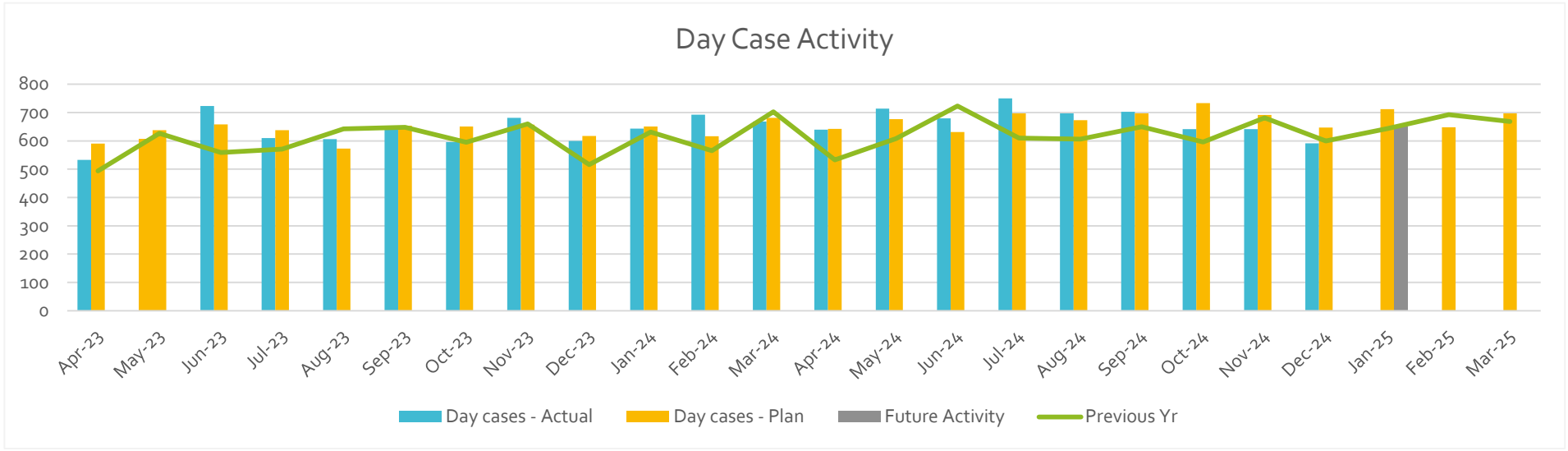
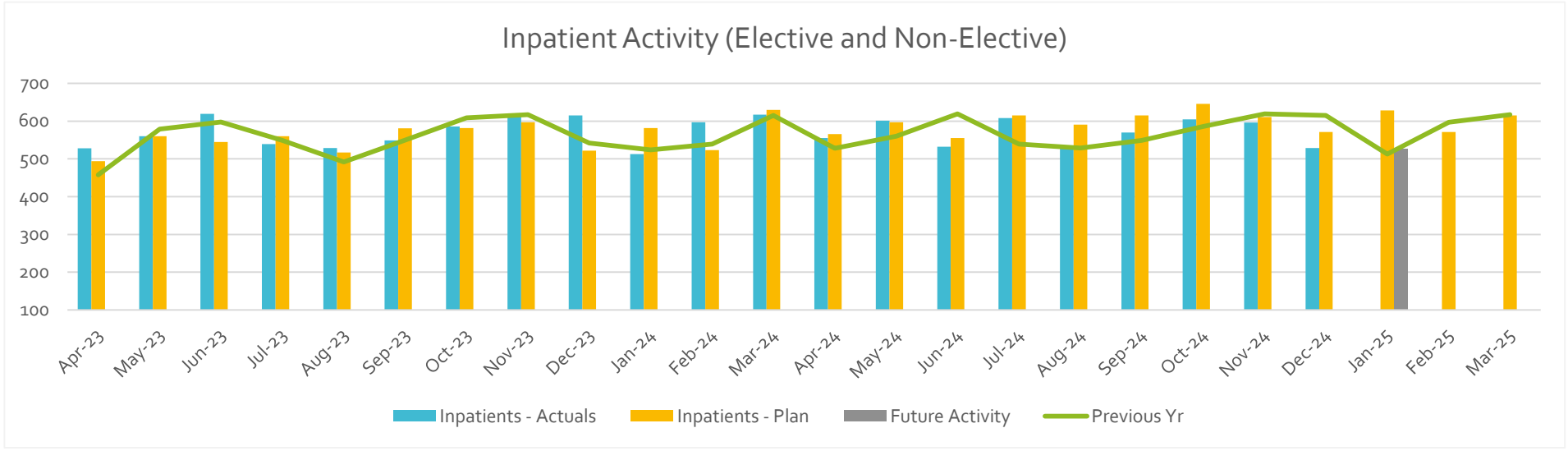
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Mean
Elective, Daycase & Non Elective
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target



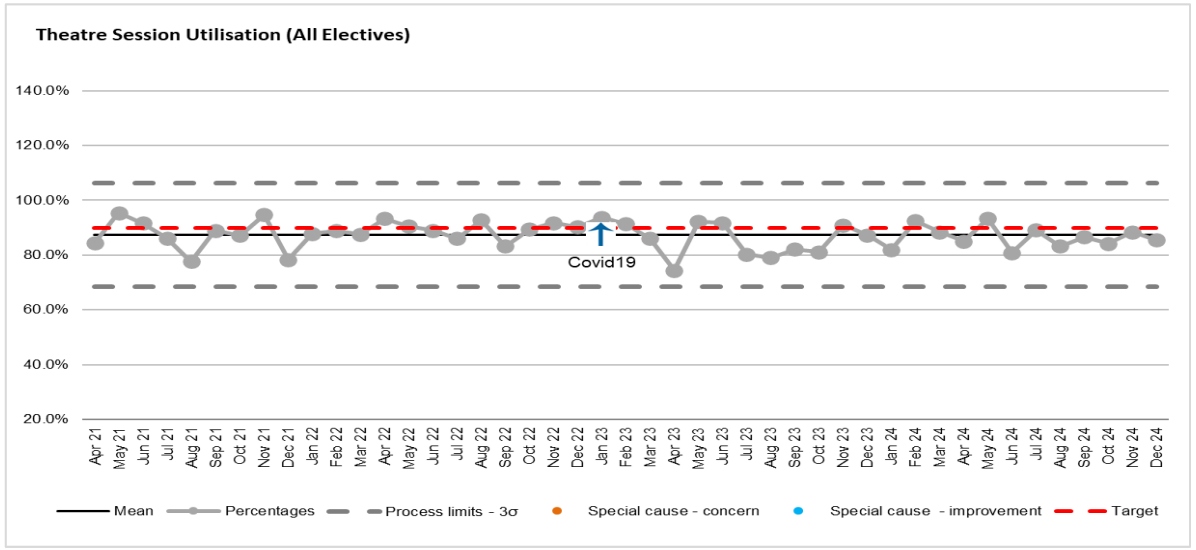


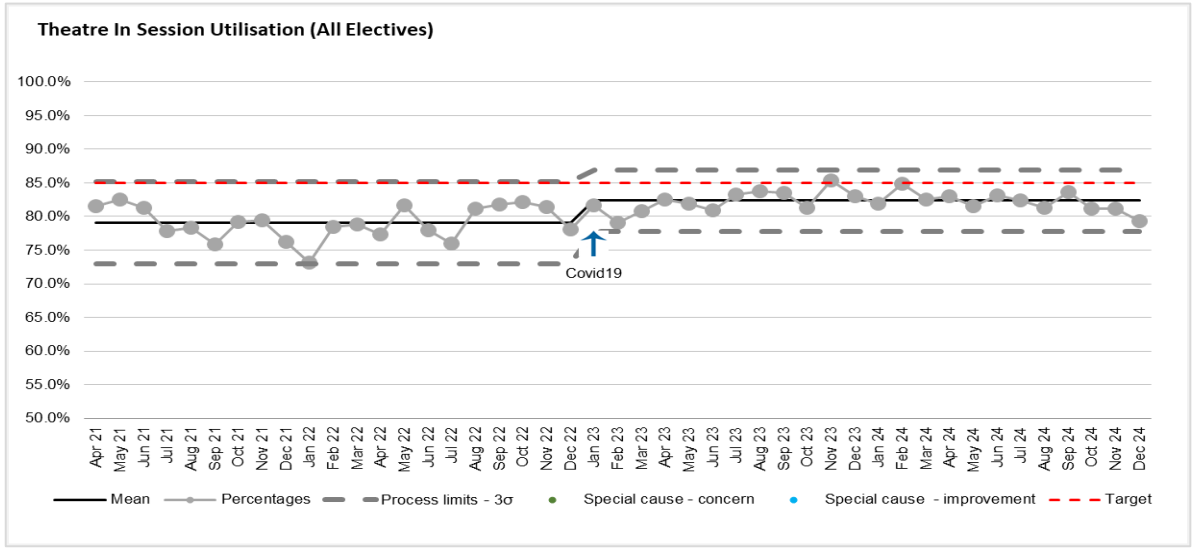
	Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	554	584	542	602	580	602	632	598	560	614	560	602	5254	4943	94%	-311
	Daycase	642	677	631	697	673	697	733	691	647	712	648	697	6088	6055	99%	-33
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	113	186	165%	73
	All Activity	**1208**	**1274**	**1186**	**1312**	**1264**	**1312**	**1379**	**1302**	**1218**	**1340**	**1219**	**1312**	**11455**	**11184**	**98%**	**-271**


Day Case Activity
800
700
600
500
400
300
200
100
0
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
Day cases - Actual
Day cases - Plan
Future Activity
Previous Yr


Inpatient Activity (Elective and Non-Elective)
700
600
500
400
300
200
100
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
Inpatients - Actuals
Inpatients - Plan
Future Activity
Previous Yr

DATA QUALITY KITEMARK





Elective Session Utilisation (December 2024)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	402	344	58	85.57%
UHB	32	27	5	84.38%
Totals	**434**	**371**	**63**	**85.48%**

Elective In Session Utilisation (December 2024)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1515	1203	311	79.44%
UHB	121	94	26	78.24%
Totals	**1635**	**1297**	**338**	**79.36%**

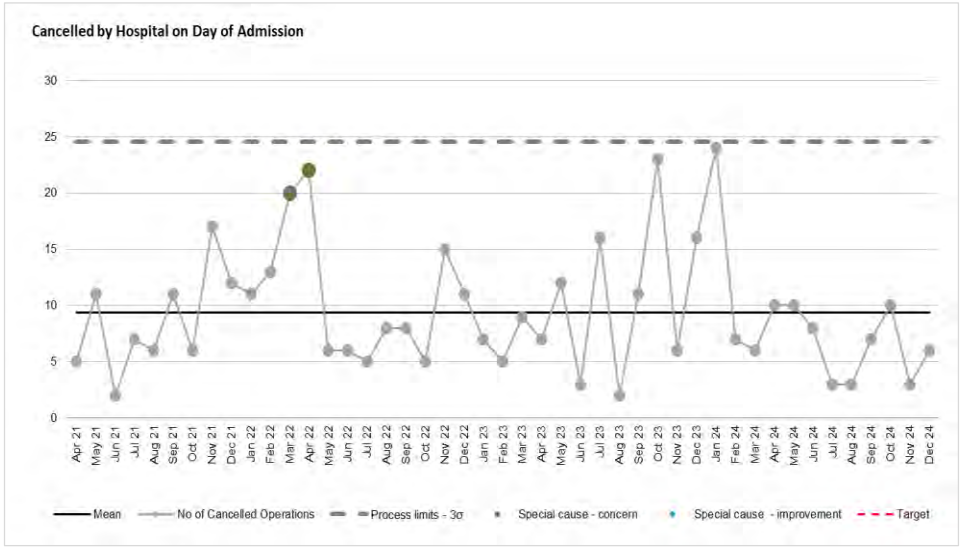
SUMMARY

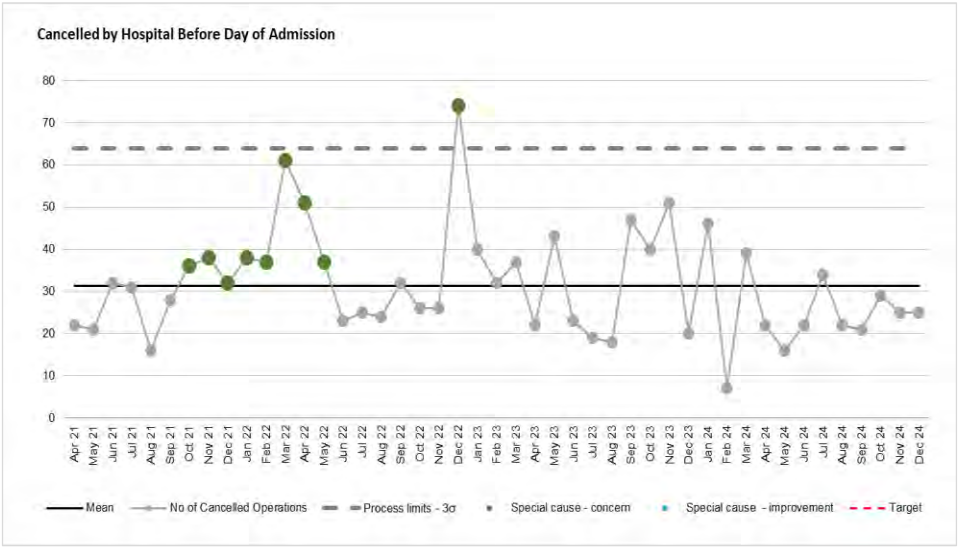
AREAS FOR IMPROVEMENT

RISKS / ISSUES

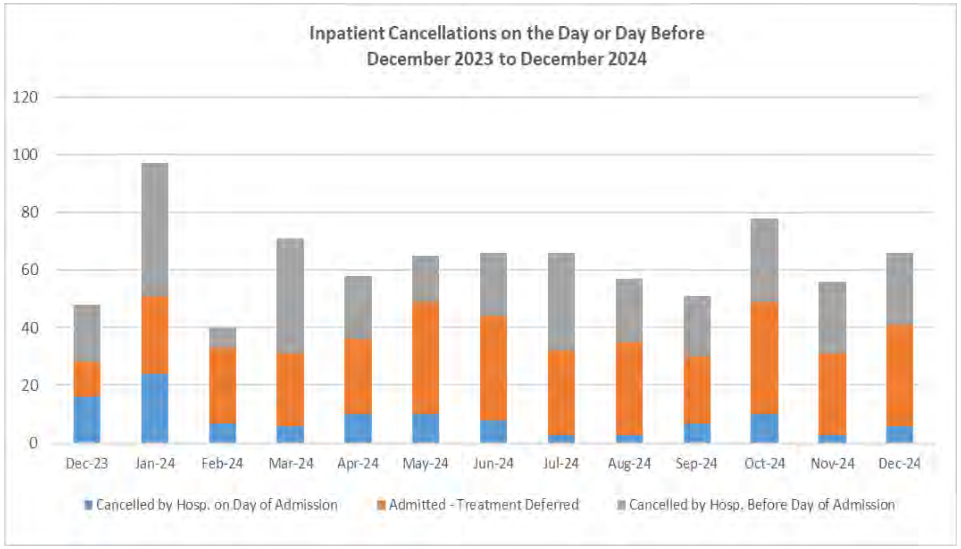
DATA QUALITY KITEMARK

Theatre Productivity -High Intensity Theatre List (HIT Lists)





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
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	39	70	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
Oct-24	10	39	29	78	0
Nov-24	3	28	25	56	0
Dec-24	6	35	25	66	0
Total	**113**	**377**	**328**	**818**	**0**

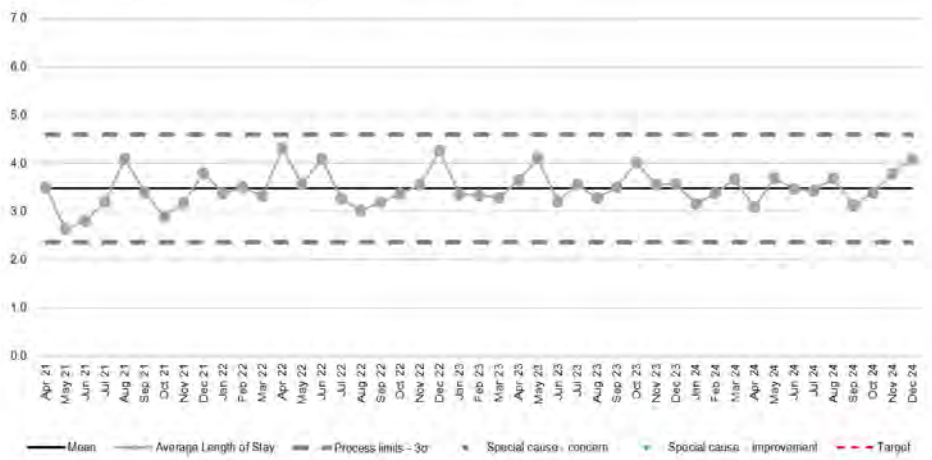


SUMMARY

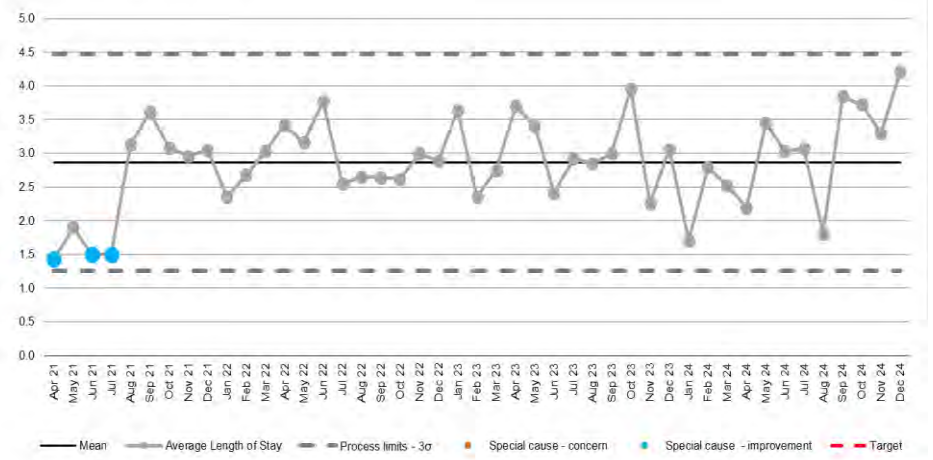
Patients cancelled on the day x 6	Patients admitted and had treatment deferred x 35	Patients cancelled by the hospital the day before the date of admission x 25

AREAS FOR IMPROVEMENT/ RISKS/ISSUES

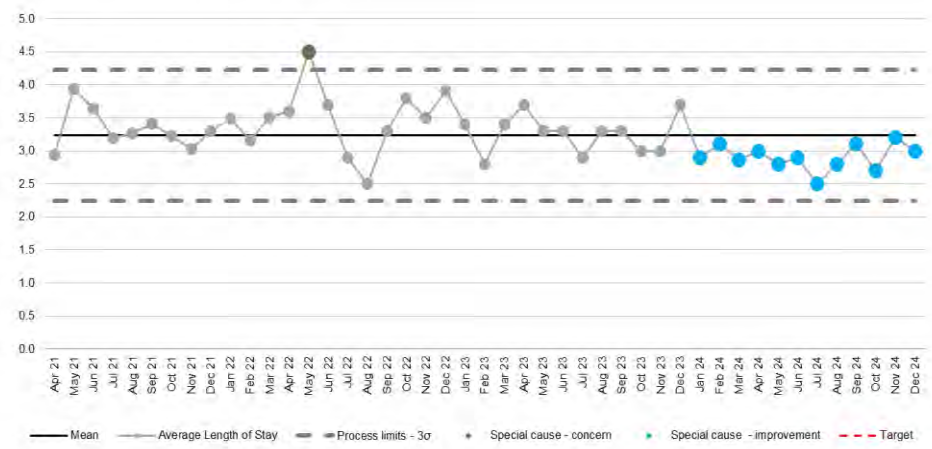
ROH Elective Average Length of Stay - Excluding Oncology, Paeds,YAH and Spinal



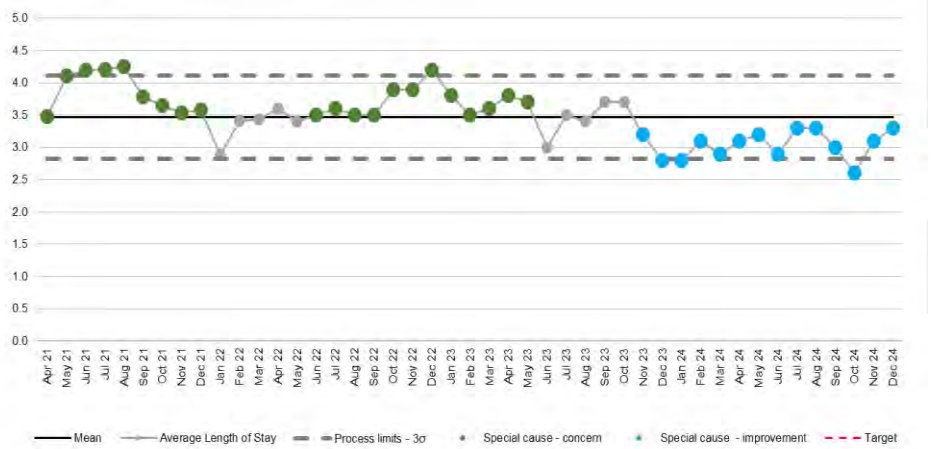
UHB Elective Average Length of Stay



Primary Hip Elective Average Length of Stay

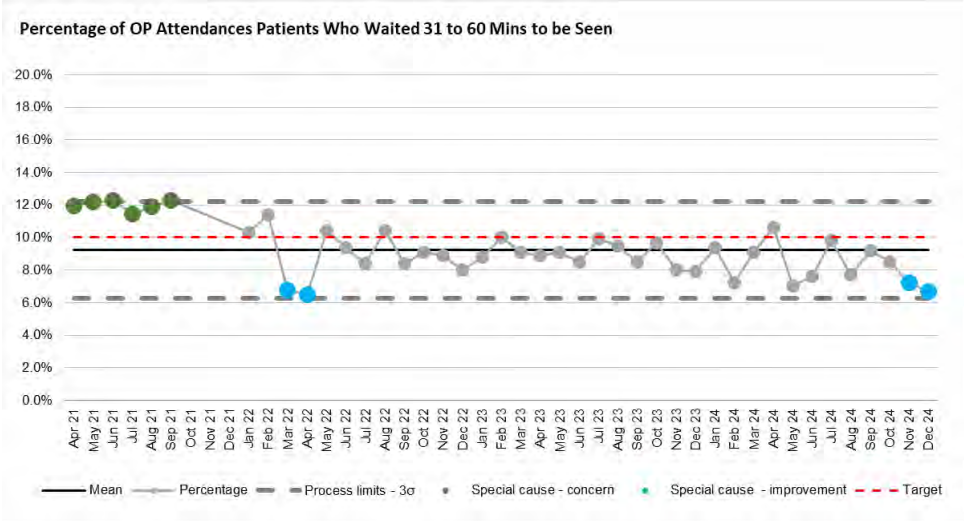


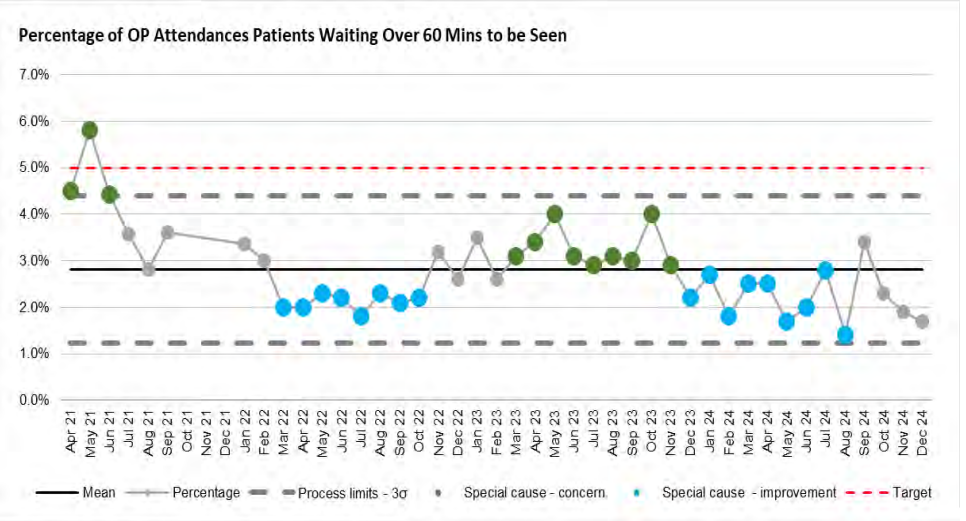
Primary Knee Elective Average Length of Stay



SUMMARY

AREAS FOR IMPROVEMENT / ACTION PLAN

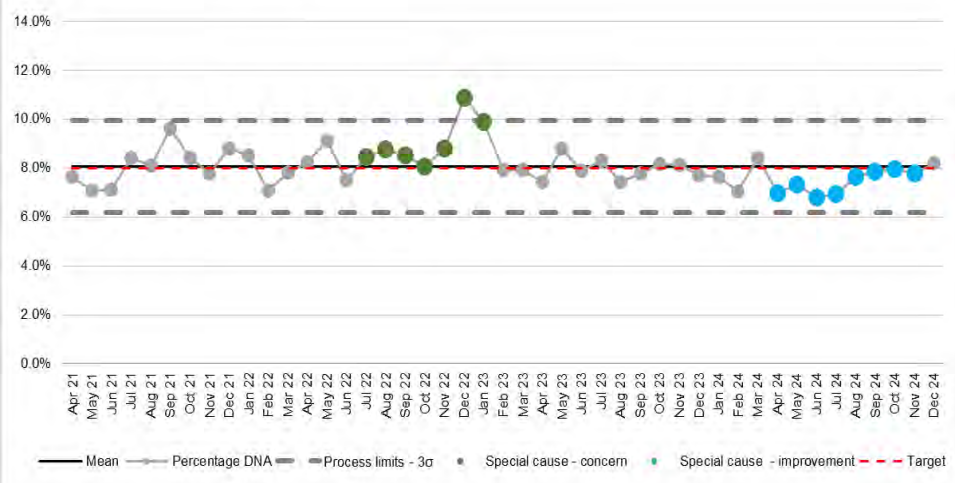




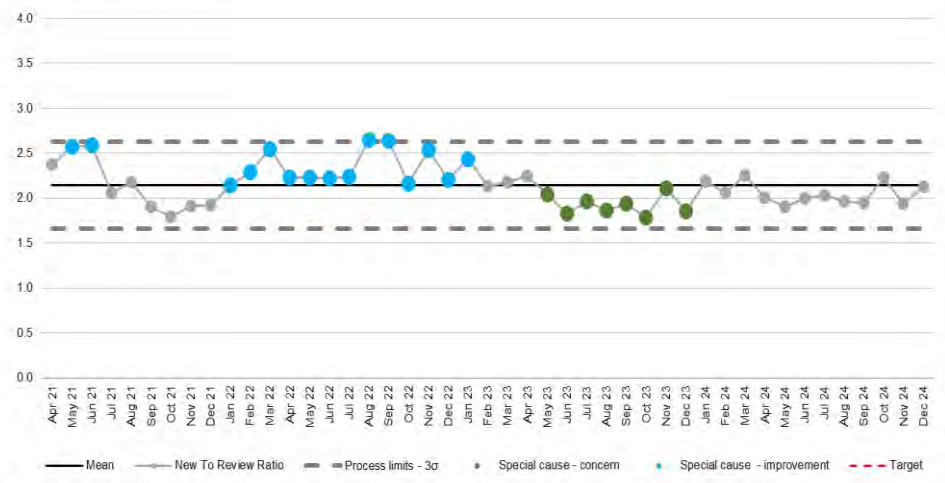
DATA QUALITY KITEMARK

DATA QUALITY KITEMARK

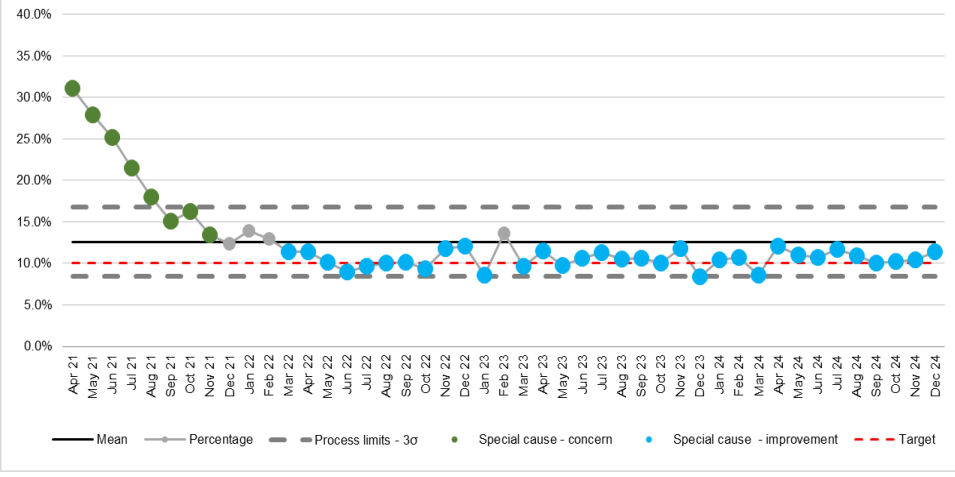
Consultant Led Outpatient DNA Rate



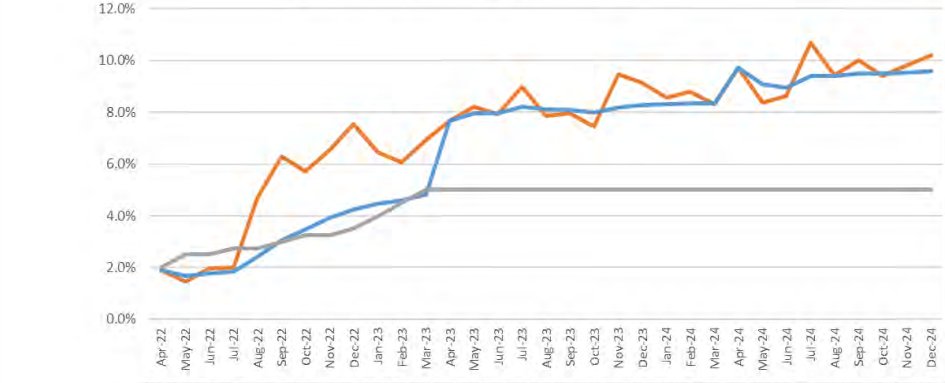
Outpatient New to Review Ratio



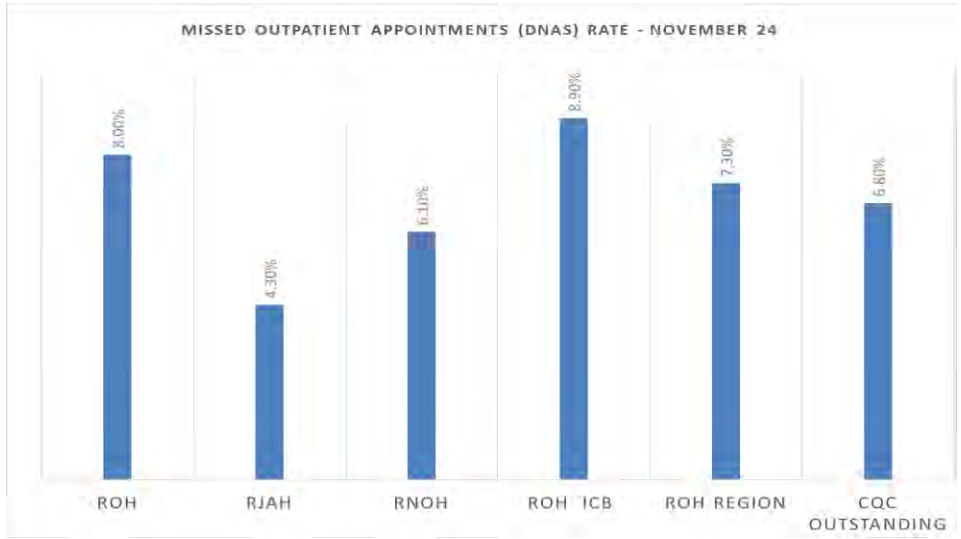
Percentage of Virtual OP Attendances

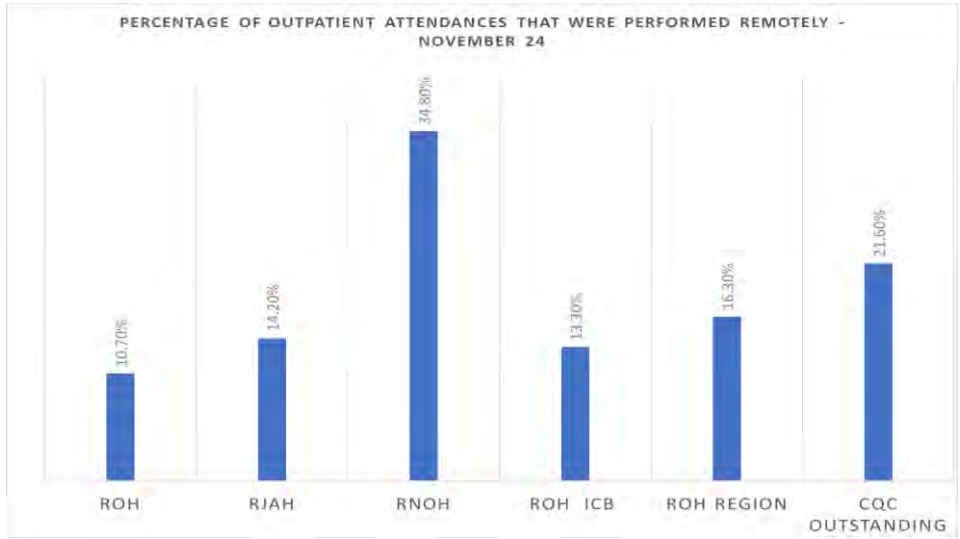


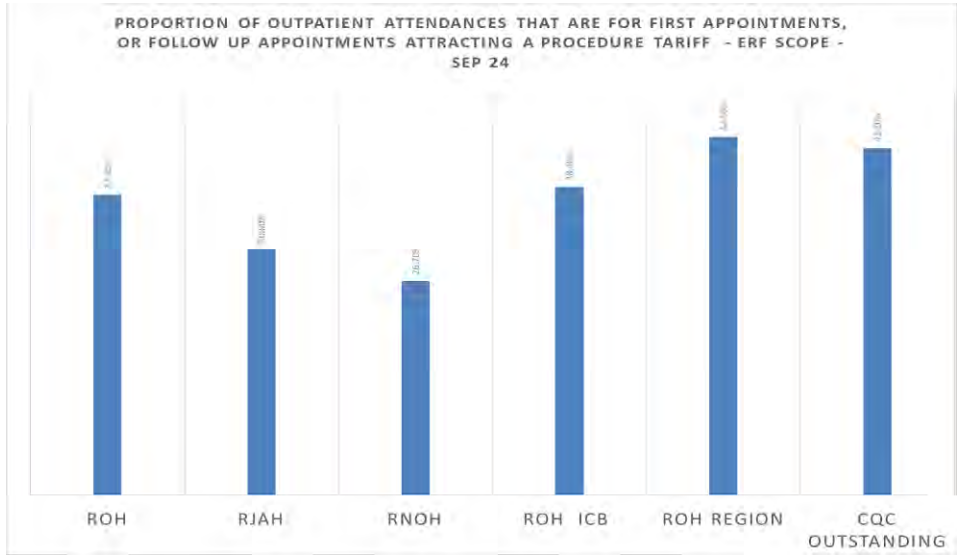
Patient Initiated Follow Ups - % Patient Added

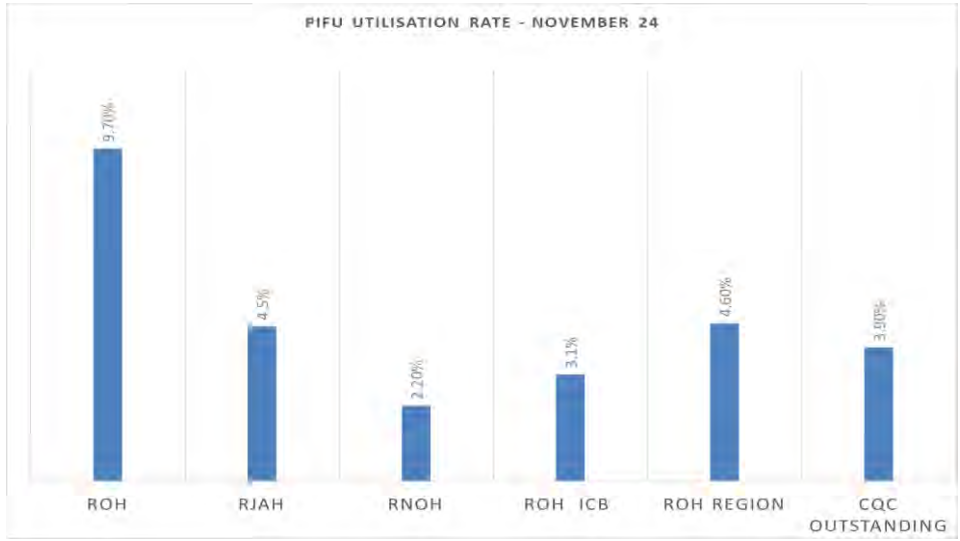


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Month Percentage	1.9%	1.5%	2.0%	2.0%	4.7%	6.3%	5.7%	6.5%	7.5%	6.4%	6.1%	6.9%	7.67	8.20	7.94	8.97	7.86	7.96	7.46	9.48	9.14	8.55	8.78	8.32	9.73	8.38	8.64	10.6	9.43	10.0	9.40	9.81	10.1
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%	9.5%	9.5%	9.6%
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%	5.0%	5.0%	5.0%









DATA QUALITY KITEMARK

SUMMARY

AREAS OF IMPROVEMENT

DATA QUALITY KITEMARK

DATA QUALITY KITEMARK

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.	Messaging to be rolled out to MSK in January 2025. NHS Way finder has gone live for stage 2. A renewed focus on patient access to the NHS app will be in place in line with the Elective reform planning guidance operational imperatives. E-meet and greet module in Dr Doctor being explored. Arthroplasty continues to show best practice with a 4.9% Missed Appointment rate.	Further review of clinic templates to ensure that capacity is maximised for new patients. Focus on spinal clinics to maximise productivity. Clinical Audit of outpatient follow up delays for Spinal patients led by Matt Revell.	Referral criteria needs to be confirmed for Primary Care. Internal primary care interface group now in place supported by COO /CMO attending system steering group with good collaboration and two way communication channels now in place across a number of clinical and non clinical development programmes Activity has been confirmed for A&G via national reporting team.	Re-focused group has met to prioritise the objectives outlined under the outpatient transformation group reporting to the Trust Productivity Group. Review of NHS impact best practice guidance underway to identify any gaps / areas for improvements.

