The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (IN PUBLIC)

Venue Remote via videoconferencing **Date** 13 January 2021: 0900h – 1030h

Members attending

Dame Yve Buckland	Chair	(YB)
Mr Tim Pile	Vice Chair and Non Executive Director	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Ayodele Ajose	Associate Non Executive Director	(AA)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Chris Ward	Deputy Director of Nursing & Clinical Governance	(CW)	[Item 1]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story - Outpatients	Presentation	CW
0915h	2	Apologies	Verbal	Chair
	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Public Board Meeting held on 4 November 2020: *for approval*	ROHTB (11/20) 016	Chair
	4.1	Actions from previous meetings	ROHTB (11/20) 016 (a)	SGL
	5	Questions from members of the public	Verbal	Chair
0910h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (1/21) 001 ROHTB (1/21) 001 (a)	YB/JW
0930h	7	Restoration & recovery update: *for assurance*	ROHTB (1/21) 002 ROHTB (1/21) 002 (a)	MP

0940h	8	Infection Prevention and Control response to the COVID-19 pandemic		
	8.1	Trust response to COVID outbreaks: *for assurance*	ROHTB (1/21) 003 ROHTB (1/22) 003 (a)	GM
	8.2	Nosocomial infections report: *for assurance*	ROHTB (1/21) 004 ROHTB (1/22) 004 (a)	GM
	8.3	Departmental risk assessments: *for assurance*	ROHTB (1/21) 005 ROHTB (1/22) 005 (a)	GM
	8.4	NHS England IPC Board Assurance Framework update: *for assurance*	ROHTB (1/21) 006 ROHTB (1/22) 006 (a)	GM
	8.5	Infection Control testing and controls gap analysis: *for assurance*	ROHTB (1/21) 007 ROHTB (1/21) 007 (a) - ROHTB (1/21) 007 (c)	GM
	8.6	Personal Protective Equipment update: *for assurance*	Verbal	GM
	8.6	Lateral testing update: *for assurance*	ROHTB (1/21) 009	SW
	8.7	Flu vaccination campaign update: *for assurance*	ROHTB (1/21) 010	SW
1000h	9	CQC action plan update: *for assurance*	ROHTB (1/21) 011	GM
1005h	10	EU exit impact: *for assurance*	ROHTB (1/21) 012 ROHTB (1/21) 012 (a)	PB
1010h	11	Board Assurance Framework: *for information*	Verbal	SGL
		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1015h	12	Exception assurance reports from the Board Committees: • Finance & Performance – key highlights • Quality & Safety – key highlights • Staff Experience & OD – assurance report	ROHTB (1/21) 013 ROHTB (1/21) 014 ROHTB (1/21) 015	
	13	Performance reports: *for assurance* • Quality & Safety • Finance & Performance	ROHTB (1/21) 016 ROHTB (1/21) 017	
	14	Meeting effectiveness	Verbal	ALL
1030h	15	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 3 March 2021 @ 0900h				

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 – UPDATED TO NOVEMBER 2020

MEMBER	MEETING DATE						TOTAL
	6/5/2020	3/6/2020	1/7/2020	2/9/2020	7/10/2020	4/14/2020	
Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	6/6
Tim Pile	✓	✓	✓	✓	✓	✓	6/6
Kathryn Sallah	✓	✓	✓	✓	✓	✓	6/6
Rod Anthony	✓	✓	✓	✓	✓	✓	6/6
Richard Phillips	✓	✓	✓	✓	✓	✓	6/6
David Gourevitch	✓	✓	✓	✓	✓	✓	6/6
Simone Jordan	✓	✓	✓	✓	✓	✓	6/6
Gianjeet Hunjan						✓	1/1
Ayodele Ajose	✓	✓	✓	✓	✓	✓	6/6
Jo Williams	✓	✓	✓	✓	✓	✓	6/6
Matthew Revell	✓	✓	✓	✓	✓	✓	6/6
Garry Marsh	✓	✓	✓	✓	✓	✓	6/6
Phil Begg	✓	✓	✓	✓	✓	✓	6/6
Marie Peplow	✓	✓	✓	✓	✓	✓	6/6
Stephen Washbourne	✓	✓	✓	✓	✓	✓	6/6
Sharon Malhi					✓	✓	2/2
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	6/6

KEY:

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday 3 March 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 3 March 2021 commencing at **0900h**. This will be a remote meeting facilitated using videoconferencing technology.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 3 March 2021: 0900h – 1230h

Members

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mrs Mandeep Johal	Freedom to Speak Up Guardian	(MJ)	[Item 1]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Freedom to Speak Up update: *for assurance*	Presentation	MJ
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 13 January 2021: *for approval*	ROHTB (1/21) 018	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (1/21) 018 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/21) 001 ROHTB (3/21) 001 (a)	TP/JW
0945h	6.1	Proposed modification of condition G4 of the NHS provider licence: *for information*	ROHTB (3/21) 001 (b)	SGL
0950h	7	Refresh & recovery update: *for assurance*	ROHTB (3/21) 002	MP

1010h	8	Infection Prevention and Control response to the COVID-19 pandemic		
	8.1	Trust response to COVID outbreaks: *for assurance*	ROHTB (3/21) 003	GM
	8.2	NHS England IPC Board Assurance Framework update: *for information*	Verbal	GM
	8.3	Personal Protective Equipment update: *for assurance*	Verbal	GM
	8.4	Lateral testing update: *for assurance*	Verbal	SW
1020h	9	Learning from Deaths update: *for assurance*	ROHTB (3/21) 004 ROHTB (3/21) 004 (a)	MR
1030h	10	Board Assurance Framework: *for information*	ROHTB (3/21) 005 ROHTB (3/21) 005 (a)	SGL
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
1035h	11	Exception assurance reports from the Board Committees: • Finance & Performance – key highlights • Staff Experience & OD – key highlights • Audit Committee – key highlights • Quality & Safety – assurance report	ROHTB (3/21) 006 ROHTB (3/21) 007 ROHTB (3/21) 008 ROHTB (3/21) 009	
1050h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance	ROHTB (3/21) 010 ROHTB (3/21) 011	
CONFIDENTIAL SESSION				
1220h	13	Any Other Business	Verbal	ALL
1225h	14	Meeting effectiveness	Verbal	ALL
Date of next meeting: Wednesday 7 April 2021 @ 0900h				

Notes

Quorum

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Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	✓	✓		8/8
Tim Pile	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Rod Anthony	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Gianjeet Hunjan						✓	✓	✓	✓	4/4
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Phil Begg	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Sharon Malhi					✓	✓	✓	✓	A	4/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9

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The Royal Orthopaedic Hospital NHS Foundation Trust

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	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
1035h	11	Exception assurance reports from the Board Committees: • Finance & Performance – key highlights • Staff Experience & OD – key highlights • Audit Committee – key highlights • Quality & Safety – assurance report	ROHTB (3/21) 006 ROHTB (3/21) 007 ROHTB (3/21) 008 ROHTB (3/21) 009	
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CONFIDENTIAL SESSION				
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Date of next meeting: Wednesday 7 April 2021 @ 0900h				

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Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	✓	✓		8/8
Tim Pile	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Rod Anthony	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Gianjeet Hunjan						✓	✓	✓	✓	4/4
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Phil Begg	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Sharon Malhi					✓	✓	✓	✓	A	4/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9

KEY:

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	Not in post or not required to attend		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.2

Venue Remote via videoconferencing **Date** 13 January 2021: 0900h – 1030h

Members attending:

Dame Yve Buckland	Chair	(YB)
Mr Tim Pile	Vice Chair and Non Executive Director	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(AP)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance:

Ms Ayodele Ajose	Associate Non Executive Director	(AA)
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)
Mr Chris Ward	Deputy Director of Nursing & Clinical Governance	(CW)
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL) [Secretariat]

Minutes	**Paper Reference**
1 Patient story – Outpatients	**Presentation**
The Board welcomed Mr Christian Ward, Deputy Director of Nursing & Clinical Governance who presented the story of patients who suffered from hearing impairment and therefore had found difficulties in interacting with the staff during the current circumstances. They for instance, found it difficult to understand instructions from a member of staff who was wearing a fluid resistant mask and another patient had experienced difficulties with accessing an interpreter for an appropriate length of time. The actions taken to address the experience were noted to include the use of transparent face masks, enhanced customer service training for staff on reception desks and revised booking arrangements for interpreters to ensure that they were booked for the entire	

length of an appointment. The Director of Strategy & Delivery noted that the case resonated with him personally given that audiology was his clinical speciality. In terms of the scale of the issue, he advised that c.10% of patients had a communication issue and in many cases this could go unidentified as they compensated including by being able to lip read well. Kathryn Sallah thanked Christian for his presentation and noted that the engagement of the Patient Experience Group in developing a solution had been valuable. She added that in terms of hearing impairment it was not always the individuals themselves that recognised the issue and were reliant on others to highlight this and assist them. Ayodele Ajose asked what support was given to patients whose first language was not English. She was advised that the use of interpreters was still permitted in the Trust as part of appointments and patient information was also provided in the commonest languages. It was noted that the Trust was starting British Sign Language (BSL) training and charitable funds was being used to make some adaptations and fund this training. Christian was asked how the nursing staff were coping with the current situation. He advised that the staff recognised the great strain in the system and were supporting the effort and changes to the services needed for now. Christian was asked to thank staff on behalf of the Board for all their efforts and dedication.	
2 Apologies	**Verbal**
Apologies were tendered from Sharon Malhi, Acting Associate Director of Workforce & OD. The Board was joined by Roko Skocic, Deputy Head of Patient Experience and by Brian Toner, Lead Governor.	
3 Declarations of interest	**Verbal**
It was noted that the register was available on request from the Company Secretary.	
4 Minutes of Public Board Meeting held on 4 November 2020: *for approval*	**ROHTB (11/20) 016**
The minutes of the last meeting were accepted as a true and accurate reflection	

of discussions held.	
4.1 Actions from previous meetings	**ROHTB (11/20) 016 (a)**
The updated action list was received and noted.	
5 Questions from members of the public	**Verbal**
There were none.	
6 Chairman's and Chief Executive's update: *for information and assurance*	**ROHTB (1/21) 001** **ROHTB (1/20) 001 (a)**
The Chief Executive reported that the current position for Covid risk assessments was 94.55%. The 'flu vaccination position was in excess 80% uptake, which it was noted was a real improvement on the previous year. The processes for the readiness for the EU exit were noted to have been tested. The staff survey was reported to be embargoed at present and the verbatim comments would be discussed at Staff Experience & OD Committee when available. Some staff had been vaccinated against Covid, this work being led by the Director of Finance. Lateral flow testing was underway and staff were being asked to report their results routinely. The suspension of parking charges would continue until the end of March 2021. The shortlisting for the 'Leading Lights' staff awards was completed. A mid summer ball had been arranged at which the staff awards would be presented. It was noted that the Chair, Yve Buckland, had been appointed as the Chair of the Birmingham & Solihull Integrated Care System. Yve was congratulated on this success. The priorities of NHS Improvement/England had been set out, one of which was health and wellbeing, against which the Board agreed that the ROH was well placed. The Executive Team was thanked for their work, efforts and support.	

Gianjeet Hunjan asked if any staff had refused vaccinations. The Chief Executive advised that there had been few slots to date offered, with these being at University Hospitals Birmingham NHSFT (UHB). In terms of the launch of the Covid vaccine, this had started on Tuesday 12 January for non-clinical staff. There was reported to be no indication to date that staff would refuse the vaccination. This would however be clearer once it had been rolled out organisation wide. There had been some staff elsewhere that had refused the Pfizer jab on the basis of medical conditions. The Astra Zeneca vaccination was noted to be more flexible. It was noted that elsewhere there was a c. 10% 'Did Not Attend' rate for vaccination slots booked. It was noted that it was good news that all staff could be vaccinated. The Chair reported that she had worked on a handover and the Board agreed that it was very pleased to have Tim Pile take on the chair position, particularly given his skills experience and network. Yve and Tim had undertaken a walkaround to deliver gifts to staff. Morale was high generally and staff were pleased to meet Tim. It was reported that the system was being supported by the ROH for its response to the new surge. The Chair advised that the first Board meeting of the Integrated Care System had been held and that she had attended the most up to date NHS Improvement briefing. Dale Bywater, Regional Director of NHS Improvement had asked that the Board check in on the Executive through the extended working hours and days. At the meeting there had been a clear focus on reducing the transmission of infection in the hospital. It was suggested that if a Board was making changes, then then restoration needed to be borne in mind. The Seacole Black, Asian and Minority Ethnic (BAME) NEDs network had delivered an update on their work to broaden diversity.	
7 Restoration and recovery update: *for assurance*	**ROHTB (1/21) 002** **ROHTB (1/20) 002 (a)**
The Chief Operating Officer reported that 11 task and finish groups had been established and operated to oversee the restoration and recovery work. The recovery had exceeded expectations and the benefits realisation would be shared at an appropriate point. Virtual appointments had been well used. Elective activity was in line with plan. Performance against the diagnostic and cancer targets had been strong. In December, five patients were waiting over 52 weeks for treatment and the overall performance against the Referral to Treatment Time target was 76% in	

December.

It was reported that due to the rise in the number of cases, there was work underway to support to the local system. Six anaesthetists had been provided to the system and the number of theatres operating had reduced from 12 to 8 to accommodate this; activity had been reduced accordingly. All patients postponed had been contacted and would be contacted again within 28 days to monitor any deterioration. The system pressures had increased again and there was a focus on intensive care and so capacity would be offered in the form of 48 beds for rehabilitation pathway. There had been a quality impact assessment undertaken for the new pathway. 53 patients had been received from UHB to date and of these 26 had been safely discharged. On Monday 11 January, the hand service and ambulatory trauma service had commenced, which allowed further support to UHB for intensive care. The services had been reconfigured were according to operational protocols and the ROH had moved at pace to adapt. The changes were noted to have been agile but the timescales for the work continuing were difficult to quantify but the progress would be reported through Finance & Performance Committee. The recovery roadmap was aspirational and there was an ambition to support services.

The Chair thanked the Chief Operating Officer and team and noted the significant contribution.

The Chief Executive noted how much work had been involved in providing the service and adapting as needed. 6000 outpatient appointments were being rescheduled and the communications with UHB would be worked through given the scale of this work.

Kathryn Sallah noted that the update was reassuring. It was noted that the Operations team was working well with the clinical directors. Kathryn advised that she had also spoken to some staff in Outpatients and there was a level of concern over the limitations in respect of IT for the video consultations. It was suggested that strengthening the IT should be accelerated including additional resource if needed. It was noted that no Outpatient appointments were being delivered at present but the Outpatients work had been given additional resource to assist with longer term changes planned and the linkage with the nursing team was working well. A Clinical Service Lead for Outpatients was being recruited.

In terms of the consultants, a very robust ward cover rota had been arranged which was to be commended.

The experience of patients on the receiving end of cancellations was questioned. It was noted that this was a slick operational process and every effort was being made to be as personal as possible with individual conversations. Updates were

given as and when available either by e-mail or phone. It was agreed that there was a good sense of assurance around the management of the operational processes.	
8 Infection Prevention and Control response to the Covid-19 pandemic	
8.1 Trust response to COVID outbreaks: *for assurance*	**ROHTB (1/21) 003** **ROHTB (1/20) 003 (a)**
The Director of Nursing & Clinical Governance presented an overview of the definition of an outbreak and the oversight mechanism of these. An outbreak was defined by NHS England to be two or more people experiencing the same illness. Each outbreak was scrutinised at the Quality & Safety Committee and Infection Prevention & Control Committee and there was also a daily oversight of the Executive Incident Management Team. Outbreak meetings were chaired on a daily basis and for 28 days a return was sent to NHS England. An outbreak meeting was also held where external stakeholders were invited and there was a detailed Root Cause Analysis that was undertaken. The detail of the outbreaks at the ROH was reviewed. There had been five in total and of these four were closed. A Ward 3 outbreak had been identified. The reasons behind the outbreak were reviewed and outlined for each. The outbreak on Ward 2 was discussed which related to one patient who had tested positive and then patients that had been on Ward 2 but had been moved elsewhere also had tested positive. In the High Dependency Unit (HDU) there were two further patients that developed Covid but had previously had no link to Ward 2. A member of staff also tested positive. The outbreak on Ward 3 was confined to a bay and this instance was reported to relate to non-compliance with the pre-operative isolation regime. Transmission to two other patients had resulted. Patients who had contracted Covid had carried on with the surgical pathway and had been discharged. It was agreed that the in depth scrutiny would continue at Quality & Safety Committee. The Chief Executive noted that from June to November, there had been a high number of patients treated and therefore the numbers of Covid were very low in context. It was suggested that a benchmark against other trusts in the system would be useful. Kathryn Sallah noted that the amount of work that was directed into the operation of the Infection Prevention and Control arrangements was considerable and excellent. Although there had been no mortality recently, there was an increased risk if the isolation guidance was not adhered to. Kathryn suggested	

that this needed to be a key message to patients. It was noted that this was a regular discussion as part of the consent process but was agreed that some of the national guidance needed to be re-emphasised. Richard Phillips noted that the detail of the response to the outbreaks was valuable. He asked, in terms of the scale and number of instances, whether this was within the expectations. He was advised by the Director of Nursing & Clinical Governance that he was assured over the diligence in terms of adherence to measures to avoid outbreaks. The processes had been endorsed by Public Health England and NHS England & Improvement. The source of the outbreaks had been rapidly identified. In terms of numbers, these were small but would hold significant interest for the CQC. The CQC relationship manager had been briefed and had not expressed any concerns highlighted to date.	
8.2 Nosocomial infections report: *for assurance*	**ROHTB (1/21) 004** **ROHTB (1/20) 004 (a)**
The summary of nosocomial infections was reviewed. It was pointed out that judgement had been reached that these were nosocomial instances based on the guidance in place at the time. It was noted that care for Covid patients had changed since and national guidance had evolved. There were five patients who were being treated for over 14 days and had contracted Covid. There had not been evidence of a failure of duty of care based on the national guidance.	
8.3 Departmental risk assessments: *for assurance*	**ROHTB (1/21) 005** **ROHTB (1/20) 005 (a)**
The departmental risk assessment reported was noted to provide assurance that the risk assessment process was continuing and most of the Covid pathways had changed since the Board last reviewed the update. This would be scrutinised further at the Quality & Safety Committee.	
8.4 NHS England IPC Board Assurance Framework update: *for assurance*	**ROHTB (1/21) 006** **ROHTB (1/20) 006 (a)**
It was highlighted that some of the non-compliance items on the IPC Board Assurance Framework had been closed including house keeping and sign off of sitreps. The outstanding issues concerned auditing housekeeping and cleaning.	
8.5 Infection Control testing and controls gap analysis: *for assurance*	**ROHTB (1/21) 007** **ROHTB (1/20) 007 (a) -** **ROHTB (1/20) 007 (c)**
The Board was noted to be largely compliant with the statements issued in the national guidance around infection control testing and controls. It was noted that the Chairman provided her own assurance on compliance. Simone Jordan asked	

how many of the changes would remain after the mass vaccination programme had been completed. It was noted that this was not clear as national guidance was not yet issued. The only infections that had increased at the Trust related to *C difficile*, however this reflected the complex trauma patients which was not a cohort that had been handled traditionally at the ROH. Kathryn Sallah suggested that the given Perspex screens and enhanced hand hygiene in all areas, there should be a reduction in staff sickness in terms of colds and 'flu. It was noted that there was a new Infection Prevention and Control team who were responsive and subject to daily scrutiny which had shown they had a good grip and oversight. There had also been good consultant engagement in the Infection Prevention and Control agenda had been good.	
8.6 Personal Protective Equipment update: *for assurance*	**Verbal**
It was reported that there was a process in place around training in FFP3 mask fitting. A log of fit testing training was kept.	
8.7 Lateral flow testing update: *for assurance*	**ROHTB (1/21) 009**
The report on lateral flow testing was received and noted. There was noted to have been good distribution of kits but the results needed to be better reported. To date, eleven positive reports had been reported, two of which had been reported incorrectly. Of the other nine, three were symptomatic and should have taken a PCR test when they developed the illness. There was noted to be an electronic reporting system. There was also a daily report to NHS England & Improvement. It was noted that there was some media attention over the accuracy of the tests. The Director of Finance was asked in terms of those staff that had not yet got kits, what timescale was involved in receiving them. It was reported that kits had been distributed to all staff, with clinical staff having been given first access. Less than 20 staff were outstanding of a kit to date. As a system, all kits had been consumed.	
8.8 Flu vaccination campaign update: *for assurance*	**ROHTB (1/21) 010** **ROHTB (1/20) 010 (a)**
It was reported that the 'fast and hard' 'flu vaccination campaign had worked well and the incentivisation had been well received. A higher level of frontline staff had received the vaccination than previously. Some residual staff were being vaccinated. The Board agreed that the was noted to be an excellent take up at c. 80%. The team responsible for the vaccinations was to be thanked and in particular Julie	

Gardner, Assistant Director of Finance. The national expectation for the Covid vaccine was noted to be a 90% take up rate.	
9 CQC action plan update: *for assurance*	**ROHTB (1/21) 011**
The Board reviewed the latest version of the CQC action plan. The key matter of attention was noted to be that the action plan was to be sustained and there were ongoing conversations and readiness for CQC inspections. The patient engagement work had been delayed. The training rates for safeguarding had improved to the position pre-Covid. It was suggested that Non Executive Directors' mandatory training needed to improved, a matter with which the Director of Corporate Affairs agreed to assist.	
10 EU exit impact: *for assurance*	**ROHTB (1/21) 012** **ROHTB (1/21) 012 (a)**
The Director of Strategy & Delivery noted that the UK had now exited from the European Union (EU). The hospital stocks and supplies had been monitored and there was no evident disruption at present. There had equally been no issue with workforce. The implications were minimal for staff in the Trust for those being attracted from the continent. In terms of data flow, there was a continuation of previous arrangements at present. Ayodele Ajose asked for the detail around the terms of recruitment of staff from the EU. She was advised that there were very few staff involved and the reciprocation agreement in place was a safeguard against issues. Overall, the Trust was in good shape and business continuity plans had been tested. It was noted that since Monday evening there were some issues as a result of the increased flow through ports but overall there had been a good flow of goods.	
11 Board Assurance Framework: *for information*	**Verbal**
It was reported that the Board Assurance Framework was currently being updated and would be presented at the next meeting. The current version had been reviewed by the Chief Executive and Director of Corporate Affairs however, who were satisfied that there was no major change to risk scores or narrative to highlight at present.	
12 Exception assurance reports from the Board Committees	

• **Finance & Performance – key highlights** In terms of finance, there was an underlying surplus to date. As a result of the ROH's system response, the operational expenditure expected would not be incurred in the last quarter which would have a positive impact on the Trust's financial position.	**ROHTB (1/21) 013**
• **Quality & Safety – key highlights** It was reported that the Committee was keeping close oversight on quality and safety through the pandemic.	**ROHTB (1/21) 014**
• **Staff Experience & OD – assurance report** It was noted that the virtual staff walkabouts would be held every six weeks.	**ROHTB (1/21) 015**
13 Performance reports: *for assurance* • **Quality & Safety**	**ROHTB (1/21) 016**
The report was received and noted.	
• **Finance & Performance**	**ROHTB (1/21) 017**
The report was received and noted.	
14 Meeting effectiveness	**Verbal**
Noting that this was to be the last meeting Chaired by Yve Buckand, Brian Toner, the lead governor highlighted that Yve was leaving the Board in a good place. Brian observed that there appeared to be total Board engagement in the running of the organisation, a situation much improved from the time he had joined. The governors offered the best wishes to Yve and it was agreed that she would be very much missed and was thanked for her chairmanship. Yve commented that the Council was very strong under Brian's leadership and there were some particularly effective individuals who were serving as governors.	
15 Any Other Business	**Verbal**
There was none.	
16 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 3 March 2021 @ 0900h.	

PUBLIC SESSION

Next Meeting: 3 March 2021, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 26.2.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 079	Patient story – JointCare follow up	Presentation	05/06/2019	Schedule in a presentation about JointCare into the Board Workplan	SGL	~~06/11/2019~~ ~~04/03/2020~~ ~~01/04/2020~~ ~~13/01/2021~~ 30/05/2021	Service partially suspended. Will look to identify patients who may have received virtual experience to present at the beginning of the next financial year.	C-19
ROHTBACT. 086	Carbon Reduction Strategy annual report	ROHTB (9/19) 020 ROHTB (9/19) 020 (a)	04/09/2019	Present a plan to create a carbon-neutral hospital to the Board at a future meeting	PB	~~31/03/2020~~ ~~13/01/2021~~ 7/04/2021	To be rescheduled for the ~~January~~ April 2021 meeting.	C-19
ROHTBACT. 089	Update from Staff Experience & OD Committee	ROHTB (11/19) 004 ROHTB (11/19) 005	06/11/2019	Present an overview of talent management to the Board at a future meeting	JWI	~~03/06/2020~~ 03/03/2021	To be rescheduled to the end of the financial year	C-19
ROHTBACT. 091	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for the Guardian of Safe Working to present an update to the Trust Board	JWI	~~01/07/2020~~ ~~13/01/2021~~ 3/03/2021	New individual appointed and will join the Board in ~~January~~ March 2021	C-19
ROHTBACT. 093	'Partnerships' extract of the Board Assurance Framework	ROHTB (3/20) 002 ROHTB (3/30) 002 (a)	04/03/2020	Provide a quarterly update on innovation to the Board	PB	~~04/11/2020~~ 7/04/2021	First report due at the April 2021 meeting.	
ROHTBACT. 096	NHS People Plan	ROHTB (9/20) 001 (b) ROHTB (9/20) 001 (b) (i) ROHTB (9/20) 001 (b) (iii)	02/09/2020	Present an overview of the progress with the Trust's version of the NHS People Plan at the March 2021 meeting	SM	03-Mar-21	To be scheduled	C-19
ROHTBACT. 092	Trust's response to the Paterson Report	ROHTB (3/20) 012 ROHTB (3/20) 012 (a)	04/03/2020	Arrange a briefing session on the Paterson Report	MR	07-Apr-21	To be scheduled	

ROHTBACT. 099	External Well led assessment and action plan	ROHTB (11/20) 006 ROHTB (11/20) 006 (a)	04/11/2020	Consider whether there is benefit in establishing a Digital Subcommittee of the Board	TP	01-Apr-21	ACTION NOT YET DUE	
ROHTBACT. 080	Chairman's & Chief Executive's update	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	05/06/2019	Organise for a demonstration of control charts to be presented to the Board	JWI	~~02/10/2019~~ ~~05/02/2020~~ ~~06/05/2020~~ 02/12/2020	Arranged for the December meeting of the Trust Board	
ROHTBACT. 083	Mental Health update	ROHTB (9/19) 008 ROHTB (9/19) 008 (a)	04/09/2019	Arrange for the Trust Board to be trained in mental health requirements	SGL	~~31/01/2019~~ 01/04/2020	Dates for Mental Health First Aid training to be circulated - this is a two day course. Details provided and will be re-circulated to Board members for those wishing to commit to the course.	
ROHTBACT. 090	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for a registrar to present their story to the Staff Experience & OD Committee	SGL	23-Jun-20	Individual to be invited to the November meeting of the Staff Experience & OD Committee. Registrar presented their experience at QSC in 2020, which addressed this action.	
ROHTBACT. 095	Chairman's and Chief Executive's update	ROHTB (9/20) 001 ROHTB (9/20) 001 (a)	02/09/2020	Present the clinical strategy to the Board when developed	MR	13-Jan-21	Included in papers for the January 2021 meeting.	
ROHTBACT. 097	Risk assessment of hospital environment	ROHTB (9/20) 005 ROHTB (9/20) 005 (a)	02/09/2020	Present an overview of the role of the Director of Infection Prevention and Control at a future meeting	GM	30-Nov-20	Role description circulated to the Board.	
ROHTBACT. 098	Progress on restoration and recovery	Verbal	04/11/2020	Circulate details of the virtual 'Coffee Catch up' sessions	SGL	30-Nov-20	Circulated and some NED attended	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**3 March 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		x

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Trust Board in Public on 3rd March 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board meeting held on the 13th January 2021 from the Chief Executive's position, this includes an overall update, wider ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 The response to Covid-19 pressures continue to dominate our activities directly and indirectly whilst we continue to support our system partners. I am extremely grateful and proud of the ROH team and to colleagues across the Trust who have volunteered to work at University Hospitals Birmingham NHSFT (UHB), working alongside and supporting their teams in the Intensive Care Units (ICU) across the sites.

On Tuesday 24th February as part of the weekly CEO NHSI Midlands and East briefing, we were joined unexpectedly by HRH The Duke of Cambridge who thanked all our teams for their contribution to the Covid pandemic. The Duke not only expressed his thanks and admiration for our teams but also enquired about everyone's own health and wellbeing. It was a real privilege for me to join the conversation but it was difficult not to feel such an immense sense of pride in the ROH team, who have and continued to be truly amazing.

2.2 Our finalised performance figure against the national flu campaign was 80.8% for front line staff and I am extremely pleased to see such a fantastic improvement against last year's performance.

2.3 We have received the final NHS Staff Survey results for 2020 which will be reviewed at Staff Experience and OD Committee in March 2021, with a full report and action plan being presented to Trust Board in April 2021. The survey is embargoed until 11th March 2021 and I am working with the team to agree the communications to support the national release. Until this date we will not know where we sit nationally with our results but we have agreed to share these with HR Directors across the BSol system for benchmarking and learning opportunities. We are still awaiting the verbatim comments.

2.4 Regrettably, our mandatory training position has deteriorated and so some remedial work to address the position has been agreed, with each member of the Executive Team now having a full list of those members of staff who need to complete their training. Staff will be asked to undertake their training, taking advantage of this time when activity is reduced. There will be routine oversight of the progress with returning to an acceptable level of compliance at the weekly Executive Team meetings and through the Staff Experience & OD Committee and the

Quality & Safety Committee. Alongside this, the training packages will be reviewed to ensure that they are as accessible as possible and their content is refreshed where needed.

2.5 We plan to review current arrangements for staff and patient parking charges at the end of February, with a view to reintroducing them at the start of April 21. Charges have been suspended throughout the pandemic.

2.6 At our relationship meeting with the CQC we have been advised that they are likely to undertake a virtual inspection of Diagnostic services in April 2021 and a Well Led virtual assurance inspection at the end of April 2021/beginning of May 2021. The inspection will not be rated and this will be used to help the CQC to see if they need to undertake a full inspection on site. Further information is expected but the Executives have already started the planning for the inspections and progress will be reported at the Trust Board meeting in April 2021.

2.7 I am delighted to announce that in February 2021, the Trust appointed Nicola Brockie to the post of Deputy Director of Nursing. Nicola joins us from Plymouth NHS Trust and I'm sure she will have an opportunity to meet with you all when she commences later this year. I would like to thank Christian Ward who has acted into the role over the last 14 months for his contribution.

2.8 We have commenced the process for the recruitment to the post of Director of People and Organisation Development with interview planned for late March 2021.

2.9 On Friday 26th February, we updated all staff that they would receive a "Wellbeing Day" which would be added to their annual leave entitlement for this year. Whilst we continue to offer daily our heartfelt thanks for everything which our teams have done over the last 12 months in the fight against Covid, I hope that this is an additional gesture to show staff how we appreciate everything they have done and how important their own wellbeing is.

2.10 On 8th March 2021, the Trust will celebrate International Women's Day and our Equality and Diversity Network are finalising their plans. This year the theme is #ChoosetoChallenge and we are encouraging colleagues who are able to participate to wear something Purple or Green, and take selfies to post, using the # to call out what they would like to challenge under the guidance of the 9 Protected Characteristics.

2.11 To celebrate LGBT+ History Month, the Trust has raised the Progress Flag. The updated design includes, in addition to the usual rainbow colours, black and brown stripes to represent marginalised LGBT+ communities of colour, along with the colours pink, light blue and white, which are used on the Transgender Pride Flag. The flag was raised by Medical Director, Matt Revell and Research Governance & Contracts Manager, Craig Pinner and was witnessed by a small group of staff from across the Trust.

3 BSol ICS (Integrated Care System) Update

3.1 The next BSoL ICS Board is due to take place on Monday 15th March 2021 where the system recovery restoration programme will be agreed.

3.2 As ICS lead for the post-Covid pathway, I was delighted to present the programme report on behalf of the system at the February ICS Board. Whilst our involvement has been to support the development of the multi-disciplinary pathway, I am extremely grateful for the programme oversight and leadership role which our team have played. Rebecca Lloyd, Amos Mallard and Alicia Stanton have been fantastic and truly showcased the expertise and talent which we have at the Trust. I have no doubt that the relationships which they have built across the system will be invaluable as we now start work on the system Orthopaedic recovery plan. It was great to also have Jaguar Landrover contact me to work with them so they can introduce a similar pathway for their team and I am sure that this will lead to shared learning across our system.

4 NHSI/E National updates

4.1 Weekly briefing calls remain in place with NHSI still with the current focus being on the vaccination programme being delivered across the Midlands and East region.

4.2 A national communication has been issued to advise that a consultation exercise will commence around a proposed amendment to licence condition G4 of the NHS provider licence. Appendix 1 (ROHTB (3/21) 001 (b)) provides greater detail.

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, the following policies have been approved:

- Maintaining High professional standards policy
- Recruitment and selcection of medical consultant staff

Routine reports on policies are also presented to the Executive Team to provide additional oversight and assurance that they are being reviewed in a timely way.

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

26th February 2021

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Proposed amendment to licence condition G4 of the NHS provider licence**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**3 March 2021**

EXECUTIVE SUMMARY:

Each year, the Trust is required to make a self-certification that it is compliant with the terms of its Foundation Trust licence. The licence comprises a number of standard conditions covering all aspects of governance, finance and operations.

NHS Improvement has recently advised that it is proposing to modify standard condition G4 of the provider licence: Fit and proper persons as Directors (also applicable to those performing equivalent or similar functions). A copy of condition G4 in its current form can be found below. The proposal is largely a technical amendment designed to align condition G4 with the fit and proper persons requirements set out in the FPP Regulations.

Reason for the proposed modification

Licence condition G4 applies to all providers holding an NHS provider licence and, by way of directions, also applies to NHS trusts. It requires that providers ensure that their directors and governors meet appropriate standards of personal behaviours and technical competence. The objective is to prevent an unfit person from holding office as a director or governor.

Since publication of the NHS provider licence, regulation 5 of the FPP Regulations has come into force. Regulation 5 sets out a fit and proper person's test (the FPP test) which applies to directors of all NHS providers registered with the Care Quality Commission, which includes all licence holders and other organisations to which licence conditions apply.

To ensure consistency of approach with the FPP Regulations, it is proposed to make some technical amendments to condition G4.

Although the FPP Regulations do not apply to governors of NHS foundation trusts, it is proposed that the provisions of condition G4 relating to governors is updated to reflect current practices.

Proposed modifications

While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:

a. qualifications, competence, skills, experience and ability to properly perform the functions of a director
b. issues of serious misconduct or mismanagement and
c. disbarment in relation to safeguarding vulnerable groups and disqualification from office.

In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.

The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.

The effect of the modification is also to remove provisions which have become redundant and bring the provisions in line with current working practices.

Further amendments proposed affect the provisions with reference to Monitor's discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.

The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors' Disqualification Act 1986. As this provision expressly relates to directors' fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors. For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

Consultation

Any proposals to modify the standard conditions of the NHS provider licence are subject to a statutory consultation process under the 2012 Act. The consultantion closes on 29 March 2021, to which all providers are invited to respond. As the lead for co-ordinating the self-assessment against the provider

lience, the Director of Corporate Affairs will respond on behalf of the ROH.

REPORT RECOMMENDATION:

The Board is asked to:

- NOTE the plans to amend licence condition G4 of the provider licence and the consultation process

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

Compliance with terms of the ROH's provider licence

PREVIOUS CONSIDERATION:

None.

Refresh and Recovery – Update to the Trust Board in March 2021

PROGRAMME:	**Refresh and Recovery**	**PROGRAMME MANAGER:**	**Alicia Stanton**	**DATE:**	**18/02/2021**
PROJECTS:	**Pre –operative and Scheduling / Inpatients / Outpatients / Workforce and Wellbeing**	**EXEC SPONSOR:**	**Marie Peplow Matt Revell**		

MILESTONES ACHIEVED

- Governance structure established and endorsed at February Trust board meeting
- Triumvirate Project Groups and leads established
- Transfer of UHB rehabilitation patients ceased 15/02/2021
- Bespoke wellbeing pack in development for the return of redeployed staff
- Patient clinical Prioritisation paper submitted for approval at R and R Programme board.

ISSUES/CONCERNS/RISKS IDENTIFIED

- Capacity for group members to attend meetings and complete actions- competing operational priorities.

DECISIONS / SUPPORT REQUIRED

- Additional interim Operational support required currently being sourced
- ROH P2/3 patients to be booked in March whilst system plan agreed
- Imaging/ therapy services recommenced 8/2/2021

WORK PLANNED (MONTH AHEAD)

- To agree sequence for the return of all redeployed staff
- Deliver bespoke wellbeing package of support
- To establish project group aims and objectives
- R&R Board to commence w/c 01/03/21
- Complete Programme Plan and agree Timelines.
- Outpatients restart w/c 22/02/21
- Deep clean and remedial estates work plan for wards and theatres agreed
- Incorporating system plans for Restoration and Recovery
- Agree communication strategy internally and externally

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Covid Outbreaks Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh – Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Christian Ward – Acting Deputy Director of Nursing and Victoria Clewer - IPC Matron**
DATE OF MEETING:	**3 March 2021**

EXECUTIVE SUMMARY:

1. Outbreaks

1.1. To date the Trust has experienced six outbreaks associated with COVID-19.

1.2. The outbreaks have been within the following areas:

Area/Dept.	Date Outbreak Declared	Date Outbreak Closed	Total № of +ve Staff	Total № of +ve Patients	Total number of Patients diagnosed at 3 - 7 days (Indeterminate)	Total № of Patients diagnosed at 8 - 14 days (probable)	Total № of Patients diagnosed at 15+ days (definite)
Pharmacy	03/09/2020	03/09/2020	3	N/A	N/A	N/A	N/A
Imaging	17/10/2020		9	N/A	N/A	N/A	N/A
Oncology	19/10/2020		9	N/A	N/A	N/A	N/A
Ward 1	15/11/2020		1	2			
Ward 2	09/12/2020	09/01/2021	1	4	3	0	1
Ward 3 (10/12)	11/01/2021	N/A	9	7	3	3	1
Ward 3	05/02/2021	N/A	0	2	2	0	0
Pharmacy	18/02/2021		2	N/A	N/A	N/A	N/A

1.3. The most recent outbreaks occurred during January and February 2021 in the following areas:

1.4. Ward 3 (Ward 10/12) – 08/01/2021

1.4.1. Outbreak which started in a four bedded bay on ward 3 which spread across several patients. Mass testing of all ward staff identified an initial five positive staff. During the outbreak the ward and staff were moved across to ward 10/12 (to create more beds for UHB rehab patients on ward 3). This move led to further positive patient and staff cases, branching off into the Operations team. See the

table above for final positive cases as of 12/02/2021. The last case identified was on 19/01/2021 – if no new cases are identified before 16/02/21 the outbreak will be closed.

1.4.2. Key causation is believed to be a patient (index case) who disclosed they had regular contact with their son (dropping off shopping etc.) during their isolation period, prior to admission. The son tested positive for COVID on 05/01/21. This was reported to the ward on 06/01/21 but no action taken – the patient was not isolated – the IPCT were not informed until the patient developed symptoms on 08/01/21.

1.4.3. This outbreak led to ward 10/12 being closed to admissions and transfers which resulted in some service delivery issues.

1.4.4. Whilst it is difficult to identify an exact mode of transmission, it is likely that patient contamination of the shared environment occurred. We must also factor in patient and staff hand hygiene as well as environmental cleanliness which are all contributory factors. For assurance, regular hand hygiene and environmental inspections were undertaken in which no significant non-compliances were observed.

1.4.5. From the identification of the index case symptoms, IPC measures were instigated to control potential transmission and risk of infection to others. The index case was isolated on 08/01/21 in a single room on ward 3 pending COVID test results. The contacts of this patient were also isolated where possible and tested. Ward management and staff were supported by IPC to ensure they had the necessary equipment, PPE and resources to safely manage this incident. On 19/01/21 wards 10 and 12 were split to better cohort nurse positive patients and contacts/asymptomatic patients.

1.4.6. Throughout the outbreak, vacated bed spaces were cleaned using detergent and chlorine solution following the COVID clean guidance. Facilities were informed of the developing situation and the ward cleaning was increased to enhanced to incorporate frequent touch point cleans of common and shared spaces.

1.5. Ward 3 Outbreak – 03/02/2021

1.5.1. Outbreak confined to patients on ward 3 – amber pathway. Started in a four bedded bay, 2 positive patients identified with a further two asymptomatic contacts. Both positive patients were transfers from QEHB. The index case was a contact of a positive COVID patient on 12/01/21 whilst an inpatient on Ward West 1 at QEHB. The patient had completed 14 days isolation on ward 728 at QEHB and tested negative before transfer to ward 3 ROH on 29/01/21. Index patient asymptomatic but identified via routine inpatient swabs. Second case was a contact of the index in bay 12 on ward 3, also a transfer from QEHB – was known to have non-resolving pyrexia whilst at QEHB and on

admission to ROH – although had multiple negative COVID swabs.

1.5.2. It is likely that both patients were incubating COVID prior to admission to ROH however we are unable to rule out patient to patient transmission whilst in bay 12 on ward 3. There were no concerns with ward cleanliness or hand hygiene/personal protective equipment usage before or during the outbreak on ward 3.

1.5.3. Due to unavailability of single rooms on ward 3 and elsewhere in the hospital, the contacts (asymptomatic) were cohort nursed in bay 12, with a dedicated nurse. They were moved to single rooms as soon as they became available. Vacated bed spaces reviewed COVID cleans. From the initial identification of symptoms, facilities were instructed to perform enhanced cleans of touch points and common spaces/shared facilities. Awareness of developing issues was heightened across all staff.

1.5.4. The outbreak is still active and under investigation and review by the outbreak management team. Regular contact is made with the ward by IPCT to offer support and guidance. There have been no impacts on service provision to date.

1.6. Pharmacy Outbreak – 18/02/2021

1.6.1. The Pharmacy outbreak from 18/02/2021 is currently contained to two members of staff with all identified contacts PPE compliant. Further work is necessary to see if on the balance of probabilities the cases are related or incidental (due to outside family/community contacts).

1.6.2. Initial actions were to create business continuity by identifying and isolating non-contacts, this group of pharmacy staff could then continue to visit wards and reconcile prescription charts within the hospital without risk.

1.6.3. All other pharmacy staff were restricted to working within Pharmacy only and separated into 1 of 2 areas only within the department to further limit potential cross contamination.

1.6.4. Further to this all staff were swabbed as part of a mass testing out of a abundance of caution, not as a result of any PPE breach. No further symptomatic or positive cases have been identified.

1.6.5. Subsequently, on microbiology agreement the initial additional measures were removed from the 25/02/2021 and the pharmacy returned to normal covid secure operational activity and practice.

REPORT RECOMMENDATION:

The Board is asked to receive this update for information.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

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

Outstanding Care – Patients
Exceptional Patient Experience and Outcomes - Patients
Culture of Continuous Improvement - Process

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 24 February 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Mortality Report & Learning from Deaths update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revell, Executive Medical Director and Ashleigh Tullett, Head of Clinical Governance**
DATE OF MEETING:	**3 March 2021**

EXECUTIVE SUMMARY:

The Trust has a qualitative approach (Learning from Deaths) and a quantitative approach (In Focus: Mortality Review) for assessment of patient deaths.

The statutory requirement for Learning from Deaths is a quarterly report to Board for deaths in hospital. This includes a dashboard that the Trust publishes on its website. Since August 2020, objectivity and speed have been improved by the engagement of the regional Medical Examiner Service. The service provides the mortality review for any death in the hospital.

The current quantitative (Mortality Review) report acquired from hospital data systems is included in the appendix.

A significant peak in mortality relating to the Covid-19 pandemic of 2020 has been discussed in previous detailed reports. All recording methods demonstrate an extraordinary rise in mortality during late Spring 2020. The peak is temporally associated with the ROH providing the regional fractured neck of femur service and the first Covid-19 pandemic wave. Outside this major consideration, there have been no major shortfalls in care declared since the last review.

REPORT RECOMMENDATION:

The Board is asked to note the plan to continue the work improving:

- cycle times for qualitative (Learning from Deaths) assessments
- communication around the process, particularly feedback to clinical teams

and the continued work to develop and automate the quantitative mortality report (Mortality Review)

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Patients, Process, Performance HF Domains: Safe Care, Efficient Care, Effective Care, Patient Centred Care, Timely Care, Equitable Care
PREVIOUS CONSIDERATION:
Quality & safety Committee on 24 February 2021.

Introduction

The Trust has a *qualitative* approach (Learning from Deaths) and a *quantitative* approach (In Focus: Mortality Review) to assessing care after a patient dies.

Method

Learning from Deaths

The process for Learning from Deaths is set out in full in the Learning from Deaths Policy. It is a screening tool and triggers a Root Cause Analysis if significant shortfalls in care or documentation are found.

Deaths in hospital are notified to governance by the clinical teams and the bereavement team. Cause of death and a review of the quality of care are carried out by the Medical Examiner service. The information from that report is fed into the learning from deaths tracker maintained by the governance department and overseen by the Associate Medical Director (Corporate).

Deaths out of hospital may be reported by the clinical team, if they are known. They are also sourced through informatics from Office of National Statistics data and the Patient Administration System.

The Learning from Deaths tracker, produced by the Governance department, is included in the Quality Report at Quality and Safety Committee.

The Learning from Deaths dashboard maintained by the governance department and published on the Trust website.

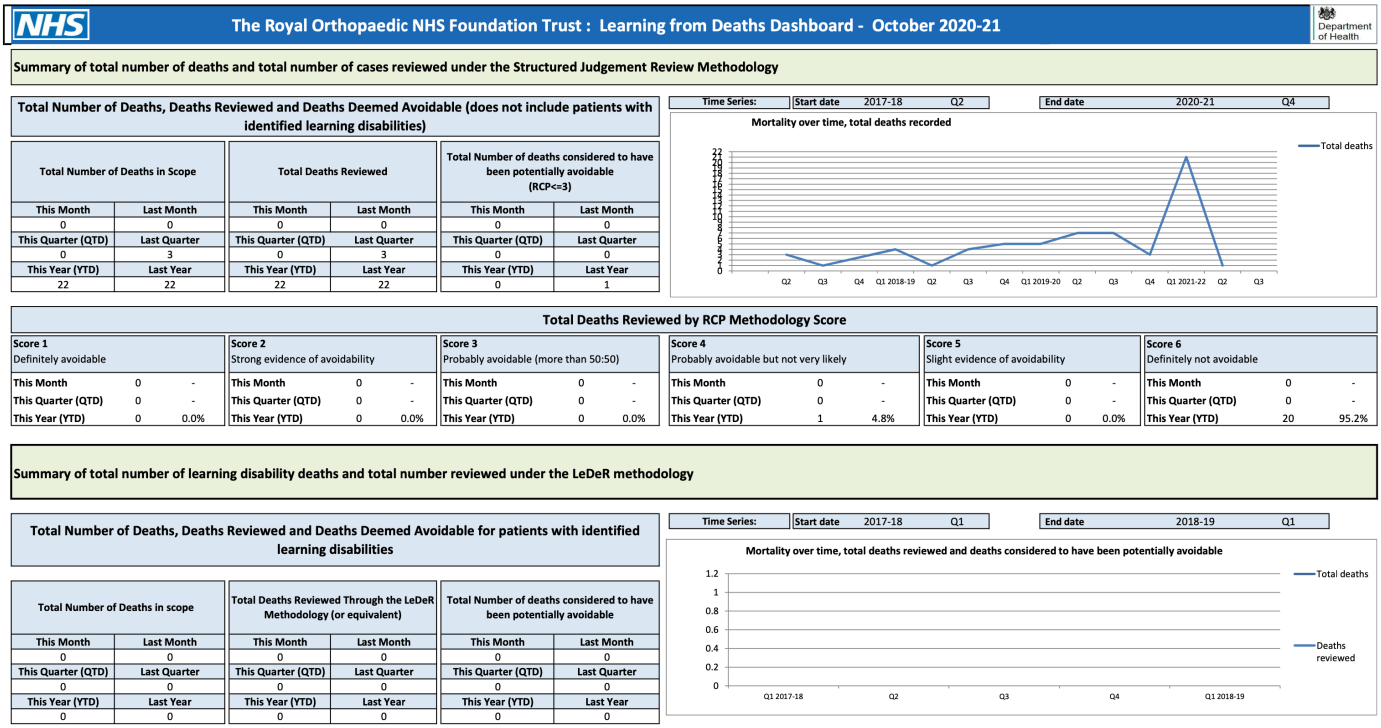
The statutory requirement for Learning from Deaths is a quarterly report to Board for deaths in hospital. This should include the dashboard which the Trust publishes on its website. The ROH Learning from Deaths policy has been revised recently. It now takes account of the Medical Examiner Service which the Trust has engaged to support mortality review for deaths in hospital. The Trust continues to review deaths out of hospital occurring within 30 days of discharge, exceeding the national requirement.

Mortality Review

The quantitative review is part of the AQILA Patient Progress Report development programme. There have been recent improvements in the business intelligence side of the process. These have allowed more accurate real-time quantification of deaths within 30 days using Patient Administration System data. They also support a patient level report based on hospital data to support the Learning from Deaths tracker. Consequently, we anticipate reduced process cycle times and a lighter administrative burden within Governance, where the Learning from Deaths process is administered.

The current Mortality review is included in Appendix 1. It describes the Trust approach to mortality analysis in detail. Data is sourced from Hospital Episode Statistics data through the Health Evaluation Data website as well as the Trusts internal informatics tables.

Reports are generated using Tableau reporting software, JMP statistical software (for the SPC charts) and the Adobe InDesign desktop publishing tool.



NHS The Royal Orthopaedic NHS Foundation Trust : Learning from Deaths Dashboard - October 2020-21

Department of Health

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	3	0	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
22	22	22	22	0	1

Time Series: Start date 2017-18 Q2 End date 2020-21 Q4

Mortality over time, total deaths recorded

Total deaths

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	4.8%	This Year (YTD)	0	0.0%	This Year (YTD)	20	95.2%

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

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

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

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable

Total deaths

Deaths reviewed

Figure 1: Current Published Learning from Deaths Dashboard

Findings

The Trust Learning from Deaths dashboard is shown in Figure 1

The current Mortality review is included in Appendix 1.

The qualitative analysis, the Trust dashboard and the Statistical Process Control chart all demonstrate the rise in Covid deaths during late Spring 2020, during which time the Trust was treating extremely frail patients with fractured neck of femur. After that there is a recovery to baseline mortality rates.

There have been no major concerns raised about the overall quality of care for any patient who died since the last report.

Recommendations

The team will continue to improve cycle times for the process and communication around the bereavement and learning from deaths process.
Reporting back individual issues to the clinical teams has been improved using Ulysses incident tracking – to be kept under evaluation.

Appendix 1 – Mortality Review

SAFE CARE

Mortality

Mortality

Background & Our Approach

The Mortality dashboard should be taken in context with the Learning from Deaths report. The Trust looks at every death within 30 days of discharge using the Royal College of Physicians Structured Judgement Review (SJR) methodology. The Trust publishes a dashboard summary on the internet and the internal tracker is included in the Quality Report at the Quality and Safety Committee.

In-hospital deaths
From August 2020, the Trust has also employed the services of the regional Medical Examiner Service. This provides objective (external) experienced medical input for in-hospital death reviews and employs a similar methodology to the SJR.

Out-of-hospital deaths
Clinical units and governance follow up on patients who have been transferred out of the hospital. There is sometimes a time delay in obtaining accurate information in the event of a death in another Trusts. We also check mortality statistics from the Office of National Statistics; these come with a minimum 30 day lag and complete the picture to include deaths in primary care that may not have been known from the GP or family.

The Learning From Deaths process has a defined scope of 30 days. We do not limit our governance reviews to 30 days, particularly if a death was part of the same spell of care or if there is important learning from the case.

Benchmarking is best done against the two other stand-alone specialist Orthopaedic Trusts because case mix and mortality rates are similar. These are the Royal National Orthopaedic Hospital (RNOH) in Stanmore and The Robert Jones and Agnes Hunt Hospital (RJAH) in Oswestry. The figures include cancer patients. RNOH and ROH take on significant volumes of cancer cases; there are fewer at RJAH. During the course of our work there are patients who come for a diagnostic procedure, following which a shared decision is made with the team that treatment will continue along a palliative route.

Deaths are relatively rare events and there is the possibility of relatively large swings in apparent numbers based on one or two cases. It is for this reason that we monitor the "crude" mortality rate and maintain emphasis on understanding the narrative behind each individual case. The use of 12 month rolling averages provides a degree of smoothing that can be useful for visualising trends by mitigating for common cause variation. Statistical Process Control (SPC) charts assist also in detecting special cause variation. It should be noted that a large change (such as experienced during Covid-19 first peak) will, by definition, remain on the 12 month rolling average indices for a year after the event.

The Hospital Standardised Mortality Rate (HSMR) is an estimate of the number of expected deaths based on case mix (a weighting taking into account the other conditions a patient has). Another commonly used metric in Trusts is the Standardised Hospital Mortality Index (SHMI). These cannot safely be applied for the Royal Orthopaedic Hospital because of our specialist work, with a resultant skew on our case mix.

There are two metrics designed to pick up any differences in care based on day of the week of admission. Historical use of these has suggested that this is not a significant factor in cases at the ROH and the metrics are probably more useful in the general hospital context to monitor care around large numbers of emergency admissions. These are monitored but therefore not regularly included in this report.

The dashboard data is taken from the Health Evaluation Data system administered by University Hospital Birmingham. The data is derived from the Hospital Episode Statistics and Office for National Statistics data. The data is available 3 months in arrears. The 90 day mortality from Pulmonary Embolus is published in the VTE dashboard.

Group	Timely monitoring	Data source
In-hospital deaths	*Real time*	*Clinicians, Governance, Medical Examiners*
Deaths within 30 days	*1 to 3 months*	*- Clinician reported* *- HED/ONS sourced*
Deaths out-of-hospital beyond 30 days	*3 months*	*Clinician reported and periodic mortality reviews (HED)*

Mortality

Analysis

The area chart in Figure 1 shows the relative proportions of deaths in hospital, within the 30 days Learning from Deaths scope and other deaths within 90 days (source HED Data). Colours represent 3 Mortality Outcome Zones – deaths in hospital, deaths within 30 days and deaths within 90 days. The blue zone represents the national standard for inclusion and presently the cases covered by the Medical Examiner service. The blue and green areas represent pit current scope for the Learning from Deaths process. The yellow zone is currently outside the Learning from Deaths process as defined by our policy, but within a clinically meaningful interval post operatively and overseen through more general clinical governance.

Figure 2 is a Statistical Process Control chart of Deaths within 30 Days. Confidence limits have been set to take account of monitoring rare events.

Both Figure 1 and Figure 2 confirm that there was a peak in mortality during the first quarter of 2020–2021 associated with the first wave of the Covid–19 pandemic. Figure 1 confirms that this occurred in all 3 outcome zones). Figure 2 confirms that for 30 day mortality, this is likely to be a special cause (Covid–19). These deaths have been examined in detail in a previous report. The increase was linked to both a change in our case mix as the role of the ROH changed temporarily during the early pandemic and to cases of Covid–19 itself.

Figure 3 shows the recorded admission diagnosis of historical deaths. This confirms that cancer deaths predominate in normal times. The peak in deaths relating to patients who had fractured neck of femur as their coded diagnosis on admission is also evident.

Figure 4 shows the place of death for the ROH historical series. Death in hospital at the ROH is commonest with home the second commonest place of death

Figure 5 shows age distribution with a peak between 70 and 75.

Figure 6 shows the operating theatre for the historical series. The peak in 2020 for theatre 9 represents is usage for fractured neck of femur patients.

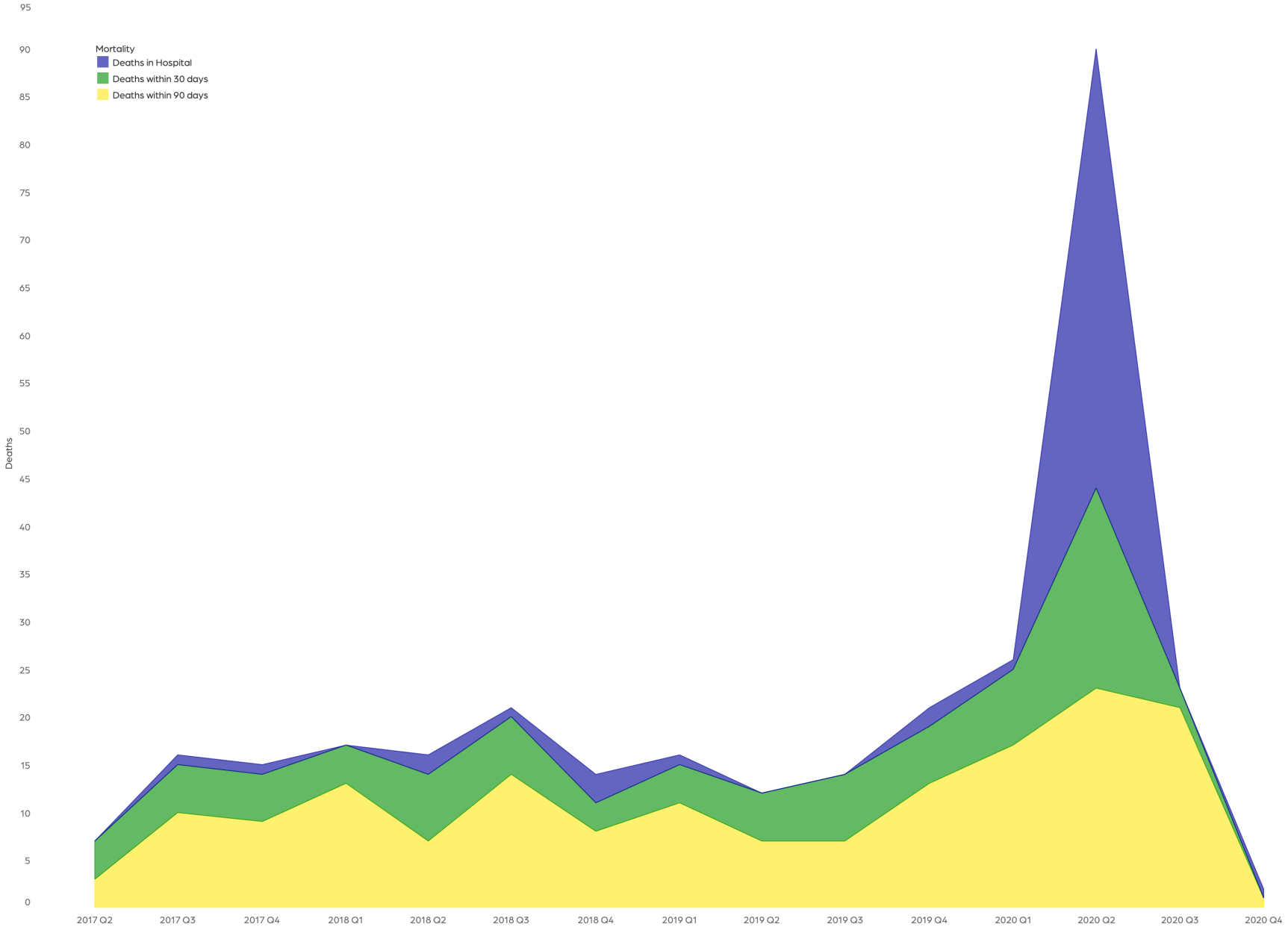
Recommendations

Data is fed back to clinical units for Morbidity and Mortality review and clinical governance process as necessary.

Continue to mature reporting and improve reporting times.

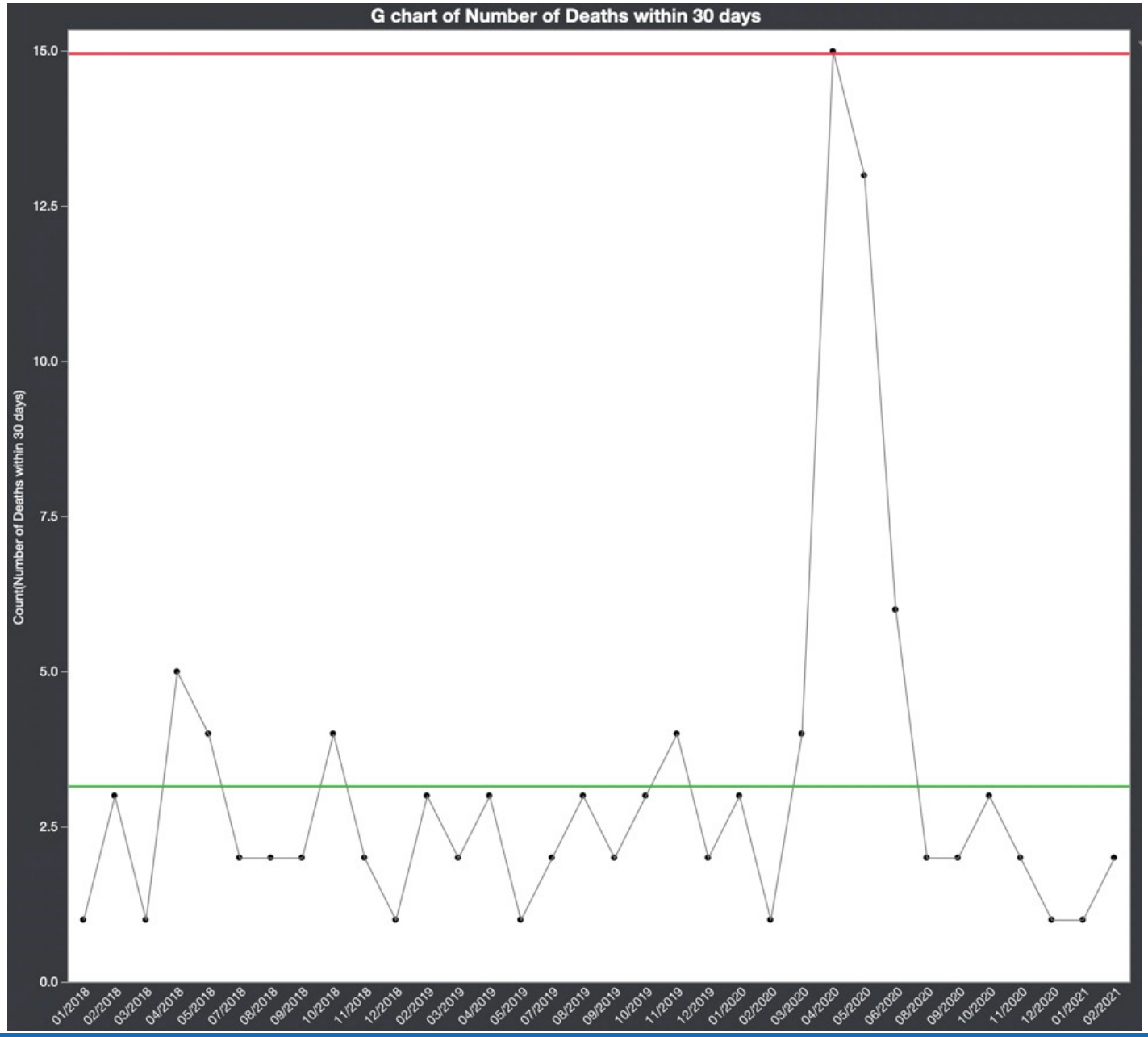
Mortality

Figure 1



Mortality

Figure 2



Mortality

Figure 3

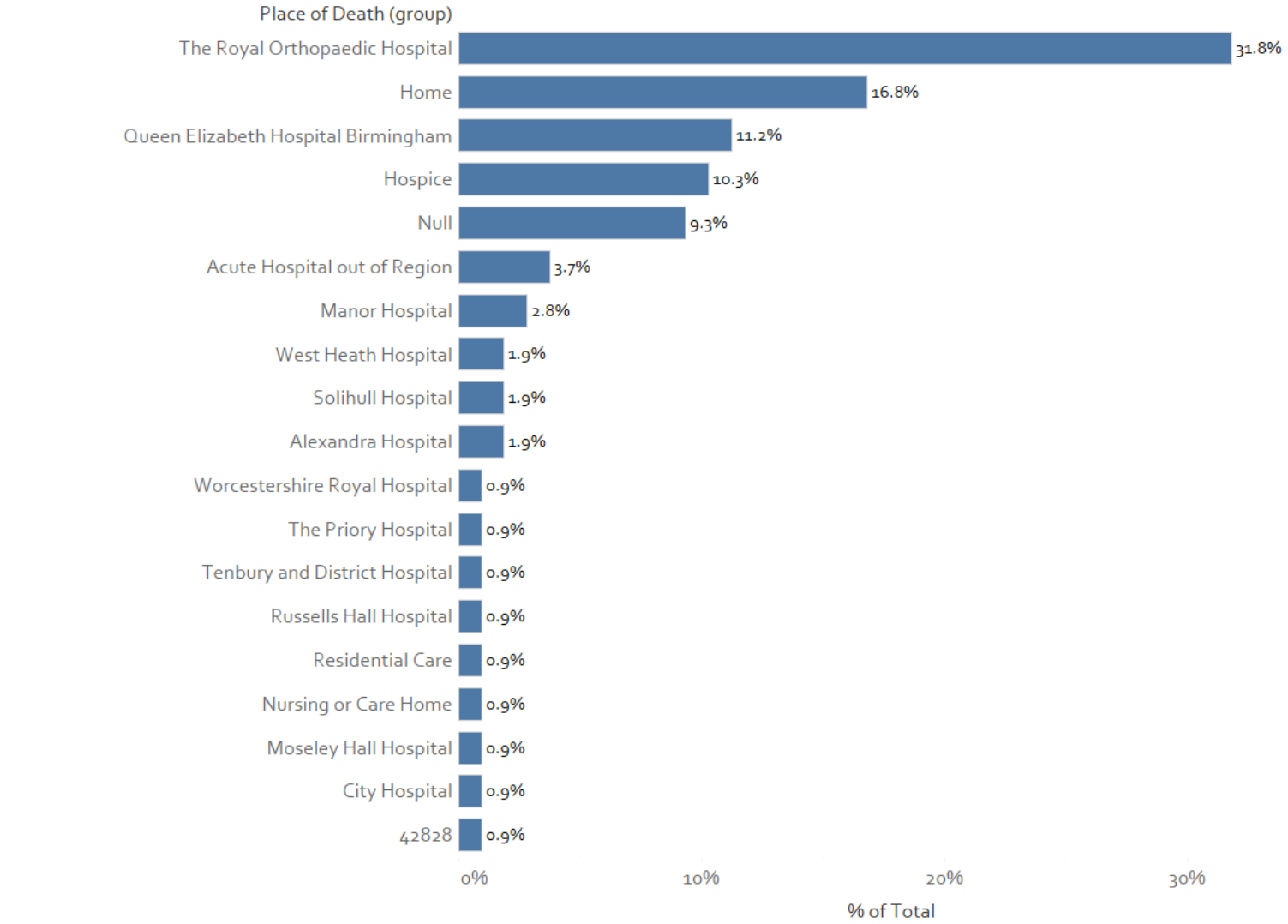
Admission Diagnosis of Patients Who Died in Hospital or Within 30 Days of Discharge January 2018 to January 2021

Diagnosis Grouping - CCS (of admission)	2018	2019	2020	2021
Null	2	1	4	3
21 - Cancer of bone and connective tissue	1	2		
42 - Secondary malignancies	4	1	1	
44 - Neoplasms of unspecified nature or uncertain behavior		1	1	
95 - Other nervous system disorders	2			
203 - Osteoarthritis	2	1		
207 - Pathological fracture	1			
212 - Other bone disease and musculoskeletal deformities	2			
225 - Joint disorders and dislocations; trauma-related			1	
226 - Fracture of neck of femur (hip)			20	
237 - Complication of device; implant or graft		1	4	
238 - Complications of surgical procedures or medical care	1		2	

Mortality

Figure 4

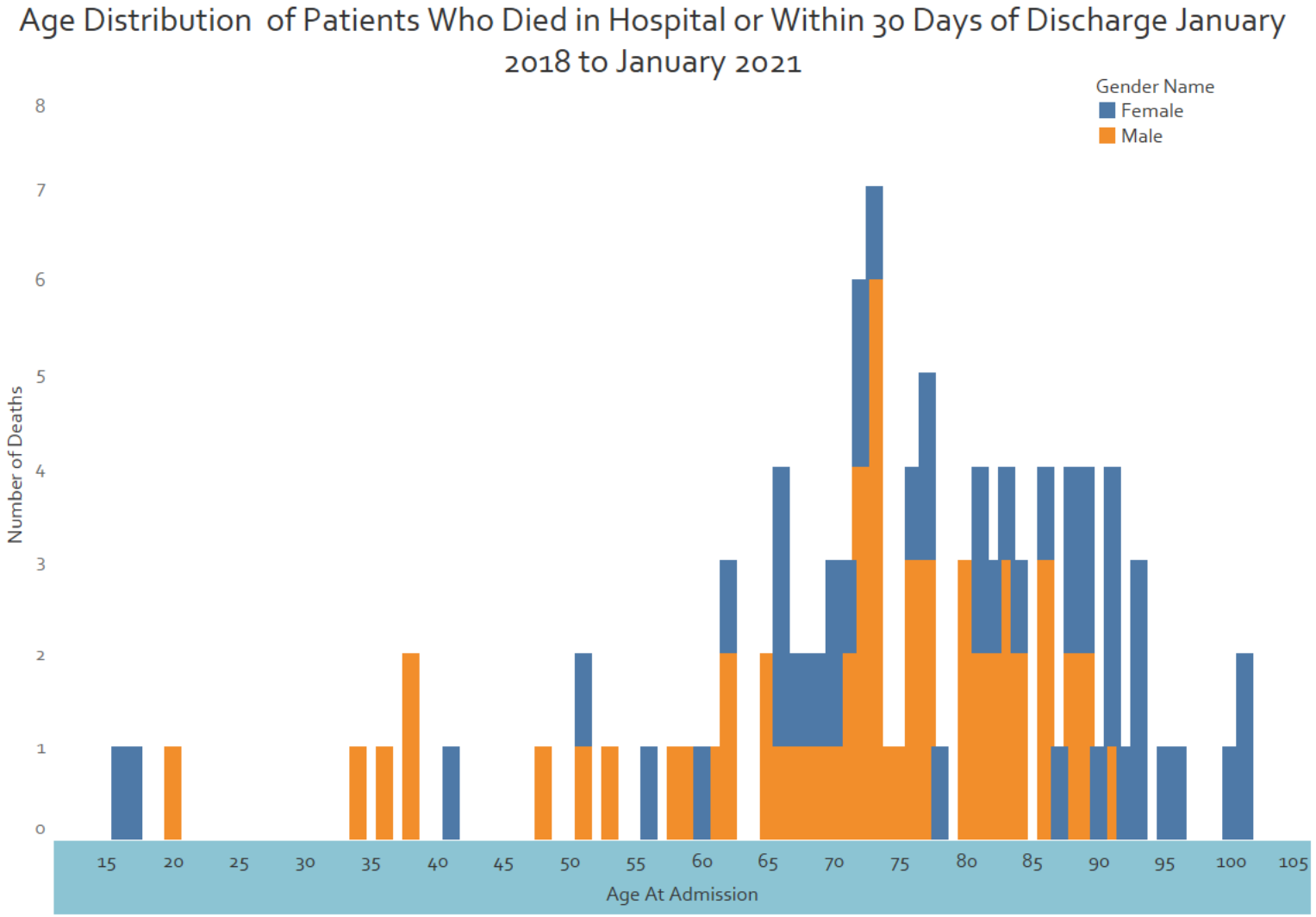
Place of Death of Patients Who Died in Hospital or Within 30 Days of Discharge January 2018 to January 2021



% of Total Count of vwMortalityFromPAS for each Place of Death (group). The marks are labelled by % of Total Count of vwMortalityFromPAS. Details are shown for Date First Month, Date Last Month and Title Extension.

Mortality

Figure 5



Mortality

Figure 6

Theatres of Patients Who Died in Hospital or Within 30 Days of Discharge January 2018 to January 2021

	2018	2019	2020	2021
Null	13	8	21	3
CT Treatment room	3	7	3	
Emergency Theatre	1	2	1	
Theatre 2	3	1	3	
Theatre 3	1		1	
Theatre 5	2	1	1	
Theatre 6	2		1	
Theatre 7	1			
Theatre 8	1	2	1	
Theatre 9		1	13	
Theatre 10		3	2	
Theatre 14			4	
Theatre 15			1	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Chairman and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**3 March 2021**

EXECUTIVE SUMMARY:

Attached is an updated Board Assurance Framework. Each risk has been reviewed and updated by the relevant risk owners.

The following risk has seen an increase to its Controlled Risk Score:

Risk 1472 – Risk relating to cross contamination of Covid possible/Covid positive patients with non-Covid patients. Controlled risk score **increased from 10 to 15**

The following risks have seen a reduction to their Controlled Risk Score:

- Risk FP7 – Risk relating to The Trust potentially experiencing supply chain disruption resulting from a failure to agree a Free Trade Deal. Controlled risk score **reduced from 12 to 8.**
- Risk FP8 – Risk relating to current IT capacity not being able to support ways of working developed during Covid 19 pandemic. Controlled risk score **reduced from 12 to 8.**

The following risks are proposed for closure/de-escalation

- Risk Covid-19 – 031 - There is an increased risk of patient harm for peri-operative patients testing positive for COVID-19. Patients with COVID have a significant morbidity and mortality.
- Risk WF21 – Risk relating to Trust failure to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients.
- Risk WF20 – Risk relating to the tax liability associated with the pension arrangements of some senior clinical staff and its potential to impact activity

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and NOTE the Board Assurance Framework
- CHALLENGE the risk scores (current and target)
- APPROVE the de-escalation or removal of risks Covid-19 – 031, WF21 and WF20
- AGREE to receive an update on further details of any risks of particular interest to the Board at

the next meeting

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	X

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

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

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

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

Aligns to all strategic objectives.

PREVIOUS CONSIDERATION:

The Trust Board last reviewed the Board Assurance Framework at its meeting in November 2020.

BOARD ASSURANCE FRAMEWORK

Risk Ref	Department	Executive Lead	Risk Statement	Risk category	Strategic Objective	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance (Internal, Peer or Independent)	Controlled			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Target risk			Date risk added
							Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating	
PATIENTS																					
1472	Infection Control	Director of Nursing & Clinical Governance/Medical Director	There is a risk that there could be cross contamination of patients that are Covid-positive or Covid-possible with non-Covid patients within clinical areas, causing the spread of the virus in a clinical setting	With safe and efficient processes that are patient centred		Quality & Safety Committee	4	5	20	Pre admission, patients are self isolating for two weeks along with their immediate household Patients are tested for Covid on two occasions pre-admission if they are an elective admission and live within a 30 mile radius of the Trust. Patients admitted from outside of the 30 mile radius are tested on admission. All patients are retested on day 7 of their inpatient stay. Patients admitted as an emergency are admitted into a single admissions area, tested and remain in this area for the duration of their stay. The hospital wards have been designated as 'Covid Protected' and 'Covid Managed', including a review of theatres and diagnostic pathways. National guidance has been reviewed and Trust-relevant local guidance has been produced for all staff to follow. All staff wear appropriate PPE as described in this guidance. Cleaning hours have been increased. All staff are screened on arrival at work for symptoms of Covid and are not allowed to enter the hospital of they are symptomatic. All beds are over two metres apart and shared bathrooms are cleaned with increased frequency. The infection prevention and control team carry out daily reviews of all patients in clinical areas to ensure appropriate isolation has occurred for symptomatic patients. Adherence to 'track and trace' guidance	Updates to Quality & Safety Committee Monthly quality reports Minutes and papers of the Infection Prevention and Control Committee and Infection Prevention Operational Group	3	5	15	↑	Feb 21 - COVID pathways in place to enable the segregation of patients as per their COVID risk (based on period of isolation, source of admission, COVID swabs and symptoms) low, medium and high risk. Ongoing monitoring of the patients on these pathways aims to move patients as required to keep pathways in operation.	Ongoing	2	5	10	Feb-21
OP5	Operations	COO	There is a reluctance by patients to undergo scheduled treatment as a result of the uncertainty created by the Covid-19 pandemic	With safe and efficient processes that are patient centred		Finance & Performance Committee	4	4	16	Consultants have been reviewing their waiting lists and clinically categorising patients using NHSI/Royal College of Surgeons criteria 1a/1b – urgent, 2 - treatment within 4 weeks, 3 – treatment within 12 weeks, 4 – treatment after 12 weeks. Consultants have subsequently contacted patients via telephone in virtual clinics with face to face appointments where clinically appropriate to discuss their current condition and based on medical history, latest scans etc., have clinically decided on when surgery will take place, all of which has been documented in the patients notes. Regular communication is in place with the CCG in a bi- weekly liaison call and a weekly communication update on restoration and recovery is in place for the GP bulletin from September 2020. Comprehensive Patient information leaflets are available and have been developed to help patients make a fully informed decisions regarding their treatment and to offer further reassurance of the changes that have been made to the Trust site to ensure government guidelines are being delivered . This information has been developed with the support of the patient carer forum and Health watch. The ROH website details the changes the Trust has made to maximise safety. The Trust has developed a 'Covid Protected' site, with appropriate zoning arrangements for Covid 'risk managed ' patients in line with government guidance. Keeping in touch calls and discussion between clinician and patient are taking place to provide an opportunity for patients to discuss the risks and make informed decisions documented in patient notes.	Papers from Executive Assurance Group; Recovery and Restoration presentation to Quality & Safety Committee and Finance & Performance Committee	3	4	12	↔	The weekly Patient Tracking List will continue to review the progress of individual patient pathways and document patients who wish to defer treatment in line with RCS guidance to enable monitoring and review of those patients who want to defer treatment so bespoke conversations can be commenced to agree a suitable solution for the ongoing care of the patient . As part of the Trust Refresh and recovery programme patient engagement in developing patient information and education material will be embedded in all working groups.	Ongoing	2	4	8	Feb-21
Covid-19 - 031	Medicine	Medical Director	There is an increased risk of patient harm for peri-operative patients testing positive for COVID-19. Patients with COVID have a significant morbidity and mortality.	With safe and efficient processes that are patient centred		Quality & Safety Committee	5	5	25	Pre-operative individual assessment on the relative risks of surgical and non-surgical treatment. COVID testing and cohorting in place. Vaccination programme rolling out nationally according to plan for national coverage. Staff immunisation underway, with most staff having received the first dose of the vaccine which will reduce the risk of nosocomial transmission through a staff vector.	Learning from Deaths updates; monthly quality reports; minutes and papers from Clinical Audit and Effectiveness Committee	2	5	10	↓	Continued roll out of vaccination programme and continued strong IPCC processes.	Proposed for Closure/de-escalation	2	5	10	Feb-21

OP1	Operations	COO	The current suspension of the Paediatric Oncology service at BCH creates long delays for patients requiring surgery leading to poor patient experience, clinical outcomes and disenfrachisement of the oncology consultants		With safe and efficient processes that are patient centred	Quality & Safety Committee and Trust Board	5	4	20	System divert in place with patients referred to alternative centre within the Sarcoma network following the decision of the daily Multi Disciplinary Team (MDT) meetings. Bi-weekly calls with network partners chaired by Specialist Commissioning lead to monitor the divert process and ensure appropriate capacity is in place for patient cohort to be managed effectively. Root Cause Analyses around the paediatric cases treated at BCH prompted the decision to cease the service are being undertaken by BCH. Outcome of Root Cause Analyses concluded. External independent review into the oncology service commissioned. The service continues to be suspended as the host organisation continues to respond to the impact of the Covid-19 pandemic. Service resumption planned for April 19th 2021 Audit of patients due to undergo surgery conducted to review any harm experienced as a result of the delayed treatment. Results presented at July 2020 Quality and Safety meeting for assurance.	Weekly update to Executive Team. Minutes of private Trust Board meetings and Quality & Safety Committee meetings which include a regular update on status with the service. Minutes of Children's Board.	4	4	16	↔	Service continues to be provided with the support of the Sarcoma Network and in particular the Royal National Orthopaedic Hospital NHS Trust. The Quality & Safety Committee of Birmingham Women's and Children's NHSFT considered a report at a meeting in September 2020 around the plans for resumption of services. There was concern that a number of outstanding risks to allow resumption of services could not be adequately mitigated and therefore the service resumption should be delayed until April 2021. A quality meeting was held between BWCH, ROH, commissioners and regulators to consider the future plans and the support needed to allow the service to resume in April 2021. A Monthly Strategic Oversight meeting and weekly operational / Risk groups meetings have recommenced. Memorandum of Understanding between BWCH and ROH is in place. Plan for resumption of services shared with both ROH and BWCH boards monthly . Network divert lifted 22/2/21 to support resumption of surgery on 19th April 2021.	Q1 21/22	1	4	4	Feb-21

PEOPLE																					
Covid-19 - 033	Workforce	Chief Executive	There is clear evidence that there is a disproportionate impact of COVID -19 on individuals who are from a BAME (Black & Ethnic Minority) background and those at higher risk due to age, gender, underlying health conditions and pregnancy ('vulnerable groups'). There is also evidence to suggest that BAME colleagues are less likely to speak up and raise concerns. There is a risk that BAME colleagues may unintentionally be placed at higher perceived/actual risk as they may not raise this. Additionally BAME staff and those deemed to be vulnerable may have higher rates of COVID related absence/illness.		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Risk assessments are currently being carried out for all BAME staff and those who fall into vulnerable groups 55% of the total number of BAE staff (297) have had a risk assessment and 82% of all staff with underlying health conditions. Managers have access to a briefing on how to effectively carry out risk assessments and additional support from HR Managers as required. Occupational Health providing support for any complex cases. There is ingoing corporate communications regarding the importance of risk assessment. The Trust achieved 100% compliance for the completion of risk assessments for BAME staff and /or those with underlying health conditions All managers are being reminded to undertake reviews of risk assessments for vulnerable staff and to undertake risk assessments with new/returning members of staff which has recently been underlined in a note to all staff around the need to undertake welfare meetings and revisit risk assessments where needed. The Trust is working with the system to develop a shared approach to embedding risk assessments into the employee wellbeing offer across BSol.	Report to Trust Board in July 20 on risk assessments; updates to Staff Experience & OD Committee; staff communication and 'Start of the Week messages	4	4	16	↔	Continue to roll out managers webinars outlining their role and responsibility in relation to staff risk assessments. Review how completion of risk assessments can be recorded electronically for ease of reporting on completion. Progress with risk assessment continues to be monitored by the Staff Experience & OD Committee. Work underway to build in risk assessment into mainstream processes such as recruitment and induction. The work within the system on this area has not progressed since last report although further work continues within the Trust to ensure that risks are being regularly monitored and discussed. Recent data has shown a 95% completion rate for risk assessments and the HR team are working with individual managers to ensure that risk assessments are complete for all staff The Workforce Information team are working with colleagues across the Trust to consider how the risk assessment form can be digitalised to ensure ease and consistency of recording information and capturing completion rates	Ongoing	2	4	8	Feb-21
WF24	Workforce	Chief Executive	There is a risk that sickness absence may increase as a result of staff exhaustion or emotional strain due to different working patterns and exposure to emotional or stressful situations during the Covid pandemic		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Sickness absence rates are monitored on a monthly basis through the operational workforce dashboards and on a weekly basis through the Board Scorecard on a weekly basis. HR managers have regular 121s with local managers to review key hr metrics, to pro-actively address any HR concerns and signposting/seeking support from Occupational Health and/or the staff counselling service as appropriate. Staff have accessing to a free EAP service and can self-refer to the staff counselling service and this is promoted through comms and via line managers regularly. The national and regional offers regarding staff health and wellbeing have been promoted to all staff including in house support from trained mental health first aiders. There has been regular communications encouraging staff to take annual leave where business needs allow. There is now a cycle of reporting outstanding annual leave to Execs by directorate and highlighting those areas where no leave has been taken so that there can be targeted conversations about wellbeing, capacity and resourcing The psychological support offer for staff is being reviewed across BSol in response to the NHS People Plan in addition to the provision of a confidential staff counselling offer and Employee Assistance Programme being provided by the Trust. There is system wide psychological support, health checks and psychological first aid training available to staff in addition to Trust level interventions and support.	Weekly Board Scorecard Workforce Snapshot Data Intranet pages Communications briefings	4	4	16	↔	Continue to monitor the Trusts absence rate (Jan 21 = 7%) , with an increase in absence relating to 'stress, anxiety and depression.' Take forward the work with colleagues to embed the Mental Health First Aider model Review and refresh the Health and Wellbeing conversation tool so that managers can be proactive in supporting staff	Ongoing	2	4	8	Feb-21
WF21	Workforce	Chief Executive	The Trust fails to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	4	16	Recruitment open days. Repositioning job advertisements to provide clarity on the ROH's unique offering. Health and Wellbeing programme. Introduction of 100 days on boarding process. New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for the pre-operative assessment centre. Potential future registration for PAs to be confirmed. Greater understanding of Nursing Associate role within Trust. NMC registration. Apprenticeships are being more widely adopted by managers	Staff Experience & OD Committee minutes and papers Health and Wellbeing week material Job adverts for key posts, including those for COO and CEO 100 induction 'road map'	3	4	12	↔	Further embedding of new staffing models. Roll out of further Health & Wellbeing initiatives and the 100 days on boarding concept. Rolling recruitment events. Proactively seek to utilise the apprenticeship levy - working with line managers to consider opportunities within their teams. Theatre Assistant Practitioner apprenticeships to be explored. Workforce design to become an integral part of HR Business Partner discussions if the Trust pursues Business Partner model. Middle grade workforce group meeting to develop model. Work has been commissioned by the BSol Chief Executives to review the economic impact of Covid across the region and discuss and agree a plan to support employment opportunities across health. Progress will be monitored through the BSol workforce group. Careers Hub being established across ICS to support talent pipeline into Provider organisations. Review recruitment practices to ensure that they are inclusive and accessible.	Proposed for Closure/de-escalation	2	4	8	Feb-21
PARTNERSHIP																					

ST1	Strategy	Chief Executive	The Trust fails to exert influence in the STP and on the plans to develop an Integrated Care System, leading to loss of identity and brand, which could impact on the level of referrals, lowering of staff morale and loss of key skills		Developing services to meet changing needs, through partnership where appropriate	Trust Board	4	4	16	Attendance at STP Board meetings and Chairs/Chief Executives forums Ongoing work with the Birmingham Hospitals Alliance Development of a draft Memorandum of Understanding with University Hospitals Birmingham NHSFT to set out future working arrangements. Clinical strategy day held on 31 July 2020, which was well attended.	Trust Board minutes and papers Presentations from STP meetings	3	4	12	↔	Further progress on development of ICS and agreed way of working across the region as restoration and recovery is progressed. Agreement of the orthopaedic pathway across the STP. Development of a stakeholder management strategy. One to one discussions between key Chief Executives in the STP. A system wide proposal regarding musculoskeletal services across the STP has been shared with the Chief Executives for discussion. It is likely that NHS England/Improvement will introduce a single waiting list for systems which has also been proposed by the ROH. A refresh of the clinical strategy for arthroscopy/arthroplasty started in August 2020. Jan 21 -The clinical strategy is being presented at the Private Trust Board meeting 13th January 2021 which incorporates the ambition for the Trust and its role in strengthening its support within the system. ROH CEO and other members of the Executive Team have key roles working with system partners on a variety of pathway programmes e.g MSK	Ongoing	2	4	8	Feb-21
ST2	Strategy	Director of Strategy & Delivery	Innovation slows at the Trust as a result of reluctance to enter into commercial partnerships due to the uncertainty over the future influences of the Integrated Care System		Developing services to meet changing needs, through partnership where appropriate	Finance & Performance Committee	4	3	12	Trust is currently engaged with commercial partners to deliver JointCare initiative Active research programme is in place at ROH	Papers from R & D Committee and upward reports to the Quality & Safety Committee. 'Perfecting Pathways' programme board summaries to FPC Joint Care promotional material	3	3	9	↔	Delivery of 'Perfecting Pathways' programme Delivery of the deliverables in the 'Partnerships' section of the Trust strategy Clarity around timescales and influence of the ICS on the future direction of the ROH Increasing number of R & D studies have been commissioned after a lull in activity over recent months as a result of distractions created by the Covid-19 pandemic. Social distancing measures have impacted on the ability to conduct a number of studies, although as part of restoration and recovery, these challenges are being worked through. Development of new studies continues to be impacted on by Covid, however, as the Trust recovers back to pre-Covid status, the current studies can recommence and new ones can open. Work is in place to ensure that new studies are ready.	Mar-21	2	3	6	Feb-21

PROCESS																							
CE2	Corporate	Chief Executive	The effectiveness of the clinical governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience, potential harm and reputational damage.	Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	3	5	15	Elective surgery has been suspended. The ROH does not hold accountability for these patients, however any waiting for surgery above 40 weeks will be redirected to the clinical team for review monthly and trigger a harm review process. There has been a pause in the routine governance meetings with a resumption date to be agreed. Surgery on patients with cancer is currently directed to the Royal National Orthopaedic Hospital and the oversight of this service is robust.	Minutes of stakeholder oversight meeting	2	5	10	↔	Elective surgery is currently suspended as attention is diverted into Covid restoration and recovery . Reinstatement of routine governance meetings between BCH and ROH. Discussion about serviced resumption covered as part of the quality review meeting held on 23 October between ROH, BWCH, NHSE. Jan21- Weekly meeting remain in place with BWCH who review the current patients pathway and any issues. The current divert to RNOH continues to support patients.	Apr-21	1	5	5	Feb-21
770	Operations	COO	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.	Safe and efficient processes that are patient-centred	Quality & Safety Committee	4	5	20	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	5	15	↔	Phase 1 and 2 of the theatre expansion programme has been handed over, the Trust have four additional operating theatres however activity is planned to increase beyond the current 12 theatre utilisation. In relation to Theatres 1, 2 and 4 the risks remain unchanged. New & separate risk relating to Division 2 not being able to release Theatres for general maintenance there is a risk of service failure to be created and added to Corporate Risk Register.	Mar-21	1	5	5	Feb-21
FP7	Finance	Exec Dir - F&P	The Trust may experience supply chain disruption resulting from a failure to agree a Free Trade Deal	With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Whilst a trade agreement has now been reached, The Trust has in place plans and contingencies developed in 2019 in response to the threat of a 'no deal' Brexit outcome, which are being revisited and refreshed.	Updates to Finance & Performance Committee	2	4	8	↓	ROH will seek to discuss supply needs with commercial partners and new NHS Supply Chain Category Towers to ensure supplies will be available.	Ongoing	2	3	6	Feb-21
FP8	Digital	Exec Dir - F&P	There is a risk that the current IT capacity and functionality will not support the new ways of working developed during the Covid-19 response, such as virtual clinics, remote operation and videoconferencing	With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Trust use of thin clients and virtual desktop, with the addition of 80 mobile devices, allowed rapid remote access for 567 staff to work from home. Initial widespread use of Loopup videoconferencing and teleconferencing supported internal and external meetings. Business case for VDI hardware replacement proposal approved by the Executive Team on 27 October 2020. The new thick clients will strengthen the capability of the Trust's IT capability to support technology for videoconferencing and to maximise the functionality of Office 365.	Finance & Performance Committee	2	4	8	↓	Whilst most remote consultations have been done by phone, Video Conferencing is being piloted in Pain Management, MSK, Therapies, Foot and ankle and expected to be adopted much wider across the Trust. Attend Anywhere is the application being used (funded centrally for 12 months with a £20k grant to purchase appropriate equipment). Moreover, the Trust is also in the process of purchasing replacement laptop and desktops as part of the thin client replacement project. This equipment is being purchased in the 202/21 financial year although rollout will continue into 21/22. Additionally, the HSCN line into the Trust is being upgraded. The secondary line has now been replaced and the primary line will be connected before the end of March 21.	Apr-21	2	3	6	Feb-21

OP4	Operations	COO	There is a risk of increased virus transmission and reproduction rates, leading to a second and further waves of the Covid-19 pandemic creating operational pressures in the hospital		Performance, People, Process, Partnerships and Patients	Trust Board	5	4	20	Flow & Cohorting and Testing & Scheduling processes have been implemented agreed Standard Operating Procedure and protocols implemented to minimise the transmission to staff and patients. Operational pathways have been reviewed to implement revised ways of working. Risk Assessments have been completed in all areas of the hospital and changes are in place to ensure staff safety whilst at work. Two pathways have been implemented to minimise the transmission of Covid 19. Protected Patient Pathways and a Risk Managed Pathway. The pathways are monitored through the three daily site office meetings. There is continued dialogue between PHE / Microbiology with learning from any outbreaks embedded in ongoing practice.	Papers from Executive Assurance Group; Recovery and Restoration presentation to Quality & Safety Committee and Finance & Performance Committee	4	4	16	↔	Home swab testing ongoing for patients living out of area. Onsite facility in place. Ongoing discussions with the STP to agree how to support the increased pressures associated with the increased rate of transmission locally and nationally. Letter issues from the Executive Team to all staff to underline the importance of compliance with social distancing and wearing of PPE in all communal areas. Staff vaccination programme commenced January 2021 , all staff offered vaccination . In addition lateral flow testing kits have been made available to all staff. Access to rapid PCR testing is also available for staff and patients for confirmation of Covid 19 status . A collaborative approach is in place with PHE and Microbiology to ensure lessons are learnt following any outbreaks and any improvements are embedded in ongoing practice.	Ongoing	2	4	8	Feb-21
OP6	Operations	COO	There is a risk that there will be insufficient capacity to handle the activity from the new services being handled by the Trust as part of the restoration and recovery phase		Delivered by highly motivated, skilled and inspiring colleagues and Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	All 12 theatres operational. Phase 2 Theatre/Ward Expansion installed and scheduled to be commissioned by December 2020 adding two more theatres and an additional 8 beds on Ward 4. Bid for second MRI scanner to support Trust/System wide diagnostics approved and planning permission received. Enabling works commenced to increase ultrasound capacity in the imaging department. Additional mobile MRI 'van days' have been secured to maintain MRI activity and an increase in interventional/ CT capacity by providing extra lists Conversion of Ward 11 into an Adult ward or to increase pre operative assessment capacity. Theatre look back meeting re-instated to monitor any incident raised on a weekly basis. Theatre allocation reviewed monthly to monitor the delivery of the level 2/3 patients. 864 meeting will monitor theatre utilisation weekly.	Recovery and restoration update to Quality & Safety Committee and Finance & Performance Committee; demand and capacity analysis to Finance & Performance Committee	3	4	12	↔	Ongoing bed capacity being monitored at the three daily Sitrep meetings. Scoping of reconfiguration of Pre-operative assessment facilities underway. Out patient extended evening sessions to re-open February 2021. Phase 2 of the theatre expansion delivered Dec 2020. Imaging services expanded opening hours ongoing. Awaiting sequencing of repatriation of staff following mutual aid to expand theatre capacity to meet system demand . Mutual aid transfer support ceased 15/2/21 . Wards 2 and 3 currently being cleaned to support Covid Managed pathways .	Ongoing	2	4	8	Feb-21
1298	Finance & Performance	Exec Dir - F&P	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Contractor Cyber Security Officer just been appointed at Band 6 for 3 months, so some progress to be made shortly with outstanding tasks. Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network.	IM&T programme board papers Presentation from CORS team to Audit Committee Audit Committee minutes Information Governance Group minutes	4	4	16	↔	1. Lack of patching/monitoring – automated processes for installing MS security patches monthly and a range of approx.. 50 other high risk software. However, any exceptions to the patching are not routinely investigated. There are approx. 7,200other pieces of software that need investigating to determine if they need to be patched and how this could be achieved, but no resource to complete this. Update 04/02/21. Endpoint Patching - Good progress in terms of end user device patching. With the workspace one, we will be able to patch both onsite and offsite devices. Server Patching - Patching within 30 days for ROH managed servers. 3rd Party Controlled Systems - Need active engagement from the system owners to accelerate remediation. This is still a serious risk. Network Patching - Patching support devices but unsupported system (F5 load-balancers) need to be replaced with suitable alternative. Software whitelisting cannot be achieved in short term due to the technical limitations. Still on the road map after the completion of workspace one (unified endpoint solution) deployment. 2. Presence of Unsupported systems – Some progress with that, limited number of unsupported systems, but no activity on this during last 4 months so problems with sustainability. Particular issues are with unsupported Macs – BI leading a project to help remediate this, but no plan or dates yet available. Externally controlled systems still pose a significant risk, plan in place to identify the vulnerabilities in their systems and report it back to them for remediation. Good progress with internally controlled systems: Windows server – No unsupported operating systems on our Trust controlled estate; Windows desktop – 3 desktops on windows 7 at path lab – been waiting for 18 months for a resolution, but no sign of anything soon despite regular Path Lab meetings. 1 windows 7 device in Pharmacy acting as DR device. This can be upgraded to Windows 10, but needs our version of Ascribe to be updated to a later version at a cost of approx.. £25k. SIRO to consider current risk and advise. Unsupported operating systems are easy target of the adversaries, still posses a significant risk. PACS devices – There are a number of workstations and servers (GE/Siemens etc.) running unsupported operating systems, but little progress made with suppliers, some of which are only warranted to run on specific OS versions. The devices are in an isolated network to help reduce risk of spreading malware to Corporate network, but not risk free. SIRO to review. Lack of business engagement, still faced with the same risk on these unsupported systems. They need to be replaced /removed to reduce the threat landscape. MACs – ongoing now for 8 years with no definite agreed solution/plan. A whole range of servers and workstations on the corporate network running operating systems. Some of the data can potentially be moved to Amplitude (BI scoping this out) and the data that can't be moved will need to be migrated to Trust servers and the front end application rewritten for browser access rather than an MAC application. Bi have indicated the earliest they can start this work is Jan 2021. There is potential for a resource from Smith & Nephew to assist with this. 3. Poor access and password audit and management – Audits were done in January 2019 which identified shortcomings, but no progress made with that. Use of PICS has hampered progress to strengthen this. No further progress on this, limitation due to PICS password limitation. A module in Manage Engine has been purchased to help strengthen passwords (avoiding easily guessable passwords such as Password1, Hospital1 etc.). The rollout of this is on the IT pending project list and not yet scheduled. However, the length of the password can't be increased from 8 because of PICS issues, which does make it much easier for malicious actors to "guess" passwords 4. Inadequate and untested incident management and disaster recovery processes – DR Testing has now started and being strengthened to enable testing of the full recovery of all Trust data – target date Apr 2020. No progress made with documentation of DR management. Central funding has been received for this - currently working with the vendor to purchase the new equipment. No further testing done – The hardware that was to be used for DR testing has been repurposed to support the VDI (increased demand caused by remote working requirements). We have had an external assessment done by MTI regarding our back up capabilities and applied for funding for hardware that will also allow us to complete more extensive DR tests. Result of bid expected in early October- 5. Poor cyber security user awareness and training – No progress made with looking at replacement training yet, but comms are working with us on this, so will help to move this forward. There is now an User Comms awareness action plan in place owned and managed jointly by IG/IT and the Comms Team. By the end of March the following will be in place: Staff survey to gain a baseline assessment of skills and knowledge; Cyber security intranet page; Clinical specific cyber security workshop; Ongoing work will be to populate the intranet page with resources and guidance, provide access to clinician cyber security elearning type training, further staff surveys to assess progress, frequent communications and reminders via normal Comms routes.	Ongoing	2	4	8	Feb-21

PERFORMANCE																						
1089	Operations	COO	REFRAMED RISK: The Trust fails to meet the national target of treating 92% and patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the Covid-19 pandemic		Delivering exceptional patient experience and world class outcomes	Finance & Performance Committee	5	5	25	The January Referral To Treatment position closed at 67.7% against the National compliance target of 92%. There are 42 patients over 52 weeks. All of these patients are category 3/4 priority level . Patients waiting in excess of 52 weeks are all going through the Trust harm review process. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis. Refreshed post-Covid Trajectory is being developed in line with the system backlog reduction working group is monitored by the Finance & Performance Committee monthly.	Weekly update to Exec Team & Ops Board; monthly finance overview	5	4	20	↔	Delivery of restoration and recovery plans. Progression of second phase of modular theatres programme and second MRI Scanner. Continued transformation of Outpatients services maximising the digital opportunities.	Dec-21	3	3	9	Feb-21
CE1	Corporate	Chief Executive	The Trust does not currently have a clear financial and operational plan in place that describes how the organisation will deliver sustainability over the medium to long term. The Trust is currently delivering consistent deficits and requires cash support to continue day to day operations		With safe and efficient processes that are patient centred	Trust Board	5	4	20	Whilst a two year financial and operational plan was signed off by the Trust Board in 2019/20, the Trust has been working with the STP to develop a longer term System Sustainability Plan (five years), although both for the Trust and the STP, this plan is different to the current set of performance improvement trajectories recently identified by NHSI The SSP reflects the Trust's 5 year strategy to become the first choice for orthopaedic care, which has recently been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. An initial Strategic Outline Case was developed and accepted by the Board outlining options for future growth. Discussions are taking place with partners in the STP to work through options for providing closer clinical integration between the ROH and other partners, which will built resilience and support the move towards financial sustainability The first phased of the theatre expansion work has been completed.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	3	4	12	↔	As part of the national COVID response, the Trust is currently (20/21) receiving fixed contract income, based on the 19/20 Mth 9 position. The Trust is currently reporting a break even position against this. Whilst we expect costs to exceed this income as activity increases, we are currently discussing with NHSI how the income would need to change to reflect that. Additionally, all historic long term debt that the Trust holds will be transferred into equity, thus improving the balance sheet, and cash to support the Months 1 and 2 positions was received at the start of April, significantly improving the cash position of the Trust. As such no additional borrowing is currently expected for the remainder of the year. Delivery of activity will remain challenging, particularly in relation to bed management, but the Trust is hopeful of recovering to pre-COVID levels of activity by the end of the year. Jan 21- The Trust continues to work with the plan and financial envelope agreed for 2020/2021. The Trust continues to work as part of a system plan to help manage the second and more significant COVID-19 wave. The second phase of Theatres is due to open in the middle of January 2021 and as mutual aid ceases for COVID the Trust will look to recover its level of activity.	Mar-21	2	4	8	Feb-21

WF20	Workforce and Staff Experience/Finance	Associate Director of Workforce & OD/Director of Finance & Performance	There is a risk that as a consequence of the current tax liability associated with pension arrangements of some senior clinical individuals that there will be a reluctance to cover additional duty hours and therefore the Trust will fall short of its activity target and financial control total		Delivered by highly motivated, skilled and inspiring colleagues	Finance & Performance Committee and Staff Experience & OD Committee	5	4	20	Pension policy agreed to include additional payments for those staff who opt out of pension Trial of service contract for anaesthetic and surgical consultant services via LLP agreements. National solution published which has assisted to some degree. Demand and capacity modelling has been undertaken which if LLP may be needed as part of future restoration and recovery plans. Overall consultant reluctance to undertake additional activity has reduced and this capacity has been built into restoration and recovery plans. Successful recruitment of additional consultants over recent months.	Board meeting minutes. Finance & Performance overview. Minutes of Finance & Performance Committee.	2	4	8	↔	Delivery of restoration and recovery plans.	Proposed for Closure/de-escalation	2	4	8	Feb-21

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
- Patient safety
- Patient experience
- Workforce capacity, capability and engagement
- Systems, information and processes
- Regulatory compliance and national targets
- Equipment & estates
- Strategy and system alignment
- Reputation and brand

UPDATED: FEBRUARY 2021

Finance & Performance Committee - 23 February 2021

Present: **Richard Phillips, Gianjeet Hunjan, Ayodele Ajose, Steve Washbourne, Jo Williams, Amanda Gaston, Alex Gilder & Simon Grainger-Lloyd**

- The continued slimmed down agenda focussed on a presentation on prosthesis contract review process, and Finance & Performance report and update on refresh & recovery.
- A presentation was delivered jointly by George Cooper and David Dunlop, both of who are consultant surgeons and Amanda Gaston, Deputy Director of Finance. The presentation outlined the process that had been followed to secure a refreshed hip & knee prosthesis contract, which ultimately is expected to deliver significant savings per annum instead of incurring a cost pressure under the current contract.
- The work demonstrated excellent team working between the consultant body, theatre teams, procurement and finance.
- The Trust delivered an in-month surplus of £1,356k (January) against the planned deficit of £813k.
- Year to date the Trust was in surplus at £2.037m, a position which had improved since the previous month and was attributable largely due to the recent funding received from the Clinical Commissioning Group (CCG) as part of the system reserve which would be used to fund the second MRI scanner. The position had also been enhanced by the continued lower level of activity being handled, which incurred a lower level of expenditure.
- An upward increase in expenditure would be expected however, as a result of the additional costs of the Phase II theatres and the increased staff establishment.
- In terms of activity delivered during January, there had been a continued reduction in day cases, inpatients and diagnostic cases.
- 64% of Outpatient activity was directed into virtual appointments, these being designed to keep in touch with patients, rather than progressing their care.
- Theatre utilisation continues to be low, which reflects the ongoing mutual aid being provided to the system in the form of anaesthetists.
- The performance against the Referral to Treatment Time (RTT) target was 67.7%, which was a further deterioration. 42 patients were waiting over 52 weeks, 29 of which are Priority 3 and 4 patients. Harm reviews have been undertaken which have not identified any issues.
- The diagnostics target had not been met as some appointments had needed to be cancelled. There had been two breaches of the 62-day cancer target, both of which were unavoidable due to the complexity of the clinical pathways involved.
- Length of stay had incrased, this being associated with the complexity of the new patient cohort and some difficulties with repatriating some patients back to their originating hospital or step down facilities.
- Paediatric oncology surgery was noted to be due to restart in April as planned and the divert had been lifted from the Royal National Orthopaedic Hospital.

- An update on the refresh and recovery work was provided which showed good progress. The transfer of rehabilitation patients from University Hospital Birmingham NHSFT (UHB) had ceased on 15 February which would allow the creation of more Covid protected clinical areas in the hospital. Clinical prioritisation work was reported to be underway.
- An update on the planning process for 2021/22 was provided. The first quarter of the year would see the current block contract arrangements remain. Work was underway with the STP to develop a plan and to work through the assumptions in terms of efficiencies required. It was noted that there was a significant impact on the Trust next year in terms of the reduced level of income expected.
- Inclusive of the movement of the system reserve (£1.8m), the forecast outturn has reduced from £2.2m to a circa £400k deficit. This may improve further over the last two months, although there is still a significant amount of uncertainty relating to the relaxation of mutual aid that is currently being provided to the system, and the speed with which restoration and recovery can be initiated.

ROHTB (3/21) 007

Staff Experience & OD Committee briefing - 24 February 2021

Present: **Simone Jordan, Richard Phillips, David Gourevitch, Jo Williams, Sharon Malhi & Simon Grainger-Lloyd**

- The workforce performance report showed that there had been an increased level of absence and work had been undertaken to cost the implications of the sickness absence. It was suggested that an element of the position reflected the mandate by the Trust to remain at or return home if an individual was displaying any of the symptoms associated with COVID.
- Other high levels of sickness absence related to anxiety, stress and depression, although it was anticipated that the Trust's strong health & wellbeing offering may assist with alleviating this.
- Return to work interview rates were highlighted to be poorer than expected and work with the Electronic Staff Record (ESR) identified that this was not a data quality issue but managers were not logging conversations onto the system or not conducting the interviews.
- Focussed work was underway to address the comparatively low rates of COVID vaccine take up among minority ethnic groups and in the recent meeting of the Multi Minority Ethnic Group (MMEG), actions had been agreed to implement vaccine champions to promote the uptake of the vaccine and dispel any associated myths. A personalised approach was also being taken to understanding the reasons why staff may be reluctant and encourage them to be immunised.
- Mandatory training completion rates were noted to be poorer than desired and work was planned to undertake some remedial work to understand the degree to which this reflected a data quality issue. A renewed focus was planned, with each Executive now having a list of staff who were non-compliant and conversations around the non-discretionary requirement to undertake the training.
- There was good work to develop and enhance the health and wellbeing offering to staff, including touch base calls with staff who had been redeployed and preparations for those staff due to rejoin the Trust after their period working elsewhere.
- Work was underway to review the wellbeing conversations, to ensure that there were received as a supportive aid and that they struck the right tone.
- It was suggested that work to prevent or address psychological burnout was needed and it was noted that there was learning from institutions such as the Fire Service which could be harnessed.
- The term 'Restoration and Recovery' would be rebranded as 'Refresh and Recovery' in line with the work being undertaken by the Operations Team.
- Some of the race equality and inclusion priorities developed across the region were shared and the work of the Leadership & Talent Management workstream, of which Sharon Mali, Acting Head of Workforce & OD was joint SRO, was discussed.

- A ROH equality & diversity action plan would be created and presented as a routine item at the Committee meetings.
- The Speak Up elements of the equality & inclusion work were being progressed by the Director of Corporate Affairs, with a new 'Freedom to Speak Up' champion model being introduced during the new couple of months.
- The Trust's inclusive recruitment practices were being reviewed and strengthened by measures, such as ensuring that appointment panels were inclusive & representative. Workforce policies and procedures were also being reviewed to ensure that they were as inclusive as possible.
- Work was underway to implement sessions following complex employment relation cases.
- Further work was planned in terms of workforce planning, which would also address talent management and succession planning.
- The update from the Integrated Care System (ICS) People Board was considered. Part of the work was to develop some shared valued.

ROHTB (3/21) 008

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board met: 24 February 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The compliance with the post admission VTE risk assessment target was highlighted to be at 64%. It was reported that there was however, proactive work by the medical lead to improve this position and the Head of Nursing for Division 1 was undertaking a review to understand what additional action could be taken by nursing staff to contribute to an improved position. • There were reported to be ongoing challenges with the data quality of the Friends and Family Test (FFT) information and the feedback was being scaled down to mandatory elements only while the position was being investigated.	• An update on the Pathology service to be provided at the next meeting. • A training session to be held for the Board on the new Liberty and Protection Safeguards is to be organised. • A discussion between the Safeguarding Lead and the Non Executive Lead for Safeguarding to be arranged.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The outstanding Central Alerting System (CAS) alert relating to food labelling was reported to be due to close shortly as the required policy was nearing sign off. • There was reported to be good progress against the Trust's quality priorities, with four out of five expected to be achieved by 31 March 2021. The remaining priority which concerned spiritual and pastoral wellbeing was expected to be delivered within the next six months. • The Executive received the outcome of an audit of the quality committees' operation during the pandemic, which showed that the committees with oversight of safety matters in particular had sat routinely. It was noted that although some of the routine meetings had not occurred, the Clinical Quality Group had continued to retain oversight of matters in their remit. The patient experience groups had not sat although there was work to do to redefine the role of these bodies and there was good evidence of patient engagement throughout the pandemic which was described in a separate paper on the agenda.	• The Committee agreed that the establishment of a health inequalities group would be beneficial, which could cover both staff and patients and could report to the relevant Board subcommittees.