SUMMARY

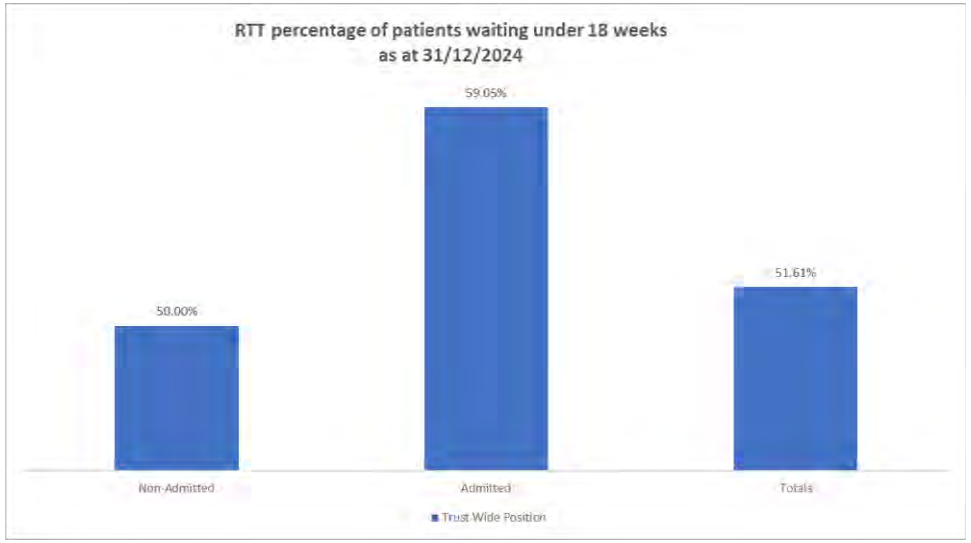
AREAS FOR IMPROVEMENT

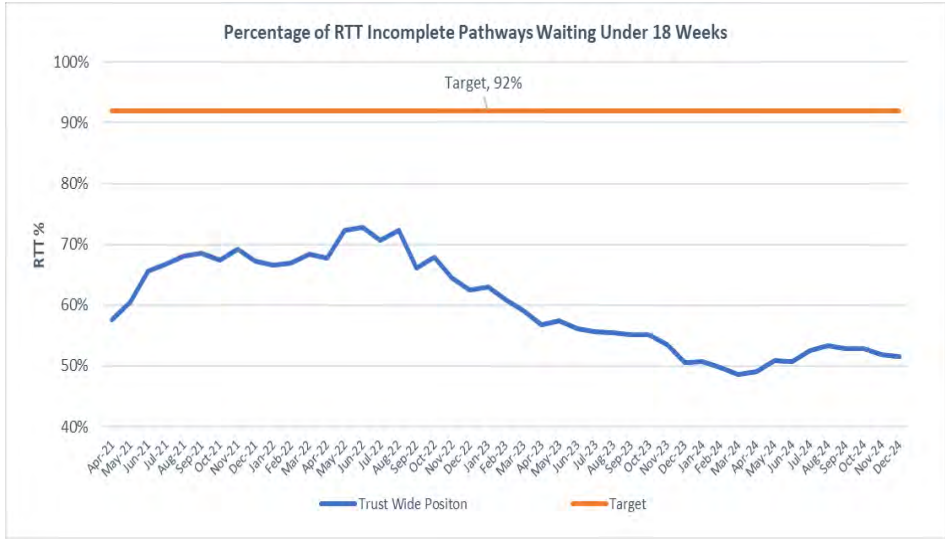
RISKS / ISSUES

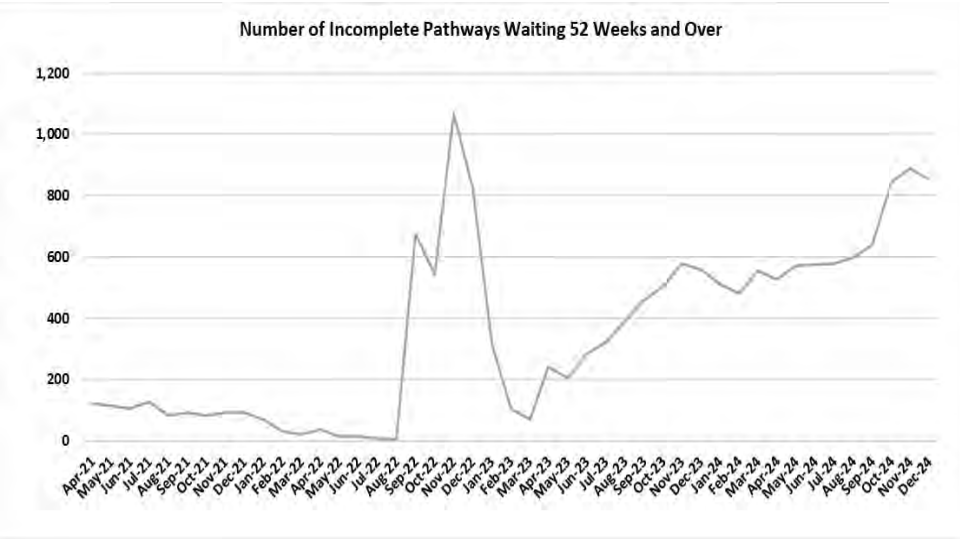
DATA QUALITY KITEMARK

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,525	650	3,175
7-13	2,334	581	2,915
14-17	1,109	293	1,402
18-26	2,135	446	2,581
27-39	1,908	372	2,280
40-47	796	131	927
48-51	343	39	382
52 weeks and over	786	69	855
Total	11,936	2,581	14,517

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	5,968	1,524	7,492
18 and over	5,968	1,057	7,025
Month End RTT %	**50.00%**	**59.05%**	**51.61%**

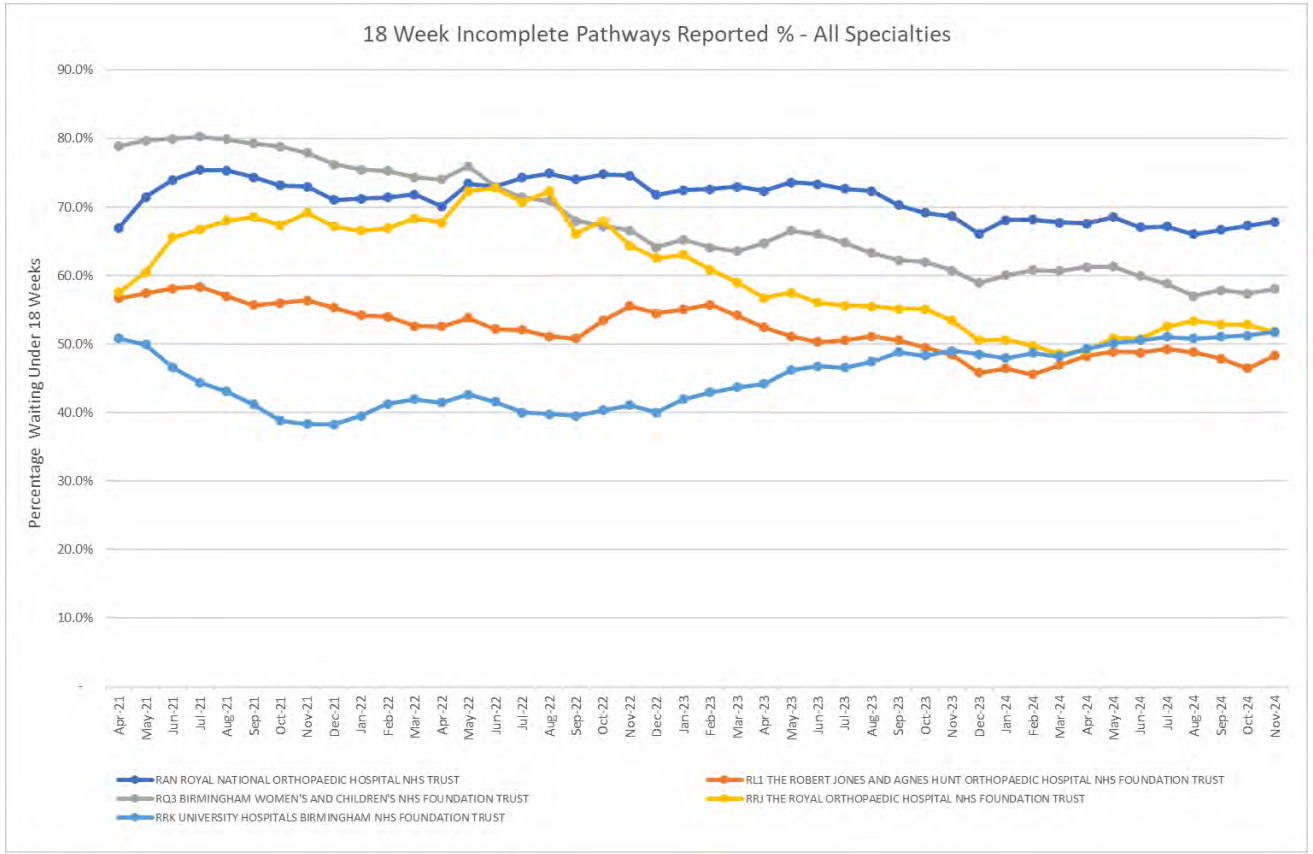






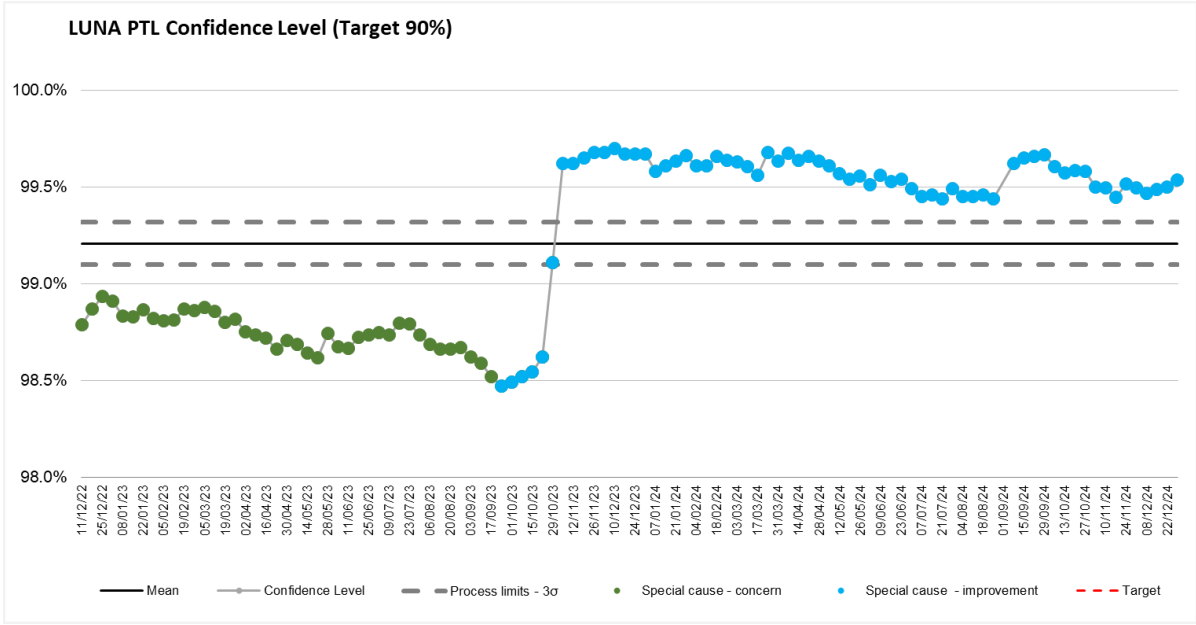
DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:



DATA QUALITY KITEMARK

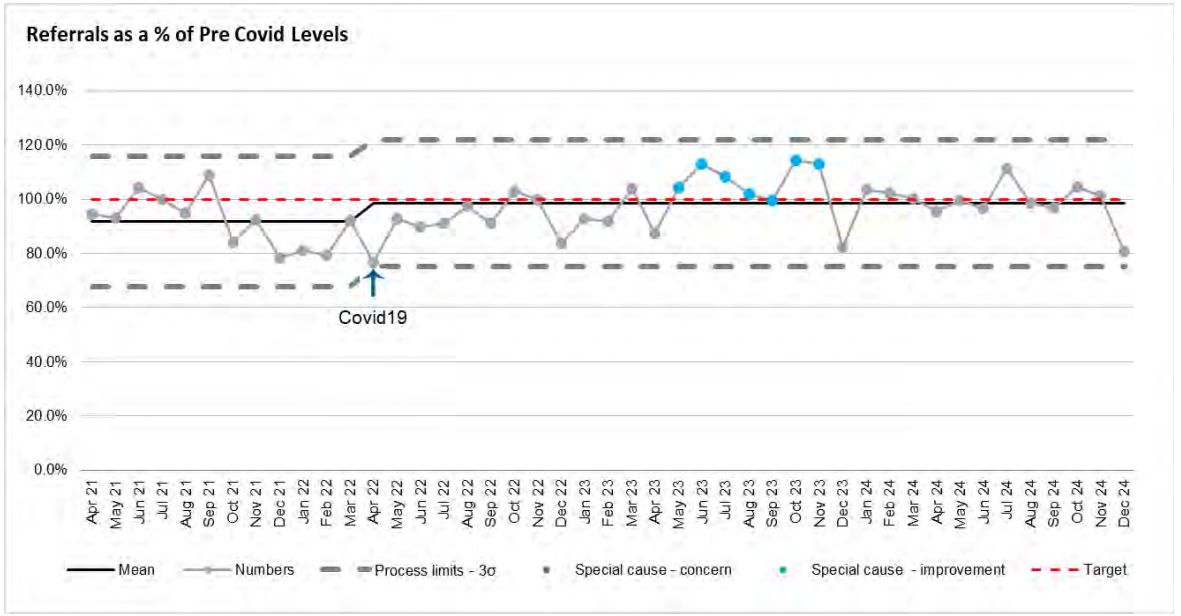
The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with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



Figures for % Against Pre Covid Referrals

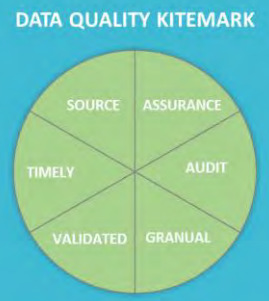
Pre Covid Level	2704

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%

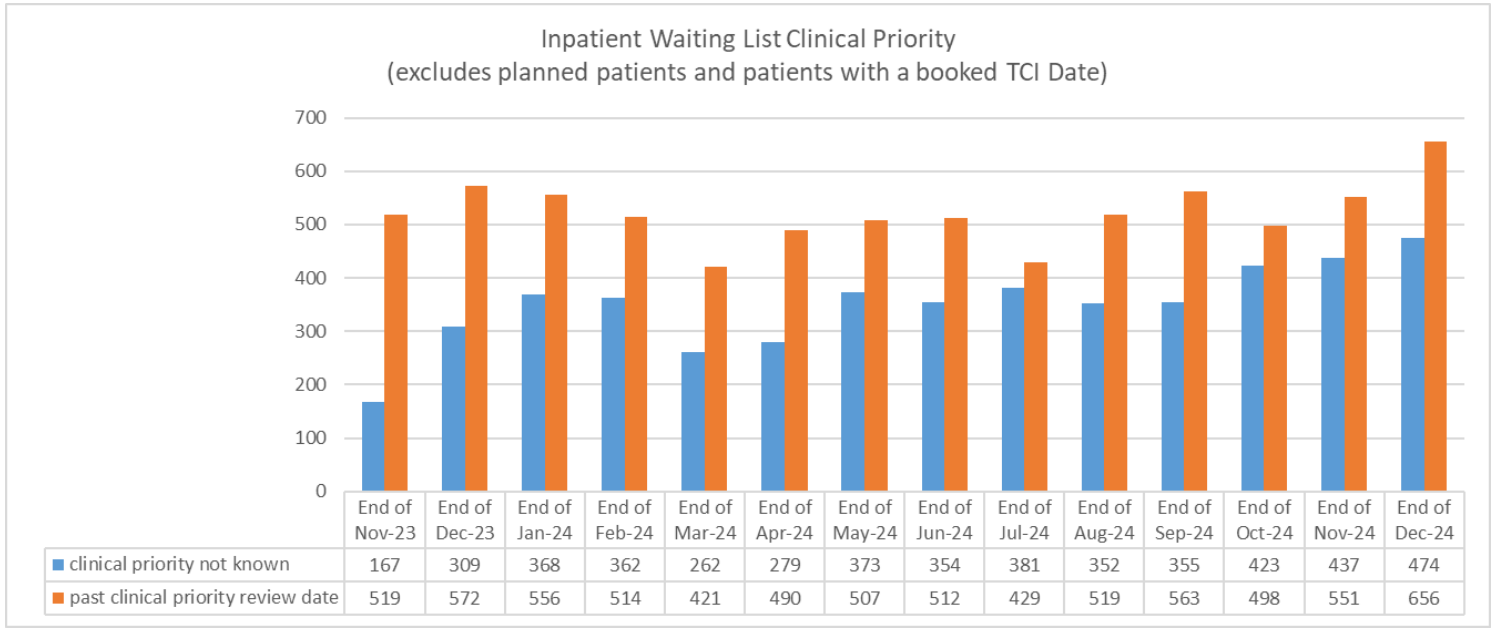
Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707	2582	2692	2609	3012	2665	2617	2826	2732	2183			
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%	95.49%	99.56%	96.49%	111.39%	98.56%	96.78%	104.51%	101.04%	80.73%			

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 17.12.24	Compliance with proposed Elective reform target 2025/26
Arthroplasty	2	71.06%	
Arthroscopy	33	57.65%	
Clinical Support	2	56.98%	
Foot and Ankle	17	54.13%	
Hands	30	43.72%	
Oncology	0	85.47%	
Oncology Arthroplasty	0	76.38%	
Spinal	479	27.90%	
Spinal Deformity	335	30.07%	
Young Adult Hips	2	66.45%	



Overdue Clinical Priority:

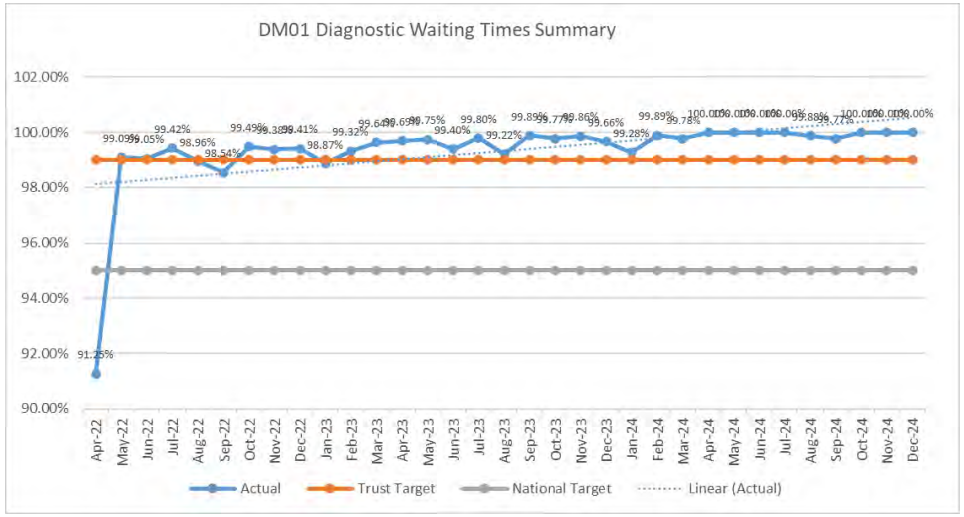


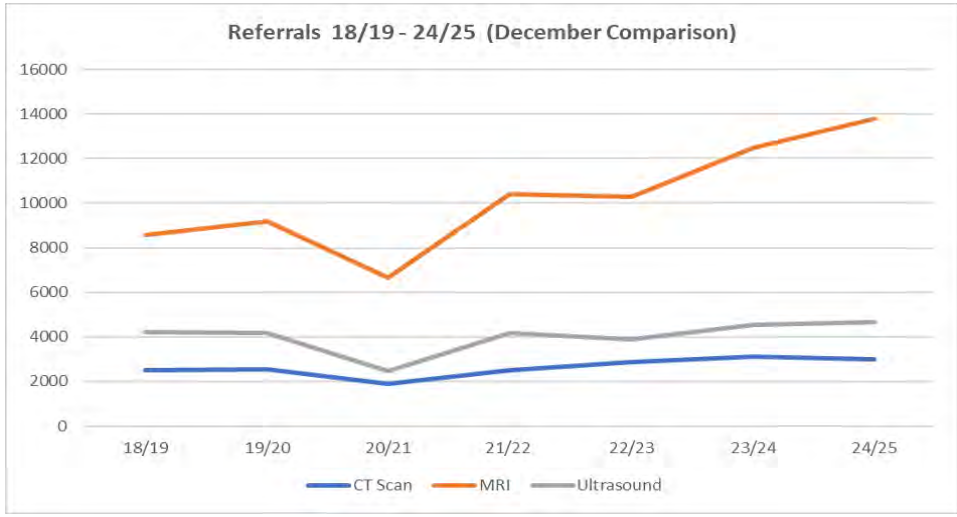
	End of Nov-23	End of Dec-23	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24	End of Oct-24	End of Nov-24	End of Dec-24
clinical priority not known	167	309	368	362	262	279	373	354	381	352	355	423	437	474
past clinical priority review date	519	572	556	514	421	490	507	512	429	519	563	498	551	656

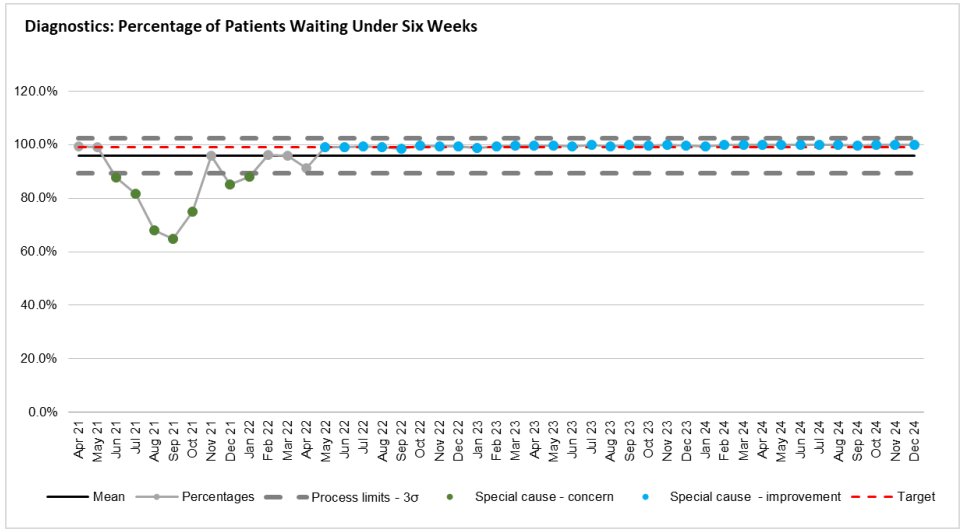
The number of patients with an unknown clinical priority has increased by 68 patients, however, the numbers that have past the clinical priority review date has reduced by 65 patients. The information continues to be shared on a monthly basis with individual services and clinicians to manage individual clinical practice and at the Monthly CSLS meeting.

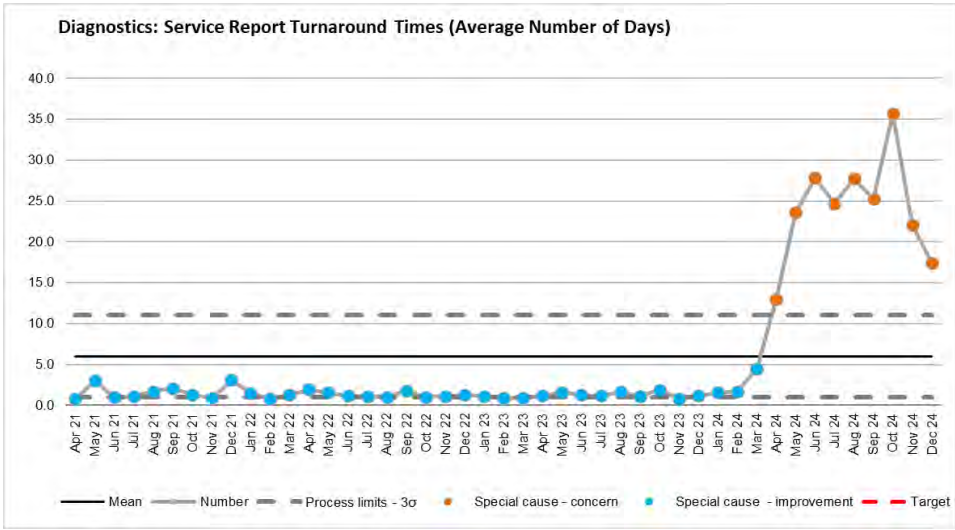
The team are liaising with the business intelligence team to test the validity of the data in response to clinical review of the current position.

DATA QUALITY KITEMARK


DM01 Diagnostic Waiting Times Summary
102.00%
100.00%
98.00%
96.00%
94.00%
92.00%
90.00%
91.25%
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
Oct-24
Nov-24
Dec-24
Actual
Trust Target
National Target
Linear (Actual)


Referrals 18/19 - 24/25 (December Comparison)
16000
14000
12000
10000
8000
6000
4000
2000
0
18/19
19/20
20/21
21/22
22/23
23/24
24/25
CT Scan
MRI
Ultrasound


Diagnostics: Percentage of Patients Waiting Under Six Weeks
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Mean
Percentages
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Diagnostics: Service Report Turnaround Times (Average Number of Days)
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Mean
Number
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

SUMMARY

AREAS FOR IMPROVEMENT

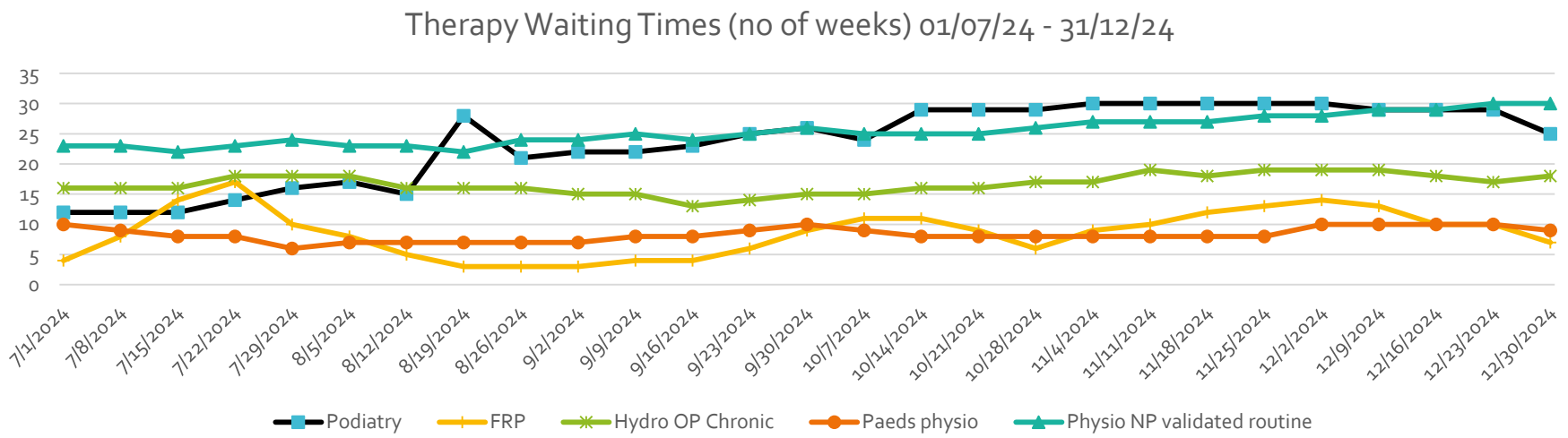
RISKS

Summary Performance Figures – January 25 (November 2024 Submission)

		November 24 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	13.0	0.0	13.0
62 day RTT to treatment	70%	75%	6.0	2.0	8.0
28 day FDS REPORTED	75%	84.6%	71.0	13.0	84
Patients over 104 days (62 day standard)					

Performance

Risks /actions ongoing



Summary – data as per 17/01/25

Risks /actions ongoing

SUMMARY

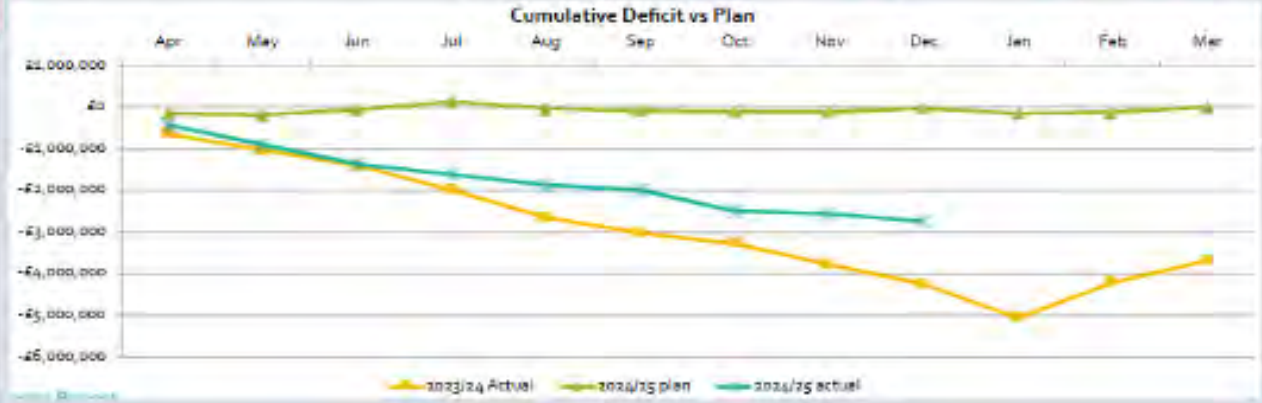
24-25 summary	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
Income Plan (£000)	425	425	425	407	255	383	467	467	298	3552
Income to be collecte	375	384	241	474	332	459	417	558	358	3598
Variance	-50	-41	-184	67	77	76	-50	91	60	46

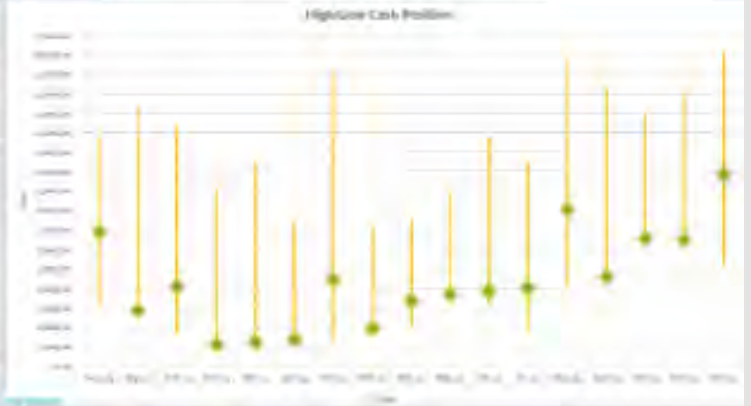
AREAS FOR IMPROVEMENT

Month 9

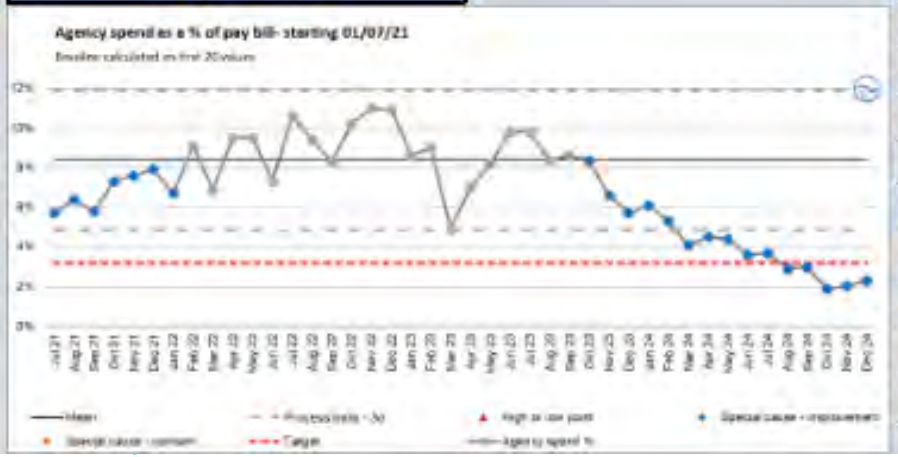
FINANCIAL PERFORMANCE

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	£11,192	£10,941	-£251	£101,662	£101,049	-£613	£135,653	£133,682	-£1,971
Other income	£529	£540	£11	£4,823	£4,821	-£2	£6,432	£6,228	-£204
Pay	-£6,995	-£6,713	£282	-£61,317	-£60,735	£582	-£82,050	-£78,543	£3,507
Non Pay	-£4,525	-£4,822	-£297	-£44,180	-£47,134	-£2,954	-£58,692	-£60,377	-£1,685
Non operating costs	-£119	-£136	-£17	-£1,070	-£822	£248	-£1,435	-£1,082	£353
Remove capital donations	£7	£8	£1	£69	£69	£0	£92	£92	£0
TOTAL	£89	-£182	-£271	-£13	-£2,752	-£2,739	£0	£0	£0