• A positive update was provided on the plans to resume the paediatric oncology service. • Good assurance was provided around the containment and handing of the recent COVID outbreaks, which were noted to be low in number as a proportion of the total patients and staff in the hospital. • The Committee received its first annual report from the Medical Director which showed a particularly strong understanding of how the responsibilities of the medical leadership team were discharged and how the team was structured. It was noted that it was pleasing to see some of the newer consultants taking on leadership roles. • An overview of the mortality and learning from deaths process was provided, which showed that there was good compliance with the national policy and oversight of the position. • A detailed update from the Quality & Safety Executive was received, which it was noted was working well and focussed on some of the operational elements that would previously have been discussed by the Quality & Safety Committee. • The Committee was joined by the Safeguarding Lead, who provided an overview of the forthcoming changes to the Deprivation of Liberties regulations. The Committee was given good assurance that any safeguarding risks as a result of the use of virtual appointments were being managed. It was noted that the new Learning Disability Nurse was now in post and good progress was being made. • There was good work to progress visibility of clinical data through joining up with the Model Hospital Club and the National Orthopaedic Alliance.	

Chair's comments on the effectiveness of the meeting: The meeting was agreed to benefit from the operation of the Quality & Safety Executive as it allowed the Quality & Safety Committee to focus on more strategic matters.

QUALITY REPORT – FEBRUARY 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	***MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY***
• Covid Outbreak on Ward 3 - Outbreak reported to the CCG as a Serious Incident and Public Health England – Investigation underway. Duty of Candour undertaken with patients. • 1 Moderate Harm patient fall – under review and investigation within the divisions • 2 VTES reported in Month – RCA and Duty of Candour underway • VTE 24-hour risk assessment compliance 64%. Work to increase 24-hour risk assessment continues, data continues to be scrutinised and escalated. Medical VTE lead is being proactive in supporting compliance improvement • Increase in Pressure ulcers reported for patients admitted to the ROH (UHB pathway) All incidents are shared with the UHB governance team • FFT data quality issues - There appears to be a disparity between data collection and results published. There is a plan to scale down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. The graphs within the quality report have been broken down by mandatory and non mandatory areas to allow the Trust to focus on the mandatory areas. • Outstanding CAS alert – Food Safety – awaiting policy to be signed off – on agenda for Clinical Quality Group in February 2021	From February 2021 the Trust will not report on the non-mandatory areas of FFT until the data quality issues are resolved.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Two Incidents with harm downgraded from the previous months. (Wrong diagnosis and Lost to follow (inappropriate pathway). Both incidents were reviewed and closed	• None specifically

• Duty of Candour audit presented to Executive Quality and Safety and showed 100% percent compliance with the regulation • WHO 100% complaint • No reportable infectons	

Quality Report February 2021 (January 2021 Data) – Front Cover and Dashboard

	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	2020/2021	2019/2020 YTD
Incidents	247	225	260	399	361	323	346	284	274	270(↓)		
Serious Incidents	0	0	0	1	0	1	2	1	2	1(↓)	8	7(Total)
Internal RCA investigations	4	2	2	1	2	2	6	3	2	3(↑)		
VTEs (Avoidable)	0	0	1	0	0	0	0	0	0	0	1	3 (Avoidable)
Falls (all falls)	6	5	4	2	5	9	12	6	6	10(↑)	65	100(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	2	0	0	1	2	2	0	0	1(↑)	8	7(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	1(Avoidable)
Complaints	4	5	1	5	7	6	7	3	3	7(↑)	48	132(Total)
PALS	13	38	39	65	95	76	95	63	62	41(↓)		
Compliments	3	11	9	9	6	15	4	12	6	5(↓)		
FFT Score %	NA	NA	97.9	98.7	92.9	95.3	95.3	93	95.1	90.5(↓)		
FFT Response %	NA	NA	41	52	23	12	65.5	47.3	36.5	32 (↓)		
Duty of Candour	17	20	15	10	8	10	10	12	11	14(↑)		
Litigation	0	0	0	0	0	0	0	0	0	0		
Coroners	0	0	0	1	0	0	0	0	0	0		
WHO %	100	100	100	100	100	100	100	100	100	100		
Infections	1	0	0	1	0	0	0	0	0	0	2	4 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

February 2021 (January 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

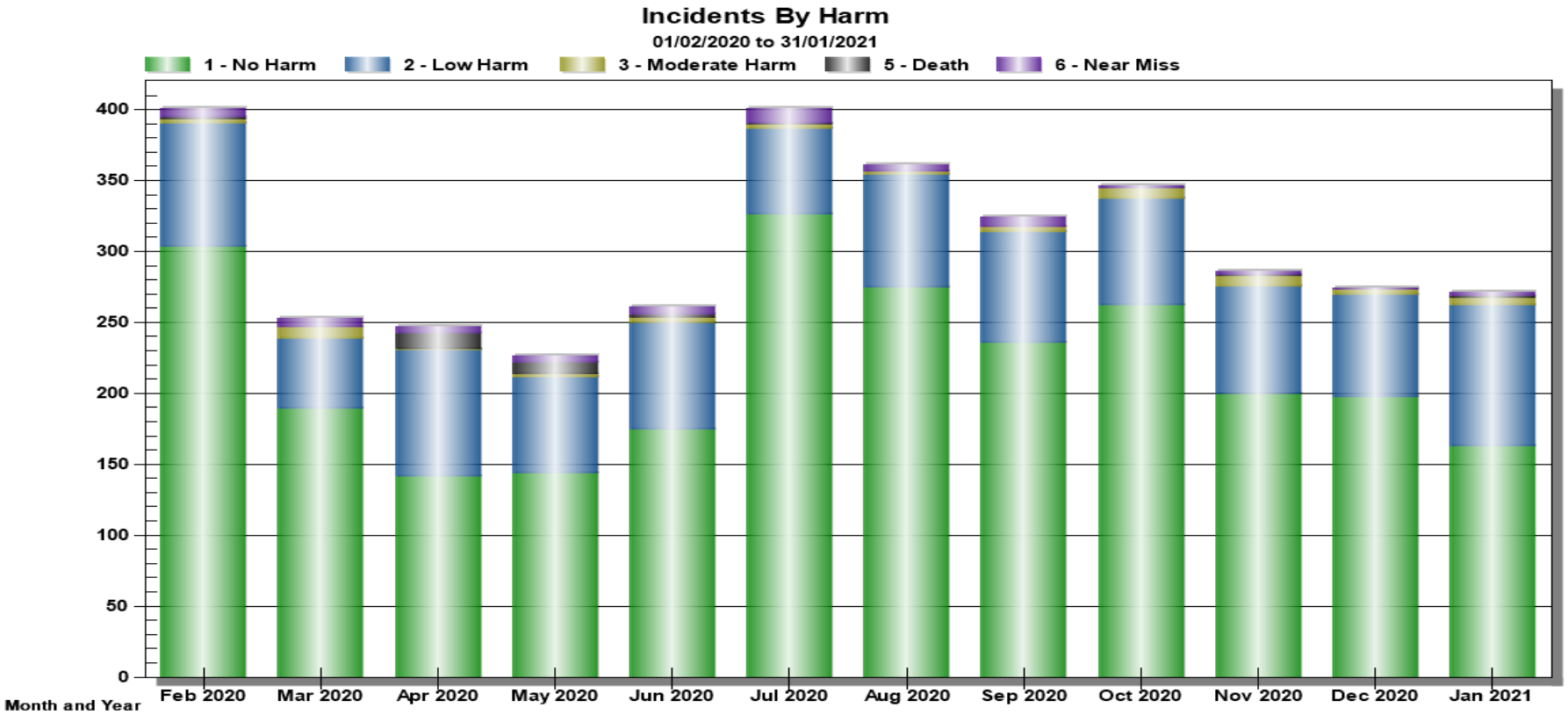
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55641)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021
1 - No Harm	303	189	141	143	174	326	274	235	262	199	197	162
2 - Low Harm	87	49	89	68	75	60	80	78	75	76	72	100
3 - Moderate Harm	3	8	1	2	4	3	2	4	7	7	4	5
5 - Death	1	0	11	8	2	1	0	0	0	1	0	1
6 - Near Miss	7	7	5	5	6	11	5	7	2	3	1	3

Data source – Ulysses

INFORMATION

In January 2021, there were a total of 270 Incidents reported on the Ulysses incident management system.

The breakdown of those incidents is as follows;

162 – No Harm
100 – Low Harm
5 - Moderate Harms
0 - Severe Harm
3 – Near Miss
0 – Death

Downgraded Incidents

Currently 2 of the reported harm in the Previous Quality report (November 2020) have been downgraded.

Patient Contacts

In January 2020, there were a total of 4753 patient contacts. There were 270 incidents reported, which amounts to 5.7 per cent of the total patient contacts. Of those 270 reported incidents, 105 incidents resulted in harm which is 2.2 per cent of the total patient contact.

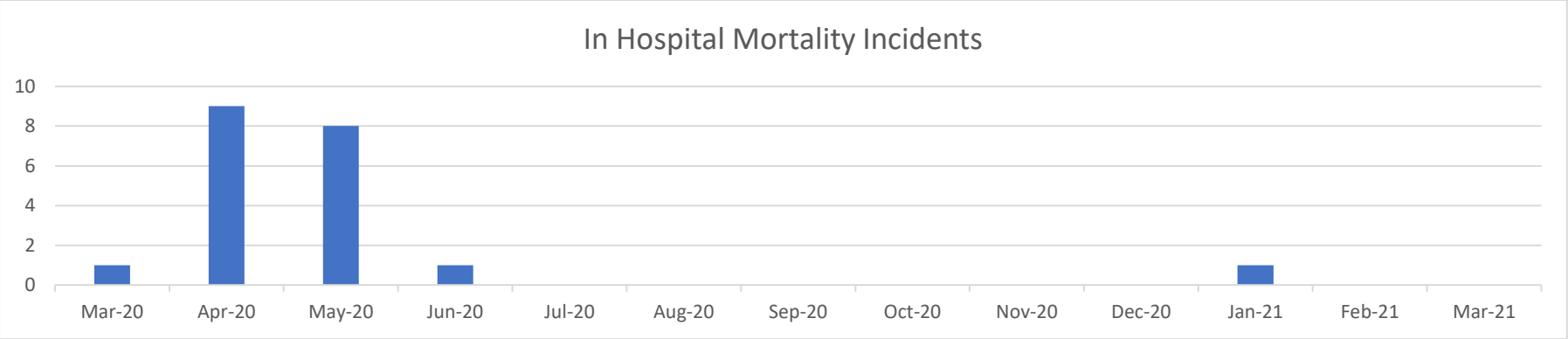
ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Clinical Governance presented an audit of compliance with Duty of Candour Regulation 20 to the Executive Quality and Safety Executive in February 2021. The audit consisted of 10 samples and showed 100% compliance with the Regulation 20. did highlight that the Trust could improve on the timeless duty of candour is undertaken with the patient and an action plan has been developed.

RISKS / ISSUES

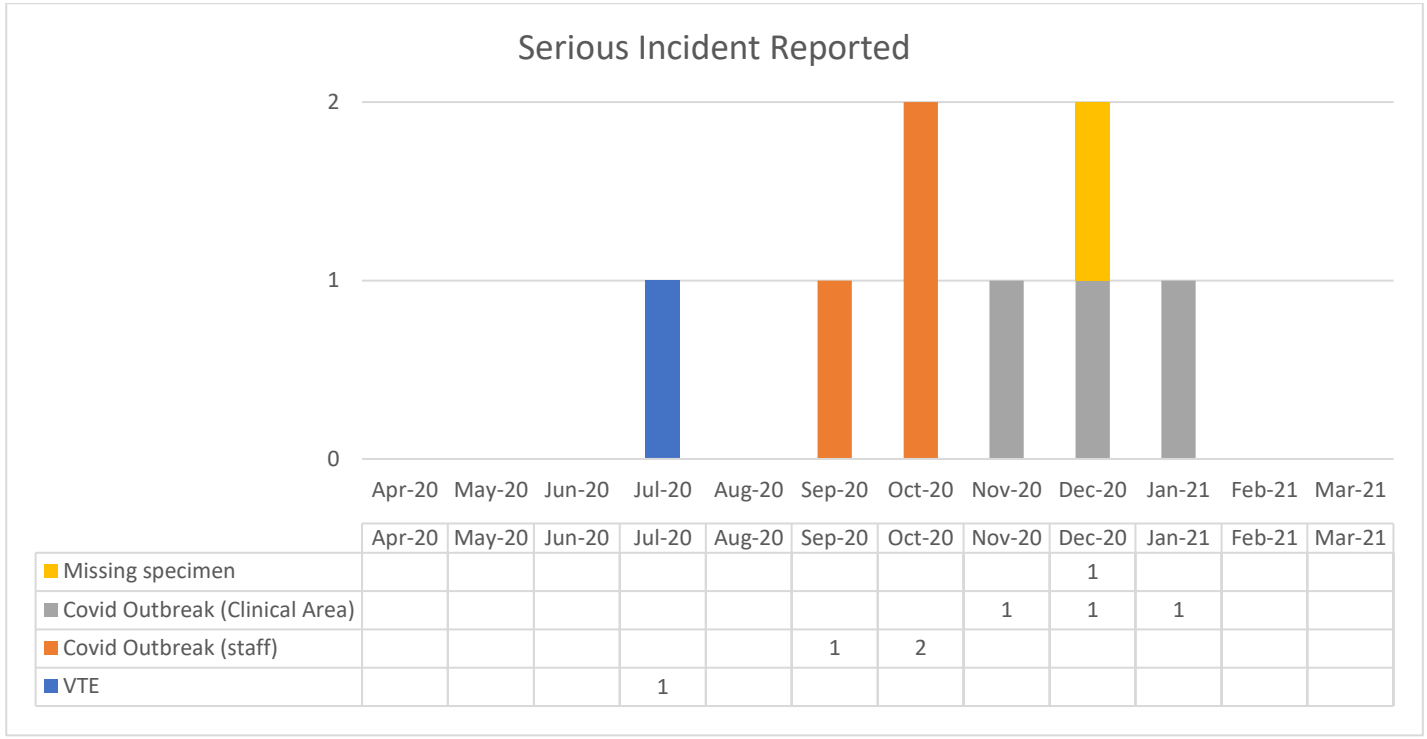
No governance training currently underway – E-Learning in scope – This is on the risk register and the PowerPoint slides are currently sent out to new staff joining the organisation

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
There was 1 In-hospital death reported in January 2021. This death is currently being reviewed via the Trusts Learning from Deaths process.
ACTIONS FOR IMPROVEMENTS / LEARNING
A new improved process is in place to review deaths within 30 days of ROH discharge from impatient services. This new process now includes an incident for each reported death. An increase in the reported deaths will be noticed in the next quality report data due to this. All deaths are currently going through the learning from deaths process. A report was considered by the Quality and Safety Committee in February 2021 which will also be discussed by the Trust Board in March.
RISKS / ISSUES
The data reported for the deaths occurring within 30 days is not always reliable due to a delay with the national system. This may cause a delay in the learning from deaths process. The Governance team is working with the Trust informatics team to improve the timeliness and accuracy of this data.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



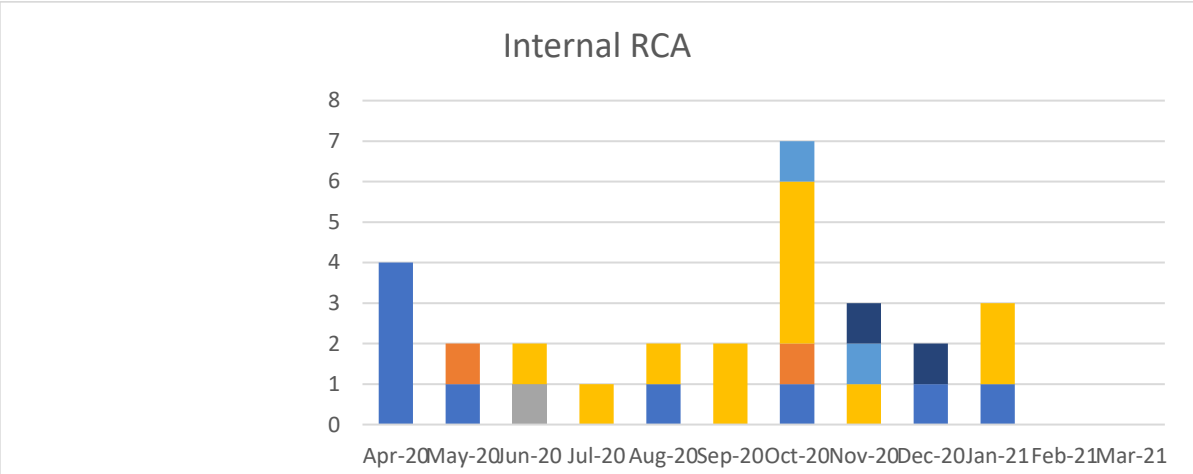
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Missing specimen									1			
Covid Outbreak (Clinical Area)								1	1	1		
Covid Outbreak (staff)						1	2					
VTE				1								

Year Totals	
19/20	7
20/21	8

Data Source – STEIS

INFORMATION
There was 1 Serious incident reported in January 2021. This was an Outbreak of Covid-19 within Ward 3. The Incident was declared as an outbreak to Public Health England and under investigation within division 1.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in January 2021. The Governance team have chased the CCG for closure of the Serious Incidents but have been informed that due to the increase of incidents reported during the pandemic there is a delay within the sign off process at the CCG.
RISKS / ISSUES
Delay is closing Serious incidents from the CCG. This may delay the Duty of Candour process and sharing the findings with patients. A discussion will be held at the Divisional Governance meetings to see how we will minimise this delay.

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**

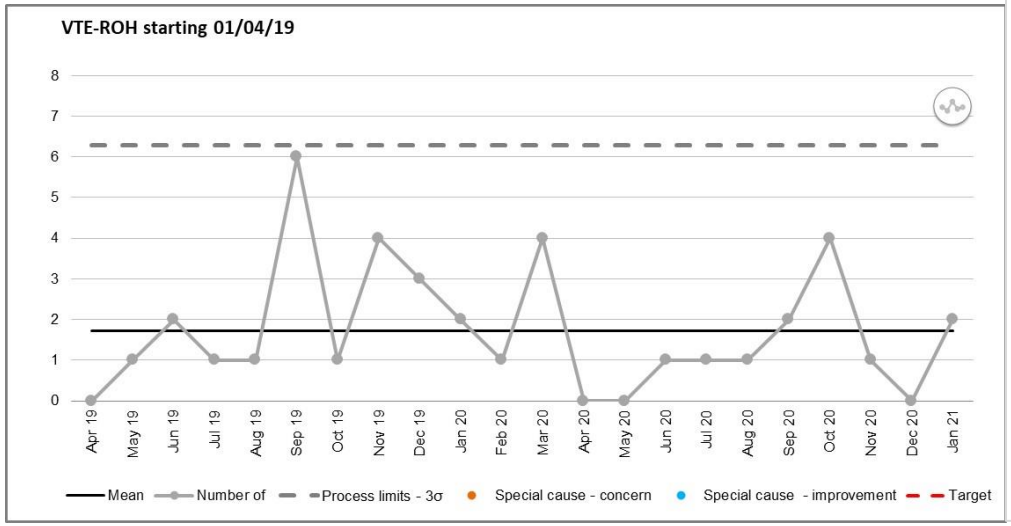


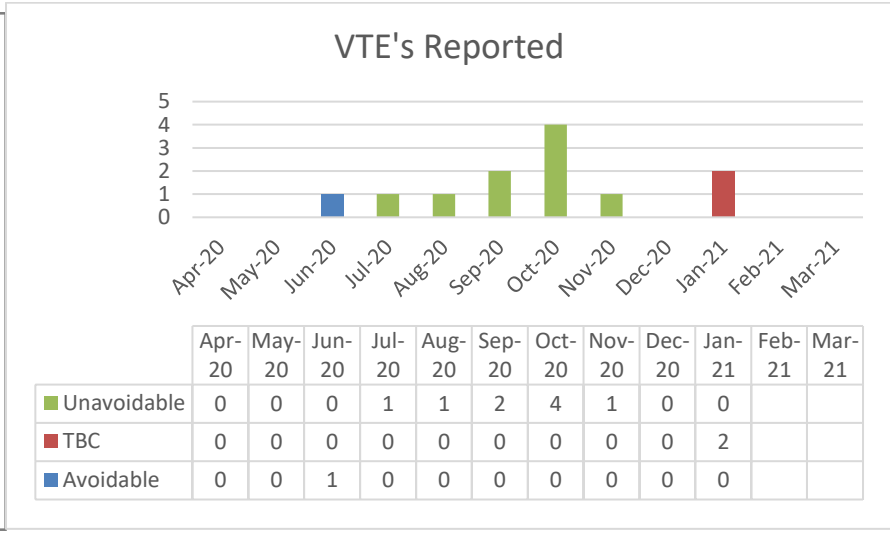
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Falls								1	1			
Physio Discharge Process Issue							1	1				
VTE			1	1	1	2	4	1		2		
Delay/Failure To Monitor			1									
Clinical Care		1					1					
Surgical Site Infection	4	1			1		1		1	1		

Data Source – Internal RCA tracker

INFORMATION
3 internal RCAs are currently underway within the divisions. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.
ACTIONS FOR IMPROVEMENTS / LEARNING
2 Internal RCAs were closed in January 2021 – all of these were unavoidable VTE's with no learning highlighted.
RISKS / ISSUES
None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Unavoidable	0	0	0	1	1	2	4	1	0	0		
TBC	0	0	0	0	0	0	0	0	0	2		
Avoidable	0	0	1	0	0	0	0	0	0	0		

Avoidable Year Totals		Total including unavoidable
19/20	3	26
20/21	1	12

Data Source – Ulysses and VTE leads

INFORMATION

2 x ROH associated VTEs were reported in January 2021 and have been escalated to RCA as per Trust Governance process. Duty of Candour has been undertaken with the patients. The SPC chart on the previous page shows that reporting of VTE's is within the recognised threshold at the ROH.

24-hour reassessment:

4hr review	282
missed 24hr review	156
total	438
24hr %	64.38356

On admission assessment

total possible	462
total assessed	449
%	97.19%

ACTIONS FOR IMPROVEMENTS / LEARNING

Work to increase 24-hour risk assessment continues, data continues to be scrutinised and escalated. Medical VTE lead is being proactive in supporting compliance improvement

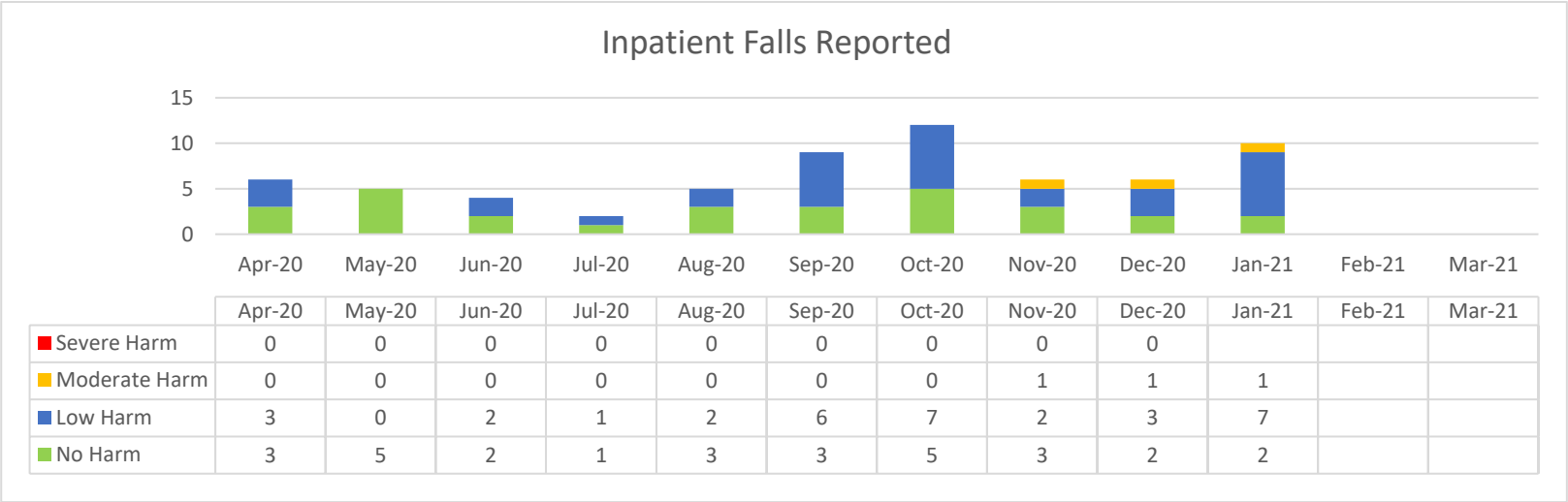
The patient safety matron is now reviewing the processes on PICS and there is a whole team approach to this challenge.

The ANP for Arthroplasty is taking the themed review that had been previously presented to the Quality and Safety Committee to the MDT meeting to promote a discussion on the number of VTEs for Total Knee replacement surgery and any changes that can be made. A potential audit is to be scoped.

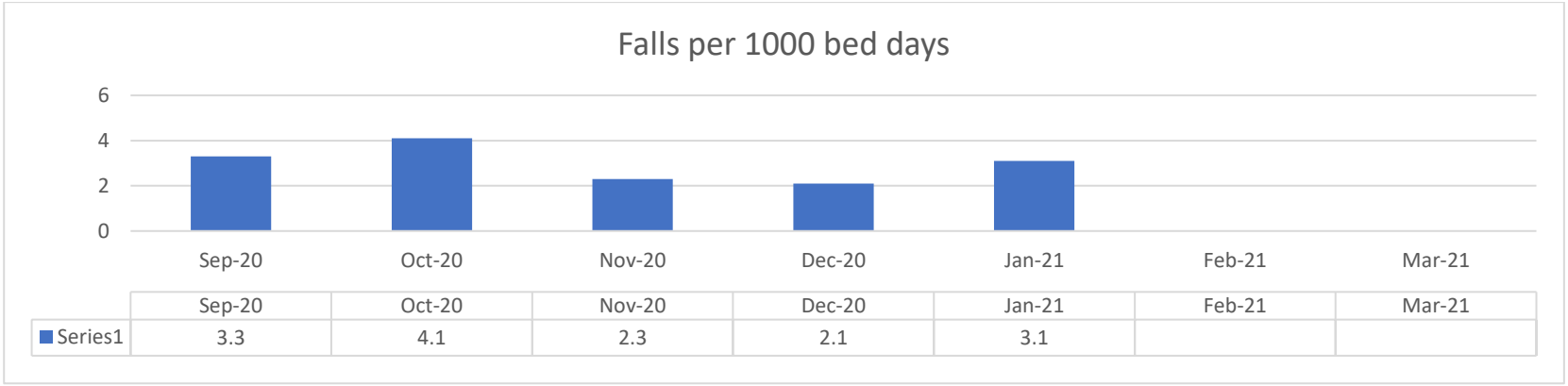
RISKS / ISSUES

Non-compliance with on admission and 24-hour risk assessment as detailed above is not in line with national or Trust Guidance. This remains on the risk register

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

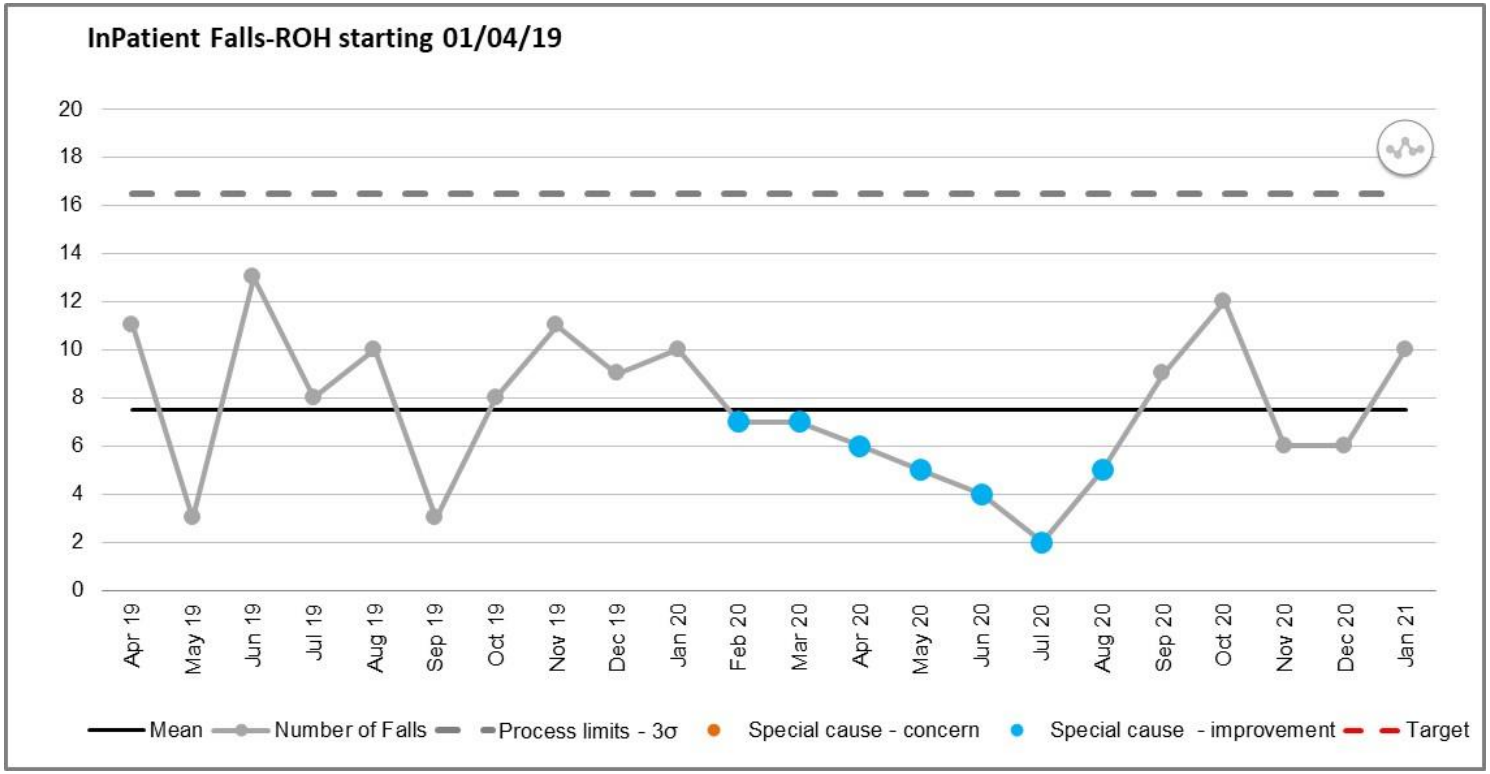


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Severe Harm	0	0	0	0	0	0	0	0	0			
Moderate Harm	0	0	0	0	0	0	0	1	1	1		
Low Harm	3	0	2	1	2	6	7	2	3	7		
No Harm	3	5	2	1	3	3	5	3	2	2		



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Series1	3.3	4.1	2.3	2.1	3.1		

Year Totals	
19/20	100
20/21	65



Data Source – Ulysses and Falls Group

INFORMATION
There were 15 incidents reported across the Trust in January 2021 relating to Falls, 1 involved a staff member: 10 x In-Patient Falls Incidents. It should be noted that the cohort of patients in the areas with increased falls are UHB rehab patients. Assessment of each patient had been made and where appropriate increased observation in place. The number of nurses on duty has also increased.

1 x Out-Patient Falls Incident

1 x Staff Member

3 x Lowered to Floor Incident

ACTIONS FOR IMPROVEMENTS / LEARNING

Completed thematic review of falls for October 2020 – A number of factors do not appear to have any link with the increase in falls reported during October 2020. These are the patient's age and type of surgery, the time of the fall and the staffing on the ward.

There are other factors which can be seen as themes across the falls incidents in October 2020. Almost a third of the patients, had pre-existing co-morbidities that pre-disposed them to falling. Over two-thirds of patients had poor mobility post-operatively, meaning they were not safe to mobilise on their own, many requiring notable support. The greatest number of falls happened in the first two days post-operatively, when patients were generally more dependent in their needs.

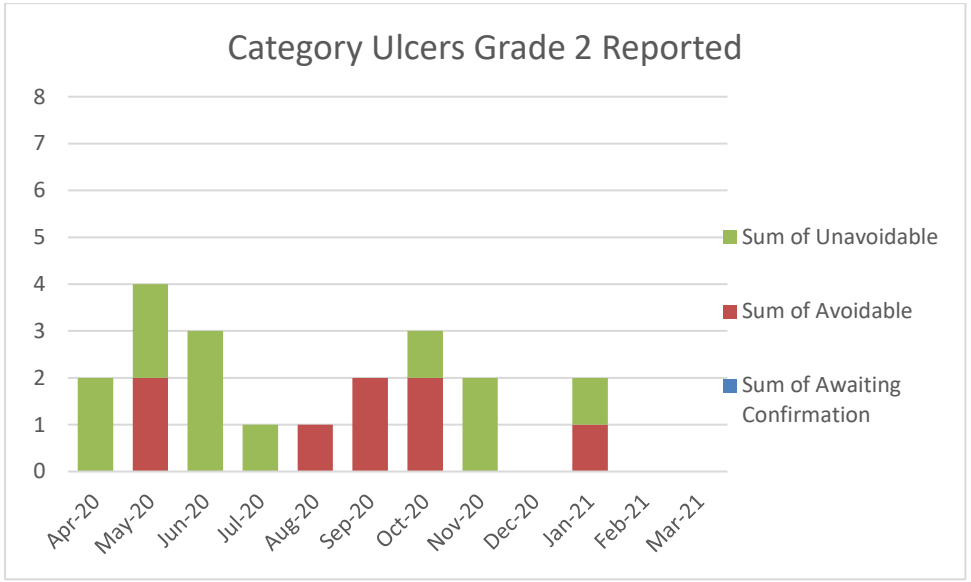
In addition, the majority of patients that had access to their call bell did not use it and nearly half of the patients attempted to mobilise against advice, mainly because they did not want to disturb staff. It appears to be a combination of factors rather than a single cause that has contributed to the increase in falls reported during October. Many of the patients that fell had several factors that would put them at greater risk of falling.

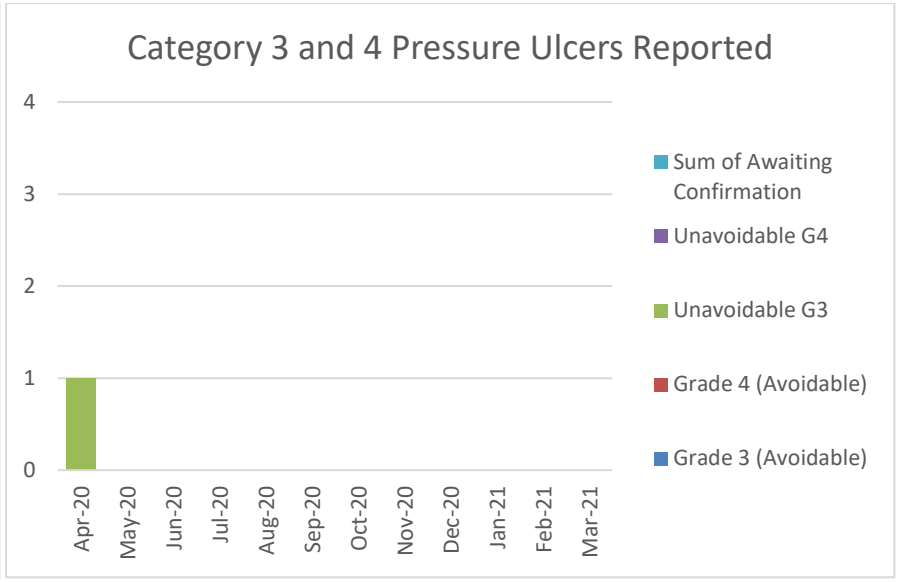
- Patient information leaflets for falls and bed rails content has been updated
- A business case has been approved for a Dementia and Mental health specialist nurse for the Trust
- WMQRS – Gap Analysis was presented at the Clinical Quality Group Meeting in January 2021. The report highlighted just one action open to meet compliance with the standard. This is in relation to the Falls boards on each clinical area and work is underway to update and improve tis.

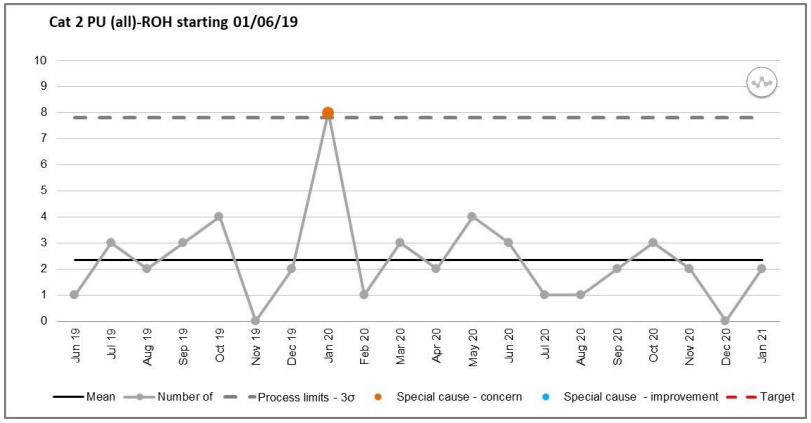
RISKS / ISSUES

None

7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.







Year Total	Cat 2	Cat 3
19/20	27	3
20/21	20	1

Data Source – Ulysses and TV team

INFORMATION

January 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	2
Category – 2 (Device)	0
Category – 1	6
Suspected Deep Tissue Injury	1
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence x 1 MASD ROH Intertriginous dermatitis – Nil

Patients admitted with PU's	PU admitted with Cat 1 x 5 None deteriorated PU admitted with Cat 2 x 15 –5 pt's own home 10 - UHB PU admitted with Cat 3 x 2 UHB - Did not deteriorate PU admitted with Cat 4 DTI – UHB

Avoidable only Pressure Ulcer CCG Contracts KPI

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	8
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

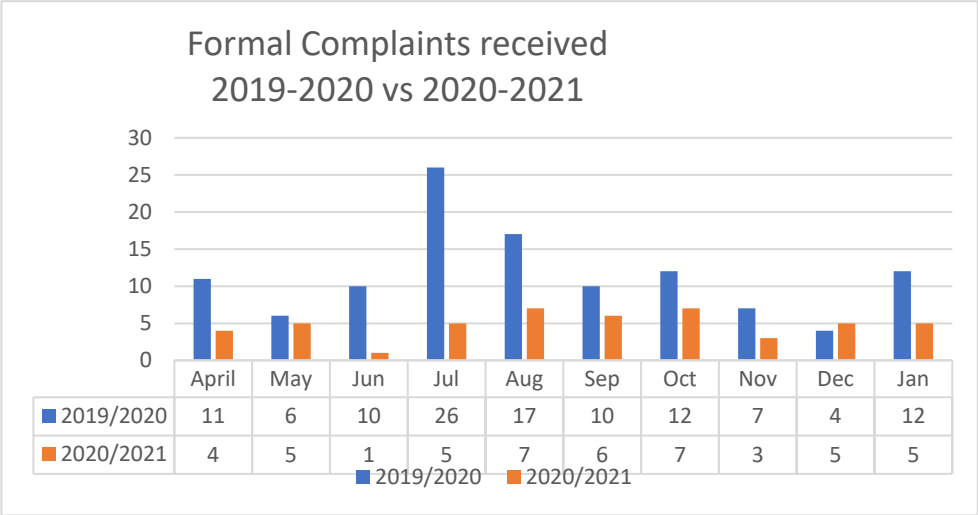
ACTIONS FOR IMPROVEMENTS / LEARNING

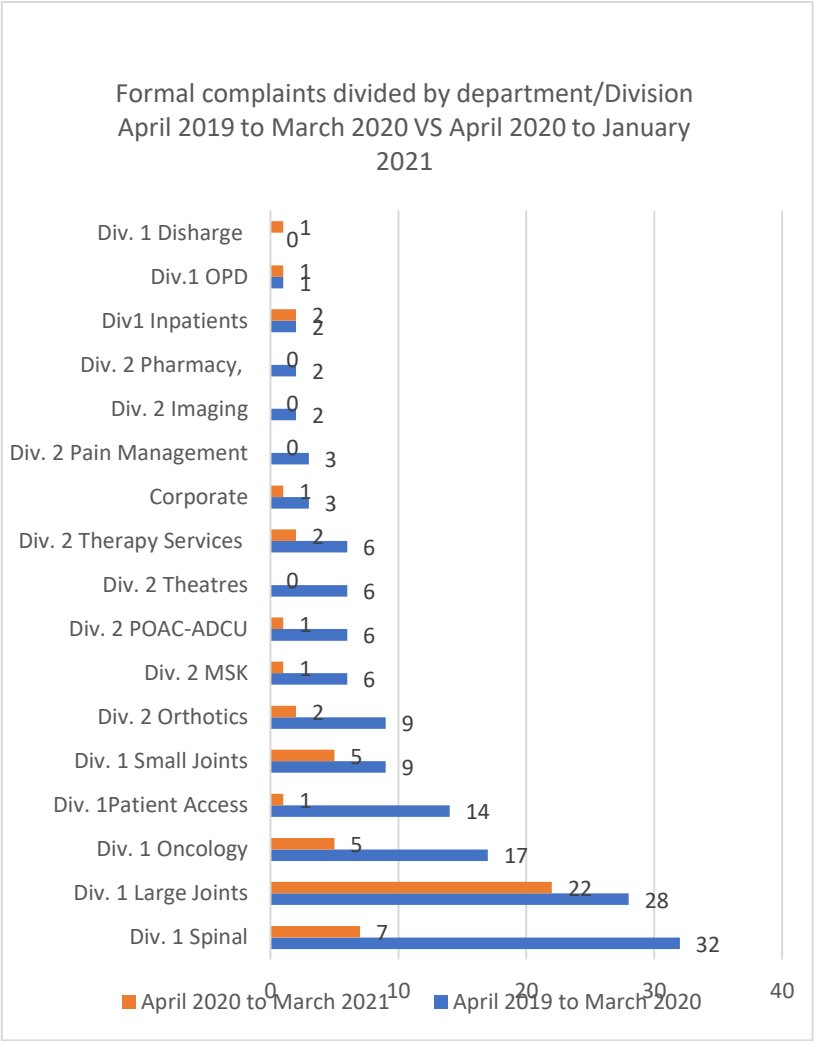
- Renasys Go pumps swopped for new improved Renasys Touch pumps in Dec 2020.
- TV Lead filmed skin assessment video to add to Fundamentals of Care on line teaching package.
- TV Competency booklet previously used will be amended to be used as support documents for the Fundamentals of Nursing Framework

RISKS / ISSUES

None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



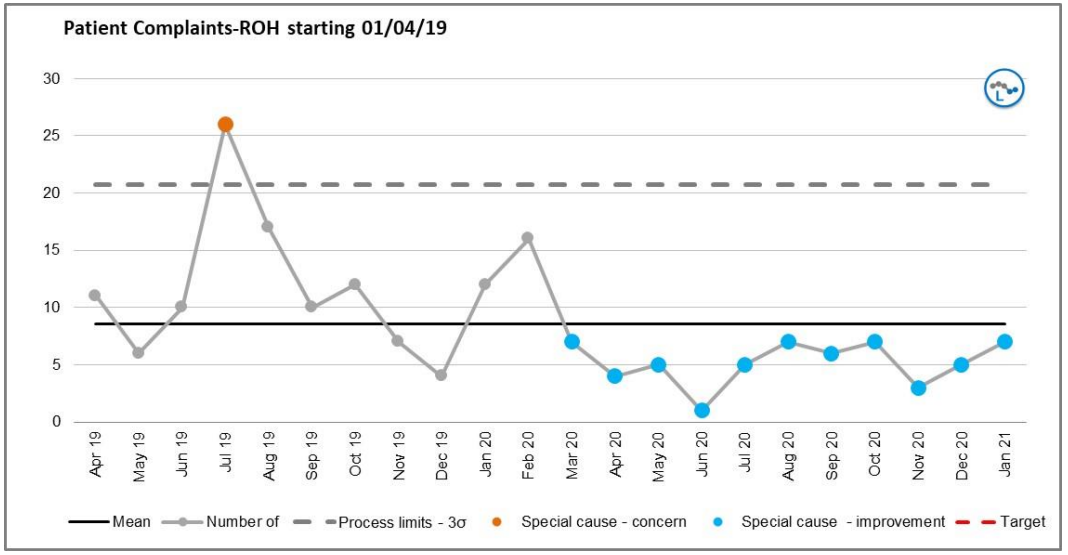


Data Source – Patient Experience team

Complaint Year Totals	
19/20	142
20/21	48

INFORMATION

Complaints



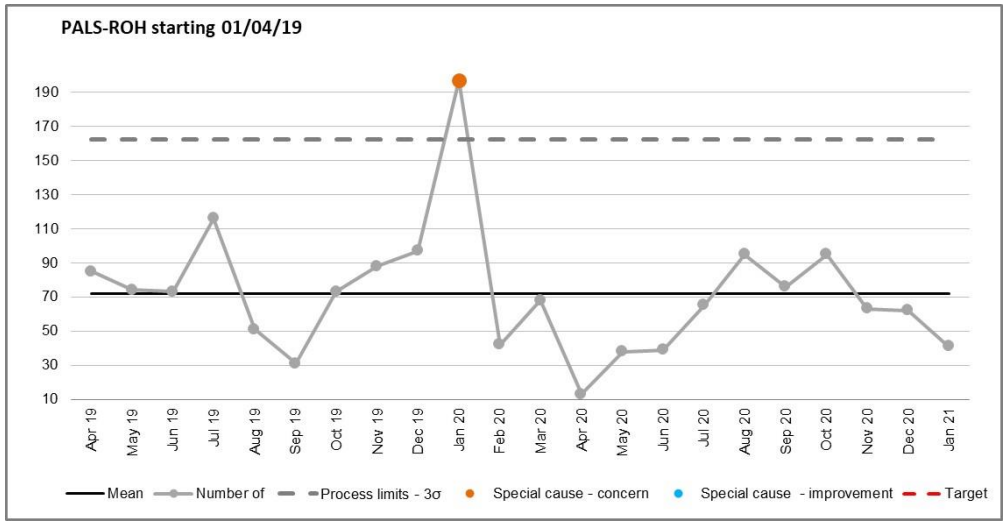
- There were 7 formal complaints received and acknowledged in January 2021, of which 3 were in relation to Division 1, 1 in relation to Division 2, 2 in relation to both divisions and 1 corporate.
- 2 complaints related to Division 1 were withdrawn by the complainant due to the complaint lead discussing the complaint with the complainant and resolving the patients concerns, both complainants received a letter from the Trust with summary of the conversation.
- Categories and subcategories of Formal complaints in January 2021 were:

Category Type/Category	Count
Appointments	**1**
Failure to Provide Follow up	1
Access to Treatment or Drugs	**1**
Access to Services	1
Admissions & Discharges	**1**

Discharge Arrangements	1
Covid-19	**1**
Cancellation of Appointment	1
Privacy, Dignity and Wellbeing	**1**
Discrimination - Disability	1

- In January 2021 – 5 Formal Complaints were closed. 4 were closed within the agreed date with patient. 1 Complaint had an extended time period, as agreed with the patient due to being a complex case, it has now been closed within the agreed date. This gives a 100% completion on time rate and meets the KPI for the month. The average response to a formal complaint was 24 days (KPI 25)
- There are currently 6 open complaints at the time of reporting.

Patient Advice and Liaison service - PALS



- In January 2021 the PALS department handled 41 contacts of which 25 were classified as concerns and 16 as enquiries. This is an increase in contacts compared to the same time last year (38 contacts in January 2020 according to Ulysses). The main themes in the PALS data relate to queries about Referral Delays and Appointment cancellations as a result of the COVID-19 pandemic.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In January 2021, 100% of enquires and 95.1% of concerns were handled within the agreed timescales with patient.
- 1 case was complex, thus having an extended timescale, as the PALS department was awaiting information from the Ward sister. Another case had an extended timescale as the Ward Manager did not follow PALS procedures.
- Top 5 categories and Top 2 subcategories PALS contacts for January 2021:

Top 5 Categories and top 2 subcategories for January 2021	
Appointments	**16**
Referral – Delay in Authorising	6
Appointment - Delay	2
Covid-19	**10**
Cancellation of Appointment	7
Appointment Booked Incorrectly	3
Patient Care Including Nutrition/Hydration	**4**
Care Needs Not Adequately Met	4
Communication	**3**
Communication Failure	1
Communication with Relatives	1
Admissions & Discharges	**3**
Discharge Arrangements	2

Patient experience KPI from April 2020 until January 2021

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-20	N/A	100	100
May-20	100	100	100
Jun-20	100	100	100
Jul-20	100	100	100
Aug-20	100	100	100
Sep-20	83.4	93.9	100
Oct-20	100	100	100
Nov-20	100	100	100
Dec-20	100	100	100
Jan-21	100	95.1	100

Compliments

There were 5 compliments recorded on Ulysses in January 2021.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Internal complaint process has changed- the divisional triumvirate identifies the lead and completes immediate actions plans.
- Deputy Head of Patient Experience has started an improvement project on the Ulysses system with new categories, departments and Directories and this will be live from April 2021 This will allow improved reporting and themes to be identified.
- The Executive Team have full oversight of the complaints in progress at the weekly Governance meeting
- Public engagement team is working on new structure to have more patient engagement
- An improved S.O.P. for PALS and complaints are in process to be created and added to Policy that is due for review in March 2021

RISKS / ISSUES

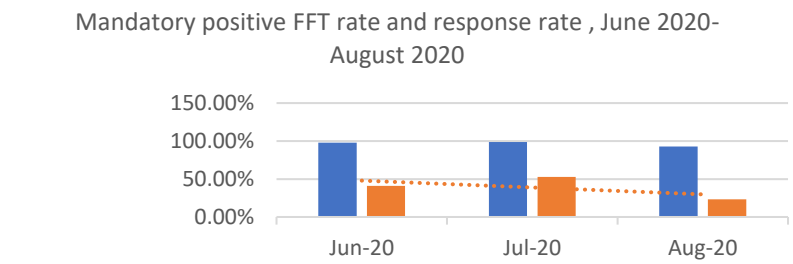
None

COMEBACK COMPLAINTS

There were no comeback complaints received in January 2021.

9. Friends and Family Test Results (collected in the iwantgreatcare system).

FFT Mandatory Reporting

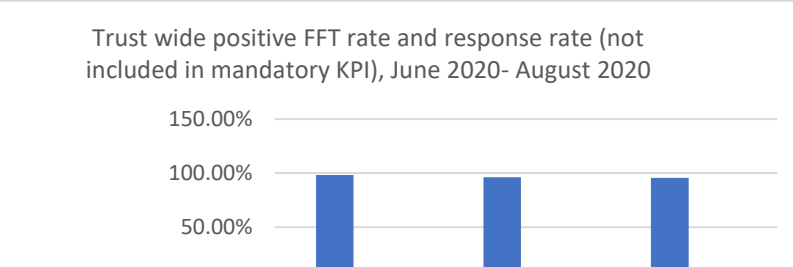


	Jun-20	Jul-20	Aug-20
Mandatory Positive rate	97.90%	98.73%	92.93%
Mandatory Response rate	41%	52.60%	23.11%

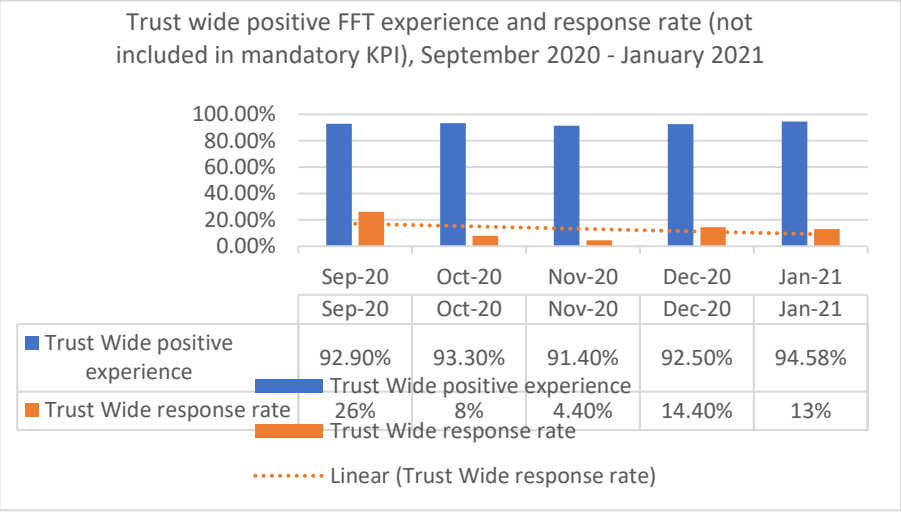


	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Mandatory Positive rate	95.32%	95.28%	92.99%	95.08%	90.51%
Mandatory Response rate	12.33%	65.50%	47.30%	36.50%	32%

FFT Non Mandatory Reporting

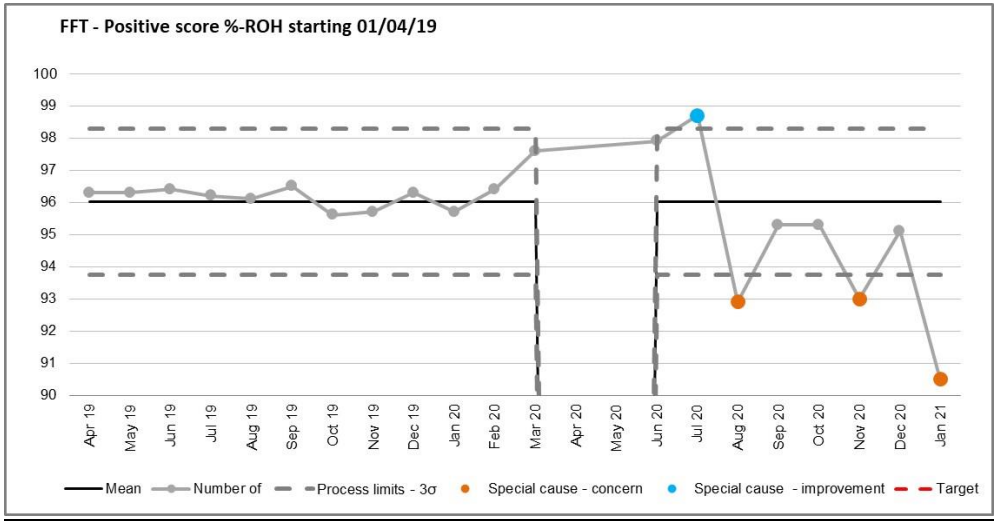


	Jun-20	Jul-20	Aug-20
Trust Wide Positive rate	98.20%	96.20%	95.50%
Response rate Trust Wide	9%	11%	8%



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Trust Wide positive experience	92.90%	93.30%	91.40%	92.50%	94.58%
Trust Wide response rate	26%	8%	4.40%	14.40%	13%

SPC chart showing the positive rate – In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison – April and May 2020 data was not collected due to the Covid 19 Pandemic.



INFORMATION

- There appears to be a disparity between data collection and results published. There is a plan to scale down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. The graphs above have been broken down by mandatory and non mandatory areas to allow the Trust to focus on the mandatory areas. From February 2021 the Trust will not report on the non-mandatory areas until the data quality issues are resolved.
- In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison.
- The Trust did not collect FFT during April and May 2020 due to COVID-19 pandemic, The Trust restarted the reporting and collection of FFT in June 2020,
- In January 2021 Trust received a confirmation email from IWGC that data from August 2020 and September 2020 was recovered. These are now included within the report
- Area Managers are receiving any compliments or concerns from patients in spreadsheet via the PALS team. This allows the areas to share with their staff for learning and improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The Public engagement team will look more closely on areas that do not fulfil mandatory 40% target in FFT response (return) rates.
- The Public engagement team reviewing possibility of sending web links for FFT in text messages to patients. This will help improve collection of the data.
- The Public Engagement team is in process of creating a template for compliment so they can be displayed to the public within departments.
- Trust is reviewing contract with the I Want Great Care software supplier

RISKS / ISSUES

- In October 2020 Public Engagement team received an email for IWGC that they have an issue with collecting data and that they did not formulate all FFT forms that have been sent to them during August 2020 nor September 2020.
- Public Engagement team recalled mandatory target data for August 2020 and did not issue mandatory target for September 2020, as IWGC did not find all forms that we sent, this is not patient identifiable data
- Data Quality issues with FFT data have been highlighted and work is underway with the software company and ROH to rectify

.

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 14 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

<u>New claims</u>

0 new claims against the Trust were received in January 2021

<u>On-going claims</u>

There are currently 26 on-going claims against the Trust.

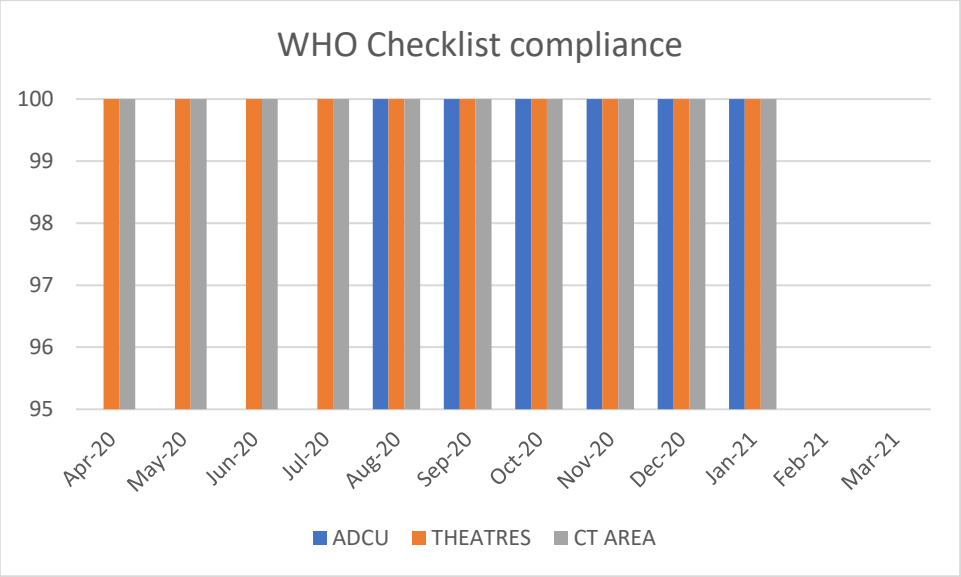
<u>Pre-Application Disclosure Requests</u>

5 new requests for Pre-Application Disclosure of medical records were received in January 2021.

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in January 2021

12. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 309

The total WHO compliance for Theatres in January 2021= 100%

CT area

Total cases = 69

The total WHO compliance for CT in January 2021 = 100%

ADCU

The total WHO compliance for ADCU in January 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non-compliance will be reported back to the relevant clinical area.

The Theatre man system originally stated 3 incomplete patients on the Theatres lists, upon review all documentation and WHO Checklists for all patients complete and therefore compliant

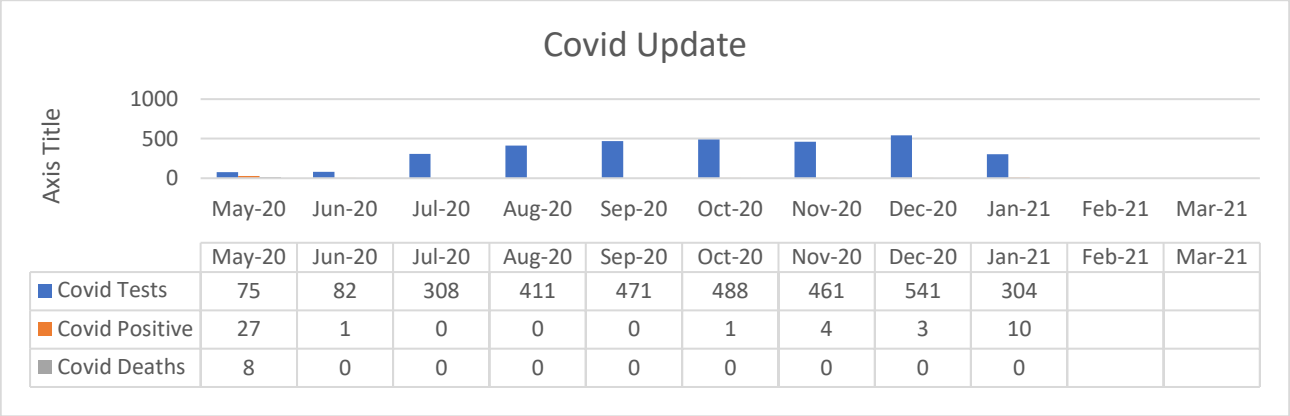
RISKS / ISSUES

None

13. Infection Prevention Control – Statutory requirement/Reportable Infections. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	January 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	1
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	1
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Covid Tests	75	82	308	411	471	488	461	541	304		
Covid Positive	27	1	0	0	0	1	4	3	10		
Covid Deaths	8	0	0	0	0	0	0	0	0		

ACTIONS FOR IMPROVEMENTS / LEARNING

10 patients tested as positive.

RISKS / ISSUES

- ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.
- Gap Analysis underway against the NHS England national Guidance

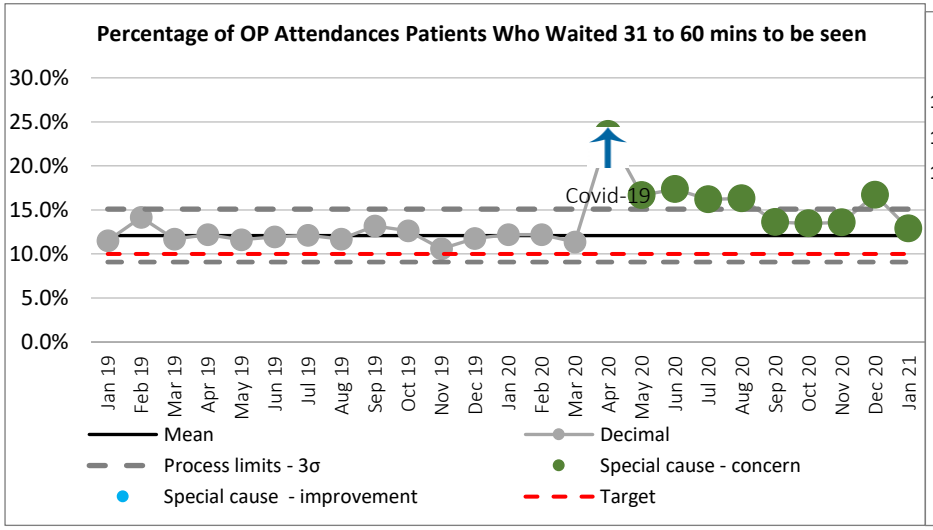
***Data Source – IPC team and Ulysses**

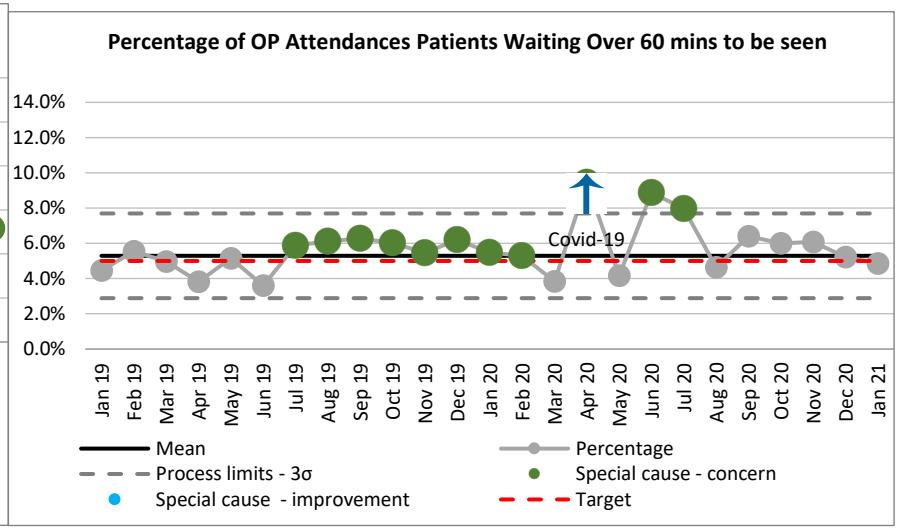
14. Safeguarding

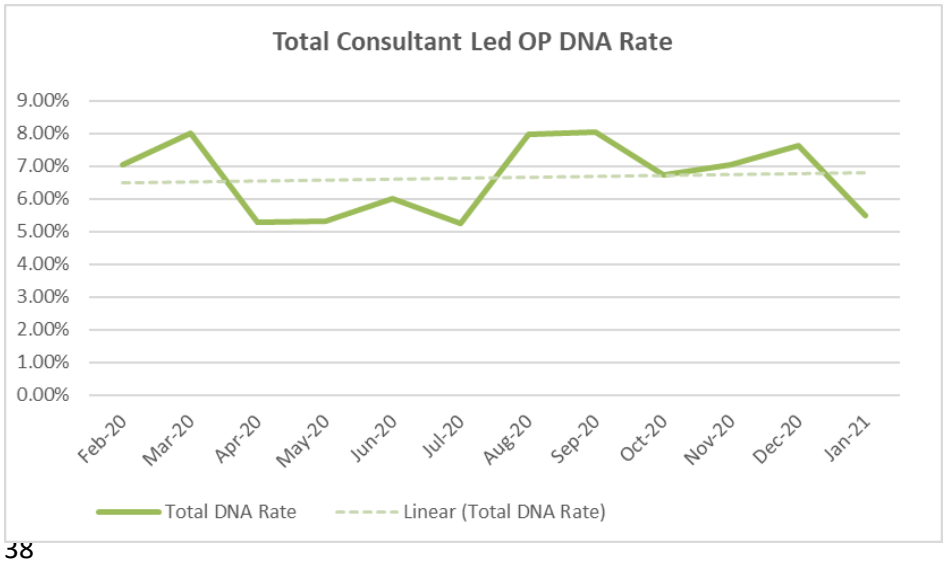
	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021
Safeguarding Adult Notifications	32	28	11	58	35	14	17	14	22	43	29	32	41
Safeguarding Children and Young People Notifications	36	28	17	3	1	5	4	6	8	22	18	27	18
Mental Health Incidents	11+	11+	6	3	4	8	17	29	52	51	25	15	7
LD Adult	19	13	5	2	0	3	2	7	3	3	7	5	5
LD Children	62	39	28	0	0	4	13	10	18	41	65	46	13
Adult Level 2	98.77	98.77	99.53	99.34%	99.23%	98.60%	98.32%	99.14%	99.14%	98.20%	98.2%	97.48%	98.12
Adult Level 3	66.42	76.62	71.86	68.69%	69.19%	75.25%	78.03%	81.78%	81.78%	85.24%	85%	85.75%	84.77
Level 4	80.00	80.00	80.00	80.00%	75.00%	75.00%	75.0%	50.0%	50%	75.0$%	80%	80%	100
Child Level 2	98.77	98.77	99.34	99.15%	99.04%	98.31%	98.04%	98.95%	98.95%	97.99%	97.92%	97.30%	97.93
Child Level 3	68.59	75.35	74.88	71.88%	71.86%	77.48%	78.90%	82.75%	81.78%	86.46%	86.45%	86.71%	85.51
Mental Capacity Act MCA	99.62	99.62	100	99.44%	99.23%	97.95%	97.57%	97.90%	97.9%	96.59%	95.41%	93.93%	97.51
Deprivation of Liberty Safeguards DoLs	99.61	99.60	100	99.62%	99.60%	98.26%	97.87%	98.03%	98.03%	96.70%	95.27%	93.76%	97.44
Prevent **WRAP**	88.78	90.68	95.33	88.56%	87.66%	84.47%	86.63%	88.89%	88.89%	84.59%	85.96%	86.88%	83.68%
CE	0	0	0	0	0	0	0	0	0	1	0	0	0
FGM	0	0	0	0	0	0	1	0	0	0	0	1	0
DOLS	4	5	2	34	12	3	4	1	3	13	5	6	20
MCA	2	2	0	1	0	0	0	3	1	1	1	1	3
PIPOT cases	0	0	0	0	0	0	0	0	1	0	0	1	

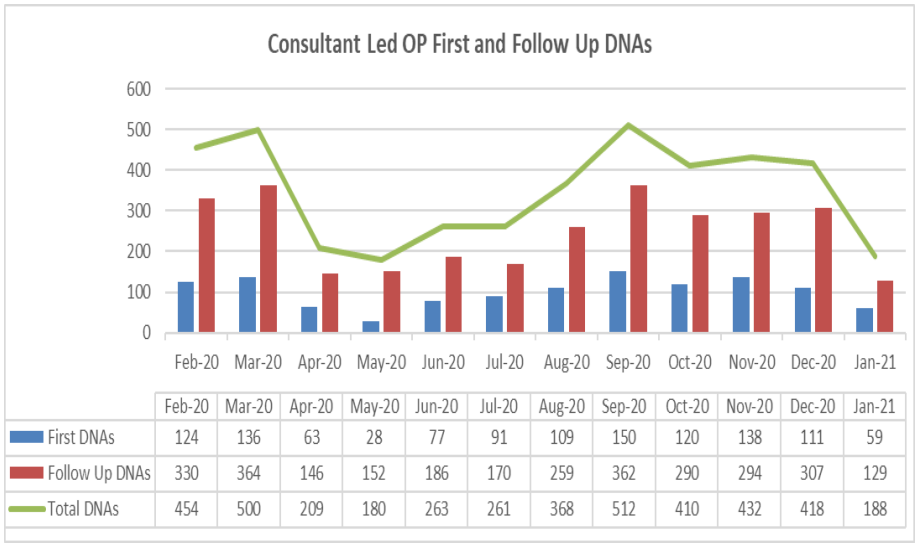
Domestic Abuse	0	2	3	4	1	2	2	0	2	3	4	3	1
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0
WNB	31	21	9	2	2	1	1	3	4	4	1	3	6
Child in Care	4	2	0	0	0	1	0	0	0	5	4	1	2
Early Help	0	0	0	0	0	0	0	0	0	6	2	0	1
DHR- scoping Reviews	0	?	1	0	1	1	0	0	2	0	0	2	0
SARs- scoping review **Or Rapid Reviews**	3	0	0	0	0	1	0	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0	0	0	1	0	0	0	0
Incidents	10	10	7	33	21	7	6	4	6	13	10	8	
Open Cases							10	7	1	8	5	18	17
Closed Cases							10	8	29	57	42	41	42

15. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
First DNAs	124	136	63	28	77	91	109	150	120	138	111	59
Follow Up DNAs	330	364	146	152	186	170	259	362	290	294	307	129
Total DNAs	454	500	209	180	263	261	368	512	410	432	418	188

INFORMATION
The technical reporting issues for outpatient waiting times have now been resolved for reporting going forward. 30 minute delays – Reduced in January at 12.09% compared to 16.7% in December. Trust Target is 10% - Trust target not achieved 60 minute delays – January 4.9% of patients were delayed compared to compared to 5.2% in December. Target is 5% therefore – Trust target achieved The position in January is an improvement compared to recent months however there is further work to be undertaken with Oncology clinic delays and patients waiting for imaging procedures . An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure our patients are seen on time for their appointments. An audit will take place of all delays in March to analyse any key issues and scope solutions.
ACTIONS FOR IMPROVEMENTS / LEARNING
The DNA rates have reduced in January to 5.49% compared to 7.42% in December and continues to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department. Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.
RISKS / ISSUES
Lack of space in outpatients continues to be a concern and currently solutions are being scoped. One of the options being explored is the use of an alternative location for virtual clinics. A sheltered and heated seated area is now on site adjacent to the Out Patient department to keep patients and visitors comfortable if they need to wait outside for their appointment, although flow of patients is monitored to ensure this is minimised.

16. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories

Referral to Treatment snapshot as at 31st January 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

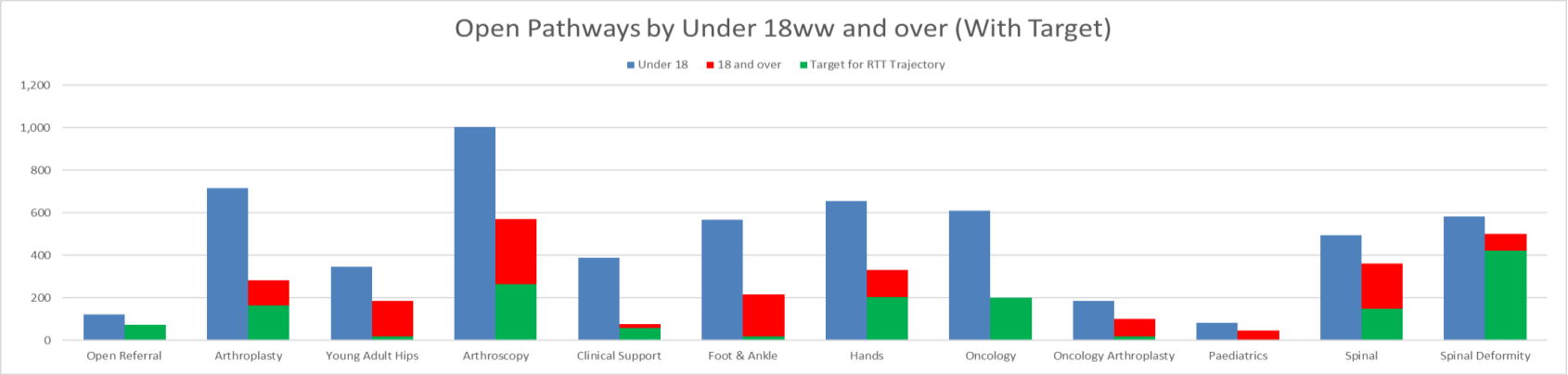
Est Over 18 Clock Stops Required		
To achieve	81.47%	1652
To achieve	71.13%	471
To achieve	81.74%	1679

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,144**	102	292	116	341	154	202	210	252	47	31	189	208
7-13	**2,322**	15	264	147	429	145	234	285	239	100	39	198	227
14-17	**1,290**	4	159	83	233	90	132	161	120	40	13	107	148
18-26	**1,569**	0	186	125	291	65	163	200	45	69	28	163	234
27-39	**749**	0	71	40	163	11	41	94	13	25	14	105	172
40-47	**254**	0	16	12	69	0	4	17	8	3	6	58	61
48-51	**132**	0	8	3	32	1	8	13	2	5	0	31	29
52 weeks and over	**42**	0	3	5	15	0	1	7	0	0	0	5	6
Total	**8,502**	121	999	531	1,573	466	785	987	679	289	131	856	1,085

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,756**	121	715	346	1,003	389	568	656	611	187	83	494	583
18 and over	**2,746**	0	284	185	570	77	217	331	68	102	48	362	502
Target for RTT Trajectory	**1575**	75	166	19	264	60	21	205	202	19	5	149	422
Target for RTT 92%	**680**	**9**	**79**	**42**	**125**	**37**	**62**	**78**	**54**	**23**	**10**	**68**	**86**

Month End RTT %	**67.70%**	**100.00%**	**71.57%**	**65.16%**	**63.76%**	**83.48%**	**72.36%**	**66.46%**	**89.99%**	**64.71%**	**63.36%**	**57.71%**	**53.73%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,171	-75	118	166	306	17	196	126	-134	83	43	213	80
Variance from target 92%	2,066	-9	205	143	445	40	155	253	14	79	38	294	416



Referral to Treatment Snapshot as at 31st January 2021 – Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

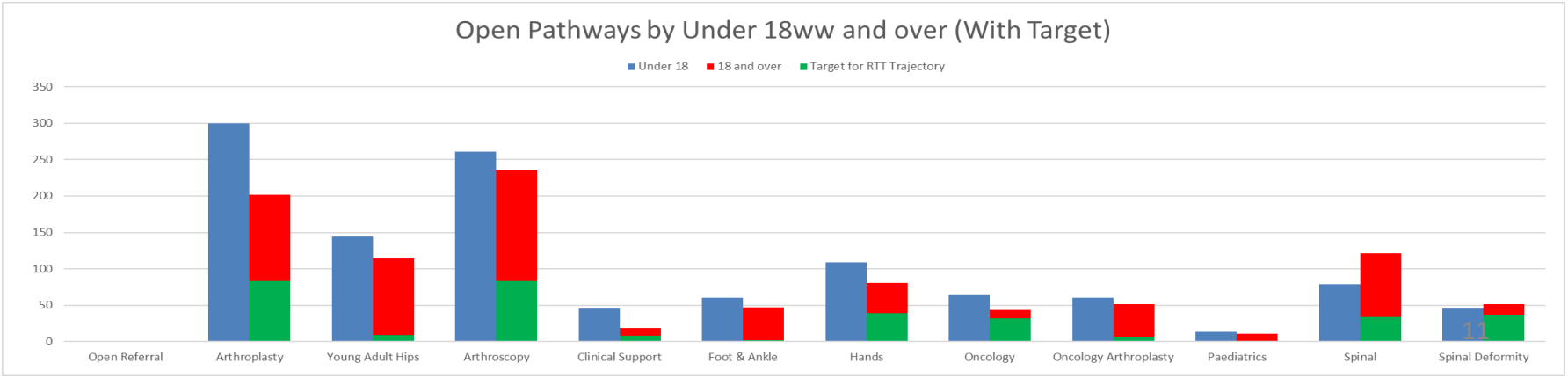
Est Over 18 Clock Stops Required		
To achieve	81.47%	816
To achieve	71.13%	573
To achieve	81.74%	821

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**312**	0	70	31	65	18	10	29	23	16	7	28	15
7-13	**529**	0	129	67	133	16	29	44	25	32	5	31	18
14-17	**340**	0	101	46	63	11	21	36	16	12	2	20	12
18-26	**529**	0	140	79	97	15	28	32	24	37	9	48	20
27-39	**228**	0	42	18	60	4	8	32	10	10	1	28	15
40-47	**105**	0	11	9	39	0	2	5	8	2	1	21	7
48-51	**87**	0	7	3	28	0	8	8	2	3	0	19	9
52 weeks and over	**29**	0	2	5	11	0	1	4	0	0	0	5	1
Total	**2,159**	0	502	258	496	64	107	190	108	112	25	200	97

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,181**	0	300	144	261	45	60	109	64	60	14	79	45
18 and over	**978**	0	202	114	235	19	47	81	44	52	11	121	52
Target for RTT Trajectory	**400**	0	83	9	83	8	2	39	32	7	1	34	37
Target for RTT 92%	**172**	**0**	**40**	**20**	**39**	**5**	**8**	**15**	**8**	**8**	**2**	**16**	**7**

Month End RTT %	**54.70%**	**n/a**	**59.76%**	**55.81%**	**52.62%**	**70.31%**	**56.07%**	**57.37%**	**59.26%**	**53.57%**	**56.00%**	**39.50%**	**46.39%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	578	0	119	105	152	11	45	42	12	45	10	87	15
Variance from target 92%	806	0	162	94	196	14	39	66	36	44	9	105	45



Referral to Treatment Snapshot as 31st January 2021 (non admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

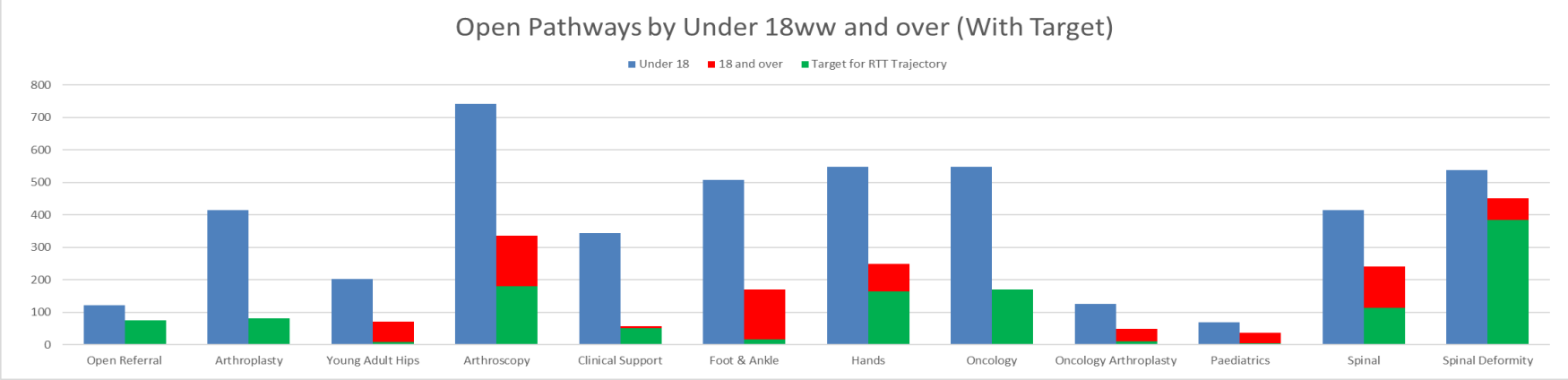
Est Over 18 Clock Stops Required		
To achieve	81.47%	837
To achieve	71.13%	-103
To achieve	81.74%	858

Select Pathway Type: Non Admitted

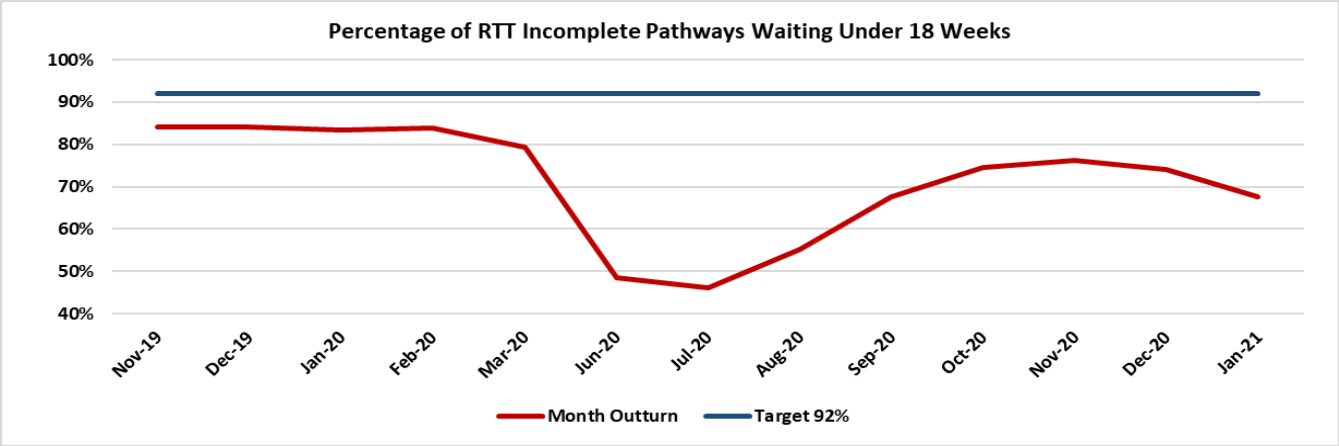
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,832**	102	222	85	276	136	192	181	229	31	24	161	193
7-13	**1,793**	15	135	80	296	129	205	241	214	68	34	167	209
14-17	**950**	4	58	37	170	79	111	125	104	28	11	87	136
18-26	**1,040**	0	46	46	194	50	135	168	21	32	19	115	214
27-39	**521**	0	29	22	103	7	33	62	3	15	13	77	157
40-47	**149**	0	5	3	30	0	2	12	0	1	5	37	54
48-51	**45**	0	1	0	4	1	0	5	0	2	0	12	20
52 weeks and over	**13**	0	1	0	4	0	0	3	0	0	0	0	5
Total	**6,343**	121	497	273	1,077	402	678	797	571	177	106	656	988

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,575**	121	415	202	742	344	508	547	547	127	69	415	538
18 and over	**1,768**	0	82	71	335	58	170	250	24	50	37	241	450
Target for RTT Trajectory	**1175**	75	82	10	181	52	18	165	170	11	4	114	385
Target for RTT 92%	**507**	**9**	**39**	**21**	**86**	**32**	**54**	**63**	**45**	**14**	**8**	**52**	**79**

Month End RTT %	**72.13%**	**100.00%**	**83.50%**	**73.99%**	**68.90%**	**85.57%**	**74.93%**	**68.63%**	**95.80%**	**71.75%**	**65.09%**	**63.26%**	**54.45%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	593	-75	0	61	154	6	152	85	-146	39	33	127	65
Variance from target 92%	1,261	-9	43	50	249	26	116	187	-21	36	29	189	371



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for January is 67.70% against the National compliance target of 92%. This is a decrease compared to December at 73.97 % and is reflective of the cessation of elective procedures in order to undertake core critical services i.e. emergencies, spinal, oncology and P2 patients during the third wave. There are 42 patients over 52 weeks. There are 29 admitted patients all are priority 3 or 4 priority level. There are 9 non admitted patients with face to face clinics or diagnostic investigations now planned.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. 386 patients are waiting over 40 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2159 patients are on the admitted waiting list (P2 – 117 patients, P3 – 412 patients, P4 – 1627 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the process is standardised across all specialties and to provide assurance going forward all patients are reviewed on a regular basis. At PTL meetings P1 and P2 patients are reviewed to ensure they are booked for surgery in the appropriate timeframe for their set priority.

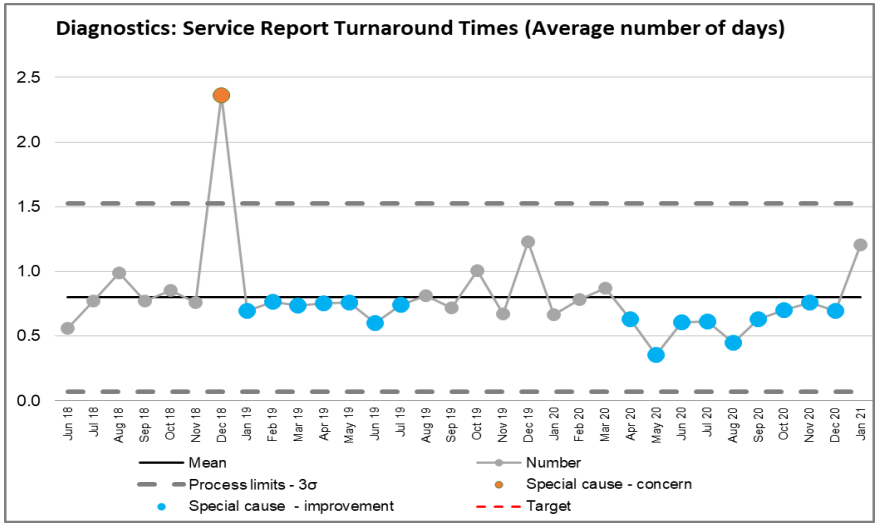
The total number of referrals into the Trust in January was 1484 which is low (55%) when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GPs to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GPs.

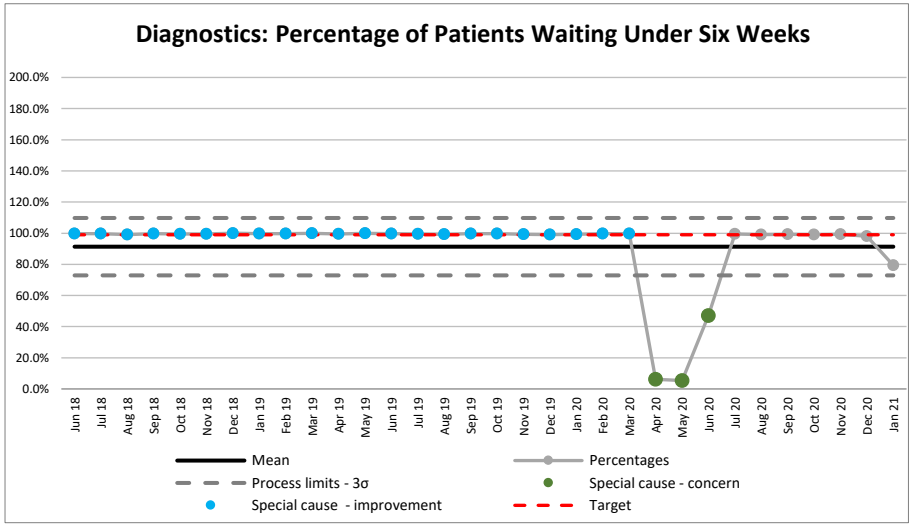
Treatment targets – This illustrates how the Trust is performing against national treatment target

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Feb-20	1051	98	450	1599	6	1593	99.6%	894	247	497	1638
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION
Imaging did not achieve the diagnostic target reporting 85.06% for January but continues to report consistently good performance for report turn around times. January saw a continued reduction in performance as a result of the suspension of non urgent referrals and provide mutual aid to the system. We have now resumed all non urgent imaging services to support the increasing waiting lists for non urgent diagnostics. The team will continue to source additional capacity to recover the diagnostic target throughout February with the expectation that the diagnostic target will be achieved by the end of March at the latest. Additional MRI capacity in the independent sector has been made available, with 20 patients being sent throughout February.
ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
Impact of a 3rd wave of covid reducing referrals further impacting on diagnostic activity . The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

Cancer Performance Targets

		Indicative	Reported Month												
Target Name	National Standard	Jan-21	Dec-20	In Target	Breach	Total	Nov-20	In Target	Breach	Total	Oct-20	In Target	Breach	Total	Q3 Perf 2020/ 2021
2ww	93%	100.0%	100.0%	61	0	61	100.0%	60	0	60	98.4%	61	1	62	99.0%
31 day first treatment	96%	100.0%	100.0%	12	0	12	100.0%	11	0	11	100.0%	13	0	13	100.0%
31 day subsequent (surgery)	94%	88.9%	100.0%	4	0	4	100.0%	9	0	9	100.0%	10	0	10	100.0%
62 day (traditional)	85%	80.0%	73.3%	5.5	2.0	7.5	57.7%	2.0	1.5	3.5	77.8%	3.5	1	4.5	69%
62 day (Cons Upgrade)	n/a	100%	100.00%	4.0	0.0	4.0	92.9%	6.5	0.5	7.0	100.0%	4.5	0.0	4.5	98.0%
28 day FDS REPORTED	75%	67%	69%	50	22	72	69.1%	56	24	80	79.4%	50	13	63	72%
28 day FDS INTERNAL	75%		73%	50	19	69	77.7%	53	6	59	85.7%	48	8	56	
No. patients treated 104+ days													1		1

INFORMATION

For the month of December 2020, all cancer waiting times standards were met with exception of the 62 day standard and FDS. A total 5.5 treatments were compliant with 62 day standard and 2 patients breached the target.

1 breach was due to ROH being middle trust for diagnostics, ROH investigated the patient for a total of 29 days then transferred to another provider for treatment therefore are accountable for a full breach, as per the updated breach allocation policy.

1 breach was due to a complex diagnostic pathway. (The patient had a total wait of 28 days for soft tissue biopsy to be reported due to needing three further complex molecular testing.)

The 28 day FDS was not achieved at 69% for December. There were 22 out of 72 patients given their diagnoses outside of 28 days, and this was mainly due to complex diagnostic pathways.

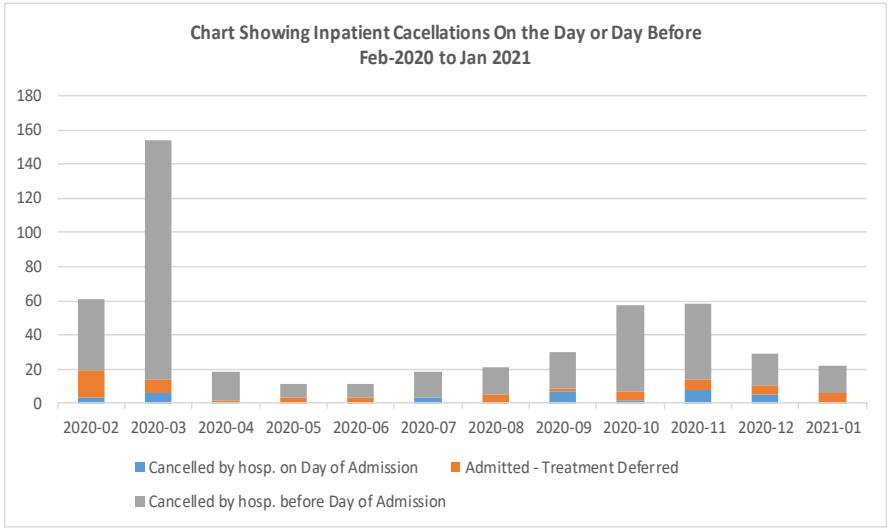
The Weekly Cancer PTL meeting continues to monitor and track patients along their pathway with an escalation protocol in place.

Risks

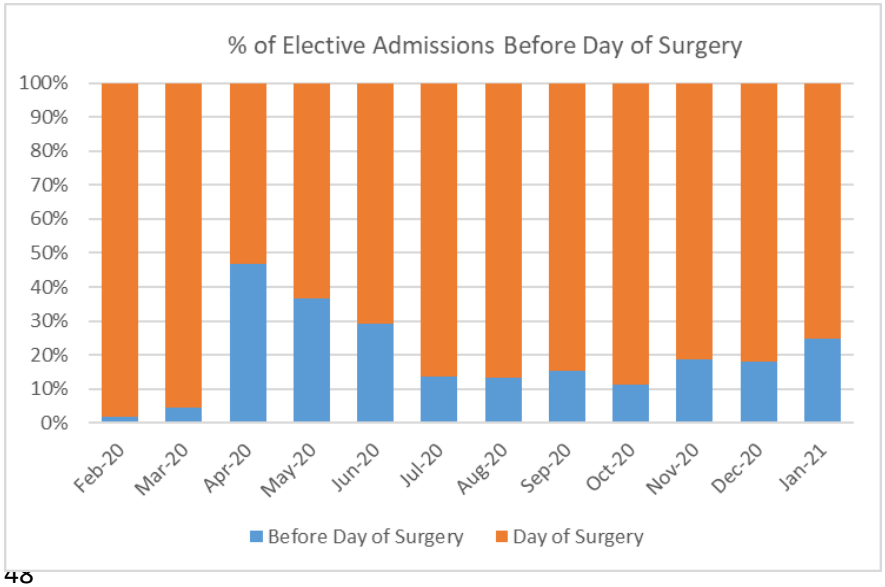
Paediatric Surgery has been suspended at Birmingham Children's Hospital. Predicted recommencement date for Surgery is April 2021. The divert for referrals remains in place to the 4 PMBT centres, 3 of which have agreed to continue reviewing and treating any patients referred into ROH. Referral divert scheduled to be lifted on 22nd February 2021.

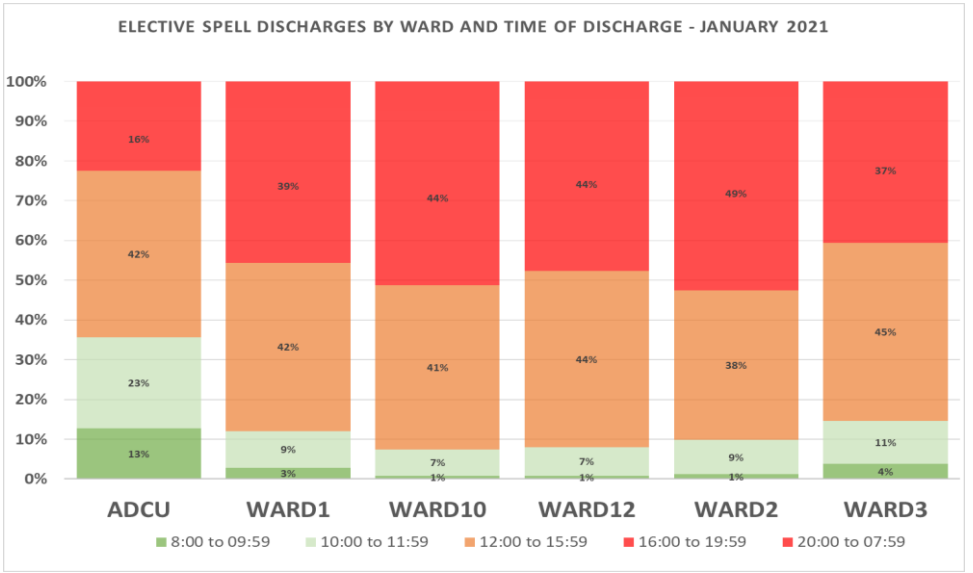
Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways, both of which are under current analysis and review. Recruitment issues remain an ongoing concern to appoint a specialist bone and soft tissue Pathologist at UHB . This is a national challenge across sarcoma centres and discussions are ongoing with UHB , Medical Director , Chief Operating Officer and the National Pathology network to source alternative solutions. This issue will be tabled for discussion at the Trust Quality and Safety Committee.

17. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



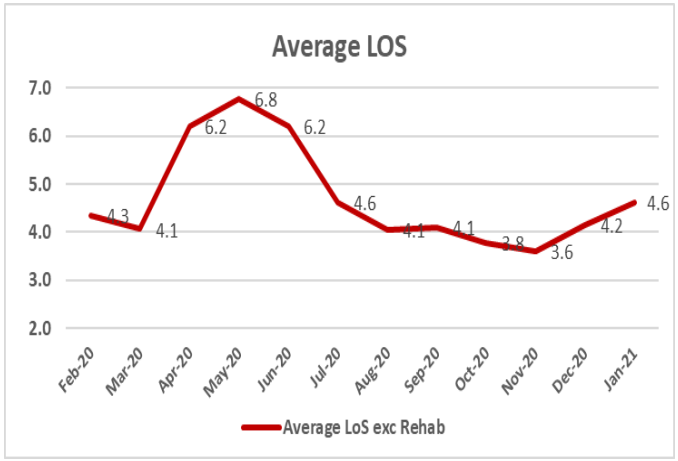
Sum of Total	Cancellation Category			
Year-Mth	Cancelled by hosp. On Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp.before Day of Admission	Grand Total
2020-02	3	16	42	61
2020-03	6	8	138	152
2020-04	1	1	15	17
2020-05	0	3	8	11
2020-06	0	3	8	11
2020-07	3	0	15	18
2020-08	0	5	16	21
2020-09	7	2	21	30
2020-10	2	5	48	55
2020-11	6	2	11	19
2020-12	4	6	14	24
2021-01	0	6	16	22
Grand Total	32	57	352	441

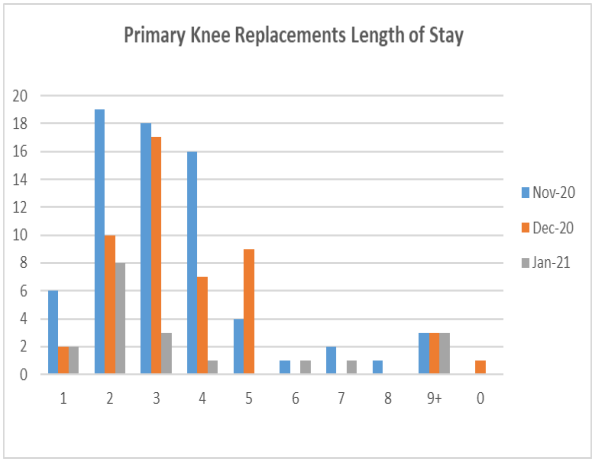


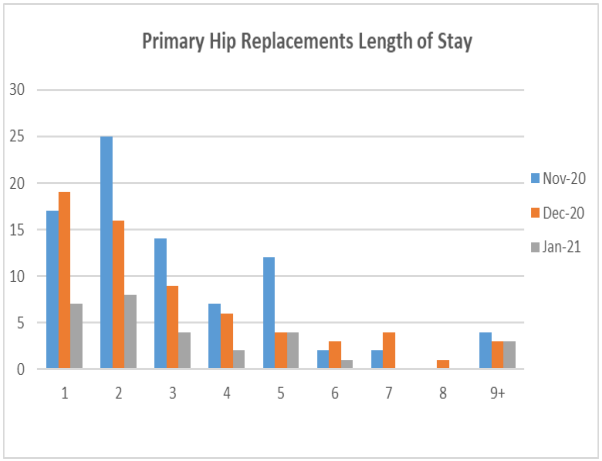


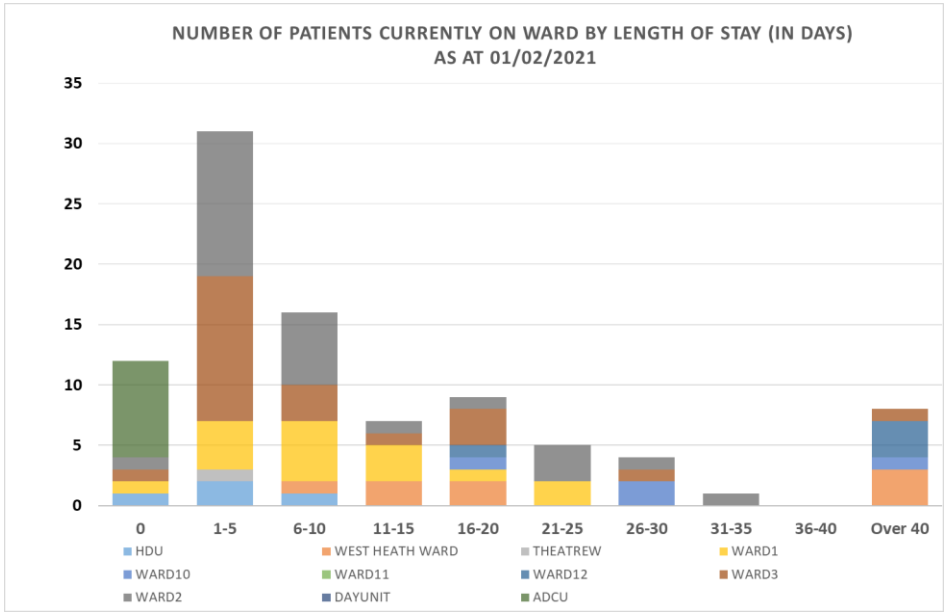
INFORMATION
There were no patients cancelled on the day of admission in January, however there were 6 patients admitted but where treatment was deferred, with reasons broken down as follows: 2 x patients self discharged 1 x patient declined to have surgery until they have received the vaccine. 1 x patient tested positive for covid 2 patients medically not fit Cancellations prior to day of surgery for January were 16 as detailed below: 1 x patient self cancelled their TCI 6 x Covid positive / household member being tested for Covid/broke isolation 5 x TCI's rescheduled/cancelled 1 x patient was cancelled due to an emergency case – patient re-scheduled. 2 x patients not medically fit – TCU deferred 1 x referring hospital did not book patients transport
ACTIONS FOR IMPROVEMENTS / LEARNING
864 continues in a strengthened format with executive oversight to maximise resources both in theatre and on wards
RISKS / ISSUES
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient cancellations which will require monitoring as services are recovered through the harm review process .

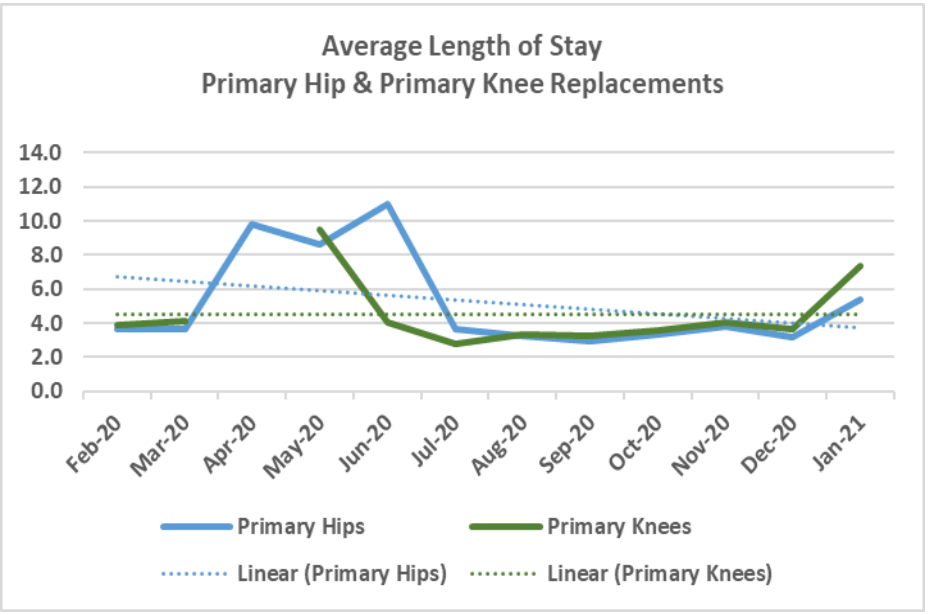
18. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION
LOS has increased in January to 4.6. as anticipated due to the profile of the elective P2 patients many whom are more complex than the usual elective activity and the profile of the patients repatriated from UHB for acute orthopaedic rehab and medical rehab. All patients with a LOS greater than 18 days have been reviewed by the Head of Nursing, Division 1. All were complex cases and remained in hospital due to on-going clinical/medical needs e.g. BIU/infected wound management, COVID, further surgery. None of those reviewed were due to delayed discharge. Any delayed discharges are discussed at the daily meeting and escalated if they is no immediate plan or resolution.
ACTIONS FOR IMPROVEMENTS / LEARNING
The roaming discharge team supported by the safeguarding team continue to provide discharge support to the wards. This supports and promotes early discharge planning.
RISKS / ISSUES
ROH for now is identified as being the pathway 2 beds for the QE Rehab patients which is likely to increase length of stay further.

19. – CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

CAS ALERTS 1 - 31 Jan 2021

ON-GOING ALERTS FROM PREVIOUS MONTHS

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
EFA/2020/001	Allergens Issues - Food Safety in the NHS.	NHS Improvement Estates and Facilities	29-Jan-20	Policy on the agenda for February 2021 Clinical Quality Group	12-Aug-20

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Finance and Performance Report

January 2020

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11	Outpatient Efficiency	
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13	Workforce Targets	

INTRODUCTION

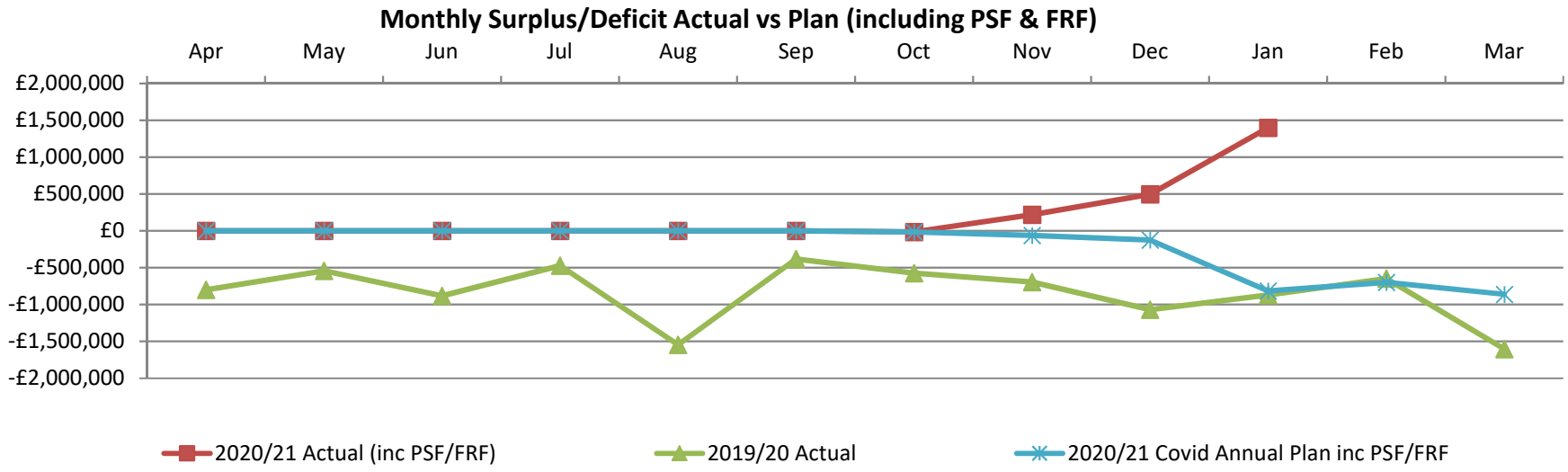
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

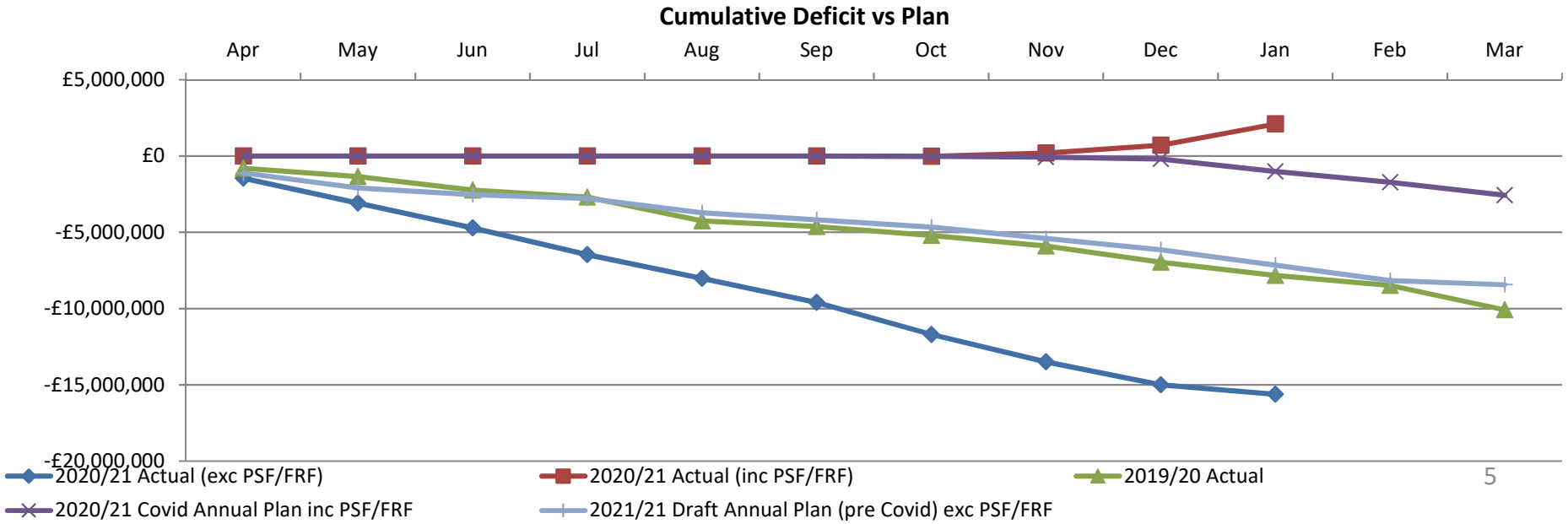
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	NHS I Plan M10 2020/21	Actual M10 2020/21	Variance
	£'000	£'000	£'000
Operating Income from Patient Care Activities (exc PSF & FRF)	71,828	73,935	2,107
Other Operating Income (Excluding top up)	2,703	3,183	480
Total Income	**74,531**	**77,118**	2,587
Employee Expenses (inc. Agency)	(46,554)	(46,606)	-52
Other operating expenses	(37,578)	(37,373)	205
Operating Deficit	(9,601)	**(8,306)**	1,295
Net Finance Costs	(1,059)	(729)	330
Net deficit	(10,661)	**(7,577)**	3,084
Remove donated asset I&E impact	55	56	1
Adjusted financial performance (exc PSF & FRF)	(10,612)	**(7,521)**	3,091
PRF/FRF monies	9,594	9,595	1
Adjusted financial performance surplus/(deficit) including PSF & FRF	(1,011)	**2,074**	3,085

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan on both a monthly and cumulative basis





INFORMATION

The trust delivered an in-month (January) surplus of £1,356,032 against an in month deficit plan of £813,000. The year to date performance is a surplus of £2,073,983, which is ahead of the planned deficit of £1,011,490. The improved performance is related primarily to an additional one off STP reserve allocation in month of £1,868,000. An underlying deficit position in month of £511,968 is reporting with the one off allocation excluded.