Agency as a % of paybill =3.2%

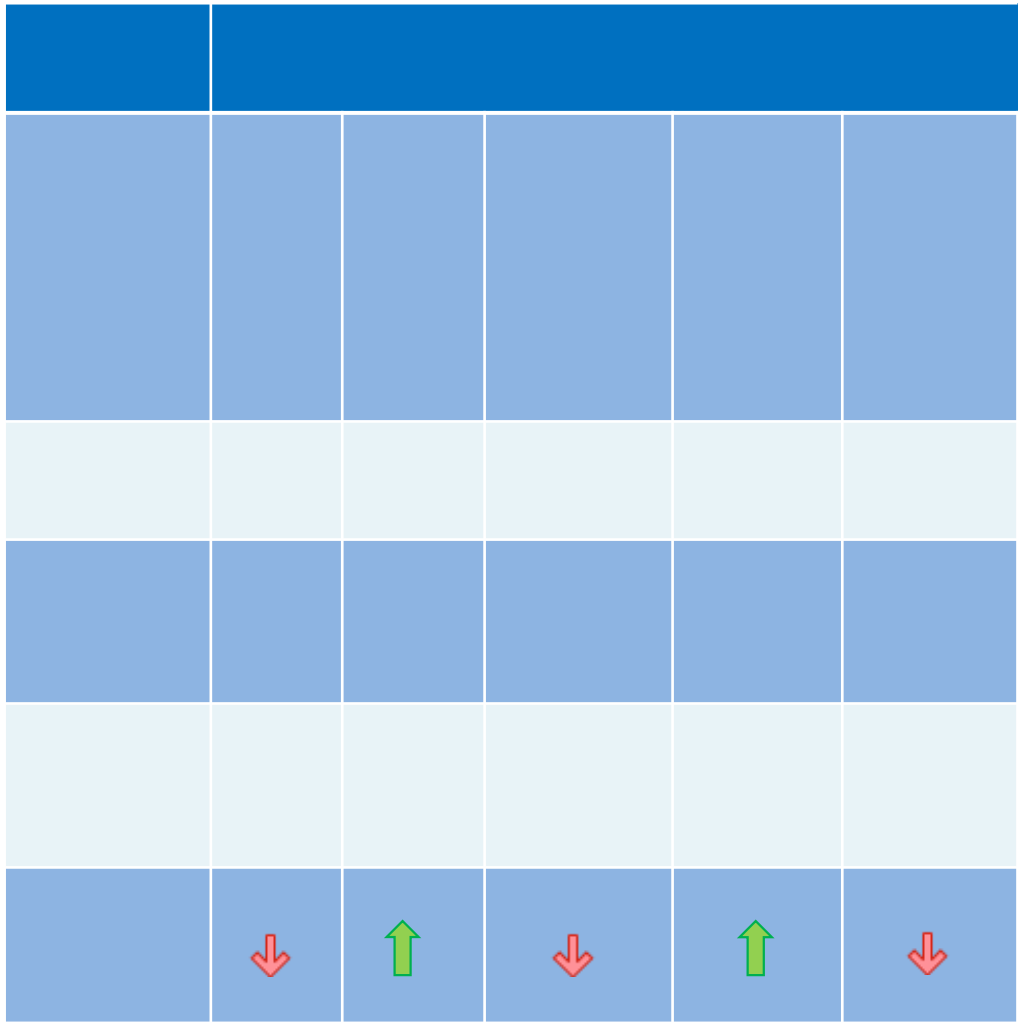


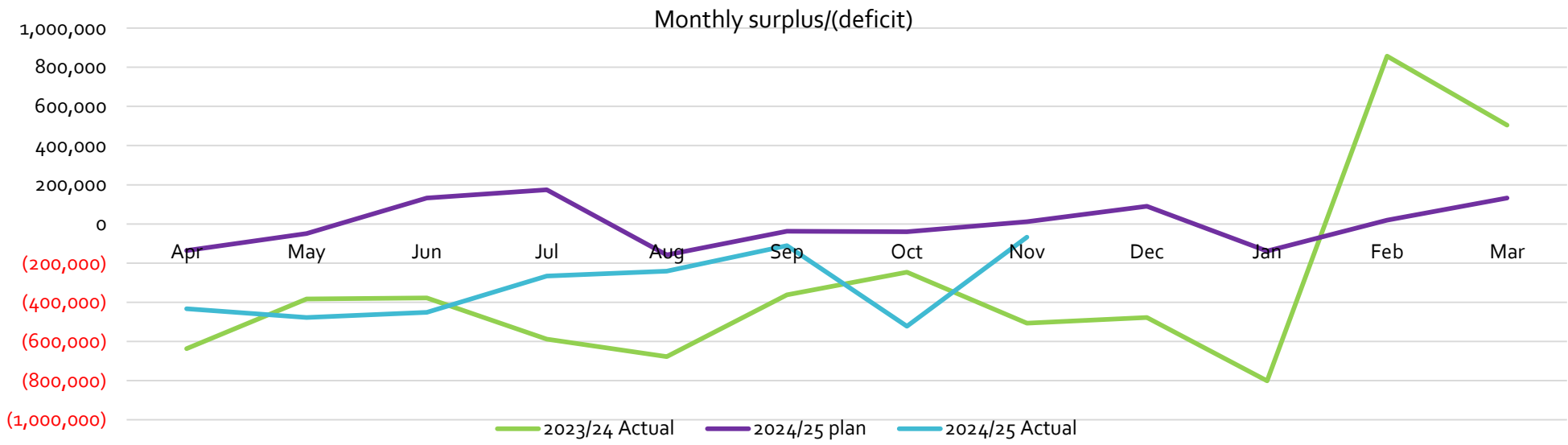
Efficiencies	YTD	Forecast
Plan	£4,339	£6,484
Actual	£3,788	£8,220
Variance	-£551	£1,736

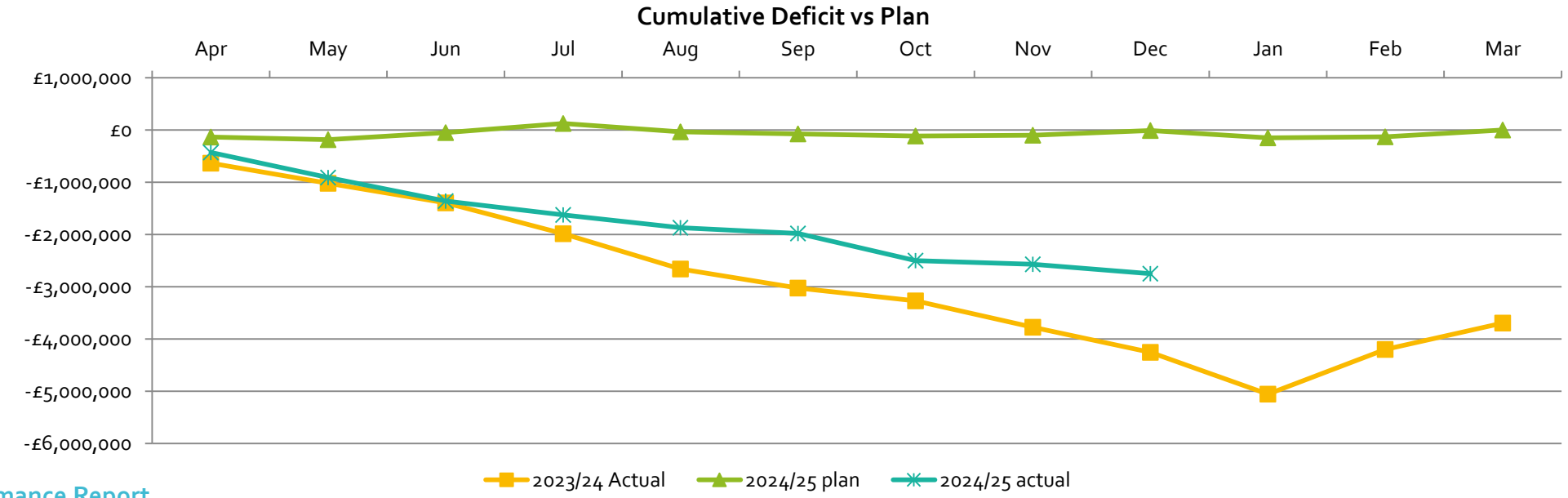
Capital	YTD	Forecast
Plan (exc IFRS16)	£3,518	£5,156
Actual	£2,932	£4,349
IFRS 16	£465	£756
Variance	£121	£51

Better Payment practice code	YTD	% move/1 prev month
Non-NHS		
By number	83.9%	0.4%
By Value	86.8%	0.3%
NHS		
By number	55.4%	-0.5%
By Value	20.5%	-1.0%
Total		
By number	83.4%	0.4%
By Value	82.6%	0.4%

SUMMARY




Monthly surplus/(deficit)
1,000,000
800,000
600,000
400,000
200,000
0
(200,000)
(400,000)
(600,000)
(800,000)
(1,000,000)
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 Actual
2024/25 plan
2024/25 Actual


Cumulative Deficit vs Plan
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
£1,000,000
£0
-£1,000,000
-£2,000,000
-£3,000,000
-£4,000,000
-£5,000,000
-£6,000,000
2023/24 Actual
2024/25 plan
2024/25 actual

SUMMARY

AREAS FOR IMPROVEMENT

RISKS / ISSUES

Elective Recovery Fund (ERF)

Based on NHSE data for M1-6 and ROH data for M6-9 the underperformance against the revised targets is shown below:-

	Target	April	May	June	July	August	September	October	November	December	YTD
NHSE Target	**£57,208,277**	4,389,353	4,714,360	4,543,279	4,746,278	3,947,029	4,478,513	4,973,961	4,860,342	4,297,829	40,950,944
Actual performance		4,163,273	4,694,054	4,183,494	5,003,505	4,364,521	4,513,054	***4,727,071***	***4,430,048***	***4,088,239***	40,167,260
Variance		(226,080)	(20,306)	(359,785)	257,227	417,492	34,541	(246,890)	(430,294)	(209,590)	(783,684)
Breakeven Target	**£60,599,277**	4,649,530	4,993,802	4,812,580	5,027,612	4,180,988	4,743,976	5,268,791	5,148,437	4,552,581	43,378,296
Variance		(486,257)	(299,748)	(629,086)	(24,107)	183,533	(230,922)	(541,719)	(718,389)	(464,342)	(2,028,306)

Note: M7-9 Actual performance is an estimate.

This shows a YTD underperformance against NHSE Target of £784k. A provision of £250k was made in month for ERF underperformance, giving a total YTD provision of £790k. This is included within the M9 reported position.

Consideration has been given to how the level of unmitigated risk there currently is related to underperformance of ERF target. The following slides summarises this along with some recovery options that have been considered.

Elective Recovery Fund (ERF)

Scenario modelling has been undertaken to understand the potential ERF outturn at year end:-

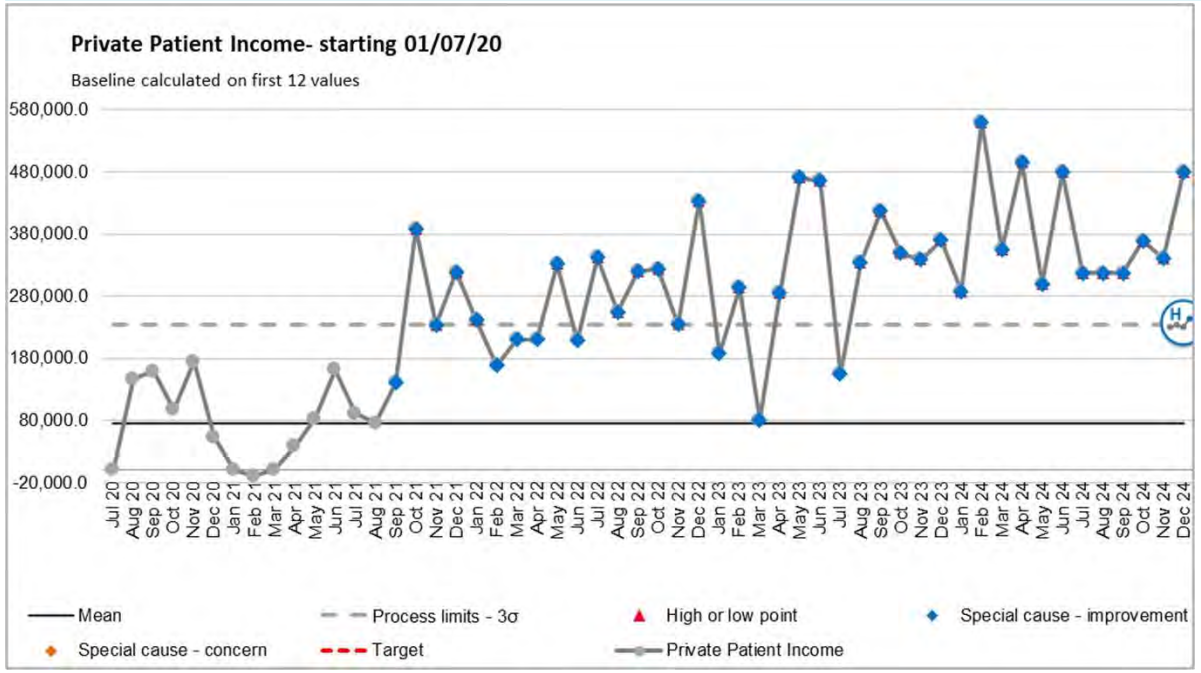
Option 1: No Change. Value of activity at current rate of performance
Option 2: The value of our current plan for Q4
Option 3: The value of the NHSE Target
Option 4: The value of Breakeven Target

	ERF Value (£'s)			
Options	**No Change**	**2**	**3**	**4**
Actual 1-9	40,167,260	40,167,260	40,167,260	40,167,260
No Change pro rata	13,389,087			
Option 2 (Deliver Plan)		15,184,455		
Option 3 (Recover NHSE Target)			17,041,018	
Option 4 (Recover B/E)				20,432,017
Income Forecast	**53,556,346**	**55,351,715**	**57,208,277**	**60,599,277**
Target	57,208,277	57,208,277	57,208,277	57,208,277
Risk	(3,651,931)	(1,856,563)	**0**	**3,391,000**
B/E Target	60,599,277	60,599,277	60,599,277	60,599,277
Risk	(7,042,931)	(5,247,562)	(3,391,000)	**0**

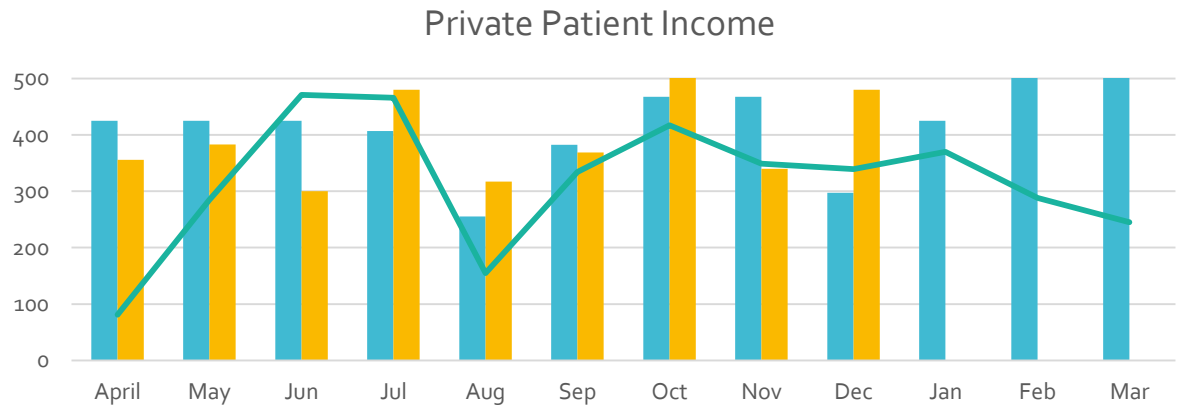
	Profile (£'s)			
	Jan	Feb	Mar	Total
Option 2	5,250,862	4,786,984	5,146,609	15,184,455
Option 3	5,895,223	5,370,610	5,775,184	17,041,018
Option 4	7,068,316	6,439,310	6,924,391	20,432,017
NHSE Target	4,711,157	5,543,855	6,002,321	16,257,333

	Activity @ plan case mix					Activity @ Current case mix			
	Jan	Feb	Mar	Total		Jan	Feb	Mar	Total
Option 2	1,326	1,208	1,299	3,833		1,362	1,241	1,335	3,937
Option 3	1,518	1,383	1,487	4,389		1,529	1,393	1,498	4,419
Option 4	1,820	1,658	1,783	5,262		1,833	1,670	1,796	5,298
Current Activity Plan	1,326	1,208	1,299	3,833		1,326	1,208	1,299	3,833
Current Booked Activity	1,334					1,334			
Additional Activity									
Option 3	184	175	188	555		195	185	198	586
Option 4	486	450	484	1,429		499	462	496	1,465

Private patient income



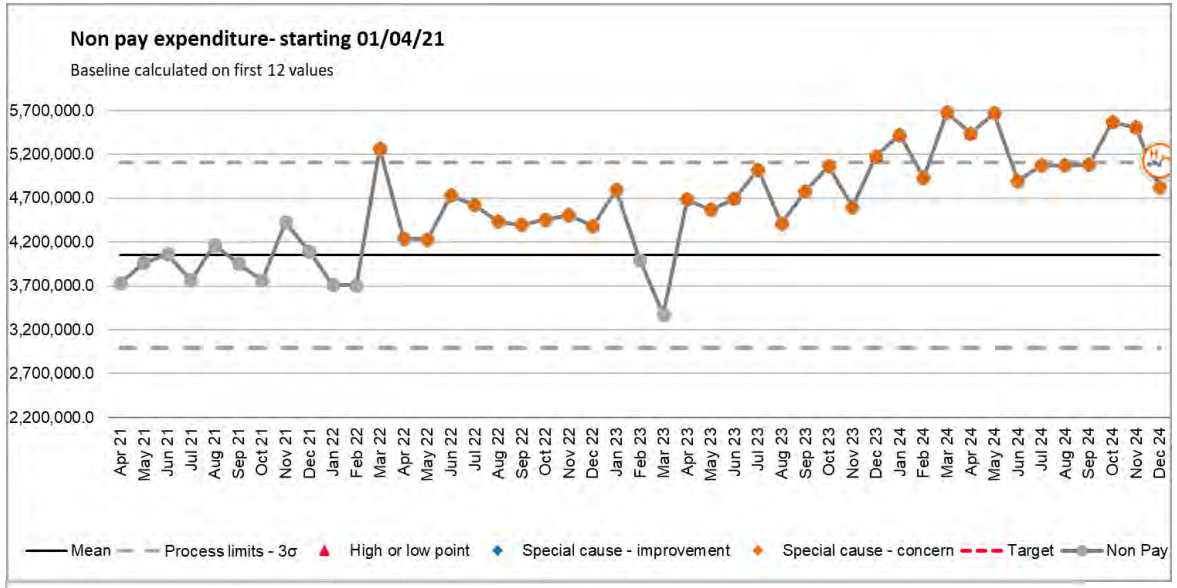
*note that the private patient income reported is different to the value reported in the operational report. The finance value includes all private patient activities and is based on the same principles of NHS reported income of being accounted for based on discharge date and not TCI

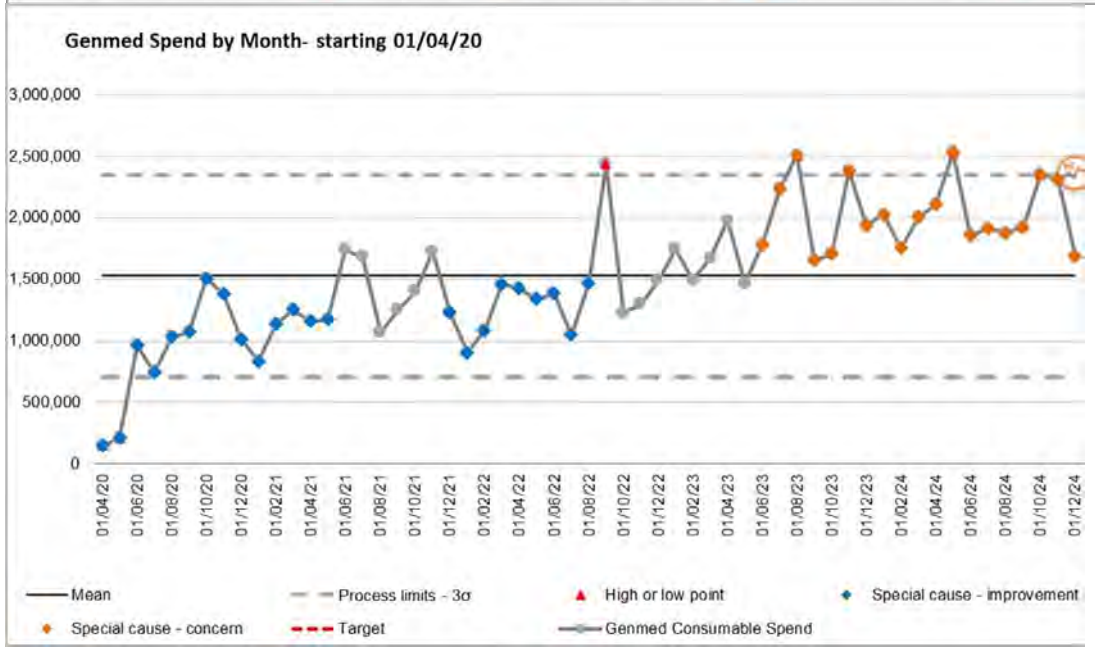


SUMMARY

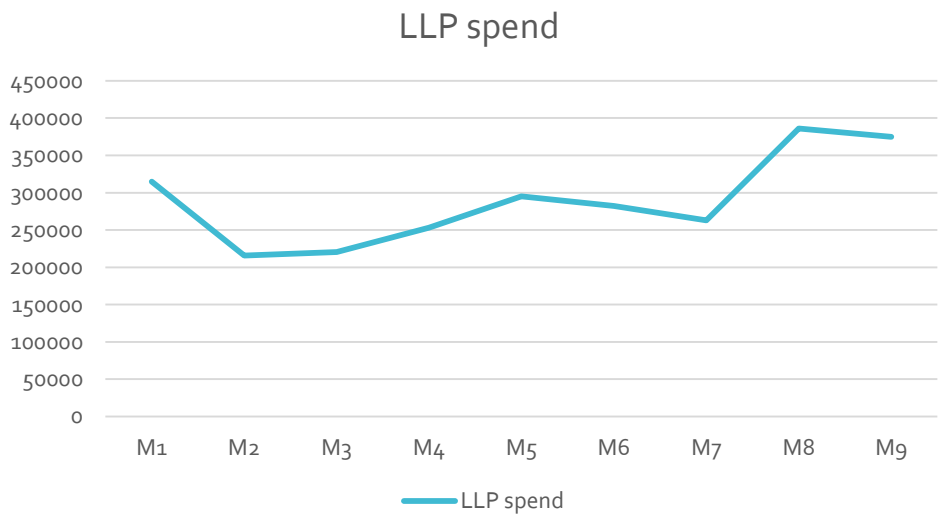
AREAS FOR IMPROVEMENT

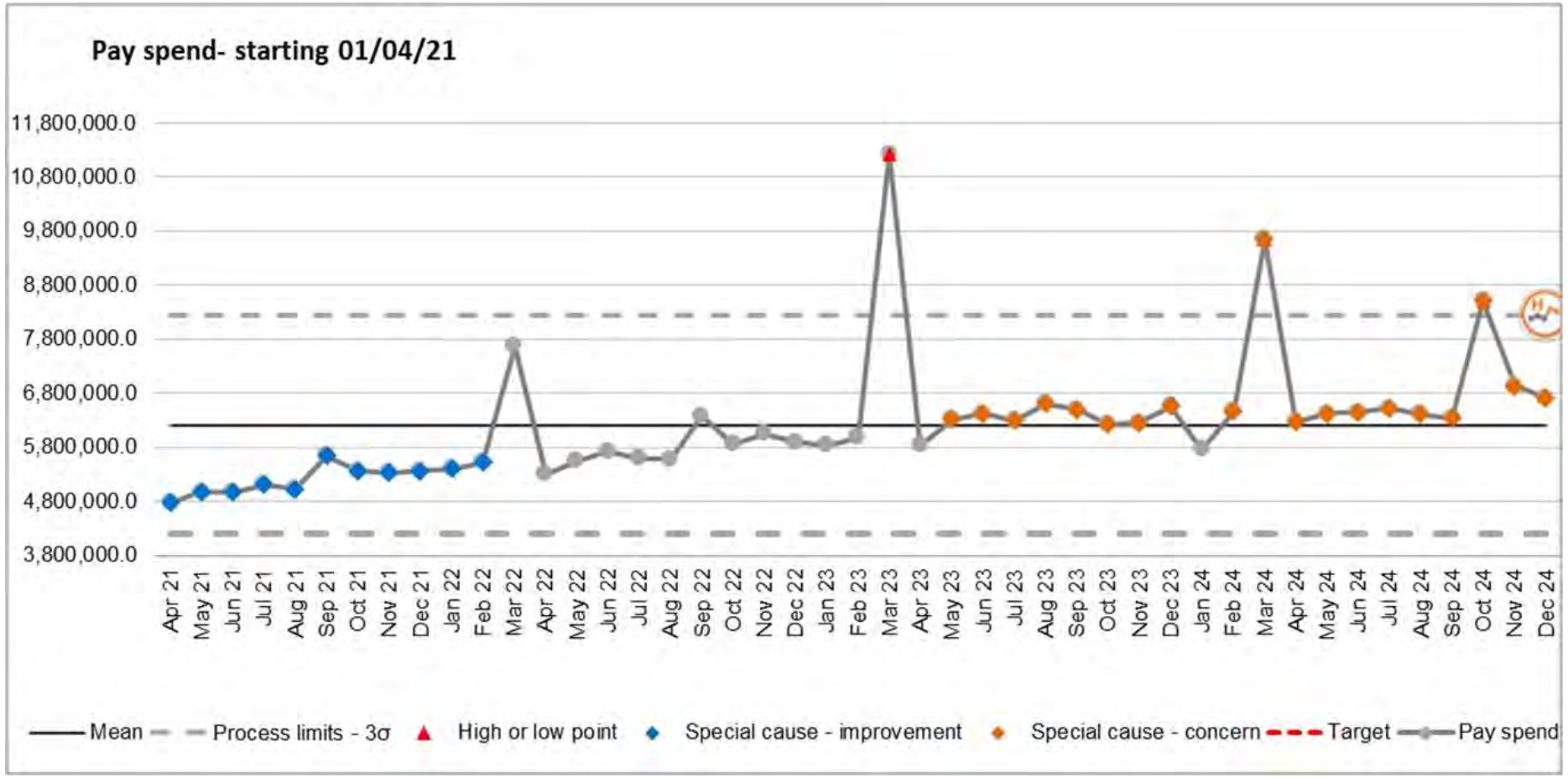
RISKS / ISSUES


Non pay expenditure- starting 01/04/21
Baseline calculated on first 12 values
5,700,000.0
5,200,000.0
4,700,000.0
4,200,000.0
3,700,000.0
3,200,000.0
2,700,000.0
2,200,000.0
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
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
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Non Pay


Genmed Spend by Month- starting 01/04/20
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
01/04/20
01/06/20
01/08/20
01/10/20
01/12/20
01/02/21
01/04/21
01/06/21
01/08/21
01/10/21
01/12/21
01/02/22
01/04/22
01/06/22
01/08/22
01/10/22
01/12/22
01/02/23
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
01/02/24
01/04/24
01/06/24
01/08/24
01/10/24
01/12/24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Genmed Consumable Spend

SUMMARY


LLP spend
450000
400000
350000
300000
250000
200000
150000
100000
50000
0
M1
M2
M3
M4
M5
M6
M7
M8
M9
LLP spend


Pay spend- starting 01/04/21
11,800,000.0
10,800,000.0
9,800,000.0
8,800,000.0
7,800,000.0
6,800,000.0
5,800,000.0
4,800,000.0
3,800,000.0
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
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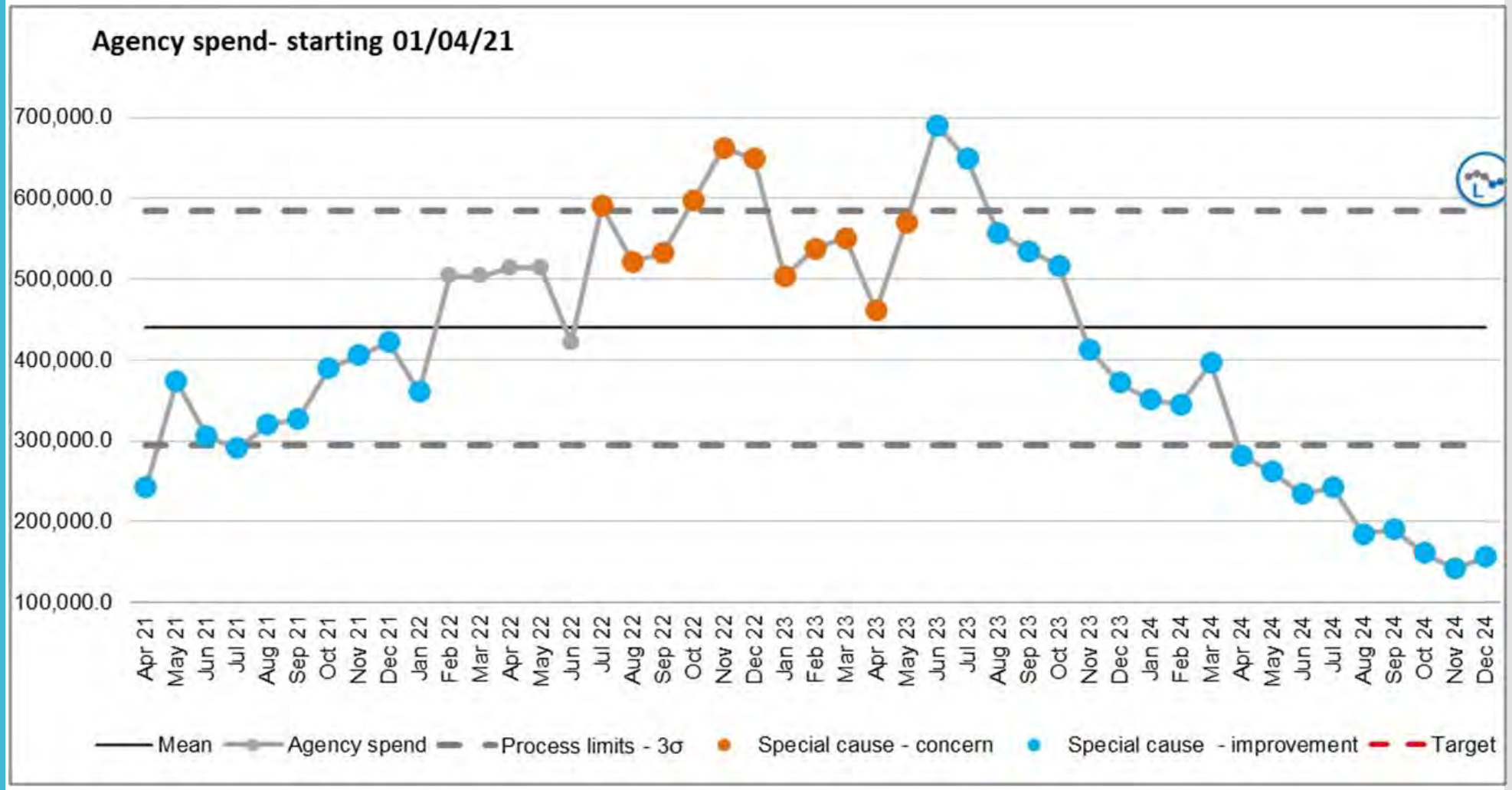
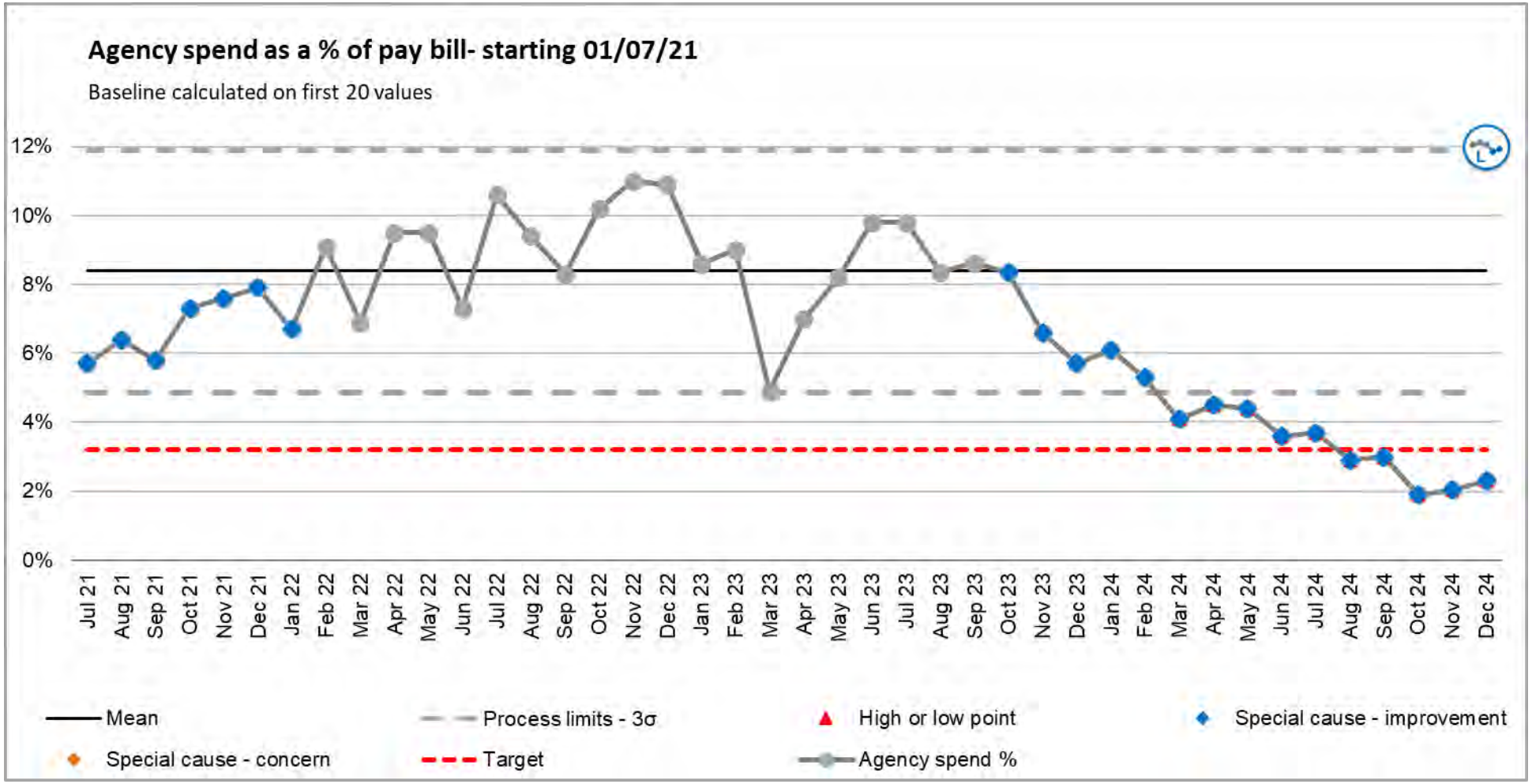
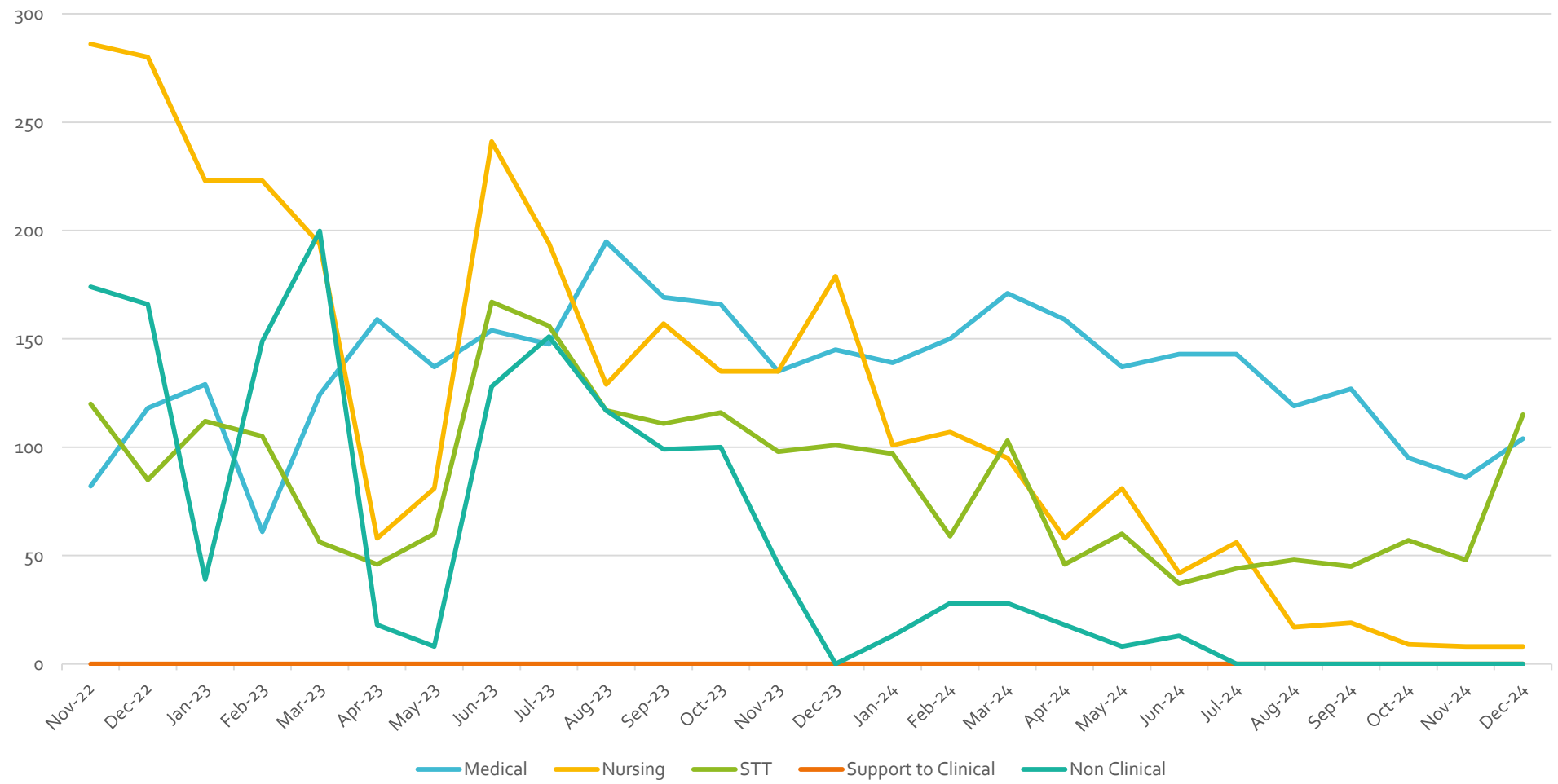
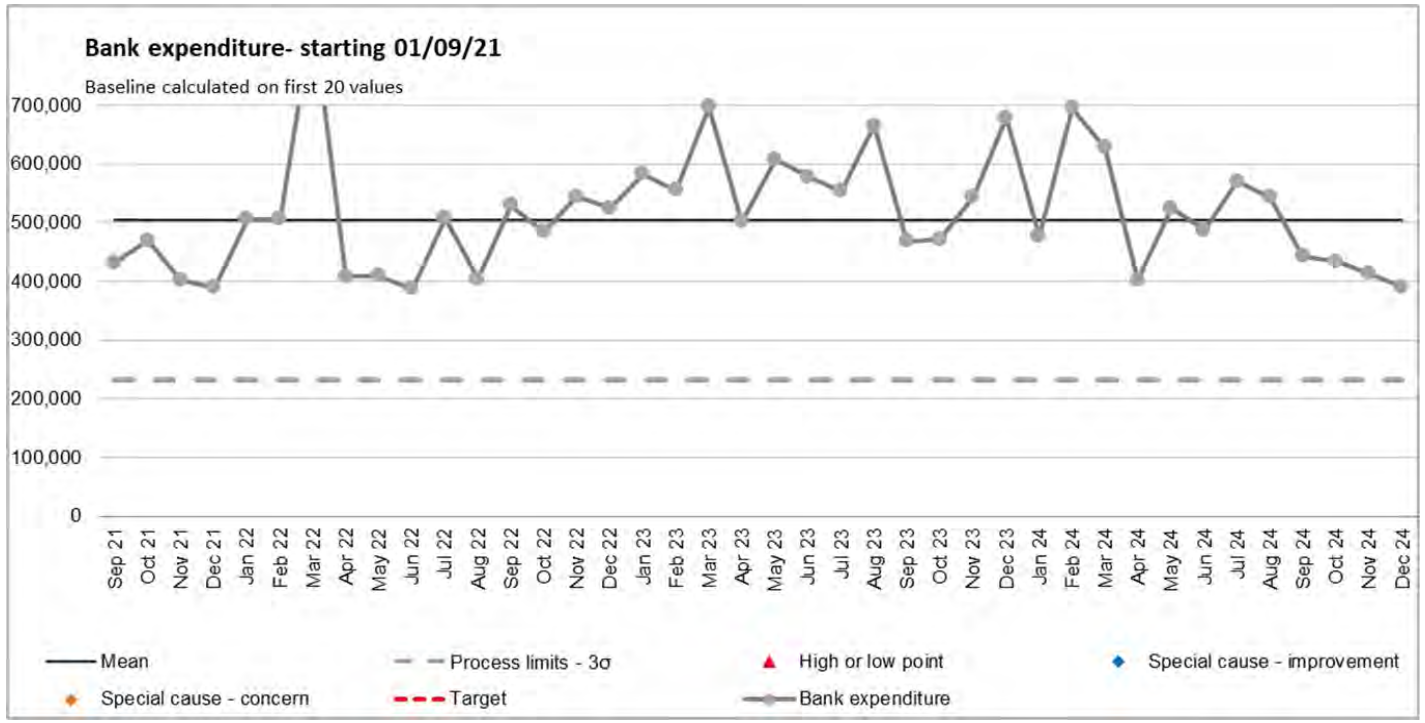
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Pay spend