	Plan	Actual	Variance
In Month	-£813,000	£1,356,032	£2,169,032
Year to date	-£1,011,490	£2,073,983	£3,085,478

The block payment system with commissioners has been extended for the remainder of the year and for the first quarter of 2021/22, although the financial envelope for that period has not yet been agreed. In addition to a monthly block allocation, the Trust are receiving an allocation of STP growth monies and a COVID allocation.

The end of year forecast position has improved to a deficit of £371,514 as a result of the additional STP reserve allocation. This includes £8.1m top up funding and £3.9m of growth and COVID allocation.

Financial planning for 2021/22 has commenced and will be shared in due course

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

The current financial block allocation does not adequately cover the costs of Phase 2 of the theatre/ward development which start from December, and therefore the Trust are expected to deliver an underlying deficit before top up, growth and COVID income are accounted for.

In addition, COVID-19 is expected to continue to have a significant operational and financial impact on the organisation and wider system. The financial impact of this will need to continue to be carefully managed.

2. Income and Activity– This illustrates the total income generated by the Trust in 2020/21, in addition to the month's activity (Inc PSF & RFF)

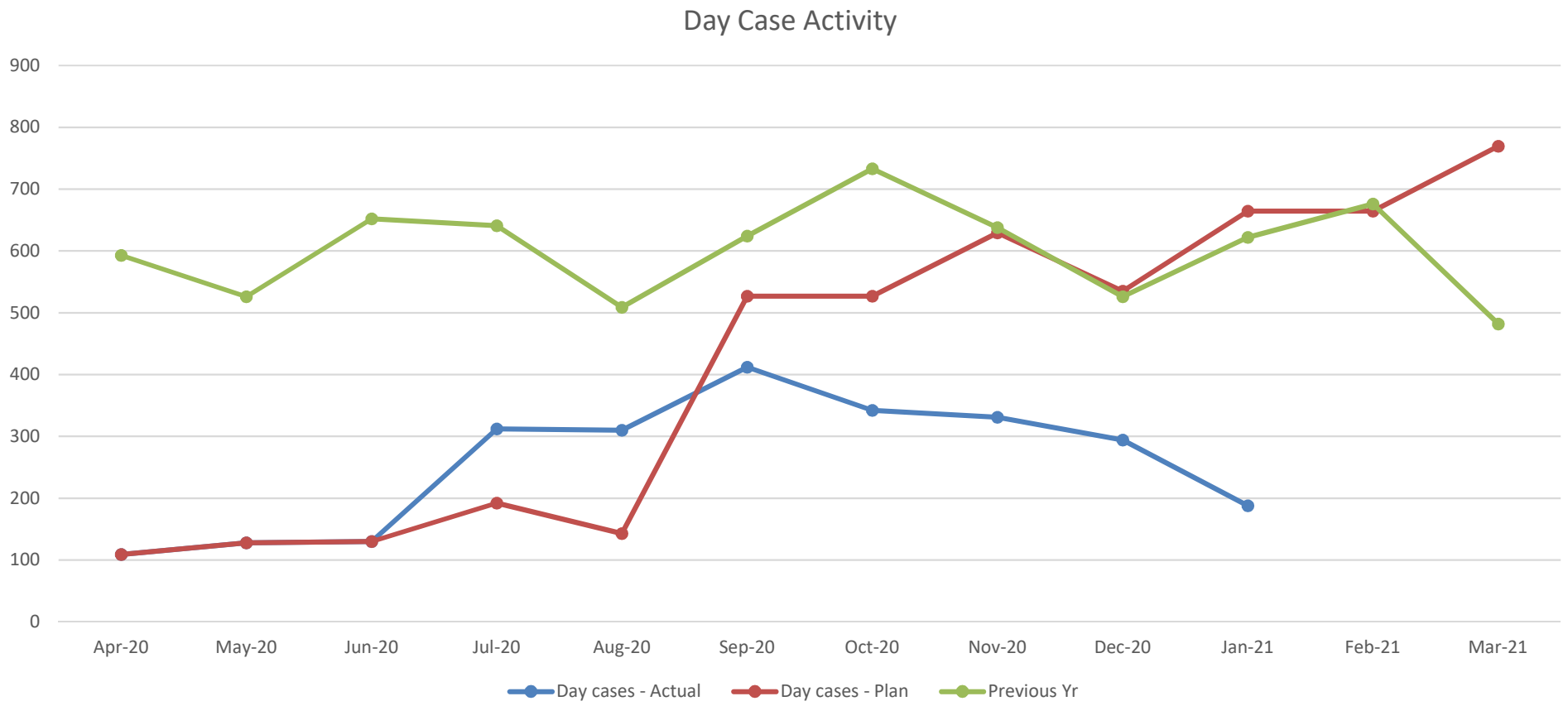
Breakdown of Block Income Received year to date

	Month 10 YTD (£000)		
	Plan	**Actual**	**Variance**
NHS England	19,230	20,355	1,125
Clinical commissioning groups	49,901	50,590	689
NHS Foundation Trusts	1,331	1,270	(61)
Private Patients	320	642	323
Research & Development	276	279	3
Education & Training	1,252	1,555	303
Other Income	2,221	2,396	175
Retrospective Top Up	9,594	9,625	31
	84,125	**86,712**	**2,588**

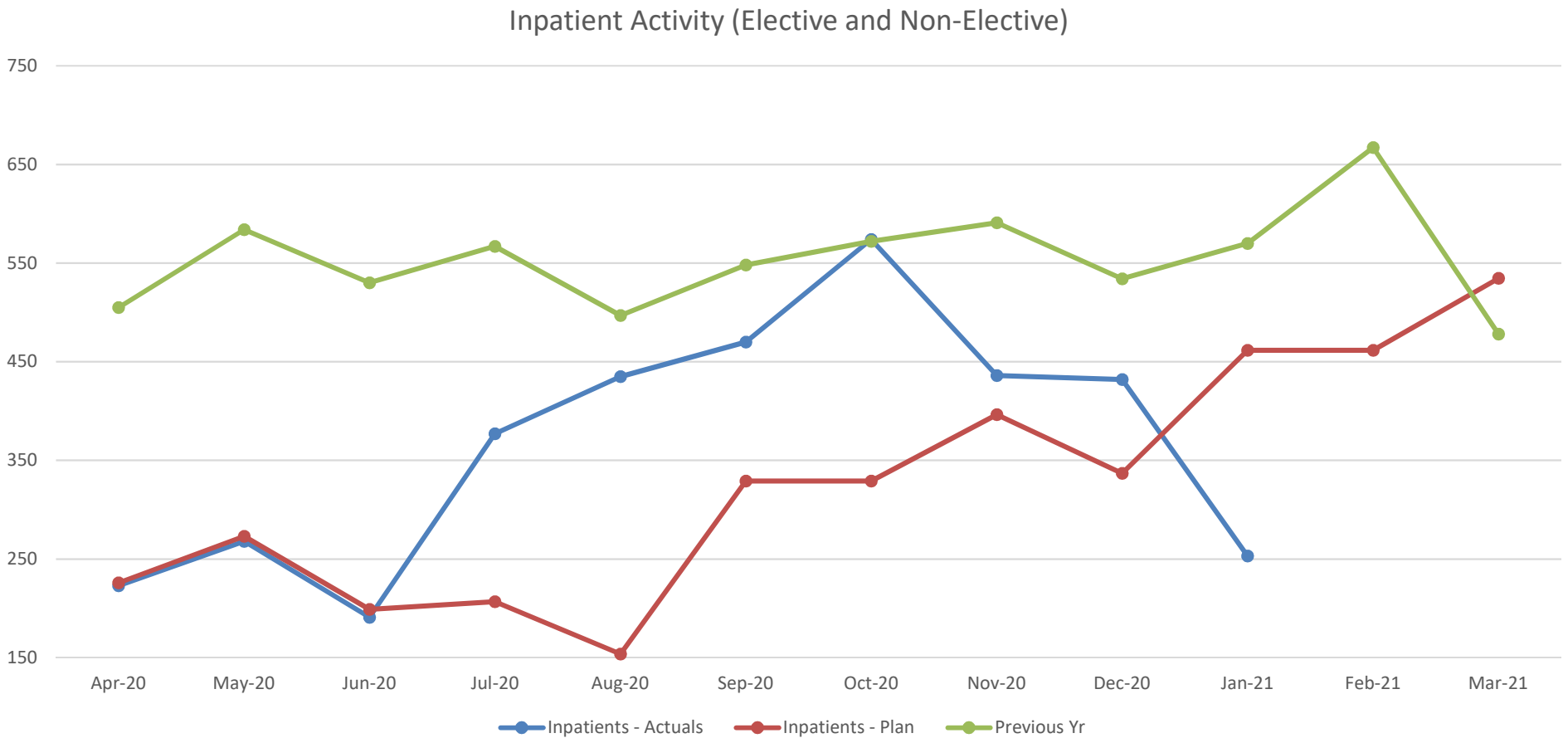
INFORMATION

Block contracts have been agreed with commissioners for the remainder of 2020/21. These block contract values have been derived from the average monthly income achieved during M1-9 of 2019/20 adjusted for an inflationary uplift (2.8%). Top up income has then been calculated to bridge the gap between income and expenditure during the same period, to support Trusts in delivering a break even position.

The COVID prospective top up for months 7 -12 is £651k per month, and top up funding of £1,358k per month.

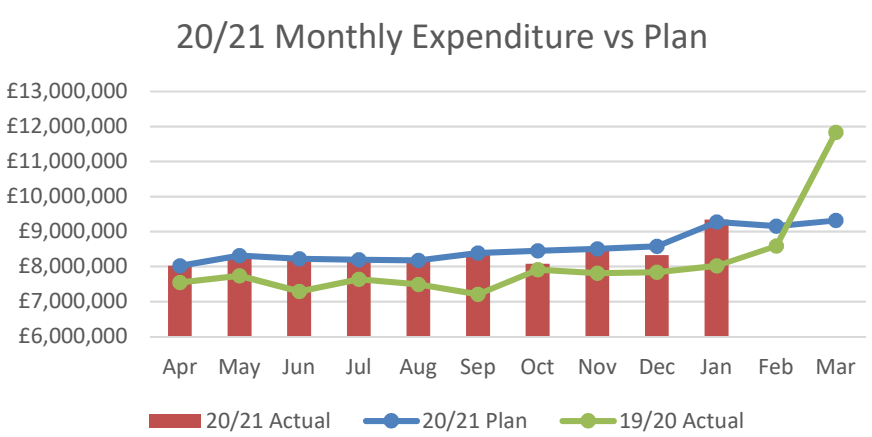


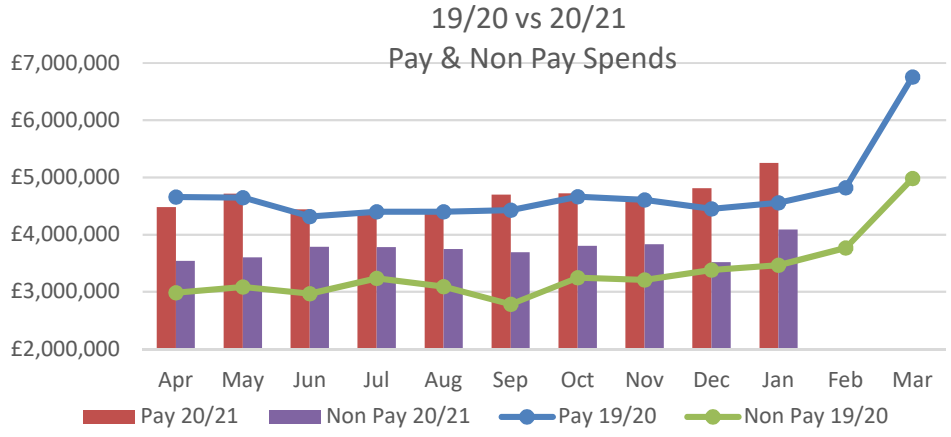
Daycase	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	109	128	130	311	321	411	341	330	293	188		
Draft Plan				192	143	527	527	630	535	665	665	770
Previous Yr	593	526	652	641	509	624	733	638	563	675	676	482



Inpatient	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	226	273	199	365	428	468	568	436	431	253		
Draft Plan				207	154	329	329	396	337	462	462	535
Previous Yr	505	584	530	567	497	548	572	591	534	568	666	478

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2020/21, compared to historic trends





COVID-19 related expenditure

Additional costs related to COVID	£'000s
Existing workforce additional shifts	737
Backfill for higher sickness absence	234
Decontamination	57
Remote working	465
PPE and other associated costs	376
Segregation of patient pathways	386
Other	52

Reimbursement for this expenditure and income loss is funded through a retrospective top up process.
Across the Midlands and East region the average claim as % operating expenditure is 5.3% (Range 1% -13.2%), to Month 9 ROH claim was 3.6%.

INFORMATION

Performance against Plan

Expenditure in January was £9,335k, which is in line with plan. This includes the additional pay and infrastructure costs relating to Phase 2 of the theatre development. The pay figure now also include a provision for annual leave that is unlikely to be taken by the end of the year

COVID-19 Expenditure

From Month 9 the COVID reimbursement scheme is a prospective top up amount. This amount has been based on the forecast expenditure related to the COVID response. This includes the purchase of IT equipment to support virtual working and additional pay costs relating to increased sickness levels and additional staffing requirements to support the vaccination hub.

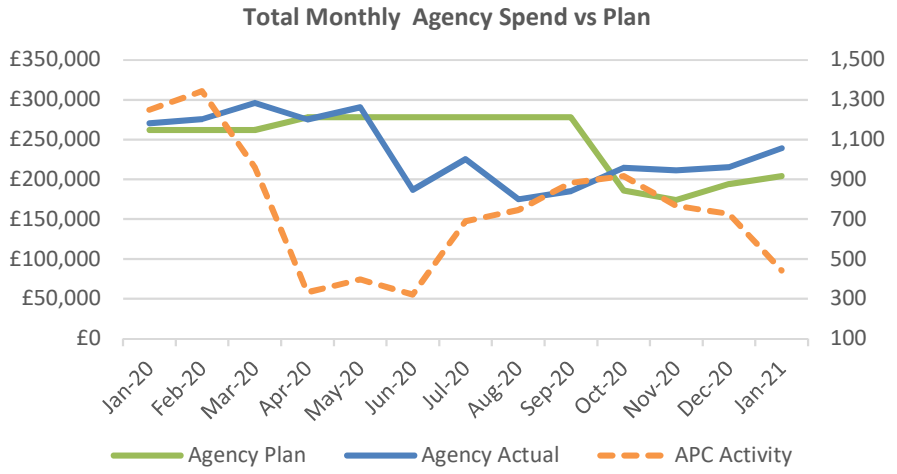
RISKS / ISSUES

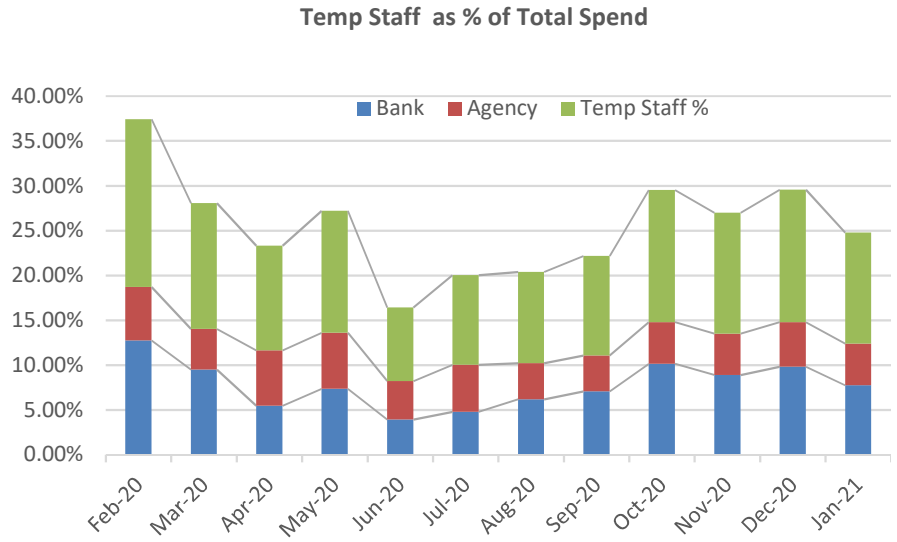
There is a risk that the Trust's response to COVID costs more to deliver than the prospective top up funding. This has been mitigated by a prudent forecast submitted reviewing intelligence gathered during the response to the first wave.

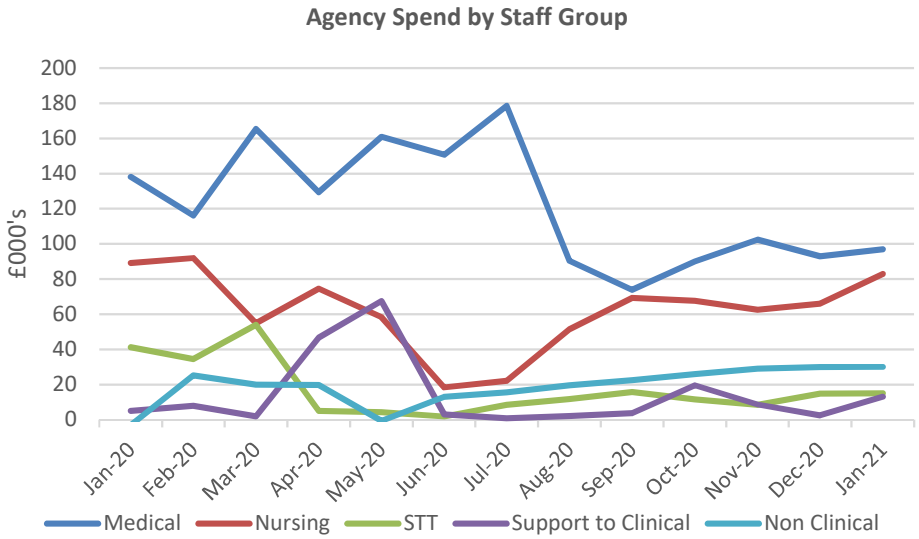
In addition, it should be expected that expenditure in some particular areas, for example in temporary staffing, infection control measures will remain high over the next couple of months. Any additional costs will continue to be tracked separately and reported centrally.

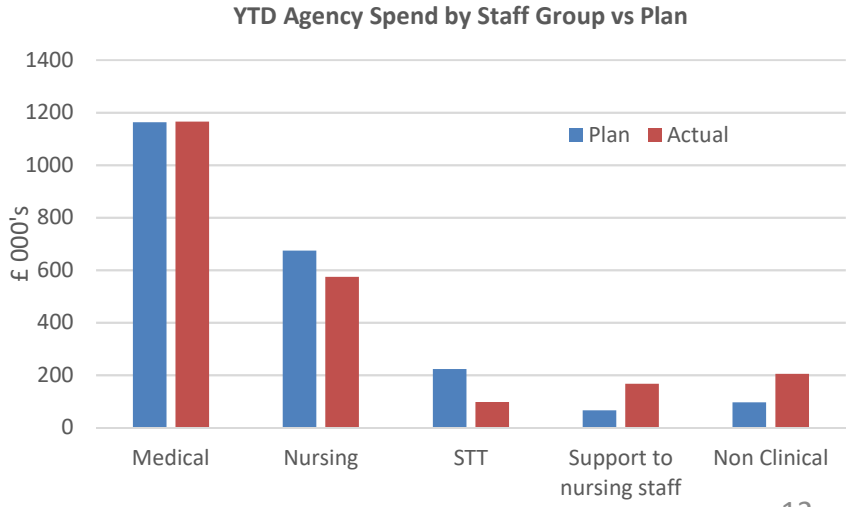
The reimbursement scheme previously extended to cover income loss directly as a result of COVID, such as private patients, car parking or rental accommodation, has now been removed. There is a greater expectation that these income levels will return to normality.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION
Total agency spend for November was £238k. A review of the detail shows slight increases in nursing, medical and support to clinical workforce. Whilst surgical activity is till low, wards have been busy due to the transfer of rehabilitation patients from UHB. The spend is still significantly lower than the corresponding period last year, even with current rates of sicknes.
ACTIONS FOR IMPROVEMENTS / LEARNING
Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary. Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.
RISKS / ISSUES

5.Cost improvement Programme Summary

INFORMATION

A CIP totalling £577,000 for months 1-10 has been achieved, and a forecast end of year position totalling £659,000, equating to 0.73%.

Work continues to deliver the prioritised schemes for this year;

- Outpatient Modernisation
- Medical agency spend reduction
- Procurement savings – product standardisation, pricing reduction and collaborative agreements

Lessons learnt from COVID response

COVID has allowed the Trust to think differently and a review of some of the lessons learnt were discussed at the recent CIP Board meetings.

- Virtual outpatients – assessment of saving on additional off site clinic rooms. New ways of working which are offering patients more convenient ways to access care
- Synertec (outsourced printing solution) – reducing printing costs but also allowing the trust to review what is printed. Next step to move towards electronic communications with patients
- Collaborative procurement – working more closely with procurement
- Service redesign opportunities – working differently has encouraged services to review patient pathways and think differently about service provision.

Non pay savings continue to be progressed despite the focus of the procurement team diverted to PPE supply during the pandemic. Some of the key schemes expected to deliver savings this year are;

- Transfer to the Total Orthopaedic Solutions 2 (TOS2) framework pricing
- Hip and knee prosthesis contract
- Trauma products
- Stationery

Learning from other organisations

The Trust participated in a National Orthopaedic Alliance CIP workshop session on 15th December. During the session organisations shared learning from delivering CIPs during the pandemic and in addition ideas for CIP planning for future.

Future workshop sessions are planned along with more detailed discussions with members of the alliance to help inform the Trusts CIP plan for future years.

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	2019/20	Month 10 YTD (£000)		
	M12	Plan	Actual	Variance
Intangible Assets	1,326	953	1,045	92
Tangible Assets	43,980	41,823	41,370	(453)
Total Non-Current Assets	**45,306**	**42,776**	**42,415**	**(361)**
Inventories	6,690	4,683	6,658	1,975
Trade and other curent Assets	10,058	12,264	12,455	191
Cash	663	7,640	9,575	1,935
Total Current Assets	**17,411**	**24,587**	**28,688**	**4,101**
Trade and other payables	(13,967)	(17,176)	(18,085)	(909)
Borrowings	(20,525)	(438)	(670)	(232)
Provisions	(406)	(2,990)	(2,901)	89
Other liabilities	(250)	(480)	(665)	(185)
Total Current Liabilities	**(35,148)**	**(21,084)**	**(22,321)**	**(1,237)**
Borrowings	(721)	(395)	(146)	(1,565)
Provisions	(526)	(527)	(527)	(2,898)
Total Non-Current Liabilities	**(1,247)**	**(922)**	**(673)**	**(4,463)**
Total Net Assets Employed	**26,322**	**45,357**	**48,109**	**2,752**
Total Taxpayers and Others Equity	**26,322**	**45,357**	**48,109**	**2,752**

INFORMATION

The movement in the borrowings balance in year remains related to the transfer of historic revenue support loans from DHSC to issued public dividend capital. The total transfer was £19.8m and was physically actioned in September.

Assets have reduced due to a sales invoice being raised to Genmed for the sale of Theatre assets to them under the managed service contract.

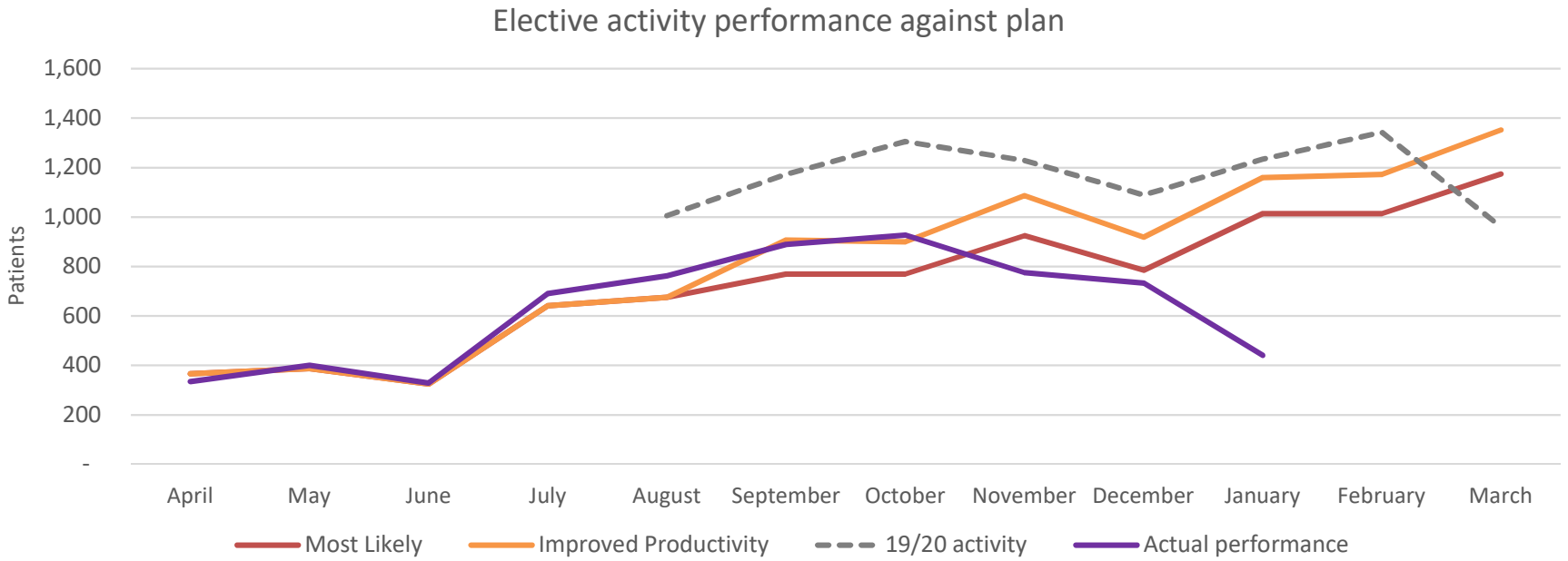
Cash in the bank at 31st January was £9.5m which is an increase of £8.9m compared to March. This is due to the Trust receiving a month's cash in advance for the block contract under the new Covid arrangements. This means that no further cash loans have had to be secured by the Trust from DHSC.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

The current arrangement in place with commissioners to receive monthly income a month in advance is expected to cease in February. This will result in a lower cash balance during March. A cashflow forecast has been completed which demonstrates there will be sufficient cash for the Trust during March.

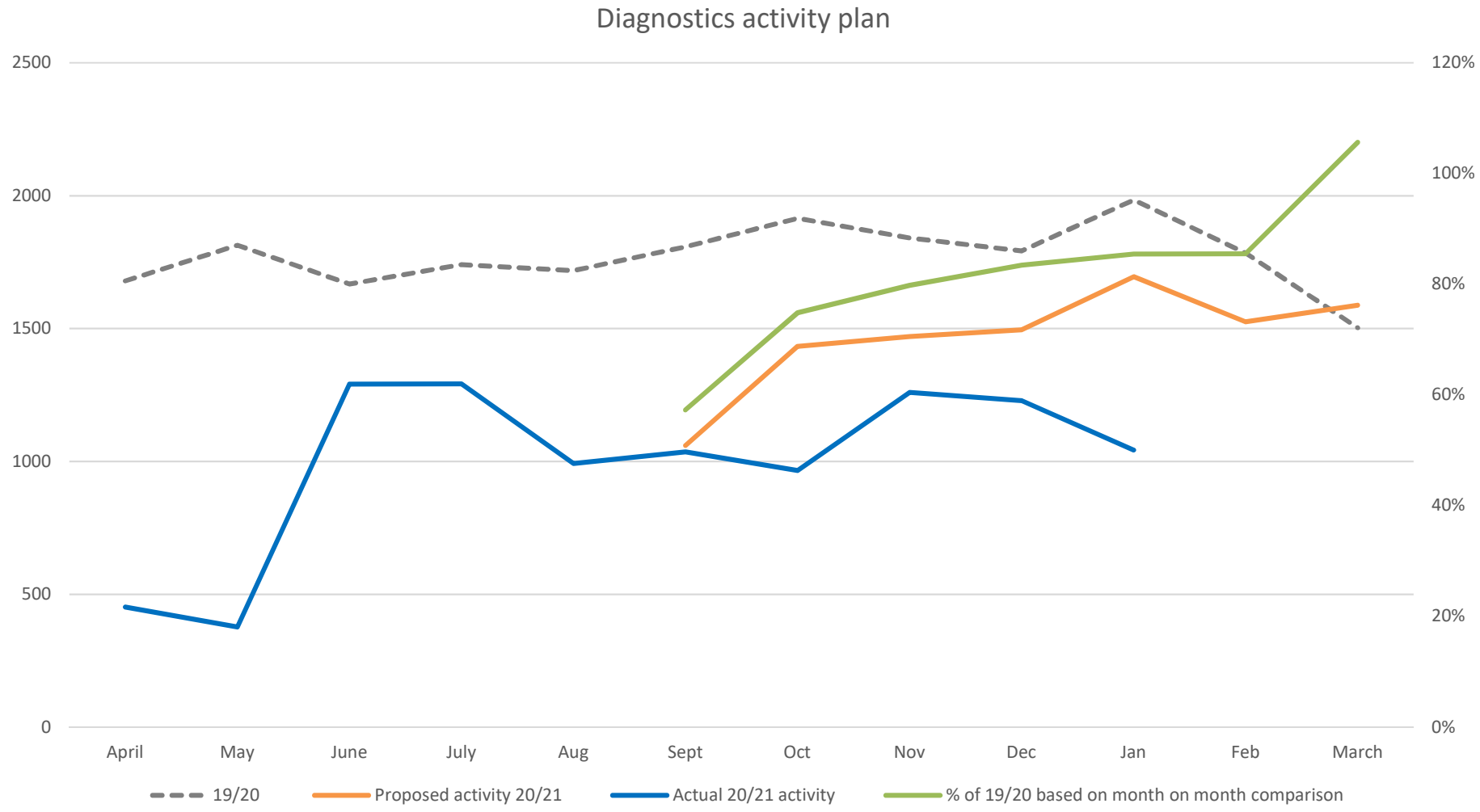
Performance against Activity plan – Elective Finance & Performance committee agreed plans



- January delivered 441 against a most likely plan of 1014, which is 36% of 19/20 activity for the same period
- A revised pro rata activity plan to account for reduced theatre availability during January has been calculated equating to a plan of 434 cases, demonstrating actual performance above this pro rata plan.
- Actual performance to date for February is significantly lower than plan as a result of the operational changes made to support the BSOL system with the COVID surge. Actual delivery and total booked activity for February totals 184 patients.

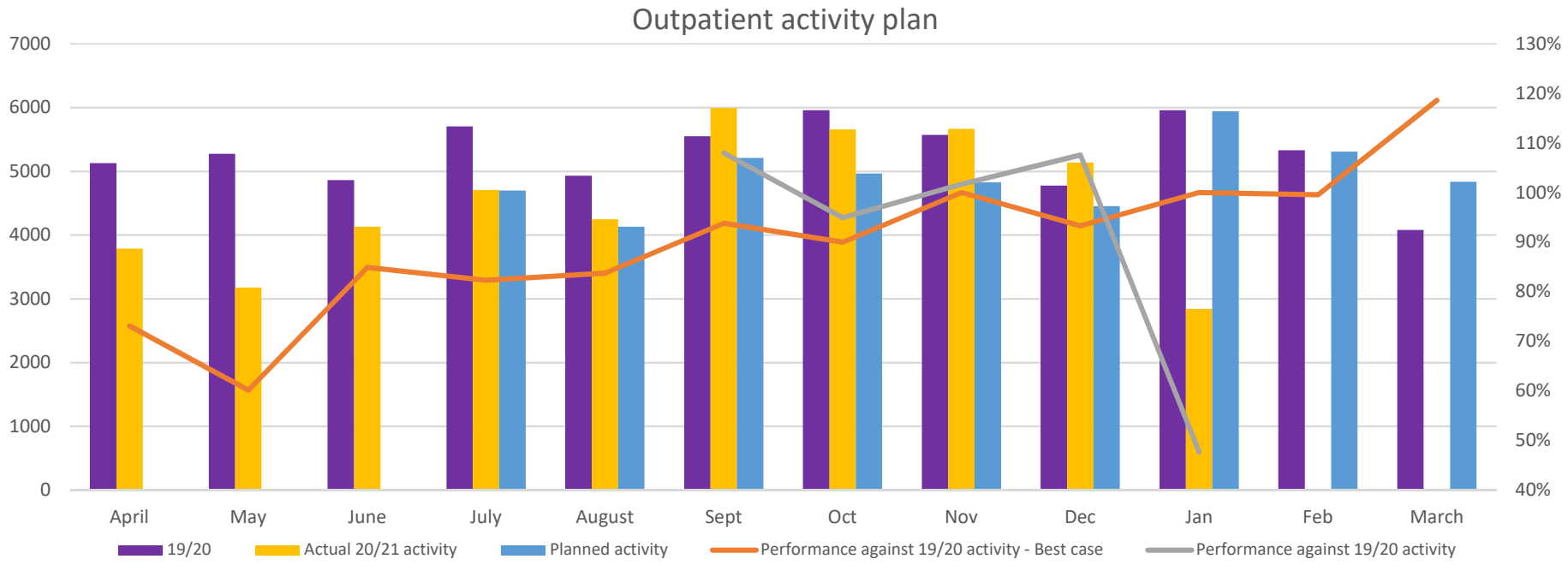
	April	May	June	July	August	September	October	November	December	January	February	March
Actual performance	335	401	329	691	762	889	927	775	733	441		
Most Likely	366	387	325	641	675	770	770	924	785	1,014	1,014	1,174
Improved Productivity	366	387	325	641	675	907	900	1,087	919	1,160	1,173	1,352
19/20 activity					1006	1172	1305	1229	1089	1233	1343	960
Actual % delivery against 1920					71%	75%	70%	63%	67%	36%		

Performance against Activity plan– Diagnostic STP final planning submission

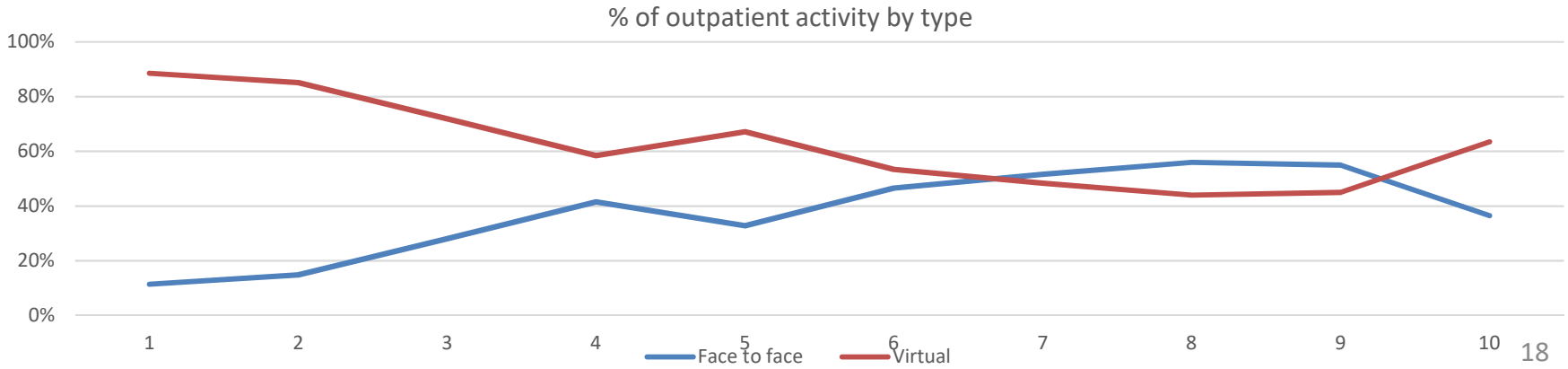


The diagnostic activity most likely projections are subject to forecasting of potential demand , however there is sufficient flexibility built into the operating model to enable expansion of capacity to ensure compliance with national diagnostic targets.

Performance against Activity plan– Outpatients STP final planning submission

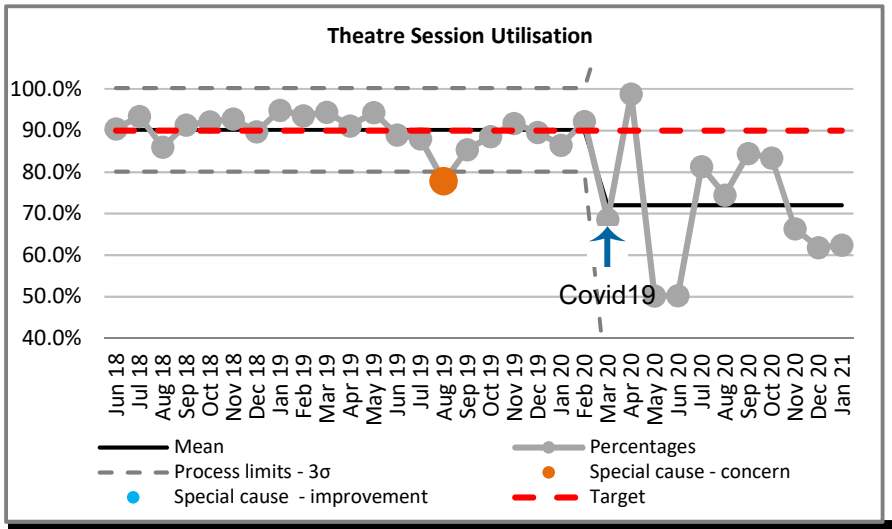


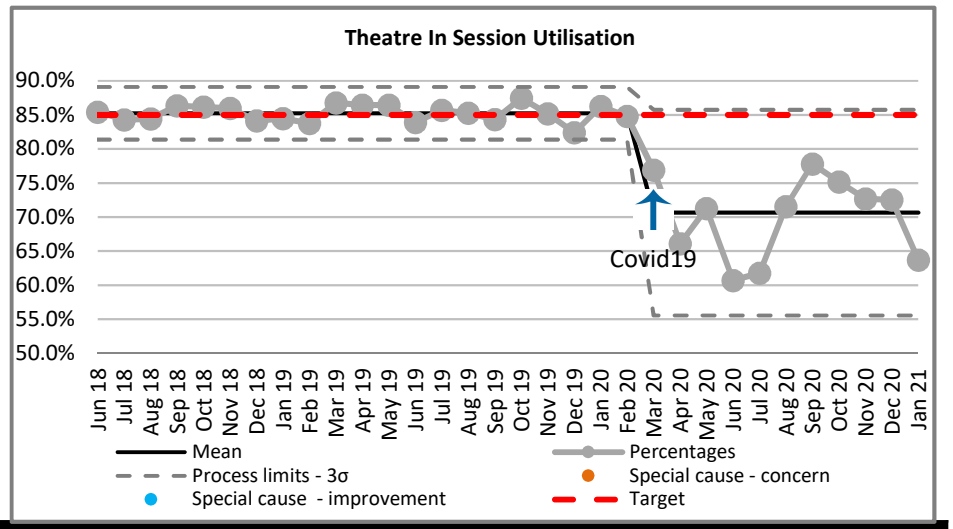
Activity in January was below plan and below 19/20 activity levels. 64% of the activity delivered virtually.



Note: Plan figures here represent the final plan submitted to STP

1. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used





INFORMATION

In response to a system level surge to NHS E/I level 4, a request for Consultant Anaesthetists to support UHB was received, resulting in the release 6 Consultants per day. This has reduced the number of operating theatres from 12 to 7 per day (plus 1 emergency) which brings the baseline available capacity from 100% to 60%, therefore list utilisation should be measured against this revised percentage.

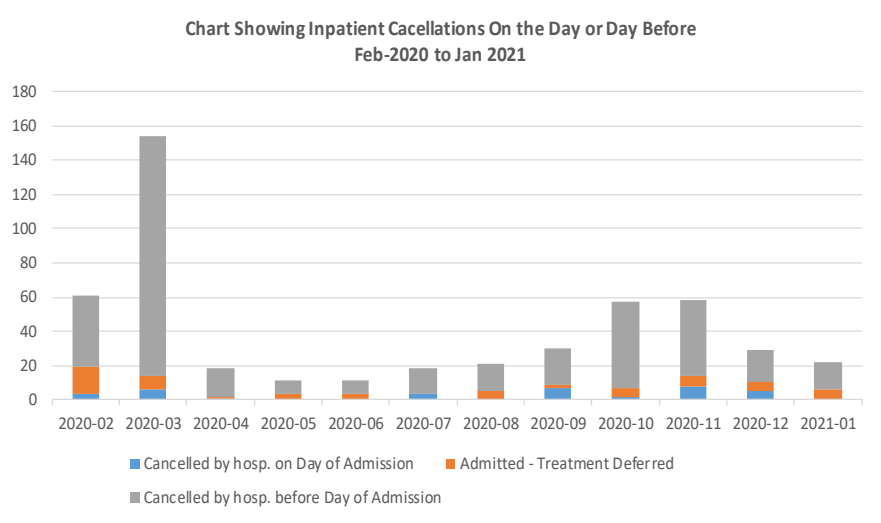
Theatre utilisation in January was 62.47% and in session utilisation was 63.70%. Since the beginning of January, theatres have only been carrying out emergency / urgent surgery, therefore January's theatre utilisation is not comparable to previous months as emergency theatre lists are excluded from traditional utilisation metrics due to the unpredictable nature of the activity.

Further support has been provided to the System, with the transfer of Ambulatory Trauma and Trauma Hands activity to the ROH, equating to 3 theatre lists per day. Also spinal emergency activity has been diverted to the ROH. It is envisaged that this ongoing support will be provided until further notice.

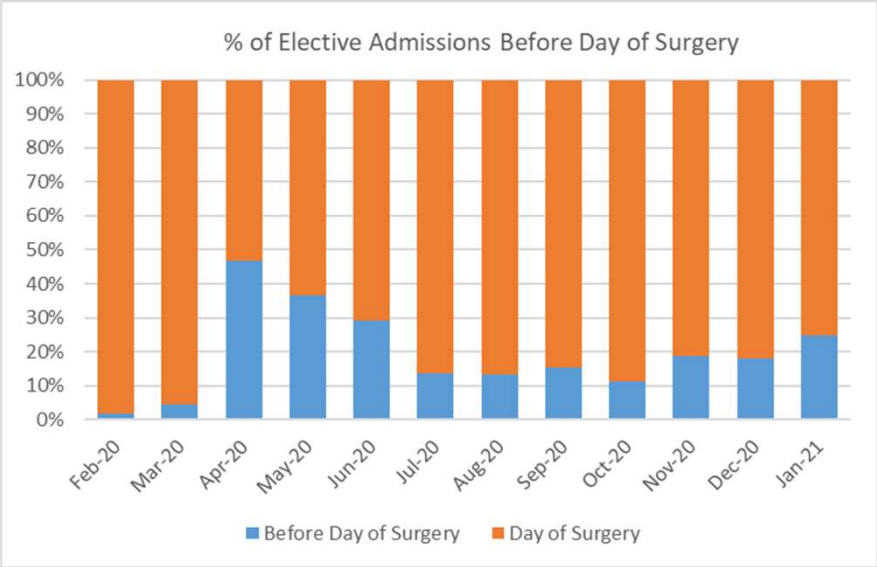
RISKS / ISSUES

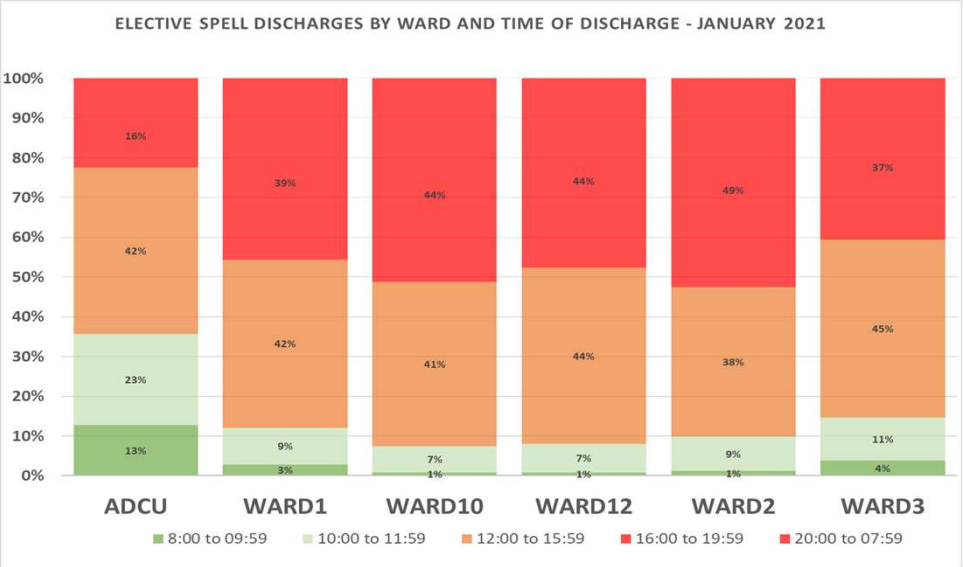
Converting theatres back to an elective footing will be reliant on the repatriation of theatre staff and anaesthetists who have been released to support ITU at UHB, but also System wide agreement as to next steps in supporting P2 activity. These discussions remain on going.

2. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



Sum of Total	Cancellation Category			
Year-Mth	Cancelled by hosp. On Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp.before Day of Admission	Grand Total
2020-02	3	16	42	61
2020-03	6	8	138	152
2020-04	1	1	15	17
2020-05	0	3	8	11
2020-06	0	3	8	11
2020-07	3	0	15	18
2020-08	0	5	16	21
2020-09	7	2	21	30
2020-10	2	5	48	55
2020-11	6	2	11	19
2020-12	4	6	14	24
2021-01	0	6	16	22
Grand Total	32	57	352	441





There were no patients cancelled on the day of admission in January, however there were 6 patients admitted but where treatment was deferred, with reasons broken down as follows:

2 x patients self discharged
1 x patient declined to have surgery until they have received the vaccine.
1 x patient tested positive for covid
2 patients medically not fit

Cancellations prior to day of surgery for January were 16 as detailed below:

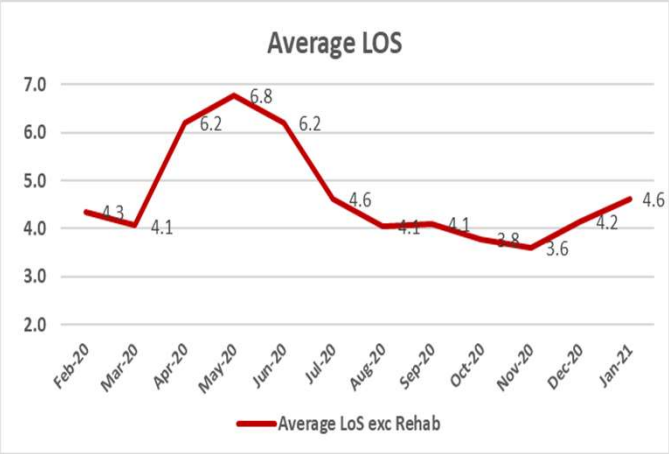
1 x patient self cancelled their TCI
6 x Covid positive / household member being tested for Covid/broke isolation
5 x TCI's rescheduled/cancelled
1 x patient was cancelled due to an emergency case – patient re-scheduled.
2 x patients not medically fit – TCU deferred
1 x referring hospital did not book patients transport

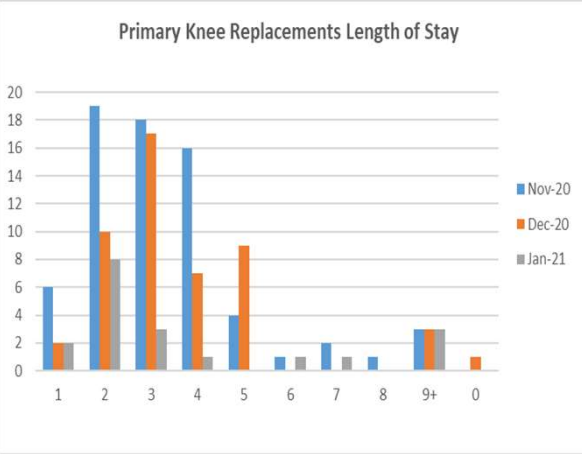
864 continues in a strengthened format with executive oversight to maximise resources both in theatre and on wards

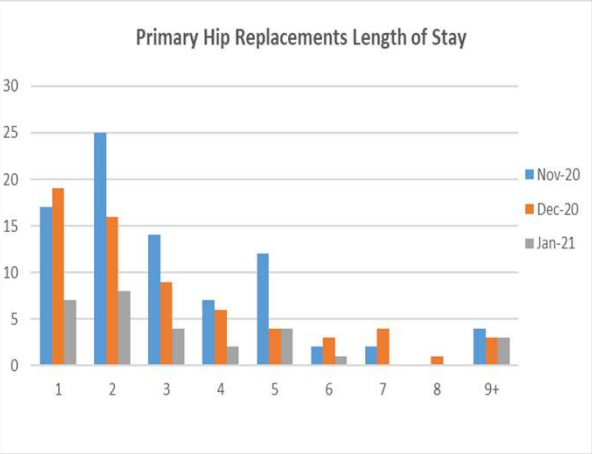
RISKS / ISSUES

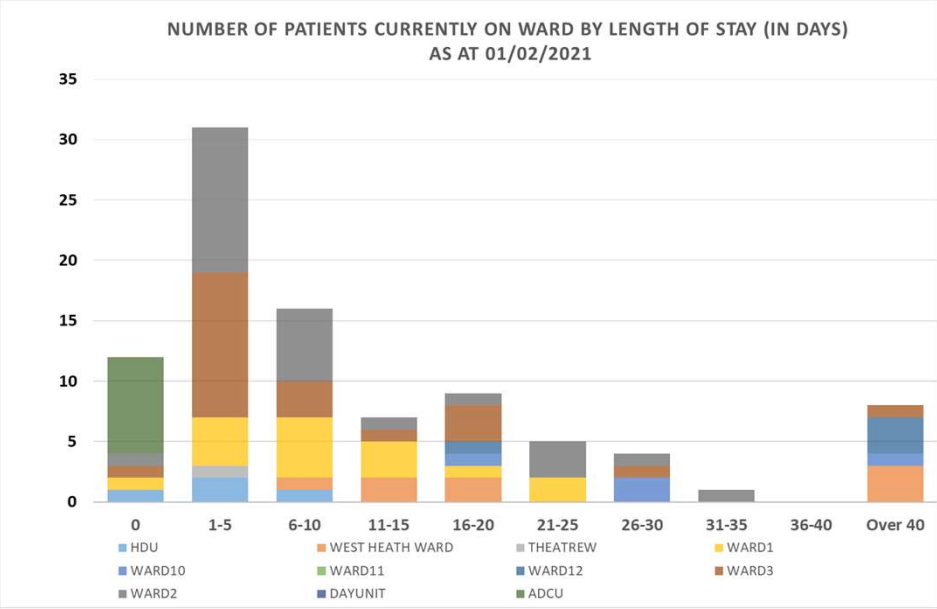
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient cancellations which will require monitoring as services are recovered through the harm review process .

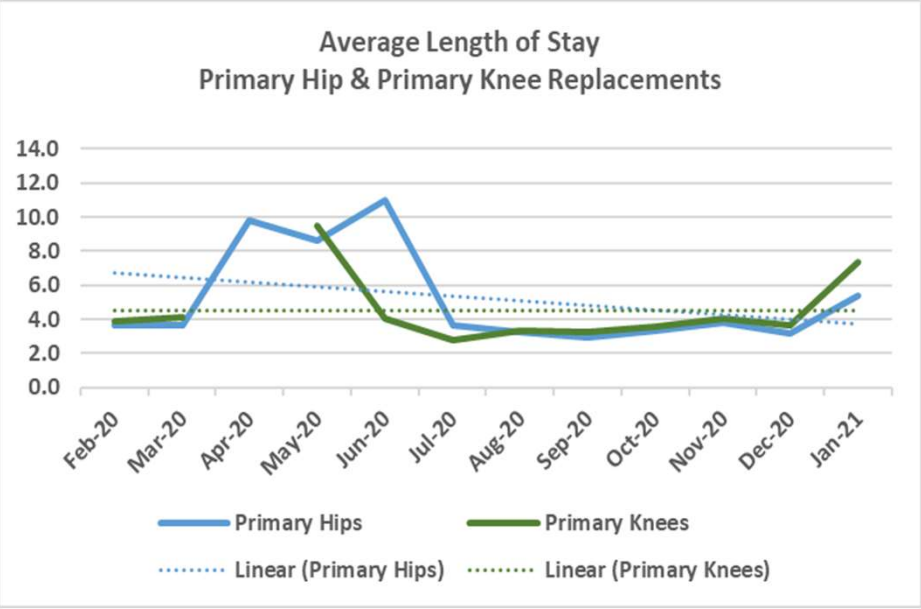
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways





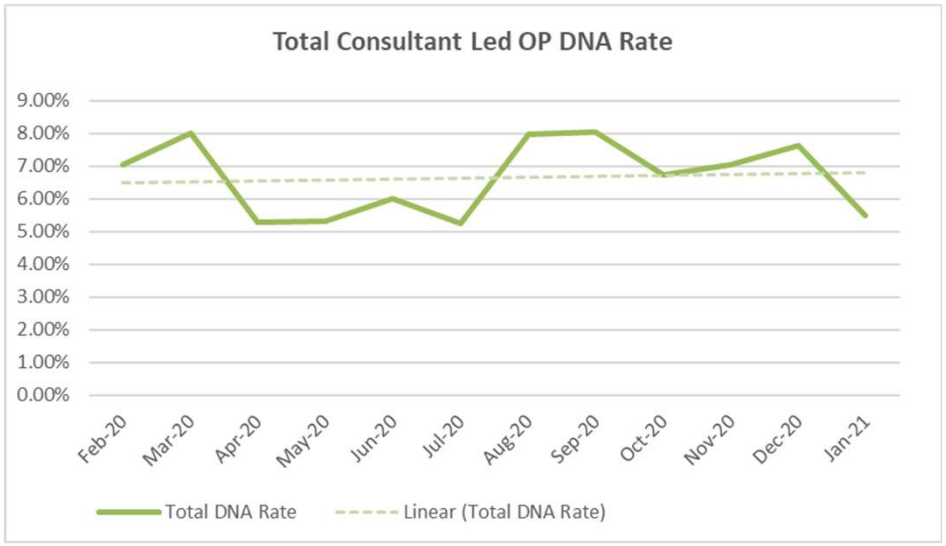


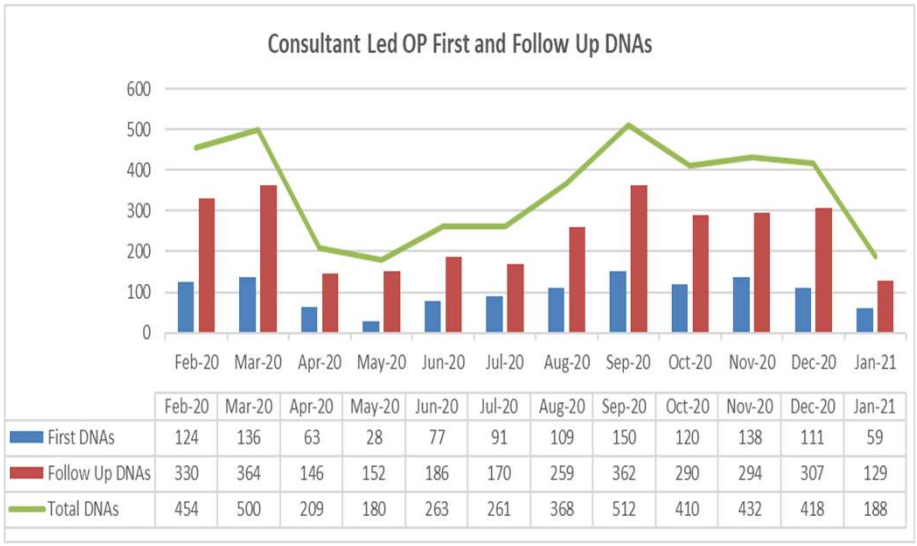




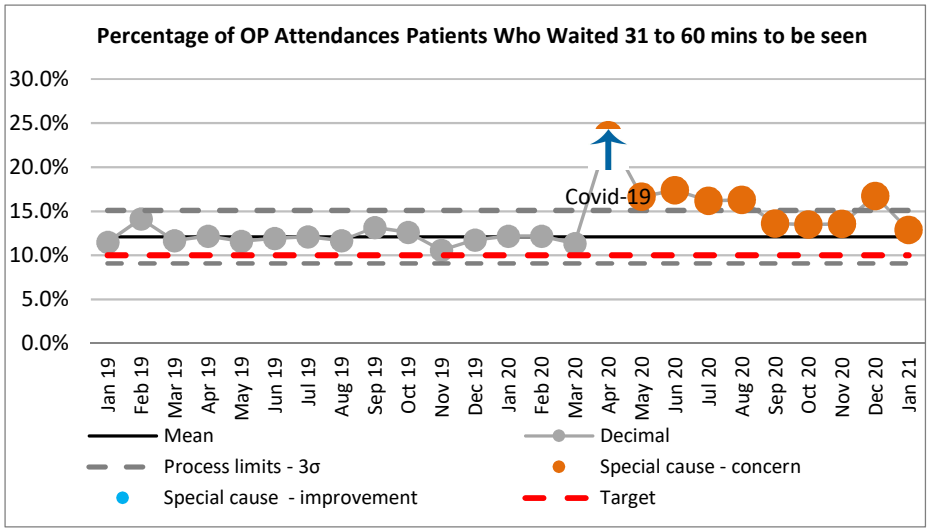
INFORMATION
LOS has increased in January to 4.6. as anticipated due to the profile of the elective P2 patients many whom are more complex than the usual elective activity and the profile of the patients repatriated from UHB for acute orthopaedic rehab and medical rehab. All patients with a LOS greater than 18 days have been reviewed by the Head of Nursing, Division 1. All were complex cases and remained in hospital due to on-going clinical/medical needs e.g. BIU/infected wound management, COVID, further surgery. None of those reviewed were due to delayed discharge. Any delayed discharges are discussed at the daily meeting and escalated if they is no immediate plan or resolution.
ACTIONS FOR IMPROVEMENTS / LEARNING
The roaming discharge team supported by the safeguarding team continue to provide discharge support to the wards. This supports and promotes early discharge planning.
RISKS / ISSUES
ROH for now is identified as being the pathway 2 beds for the QE Rehab patients which is likely to increase length of stay further.

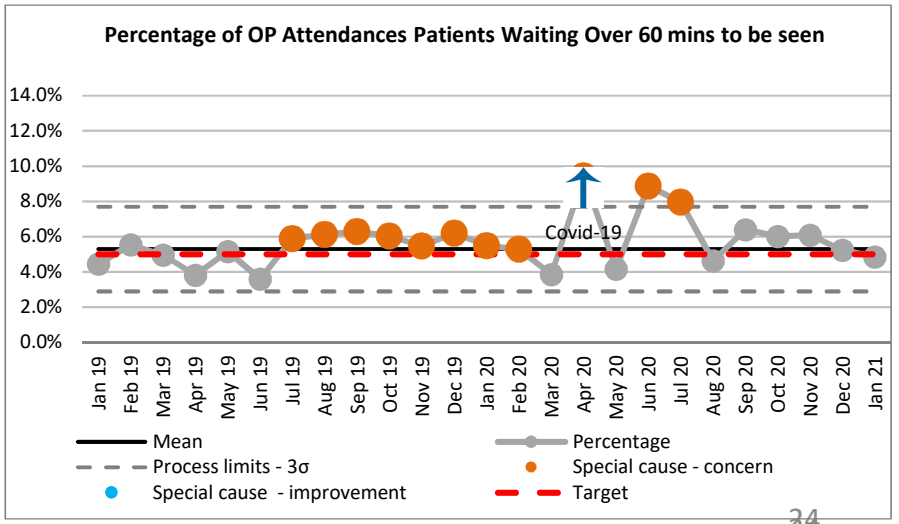
11. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients





	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
First DNAs	124	136	63	28	77	91	109	150	120	138	111	59
Follow Up DNAs	330	364	146	152	186	170	259	362	290	294	307	129
Total DNAs	454	500	209	180	263	261	368	512	410	432	418	188





INFORMATION

The technical reporting issues for outpatient waiting times have now been resolved for reporting going forward.

30 minute delays – Reduced in January at **12.09%** compared to **16.7%** in December. Trust Target is **10% -** Trust target not achieved
60 minute delays – January **4.9%** of patients were delayed compared to compared to **5.2%** in December. Target is 5% therefore – Trust target achieved

The position in January is an improvement compared to recent months however there is further work to be undertaken with Oncology clinic delays and patients waiting for imaging procedures .

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure our patients are seen on time for their appointments.

An audit will take place of all delays in March to analyse any key issues and scope solutions.

ACTIONS FOR IMPROVEMENTS / LEARNING

The DNA rates have reduced in January to **5.49%** compared to **7.42%** in December and continues to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department.

Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

RISKS / ISSUES

Lack of space in outpatients continues to be a concern and currently solutions are being scoped. One of the options being explored is the use of an alternative location for virtual clinics.
A sheltered and heated seated area is now on site adjacent to the Out Patient department to keep patients and visitors comfortable if they need to wait outside for their appointment, although flow of patients is monitored to ensure this is minimised.

12. Referral to Treatment snapshot as at 31st January 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

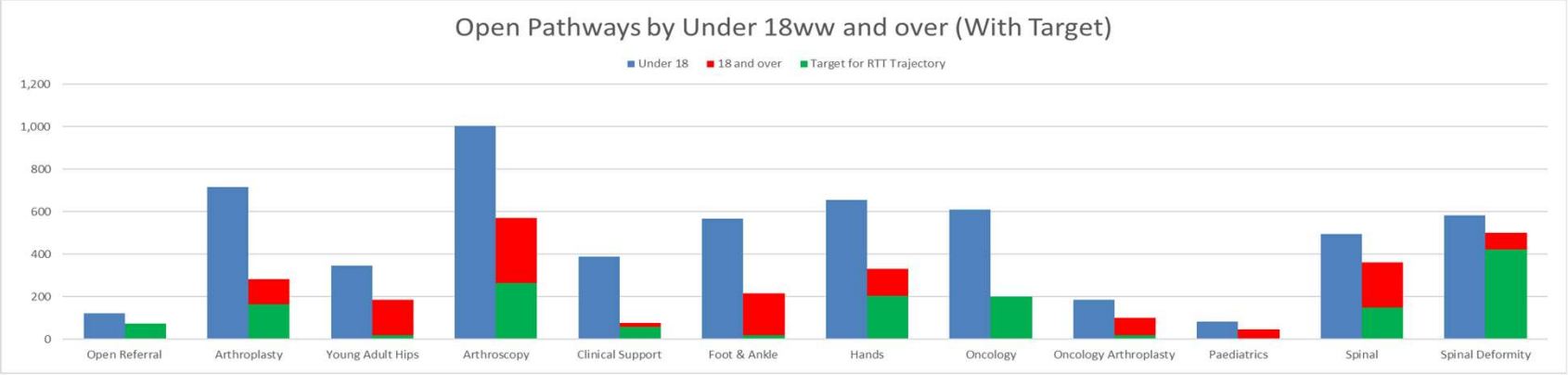
Est Over 18 Clock Stops Required		
To achieve	81.47%	1652
To achieve	71.13%	471
To achieve	81.74%	1679

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,144**	102	292	116	341	154	202	210	252	47	31	189	208
7-13	**2,322**	15	264	147	429	145	234	285	239	100	39	198	227
14-17	**1,290**	4	159	83	233	90	132	161	120	40	13	107	148
18-26	**1,569**	0	186	125	291	65	163	200	45	69	28	163	234
27-39	**749**	0	71	40	163	11	41	94	13	25	14	105	172
40-47	**254**	0	16	12	69	0	4	17	8	3	6	58	61
48-51	**132**	0	8	3	32	1	8	13	2	5	0	31	29
52 weeks and over	**42**	0	3	5	15	0	1	7	0	0	0	5	6
Total	**8,502**	121	999	531	1,573	466	785	987	679	289	131	856	1,085

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,756**	121	715	346	1,003	389	568	656	611	187	83	494	583
18 and over	**2,746**	0	284	185	570	77	217	331	68	102	48	362	502
Target for RTT Trajectory	**1575**	75	166	19	264	60	21	205	202	19	5	149	422
Target for RTT 92%	**680**	**9**	**79**	**42**	**125**	**37**	**62**	**78**	**54**	**23**	**10**	**68**	**86**

Month End RTT %	**67.70%**	**100.00%**	**71.57%**	**65.16%**	**63.76%**	**83.48%**	**72.36%**	**66.46%**	**89.99%**	**64.71%**	**63.36%**	**57.71%**	**53.73%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,171	-75	118	166	306	17	196	126	-134	83	43	213	80
Variance from target 92%	2,066	-9	205	143	445	40	155	253	14	79	38	294	416



Referral to Treatment Snapshot as at 31st January 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

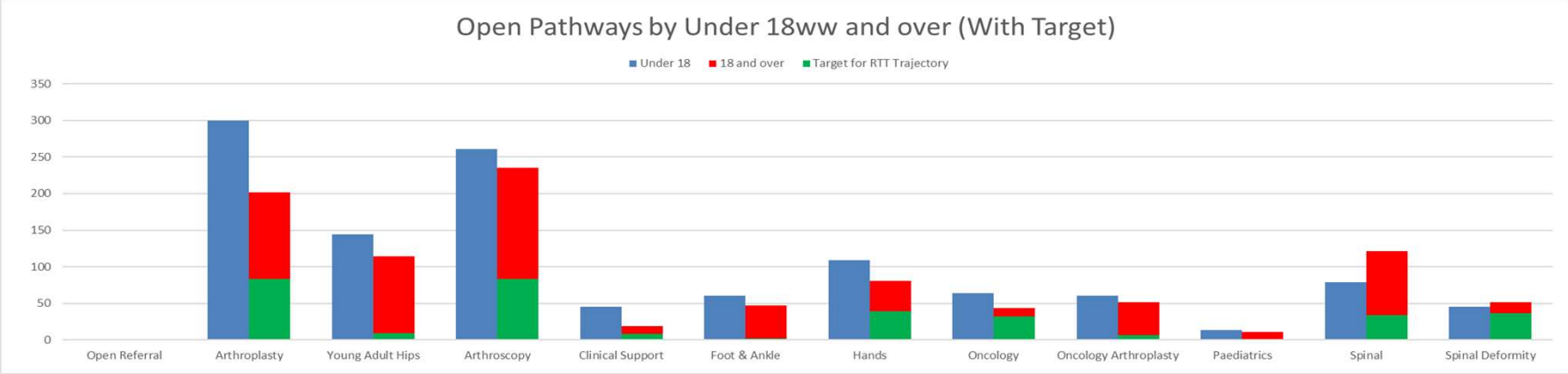
Est Over 18 Clock Stops Required		
To achieve	81.47%	816
To achieve	71.13%	573
To achieve	81.74%	821

Select Pathway Type: **Admitted**

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**312**	0	70	31	65	18	10	29	23	16	7	28	15
7-13	**529**	0	129	67	133	16	29	44	25	32	5	31	18
14-17	**340**	0	101	46	63	11	21	36	16	12	2	20	12
18-26	**529**	0	140	79	97	15	28	32	24	37	9	48	20
27-39	**228**	0	42	18	60	4	8	32	10	10	1	28	15
40-47	**105**	0	11	9	39	0	2	5	8	2	1	21	7
48-51	**87**	0	7	3	28	0	8	8	2	3	0	19	9
52 weeks and over	**29**	0	2	5	11	0	1	4	0	0	0	5	1
Total	**2,159**	0	502	258	496	64	107	190	108	112	25	200	97

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,181**	0	300	144	261	45	60	109	64	60	14	79	45
18 and over	**978**	0	202	114	235	19	47	81	44	52	11	121	52
Target for RTT Trajectory	**400**	0	83	9	83	8	2	39	32	7	1	34	37
Target for RTT 92%	**172**	**0**	**40**	**20**	**39**	**5**	**8**	**15**	**8**	**8**	**2**	**16**	**7**

Month End RTT %	**54.70%**	n/a	**59.76%**	**55.81%**	**52.62%**	**70.31%**	**56.07%**	**57.37%**	**59.26%**	**53.57%**	**56.00%**	**39.50%**	**46.39%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	578	0	119	105	152	11	45	42	12	45	10	87	15
Variance from target 92%	806	0	162	94	196	14	39	66	36	44	9	105	45



Referral to Treatment Snapshot as 31st January 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2021

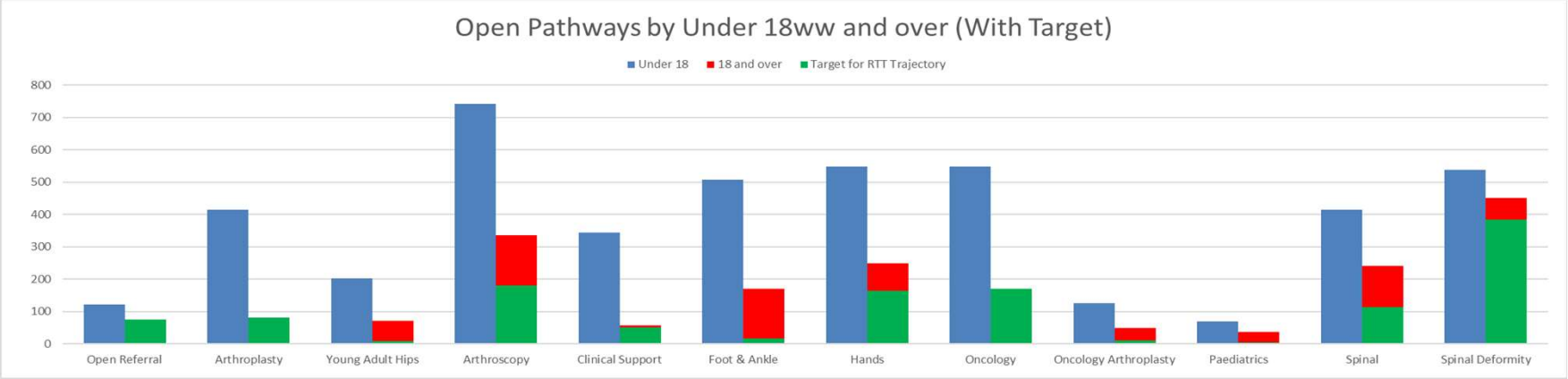
Est Over 18 Clock Stops Required		
To achieve	81.47%	837
To achieve	71.13%	-103
To achieve	81.74%	858

Select Pathway Type: Non Admitted

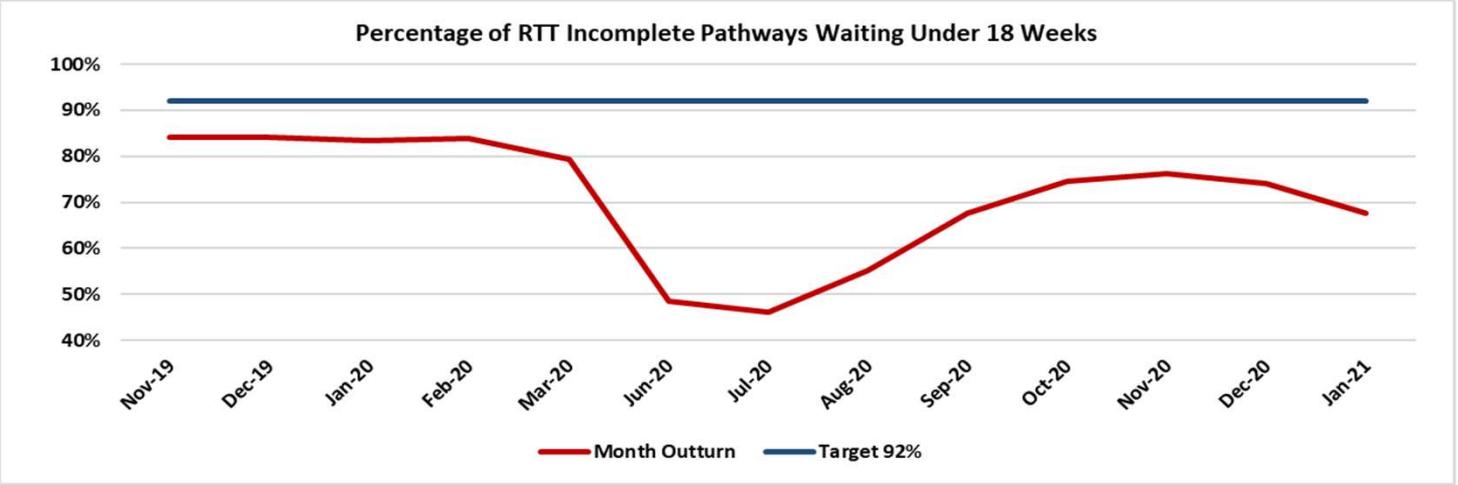
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,832**	102	222	85	276	136	192	181	229	31	24	161	193
7-13	**1,793**	15	135	80	296	129	205	241	214	68	34	167	209
14-17	**950**	4	58	37	170	79	111	125	104	28	11	87	136
18-26	**1,040**	0	46	46	194	50	135	168	21	32	19	115	214
27-39	**521**	0	29	22	103	7	33	62	3	15	13	77	157
40-47	**149**	0	5	3	30	0	2	12	0	1	5	37	54
48-51	**45**	0	1	0	4	1	0	5	0	2	0	12	20
52 weeks and over	**13**	0	1	0	4	0	0	3	0	0	0	0	5
Total	**6,343**	121	497	273	1,077	402	678	797	571	177	106	656	988

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,575**	121	415	202	742	344	508	547	547	127	69	415	538
18 and over	**1,768**	0	82	71	335	58	170	250	24	50	37	241	450
Target for RTT Trajectory	**1175**	75	82	10	181	52	18	165	170	11	4	114	385
Target for RTT 92%	**507**	**9**	**39**	**21**	**86**	**32**	**54**	**63**	**45**	**14**	**8**	**52**	**79**

Month End RTT %	**72.13%**	**100.00%**	**83.50%**	**73.99%**	**68.90%**	**85.57%**	**74.93%**	**68.63%**	**95.80%**	**71.75%**	**65.09%**	**63.26%**	**54.45%**
31/01/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	593	-75	0	61	154	6	152	85	-146	39	33	127	65
Variance from target 92%	1,261	-9	43	50	249	26	116	187	-21	36	29	189	371



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for January is **67.70%** against the National compliance target of 92%. This is a decrease compared to December at **73.97 %** and is reflective of the cessation of elective procedures in order to undertake core critical services i.e. emergencies, spinal, oncology and P2 patients during the third wave. There are 42 patients over 52 weeks. There are 29 admitted patients all are priority 3 or 4 priority level. There are 9 non admitted patients with face to face clinics or diagnostic investigations now planned.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. 386 patients are waiting over 40 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2159 patients are on the admitted waiting list (P2 – 117 patients, P3 – 412 patients, P4 – 1627 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the process is standardised across all specialties and to provide assurance going forward all patients are reviewed on a regular basis. At PTL meetings P1 and P2 patients are reviewed to ensure they are booked for surgery in the appropriate timeframe for their set priority.

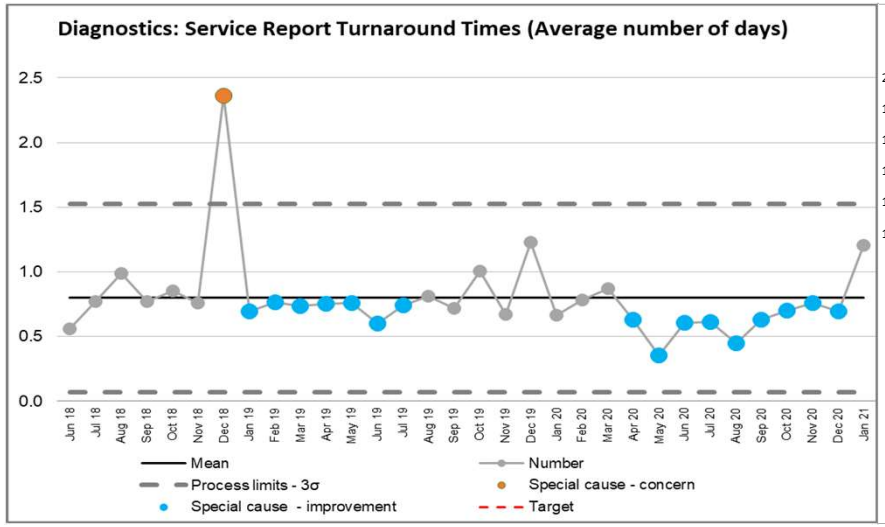
The total number of referrals into the Trust in January was 1484 which is low (55%) when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

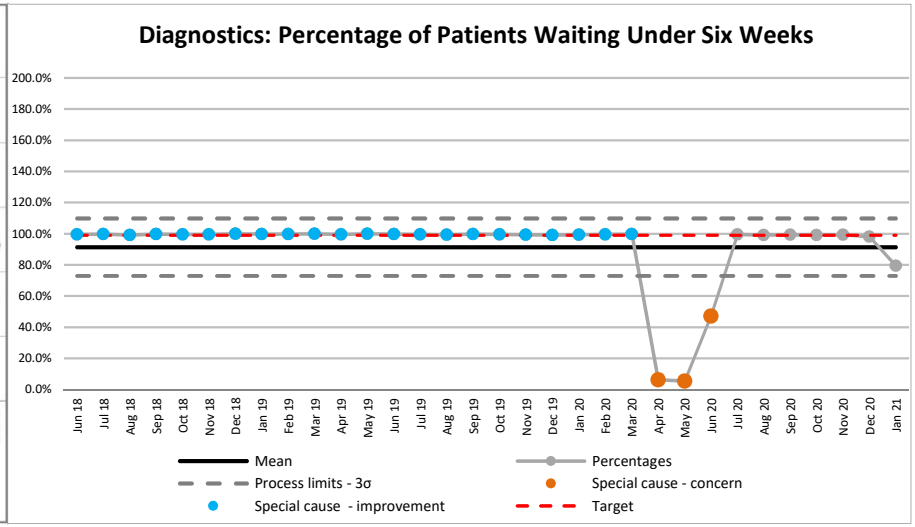
Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Feb-20	1051	98	450	1599	6	1593	99.6%	894	247	497	1638
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION
Imaging did not achieve the diagnostic target reporting 85.06% for January but continues to report consistently good performance for report turn around times. January saw a continued reduction in performance as a result of the **suspension of non urgent referrals** and provide mutual aid to the system. We have now resumed all non urgent imaging services to support the increasing waiting lists for non urgent diagnostics. The team will continue to source additional capacity to recover the diagnostic target throughout February with the expectation that the diagnostic target will be achieved by the end of March at the latest. Additional MRI capacity in the independent sector has been made available, with 20 patients being sent throughout February.
ACTIONS FOR IMPROVEMENTS / LEARNING
RISKS / ISSUES
Impact of a 3rd wave of covid reducing referrals further impacting on diagnostic activity . The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

		Indicative	*Reported Month*												
Target Name	**National Standard**	***Jan-21***	***Dec-20***	**In Target**	**Breach**	**Total**	**Nov-20**	**In Target**	**Breach**	**Total**	**Oct-20**	**In Target**	**Breach**	**Total**	**Q3 Perf 2020/ 2021**
2ww	93%	**100.0%**	**100.0%**	**61**	**0**	**61**	**100.0%**	**60**	**0**	**60**	**98.4%**	**61**	**1**	**62**	**99.0%**
31 day first treatment	96%	**100.0%**	**100.0%**	**12**	**0**	**12**	**100.0%**	**11**	**0**	**11**	**100.0%**	**13**	**0**	**13**	**100.0%**
31 day subsequent (surgery)	94%	**88.9%**	**100.0%**	**4**	**0**	**4**	**100.0%**	**9**	**0**	**9**	**100.0%**	**10**	**0**	**10**	**100.0%**
62 day (traditional)	85%	**80.0%**	**73.3%**	**5.5**	**2.0**	**7.5**	**57.7%**	**2.0**	**1.5**	**3.5**	**77.8%**	**3.5**	**1**	**4.5**	**69%**
62 day (Cons Upgrade)	n/a	100%	100.00%	**4.0**	**0.0**	**4.0**	*92.9%*	**6.5**	**0.5**	**7.0**	**100.0%**	**4.5**	**0.0**	**4.5**	**98.0%**
28 day FDS REPORTED	75%	67%	69%	**50**	**22**	**72**	*69.1%*	**56**	**24**	**80**	**79.4%**	**50**	**13**	**63**	**72%**
28 day FDS INTERNAL	75%		73%	50	19	69	*77.7%*	53	6	59	85.7%	48	8	56	
No. patients treated 104+ days													**1**		1

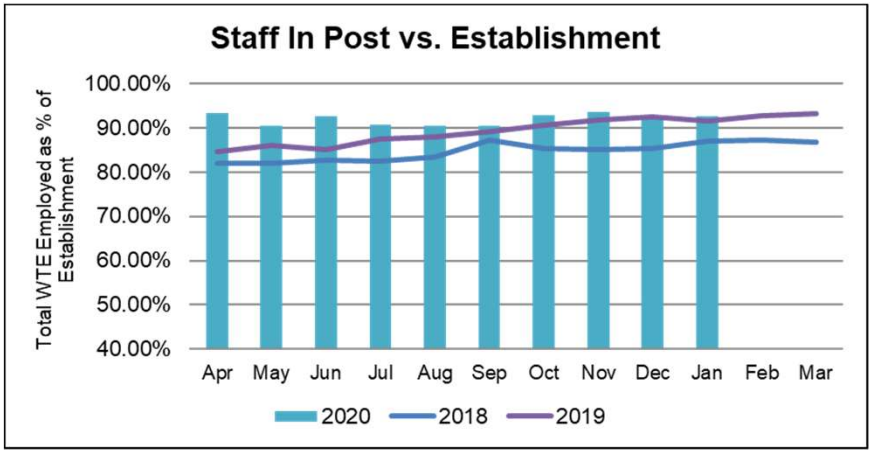
PERFORMANCE/IMPROVEMENTS/LEARNING

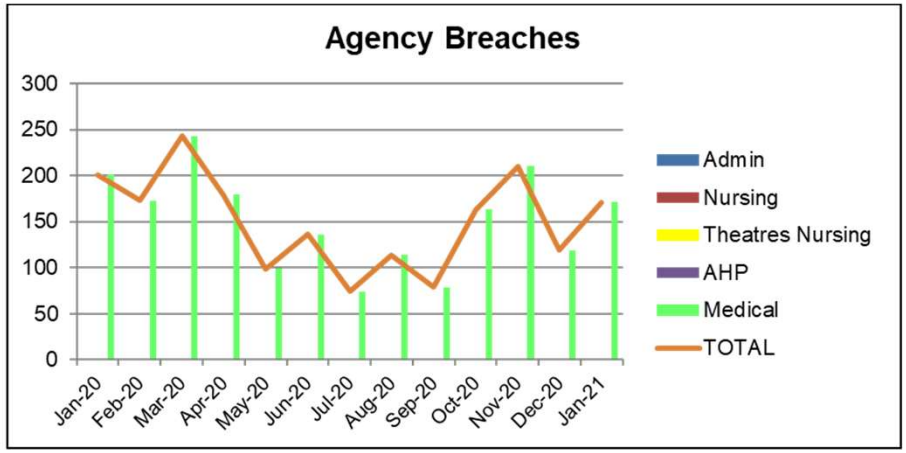
For the month of December 2020, all cancer waiting times standards were met with exception of the 62 day standard and FDS. A total 5.5 treatments were compliant with 62 day standard and 2 patients breached the target.
1 breach was due to ROH being middle trust for diagnostics, ROH investigated the patient for a total of 29 days then transferred to another provider for treatment therefore are accountable for a full breach, as per the updated breach allocation policy.
1 breach was due to a complex diagnostic pathway. (The patient had a total wait of 28 days for soft tissue biopsy to be reported due to needing three further complex molecular testing.)
The 28 day FDS was not achieved at 69% for December. There were 22 out of 72 patients given their diagnoses outside of 28 days, and this was mainly due to complex diagnostic pathways.
The Weekly Cancer PTL meeting continues to monitor and track patients along their pathway with an escalation protocol in place.

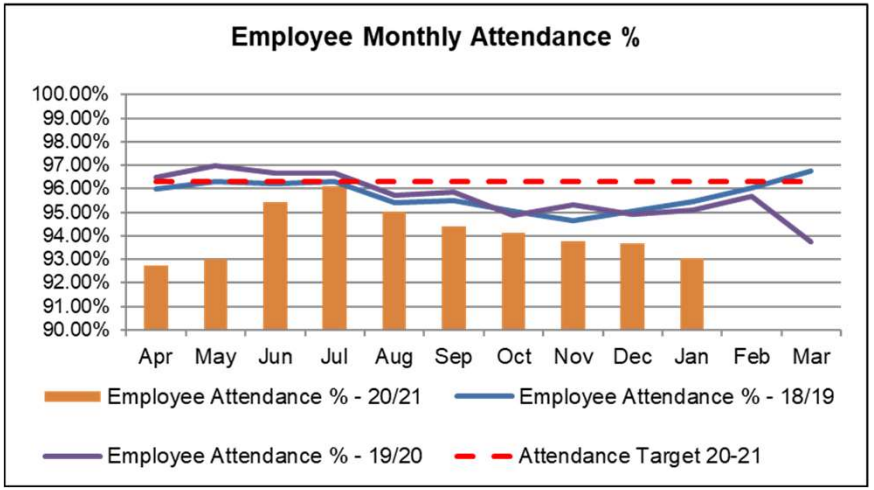
RISKS / ISSUES

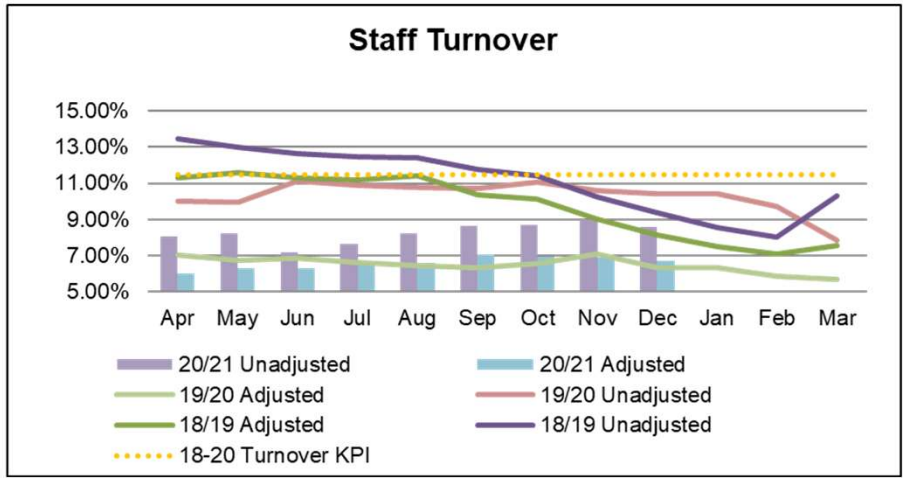
Paediatric Surgery has been suspended at Birmingham Children's Hospital. Predicted recommencement date for Surgery is April 2021. The divert for referrals remains in place to the 4 PMBT centres, 3 of which have agreed to continue reviewing and treating any patients referred into ROH. Referral divert scheduled to be lifted on 22nd February 2021.
Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways, both of which are under current analysis and review. Recruitment issues remain an ongoing concern to appoint a specialist bone and soft tissue Pathologist at UHB . This is a national challenge across sarcoma centres and discussions are ongoing with UHB , Medical Director , Chief Operating Officer and the National Pathology network to source alternative solutions. This issue will be tabled for discussion at the Trust Quality and Safety Committee.

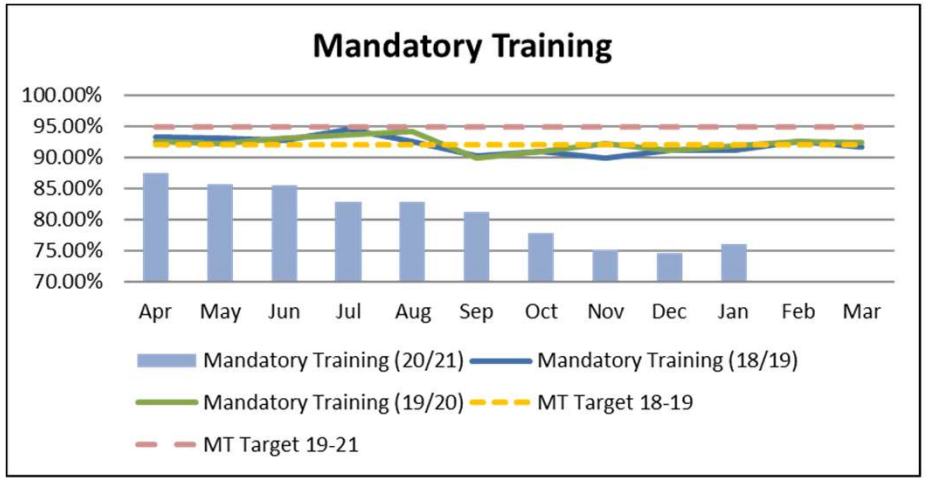
2. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

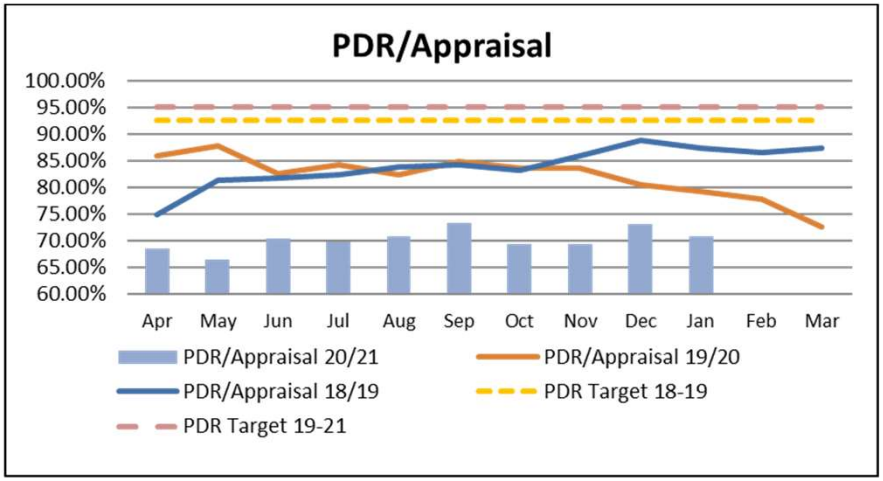


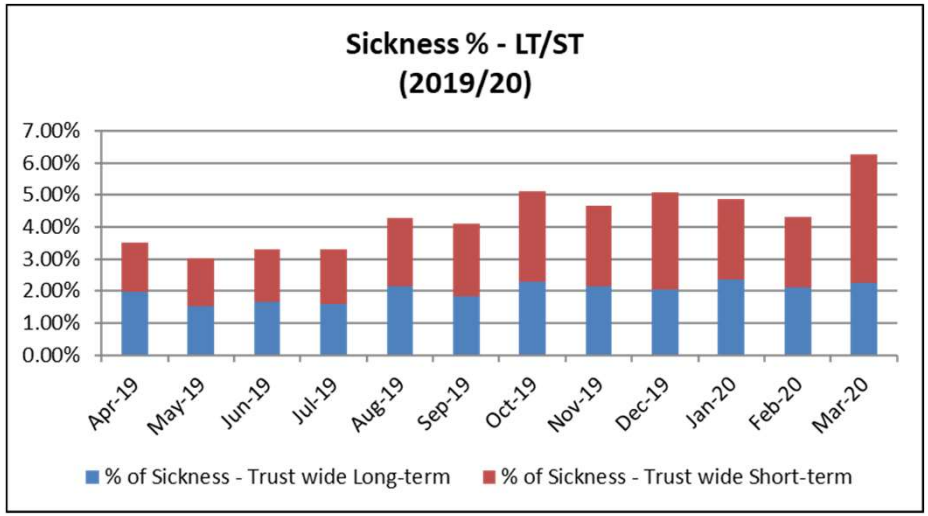


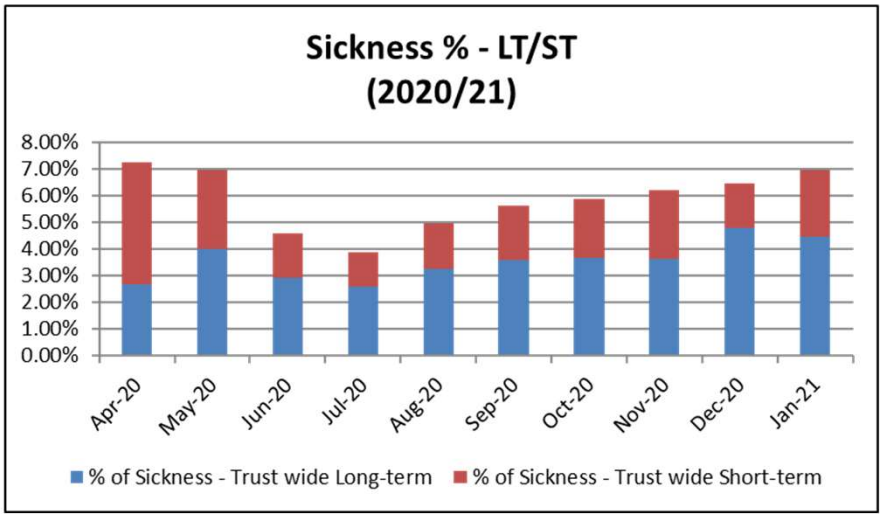





Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (20/21)
Mandatory Training (18/19)
Mandatory Training (19/20)
MT Target 18-19
MT Target 19-21


PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal 20/21
PDR/Appraisal 19/20
PDR/Appraisal 18/19
PDR Target 18-19
PDR Target 19-21


Sickness % - LT/ST
(2019/20)
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Sickness % - LT/ST
(2020/21)
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term

ROHFP (01-20) 002 Finance & Performance Report

<table>
<tr><td colspan="2"><u>Overview</u>
January 2021 saw an overall decrease in the Trust's vacancy rates (specifically clinical vacancies), and appraisal completion. Turnover and Attendance figures have remained fairly constant and mandatory training figures saw an improvement for the first time since February 2020. There was also an increase in Agency Breaches of 52 compared to last month</td></tr>
<tr><td><u>Vacancy</u>
The number of staff on the payroll in December stood at 1118 (1045.20 - WTE), an increase of 8.93 WTE.

• The Trust vacancy position decreased by 0.60% to 92.58%, retaining an amber status against the Trust's target of 93%.
• The number of clinical staff vacancies decreased by 1.31% to 93.00%, moving to the green status for the first time since June 2020. This is against the Trust's target of 92%.
• The number of non-clinical vacancies also increased by 0.62% to 91.85%, retaining a red status against the Trust's revised target of 92%.</td><td><u>Monthly Attendance</u>
• Monthly attendance decreased slightly by 0.62% to 93.05%, retaining it's red status against the Trust's target of 96.3%.
• The underlying 12-month average attendance figure also slightly decreased by 0.16% to 94.24% retaining it's red status against the Trust's target of 96.3%.
• Long term sickness data decreased by 0.32% to 4.47%

The figures have been quite similar over the past 3 months with little variation and we are expecting the figures to show a similar trend throughout the national lockdown. The figures should also begin to show some improvement following a large number of staff being vaccinated. Covid-19 absence data is still being reported daily to NHS England and weekly figures are being submitted to the BSOL STP</td></tr>
<tr><td>. <u>Appraisals</u>
• Appraisals completions decreased by 2.42% to 70.76%, and retains a red status against the Trust target of 95%

The ESR and HR teams are continuing to liaise directly with teams to address the hotspots of non-compliance. Medical appraisals are being scheduled where possible following the suspension of medical appraisals last year which was uplifted in September 2020.</td><td><u>Mandatory Training</u>
• Mandatory training increased by 1.46% to 76.05% in December, retaining the red status against the Trust revised target of 95%

This is first increase seen since Feb 2020 which is encouraging. Staff are still actively being encouraged to complete their mandatory training via e-learning and the Learning and Development Team are continuing to liaise with neighbouring Trusts to align competencies and courses to streamline mandatory training compliance for staff transferring between Trusts.</td></tr>
<tr><td><u>Turnover Figures</u>
• Unadjusted Turnover (all leavers except Junior Doctors) didn't change from last month, remaining at 8.59%, and retaining a green status against the Trust's target of 11.5%.
• Adjusted Turnover (substantive staff leavers excluding flexible retirements) decreased by 0.21% to 6.48%, retaining a green status against the Trust's revised target of 11.5%.</td><td><u>Agency Breaches</u>
Agency Breaches increased from 119 shift breaches in December to 171 shift breaches in January 2021. The entirety of this shift breaches were medical usage. There were no AHP, Nursing or Admin breaches.</td></tr>
<tr><td>ACTIONS FOR IMPROVEMENTS / LEARNING</td><td>RISKS / ISSUES</td></tr>
<tr><td>• Re-introducing the appraisal preliminary report to encourage managers to record their completed appraisals on the system.
• Manager Dashboard to be finalised in the upcoming months to support managers with viewing their own workforce data</td><td>• Mandatory training and appraisal figures need to be monitored and improved
• Staff attendance needs to be closely monitored and RTW's accurately recorded on the systems to assure that sickness is being managed properly</td></tr>
</table>

	Dec-20	Jan-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	8.59%	8.59%	0.00%	⇔	<=11.5%
Staff Turnover (%) - Adjusted	6.69%	6.48%	-0.21%	⇧	<=11.5%
Total WTE Employed as % of Establishment	91.98%	92.58%	0.60%	⇧	>=93%
Total WTE Employed as % of Establishment - Clinical	91.69%	93.00%	1.31%	⇧	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	92.47%	91.85%	-0.62%	⇩	>=96%
% of Attendance	93.67%	93.05%	-0.62%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.40%	94.24%	-0.16%	⇩	>=96.3%
% of Sickness - Trust wide Long-term	4.79%	4.47%	-0.32%	⇧	-
% Staff received mandatory training last 12 months	74.59%	76.05%	1.46%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	73.18%	70.76%	-2.42%	⇩	>=95%

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday 7 April 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 7 April 2021 commencing at **0900h**. This will be a remote meeting facilitated using videoconferencing technology.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 7 April 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Admissions and Day Case Unit	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 3 March 2021: *for approval*	ROHTB (3/21) 019	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (3/21) 019 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (4/21) 001 ROHTB (4/21) 001 (a)	TP/JW
0950h	7	Refresh & recovery update and roadmap: *for assurance*	ROHTB (4/21) 002	MP
1000h	8	**Infection Prevention and Control response to the COVID-19 pandemic**		
	8.1	Trust response to COVID outbreaks: *for assurance*	ROHTB (4/21) 003 ROHTB (4/21) 003 (a)	GM

	8.2	NHS England IPC Board Assurance Framework update: *for information*	ROHTB (4/21) 004 ROHTB (4/21) 004 (a)	GM
	8.3	Health & Safety Executive COVID-19 spot check: *for assurance*	Verbal	GM
1020h	9	**Staff Experience and Health & Wellbeing**		
	9.1	Staff survey 2020 results and action plan: *for assurance*	ROHTB (4/21) 006 ROHTB (4/21) 006 (a)	JW
	9.2	Diversity, equality, respect and inclusion update: *for information*	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	SM
	9.3	Health & wellbeing update: *for assurance*	ROHTB (4/21) 008 ROHTB (4/21) 008 (a)	SM
	9.4	Disciplinary policy: *for assurance*	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	SM
1045h	10	**Governance & compliance**		
	10.1	Preparation for the CQC Transitional Monitoring Approach assessment	ROHTB (4/21) 010 ROHTB (4/21) 010 (a)	JW
	10.2	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 011 ROHTB (4/21) 011 (a)	SGL
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
1100h	11	Exception assurance reports from the Board Committees: • Finance & Performance – key highlights • Staff Experience & OD – key highlights • Quality & Safety – assurance report • Charitable Funds – assurance report	ROHTB (4/21) 012 ROHTB (4/21) 013 ROHTB (4/21) 014 ROHTB (4/21) 015	
1115h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance • Workforce	ROHTB (4/21) 016 ROHTB (4/21) 017	
	CONFIDENTIAL SESSION			
1130h	13	Exclusion of the press and public	Verbal	Chair
Date of next meeting: Wednesday 5 May 2021 @ 0900h				

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 – UPDATED TO FEBRUARY 2020

MEMBER	ATTENDANCE									TOTAL
	6/5/2020	3/6/2020	1/7/2020	2/9/2020	7/10/2020	4/11/2020	3/12/2020	13/01/2021	3/02/2021	
Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	✓	✓		8/8
Tim Pile	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Rod Anthony	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Gianjeet Hunjan						✓	✓	✓	✓	4/4
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Phil Begg	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Sharon Malhi					✓	✓	✓	✓	A	4/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (IN PUBLIC)

Venue Remote via videoconferencing **Date** 7 April 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Admissions and Day Case Unit	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 3 March 2021: *for approval*	ROHTB (3/21) 019	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (3/21) 019 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (4/21) 001 ROHTB (4/21) 001 (a)	TP/JW
0950h	7	Refresh & recovery update: *for assurance*	ROHTB (4/21) 002	MP
1000h	8	**Infection Prevention and Control response to the COVID-19 pandemic**		
	8.1	Infection Control annual report: *for approval*	ROHTB (4/21) 003 ROHTB (4/21) 003 (a)	GM

	8.2	Trust response to COVID outbreaks: *for assurance*	ROHTB (4/21) 004 ROHTB (4/21) 004 (a)	GM
	8.3	NHS England IPC Board Assurance Framework update: *for assurance*	ROHTB (4/21) 005 ROHTB (4/21) 005 (a)	GM
	8.4	Health & Safety Executive COVID-19 spot check: *for information*	Verbal	GM
1020h	9	**Staff Experience and Health & Wellbeing**		
	9.1	Staff survey 2020 results and action plan: *for assurance*	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	SM
	9.2	Diversity, equality, respect and inclusion update: *for assurance*	ROHTB (4/21) 008	SM
	9.3	Health & wellbeing update including the role of the Health & Wellbeing Guardian: *for assurance*	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	SM
	9.4	Learning Lessons to Improve our People Practice: *for assurance*	ROHTB (4/21) 010 ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)	SM
1045h	10	**Governance & compliance**		
	10.1	CQC Transitional Monitoring Approach key lines of enquiry self-assessment and action plan: *for assurance*	ROHTB (4/21) 011 ROHTB (4/21) 011 (a) ROHTB (4/21) 011 (b)	JW
	10.2	Annual cycle of business and strategic board work & development plan: *for approval*	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	SGL
		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1100h	11	Exception assurance reports from the Board Committees: • Finance & Performance – key highlights • Staff Experience & OD – key highlights • Quality & Safety – assurance report • Charitable Funds – assurance report	ROHTB (4/21) 013 ROHTB (4/21) 014 ROHTB (4/21) 015 ROHTB (4/21) 016	
1115h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance • Workforce	ROHTB (4/21) 017 ROHTB (4/21) 018 ROHTB (4/21) 019	

CONFIDENTIAL SESSION				
1130h	13	Exclusion of the press and public	Verbal	Chair
Date of next meeting: Wednesday 5 May 2021 @ 0900h				

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.

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ATTENDANCE REGISTER – UPDATED TO MARCH 2021

MEMBER	ATTENDANCE										TOTAL
	6/5/2020	3/6/2020	1/7/2020	2/9/2020	7/10/2020	4/11/2020	3/12/2020	13/01/2021	3/02/2021	3/03/2021	
Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	✓	✓			8/8
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Rod Anthony	✓	✓	✓	✓	✓	✓					6/6
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Gianjeet Hunjan						✓	✓	✓	✓	✓	4/4
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Phil Begg	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Sharon Malhi					✓	✓	✓	✓	A	✓	5/6
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (In Public) - DRAFT Version 0.3

Venue Remote via videoconferencing **Date** 3 March 2021: 0900h – 1230h

Members attending:

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayo Ajose	Non Executive Director	(AA)
Mrs Jo Williams	Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Mr Leslie Williams	Non Executive Director Designate	(LW)	[Observer]
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mrs Mandeep Johal	Freedom to Speak Up Guardian	(MJ)	[Item 1]
Ms Ali Gray	Charity Manager	(AG)	[Item 15]
Mrs Amanda Gaston	Deputy Director of Finance	(AGA)	[Item 21]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Freedom to Speak Up update: *for assurance*	**Presentation**
The Board was joined by the Freedom to Speak Up Guardian (FTSUG) who presented her statutory annual report. It was noted that the majority of the concerns raised during the last period related to attitudes and behaviours. Bullying allegations were noted to be of concern. The Director of Nursing & Clinical Governance asked for a comparison to previous years and whether there was work planned to address such concerns. The Acting Associate Director of Workforce & OD noted that a zero tolerance campaign around bullying and harassment was being promoted but it was noted	

that it was positive that the issues were being raised and identified more robustly. The bullying and harassment policy would also be rebranded as the civility and respect policy. There was reported to be much work underway in terms of wellbeing and supporting staff affected by the pandemic. It was noted that the recruitment of the Freedom to Speak Up champions would be useful. In terms of the high level of concerns raised by the portering team, this was noted to reflect some concerns at the start of the pandemic around access to Personal Protective Equipment (PPE) and moving patients around the site which had been difficult to implement in the face of poor national guidance; this had created anxiety. It was suggested that the porters should be part of the FTSU champions group if possible. The support for managers of staff raising concerns was discussed and it was agreed that the relationship with managers and the FTSUG was key to ensure that they were supported and the issues were generally resolved in conjunction and without animosity. In terms of direct support for managers a period of fact finding would be undertaken for individual cases to inform whether there a move to a formal process. The Organisational Development team would also be used where appropriate to support the work too. This would also ensure that individuals were not reluctant to take on leadership positions given that they were aware of the support for them in these roles. There was noted to have been an increase in the number of anonymous concerns raised given that some of the concerns were of a sensitive nature. It was agreed to be pleasing that some vulnerable groups were now speaking up and they would be encouraged to raise concerns and issues in a non-anonymous way. It was suggested that the wider plans for widening the FTSU offering to staff groups of other protected characteristics needed to be given focus. There was reported to be a national online training programme in place which would be delivered through the Electronic Staff Record (ESR). Board support for the work was underlined by the Chairman. Mandy Johal was thanked for her report.	
2 Apologies	**Verbal**
There were no apologies tendered.	
3 Declarations of Interest	**Verbal**
The Register of Interests was available on request from Company Secretary.	

4 Minutes of the Board Meeting held in public on 13 January 2021: *for approval*	**ROHTB (1/21) 018**
The minutes of the previous meeting held in public were accepted as a true and accurate reflection of discussions held.	
4.1 Actions from previous meetings in public: *for assurance*	**ROHTB (1/21) 018 (a)**
It was noted that there remained several actions which needed to be rescheduled and a discussion would be held with the Executive Team to agree a more suitable timing for those delayed. Some would form part of the Board's strategic workplan.	
5 Questions from members of the public	**Verbal**
There were none.	
6 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (3/21) 001** **ROHTB (3/21) 001 (a)**
The Chief Executive advised that the Executive Team was proud of the way in which the staff had supported the COVID-19 response. Some of the staff were returning from other organisations after a period of redeployment to help with the response across the system. Staff were keen to return to delivering the work at the ROH. Uptake of the 'flu vaccine was reported to be good at in excess of 80%. The staff survey was reported to be being published on 11 March and the performance would be discussed by the Board in April. Parking charges would be reintroduced at the beginning of April for patients and from beginning of July for staff. This was in contrast to the position elsewhere where parking charges had been introduced some months ago. The Communications Team had supported the wellbeing day announcement and over 36,000 people had interacted with this on various social media platforms. The majority of the Chairman's work since the last meeting had been around the Integrated Care System (ICS) and the collaboration with the local system. The assets of the ROH would be used for the benefit of the local citizens. It was reported that a panel of the governors had been convened who had supported the appointment of Les Williams as a new Non Executive Director and Ayodele Ajose to be full Non Executive Director. It had been a pleasure to hear	

the passion and planned contribution of both individuals.	
6.1 Proposed modification of condition G4 of the NHS provider licence: *for information*	**ROHTB (3/21) 001 (b)**
The Director of Corporate Affairs & Company Secretary presented the proposal by NHS Improvement to amend the text in the Foundation Trust provider licences to better match the wording and requirements in the CQC regulation regarding the Fit and Proper Persons Test. This was noted to be a technical amendment as the new requirements proposed were the standard pre-employment checks that the organisation already undertook for Board members.	
7 Refresh & recovery update: *for assurance*	**ROHTB (3/21) 002**
The Chief Operating Officer presented an overview of the refresh and recovery work, noting that the brevity of the report did not reflect the amount of work undertaken over the past few weeks. It was reported that the governance structure for the work had been established and endorsed and the leads for the workstreams were in place. There was continuity of care for patients. Patients were being repatriated and remedial work was being undertaken. Staff were returning from elsewhere and most will rejoin the ROH by the end of March. Wellbeing packs were being arranged for their arrival back. The patient clinical prioritisation report would be presented to the refresh and recovery board. This was also extended to Outpatients. In terms of decisions taken, additional operational management support would shortly be in place. Imaging and therapy services had restarted in February. The project group aims and objectives were being agreed and the Quality Service Improvement and Redesign (QSIR) methodology would be used as a framework for the work. The timelines for the plans would be presented next month. 1200 Outpatients were being seen with 43% being seen virtually. The restoration and recovery work would be built into that of the system and a roadmap was being developed. This would also be considered at the Finance & Performance Committee. The format of the report was welcomed. It was noted that the first wave provided some points of learning around collaboration between the Chief Operating Officer, Medical Director and Director	

of Nursing & Clinical Governance which were picked up in this latest piece of work. The speed with which the work was progressing was noted to be excellent and the Trust had worked well on its responsibilities in the system. This was understood and appreciated at the highest levels. Thanks were given to the team for their ongoing work.	
8 Infection Prevention and Control response to the COVID-19 pandemic	
8.1 Trust response to COVID outbreaks: *for assurance*	**ROHTB (3/21) 003**
The Director of Nursing & Clinical Governance presented a summary of the outbreaks that had been reported to date. Since the last meeting, there had been a new outbreak in Ward 3, which involved two new patients on the pathway that started at University Hospitals Birmingham NHSFT (UHB), who despite screening, had developed COVID-19 subsequently. This outbreak was contained to these two individuals. A second outbreak had occurred in the Pharmacy department. The initial diagnostic was underway and it had been identified that staff had been in close proximity to each other. One individual had come into contact with significant exposure to COVID-19 outside of the organisation. There had been no operational issues as a result of the outbreak and no patients had been involved. It was noted that the Pharmacy estate was old and that capital work had been started to enhance the environment. There was noted to be a significant amount of estates work underway across the Trust. The pharmacy element would be completed by the end of April. Vaccine uptake was reported to be at 82% overall and for front line clinical staff this was 77%. In terms of staff from a Black, Asian and Minority Ethnic background, uptake was 57%. There was noted to have been low take up in Pharmacy. The was good uptake by Consultant staff and there were also good vaccination rates among nursing staff. It was reported that there was more information being provided to address vaccination hesitancy. It was suggested that the FTSUG could help with the work. There was reported to be work that was undertaken by the Multi Minority Ethnic Group (MMEG) and it was agreed that an individualised approach should be adopted and champions would be identified to help with these discussions. There was noted to be a link between take up and the COVID-19 absences. Gianjeet Hunjan reported that there were various videos available to help with the messaging. She also suggested that there needed to be a balanced approach so that individuals did not feel intimidated. It was noted that there had been no target set for vaccinations at present.	

8.2 NHS England IPC Board Assurance Framework update: *for information*	**Verbal**
It was noted that the NHS England IPC Board Assurance Framework had been reviewed at the last meeting and there were no concerns with compliance. Version 3 had been issued and a gap analysis would be undertaken which would be presented to Trust Board and Infection Prevention & Control Committee.	
ACTION: GM to present the position against the updated IPC Board Assurance Framework at the next meeting	
8.3 Personal Protective Equipment update: *for assurance*	**Verbal**
The Director of Nursing & Clinical Governance advised that some of the guidance around the use of Personal Protective Equipment (PPE) had changed recently but the Trust was above the standard in terms of the masks used. The main impact was on theatre staff at present. There was reported to be some focussed work underway on FFP3 fit testing for the various brands of masks. There were now two brands which would be continuously used. A risk assessment would be undertaken if staff could not wear a FFP3 mask. The alternative was a hood and these were readily available in the organisation for aerosol generating procedures. FFP3 masks were not routinely advocated across the Trust. There were no procurement and supply issues for staff.	
8.4 Lateral testing update: *for assurance*	**Verbal**
The Director of Finance advised that a second delivery of test kits had been received and many staff were now using their second boxes. There were no reported issues but there remained a gap between tests undertaken and reported results. It was noted that there was a professional responsibility to undertake the tests.	
9 Learning from Deaths update: *for assurance*	**ROHTB (3/21) 004** **ROHTB (3/21) 004 (a)**
The Medical Director reported that the Learning from Deaths process was nationally mandated. At the ROH the national standard was exceeded as it included in hospital deaths but all deaths within 30 days were also reviewed by the Associate Medical Director. Information from quantitative data was also reviewed which showed deaths in hospital, those within 30 days and the number of deaths within 90 days. The overall picture showed a spike in the first two quarters of the financial year	

2020/21 related to COVID-19 and the fractured neck of femur cohort being treated. The Board agreed that this was a good and digestible report and would be useful to the CQC as part of their oversight of the organisation. It was questioned how the staff were coping with handling the higher than usual levels of mortality. The Director of Nursing & Clinical Governance was noted to be talking to the staff about their experience. Letters from the families had been received thanking the staff for their care, compassion and dignity. Some work had also been done to ensure that staff understood the usual mortality of fractured neck of femur patients and to highlight that the staff had done well given the position at the ROH. Porters were noted to be a key part of the process. In terms of end of life training, the experience had shown what was needed from the breaking bad news experiences. Family members were invited to visit those patients who were due to die and PPE had been provided to these individuals where this was the case. It was noted that only one formal complaint around End of Life Care had been received. It was reported that the wellbeing officer had also helped with support on an individualised basis. Going forward critical debriefing of staff was also planned which would be useful. It was noted that excellent leadership had been seen during the pandemic. The Director of Strategy & Delivery noted that the arrival of the temporary mortuary had caused anxiety initially and therefore a briefing for the porters had been arranged. It was noted that it had been agreed that the temporary mortuary contract would end on 31 March 2021.	
10 Board Assurance Framework: *for information*	**ROHTB (3/21) 005** **ROHTB (3/21) 005 (a)**
The Director of Corporate Affairs & Company Secretary advised that the Board Assurance Framework had been fully updated since the last meeting and there were some proposed changes to the risk scores. Two risks were proposed for de-escalation and one risk was proposed for closure, which the Board was asked to approve. It was agreed that the BAF would be refreshed in April to remove the Paediatric oncology services risk. Ayodele Ajose suggested that the risk around IT was concerning and highlighted a number of failures in terms of the robustness of the IT infrastructure and security. The Director of Finance reported that the Data Protection and Security Toolkit (DPST) was a key tool that measured compliance against a number of related standards and offered the mitigations where there was a recognised shortfall.	

Effort has been directed into addressing the areas which would be of most impact. It was reported that the absent software did not affect core functionality. It was agreed that there needed to be further work on the development of the IT strategy. There was reported to be some collaborative work across the system facilitated by Deloitte and there was some good work with UHB underway around IT and digitisation. This would be a benefit of being part of the Integrated Care System (ICS) and system working. It was agreed that there needed to be clarity on the future direction and a piecemeal approach was discouraged. Ayodele Ajose suggested that Service Level Agreements (SLAs) needed to be developed and consideration be given to potential TUPE issues in some circumstances. Reassurance was given that there were no transfers to another provider without an SLA being in place and that in terms of the IT systems work, there was a contract in place for the Prescribing Information and Communications System (PICS) for example. It was agreed that the timescale for the Deloittes work would be shared at the next meeting. It was noted that the ROH had moved on significantly in terms of its IT systems and there was good progress. These developments would gain visibility through the various Board subcommittees. It was agreed that a deep dive into IT should be scheduled for a future Board meeting. On a separate matter, it was noted that in terms of finance, consultation had started for the transactional finance function to transfer to UHB which addressed the TUPE concern raised earlier. It was agreed that the IT risk would be updated in light of the most recently report to Audit Committee. The plan for the risks to be de-escalated and closed were agreed.	
ACTION: SW to refresh the IT risk on the Board Assurance Framework	
11 Exception assurance reports from the Board Committees • **Finance & Performance – key highlights**	**ROHTB (3/21) 006**
It was reported that the Committee had been joined by two clinicians to discuss a procurement exercise for some implants. It was noted that the financial position had moved in month as a result of the £1.8m received from the Clinical Commissioning Group. This would be used to support the second MRI scheme from a cash perspective.	
• **Staff Experience & OD – key highlights**	**ROHTB (3/21) 007**

It was noted that the majority of the issues covered by the Committee had been discussed at the Board meeting so far. There was work underway on data quality for some of the key metrics. Access to a rest & recuperation room and other staff support was provided as a basic offering. The new virtual walkabouts would commence shortly. Simone Jordan reported that she had joined a Schwartz Round recently. There had been a challenge around the return on investment of some of the wellbeing initiatives which had been satisfied.	
• **Quality & Safety – assurance report**	**ROHTB (3/21) 008**
It was reported that a training session would be held for the Board on the new changes to the current Deprivation of Liberties legislation. A health inequalities group would be established which would look at the expected outcomes for our patients. This was noted to be a good initiative given that in Birmingham & Solihull the track record for outcomes was very poor.	
12 Performance reports: *for assurance*	
• **Quality & Safety**	**ROHTB (3/21) 010**
The report was received and noted.	
• **Finance & Performance**	**ROHTB (3/21) 011**
The report was received and noted.	
13 Exclusion of the press and public	**Verbal**
Simone Jordan offered her apologies for the confidential session. The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	

PUBLIC SESSION

Next Meeting: 7 April 2021, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 01.04.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 099	NHS England IPC Board Assurance Framework update	Verbal	03/03/2021	Present the position against the updated IPC Board Assurance Framework at the next meeting	GM	07-Apr-21	Included on the agenda of the April 2021 Board meeting	
ROHTBACT. 100	Board Assurance Framework	ROHTB (3/21) 005 ROHTB (3/21) 005 (a)	03/03/2021	Refresh the IT risk on the Board Assurance Framework	SW	05-May-21	To be included in the refreshed BAF dueto be considered by the Board in May 2021.	
ROHTBACT. 079	Patient story – JointCare follow up	Presentation	05/06/2019	Schedule in a presentation about JointCare into the Board Workplan	SGL	~~06/11/2019~~ ~~04/03/2020~~ ~~01/04/2020~~ ~~13/01/2021~~ 30/05/2021	Service partially suspended. Will look to identify patients who may have received virtual experience to present at the beginning of the next financial year.	C-19
ROHTBACT. 086	Carbon Reduction Strategy annual report	ROHTB (9/19) 020 ROHTB (9/19) 020 (a)	04/09/2019	Present a plan to create a carbon-neutral hospital to the Board at a future meeting	PB	~~31/03/2020~~ ~~13/01/2021~~ 7/04/2021	To be rescheduled for the ~~January~~ April 2021 meeting. **STRATEGIC WORKPLAN FOR JUNE 2021**	C-19
ROHTBACT. 089	Update from Staff Experience & OD Committee	ROHTB (11/19) 004 ROHTB (11/19) 005	06/11/2019	Present an overview of talent management to the Board at a future meeting	JWI	~~03/06/2020~~ 03/03/2021	To be rescheduled to the end of the financial year **STRATEGIC WORKPLAN FOR MAY 2021**	C-19
ROHTBACT. 091	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for the Guardian of Safe Working to present an update to the Trust Board	JWI	~~01/07/2020~~ ~~13/01/2021~~ 2/06/2021	New individual appointed and will join the Board in ~~January~~ June 2021	C-19
ROHTBACT. 093	'Partnerships' extract of the Board Assurance Framework	ROHTB (3/20) 002 ROHTB (3/30) 002 (a)	04/03/2020	Provide a quarterly update on innovation to the Board	PB	~~04/11/2020~~ 7/04/2021	First report due at the April 2021 meeting. **STRATEGIC WORKPLAN FOR NOVEMBER 2021**	
ROHTBACT. 096	NHS People Plan	ROHTB (9/20) 001 (b) ROHTB (9/20) 001 (b) (i) ROHTB (9/20) 001 (b) (iii)	02/09/2020	Present an overview of the progress with the Trust's version of the NHS People Plan at the March 2021 meeting	SM	03-Mar-21	**STRATEGIC WORKPLAN FOR JUNE 2021**	C-19

ROHTBACT. 092	Trust's response to the Paterson Report	ROHTB (3/20) 012 ROHTB (3/20) 012 (a)	04/03/2020	Arrange a briefing session on the Paterson Report	MR	07-Apr-21	To be scheduled	
ROHTBACT. 099	External Well led assessment and action plan	ROHTB (11/20) 006 ROHTB (11/20) 006 (a)	04/11/2020	Consider whether there is benefit in establishing a Digital Subcommittee of the Board	TP	01-Apr-21	ACTION NOT YET DUE **STRATEGIC WORKPLAN FOR JULY 2021**	
ROHTBACT. 080	Chairman's & Chief Executive's update	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	05/06/2019	Organise for a demonstration of control charts to be presented to the Board	JWI	~~02/10/2019~~ ~~05/02/2020~~ ~~06/05/2020~~ 02/12/2020	Arranged for the December meeting of the Trust Board	
ROHTBACT. 083	Mental Health update	ROHTB (9/19) 008 ROHTB (9/19) 008 (a)	04/09/2019	Arrange for the Trust Board to be trained in mental health requirements	SGL	~~31/01/2019~~ 01/04/2020	Dates for Mental Health First Aid training to be circulated - this is a two day course. Details provided and will be re-circulated to Board members for those wishing to commit to the course.	
ROHTBACT. 090	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for a registrar to present their story to the Staff Experience & OD Committee	SGL	23-Jun-20	Individual to be invited to the November meeting of the Staff Experience & OD Committee. Registrar presented their experience at QSC in 2020, which addressed this action.	
ROHTBACT. 095	Chairman's and Chief Executive's update	ROHTB (9/20) 001 ROHTB (9/20) 001 (a)	02/09/2020	Present the clinical strategy to the Board when developed	MR	13-Jan-21	Included in papers for the January 2021 meeting.	
ROHTBACT. 097	Risk assessment of hospital environment	ROHTB (9/20) 005 ROHTB (9/20) 005 (a)	02/09/2020	Present an overview of the role of the Director of Infection Prevention and Control at a future meeting	GM	30-Nov-20	Role description circulated to the Board.	
ROHTBACT. 098	Progress on restoration and recovery	Verbal	04/11/2020	Circulate details of the virtual 'Coffee Catch up' sessions	SGL	30-Nov-20	Circulated and some NED attended	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**7 April 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		x

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (4/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Trust Board in Public on 7th April 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board meeting held on the 3rd March 2021 from the Chief Executive's position, this includes an overall update, wider ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 On Thursday 25th March at the NHS England public board meeting, NHS Chief Executive, Sir Simon Stevens announced that the national incident level for the NHS COVID-19 response would be reduced from Level 4 to Level 3. Local systems and networks are asked to continue to identify and implement learning from the response to date to build resilience ahead of potential demand on our services and in advance of next winter. Local outbreaks and variants of concern will continue to be closely monitored. It was also advised that given the continued uncertainty, the situation would remain under close review, retaining the option to revert to a Level 4 incident as required.

2.2 Work continues to focus on our role in supporting our system restoration and recovery. Daily conference calls have now been stood down with all system partners. The Chief Operating Officers (COOs) across all providers continue to meet three times a week to agree the operational changes required to address the system backlog for adults across Birmingham and Solihull (BSol).

2.3 A gap analysis has been undertaken against the CQC's Transitional Monitoring Approach (TMA) key lines of enquiry, in preparation for our Well Led virtual inspection. This is likely to take place at the end of April 2021/beginning of May 2021. The inspection will not be rated and this will be to inform the CQC's decision as to whether they undertake a full inspection on site. **See paper ROHTB (4/21) 011 & 011 (a).**

2.4 Mandatory training continues to be monitored through Divisional Performance Committees with a trajectory of improvement in place. There will be a further review of the trajectories at the end of April 21. The team continues to review the current delivery process for training to ensure that it meets the needs of the users whilst adapting to COVID restrictions.

2.5 On 11 March 2021, the NHS Staff Survey results for 2020 were published. The survey was conducted in October and November 2020. 631 staff (56%) completed the survey and I am very grateful to all colleagues who responded to the survey when we know that some of them had been facing some of the most difficult challenges of their careers.

Benchmarked against 14 specialist trusts, it was pleasing to see that over 90% of staff would recommend the Trust if a friend or relative needed treatment. Our position benchmarked against both our colleagues in the region is very favourable and clearly the results also provide a clear insight into both where we are making improvements and where we need to do more. Further details of our survey results and the implications for how we plan to respond to them are set out in paper **ROHTB (4/21) 007 & 007 (a).**

2.6 On Tuesday, 6 April the Executive Team will conduct the second of the 'Chat & Check' visits. The visits are unannounced and are intended to provide an additional route for staff to talk to the Team about their experiences of working at ROH.

3 BSol ICS (Integrated Care System) Update

3.1 The next BSoL ICS Board is due to take place on Monday 12 April 2021 where the system recovery restoration plan will be presented. There is also a discussion planned to understand the role of "place" and plans for Provider Collaboration.

3.2 Recruitment is current underway for the appointment of Non-Executive Directors for the ICS Board.

3.3 David Melbourne, Deputy CEO and Finance Director at Birmingham Women's and Children's NHSFT will be supporting the ICS as Programme Director from April 2021.

4 POLICY APPROVAL

4.1 Since the Trust Board last sat, the following policies have been approved:

- Food allergens

Routine reports on policies are also presented to the Executive Team to provide additional oversight and assurance that they are being reviewed in a timely way.

5 RECOMMENDATION(S)

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

5.2 Note the contents of the report.

Jo Williams
Chief Executive

1 April 2021

REPORT TO THE TRUST BOARD

PROGRAMME:	**Refresh and Recover**	**PROGRAMME MANAGER:**	**Alicia Stanton**	**DATE:**	**22/03/2021**
PROJECTS:	**Preop and Scheduling / Inpatients / Outpatients / Workforce and Wellbeing**	**EXEC SPONSOR:**	**Marie Peplow Matt Revell**		

MILESTONES ACHIEVED

- Outpatients restarted
- First R&R Board
- Development of historic COVID protocol
- Estates works completed on wards
- Agreed Theatres Recovery plan to safely increase capacity
- Redeployed staff returning (completed by 31/03/21)

ISSUES/CONCERNS/RISKS IDENTIFIED

- Concerns over the capacity of group members to attend meetings and complete actions
- ADCU will remain an amber area, due to hand and ambulatory trauma patients, so green patients will need to be admitted directly to wards
- Risk of cancellations due to staff or patient confusion over new pre-admission protocol – Robust communication strategy in place to aid transition
- Impact on access to theatre sessions – task and finish group being created to address cross-site working

DECISIONS

- Change to Preoperative admission protocol for elective patients from 14 days isolation with 2 swabs, to 3 days isolation with 1 swab (in line with NICE guidance)
- Decision to create a task and finish group to develop system orthopaedic working

WORK PLANNED (MONTH AHEAD)

- Outpatients waiting area audit
- Scoping of alternative location for clinic virtual appointments
- Communications strategy for launch of new preoperative admission protocol – to include consultant webinar
- Preoperative admission protocol launches April 12th
- Bed modelling to incorporate 3 session theatre days, and Saturday sessions
- Scoping of current vacancies list to identify recruitment opportunities
- Meeting with UHB to launch cross site task and finish group, created to work up operational delivery model

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Report from the Director of Infection Prevention & Control**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing and Clinical Governance & Director of Infection Prevention & Control**
AUTHOR:	**Ash Tullett, Head of Clinical Governance and Garry Marsh**
DATE OF MEETING:	**7th April 2021**

EXECUTIVE SUMMARY:

This is Infection Prevention and Control Annual Report for 2019/20. There has been a delayed submission this year due to a lack of senior members in the Infection Control Department. The report was approved at the IPC committee in March 2021.

The report has been developed using the following criteria of the Hygiene Code as recommended by NHS Improvement.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

Summary

2019-2020 has been a busy and challenging year for ROH staff and for the IPC Team. The number of infection prevention improvements continue to improve the patients' experience and strengthen patient safety processes and standards.

These improvements demonstrate ROH's commitment to harm free care and reduction in avoidable health-care associated infections. Performance on mandatory surveillance is exemplary compared to national data, perhaps reflecting the elective nature of our work, but there is no room for complacency. CQUIN performance shows engagement and again we have achieved our targets. Together with our staff, governors and volunteers we have created vision and values which clearly state where we are going and how, as a team, we will behave towards each other, our patients, and partners.

Infection prevention and control is the responsibility of all of us and is fundamental when delivering the vision and values of ROH. By incorporating the principles of infection prevention into routine daily clinical practice, patient safety can be enhanced and the risk of patients acquiring an infection during episodes of health care can be minimised. Our staff demonstrate through practice that they care about patient safety. We should all be proud of the reductions made in harms, including reductions in hospital-associated infections.

Given the Covid-19 Pandemic declared in March 2020, 2020-21 is one of the most challenging years for ROH and the NHS with Infection prevention and control playing the vital role of maintaining services at the ROH and ensuring our patients are safe.

REPORT RECOMMENDATION:

The Board is asked to note and accept the report.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

National requirement

PREVIOUS CONSIDERATION:

Infection Prevention & Control Committee in March 2021.

The Royal Orthopaedic Hospital NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2019/2020

Author – Garry Marsh -Director of IPC

Approved at – Infection prevention and control Committee

Date of approval – March 2021

Introduction from the Director of Infection Prevention and Control

Infection prevention and control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (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 Director of Infection Prevention and Control's annual report for 2019/2020

The NHS continues to experience unprecedented challenge clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centred and safety-focused. Our vision is to constantly provide the highest possible standards of care across our healthcare economy.

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 for the NHS on the prevention and control of healthcare associated infections and related guidance (see table of criteria on following page). The IPC agenda has continued to be strengthened with a highly visible and flexible Infection Prevention Team (Infection Prevention Nurses, Surgical Site Infection HCA and an administrator)

The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008 (updated 2015), at the heart of this law there are two principles:

To deliver continuous improvements of care and that it meets the need of the patient. With this in mind patient safety remains the number one priority for the Trust. Infection Prevention is one of the key elements to ensure ROH has a safe environment and practice which is reflected in the Trust's vision, values and objectives with milestones turning the vision into a reality.

Improvements in health and care are linked and the NHS and its public, private, and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors and volunteers across ROH, Clinical Commissioning Groups (CCG) and Public Health England (PHE) in relation to the prevention of avoidable HCAIs.

Garry Marsh

Director of Nursing and Governance / Director of Infection Prevention and Control

Hygiene Code Criteria and Contents of report

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
   a. **The Director of Infection Prevention and Control**
   b. **The Infection Prevention and Control Team**
   c. **Committee Structures and Assurance Processes**
   d. **Trust Board**
   e. **Quality and Safety Committee**
   f. **Infection Prevention and Control Committee**
   g. **Surveillance of Healthcare Associated Infection (HCAI)**
   h. **Meticillin resistant staphylococcus aureus blood stream infections (MRSA)**
   i. **Meticillin-sensitive staphlococcus aureus blood stream infections (MSSA)**
   j. **Clostridium Difficile Infection (CDI)**
   k. **ROH CDI Action Plan**
   l. **Gram negative – bloodstream infections – Escherichia coli (E-coli)**
   m. **Vancomycin/glycopeptides resistant enterococci (vre/gre)**
   n. **Carbapenemase producing enterobateriaceae (cpe)**
   o. **Tuberculosis (tb)**
   p. **Norovirus outbreaks**
   q. **Covid-19**
   r. **Audit programme to ensure key policies are implemented**
   s. **Audits of hand hygiene practice**
   t. **Staff information and training**
   u. **Seasonal Staff Influenza Vaccination Campaign**
   v. **IPC Link Workers**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
   2.1 Providing a clean safe environment
   2.2 Water Systems Management
   2.3 Management of Decontamination
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
   5.1 Surgical Site Infection (SSI)
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

COVID-19 and this data

Counts of cases for the most recent quarter (January to March 2020) were lower than expected nationally in the NHS. It is clear that the global pandemic of COVID-19 is having an effect on the number of cases reported to the surveillance of BSI and CDI. From an analysis of voluntary microbiology surveillance, there has also been a reduction in the number of cases of other bloodstream infections, not only those covered by the mandatory surveillance. In response to the pandemic, many elective procedures in hospitals were cancelled. Hospital patient populations changed dramatically in their composition; in order for us to understand the true incidence rate of infections, we will need to consider closely these changes.

Compliance criterion 1

1. **Systems to manage and monitor the prevention and control of infection. These systems**
   use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

1a) The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable HCAIs at all levels in the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.
The DIPC will offer commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice.
At the ROH the Director of Nursing and Governance holds the role of DIPC.

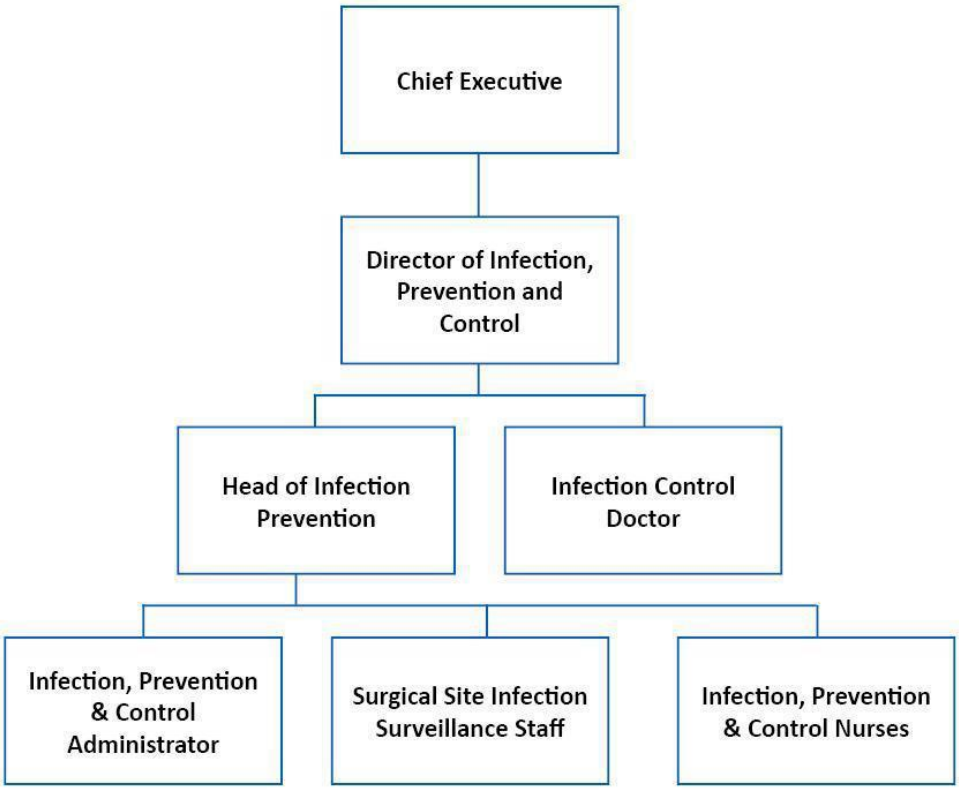
1b) The Infection Prevention and Control Team

The IPC Team is led by the Matron for IPC and is supported by Infection Prevention Nurse Specialists, Surgical Site Surveillance Health Care Assistant and an Administrator.

The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

The DIPC has overall responsibility for the IPC Team that works collaboratively alongside the front-line clinical leaders at the Trust.

IPC Team Structure



1c) Committee Structures and Assurance Processes



1d) Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive (CE) has overall responsibility for the control of infection at ROH. IPC matters.

1e) Quality and Safety Committee

The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety and continuous monitoring and improvement in relation to IPC. The QSC receives assurance from the IPCC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report on surveillance and outbreaks within the Quality Account.

1f) Infection Prevention and Control Committee

IPCC, chaired by the DIPC, provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to HCAIs.

1g) Surveillance of Healthcare Associated Infection (HCAI)

Surveillance is undertaken on a number of alert organisms and mandatory reporting to PHE is undertaken. Performance is monitored by Birmingham and Solihull Clinical Commissioning Group (CCG). Overall performance at ROH is excellent.

1h) Meticillin resistant staphylococcus aureus blood stream infections

S. aureus is an organism harmlessly carried by around 30% of the healthy population. Its importance is that it is a leading cause of surgical site infection (post-operative wound infection).

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality. The risk of prosthetic joint infection and other orthopaedic implants is a particular concern in the patient population that ROH treats.

MRSA is a type of staph aureus that is resistant to the most commonly used group of antibiotics for perioperative prophylaxis i.e. prevention of post-operative wound infection. It is less commonly carried than the more sensitive strains.

ROH continues to mitigate the risk of MRSA infection by active pre admission screening and isolation of colonized patients, in keeping with national guidance. Screening results also enables effective use of appropriate prophylactic antibiotics in colonized patients.

The ROH IPC also comply with national guidance to reduce the risk of blood stream infection. Low rates of blood stream infection therefore offer assurance of:

• Effective screening strategies

• Management and care of devices

• Antibiotic prophylaxis

• Compliance with national guidance

For the period covered by this report there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;

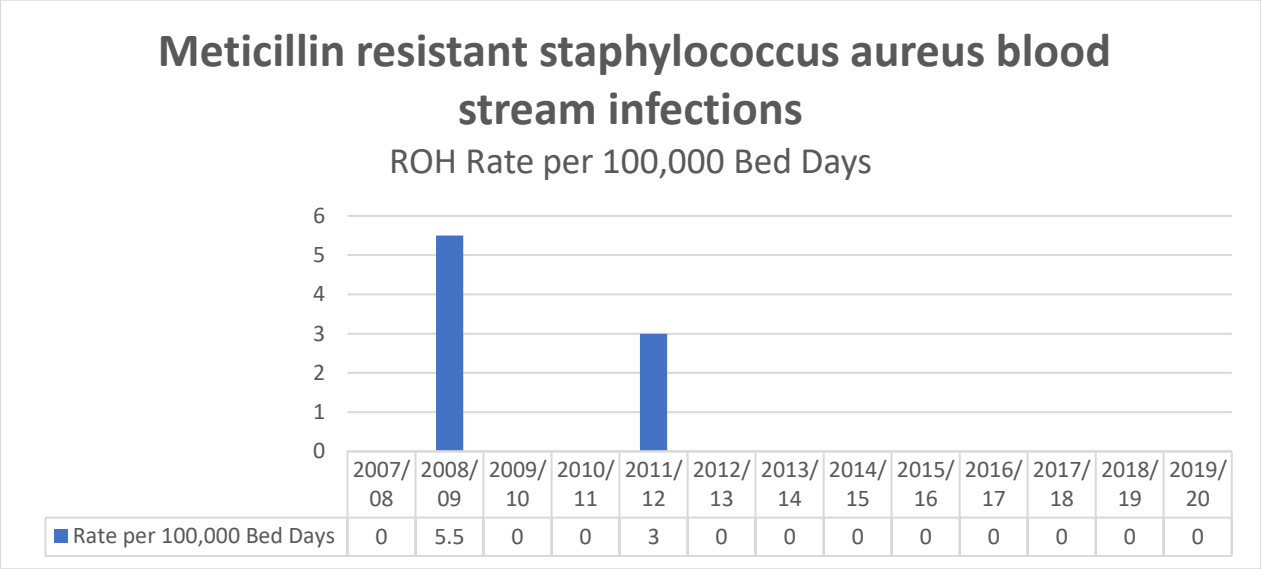
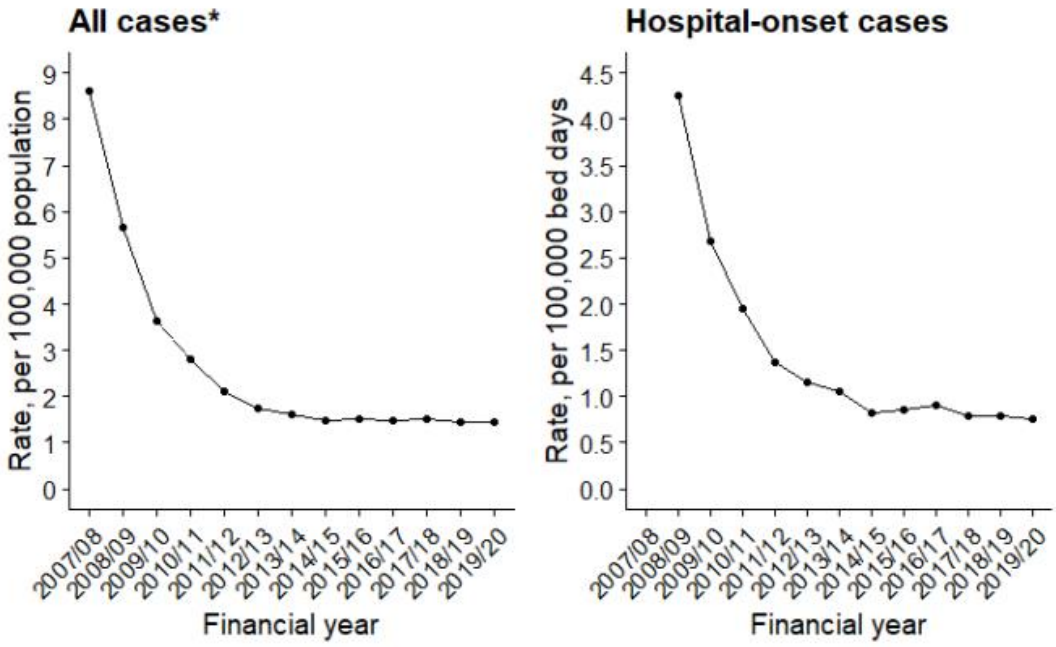


Figure 16: Trends in the all case and hospital-onset rate of MRSA bacteraemia, England: 2007/08 to2019/20



Epidemiological analyses of Staphylococcus aureus bacteraemia data

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007 (figures 4a, table S4a). The incidence rate of all reported cases fell by 85% from 10.2 cases per 100,000 population April to June 2007 to 1.5 cases per 100,000 in January to March 2014. The rate has subsequently decreased to 1.4 cases per 100,000 population between January to March 2014 and January to March 2020. A similar trend was observed with the incidence rate of hospital-onset cases (figures 4b, table S4a). There was a steep decrease of 79% from 4.9 cases per 100,000 bed-days in April to June 2008 to 1.0 January to March 2014. Subsequently, between January to March 2014 and January to March 2020, the rate decreased to 0.8 cases per 100,000 bed-days. Comparing the most recent quarter (January to March 2020) to the same period in the previous year (January to March 2019) shows an 11.7% increase in the count of all reported cases from 179 to 200, while the incidence rate increased 11.7% from 1.3 to 1.4 cases per 100,000 population. The count of hospital-onset MRSA bacteraemia cases increased 21.7% from 60 to 73 which corresponds to an increase in the incidence rate of 21.7% from 0.7 to 0.8 per 100,000 bed-days. Community-onset MRSA bacteraemia cases increased 6.7% from 119 to 127, while the community-onset incidence rate remained steady at 0.9 cases per 100,000 population.

A total of 13,007 Staphylococcus aureus bacteraemia cases were reported to PHE in 2019/20 through both the meticillin resistant S. aureus (MRSA) bacteraemia and meticillin-susceptible S. aureus (MSSA) bacteraemia surveillance schemes. This represents a 0.8% increase in the numbers of bacteraemias caused by S. aureus from 2018/19 (n = 12,903) and a 31.6% increase from 2011/12 (n = 9,883) when MSSA reporting was made mandatory. In 2019/20, 6.3% (n = 814) of S. aureus bacteraemia reports were caused by MRSA. This is a decrease from 2011/12, when 11.3% (n = 1,116) of reports were caused by MRSA and a 0.9% increase from 2018/19 when 807 infections were caused by MRSA. At its peak (2007/2008) MRSA bacteraemias accounted for approximately 40% of all S. aureus bacteraemia cases in England (Johnson AP 2005).

1i) Meticillin-sensitive staphlococcus aureus blood stream infections

Meticillin-sensitive Staphylococcus aureus is a type of bacterium which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.
MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

Epidemiological analyses of Meticillin-Sensitive Staphylococcus aureus (MSSA)

Rates of Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia continued to increase moderately from 2011/12 when the surveillance was introduced. The rate increased marginally from 21.6 cases per 100,000 population in 2018/19 to 21.8 per 100,000 population in 2019/20. In contrast to MSSA, rates of MRSA bacteraemia and CDI have remained low in comparison to rates at their peak, at 1.5 and 23.5 per 100,000 population, respectively in 2019/20. However, for 2019/2020 CDI saw an 11% increase on the previous year, this may have reflected an unusually low year in 2018/19 rather than the beginning of a rising trend in 2019/20.

A total of 12,193 cases of MSSA bacteraemia were reported by NHS acute Trusts in England between 1 April 2019 and 31 March 2020. This is an increase of 0.8% from 2018/19 (n = 12,096), and an increase of 39.1% from 2011/12 (n = 8,767). Figure 20 shows the trends in rates of MSSA cases for all cases and hospital-onset cases from 2011/12 to 2019/20. The rate of all MSSA cases per 100,000 population, per year, has risen from 16.4 in 2011/12 to 21.8 in 2019/20.

MSSA blood stream infections cases continue to be monitored by ROH. Currently this data collection is part of national surveillance only. In total this year there has been 1 hospital associated case(post-48 hours after admission) reported and 1 pre - 48hour case reported

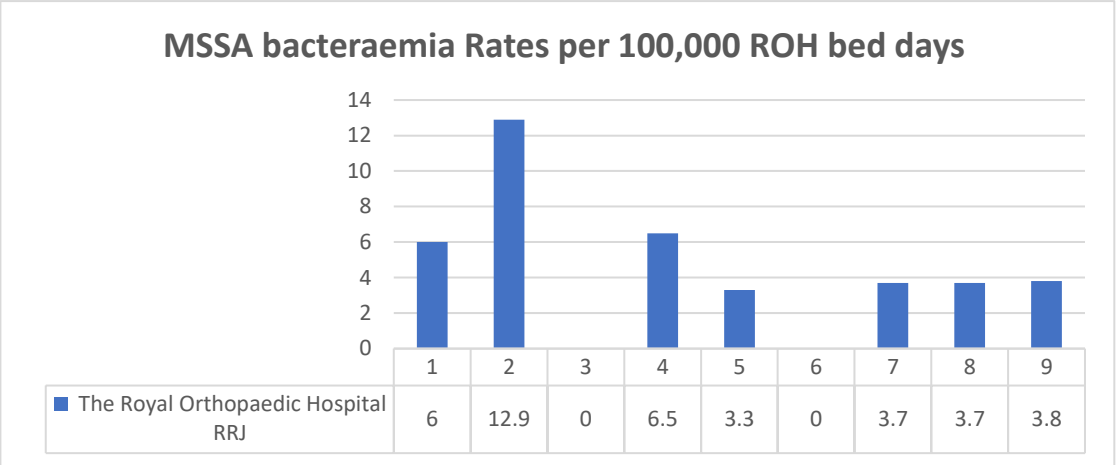
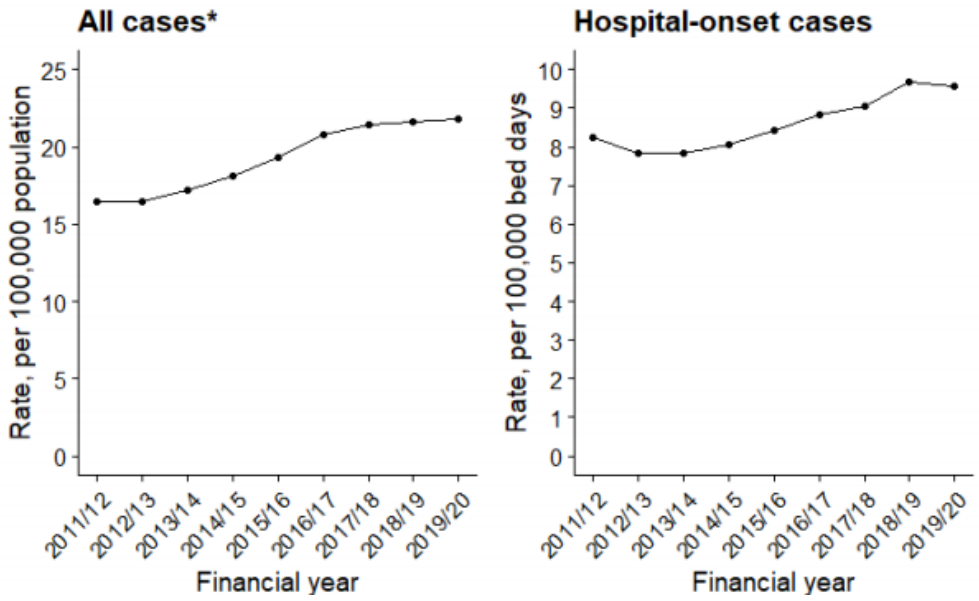


Figure 20: Trends in the rate of MSSA bacteraemia, England: 2011/12 to 2019/20



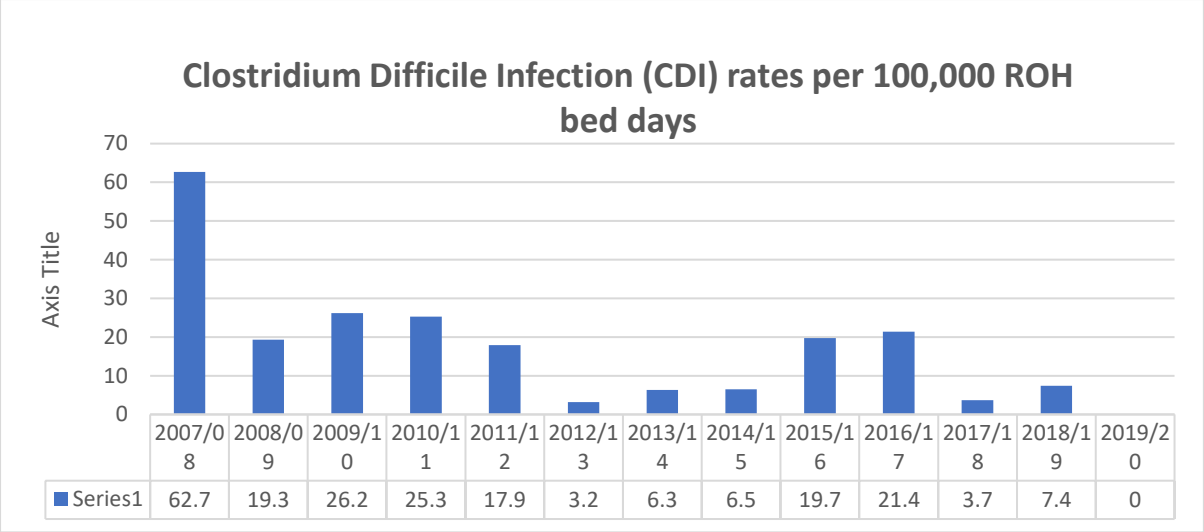
1j) Clostridium Difficile Infection (CDI)

Up to and including 2018/19, NHS organisations have continued to be required to demonstrate year on year reductions in Clostridium difficile Infection (CDI) cases. However, as published data shows, the rate of improvement for CDI has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors, including the biology and epidemiology of the Clostridium difficile (CD) organism.

There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry CD in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

Cases of CDI that are considered to have been acquired in that the Trust are defined as sample taken "on or after 48 hours of admission".

No case was apportioned to the ROH in 2019/2020.

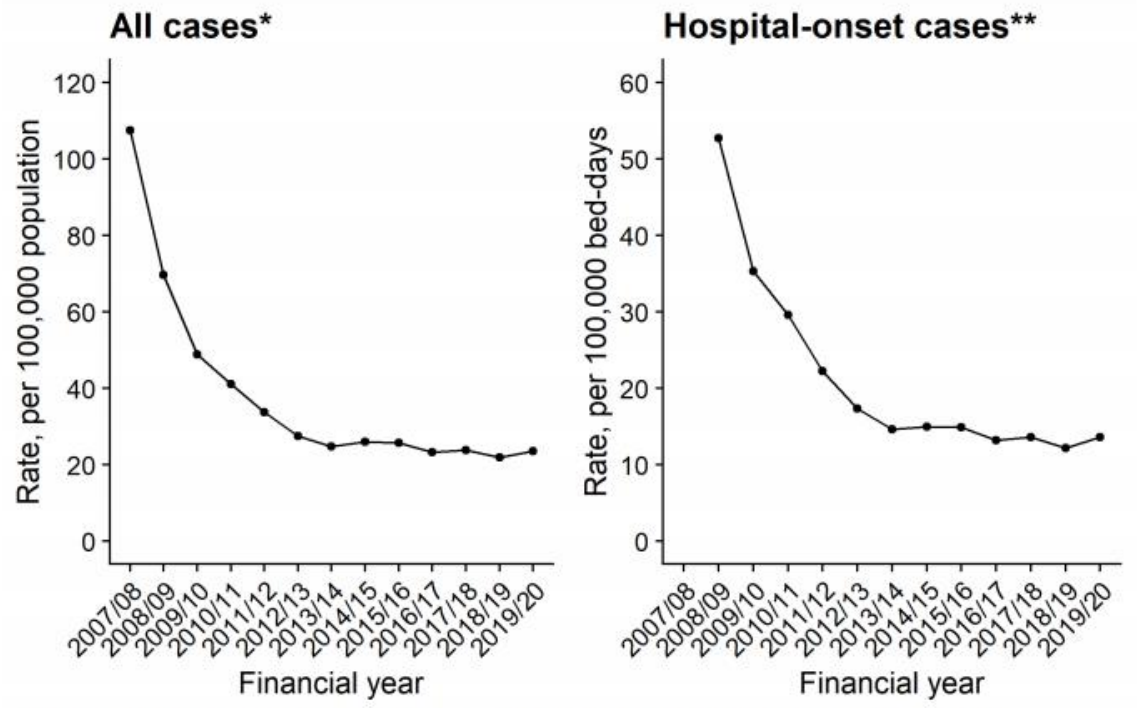


Epidemiological analyses of *Clostridium difficile* infection data (England)

A total of 13,177 cases of Clostridioides difficile infection were reported by NHS trusts in England between 1 April 2019 and 31 March 2020. This is a small increase of 7.4% from 2018/19 (n = 12,274), and a decrease of 76.3% from 2007/08 (n = 55,498). Figure 17 shows the trends in rates of CDI cases for all cases and hospital-onset cases from 2007/08 to 2019/20. The rate of all CDI cases per 100,000 population, per year has fallen from 107.6 in 2007/08 to 23.5 in 2019/20.

Between 2007/08 and 2012/13 rates of CDI fell rapidly. Since 2012/13 there has been a fluctuation around the same rate. The rapid decline in the rate of all cases of CDI has been mirrored in hospital-onset cases, except for the most recent year which saw a substantial increase in rate on the preceding year. However, the decline in community onset cases has not been so rapid and community-onset cases now constitute 64.3% of cases. Many of the interventions aimed at the reduction of CDI rates were targeted at the hospital setting, which likely explains the greater reduction in hospital-onset cases compared to community-onset cases. However, the division of cases into hospital-onset and community-onset cases does not account for the effect of any prior admissions to hospital which could increase the risk of CDI. For this reason, and to better align CDI surveillance in England with that performed by ECDC and CDC, reporting of information on prior trust exposure was introduced in April 2017.

Figure 24: Trends in the rate of *C. difficile* infection, England: 2007/08 to 2019/20



* Mid-year population estimates for 2019/20 were not available at time of publication and so population data for 2018/19 were used as a proxy.

1k) ROH CDI Action Plan

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Service (BIS) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors. All HCAI CDI cases are subject to a post infection review and each case is discussed with the Lead IPC Nurse at Birmingham and Solihull Clinical Commissioning Group (BSolCCG) to determine the avoidability (lapses in care) with feedback given to IPCC and relevant Divisions. The Divisions action Duty of Candour where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridium Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridium Difficile within a period of 28 days and associated with stay in the same ward or area. Should this occur samples are obtained and submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

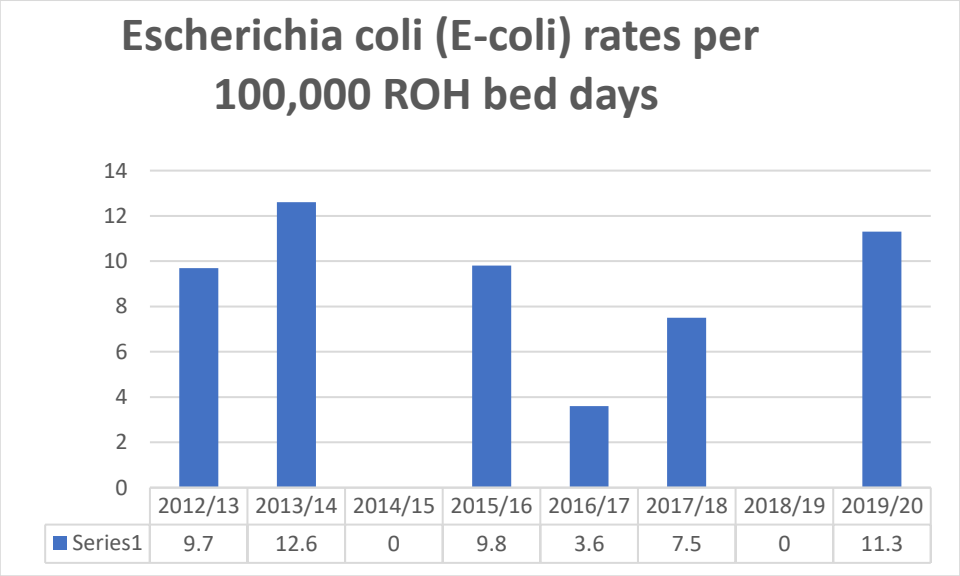
1l) Gram negative – bloodstream infections – Escherichia coli (E-coli)

Gram negatives (GN) are a group of organisms that form part of the normal gut flora.
They are particularly associated with urinary tract infection (UTI) which may also lead to blood stream infection (BSI). This risk may be increased by inappropriate care and use of urinary catheters. The very nature of orthopaedic surgery entails use of urinary catheters and therefore the stringent management of catheters is paramount to clean safe care. E-Coli is the most commonly seen representative in this group.

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021. Gram-negative BSIs are believed to have contributed to 5,500 NHS patient deaths in 2015. The initial focus to support this ambition is on E-coli BSI reduction. Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE.

Three cases were apportioned to the Trust in 2019/2020.



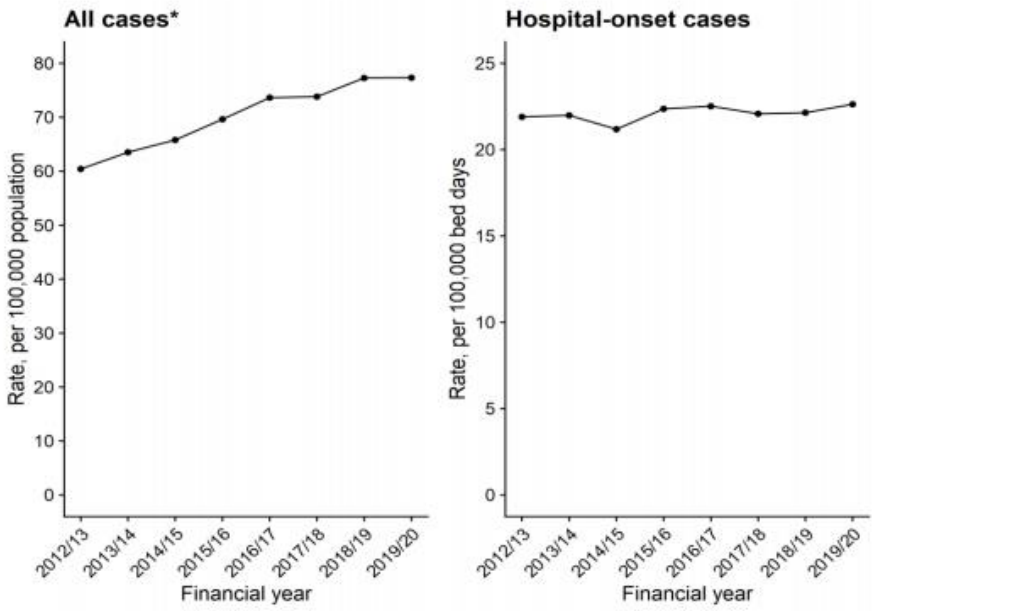
Epidemiological analyses of Gram- negative bacteraemia data (England)

***E. coli* bacteraemia**

A total of 43,294 cases of E. coli bacteraemia were reported by NHS trusts in England between 1 April 2019 and 31 March 2020. Of the 43,294 E. coli cases, 7,812 (18.0%) were hospital-onset. The total number of cases reported in 2019/20 is broadly similar to 2018/19 (n = 43,262), and an increase of 34.0% from 2012/13 (n = 32,309). Figure 1 shows the trends in the rates of E. coli cases

from 2012/13 to 2019/20. The rate of total E. coli cases per 100,000 population has risen from 60.4 in 2012/13 to 77.3 in 2019/20 (Table 1).

Figure 1: Trends in the rate of *E. coli* bacteraemia in England: 2012/13 to 2019/20



*2019/20 population data were not available at time of preparation and 2018/19 population data were used in place.

1m) Vancomycin/glycopeptides resistant enterococci (vre/gre)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.
VRE/GRE may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.
For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

1n) Carbapenemase producing enterobateriaceae (cpe)

These are a sub-set of gram negatives (see above section) which are particularly resistant to antibiotics. They are seen commonly in the Indian subcontinent and in some Mediterranean countries which have historically had a poor record on antimicrobial stewardship and IPC.
There is an increasing concern nationally about their spread in healthcare.
PHE published a toolkit in 2013 to control the spread in healthcare and onwards in the community.
ROH adhere to the toolkit.

For the period covered in this report there have been zero cases of CPE at ROH which is the same compared to the previous year.

1o) Tuberculosis (tb)

Tuberculosis (TB) is an infection caused by a bacterium belonging to the Mycobacterium tuberculosis complex. TB is a notifiable disease in the UK. Suspected and confirmed diseases must be notified within three working days. It is a serious disease that can affect most organs but often presents as a lung infection. In the context of ROH practice it can also cause joint, bone and spinal infection.
For the period covered in this report ROH had zero cases of TB infection.

1p) Norovirus outbreaks

Norovirus causes diarrhoea and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or from their environment through contamination. In hospital this environmental risk is considerable and outbreaks are common. Management therefore relies on prompt recognition of symptoms, robust isolation and IPC procedures as well as fastidious environmental cleaning.
For the period covered in this report ROH had no confirmed case of Norovirus

1q) Covid-19

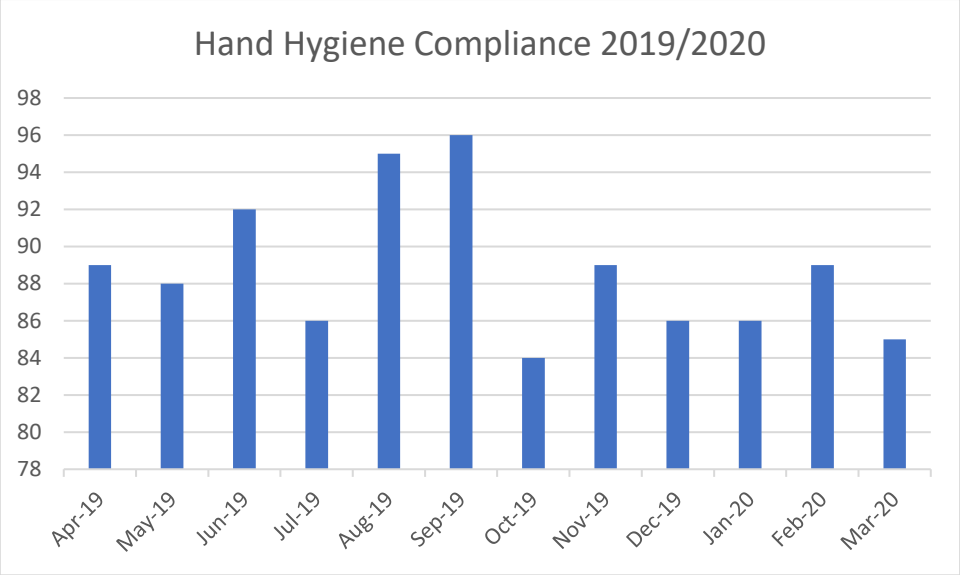
The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases in the UK were confirmed in late January 2020. COVID-19 surveillance in the UK has been on-going since January 2020. The work of the IPC team was significantly impacted by the COVID-19 pandemic from mid-January 2020, initially with the management of potential cases of SARS-CoV-2 infection as a high consequence infectious disease (HCID), and then as significant numbers of cases were managed in the Trust in March 2020 onwards

1r) Audit programme to ensure key policies are implemented

The ROH has a programme of audits in place undertaken by both clinical areas and the IPC Team to provide assurance around practice and consistent compliance with evidence-based practice and policies. Where a period if increased incidence occurs / risks are identified the IPC Team undertake additional audits in accordance with risk requirement. Action plans are devised by areas where issues are highlighted and these are managed and monitored within the divisions and escalated to IPCC and upwardly reported through the robust ROH Governance structure.

1s) Audits of hand hygiene practice

Hand hygiene continues to be included in the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas.
Hand hygiene is audited across all wards and departments, on a monthly basis, following the WHO 5Moments of Hand Hygiene.
The Trust continues to focus on four main components:
Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view.
Audit of hand washing practice at least monthly.



Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
Raised awareness of hand hygiene and the 'Bare below the elbow' dress code



1t) Staff information and training

- The IPC Team has provided mandatory hand hygiene training for all ROH employees through induction days, mandatory study days, and ward-based enhanced training.

- The IPC Team facilitate bi-monthly meetings for infection prevention link staff (from each ward and department)

- The IPC Team facilitate an annual study day for all interested employees from ROH.

- Grab Packs for hand hygiene, Influenza, MRSA, personal protective equipment and CPE have been developed and implemented across ROH to support staff with effective application from theory to practice within their areas of work.

- A bespoke hand hygiene training session has been developed for estates and facilities which will be implemented in 2019/20.

- The IPC Team continues to work collaboratively with suppliers and Estates and Facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment or processes.

- ROH hand hygiene provider, DEB UK, have standardized products, posters, dispensers across the Trust and continue to provide training and audit at operational level for all clinical areas.

- The induction IPC training package was updated to reflect the requirements of new employees to ROH.

- Communication of key messages via a number of media including social networks.

- The World Health Organisation (WHO) '-Five Moments of Hand Hygiene' is in use across ROH with the support from Communications. This campaign continues to be communicated both internally and externally with the support from social media.

- Additional on-going infection prevention surveillance and support continues across ROH with daily infection prevention visits to high risk areas.

- Bespoke infection prevention training has been developed, in line with HBN 00-09, for all preferred contractors coming into ROH.

- The IPC Team continue to work with clinical staff and support clinical site managers with safe bed utilisation.

- The IPC Team facilitated the national antibiotic awareness and hand hygiene days across ROH, this is in addition to promotional activities that they have supported throughout the year.

1u) Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2019 with a wealth of information available to staff on the Trust intranet, information boards across the site and locally based influenza champions. The uptake for 2019/2020 was 63%



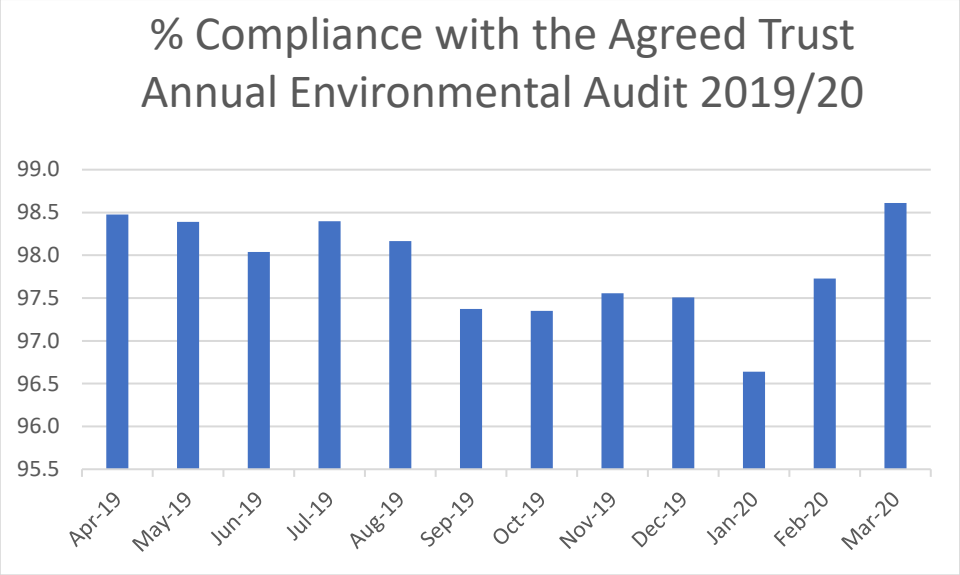
1v) IPC Link Workers

ROH, within each clinical area, has in place dedicated IPC Link Workers these include registered nurses, healthcare assistants and allied health care professionals. . These staff are supported by the IPC Team and attend bi-monthly meetings alongside education / study days to support them in their roles. They provide advice, support, education and training to operational staff as well as monitoring compliance with the IPC agenda.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

2.1 Providing a clean safe environment

- There is a designated Facilities Manager for cleaning services that are managed in house.
- The IPC Team support ROH bed management / clinical staff to ensure efficient / appropriate bed utilisation
- IPC Team are involved in capital planning schemes to support the needs of IP across ROH in refurbishments and new builds.
- The IPC Team oversees assurance of standards and reduction of risk in partnership with divisional management teams through audit, monitoring of standards, and shared learning.
- ROH use Bioquelle (hydrogen peroxide vapour), a specialised decontamination method, for the removal of environmental contaminants to ensure a safe, clean environment.
- Domestic staff continue to provide cover in all patient areas from 6am until 9pm. (Monday – Friday) and 8.30am – 7pm (weekends and bank holidays).
- Training for domestic staff continues to be provided by British Institute for Cleaning Standards and is refreshed annually.
- Head of Infection Prevention meets, on a monthly basis with Head of Estates / Facilities to review cleanliness standards and any issues identified by monthly audits. Issues are discussed at IPOG and escalated, as required to IPCC.
- ROH contract out to an accredited facility for decontamination services.
- ROH theatres have a schedule of annual shutdown for general maintenance and cleaning.
- ROH participate in the annual Patient Led Assessments of The Care Environment (PLACE).



ROH has been exceeding the threshold of 95% set by the Commissioners in 2019/20.

2.2 Water Systems Management

- Following the Department of Health publication, 'Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems: advice for augmented care units' (2012), ROH test and monitor waters from augmented care areas. Additional areas are tested if there was a clinical suspicion that waters may have been linked to a patient's infection or colonisation. The Consultant Microbiologists support this management process and provide advice / support as required.

- ROH Water Safety Group, which includes a dedicated Authorised Engineer for waters, is responsible for the oversight of water safety and continue to meet on a bi-monthly basis.

- The Water Safety group is a sub group of IPCC and reports directly to IPCC. The group is chaired by the Head of Estates.

- Estates and Facilities, Consultant Microbiologists, and the IPC Team support the water management process across ROH.

2.3 Management of Decontamination

The management and compliance currently falls into three distinct areas;

- Estates – for medical device reprocessing equipment / scheduled maintenance where required
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies.
- User – to comply with Trust Policies and to ensure that decontamination of equipment is fit for use and subject to periodic testing and maintenance as advised by the manufacturer / contractual agreement.

- No local decontamination is undertaken on site – ROH contract out to BBraun, accredited decontamination service, for full management of surgical instrumentation.

A planned programme of maintenance and refurbishment of all theatres at the ROH occurred on the Friday 19th April, 2019 with re-commencement of surgery om Monday 29th April, 2019.

3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

The Antimicrobial Stewardship (AMS) Group formed in 2017/18 and has produced an Antimicrobial Stewardship Strategy to outline the roles and responsibilities of all members of staff within the Trust at tackling Antimicrobial Resistance. Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Lead Antimicrobial Pharmacist. A number of audits have been completed to assess appropriateness of antimicrobial usage and also the review of antimicrobial antibiotics used within the Trust. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with Microbiologists.

The antimicrobial guidelines were updated by the Lead Antimicrobial Pharmacist and Microbiologists at the University of Hospitals Birmingham Trust. These were uploaded to the Trust's intranet and launched within the Trust; a summary card was produced to improve staff awareness and compliance with the guidelines. The current deteriorating/septic patient policy is in process of being updated and has been renamed as the Policy for the Escalation of the Deteriorating adult. This contains the new updates to the early warning scoring system, NEWS2, which has been adopted in all areas across the Trust, excluding Paediatrics.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.

- The IPC Team work collaboratively with ROH Communications team who support dissemination of IPC communications both internally and externally as required.

- The IPC Team meet monthly to update each other on areas of work and plan ahead.

- The IPC Team provide a quarterly newsletter across the Trust.

- All wards / departments have an IPC information board for patients / visitors which is updated monthly.

- IPC information stalls are used across site quarterly with time specific information for staff, patients and visitors to the Trust.

- All Infection Prevention Nurses undergo an annual appraisal.

- The IPC Team utilise social media that enables communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating to a wider health economy.

- The ROH Weekly Message from the CEO supports and cascades messages from the IPC Team across the organization and gives prominence to Executive leadership and support of IPC activities, supporting “Board to Ward”.

- The IPC Team have dedicated space on the Trust Intranet and on the Trust Internet site.

- The Trust Intranet promotes infection prevention issues and guides users to information on MRSA, Clostridium Difficile and other organisms.

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

5.1 Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient’s length of stay in hospital and “are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI.

However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition” National Institute for Health and Clinical excellence (NICE) (2008)3.

Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	✓
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	✓
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	Glucose control	+	✓
Post-operative	Wound management	+ / -	✓
	Surveillance and feedback of rates	+	✓

Many of these actions are in place, with the addition of others exceeding the National Guidance, at ROH. ROH have in place an established wound care helpline that can offer the patient an appointment at the SSI clinic, on the same day, should it be required This allows the review of

patients by specialist staff allowing rapid treatment / admission where required avoiding visits to the GP and unnecessary prescribing of antibiotics.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

- hip replacement
- knee replacement
- repair of neck of femur
- reduction of long bone fracture

Primary arthroplasty surgery is constantly reviewed and monitored as part of the SSI surveillance programme at ROH. SSI surveillance is routinely carried out according to Public Health England protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30 day surveillance was introduced.

The data presented below is a combination of Mandatory surveillance data for Surgical Site Infections identified following hip and knee replacement surgery carried out and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in-house surveillance scheme conducted by the IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.

SSI Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Hips	3.5%	3.8%	2.9%	2.0%	1.0%	1.5%	1.2%	2.4%	1.4%	2.3%	2.2%
Knees	6.7%	5.8%	6.9%	4.4%	2.6%	2.9%	1.8%	2.3%	2.0%	3.2%	2.0%
No. of SSI	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Hips	37	44	33	26	13	21	15	31	17	11	24
Knees	65	52	61	41	23	25	17	23	21	14	21
No. of procedures	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Hips	1063	1144	1153	1274	1240	1371	1261	1271	1189	487	1075
Knees	974	896	880	932	887	875	956	992	1071	433	1028

During 2018 we did not participate in all four quarters, hence the lower number of procedures in comparison to other years.

The number of SSI's also include patient reported infections. However, it is important to note that National Benchmarks do not take into account patient reported infections, only those detected as an inpatient/at readmission.

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions.

All clinical staff receive training and education in optimum infection prevention practices during induction and mandatory training and Link Workers teaching sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.

7. Provide or secure adequate isolation facilities

Isolation Rooms

Wards

39 isolation rooms with en-suites.

3 isolation rooms without en-suite.

HDU

2 Adult Side Rooms without en-suites.

2 paediatric isolation rooms with en-suite.

Isolation room numbers have been sufficient to meet the needs of safe clean service provision over 2019/20.

8. Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose-built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full (UKAS) accreditation ISO Standard 15189. ROH has electronic access to results to facilitate patient care.

9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, procedures and manuals are available for staff to view on the Trust Intranet. There is a formal Governance structure in place for reviewing and ratifying such documents within the Trust and Clinical Governance has produced a directory of documents alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated**.**

10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participates in mandatory updates for all staff groups (clinical and non-clinical). A representative from the Occupational Health Service is a member of the IPCC.

Occupational Health services are provided to staff via an SLA with the University Hospitals Birmingham (UHB). Occupational Health staff travel from UHB to ROH to provide one session (1 day) per week to support the Occupational Health requirements.

Summary

2019-2020 has been a busy and challenging year for ROH staff and for the IPC Team. I am delighted in the number of infection prevention improvements that continue to improve the patients' experience and strengthen patient safety processes and standards.

These improvements demonstrate ROH's commitment to harm free care and reduction in avoidable health-care associated infections. Performance on mandatory surveillance is exemplary compared to national data, perhaps reflecting the elective nature of our work, but there is no room for complacency. CQUIN performance shows engagement and again we have achieved our targets. Together with our staff, governors and volunteers we have created vision and values which clearly state where we are going and how, as a team, we will behave towards each other, our patients, and partners.

Infection prevention and control is the responsibility of all of us and is fundamental when delivering the vision and values of ROH. By incorporating the principles of infection prevention into routine daily clinical practice, patient safety can be enhanced and the risk of patients acquiring an infection during episodes of health care can be minimised. Our staff demonstrate through practice that they care about patient safety. We should all be proud of the reductions made in harms, including reductions in hospital-associated infections.

Given the Covid-19 Pandemic declared in March 2020, 2020-21 will be one of the most challenging years for ROH and the NHS with Infection prevention and control playing the vital role of maintaining services at the ROH and ensuring our patients are safe.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Covid Outbreak Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Victoria Clewer, Infection Prevention & Control Matron**
DATE OF MEETING:	**7th April 2021**

EXECUTIVE SUMMARY:

- There have been two outbreaks in February 2021, an outbreak is two or more cases within an defined or linked environment(s).
- Both outbreaks were limited to two individuals, were identified quickly and action taken to limit any further spread whilst maintaining maximum operational capacity.
- The Ward 3 outbreak linked to covid positive patient contact prior to transfer from Queen Elizabeth Hospital, Birmingham. This has been fed back to QEHB for further investigation and understanding.
- The Ward 3 patients effected were cohorted and placed within siderooms in an area identified for covid positive and contacts previously.
- The Pharmacy outbreak index case potentially might have occurred due to family positive contacts.
- In both outbreaks further extended testing of patient and staff contacts have been (where necessary) completed out of an abundance of caution.
- All outbreaks are now closed on the ROH site.

REPORT RECOMMENDATION:

- Trust Board is asked to receive and note the report which is presented to ensure that the Board is aware of outbreaks on ROH site and the actions taken.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
		X

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

Financial		Environmental	x	Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	**x**
Comments: [*elaborate on the impact suggested above*]					

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

CQC Key Lines of Enquiry/NHS England Assurance Framework

PREVIOUS CONSIDERATION:
Quality & Safety Committee on 31 March 2021

COVID Outbreaks Update

Report to Trust Board in Public – 7 April 2021

1. Detail of Outbreaks

1.1. To date the Trust has experienced eight outbreaks associated with COVID-19.

1.2. The outbreaks have been within the following areas:

Area/Dept.	Date Outbreak Declared	Date Outbreak Closed	Total № of +ve Staff	Total № of +ve Patients	Total number of Patients diagnosed at 3 - 7 days (Indeterminate)	Total № of Patients diagnosed at 8 - 14 days (probable)	Total № of Patients diagnosed at 15+ days (definite)
Pharmacy	03/09/2020	01/10/2020	3	N/A	N/A	N/A	N/A
Imaging	17/10/2020	14/11/2020	9	N/A	N/A	N/A	N/A
Oncology	19/10/2020	16/11/2020	9	N/A	N/A	N/A	N/A
Ward 1	15/11/2020	13/12/2020	1	2	1	0	1
Ward 2	09/12/2020	09/01/2021	1	4	3	0	1
Ward 3 (10/12)	11/01/2021	08/02/2021	9	7	3	3	1
Ward 3	05/02/2021	04/03/2021	0	2	2	0	0
Pharmacy	19/02/2021	20/03/2021	2	0	N/A	N/A	N/A

1.3. Six outbreaks have been narrated and discussed in previous papers to board. The most recent two outbreaks occurred during February 2021 in the following areas:

1.4. **Ward 3 Outbreak – 03/02/2021 – 04/03/2021**

1.4.1. Outbreak confined to patients on ward 3 – amber pathway. Started within a four bedded bay (Bay 12), two positive patients identified with a further two asymptomatic contacts. Both positive patients were transfers from Queen Eliizabeth Hospital Birmingham (QEHB). The index case was a contact of a positive COVID patient on 12/01/21 whilst an inpatient on Ward West 1 at QEHB. The patient had completed 14 days isolation on ward 728 at QEHB and tested negative before transfer to ward 3 ROH on 29/01/21. Index patient was asymptomatic but identified via routine inpatient swabs. Second case was a contact of the index in bay 12 on ward 3, also a transfer from QEHB – was known to have non-resolving pyrexia whilst at QEHB and on admission to ROH – although had multiple negative COVID swabs.

1.4.2. It is likely that both patients whilst asymptomatic were incubating COVID prior to admission to ROH however we are unable to rule out patient to patient transmission

whilst in bay 12 on ward 3. There were no concerns with ward cleanliness or hand hygiene/personal protective equipment usage before or during the outbreak on ward 3.

1.4.3. Due to unavailability of single rooms on ward 3 and elsewhere in the hospital, the contacts (asymptomatic) were cohort nursed in bay 12, with a dedicated nurse. They were moved to single rooms as soon as they became available. Vacated bed spaces receiving COVID cleans. From the initial identification of symptoms, facilities were instructed to perform enhanced cleans of touch points and common spaces/shared facilities. Awareness of developing issues was heightened across all staff.

1.4.4. The outbreak was closed on the 4th March 2021, 28 days after the last reported positive case.

1.5. **Pharmacy – 19/02/2021 – 20/03/2021**

1.5.1. Outbreak involving staff from the Pharmacy department only. No patient involvement. Index case identified via lateral flow testing (LFT) at home staff member being asymptomatic. Result confirmed via PCR testing. Last worked in hospital on 13/02/2021, remained off work following positive LFT. Identified two contacts who worked closely with index case on 13/02/2021 (non-significant due to no breach in PPE so able to continue working). One of the contacts felt 'unwell' at work on 19/02/2021 and undertook an LFT at work (against policy) result was positive, instructed to go home immediately and arrange PCR testing. This result was confirmed positive. The third contact of the index case was PCR tested, this result was negative. As a precaution fifteen staff within the pharmacy department were tested via PCR, no further positive cases were identified.

1.5.2. During the investigation of the outbreak it was identified that the index case's family also tested positive to COVID-19, whether this was as a result of the index case or not is undeterminable.

1.5.3. Prompt recognition of the cases by pharmacy management and communication between the department and the IPC team facilitated swift actions to limit the spread.

1.5.4. The Pharmacy department staff were split so that those who had any contact with those identified in the outbreak were restricted to working in the Pharmacy department only with no clinical contact and no contact with Pharmacy staff covering clinical areas.

1.5.5. The Pharmacy department is too small for the number of staff and the work undertaken, construction works is underway to provide a new Pharmacy department with a more spacious environment.

1.5.6. Historically, Pharmacy had not been included in 6 monthly IPC audits of environment and practice. However, going forward they will be included in the audit programme. The department are also undertaking their own in-house hand hygiene and IPC practices monitoring working closely with the IPCT to monitor overall practice and compliance.

2. Recommendation

The Trust Board is asked to receive and note the report which is presented to ensure that the Board is aware of outbreaks on ROH site and the actions taken.

Victoria Clewer
Infection Prevention & Control Matron
1 April 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Infection prevention and control Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Ash Tullett, Head of Clinical Governance and Garry Marsh**
DATE OF MEETING:	**7 April 2021**

EXECUTIVE SUMMARY:

February 2021 - New guidance (version 1.6) and Background

The Trust has received a notification from NHS improvement to inform us that the Infection prevention and control board assurance framework (IPC BAF) has been further updated, refined and published. (February 2021 - version 1.6).

NHS England developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

Attached with this paper is the gap analysis undertaken by the Head of Clinical Governance, Executive Director of Nursing and Clinical Governance/The Director of Infection Prevention and Control (DIPC) and the IPC Matron against the Infection prevention and control board assurance framework (version1.6). As part of the gap analysis each statement was 'RAG' rated by the following criteria.

Compliance	Green
Non-Compliance with mitigation	Amber
Non-Compliance with no mitigation	Red

The new IPC BAF released has been cross referenced (attached) by the Head of Clinical Governance with the old version to highlight any new or amended areas of focus. The new areas have been highlighted within the report. The new areas that have changed are 1b, 1c, 1d, 1e, 1f, 1g, 1r, 1s, 2p, 2q. 5f, 5l, 6c, 8g, 8h, 8i, 8j, 8k, 8l and 8m. From the new sections, one was deemed as amber;

5L NEW	There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention	Executive Director of Nursing and Clinical Governance	Infection Control Team		Audit of inpatient screening to be implemented and monitored by IPC. Report to divisions via team meeting

One section was removed from the previous version

Removed	compliance with the national guidance around discharge or transfer of COVID-19 positive patients

Conclusion

The Trust has a multi professional group that approved the new IPC BAF and a gap analysis against the IPC BAF at the IPC committee in March 2021.

The conclusion of the gap analysis was that the Trust has a clear pathway, processes, and policies in place around infection prevention and control during the Covid-19 Pandemic and that all training detailed within the gap analysis is supported by attendance and/or competency sign off sheets. It is to note that none of the gaps were rated 'Red' and the only amber was ref 5L with the narrative included above.

The next stage is to review the evidence that supports the gap analysis. This will give greater assurance that the Trust complies with the requirements in the Infection prevention and control board assurance framework. This piece of work will be undertaken with oversight from the DIPC and the IPC committee.

REPORT RECOMMENDATION:

The Board is asked to receive and note the updated IPC BAF, the initial gap analysis undertaken and the plan to collect evidence to support the assessment.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

CQC Key Lines of Enquiry/NHS England Assurance Framework

PREVIOUS CONSIDERATION:

None

ROH Infection prevention and control board assurance framework - February 2021 - ROH Version 1.5

The Royal Orthopaedic Hospital NHS Foundation Trust

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
1	Systems and processes are in place to ensure:							
1a	infection risk is assessed at the front door and this is documented in patient notes	Executive Director of Nursing and Clinical Governance	Infection Control Team		There is a clearly described pathway for this. Each elective patient prior to coming to the ROH have been instructed to self isolate for 14 days and have been screened as negative for Covid will be placed onto Ward 2/3 or 12. Patients that have not self isolated for 14 days and have not been screened will be placed onto Ward 1 Patients with confirmed covid will be placed onto CYP HDU or Ward 4 (if cases) increase and isolated. If a patient becomes symptomatic they will be assessed and transferred into a side room. The patient will then be assessed for transfer to a Covid Ward - The Trust have a clear escalation process. The patient pathways are to be adapted to the PHE guidance and the new pathways agreed with the UHB patients	None	None	Pathway Document
1b NEW	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	Executive Director of Nursing and Clinical Governance	Infection Control Team		Patients are admitted directly to HDU CYP if positive and Ward 4 if numbers increase. Patients are isolated if displaying symptoms and only transferred from speciality ward if confirmed positive. Contacts of suspected cases are isolated until results known and Covid is clinically ruled out. IPC team have records of all patient movement and COVID patients and their movement is discussed at the three ties daily site meetings. Contacts of confirmed cases are isolated for 14 days. Patient moves can be tracked via PICS	None	Bed management policy to be amended.	Daily Isolation form
1c NEW	that on occasions when it is necessary to cohort COVID or non COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.							
Removed	compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Executive Director of Nursing and Clinical Governance	Discharge team/Matrons		Discharge processes are in place and monitored by the Discharge teams in line with national guidance. Any issues or breaches of the guidance such as delays or barriers to discharge are escalated to the Clinical Commissioning Group and discussed at the Site meeting 3 x daily.	None	None	Process document
1d NEW	monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice Staff adherence to hand hygiene? staff social distancing across the workplace staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting	Executive Director of Nursing and Clinical Governance	Infection Control Team		IPC audits are undertaken and presented at the IPC committee and are included in the condition reports for Division1 and 2. This looks to monitor the compliance with the IPC standards.	None	None	Dashboard and condition reports + IPC report

1e NEW	monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Executive Director of Nursing and Clinical Governance	Infection Control Team/JG		Audits are currently undertaken to monitor compliance with PPE. . A ROH comms has been sent to all staff in all areas to remind them of their individual accountability in the use of PPE. Each area has team leaders and managers that lead on PPE for their area. Work is underway with JG on safety guardians/champions in non clincail areas	Further work is needed in relation to safety champions and to audit the compliance in non clinical areas		
1f NEW	Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	Executive Director of Nursing and Clinical Governance	Julie Gardner		Twice weekley lateral flow tests have been rolled out Trust wide with all staff offered the tests. Complaince is measured via a database. IPC team investigate each postive case to track and trace the staff member across the Trust. If spread of the infection has occured an outbreak investigation is declared and undertaken.	None	None	Database of staff undertaking lateral flow tests.
1g	additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	Executive Director of Nursing and Clinical Governance	HR team/IPC team		NA to the ROH as there is no hugh noscomial rate. Targeted testing has occurred for departments with outbreaks.	None	None	Outbreak documentation
1h	staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Executive Director of Nursing and Clinical Governance	HR team		The Trust has a Covid intranet page that includes SOPS and flow charts for Staff testing and Isolation. The Trust has rolled out lateral flow testing for staff to complete twice per week with over 1100 units issued.	None	None	Flow charts on + intranet page
1i	training in IPC standard infection control and transmission-based precautions are provided to all staff	Executive Director of Nursing and Clinical Governance	HR team		All staff received mandatory training on infection control and transmission based precautions. This is also included in the Trusts Covid guidance and training.	None	None	Training rates on ESR
1j	IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	Executive Director of Nursing and Clinical Governance	HR team		All staff received mandatory training on infection control and transmission based precautions. This is also included in the Trusts Covid guidance and training. Staff also have access to Covid-19 e-learning.	None	None	Training rates on ESR
1k	all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Executive Director of Nursing and Clinical Governance	HR team		At the ROH it is mandatory to wear a mask and each staff member is provided on the entrance. Staff communication is regular in reminding staff to be compliant with the Trust IPC guidance. The IPC have a clinical presence and challenge poor compliance	None	None	Comms emails + intranet page
1l	all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has adhered to PHE guidance at all times with daily briefing including any updates for staff with no shortages in PPE availability with PPE training delivered. 632 staff have been trained. The training sessions are undertaken by the IPC and clinical educators. Staff are released by managers. Training records evidence this. Staff also have access to PPE training videos on the Trust website.	None	None	ad hoc training is available by IPC.
1m	national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Executive Director of Nursing and Clinical Governance	Infection Control Team DIPC		The DIPC reviews all new guidance via the incident command distribution and as circulated by the NHSI/E IPC team with MDT meetings to coordinate response within the Trust;	None	None	Comms and intranet page + previous version of the guidance
1n	changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Executive Director of Nursing and Clinical Governance	Executive Director of Nursing and Clinical Governance		The DIPC highlights to Executive Colleagues any changes and has undertaken briefings at Quality & Safety Committee and Trust Board.	None	None	Evidence on the Sitrep within the site office

1o	risks are reflected in risk registers and the board assurance framework where appropriate	Executive Director of Nursing and Clinical Governance	Company Secretary		The Trust has maintained a COVID 19 risk register. This is discussed at Board and Executive Level. The action plan has now be closed and any risks have been added to the corporate Risk Register.	None	None	Evidence of the previous Covid Risk register, Evidence of the current BAF and Evidence of board agenda + minutes
1p	robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Executive Director of Nursing and Clinical Governance	Infection Control Team		The IPC team have divided their work to ensure business as usual IPC continues to be undertaken; with no cessation of RCA meetings, routine MRSA screening. The IPC team still undertake Ward reviews. Environmental Audits, PIRs and audits are still undertaken.	None	None	Evidence of audits PIR report from IPC MRSA compliance figures
1q	That Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	Executive Director of Nursing and Clinical Governance	Executive Director of Nursing and Clinical Governance		The Trust currently have a number of daily returns that are submitted. These are not currently signed off by the CEO or DIPC. The Trust currently have an issue with the submission to the national Outbreak System Standard Response system. The Sitreps are signed of by the Director of Corporate Affairs & Company Secretary and Data Protection Officer (DPO) with oversight at the daily executive incident management meetings attended by both the DIPC and CEO.	no CEO or dipc sign off and system issues	None	None
1r NEW	This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	Executive Director of Nursing and Clinical Governance	Executive Director of Nursing and Clinical Governance		The IPC BAF has been a regular agenda item at IPCC and Trust Board with scrutiny undertaken within these committees	None	None	None
1s	ensure Trust Board has oversight of ongoing outbreaks and action plans.	Executive Director of Nursing and Clinical Governance	Infection Control Team		all outbreaks are included in the Quality report and reported to the CCG. This is also reported to the board via the IPC committee. The full investigation findings will be presented with action plans.	None	None	None
1s NEW	there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Executive Director of Nursing and Clinical Governance	Executive Director of Nursing and Clinical Governance			None	None	None

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
2a	designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Executive Director of Nursing and Clinical Governance	Infection Control Team		HDU CYP area have a dedicated space to care for COVID patients and PPE training has been undertaken; HDU have a methodology to care for patients with COVID - The IPC team have training records. Ward 4 is used as a Covid cohort area if numbers increase and includes the same standard as care.	None	None	Pathway document PPE training records
2b	designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Executive Director of Nursing and Clinical Governance	Facilities Manager		Each clinical area has allocated housekeeping teams and do not move between clinical areas during shifts. Facilities staff have received PPE training. The IPC team have training records.	None	The training is offered to all staff including agency.	Evidence of PPE training and percentage of housekeepers who have completed.
2c	decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team		Adherence to the Trusts COVID-19 Terminal Decontamination and cleaning instruction document evidenced – Training has been undertaken on cleaning practices and methodology for housekeepers. (Housekeeping/Nursing Local Training Competencies in place and (Observations of best practice) – Environmental Cleanliness). Covid 19 Cleaning checklist is in place for both nursing and housekeepers.	None	None	Evidence of compliance with the checklist Number of terminal cleans month on month policy or SOP for terminal cleans
2d	increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Executive Director of Nursing and Clinical Governance	Facilities Manager		Additional and increased frequency cleaning hours actioned within all wards (Higher environmental contamination risk). Touch point cleaning actioned every two – three hours within public areas; surfaces,lifts,corridors and handrails	None	None	Rotas? Do we have a SOP for am/pm cleaning in clinical areas

2e	cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Executive Director of Nursing and Clinical Governance	Facilities Manager		The Trust cleaning is carried out with the detergent and as per national guidance. All staff are trained in the correct solution mixture. The housekeeping team have a checklist that covers the guidance and there are posters in areas providing staff with the information. he housekeeping team have a checklist that covers the guidance and there is posters in areas providing staff with the information. Training records evidence compliance.	None	Training is provided to all staff. Dilution ratio posters on display within all Housekeeping sluices. Plan's to include in competencies for staff and all staff to be retrained and recorded.	Training records and training matrix
2f	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	Executive Director of Nursing and Clinical Governance	Facilities Manager		The Trust cleaning is carried out as per national guidance. All staff are trained in the correct solution contact time. Training records evidence compliance.	None	This is included in the Training. Plan's to include in competencies for staff and all staff to be retrained and recorded.	Training records and training matrix
2g	'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	Executive Director of Nursing and Clinical Governance	Facilities Manager		Additional and increased frequency cleaning hours actioned within frequently touched areas. The Trust cleaning is carried out as per national guidance and local guidance.	None	None	Do we have rotas to evidence?
2h	electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		The Trust cleaning is carried out as per national guidance. The Trust have a Covid risk assessment team reviewing the working environment.	None	None	Individual Risk assessments in each areas will review individual risk. Staff are reminded to clean these areas regular. This is included in the local guidance.
2i	rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Executive Director of Nursing and Clinical Governance	Infection Control Team		Waste is removed at least twice a day. All clinical area's where PPE is removed is cleaned twice per day and documented. PPE doffing areas have been removed as reviewed as unnecessary	None	None	Evidence of cleaning
2j	linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		The Trust is compliant with this standard and has a process to evidence compliance. This is monitored by the Ward Manager.	None	None	Audits
2k	single use items are used where possible and according to single use policy	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		The Trust has continued to use single items as they are designed.	None	None	BP cuff narrative need where we can get
2l	reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		Processes exist to ensure compliance and included in the Ward cleanliness audit.	None	None	what are the results and do we have a SOP
2m New	ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		The Facilities team currently audit (cleaning for credit) non clinical areas quarterly and yearly for low risk areas with actions in place to address any issues.	Facilities manager to review if the audits need to be undertaken more frequently		

2n	ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Executive Director of Strategy and Delivery	Director of Estates		have two systems of ventilation operating in admissions/waiting areas throughout the Trust, these being: •Natural ventilation – openable windows are available, in above ground patient areas these windows are restricted to 100mm opening •Mechanical ventilation – we have a number of separate supply and extract air conditioning systems operating in admissions/waiting areas throughout the Trust which supply filtered air. The system are maintained on a regular basis.	None	The waiting area in OPD is currently a supply and extract ventilation system.	Is this on the risk register? What is the action?
2o	there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Executive Director of Nursing and Clinical Governance	Facilities Manager/Infection Control Team		All patient pathways in the organisation are cleaned with general purpose detergent and the correct solution of disinfectant. This includes the high risk and low risk areas of the pathway.	None	None	
2p NEW	monitor adherence environmental decontamination with actions in place to mitigate any identified risk	Executive Director of Nursing and Clinical Governance						
2q NEW	monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	Executive Director of Nursing and Clinical Governance						
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
3a	arrangements around antimicrobial stewardship is maintained	Executive Director of Nursing and Clinical Governance	Deputy Chief Pharmacist		The Deputy Chief Pharmacist continues to carry out reviews of antibiotic usage and prescribing with involvement in any Root Cause Analysis undertaken around antibiotic usage where appropriate.		Deputy Chief Pharmacist submits report to IPC Committee for MDT scrutiny	
3b	mandatory reporting requirements are adhered to and boards continue to maintain oversight	Executive Director of Nursing and Clinical Governance	Deputy Chief Pharmacist		Antimicrobial report to IPC CCG submissions are currently suspended Review of the new NICE Rapid guidelines undertaken against Trust guidance. Reportable infections are included in the Quality Report and upwardly reported to the Board.	None	None	Board agenda - Quality Report
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
4a	implementation of national guidance on visiting patients in a care setting	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust ceased visiting on 24.03.2020 allowing only visitors from the criteria described within the national guidance with the exception of End of Life patients or Vulnerable adults & children. The Trust is launching the rule of one methodology to reintroduce visitors into the organisational as per national guidance. Masks are provided with a temp check on arrival. The Trust also has educational posters on using masks and hand washing. The Ward provide further education on PPE.	None	None	Sops for visiting + risk register entry
4b	areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	Executive Director of Nursing and Clinical Governance	Infection Control Team		Cohort areas have signage in place to prewarn people and have access restriction processes in place. Work is underway with comms to simplify and make these clearer. This needs to be reviewed as the roh site is no longer covid protected.	None	None	Copies of signage
4c	information and guidance on COVID-19 is available on all trust websites with easy read versions	Executive Director of Nursing and Clinical Governance	Communications team		The Trust has a narrative on its public facing website with more detailed guidance and a COVID ICON on the intranet for staff usage with an associated daily staff communication of changes and relevant guidance linkage.	None	None	screenshot of website
4d	infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Executive Director of Nursing and Clinical Governance	Infection Control Team		COVID status is tested on admission and result stored on PICS. All handover information has COVID status recorded. COVID status is part of the patients discharge planning and recorded within the discharge summary.	None	None	

4e	there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has posters and are greeted at both entrances to the Trust by a member of staff. All information is clearly displayed and written information is available.	None	None	Posters and information sheets
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
5a	screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Executive Director of Nursing and Clinical Governance	Infection Control Team		There is a clearly described pathway for this. Each elective patient prior to coming to the ROH have been instructed to self isolate for 14 days and have been screened as negative for Covid will be placed onto Ward 2/3 or 12. Patients that have not self isolated for 14 days and have not been screened will be placed onto Ward 1 Patients with confirmed covid will be placed onto CYP HDU or Ward 4 (if cases) increase and isolated. If a patient becomes symptomatic they will be assessed and transferred into a side room. The patient will then be assessed for transfer to a Covid Ward - The Trust have a clear escalation process. The patient pathways are to be adapted to the PHE guidance and the new pathways agreed with the UHB patients	None	None	
5b	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team		There is a clearly described pathway for this. Each elective patient prior to coming to the ROH have been instructed to self isolate for 14 days and have been screened as negative for Covid will be placed onto Ward 2/3 or 12. Patients that have not self isolated for 14 days and have not been screened will be placed onto Ward 1 Patients with confirmed covid will be placed onto CYP HDU or Ward 4 (if cases) increase and isolated. If a patient becomes symptomatic they will be assessed and transferred into a side room. The patient will then be assessed for transfer to a Covid Ward - The Trust have a clear escalation process. The patient pathways are to be adapted to the PHE guidance and the new pathways agreed with the UHB patients	None	None	
5c	staff are aware of agreed template for triage questions to ask	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has an agreed template and this has been communicated to the staff	None	None	template
5d	triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Executive Director of Nursing and Clinical Governance	Site team		The Trust Site team includes a clinical bleep holder and are competent in the triage of patients to the correct area.	None	None	
5e	face coverings are used by all outpatients and visitors	Executive Director of Nursing and Clinical Governance	Infection Control Team		This is included in the guidance and communicated to all staff. As of the 15th June 2020 all patients, Staff and visitors are assessed at the entrance of the Trust for Covid symptoms and are issued with PPE. Patients with symptoms will be issued to wear a mask and isolated as per Trust pathways and guidance	None	None	
5f NEW	Face masks are available for all patients and they are always advised to wear them	Executive Director of Nursing and Clinical Governance	Infection Control Team		This is included in the guidance and communicated to all staff. As of the 15th June 2020 all patients, Staff and visitors are assessed at the entrance of the Trust for Covid symptoms and are issued with PPE. Patients with symptoms will be issued to wear a mask and isolated as per Trust pathways and guidance	None	None	
5g	provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Executive Director of Nursing and Clinical Governance	Infection Control Team		Advice is given to all patients on the use of masks. Only when is compromises their care will they not have a mask. All patients are encouraged and reminded to use masks. Leaflets regarding mask use is provided at the mask stations on entry to the ROH.	None	None	
5h NEW	Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Executive Director of Nursing and Clinical Governance	Infection Control Team					

5i	ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Executive Director of Nursing and Clinical Governance	Infection Control Team		Estates are currently undertaking risk assessments for the workplace environment. Each individual areas will be assessed. Use of screens along side social distancing and masks in all areas.	None	None	Paper on workplace safety was submitted to Execs and Sub Board
5j	for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has followed national guidance. Any contacts are isolated. The IPC team have a folder that includes patients and their contacts. Database of contacts is kept.	In cases where this didn't happen, this was not incident reported or recorded	None	have we done anything to evidence this?
5k	patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Executive Director of Nursing and Clinical Governance	Infection Control Team		Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced. If patients have previously been in a bay the empty beds are closed and all patients within that bay are isolated for 14 days and informed of contact. This is monitored by the nurse In Charge of the clinical area.	Summary reports of any delays in isolation not available. Incident forms not generated.	None	Daily IPC team reviews of clinical areas with immediate action taken to ensure isolation.
5L NEW	There is evidence of compliance with routine patient testing protocols in line with Key actions: infection preventio	Executive Director of Nursing and Clinical Governance	Infection Control Team					
5M	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Executive Director of Nursing and Clinical Governance	OPD manager		Outpatient areas including diagnostics have processes in place to manage patients who display symptoms of COVID which direct patients to appropriate access to healthcare outside of the Trust. Staff have received bespoke training and a step by step guide to support. As of the 15th June 2020 all patients, Staff and visitors are assessed at the entrance of the Trust for Covid symptoms and are issued with PPE	None	None	do we have SOPS or pathways to evidence this?
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
6a	separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Executive Director of Nursing and Clinical Governance	Infection Control Team		There is a clearly described pathway for this. Each elective patient prior to coming to the ROH have been instructed to self isolate for 14 days and have been screened as negative for Covid will be placed onto Ward 2/3 or 12. Patients that have not self isolated for 14 days and have not been screened will be placed onto Ward 1 Patients with confirmed covid will be placed onto CYP HDU or Ward 4 (if cases) increase and isolated. If a patient becomes symptomatic they will be assessed and transferred into a side room. The patient will then be assessed for transfer to a Covid Ward - The Trust have a clear escalation process. The patient pathways are to be adapted to the PHE guidance and the new pathways agreed with the UHB patients	None	None	
6b	all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	Executive Director of Nursing and Clinical Governance	Infection Control Team		Staff have received training in PPE and records of training maintained. Posters for quick reference are also in place for staff. This is evidenced by training records and the Trust guidance	None	None	
6c NEW	all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.	Executive Director of Nursing and Clinical Governance	Infection Control Team		Staff have received training in PPE and records of training maintained. Posters for quick reference are also in place for staff. This is evidenced by training records and the Trust guidance	None	None	
6d	a record of staff training is maintained	Executive Director of Nursing and Clinical Governance	Infection Control Team		Records of staff training are in place.	None	None	None
6e REMOVED	appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has received the CAS alert. However, at no time has the Trust been at PPE stock levels that have required reuse of PPE.	None	None	Paper from JG

6f REMOVED	any incidents relating to the re-use of PPE are monitored and appropriate action taken	Executive Director of Nursing and Clinical Governance	Infection Control Team		Not applicable. The Trust have not had to reuse PPE	None	None	
6g	adherence to PHE national guidance on the use of PPE is regularly audited	Executive Director of Nursing and Clinical Governance	Infection Control Team		Observational audits are undertaken by senior staff within clinical areas. These show over usage of PPE as oppose under usage. PPE snapshot audits are undertaken.	Non	None	
6h	hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: o hand hygiene facilities including instructional posters o good respiratory hygiene measures o maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care o frequent decontamination of equipment and environment in both clinical and non-clinical areas o clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas o staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has clear information that covers all areas of this requirement. This is including in the IPC guidance and the Trust has posters and comms in the Trust.			
6i	staff regularly undertake hand hygiene and observe standard infection control precautions	Executive Director of Nursing and Clinical Governance	Infection Control Team		Staff are trained in mandatory training regarding handwashing and this has been reemphasised in all PPE training & briefings.	None	None	audit results
6j	the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	Executive Director of Strategy and Delivery	Director of Estates		There are no hand dryers in any of the patient areas. Hand dryers in use in communal area bathrooms - canteen etc - this is to be reviewed	None	None	all patient areas use paper towels rather than hand dryers
6k	guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		Posters are in place	None	None	
6l	staff understand the requirements for uniform laundering where this is not provided for on site	Executive Director of Nursing and Clinical Governance	Infection Control Team		Staff have been educated in how to launder their uniforms and transport to and from home. This was part of a longstanding policy and is in the local Covid guidance	None	None	
6m	all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Executive Director of Nursing and Clinical Governance	HR		Staff are clear on the symptoms and this has been communicated regularly within Trust communication briefings. Absence is monitored daily and absence levels would imply staff are aware of actions to take. Staff absences are contained within the Sitrep. There is a clear process for staff in reporting covid related sickness and absence.	New process needs auditing	None	

6n	a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has a daily planning call to monitor the local and nation requirements in relation to the pandemic. This includes the executive team. Within this meeting decisions are discussed to respond to the pandemic as necessary	None	None	
6o	positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Executive Director of Nursing and Clinical Governance	Infection Control Team		Each positive case has received an investigation to understand the source. Any situation where 2 cases or more have been identified in an area, an outbreak is declared and all the relevant steps with PHE and the CCG are undertaken. This includes an RCA into the outbreak.	None	None	
6p	robust policies and procedures are in place for the identification of and management of outbreaks of infection	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has a policy to manage outbreaks, although this needs to be reviewed and include staff areas	Needs reviewing to ensure it meets requirements	None	
7.Provide or secure adequate isolation facilities								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
7a	restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Executive Director of Nursing and Clinical Governance	Infection Control Team		The only Trust Covid managed area is Ward 1 - this is clearly sign posted and entrance to the Ward is restricted. Work will be undertaken to define each area based on the national PHE guidance. Ward 4 and CYP HDU are used as the covid cohort areas.	None	None	
7b	areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Executive Director of Nursing and Clinical Governance	Infection Control Team		The only Trust Covid managed area is Ward 1 - this is clearly sign posted and entrance to the Ward is restricted. Work will be undertaken to define each area based on the national PHE guidance. Ward 4 and CYP HDU are used as the covid cohort areas.	None	None	
7c	patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Executive Director of Nursing and Clinical Governance	Infection Control Team		HDU CYP is the COHORT areas for COVID with an agreed pathway for admission in place with IPC team monitoring in place. Suspected COVID are isolated in ward areas and if within a bay empty beds closed. Designated theatres for positive & symptomatic patients also in place.	None	None	Evidence pathway document
7d	areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team		Areas are compliant and the pathways have been reviewed by microbiology and approved. Written assurance has been received by the DIPC by matrons to endorse compliance with the standards. Alerts are included onto PICS and daily review continues	None	None	what evidence
7e	patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Executive Director of Nursing and Clinical Governance	Infection Control Team		The IPC team continues to monitor all patients and non COVID related infections and appropriately isolate with clear identification system in place.	None	None	
8. Secure adequate access to laboratory support as appropriate								
Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
8a	ensure screens taken on admission given priority and reported within 24hrs	Executive Director of Nursing and Clinical Governance	Infection Control Team		On admission screens are treated as priority and usually reported within 24 hours. Where this does not happen an incident report is generated	None	None	
8b	regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Executive Director of Nursing and Clinical Governance	Infection Control Team		The ROH use the labs at UHB. The testing turnaround times are available on request and are monitored at UHB	None	None	
8c	testing is undertaken by competent and trained individuals	Executive Director of Nursing and Clinical Governance	Infection Control Team		Labs are not provided by the Trust but the Trust utilises appropriately registered and licenced labs for its testing.	None	None	

8d	patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team		The Trust has a process in place that follows national PHE guidance and a system to monitor and ensure all staff and patients are tested as required. The Trust has also rolled out lateral flow testing to staff with over 1000 units issued.	None	None	
8e	regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Executive Director of Nursing and Clinical Governance	Infection Control Team/UHB labs		Databases of staff and patients are held within HR and IPC team. The labs at UHB also record all identified cases and report them back to the IPC/HR teams.	None	None	Databases and reports for the UHB labs
8f	screening for other potential infections takes place	Executive Director of Nursing and Clinical Governance	Infection Control Team		Testing for patients continues for other infections. This is included on the PICS system Staff have access to occupational health as normal for other illnesses.	None	None	
8g NEW	that all emergency patients are tested for COVID-19 on admission.	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8h NEW	that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8i NEW	that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8j NEW	that sites with high nosocomial rates should consider testing COVID negative patients daily.	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8k NEW	that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8l NEW	that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	
8m NEW	that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	Executive Director of Nursing and Clinical Governance	Infection Control Team			None	None	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Ref	Key lines of enquiry	Exec Lead	Operational Lead	RAG rating	Evidence	Gaps in assurance	Mitigating actions	Stored Evidence
9a	staff are supported in adhering to all IPC policies, including those for other alert organisms	Executive Director of Nursing and Clinical Governance	Infection Control Team		COVID and other infections requiring isolation are discussed three times per day in site meetings. IPC visit areas daily and record a plan of care for patients for staff to follow. Divisional Nursing teams also undertake daily walkarounds. Audits are in place to measure compliance	None	None	What audits?
9b	any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		This is communicated in the daily electronic staff briefing, on the daily IPC calls with senior staff and distribution of paper copies of guidance changes to clinical areas.	None	None	Covid Guidance

9c	all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		This is described within the Trusts COVID guidance. Any identified non-compliance is incident reported by the portering teams and addressed the facilities manager	None	None	Covid Guidance
9d	PPE stock is appropriately stored and accessible to staff who require it	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		The Trust has an ordering and stock management system in place on a daily basis. The Trust has central stores of PPE accessible 24/7 with distribution to all areas of the Trust on a daily basis to maintain PPE stock levels within all areas. Any issues are highlighted in the site meeting 3 times daily.	None	None	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
10a	staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Executive Director of Nursing and Clinical Governance	Hr Teams		The Trust has a policy and process in place to risk assess all staff that fulfil these criteria. This includes BAME staff. Wellbeing calls are made to those staff medically excluded.	None	None	Risk assessment paper
10b	that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Executive Director of Nursing and Clinical Governance	Hr Teams		All staff that meet the at risk groups are identified risk assessed as according to the HR process. Staff are reminded to monitor these risk assessments regular and timely. Tier 1 risk assessments are recorded on ESR	None	None	
10c	staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		The Trust undertakes Fit Testing for its staff and where failed has alternative FFP3 PPE in place.	None	None	
10d	staff who carry out fit test training are trained and competent to do so	Executive Director of Nursing and Clinical Governance	Infection Control Team/Communications team		The fit testing was undertaken by trained individuals from the supplier.	None	None	
10e	all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 1		The Trust undertakes Fit Testing for its staff and where failed has alternative FFP3 PPE in place.	None	None	
10f	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 2		The Trust undertakes Fit Testing for its staff and this is recorded on a central database	None	None	
10g	for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 3		For those that fail the fit test an alternative powered hood is available for use. This is recorded against the person record	None	None	
10h	for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 4		For those that fail the fit test an alternative powered hood is available for use. This is recorded against the person record	None	None	
10i	a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 5		For those that fail the fit test an alternative powered hood is available for use. This is recorded against the person record	None	None	

10j	following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Executive Director of Nursing and Clinical Governance	Head of Nursing Div 6		For those that fail the fit test an alternative powered hood is available for use. This is recorded against the person record	None	None	
10k	boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Executive Director of Nursing and Clinical Governance	Executive Director of Nursing and Clinical Governance		Staff are fit tested on the correct make, model, type and size of facepiece that is available in the Trust. If a new facepiece is used the staff member is to be trained again in the alternative. The training is undertaken by a competent person from the supplier. A record is kept and maintained of staff who have passed and failed the fit testing. those staff that have failed use an alternative powered hood. This is on the agenda for Board in January 2021	None	None	
10l	consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Executive Director of Nursing and Clinical Governance	Infection Control Team/		The pathways have remained consistent to avoid any cross over of care pathways and staff movement. Where possible staff remain on their substantive ward. Staffing is reviewed and monitored via Rostering and can evidence any staff movements	None	None	
10m	all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Executive Director of Nursing and Clinical Governance	Infection Control Team/		This is promoted via comms and daily briefs. As if the 15th June all staff must wear masks if not able to socially distance. Each workplace environment will be risk assessed and reviewed to see if social distancing can take place. This is all staff at all times.	None	None	workplace safety paper
10n	health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Executive Director of Nursing and Clinical Governance	Infection Control Team/		Each area within the Trust has been risk assessed by the PMO's and risks are managed and mitigated on the Ulysses system	None	None	
10o	staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Executive Director of Nursing and Clinical Governance	HR teams		All Staff wear masks at all times in all areas.	None	None	
10p	staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Executive Director of Nursing and Clinical Governance	HR teams		All staff who are self isolating have contact from the Trust to offer access to testing. Regular wellbeing discussions are held with staff monthly in their 1 to1 with managers.	None	None	
10q	staff who test positive have adequate information and support to aid their recovery and return to work	Executive Director of Nursing and Clinical Governance	HR teams		The Trust has a wellbeing process and described support in place. All positive staff are monitored in line with existing attendance policy and declared fit to work before returning using an interview.	None	None	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**2020 Staff Survey Results and Next Steps**
SPONSOR (EXECUTIVE DIRECTOR):	**Joanne Williams, Chief Executive**
AUTHOR:	**Sharon Malhi, Associate Director – Workforce and OD**
DATE OF MEETING:	**7 April 2021**

EXECUTIVE SUMMARY:

The NHS Staff Survey Results for 2020 were published on the 11th March 2021. This report provides the Trust Board with a high-level summary of the highlights from the Staff Survey 2020.

631 employees at the Trust complete the survey during October and November 2020. This is a 56% overall response rate which has significantly improved from the 2019 response rate of 51%. The median response rate for the benchmark group of a total of 14 specialist Trusts was 56%. This year the Staff Survey also includes the COVID 19 classification breakdowns by theme.

The Royal Orthopaedic Hospital NHS Foundation Trust ('the Trust') has scored marginally above the average for the benchmark group in relation to the following 3/10 themes. These are outlined further in the attached slide pack (Appendix 1). The full staff survey report is available to Board members on request.

- Equality, Diversity and Inclusion
- Immediate Managers
- Safe environment – bullying and harassment

Initial analysis of the report has identified 6 key themes where the Trust has scored below average in 2020 and/or there has been a decline since 2019. These are

- Morale (declined and below average)
- Quality of Care (below average)
- Safe environment – violence (decline)
- Safety Culture (decline and below average)
- Staff engagement (decline and below average)
- Team working (decline)

Additionally, the responses to the questions have also been categorised by areas of 'strength,' 'opportunity for improvement' and 'areas for improvement' as shown in Table 1 overleaf.

Table 1: Table to show the number of questions which indicate a 'strength,' 'opportunity for improvement' and 'areas for improvement.'

Areas of Strengths and Improvements	ROH 2020 (No. of questions)
GREEN indicates 'strength'- agreement from 65% or more of staff:	**43**
AMBER indicates 'opportunities for improvement' - agreement from 41% to 64% of staff	23
RED indicates 'areas for improvement' - agreement from 40% or fewer staff.	5

6 priority areas have been identified as areas of focus for 2021 .These are

- Health, Wellbeing and Safety
- Bullying and Harassment
- Staff engagement
- Line Managers and Team Working
- Career Progression and Retention
- Engagement with Senior Managers

The Staff Survey also considers performance against the indicators within the Workforce Race Equality Standards (WRES) and Workforce Disability Standards (WDES). The Trust has seen slight improvements across the WRES indicators and has been amongst the best performing organisations in relation to indicator 5 – the % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This positive trend is not consistent with the WDES indicators and further work is required to consider improvements in supporting disabled staff. Actions around Equality and Diversity will be addressed through the Equality and Diversity Action plan (currently being drafted) which will support the delivery of the Inclusion Strategy.