Agency spend- starting 01/04/21
700,000.0
600,000.0
500,000.0
400,000.0
300,000.0
200,000.0
100,000.0
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
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
Mean
Agency spend
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Agency spend as a % of pay bill- starting 01/07/21
Baseline calculated on first 20 values
12%
10%
8%
6%
4%
2%
0%
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
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
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Agency spend %

Agency spend by staff group




Bank expenditure- starting 01/09/21
Baseline calculated on first 20 values
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
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
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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
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Bank expenditure

	£'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**	**-522**	**-78**	**-181**				
Variance	**140**	**-709**	**-279**	**-460**				
Revised trajectory to breakeven				**563**	**442**	**615**	**787**	**2407**
Variance to revised trajectory				**-744**				

SUMMARY

Risks/Issues

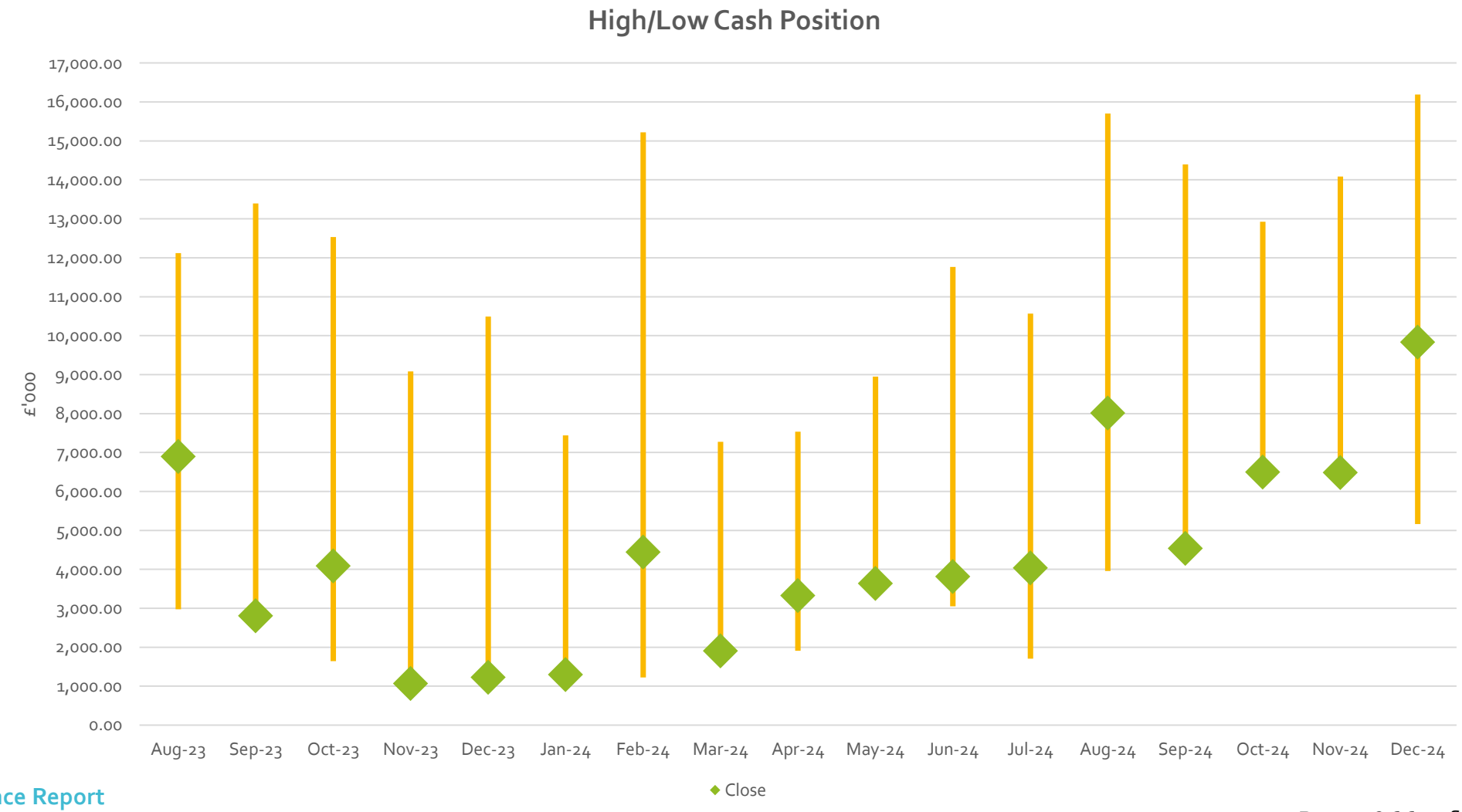
Actions

SUMMARY

Stream	Scheme Name	Plan	YTD Spend	Variance	Forecast	Variance
Strategic Estates	Oncology office refurbishment/relocation	1,196,222	1,098,992	97,230	1,196,222	0
Strategic Estates	Retention - Relocation of Facilites to the Old Pharmacy building	6,582	1,246	5,336	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	23,940	376,060	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	95,005	(5)	95,000	0
Strategic Estates	Roof Replacement inc Large and Small Joint Medical Secretary block / Plaster room / Theatre 3, Hydrotherapy roofs	70,000	27,672	42,328	74,672	(4,672)
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	131,430	18,570	150,000	0
Equipment	Pool allocation for scheme prioritisation by budget holder	200,000	134,202	65,798	200,000	0
Equipment	Image intensifiers x 5	804,000	659,160	144,840	804,000	0
Information Technology	Pool allocation for scheme prioritisation by budget holder	100,000	12,000	88,000	84,024	15,976
Information Technology	EPR	200,000	104,692	95,308	428,659	(228,659)
Information Technology	Networking	0	890,576	(890,576)	890,576	(890,576)
Reserve		122,425	(244,879)	367,304	(244,879)	367,304
TOTAL		**3,499,000**	**2,939,922**	**559,078**	**4,150,627**	**(651,627)**
	Additional system capital - backlog maintenance	1,600,000	0	1,600,000	948,373	651,627
TOTAL EXCL. IFRS16 ADJ		**5,099,000**	**2,939,922**	**2,159,078**	**5,099,000**	**0**
	IFRS 16 Adjustment for revaluation of Modular theatres and other leases	756,000	456,000	300,000	456,000	300,000
TOTAL CDEL		**5,855,000**	**3,395,922**	**2,459,078**	**5,555,000**	**300,000**

SUMMARY

	2023/24 M12	2024/25 M9	Movement
	981	743	(238)
	66,219	64,607	(1,612)
	66,379	**65,350**	**(1,029)**
	1	23	22
	8,299	8,262	(37)
	1,699	8,138	6,439
	9,893	**16,423**	**6,530**
	(13,896)	(18,156)	(4,260)
	(16,145)	(14,405)	1,740
	(1,187)	(1,209)	(22)
	(1,233)	(3,221)	(1,988)
	(32,461)	**(36,991)**	**(4,530)**
	43,811	**44,782**	**971**
	43,811	**44,782**	**971**


High/Low Cash Position
£'000
17,000.00
16,000.00
15,000.00
14,000.00
13,000.00
12,000.00
11,000.00
10,000.00
9,000.00
8,000.00
7,000.00
6,000.00
5,000.00
4,000.00
3,000.00
2,000.00
1,000.00
0.00
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
Close

Total Performance	YTD				FOT				Prior Month variance £000s	YTD Performance against trajectory		
	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plar £000s	FOT £000s	Variance £000s		YTD Trajectory £000s	Current YTD Actual £000s	Variance to Trajectory £000s
BSOL ICB	7,113	7,113	7,670	557	11,405	11,405	11,405	0	659	7,113	7,670	557
BSMHT	1,795	1,795	1,208	-587	2,069	2,069	2,069	0	-878	1,795	1,208	-587
BCHC	41	41	291	250	0	0	0	0	397	41	291	250
BWC	2,250	2,250	-3,387	-5,636	3,000	3,000	3,000	0	-5,640	-3,034	-3,387	-353
ROH	-13	-13	-2,753	-2,740	0	1	0	-1	-2,469	-1,821	-2,753	-932
UHB	-23,649	-23,649	-89,766	-66,117	-16,474	-16,474	-16,474	0	-56,670	-81,461	-89,766	-8,305
Total	-12,463	-12,463	-86,736	-74,273	0	1	-1	-2	-64,600	-77,367	-86,736	-9,369

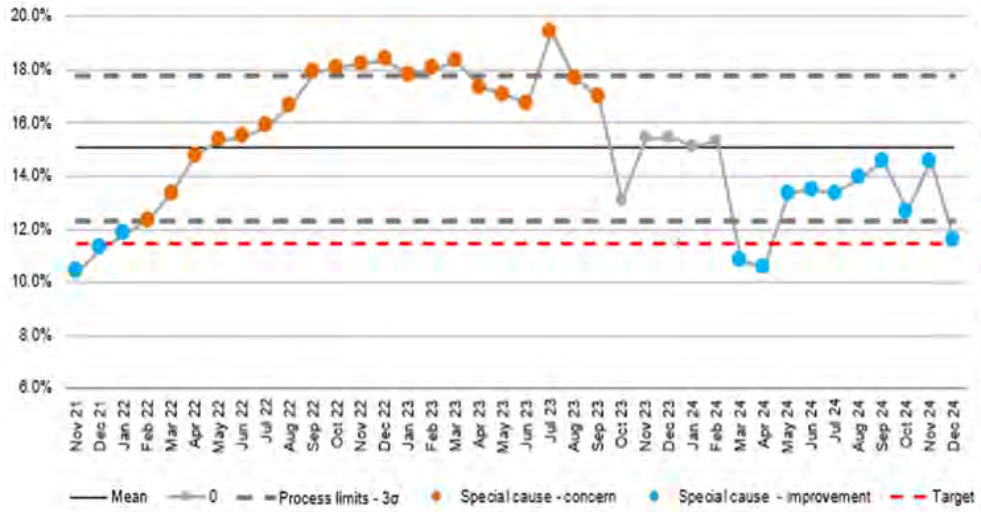
SUMMARY

Risks/Issues

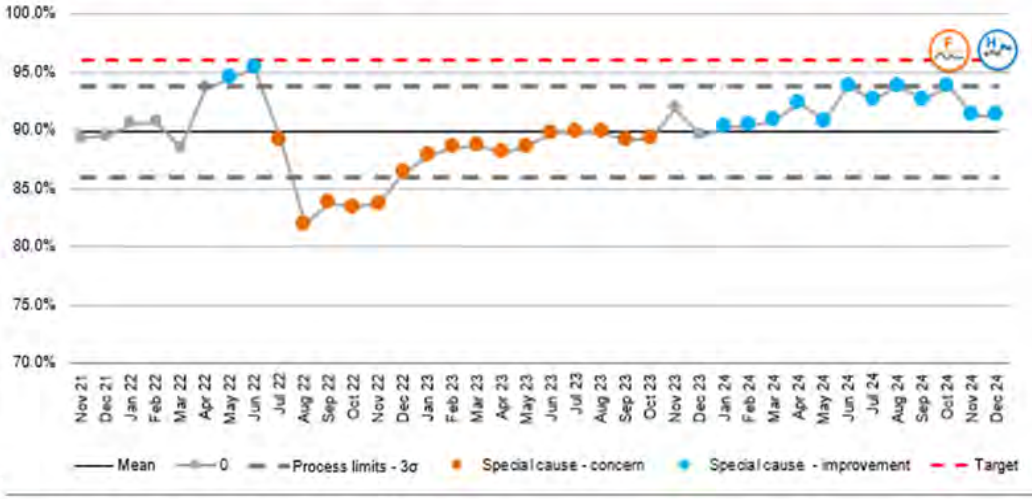
Actions

Trust Workforce Metrics	Nov-24	Dec-24	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1463	1461	-2	-	-
Staff In Post - Full Time Equivalent	1291.48	1290.59	-0.89	-	-
Staf Turnover % - Unadjusted	12.09%	11.56%	-0.53%	↓	<=11.5%
Staf Turnover % - Adjusted	11.25%	10.74%	-0.51%	↓	<=11.5%
Total WTE Employed as % of Establishment	89.69%	89.69%	0.00%	↓	>=93%
Total WTE Employed as % of Establishment - Clinical	88.74%	88.74%	0.00%	↓	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	91.34%	91.34%	0.00%	↑	>=96%
% Of Attendance	93.46%	93.22%	-0.24%	↓	>=96.3%
% Of 12 mth MAA Attendance	94.18%	94.20%	0.02%	↑	>=96.3%
% Staff received mandatory training last 12 months	89.27%	89.68%	0.41%	↑	>=93%
% Staff received formal PDR/appraisal last 12 months	92.07%	92.09%	0.02%	↑	>=95%
% of Sickness - Trust wide Long-term	3.41%	3.69%	0.28%	↓	-
% of Sickness - Trust wide Short-term	3.12%	3.09%	-0.03%	↓	-
Return To Work Completion %	60.84%	55.85%	-4.99%		>=80%

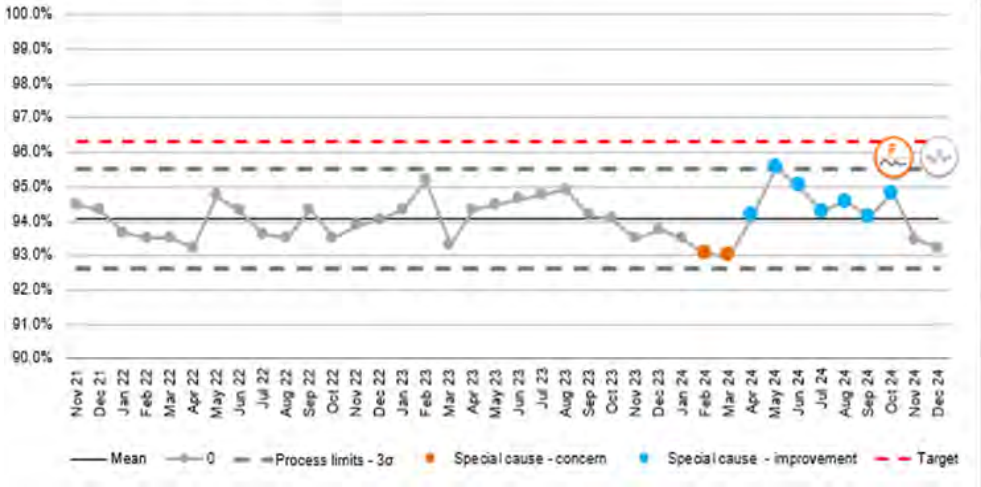
Staff Turnover (%) - Unadjusted- starting 01/11/21



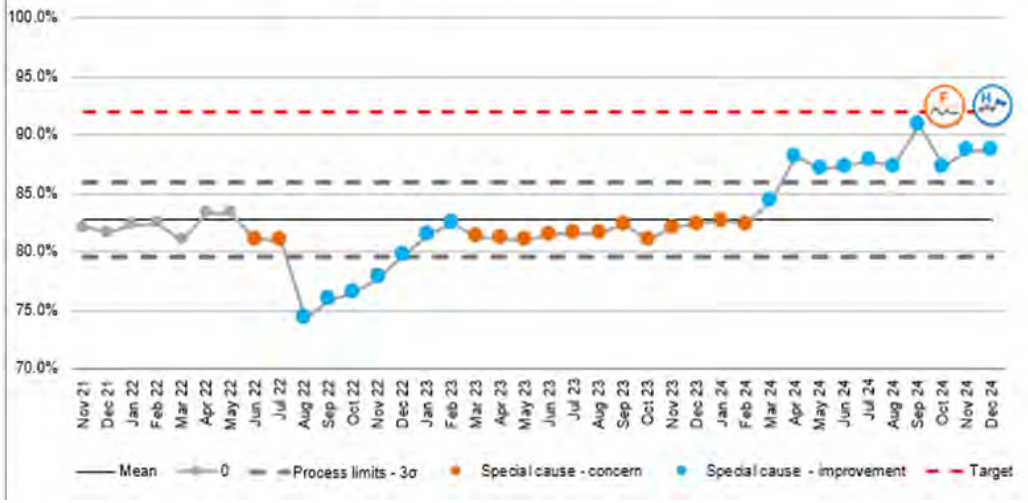
Non-Clinical Establishment %- starting 01/11/21

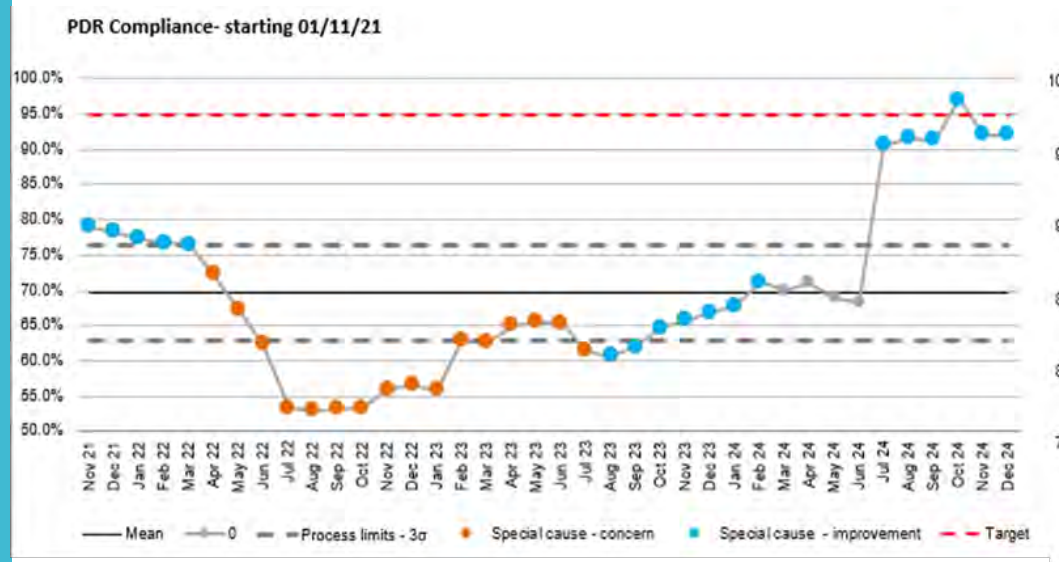


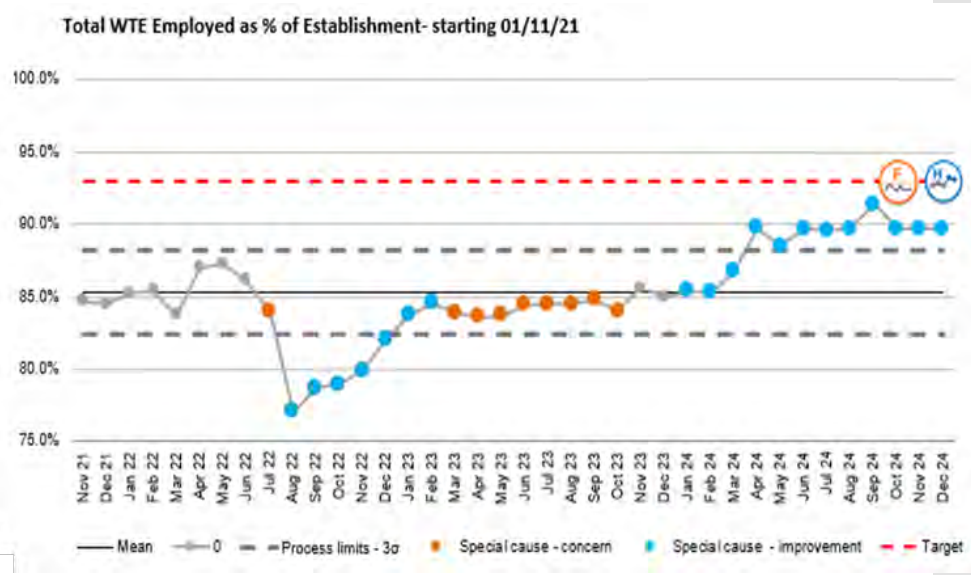
Monthly Attendance- starting 01/11/21



Clinical Establishment %- starting 01/11/21




PDR Compliance- starting 01/11/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
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 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Total WTE Employed as % of Establishment- starting 01/11/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
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 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

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.

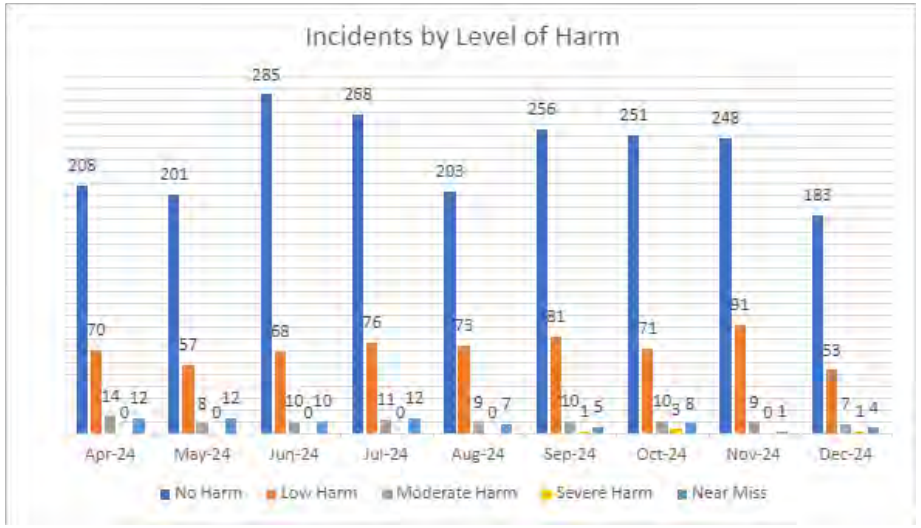
A grey assurance icon indicates inconsistently passing and falling short of the target.

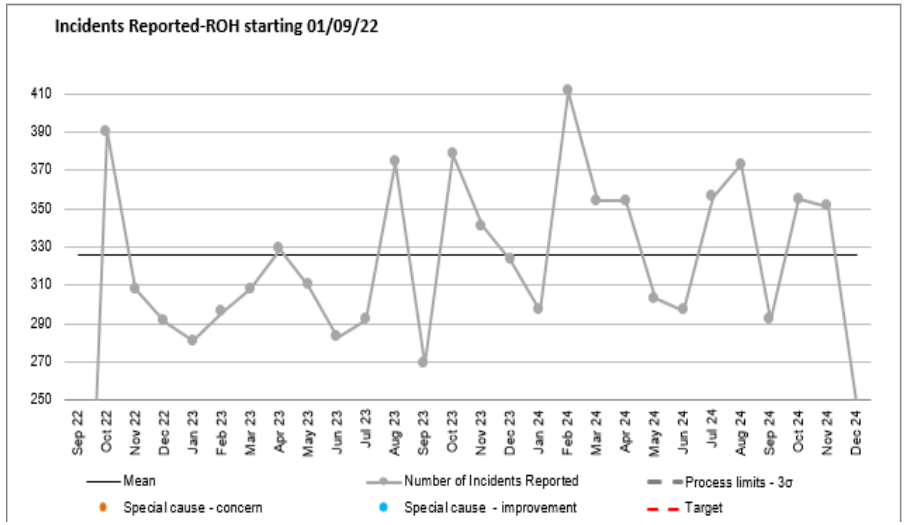
For measures without a target you will instead see the "No Target" icon.

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.

			L	P
			L	P
			∿	P
			H	P
			L	P
			∿	P
			∿	P
			L	P
			∿	P
			H	P
			∿	P
			H	P





Quality Improvement & Learning

During December there was 1 severe Harm incident reported – please see medication error incidents section on slide 14
The reduction in incidents reported in month is likely due to reduced activity and planned theatre maintenance in December 2024.

Updates on PSIIs reported in October 2024.

Wrong Implant Never Event
1st draft of PSII received and sent for review. Final draft due 20.01.2025

Wrong Site Surgery Never Event
Final draft received and signed off in divisional governance.

Quality Improvement & Learning

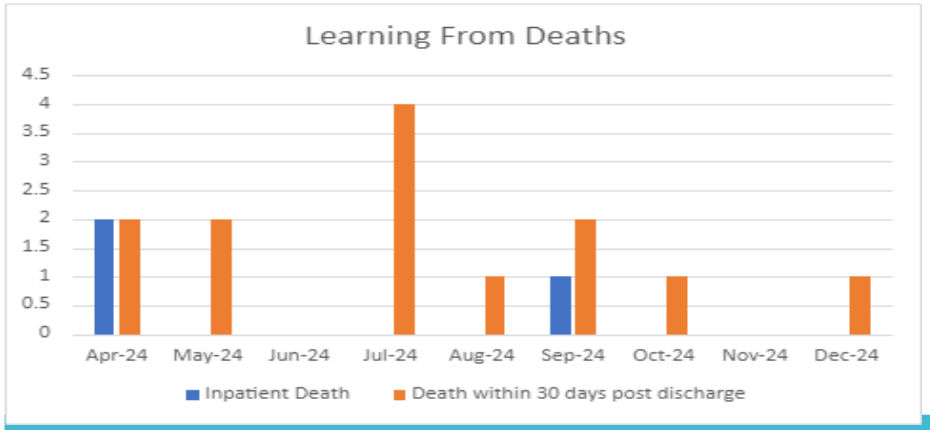
Quality Improvement

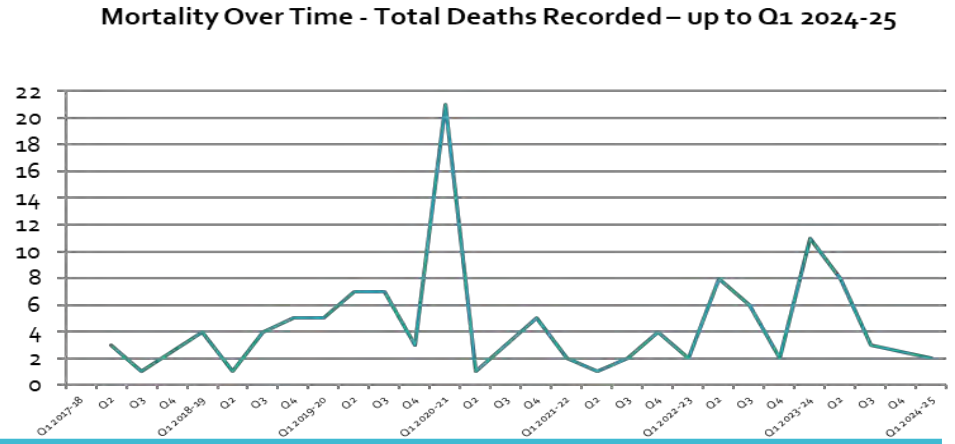
A plan is currently being devised to improve the sharing of the outcome of patient safety incidents, whether the incident is managed locally or whether the incident is taken through the Trusts governance process and managed in accordance with our PSIRF Response Plan.

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'.

PSII			
AAR			
MDT			
Thematic Review			





Quality Improvement & Learning

There were no inpatient deaths in December 2024.

There was 1 patient death within 30 days of leaving ROH care in December 2024. This case is being reviewed under the Trust's Learning from Deaths process.

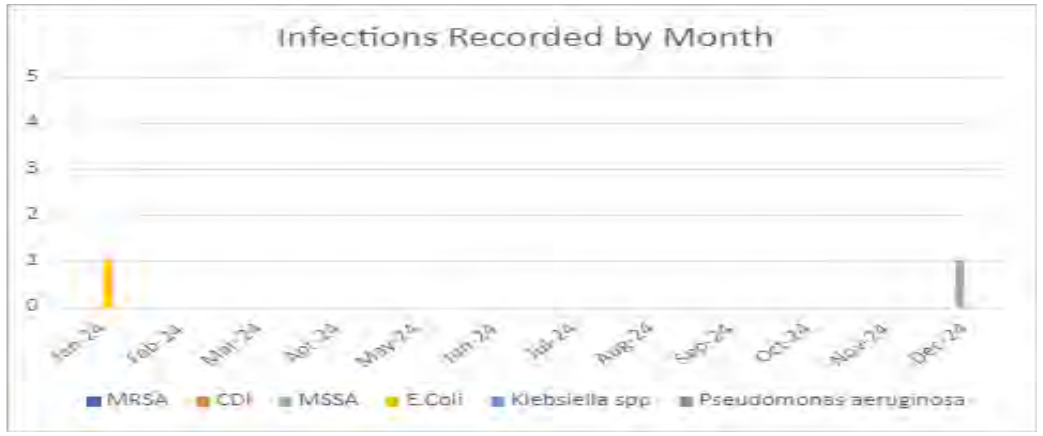
Quality Improvement & Learning.... Continued

Update on Coroner Inquest held in Dec 2024

An inquest was held on 5 December 2024into the death of a Trust patient

The coroner provided a narrative conclusion that the patient died of a complication of necessary surgery.

The coroner also issued the trust with a Regulation 28 Preventing Future Deaths Report in relation to 2 concerns. The first concern related to the absence of reference to a peritoneal tear in the operation note and the second concern related to the investigations conducted by the trust and the absence of a PSII into the cause of death. The Trust has responded to the concerns as required by the deadline set.



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

1 case of Methicillin-Sensitive *Staphylococcus aureus* (MSSA) bloodstream infection was reported in December 2024. Patients results discussed with microbiologist and appropriate antibiotics commenced.

IPC Safety Priorities - Update

Antimicrobial Stewardship

Much work has been undertaken to review surgical prophylaxis as has been described under the SSI IPC priority. In addition to this, there is a focus on the judicious use of antimicrobials, monitoring consumption and prescribing practices. This is actioned through:

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

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

Antimicrobial pharmacist and IPC lead nurse have reviewed the antimicrobial stewardship objectives to ensure they consider the

Quality Improvement & Learning - continued

Invasive Devices

In response to an MSSA BSI related to a PIVC and in addition to concerns regarding the PIVC and CVAD high impact intervention audit data, a short-life vascular access device (VAD) group was set up to review practice and implement quality improvement work to address any issues. The groups work concluded at the end of March 2024, however there are a few ongoing actions that are monitored at the IPC committee.

Promoting the completion of invasive device insertion documentation from theatre (point of insertion) to ensure accurate records and evidence of care taking place.

There is ongoing debate between the anaesthetist, IPC, and clinical teams around the documentation of PIVC insertion in theatre. This information is currently captured in the anaesthetic record and is documented by the anaesthetists. However, the insertion needs to be also captured via the existing PIVC insertion and ongoing care record that is used by recovery and clinicians in the ward setting. A meeting has been set up by the DIPC to explore this further and find a resolution.

Reintroduction of needle free connectors is being led by the Head of Nursing for division 1, this will help to improve safe practices associated with PIVC and CVAD use.

BBraun have been onsite to deliver training and awareness of the updated processes.
PVC care record to be updated to reflect the needle free connector change.

As part of the IPC audit programme review, audit of PIVC and CVAD insertion and ongoing care is being reviewed with a view to move away from high-impact interventions and instead implement quarterly point prevalence surveys of practice in clinical areas.

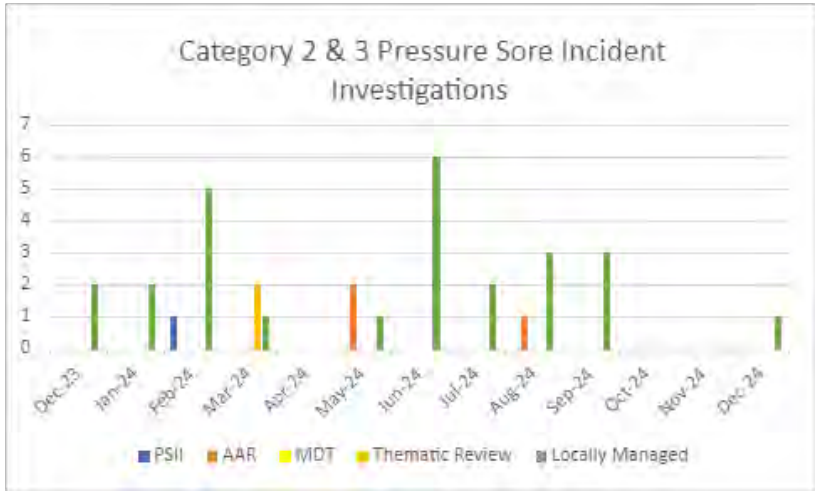
Updated audit template, format and process created. Awaiting formal implementation of audit programme and transition to new audit.

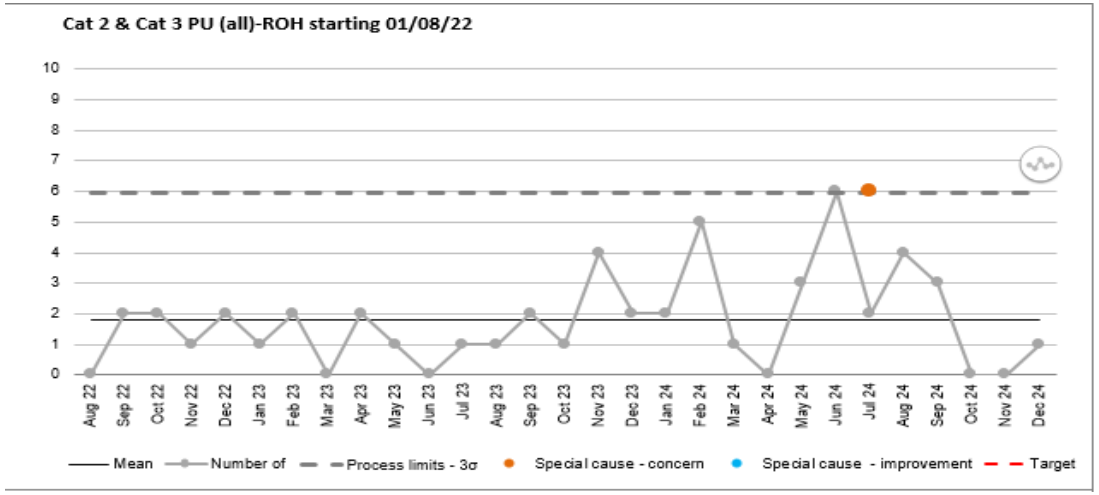
Antimicrobial Stewardship

Much work has been undertaken to review surgical prophylaxis as has been described under the SSI IPC priority. In addition to this, there is a focus on the judicious use of antimicrobials, monitoring consumption and prescribing practices.