The approach to addressing the feedback on key themes, engagement with staff and the development of action plans is outlined in Appendix 1.

REPORT RECOMMENDATION:

The Trust Board is asked to receive this information, discuss and support next steps

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**x**	Environmental		Communications & Media	x
Business and market share	**x**	Legal & Policy	x	Patient Experience	**x**
Clinical	**x**	Equality and Diversity	x	Workforce	**x**
Comments: [*elaborate on the impact suggested above*]					

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

Aligned to the Trusts vision and Corporate Strategy goals across all 5 domains

PREVIOUS CONSIDERATION:

Staff Experience & OD Committee assurance breifing on 31 March 2021

NHS National Staff Survey 20/21
An overview



RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

YOUR 2020 STAFF SURVEY FEEDBACK

Thank you to everyone who completed their 2020 staff survey. More people than ever completed this year, 56% which is fantastic! The completion rate has improved from 51% last year which will mean we will get a lot more information to share staff members this year.

COVID has had an undeniable impact on everyone who works in the NHS. The feedback from the staff survey will naturally reflect our experiences during the pandemic.

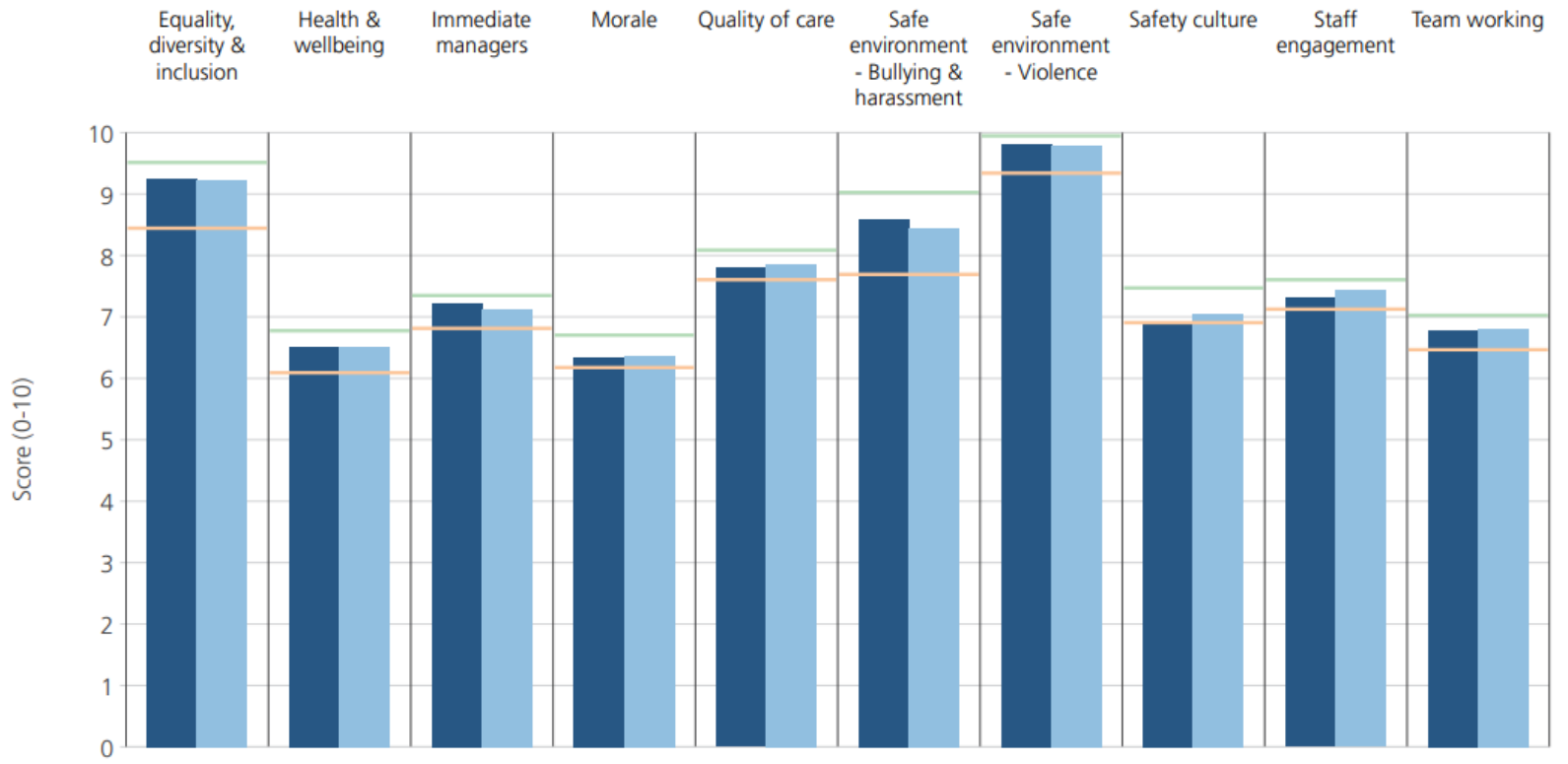
There will be a number of ways that you will be able to find out more about result for the Trust and also in your area.



Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	9.3	6.5	7.2	6.3	7.8	8.6	9.8	6.9	7.3	6.8
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5
Responses	624	630	629	626	528	629	626	628	630	621

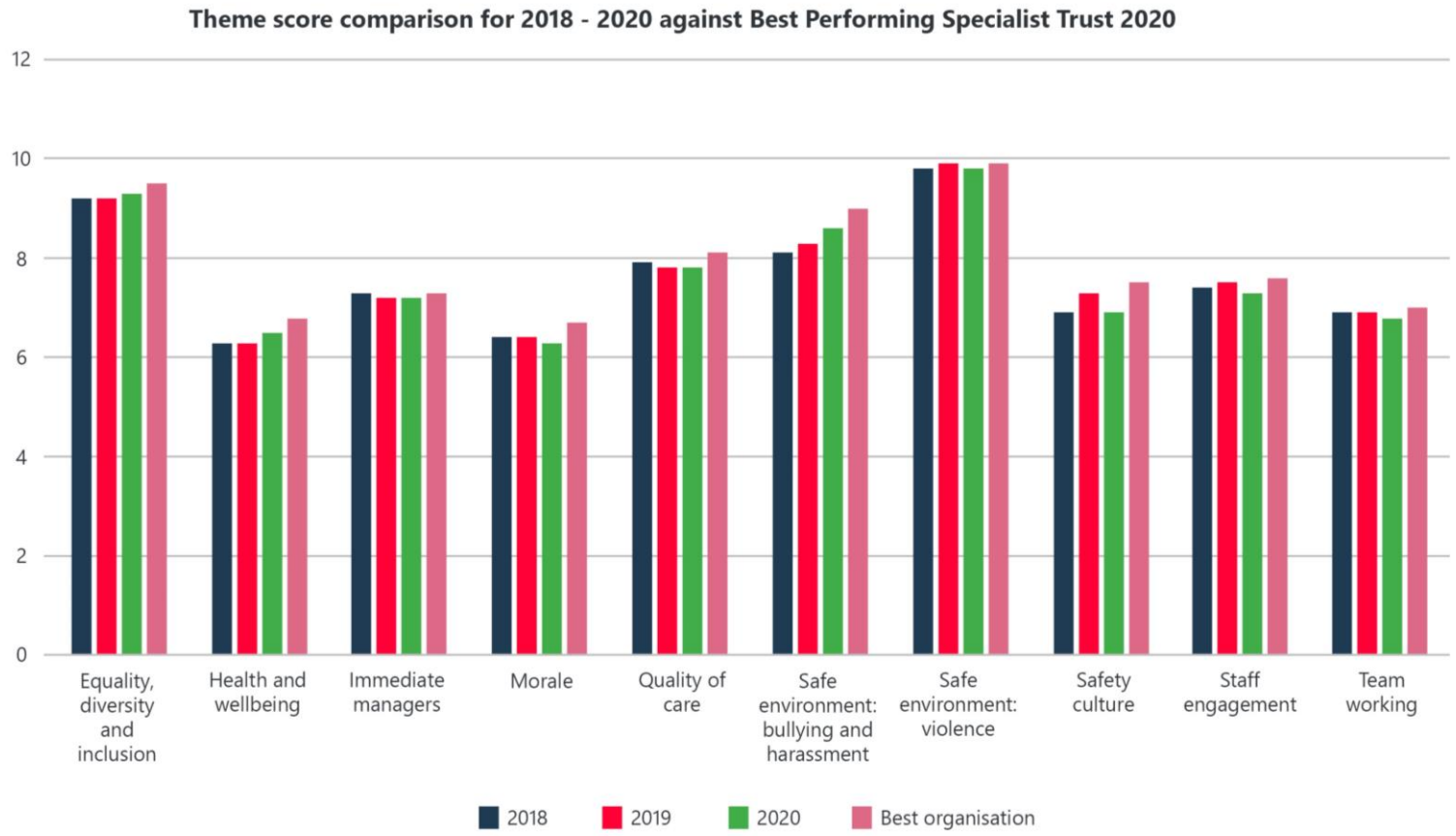
EVERY VOICE MATTERS

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

Comparison across BSOL

	ROH	BWCH	BCHT	BMHT	UHB
Response Rate	56%	45.5%	43%	47.10%	38.10%
Equality, Diversity and inclusion	9.3	9.1	8.8	8.5	8.9
Health and Wellbeing	6.5	6.1	6.0	6.1	5.8
Immediate Managers	7.2	7	7.0	7.3	6.6
Morale	6.3	6.2	6.1	6.4	6.0
Quality of Care	7.8	7.4	7.5	7.5	7.5
Safe environment - Bullying & Harassment	8.6	8.4	8.2	7.7	8.1
Safe environment Violence	9.8	9.7	9.6	9.2	9.4
Safety Culture	6.9	6.9	6.8	6.6	6.6
Staff Engagement	7.3	7.2	6.9	7.1	6.8
Team working	6.8	6.6	6.6	6.7	6.2

IMPROVEMENTS IN THE LAST THREE YEARS
THEME SCORE COMPARISON



EVERY VOICE MATTERS

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

SURVEY THEMES

The table below illustrates our scores against other specialist acute Trusts. Each theme is scored on a 0-10 scale. where a higher score is more positive than a lower score.



EVERY VOICE MATTERS

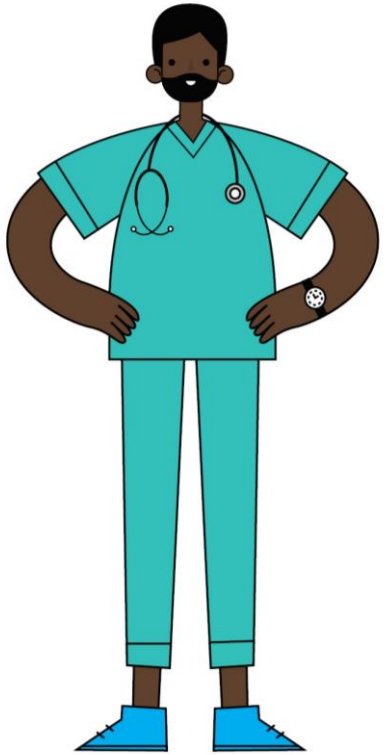
RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

SURVEY THEMES

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Based on your feedback, we have identified six priority areas to focus on in 2021. We will work together to prioritise these areas and make progress.

- HEALTH WELLBEING AND SAFETY
- BULLYING AND HARASSMENT
- STAFF ENGAGEMENT
- LINE MANAGERS AND TEAM-WORKING
- CAREER PROGRESSION AND RETENTION
- ENGAGEMENT WITH SENIOR MANAGERS



EVERY VOICE MATTERS

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Highest scoring questions across the trust

Q3a – I always know what my work responsibilities are
Q7b – I feel that my role makes a difference to patients / service users
Q12a – In the last 12 months I have never personally experienced physical violence at work from patients/service users, their relatives or other members of the public
Q12b – In the last 12 months I have never personally experienced physical violence at work from managers
Q12c – In the last 12 months I have never personally experienced physical violence at work from other colleagues
Q15a – In the last 12 months I have never personally experienced discrimination at work from patients/service users, their relatives or other members of the public

Lowest scoring questions across the trust

Q5g – I am satisfied with my level of pay

Q6a – Unrealistic time pressures

Q9b – Communication between senior management and staff is effective

Q9c –Senior managers here try to involve staff in important decisions

Q9d – Senior managers act on staff feedback

Engagement plan overview

Phase 1: Analysis, Interpretation, Message refinement and development – by end of April 21

Share results and infographic within Trust
Engagement with Exec Team, Individual Execs, key staff members and groups
e.g. Staff side, People Committee, SE&OD, Trust Board and also You Said, We Did
Communication packs using different formats

Phase 2: Sharing organisation action plan – by end of May 21

Full review of results and development **of organisational action plan**
Messaging across comms channels including intranet page
Execs to develop actions plans in Directorates
Focus group to inform action planning
Listening sessions with staff network groups

Phase 3 : Message delivery – by end of June 21

Infographics to include key areas and actions
Launch of action plan with theme of Your Said, We will do
Integration into business planning
Reporting back to Trust Board



NEXT STEPS

STUDY THE DATA

We will study the data to make sure we are clear what the survey tells us about the Trust and individual areas.

HAVE A CONVERSATION

We will hold focus groups and discussions in areas to share feedback and understand more about how to drive the improvements you want.

MAKE AN ACTION PLAN

We will work with each area to develop an action plan for improvement that is based on your feedback.

FOLLOW UP REGULARLY

We will monitor action plans and check in regularly to see if progress is being made.

REPORT TO THE TRUST BOARD ON 7 APRIL 2021

GROUP/MEETING TITLE:	Diversity, Equality, Respect & Inclusion	MANAGER:	Clare Mair	DATE:	29th March

MILESTONES ACHIEVED (OVER LAST MONTH)

OD

- Staff walkabout schedule now in place for next 12 months. Current virtual format will be reviewed in line with restrictions. Dates to be sent to all NEDs
- Third virtual Schwartz Round to recognise the Impact of Covid
- Long Service Awards ceremony for 2020 applicants
- Initial staff survey information shared across the Trust (part of Phase I)
- Staff survey focus group pilot completed
- Budget allocation confirmed for staff support as part of regional Wellbeing Super Steering committee (£2m project)

Inclusion

- Network meeting for Equality and Diversity and Multi Minority Ethnic Group (MMEG) and Disability network completed
- MMEG Chair recruited.
- Second evaluation meeting with WDES Project team completed with positive feedback received on progress (taking into account Covid challenges)
- Regional NHS LGBT+ conference on March 25th with representation from Matt Revell as Executive Lead and David Richardson as ROH representative.

ISSUES/CONCERNS/RISKS IDENTIFIED

- Engaging colleagues in staff networks meetings to balance with patient facing/job role priorities
- Resource for current workload due to key projects
- Supporting shielding staff
- Supporting return of redeployed staff
- Engagement of colleagues on OD intervention delivered with a virtual media format

DECISIONS / SUPPORT REQUIRED

OD

- Application for Inclusive Companies 2021 Top 50 and awards
- Format for line manager development linked to staff survey feedback being developed (including feedback from Me as Manager pilot)

WORK PLANNED (MONTH AHEAD)

OD

- Work to be undertaken with Executive Directors to share staff survey results in Directorates and across the Trust
- Work to continue to confirm organisational action plan for staff survey and engagement
- Staff survey focus groups to continue
- Recovery and Recovery work stream commenced to concentrate on Workforce and Wellbeing

	• Review of Long Service policy • Initial work on Wellbeing Guardian diagnostic (with Wellbeing officer) • Recommendations to be finalised for Recruitment Project **Inclusion** • Planning for WRES and WDES reporting • Planning for E&D report (to include EDS 2 framework) • Continued work on WDES Funding bid. Project includes a photography and video exhibition, buddy scheme and awareness sessions. Due to be launched in May 21 • Recruitment of Chair for Disability network • Start project planning for Stonewall accreditation – delayed • Initial work for Reverse Mentoring scheme to now encompass Trust wide approach – work ongoing • Finalise Inclusion documents • Ongoing review of Equality and Diversity with key colleagues across the Trust • Confirmation of Inclusion calendar events with staff network groups
KEY BENEFITS: MEASURING SUCCESS OF THE PROGRAMME	
To be confirmed	

REPORT TO THE TRUST BOARD ON 7 APRIL 2021

GROUP/MEETING TITLE:	Health and Wellbeing	LEAD:	Laura Tilley Hood	DATE:	30th March

MILESTONES ACHIEVED (OVER LAST MONTH)

Health and Wellbeing

- Updated Wellbeing Packs with signposting and support for staff delivered to all areas
- Menopause Support Group
- Health and Wellbeing Room – questionnaire for staff to engage with what we want in the room
- Application form to be taken to Room Committee to secure space for the room
- Pop up Your Space Room in ADCU
- Collection of donations for Rubery Swap Shop
- Time to Talk drop in sessions
- Launch of ROH Wellbeing twitter account

ISSUES/CONCERNS/RISKS IDENTIFIED

- Engaging colleagues in during work hours
- Supporting staff
- Managers feedback on Health and Wellbeing question set – review and consultation in progress

DECISIONS / SUPPORT REQUIRED

- Health and Wellbeing Room application sent to Accommodation Review Group

WORK PLANNED (MONTH AHEAD)

Health and Wellbeing

- Three listening Sessions for shielding staff returning
- Updated Health and Wellbeing conversation questions shared with colleagues to gain feedback
- Update nationally regarding Health and Wellbeing Conversations, use this guidance within the trust
- Collection of Easter Eggs within department for Northfield Community Partnership (NCP)

	• Managers Meeting – Support for Teams – continuing to support managers via a fortnightly call, offering signposting and guidance • Thrive at work – continue with Bronze Accreditation, collecting information from key staff members and uploaded evidence to the dashboard. • Health and Wellbeing Room questionnaire data to be reviewed • Meeting with Health and Wellbeing Champions • Supporting redeployed colleagues returning to ROH • Updated calendar of Wellbeing events shared with colleagues • Virtual Health and Wellbeing week 26th – 30th April • Initial work for Wellbeing strategy content • Working towards Thrive at Work Bronze level – awaiting update on additional evidence required

KEY BENEFITS: MEASURING SUCCESS OF THE PROGRAMME

Some metrics are being developed and discussed at a regional level at present.

Trust Board: Wellbeing Guardian role

Monday 8th March 2021

Overview

- Set out in the NHS People Plan 2020-21 to create a culture of wellbeing, where our NHS people are well looked after and cared for.

These policy areas outline three key roles:

- **Wellbeing Guardians**: A non-executive director (or equivalent) who looks at the organisation's activities from a health and wellbeing perspective and acts as a critical friend.
- **Health and Wellbeing Champions**: People at all levels of our NHS organisations who promote and identify ways to enable the wellbeing of their colleagues.
- **Health and Wellbeing Conversations**: Supportive conversations between colleagues and their line managers

What is a Wellbeing Guardian?

Background

- The NHS Staff and Learners' Mental Wellbeing Commission (2019) identified a lack of uniformity in board-level leadership around the wellbeing of our NHS people.
- The review recommended improving the consistency across NHS boards through the introduction of a board-level Wellbeing Guardian role

Vision for the role

- The Wellbeing Guardian is recommended to be a **board-level role** that provides **oversight, assurance and support to the NHS board** to fulfil their legal responsibility

- Every NHS organisation

Who can be a Wellbeing Guardian?

- Where organisations have **non-executive directors (NEDs)**, it is recommended that it is one of them who is appointed into the Wellbeing Guardian role.

- The Wellbeing Guardian should:
  - **Care** about people, find ways to connect with staff and staff networks and listen well
  - Work closely with and support the **HR Director** and other executives who lead in this area
  - Feel confident in **challenging the Board** and other senior leaders, questioning decisions that could impact on the wellbeing of our NHS people, and challenging behaviours or aspects of the culture that are likely to be detrimental to others.
  - Be fully cognisant of the **protected characteristics** outlined in the Equality Act and be committed to ensuring that disparities on the basis of a protected characteristic are eradicated.

Nine principles supported by the wellbeing guardian

Principle One
The health and wellbeing of our NHS people and those learning and working in the NHS should **not be compromised by the work** they do for the NHS.

Principle Two
Where an individual or team is exposed to a particularly **distressing clinical event**, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.

Principle Three
Regular assurance will be provided to the wellbeing guardian to ensure that **wellness induction** (previously wellbeing 'check-in') are being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.

Principle Four
The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have **ready access to a self-referral**, proactive and confidential occupational health service that promotes and protects wellbeing.

Principle Five
The **death by suicide** of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.

Principle Six
The NHS will ensure that all our NHS people and learners have an **environment that is both safe and supportive** of their mental and psychological wellbeing, as well as their physical wellbeing.

Principle Seven
The NHS will ensure that the **cultural and spiritual** needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.

Principle Eight
The NHS will ensure the wellbeing and make the necessary adjustments for the **nine groups** protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).

Principle Nine
The wellbeing guardian will provide suitable challenge to the board to be **assured** that the organisation is **working with system leaders and regulators**, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.

How do I implement a wellbeing guardian in my organisation?

- Organisations and systems are at different places in their journey to support and improve the health and wellbeing of our NHS people, therefore we have suggested the following phases to support with implementation of the Wellbeing Guardian role.
- Board/organisations self-assess against the below three phases to determine tcurrent “status”. They can then follow the guidance below on what potential next steps could be.

Phase 1: Health and wellbeing has limited coverage at board level

Phase 2: Principles of wellbeing guardian role are largely embedded

Phase 3: Health and wellbeing is routinely considered and included in board activity

Check list – Phase One

To support systems with the rollout of the Wellbeing Guardian role, the Board is invited to use this checklist to help inform their thinking and support the delivery of this role.

Step	Yes/No
Have we completed our NHS Health and Wellbeing Diagnostic assessment to assess current health and wellbeing performance and identify priority activities? If not, do we need any support in completing this?	
Have we as the board agreed which priority actions should be included in the Wellbeing Guardian role description and how the nine principles will be phased in?	
Do we currently have any NEDs appointed to our board? If not, what similar role is in place?	
Have we identified a suitable candidate for the Wellbeing Guardian?	
Do we now feel confident to move on to phase two?	

Check list – Phase Two

To support systems with the rollout of the Wellbeing Guardian role, the Board is invited to use the below checklist to help shape their thinking and support the delivery of this role.

Step	Yes/No
Our Wellbeing Guardian role is established and working well within the board.	
We are confident that most of the nine principles are routinely evidenced at board meetings and that we have a clear plan in place to support equality and inclusion in the workplace.	
We have an organisation-wide health and wellbeing strategy in place that is being delivered by the organisation and reviewed regularly by the Board. If not, do we need to add this to our agenda and a standing item?	
Our local staff experience measures indicate a compassionate and inclusive culture is in place or is in development, as outlined in the NHS People Plan.	
We feel confident to move on to phase three.	

Check list – Phase Three

To support systems with the rollout of the Wellbeing Guardian role, the Board is invited to use the below checklist to help shape their thinking and support the delivery of this role.

Step	Yes/No
All board members routinely consider the health and wellbeing of our workforce in their strategic and operational plans and performance reporting. If not, how do we introduce this and embed it across the board?	
We have processes in place that enable staff stories to be regularly fed back to the board.	
We are confident that all nine principles outlined in this document are being delivered.	
We have completed the NHS Health and Wellbeing Diagnostic Tool and our dashboard is green.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Learning Lessons to Improve our People Practice**
SPONSOR (EXECUTIVE DIRECTOR):	**Joanne Williams, Chief Executive**
AUTHOR:	**Sharon Malhi, Associate Director of Workforce & OD**
DATE OF MEETING:	**7th April 2021**

EXECUTIVE SUMMARY:

The letter in Appendix 1 outlines the expectations of NHS Trusts in relation to good people practice requesting that all Trusts reflect on their current Disciplinary Procedures, review the recommendations that were issued to Trusts in May 2019 by Baroness Dido Harding (see Appendix 2) and consider what has worked well and what could be further improved.

The Trusts revised Disciplinary Policy and Procedure is attached in Appendix 3. This policy has been reviewed and revised in accordance with the recommendations and legal advice has been sought on the quality of the revised policy and procedure which has endorsed the Trusts policy and approach.

REPORT RECOMMENDATION:

The Trust Board is asked to note the revised Disciplinary Policy and Procedure as required by the national mandate.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x	**x**	x

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

Financial	**x**	Environmental		Communications & Media	x
Business and market share	**x**	Legal & Policy	x	Patient Experience	**x**
Clinical	**x**	Equality and Diversity	x	Workforce	**x**
Comments: [*elaborate on the impact suggested above*]					

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

People element of the Trust's strategy

PREVIOUS CONSIDERATION:

Staff Experience & OD Committee assurance breifing on 31 March 2021

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes



Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Classification: Official

Publication approval reference: PAR293

Prerana Issar

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

To:

- NHS trust CEOs, HR directors, workforce directors
- NHS foundation trust CEOs, HR directors, workforce directors

01 December 2020

Dear Colleagues,

Re: Sharing good practice to improve our people practices

I hope you are doing well in these challenging times.

In May 2019 we shared with you an important piece of work in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) four years ago. Sadly, Amin Abdullah, a nurse who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life. Details of the investigation, conducted by an appointed advisory group, together with the reasons for its commission, are provided in the enclosed letter (enclosure 1).

The advisory group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). In addition, in November 2019, I wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system (enclosure 2).

Since Amin's passing, ICHT has worked collaboratively with Amin's partner Terry Skitmore and his advocate Narinder Kapur, alongside other stakeholders, to create a revised policy for handling staff related concerns or complaints. I am writing to share this with you as an example of good people practice, albeit arising from such tragic circumstances (enclosure 3).

The shared learning from Amin's experience has demonstrated the need for us to work continuously and collaboratively, to ensure that our people practices are inclusive, compassionate and person-centred, with an overriding objective as to the safety and wellbeing of our people. These values are central to our recently published People Plan and People Promise.

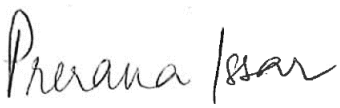
Our collective goal is to ensure we enable a fair and compassionate culture in our NHS. I urge you to honestly reflect on your organisation's disciplinary procedures, review the recommendations we issued in May 2019 and the attached example of good practice, and consider what has worked well and what could be further improved.

Where action is required, I urge NHS organisations to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a **Public** Board or equivalent. We will continue work with the CQC to embed the learning from these reviews to form part of the formal oversight framework. I would also like to suggest your policy is made available on your organisation's public website by the end of the financial year.

As we prepare for the second wave of COVID-19, our staff should feel supported in every sense, including demonstrating a sensitive and compassionate approach to colleagues throughout the disciplinary procedure and process.

Many thanks for everything you are doing to provide services during this challenging time.

Best wishes,



Prerana Issar
NHS Chief People Officer

Enclosure

1. Learning lessons to improve our people practices – Letter to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

2. Guidance and standards for registrants in relation to local investigations and disciplinary procedures - Letter from Prerana Issar to healthcare professional and regulatory bodies, 04 November 2019.

3. Imperial College Healthcare NHS Trust - Disciplinary Policy and Procedure, July 2020.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

DISCIPLINARY POLICY

To be read in conjunction with the Disciplinary Procedure included within this document

Policy author	HR Manager
Accountable Executive Lead	Chief Executive Officer
Approving body	TCC
Policy reference	ROH/XXX/NNN [Assigned by Governance Team]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – All staff will read this policy as necessary

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1 – All staff will use this policy as necessary

POLICY APPROVAL DATE:
October 2020

POLICY IMPLEMENTATION DATE:
October 2020

DATE POLICY TO BE REVIEWED:
October 2023

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1	March 2014	March 2014	March 2015	Initial policy written and implemented
2	June 2016	N/A	N/A	Policy reviewed and updated as appropriate in line with changes.
3	July 2016	N/A	N/A	Final draft, following further discussion with trade unions.
4	August 2016	N/A	N/A	An initial draft of this policy was shared with TMC members, Executive Team, Key clinical & corporate leads and stakeholders for comments and input. Policy updated as appropriate.
5	September 2016	October 2016	October 2019	Final version, taken to TCC for approval then TMC.
6	October 2020	October 2020	October 2023	Policy reviewed and updated. Draft shared with Trust for consultation and taken to TCC for approval.

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DISCIPLINARY POLICY

1.0 INTRODUCTION

1.1 The main purpose of the disciplinary policy is to bring about an improvement in levels of conduct through informal or formal action.

2.0 SCOPE

2.1 This policy applies to all staff except Bank Staff who should refer to the Bank Policy.

2.2 The policy does not apply to issues of capability/poor performance or poor attendance due to sickness and should be dealt with in accordance with the Capability and Performance Management Policy or Sickness Absence Management Policy respectively.

2.3 This policy should be read in conjunction with all appropriate codes and conduct/rules for professional bodies. In cases involving professional competence or personal conduct of medical staff, this policy should be read in conjunction with the document Maintaining High Professional Standards in the Modern NHS; a disciplinary framework for the initial handling of concerns about doctors and dentists in the NHS.

2.4 The Disciplinary Policy has been written based on guidance from the Advisory Conciliation and Arbitration Service (ACAS Code) and is designed to assist line managers, employees and trade union representatives to deal with disciplinary situations in the workplace in a fair and consistent manner.

3.0 OTHER POLICIES TO WHICH THIS POLICY RELATES

- Capability and Performance Management Policy
- Sickness Absence Management Policy
- Grievance Policy
- Bullying and Harassment Policy
- Maintaining High Professional Standards Policy
- Equality and Diversity Policy

4.0 PRINCIPLES

The following principles will apply to the application of this policy:

4.1 It is the responsibility of the employees to ensure that they are aware of the Disciplinary Procedure and of the standard of conduct that is expected of them.

4.2 The Trust encourages the use of informal methods of dealing with minor lapses in conduct through the development and application of good employment practices.

4.3 If a decision is made to invoke the disciplinary procedure then it is manager's responsibility with support from the Divisional HR Manager to ensure the procedure will be operated promptly and should not unreasonably delay meetings, decisions or confirmation of those decisions.

4.4 Disciplinary issues will be dealt with in an open, transparent and fair manner and will be applied in a consistent and non-discriminatory way.

4.5 Confidentiality will be maintained at all stages of the process, including within the terms of reference, statement of case, this includes anonymising third party patient information in bundles of documents to prevent disclosure of the identity of the persons concerned.

4.6 Necessary investigations will be carried out to establish the facts of the case.

4.7 The disciplinary process may be suspended or postponed if the Investigating Officer discovers a situation that would have a material effect on the outcome of the case.

4.8 Employees against whom disciplinary procedures have been invoked have the right:

- To be informed, where a disciplinary hearing is necessary of the nature of the allegations in writing and will be given an opportunity to state their case with regards to any appropriate disciplinary sanction.
- To be represented by a Trade Union representative or accompanied by a work colleague at any stage in the procedure.
- Right of appeal against any decision as designated in Section 6.7.
- Not to be dismissed for a first breach of discipline except in the case of gross misconduct.

5.0 ROLES AND RESPONSIBILITIES

5.1 Responsibilities of the Trust Board/Executive Directors

- Responsibility to oversee this policy and ensure that appropriate processes and actions are in place to ensure employees are treated in a fair and consistent manner.

5.2 Responsibilities of the Head of Department /Divisional Manager

- Ensure appropriate systems and processes are in place across their area of responsibility, to monitor timescales for disciplinary investigations and disseminate shared learning from any matters arising from the investigations in their own area of responsibility.
- Appointing the Investigating Officer, when required, thus ensuring all disciplinary matters are dealt with in a timely manner and in accordance with this policy.

5.3 Responsibilities of the Manager

- Ensuring employees are aware of this policy and its contents and that their employees understand the standards of conduct and attendance required.
- Responsible for ensuring that high standards are maintained, bringing any concerns they may have about a particular employee to their attention in a timely and sensitive manner.
- Participating in any Trust training deemed necessary to ensure that they have the necessary skills to undertake their responsibilities appropriately.

5.4 Responsibilities of the Human Resources Department

- The Associate Director for Workforce and Organisational Development will oversee the introduction, operation and monitoring of the Disciplinary Policy and Procedure and discharge the Trust Board responsibility with regard to this policy.
- Ensuring that the Disciplinary Procedure is applied fairly, equitably and consistently throughout the Trust.
- Assess whether an informal approach could resolve any potential situation before the need to invoke formal disciplinary proceedings.

- Providing advice and guidance on the correct application throughout all stages of the Disciplinary Procedure.
- Maintaining records of outcomes of formal disciplinaries for the purposes of ensuring a consistent approach, including records on ESR.
- Monitoring all disciplinary matters across the Trust and provide the Trust Board with regular reports on the types and outcomes of disciplinary investigations undertaken within the Trust, including reports on the profile of staff subject to disciplinary to ensure discrimination does not occur.
- Providing training to line managers in relation to the policy and procedure.

5.5 Responsibilities of Peer Support

- Where a formal disciplinary investigation is invoked, employees will be assigned peer support throughout the process to provide pastoral support.
- Provide ongoing informal support and guidance to staff going through an investigation. It is not the role of Peer Support to represent the staff member at meetings or a hearing during the investigation process.

5.6 Responsibilities of the Employee

- Where the informal or formal stage of the disciplinary procedure is invoked, employees are required to participate fully in the process, in a timely and constructive manner, whether this concerns them personally or a work colleague. The purpose is to establish the facts fully and as quickly as possible and, unless all contribute appropriately, the findings may be incomplete, possibly resulting in inaccurate conclusions being drawn.
- Ensure they understand the standards of behaviour and conduct expected by the Trust and familiarise themselves with the Trust Values.

6.0 PROCEDURE

6.1 The Disciplinary Policy has two stages, Informal and Formal. The informal stage will not be considered for cases of alleged serious misconduct or gross misconduct.

6.2 Should formal disciplinary action be commenced; an investigation will be held in line with the Disciplinary Procedure.

6.3 Suspension may be considered in some circumstances due to the seriousness of the allegations, of the risk the employee poses to the investigation by remaining at work. A suspension risk assessment will be undertaken and alternative courses of action will be considered in the first instance such as: -

- Restricted duties in existing role and location (e.g. it may be appropriate to consider this course of action where the employee has committed a drug error).
- Placing the employee under additional supervision if practicable.
- Temporary assignment to a different role that is within the skills and knowledge of the employee.

6.4 The panel hearing the case may give some of the below outcomes in conjunction with a warning:

- That no further action is necessary
- The imposition, extension or renewal of any formal warnings issued under this procedure;
- The temporary or permanent transfer of an employee to an alternative post/department within the Trust.
- That matters should be considered under an alternative procedure i.e. Capability and Performance Management Policy.

- Downgrading (no salary protection payable).
- Change of shift pattern (no salary protection available).
- Restrictions/termination of Bank work.

6.5 There are two levels of warning in the formal disciplinary procedure which can be given to an employee dependent upon the gravity of the case and/or the ongoing nature of the misconduct:

- Stage 1 – First Written Warning (will remain on file for 12 months)
- Stage 2 – Final Written Warning (will remain on file for 24 months)

6.6 Where the allegations are of a serious nature which may impact on the employee's suitability to work, a referral to the relevant external professional bodies may be made.

6.7 Appeals Procedure

6.7.1 All employees have the right to appeal against any formal disciplinary action and must do so in writing to the Associate Director for Workforce and OD within ten working days of receipt of the written confirmation of the disciplinary decision.

6.7.2 The appeal hearing will be heard by a minimum two-member panel that have had no previous involvement in the case. The panel members should be an appropriate senior manager and an HR representative. As a minimum the appeal must be chaired by an Executive Director. In cases where there are professional specific issues the panel composition must contain a representative from the relevant professional area.

6.7.3 The decision made at the appeal hearing will be final and there will be no further stages of appeal.

6.8 Failure to Attend a Disciplinary Meeting/Hearing or Requesting a Postponement

6.8.1 An employee is able to make a request for postponement of the disciplinary meeting/hearing for the Trust to consider and the Trust may rearrange a new date. If the employee is unable to/fails attend the rearranged meeting/hearing without good cause, the Trust reserves the right to proceed with process and will make a decision based on the information available.

6.9 Some other Substantial Reason (SOSR) or Statutory Debarment

6.1 Dismissal procedures for these reasons will be dealt with in accordance with the Disciplinary Procedure except that dismissal may be the outcome without the employee going through any first or final warning process. In all cases, the organisation will ensure that a fair process has been followed in relation to identifying and investigating any allegations.

6.10 Overlapping of Grievance and Disciplinary Cases

6.10.1 If a grievance is lodged relating to a current matter, it will be addressed during the disciplinary process. Only in exceptional circumstances will an on-going disciplinary process be suspended on account of a grievance being submitted.

6.10.2 Where a separate grievance process is underway (i.e. a formal grievance has been submitted as per the Grievance and Disputes Policy) the two processes shall be dealt with concurrently and in

accordance with the respective policies and procedures.

7.0 CONSULTATION

An initial draft of this policy was shared with staff side and all other staff for comments and input. Amendments based on this feedback have been included where possible and deemed appropriate.

8.0 AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

The Disciplinary Policy and Procedure will be monitored and reviewed by the Human Resources Department and Trust Consultative Committee as per the review date or earlier if significant events require.

The Trust acknowledges the importance of skills training for managers and will therefore ensure that appropriate training for managers in respect of the Disciplinary Policy and Procedure will be provided as identified and where required.

9.0 TRAINING AND AWARENESS

This policy will be disseminated via the current communication channels and will replace the existing policy on the Trusts intranet.

Ongoing training, advice and support will be provided by the HR Operations Team to support staff and managers in understanding and adhering to this policy.

10.0 EQUALITY AND DIVERSITY

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need.

Managers will not discriminate in the application of this policy/procedure in respect of the protected characteristics as defined within the Equality Act 2010 and not contravene the prohibited conduct contained within this.

11.0 REVIEW

The Disciplinary Policy and Procedure will be reviewed at three yearly intervals from the date of review or, if required, by changes in legislation, significant developments in employment law practice.

12.0 REFERENCE DOCUMENTS AND BIBLIOGRAPHY

This policy and procedure was developed in line with best practice and up to date research with reference to the sources of information listed below:

- Agenda for Change NHS Terms and Conditions of Service
- ACAS Code of Practice- Disciplinary and Grievance Procedures (March 2015)
- Employment Rights Act 1996
- Employment Relations Act 1999
- Equality Act 2010
- Disclosure and Barring Service (DBS) Duty to Refer

- Medical Staff Disciplinary Procedure - Maintaining High Professional Standards in the Modern NHS
- Professional codes of practice

13.0 FURTHER ENQUIRIES

Further information regarding this policy is available from the HR Team on 0121 685 4000 ext 55404.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Equality Impact Assessment

Initial Assessment form

The Initial Equality Impact Assessment (EIA) is a quick and easy screening process. It should:

1. Identify those policies which require a full EIA by looking at:

    - Negative, positive or no impact on any of the protected characteristics.
    - Opportunity to promote equality for the protected characteristics.
    - Data/feedback to prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed

Division or Corporate area:	**Workforce & OD**
Speciality/Service Area	**Human Resources**
Executive Lead (enter name and designation):	**Jo Williams, CEO**
Title of Policy:	Disciplinary Policy and Procedure

Q1) What is the aim of your Policy?

To outline the process in managing conduct issues informally and formally

Q2) State to which Trust strategic objective this Policy relates:

Q3) Who benefits from your Policy?

All staff members

Q4) Do you have any feedback data that influences, affects or shapes this Policy?

Yes	No
x Please complete below.	☐ Please go to question 5

What is your source of feedback?

- x Monitoring Data
- ☐ Previous EIAs
- x National Reports
- ☐ Internal Audits
- x Patient Surveys
- x Complaints / Incidents / Claims / Litigation
- x Focus Groups
- ☐ Equality & Diversity Training
- ☐ Other (please state)

What does this source of feedback reveal?

To effectively manage conduct issues with early intervention and have a more efficient investigation process.

Q5) Thinking about each group below does or could the Policy have a negative impact on members of the protected characteristics below?

Protected Characteristic	Yes	No	Unclear
Age	☐	X	☐
Disability	☐	X	☐
Race	☐	X	☐
Sex	☐	X	☐
Gender Reassignment	☐	X	☐
Sexual Orientation	☐	X	☐
Religion or belief	☐	X	☐
Pregnancy & Maternity	☐	X	☐
Marriage & Civil Partnership	☐	X	☐
Other socially excluded groups	☐	X	☐

If the answer is “yes” or “Unclear” please complete a full EIA

Q6) Who was involved in the EIA and how?

Meesha Ranpuria – HR Manager
Annwyn Williams – HR Manager

How were they involved?

☐ Surveys
☐ Team Meeting
x Group Review
☐ Other

Please specify:

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	x	yes	☐

Q7a) If 'No' Explain why you have made this decision?

The group review went through each protected characteristic to identify any negative/potential negative impact. The group did not identify any form is indirect/direct discrimination.

Q7b) If 'yes' explain the negative impact – you may need to complete a full EIA

If a negative impact has been identified please continue to undertaking a full impact assessment. If no negative impact has been identified please submit your Initial Equality Impact Assessment to roh-tr.governance@nhs.net

Justification Statement:
As member of ROH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	Meesha Ranpuria
Designation:	HR Manager
Date:	21st August 2020
Contact number:	07970 964256

This EIA has been approved:

Name:	
Designation:	
Date:	
Contact number:	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Equality Impact Assessment

Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Equality Impact Assessment form. This will involve you questioning aspects of a proposed/existing policy, guideline or strategy and forecasting the likely effect on different groups.

Step 1) What is the impact?

1) Why have you carried out this Full Equality Impact Assessment?

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination or anyone else who will be impacted on by your policy, guideline or strategy.

Step 2) What are the differences?

2a) Identify the Equality group(s) that will be affected by the impact and state what the differences are:

Protected Characteristic	**Negative / Potential Negative Impact**	**Positive / Potential Positive Impact**	**How is the Equality group identified affected in a different way to others as a result of the policy, guideline or strategy?**
Age	☐	☐	
Disability	☐	☐	
Race	☐	☐	
Sex	☐	☐	
Gender Reassignment	☐	☐	
Sexual Orientation	☐	☐	
Religion or Belief	☐	☐	
Pregnancy & Maternity	☐	☐	
Marriage & Civil Partnership	☐	☐	
Other socially excluded groups	☐	☐	

2b) If this EIA indicates that there is insufficient evidence to judge whether there is differential impact please state why below.

Step 3) Consultation

3a) With whom have you consulted on your policy and when did the consultation take place?

3b) As a result of the consultation are there any further changes to the policy needed?

Step 4) Plan to address negative impact

4a) Please complete your action plan using the table below. Detail how you are going to address the negative impact, stating the timescales involved.

Protected Characteristic	Negative Impact	Action Required	Cost Implications	Expected Outcome	Lead (name and job title)	Timescale (specify dates)

Completed by:

Name:	
Designation:	
Date:	

Contact number:	

This EIA has been approved by:

Name:	
Designation:	
Date:	
Contact number:	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Disciplinary Policy and Procedure
ACCOUNTABLE EXECUTIVE LEAD:	Chief Executive Officer
POLICY AUTHOR:	HR Manager
APPROVED BY:	TCC
DATE OF APPROVAL:	6th October 2020

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

IMPLEMENTATION PLAN OWNER: _____

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a	Comms to go out Trustwide	HR Manager	No	December 2020	In progress	
b						
c						
d						
2	*Training*					
a	Webinar to be completed	HR Manager	No	December 2020	In progress	
b	Training to be confirmed (virtual/face to face)	HR Manager				
c	Investigating Officer Training to be completed	HR Manager	No	December 2020	In progress	
d	Training to be confirmed (virtual/face to face)	HR Manager	No	December 2020	In progress	
3	*Resources*					
a	Acting Senior HR Manager					
b	HR Manager					
c	Deputy HR Manager					
d	Comms Team					
4	*Monitoring Effectiveness & Evaluation*					
a	Weekly Senior HR Meetings					
b						
c						
d						

Final date when plan is expected to be fully implemented: __December 2020_____

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

DISCIPLINARY PROCEDURE

To be read in conjunction with the Disciplinary Policy

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DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1				New procedure

1. Introduction

1.1 This guidance is designed to support the Disciplinary Policy and outlines best practice for Managers when addressing and managing misconduct issues within the Trust.

1.2 The principles of the Disciplinary Policy apply to every part of this procedure.

1.3 Templates letters are available on the intranet.

2. Procedure

2.1 Informal Stage – Counselling

2.1.1 In some cases, it may be appropriate for a line manager to counsel the employee regarding their conduct with the aim of improving their behaviour and without recourse to the formal stages of the Disciplinary Policy. Please see Appendix B for examples of misconduct.

2.1.2 It should normally be possible to deal with cases of minor misconduct, i.e. lateness, without delay. When counselling an employee, the manager must explain the purpose of the counselling outlining the issues of concern and ensure future expectations are clearly understood and failure to do so may result in formal action as per the Disciplinary Procedure. If relevant, develop an action plan to improve the situation and prevent a recurrence of the misconduct. An appropriate record of the professional discussion should be documented and retained on the employees file.

2.1.3 There may be occasions where more formal disciplinary action is required where an issue has been discussed informally with an employee and:

- The issue has not been resolved in the timescales set with the employee and the problem persists
- The required improvements in conduct/behaviour are not achieved
- Further information becomes available during discussion which make the matter sufficiently serious

2.1.4 As this does not represent formal disciplinary action, there is no requirement to involve a Human Resources representative and/or Trade Union representative at this stage of the procedure unless either party requests such a representative.

2.1.5 It may be necessary to consider referring the staff member to Occupational Health at any stage of the process. The employees line manager should discuss this the Divisional HR Manager.

2.2 Formal Stage

2.2.1 Where the informal procedure has not led to improved conduct of behaviour, or where the alleged or actual misconduct is of such a serious nature, this must be addressed at a formal level even if they are a first offence.

2.2.2 An investigation of the facts will be carried out as outlined in Section 4 to determine whether there is a disciplinary case to answer.

2.2.3 Employees who are required to take part in an investigation should ensure that they abide by confidentiality and not disclose details of their involvement in this procedure to others to whom it may not be appropriate. If employees require support during the process they should discuss this with their line manager and/or the Divisional HR Manager to identify where additional support may be found.

2.2.4 Employees are entitled to accompanied at all formal stages of the Disciplinary procedure by a Work Colleague or Trade Union Representative.

3. <u>Suspension</u>

3.1 Due to the seriousness of the allegations, or the risk that the employee poses to the investigation by remaining in work, it may be necessary to consider suspending the employee whilst the disciplinary process is undertaken. Where suspension is being considered for medical staff the procedure for Maintaining High Professional Standards in the NHS must be referred to in the first instance.

3.2 The decision to suspend an employee should only be taken when alternative courses of action have been fully explored and considered such as: -

- Restricted duties in existing role and location (e.g. it may be appropriate to consider this course of action where the employee has committed a drug error).
- Placing the employee under additional supervision if practicable.
- Temporary assignment to a different role that is within the skills and knowledge of the employee.

3.3 Prior to deciding to suspend, a risk assessment (see Appendix D) should be completed by your line or another identified manager and all reasonable alternatives to suspension should be considered. If the decision is to suspend, the same manager will complete the suspension and document appropriately.

3.4 Suspension is on full pay and is defined as guaranteed remuneration that the employee would have received had they been at work and which reflects their usual working pattern. Where an employee is normally in receipt of additional allowances, he/she will continue to receive during the course of that duty roster. Overtime, additional hours and bank shift payments are not guaranteed earnings and are not included in the definition of pay, therefore will not be paid during periods of suspension from work.

3.5 Managers wishing to suspend an employee should meet with them, ideally face-to-face or by telephone if this is not possible, and confirm the reasons why they have been suspended. All conversations concerning suspension should be followed up in writing immediately. The letter should:

- make it clear that the employee is suspended, the reasons for this, and the anticipated length of suspension

- explain the employees' rights and obligations during the period of suspension, including that they should remain available for contact during normal working hours throughout the period of suspension
- The employee must make themselves available for any meetings that may be arranged as part of the investigation and disciplinary process whilst under suspension.
- state that the employment contract continues but that the employee is not to report to work and must not contact colleagues
- state the employee is not permitted to undertake any Bank work or other paid work during the suspension. Should the employee have alternative work, a decision may be made to notify their other employer of their suspension
- notify the employee their point of contact during their period of suspension

3.6 Where an employee fails to attend meetings whilst under suspension, entitlement to full pay may be withheld if it is deemed that the employee is not adhering to terms of their suspension.

3.7 During any period of suspension, the employee may request and/or take annual leave in accordance with normal policies. It should be noted that where an employee has been suspended the usual provisions regarding the carry-over of annual leave will apply in accordance with the Annual Leave Policy.

3.8 If the employee produces a medical certificate during the period of suspension they will be recorded as being absent from work owing to sickness absence.

3.9 When the period of annual or sick leave ceases the employee's suspension will, if necessary, be re-established.

3.10 The suspending manager must ensure the suspension is reviewed every 4 weeks ideally face-to-face or by telephone if this is not possible and this discussion should be documented.

4. Investigation – Establishing the Facts

4.1 The purpose of an investigation is to ensure an appropriate and impartial investigation into the circumstances and facts relating to a complaint/allegation is undertaken. Prior to any disciplinary action being considered. Areas to be explored are as follows:

- To ascertain the facts as far as is reasonably possible
- To give the employee an opportunity to offer an explanation
- To investigate the circumstances surrounding the allegations
- To take a balanced view of information obtained during the investigation
- To prepare an investigation report detailing the main findings.

4.2 Safeguarding

4.2.1 In some situations, allegations of misconduct may come to light as a result of Safeguarding. Where a separate safeguarding process is underway that does not impact upon the disciplinary processes the two processes shall be dealt with separately and in accordance with the respective policies and procedures.

4.3 Criminal Charges or Convictions

4.3.1 If an employee is charged with, or convicted of, a criminal offence, the employee must inform their line managers immediately. Whether a decision is made to proceed with the investigation or not, will be dependent on the offence. All situations will be reviewed and will be investigated further if appropriate.

4.3.2 Failure to disclose cautions or convictions immediately will be treated as a serious matter and a breach of the Disciplinary policy, and will be investigated accordingly.

4.3.3 The Trust reserves the right to undertake a DBS check if it is felt necessary.

4.4 Referral to Professional Bodies

4.4.1 The relevant professional lead will make a referral to the relevant professional body where the employee is seen to not be upholding their professional values, bring their profession into disrepute or breaches' their professional codes.

4.4.2 Where a referral is under consideration advice must be sought from the relevant clinically qualified Director e.g. The Director of Nursing and Clinical Governance for a nurse.

4.4.3 The Trust has a zero-tolerance approach to fraud and corruption, and all allegations will be thoroughly investigated in accordance with the Disciplinary Policy and the Counter Fraud and Bribery Policy by the Local Counter Fraud Specialist (LCFS) and/or the Trust's HR or Finance Department in accordance with the Trust.

4.4.4 In cases where the allegation involves potential criminal misconduct at work then the matter will be referred to the police.

4.4.5 NHS Counter Fraud and Security Management Services have also produced a counter fraud and corruption manual which details procedures that all health bodies should follow to counter fraud & corruption within the NHS.

4.5 There may be instances where the employee admits there has been a case of misconduct or situations where the issue can be evidenced by collated documentation without enquiry into anyone other than the employee, this investigation may take the form of a fact-finding enquiry. In such cases, the line manager or other nominated manager will put together the evidence and send it to the employee without unreasonable delay, together with a letter setting out the specific allegations, inviting the employee to attend a formal meeting and confirming the right to be accompanied. In these instances, managers should refer to the Fair blame Process (see Appendix E) to assist with this process and seek advice from the Divisional HR Manager.

4.6 Where the allegations are more complex, a full investigation will be convened into the circumstances of the alleged misconduct, and an Investigating Officer will be appointed to carry out a formal investigation. The Head of Department or Divisional HR Manager can advise on who might be appropriate to carry out the investigation. The purpose of the investigation is to:

- Establish the nature of the allegations

- Gather evidence to enable a decision to be taken on whether there is a disciplinary case to answer

4.7 Once a manager is made aware of an incident, issue or formal complaint involving a member of their team, they should seek advice from their line manager and the Divisional HR Manager and proceed with informing the employee of the alleged misconduct without unreasonable delay. This is best done face to face; however, it is recognised that this may not always be possible and a telephone conversation may be necessary. The employee should be informed that an investigation will take place to establish the facts surrounding the allegation(s) and that this could lead to possible disciplinary action. In the event that the allegation(s) may amount to gross misconduct, the employee should be made aware that their employment may be at risk.

4.8 The Investigating Officer will outline the terms of reference for the investigation and will then gather all of the necessary documentation to assist the investigation, and will also interview the employee involved and any other person (witness) who may be relevant to the process.

4.9 An investigation should be concluded as soon as reasonably possible and within 28 days. There may be occasions where this timescale cannot be met and the Investigating Officer must inform the employee in writing of the reason for delay and inform the employee of the timescale for completion.

4.10 Investigatory interviews are part of the process to establish whether disciplinary action is warranted. As part of the investigation, the employee who is the subject of the allegation will be asked to attend an investigatory interview. The Investigating Officer should write to the employee inviting him/her to the investigatory meeting. The employee must inform the Investigating Officer of any facts or witnesses that he/she feels are relevant to the case.

4.11 Employees who are required to assist in the investigatory process (e.g. by preparing signed witness statements, attending investigatory meetings and disciplinary hearings as witnesses) must cooperate and should not unreasonably refuse to engage in this process. In some circumstances, the investigation may proceed based on the evidence available.

4.12 Evidence collated including witness statements and notes from their interviews/meetings will be used as part of the report. Witnesses may be required to attend a disciplinary hearing resulting from an investigation and should be informed of this.

4.13 The Investigating Officer may decide following consideration of the findings from the investigation that:

- There in no case to answer and therefore no disciplinary action will be taken but there may be recommendations identified for the employee and Trust.
- The matter should be dealt with informally with appropriate support and training. It may be appropriate to refer to the Capability and Performance Management Policy if the issue relates to performance.
- There is a case to answer where consideration will be given to the Fair blame Process or referral to a disciplinary hearing.

4.14 Allegations Against a Trade Union Representative

4.14.1 Where the allegations are made against a trade union representative no action, other than suspension if the allegation requires it, should be taken until the matter has been discussed with the Associate Director of Workforce and OD or the Head of Human Resources and the representative's full-time officer.

5. Resignation during an investigation or prior to a Disciplinary Hearing

5.1 If an employee resigns with/without notice from the Trust partway through a disciplinary process or prior to a disciplinary hearing, they will be advised that the investigation may continue to concluded even after they have left the organisation. If there is a case to answer the employee will be invited to attend a Disciplinary hearing, which may take place after the employee has left the organisation, and a sanction may be issued. Whilst the reason for leaving the organisation will remain as 'resignation during disciplinary proceedings', any disciplinary sanction will be recorded on the employee's personal file and future reference requests that the Trust may receive for the duration of the warning period.

5.2 Where the allegations are of a serious nature which may impact on the employee's suitability to work, a referral to the relevant external professional bodies may be made. Employees will be informed of this in writing.

5.3 In cases of gross misconduct, summary dismissal without notice pay will apply.

6. Disciplinary Hearing

6.1 Disciplinary Hearings will be heard by a two-member panel who have had no previous involvement in the case. The panel members should be an appropriate senior manager and a HR Representative. Where it is relevant to the case, a further member of the panel should participate from the same professional body. Where the panel are considering allegations of gross misconduct or where dismissal may be an outcome, the senior manager on the panel must have the authority to dismiss (see Appendix A).

6.2 In very exceptional circumstances the panel may invite a Senior Manager or Human Resources Representative from a partner organisation or another NHS Trust.

6.3 The Panel Chair will ensure the employee is invited to the disciplinary hearing and will be provided with sufficient notice. The employee will be provided with:

- The date, time and place of the hearing
- The specific allegations made (enclosing copies of any relevant statements, correspondence etc)
- The employees right to be accompanied
- Who will be present including the identity of any witnesses
- Possible outcomes of the hearing

- A request that the employee submits any relevant documents to the Disciplining Manager in advance of the hearing (this does not preclude later submission of information at the hearing) and names of any witnesses the employee wishes to call who will also be given sufficient notice of the hearing taking place.

6.4 It is the responsibility of the Investigating Officer to contact witnesses in support of the organisation and ensure that they are able to attend.

6.5 It is the responsibility of the employee to contact witnesses in support of their case and ensure that they are able to attend.

6.6 The Disciplinary panel will follow the procedure outlined in Appendix A.

6.7 Disciplinary hearings will be recorded with the employees' consent. If an employee refuses, the reasons for this be must explored. Where a hearing has been recorded, a copy of the minutes will be typed up and provided to the employee.

6.8 Any sanction issued at the Disciplinary Hearing will commence from the hearing date.

6.9 The outcome from the disciplinary hearing will detail the process undergone and the reasoning for the decision of the panel. It will also confirm the right of appeal and will be issued to the employee within 5 working days of the meeting.

7. <u>Sanctions</u>

7.1 The Disciplining Manager will consider all the representations made during the disciplinary hearing and then decide whether, on the balance of probabilities the allegation(s) are proved and if so, what level of disciplinary sanction, up to and including dismissal, is appropriate.

7.2 The Disciplining Manager may consider existing live warnings on the employee's file when considering the most appropriate sanction.

7.3 The panel hearing the case may also decide in conjunction with a warning:

- That no further action is necessary
- The imposition, extension or renewal of any formal warnings issued under this procedure;
- The temporary or permanent transfer of an employee to an alternative post/department within the Trust.
- That matters should be considered under an alternative procedure i.e. Capability and Performance Management Policy.
- Downgrading (no salary protection payable).
- Change of shift pattern (no salary protection available).
- Restrictions/termination of Bank work.

7.4 The above list is not exhaustive and the outcome may be varied according to the circumstances of the case.

7.5 Incremental increases will be withheld for the duration of any warning issued under the disciplinary procedure.

7.6 Incremental increases will also be withheld if on the due date the employee is subject to disciplinary proceedings. If no disciplinary action is subsequently taken, the increment will be awarded, backdated to the due date.

7.7 There are two levels of warning in the formal disciplinary procedure which can be given to an employee dependent upon the gravity of the case and/or the ongoing nature of the misconduct:

- Stage 1 – First Written Warning (will remain on file for 12 months)
- Stage 2 – Final Written Warning (will remain on file for 24 months)

7.8 Stage 1 – First Written Warning

7.8.1 This is usually given if there has been either a minor breach in conduct which remains unresolved by informal action, or a first more serious breach of conduct.

7.8.2 The First Written warning will set out the nature of the misconduct and advise the employee of the reason for the warning, including the period the warning will remain in force, the improvement of change in behaviour required and the consequences of any repetition or failure to improve.

7.8.3 A copy of the First Written Warning will usually be kept on the employee's personal file for a period of 12 months from the date of issue.

7.9 Stage 2 – Final Written Warning

7.9.1 A final Written Warning will be given in cases involving a serious breach of conduct that cannot be tolerated again, or where the employee's conduct continues to be unsatisfactory and they have a current First Written Warning on their personal file.

7.9.2 The Final Written warning will set out the nature of the misconduct and advise the employee of the reason for the warning, including the period the warning will remain in force, the improvement of change in behaviour required and that any repetition or failure to improve or modify their behaviour may lead to their dismissal.

7.9.3 A copy of the Final Written Warning will usually be kept on the employee's personal file for a period of 24 months from the date of issue.

8. Dismissal – with or without notice

8.1 Dismissal will not normally take place for a first breach of discipline, but where the allegations are upheld and are so serious as to constitute gross misconduct or negligence, summarily dismissal may be considered where dismissal would take effect immediately and the employee would not be entitled to notice pay.

8.2 Unless the employee is being dismissed for reasons of Gross Misconduct/Negligence, they should receive the appropriate pay in lieu of notice, payment for any outstanding annual leave and will not be expected to work their notice period.

9. Expired Warnings

9.1 Once the effective period of the warning is spent, all documentation relating to the disciplinary action, including any letters confirming the outcome will be retained on the employee's personal file for a period of no more than 6 years, but will be disregarded for the purposes of disciplinary processes after the expiry date of the warning.

10. Appeals Procedure

10.1 All employees have the right to appeal against any formal disciplinary action. The opportunity to appeal against a disciplinary decision is essential to natural justice. However, it is important to set out grounds under which an appeal will be heard.

10.2 To lodge an appeal the employee must write to the Associate Director of Workforce and OD confirming the grounds of their appeal, within ten working days of receipt of the written confirmation of the disciplinary decision. The appeal could be but not exhaustive to:

- new evidence has come to light that was not available at the disciplinary hearing;
- the sanction imposed was too severe or disproportionate to the misconduct;
- the procedure was not correctly followed.

10.3 The appeal hearing will be heard by a minimum two-member panel that have had no previous involvement in the case. The panel members should be an appropriate senior manager and an HR representative. As a minimum the appeal must be chaired by an Executive Director. In cases where there are professional specific issues the panel composition must contain a representative from the relevant professional area. The Appeal panel will follow the procedure outlined in Appendix G.

10.4 Appeal hearings will be recorded with the employees' consent. If an employee refuses, the reasons for this be must explored. Where a hearing has been recorded, a copy of the minutes will be typed up and provided to the employee.

10.5 The outcome from the appeal hearing will detail the process undergone and the reasoning for the decision of the panel and will be issued to the employee within 5 working days of the meeting.

11. Failure to Attend a Disciplinary Meeting/Hearing or Requesting a Postponement

11.1 An employee is able to make a request for postponement of the disciplinary meeting/hearing for the Trust to consider. If the employee is unable to attend the meeting/hearing, the reason(s) should be explored and it may be appropriate to arrange a new date. If the employee is unable to attend the rearranged meeting/hearing without good cause, the Trust reserves the right to proceed with process and will make a decision based on the information available.

11.2 Where the request for postponement is due to ill health, further advice may need to be sought from Occupational Health.

11.3 If an employee fails to attend a meeting/hearing convened under this procedure, the meeting/hearing will be adjourned to ascertain the reason for their absence. The meeting/hearing will be rearranged on one occasion and if the employee fails to attend without good cause, the Trust reserves the right to proceed with process and will make a decision based on the information available.

12. Some other Substantial Reason (SOSR) or Statutory Debarment

12.1 Dismissal procedures for these reasons will be dealt with in accordance with the Disciplinary Procedure except that dismissal may be the outcome without the employee going through any first or final warning process. In all cases, the organisation will ensure that a fair process has been followed in relation to identifying and investigating any allegations in line with the Disciplinary Policy. Example of potential reasons for dismissal under SOSR can be found in Appendix C.

13. Overlapping of Grievance and Disciplinary Cases

13.1 If a grievance is lodged relating to an on-going disciplinary matter, advice on the most appropriate course of action should be requested from the Divisional HR Manager.

13.2 A grievance related to a current matter will be addressed during the disciplinary process. Only in exceptional circumstances will an on-going disciplinary process be suspended on account of a grievance being submitted.

13.3 Where a separate grievance process is underway (i.e. a formal grievance has been submitted as per the Grievance and Disputes Policy) that does not impact upon the disciplinary processes the two processes shall be dealt with separately and in accordance with the respective policies and procedures.

14.0 Reference Documents and Bibliography

This procedure was developed in line with best practice and up to date research with reference to the sources of information listed below:

- Agenda for Change NHS Terms and Conditions of Service
- ACAS Code of Practice- Disciplinary and Grievance Procedures (March 2015)
- Employment Rights Act 1996
- Employment Relations Act 1999
- Equality Act 2010
- Disclosure and Barring Service (DBS) Duty to Refer
- Medical Staff Disciplinary Procedure - Maintaining High Professional Standards in the Modern NHS
- Professional Codes of Practice

Appendices

APPENDIX A

The authority to dismiss an employee (other than Executive Directors, where the authority to dismiss rests with the Chief Executive) rests with an appropriate senior manager at Band 8a or above. This authority is delegated by the Board to any member of staff in any of the above roles who has been seconded in from another employer. An employee may not, however, be dismissed by a manager to whom they are directly responsible.

Authority to dismiss the Chief Executive rests with the Trust Chair.

APPENDIX B

MISCONDUCT AND GROSS MISCONDUCT – EXAMPLES

The following is a list of examples of misconduct and gross misconduct, which may result in informal action or formal disciplinary action depending upon the circumstances. Each case is dependent on the circumstances and context, and may therefore be deemed more or less serious than outlined below.

This list is not exhaustive but is provided to give guidance.

Misconduct

- Unauthorised absence
- Poor timekeeping
- Minor breaches of contract, terms and conditions of employment
- Breach of confidentiality – disclosure or misuse of privileged information including either personal information about a patient or an employee. Serious instances of this could be gross misconduct.
- Participating without authority in other employment, trade or business or profession outside the Trust, which is prejudicial to the Trust.
- Abuse or misuse of any of the facilities or property of the Trust.
- Failure to carry out reasonable instructions given by management effectively and in a timely manner.
- Unacceptable conduct contrary to the NHS/Trust guidelines, policies or standards as communicated from time to time.
- Any conduct or performance likely to bring the Trust into disrepute.
- Inappropriate use, misuse or abuse of the Trust's IT systems.
- Any breach of directorate, department or HR policy, protocols or procedures.
- Posting or blogging on social networking sites such as 'Face book' and 'Twitter' anything that brings the Trust's reputation into disrepute, what an employee thinks about a Manager's decisions, or something that defames another staff member's character. Serious instances of this could be gross misconduct.
- Poor practice re use of smartcard/electronic system access rights.
- Smoking on site which contravenes the Trust's Smoking Policy
- Deliberate breach of health and safety (rules and procedures) protocols

Gross Misconduct

All of the above as determined by the seriousness of the offence could also be considered as Gross Misconduct.

Examples of offences, which would normally be regarded as gross misconduct and would be considered serious disciplinary offences, and which could result in summary dismissal, are:

- Failure (where necessary) to hold statutory registration
- Physical violence and assault
- Theft or Embezzlement or Fraud including any breach of Trust Standing Financial Instructions
- Racial or sexual abuse, harassment, bullying or mistreatment of staff or patients
- Discrimination, harassment or bullying of staff or patients on grounds of any of the protected characteristics (see the Equality and Diversity Policy)
- Serious breach of confidentiality (this applies to all breaches of confidentiality involving the release of patient and staff information without consent or proper cause)

- Abuse of position or release of information including either personal information about a patient or employee, which could harm the Trust's interests and image. This also includes information gleaned from any source including IT systems and resulting from abuse of privileged position.
- Gross insubordination, failure to obey clear reasonable instructions as issued by managers
- Deliberate malicious damage to Trust property.
- Gross carelessness or negligence, including any action or inaction, which threatens the health or safety of a patient, employee or member of the public.
- Deliberate and serious breach of health and safety (rules and procedures) protocols
- Being under the influence of a substance whilst at work or on Trust premises or acting in an official capacity.
- Taking, possessing or selling illegal drugs, or taking any drugs (except over-the-counter remedies) which have not been prescribed to you on medical grounds.
- Deliberate falsification of any records, including deliberate abuse of the flexible working hours system.
- Serious breach of security.
- Serious breach of conduct rules or any of the Trust's Employment Policies
- Negligence which causes serious financial loss, damage to property or injury to people.
- The intentional viewing or downloading of pornographic or other derogatory, defamatory, obscene or inappropriate material from internet or e-mail systems.
- Deliberately making a false or malicious disclosure or complaint
- Knowingly giving false information or deliberately omitting relevant information on a job application form or curriculum vitae or any other document or report.
- Conviction for a criminal offence which is related to your employment.
- Accepting or soliciting gifts or hospitality as an inducement to show favour.
- Serious breach of procurement policies.
- Serious action that may bringing the Trust into disrepute

APPENDIX C

Some Other Substantial Reason (SOSR)

The law contemplates that not all dismissals can be fitted into the categories of conduct, capability, statutory debarment, redundancy or retirement. Issues that fall outside these categories are known as Some Other Substantial Reason (SOSR).

The following is a list of examples where dismissal due to SOSR may be considered. non-exhaustive list of SOSRs. This list is not exhaustive but is provided to give guidance.

- Refusal to agree with a change in terms and conditions due to a re-organisation.
- A funder considers an employee to be unacceptable to work in a service they fund.
- Personality conflicts.
- Breach of contract or implied terms.
- Imprisonment or other frustration of contract.
- Breach of trust, confidence and good faith.
- Risk of disclosure of confidential information.

APPENDIX D SUSPENSION RISK ASSESSMENT

Suspension should only be considered when it is anticipated that an individual remaining in work may cause a risk to patient care, members of staff or the investigation. Temporary redeployment to an alternative role, restrictions on practice or increased supervision should be considered and, if appropriate, put in place for the duration of the investigation as an alternative.

This risk assessment tool is to be used prior to any decision being taken about whether to suspend/redeploy or amend the duties of an employee. It should be completed by an appropriate manager once they have established that an investigation is necessary. This should be done with advice from the Divisional HR Manager.

Date:	
Manager:	
HR Manager:	
Name of employee:	
Department/directorate:	
Issue/incident:	
Reported by:	
Evidence obtained prior to risk assessment:	

Risk analysis (see table below for grading)

Risks	Yes	No	Risk Likelihood (L)	Risk Consequence (C)	Score (L x C)
Risk of harm to patients/clients	☐	☐			
Risk of harm to employees	☐	☐			
Risk of harm to self	☐	☐			
Risk of harm to ROH	☐	☐			
Risk of continued fraud	☐	☐			
Risk to service provision	☐	☐			
Risk to investigation process	☐	☐			
Some other substantial reason	☐	☐			

Risk grading

	Likelihood (L)				
Consequence (C)	**1 – Rare**	**2 - Unlikely**	**3 - Possible**	**4 - Likely**	**5 – Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5
1 – 3 Low risk	**4 – 6 Moderate**	**8 – 12 High risk**	**15 – 25 Extreme risk**		

Actions to be taken to reduce risk

Risk	Mitigation action	New Risk Rating (following implementation of mitigation action)

Decision on outcomes following risk analysis

Risk options	Yes	No	Reason for risk option
No requirement to take action identified	☐	☐	
Manage the risk and allow the employee to remain within their role under close supervision	☐	☐	
Reduce the risk and limit duties and role under supervision within the same workplace	☐	☐	
Transfer the risk and redeploy the employee temporarily to alternative employment within the Organisation	☐	☐	
Avoid the risk and exclude the employee	☐	☐	

Signed: Name and Job Title:	Date:
Signed: Name of HR Manager:	Date:
DATE TO BE REVIEWED:	

Please ensure a copy of this form is retained on the investigation file.

APPENDIX E FAIR BLAME PROCESS

There may be instances where an employee admits there has been a case of misconduct. In these circumstances, in may be appropriate to consider the fair blame disciplinary process with the agreement of the employee. Managers must speak with the Divisional HR Manager before initiating this process.

Situations where fair blame may be appropriate: -

- Incidents regarded as 'misconduct' (rather than gross misconduct)
- The employee admits the allegation(s) in full and accepts responsibility for their actions
- The employee doesn't have a live Final Written Warning on file

The fair blame disciplinary process allows cases of misconduct, i.e. lateness, to be dealt with in a timely manner by the manager as there is no requirement for an Investigating Officer to be appointed.

A thorough examination of the facts will be required by the manager and the employee must provide a written statement to the manager addressing the allegations. The manager may also seek written statements from relevant witnesses, and gather any other relevant information.

A review of the issue/incident/allegation will take place in a meeting with the line manager and employee and a record must be made of the meeting. A written invitation to the meeting of fair blame must be sent – no witnesses will be necessary. The employee has the right to be accompanied by a work colleague or trade union representative.

The maximum sanction that will be given at a fair blame meeting is a Final Written Warning and additional sanctions which may be considered at all stages. If the employee accepts the sanction, the outcome of the meeting will be confirmed in writing within five days of the meeting with a copy remaining on their personal file. Written confirmation of their right to appeal will be provided.

HR will be present to support the fair blame meeting to discuss the outcome. Copies of all documents collated during the fair blame process must also be sent to HR.

The usual provisions on incremental progression apply where a sanction is awarded.

In the event that no agreement can be reached, the investigation will be progressed to a disciplinary hearing. In such cases, the sanction suggested within the fair blame process will not be referenced at a later date should the investigation result in a Disciplinary Hearing.

APPENDIX F PROCEDURE FOR DISCIPLINARY HEARINGS

In order to ensure consistency throughout the Trust, the following arrangements have been agreed with the trade unions through the TCC and must be followed for every disciplinary hearing.

It should be noted that the disciplinary hearing will be recorded for transcription with the agreement of the employee.

1. ARRANGEMENTS ON THE DAY

1.1 Each party shall be allocated a separate room for themselves and any witnesses they intend to call. If this is not possible each party will be contacted to ensure suitable alternative arrangements are in place.

1.2 The designated chair of the panel shall introduce all parties and go through the format for the hearing. Nothing in the policy prevents the panel from adjourning at any stage to clarify or amplify any statement or for example to seek advice on procedural issues. Adjournments can be requested by either side or by panel members. The length of the adjournment must be agreed with both parties and should be what is reasonable in the circumstances.

1.3 The management side shall open by presenting their case in the presence of the staff member and, where there is one, trade union representative/ companion. Witnesses may be called and questioned.

1.4 The staff member or trade union representative may then ask questions of the management side representative and witnesses.

1.5 The panel members may then have an opportunity to ask questions.

1.6 The management side may then re-examine the witnesses if necessary. The witnesses shall then withdraw but, if the panel feels it is necessary, they can be asked to wait.

1.7 The trade union representative or employee shall then present their case in the presence of the management side and may call witnesses and question them.

1.8 The management side may then question the employee against whom the allegations have been made and any witnesses.

1.9 The panel may then ask questions.

1.10 The trade union representative or employee may then clarify details or.re-examine witnesses, if necessary. The witnesses shall then withdraw; however, the panel can request them to be available if necessary

1.11 If the chair of the panel feels it is necessary to receive further information from either party, the chair of the panel can adjourn the hearing for this information to be presented to the hearing. This should be completed in a reasonable and agreed timescale to minimise delay.

1.12 The management side shall then be asked to sum up, followed by the trade union representative/ companion or employee.

1.13 No new information can be introduced at this stage of the hearing or requested by the panel.

1.14 The panel shall then adjourn to make a decision. If any points requiring clarification arise, BOTH sides must be recalled together, even if only one side is concerned.

1.15 Prior to a decision being reached, the chair of the panel will ask the employee whether they wish to receive the decision in writing or whether they wish both sides to be recalled to hear the decision. If the decision is made that both sides are to be recalled, this will take place within 5 working days. If the employee confirms that they shall be notified of the panel's decision in writing, this will be within 5 working days of the panel reaching a decision, which will include their right of appeal.

1.16 The decision must always be clearly set out including the reasons why this is felt appropriate. The panel must provide a written decision in all cases and that must be sent

to the employee, and trade union representative if agreed by the employee. The employee must also be notified of their right of appeal within 5 working days of the panel reaching its decision.

APPENDIX G PROCEDURE FOR APPEAL HEARINGS

In order to ensure consistency throughout the Trust, the following arrangements have been agreed with the trade unions through the TCC and must be followed for every disciplinary appeal.

Potential grounds of appeal could include that:

- new evidence has come to light that was not available at the disciplinary hearing;
- the sanction imposed was too severe or disproportionate to the misconduct;
- the procedure was not correctly followed.

1. PRE-HEARING

1.1 Before any disciplinary appeal commences, all the panel members and presenting officers MUST have copies of:

- the written allegation(s)
- the written record of the disciplinary hearing
- the written investigatory report and any management side case presented at the hearing
- the written employee's case presented at the hearing
- the appeal letter to the Director of Workforce and OD outlining the reasons for appeal
- the letter from the chair of the panel of the original hearing outlining the panel decision.

In addition, both the management side and trade union representative/ companion or employee need to make available to the panel any further information that they wish the panel to consider. If this is new information which was not available at the disciplinary hearing, the panel will need an explanation to why it was not presented at the disciplinary hearing.

The HR Department will forward the above documents to the panel, the management side, the employee and their trade union representative. At least 5 working days before the appeal. If this is not possible each party will be contacted to ensure suitable alternative arrangements are in place.

It should be noted that the appeal hearing will be recorded for transcription with the agreement of the employee.

2. ARRANGEMENTS ON THE DAY

2.1 Each party shall be allocated a separate room.

2.2 The designated chair of the appeal panel shall introduce all parties and go through the format for the hearing. Nothing in the policy prevents the appeal panel from adjourning at any stage to clarify or amplify any statement. The length of any adjournment must be agreed with both parties. Adjournments can be requested by either side or by appeal panel members.

2.3 The chair of the appeal panel will normally open by inviting the trade union representative or employee to present the basis of their appeal, outlining their reasons. Any witnesses for staff side who were present at the original disciplinary hearing may be called and questioned in relation to the grounds of appeal, or any witnesses that are considered as providing new evidence which had not come to light at the original disciplinary hearing.

2.4 The management side may then ask questions of the employee or trade union representative and any witnesses.

2.5 The appeal panel members may then have an opportunity to ask questions

2.6 The management side shall then respond to the basis of the appeal outlining the reasons the original disciplinary panel reached its conclusion in these areas. Any witnesses for management side who were present at the original disciplinary hearing may be called and questioned in relation to the grounds of the appeal.

2.7 The employee or trade union representative may then question the management side representatives and any witnesses

2.8 The appeal panel may then ask questions.

2.9 The employee or trade union representative shall then be asked to sum up, followed by the management side.

2.10 The appeal panel shall then adjourn to make a decision. If any points requiring clarification arise, BOTH sides must be recalled together, even if only one side is concerned.

2.11 Once a decision is reached, which is normally on the same day, both sides are recalled and informed together. If a decision cannot be reached immediately, both sides are recalled and informed they shall be notified in writing. This will be within five working days of the panel reaching a decision. This will be final decision and final part of the process.

2.12 The decision must always be clearly set out including the reasons why this is felt appropriate. The appeal panel must provide a written decision which is sent to the employee, or trade union representative

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Transitional Monitoring Approach – Self assessment against key lines of enquiry**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**7 April 2021**

EXECUTIVE SUMMARY:

As the risks from the coronavirus pandemic change, the CQC is evolving its approach to regulating.

The CQC is adapting and developing its methods by using a transitional approach to monitoring services (TMA). This focuses on safety, how effectively a service is led and how easily people can access the service.

It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so the CQC can continually monitor risk in a service
- using technology and local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where the CQC has concerns

After reviewing information that we have about an organisation's service, the CQC will have a conversation with a provider either online or by telephone. The CQC is keen to point out that this is not an inspection and services arew not rated following a call.

The call will help the CQC to decide whether it needs to take further regulatory action at this time, for example an inspection.

Attached is a self-assessment against the TMA key lines of enquiry, which demonstrates that by and large the Trust is compliant with requirements, with few gaps. This assessment included input from Executive colleagues where offered.

A short action plan is provided to show what work is planned to address the identified gaps.

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the self-assessment and action plan to address gaps.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*: The receiving body is asked to receive, consider and:		
Note and accept	**Approve the recommendation**	**Discuss**
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**X**	Environmental	**X**	Communications & Media	**X**
Business and market share	**X**	Legal & Policy	**X**	Patient Experience	**X**
Clinical	**X**	Equality and Diversity	**X**	Workforce	**X**
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Compliance with CQC regulatory framework

PREVIOUS CONSIDERATION:
Executive Team on 9 March 2021 and Quality & Safety Executive on 23 March 2021.

ROHTB (4/21) 011 (a)

CQC Transitional Monitoring Approach – Key Lines of Enquiry – 2021

SAFE

KEY LINE OF ENQUIRY	EXECUTIVE LEAD	RESPONSE
S1 – HOW DO SYSTEMS, PROCESSES AND PRACTICES KEEP PEOPLE SAFE AND SAFEGUARDED FROM ABUSE?		
1. What is the trust's process for COVID-19 testing for patients?	MD	The Trust's traditional cohort of patients are individuals undergoing planned surgery. For these individuals, a two week pre-operative isolation period is required for the patient and their household, with two PCR tests being undertaken during this period for the patient prior to attending for surgery. These individuals are placed on COVID protected wards. For other cohorts of patients transferring from elsewhere, evidence of a single test prior to admission is requested and the individuals are placed on COVID risk managed wards. Emergency patients accepted who may have not been tested prior to admission are placed on risk managed wards and a confirmatory test undertaken as soon as possible, with the aim of receiving a result within 24 hours. Patients on the COVID risk managed pathway are isolated until a negative swab is received. Patients developing symptoms after admission are isolated & tested and moved to a cohort area for COVID positive patients should they test positive for COVID.

2. Was there anything key from the findings of the infection prevention and control board assurance framework?	DN&CG	There were no major gaps identified, aside from evidence of cleaning audits, an issue which was addressed by the Head of Facilities. The IPC BAF has been considered at each public meeting of the Trust Board since it was introduced.
3. How have safeguarding arrangements changed over the COVID-19 pandemic?	DN&CG	Work has been undertaken to assess the risk of conducting virtual Outpatient appointments for known vulnerable patients. For these individuals, a face to face appointment has been arranged where possible. A standard operating procedure for the operation of virtual clinics is in draft and will be launched in April 2021 within the Trust. The Trust has supported the non-redeployment of the Safeguarding team staff to ensure the safeguarding of our patients and risk and concerns are acted upon. Trust has ensured priority is given to accessing Safeguarding training, with this being reinstated on a face to face basis for Level 3 from July 2020. This has been delivered in line with the social distancing restrictions. Additional sessions have been offered to help support staff to attend Level 3 training. The Safeguarding Lead and Named Nurse have attended key meetings via MSTeams the leads and operational groups with CCG and partner agencies for adults and children on a weekly, fortnightly and monthly meetings and reporting at both. Safeguarding nurse has supported ward areas and discharge sister to help ensure discharge for patients for complex care patients.

4. What are the themes and trends from recent safeguarding incidents and what action is being taken in response?	DN&CG	Themes identified are: • Increase in number of patients requiring Deprivation of Liberties (DoLs) request for authorisation • Domestic Abuse concerns being raised for current and historical patients and staff • Risks being identified by staff addressed by proactive intervention and support being offered and Early Help referrals • Mental Health concerns, suicidal thoughts due to isolation Action taken in response: • Increase in Deprivation of Liberty requests for authorisation with regard to patient trauma orthopaedic pathway and patients from UHB transfer pathways. To support this staff have been provided with training on increased observation, also practical sessions on Mental Capacity Act (MCA) and DoLs documentation to provide enhanced skills, competence and confidence in staff. Support offered directly to ward and depts by the Safeguarding team. • In line with national levels, there has been an increase in Domestic Abuse contacts. The staff have been provided Domestic Abuse and DASH tool training. Domestic Abuse policy implementation plan revisited. Audit undertaken with regard to standard of MCA assessments and DoLS request and documentation, with results presented to Trust Safeguarding Committee and action plan monitored. • Mental Health concerns disclosure in line with national and local increase. Further staff trained as Mental Health

		First Aiders to offer immediate support and signposting to patients and staff as required. Trust has supported the training for two 'train the trainer' for Children and Young People Mental Health First Aid training. • Trust Safeguarding intranet page updated with regard to Child Exploitation. • Staff have been encouraged to access training offered by the local Safeguarding Adults Board and Children's Partnership. • All levels of safeguarding training have been reviewed and updated in line with internal cases learning, external and learning themed reviews and serious case reviews both child and adults. • Safeguarding supervision sessions are being offered and supported for staff. Individual case discussions and escalation of concerns where appropriate to Clinical Commissioning Group Designated Safeguarding Team.
S2 – HOW ARE RISKS TO PEOPLE ASSESSED AND THEIR SAFETY MONITORED AND MANAGED, SO THEY ARE SUPPORTED TO STAY SAFE?		
1. Are there realistic and workable plans for managing staff and skill levels if the pandemic leads to shortfalls and emergencies?	ADW&OD	The Trust's daily Incident Management Team (IMT) received daily updates on staffing issues and concerns. Department level business continuity plans have been invoked where required and temporary staffing employed in areas where needed. Additional oversight of clinical staffing levels is provided by the site office, led by a silver command duty manager for the 24-hour period, supported by a gold command Executive on-call.
2. How is the trust performing against mandatory training targets?	CEO	The Trust's performance against mandatory training targets is poorer than desired at present. Staff are being strongly encouraged to undertake the training during this period of

		reduced activity, making use of online training packages where possible. Each Executive Director has a list of staff who are currently outstanding training and one to one conversations with staff around the plans to undertake training are occurring where required. The Staff Experience & OD and Quality & Safety Committee (both sub Board committees) are overseeing improvement plans on behalf of the Trust Board. Plans for recovery are also shared and monitored at Divisional Performance Meetings.
GAPS AND ACTIONS NEEDED		
Mandatory training		

EFFECTIVE

KEY LINE OF ENQUIRY	EXECUTIVE LEAD	RESPONSE
E4 – HOW DO STAFF, TEAMS AND SERVICES WORK TOGETHER WITHIN AND ACROSS ORGANISATIONS TO DELIVER EFFECTIVE CARE & TREATMENT?		
1. How is the trust working with partners in response to, during and rehabilitation from the crisis? Are there plans for ICP/STP phase 3 system working? What are the challenges and what oversight is in place to ensure that partnership/system working is effective?	CEO	The Trust has and continues to work closely with partner organisations in the Birmingham & Solihull system and during the pandemic has delivered pathways usually handled by other partners to allow due focus on the Covid cohort in ICUs. In the early part of the pandemic, the ROH took trauma fractured neck of femur cases from University Hospital Birmingham, retroperitoneal sarcoma cases and ambulatory trauma cases, all of which were subsequently repatriated as the crisis lessened over the summer 2020. In the second wave of the pandemic, the ROH offered mutual aid in the form of nursing staff, Allied Health Professionals (AHPs), consultant staff and anaesthetists to support the increasing burden in the ICUs of University Hospitals Birmingham NHSFT. As the only designated organisation for orthopaedic services as part of the system-wide restoration and recovery plans, the ROH will be critical to the restoration plans for elective services in the region. A key challenge attached to this will be the impact on the Trust's performance against constitutional standards and an increased level of patients who will have waited over 52 weeks which would be part of the new waiting list taken from the

		system. This has implications for the resource to undertake harm review on these patients which would need to be considered and addressed. The Trust continues to participate in the system communications as part of the ongoing strategic and tactical calls between organisations. The Trust is also working with the developing Integrated Care System to agree its contribution at the wider system level.
2. How is the trust assuring itself that there are protocols in place for how and in what circumstances multidisciplinary team meetings are held, and that they are effective? For example, specifically in relation to cancer services.	COO	MDT meetings and all associated cancer pathway support has continued throughout the pandemic and capacity to deliver these critical meetings has been maintained. This is monitored at a monthly Cancer Board meeting and any challenges discussed and actioned. This group feeds into the Trust's Quality and Safety Committee meeting where any issues /risks can be escalated. Some meetings are taking place virtually supported by the IT department on the most appropriate and effective digital platforms.

GAPS AND ACTIONS NEEDED
None

CARING

KEY LINE OF ENQUIRY	EXECUTIVE LEAD	RESPONSE
C1 – HOW DOES THE SERVICE ENSURE THAT PEOPLE ARE TREATED WITH KINDNESS, RESPECT AND COMPASSION AND THAT THEY ARE GIVEN EMOTIONAL SUPPORT WHEN NEEDED?		
1. How is the trust supporting and engaging with patients and their families/loved ones?	DN&CG	The Trust has paused its formal Patient Experience & Engagement Forums, however there has been much work and good evidence of patient engagement through the pandemic, including specific initiatives such as: ✓ Feedback on new website via Healthwatch (April 2020) ✓ Discussions with Patient Engagement & Experience Group around virtual consultations (June 2020) ✓ Outpatients collected feedback from patients about their experience and potential improvements (July 2020) ✓ Public asked to share a note of thanks which were included in staff wellbeing bags (July 2020) ✓ Digital participation in public Board meetings, Council of Governors & AGM (September/October 2020) ✓ Patients asked for feedback on the design and delivery of new Modular Theatre building ✓ Patient feedback canvassed around planned patient entertainment system ✓ Feedback surveys on orthotics, podiatry and physiotherapy ✓ Feedback collected from children & young people on design of new CYP OPD

		There are plans within the next few months to reinvigorate the formal patient engagement and experience strategies and the lessons learned from the pandemic will be built into these. See Appendix 1 for an infographic developed to summarise these plans. In September 2020, the Trust's Compalints & PALs department started the 'Letters for Loved Ones' service and since October 2020 the ROH for loved ones received and delivered over 200 letters from the friends and families to our patients. We have advertised ROH for the Loved Ones via Trust social media accounts on weekly basis (Instagram, Twitter and Facebook), on the ROH internet page and we are sending letters to our patients with their admission information. See Appendix 2.
2. How does the trust ensure itself that the care delivered is compassionate and upholds people's human rights? Can you give examples?	DN&CG	The Trust has in place a set of policies and procedures designed to ensure that the treatment upholds the basic principles of human rights, including a privacy and dignity policy and a set of robust safeguarding measures. DoLs/MCA assessment undertaken routinely and reasonable adjustments are being made where identified. In terms of specifics, for a Trust traditionally experiencing low mortality rates, a case by case approach was taken to end of life arrangements for those who may have contracted COVID and were being treated in the hospital. Where possible we facilitated end of life meetings between family members and their loved ones, taking specific care to ensure that there were safeguards in

		place to prevent infection transmission through the use of PPE for visitors. Complaints and compliments have been monitored closely during the pandemic aside from one complaint about end of life care of an individual, there has been good feedback about how patients have been treated during this difficult time. Key performance indicators of care have been routinely monitored and are included in the Quality report.
3. What are the themes and trends from recent complaints? What action are you taking in response?	DN&CG	A key theme raised through the complaints processes was that of appointment changes. This reflected the impact of the pandemic and the move away from face to face appointments to virtual consultations. The theme also reflected the need to postpone some patient appointments to accommodate new cohorts of patients received from elsewhere in the system as part of the wider response to the pandemic. Much work has been done to pursue an individualised approach to keeping in touch with patients whose appointments may have been rescheduled, so they feel informed of and engaged with the changes. This process is also detailed within a harm review summary prepared by the Associate Medical Director.
4. Does the trust provide suitable accurate information on infections, in a timely way, to people using services, their visitors and any person concerned with providing further support or nursing/medical care?	DN&CG	The public Trust Board agendas have included a routine slot for the discussion of IPCC matters which has included a section on outbreaks, nosocomial infections and risk assessment of the clinical areas.

		The Council of Governors has also been kept updated of the infection control situation in the hospital as part of regular informal briefings. Duty of Candour conversations have been held with patients who may have contracted COVID while in hospital as part of Root Cause Analyses undertaken for these cases. Visibility of infection levels has been provided through the daily Incident Management Team meetings involving the Executive Team and key deputies. The infection rates are also reported on the daily (x3) site reports prepared by the site office and silver command duty manager. The Infection Prevention and Control Team has been on duty throughout the pandemic and provided strong support to any site changes needed. The Trust's website has been updated to provide information for patients and visitors around the site configuration and expectations when in the hospital. Information is also provided at the entrances to the hospital around avoiding coming on site in the event that an individual is experiencing any of the potential symptoms of COVID.

GAPS AND ACTIONS NEEDED
None

ROHTB (4/21) 011 (a)

RESPONSIVE

KEY LINE OF ENQUIRY	EXECUTIVE LEAD	RESPONSE
R1 – DO SERVICES TAKE ACCOUNT OF THE PARTICULAR NEEDS AND CHOICES OF DIFFERENT PEOPLE?		
1. How has the trust ensured compliance with equality and human rights legal requirements for patients during the pandemic?	DN&CG	The Trust has in place a set of policies and procedures designed to ensure that the treatment upholds the basic principles of human rights, including a privacy and dignity policy and a set of robust safeguarding measures. New patient pathways undergo an equality impact assessment before commencing to ensure that there are no issues which could compromise the care of the patients from an equality perspective. These equality impact assessments are considered by an Executive Assurance Group and by the Trust's Quality & Safety Committee.
2. How are services delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances? This may include: • ensuring that each patient's information and communication needs are identified, recorded, flagged, shared and met • identifying and making other reasonable adjustments for disabled people • Where new protocols for admission are being used, how are these being communicated to staff and how are they reviewed to ensure they are non-discriminatory?	COO	As above. In addition to the EIA, a project charter is drawn up for each new service and the pathway implemented using a Quality Service Improvement and Redesign methodology to ensure it is implemented safely, robustly and all involved understand the expectations of the new pathway.

• Are datasets complete and timely, to underpin an understanding of and response to inequalities?		
R2 – CAN PEOPLE ACCESS CARE AND TREATMENT IN A TIMELY WAY?		
How is the trust managing ongoing access to services and restarting planned procedures and services in an inclusive way to reduce health inequalities and to ensure that high-risk patients/pathways are identified and prioritised appropriately, including re-instating services and handling backlogs of activity?	COO	All patients who have been deferred due to cessation of services have been added to a waiting list and will be reappointed in chronological order. Partial/waiting list booking is being implemented to highlight any capacity issues for review patients and a new electronic referral triage system is being implemented which will allow clinical priorities of patients to be clearly highlighted. All patients on an admitted pathway have a clinical priority assigned and these are reviewed weekly at the patient tracking list meeting. The Trust has a clear harm review process which provides a framework to support the delivery of safe and effective care, understanding any harm or potential harm for patients as a result of the pandemic and managing the patients awaiting treatment.
How is the trust developing digitally enabled care pathways in ways that increase inclusion?	DFP/COO	The Trust offers both telephone and video consultation media, and is aware that there will be digital poverty / inequalities across the region. Patients who are unable to access video consultations will be offered telephone consultations where appropriate. The use of virtual consultation media is being rolled out across the Trust, who are also working with external consultants to maximise this and its benefits. Other key projects underway or planned include:

		• Speech Recognition • Partial Booking Testing of the waiting list creation process will be undertaken week commencing 8 March. The project is still on track to go live the week commencing 22 March and detailed time lines have been shared with the team • DrDoctor/Synertec Patient led booking is the next step in this project but due to covering the operational role managing outpatients and prioritising partial booking go live this has not progressed further. • Access Able A representative from Access Able is attending the patient experience and engagement forum to demonstrate this resource. A go live date is planned for April 2021. • Electronic Referrals (RMS)

GAPS AND ACTIONS NEEDED
None.

WELL LED

KEY LINE OF ENQUIRY	EXECUTIVE LEAD	RESPONSE
W1 – IS THERE LEADERSHIP CAPACITY AND CAPABILITY TO DELIVER HIGH-QUALITY, SUSTAINABLE CARE?		
1. Has there been any impact on leadership capacity as a result of the COVID-19 crisis? Are there plans and mitigations in place should it be affected?	ADW&OD	• Sickness absence has been monitored closely throughout the pandemic with daily reports on absence per staff group being issued. • Where areas of risk were identified proactive mitigations were put in place. For instance, the Operations leadership team was adversely impacted by COVID-related absence, however business continuity plans were enacted ensure continuity of service, with temporary support being sought from other relevant areas of the Trust. • Rotation of key staff in the same area has been used to minimise social contact. This included members of the Executive Team at the start of the pandemic. • Activity levels have been lower than planned during the pandemic which has provided some relief from operational pressures.
2. Do leaders understand the challenges to quality and sustainability during this period, and can they identify the actions needed to address them?	Exec Team	• A robust process was undertaken for any service changes or new pathways implemented during the period, including Quality Impact Assessments and the application of a QSIR approach to ensure that changes were made in a safe and sustainable way. • The Chief Executive led several briefings to keep staff updated about the challenges that the Trust was facing,

		changes happening and actions being taken as the pandemic progressed. • Risks as a result of the pandemic have been clearly articulated in the Trust's risk registers and Board Assurance Framework. • The monthly Quality Report details incident numbers and themes.
3. Is there a named executive Board member responsible for tackling health inequalities?	DN&CG	• The Director of Nursing & Clinical Governance is the Board lead for inequalities.
4. Is there a named executive board member responsible for IPC?	DN&CG	• The Director of Nursing & Clinical Governance is also the Director of Infection Prevention & Control
5. How stable is board leadership?	Chair	• The Board has been stable at the Executive-level for many months now, with the last appointment being that of the Chief Operating Office in Summer 2019. • The Chairmanship of the Trust changed in January 2021, however the new Chair was the previous Vice Chair of the Trust and this has ensured continuity and continued stability. Two new Non Executives have joined the organisation since October 2020 and the two previous Associate Non Executives have also been successful in securing substantive Non Executive positions. • The Director of Finance remains on secondment from UHB as part of mutual system support arrangements.
W3 – IS THERE A CULTURE OF HIGH-QUALITY, SUSTAINABLE CARE?		
1. How are you protecting the health, safety and wellbeing of all staff?	ADW&OD	• There has been a considerable focus on health, wellbeing and safety of staff during the pandemic.

		• At no point has the Trust been in a position where there has been insufficient PPE or PPE has had to be reused. • Regular wellbeing catch up virtual meetings have been held with staff redeployed into positions across the system to help with operational pressures in partner organisations. • The Trust employs a Wellbeing Officer who has developed wellbeing and welcome packs for those returning from elsewhere. • Managers have held regular 'keeping in touch' conversations with those staff shielding. • A dedicated wellbeing space has been organised for staff to use when they need downtime from the pressures of the pandemic. • Managers are encouraged to hold regular wellbeing conversations with their staff. • Virtual staff walkabouts have been held, these being led by the Non Executives of the Staff Experience & OD Committee. • All staff have been awarded a wellbeing day to take in addition to their annual leave entitlement. • A dedicated wellbeing page is included on the Trust's intranet for staff to access a range of advice and resources. • The Freedom to Speak Up Guardian has continued to work throughout the pandemic, encouraging staff to speak up about matters of safety or concern. • The results of the staff survey show an improved against the indicators concerning Health & Wellbeing and safe environment.

		• The Trust's Schwartz Rounds have continued to operate during the pandemic the latest being 24 February where staff were encouraged to talk about their experience during the Covid pandemic. • Staff Covid risk assessments have been undertaken for all staff with those from vulnerable groups undergoing a higher level of risk assessment. This process is built into recruitment processes now.
2. How are you supporting staff to raise concerns? (FTSU)	DCA&CS	• The Freedom to Speak Up Guardian has continued to work throughout the pandemic, encouraging staff to speak up about matters of safety or concern. • The latest report to the Board on FTSU concerns was presented in March 2021. • A new model is being developed to implement a range of FTSU champions to widen the approach to FTSU and expand the offering to cover bulling and harassment concerns.
3. How do you make sure you comply with equality and human rights legal requirements for staff during the pandemic?	ADW&OD	• The Trust has established a number of staff networks which have provided a focus on ensuring that those staff from a protected characteristic, including ethnicity are protected, developed and treated with equality at work – MMEG and LQBT+. • The Trust celebrates and/or acknowledges the main festivals of those from faith and protected characteristics. • The Trust has a range of policies in place, designed to provide structure and procedures to ensure that staff are treated equally and according to legal requirements. • Staff Covid risk assessment shave been undertaken for all staff with those from vulnerable groups undergoing a

		higher level of risk assessment. This process is built into recruitment processes now.
4. Has there been any impact on the culture of the trust in response to the pandemic?	CEO	• More anonymous concerns have been raised with the FTSUG, particularly around the theme of bullying and harassment. It is anticipated that although not initially a positive change, this reflects a culture where staff are willing to speak up about concerns. • The initial stages of the response to the pandemic created some uncertainty among staff groups such as portering who were required to operate according to different processes. Work was undertaken to engage with teams such as this in the plans for change and a specific group of Project Support Officers worked closely with staff through the period. • Staff have been very receptive to the health and wellbeing offers.
5. How are you progressing your action plan to work towards board and senior staffing to at least match the overall ethnic group composition of the workforce or local community?	Chair & CEO	• We have improved the diversity of the Board with the addition of two new Non Executives from a BAME background and the Board is also attended by the Associate Director of Workforce & OD who is also from a BAME background. • The Trust has established a Multi Minority Ethnicity Group which is working well and is working through initiatives to ensure that the Trust is as inclusive as possible. • The Trust has been awarded as one of the Top 50 employer of choice for Inclusive Companies (October2020). • Work continues at a local level to identify talent and promote development among colleagues from a minority background.

		• Work has been undertaken by the FTSUG to understand challenges with recruitment of staff from a BAME background and a series of recommendations, including ensuring that recruitment panels are as diverse as possible are being progressed.
W4 – ARE THERE CLEAR RESPONSIBILITIES, ROLES AND SYSTEMS OF ACCOUNTABILITY TO SUPPORT GOOD GOVERNANCE AND MANAGEMENT		
1. Is there a systematic approach to ensuring that actions from National Patient Safety Alerts have been implemented?	DS&D	• A systematic approach to handling safety alerts coming into the organisation is in place, with these being routed through the Health & Safety Adviser who then channels these through to the appropriate Director for action and copies in the Executive Director with responsibility for health and Safety. These are then reported, for action and monitoring purposes, at the Drugs & Therapeutics Committee, Medical Devices Advisory Group or Health & Safety Group according to the nature of the alert and upward to the Trust Board through the Quality and Safety Committee. • A report summarising the process is being presented to the Quality & Safety Committee in March 2021.
2. How is the trust maintaining oversight, quality, and governance for sub-contracted services?	COO	• The Trust has few contracted services, these being orthotics and the managed service contract for theatres. Oversight of these services is through the Operations and financial teams who monitor performance against the Service Level Agreements in place. No issues have been raised to date.
W5 – ARE THERE CLEAR AND EFFECTIVE PROCESSES FOR MANAGING RISKS, ISSUES AND PERFORMANCE?		
1. How has risk management and governance changed as a result of COVID-19?	DCA&CS	• In the first wave of the pandemic, the Trust established a specific Covid risk register which featured key risks around the new pathways the Trust was hosting, infection control,

		patient experience and staff welfare. This temporarily replaced the Board oversight of the BAF but with increased frequency. The risks from the Covid risk register were reviewed towards the end of the first wave and migrated onto the BAF if they remained of sufficient severity or de-escalated onto local risk registers for monitoring. • The governance arrangements of the Trust were guided by the national mandated from NHS Improvement in their 'Reducing the Burden' letters. Non essential meetings were cancelled and Board Committee agendas, aside from the Quality & Safety Committee were streamlined, with assurance briefings taking the place of full meetings instead. • In April 2020, the Board was asked to approve a set of revised and temporary governance arrangements which were the reviewed in July 2020 when there was agreement to reset the arrangements. • The Board and its Committees continue to meet virtually and walkabouts are also undertaken by virtual means. • An audit of the operation of the quality groups has been undertaken and was presented to the Quality & Safety Executive, which showed that the majority of the key bodies had continued to meet throughout the pandemic. This was with the exception of the Patient Experience groups, the future direction of which is being reviewed. • The Council of Governors has continued to be engaged with the changes and Trust's response and formal business has been limited to appointment panels through the period.

		• The Trust presented the changes to the governance arrangements to the NHS Providers annual conference in October which received positive feedback.
2. How will the trust ensure that effective performance management processes are in place to manage and reduce backlogs of elective and cancer patients?	COO	• The Trust is working closely with system partners to agree a programme of restoration of recovery and has been identified to be the key partner to reducing the system's orthopaedic backlog. • The Trust's Chief Operating Officer is an active member of the Operational Delivery Group and daily tactical calls are joined with system partners to discuss and inform the system operational plans. • An internal programme board has being established to provide oversight of a range of workstreams covering pre-op, inpatient pathways, outpatients and workforce. • The Trust's harm review process continues to operate, reviewing all individuals whose treatment date has been delayed beyond 52 weeks and all cancer breaches as best practice. • The Executive Team receives a weekly activity assurance report which monitors key performance metrics, the Trust's waiting list and performance against the constitutional standards. The monthly Finance & Performance Committee also monitors operational performance with the Quality & Safety Committee monitoring any impact the arrangements may have on quality & outcomes. • Additional operational support has been sourced to support this refresh and recovery programme .

3. How has the trust followed up on issues, learning and actions following CQC's emergency support framework (ESF) call about infection prevention and control (IPC)?	DN&CG	• The Trust received a positive outcome from the discussion around the IPC arrangements, with no recommendations being raised of significance. • The Director of Nursing & Clinical Governance continues to keep the Trust Board sighted on any IPC concerns or developments, with a regular slot on the public Board agenda to update on outbreaks, PPE and present the NHS England IPC BAF assessment. • Monthly calls are in place with the CQC relationship manager for the ROH.
4. How is the trust progressing its review to ensure the completeness of patient ethnicity data by no later 31 December?	COO	• The Trust has a data quality group chaired by the Chief Operating Officer ensuring all aspects of data quality are continually monitored and compliance with national standards are delivered. Current process to ensure completeness of patient ethnicity data is progressing well.
W7 – ARE THE PEOPLE WHO USE SRVICES, THE PUBLIC, STAFF AND EXTERNAL PARTNERS ENGAGED AND INVOLVED TO SUPPORT HIGH QUALITY SUSTAINABLE SERVICES?		
1. How is the trust supporting patients and their loved ones/carers to give feedback? How is this feedback used for continuous improvement?	DN&CG	• The Trust has undertaken a number of patient engagement initiatives through the pandemic, which has helped shape the changes and service offerings, including: ✓ Feedback on new website via Healthwatch (April 2020) ✓ Discussions with Patient Engagement & Experience Group around virtual consultations (June 2020) ✓ Outpatients collected feedback from patients about their experience and potential improvements (July 2020) ✓ Public asked to share a note of thanks which were included in staff wellbeing bags (July 2020) ✓ Digital participation in public Board meetings, Council of Governors & AGM (September/October 2020)

		✓ Patients asked for feedback on the design and delivery of new Modular Theatre building ✓ Patient feedback canvassed around planned patient entertainment system ✓ Feedback surveys on orthotics, podiatry and physiotherapy ✓ Feedback collected from children & young people on design of new CYP OPD • A specific and ongoing piece of work will be undertaken around the value and perception of virtual appointments. • A review is planned around the form and function of the Trust's Patient Experience & Engagement Group and the Patient & Carers' Forum. • Complaints are monitored for key trends and investigations undertaken where there are serious concerns to identify lessons learned ad shape revised practices. • In September 2020, the Trust's Compalints & PALs department started the 'Letters for Loved Ones' service and since October 2020 the ROH for loved ones received and delivered over 200 letters from the friends and families to our patients. We have advertised ROH for the Loved Ones via Trust social media accounts on weekly basis (Instagram, Twitter and Facebook), on the ROH internet page and we are sending letters to our patients with their admission information. See Appendix 2. • The Trust has facilitated conversations between patients and their relatives through the use of additional iPads on wards which can be used to FaceTime between individuals.

		• The Council of Governors remains a key body from which the voice of the patient and public is heard.
2. How is the trust working with partners in response to or during the COVID-19 crisis?	CEO	• The Trust is a key partner in the Birmingham and Solihull STP and ICS. • There are numerous for a in place for system wide discussions, such as daily strategic and tactical calls, the weekly Chief Executives and Chief Operating Officers meetings, meetings of the regional Medical Directors and ICS Strategy directors. • The Trust has contributed well to the system response over the course of the pandemic, initially taking fractured neck of femur trauma patients and the ambulatory trauma and rehabilitation orthopaedic patients in the second wave of the pandemic. • The system wide recovery and restoration plan is being developed, where the ROH will be a key partner in addressing the elective backlog. • The Trust has provided mutual aid in the form of consultant, anaesthetist and nursing staff to support operational pressures in ITU and UHB and has adjusted the Trust's theatre capacity and activity profile accordingly.
3. What community engagement is the trust carrying out to mitigate risks of COVID-19 for people in particular high-risk groups – such as different ethnic groups, people with long term conditions, older people and people in lower socio-economic groups?	DN&CG	• A health inequalities group is being established, this being led by the Director of Nursing & Clinical Governance, which will report to the Trust's Quality & Safety Committee. • A GP liaison manager is in place to progress discussions with primary care partners. • Any themes from feedback from the patient engagement activities set out in W7.1 that relate to inequalities are being

		picked up as part of the work of the internal project group looking at refresh and recovery. • Patient stories are being captured and reported to the Trust Board. The latest report included the impact of Covid on patients with hearing impairment where the Trust was able to demonstrate adaptations in terms of face masks and interpreting services.
W8 – ARE THERE ROBUST SYSTEMS AND PROCESSES FOR LEARNING, CONTINUOUS IMPROVEMENT AND INNOVATION?		
1. How does the trust assure itself that learning is shared and embedded?	DN&CG	• Trends in complaints and incidents are reviewed at Divisional Governance meetings. • A weekly Executive Quality Assurance meeting is held between the Director of Nursing & Clinical Governance, Medical Director and Chief Operating Officer to review, complaints, incidents and the progress of Root Cause Analyses (RCAs). • Lessons learned are captured in the Trust's monthly Quality Report which is scrutinised at Quality & Safety Committee and at Clinical Quality Group. • A new Quality & safety executive has been established to review deep dives into areas of concern and to provide upward assurance on operational issues to the Quality & Safety Committee. A more localised view is considered at Divisional Governance meetings. • Clinical audit processes are being strengthened under the leadership of the Medical Director through the use of the AQILA panel.
2. Are there any examples of learning in response to a crisis, and beyond, that you would like to share?	ALL	• The rigour to service change through adopting the QSIR model was key to ensuring that quality and safety were maintained throughout the delivery of pathways that were non-traditional for the Trust.

		• Use of daily IMT calls provided a useful and valuable forum for resolving issues and ensuring that all senior staff were informed of latest developments across the various portfolios. • Resilience of single points of failure needs attention for responsibilities such as PPE management and submission of daily returns. • The value of virtual technology for some appointments such as Outpatient follow up. • Keeping in touch with staff shielding or working remotely is necessary to ensure they retain that sense of belonging. • Visibility of senior managers is a tricky balance – too much can be seen as hampering efforts and too little suggests avoidance. • Approach to second wave recovery has been informed by a number of learning points identified in the restoration and recovery closure documents. These helped to shape the approach to recovery following the second wave.
3. Are there any examples of innovation?	ALL	• Virtual 'Coffee Catch Up' meetings. • Virtual walkabouts by individuals unable to come onto site. • Use of Project Support Officers to manage the changes on site needed and to secure the engagement of staff. • Small tokens pay dividends in terms of staff morale – celebration of St Valentine's Day with Love Hearts and the offer of a well being day. • Board scorecard to provide a snapshot between meetings of the key state of the Trust in terms of staffing, operations, finances, IPC and governance.

		• The Trust Model Hospital Club has driven a culture of continuous improvement by a multidisciplinary approach to reviewing the model hospital information and other national benchmarking reports – cited as 'excellent practice' by GIRFT.