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

Antimicrobial pharmacist and IPC lead nurse have reviewed the antimicrobial stewardship objectives to ensure they consider the recommended actions from the 'UK 5-year action plan for antimicrobial resistance 2024 to 2029'.





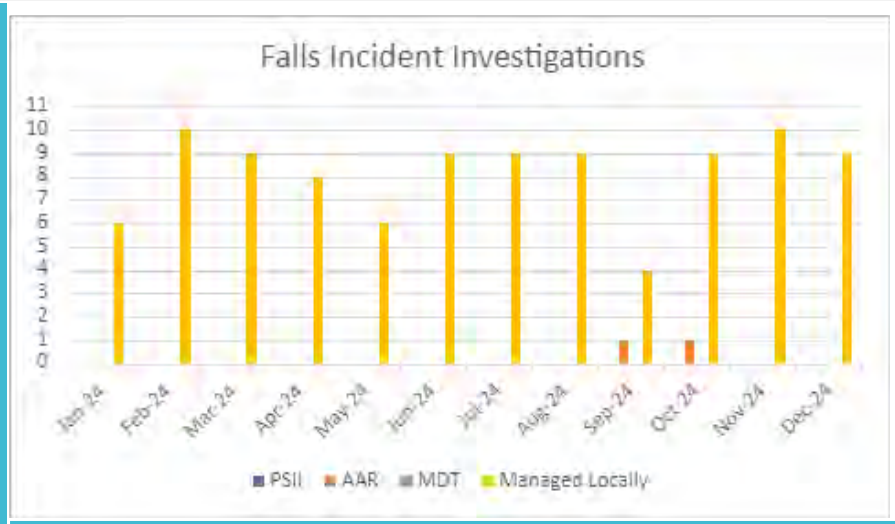
Quality Improvement & Learning

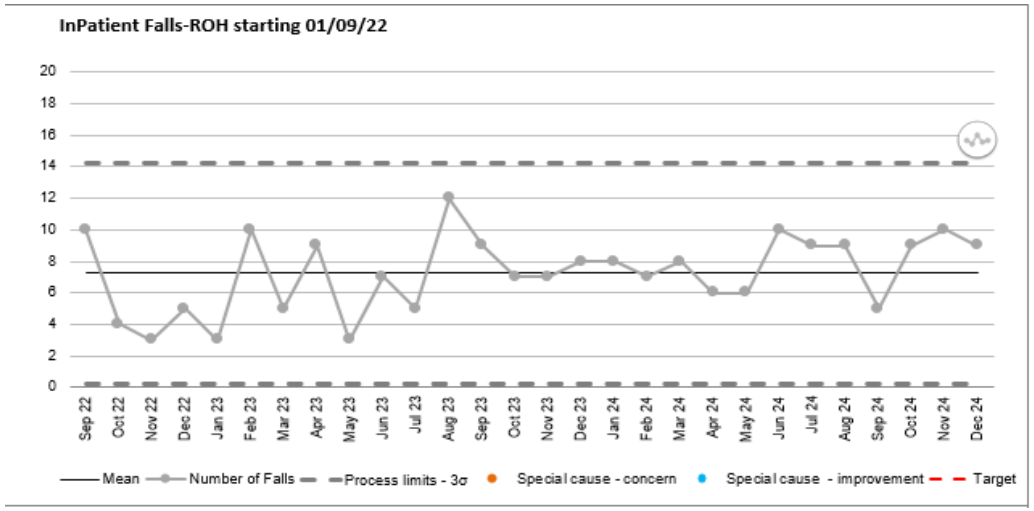
There was 1 confirmed ROH acquired category 2 pressure ulcer incident reported in December 2024 – PU triage form completed, and incident being managed locally.

<u>Quality Improvement</u>
Purpose T implementation plan in progress, draft documentation with Comms team.

Tissue Viability Service Review
Took place on 08/01/2025 with Chief Nurse, Lead Infection Prevention and Control Nurse – different ways of working discussed – more details to follow.

Collaborative working
TV lead Nurse from Royal National Orthopaedic Hospital has asked re sharing PU data quarterly for benchmarking purposes and also RJAH aim have an ortho TV alliance group to share common themes/problems/improvement. TV lead to have conversation with Chief Nurse.





Quality Improvement & Learning

There were **9** inpatient falls reported in December 2024

All incidents are being managed locally

Themes:

4 of the reported falls were unwitnessed .

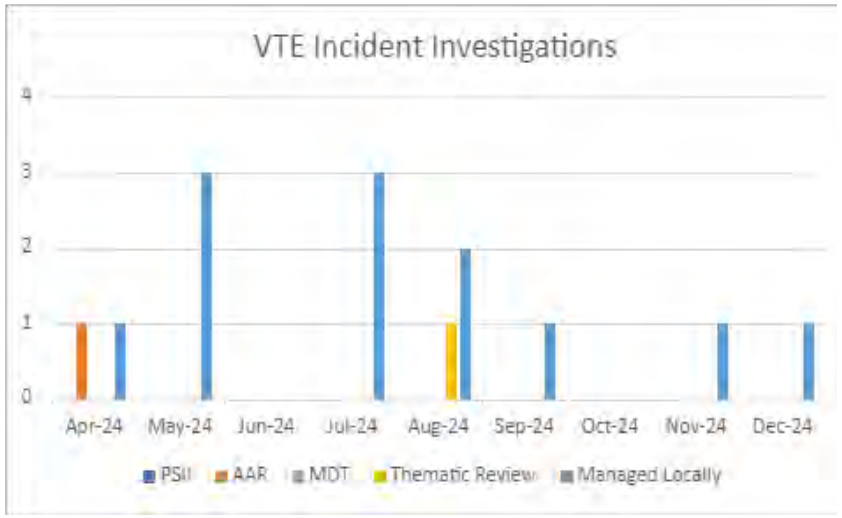
4 of the falls reported were for the same patient on ward 1. Patient didn't follow advice re: mobilisation and calling for support in the bathroom. Capacity was present and extra measures were put in place. Consideration of DOLs was ongoing. Discussed within divisional governance meeting and local management agreed.

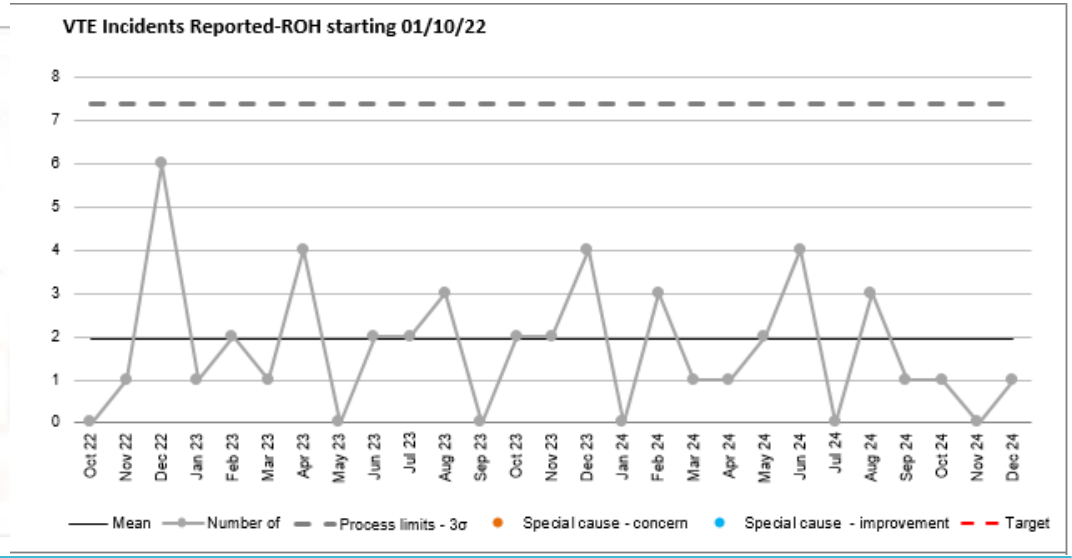
Quality and Improvement Work

Audit of falling leaves usage started

Mini audit to review why patients are falling after mobilising against advice now live – will run until Mar 25

New and updated falls risk assessment tool on PICS for use across all patient areas – still awaited.





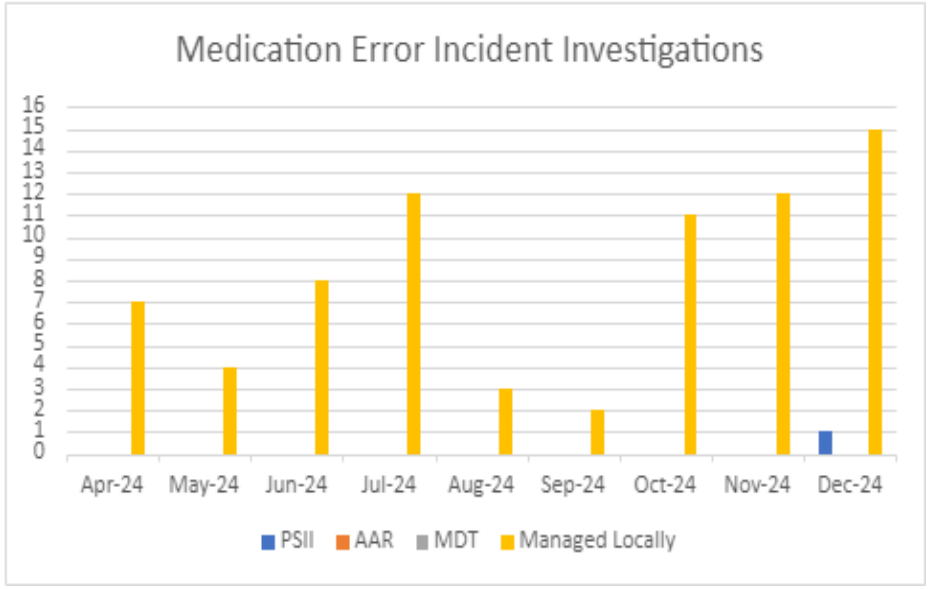
Quality Improvement & Learning

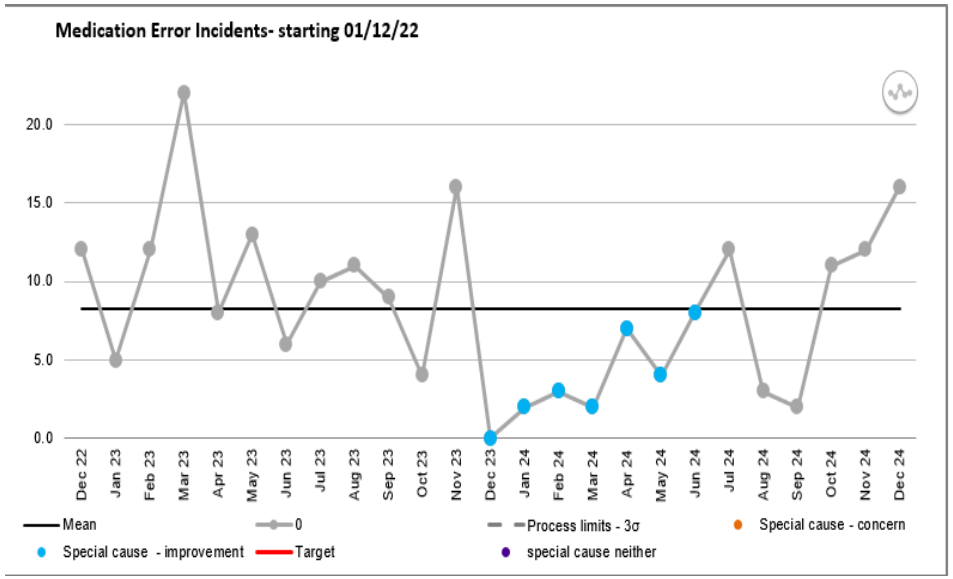
There was 1 VTE incident reported in December 2024. This will be managed locally with staff completing a VTE Triage Questionnaire to determine avoidability in line with the current PSIRF plan.

<u>VTE On Admission Assessment Compliance</u>

Compliance figure for December 2024: 98.21%

<u>Update on previously reported Thematic Review (Reported in August 2024 Quality Report)</u>
All completed VTE Triage forms have now been submitted for the thematic review to now take place. An update will be provided in a future report.





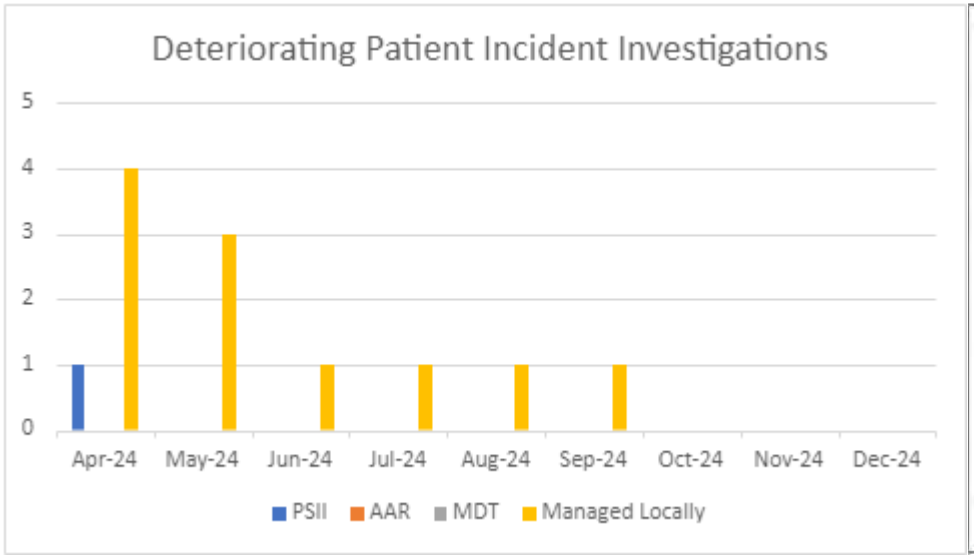
Quality Improvement & Learning

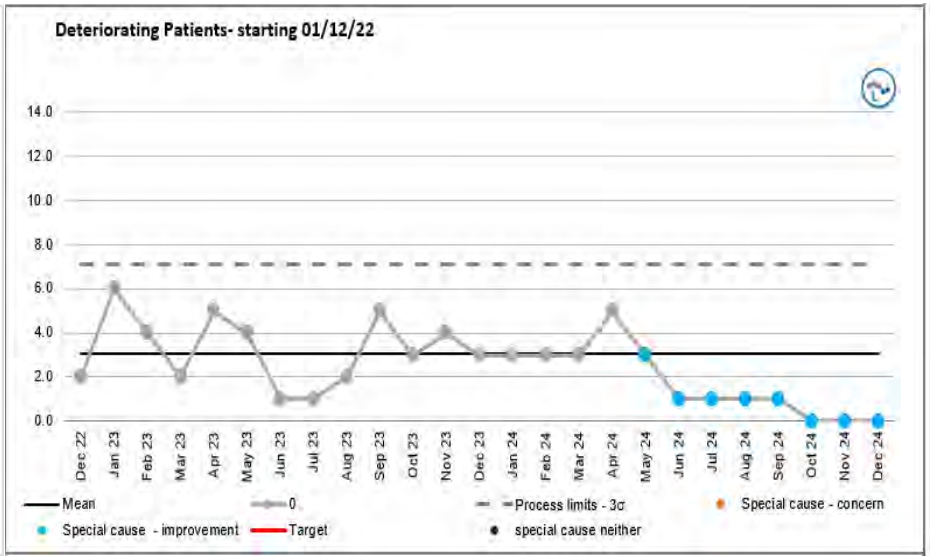
There were 16 Medication Error incidents reported in December 2024.

15 of those incidents were no or low ham and are being managed locally.

1 of the incidents was reported a severe harm incident relating to the administration of the wrong drug and the wrong amount. This incident will be looked at using the PSII investigation methodology, with an update on the outcomes and learning to be shared in a future report. Verbal and written DoC has been recorded and sent to the patient..

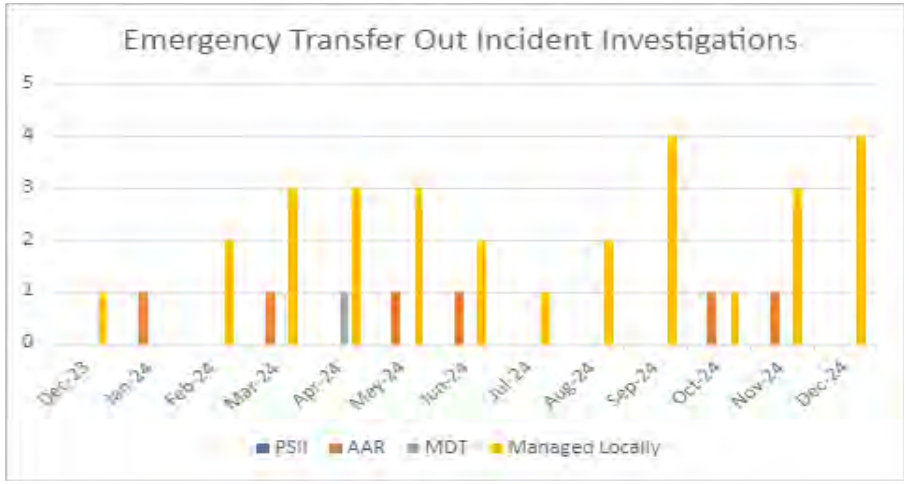
The volume of medication incidents reported continues to rise, this has been discussed within divisional governance meeting and will also form part of the PSIRF priorities annual review in January 2025 to ensure that a closer look at these incidents is initiated and themes and trends are identified and are monitored going forward.

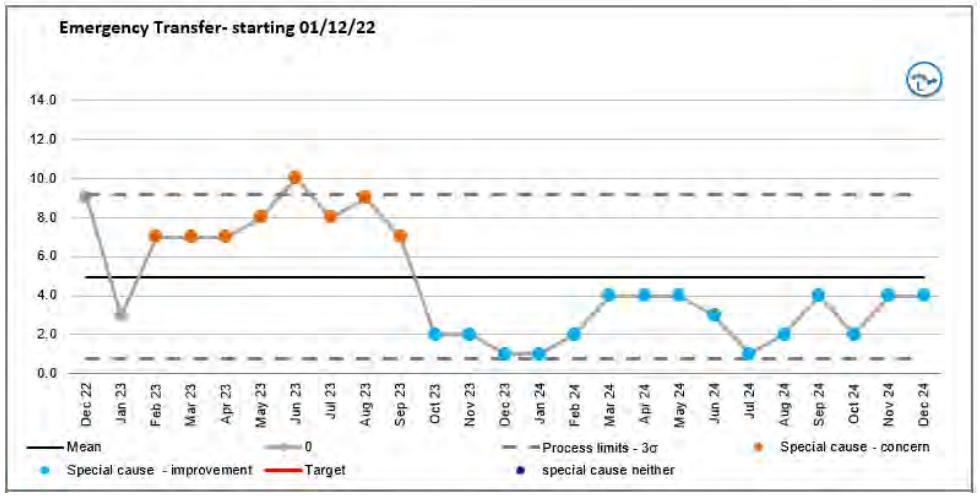




Quality Improvement & Learning

There were no deteriorating patient incidents reported in December 2024.





Quality Improvement & Learning

There were 4 emergency transfer out incidents reported in December 2024.

All incidents are being managed locally.

The Trust received **7** complaints in December 2024

Below are the departments that received complaints in December 2024

Anaesthetics
Appointments
Imaging
Large Joints x2
Pain Management
Patient Experience

In December 2024, the complaints team closed **11** formal complaints. **6** complaints breached the timeframe agreed with the complainant. **KPI = 46%**

At the time of producing this report, (08/01/2025) we currently have **11** formal complaints open and **4** formal complaints that are paused awaiting confirmation from the complainant.

Departments that have open complaints at the time of writing report

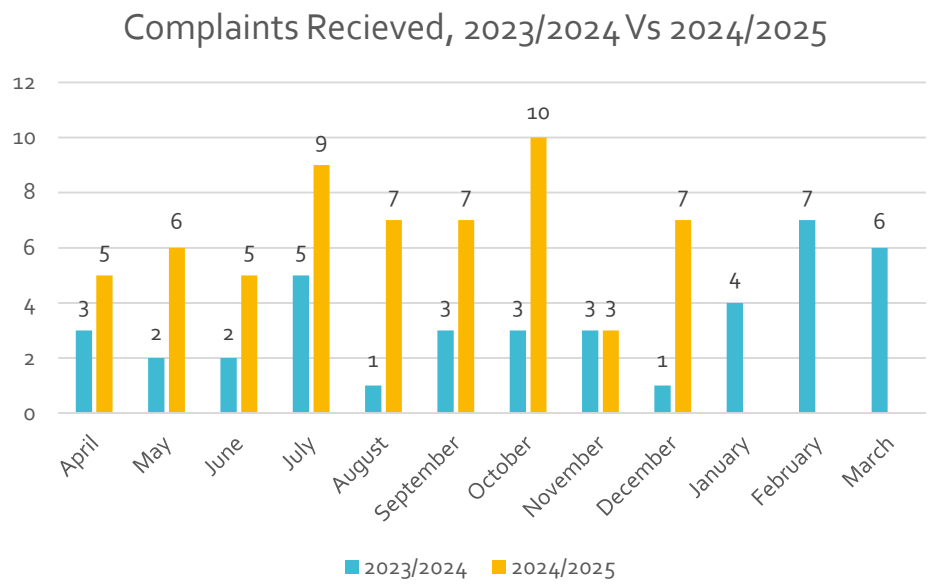
Oncology
Spinal x4
Large Joints x3
Patient Experience
MSK
Appointments

1 Complaint is open where the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

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 December 2024 the Trust received **0 requests for a resolution meeting.**

Complaints



KPI's

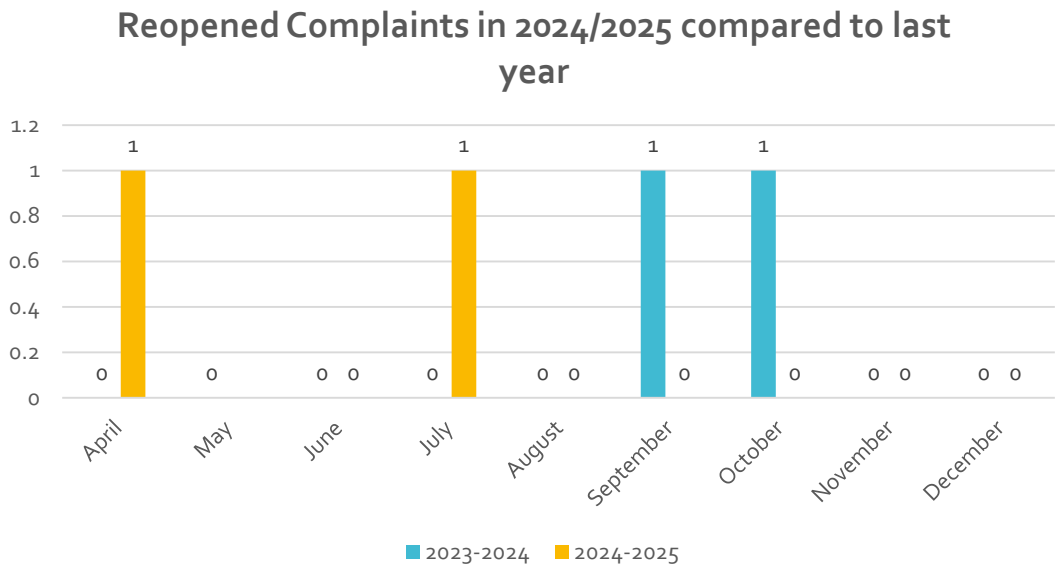
KPI0	Complaints %
April 2024	100%
May 2024	57%
June 2024	0%
July 2024	50%
August 2024	40%
September 2024	50%
October 2024	50%
November 2024	0%
December 2024	46%

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

Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – December 2024	62

The Complaints KPI in December is 46% because 6 complaints out of 11 received breached the timeframe agreed with the complainant

Complaint Themes



Reopened complaints

The Trust received 0 requests to reopen a complaint in December 2024.

The Trust currently has 1 PHSO complaints case open – At present, the PHSO are currently investigating the complaint

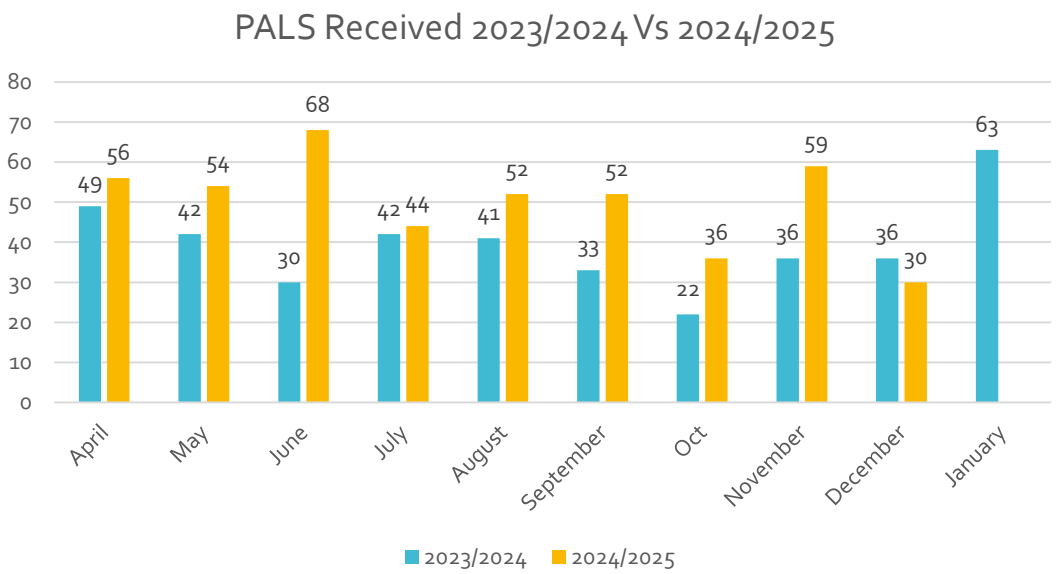
Themes of complaints currently open

1. Communication
2. Values and Behaviours
3. Delays with treatment

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, executives and identified leads
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	
April 2024	34%
May 2024	48%
June 2024	58%
July 2024	86%
August 2024	76%
September 2024	59%
October 2024	61%
November 2024	52%
December 2024	77%

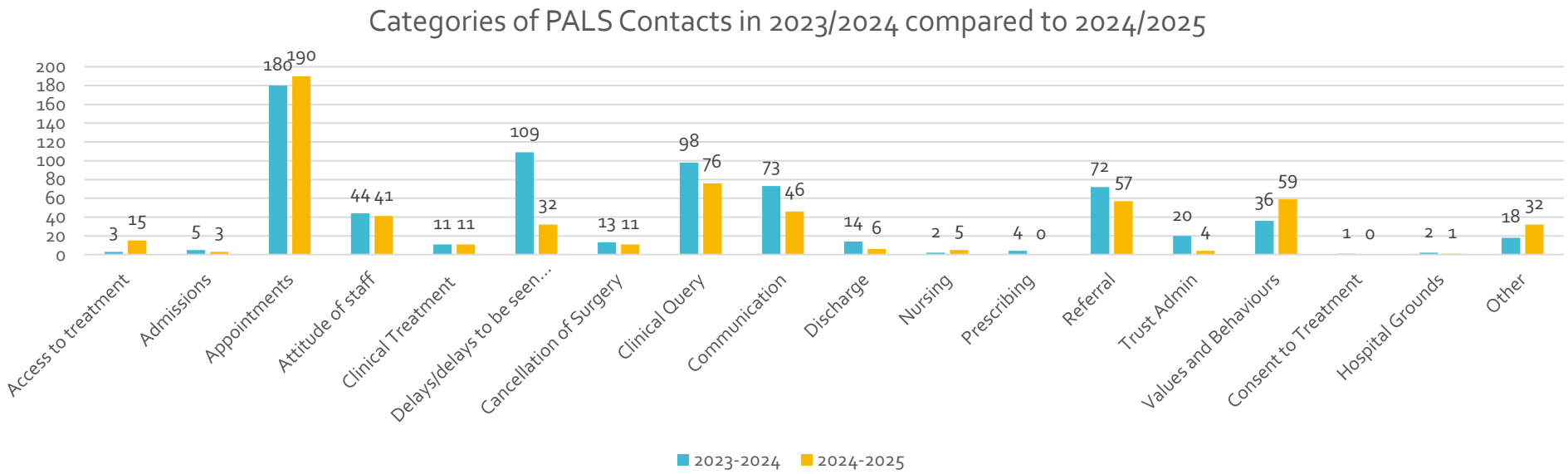
7 PALS Cases breached in December 2024
The KPI of 80% for PALS Contacts was not met

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.

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

PALS Themes



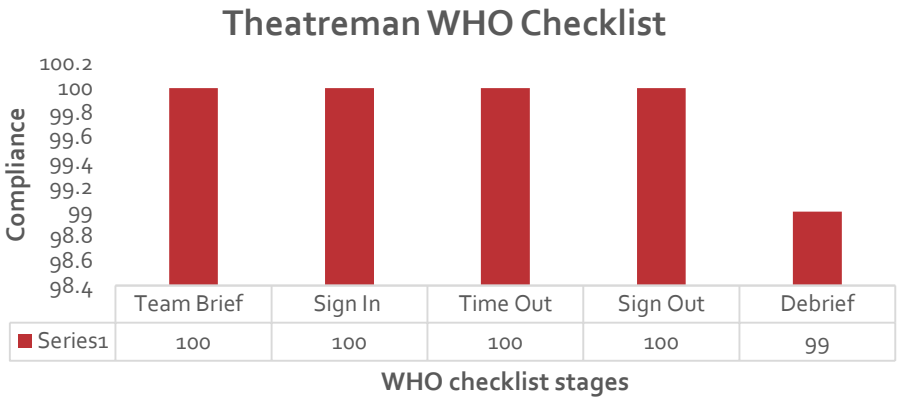
Themes

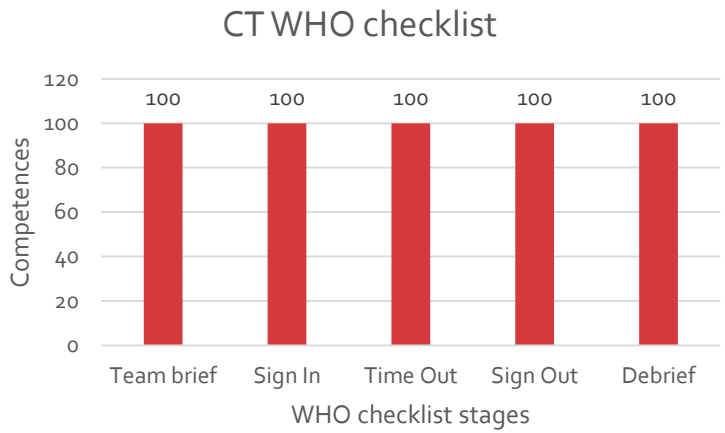
Appointments – 8 out of 30 received

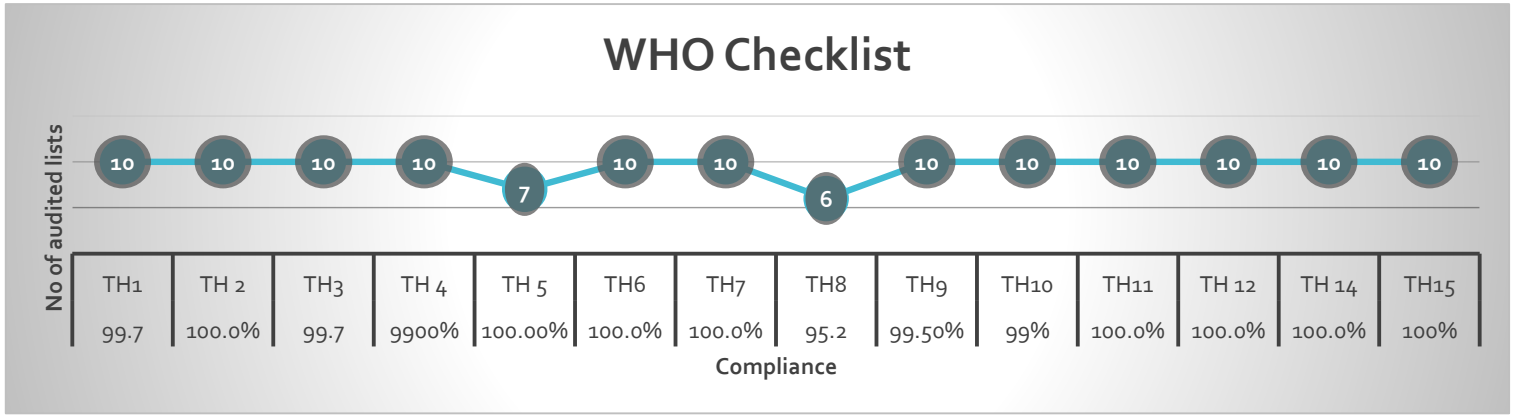
Clinical Query– 7 out of 30 received

What we have done / are doing:

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 alongside the weekly reminders and is meeting with leads to support resolution.
PALS Team are managing and resolving PALS contacts within their remit.







Quality Improvement & Learning

Theatres 5 and 8 did not submit 10 audits set on AMAT.
Cluster leads continue working with their respective teams in ensuring that audits are completed in a timely manner.

Work in Progress – Meeting arranged for the 10th of December 2024 had to be rescheduled due to unexpected unavailability. Awaiting new date.

CAS ALERTS 1-31 DEC 2024

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/013/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT) - Additional actions This alert contains actions which are in addition to those outlined in the National Patient Safety Alert (NatPSA/2024/007/DHSC) issued on 24th May 2024. There are limited supplies of pancreatic enzyme replacement therapies (PERT). •Creon® 10,000 and 25,000 capsules remain in limited supply until 2026. •Nutrizym® 22 capsules and Pancrex V® capsules and powder are intermittently available but are unable to fully cover the gap in supply	National Patient Safety Alert - DHSC	18-Dec-24	Assessed – not relevant to organisation	31-Jan-25

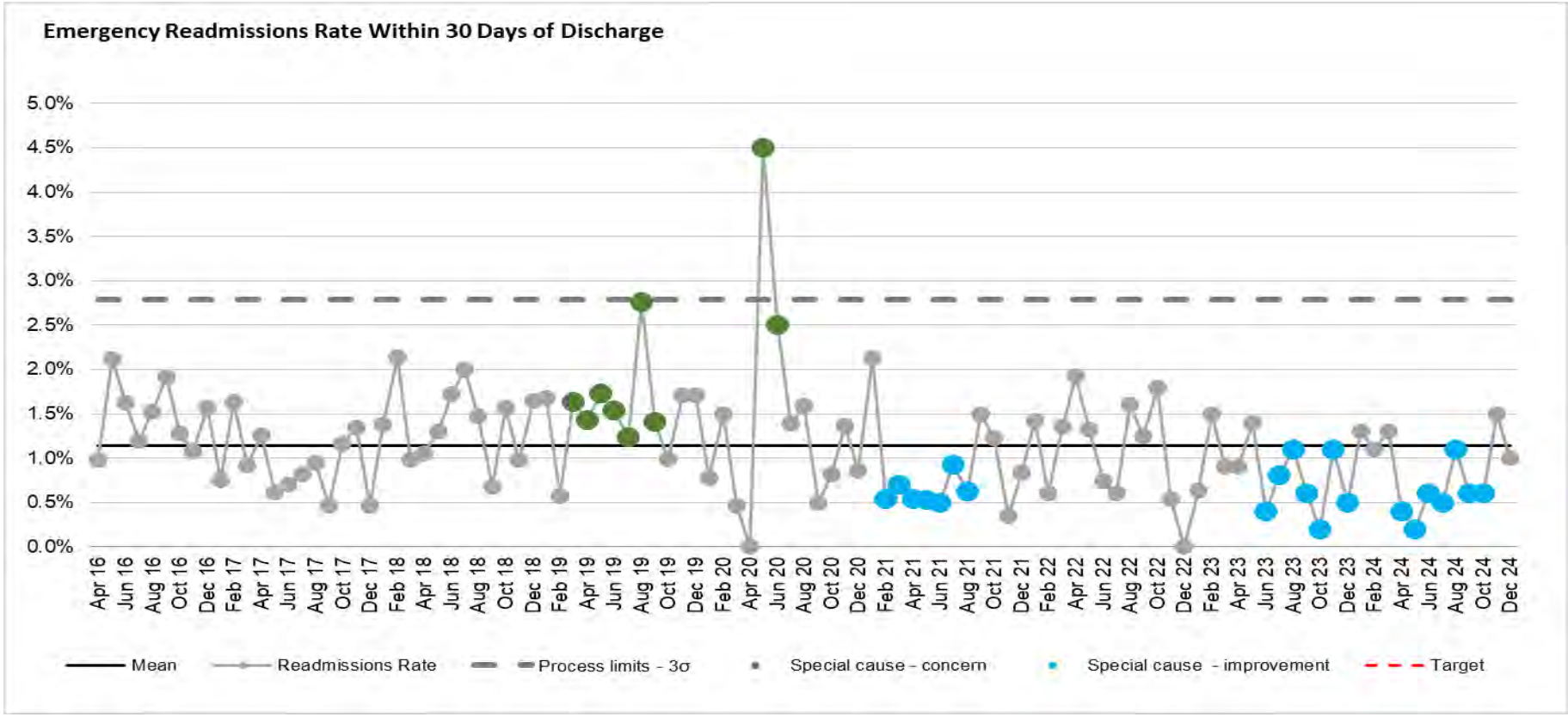
Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks. This National Patient Safety Alert, issued by the NHS England National Patient Safety Team, and co-badged 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…

Actions underway:

System engagement has reduced. Therefore, a local approach has been agreed. Aim is for patients with equipment (at discharge), to be issued with a copy of their risk assessments at discharge. This is currently being agreed locally and to be implemented in the coming weeks. Aimed to be complete by the end of November 24.

KPI	Dec 2024
Safeguarding Adult Notifications	49
Safeguarding Children and Young People Notifications	40
Adults Level 1- Target 90%	98.32%
Adult Level 2 -Target 85%	93.67%
Adult Level 3- Target 85%	87.98%
Level 4- Target 90%	100.0%
Child Level 1 -Target 90%	97.79%
Child Level 2- Target 85%	93.51%
Child Level 3- Target 85%	87.23%
Mental Capacity Act MCA- Target 85%	93.59%
Deprivation of Liberty Safeguards DoLs	93.52%
Prevent Awareness- Target 95%	91.76%
WRAP (prevent level 3)- Target 90%	89.71%
FGM	1
DOLS	5
MCA	9
PIPOT cases	1
PREVENT Notifications	0



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
No of Readmissions	6	6	7	2	1	3	3	5	3	3	8	5
Denominator	462	546	548	495	534	472	559	458	510	535	543	478
% Readmissions	1.3%	1.1%	1.3%	0.4%	0.2%	0.6%	0.5%	1.1%	0.6%	0.6%	1.5%	1.0%

There were 16 concerns raised to FTSU in December 2024.

The themes from concerns raised were in relation to:-

Attitude of staffs towards overseas workers
The understanding of the sickness policy and manages approach to it
Attitudes and behaviours of management

Quality Improvements & Learning

Future quality improvement work relating to FTSU includes plans to:-

Increase Network of Champion to 12.
Develop FTSU team structure.
Improve Board report to include case studies.
Improve FTSU data collection spread sheet.

December data for January report	Fill Rate				Workforce				Rostering KPIs			Care Hours Per Patient Day					Nurse Sensitive Indicators			Patient Satisfaction	
Ward Name	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate-Non reg	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster approved by deadline (14/10/24)	Net Hours	Annual leave 12-16%	Cumulative count of pts at 23.59 per day	Actual CHPPD	Red Flags	Enhanced Care Hours	Medication Administration Error or concern	Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints
Ward 1	93%	102%	99%	104%	91.29%	22.80%	5.3%	0.0%	Yes	70.50	12.20%	338	9.3	0	23	1	0	4	0	0
Ward 2	89%	92%	95%	95%	99.28%	15.9%	5.4%	0.0%	No	-0.54	14.90%	376	6.70	0	0	0	2	3	0	0
Ward 3	85%	160%	105%	237%	95.41%	12.8%	3.4%	12.5%	No	33.50	18.10%	589	8.50	0	1093	1	2	1	0	0
Ward 4	99%	113%	99%	137%	78.08%	16.8%	4.8%	3.9%	Yes	3.71	12.10%	404	9.90	0	245	1	0	1	0	0
Ward 12	81%	100%	100%	100%	85.96%	15.1%	9.0%	9.7%	Yes	27.71	14.10%	334	8.50	0	0	2	1	0	1	0
HDU	125%	113%	119%	100%	88.70%	0.0%	6.8%	0.0%	Yes	54.00	8.40%	92	27.10	3	33	1	1	0	1	0
Theatre All					89.36%	12.3%	6.7%	2.7%						0		0	0	0	0	0
Theatre- main					87.05%	9.2%	7.6%	2.6%	Yes	-81.70	8.90%			0					0	0
Theatre-Recovery					87.62%	3.1%	5.5%	3.2%	Yes	0.50	13.00%			0					0	0
Discharge Lounge					85.84%	0.0%	0.8%	0.0%	Yes	0.00	8.30%			0					1	0
Total/Combined	94%	118%	103%	140%	88.9%	10.8%	5.5%	3.5%		107.68	12.22%	2133	9.40	3	1394	6	6	9	3	0

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.

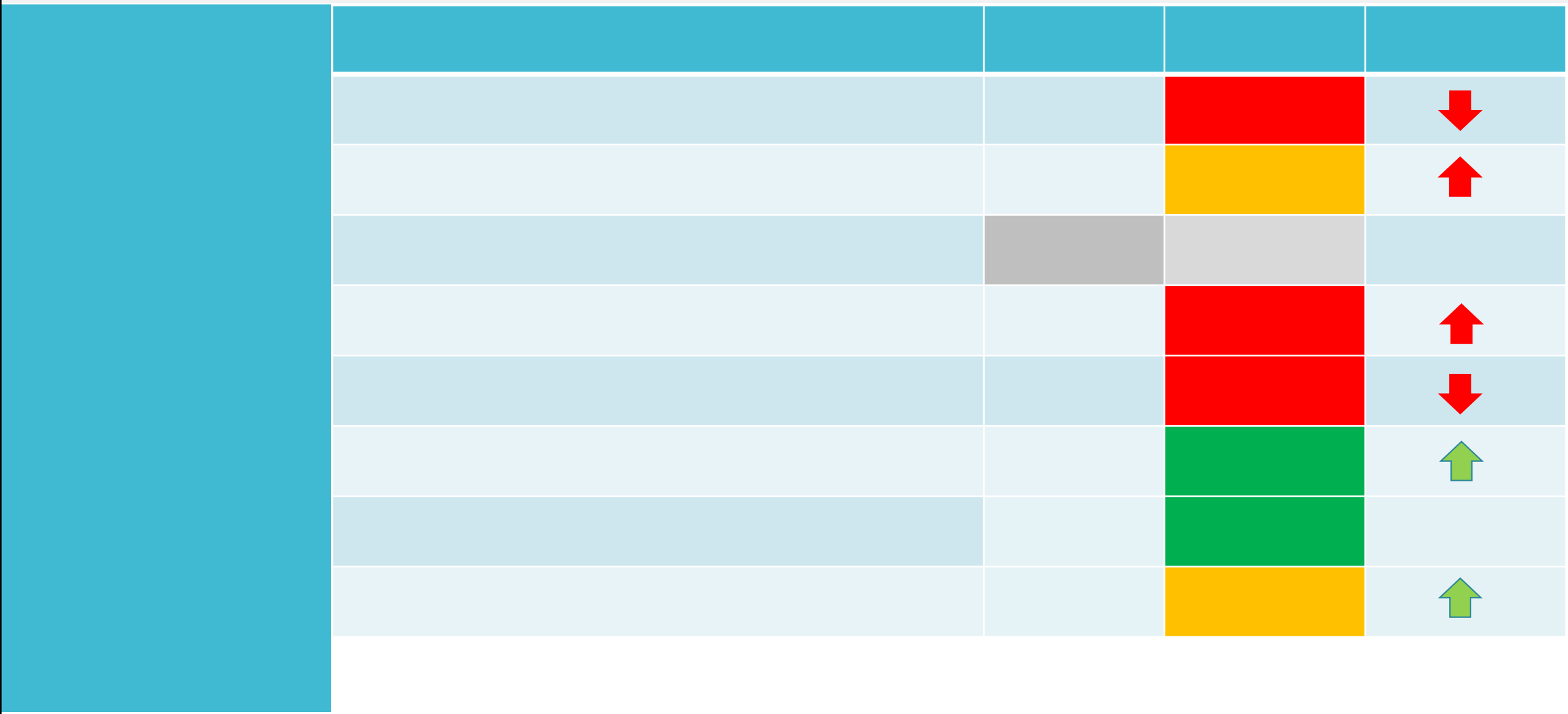
A grey assurance icon indicates inconsistently passing and falling short of the target.

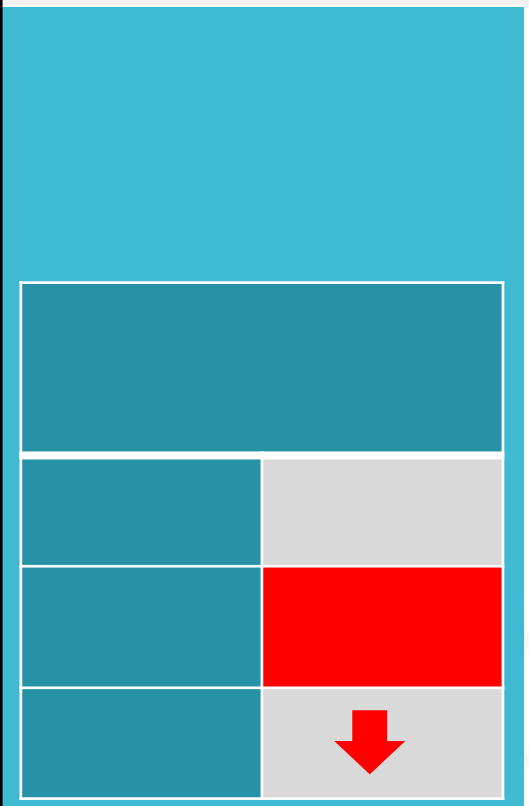
For measures without a target you will instead see the "No Target" icon.

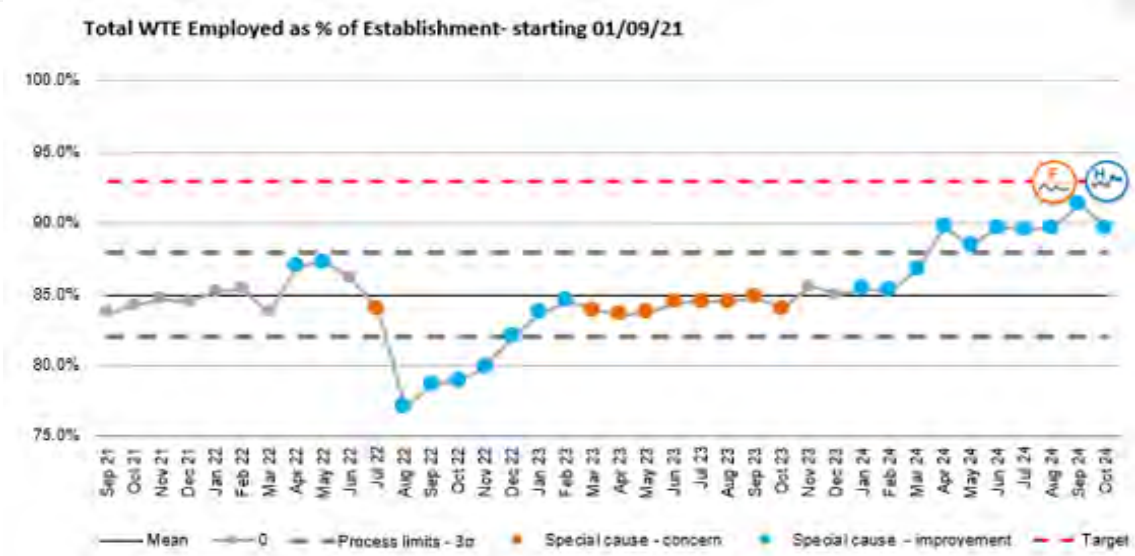
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

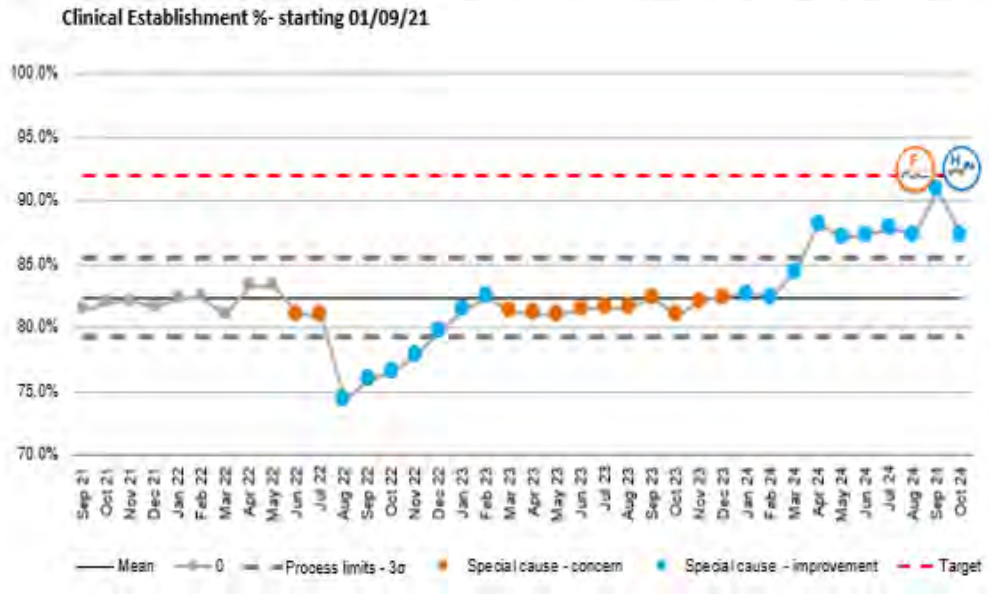
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

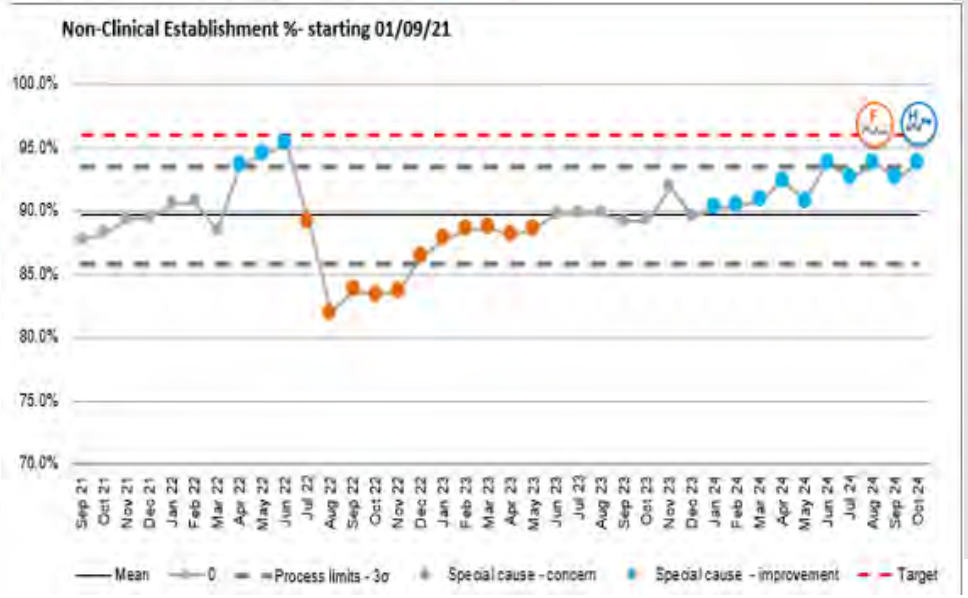
					P
					F
					P
					P
					P
					No Target
					P
					F
					No Target
					F
					F
					F
					No Target





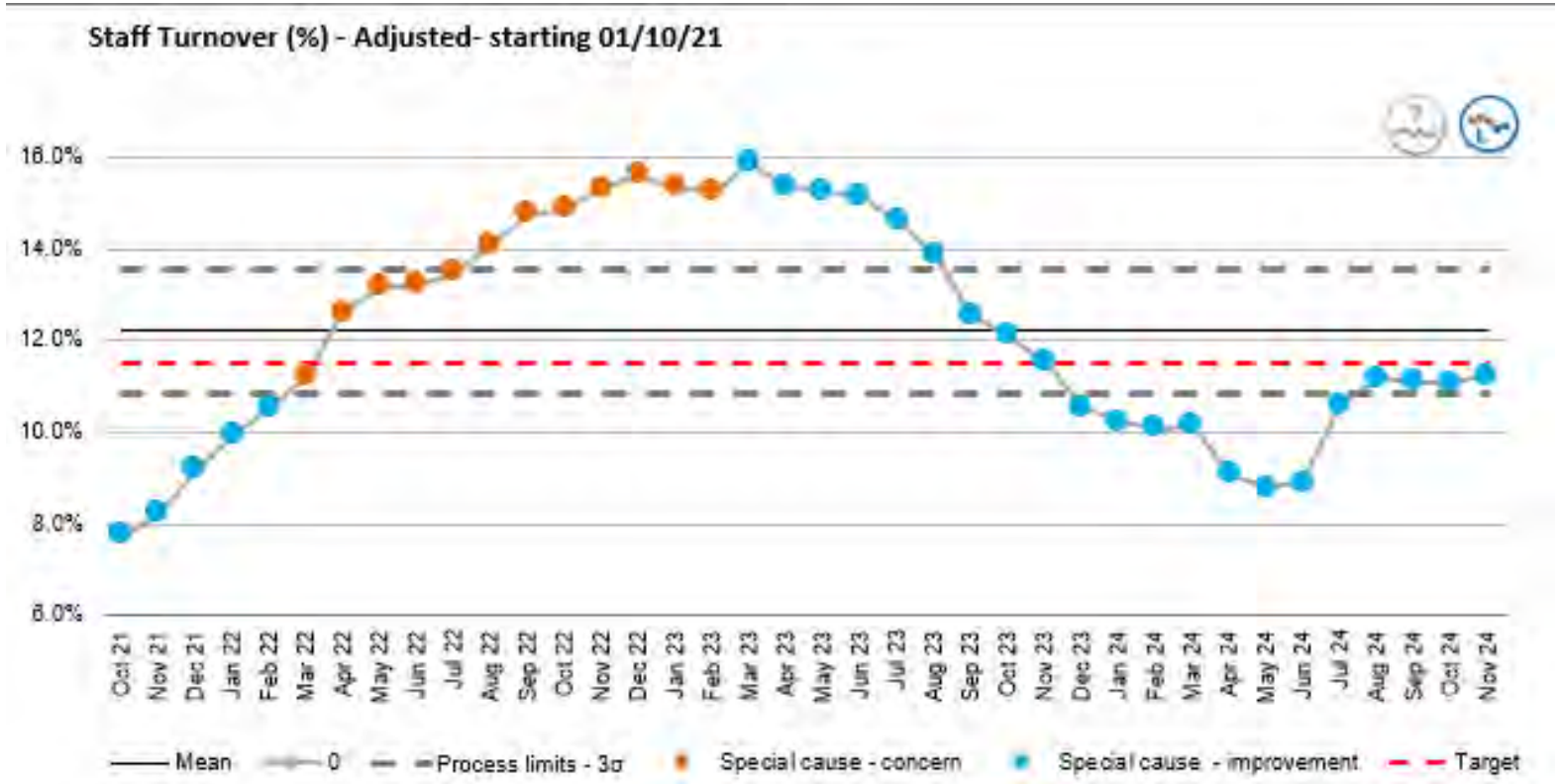

Total WTE Employed as % of Establishment- starting 01/09/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

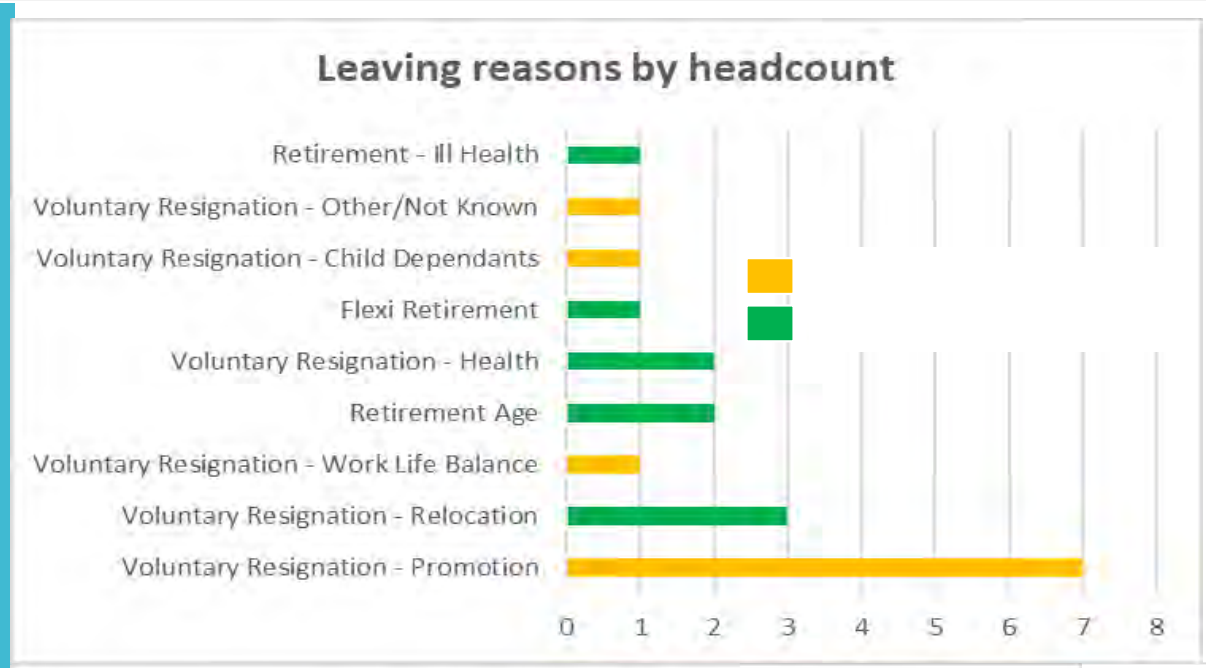

Clinical Establishment %- starting 01/09/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Non-Clinical Establishment %- starting 01/09/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

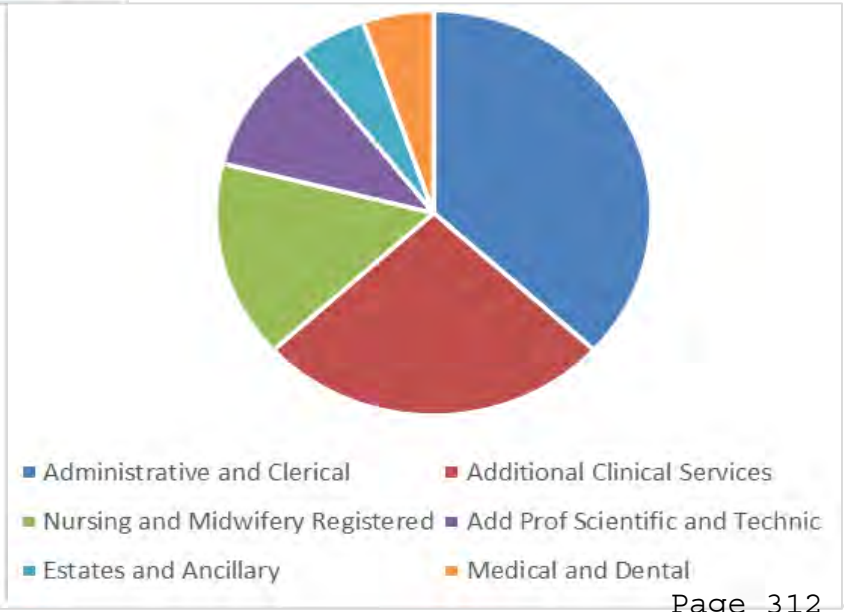
Adjusted turnover

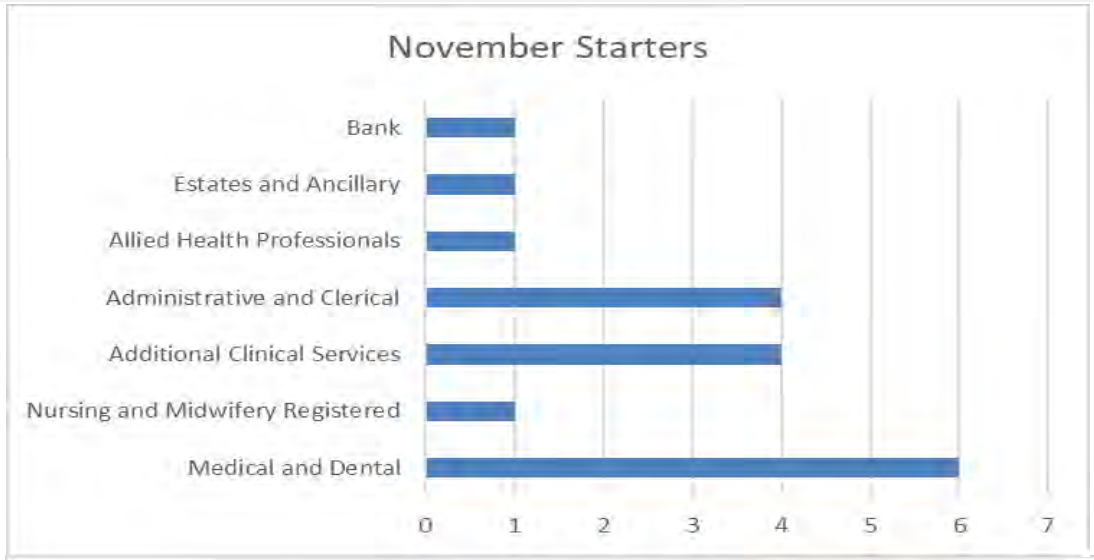
-
-
-




Leaving reasons by headcount
Retirement - Ill Health
Voluntary Resignation - Other/Not Known
Voluntary Resignation - Child Dependants
Flexi Retirement
Voluntary Resignation - Health
Retirement Age
Voluntary Resignation - Work Life Balance
Voluntary Resignation - Relocation
Voluntary Resignation - Promotion
0 1 2 3 4 5 6 7 8

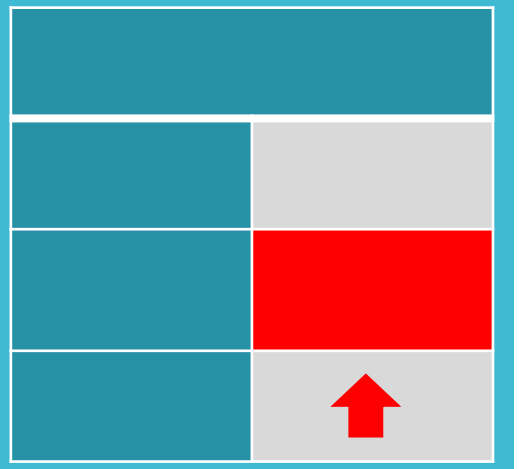

Length of service for leavers
20 - 30 years
Less than 1 year
2 - 5 years
5 - 10 years
1 - 2 years
0 1 2 3 4 5 6

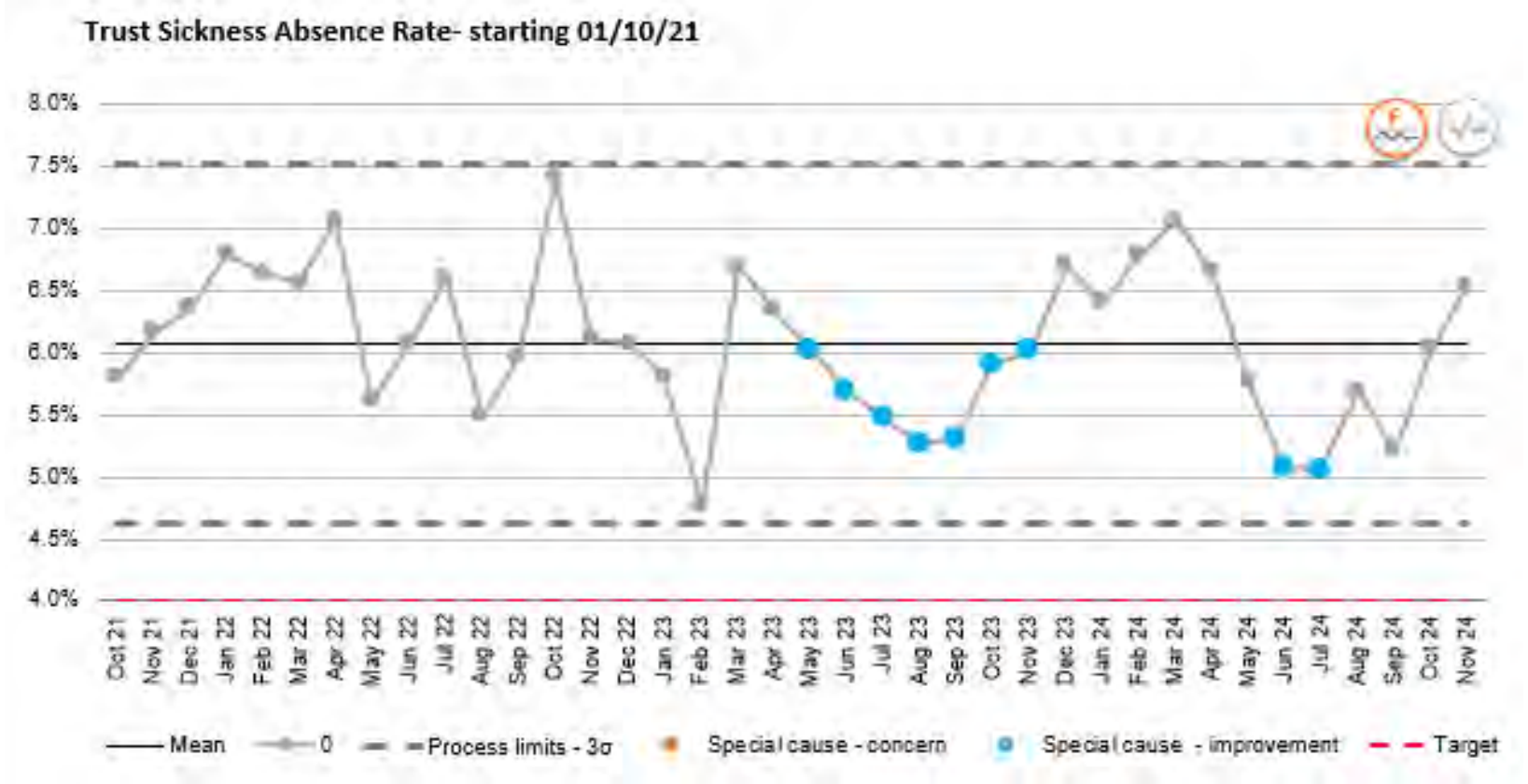

Administrative and Clerical
Additional Clinical Services
Nursing and Midwifery Registered
Add Prof Scientific and Technic
Estates and Ancillary
Medical and Dental


November Starters
Bank
Estates and Ancillary
Allied Health Professionals
Administrative and Clerical
Additional Clinical Services
Nursing and Midwifery Registered
Medical and Dental
0
1
2
3
4
5
6
7


Time to hire 1 October to 11 Dec 24
Overall time to hire
Conditional offer to checks complete
Advertisement to conditional offer
0
10
20
30
40
50
60
Target
Current performance

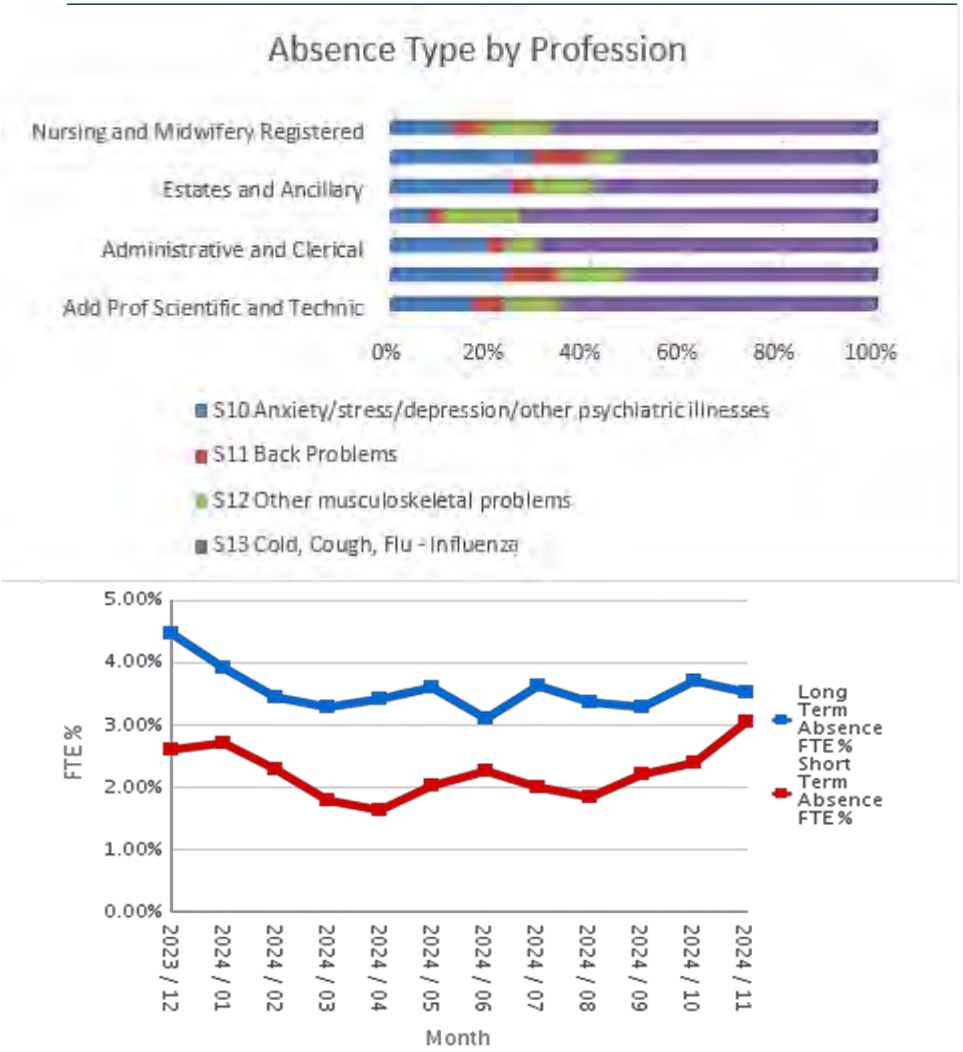
Employee Relations

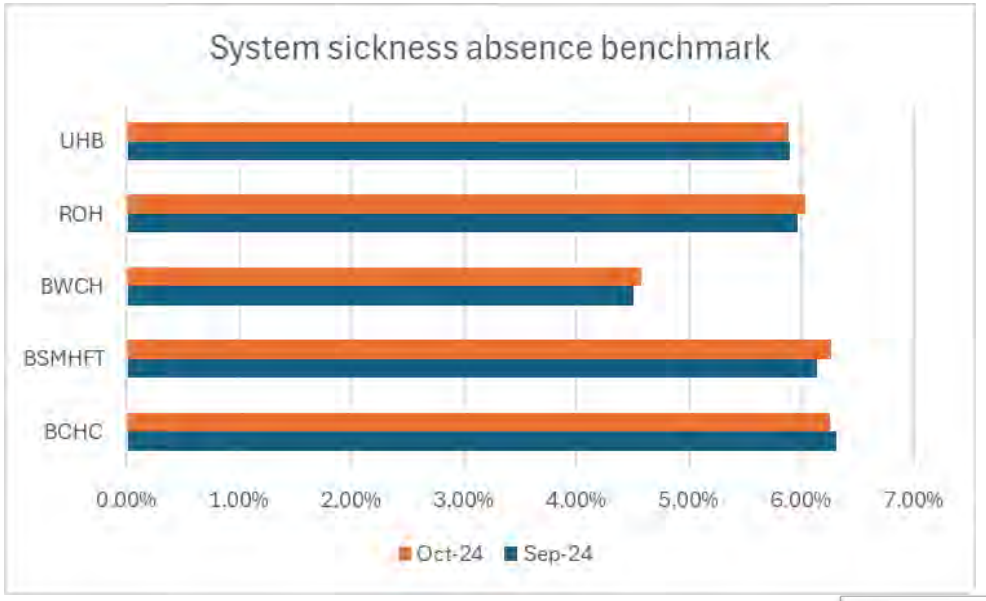


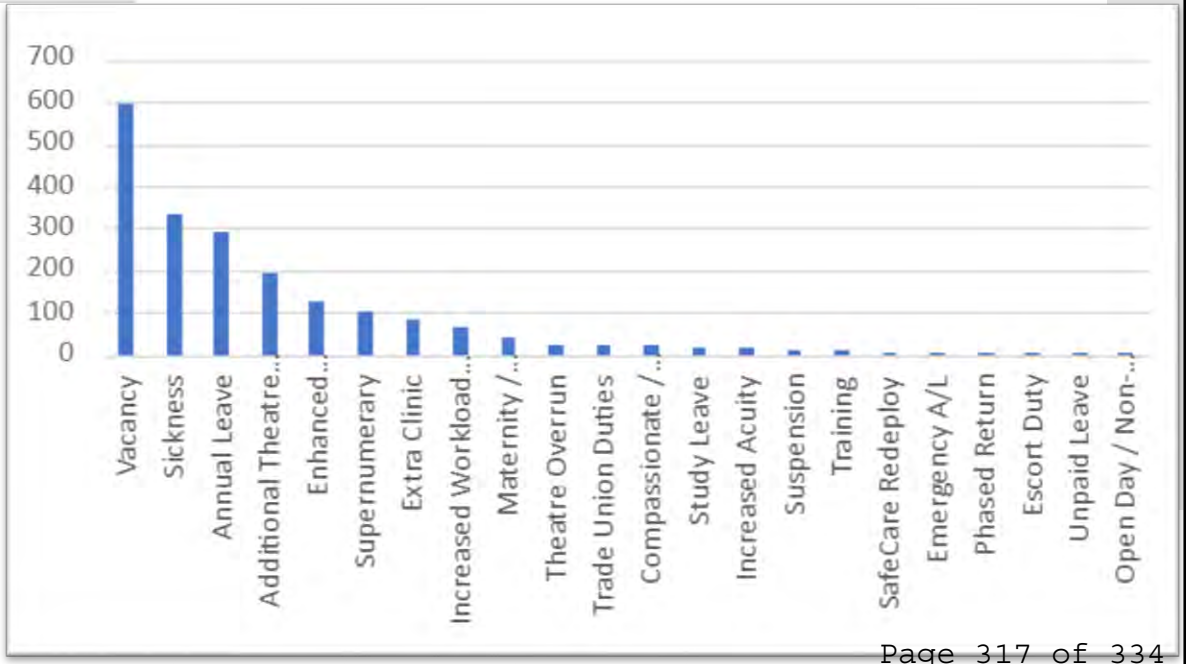

Trust Sickness Absence Rate- starting 01/10/21
8.0%
7.5%
7.0%
6.5%
6.0%
5.5%
5.0%
4.5%
4.0%
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Return to work compliance (logged on ESR)