GAPS AND ACTIONS NEEDED

Health inequalities
Formal patient experience forums
Integrated performance dashboard
Disparate IT systems

CQC TRANSITIONAL MONITORING APPROACH - ACTION PLAN TO ADDRESS GAPS IN ASSURANCE

Gap	Action Planned	Timescale	Accountable Lead
Mandatory training rates have not been sustained through the pandemic	• Each Executive Team member has a list of staff that are non-compliant with mandatory training requirements • An update is considered at each meeting of the Executive Team. The position is also scrutinised at Quality & Safety Committee and Staff Experience & OD Committee • Divisional performance reviews in March will discuss recovery trajectories in the key areas of the Trust	April 2021	Chief Executive
Implementation of a structure to oversee Health Inequalities work	• The Director of Nursing & Clinical Governance has been identified as the Board lead for Health Inequalities • A Trustwide group will be established in April covering health inequalities for staff and patients which will report to the Quality & Safety Committee and Staff Experience & OD Committee	April 2021	Director of Nursing & Clinical Governance
Meeting of the formal Patient Experience forums lapsed during the pandemic	• The operation of the Patient Experience & Engagement Group and Patient & Carer's Forum are being reviewed with a view to eliminating duplication of discussions and to provide a more strategic focus on the delivery of a patient experience strategy	June 2021	Director of Nursing & Clinical Governance

Gap	Action Planned	Timescale	Accountable Lead
	• There has been much good evidence of patient engagement throughout the pandemic, including the use of virtual 'Coffee Catch Up' sessions which will be rolled out to other specialities		
The Trust continues to operate with disparate IT systems	• A system wide piece of work around IT is underway, this being lead by Deloitte LLP. • A number of system upgrades at the ROH site have been implemented over recent months, including the roll out of Office 365 and the implementation of virtual consultation technology.	June 2021	Director of Finance & Performance
Establishment of an integrated performance dashboard	• Revised finance & operations performance pack to be available in Quarter 1 2021/22, with the quality element included in Quarter 2 which will provide an integrated view of performance against all key performance metrics for use by the Board & its committees	September 2021	Director of Finance & Performance

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual cycle of business and Board strategic work/development plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**7 April 2021**

EXECUTIVE SUMMARY:

The attached presents a schedule of business for the Board to consider at its meetings during 2021/22.

The schedule is drawn from a review of previous Board agendas, statutory items and best practice examples, namely those from the Healthy Board (NHS Leadership Academy) and FT Provider's guidance.

To create a strategic focus to the work of the Board and to identify Board development opportunities, Board members were asked to suggest a list of topics for discusssion for inclusion in the wider Board workplan. This is attached as the second appendix.

REPORT RECOMMENDATION:

The Board is asked to:

- APPROVE the cycle of business and strategic work & development plan

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

Well led element of the CQC assessment framework

Relate to a number of areas on the Board Assurance Framework

PREVIOUS CONSIDERATION:

3 March 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD REPORTING CYCLE 2021/22

	Q1	Q2	Q3	Q4
Standing Reports				
Chair and Chief Executive's Update	✓	✓	✓	✓
Patient/Service Improvement Story	✓	✓	✓	✓
Wellbeing update	✓	✓	✓	✓
Finance and Performance Overview	✓	✓	✓	✓
Quality Report	✓	✓	✓	✓
Workforce Overview	✓	✓	✓	✓
Meeting Effectiveness	✓	✓	✓	✓
Committee updates	✓	✓	✓	✓
Quarterly Report				
Progress with the delivery of the Strategy	✓	✓	✓	✓
Board Assurance Framework Update	✓	✓	✓	✓
Update from Council of Governor meetings	✓	✓	✓	✓
Learning from Deaths	✓	✓	✓	✓
CQC action plan	✓	✓	✓	✓
Diversity, Equality, Respect & Inclusion	✓	✓	✓	✓
Annual Reports				
Quality & Safety				
National Inpatient Survey Results and action plan		✓		
Annual Complaints Report	✓			
Infection Control Annual Report	✓			
Health and Safety Annual Report	✓			
Safeguarding		✓		
Safe Staffing Report	✓		✓	
Workforce				
Gender Pay Gap analysis	✓			
Freedom to Speak Up presentation				✓
Annual Statement of Compliance - medical staff revalidation & Appraisal		✓		
Finance, Strategy and Operations				
Operational Plan & budget sign off	✓			
Approval of Annual Report & Accounts 2020/21	✓			
Sign off annual external audit plan	✓			
Self assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)		✓		
Estates Strategy Review				✓
Carbon Reduction Strategy update	✓			
Fire safety annual report	✓			
Perfecting Pathways update	✓	✓	✓	✓
Corporate Governance & Compliance				
NHSI Annual Declarations 2020/21	✓			
2022/23 Board Workplan				✓
ToR and membership of Board Committees	✓			
Committee Annual Reports	✓			
Approve changes to SOs/SFIs			✓	
Well Led Assessment update	✓			
Freedom of Information Annual report		✓		
Declaration of compliance with CQC Fundamental Standards	✓			
Corporate Risk Register	✓		✓	

STRATEGIC BOARD WORKPLAN – 2021/22

TOPIC	LEAD	BOARD MEETING
• Diversity, equality, respect and inclusion • Provision of a health & mental wellbeing offering	CEO/ADW&OD ADW&OD	April 2021
• Strategic workforce plan - planning, redesign, talent management & succession planning • Inequalities strategy • Governance of joint pathways	ADW&OD DN&CG COO/MD	May 2021
• Implications of working in an ICS and how we prepare our staff • ROH People Plan • Carbon strategy	CEO/ADW&OD ADW&OD DS&D	June 2021
• Fit for purpose IT, infrastructure & digitisation for the future • Board walkabouts & engagement	DF&PM DCA&CS	July 2021
• Use of data & information • Quantifying and evidencing excellence, using quality outcome measures • Patient experience strategy	DF&PM MD DN&CG	September 2021
• Therapies strategy • Communications strategy, marketing strategy & branding • The role of the charitable corporate Trustee • Private patient strategy	COO DS&D DS&D COO	October 2021
• The current use and future strategy for robotics • Innovation & research at the ROH including collaborations • Progress with the clinical strategy	COO/MD DS&D MD	November 2021
• Risk appetite • BAF deep dive • Well led update • Update on changes to the Deprivation of Liberty Safeguards	DCA&CS	December 2021
• Theatre efficiency & productivity • Estates strategy	COO DS&D	January 2022
• Nursing strategy • Diversity, equality, respect and inclusion update	DN&CG ADW&OD	February 2022

TOPIC	LEAD	BOARD MEETING
• Progress against the strategic workforce plan • Board effectiveness review & stocktake	DP&OD DCA&CS	March 2022

KEY TO REPSOSNSIBLE LEADS:

Abbreviation	Role title
CEO	Chief Executive
DN&CG	Director of Nursing & Clinical Governance
DS&D	Director of Strategy & Delivery
COO	Chief Operating Officer
MD	Medical Director
DF&PM	Director of Finance & Performance Management
ADW&OD	Associate Director of Workforce & OD
DCA&CS	Director of CorporateAffairs & Company Secretary

Finance & Performance Committee – 30 March 2021

Present: **Richard Phillips, Gianjeet Hunjan, Ayodele Ajose, Les Williams, Steve Washbourne, Jo Williams, Amanda Gaston, Alex Gilder, Marie Raftery & Simon Grainger-Lloyd**

- The continued slimmed down agenda focussed on the main performance pack and a planning update for the coming year. Summary reports for restoration & recovery work and the 'Perfecting Pathways' Programme Board were received for information.
- The Trust was reported to have achieved an in month surplus of £700k, bringing the year to date position to £2.1m surplus. The reason for the overperformance against the plan was reported to be the lower level of non-pay expenditure as a result of the lower levels of activity being currently handled.
- The Cost Improvement Programme was outlined, which included some elements concerning efficiency, including procurement savings, a reduction in 'Did Not Attend' instances and the benefits as a result of the managed service contract.
- The cash position was noted to be strong.
- There was reported to remain uncertainty over the funding and the 'ask' in terms of refresh and recovery for the system.
- The activity position reflected the ongoing mutual aid to support the system. Ten theatres were currently being used however and the activity position was improving, including diagnostics and Outpatients.
- All redeployed anaesthetists would return to the ROH shortly which would allow an increase in the number of theatres that could be used to a maximum of 14 by the middle of April. It was highlighted that the national mandate to address the waiting lists did not align to the advice to allow staff time to rest and recuperate after an exceptionally busy time over the past few months.
- There was a low level of cancellations seen, with only one on the day being reported.
- Length of stay had increased as a result of the higher proprtion of complex cases being treated, with the number of arthroplasty patients being seen at present being low. The position had been further exacerbated by a patient who had a particularly ong length of stay.
- 'Did Not Attend' rates were improved, with a downward trend from January and options for virtual clinics were being explored.
- The position against the 18 weeks Referral to Treatment Time target had deteriorated to 59.7% and there were 142 patients waiting over 52 weeks for treatment. All of these who were Priority 2 and 3 had been scheduled for treatment and harm reviews had been undertaken which had not identified any adverse impact.
- The majority of cancer targets had been met, with the exception of the 62-day standard, where there had been a breach of two cases due to the complexity of these.
- The divert for the paediatric oncology service had been lifted and the plan to resume surgery on 19 April for these patients remained on track.

- The latest system plan options for 2021/22 were outlined, which proposed three possible scenarios.
- It was noted that the national planning guidance included an elective incentive scheme which would reimburse trusts at 100% of tariff for any overachievement of the targets.
- Tariff consultation was planned which would be issued in the second half of the year.
- The CQUIN scheme and best practice tariff would be reintroduced.
- The initial and final draft plans would be presented to the Finance & Performance Committee between April and June 2021.

ROHTB (4/21) 014

Staff Experience & OD Committee briefing – 31 March 2021

Present: **Simone Jordan, Richard Phillips, David Gourevitch, Jo Williams, Sharon Malhi & Simon Grainger-Lloyd**

- It was reported that Health & Wellbeing remained a priority both nationally and at the ROH and support was being given to managers to support the conversations that were needed with staff.
- Staff that were previously shielding were being encouraged to return to site and the approach and support for individuals was being determined by risk assessments, alongside the personal wishes of staff members.
- Some health and wellbeing metrics that could be used to demonstrate success were being discussed regionally.
- The outline plan for the implementation of a Wellbeing Guardian was discussed. This would be a Non Executive Director and the process for selection would be worked through with the Trust Chair. Appropriate infrastructure would need to be implemented to allow this role to function well. There were also plans to select 13-14 wellbeing champions across the Trust that would provide support to the work of this individual. The plans would be presented to the Trust Board.
- The Committee was pleased to learn that there had been an appointment to the role of Chair of the Multi Minority Ethnic Group (MMEG); this was to be Falon Paris-Caines.
- The Trust had participated in the regional LGBTQ+ event recently.
- The membership of Inclusive Companies was to be renewed. It was suggested that a guest speaker could be sought from Inclusive Companies or one of the higher ranking companies than the ROH who could facilitate a session at a future meeting of the Staff Experience & OD Committee.
- The latest version of the disciplinary policy was reviewed and it was noted that there had been a national mandate that this should be shared with the Trust Board in public. It was agreed that the numbers and themes of disciplinary cases, including those under the Maintaining High Professional Standards (MHPS) framework, should be shared with the Board and the Staff Experience & OD Committee.
- The latest results of the Staff Survey were discussed. The key areas of focus for the Trust were to be on morale, staff engagement, quality of care and safety (psychological wellbeing and bullying & harassment). Directorate level results were being reviewed and the Executive Team members had each met with the Head of Inclusion & OD to share the results for each of their respective areas. An organisational action plan would be developed and shared with the Staff Experience & OD Committee in May. Each Executive would be invited to the Staff Experience & OD Committee to present progress with their action plans.
- The workforce performance report was reviewed which highlighted areas of concern around: attendance, mandatory training and appraisal.

- The current mandatory training position was noted to be below the required position, however trajectories were in place to improve the performance and the Executives had good mechanisms for scrutinising and monitoring the position. All staff had been asked to regain compliance by 30 April 2021.
- It was agreed to be useful to see the workforce profile, which would inform planning and identification of risks.
- It was suggested that benchmark information was needed in the workforce report in future to demonstrate for instance, the Trust's position in terms of the ethnic mix of staff. This information could also be used by the new Inequalities Board.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 31 March 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The compliance with the post admission VTE risk assessment target was highlighted as continuing to be below expected best practice. It was reported that there was however, proactive work by the medical lead to improve this position and the Head of Nursing for Division 1 was undertaking a review to understand what additional action could be taken by nursing staff to contribute to an improved position. The Medical Director would also be leading a piece of work to ensure that there was a full investigation into all cases where there was non-compliance with this requirement. The Committee urged strong attention be given to improving this position. • There were reported to be ongoing challenges with the data quality of the Friends and Family Test (FFT) information and the feedback was being scaled down to mandatory elements only while the position was being investigated. • The national and local issues with the provision of pathology services were discussed. Work was underway with system partners to address the issue and agree actions needed going forward. • There had been a further reduction in the performance against the national Referral to Treatment target to 59.72% and the number of patients waiting in excess of 52 weeks had increased as a result of the ongoing cessation of elective activity. • It was reported that the Quality & Safety Executive (QSE) had reviewed a gap analysis against resuscitation standards. There remained a number of actions to complete before full compliance was achieved. A further update would be presented to the QSE at the next meeting. • The current mandatory training position was noted to be below the required position, however trajectories were in place to improve the	• The Executives were asked to think through how lessons learned and those lessons from previous incidents, complaints or claims which had not been embedded could be better highlighted and acted upon. It was also suggested that there was a need to use benchmarking information better. • An update on virtual appointments to be scheduled for a future meeting. • The Safeguarding Strategy to be presented to the Trust Board for final approval. • A presentation on the work of advanced practitioners in improving services and quality outcomes to be delivered at a future meeting.

performance and the Executives had good mechanisms for scrutinising and monitoring the position. • The risk around a shortage of the drug Propofol was discussed and assurance was given that alternatives were available if needed.	
POSITIVE ASSURANCES TO PROVIDE • The Board received a positive report from a Senior Sister who had led an 'Outstanding Care Every time' programme. This had been commissioned to look at Intention 4 of the nursing strategy, designed to ensure we deliver the Fundamentals of Care well. The work reviewed audits, incident trends, walkabouts feedback and care Key Performance Indicators to identify issues and improvements. It was hoped that the training package created would lend itself to accreditation. • The Learning from Deaths position was reviewed and it was highlighted that the Trust's review exceeded the national requirements. The higher than level of deaths reported was noted to reflect improved business intelligence capability in addition to an elevated level as a result of the more frail and complex cohort of patients treated during the pandemic. • An update on delivery of the clinical audit plan was received from the Head of Clinical Effectiveness. The report provided some good assurance that the audit process was embedded and there was good engagement across the organisation, with an increased number of audits and service evaluations having been recorded. There was also some good work within the National Orthopaedic Alliance on audit work. • An update on the COVID-19 outbreak on Ward 3 and Pharmacy was provided by the Head of Infection Prevention & Control. The Committee agreed that the action taken had been swift and robust. • The plans for the preparation of the Quality Account 2020/21 were outlined. The final report would be published in June 2021. Work was underway to identify Quality Priorities for 2021/22.	**DECISIONS MADE** • The Committee approved the amendments to the Safeguarding Group terms of reference.

• Although there was some delay, there was good progress towards achieving the Quality Standards for Imaging. There remained good consultant engagement. • There had been less radiation safety incidents reported which reflected to some degree the less activity handled during the past few months. Where there had been incidents, there was good assurance provided that the systems and processes to understand the reasons and to learn lessons in place. The work to implement a second MRI scanner was progressing well. • The Committee reviewed the clinical and operational risks on the extract of the Board Assurance Framework to ensure it was satisfied that the mitigations of those risks remaining at red status were adequate.	

Chair's comments on the effectiveness of the meeting: It was agreed that the discussions had been productive, however guests should be limited to a smaller number in future.

ROHTB (4/21) 016

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 10 March 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Regarding the Throne Project, there were reported to have been some delays with completing the work in bathrooms due to the impact of COVID-19, however the refresh and recovery work would provide opportunity to complete the works during the fallow periods of activity on the wards. It was anticipated that the works would be completed by summer. •	• The Trust Board to receive an update on the progress with the delivery of the Charity strategy in October 2021 and this would also include a session to refresh the Trustees of their statutory duties. • Present the proposed Charity branding at a future meeting. • Present an update on the contactless technology at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Tammy Foo was introduced as the new Fundraising Officer. Tammy would be focussing her initial efforts on engagement around corporate and community fundraising schemes. • The Committee considered the Charity governance improvement plan which has been supported by the Trust Board and it also agreed the proposal to amend the Scheme of Delegation around Charitable funds, to provide greater degree of flexibility for the Charity Manager to authorise low level spend. • The Charity strategy was considered and it was agreed that in terms of the projects that would fall under the strategy, there needed to be balanced approach between investment/effort and predicted yield of the schemes. Some large scale projects would also take some time to deliver the full benefits. • An overview of the work of the Charity team since October 2020 was presented by the Fundraising & Membership Officer. • There was reported to have been good engagement on social media and with the Charity's website, with a 38% increase in individuals accessing the latter. • The work with Nightingale Football Club was outlined, with the ROH Charity logo being featured on the players' kit and the team playing to raise funds for the NHS Charities Together.	• The Charity strategy was accepted, subject to any final comments received, such as those from Trustees not present and the final version would be circulated for virtual approval. • The Committee supported the purchase of the Charity database solution and it was agreed that the approval of the final contract terms and conditions would be delegated to the Trustees outside of the meeting. • The Trustees approved the bid for Electrocardiogram machines for the Admissions & Day Case Unit, which was funded by a legacy specific to this cause.

• It was reported that over £6000 had been raised in the Christmas appeal, this being the highest amount raised in a festive appeal to date. • It was reported that the hospital's wellbeing room would be named after Sir Cpt Tom Moore. • The plans for the summer ball were discussed. The date of the event was reported to have moved to 9 July 2021, which was within the week of the NHS birthday (5 July). • The Director of Finance reported that there had been an increase in the value of the funds and investments since the last meeting. • The Committee Chair advised that he had received an update on the work of the Dubrowsky laboratory and there had been good progress with identifying and arranging research trials. A research student was being appointed to support the work and there was a good link created with Aston University. • It was noted that there was work planned by the Charity during Scoliosis awareness week	

Chair's comments on the effectiveness of the meeting: It was noted that in line with other Board subcommittees in response to the COVID-19 pandemic, the meeting attendance had been scaled back. The meeting was quorate, given that three Trustees were present. It was noted that in future an actions and decisions log would be presented at each meeting in line with practice at other Board subcommittees. This would help track delivery of actions raised at the meetings and keep a log of decisions taken in relation to bid presented for Trustee approval

QUALITY REPORT MARCH 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	*MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY*
6 x Moderate Harms reported. • *1 x C. difficile infection reported – currently under a post Infection review investigation* • *1 x fall with harm (dislocation) - Root Cause Analysis (RCA) and duty of candour are both underway.* • *1 x post discharge VTE reported - Root Cause Analysis (RCA) and duty of candour are both underway.* • *1 x patient was lost to physio follow up (harm to be confirmed) Root Cause Analysis (RCA) and duty of candour are both underway.* • *2 x incidents in relation to Covid-19 outbreaks - 1 x staff outbreak(Pharmacy) and 1 x patient (ward 3/12). All incidents are under review. The Covid-19 outbreaks are recorded as Serious Incidents as agreement with Public Health England.* ***Friends and Family Data issues.*** *There appears to be a disparity between data collection and the results published. There is a plan to scale down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. The graphs within the quality report have been broken down by mandatory and non mandatory areas to allow the Trust to focus on the mandatory areas.* ***Continued poor compliance with mandatory 24-hour re-assessment.*** *This continues to monitored monthly and escalated to Medical Director and Consultants identified as responsible for Junior Doctor supervision. Medical Lead is undertaking a piece of work to look at data in more detail and addressing directly with individuals.*	***Trust Post infection Review process for infections*** *The process is under review to support Governance oversight of themes and learning.* ***Learning from deaths reviews on 17 post ROH deaths recorded.*** *17 deaths were reported on the Ulysses system in February 2021 as part of a process to review the deaths occurring within 30 days of patients being discharged from the ROH. All of these deaths occurred out of hospital in the last 12 months and will be reviewed within the Trusts learning from deaths process. This process will be ongoing and further incidents will be recorded each month.*

Outstanding CAS alert *– Food Safety – food allergy policy has been signed off which will allow the alert to be closed*	
POSITIVE ASSURANCES TO PROVIDE **Reduction in falls incidents reported.** *There has been a reduction in the number of falls incidents reported in Month (February 2021).* **The Trust has seen an increase in pressure ulcer related incidents.** *These incidents are in relation to patients transferred to ROH from UHB. The Tissue Viability lead has noted a positive that at the ROH deterioration did not occur in these pressure ulcers.* **Complaints have significantly reduced in the year.** *The SPC chart within this report shows a downward trend.* **WHO – 100% Compliance rate**	**DECISIONS MADE** **None**

Quality Report March 2021 (February 2021 Data) – Front Cover and Dashboard

	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	2020/2021	2019/2020 YTD
Incidents	247	225	260	399	361	323	346	284	274	270	297(↑)		
Serious Incidents	0	0	0	1	0	1	2	1	2	1	2(↑)	10	7(Total)
Internal RCA investigations	4	2	2	1	2	2	6	3	2	3	4(↑)		
VTEs (Avoidable)	0	0	1	0	0	0	0	0	0	0	1(↑)	1	3 (Avoidable)
Falls	6	5	4	2	5	9	12	6	6	10	6(↓)	71	100(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	2	0	0	1	2	2	0	0	1	2(↑)	10	7(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	1(Avoidable)
Complaints	4	5	1	5	7	6	7	3	3	7	3(↓)	51	132(Total)
PALS	13	38	39	65	95	76	95	63	62	41	35(↓)		
Compliments	3	11	9	9	6	15	4	12	6	5	5		
FFT Score %	NA	NA	97.9	98.7	92.9	95.3	95.3	93	95.1	90.5	89.8(↓)		
FFT Response %	NA	NA	41	52	23	12	65.5	47.3	36.5	32	25(↓)		
Duty of Candour	17	20	15	10	8	10	10	12	11	14	14		
Litigation	0	0	0	0	0	0	0	0	0	0	0		
Coroners	0	0	0	1	0	0	0	0	0	0	0		
WHO %	100	100	100	100	100	100	100	100	100	100	100		
Infections	1	0	0	1	0	0	0	0	0	0	1(↑)	3	4 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

March 2021 (February 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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10	Duty of Candour
11	Litigation and Coroners Inquests
12	WHO Surgical Safety Checklist
13	Infection Prevention Control + Covid update
14	Safeguarding
15	Outpatient efficiency
16	Treatment targets
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1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

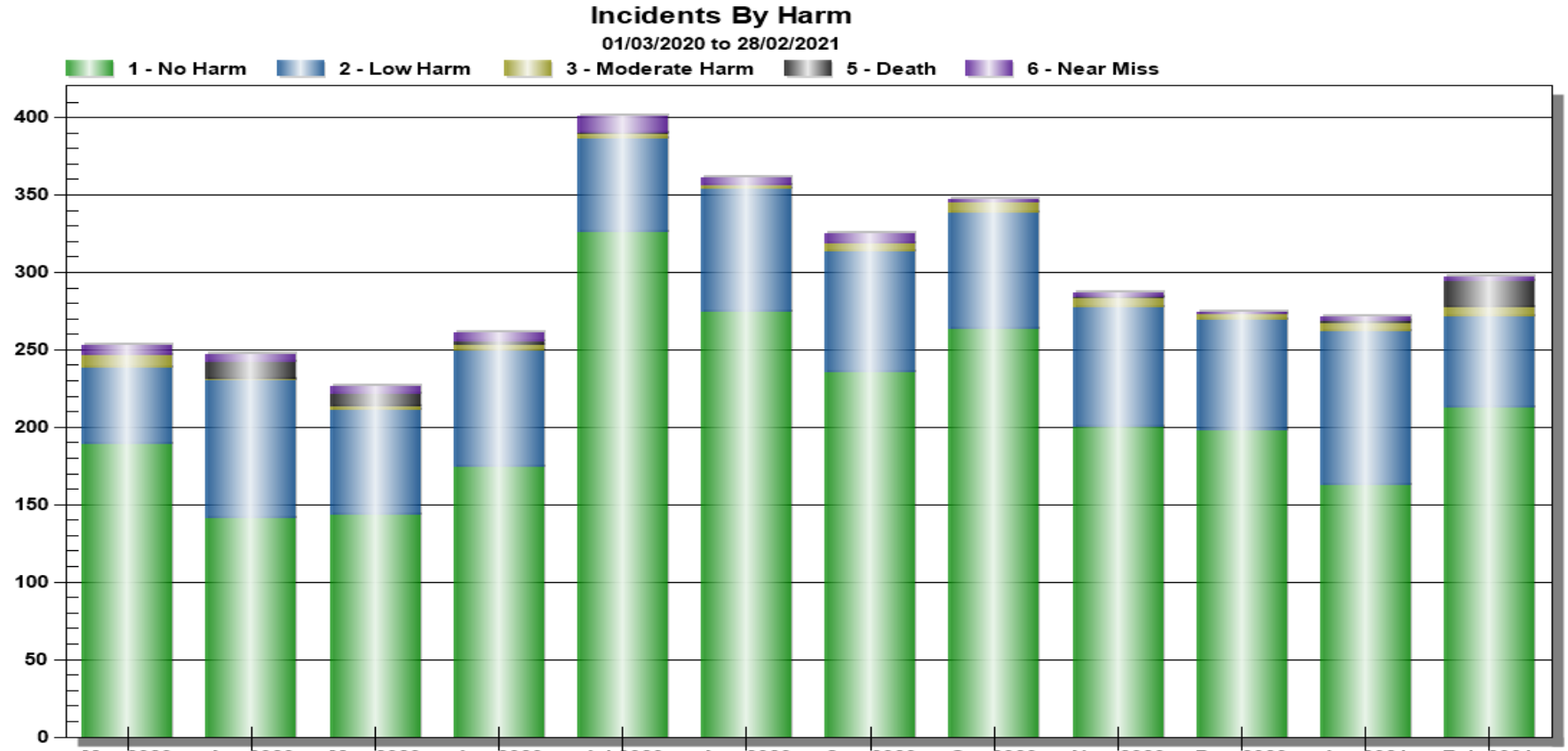
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55641)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021
1 - No Harm	189	141	143	174	326	274	235	263	200	198	162	212
2 - Low Harm	49	89	68	75	60	80	78	75	77	71	100	59
3 - Moderate Harm	8	1	2	4	3	2	5	7	6	4	5	6
5 - Death	0	11	8	2	1	0	0	0	1	0	1	17
6 - Near Miss	7	5	5	6	11	5	7	2	3	1	3	3

Data source – Ulysses

INFORMATION

In February 2021, there were a total of 297 Incidents reported on the Ulysses incident management system. The 17* deaths were reported on the Ulysses system as part of a new process to review the deaths occurring within 30 days of patients being discharged from the ROH. All of these deaths occurred out of hospital in the last 12 months and will be reviewed within the learning from deaths process.

The breakdown of those incidents is as follows;

212 – No Harm
59 - Low Harm
6 - Moderate Harms
0 - Severe Harm
3 – Near Miss
17* – Death

Downgraded Incidents

Currently 0 of the reported harm in the Previous Quality report (February 2021) have been downgraded.

Patient Contacts

In February 2021, there were a total of 3301 patient contacts. There were 297 incidents reported, which amounts to 8.9 per cent of the total patient contacts. Of those 297 reported incidents, 92 incidents resulted in harm which is 2.8 per cent of the total patient contact.

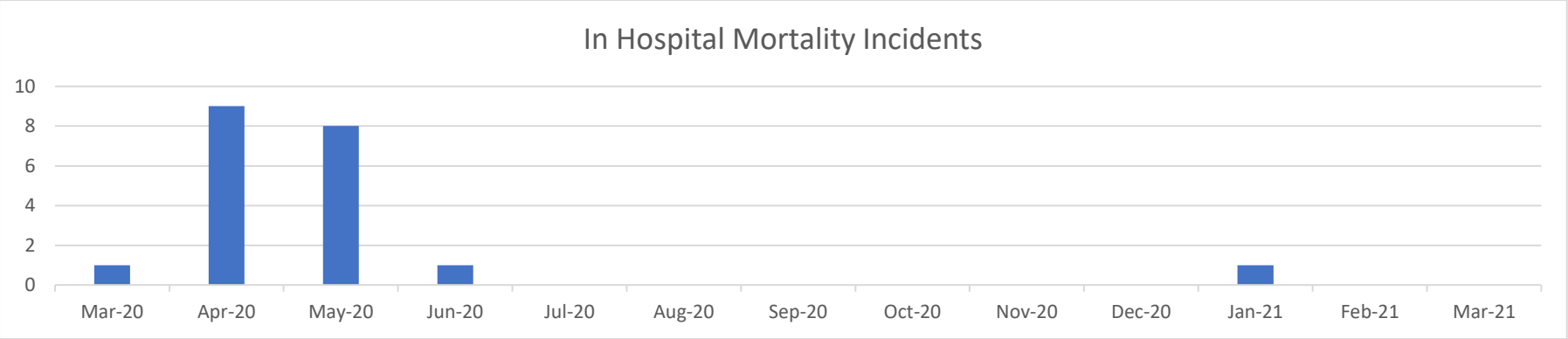
ACTIONS FOR IMPROVEMENTS / LEARNING

The Governance team are currently supporting the IPC team in improving the Trusts PIR process for the Trust to ensure it remains consistent and the learning from these reviews can be shared and managed within the divisions. This will include a review of the outbreak investigations process.

The Head of Clinical governance has produced a report on the safety record of the Trust for the last 5 years as part of the CQC key Lines of Enquiry review. This will be on the agenda for Quality and Safety Committee.

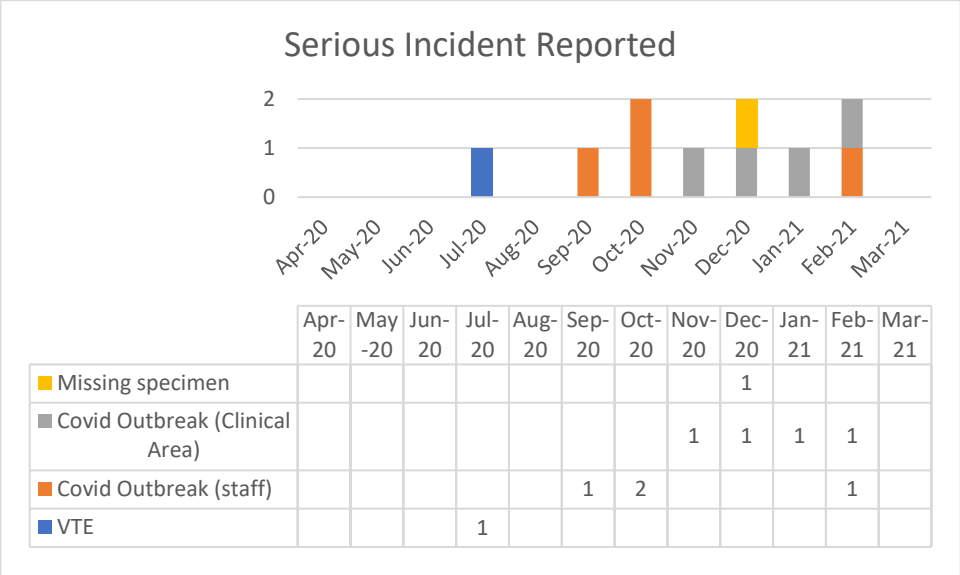
RISKS / ISSUES
None

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
There was 0 In-hospital death reported in February 2021 – As mentioned on the incident page, 17* deaths were reported on the Ulysses system as part of a new process to review the deaths occurring within 30 days of patients being disgorged from the ROH. All of these deaths occurred out of hospital in the last 12 months and will be reviewed within the learning from deaths process with oversight from the Executive Medical Director.
ACTIONS FOR IMPROVEMENTS / LEARNING
A new improved process is in place to review deaths within 30 days of ROH discharge from impatient services. This new process now includes an incident for each reported death. An increase in the reported deaths will be noticed in the next quality report data due to this. All deaths are currently going through the learning from deaths process.
RISKS / ISSUES
The data reported for the deaths occurring within 30 days is not always reliable due to a delay with the national system. This may cause a delay in the learning from deaths process. The Governance team is working with the Trust informatics team to improve the timeliness and accuracy of this data.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



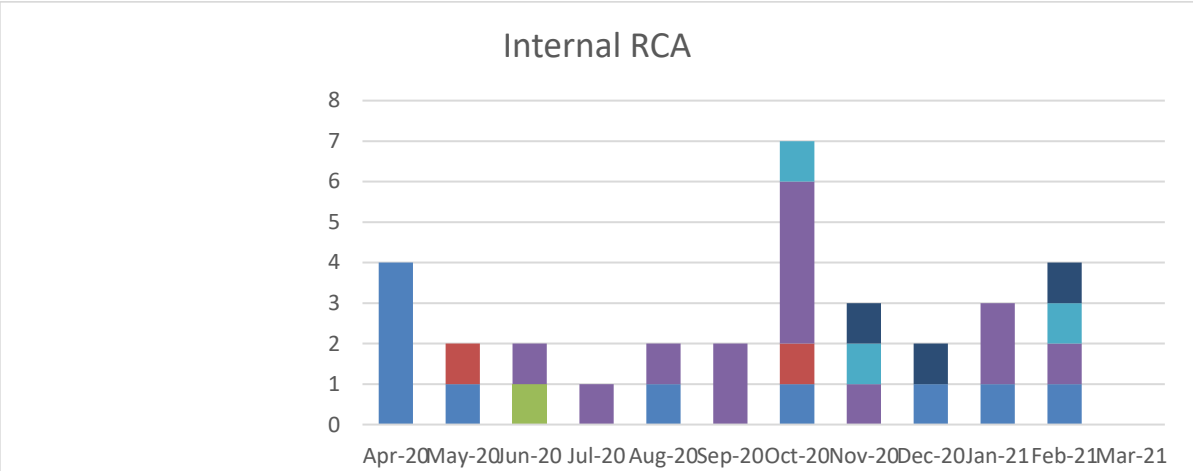
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Missing specimen									1			
Covid Outbreak (Clinical Area)								1	1	1	1	
Covid Outbreak (staff)						1	2				1	
VTE				1								

Year Totals	
19/20	7
20/21	10

Data Source – STEIS

INFORMATION
There were two Serious incidents reported in February 2021. These were both Outbreak of Covid-19 within Ward 3/12 and a staff outbreak in pharmacy. The Incidents was declared as an outbreak to Public Health England and under investigation within the divisions.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in February 2021. The Governance team have chased the CCG for closure of the Serious Incidents but have been informed that due to the increase of incidents reported during the pandemic there is a delay within the sign off process at the CCG. It has been confirmed these have been closed in March 2021 and will be included in the next quality report.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**

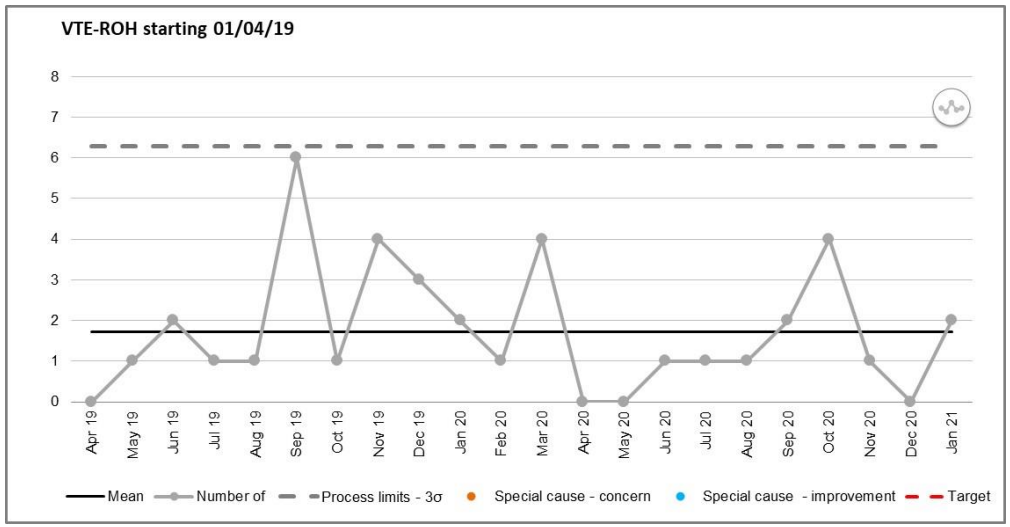


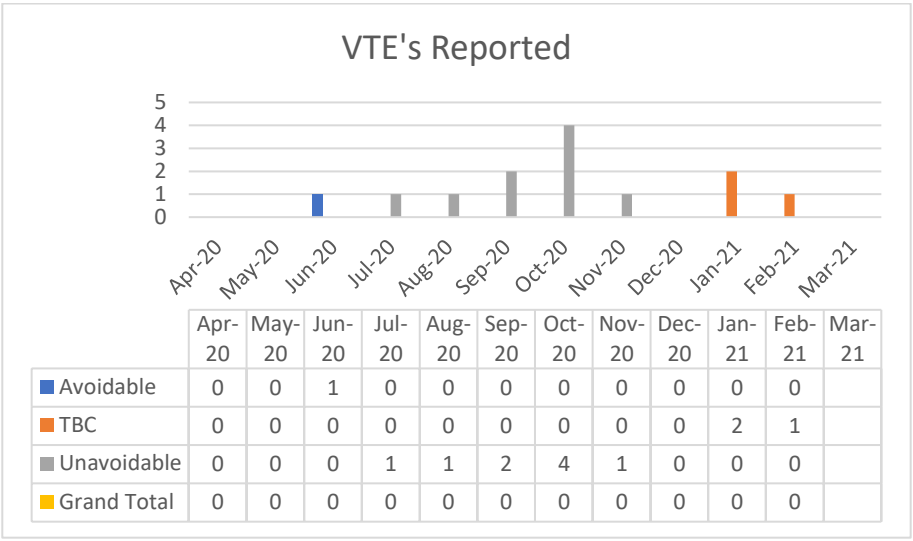
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Falls								1	1		1	
Physio Discharge Process Issue							1	1			1	
VTE			1	1	1	2	4	1		2	1	
Delay/Failure To Monitor			1									
Clinical Care		1					1					
Infection	4	1			1		1		1	1	1	

Data Source – Internal RCA tracker

INFORMATION
Three internal RCAs are currently underway within the divisions. This are also detailed on the incident page. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.
ACTIONS FOR IMPROVEMENTS / LEARNING
3 Internal RCAs were closed in February 2021 – 2 of these were unavoidable VTEs with no learning highlighted.
RISKS / ISSUES
None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Avoidable	0	0	1	0	0	0	0	0	0	0	0	
TBC	0	0	0	0	0	0	0	0	0	2	1	
Unavoidable	0	0	0	1	1	2	4	1	0	0	0	
Grand Total	0	0	0	0	0	0	0	0	0	0	0	

Avoidable Year Totals		Total including unavoidable
19/20	3	26
20/21	1	13

Data Source – Ulysses and VTE leads

INFORMATION

1 x ROH associated VTEs were reported in February 2021 and have been escalated to RCA as per Trust Governance process. Duty of Candour has been undertaken with the patients. The SPC chart on the previous page shows that reporting of VTEs is within the recognised threshold at the ROH.

24-hour reassessment:

4hr review	282
missed 24hr review	156
total	438
24hr %	64.38356

On admission assessment

total possible	462
total assessed	449
%	97.19%

ACTIONS FOR IMPROVEMENTS / LEARNING

Work to increase 24-hour risk assessment continues, data continues to be scrutinised and escalated. Medical VTE lead is being proactive in supporting compliance improvement

The patient safety matron is now reviewing the processes on PICS and there is a whole team approach to this challenge.

The ANP for Arthroplasty is taking the themed review that had been previously presented to the Quality and Safety Committee to the MDT meeting to promote a discussion on the number of VTEs for Total Knee replacement surgery and any changes that can be made. A potential audit is to be scoped.

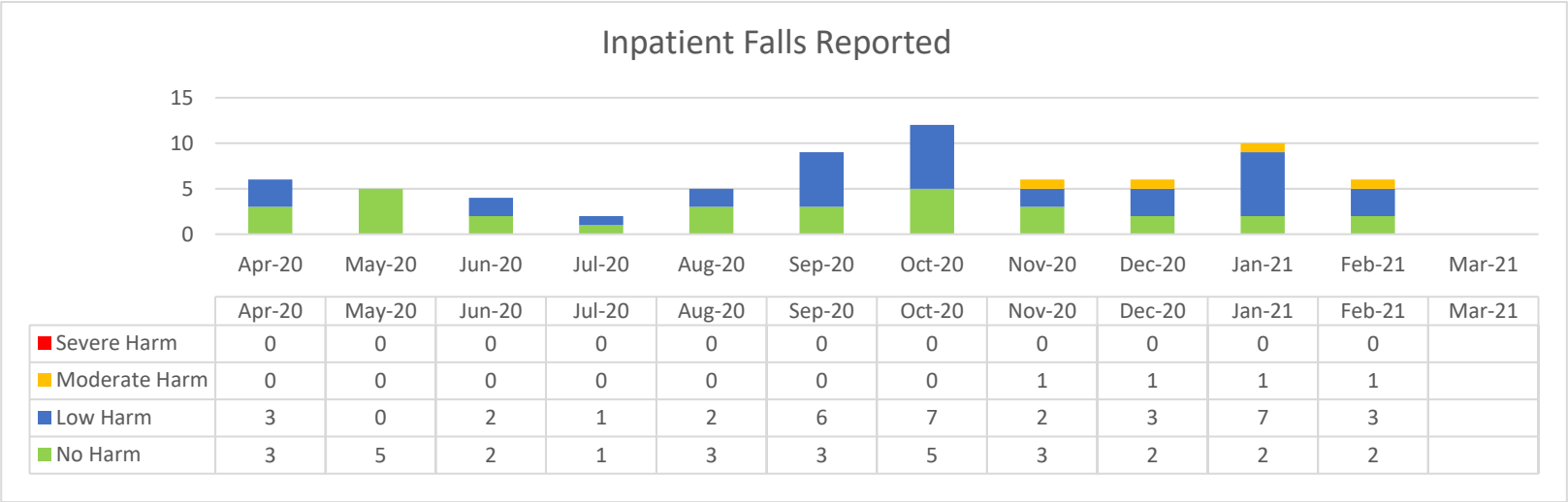
VTE awareness sessions continue to be delivered on all clinical update days for HCAs. New doctors receive a session delivered by Medical VTE Lead on induction.

PICS team cover VTE risk assessment requirements in all PICS training. Additional training to medical staff on the completion of the24 hour VTE risk assessment on PICS has been provided.

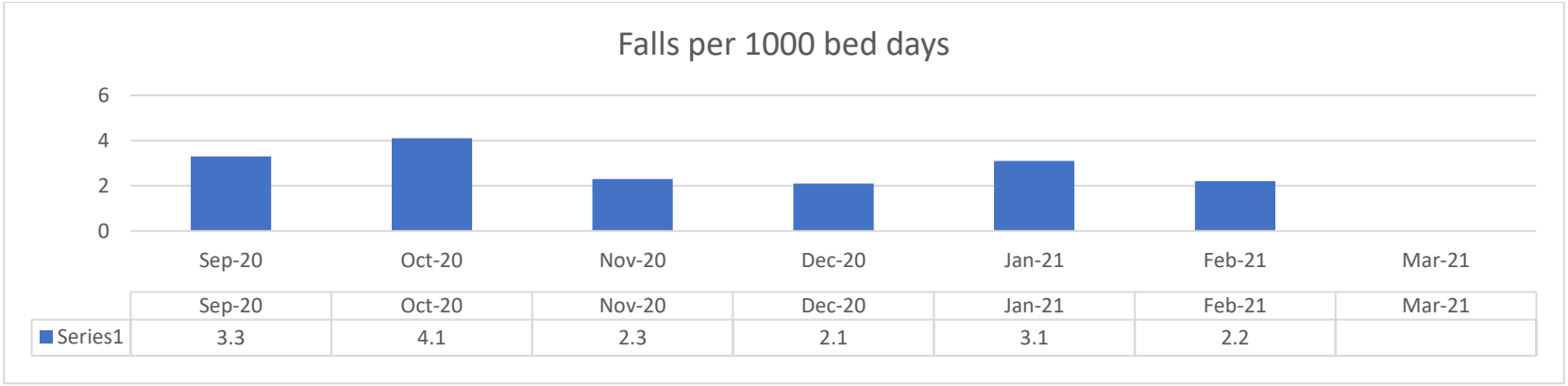
RISKS / ISSUES

Continued poor compliance with mandatory 24-hour re-assessment. This continues to monitored monthly and escalated to Medical Director and Consultants identified as responsible for Junior Doctor supervision. Medical Lead is undertaking a piece of work to look at data in more detail and addressing directly with individuals.

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

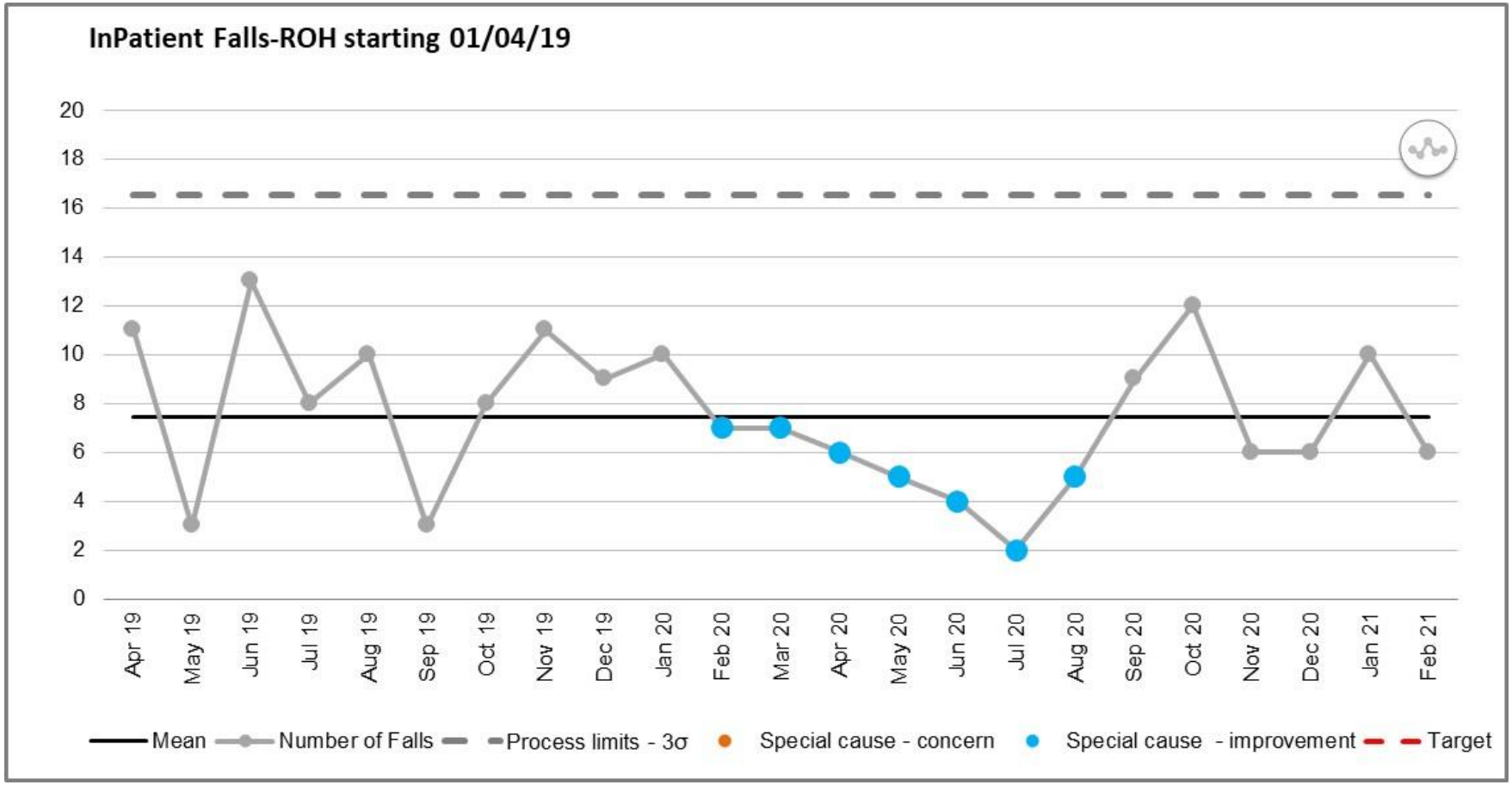


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	
Moderate Harm	0	0	0	0	0	0	0	1	1	1	1	
Low Harm	3	0	2	1	2	6	7	2	3	7	3	
No Harm	3	5	2	1	3	3	5	3	2	2	2	



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Series1	3.3	4.1	2.3	2.1	3.1	2.2	

Year Totals	
19/20	100
20/21	71



Data Source – Ulysses and Falls Group

INFORMATION

There were 8 incidents reported across the Trust in February 2021 relating to Falls, one involving a non-patient:

6 x In-Patient Falls Incidents

1 x Lowered to Floor Incident

1 x Non-Patient Incident

There remains a low number of falls in the last month. Shared learning has taken place across the wards around incident No. 34683, regarding the appropriate use of bedrails for confused patients and ensuring that 1:1 supervision when needed is maintained. This will be emphasised on falls awareness sessions at clinical skills training days. The outcome of an RCA into incident 34853 is awaited.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

- Continuing to look at patient engagement around Falls and how best we approach this, (currently on hold)
- Reviewed information on Falls notice boards, format complete, to be sent to printers
- Reviewing Welcome Pack issued to patients in Pre-op, as contains duplication of some information in both falls and bed rails leaflet
- Reviewing Slips, Trips and Falls Policy
- Reviewing data around falls incidents in the last year, to see if any themes can be identified

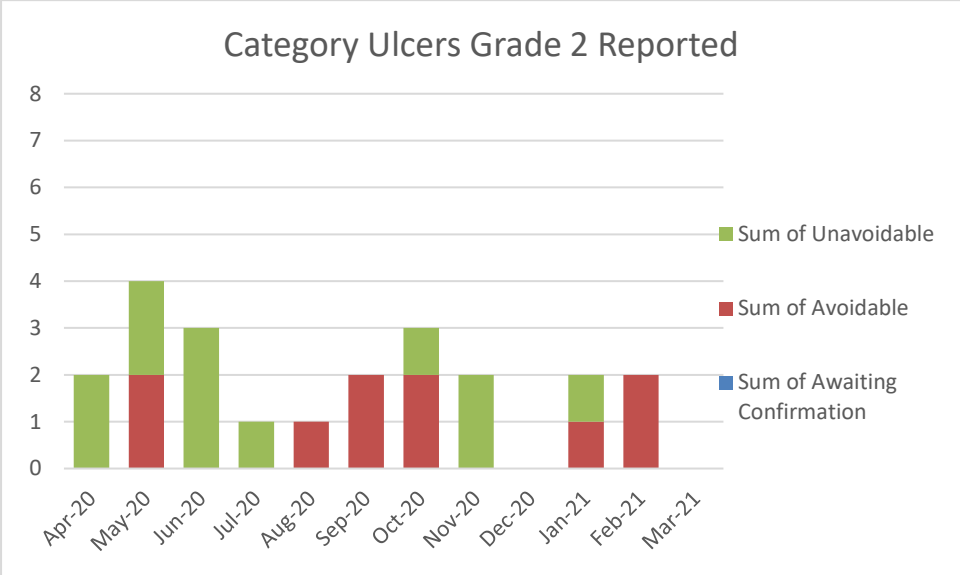
Positive Assurance

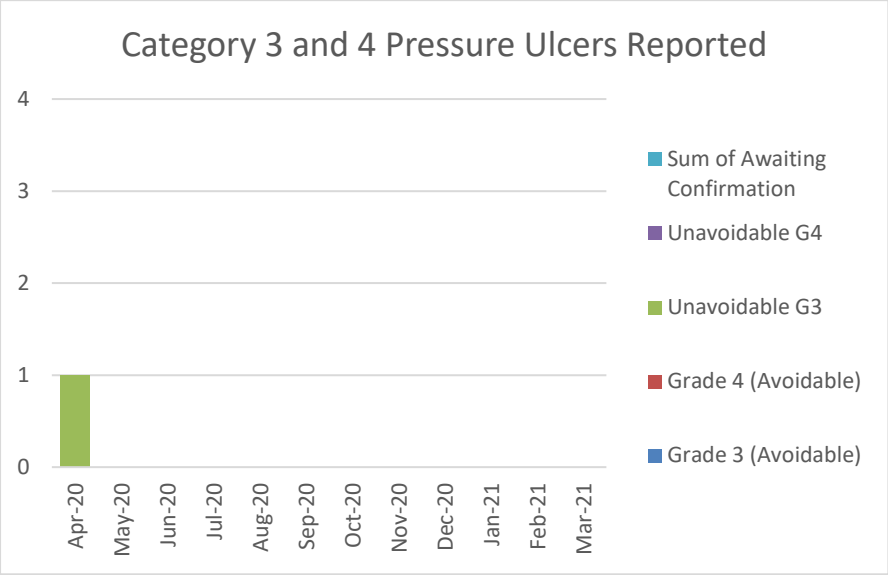
- Ongoing notable reduction in the number of falls reported in the last month
- Shared learning around use of bedrails and appropriate supervision of patients will be emphasised at falls awareness sessions on clinical skills days

RISKS / ISSUES

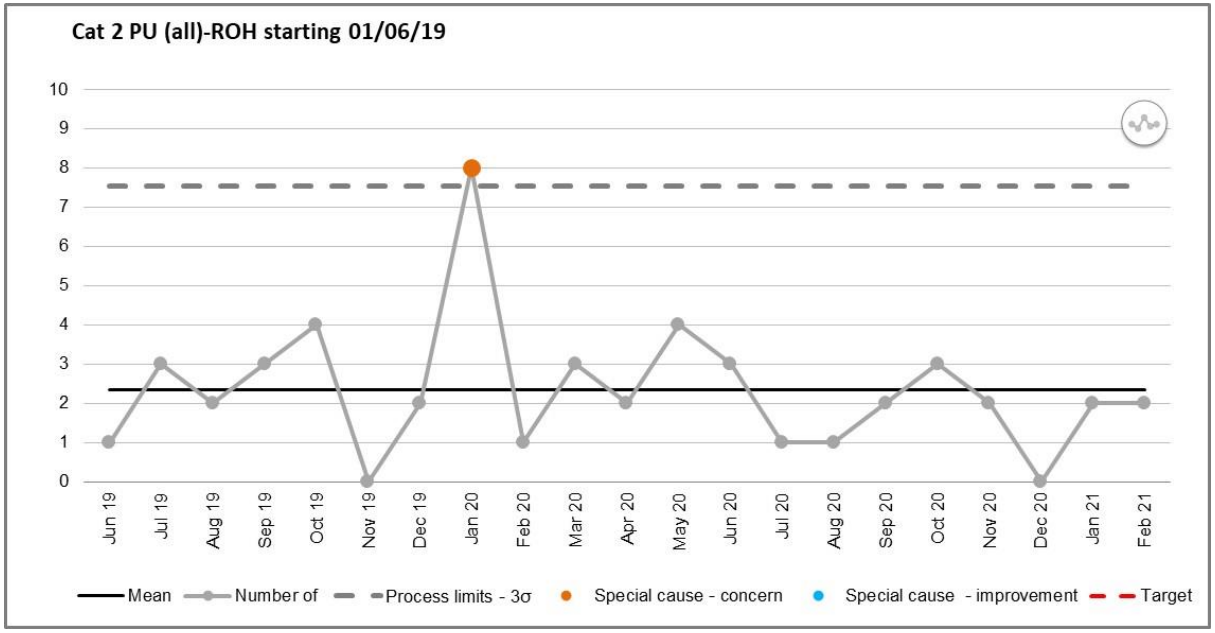
None

7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.





Year Total	Cat 2	Cat 3
19/20	27	3
20/21	22	1



Data Source – Ulysses and TV team

INFORMATION

February 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	2 - Ward 12 and Ward 2
Category – 2 (Device)	0
Category – 1	2 – none deteriorated
Suspected Deep Tissue Injury	2 – both on Ward 2

ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence Nil MASD ROH Intertriginous dermatitis – Nil MASD admitted with Incontinence x 11 MASD admitted with Intertriginous dermatitis x 2

Patients admitted with PU's	PU admitted with Cat 1 x 5 PU admitted with Cat 2 x 15 PU admitted with Cat 3 x 5 PU admitted with Cat 4 DTI PU admitted with Cat UNGRADEABLE (at least a Cat 3) x2 PU admitted with SDTI

Avoidable only Pressure Ulcer CCG Contracts KPI

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

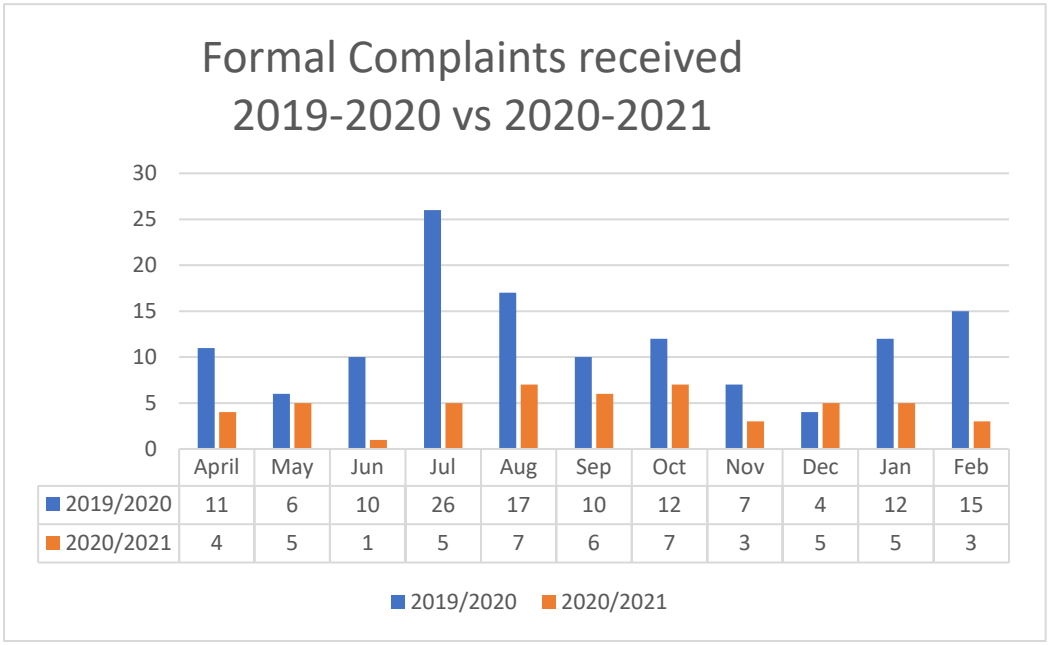
ACTIONS FOR IMPROVEMENTS / LEARNING

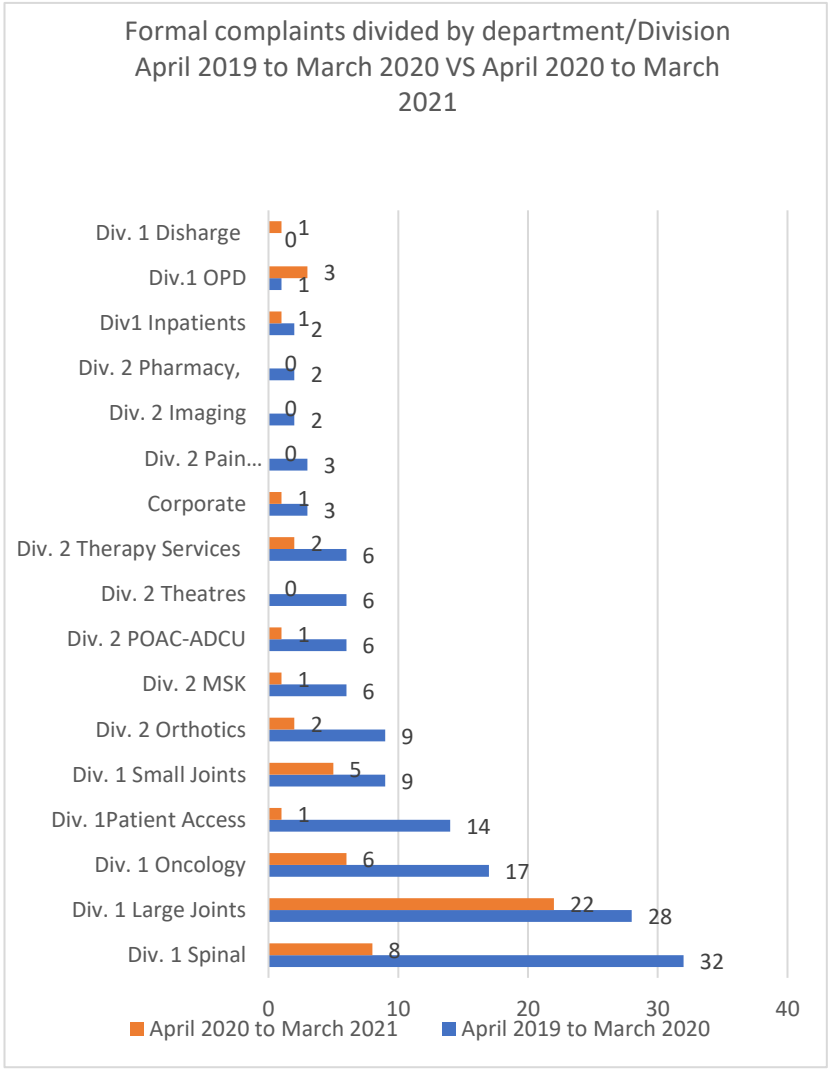
Increase in PU incidents from patients transferred to ROH from UHB. TV Lead noted that at ROH, deterioration did not occur. However, longer stay patients were at different risk of developing PU. They reported advice to Ward Managers for dissemination to staff around Pressure Relief and monitoring time patients spend sitting in a bedside chair. CQG group to continue monitoring to ensure the rate of PU returns to normal levels.

RISKS / ISSUES

None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



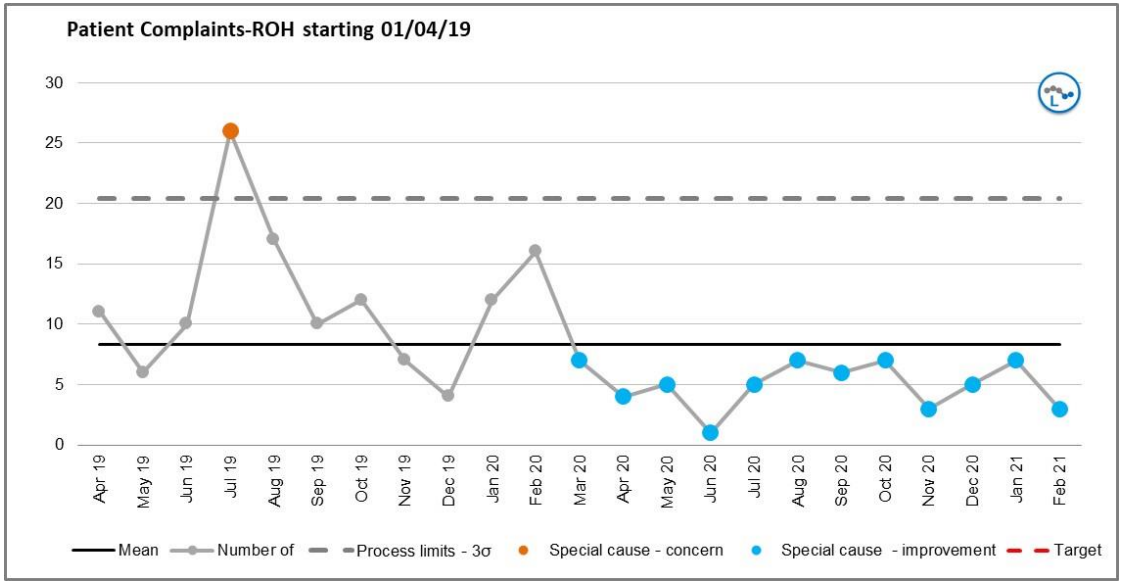


Data Source – Patient Experience team

Complaint Year Totals	
19/20	142
20/21	51

INFORMATION

Complaints

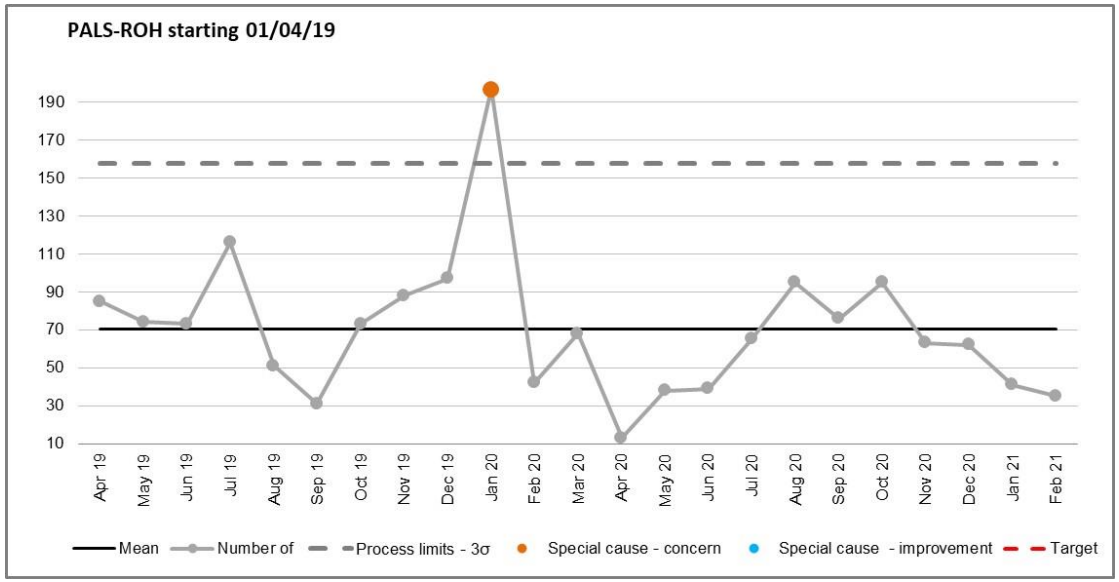


- There were 3 formal complaints acknowledged in February 2021 of which 3 were in relation to Division 1.
- Categories and subcategories of Formal complaints in February 2021 were:

Categories and Subcategories	Count
Communication/Info to Patients	**1**
Communication	1
Complications Following Surgery	**1**
Clinical	1
Discrimination - Disability	**1**
Privacy, Dignity And Wellbeing	1
Grand Total	**3**

- In February 2021, five formal complaint were closed within agreed date with the patient. This gives a 100% completion rate and meets the KPI for February 2021. The average timeframe response to formal complaints was 20 days.
- There is currently (2nd March 2021) 1 open complaint in relation with Division 1 and 1 in relation to both Divisions.

Patient Advice and Liaison service - PALS



- In February 2021 the PALS department handled 35 contacts of which 20 were classified as concerns and 15 as enquiries. This is a decrease in contacts compared to the same time last year (43 contacts in December 2019 according to Ulysses). The main themes in the PALS data relate to queries about appointment availability.

- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In February 2021, 100% of enquires and 100% of concerns were handled within the agreed timescales with patient.
- Top 5 categories and Top 2 subcategories PALS contacts for February 2021

Top 5 Categories and top 2 subcategories for February 2021	
Appointments	**16**
Referral – Delay in Authorising	6
Appointment - Delay	2
Covid-19	**10**
Cancellation of Appointment	7
Appointment Booked Incorrectly	3
Patient Care Including Nutrition/Hydration	**4**
Care Needs Not Adequately Met	4
Communication	**3**
Communication Failure	1
Communication with Relatives	1
Admissions & Discharges	**3**
Discharge Arrangements	2

Patient experience KPI from April 2020 until February 2021

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-20	N/A	100	100
May-20	100	100	100
Jun-20	100	100	100
Jul-20	100	100	100
Aug-20	100	100	100
Sep-20	83.4	93.9	100
Oct-20	100	100	100
Nov-20	100	100	100
Dec-20	100	100	100
Jan-21	100	95.1	100
Feb-21	100	100	100

Compliments

There were 5 compliments recorded on Ulysses in February 2021

ACTIONS FOR IMPROVEMENTS / LEARNING

- Deputy Head of Patient Experience has started an improvement project on the Ulysses system with new categories, departments and Directories and this will be live from April 2021 This will allow improved reporting and themes to be identified.
- The Executive Team have full oversight of the complaints in progress at the weekly Governance meeting
- An improved S.O.P. for PALS and complaints are in process to be created and added to Policy that is due for review in March 2021
- Head of Patient Experience role has been recruited to as of March 2021

RISKS / ISSUES

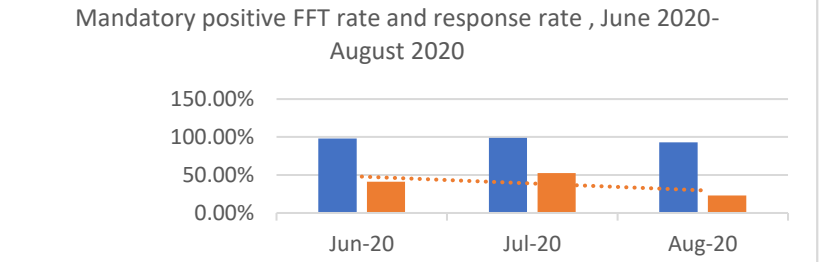
None

COMEBACK COMPLAINTS

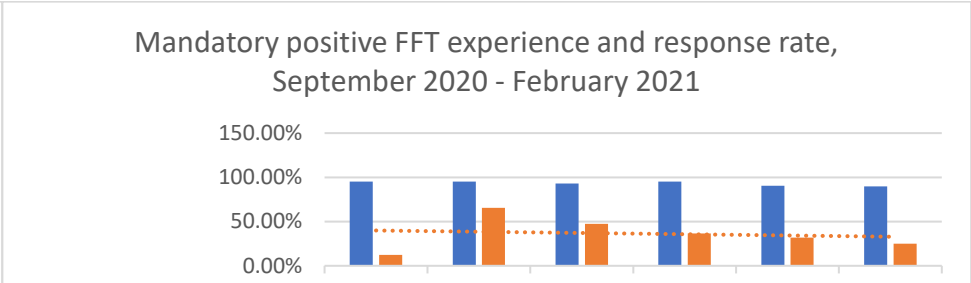
There were no Comeback Complaints for February 2021

9. Friends and Family Test Results (collected in the iwantgreatcare system).

FFT Mandatory Reporting

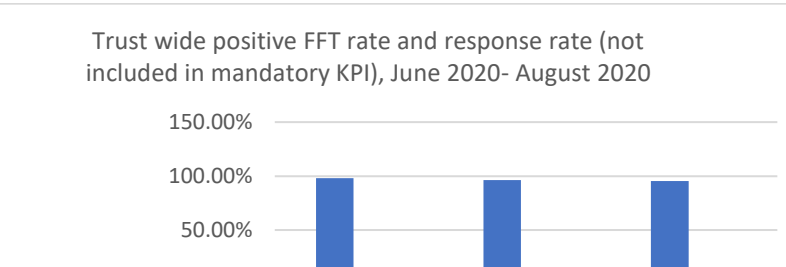


	Jun-20	Jul-20	Aug-20
Mandatory Positive rate	97.90%	98.73%	92.93%
Mandatory Response rate	41%	52.60%	23.11%

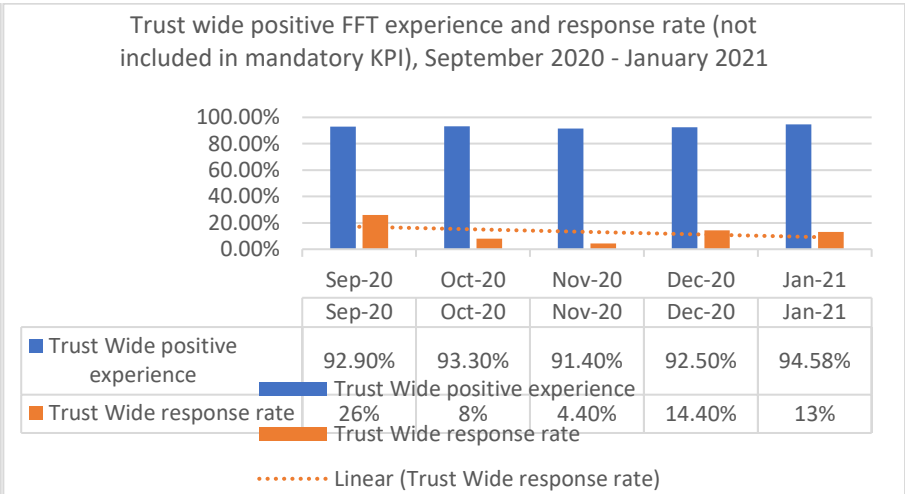


	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Mandatory Positive rate	95.32%	95.28%	92.99%	95.08%	90.51%	89.87%
Mandatory Response rate	12.33%	65.50%	47.30%	36.50%	32%	25%

FFT Non Mandatory Reporting

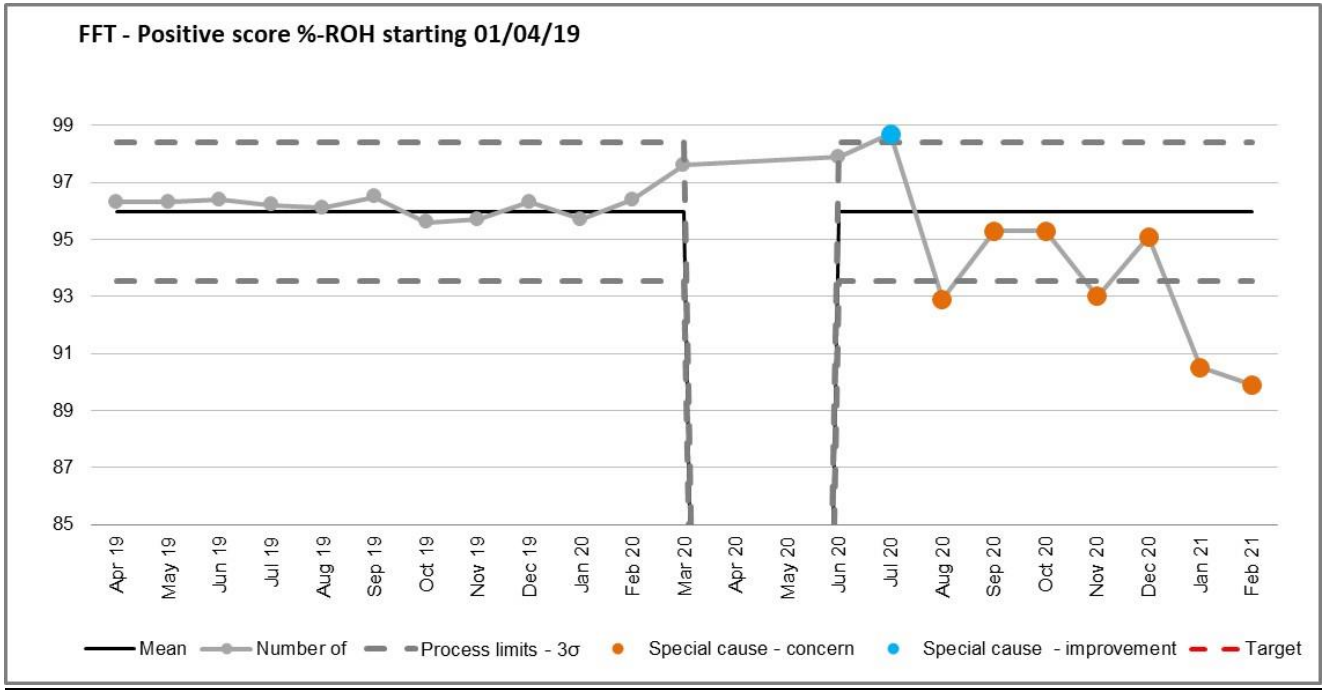


	Jun-20	Jul-20	Aug-20
Trust Wide Positive rate	98.20%	96.20%	95.50%
Response rate Trust Wide	9%	11%	8%



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Trust Wide positive experience	92.90%	93.30%	91.40%	92.50%	94.58%
Trust Wide response rate	26%	8%	4.40%	14.40%	13%

SPC chart showing the positive rate – In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison – April and May 2020 data was not collected due to the Covid 19 Pandemic.



INFORMATION
• There appears to be a disparity between data collection and results published. There is a plan to scale down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. The graphs above have been broken down by mandatory and non mandatory areas to allow the Trust to focus on the mandatory areas. From February 2021 the Trust will not report on the non-mandatory areas until the data quality issues are resolved. • In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison. • The Trust did not collect FFT during April and May 2020 due to COVID-19 pandemic, The Trust restarted the reporting and collection of FFT in June 2020,

- In February 2021 Trust received a confirmation email from IWGC that data from August 2020 and September 2020 was recovered. These are now included within the report
- Area Managers are receiving any compliments or concerns from patients in spreadsheet via the PALS team. This allows the areas to share with their staff for learning and improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The Public engagement team will look more closely on areas that do not fulfil mandatory 40% target in FFT response (return) rates.
- The Public engagement team reviewing possibility of sending web links for FFT in text messages to patients. This will help improve collection of the data.
- The Public Engagement team is in process of creating a template for compliment so they can be displayed to the public within departments.
- Trust is reviewing contract with the I Want Great Care software supplier

RISKS / ISSUES

- In October 2020 Public Engagement team received an email for IWGC that they have an issue with collecting data and that they did not formulate all FFT forms that have been sent to them during August 2020 nor September 2020.
- Public Engagement team recalled mandatory target data for August 2020 and did not issue mandatory target for September 2020, as IWGC did not find all forms that we sent, this is not patient identifiable data
- Data Quality issues with FFT data have been highlighted and work is underway with the software company and ROH to rectify

.

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 14 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

0 new claims against the Trust were received in February 2021

On-going claims

There are currently 26 on-going claims against the Trust.

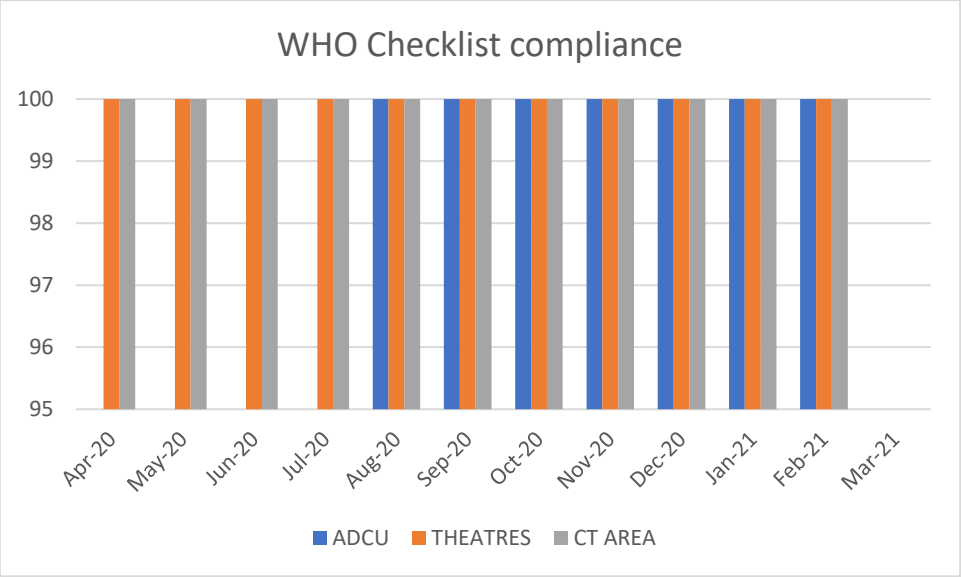
Pre-Application Disclosure Requests

5 new requests for Pre-Application Disclosure of medical records were received in February 2021.

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in February 2021

12. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 297

The total WHO compliance for Theatres in February 2021= 100%

CT area

Total cases = 76

The total WHO compliance for CT February 2021 = 100%

ADCU

The total WHO compliance for ADCU in February 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non-compliance will be reported back to the relevant clinical area.

The Theatre man system originally stated 3 incomplete patients on the Theatres lists, upon review all documentation and WHO Checklists for all patients complete and therefore compliant

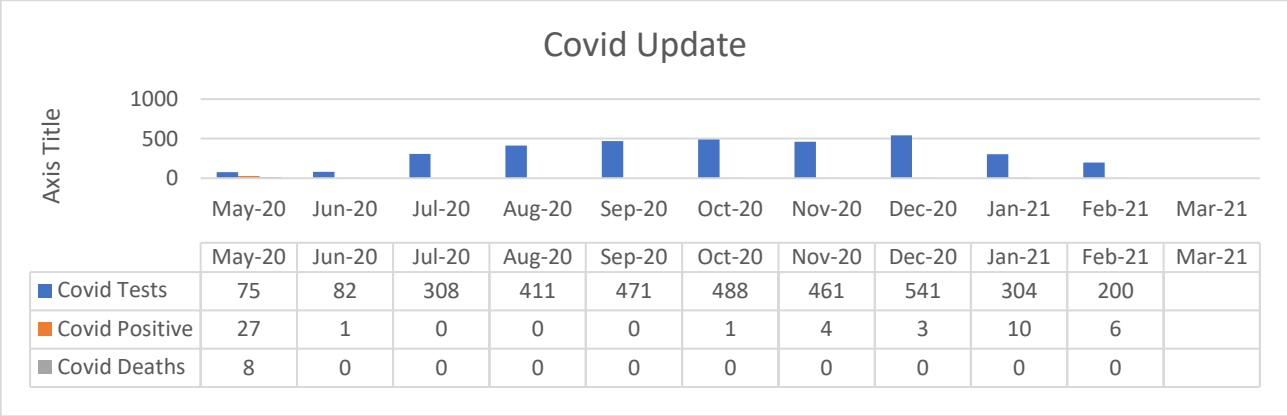
RISKS / ISSUES

None

13. Infection Prevention Control – Statutory requirement/Reportable Infections. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	February 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	1	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	1
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Covid Tests	75	82	308	411	471	488	461	541	304	200	
Covid Positive	27	1	0	0	0	1	4	3	10	6	
Covid Deaths	8	0	0	0	0	0	0	0	0	0	

ACTIONS FOR IMPROVEMENTS / LEARNING

1 x Post 72-hour Clostridium difficile infection (CDI) reported and currently under investigation within the Trust.

5 patients tested as positive.

RISKS / ISSUES

None

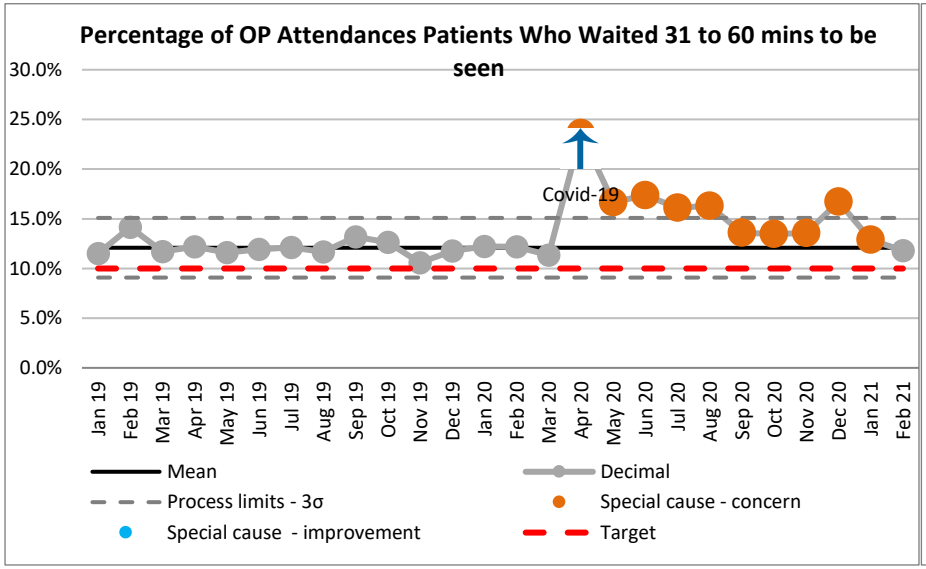
***Data Source – IPC team and Ulysses**

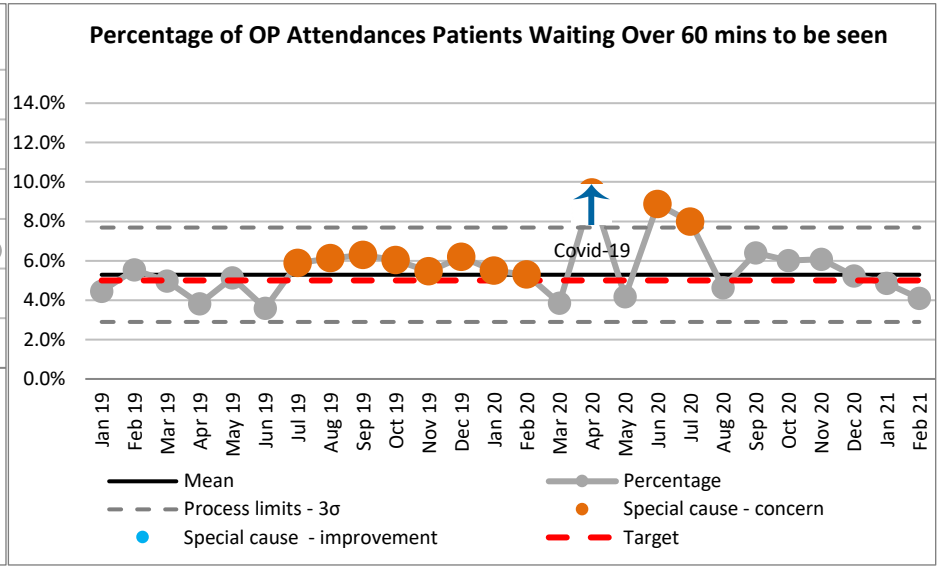
14. Safeguarding

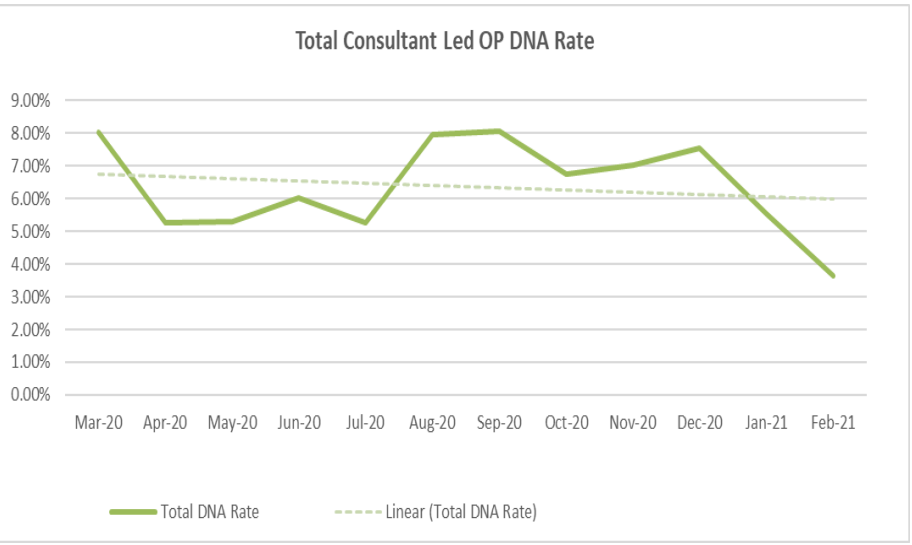
	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021
Safeguarding Adult Notifications	32	28	11	58	35	14	17	14	22	43	29	32	40	35
Safeguarding Children and Young People Notifications	36	28	17	3	1	5	4	6	8	22	18	27	19	12
Mental Health Incidents	11+	11+	6	3	4	8	17	29	52	51	25	15	7	11
LD Adult	19	13	5	2	0	3	2	7	3	3	7	5	5	3
LD Children	62	39	28	0	0	4	13	10	18	41	65	46	13	24
Adult Level 2	98.77	98.77	99.53	99.34%	99.23%	98.60%	98.32%	99.14%	99.14%	98.20%	98.2%	97.48%	98.12	98.33%
Adult Level 3	66.42	76.62	71.86	68.69%	69.19%	75.25%	78.03%	81.78%	81.78%	85.24%	85%	85.75%	84.77	84.63
Level 4	80.00	80.00	80.00	80.00%	75.00%	75.00%	75.0%	50.0%	50%	75.0$%	80%	80%	100	100%
Child Level 2	98.77	98.77	99.34	99.15%	99.04%	98.31%	98.04%	98.95%	98.95%	97.99%	97.92%	97.30%	97.93	98.24%
Child Level 3	68.59	75.35	74.88	71.88%	71.86%	77.48%	78.90%	82.75%	81.78%	86.46%	86.45%	86.71%	85.51	85.34%
Mental Capacity Act MCA	99.62	99.62	100	99.44%	99.23%	97.95%	97.57%	97.90%	97.9%	96.59%	95.41%	93.93%	97.51	92.79%
Deprivation of Liberty Safeguards DoLs	99.61	99.60	100	99.62%	99.60%	98.26%	97.87%	98.03%	98.03%	96.70%	95.27%	93.76%	97.44	95.68%
Prevent **WRAP**	88.78	90.68	95.33	88.56%	87.66%	84.47%	86.63%	88.89%	88.89%	84.59%	85.96%	86.88%	83.68%	82.65%
CE	0	0	0	0	0	0	0	0	0	1	0	0	0	0
FGM	0	0	0	0	0	0	1	0	0	0	0	1	0	0
DOLS	4	5	2	34	12	3	4	1	3	13	5	6	20	21
MCA	2	2	0	1	0	0	0	3	1	1	1	1	3	0
PIPOT cases	0	0	0	0	0	0	0	0	1	0	0	1		0

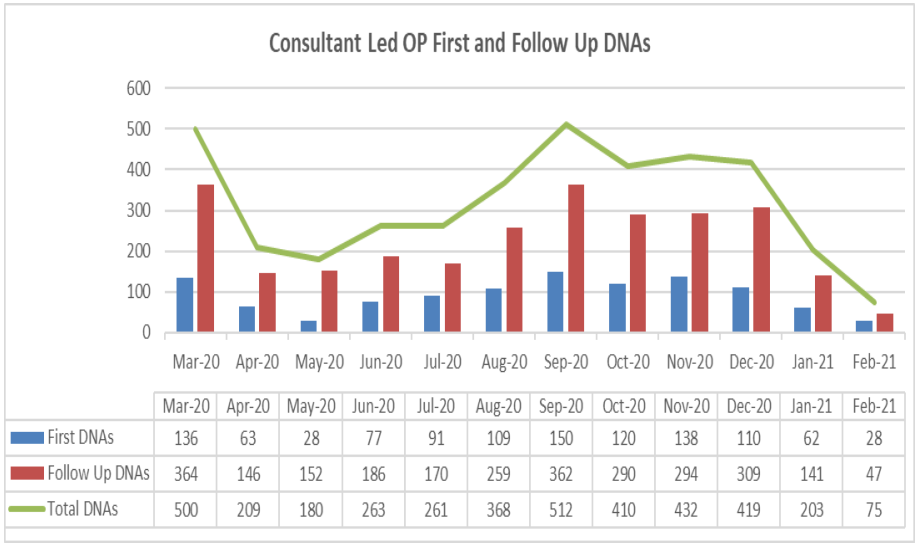
Domestic Abuse	0	2	3	4	1	2	2	0	2	3	4	3	1	2
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WNB	31	21	9	2	2	1	1	3	4	4	1	3	6	3
Child in Care	4	2	0	0	0	1	0	0	0	5	4	1	2	1
Early Help	0	0	0	0	0	0	0	0	0	6	2	0	1	4
DHR- scoping Reviews	0	?	1	0	1	1	0	0	2	0	0	2	0	0
SARs- scoping review **Or Rapid Reviews**	3	0	0	0	0	1	0	0	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Incidents	10	10	7	33	21	7	6	4	6	13	10	8	24	27
Open Cases							10	7	1	8	5	18	2	3
Closed Cases							10	8	29	57	42	41		44

15. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
First DNAs	136	63	28	77	91	109	150	120	138	110	62	28
Follow Up DNAs	364	146	152	186	170	259	362	290	294	309	141	47
Total DNAs	500	209	180	263	261	368	512	410	432	419	203	75

INFORMATION

Both 30 minute and 60 minute delay metrics have improved in February

30 minute delays – February position is 11.8% compared to 12.09% in January. (Below trust target of 10%)
60 minute delays – February position is 4.1% compared to 4.9% in January. Target is 5% therefore

A task and finish group is in place as part of the refresh and recovery programme to support and resolve the issues identified on a daily basis from the daily huddles. A morning huddle is in place to identify any concerns to start the day and to ensure all clinics start on time. The afternoon huddle will undertake a forward look for the next two days to identify and resolve any potential concerns or issues.

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure patients are seen on time for their appointments. Incident reports are submitted for any clinic delays more than 30 minutes and these will be reviewed and issues resolved as they are identified and also pick up any key themes and trends.

The DNA rates have reduced in February to 3.64% compared to January's 5.54% and continue to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department to support and oversee operations.

ACTIONS FOR IMPROVEMENTS / LEARNING

Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

Due to the reduction in capacity within imaging to ensure appropriate social distancing arrangements are in place some patients are needing to wait for a space in imaging if they require an x-ray that has not been pre-planned . Work is underway with the team to ensure that for all patients awaiting imaging, especially those with special needs are supported appropriately and communication around these patients is flowing between the two departments seamlessly to enable this to happen.

RISKS / ISSUES

Lack of capacity in outpatients continues to be a concern, evenings and weekends need to be considered in job plans and currently scoping options for alternative locations for virtual clinics and further extended working days .

16. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories

Referral to Treatment snapshot as at 31st February 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

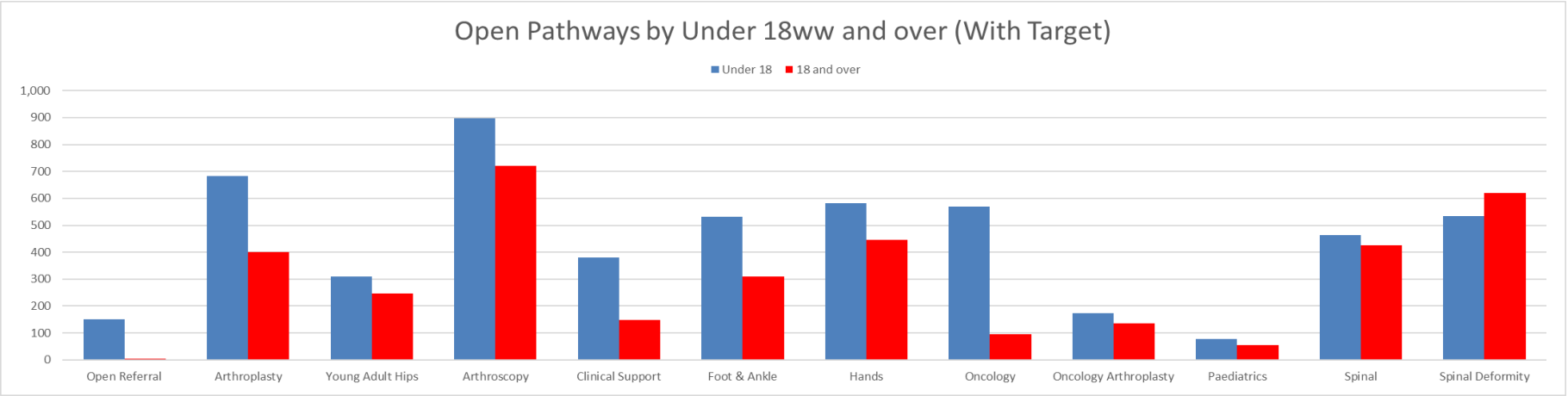
Est Over 18 Clock Stops Required		
To achieve	81.47%	2748
To achieve	71.13%	1651
To achieve	81.74%	2773

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,957**	102	265	86	301	152	172	179	265	47	27	172	189
7-13	**2,166**	45	294	145	369	146	224	247	180	66	31	196	223
14-17	**1,224**	3	124	78	227	81	135	156	124	61	19	95	121
18-26	**2,097**	4	249	161	385	125	221	281	73	92	31	198	277
27-39	**1,054**	0	124	59	211	20	75	129	12	39	18	140	227
40-47	**201**	0	12	12	47	0	4	17	9	1	4	40	55
48-51	**112**	0	7	6	34	0	1	9	0	2	1	21	31
52 weeks and over	**142**	0	9	8	43	3	8	11	2	2	0	26	30
Total	**8,953**	154	1,084	555	1,617	527	840	1,029	665	310	131	888	1,153

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,347**	150	683	309	897	379	531	582	569	174	77	463	533
18 and over	**3,606**	4	401	246	720	148	309	447	96	136	54	425	620
Target for RTT 92%	**716**	**12**	**86**	**44**	**129**	**42**	**67**	**82**	**53**	**24**	**10**	**71**	**92**

Month End RTT %	59.72%	97.40%	63.01%	55.68%	55.47%	71.92%	63.21%	56.56%	85.56%	56.13%	58.78%	52.14%	46.23%



Referral to Treatment Snapshot as at 31st February 2021 – Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

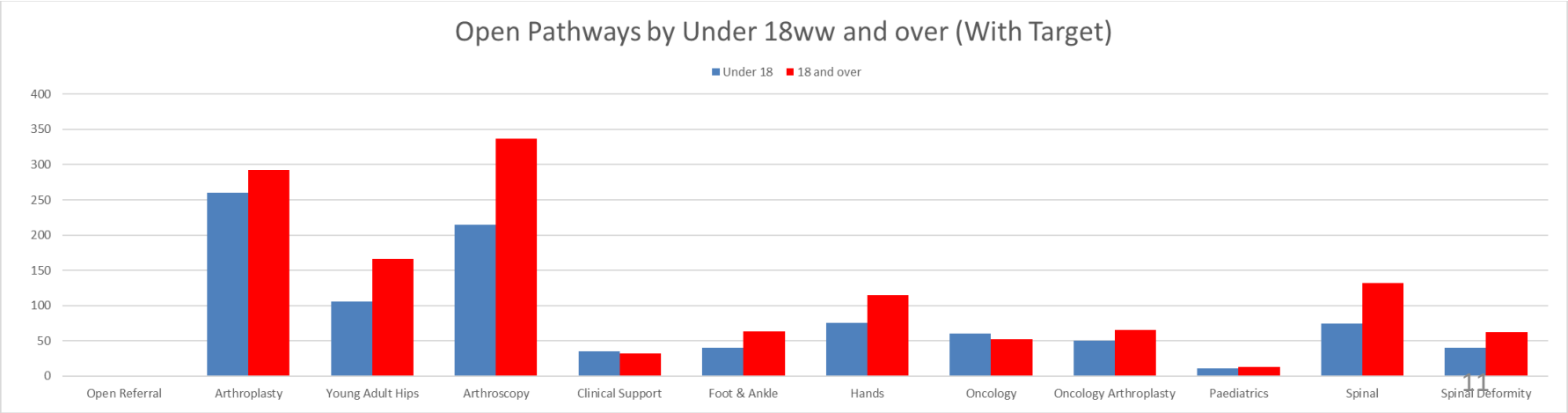
Est Over 18 Clock Stops Required		
To achieve	81.47%	1275
To achieve	71.13%	1077
To achieve	81.74%	1280

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**184**	1	52	10	38	5	2	7	32	10	2	15	10
7-13	**492**	0	133	53	98	24	24	45	22	26	9	39	19
14-17	**291**	0	75	43	79	6	14	23	6	14	0	20	11
18-26	**709**	0	189	103	149	23	40	49	32	39	7	56	22
27-39	**382**	0	83	43	92	7	12	50	10	21	5	38	21
40-47	**81**	0	7	7	35	0	2	4	8	1	1	13	3
48-51	**56**	0	5	6	22	0	1	5	0	2	0	8	7
52 weeks and over	**101**	0	8	7	39	2	8	7	2	2	0	17	9
Total	**2,296**	1	552	272	552	67	103	190	112	115	24	206	102

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**967**	1	260	106	215	35	40	75	60	50	11	74	40
18 and over	**1,329**	0	292	166	337	32	63	115	52	65	13	132	62
Target for RTT 92%	**183**	**0**	**44**	**21**	**44**	**5**	**8**	**15**	**8**	**9**	**1**	**16**	**8**

Month End RTT %	42.12%	100.00%	47.10%	38.97%	38.95%	52.24%	38.83%	39.47%	53.57%	43.48%	45.83%	35.92%	39.22%



Referral to Treatment Snapshot as 31st February 2021 (non admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

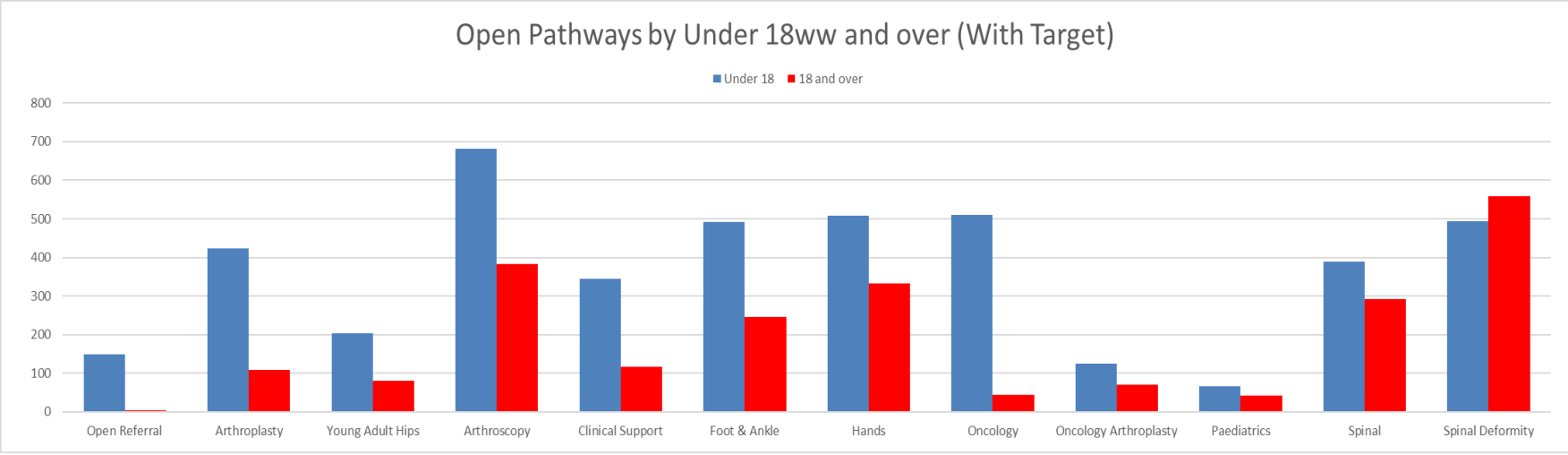
Est Over 18 Clock Stops Required		
To achieve	81.47%	1473
To achieve	71.13%	574
To achieve	81.74%	1493

Select Pathway Type: Non Admitted

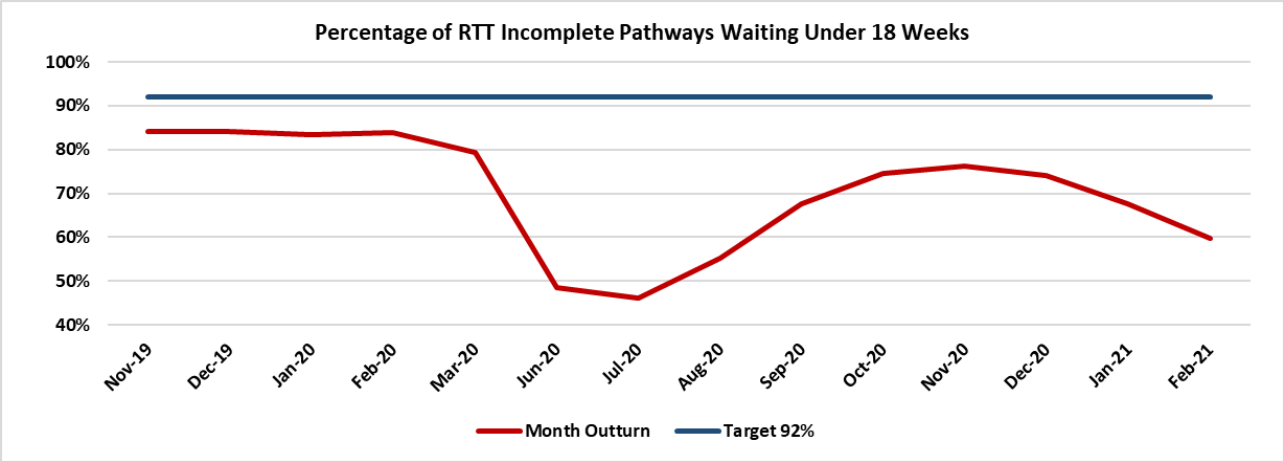
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,773**	101	213	76	263	147	170	172	233	37	25	157	179
7-13	**1,674**	45	161	92	271	122	200	202	158	40	22	157	204
14-17	**933**	3	49	35	148	75	121	133	118	47	19	75	110
18-26	**1,388**	4	60	58	236	102	181	232	41	53	24	142	255
27-39	**672**	0	41	16	119	13	63	79	2	18	13	102	206
40-47	**120**	0	5	5	12	0	2	13	1	0	3	27	52
48-51	**56**	0	2	0	12	0	0	4	0	0	1	13	24
52 weeks and over	**41**	0	1	1	4	1	0	4	0	0	0	9	21
Total	**6,657**	153	532	283	1,065	460	737	839	553	195	107	682	1,051

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,380**	149	423	203	682	344	491	507	509	124	66	389	493
18 and over	**2,277**	4	109	80	383	116	246	332	44	71	41	293	558
Target for RTT 92%	**532**	**12**	**42**	**22**	**85**	**36**	**58**	**67**	**44**	**15**	**8**	**54**	**84**

Month End RTT %	**65.80%**	**97.39%**	**79.51%**	**71.73%**	**64.04%**	**74.78%**	**66.62%**	**60.43%**	**92.04%**	**63.59%**	**61.68%**	**57.04%**	**46.91%**



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for February is 59.72% against the National compliance target of 92%. This is a decrease compared to January 21 at 67.70% and is reflective of the cessation of elective procedures in order to undertake core critical services i.e. emergencies, spinal, oncology. There are 142 patients over 52 weeks - 101 admitted patients, all priority 2 and 3 patients are booked for March and in the process of being booked for April, 47 are priority 4. There are 41 non admitted patients with face to face clinics or diagnostic investigations now planned and additional OPD capacity for Spinal is planned for April.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2296 patients are on the admitted waiting list (P1b – 5, P2 – 260 patients, P3 – 607 patients, P4 – 1420 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the process is standardised across all specialties and to provide assurance going forward all patients are reviewed on a regular basis.

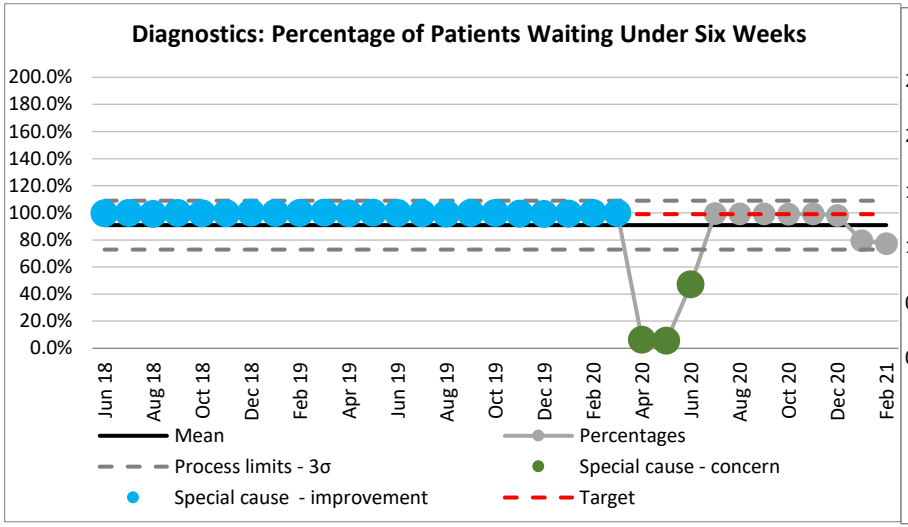
The total number of referrals into the Trust in February was 1348 which is low (55%) when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.

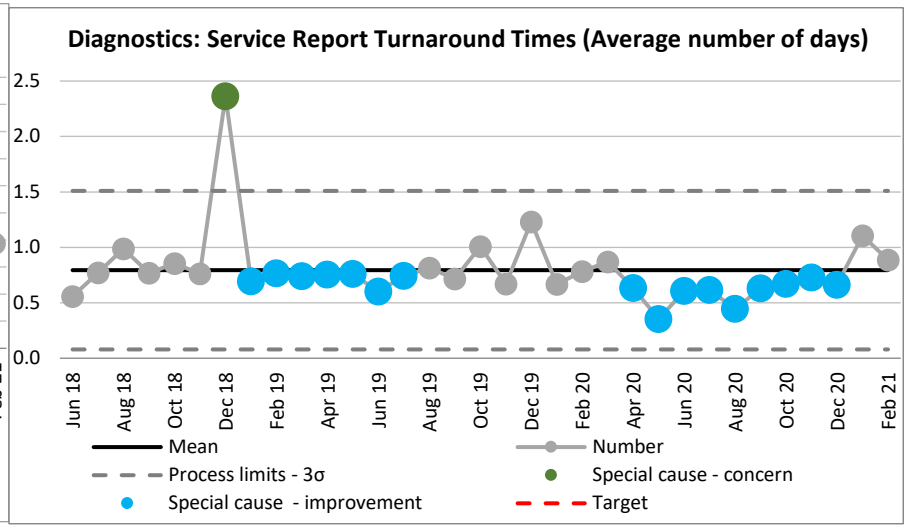
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION
Imaging did not achieve the diagnostic target reporting 77.02% for February but continues to report consistently good performance for report turn around times. Position as at 14th March reporting 91.56%, 45 patients over 6 weeks to book, progress is being monitored weekly to ensure compliance is 99% by month end. February saw a continued reduction in performance as a result of the **suspension of non urgent referrals** and providing mutual aid to the system. We have now resumed all non urgent imaging services to support the increasing waiting lists for non urgent diagnostics. The team will continue to source additional capacity to recover the diagnostic target throughout March with the expectation that the diagnostic target will be achieved by the end of financial quarter at the latest. Additional MRI capacity in the independent sector has been made available, with 20 patients being sent throughout February.

ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
Impact of a 3rd wave of covid reducing referrals further impacting on diagnostic activity . The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

Cancer Performance Targets

		Indicative	*Reported Month*												
Target Name	National Standard	*Feb-21*	*Jan-21*	In Target	Breach	Total	*Dec-20*	In Target	Breach	Total	Nov-20	In Target	Breach	Total	Q3 Perf 2020/ 2021
2ww	93%	100.0%	100.0%	40	0	40	100.0%	61	0	61	100.0%	60	0	60	99.0%
31 day first treatment	96%	100.0%	100.0%	18	0	18	100.0%	12	0	12	100.0%	11	0	11	100.0%
31 day subsequent (surgery)	94%	100.0%	91.0%	10	1	11	100.0%	4	0	4	100.0%	9	0	9	100.0%
62 day (traditional)	85%	69.2%	76.5%	6.5	2.0	8.5	73.3%	5.5	2.0	7.5	57.7%	2.0	1.5	3.5	69%
62 day (Cons Upgrade)	n/a	100%	100.00%	7.5	0.0	7.5	100.00%	4.0	0.0	4.0	92.9%	6.5	0.5	7.0	98.0%
28 day FDS REPORTED	75%	78.8%	65.0%	41	22	63	69.0%	50	22	72	69.1%	56	24	80	72%
28 day FDS INTERNAL	75%		79%	50	13	63	73%	50	19	69	77.7%	53	6	59	
No. patients treated 104+ days															1

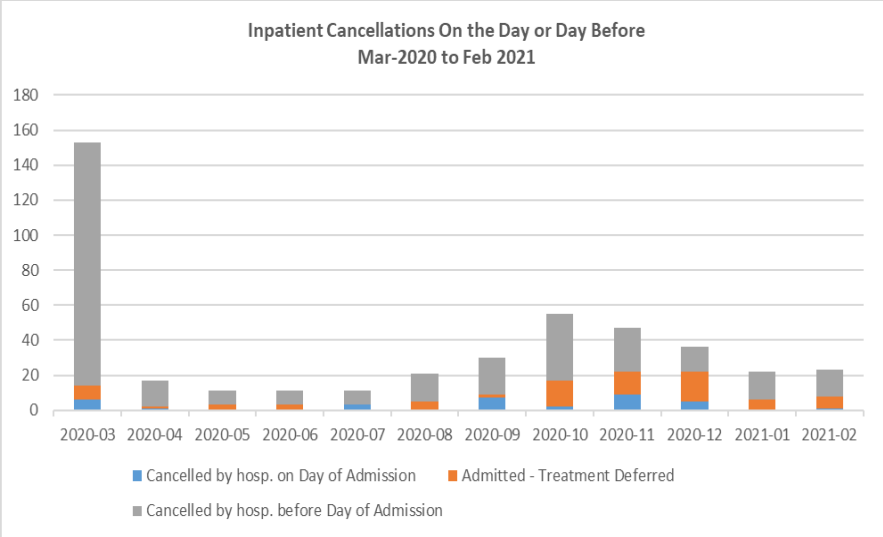
INFORMATION

- For the month of January 2021, the Trust was compliant with the national standards for 2WW, 31 day first and 62 day consultant upgrade .
- The Trust breached 62 day standard @ 76.5%, 31 day subsequent @ 91% and 28 day faster diagnosis @ 65%.
- 6.5 treatments were delivered within 62 day target with 2 breaches (2 x 0.5 breaches due to late tertiaries out and 1 full breach due to a complex patient diagnostic pathway).
- The Trust's performance for the 62 day target for February 2021 is currently predicted at 69.2% with 4.5 treatments within target and 2 breaches (2 x full breaches due to complex pathway and a patient being rejected for radiotherapy resulting in referral back for surgery) – submission closes 31.03.21.
- The Weekly Cancer PTL meeting continues to monitor and track patients along their pathway with an escalation protocol in place to alert concerns in meeting national standards.
- Paediatric referral divert ceased on 22nd February 2021, and the PMBT service resumed on 01.03.21 with PMDT on Tuesdays @ 8am, image guided lists on Wednesdays, and new patient clinics on Tuesday afternoons. First operating list is scheduled for 19.04.21.

Risks

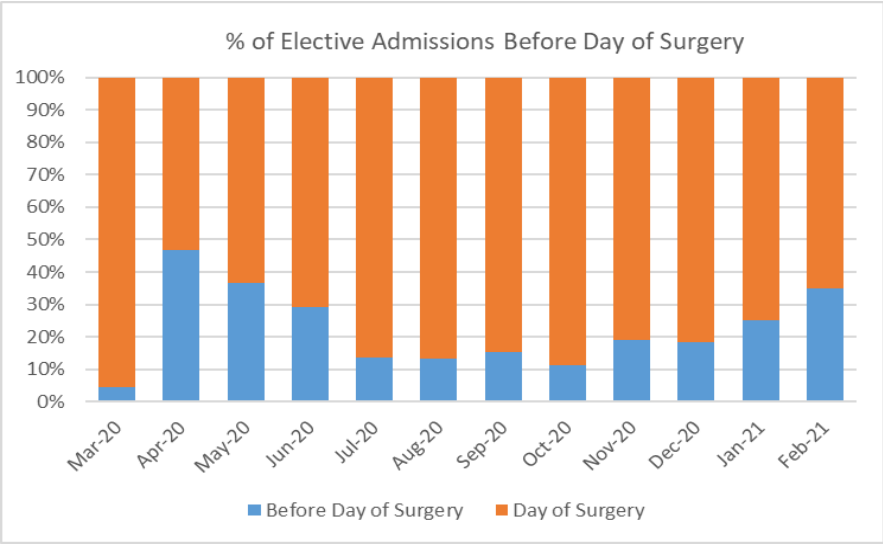
- Ongoing concerns regarding histological reporting resulting in delays in patient pathways, both of which are under current analysis/review. Recruitment issues remain an ongoing concern to appoint a specialist bone & soft tissue pathologist (national problem). Escalated via NOA to enable national discussion/resolution

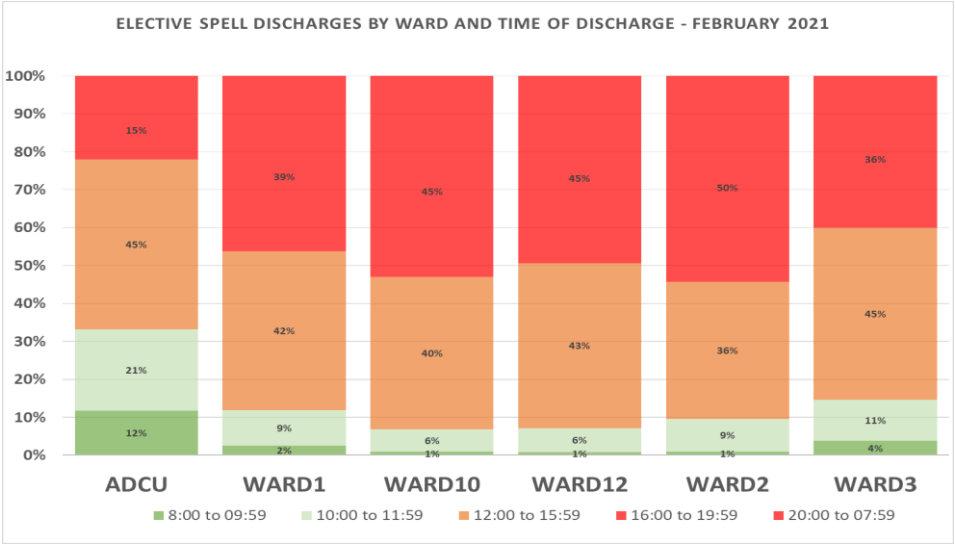
17. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total
2020-03	6	8	139	153
2020-04	1	1	15	17
2020-05		3	8	11
2020-06		3	8	11
2020-07	3		8	11
2020-08		5	16	21
2020-09	7	2	21	30
2020-10	2	15	38	55
2020-11	9	13	25	47
2020-12	5	17	14	36
2021-01		6	16	22
2021-02	1	7	15	23
Grand Total	**34**	**80**	**323**	**437**

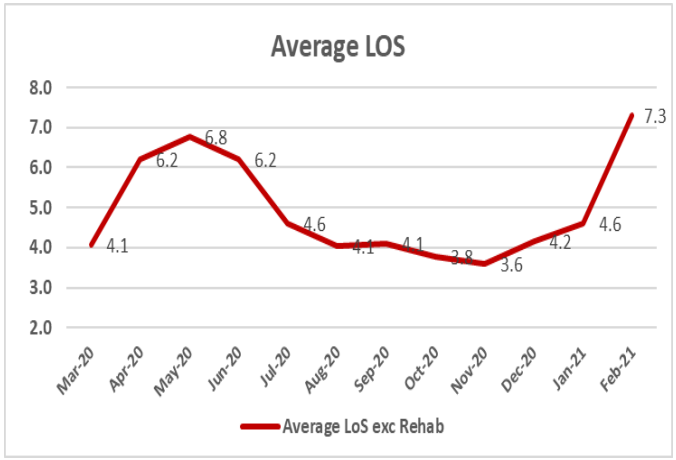
Cancelled Ops Not Seen Within 28 Days
4
0
0
0
0
0
0
0
1
0
0
0
5

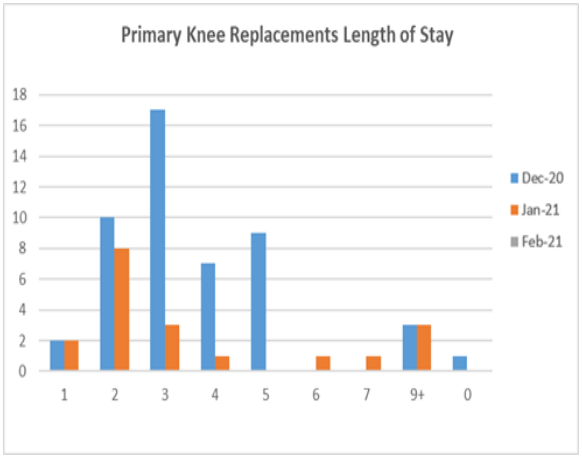


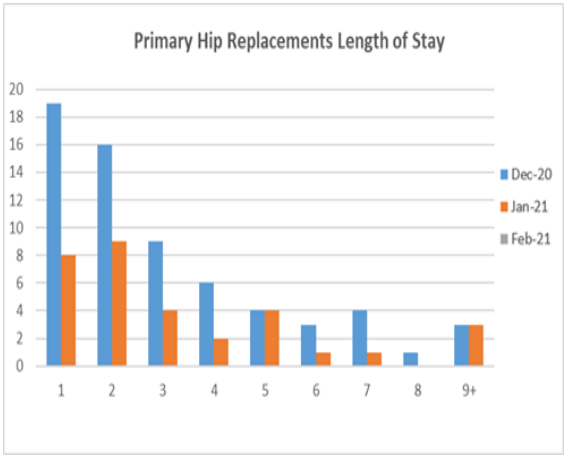


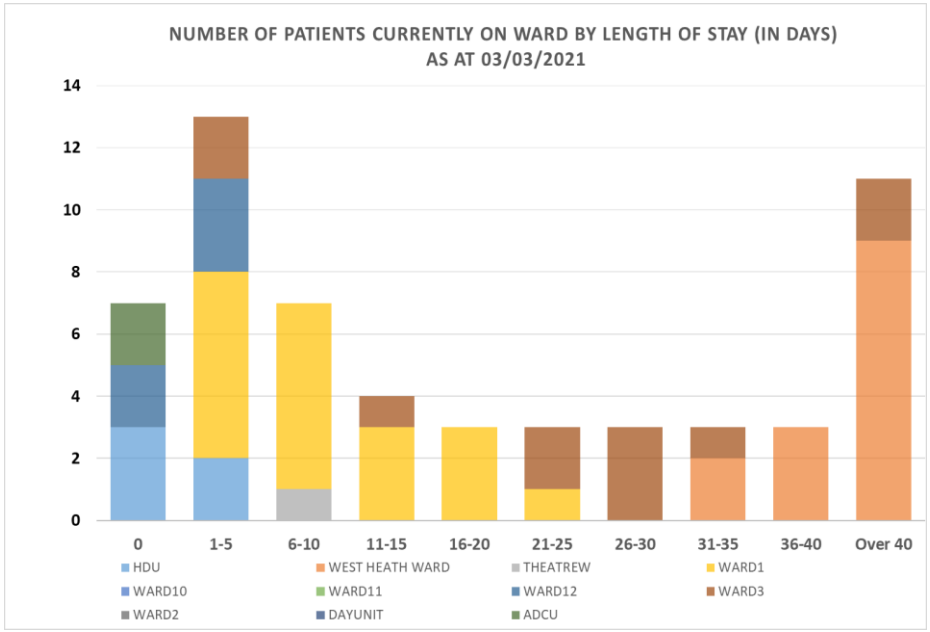
INFORMATION
There was 1 patient cancelled on the day of admission in February, however there were 7 patients admitted but where treatment was deferred, with reasons broken down as follows: 1 x Surgeon availability due to needing to self-isolate 2 x Medically unfit 1 x Patient recently had COVID vaccine 1 x Patient on antibiotics 2 x Patients no longer wanted surgery Cancellations prior to day of surgery for February were 15 as detailed below: 2 x Patient unwell after COVID-19 vaccine 7 x TCI's rescheduled/cancelled 1 x Medically unfit 2 x COVID swab results not available 1 x Patient DNA COVID swab 2 x COVID positive
ACTIONS FOR IMPROVEMENTS / LEARNING
864 continues in a strengthened format with executive oversight to maximise resources both in theatre and on wards
RISKS / ISSUES
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient cancellations which will require monitoring as services are recovered through the harm review process .

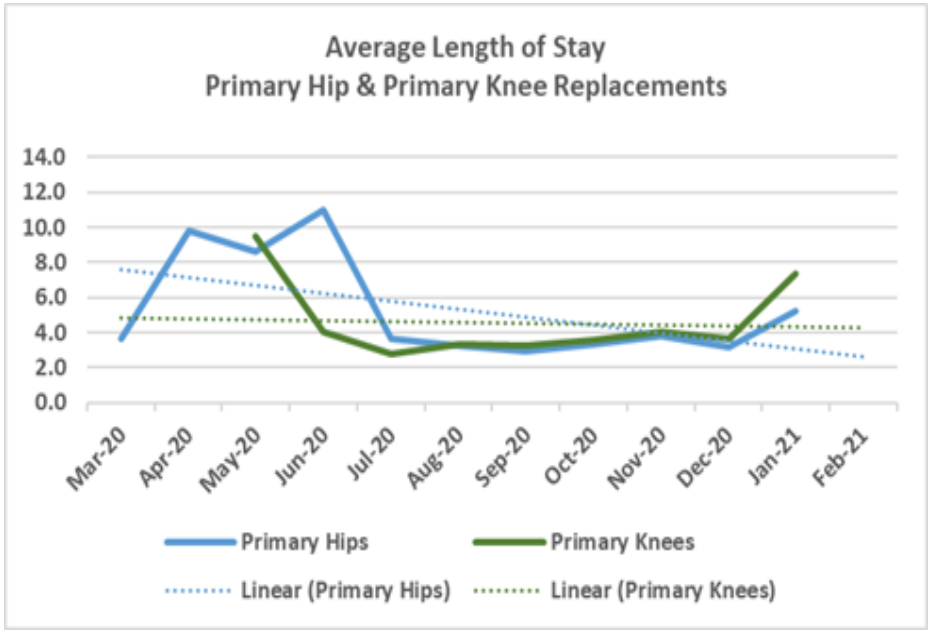
18. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION
LOS has increased from 4.6 in January to 7.3 in February 2021. The records of all patients with a length of stay recorded as greater than 20 days have been reviewed by Head of Nursing Division 1. All were complex oncology or spinal patients with on-going clinical medical needs which included BIU, infected wound management, further surgery or COVID. One Oncology patient had multiple infections resulting in a stay of 73 days Patients operated on in this period met the Trust categorisation for urgent surgery therefore no primary hips or knees were operated on during February. 10 patients in February had delayed Transfers of Care, these patients were mainly the Acute Rehab Pathway patients transferred from UHB to ROH as part of the agreed mutual aid support. The delays totalled 78 days. All delayed discharges are discussed at the daily 1pm meeting and escalated if they is no immediate plan or resolution.
ACTIONS FOR IMPROVEMENTS / LEARNING
The roaming discharge team supported by the safeguarding team have continued to provide discharge support to the wards. This supports and promotes early discharge planning. Discussions have commenced as to how this will be maintained and increased to ensure patient flow enables 7.15am admissions to wards.
RISKS / ISSUES
Increased length of stay due to reasons listed above may impact on patient flow and available bed capacity, however a dynamic bed modelling framework is now in place to ensure forecasting of bed capacity meets demand thus avoiding any cancellations pro actively.

19. – CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

CAS ALERTS 1 - 31 Jan 2021

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
EFA/2020/001	Allergens Issues - Food Safety in the NHS.	NHS Improvement Estates and Facilities	29-Jan-20	**4 Mach 2021** Due to feedback from stakeholders draft policy is now being amended. On-going.	12-Aug-20
SDA/2021/002	Propofol emulsion for infusion and injection (all strengths) - Supply disruption Due to the significant increase in demand for propofol to support the UK's COVID-19 response there are limited supplies of high volume propofol presentations, listed below, in the supply chain:	DHSC & NHS England and Improvement: Supply disruption alert	03-Feb-21	Sent to Pharmacy.*'There is a national shortage of propofol 50ml and 100ml bottles. This shouldn't come as any surprise to those of you who*	15 Feb 21

	•Propofol 1% 100ml vials; •Propofol 1% 50ml vials; and •Propofol 2% 50ml vials. Further deliveries are expected over the coming weeks, however intermittent supply issues across this range of propofol presentations and concentrations are likely to occur for several weeks. This alert contains advice on the management of affected patients.			*have seen our bulging ICUs lately'.* *'Can I ask that you use 3x20ml Propofol 1% amps for TIVA where possible for the foreseeable? We'll let you know when the supply base is back to normal'.*	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Finance and Performance Report

February 2020

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8	Theatre In-Session Usage	
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13	Workforce Targets	

INTRODUCTION

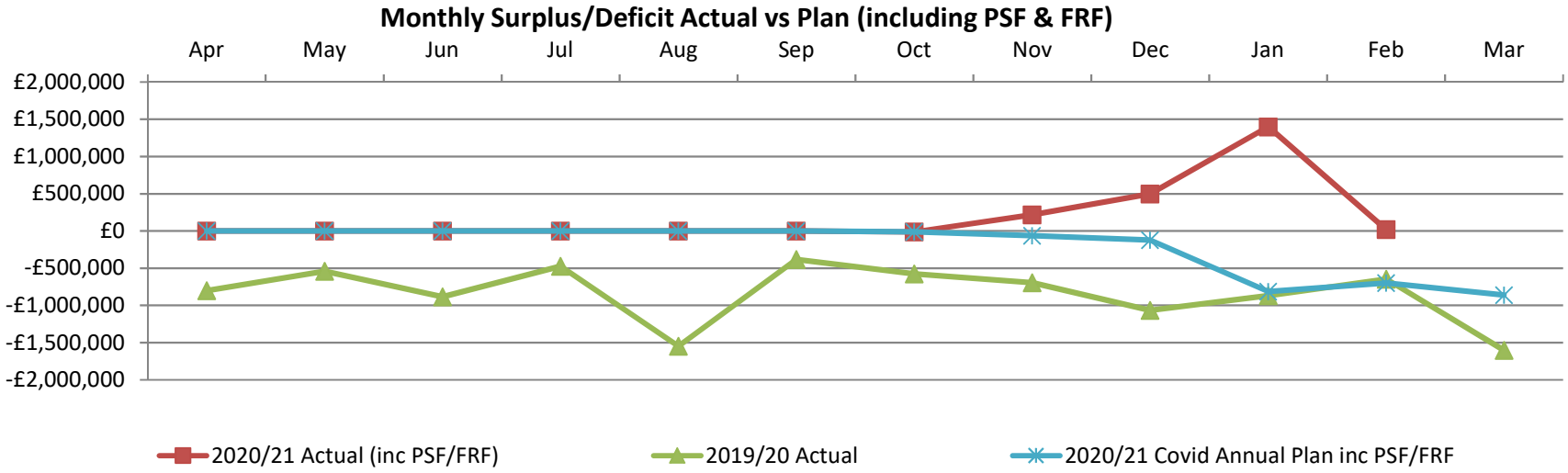
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

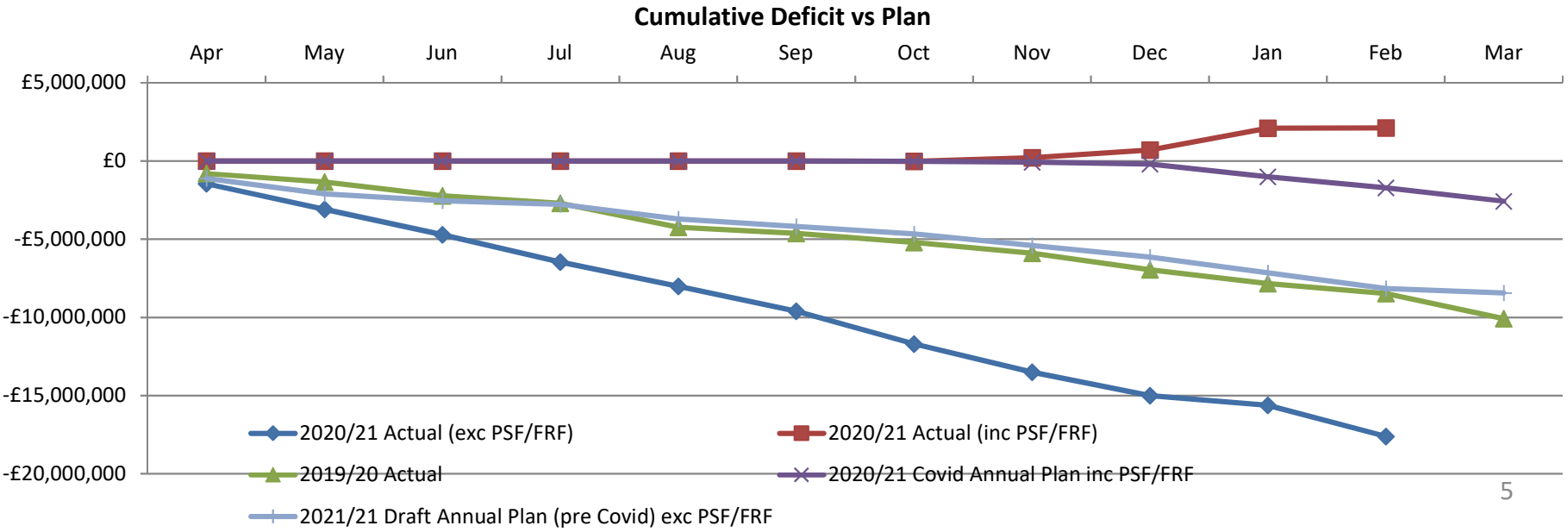
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	NHS I Plan M11 2020/21	Actual M11 2020/21	Variance
	£'000	£'000	£'000
Operating Income from Patient Care Activities (exc PSF & FRF)	80,143	82,215	2,072
Other Operating Income (Excluding top up)	2,945	3,488	543
Total Income	**83,088**	**85,703**	**2,615**
Employee Expenses (inc. Agency)	(51,571)	(51,403)	168
Other operating expenses	(41,716)	(40,965)	751
Operating Deficit	**(10,199)**	**(6,665)**	**3,534**
Net Finance Costs	(1,163)	(800)	363
Net deficit	**(11,362)**	**(7,465)**	**3,897**
Remove donated asset I&E impact	60	60	-
Adjusted financial performance (exc PSF & FRF)	**(11,302)**	**(7,405)**	**(3,897)**
PRF/FRF monies	9,594	9,514	(80)
Adjusted financial performance surplus/(deficit) including PSF & FRF	**(1,708)**	**2,109**	**3,817**

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan on both a monthly and cumulative basis





INFORMATION

The trust delivered an in-month (February) surplus of £48,452 against an in month deficit plan of £696,856. The year to date performance is a surplus of £2,108,535, which is ahead of the planned deficit of £1,708,350. The improved performance is related primarily to an additional one off STP reserve allocation in January of £1,868,000. An underlying surplus position year to date of £240,535 with the one off allocation excluded.

	Plan	Actual	Variance
In Month	-£696,856	£48,452	£745,308
Year to date	-£1,708,351	£2,108,535	£3,816,886

The block payment system with commissioners has been extended for the remainder of the year and for the first quarter of 2021/22, although the financial envelope for that period has not yet been agreed. In addition to a monthly block allocation, the Trust are receiving an allocation of STP growth monies and a COVID allocation.

The end of year forecast position has improved to a deficit of £371,514 as a result of the additional STP reserve allocation. This includes £8.1m top up funding and £3.9m of growth and COVID allocation.

Financial planning for 2021/22 has commenced and will be shared in due course

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

The current financial block allocation does not adequately cover the costs of Phase 2 of the theatre/ward development which start from December, and therefore the Trust are expected to deliver an underlying deficit before top up, growth and COVID income are accounted for.

In addition, COVID-19 is expected to continue to have a significant operational and financial impact on the organisation and wider system. The financial impact of this will need to continue to be carefully managed.

2. Income and Activity– This illustrates the total income generated by the Trust in 2020/21, in addition to the month's activity (Inc PSF & RFF)

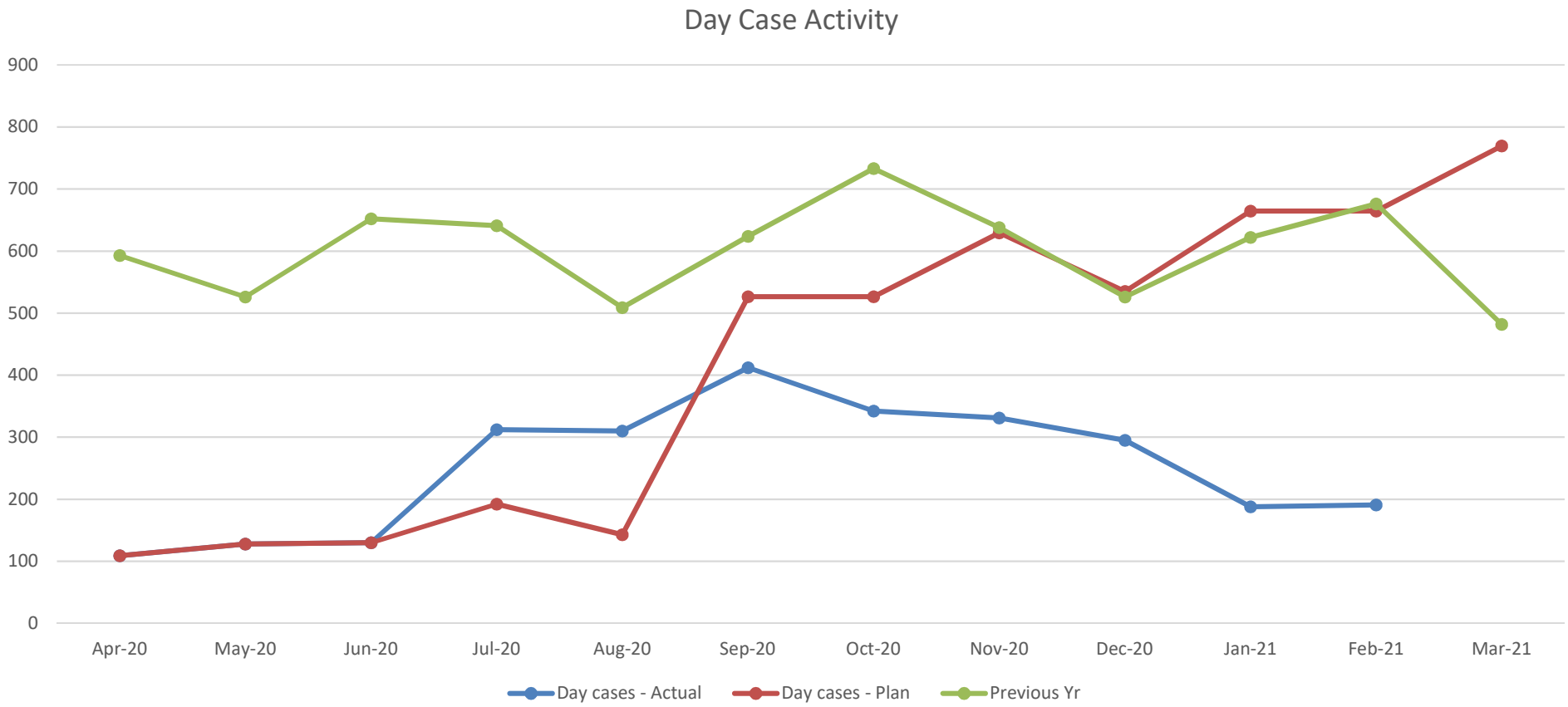
Breakdown of Block Income Received year to date

	Month 11 YTD (£000)		
	Plan	**Actual**	**Variance**
NHS England	21,153	22,308	1,155
Clinical commissioning groups	56,009	56,697	688
NHS Foundation Trusts	1,473	1,397	(76)
Private Patients	361	642	281
Research & Development	305	313	8
Education & Training	1,326	1,808	482
Other Income	2,460	2,538	78
Retrospective Top Up	9,594	9,514	(80)
	92,681	**95,217**	**2,536**

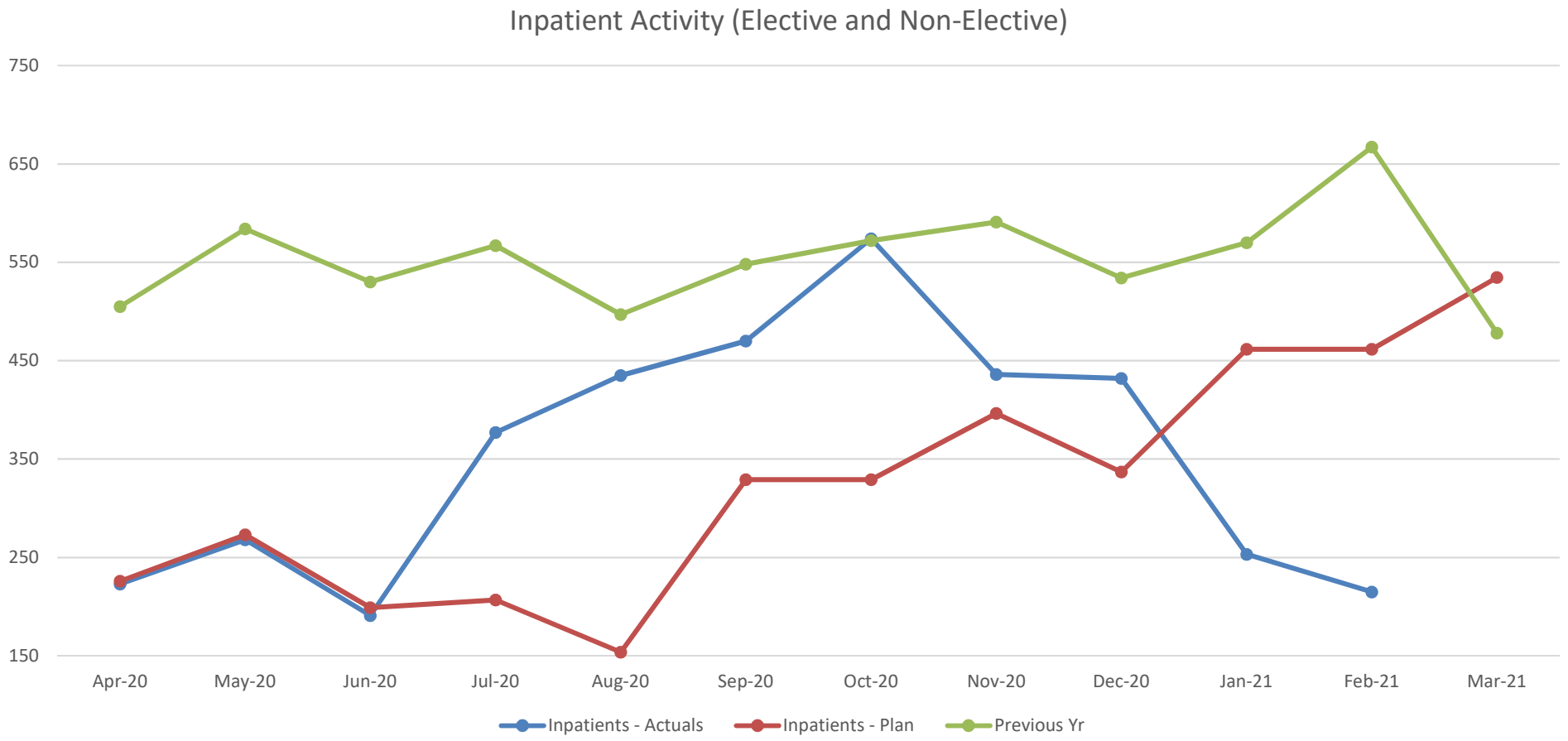
INFORMATION

Block contracts have been agreed with commissioners for the remainder of 2020/21. These block contract values have been derived from the average monthly income achieved during M1-9 of 2019/20 adjusted for an inflationary uplift (2.8%). Top up income has then been calculated to bridge the gap between income and expenditure during the same period, to support Trusts in delivering a break even position.

The COVID prospective top up for months 7 -12 is £651k per month, and top up funding of £1,358k per month.

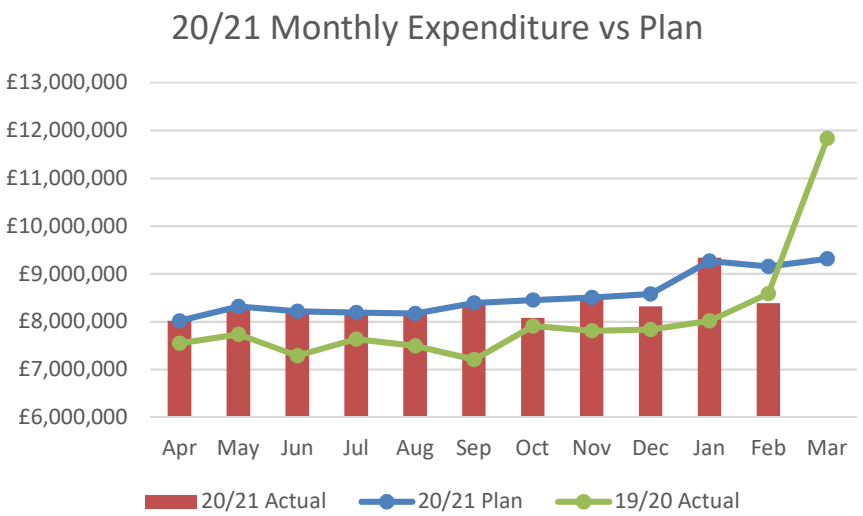


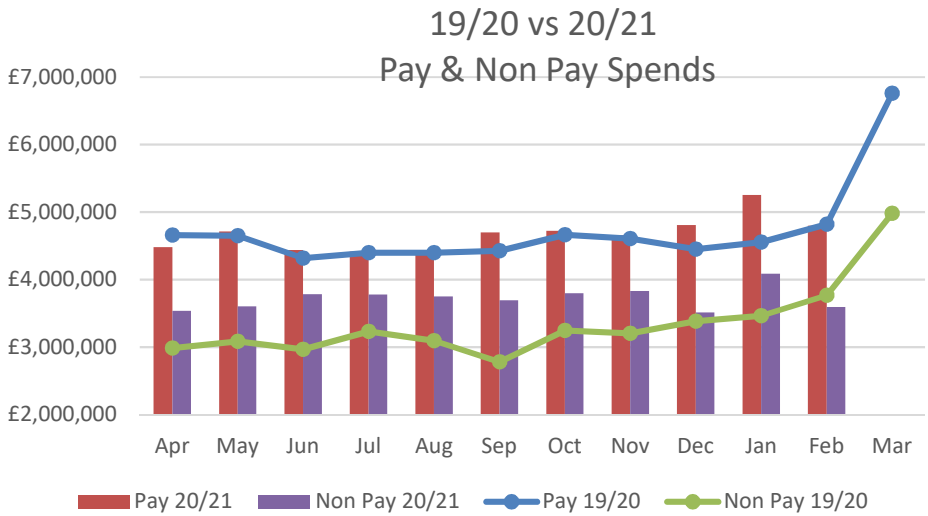
Daycase	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	109	128	130	311	321	411	341	330	293	188	191	
Draft Plan				192	143	527	527	630	535	665	665	770
Previous Yr	593	526	652	641	509	624	733	638	563	675	676	482



Inpatient	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	226	273	199	365	428	468	568	436	431	253	215	
Draft Plan				207	154	329	329	396	337	462	462	535
Previous Yr	505	584	530	567	497	548	572	591	534	568	666	478

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2020/21, compared to historic trends





COVID-19 related expenditure

Additional costs related to COVID	£'000s
Existing workforce additional shifts	953
Backfill for higher sickness absence	245
Decontamination	63
Remote working	469
PPE and other associated costs	376
Segregation of patient pathways	429
Other	80

Reimbursement for this expenditure and income loss is funded through a retrospective top up process.
Across the Midlands and East region the average claim as % operating expenditure is 5.3% (Range 1% -13.2%), to Month 11 ROH claim was 2.8%.

INFORMATION

Performance against Plan

Expenditure in February was £8,390k, which is in line with plan. This includes the additional pay and infrastructure costs relating to Phase 2 of the theatre development. The pay figure now also include a provision for annual leave that is unlikely to be taken by the end of the year.

COVID-19 Expenditure

From Month 7 the COVID reimbursement scheme is a prospective top up amount. This amount has been based on the forecast expenditure related to the COVID response. This includes the purchase of IT equipment to support virtual working and additional pay costs relating to increased sickness levels and additional staffing requirements to support the vaccination hub.

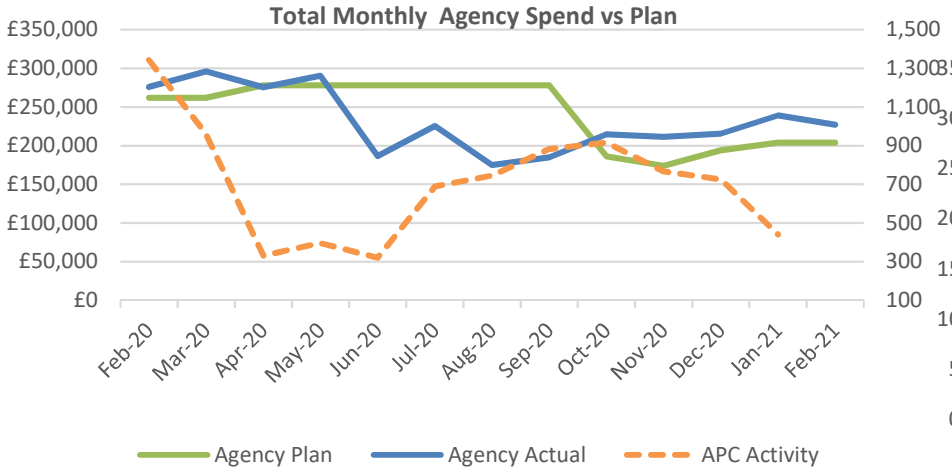
RISKS / ISSUES

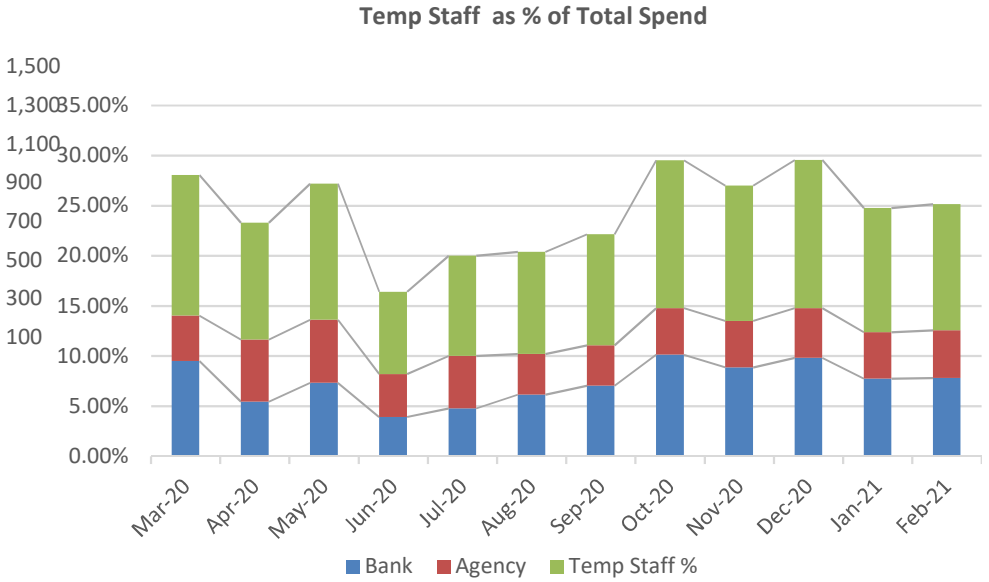
There is a risk that the Trust's response to COVID costs more to deliver than the prospective top up funding. This has been mitigated by a prudent forecast submitted reviewing intelligence gathered during the response to the first wave.

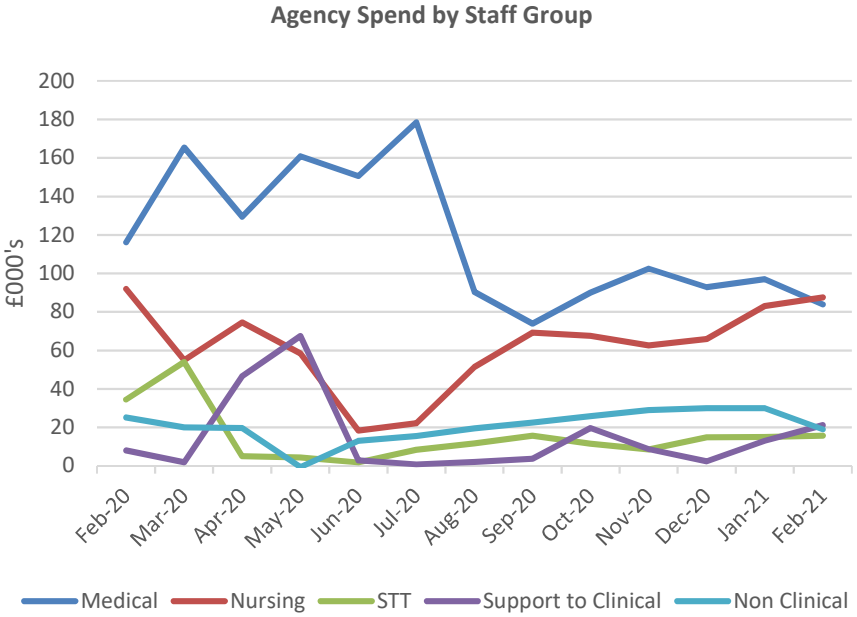
In addition, it should be expected that expenditure in some particular areas, for example in temporary staffing, infection control measures will remain high over the next couple of months. Any additional costs will continue to be tracked separately and reported centrally.

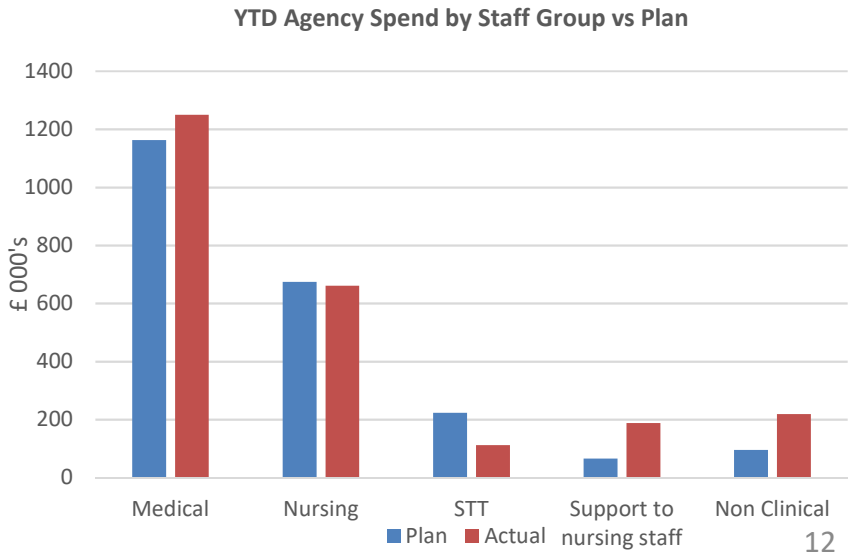
The reimbursement scheme previously extended to cover income loss directly as a result of COVID, such as private patients, car parking or rental accommodation, has now been removed. There is a greater expectation that these income levels will return to normality.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION
Total agency spend for February was £227k. A review of the detail shows increases in nursing staff whilst other staffing groups remain fairly consistent with previous months. Whilst surgical activity is still low, wards have been busy due to the transfer of rehabilitation patients from UHB. The spend is still significantly lower than the corresponding period last year, even with current rates of sickness.
ACTIONS FOR IMPROVEMENTS / LEARNING
Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary. Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.
RISKS / ISSUES

5.Cost improvement Programme Summary

INFORMATION

A CIP totalling £577,000 for months 1-10 has been achieved, and a forecast end of year position totalling £659,000, equating to 0.73%.

Business planning sessions with services and departments has identified CIP schemes for 2021/22 totalling £1,615k . Many other schemes have been identified and require further work to identify the estimated savings.

The main schemes identified are;

- Digital Transformation – Expansion of paperless communications, text message reminders and partial booking for booking appointments
- Medical Workforce efficiencies –reduction in agency spend through collaborative bank set up, alternative roles and Direct Engagement
- Procurement initiatives – Continuation of work to review products, prices and contracts with suppliers of non pay goods & services.
- Service transformation – Implementation of a new spinal endoscopic service and a rationalisation of suppliers.
- Theatres Managed Service contract - VAT savings and economies of scale purchasing savings

Scheme	21/22 (£000s)
Div 1	**£521**
Digital transformation	£78
DNA Rate Reduction - OP	£50
Private Patients	£120
Procurement	£183
Spinal Service Transformation	£90
Div 1&2	**£264**
Medical Workforce	£264
Div 2	**£830**
Admin vacancy	
DNA Rate Reduction - OP	£135
Managed Theatres Service	£696
Medical Workforce	
(blank)	
Grand Total	**£1,615**

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	2019/20	Month 11 YTD (£000)		
	M12	Plan	Actual	Variance
Intangible Assets	1,326	912	964	52
Tangible Assets	43,980	41,917	42,544	627
Total Non-Current Assets	**45,306**	**42,829**	**43,508**	**679**
Inventories	6,690	4,183	6,631	2,448
Trade and other curent Assets	10,058	12,764	10,008	(2,756)
Cash	663	7,079	14,167	7,088
Total Current Assets	**17,411**	**24,026**	**30,806**	**6,780**
Trade and other payables	(13,967)	(16,926)	(21,079)	(4,153)
Borrowings	(20,525)	(374)	(660)	(286)
Provisions	(406)	(3,240)	(2,901)	339
Other liabilities	(250)	(480)	(906)	(426)
Total Current Liabilities	**(35,148)**	**(21,020)**	**(25,546)**	**(4,526)**
Borrowings	(721)	(394)	(142)	(4,899)
Provisions	(526)	(527)	(526)	(9,512)
Total Non-Current Liabilities	**(1,247)**	**(921)**	**(668)**	**(14,411)**
Total Net Assets Employed	**26,322**	**44,914**	**48,100**	**3,186**
Total Taxpayers and Others Equity	**26,322**	**44,914**	**48,100**	**3,186**

INFORMATION

The movement in the borrowings balance in year remains related to the transfer of historic revenue support loans from DHSC to issued public dividend capital. The total transfer was £19.8m and was physically actioned in September.

Assets have reduced due to a sales invoice being raised to Genmed for the sale of Theatre assets to them under the managed service contract.

Cash in the bank at 28th February was £14.2m which is an increase of £13.5m compared to March. This is due to the Trust receiving a month's cash in advance for the block contract under the new Covid arrangements, in addition to some in-month timing differences. This means that no further cash loans have had to be secured by the Trust from DHSC.

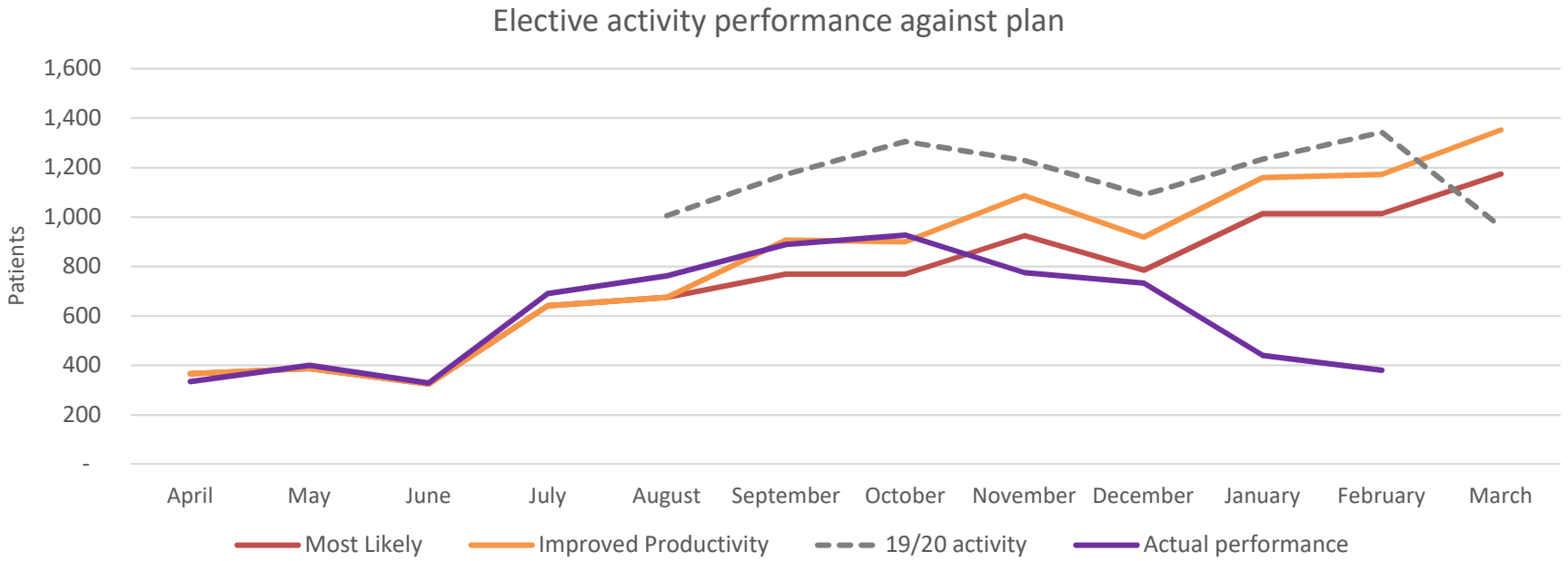
ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

The current arrangement in place with commissioners to receive monthly income a month in advance has ceased in February. This will result in a lower cash balance during March. A cashflow forecast has been completed which demonstrates there will be sufficient cash for the Trust during March.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

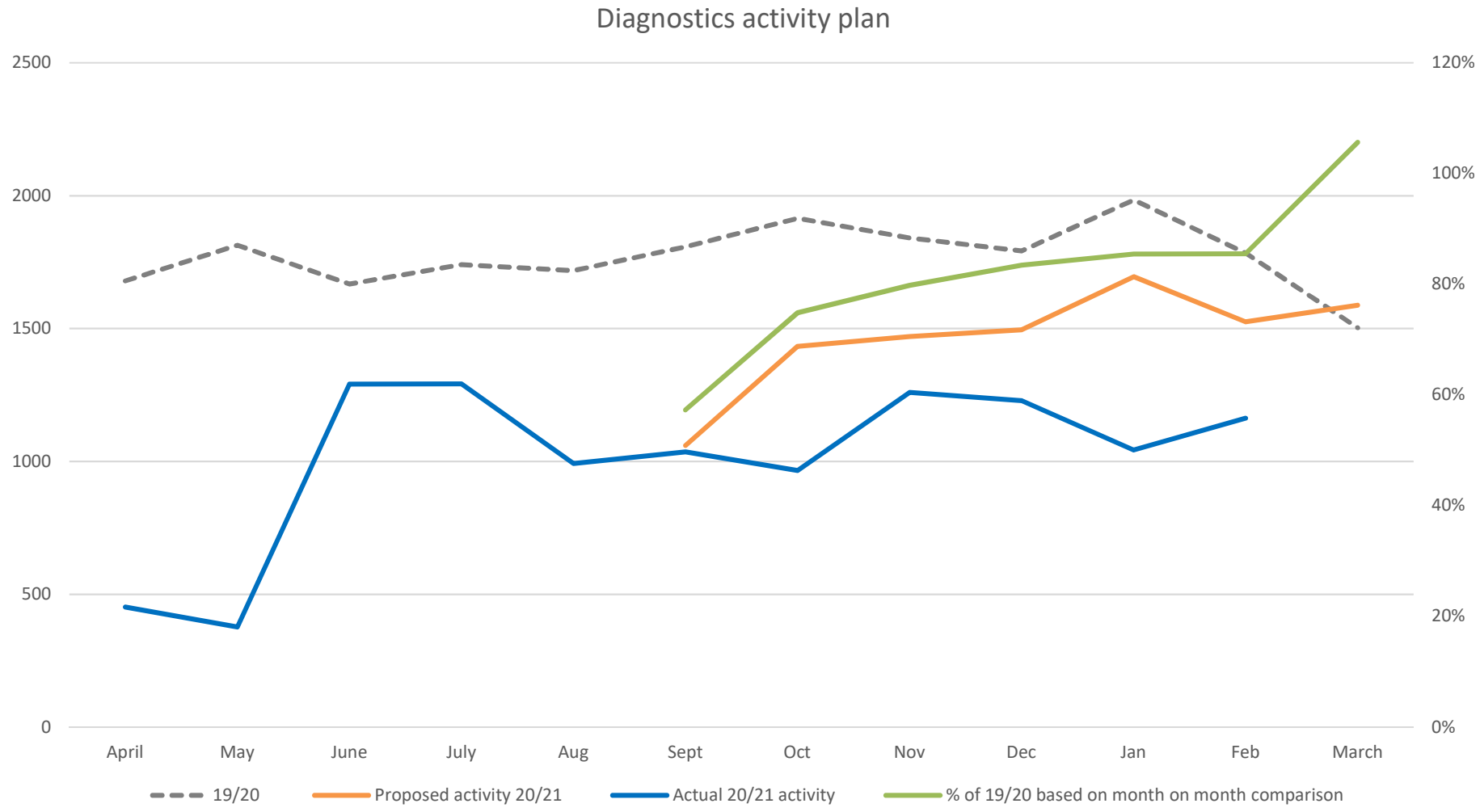
Performance against Activity plan – Elective Finance & Performance committee agreed plans



- February delivered 380 against a most likely plan of 1014, which is 28% of 19/20 activity for the same period
- A revised pro rata activity plan to account for reduced theatre availability during February has been calculated equating to a plan of 434 cases
- Actual performance year to date is significantly lower than plan as a result of the operational changes made to support the BSOL system with the COVID surge. Actual delivery and total booked activity for March totals 582 patients.

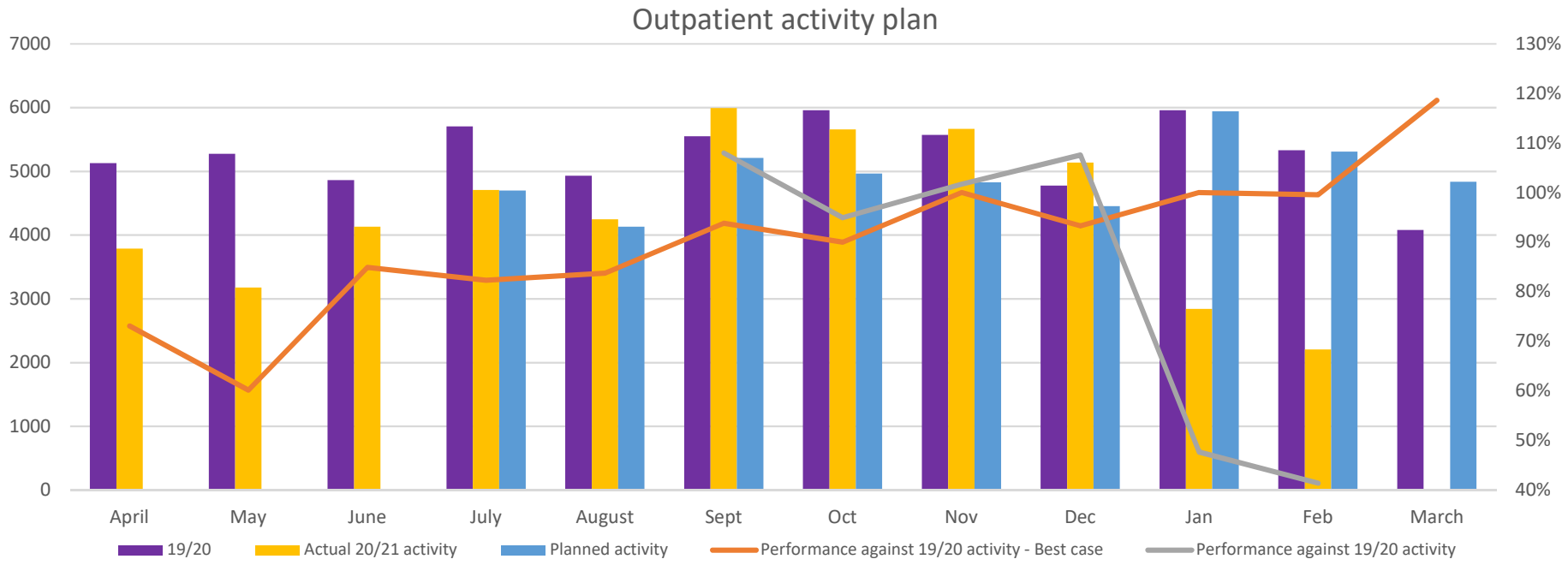
	April	May	June	July	August	September	October	November	December	January	February	March
Actual performance	335	401	329	691	762	889	927	775	733	441	380	
Most Likely	366	387	325	641	675	770	770	924	785	1,014	1,014	1,174
Improved Productivity	366	387	325	641	675	907	900	1,087	919	1,160	1,173	1,352
19/20 activity					1006	1172	1305	1229	1089	1233	1343	960
Actual % delivery against 1920					71%	75%	70%	63%	67%	36%	28%	

Performance against Activity plan– Diagnostic STP final planning submission

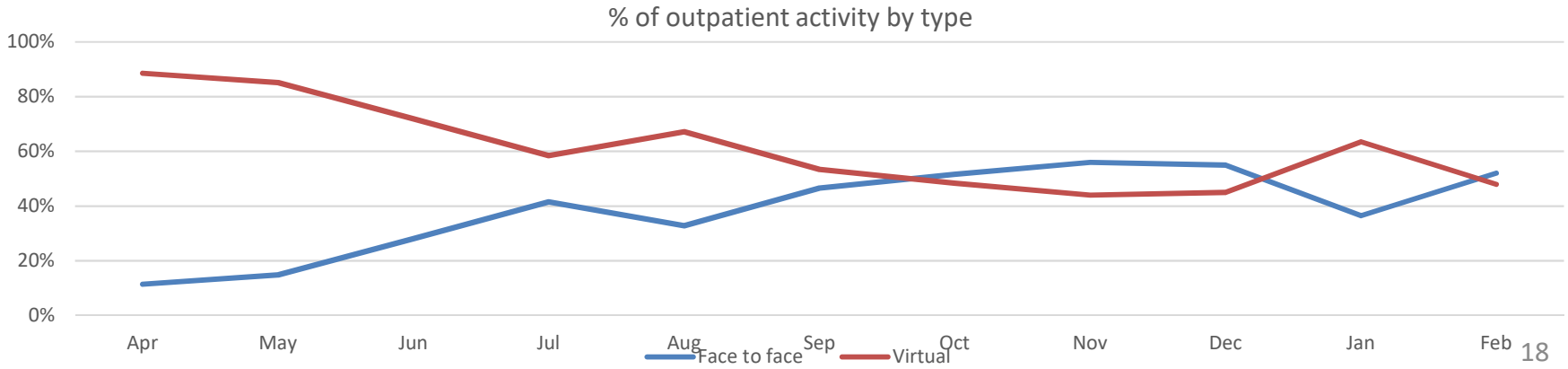


The diagnostic activity most likely projections are subject to forecasting of potential demand , however there is sufficient flexibility built into the operating model to enable expansion of capacity to ensure compliance with national diagnostic targets.

Performance against Activity plan– Outpatients STP final planning submission

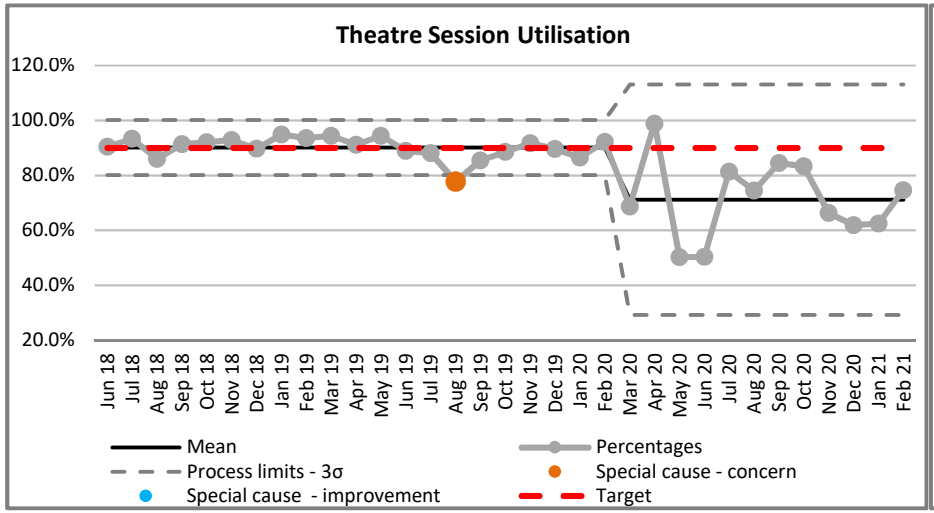


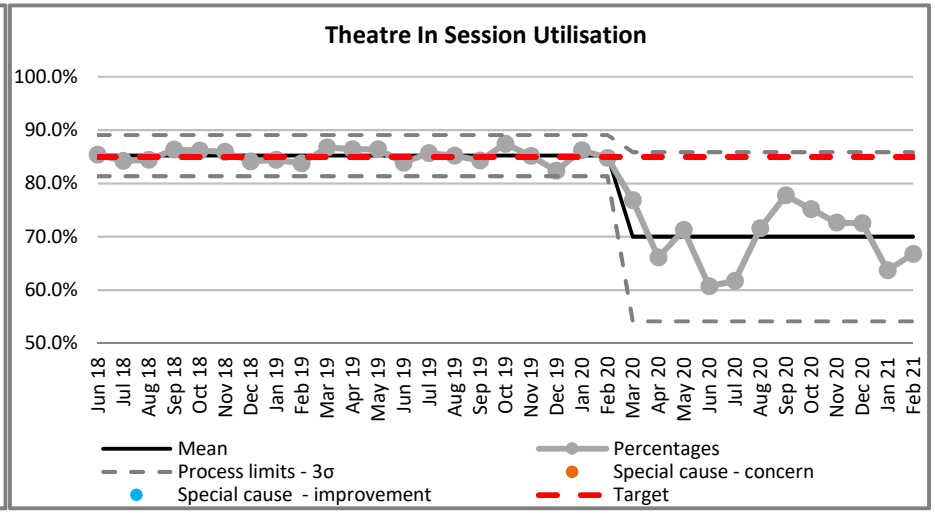
Activity in Febuary was below plan and below 19/20 activity levels. 48% of the activity delivered virtually.



Note: Plan figures here represent the final plan submitted to STP

1. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used





INFORMATION

In response to a system level surge to NHS E/I level 4, a request for Consultant Anaesthetists to support UHB was received, resulting in the release 6 Consultants per day. This support continued throughout February affecting our ability to increase the number of theatres available.

The case mix prioritised during February remained that of urgent P2 and emergency work, in addition to this Spinal emergency referrals continued to be transferred from UHB to ROH. Therefore out of the 10 theatres we had available 5 of these were allocated to support emergency workload which was predominantly from UHB.

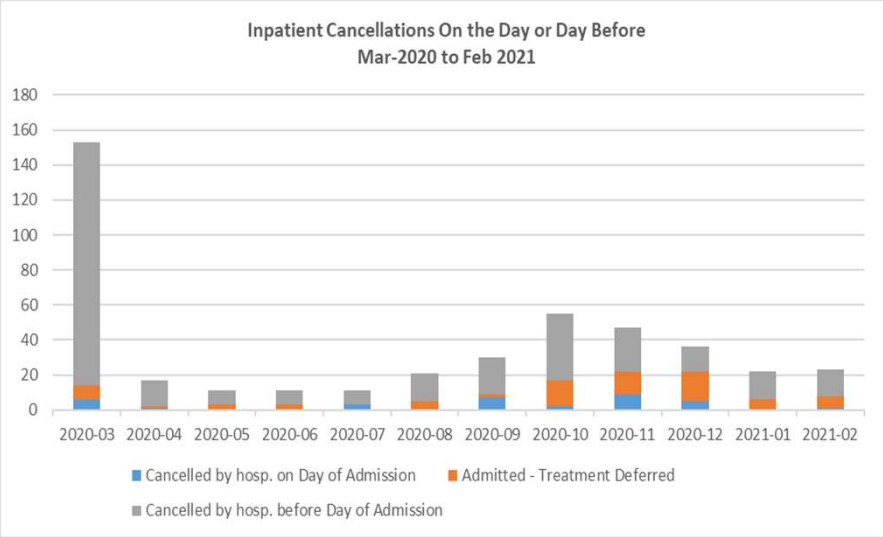
Theatre utilisation for February is therefore, based on 5 elective theatres at 74.58 % for theatre session utilisation and 66.79% for in session utilisation. The challenge still remains in respect of being unable to back fill lists when last minute cancellations occur due to the current 14 day isolation rules. Discussions are being had to review this in the context of the vaccine roll out and decreases in infection rates over recent weeks.

In March focus will be on maximising the 5 elective theatres whilst undertaking remedial maintenance work in theatres and at ward level to ensure the opening of 12 theatres in April and 14 theatres in May to support the reduction of the elective backlog in Q1

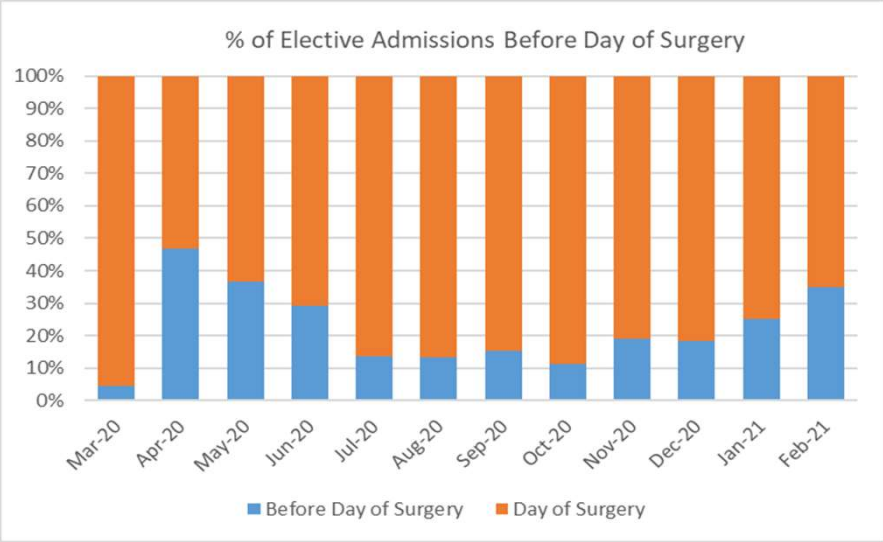
RISKS / ISSUES

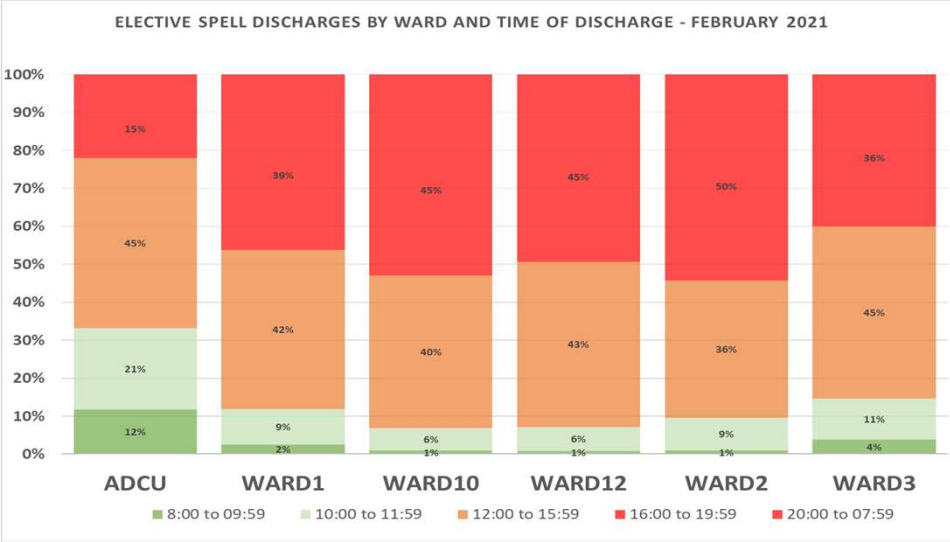
Converting theatres back to an elective footing will be reliant on the repatriation of theatre staff and anaesthetists who have been released to support ITU at UHB, but also System wide agreement as to next steps in supporting P2 activity. These discussions remain on going.

2. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



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
2020-03	6	8	139	153	4
2020-04	1	1	15	17	0
2020-05		3	8	11	0
2020-06		3	8	11	0
2020-07	3		8	11	0
2020-08		5	16	21	0
2020-09	7	2	21	30	0
2020-10	2	15	38	55	0
2020-11	9	13	25	47	1
2020-12	5	17	14	36	0
2021-01		6	16	22	0
2021-02	1	7	15	23	0
Grand Total	**34**	**80**	**323**	**437**	**5**





There was 1 patient cancelled on the day of admission in February, however there were 7 patients admitted but where treatment was deferred, with reasons broken down as follows:

1 x Surgeon availability due to needing to self-isolate
2 x Medically unfit
1 x Patient recently had COVID vaccine
1 x Patient on antibiotics
2 x Patients no longer wanted surgery

Cancellations prior to day of surgery for February were 15 as detailed below:

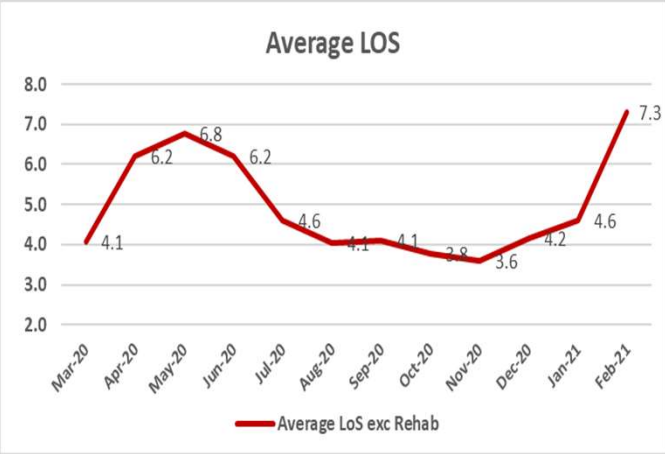
2 x Patient unwell after COVID-19 vaccine
7 x TCI's rescheduled/cancelled
1 x Medically unfit
2 x COVID swab results not available
1 x Patient DNA COVID swab
2 x COVID positive

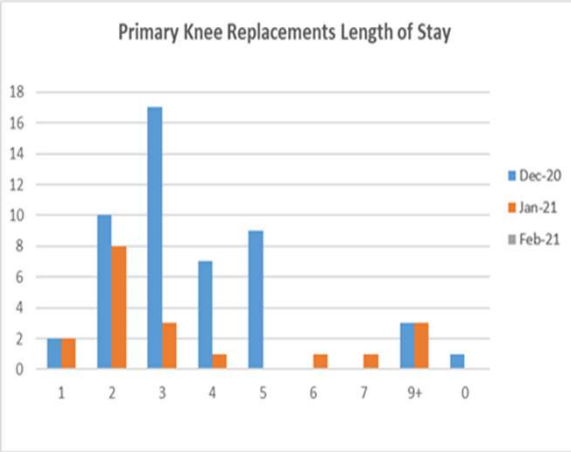
864 continues in a strengthened format with executive oversight to maximise resources both in theatre and on wards

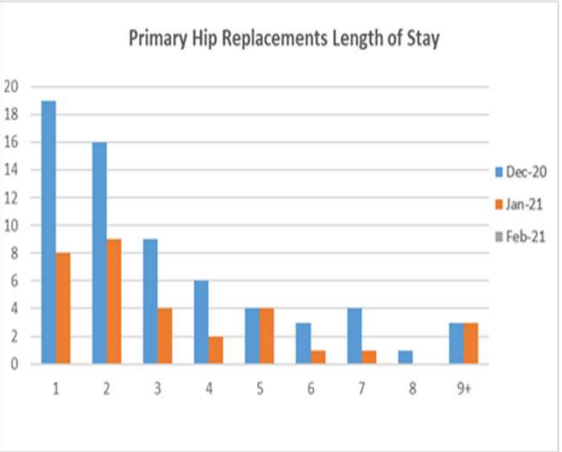
RISKS / ISSUES

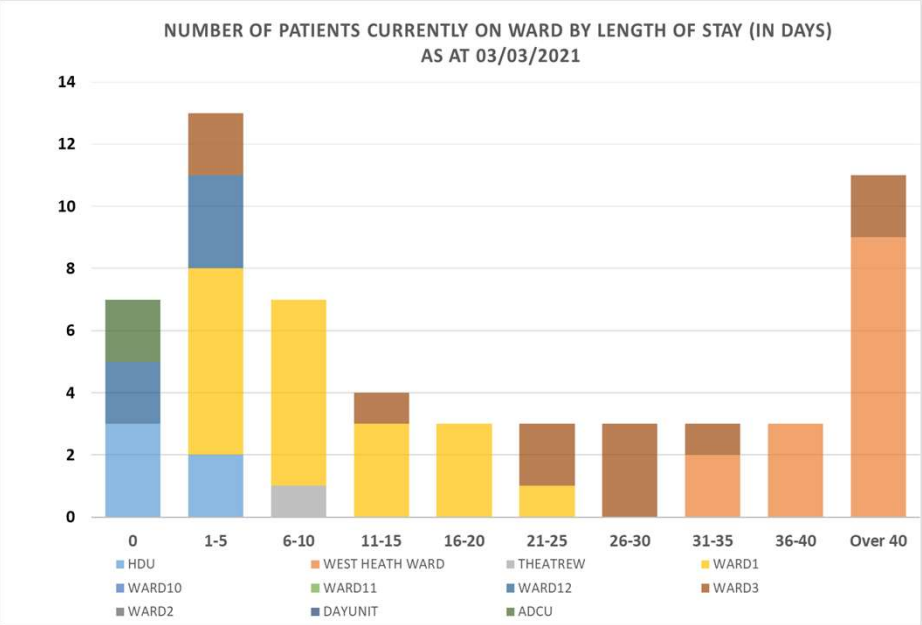
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient cancellations which will require monitoring as services are recovered through the harm review process .

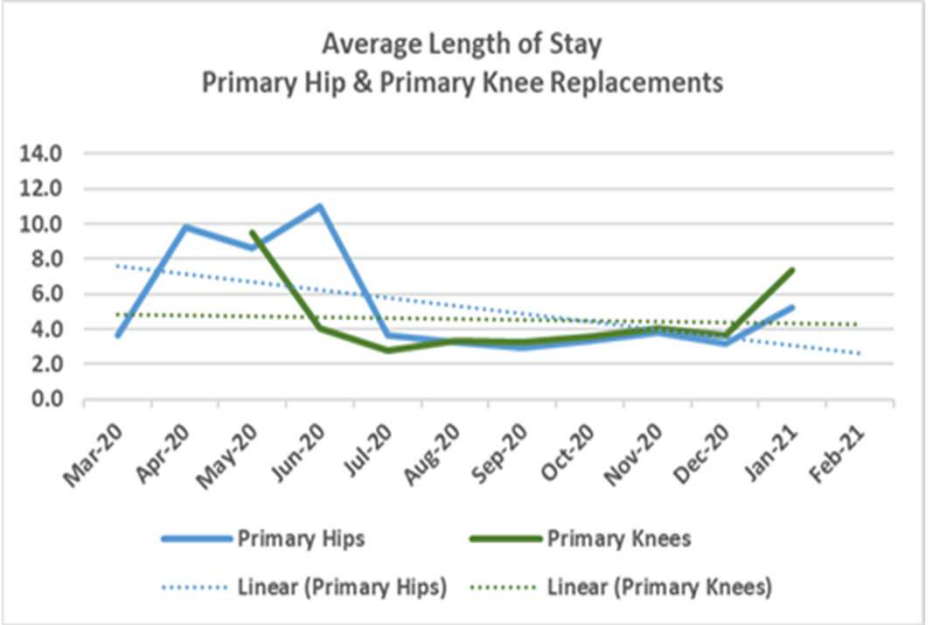
3. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways





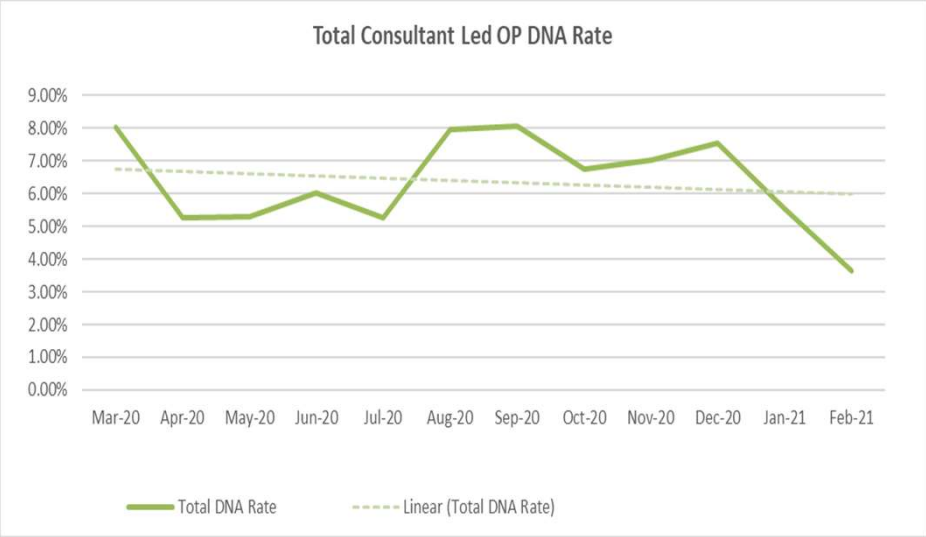


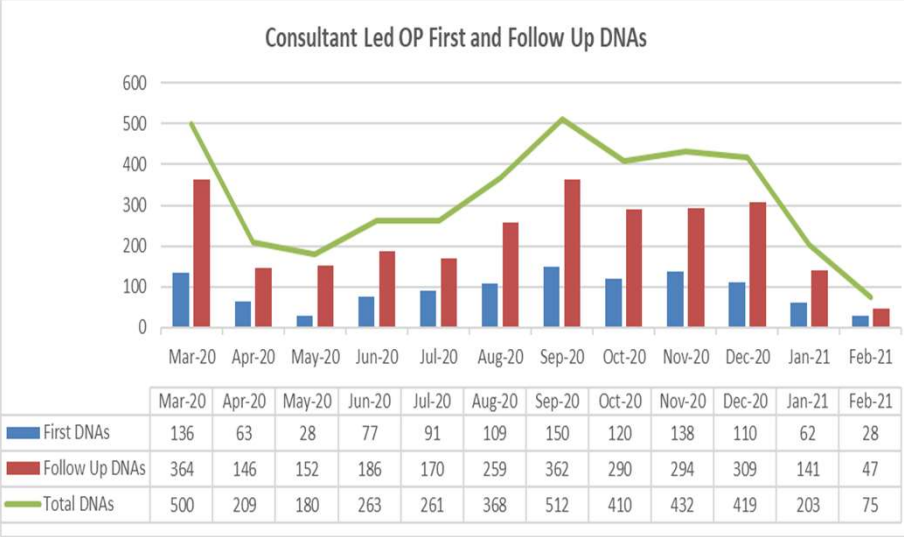




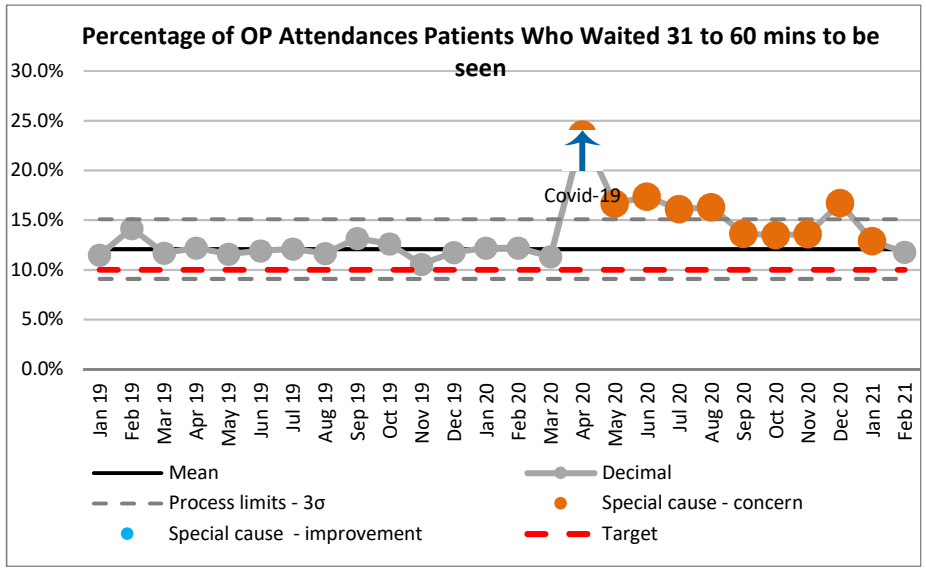
INFORMATION
LOS has increased from 4.6 in January to 7.3 in February 2021. The records of all patients with a length of stay recorded as greater than 20 days have been reviewed by Head of Nursing Division 1. All were complex oncology or spinal patients with on-going clinical medical needs which included BIU, infected wound management, further surgery or COVID. One Oncology patient had multiple infections resulting in a stay of 73 days Patients operated on in this period met the Trust categorisation for urgent surgery therefore no primary hips or knees were operated on during February. 10 patients in February had delayed Transfers of Care, these patients were mainly the Acute Rehab Pathway patients transferred from UHB to ROH as part of the agreed mutual aid support. The delays totalled 78 days. All delayed discharges are discussed at the daily 1pm meeting and escalated if they is no immediate plan or resolution.
ACTIONS FOR IMPROVEMENTS / LEARNING
The roaming discharge team supported by the safeguarding team have continued to provide discharge support to the wards. This supports and promotes early discharge planning. Discussions have commenced as to how this will be maintained and increased to ensure patient flow enables 7.15am admissions to wards.
RISKS / ISSUES
Increased length of stay due to reasons listed above may impact on patient flow and available bed capacity, however a dynamic bed modelling framework is now in place to ensure forecasting of bed capacity meets demand thus avoiding any cancellations pro actively.

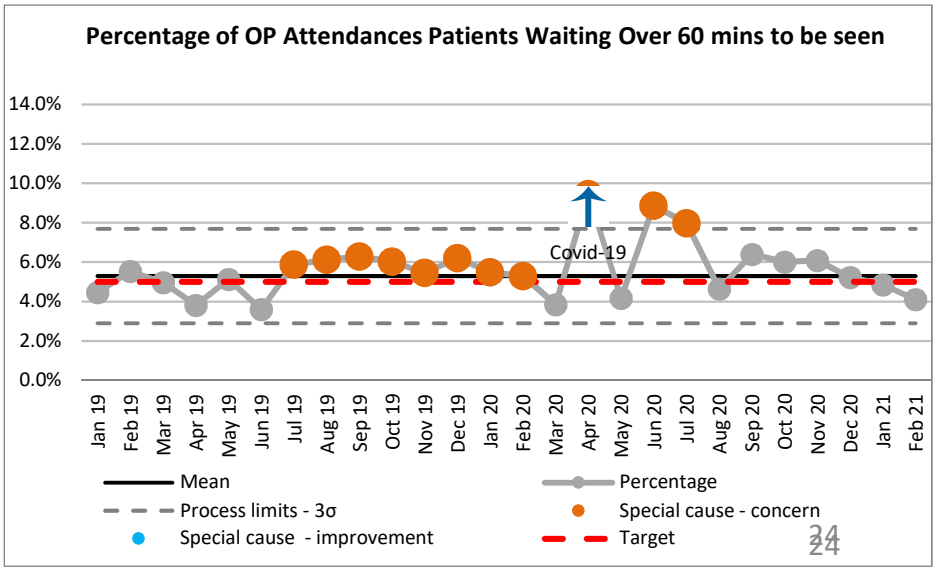
4. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients





	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
First DNAs	136	63	28	77	91	109	150	120	138	110	62	28
Follow Up DNAs	364	146	152	186	170	259	362	290	294	309	141	47
Total DNAs	500	209	180	263	261	368	512	410	432	419	203	75





INFORMATION

Both 30 minute and 60 minute delay metrics have improved in February

30 minute delays – February position is **11.8%** compared to **12.09%** in January. (Below trust target of 10%)
60 minute delays – February position is **4.1%** compared to **4.9%** in January. Target is **5%** therefore

A task and finish group is in place as part of the refresh and recovery programme to support and resolve the issues identified on a daily basis from the daily huddles. A morning huddle is in place to identify any concerns to start the day and to ensure all clinics start on time. The afternoon huddle will undertake a forward look for the next two days to identify and resolve any potential concerns or issues.

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure patients are seen on time for their appointments. Incident reports are submitted for any clinic delays more than 30 minutes and these will be reviewed and issues resolved as they are identified and also pick up any key themes and trends.

The DNA rates have reduced in February to **3.64%** compared to January's **5.54%** and continue to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department to support and oversee operations.

ACTIONS FOR IMPROVEMENTS / LEARNING

Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

Due to the reduction in capacity within imaging to ensure appropriate social distancing arrangements are in place some patients are needing to wait for a space in imaging if they require an x-ray that has not been pre-planned . Work is underway with the team to ensure that for all patients awaiting imaging, especially those with special needs are supported appropriately and communication around these patients is flowing between the two departments seamlessly to enable this to happen.

RISKS / ISSUES

Lack of capacity in outpatients continues to be a concern, evenings and weekends need to be considered in job plans and currently scoping options for alternative locations for virtual clinics and further extended working days .

5. Referral to Treatment Snapshot as at 28th February2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

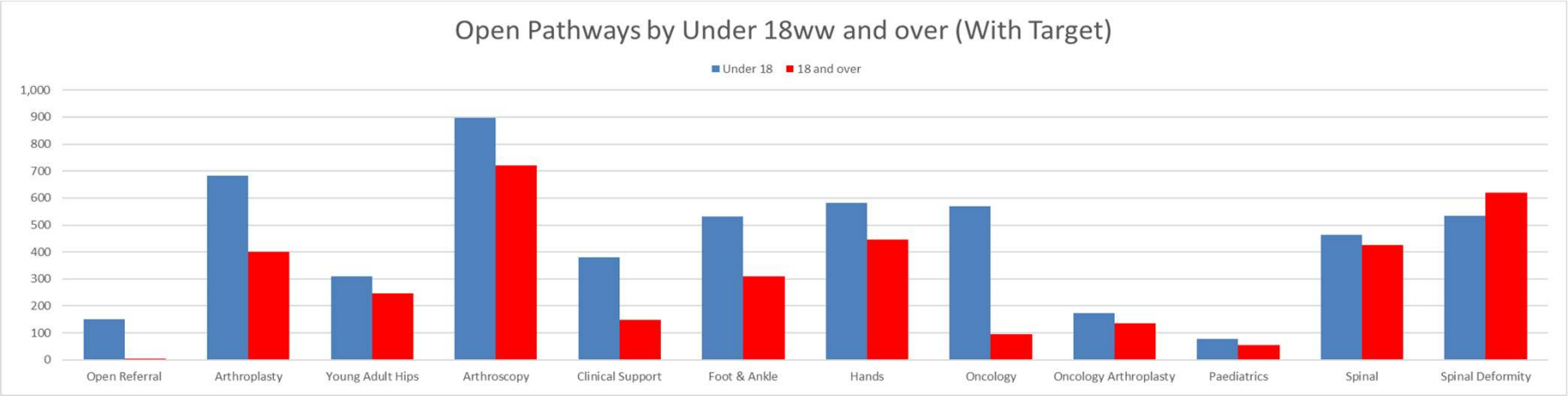
	Est Over 18 Clock Stops Required	
To achieve	81.47%	2748
To achieve	71.13%	1651
To achieve	81.74%	2773

Select Pathway Type: **Both**

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,957**	102	265	86	301	152	172	179	265	47	27	172	189
7-13	**2,166**	45	294	145	369	146	224	247	180	66	31	196	223
14-17	**1,224**	3	124	78	227	81	135	156	124	61	19	95	121
18-26	**2,097**	4	249	161	385	125	221	281	73	92	31	198	277
27-39	**1,054**	0	124	59	211	20	75	129	12	39	18	140	227
40-47	**201**	0	12	12	47	0	4	17	9	1	4	40	55
48-51	**112**	0	7	6	34	0	1	9	0	2	1	21	31
52 weeks and over	**142**	0	9	8	43	3	8	11	2	2	0	26	30
Total	**8,953**	154	1,084	555	1,617	527	840	1,029	665	310	131	888	1,153

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,347**	150	683	309	897	379	531	582	569	174	77	463	533
18 and over	**3,606**	4	401	246	720	148	309	447	96	136	54	425	620
Target for RTT 92%	**716**	**12**	**86**	**44**	**129**	**42**	**67**	**82**	**53**	**24**	**10**	**71**	**92**

Month End RTT %	**59.72%**	**97.40%**	**63.01%**	**55.68%**	**55.47%**	**71.92%**	**63.21%**	**56.56%**	**85.56%**	**56.13%**	**58.78%**	**52.14%**	**46.23%**



Referral to Treatment Snapshot as at 28th February 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

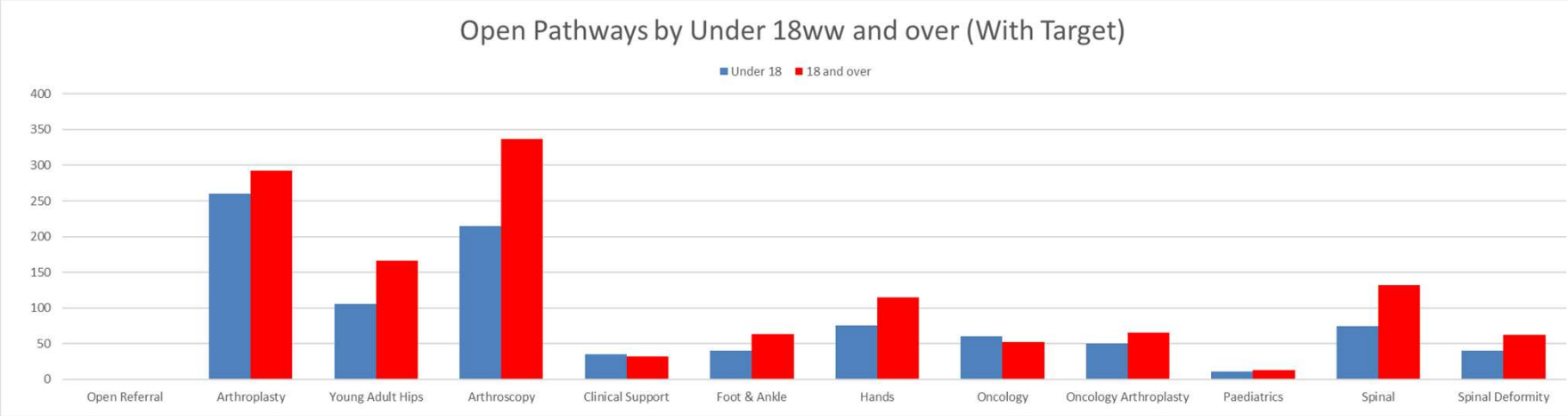
Est Over 18 Clock Stops Required		
To achieve	81.47%	1275
To achieve	71.13%	1077
To achieve	81.74%	1280

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**184**	1	52	10	38	5	2	7	32	10	2	15	10
7-13	**492**	0	133	53	98	24	24	45	22	26	9	39	19
14-17	**291**	0	75	43	79	6	14	23	6	14	0	20	11
18-26	**709**	0	189	103	149	23	40	49	32	39	7	56	22
27-39	**382**	0	83	43	92	7	12	50	10	21	5	38	21
40-47	**81**	0	7	7	35	0	2	4	8	1	1	13	3
48-51	**56**	0	5	6	22	0	1	5	0	2	0	8	7
52 weeks and over	**101**	0	8	7	39	2	8	7	2	2	0	17	9
Total	**2,296**	1	552	272	552	67	103	190	112	115	24	206	102

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**967**	1	260	106	215	35	40	75	60	50	11	74	40
18 and over	**1,329**	0	292	166	337	32	63	115	52	65	13	132	62
Target for RTT 92%	**183**	**0**	**44**	**21**	**44**	**5**	**8**	**15**	**8**	**9**	**1**	**16**	**8**

Month End RTT %	42.12%	100.00%	47.10%	38.97%	38.95%	52.24%	38.83%	39.47%	53.57%	43.48%	45.83%	35.92%	39.22%



Referral to Treatment Snapshot as 28th February 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 28/02/2021

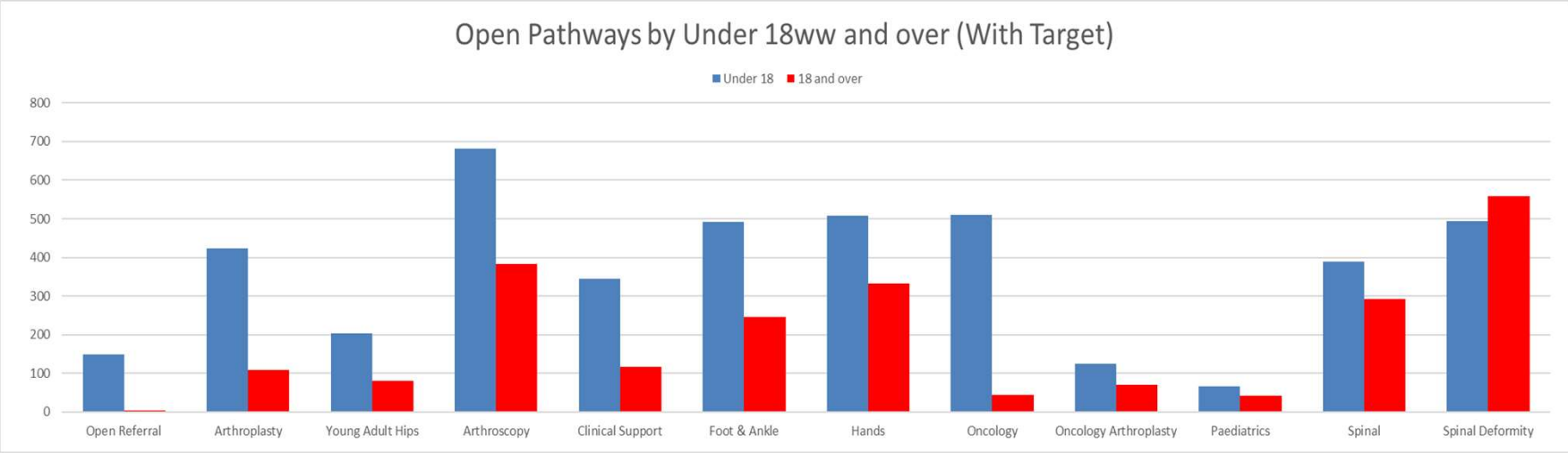
Est Over 18 Clock Stops Required		
To achieve	81.47%	1473
To achieve	71.13%	574
To achieve	81.74%	1493

Select Pathway Type: Non Admitted

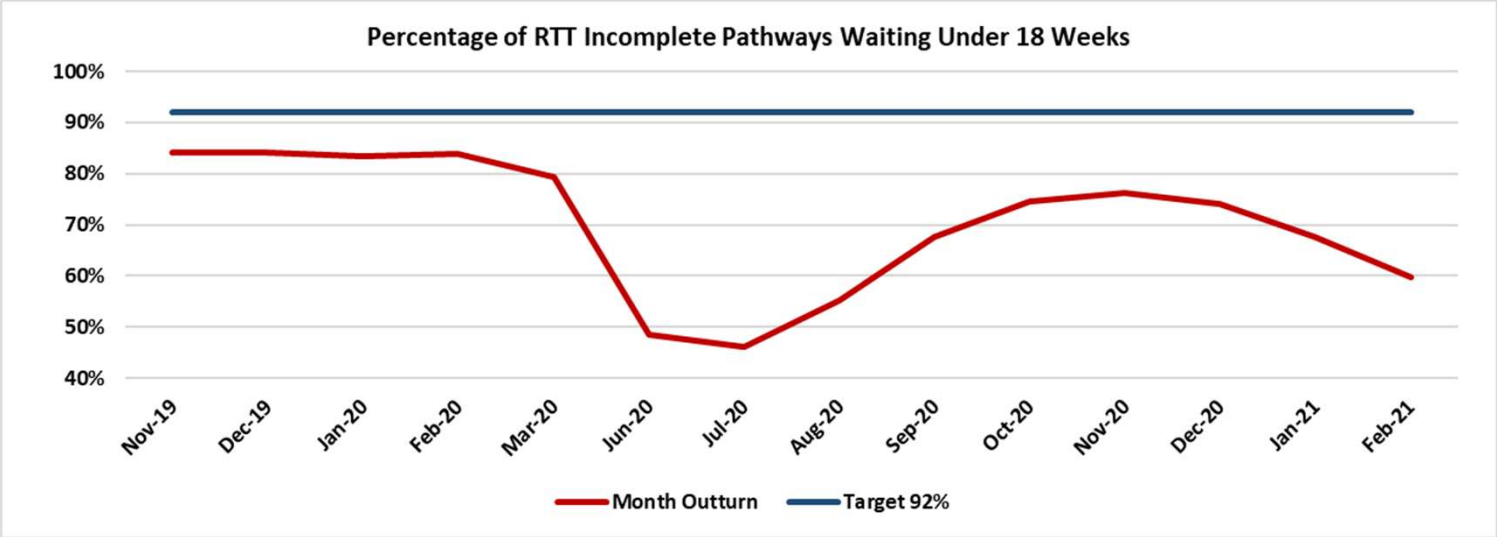
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**1,773**	101	213	76	263	147	170	172	233	37	25	157	179
7-13	**1,674**	45	161	92	271	122	200	202	158	40	22	157	204
14-17	**933**	3	49	35	148	75	121	133	118	47	19	75	110
18-26	**1,388**	4	60	58	236	102	181	232	41	53	24	142	255
27-39	**672**	0	41	16	119	13	63	79	2	18	13	102	206
40-47	**120**	0	5	5	12	0	2	13	1	0	3	27	52
48-51	**56**	0	2	0	12	0	0	4	0	0	1	13	24
52 weeks and over	**41**	0	1	1	4	1	0	4	0	0	0	9	21
Total	**6,657**	153	532	283	1,065	460	737	839	553	195	107	682	1,051

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,380**	149	423	203	682	344	491	507	509	124	66	389	493
18 and over	**2,277**	4	109	80	383	116	246	332	44	71	41	293	558
Target for RTT 92%	**532**	**12**	**42**	**22**	**85**	**36**	**58**	**67**	**44**	**15**	**8**	**54**	**84**

Month End RTT %	**65.80%**	**97.39%**	**79.51%**	**71.73%**	**64.04%**	**74.78%**	**66.62%**	**60.43%**	**92.04%**	**63.59%**	**61.68%**	**57.04%**	**46.91%**



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for February is **59.72%** against the National compliance target of 92%. This is a decrease compared to January 21 at **67.70%** and is reflective of the cessation of elective procedures in order to undertake core critical services i.e. emergencies, spinal, oncology. There are 142 patients over 52 weeks - 101 admitted patients, all priority 2 and 3 patients are booked for March and in the process of being booked for April, 47 are priority 4. There are 41 non admitted patients with face to face clinics or diagnostic investigations now planned and additional OPD capacity for Spinal is planned for April.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2296 patients are on the admitted waiting list (P1b – 5, P2 – 260 patients, P3 – 607 patients, P4 – 1420 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the process is standardised across all specialties and to provide assurance going forward all patients are reviewed on a regular basis.

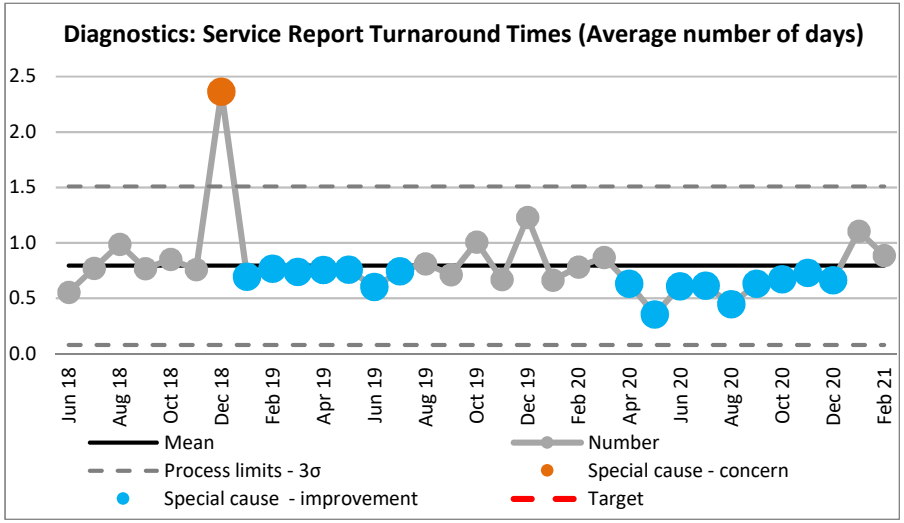
The total number of referrals into the Trust in February was 1348 which is low (55%) when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

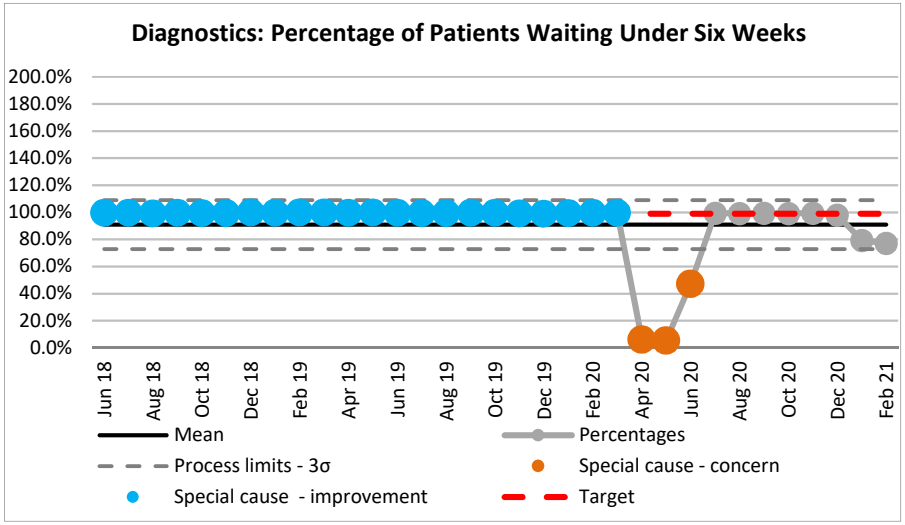
6.Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION
Imaging did not achieve the diagnostic target reporting 77.02% for February but continues to report consistently good performance for report turn around times. Position as at 14th March reporting 91.56%, 45 patients over 6 weeks to book, progress is being monitored weekly to ensure compliance is 99% by month end. February saw a continued reduction in performance as a result of the **suspension of non urgent referrals** and providing mutual aid to the system. We have now resumed all non urgent imaging services to support the increasing waiting lists for non urgent diagnostics. The team will continue to source additional capacity to recover the diagnostic target throughout March with the expectation that the diagnostic target will be achieved by the end of financial quarter at the latest. Additional MRI capacity in the independent sector has been made available, with 20 patients being sent throughout February.
ACTIONS FOR IMPROVEMENTS / LEARNING
RISKS / ISSUES
Impact of a 3rd wave of covid reducing referrals further impacting on diagnostic activity . The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

		Indicative	Reported Month												
Target Name	National Standard	Feb-21	Jan-21	In Target	Breach	Total	Dec-20	In Target	Breach	Total	Nov-20	In Target	Breach	Total	Q3 Perf 2020/ 2021
2ww	93%	100.0%	100.0%	40	0	40	100.0%	61	0	61	100.0%	60	0	60	99.0%
31 day first treatment	96%	100.0%	100.0%	18	0	18	100.0%	12	0	12	100.0%	11	0	11	100.0%
31 day subsequent (surgery)	94%	100.0%	91.0%	10	1	11	100.0%	4	0	4	100.0%	9	0	9	100.0%
62 day (traditional)	85%	69.2%	76.5%	6.5	2.0	8.5	73.3%	5.5	2.0	7.5	57.7%	2.0	1.5	3.5	69%
62 day (Cons Upgrade)	n/a	100%	100.00%	7.5	0.0	7.5	100.00%	4.0	0.0	4.0	92.9%	6.5	0.5	7.0	98.0%
28 day FDS REPORTED	75%	78.8%	65.0%	41	22	63	69.0%	50	22	72	69.1%	56	24	80	72%
28 day FDS INTERNAL	75%		79%	50	13	63	73%	50	19	69	77.7%	53	6	59	
No. patients treated 104+ days															1

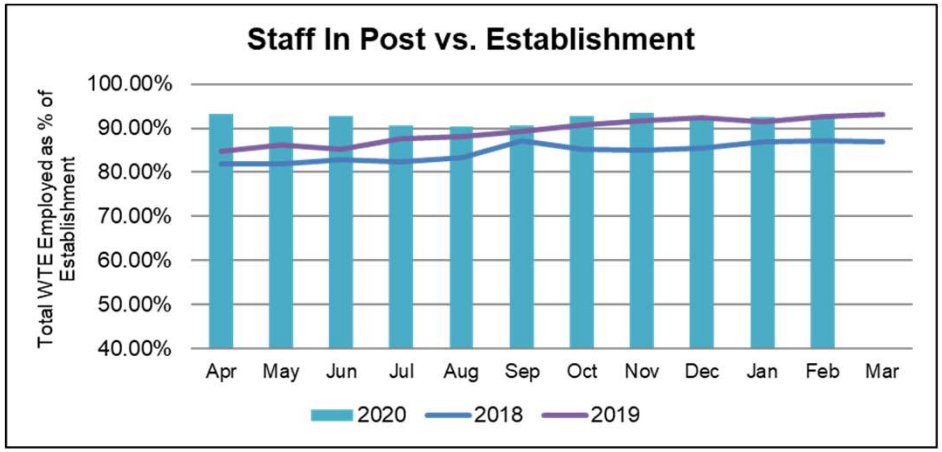
PERFORMANCE/IMPROVEMENTS/LEARNING

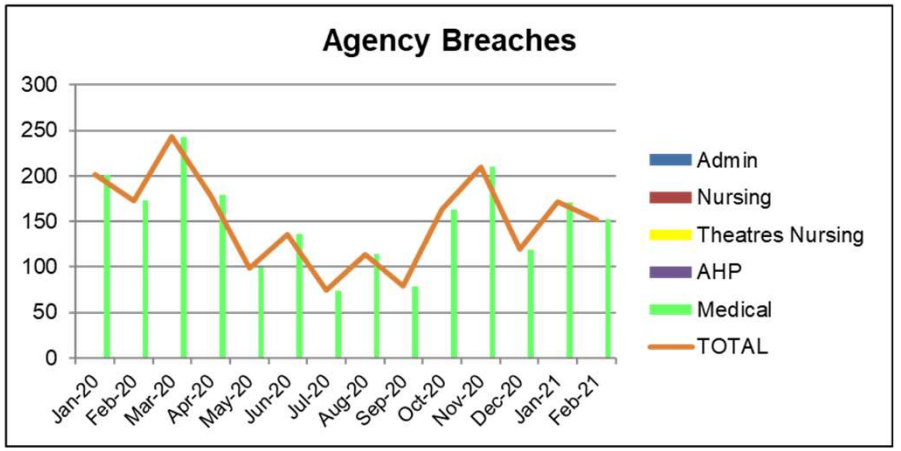
- For the month of January 2021, the Trust was compliant with the national standards **for 2WW, 31 day first and 62 day consultant upgrade** .
- The Trust breached 62 day standard @ 76.5%, 31 day subsequent @ 91% and 28 day faster diagnosis @ 65%.
- 6.5 treatments were delivered within 62 day target with 2 breaches (2 x 0.5 breaches due to late tertiaries out and 1 full breach due to a complex patient diagnostic pathway).
- The Trust's performance for the 62 day target for February 2021 is currently predicted at 69.2% with 4.5 treatments within target and 2 breaches (2 x full breaches due to complex pathway and a patient being rejected for radiotherapy resulting in referral back for surgery) – submission closes 31.03.21.
- The Weekly Cancer PTL meeting continues to monitor and track patients along their pathway with an escalation protocol in place to alert concerns in meeting national standards.
- Paediatric referral divert ceased on 22nd February 2021, and the PMBT service resumed on 01.03.21 with PMDT on Tuesdays @ 8am, image guided lists on Wednesdays, and new patient clinics on Tuesday afternoons. First operating list is scheduled for 19.04.21.