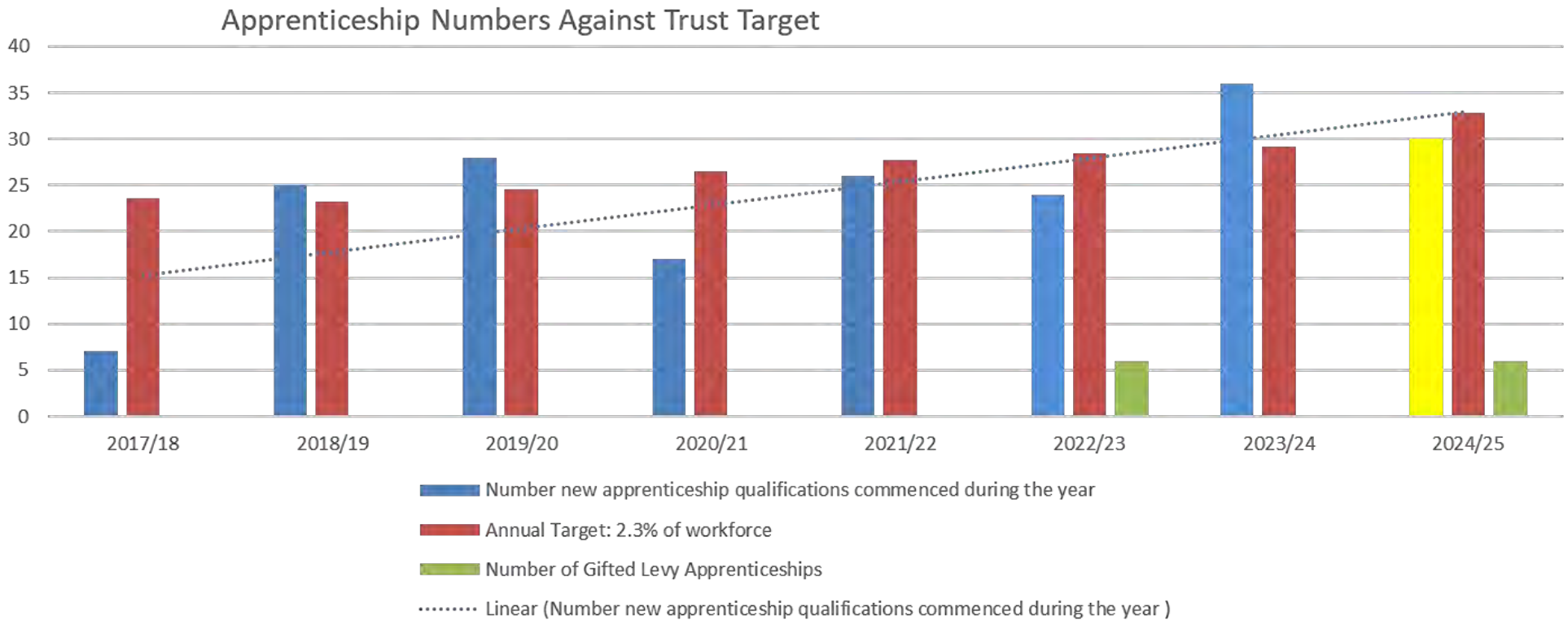
Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	26.6
S13 Cold, Cough, Flu - Influenza	13.0
S98 Other known causes - not elsewhere classified	10.0




System sickness absence benchmark
UHB
ROH
BWCH
BSMHFT
BCHC
0.00%
1.00%
2.00%
3.00%
4.00%
5.00%
6.00%
7.00%
Oct-24
Sep-24


700
600
500
400
300
200
100
0
Vacancy
Sickness
Annual Leave
Additional Theatre...
Enhanced...
Supernumerary
Extra Clinic
Increased Workload...
Maternity /...
Theatre Overrun
Trade Union Duties
Compassionate /...
Study Leave
Increased Acuity
Suspension
Training
SafeCare Redeploy
Emergency A/L
Phased Return
Escort Duty
Unpaid Leave
Open Day / Non-...

Education and Training

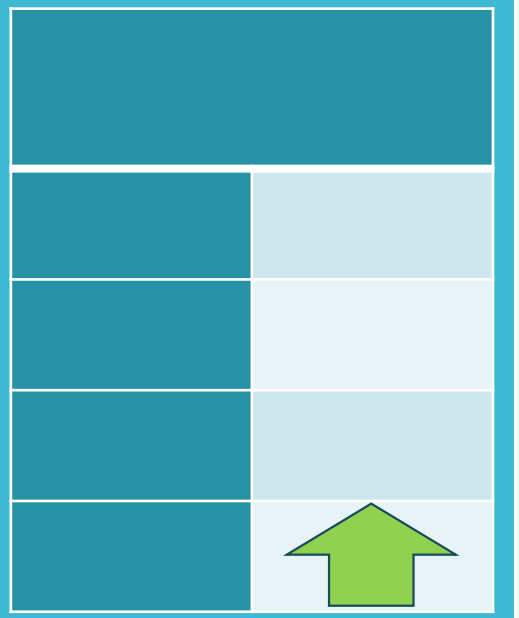


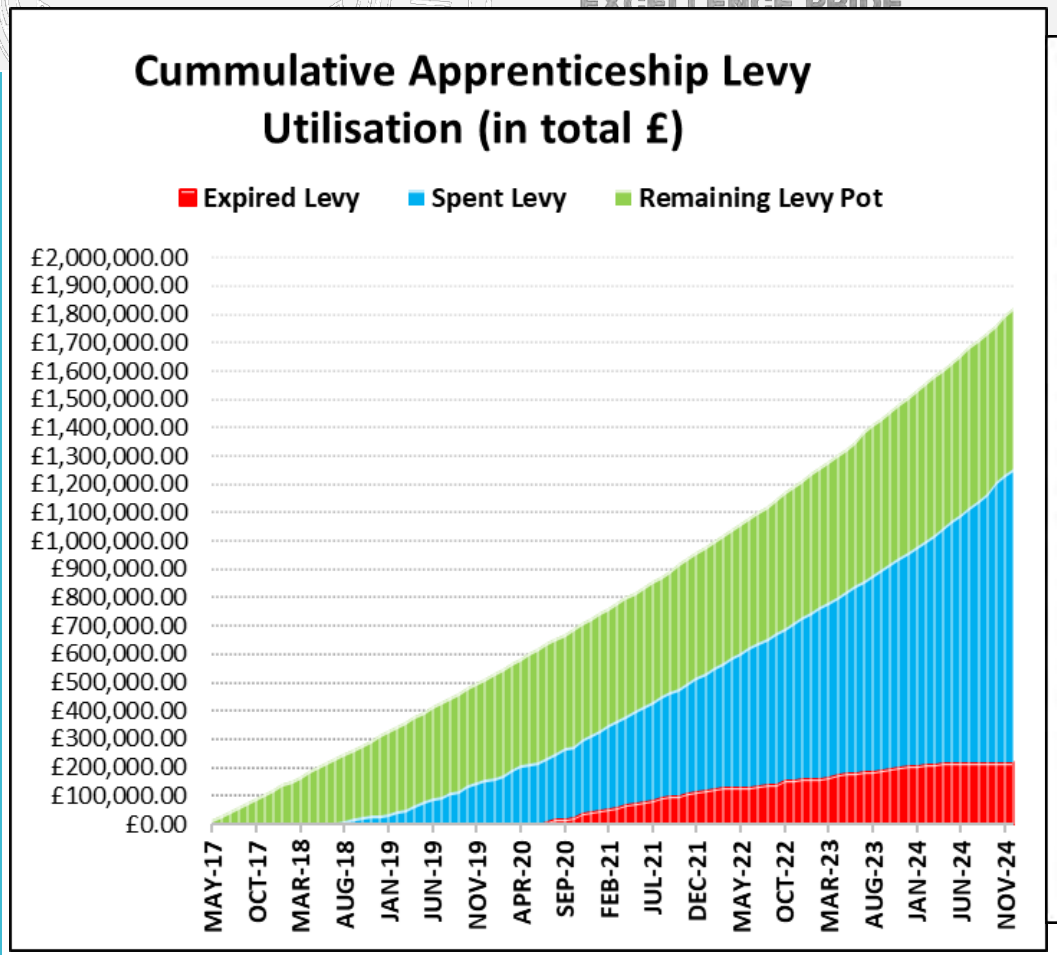
Achievement toward annual target:

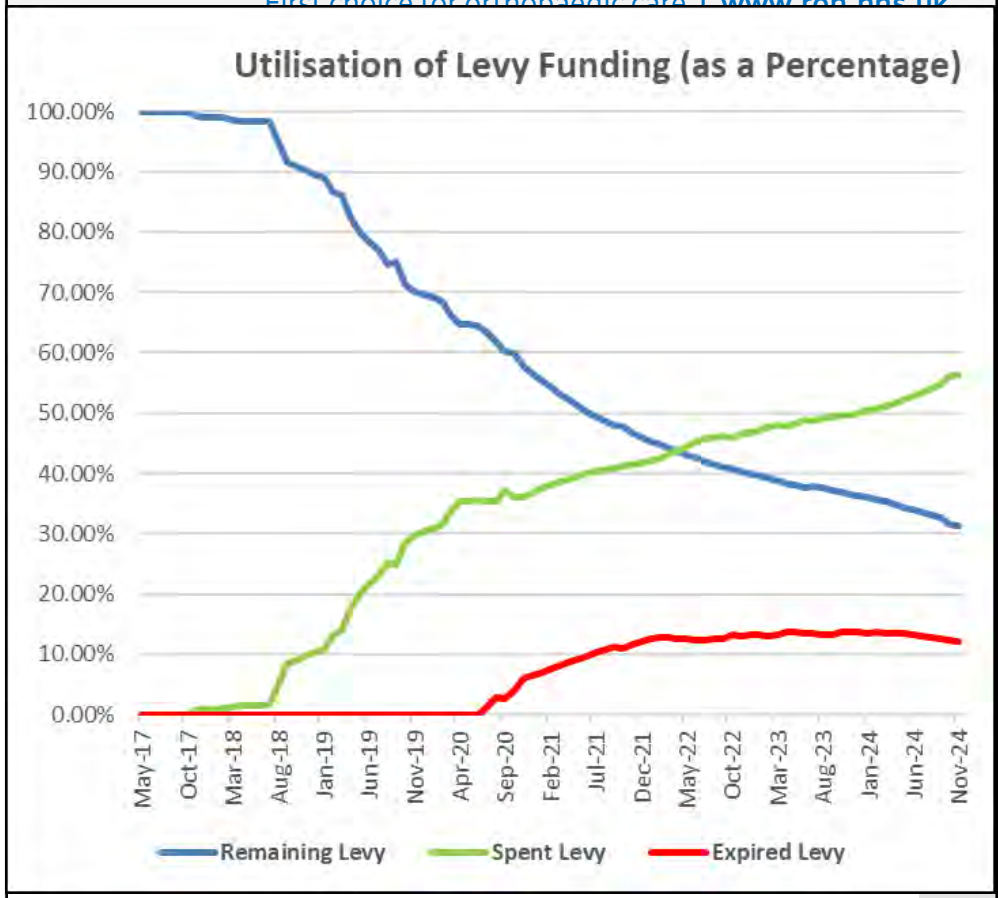
This graph shows number of new apprenticeship qualifications commenced in each year against the annual local trust target for that year.

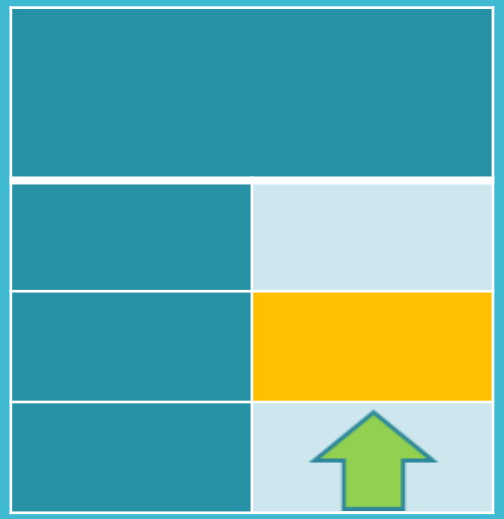
On 11th December 2024 we have had 2 new apprenticeship qualifications commence since 1st April 2024. There is 1 additional role in pre-employment stage commencing in January 2025. Due to the trusts current financial and performance challenges, and the recent restrictions around recruitment, there is a risk that we will not recruit any additional apprenticeships this financial year. We are therefore expecting to achieve 30 apprenticeship starts, against our annual national target of 33 (91%), and our locally set target of 40 (75%).

For this year we have opened gifting applications to SME organisations, and 4 health care charities are using our levy to support 6 apprenticeship career qualifications. This gifting approach ensures we do not expire any levy funding.

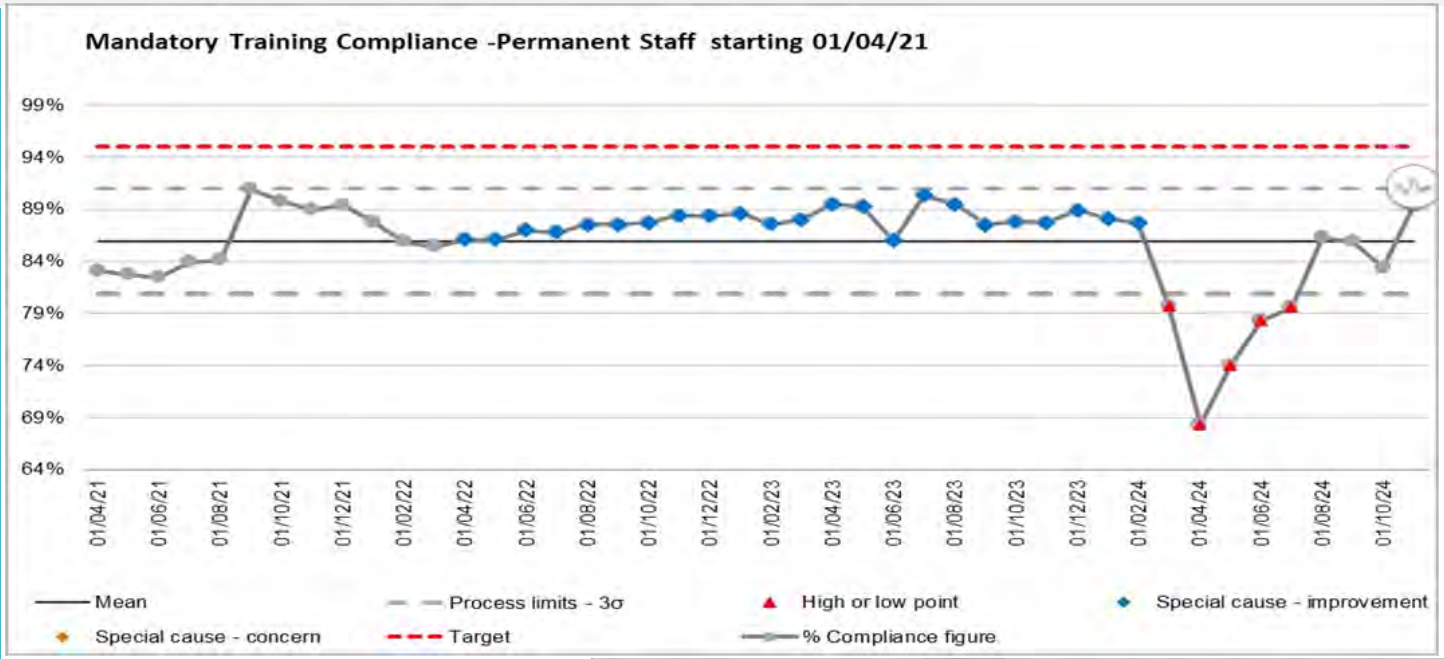


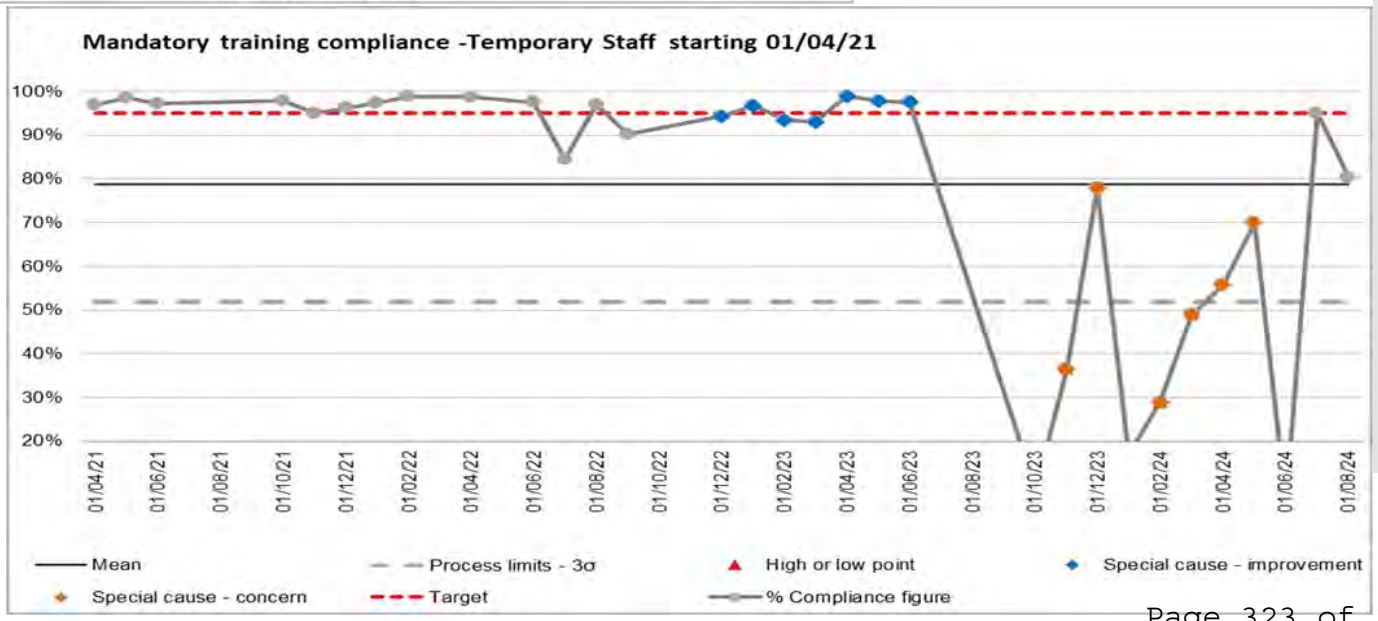

Cummulative Apprenticeship Levy Utilisation (in total £)
Expired Levy
Spent Levy
Remaining Levy Pot
£2,000,000.00
£1,900,000.00
£1,800,000.00
£1,700,000.00
£1,600,000.00
£1,500,000.00
£1,400,000.00
£1,300,000.00
£1,200,000.00
£1,100,000.00
£1,000,000.00
£900,000.00
£800,000.00
£700,000.00
£600,000.00
£500,000.00
£400,000.00
£300,000.00
£200,000.00
£100,000.00
£0.00
MAY-17
OCT-17
MAR-18
AUG-18
JAN-19
JUN-19
NOV-19
APR-20
SEP-20
FEB-21
JUL-21
DEC-21
MAY-22
OCT-22
MAR-23
AUG-23
JAN-24
JUN-24
NOV-24

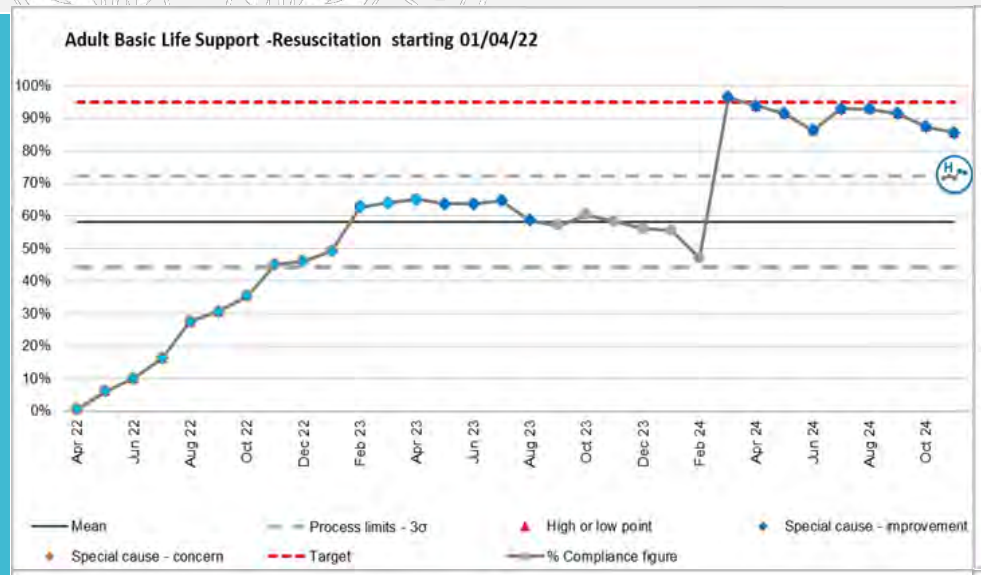

Utilisation of Levy Funding (as a Percentage)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
May-17
Oct-17
Mar-18
Aug-18
Jan-19
Jun-19
Nov-19
Apr-20
Sep-20
Feb-21
Jul-21
Dec-21
May-22
Oct-22
Mar-23
Aug-23
Jan-24
Jun-24
Nov-24
Remaining Levy
Spent Levy
Expired Levy

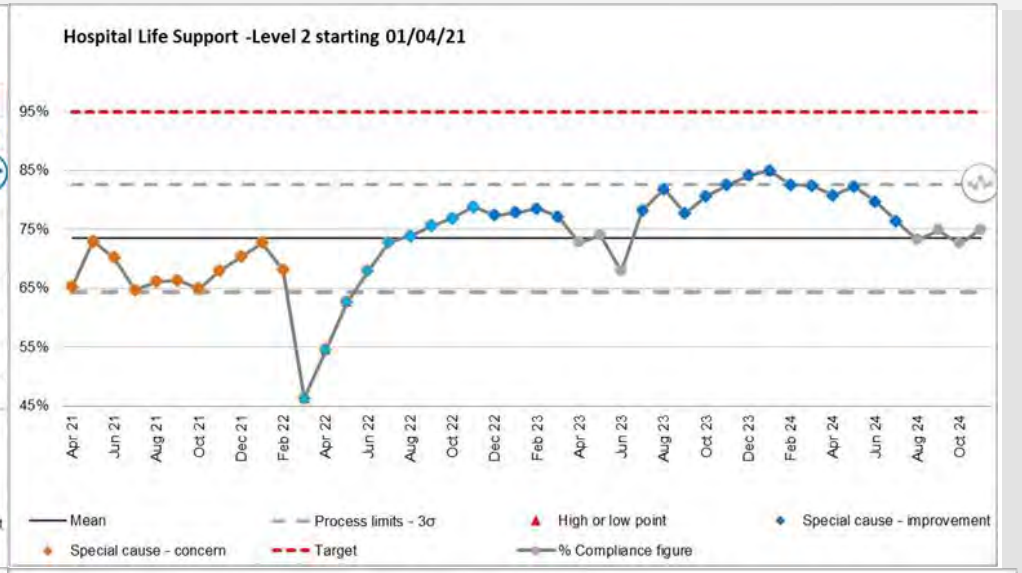


COURSE	Compliance %age	COMMENTS	TREND
Core Mandatory Training – Permanent Staff	89.27%	Compliance is improving but has slightly decreased this month. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). % increase due to Cyber and IG	
Core Mandatory Training – Temporary Staff	80.35%	Based on staff working on the Bank who are **compliant** with training	
Cyber	84.30%	Constant slight increase month on month	
IG	86.22%	Constant slight increase month on month	
Basic Life Support – Level 1	85.58%	Following direct mail chasing completions this has vastly improved. Target audience – non clinical.	
Hospital Life Support – Level 2	74.92%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	
Immediate Life Support	80.14%	Large jump in compliance following an increase in activity	
Advanced Life Support	97.62%	Large increase in % this month due to a session being put on	
Paediatric Immediate Life Support	50%	Target achieved earlier this year, a few out of date. There is a session in Dec which is fully booked and a session scheduled for February 2025.	
Patient Handling	82.84%	Good progress overall this year but less stable during the last few months; need to sustain improvement.	
Conflict Resolution	78.32%	Significant increase this month since the competency was changed from once only to three yearly.	
NEWS2	98.63%	Consistently achieving over 95% compliance since June 2022.	
Safe use of Insulin	87.36%	Staying the same over the last few months.	
VTE	93.46%	Stayed the same over the last few months.	
CONSENT	85.54%	Slight decrease on last months, accessed via BMJ.	
IPC2	84.39%	Continual increase during the last few months.	
Food Hygiene	93.65%	Slight decrease on last month	


Mandatory Training Compliance -Permanent Staff starting 01/04/21
99%
94%
89%
84%
79%
74%
69%
64%
01/04/21
01/06/21
01/08/21
01/10/21
01/12/21
01/02/22
01/04/22
01/06/22
01/08/22
01/10/22
01/12/22
01/02/23
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
01/02/24
01/04/24
01/06/24
01/08/24
01/10/24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Mandatory training compliance -Temporary Staff starting 01/04/21
100%
90%
80%
70%
60%
50%
40%
30%
20%
01/04/21
01/06/21
01/08/21
01/10/21
01/12/21
01/02/22
01/04/22
01/06/22
01/08/22
01/10/22
01/12/22
01/02/23
01/04/23
01/06/23
01/08/23
01/10/23
01/12/23
01/02/24
01/04/24
01/06/24
01/08/24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Adult Basic Life Support -Resuscitation starting 01/04/22
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Apr 23
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Hospital Life Support -Level 2 starting 01/04/21
95%
85%
75%
65%
55%
45%
Apr 21
Jun 21
Aug 21
Oct 21
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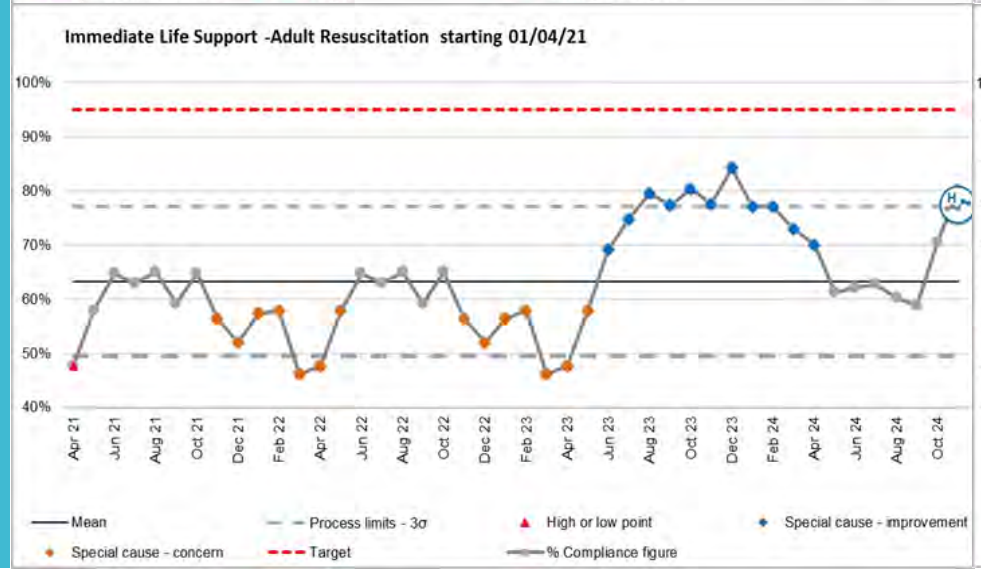
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Immediate Life Support -Adult Resuscitation starting 01/04/21
100%
90%
80%
70%
60%
50%
40%
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
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Aug 22
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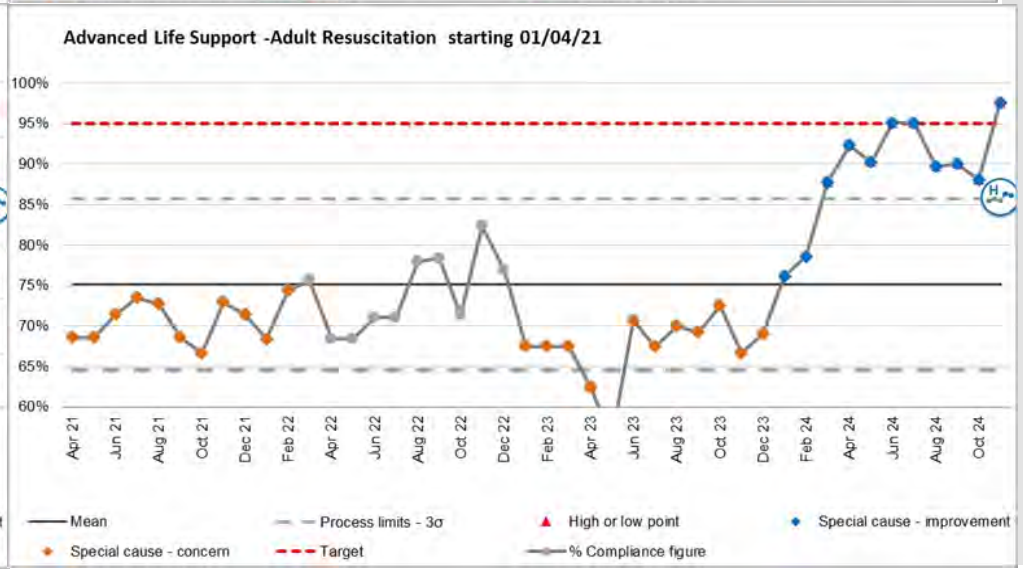
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Advanced Life Support -Adult Resuscitation starting 01/04/21
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
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Aug 22
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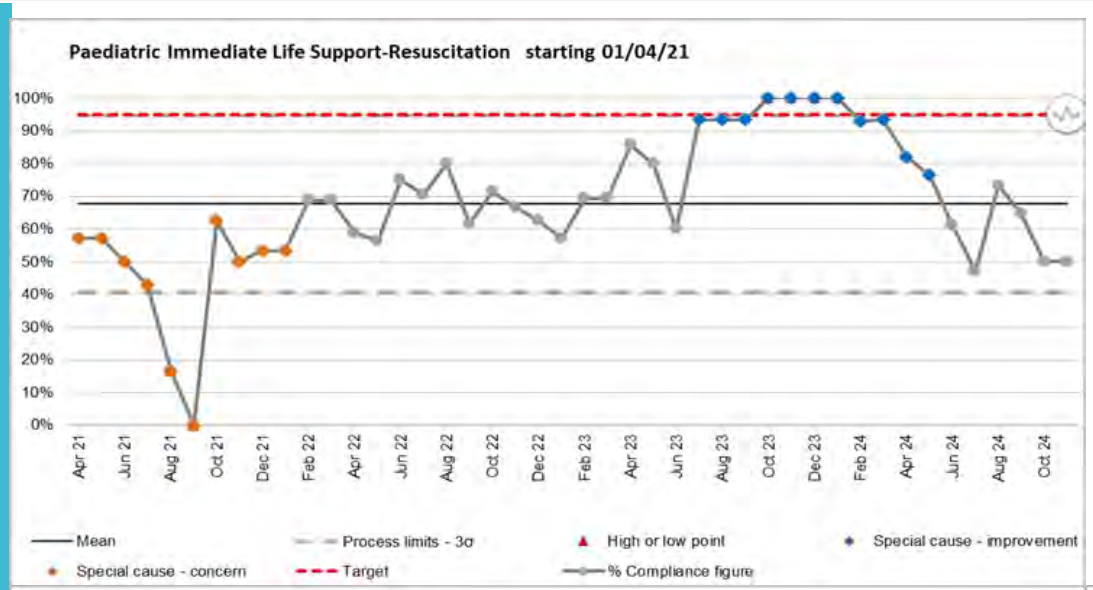
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Paediatric Immediate Life Support-Resuscitation starting 01/04/21
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr 21
Jun 21
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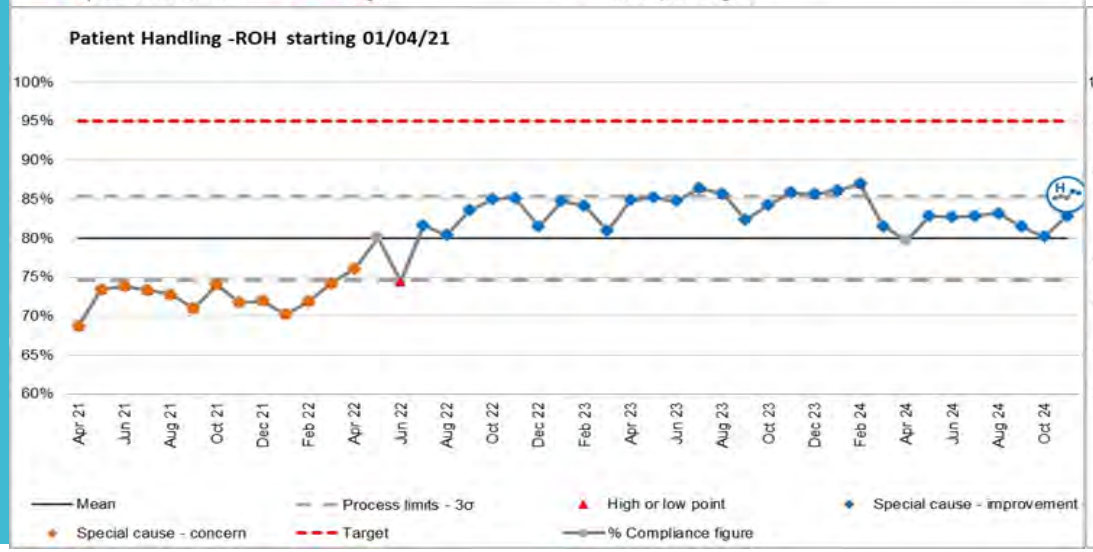
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Patient Handling -ROH starting 01/04/21
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr 21
Jun 21
Aug 21
Oct 21
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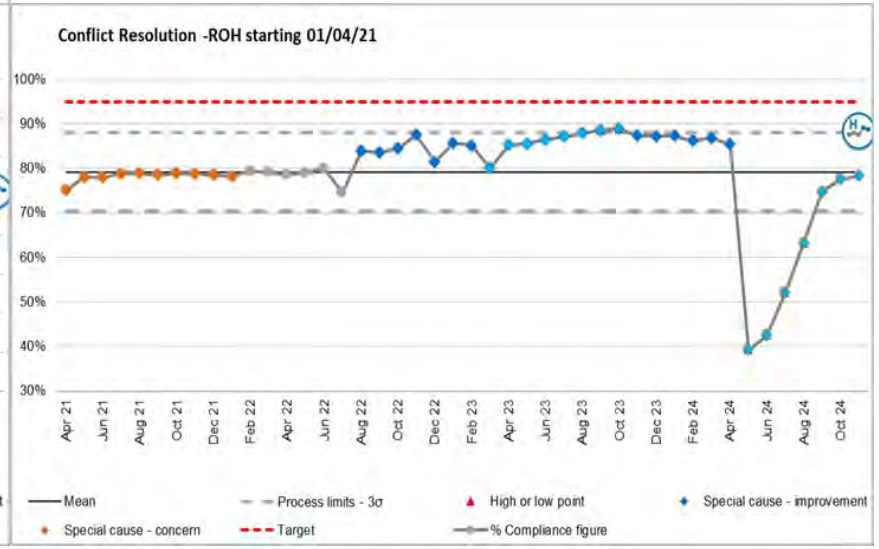
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Conflict Resolution -ROH starting 01/04/21
100%
90%
80%
70%
60%
50%
40%
30%
Apr 21
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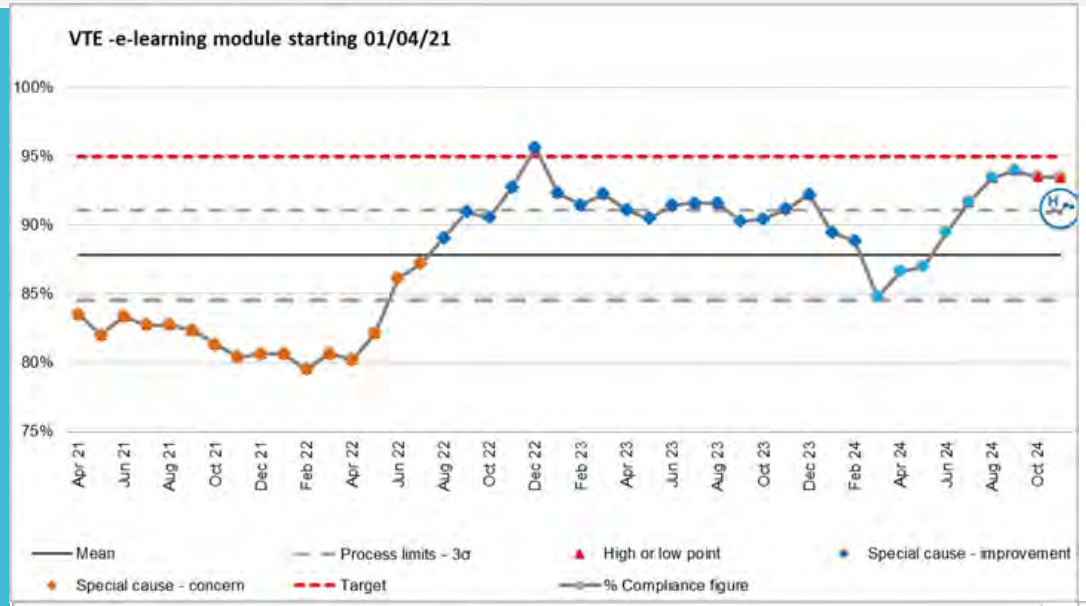
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


VTE -e-learning module starting 01/04/21
100%
95%
90%
85%
80%
75%
Apr 21
Jun 21
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Feb 22
Apr 22
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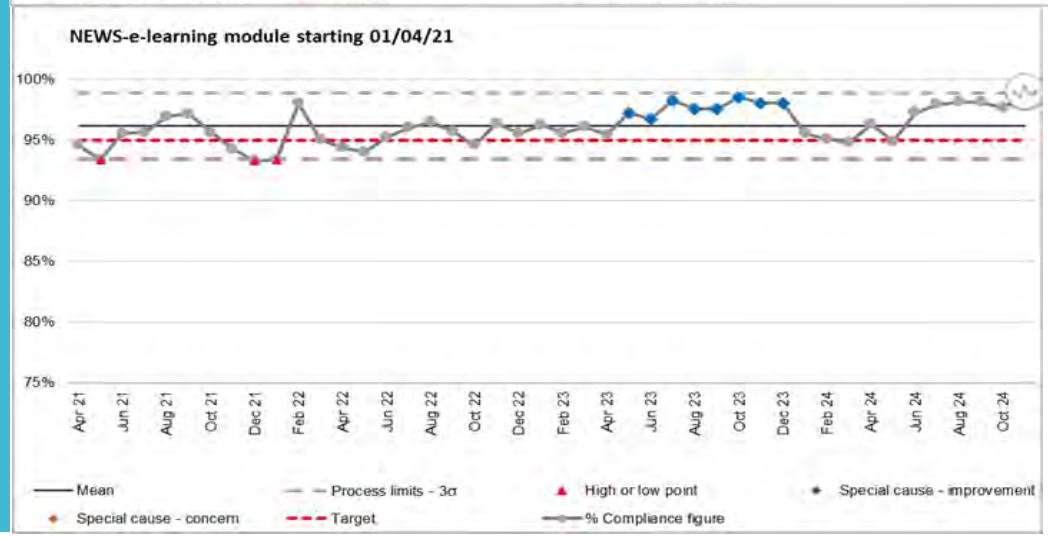
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


NEWS-e-learning module starting 01/04/21
100%
95%
90%
85%
80%
75%
Apr 21
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Feb 24
Apr 24
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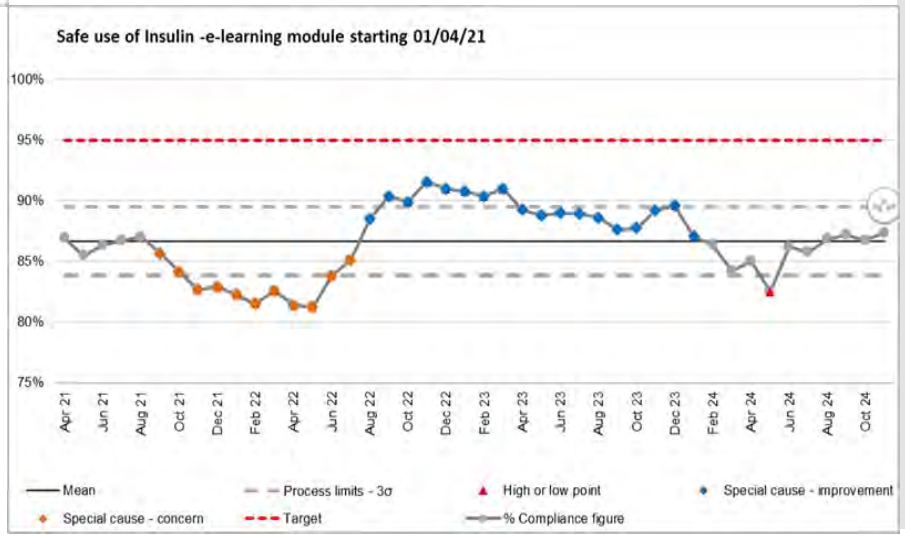
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Safe use of Insulin -e-learning module starting 01/04/21
100%
95%
90%
85%
80%
75%
Apr 21
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Dec 21
Feb 22
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Apr 24
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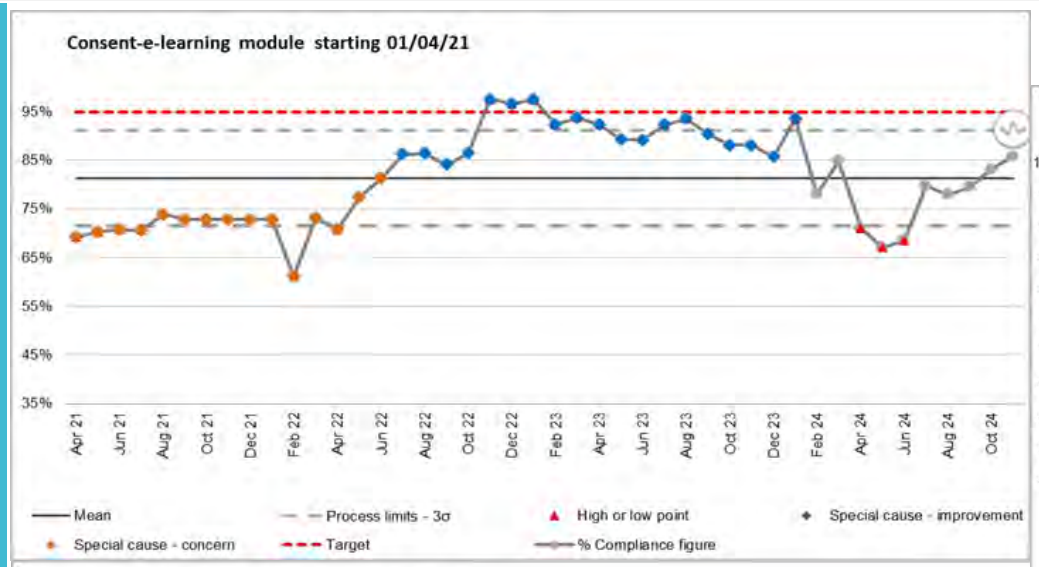
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Consent-e-learning module starting 01/04/21
95%
85%
75%
65%
55%
45%
35%
Apr 21
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Dec 21
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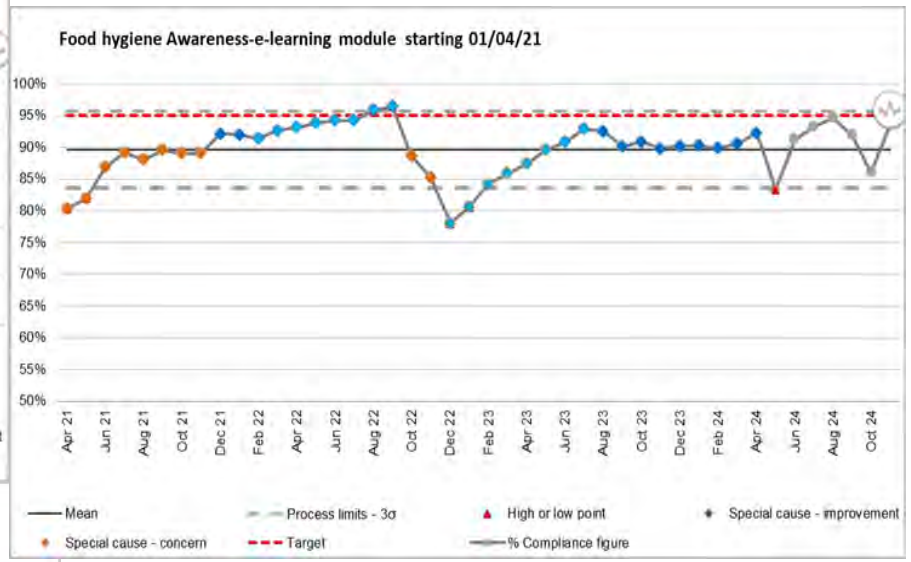
Apr 24
Jun 24
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


Food hygiene Awareness-e-learning module starting 01/04/21
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Apr 21
Jun 21
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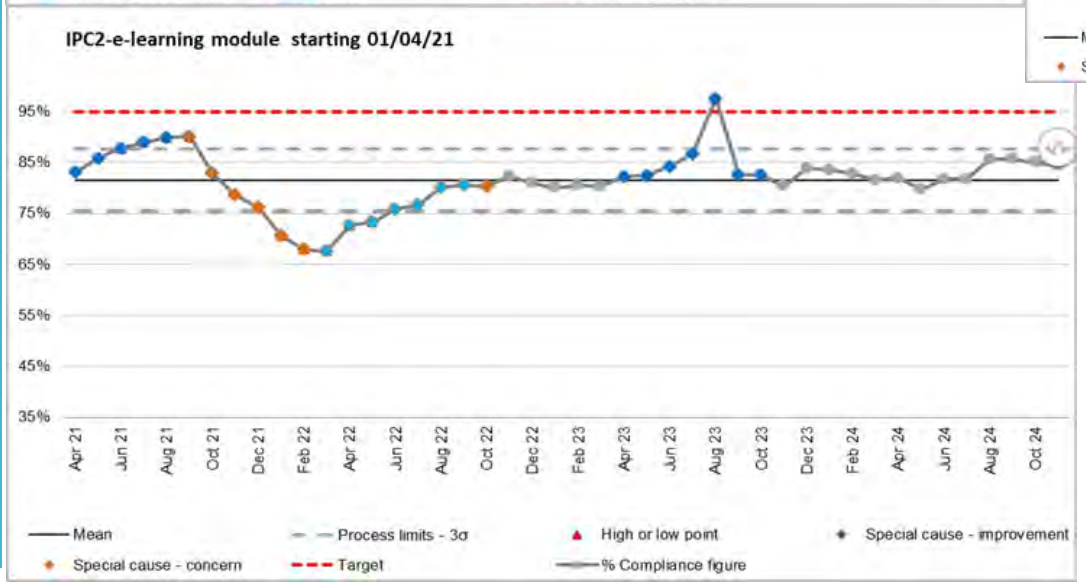
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure


IPC2-e-learning module starting 01/04/21
95%
85%
75%
65%
55%
45%
35%
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Oct 21
Dec 21
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Feb 24
Apr 24
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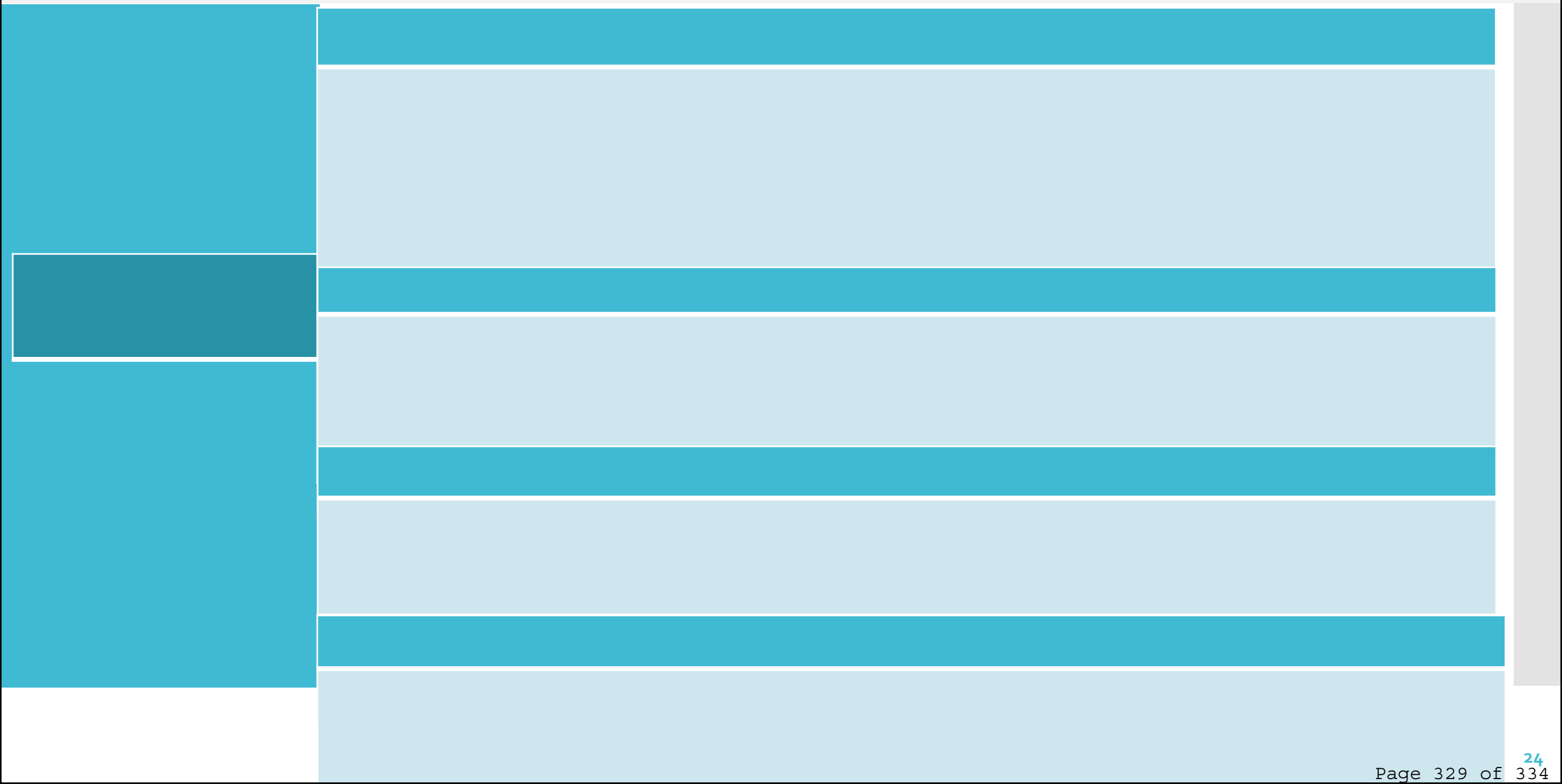
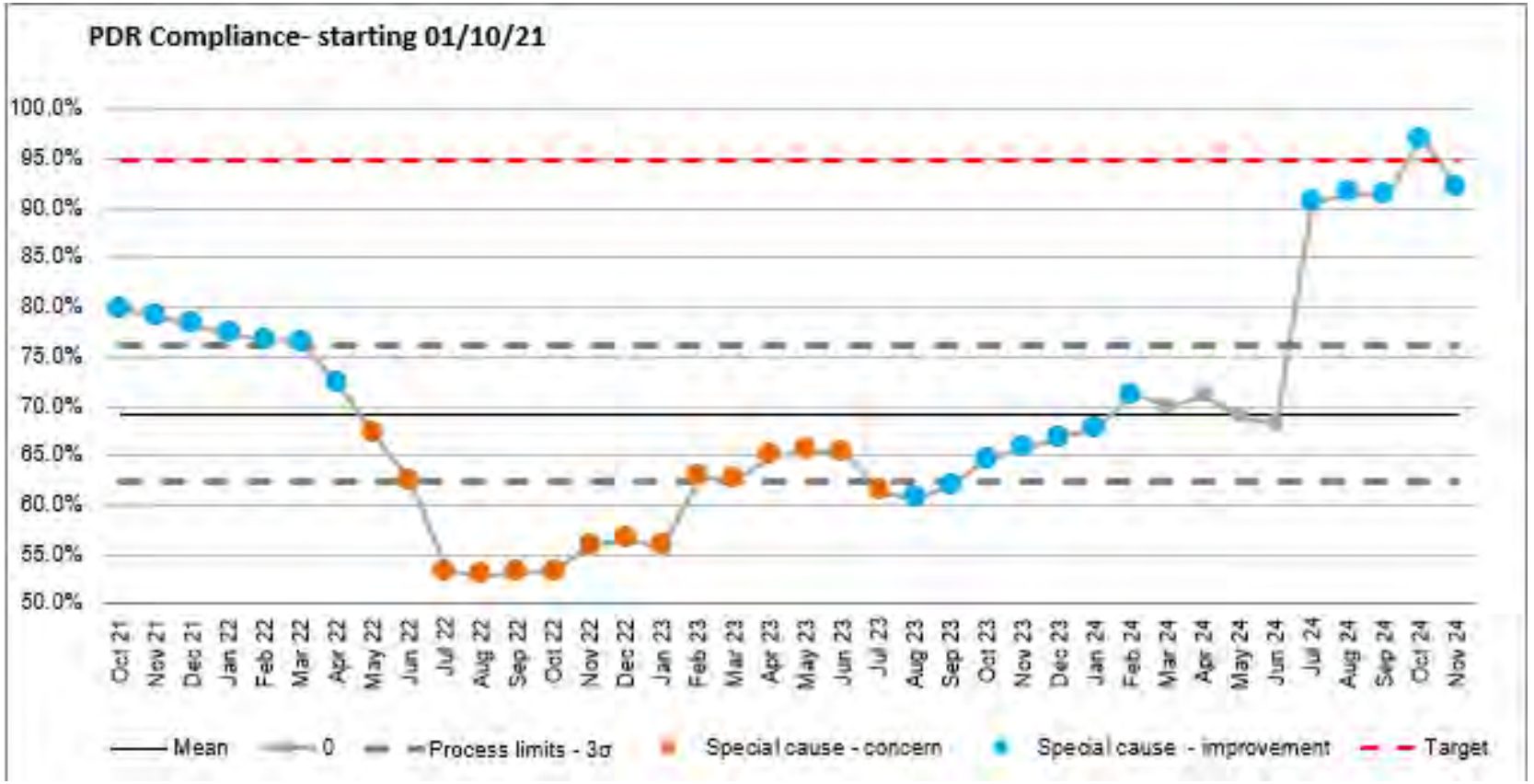
Aug 24
Oct 24
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
% Compliance figure




PDR Compliance- starting 01/10/21
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Oct 21
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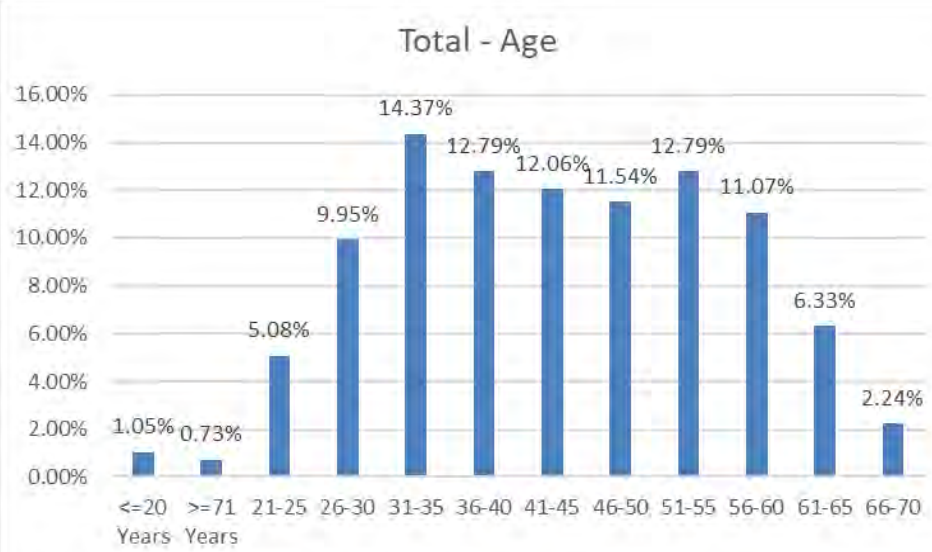
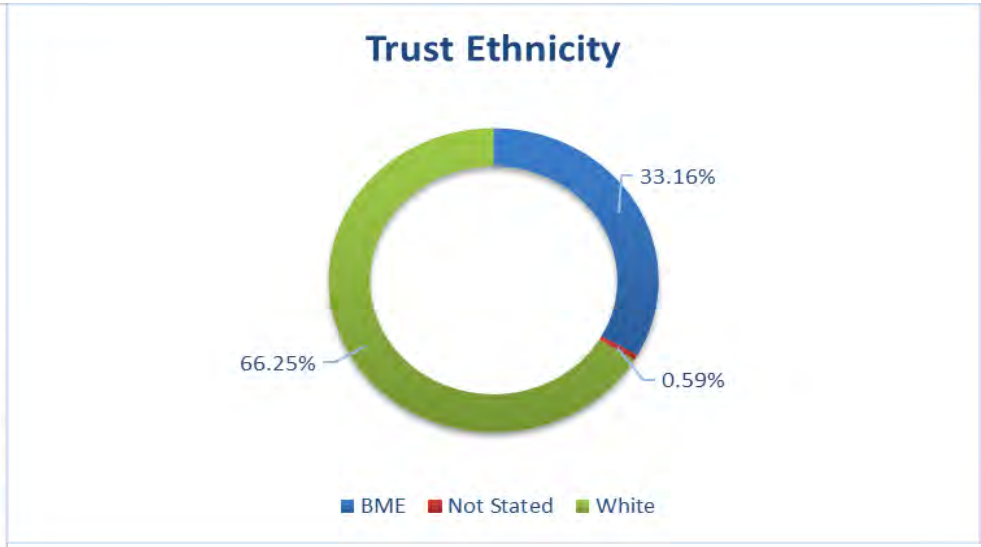
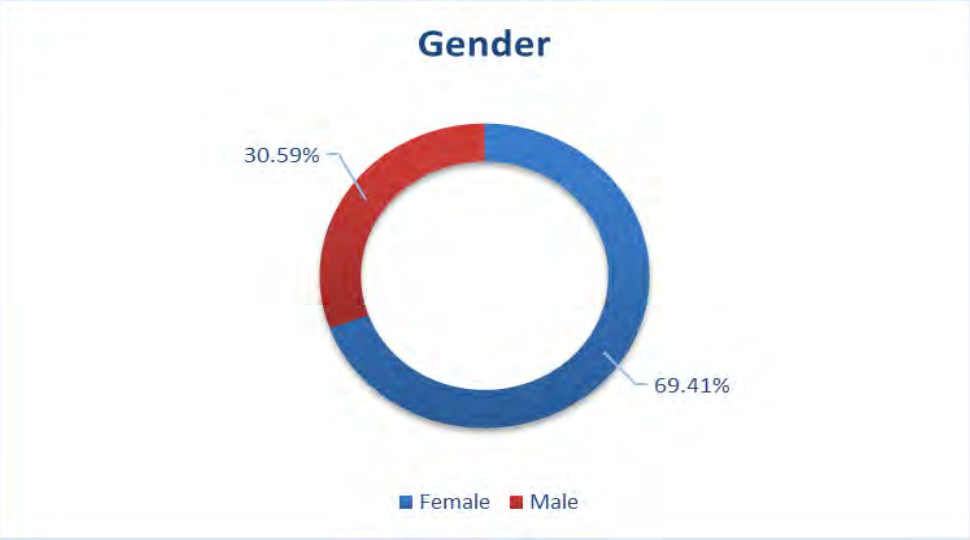
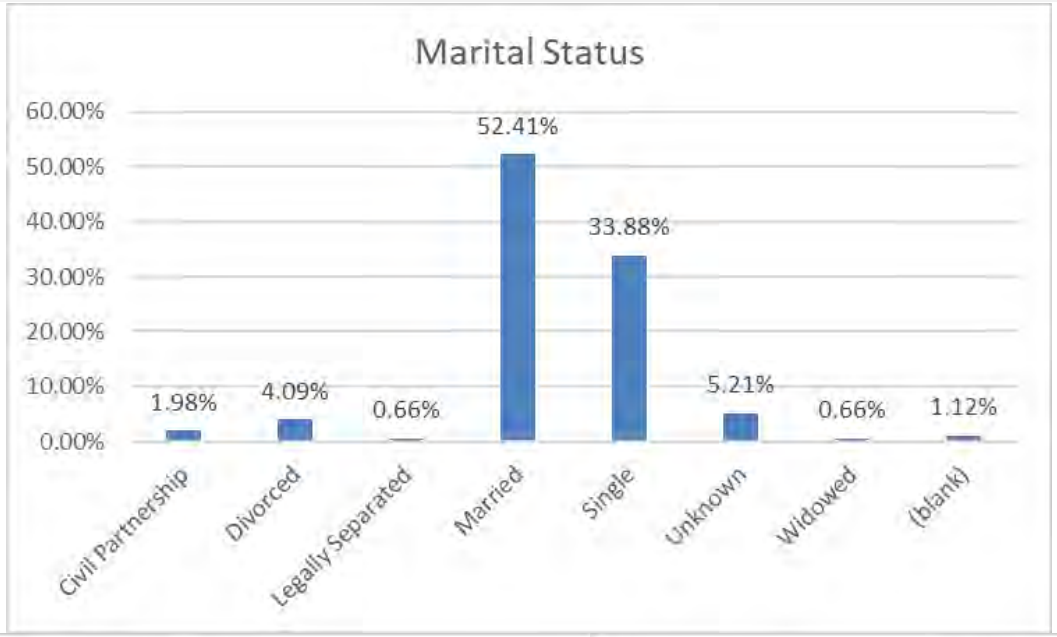
Oct 24
Nov 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

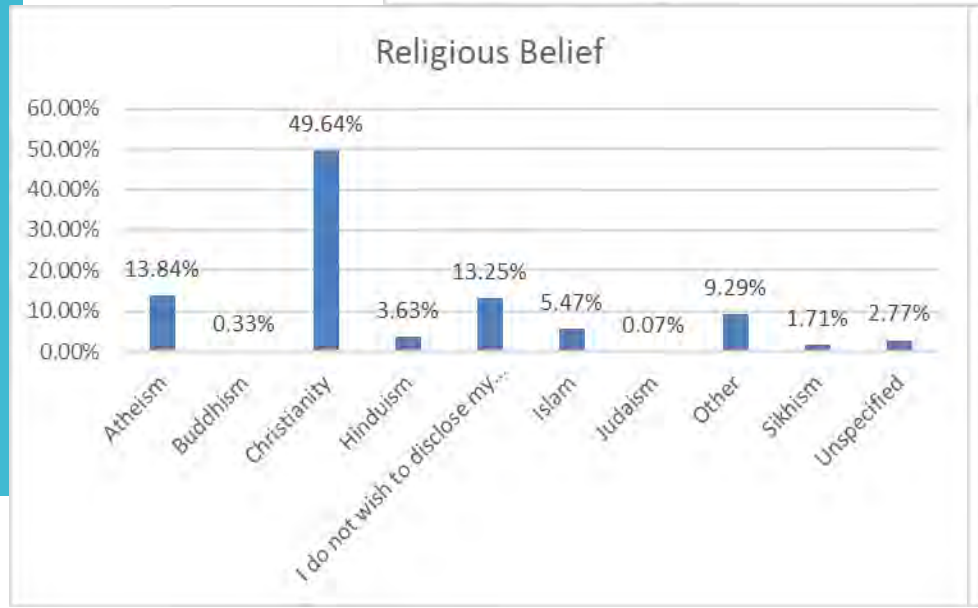
Workforce Demographics

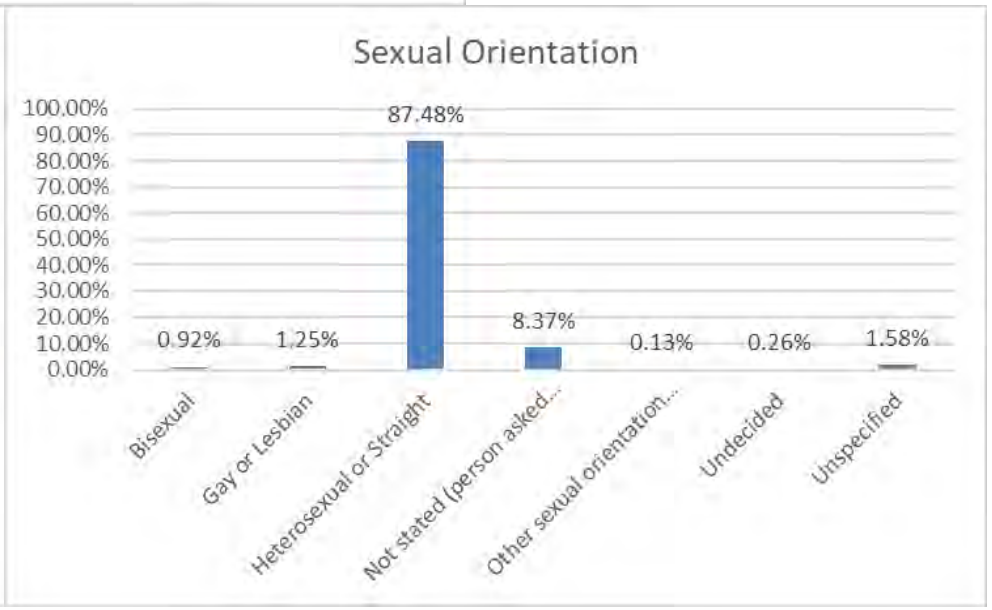


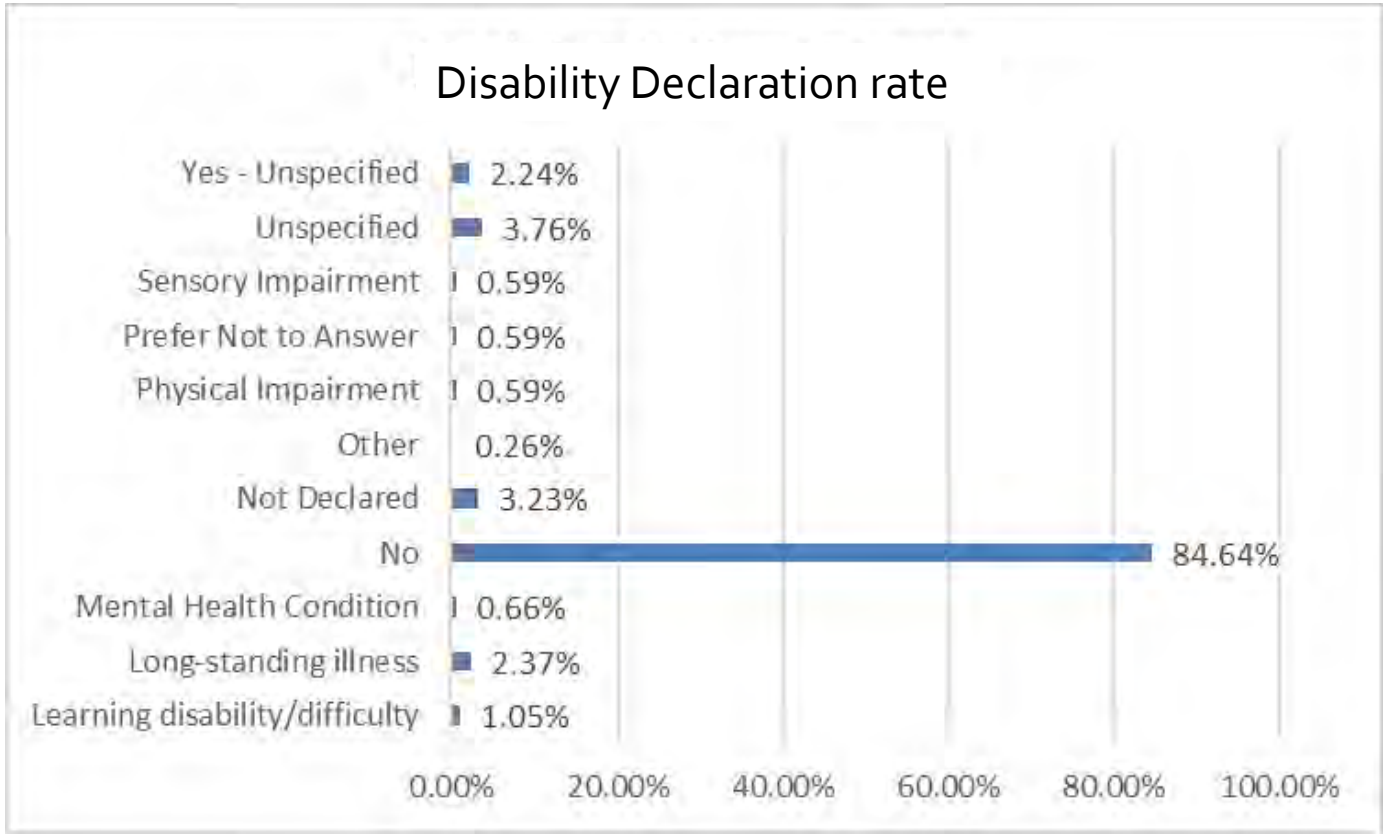





Marital Status
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
1.98%
4.09%
0.66%
52.41%
33.88%
5.21%
0.66%
1.12%
Civil Partnership
Divorced
Legally Separated
Married
Single
Unknown
Widowed
(blank)


Religious Belief
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
13.84%
0.33%
49.64%
3.63%
13.25%
5.47%
0.07%
9.29%
1.71%
2.77%
Atheism
Buddhism
Christianity
Hinduism
I do not wish to disclose my...
Islam
Judaism
Other
Sikhism
Unspecified


Sexual Orientation
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
0.92%
1.25%
87.48%
8.37%
0.13%
0.26%
1.58%
Bisexual
Gay or Lesbian
Heterosexual or Straight
Not stated (person asked...
Other sexual orientation...
Undecided
Unspecified


Disability Declaration rate
Yes - Unspecified 2.24%
Unspecified 3.76%
Sensory Impairment 0.59%
Prefer Not to Answer 0.59%
Physical Impairment 0.59%
Other 0.26%
Not Declared 3.23%
No 84.64%
Mental Health Condition 0.66%
Long-standing illness 2.37%
Learning disability/difficulty 1.05%
0.00% 20.00% 40.00% 60.00% 80.00% 100.00%

Staff Group	% Annual Leave Taken
Add Prof scientific and technic	57.13%
Additional Clinical Services	62.36%
Administrative and Clerical	65.81%
Allied Health Professionals	59.77%
Estates and Ancillary	60.87%
Nursing and Midwifery Registered	61.85%