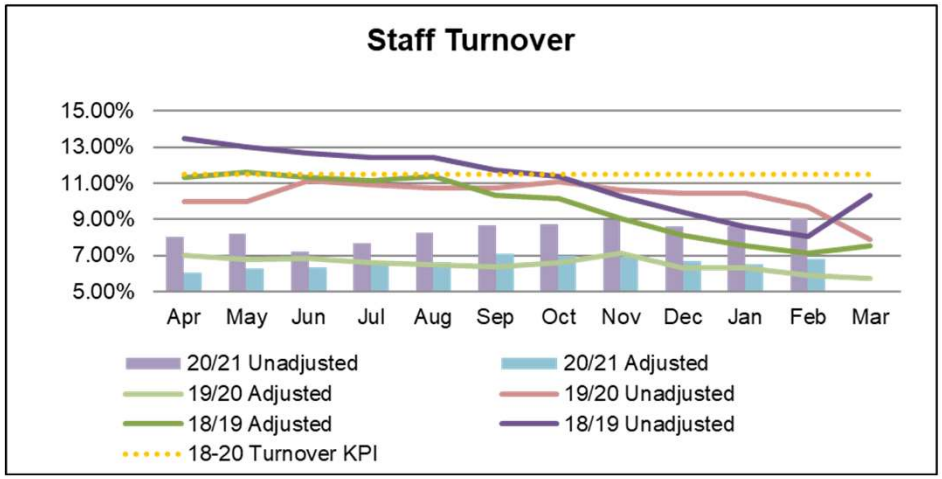
RISKS / ISSUES

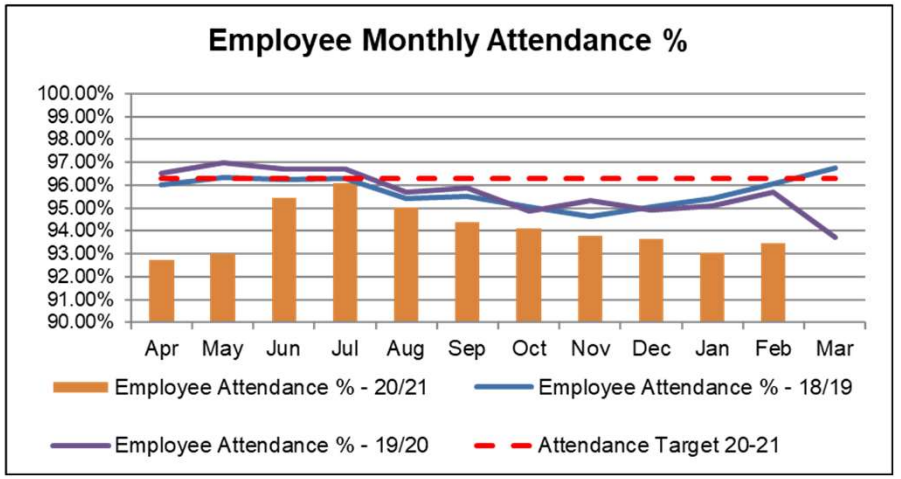
- Ongoing concerns regarding histological reporting resulting in delays in patient pathways, both of which are under current analysis/review. Recruitment issues remain an ongoing concern to appoint a specialist bone & soft tissue pathologist (national problem). Escalated via NOA to enable national discussion/resolution

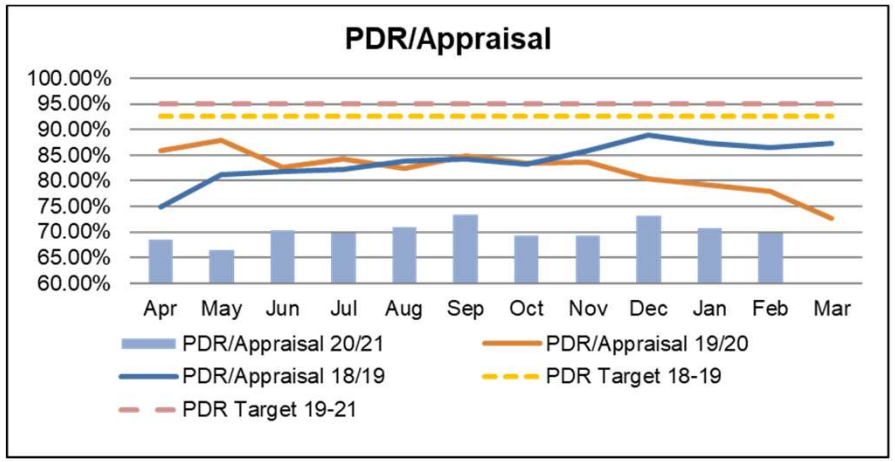
2. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

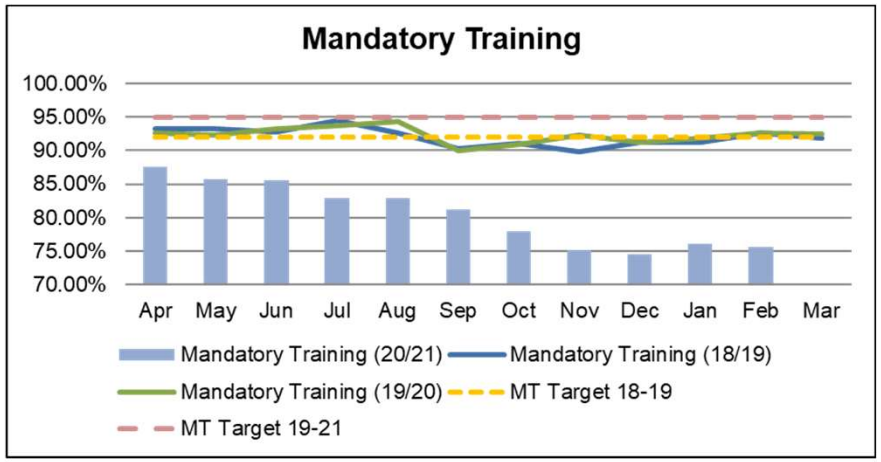


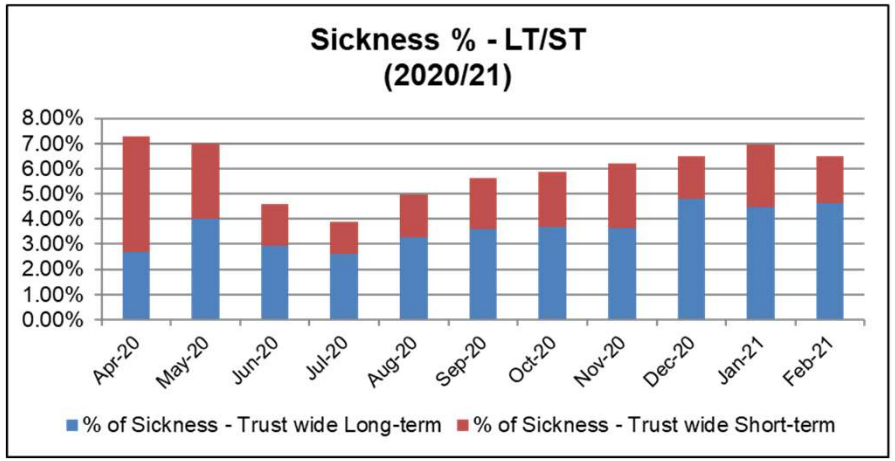


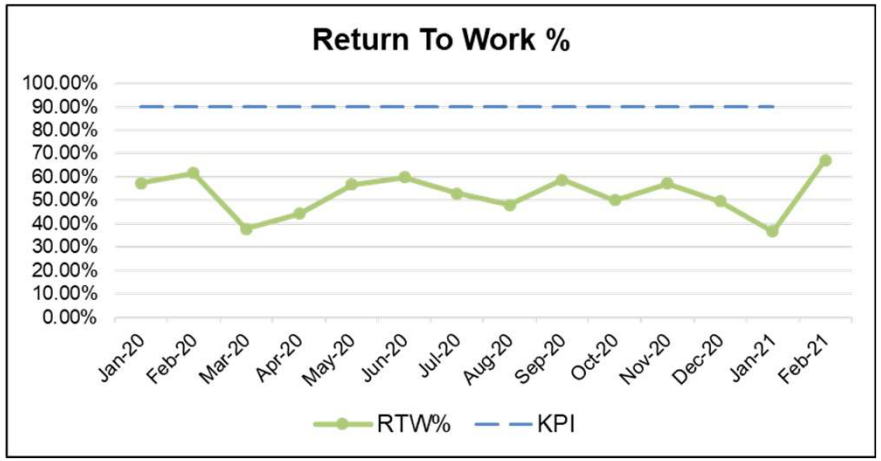





PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal 20/21
PDR/Appraisal 19/20
PDR/Appraisal 18/19
PDR Target 18-19
PDR Target 19-21


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (20/21)
Mandatory Training (18/19)
Mandatory Training (19/20)
MT Target 18-19
MT Target 19-21


Sickness % - LT/ST
(2020/21)
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Return To Work %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21
RTW%
KPI

Overall Headlines

February 2021 saw an improvement in the Trust's vacancy rates meaning that overall Trust is now on target with non-clinical vacancies 0.44% off target. Mandatory training and appraisal figures decreased slightly this month, and turnover figures for February 2021 increased, specifically unadjusted turnover which increased to just over 9% for the first time in 12 months.

Vacancy

The number of staff on the payroll in December stood at **1188** (**1049.23 - WTE)**, an increase of **4.03 WTE**.

- The Trust vacancy position improved by **0.43%** to **93.01%,** moving to the green status for the first time since November 2020, against the Trust's target of **93%.**
- The number of clinical staff vacancies decreased by **0.40%** to **93.40%,** retaining it's green status against the Trust's target of **92%.**
- The number of non-clinical vacancies also increased by **0.71%** to **92.56%,** retaining it's red status but moving closer to the Trust's revised target of **96%.**

Monthly Attendance

- Monthly attendance increased slightly by **0.44%** to **93.49%,** retaining it's red status against the Trust's target of **96.3%.**
- The underlying 12-month average attendance figure also slightly decreased by **0.15%** to **94.04%** retaining it's red status against the Trust's target of **96.3%.**
- Long term sickness data slightly increased by **0.18%** to **4.65%**

The figures have been quite similar over the past 3 months and we are expecting the figures to slightly improve following the COVID vaccination programme. Covid-19 absence data is still being reported daily to NHS England and weekly figures are being submitted to the BSOL STP

. **Appraisals**

- Appraisals completions decreased by 1.12% to **69.64%,** and retains a red status against the Trust target of **95%**

The ESR & HR Teams are continuing to liaise directly with teams where there is continual non-compliance and also support managers with ensuring the information is accurately recorded on ESR in a timely manner. Medical appraisals are starting to be re-scheduled again where possible following the suspension of medical appraisals last year which was uplifted in September 2020.

Mandatory Training

- Mandatory training increased by **1.46%** to **76.05%** in December, retaining the red status against the Trust revised target of **95%**

Staff are still actively being encouraged to complete their mandatory training via e-Learning and new starters are also being supported with completing their mandatory training prior to starting.

Turnover Figures

- Unadjusted Turnover (all leavers except Junior Doctors) increased to **9.07%,** and retaining a green status against the Trust's target of **11.5%.**
- Adjusted Turnover (substantive staff leavers excluding flexible retirements) also increased by **0.33%** to **6.81%,** retaining a green status against the Trust's revised target of **11.5%.**

Agency Breaches

Agency Breaches decreased from **171** shift breaches in January 2021 to **152** shift breaches in February 2021. The entirety of this shift breaches were medical usage. There were no AHP, Nursing or Admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Re-introducing the appraisal preliminary report to encourage managers to record their completed appraisals on the system.
- Manager Dashboard to be finalised in the upcoming months to support managers with viewing their own workforce data

RISKS / ISSUES

- Mandatory training and appraisal figures need to be monitored and improved
- Turnover figures should be monitored, specifically unadjusted turnover as this is now more than 9%

	Jan-21	Feb-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	8.59%	9.07%	0.48%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	6.48%	6.81%	0.33%	⇧	<=11.5%
Total WTE Employed as % of Establishment	92.58%	93.01%	0.43%	⇩	>=93%
Total WTE Employed as % of Establishment - Clinical	93.00%	93.40%	0.40%	⇩	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	91.85%	92.56%	0.71%	⇩	>=96%
% of Attendance	93.05%	93.49%	0.44%	⇧	>=96.3%
% of 12 mth MAA Attendance	94.24%	94.09%	-0.15%	⇩	>=96.3%
% Staff received mandatory training last 12 months	76.05%	75.61%	-0.44%	⇩	>=95%
% Staff received formal PDR/appraisal last 12 months	70.76%	69.64%	-1.12%	⇩	>=95%
% of Sickness - Trust wide Long-term	4.47%	4.65%	0.18%	⇧	-
% of Sickness - Trust wide Short-term	2.47%	1.86%	-0.61%	⇩	-
Return To Work Completion %	36.72%	67.26%	30.54%	⇧	>=80%

Workforce Performance Report

As at 28th February 2021

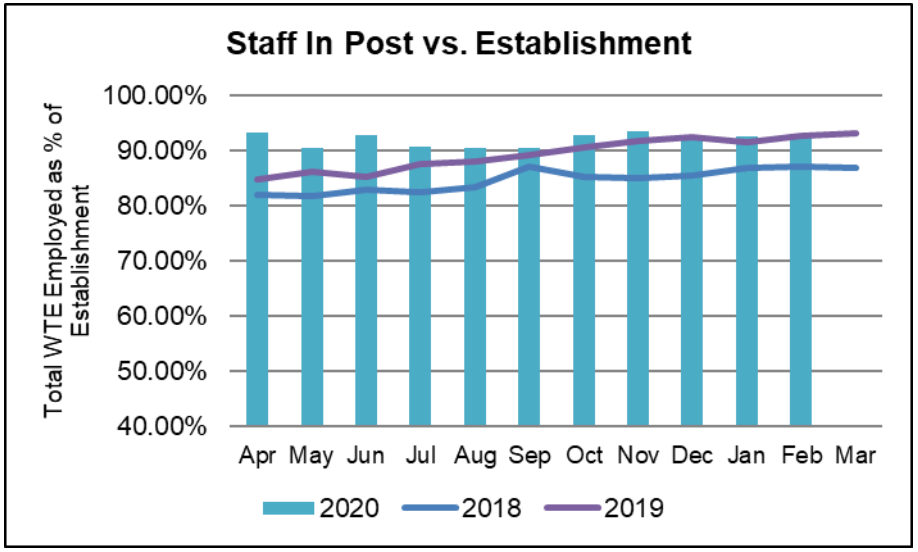
Please be aware that the information included in this report relies upon the timely update of information into ESR and Healthroster, this report is based on data as at the 5th working day in March, please note the figures are likely to change if information is input into the systems after the cut-off date.

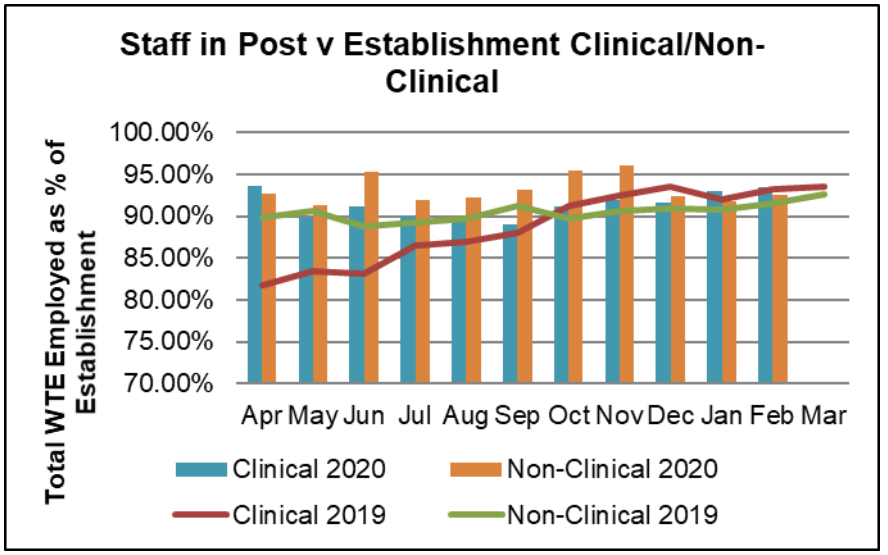
1 Trust Overall Summary

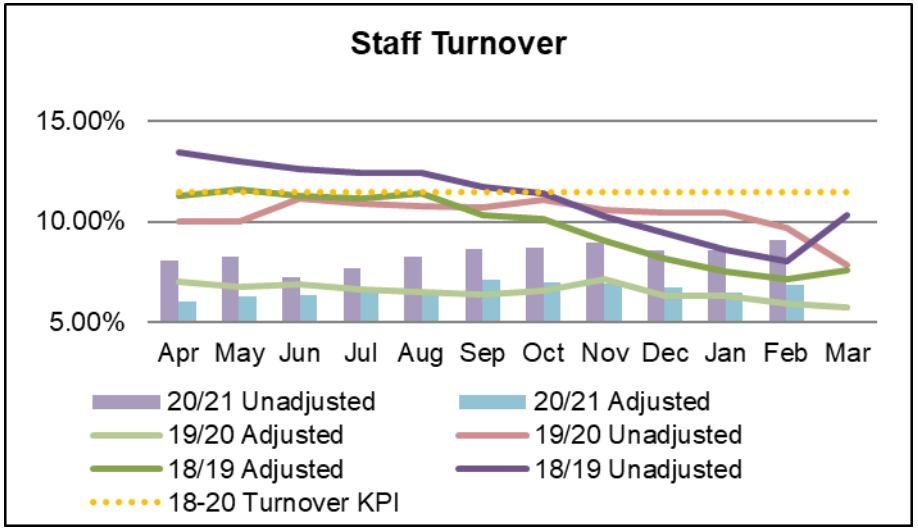
	Jan-21	Feb-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	8.59%	9.07%	0.48%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	6.48%	6.81%	0.33%	⇧	<=11.5%
Total WTE Employed as % of Establishment	92.58%	93.01%	0.43%	⇩	>=93%
Total WTE Employed as % of Establishment - Clinical	93.00%	93.40%	0.40%	⇩	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	91.85%	92.56%	0.71%	⇩	>=96%
% of Attendance	93.05%	93.49%	0.44%	⇧	>=96.3%
% of 12 mth MAA Attendance	94.24%	94.09%	-0.15%	⇩	>=96.3%
% Staff received mandatory training last 12 months	76.05%	75.61%	-0.44%	⇩	>=95%
% Staff received formal PDR/appraisal last 12 months	70.76%	69.64%	-1.12%	⇩	>=95%
% of Sickness - Trust wide Long-term	4.47%	4.65%	0.18%	⇧	-
% of Sickness - Trust wide Short-term	2.47%	1.86%	-0.61%	⇩	-
Return To Work Completion %	36.72%	67.26%	30.54%	⇧	>=80%

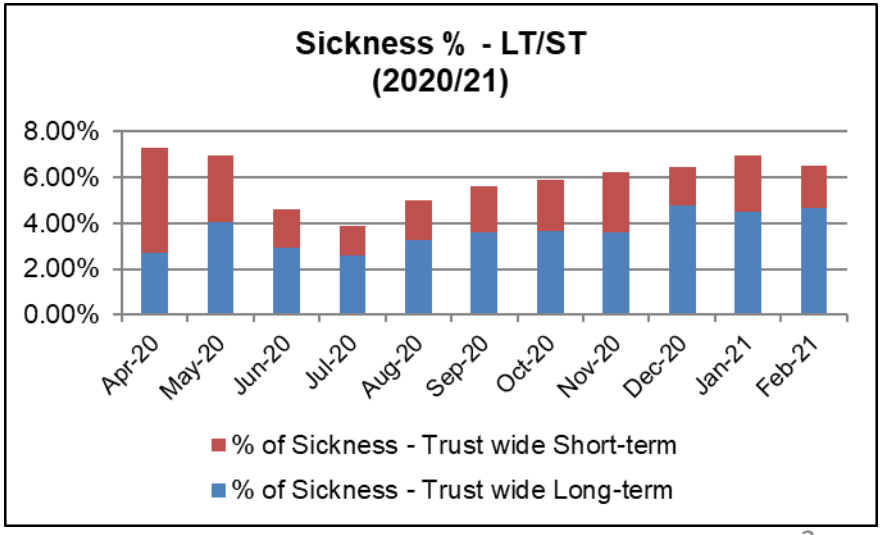
*Adjusted Turnover (substantive leavers exc. flexible retirements
*Unadjusted Turnover (all leavers excluding Junior Doctors)

2 Trustwide Performance Graphs

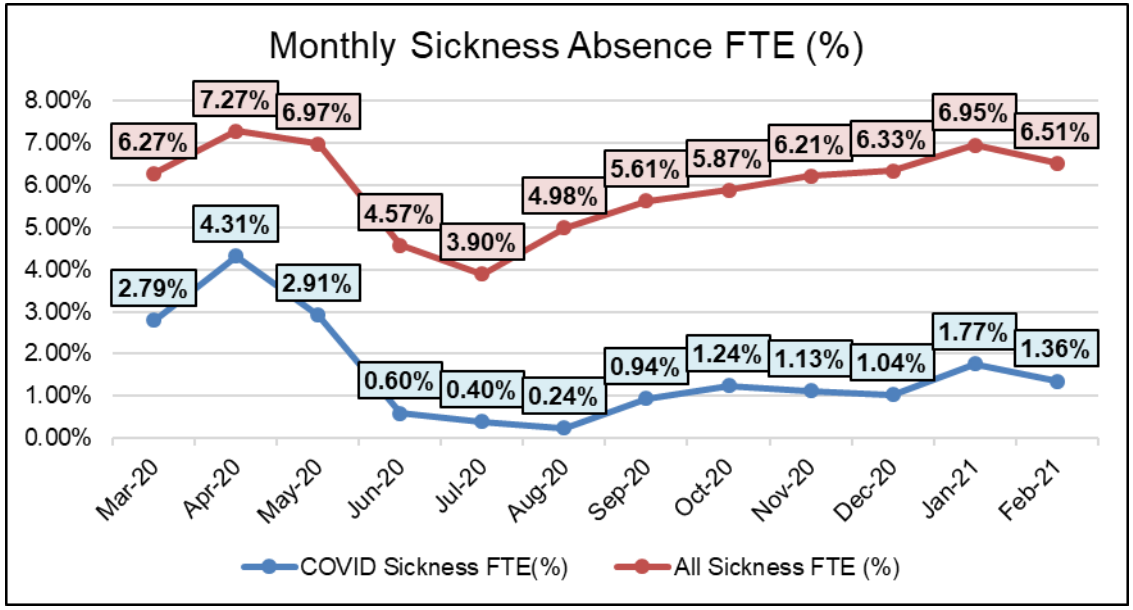








3 COVID Sickness Absence

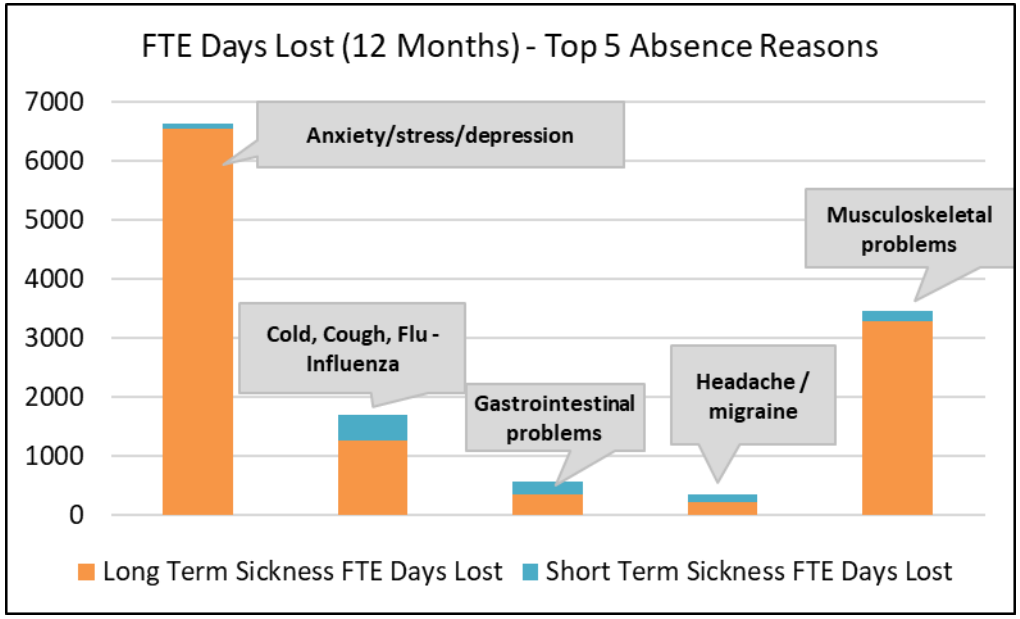


Month	Monthly COVID Sickness Absence FTE(%)	Monthly COVID Sickness Absence Estimated Cost
Mar-20	2.79%	£92,987.59
Apr-20	4.31%	£120,138.33
May-20	2.91%	£69,823.14
Jun-20	0.60%	£16,659.69
Jul-20	0.40%	£9,135.48
Aug-20	0.24%	£8,182.28
Sep-20	0.94%	£21,987.24
Oct-20	1.24%	£32,471.85
Nov-20	1.13%	£28,841.64
Dec-20	1.04%	£31,547.90
Jan-21	1.77%	£54,699.03
Feb-21	1.36%	£44,399.94

3 Sickness Absence

Top Absence Reasons (Last 12 Months) – Feb 2021

Absence Reason	Amount of Episodes	FTE Days Lost	Absence Estimated Cost (12 Months)
Cold, Cough, Flu - Influenza	455	4404.13	£438,508.52
Gastrointestinal problems	230	1007.87	£86,870.77
Musculoskeletal problems	227	4176.11	£336,659.54
Anxiety/stress/depression	183	7267.49	£686,757.16
Headache / migraine	117	454.28	£47,672.56



Monthly Sickness Absence FTE (%)

Month	All Sickness Absence FTE (%)	Sickness Absence Monthly Estimated Cost
Mar-20	6.27%	£195,637.32
Apr-20	7.27%	£220,982.08
May-20	6.97%	£214,079.76
Jun-20	4.57%	£127,097.34
Jul-20	3.90%	£110,123.36
Aug-20	4.98%	£135,973.44
Sep-20	5.61%	£147,390.73
Oct-20	5.87%	£171,708.41
Nov-20	6.21%	£180,007.50
Dec-20	6.33%	£182,434.49
Jan-21	6.95%	£196,600.78
Feb-21	6.51%	£167,353.02

3 Return To Work

Return to Work

— Following Return To Work completion rates being flagged as potential cause for concern at **36.72%** in January 2021, there was a **30.54%** increase in February 2021 to **67.26%** in February 2021

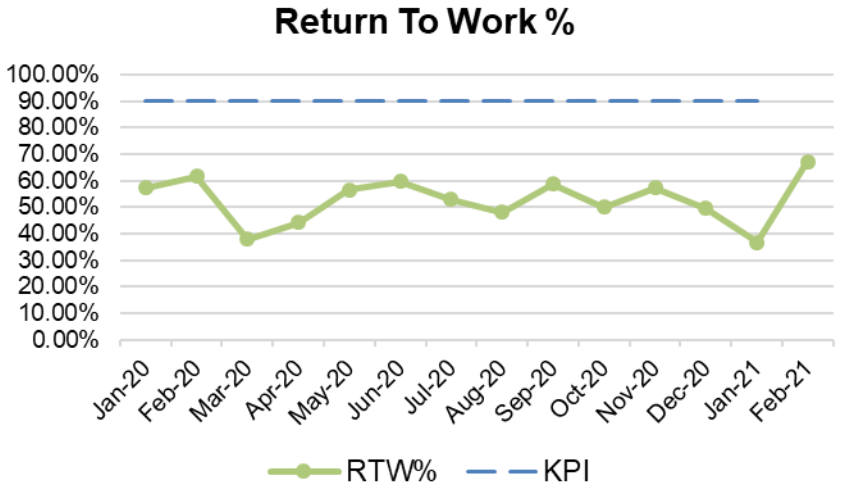
— This moves the Return to Work figures Trust wide to the amber status against the Trust KPI of 80% for the first time in over a year

Issues / Risks Identified

- Managers this month benefited from receiving a preliminary report to identity any outstanding return to work dates not entered into the system. The completion rates increased significantly following this.
- The time frame to update return to work completion dates is a bit narrow. This is due to the window between the monthly workforce report distribution and sync dates between ESR and e-Rostering being very small
- Return to work completion rates appear to be a data quality issue mainly
- There is a known national system error on ESR where when attempting to update return to work dates on ESR, managers experience an unexpected error. Managers are advised to contact the ESR Team who can update this on a core side

Proposed Actions

- We will continue to do a preliminary report, including the introduction of an e-Rostering preliminary report to identify missing return to work completion dates before the information is transferred to ESR
- This will give managers a bigger window in ensuring their data is accurate on the correct system for at the right time



4 Workforce Profile

AGE

Age Band	Headcount
<=20 Years	6
21-25	83
26-30	141
31-35	148
36-40	138
41-45	150
46-50	164
51-55	152
56-60	124
61-65	57
66-70	29
>=71 Years	8
Trust Total	**1200**

% of Workforce Over 51 **30.83%**

ETHNIC ORIGIN

Ethnic Origin	Headcount	% of Workforce
BME	326	**27.17%**
White	874	**72.83%**

GENDER

Gender	Headcount	% of Workforce
Female	850	**70.83%**
Male	350	**29.17%**

DISABILITY

Disability Status	Headcount	% of Workforce
No	959	**79.92%**
Not Declared	201	**16.75%**
Yes	40	**3.33%**

*as at 27th March 2021

3 Workforce Profile

SEXUAL ORIENTATION

Sexual Oritentation	Headcount	% of Workforce
Bisexual	3	0.25%
Gay or Lesbian	22	1.83%
Heterosexual or Straight	979	81.58%
Not Stated / Unspecified	193	16.08%
Other sexual orientation not listed	2	0.17%
Undecided	1	0.08%

MARITAL STATUS

Marital Status	Headcount	% of Workforce
Civil Partnership	18	1.50%
Divorced	75	6.25%
Legally Separated	10	0.83%
Married	598	49.83%
Single	416	34.67%
Unknown	76	6.33%
Widowed	7	0.58%

RELIGION

Religion	Headcount	% of Workforce
Atheism	131	10.92%
Buddhism	2	0.17%
Christianity	576	48.00%
Hinduism	44	3.67%
Not Disclosed	151	12.58%
Islam	47	3.92%
Other	115	9.58%
Sikhism	22	1.83%
Unspecified	112	9.33%

*as at 27th March 2021

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 5 May 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mr Matthew Corden	CQC relationship manager	(MC)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0920h	1	Apologies	Verbal	Chair
0922h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	3	Minutes of Board meeting held in Public on 7 April 2021: *for approval*	ROHTB (4/21) 026	Chair
	3.1	Actions from previous meetings in public: *for assurance*	ROHTB (4/21) 026 (a)	SGL
0925h	4	Questions from members of the public	Verbal	Chair
0927h	5	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (5/21) 001 ROHTB (5/21) 001 (a) ROHTB (5/21) 001 (b)	TP/JW
0950h	6	Refresh & recovery update: *for assurance*	ROHTB (5/21) 002	MP
1000h	7	**Inequalities**		
	7.1	Birmingham & Solihull system and ROH approach: *for assurance*	ROHTB (5/21) 003 ROHTB (5/21) 003 (a) ROHTB (5/21) 003 (b)	GM

	7.2	Children & Young People inequalities workstream: *for assurance*	ROHTB (5/21) 004 ROHTB (5/21) 004 (a)	GM
	7.3	Children & Young People inequalities case study: *for information*	Presentation	GM
1030h	8	Infection Prevention and Control & response to the Covid-19 pandemic		
	8.1	Health & Safety Executive COVID-19 spot check: *for information*	ROHTB (5/21) 007 ROHTB (5/21) 007 (a) ROHTB (5/21) 007 (b)	GM
1040h	9	Staff Experience and Health & Wellbeing		
	9.1	Strategic workforce plan – the approach to planning, redesign, talent management and succession planning: *for assurance*	ROHTB (5/21) 008 ROHTB (5/21) 008 (a)	SM
1050h	10	Governance & compliance		
	10.1	Paterson Inquiry update: *for assurance*	ROHTB (5/21) 009 ROHTB (5/21) 009 (a)	MR
	10.2	Annual complaints report: *for approval*	ROHTB (5/21) 010 ROHTB (5/21) 010 (a)	GM
	10.3	Board Assurance Framework: *for assurance*	ROHTB (5/21) 011 ROHTB (5/21) 011 (a)	ALL
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
1105h	11	Exception assurance reports from the Board Committees: • Finance & Performance – assurance report • Staff Experience & OD workshop – key highlights • Quality & Safety – assurance report	ROHTB (5/21) 012 Verbal ROHTB (5/21) 013	
1115h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance	ROHTB (5/21) 014 ROHTB (5/21) 015	

CONFIDENTIAL SESSION				
1130h	13	Exclusion of the press and public	Verbal	Chair
	14	Declarations of interest on any matters in the private session	Verbal	ALL
1132h	15	Minutes of the previous meeting in private held on 7 April 2021: *for approval*	ROHTB (4/21) 026 (P)	Chair
1135h	15.1	Actions from previous meetings in private: *for assurance*	ROHTB (4/21) 026 (a) (P)	SGL
1140h	16	Chair and Chief Executive update on any confidential matters: *for information and assurance*	Verbal	TP/JW
1155h	17	System plan 2021/22 update: *for information*	ROHTB (5/21) 017 (P) ROHTB (5/21) 017 (P) (a)	SW
1205h	**18**	**Joint pathway working**		
	18.1	Resumption of paediatric oncology services and business as usual: *for assurance*	ROHTB (5/21) 018 (P) ROHTB (5/21) 018 (P) (a)	MP
	18.2	Robert Jones & Agnes Hunt oncology service: *for information*	Verbal	MP
	18.3	University Hospital Birmingham orthopaedic pathway: *for assurance*	ROHTB (5/21) 019 (P) ROHTB (5/21) 019 (P) (a) ROHTB (5/21) 019 (P) (b)	MP
1225h	19	Never Event update: *for assurance*	ROHTB (5/21) 020 (P) ROHTB (5/21) 020 (P) (a) - ROHTB (5/21) 020 (P) (d)	GM
1230h	20	Committee minutes and summaries: *for information*	ROHTB (5/21) 021 (P) ROHTB (5/21) 022 (P)	ALL
1235h	21	Any Other Business	Verbal	ALL
1245h	22	Meeting effectiveness	Verbal	ALL
Date of next meeting: Wednesday 2 June 2021 @ 0900h				

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 – UPDATED TO APRIL 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓										1/1
Kathryn Sallah	✓										1/1
Richard Phillips	✓										1/1
David Gourevitch	✓										1/1
Simone Jordan	✓										1/1
Gianjeet Hunjan	✓										1/1
Ayodele Ajose	✓										1/1
Les Williams	✓										1/1
Jo Williams	✓										1/1
Matthew Revell	✓										1/1
Garry Marsh	✓										1/1
Phil Begg	✓										1/1
Marie Peplow	✓										1/1
Stephen Washbourne	✓										1/1
Sharon Malhi	✓										1/1
Simon Grainger-Lloyd	✓										1/1

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (in Public) - DRAFT Version 0.3

Venue Remote via videoconferencing **Date** 7 April 2021: 0900h – 1300h

Members attending:

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing and Clinical Governance	(GM)

In attendance:

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story: Admissions and Day Case Unit	**Presentation**
The Board was joined by Sue Smith, Head of Nursing for Division 2, who presented the story of a patient who had been treated through the Admissions and Day Case Unit (ADCU). The key points of learning from the experience were the need to empathise, listen and improve. Kathryn Sallah noted that the first contact was important and it was everyone's business to make patients welcome and acknowledge the anxiety of the patient when they arrived at the hospital. It was noted that ADCU had changed during the past few years and there had been a difference in experience through the COVID	

pandemic. It was noted that work was underway to help with the development of a rapport between staff and patients through the use of a customer care course. The Director of Nursing & Clinical Governance noted that the balance of the patient experience appeared to have been good across the medical profession, nursing staff and other staff groups. He also noted that for many years there had been a cultural norm for senior leaders to identify the patient story but in this case, this patient experience had been suggested by a staff nurse as part of their professional development. The Board offered thanks to the staff nurse and to Mrs Smith for her presentation.	
2 Apologies	**Verbal**
No apologies were tendered. The Board welcomed Les Williams to his first meeting as a Non Executive Director.	
3 Declarations of Interest	**Verbal**
It was noted that the declarations of interest register was available on request from Company Secretary. Phil Begg reported that he now worked a day a week for Aston University.	
4 Minutes of the Board Meeting held in Public on 3 March 2021: *for approval*	**ROHTB (3/21) 019**
The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held at the last meeting.	
4.1 Actions from previous meetings in public: *for assurance*	**ROHTB (3/21) 019 (a)**
It was noted that a number of actions were now captured as part of the strategic work and development plan and it was proposed that these were removed from the actions log. The Board agreed with this approach.	
5 Questions from members of the public	**Verbal**
There were no questions from members of the public that had been submitted.	
6 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (4/21) 001** **ROHTB (4/21) 001 (a)**
The Chief Executive reported that it was pleasing to note that NHS England had reduced the incident level from Level 4 to Level 3 under the national Emergency Preparedness Resilience Response (EPRR) framework. The impact of this was yet to be felt in terms of reporting requirements however with continued multiple daily submissions being needed. It was noted that the daily system calls with University	

Hospitals Birmingham NHSFT and other partners had been stood down. There was reported to have been no further contact with the CQC since the last meeting around the scheduling of the well led assessment. In terms of the Integrated Care System (ICS), David Melbourne, Director of Finance at Birmingham Women's and Children's NHSFT (BWC) had been appointed as the interim programme director and Paul Jennings, the Chief Executive of the Clinical Commissioning Group (CCG) was retiring. The recruitment process for the Chief Executive of the ICS was planned shortly. It was noted that 90% of staff would recommend the Trust as a place for friends and family to be treated. Les Williams asked what key responsibilities the new ICS members held and asked for details around their objectives. It was noted that the ICS Board was embryonic at present and David Melbourne had been appointed to develop the architecture and governance framework and to offer support to the Chair of the Integrated Care System. It was noted that the direction and responsibilities would be clearer in the next few weeks. Noting that the current position for mandatory training was unacceptable, the Chief Executive was challenged to set a date by which staff should complete the training. The Chief Executive reported that all staff had until end of April 2021 to complete mandatory training, a position which was being monitored closely by the Executive Team. In the event that staff did not complete this requirement, an escalation process was in place. The Chairman reported that he was working to develop the ROH's role in the ICS. It was noted that the development of the 'Committees in Common' approach also needed to be finalised for the provider organisations. The Chairman advised that he had visited the diagnostics department and a series of further visits had been set up which he would undertake over the next few weeks. He had also hosted, together with the Chief Executive, the long service awards on 12 March 2021 which he commented was a humbling experience. It was reported that Kathryn Sallah had been appointed as the Senior Independent Director (SID) and Simone Jordan would take on the Vice Chair role. Thanks were given to both for their support.	
7 Refresh and Recovery Update: *for assurance*	**ROHTB (4/21) 002**
The Chief Operating Officer provided an update on the 'Refresh and Recovery' programme which comprised four active workstreams: preoperative and	

scheduling processes; Inpatients; Outpatients; and workforce & wellbeing.

In terms of Outpatients, it was noted that 5000 patients had been seen. This included a significant number through virtual clinics.

It was reported that the current 14-day isolation process would be adjusted to be in line with the national guidance, which required less time isolating before surgery and one swab test in advance. This change would be supported by a webinar. All theatres (14) would open on 19 April, this being ahead of schedule.

Remedial estates work was underway in wards and theatres while activity had been reduced. This period had also been used to give staff time to have rest and to undertake mandatory training.

The redeployed staff had returned and were being given support as they rejoined the hospital.

In terms of additional work to support the system, this was being worked through. A task and finish group had been established to determine the governance model for the work to address the backlog.

An audit on Outpatients are was underway and a location for virtual clinics was being scoped.

In terms of bed modelling, this would be built into the daily site reports.

Vacancies were being scoped to identify recruitment opportunities.

Kathryn Sallah noted that there were a significant number of task and finish groups and asked whether there was sufficient capacity to attend and support these. It was noted that the refresh and recovery groups had been reduced from ten to four which reduced the burden on staff. These were necessary however for oversight and assurance. The Chief Executive noted that the task and finish groups were being clinically led which demonstrated that individuals who would not usually take on such responsibilities were taking ownership and leading this work. System working was noted to have created a significant burden on the Operations team but also on nursing & medical colleagues.

Richard Phillips reported that the ambition to open 14 theatres had been challenged at the recent meeting of the Finance & Performance Committee and there had been a good level of assurance that this could be managed effectively; there was excitement among staff to do this. The Chairman echoed that there was momentum in returning to a sense of normality.

Thanks were expressed to the team and to the Chief Operating Officer for her

leadership over this time.	
8 Infection Prevention and Control response to the COVID-19 pandemic	
8.1 Infection Control annual report: *for approval*	**ROHTB (4/21) 003** **ROHTB (4/21) 003 (a)**
The Director of Nursing & Clinical Governance presented the 2019/20 annual report on Infection Prevention and Control which had been scrutinised and signed off by the Infection Prevention and Control Committee (IPCC). From a governance perspective the content demonstrated good compliance with the hygiene code, which was routinely scrutinised at IPCC and was reported upwards to the Quality & Safety Committee, including through a section in the Quality Report on notifiable infections. There were reported to have been three *E.coli* bacteraemia infections notified during the year. There had been a national campaign to reduce these linked to catherisation and it was highlighted that the organisation had an *E.coli* reduction plan that had been signed off by the Clinical Commissioning Group (CCG). The Trust's hand hygiene compliance audit was noted to show compliance below 100%. The Director of Nursing & Clinical Governance noted that it was challenging to achieve this and in the recent outbreak meetings, there had been an open declaration as to the position. The CCG had been positive around the Trust's position however, in that it suggested a robust audit process. It was noted that compliance was determined through an observational audit using a recognised tool. It was noted that when the audit was undertaken and non-compliance was identified, then there would be re-education undertaken and the area would be reaudited to check compliance at a later date. In terms of cleanliness, a monthly audit programme was undertaken using an accredited tool. The 95% position had been achieved. It was noted that the report reflected one month of the COVID pandemic. The Director of Nursing & Clinical Governance acknowledged that there had been a steady improvement in terms of infection rates, including surgical site infections (SSIs). The work was being supported by the new IPCC team and there was good engagement with the Clinical Service Leads. The Board approved the annual report.	
ACTION: SGL to arrange for the annual Infection Control report to be published on the Trust's internet site	

8.2 Trust response to COVID outbreaks: *for assurance*	**ROHTB (4/21) 004** **ROHTB (4/21) 004 (a)**
The Director of Nursing & Clinical Governance presented a summary report on COVID outbreaks which had been scrutinised by the Quality & Safety Committee, which had also received external scrutiny. It was noted that the outbreaks had also been summarised previously at the Board meetings. The outbreaks on Ward 3 and Pharmacy had now been closed. The causation on Ward 3 was reported to be a patient on the UHB pathway that had become symptomatic. The outbreak in Pharmacy was noted to have been caused by exposure of a member of staff to an infected individual in their personal life. It was reported that to date there had been eight outbreaks in total. There had been three patients that had fulfilled the criteria as contracting a hospital acquired infection.	
8.3 NHS England IPC Board Assurance Framework update: *for assurance*	**ROHTB (4/21) 005** **ROHTB (4/21) 005 (a)**
The Director of Nursing & Clinical Governance presented the revised Infection Prevention and Control Board Assurance Framework (BAF) and reported that this was scrutinised by the IPCC. A review had been undertaken against Version 3 of the BAF. There was one amber rating that reflected that the Trust was not auditing compliance with inpatient testing. Work was underway with the Deputy Chief Operating Officer to address this shortfall within the next month. Evidence would be collected to demonstrate compliance with the BAF requirements overall. David Gourevitch, who had attended the recent meeting of the IPCC thanked the Director of Nursing & Clinical Governance for chairing the Committee so robustly.	
8.4 Health and Safety Executive COVID-19 spot check: *for information*	**Verbal**
The Director of Nursing & Clinical Governance advised that the Health and Safety Executive had undertaken a series of spot checks during December 2020 and January 2021 around how organisations were dealing with COVID. In total 17 organisations had been inspected. The inspection included elements around risk assessment, management, cleaning & hygiene, dealing with suspected COVID cases and Personal Protective Equipment. A summary of these findings had been provided to all trusts and were broken down into good and poorer findings. The Board was advised that the opportunity had been taken to undertake a gap analysis against these findings and to rate them according to compliance. This would be scrutinised and reviewed at the Quality & Safety Executive, the outcome of which would be reported to the Quality & Safety Committee and the Trust	

Board.	
ACTION: **GM to present the Health & Safety Executive gap analysis to the Quality & Safety Committee and Trust Board**	
9 Staff Experience and Health & Wellbeing	
9.1 Staff survey 2020 results and action plan: *for assurance*	**ROHTB (4/21) 007** **ROHTB (4/21) 007 (a)**
The Acting Associate Director of Workforce & OD reported that the staff survey had been carried out in October 2020 and a 56% response rate had been achieved, this being the highest level of participation for some time. The period of the survey was noted to include the COVID pandemic period. In terms of the elements relating to Equality & Diversity, managers support and safe environment, these were noted to be rated marginally above the average position. There were noted to be some areas where there had been a slight deterioration. The focus on health and wellbeing was noted to be reflected within the survey. It was reported that the questions around safety culture were around learning lessons. Work was noted to be underway with directorates to review directorate level results. Focus groups were being held across the Trust and engagement was being encouraged to develop a response to the survey results. It was reported that the action plan would be presented to the Trust Board in June and would address the key themes. A quarterly report against the action plan would be scheduled into the workplan of the Trust Board. The Chief Executive suggested that there was increased confidence by staff that the Board would act on the results and ensure that there was robust oversight of the actions taken. The Chairman agreed and suggested a 'You Said, We Did' feedback approach could be adopted. Simone Jordan suggested that quality improvement needed to be given a key focus to ensure that a number of initiatives across the Trust were joined up and to set this as the way business was conducted at the ROH. In terms of quality of care being below average, this had been discussed with the Director of Nursing & Clinical Governance and it was agreed that this would be tested in terms of staff understanding of this point. It was noted that part of this	

related to staff understanding the impact of their role on the quality of care even if they worked in a support function. The Director of Nursing & Clinical Governance illustrated this point by highlighting that the catering department did not rate how they contributed to the quality of care and therefore more focussed work was planned to develop an understanding of how they contributed. It was noted that portering had delivered a good response but their response appeared to reflect how they felt they were cared for rather than quality of care they were delivering to the patients. There was also an indication that portering did not feel that the ROH's response to incidents raised was satisfactory. Work would be undertaken to address these concerns and understanding. The Chief Operating Officer reported that the 'Admin Matters' forum would also be discussing this issue. It was noted that the way that the way some of the results were reported appeared to be concerning, however there was marginal and non-statistical change where there had been a decline. It was suggested that this needed to be picked up in the messaging and context. Richard Phillips suggested that, although the response rate had been good, work should be undertaken to drive up the response rates even further. It was noted that this was not the only measure to measure staff satisfaction and the networks and team meetings should also be used to triangulate with the results of the staff survey. The networks were agreed to be especially important and fundamental to gaining an understanding of the matters on the ground. In terms of lower scoring questions, these reflected systemic issues across the NHS in some cases. In terms of pay for instance, this was a national view, however the appropriateness of roles to the level of pay needed to be reviewed. The theme around unrealistic time pressures was noted to reflect the demands as a result of the need to respond to the COVID pandemic. The theme around senior management communication and acting on feedback needed focus for the Trust as it was an area of underperformance. It was agreed to be important to reflect back the actions undertaken already since the survey was conducted.	
ACTION: **SM to present the Staff Survey action plan at the June 2021 meeting**	
9.2 Diversity, equality, respect and inclusion update: *for assurance*	**ROHTB (4/21) 008**
The Acting Associate Director of Workforce & OD reported that the key points of the report included that there had been success in appointing to chair of the Multi Minority Ethnic Group (MMEG). This role was to be taken on by Falon Paris-Caines, a member of the Communications Team. The Chief Executive commented that this	

was an excellent appointment. The Board was advised that the ROH had been represented at the LGBT+ regional conference in March 2021. There was noted to be further work to do to around the diversity, equality, respect and inclusion agenda, including the implementation of a programme of reverse mentoring. It was reported that £20k funding had been received to support the disability agenda and work was underway to shift the culture to support the disclosure of disability where needed. The membership of 'Inclusive Companies' would be renewed for 2021. The Trust was reported to be working on an action plan to support the inclusion work which currently encompassed a number of separate action plans. This would be presented at the June 2021 Board meeting. The Trust was reported to score well in terms of the Workforce Race Equality Standards (WRES) but more work was needed on Workforce Disability Equality Standards (WDES). An inclusion calendar was being developed. There was a focus on the bullying and harassment policy, by rebranding it as the policy for 'civility and respect'. The Chief Executive noted that work was ongoing at present around respect and focus groups were being set up around setting a range of behaviours against each of the Trust values. It was suggested that respect underpinned all work and values. The impact and outcome of the work was noted to have been discussed at Staff Experience & OD and this was to be developed further.	
ACTION: SM to present the equality and diversity action plan in June 2021	
9.3 Health & wellbeing update including the role of the Wellbeing Guardian: *for assurance*	**ROHTB (4/21) 009** **ROHTB (4/21) 009 (a)**
It was reported that Health and Wellbeing conversations had been rolled out as part of the COVID response and these were being reviewed and amended where needed. It was suggested that these may be mandated in June as part of the NHS People Plan. The risk assessment approach was being developed. Listening sessions for shielding staff were being undertaken and managers would be engaged continuously to help	

support the return of staff that had been working at home. A process was reported to be underway to recruit health and wellbeing champions. The Board was advised that a wellbeing strategy with key metrics was being developed and a roadmap created to set out the key activities. The Wellbeing Guardian was to be appointed and this process would be with discussion with the Chairman. Expressions of interest would be requested, with the aim to have an individual identified within the next few weeks. Once this was appointed, the priorities for the work would be set. This work also needed to be scrutinised at the Staff Experience & OD Committee. It was noted that wellbeing was also a matter of focus in the private sector. It was noted that there was work with the Communications team to define the different guardians and champions to ensure that the various remits were clarified for staff. It was suggested that the various statutory roles be clarified for the Non Executives and other Board members. It was noted that the champion responsibilities also took individuals away from direct clinical care. It was noted that methods needed to be thought through to measure the effectiveness of the roles. The link to these responsibilities with the chairmanship of the various subcommittees also needed to be considered.	
ACTION: TP/SGL to identify the Health and Wellbeing Guardian **ACTION: SGL to prepare a summary of the statutory roles that Non Executives were expected to undertake**	
9.4 Learning Lessons to Improve our People Practice: *for assurance*	**ROHTB (4/21) 010** **ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)**
It was reported that the disciplinary policy and procedure had been reviewed in line with the national mandates. The policy had been revised in terms of best practice and to align it to the Imperial College policy that had been held up as best practice. Legal advice had been sought around the development of the policy which had agreed that the ROH's policy was best in class. In terms of decision making around taking disciplinary action, there was a flow chart to support this. The policy was to be launched when the Trust was in a position to train all those who needed to be. Adequate support for those being subject to the policies was also noted to be needed. Numbers of cases were included in the workforce performance reports and work was planned to expand this section of the report to make it more meaningful.	

In terms of the Maintaining High Professional Standards (MHPS) framework, the responsibility for oversight from the Board was noted to be set out. Les Williams noted that suspension required more than one person in the guidance but this was not consistent with the policy & procedure. He suggested that this decision should not be taken in isolation. The Chief Executive advised that as the ROH was a small organisation, there was a deliberate rationalisation of the individuals involved. The Executive on-call would escalate to the Chief Executive in the event that there was an out of hours event. Again, it was suggested that this should not be taken in isolation but this would be informed by the risk assessment. In terms of the appeal process, Les Williams suggested that a Non Executive could chair the panel from a point of independence. The Chief Executive agreed with this approach. Gianjeet Hunjan highlighted that the Non Executives also needed access to the tools to be able to discharge the duties required under this policy. Ayodele Ajose noted that the informal stage suggested that this was counselling which would be documented, as was the first written warning stage. She asked how consistently this was applied and for clarity as to the differences between the stages. The Acting Associate Director of Workforce & OD advised that it was at the formal stage where there was more discussion around the potential outcome of the process, whereas the informal stage was aimed at achieving a resolution earlier. This would be clarified in the policy and procedure. The governance around expired warning was questioned in terms of how care would be taken to ensure that these would not be made accessible inappropriately. It was reported that the Human Resources team would assist with keeping the records of these and support the process to ensure that the individual was being treated equitably. This would also lie with the training of managers to ensure that there was consistency in the approach being taken. It was noted that the isolation associated with suspension was a major issue from a wellbeing perspective. It was suggested that there needed to be a lead for training so there was consistency rather than this being dispersed throughout the organisation. The Acting Associate Director of Workforce & OD was asked to re-present the policy to the Trust Board at a future meeting following further comment.	
ACTION: **SM to present the revised disciplinary policy at a future meeting**	
10 Governance & compliance	

10.1 CQC Transitional Monitoring Approach key lines of enquiry self-assessment and action plan: *for assurance*	**ROHTB (4/21) 011** **ROHTB (4/21) 011 (a) - ROHTB (4/21) 011 (d)**
The Chief Executive noted that there had been a much work to develop a gap analysis against the new CQC Transitional Monitoring Approach (TMA) key lines of enquiry. The journey over the last 12 months would be articulated to the CQC as part of the well led discussion. The action plan to address the shortfalls was noted, a key element of which was mandatory training. It was suggested that there needed to be clarity to highlight that the position was due to the impact of COVID. It was noted that there would be no rating after the well led discussion with the CQC but it would inform their decision as to whether there should be a full inspection. It was noted that the 'Coffee Catch Up' sessions were virtual at present and these would be rolled out to other specialities.	
10.2 Annual cycle of business and strategic board work & development plan: *for approval*	**ROHTB (4/21) 012** **ROHTB (4/21) 012 (a)** **ROHTB (4/21) 012 (b)**
The Director of Corporate Affairs & Company Secretary presented a schedule of business for the Board to consider at its meetings during 2021/22. The schedule was noted to be drawn from a review of previous Board agendas, statutory items and best practice examples, namely those from the Healthy Board (NHS Leadership Academy) and FT Provider's guidance. It was noted that to create a strategic focus to the work of the Board and to identify Board development opportunities, Board members had been asked to suggest a list of topics for discussion for inclusion in the wider Board workplan which was provided as a separate appendix to the main schedule of business. The Director of Nursing & Clinical Governance suggested that there needed to be greater detail on Board development opportunities, particularly on team building work. It was agreed that this should be built into the workplan. It was agreed that an update on IT was needed at the Finance & Performance Committee, with an update on system working and programmes of work at the July Trust Board meeting.	
ACTION: SW to present an update on the system IT approach to the Finance	

& Performance Committee **ACTION: SW to present an update on the IT Programmes of work at the July 2021 meeting**	
11 Exception assurance reports from the Board Committees: • **Finance and Performance – key highlights** • **Staff Experience & OD – key highlights** • **Quality & Safety – assurance report** • **Charitable Funds – assurance report**	**ROHTB (4/21) 013** **ROHTB (4/21) 014** **ROHTB (4/21) 015** **ROHTB (4/21) 016**
Richard Phillips acknowledged on behalf of the Finance & Performance Committee the progress that had been made on the Cost Improvement Programme and that there were a significant number of schemes which were transformative and drove efficiency. There was good progress on the development of the capital plan. Simone Jordan advised that all Board members were welcome to join the virtual walkabouts. Kathryn Sallah noted that there were some good reports received at the recent meeting of the Quality & Safety Committee, one being around the Excellence in Care programme. It was reported that there had been an issue raised in relation to the Pathology service, which reflected some national challenges. It was noted that since the meeting, the two open Central Alerting System (CAS) alerts had been closed. The first assurance report from the Charitable Funds Committee was received. David Gourevitch noted that there had been some delay in the work of the Charity due to COVID, however as the impact of the pandemic eased the work would be prioritised. There was anticipation that the work would progress better in the next year.	
12 Performance reports: *for assurance* • **Quality & Safety** • **Finance & Performance** • **Workforce**	**ROHTB (4/21) 017** **ROHTB (4/21) 018** **ROHTB (4/21) 019**
The performance reported were received and noted.	

13 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
The next meeting is scheduled for Wednesday 5 May 2021 @ 0900h.	

PUBLIC SESSION

Next Meeting: 5 May 2021, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 30.04.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 091	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for the Guardian of Safe Working to present an update to the Trust Board	JWI	~~01/07/2020~~ ~~13/01/2021~~ 2/06/2021	New individual appointed and will join the Board in ~~January~~ June 2021	C-19
ROHTBACT. 092	Trust's response to the Paterson Report	ROHTB (3/20) 012 ROHTB (3/20) 012 (a)	04/03/2020	Arrange a briefing session on the Paterson Report	MR	07-Apr-21	Included on the agenda of the May 2021 meeting	
ROHTBACT. 100	Board Assurance Framework	ROHTB (3/21) 005 ROHTB (3/21) 005 (a)	03/03/2021	Refresh the IT risk on the Board Assurance Framework	SW	05-May-21	Included in the refreshed BAF due to be considered by the Board in May 2021.	
ROHTBACT.103	Staff survey 2020 results and action plan	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	07/04/2021	Present the Staff Survey action plan at the June 2021 meeting	SM	02-Jun-21	ACTION NOT YET DUE	
ROHTBACT.104	Diversity, equality, respect and inclusion update	ROHTB (4/21) 008	07/04/2021	present the equality and diversity action plan in June 2021	SM	02-Jun-21	ACTION NOT YET DUE	
ROHTBACT.105	Health & wellbeing update including the role of the Wellbeing Guardian	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	07/04/2021	identify the Health and Wellbeing Guardian	TP/SGL	15-May-21	ACTION NOT YET DUE	
ROHTBACT.106	Health & wellbeing update including the role of the Wellbeing Guardian	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	07/04/2021	Prepare a summary of the statutory roles that Non Executives were expected to undertake	SGL	02-Jun-21	ACTION NOT YET DUE	
ROHTBACT.107	Learning Lessons to Improve our People Practice	ROHTB (4/21) 010 ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)	07/04/2021	Present the revised disciplinary policy at a future meeting	SM	07-Jul-21	ACTION NOT YET DUE	

ROHTBACT.108	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the system IT approach to the Finance & Performance Committee	SW	25-May-21	ACTION NOT YET DUE	
ROHTBACT.109	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the IT Programmes of work at the July 2021 meeting	SW	07-Jul-21	ACTION NOT YET DUE	
ROHTBACT. 099	NHS England IPC Board Assurance Framework update	Verbal	03/03/2021	Present the position against the updated IPC Board Assurance Framework at the next meeting	GM	07-Apr-21	Included on the agenda of the April 2021 Board meeting	
ROHTBACT.101	Infection Control annual report	ROHTB (4/21) 003 ROHTB (4/21) 003 (a)	07/04/2021	Arrange for the annual Infection Control report to be published on the Trust's internet site	SGL	30-Apr-21	Added to the Trust's internet site	
ROHTBACT.102	Health and Safety Executive COVID-19 spot check	Verbal	07/04/2021	Present the Health & Safety Executive gap analysis to the Quality & Safety Committee and Trust Board	GM	28-Apr-21	Discussed at the April 2021 meeting and to Board in May 2021	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (5/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board (in Public) on 5th May 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 7th April 2021 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Our work continues to focus on delivering support to our system restoration and recovery. The Chief Operating Officers (COOs) across all providers continue to meet three times a week to oversee the operational changes agreed to address the system backlog for adults across Birmingham and Solihull (BSol).

2.2 As at 26th April 2021, we have vaccinated 990 staff (84.33%) against COVID-19, with 263 (64%) of staff being from a Black, Asian and Minority Ethnic (BAME) background accessing the jab. I would like to thank the vaccination team who have delivered this project - a phenomenal achievement and I am very grateful for all the hours the team has contributed into making this such a success. Work continues to engage with all staff who have not yet accessed the vaccination. We continue to issue and request that staff continue to use a lateral flow test with 100% distribution and staff required to report results weekly.

2.3 Mandatory training continues to be monitored through Divisional Performance committees with a trajectory of improvement, with a review of progress at the end of May 21. It was great to see that at the end of April we had seen a significant improvement in performance. The team continues to review the current delivery process for training to ensure that it meets the needs of the users whilst adapting to COVID-19 restrictions.

2.4 On 30th April the Trust launched its refreshed **ROH Life "***Your new Trust newspaper***".** ROH Life features news, updates and need-to-know information from across the Trust, as well as interviews with staff and patients. We will be shining a light on the fantastic projects and work our staff undertake every day. Its first edition showcases some of the projects which the team has delivered over the last 12 months. A digital copy is attached as Appendix 1. We will be publishing spring, summer, autumn and winter editions of the newspaper. Thank you to Anthony May, Senior Communication Officer for his commitment and leadership in making this a reality and a great read!

2.5 During April, I had the opportunity to see some of the changes we have implemented to the Children and Young People Unit, co-located within Outpatients. The team are transforming the space to include, bright and colourful waiting areas with entertainment, newly decorated clinic rooms tailored for comfort and reassurance with an improved playroom for younger patients. Further work is ongoing with a rejuvenated sensory facility and specialist physiotherapy equipment in our bespoke gymnasium. Many of the changes have been supported with charitable funds and we are extremely grateful to everyone who has donated money to the scheme.

2.6 We have worked in partnership with AccessAble to create detailed Access Guides to facilities, wards and departments at the Royal Orthopaedic Hospital. Our launch which went live on Wednesday 28th April, included guides on 100% facts, figures and photographs and give patients useful information to plan their visit to us and assure them that we are accessible and have considered their needs. Patients can check out everything from parking to hearing loops, walking distances and accessible toilets. The free Accessibility Guide is for staff and visitors and is available at www.roh.nhs.uk and www.AccessAble.co.uk and on the AccessAble App. It was fantastic to be able to see this being implemented in the Trust and thank you to everyone involved in the project at the ROH and AccessAble.

2.7 We have come a long way since the start of the pandemic and staff have had to adapt to new ways of working. A huge amount of work has been undertaken over the last 12 months in order to keep staff safe from COVID-19. From the early days of the pandemic when PPE guidance changed frequently, to the introduction of Lateral Flow Testing kits and the vaccination programme – many different aspects of safety have been considered, introduced and supported and during April we reflected with our team some of the key initiatives that were fundamental to creating as safe an environment as possible during the pandemic.

All of these measures have taken time, effort and energy. I would like to thank everyone who has been directly or indirectly involved; these measures have helped to keep the Trust as safe as possible. I would like to give a special mention to our Project Support Officers (PSOs) – Ossie Powell, Ryan McComb, and Sean Flynn. They were instrumental in helping managers with risk assessments in offices, signage, Perspex barriers and generally helping to create a safe environment.

A big thank you also to everyone who has adapted to new ways of working while continuing to provide services and support patients. The resilience and adaptability everyone has shown is amazing and are useful reminders that we work in a dynamic health system that requires us to respond to change and challenge.

We are also aware that we must not lose focus now and as we move closer to the lifting of restrictions; we are encouraging everyone to continue to follow the guidance, maintaining safety at all times.



Risk assessments were carried out in all offices and communal areas



Temperature checks were introduced for everyone entering the Trust and masks are provided to reduce transmission



More sanitising points around the Trust to maintain hand hygiene



Staff able to work from home were encouraged to do so to limit numbers on site



Social distancing in office spaces and public areas



Shielding and vulnerable staff were supported through listening sessions and by our wellbeing officer



Counselling service and wellbeing activities available to ensure staff wellbeing



Meetings and essential training was delivered virtually



Screens installed at reception desks for protection where a 2m distance cannot be maintained



Increased cleaning and waste services to ensure areas are clean and safe



Appropriate PPE for clinical colleagues and masks provided for all staff to wear at all times



Government guidance shared with staff and regular communication maintained



Lateral flow tests were introduced for all members of staff



Staff encouraged to open windows to increase air flow, reducing the amount of viral particles in the air



Mask fit test training delivered to staff ensuring respiratory protection equipment provides adequate protection for the individual wearer's face

2.8 On Monday 19th April 2021, we adjusted our Elective Preoperative Admissions Protocol to be aligned to with the NICE guidance. Patients will now undertake 14 days strict social-distancing, three days isolation before admission (for patient and patient's household) and only one COVID-19 swab three days before admission. The changes have been approved by the clinical working group and is a reduction in the pre-admission isolation period and number of tests carried out which has been in place for the last 12 months.

2.9 Work continues with regular Managers Support briefings which Laura Tilley Hood is delivering in her Engagement and Wellbeing Officer role. Themes this month include Stress Awareness, #ProjectM, connecting and supporting leaders across the NHS, lateral flow test, supporting colleagues returning to the ROH after redeployment, shielding, working from home and staff survey focus groups.

2.10 Thank you to colleagues for sharing and helping to signpost staff to the guide developed to support staff observing the holy month of Ramadan. The guide explains Ramadan and outlines how we can support Muslim colleagues, particularly as we continue our 'road map' out of national lockdown. The holy month of Ramadan began on Monday 12 April and lasts for 29 - 30 days, ending with the celebration of Eid-ul-Fitr, which is likely to be on Wednesday 12 May.

2.11 On Friday 30th April Captain Tom Moore would have been 101 years old. To celebrate the day his family launched the next phase to build on his legacy and to honour him and his amazing achievements. The Captain Tom Foundation asked everyone, of all ages and abilities, to take part in the Captain Tom 100. Thank you to all staff who took part in the celebrations #CaptainTom100.

2.12 Staff networks are an incredibly important part of the culture of ROH and I was pleased to announce that Falon Paris-Caines has been appointed Chair of ROH's Multi Minority Ethnic Group (MMEG) staff network. Falon, a member of the Communications Team, joined the Trust over four years ago and has been a member of the MMEG network since its inception last year. As an important step forward in the Inclusion journey at ROH we are delighted that Falon will now lead and continue the fantastic work that the MMEG network has started.

2.13 On Thursday 29th April, I attended a webinar held by NHSE/I to introduce the Health Inequalities work being undertaken nationally to support systems review and manage their waiting list. System plans are required to take due regard of the need to reduce pre-pandemic and pandemic-related health inequalities, using related waiting list data that is embedded within system performance frameworks to measure access, outcome and experience for BAME populations. This work will be overseen by the BSol system Inequalities Group and the Chief Operating Officers Operational Delivery Group which meets weekly. Further guidance is expected in the next few weeks to support systems and trusts managing their elective waiting lists.

2.14 On Tuesday 6th April, the Executive Team undertook its second 'Chat and Check' walkabout. The following areas received a visit by pairs of the Executive Team: IT; Oncology administration; Pharmacy; and Medical Records. The visits were largely positive and gave the Executive Team the opportunity to find out first-hand how staff were feeling and to review the working conditions of these important teams.

2.15 Executive appraisals have been held over the last month, with a couple remaining to be held in May. The process will consider some feedback from a 360 degree approach and will also

consider performance against previous objectives, with a new set being developed for delivery over the coming year. Where needed, DBS checks have been refreshed and into May the usual Fit and Proper Persons Test self-declarations will be canvassed in line with the Trust's policy.

2.16 We have had notification from the CQC that they are ready to schedule a well-led assessment visit for the Trust. The assessment will be an assurance process in line with the CQC's Transitional Monitoring Approach. The CQC will assess the Trust against a number of Key Lines of Enquiry and the outcome will be used by the CQC to determine whether they wish to undertake a full assessment against the well led framework. It is likely that the assessment will be in June 2021. In addition to this, the Imaging area will be assessed by the CQC, this being the first time the area will have been subject to the routine CQC assessment.

3 BSol ICS (Integrated Care System) Update

3.1 The BSol ICS Board strategy session took place on Monday 12 April 2021 where we discussed:

- An overview of ICS transition approach and timeline
- The approach to inequalities and the priorities within this programme
- A proposal for a Place-based partnership approach

3.2 Recruitment continues for the appointment of Non-Executive Directors for the ICS Board, one for Finance and one for Inequalities.

3.3 The recruitment process will now commence for a Chief Executive for the ICS and I am grateful to Simon Grainger-Lloyd for agreeing to help the ICS with the appointment into this post and to support the development of their governance processes.

4 NHSI/E National updates

4.1 Weekly briefing calls throughout May will now be reduced to fortnightly with the focus being on system recovery and restoration.

4.2 On Thursday 29th April, Sir Simon Stevens, NHS Chief Executive has confirmed that in July 2021 he will stand down from his post and a recruitment process will now commence to appoint his successor. Sir Simon has worked tirelessly throughout his seven-year tenure and the pandemic supporting NHS Leaders and staff.

4.3 Work continues working across the system to finalise the priorities and operational planning for 2021/2022 which is a draft submission to NHSE/I on the 6th May 2021.

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, the following policy was approved by the Chief Executive on the advice of the Executive Team:

- Information Security

6 RECOMMENDATION(S)

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

Jo Williams
Chief Executive

30th April 2021

TRUST BOARD | UPWARD REPORT

PROGRAMME:	**Restoration and Recovery Phase 2: Refresh and Recover**	**PROJECT MANAGER:**	**Alicia Stanton**	**DATE:**	**20/04/2021**
PROJECTS:	**Preop and Scheduling / Inpatients / Outpatients / Workforce and Wellbeing / ROH-UHB System**	**EXEC SPONSOR:**	**Marie Peplow/ Matt Revell**		

MILESTONES ACHIEVED (OVER LAST MONTH)

Preop and Scheduling
- Successful launch of the new elective preadmission testing protocol w/c 19/2/21
- Theatres risk assessment and recovery plan completed
- Increased to 14 theatres in operation

Inpatients
- Review of visiting policy
- Review of discharge lounge and current discharge protocol
- Proactive Bed modelling incorporated on Site Report weekly

Outpatients
- Recommencement of activity at Lordswood agreed
- Sub-groups for virtual clinics, capacity and templates, patient letters and imaging arranged

Workforce and Wellbeing
- Return of all redeployed and shielding staff – wellbeing packs, listening sessions, what's app groups and manager support all in place.
- Workforce planning baseline underway.

ROH-UHB System
- Addition of 5th group – ROH/UHB systems group
- System governance developed and agreed
- All project and governance documentation completed
- Honorary contracts and inductions completed for UHB surgeons
- Wider UHB support started 19/04/21 with 2 lists every week day
- Continuing to support ambulatory trauma lists

ISSUES/CONCERNS/RISKS IDENTIFIED

Preop and Scheduling
- Risk of miscommunication/misinformation during changeover of the testing protocol (comms plan in place to mitigate this)

Outpatients
- Physiotherapy backlog (planning in progress)
- Lack of capacity to accommodate activity- virtual clinic environment being scoped

ROH-UHB System
- UHB surgeons operating in an unfamiliar environment (review and mitigation in place)
- Reduced capacity for ROH surgeons to operate (increase to 14 theatres, and scoping additional weekend sessions)

DECISIONS / SUPPORT REQUIRED

- Pre- op protocol agreed and launched
- UHB governance framework agreed

WORK PLANNED (MONTH AHEAD)

Preop and Scheduling
- POAC relocation
- Implementation of Theatre Recovery plan

Inpatients
- Discharge lounge review

Outpatients
- Audit of Imaging walk-ins and review of patient flow between Outpatients and Imaging
- Restart outpatient physiotherapy gym classes (with reduced numbers)
- Review of outpatient opening times
- Scoping of virtual clinic space

Workforce and Wellbeing
- Drop-in sessions for returning staff
- Wellbeing week
- Vacancy review of all posts fundamental to recovery

ROH-UHB System
- Improved preop process for UHB patients (to all be on ROH site)
- Operational, governance and oversight meetings
- Final inductions of UHB staff

KEY BENEFITS: MEASURING SUCCESS OF THE PROGRAMME

- All outpatient services restarted
- Elective surgery restarted (including ROH and UHB patients) – treatment of priority patients at risk of potential harm
- Effective partnership working (integrated and standardised pathways)
- Reduced system waiting times

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Health Inequalities – Birmingham and Solihull System and ROH approach**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing & Clinical Governance**
AUTHOR:	**Garry Marsh, Director of Nursing & Clinical Governance**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

This paper describes;

- The 2021/22 national planning guidance commitment to reduce Health Inequalities;
- The Integrated Care System Health Inequalities Board and its proposed workstreams;
- The proposed Governance structure for delivering Health Inequalities Reduction within the Trust;
- The named Director and Non-executive Director for the Trust to lead the Health Inequalities Reduction work.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Note the planning guidance in relation to Health Inequalities;
- Note the establishment of an ICS Health Inequalities Board and its governance;
- Approve the proposed governance approach within the Trust to be established;
- Approve the named Director & Non-Executive to lead the Health Inequalities work

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	**X**	

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

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

Comments: This paper describes the structure to deliver the policy requirements associated with Reducing Health Inequalities which will have better experience for both our patients and our staff.

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



PREVIOUS CONSIDERATION:

No previous consideration.

FOR ASSURANCE

ROHTB (5/21) 003 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BIRMINGHAM & SOLIHULL SYSTEM AND ROH APPROACH TO INEQUALITIES

REPORT TO TRUST BOARD – 5 MAY 2021

1.0 BACKGROUND

1.1 Whilst Health Inequalities has always been an agenda item within the NHS the COVID pandemic and some of the subsequent findings and research have heightened the vulnerabilities of some individuals within populations and brought the Health Inequalities agenda to the forefront.

2.0 NHS PLANNING GUIDANCE

2.1 Within the NHS Planning Guidance 2021/22 the following are detailed as Health Inequality Priorities:

- Restore NHS Services inclusively. Systems use data to deliver inclusive restoration of services – ethnicity and deprivation;
- Mitigate against digital exclusion. Ensure that the move to digital consultation does not disadvantage some groups of patients;
- Ensure datasets are complete and timely. Capture data on ethnicity across all services including primary care;
- Accelerate preventative programmes that proactively engage those at greatest risk of poor outcomes. Examples include vaccinations, annual health checks for people with a Learning Disability or Mental Health Needs, continuity of care for mothers;
- Strengthening leadership and accountability. A named board level lead identified.

2.2 In addition, access to the Elective Recovery Fund has also been described for;

- Restore NHS Services inclusively.
- Mitigate against digital exclusion.

3.0 BIRMINGHAM & SOLIHULL INTEGRATED CARE SYSTEM (ICS) APPROACH

3.1 Prior to the planning guidance an ICS working group was established in 2020 to focus on health inequalities.

This will formerly become the ICS Inequalities Board from May 2021. Proposed Terms of Reference (TOR) will be approved at this meeting. A copy of these are attached with this paper.

3.2 The priorities of the ICS Inequalities Board are described within the table below:

Birmingham & Solihull ICS Inequalities Work Programme
Priorities 2021/22

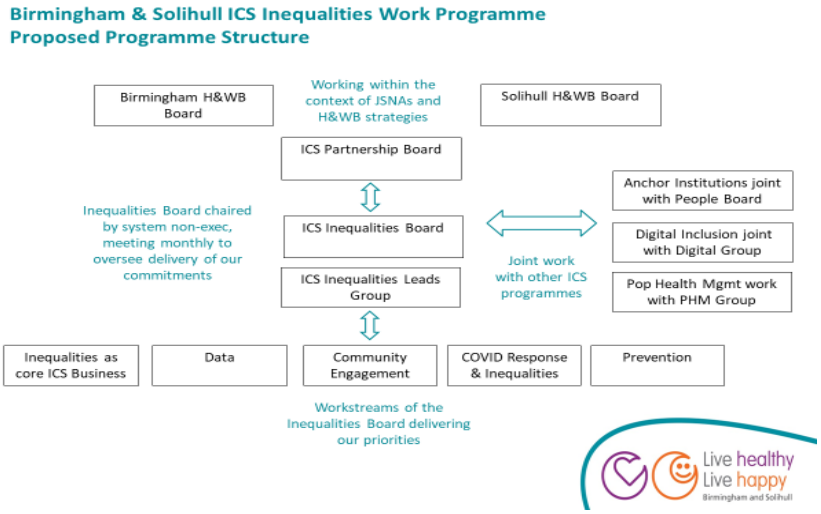
Workstream	Priorities 2021/22				
Inequalities as ICS Core Business	Midlands Health Inequalities Toolkit	BSol Inequalities leads Network	HI Priorities for ICS workstreams	HI Priorities for NHS trusts	HI leadership development
Data	NHS activity ethnicity coding	Locality & PCN level data	Mapping access to NHS services	Activity analysis joint with BCWB	Tracking Impact inc ICS OF
Community Engagement	PCN-level prototypes (x2)	Locality stakeholders	BLACHIR – NHS input		
COVID Response & Inequalities	Waiting Lists – equality analysis	Vaccination – inequalities grp	Long COVID equity of access	Equality impact of recovery plan	
Prevention	Early Years - BFS HI priorities	Long Term Condition pathways	Mental Health pathways	Maternity pathways (BUMP)	
Anchor Institutions	Joint work with the People Board	Recruitment Opportunities	Social Value procurement	Living Wage commitment	
Digital Inclusion	Joint work with the Digital Group	Digital inclusion strategy			
Population Health Management	Led by the PHM programme	Inequalities built into PHM approach			

Live healthy
Live happy
Birmingham and Solihull

3.3 The priorities for focus will be finalised at the first ICS Inequalities Board but are expected to be:

- Mental Heath
- Maternity
- Anchor Organisation

3.4 The governance structure of the ICS Inequalities Board is presented below.



4.0 THE ROYAL ORTHOPAEDIC HOSPITAL APPROACH

4.1 Strengthening Leadership & Accountability

4.1.1 The named Board level lead is Garry Marsh, Director of Nursing & Clinical Governance who is a member of the ICS Inequalities Board.

4.1.2 Kathryn Sallah, Non-Executive Director will also become a member of the ICS Inequalities Board from May 2021.

4.2 Proposed Governance

4.2.1 A Health Inequalities Group will be established, chaired by the Director of Nursing & Clinical Governance which will have a subset of workstreams that report into it. The TOR will be finalised when the ICS Inequalities Board has approved their TOR in order that alignment can be achieved.

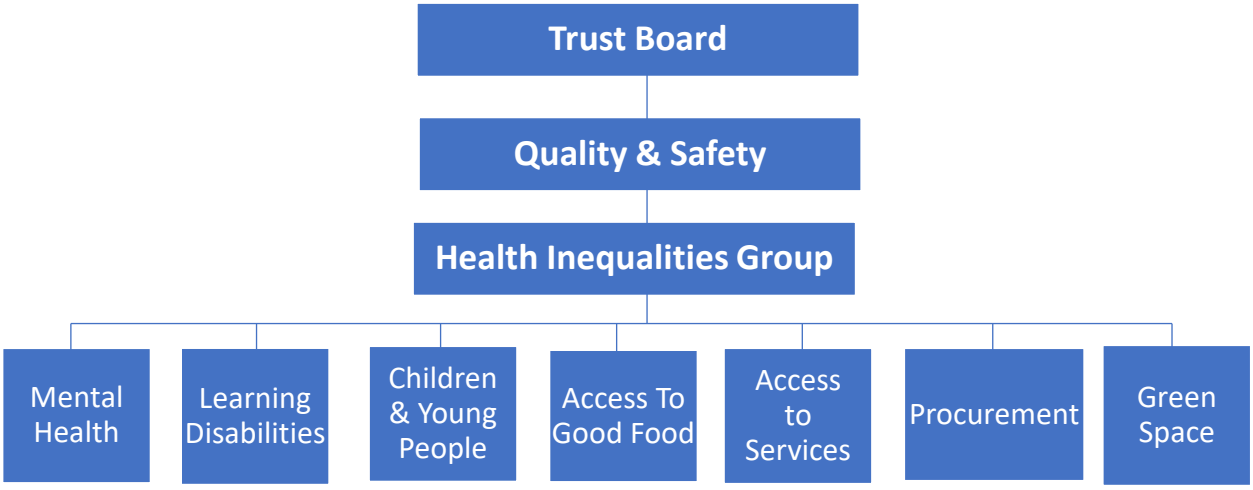
4.2.2 The workstreams provisionally identified which build on existing work already underway but will ensure the inclusion of Health Inequalities are:

- Mental Health;
- Learning Disabilities
- Children's & Young Persons
- Access to Good Food;
- Access to Services
- Procurement
- Green Space

4.2.3 An Executive lead will be identified by alignment through portfolio accountability for each workstream.

4.2.4 The Health Inequalities Group will report to the Quality & Safety Committee chaired by Kathryn Sallah, Non-Executive Director, which in turn reports to Trust Board.

4.2.5 The proposed structure is presented below:



5.0 RECOMMENDATION

5.1 Trust Board is asked to:

- Note the planning guidance in relation to Health Inequalities;
- Note the establishment of an ICS Health Inequalities Board and its governance;
- Approve the proposed governance approach within the Trust to be established;
- Approve the named Director & Non-Executive to lead the Health Inequalities work.

Garry Marsh
Director of Nursing & Clinical Governance

29 April 2021

ROHTB (5/21) 003 (b)

DRAFT FOR DISCUSSION
V2 7TH APRIL 2021

Birmingham and Solihull Integrated Care System
Inequalities Board

Terms of Reference

Statement of Intent

As the Inequalities Board of the Birmingham & Solihull Integrated Care System we aim to make a difference to the lives of the people of Birmingham & Solihull by putting inequalities and their impact on health at the heart of the work of the ICS and its organisations. We will know we have succeeded when the organisations in the ICS are working together to make a demonstrable impact on the impact of inequalities on the health of the people we serve.

1. Purpose of the Inequalities Board

The Birmingham & Solihull (BSol) ICS Inequalities Board is a collaboration across the health and social care system in the ICS to set direction and support delivery by the partners to contribute to improving the health and wellbeing of the people of Birmingham and Solihull by putting action to tackle inequalities and the impact of inequalities on health at the heart of the work of the ICS.

The Inequalities Board supports delivery of the BSol ICS Long Term Plan commitment to "*reduce inequalities in health and wellbeing across our diverse communities in Birmingham and Solihull. . . .We want to promote inclusive communities, reducing social isolation, as well as valuing mental health equally with physical health.*"

The Inequalities Board will also support delivery of the national NHS Long Term Plan relating to Inequalities and other national and regional strategies tackling inequalities and their impact on health.

The Inequalities Board will work closely with the ICS People Board. We have agreed that work on equality, diversity and inclusion for the NHS workforce and for organisations as employers will be led by the People Board. The Inequalities Board and the People Board will work together on the wider Anchor Institution agenda for the ICS.

The Inequalities Board will report regularly to the ICS Partnership Board. It will also report to the Health & Wellbeing Boards in Birmingham and Solihull as agreed with the Chairs of those boards.

2. Responsibilities

The ICS Board has approved an initial work programme for the Inequalities Board at its meeting in December 2020. This work programme has also been presented to the Health & Wellbeing Boards in Birmingham and Solihull in March 2021. This work programmes forms the core of the work of the Inequalities Board and accompanies these terms of reference as an appendix.

The Inequalities Board will:

- develop and lead the delivery of the ICS's approach to tackling inequalities and their impact on health including agreeing an annual work programme;
- ensure that the ICS and its constituent organisations understand and are able to use the available data on inequalities and their impact on health across Birmingham and Solihull;
- champion community engagement and co-production within the work of the ICS and its constituent organisations including supporting Primary Care Networks to deliver effective community engagement within their neighbourhoods;
- ensure that the ICS and its constituent organisations understand the potential of their role as Anchor Institutions and support a small number of system-priorities for action;
- work with other groups within the ICS to ensure that our system response to COVID19 takes full account of the impact of inequalities including in the COVID19 vaccination programme and in delivering recovery and restoration of services;
- develop and support the ICS and its constituent organisations to deliver services that promote prevention and early intervention, identifying and responding to the communities that need this most;
- ensure that all of the workstreams of the ICS take full account of the impact of inequalities including, for example, the People Board and digital and estates workstreams;
- work with the client-group based partnerships that are leading service transformation for services for older people and children (e.g. Birmingham Integrated Care Partnership, Birmingham Children's Partnership, Solihull Together) to ensure that their work takes full account of inequalities and their impact on health;
- build a network of professionals within the ICS who have the capability and capacity to work within their constituent organisations to tackle inequalities;
- ensure that the ICS makes full use of the NHS Midlands Health Inequalities toolkit in our approach to tackling inequalities and their impact on health;
- contribute to the development and delivery of a population health management strategy for the ICS using data to deliver improved targeting of care to those who need it most.

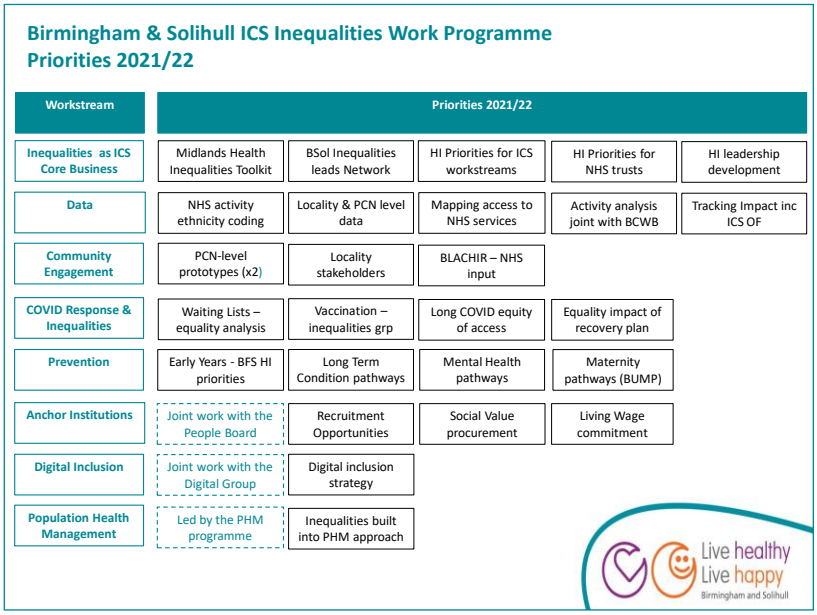
3. Membership

The membership of the Board will be as follows:

- System Non-Executive Lead for Inequalities – to be appointed
- System Senior Responsible Officer (SRO) for Inequalities – Richard Kirby, CEO, BCHC
- Programme Lead – Inequalities
- BSol ICS Assistant Chief Executive
- Representatives (Exec Leads or their nominees) from NHS organisations
    - BCHC
    - BWCH
    - BSMHT
    - ROH
    - UHB
    - BSol CCG
    - SWB CCG
- GP representation from Birmingham and Solihull
- Representatives from local authorities – Public Health directors / their nominees / other representatives
    - Birmingham City Council
    - Solihull MBC
- Healthwatch – Birmingham & Solihull
- Voluntary and community sector representatives – Birmingham & Solihull

4. Workstreams and Structure

The Inequalities Board will deliver its responsibilities through a series of workstreams. The current draft structure for these workstreams and the Board is set out in the diagram below.



5. Quorum

The meeting will be quorate with a minimum of:

- at least one of: system non-exec, SRO and/or ICS Asst CEO;
- representation from at least 3 of 5 NHS providers;
- at least one local authority representative;
- at least one CCG representative.

If the quorum has not been reached, then the meeting may proceed if those attending agree

6. Decision making and Dispute Resolution

The Board will make decisions on system matters. The Chair will actively seek to reach decisions by consensus. Should this not be possible then a vote of the Board's members will be required. The decision will be made by simple majority. If the Board is not quorate then decision rights shall be amended.

Conflicts of interest will be considered on a case by case with the Chair.

Members will be required to declare relevant interests verbally at the start of a meeting and, at the Chair's discretion, they may be asked to leave the meeting while a particular topic is being discussed.

If any member of the Board has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a casting vote to prevent a deadlock.

7. Meetings

Meetings will take place monthly by agreement with the Chair. The Board may meet either in person or via telephone/video conference.

The chair may at times convene additional meetings to consider business that requires urgent attention.

All members will be able to propose agenda items. The agenda will be agreed by the Chair.

Notice of each meeting confirming the venue, time and date, together with an agenda and papers to be discussed, shall be made available to each member of the board, no less than five working days before the date of the meeting in electronic form.

Papers will be tabled only in exceptional circumstances.

Meeting minutes and action tracker, in draft, will be circulated to all attendees 5 working days after the meeting and agreed at the following meeting.

8. Governance and Reporting Arrangements

The Inequalities workstream SRO sits on the ICS Board and will report to that board on the work of Inequalities Board summarising areas where action or improvement is needed.

The workstream SRO or delegated representative(s) will sit on the Midlands Regional Inequalities Board in accordance with representation and decision-making role(s) defined by this Board.

7th April 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Health Inequalities – Children and Young People Workstream – Enhancing Employment Opportunities Project**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing & Clinical Governance**
AUTHOR:	**Garry Marsh, Director of Nursing & Clinical Governance**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

This paper has detailed national, local and organisational drivers for a project to increase the employment opportunities for young people at the Trust outlining the benefits to both individuals and our patients and also the alignment to Health Inequalities reduction.

REPORT RECOMMENDATION:

Trust Board are asked to:

- Note the content of the paper and the project intentions;
- Approve the project being progressed within the Trust.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	**x**	

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

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

Comments: This paper describes the structure to deliver a workforce project the policy requirements associated with Reducing Health Inequalities by recruiting more young people which will have better experience for both our patients and our staff.

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



PREVIOUS CONSIDERATION:
No previous consideration.

FOR ASSURANCE

ROHTB (5/21) 004 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PROJECT TO REDUCE LONGER IMPACT OF HEALTH INEQUALITIES THROUGH INCREASED RECRUITMENT OF YOUNG PEOPLE

REPORT TO TRUST BOARD – 5 MAY 2021

The purpose of this project is to enhance employment for young people at the ROH thus contributing to the reduction in health inequalities gained through the benefits of employment which will be further described later within this paper.

1.0 WHAT IS A HEALTH INEQUALITY?

1.1 Health Inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

1.2 Health inequalities have been documented across at least four dimensions and individuals can often fall into various combinations of these categories. These categories are:

- Socio economic status and deprivation;
- Protected characteristics as described within the Equality Act (2010);
- Inclusion health groups such as the homeless, migrants;
- Geography

2.0 WHY YOUNG PEOPLE?

2.1 The stronger impact on health and health inequalities are the wider detriments which impact on health and compound health inequalities over a lifetime. Historically, whilst much work has been undertaken around health inequalities on older age groups, it has been demonstrated that there has been an absence of attention on adolescents and those in early adulthood who are distinct from other age groups in their needs. There is also now collective agreement that young people up to the age of 25 should be considered in the design of Children & Young Person services.

2.2 Adolescence and early adulthood sees several transitions which will impact on life and the risk of health inequalities an individual may experience. These are:

- Transition from education to employment;
- Financial and housing transition;
- Living independently

- Social transition where peers and others outside of immediate family take on a greater influence;
- Making own life choices including health decisions

Without support, any of these transitions can lead to increased vulnerability of the young person and in turn begin the risks of health inequalities.

3.0 WHY IS THIS RELEVANT TO BIRMINGHAM?

- 1,137,150 people live in Birmingham and 72% of the population are under 45 years of age, with an almost equitable spilt in the gender of the population
- Birmingham is often described as one of the youngest cities in England and 40% of its population are 0-25years old (13% over 65)
- 40% of the population live in the 10% most deprived areas of England
- 42.1% of Birmingham's population is from BAME groups (15% nationally)
- Life expectancy is lower than the national average
- Less than 1% of supported adults with a Learning Disability are in paid employment

4.0 WHY IS THIS RELEVANT TO THE ROYAL ORTHOPAEDIC HOSPITAL?

Birmingham has 5 localities each made up of two constituencies.



Our hospital is based within the South of Birmingham.

4.1 Index of Multiple Deprivation (IMD)

4.1.1 The IMD measures 7 distinct domains of deprivation;

- Income:
- Employment
- Health Deprivation & Disability
- Education, Skills & Training
- Crime
- Barriers to housing and services
- Living environment

4.1.2 This is a measure of the relative levels of deprivation at small area levels. As stated Birmingham has high levels of deprivation. The map below shows the outcomes of the city and most relevant the area which we serve.

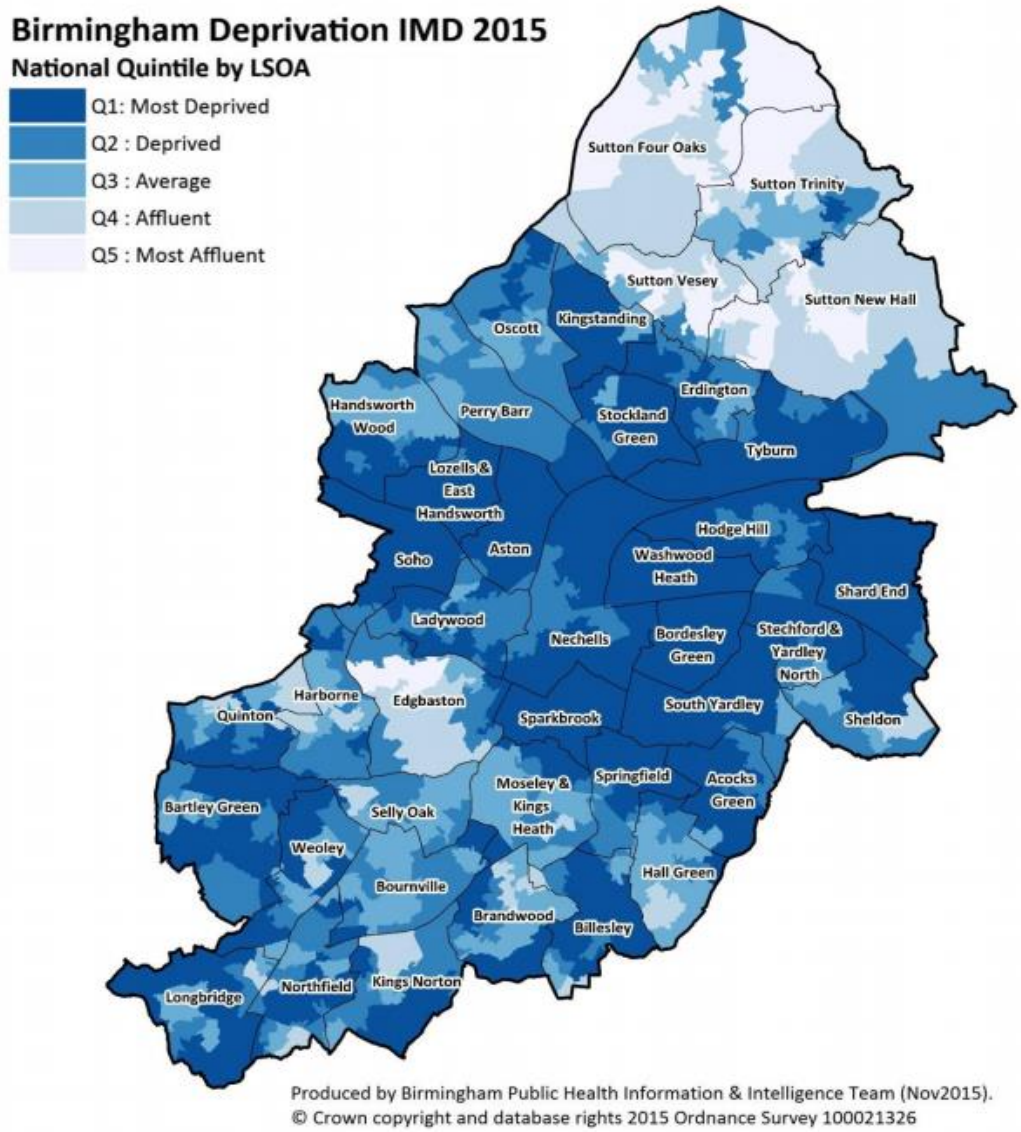
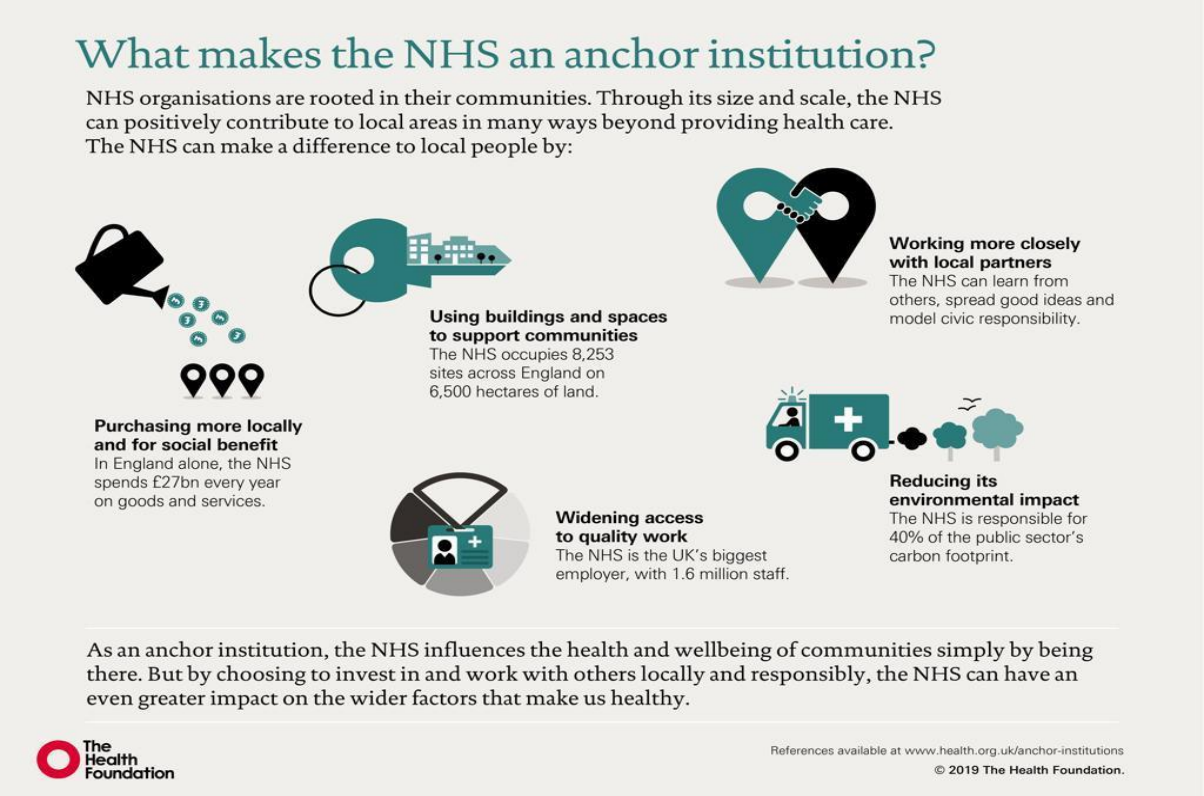


Figure 24 - deprivation map by Birmingham ward. Source: IMD 2015

5.0 Anchor Institution

5.1 An anchor organisation in the context of the NHS is a large, public sector organisation that is unlikely to relocate and has a significant stake in the geographical area. The role of NHS organisations and how they can contribute to the health and wellbeing of their local communities is summarised in the chart below:



5.2 As stated, the purpose of this project is to enhance employment for young people at the ROH thus contributing to the reduction in health inequalities gained through the benefits of employment which will be further described later within this paper.

The Anchor Organisation in its role in employment

5.3 The NHS employs more than 1.6million people and is a critical source of economic opportunity for local people.

5.4 There is a strong link between work and health and for work to have a positive impact on health it must be "good work" providing stable employment, paying a living wage, offering fair work conditions, work life balance and career progression.

5.5 By helping more residents from the local community into NHS employment the gap for some of the key drivers for health inequalities may begin to narrow. Building a workforce from the local community can also better respond to patient's needs.

6.0 The Drivers from Young People

6.1 Young people commonly raise scarcity of good quality employment opportunities and many describe seeing a lack of permanent full-time opportunities as a driver for accepting less hours or temporary work often in roles they are over skilled for.

6.2 The risk of unemployment increases stress experienced by young people worsened by the often-restricted access to this group of state benefits. At its extreme this absence of cash can see young people pulled towards crime.

6.3 Young people particularly quote absence of recognition by employers of vocational qualifications as a challenge with evidence showing in the absence of more traditional academic qualifications the risk of access to only temporary or zero hours work is heightened.

6.4 Flexibility and accessibility is also a challenge for young people in particular good quality part time work that allows a study/work combination in life or indeed the cohort of young people who are parents.

Impact of COVID19

6.5 During the COVID pandemic there has been a 120% increase in young people claiming benefits mainly due to the earlier stated link with high employment in temporary, agency and zero hours contracts with high employment rates within the retail and hospitality sectors.

6.6 As previously stated between the age of 12-24 years is key for social and emotional development and it is evident that COVID has had a negative impact on the mental resilience of young people with many feeling hopelessness, loneliness and a recent report from the Samaritans stated 14% had thought about suicide. Many young people have also had a loss of transition points that allow social and emotional development with their only connection being their family and household.

7.0 The Drivers at the Royal Orthopaedic Hospital?

7.1 Our Patient Cohort

7.1.1 Each year the ROH provides care to 88,342 children and young people with 78,918 seen in outpatients and 9424 have inpatient stays.

7.1.2 The age of these cohorts are shown over the page.

Inpatient Activity and Consultant Led Outpatients Appointments 2020

	Age Group				
Activity Type	**0-15 Years**	**16-17 Years**	**18-24 Years**	**25+ Years**	**Total**
Consultant Led Outpatient	4667	2247	4670	67334	78918
Inpatients	61	258	749	8356	9424
Total	**4728**	**2505**	**5419**	**75690**	**88342**

NB - Outpatients includes all appointments ie 'Did Not Attend'/cancellations

7.2 Our Workforce

7.2.1 An analysis of the workforce has been undertaken using Electronic Staff Record (ESR) data around the cohort of staff currently employed by the Trust as detailed below:

Trust Total		
Age Band	**Headcount**	%
<=20 Years	6	**0.50%**
21-25	83	**6.92%**
26-30	141	**11.75%**
31-35	148	**12.33%**
36-40	138	**11.50%**
41-45	150	**12.50%**
46-50	164	**13.67%**
51-55	152	**12.67%**
56-60	124	**10.33%**
61-65	57	**4.75%**
66-70	29	**2.42%**
>=71 Years	8	**0.67%**
Trust Total	**1200**	

7.2.2 The workforce was further broken down into the Director of Nursing & Clinical Governance portfolio given the face to face contact and impact on direct care this workforce offers.

Nursing & Facilities		
Age Band	**Headcount**	%
<=20 Years	1	**0.16%**
21-25	49	**7.72%**
26-30	83	**13.07%**
31-35	71	**11.18%**
36-40	66	**10.39%**
41-45	66	**10.39%**
46-50	87	**13.70%**
51-55	90	**14.17%**
56-60	68	**10.71%**
61-65	27	**4.25%**
66-70	21	**3.31%**
>=71 Years	6	**0.94%**
Total Staff	**635**	

7.2.3 This clearly demonstrates that the Trust is not maximising its opportunities to ensure the workforce is representative of its patient group but also demonstrates there is scope to undertake a piece of targeted work with this cohort of young people in line with the reducing health inequalities this cohort may experience if not within employment.

7.2.4 However, benchmarking against the wider NHS workforce, it should be noted that only 6% of the workforce are under 25, the ROH currently being at 7.42% so ranking above this statistic.

7.2.5 It should also be noted that these figures exclude our Bank staff.

8.0 Project Risk Scoring

8.1 Given the volume of work the NHS faces in addressing health inequalities (which has been given additional focus linked with the COVID pandemic) and susceptibility of individuals from groups with strong links to a greater risk of experiencing health inequalities, a commitment has been made to prioritise interventions with higher impact benefits for the population.

8.2 In order to allow the NHS within the Midlands to prioritise a toolkit titled “Addressing Regional Health Inequalities” has been launched.

8.3 Whilst the toolkit is designed for Regional Health Inequalities, its principles can be applied to more local work which has been undertaken against this project. The local Integrated Care System (ICS) has made one of its three main priorities for this financial year the "growth of NHS organisations as Anchor Organisations.

8.4 In order to evaluate the impact of this scheme, a score has been undertaken using the Addressing Regional Health Inequalities tool kit and its prioritising scoring matrix which is detailed below:

Health Benefit	Benefit to >2m of population	Benefit to <2m and >500k of population	Benefit to <500k of population
Population	10	6	3
	Five> Protected Characteristic Group	Two-five Protected Characteristic Groups	One Protected Characteristic Group
Protected Characteristic	15	12	10
			Bonus for COVID inequality relevant
			5
			Bonus for ethnicity
			5
Specified task	Statutory duty, mandatory or legal	COVID priority or LTP task	Implied LTP task
	10	6	3
Political sensitivity	High (e.g. Secretary of State, Simon Stevens commitment)	Medium (e.g. Midlands RLT commitment)	Low (local commitment)
	5	3	1
Value	To patient (experience, health outcomes) AND system (population, quality, cost, predictability)	To patient (experience, health outcomes) OR system (population, quality, cost, predictability)	Evidence gathering (currently not recorded/collected)
	15	10	5
Is it quick?	Delivered in 1-2 months	Delivered in 2-6 months	Delivered in more than 6 months
	5	3	1
Is it easy?	Already have a developed concept that can be adapted	Existing evidence base but nothing is developed	No evidence base, but seems like a good idea
National	10	6	3
	Easy to implement with stakeholders (patients AND workforce)	Challenging to implement with stakeholders (patients OR workforce)	Complex to implement (patients AND system)
Local	10	6	3

8.5 When this matrix has been applied the Director of Nursing & Clinical Governance has calculated the following scores under each domain of the matrix:

Health Benefit	Score
Population	3
Protected Characteristic	12
Specific Task	6
Political Sensitivity	1

Value	10
Is it quick?	3
Is it easy? National	10
Is it easy? Local	6
Total Score	51

8.6 Aligned to the regional toolkit prioritisation criteria this makes the project a medium priority.

8.7 It is concluded by the Director of Nursing & Clinical Governance that this action is therefore of benefit to undertake and also aligns to local ICS priorities.

9.0 Benefits

9.1 A summary of key benefits are detailed below;

Benefits to individuals

- Work of a good quality;
- Social Connection;
- Access to training & education (both job related and life skills);
- Access to affordable housing;
- Access to Health & Wellbeing initiatives.

Benefits to our patients and our organisation

- Staff who enhance the experience of patients and their relatives from the CYP cohort;
- Retention of staff and future workforce growth in difficult to fill roles through access to education and training;
- Income through better occupancy rates within staff accommodation;
- Support the reduction in agency spend through the benefits employing CYP achieves in both the short term and longer term;
- Alignment with the Trust Strategy domains;
- Demonstrates compliance by the Trust to the Equality Act (2010) in relation to age.

10.0 Summary

10.1 This paper has detailed national, local and organisational drivers for the project to increase the employment opportunities for young people at the Trust outlining the benefits to both individuals and our patients and also the alignment to the Health Inequalities agenda.

11 RECDOMMENDATION

11.1 The Trust Board is asked to:

- Note the content of the paper and the project intentions;
- Approve the project being progressed within the Trust.

Garry Marsh
Director of Nursing & Clinical Governance

30 April 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Health & Safety Executive COVID-19 Spot Check Inspections Gap Analysis**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

On 2nd March 2021 the Health & Safety Executive (HSE) wrote to Chief Executive Officers at Provider organisations with the findings of 17 inspections they had undertaken between December 2020 and January 2021 within the NHS. This letter and report are attached at ROHTB (5/21) 007 (a) & (b).

The report was broken down into 7 sections;

- Risk Assessment
- Management arrangements specific to COVID
- Social Distancing
- Cleaning & Hygiene Measures
- Ventilation
- Dealing with Suspected Cases
- Personal Protective Equipment (PPE)

The HSE did not give detail of the full assessment criteria that had been used during these inspections but recommended that "Boards reviewed the detailed findings of the inspections in order to assure themselves that adequate COVID control measures are in place and remain so during the pandemic".

The detailed findings were divided into the 7 categories and presented as examples of good practice and examples of where improvements were required.

Trust Methodology of Assessment

The Trust has therefore undertaken a review against these findings and asked for assurance against each section suing the Trust experts in each field.

These were;

- Risk Assessment – Adam Roberts, Corporate Governance Manager & Assistant Company Secretary
- Management Arrangements – Garry Marsh, Director of Nursing & Clinical Governance
- Social Distancing – Carl Measey, Health and Safety Adviser & Rebecca Lloyd, Deputy Director of Strategy & Performance
- Cleaning & Hygiene Measures – Steve Harnett, Facilities Manager
- Ventilation - Carl Measey, Health and Safety Adviser & Stuart Lovack, Associate Director of Estates

- Dealing with suspected cases - Victoria Clewer, IPC Matron
- PPE – Victoria Clewer, IPC Matron

Once the initial assessment had been undertaken by the above a confirm and challenge meeting was held, jointly chaired by Garry Marsh, in his capacity as DIPC and Phil Begg in his capacity as accountable Director for Health & Safety.

The revised and final version was presented to the Quality & Safety Executive meeting on Tuesday 20th April 2021 chaired by Jo Williams, Chief Executive Officer.

Outcome

The assessment considered 48 examples of good practice and 63 examples of practice where improvement was required as described within the HSE report.

The Trust had 7 that required improvement against these examples.

These are as listed below;

- Monitoring arrangements were not in place to ensure policies and procedures were read and were followed;
- Compliance with risk assessment control measures were not being audited resulting in the non-compliance issues contained in this report;
- Lunch breaks and shifts staggered in the engineering/domestic department to reduce traffic flow through the building and numbers using the changing and toilet facilities at any one time;
- Maxillofacial department in the outpatient's department engaged a competent ventilation contractor to assess air changes in each treatment room. They then implemented a system to ensure those rooms with greatest number of air changes were used for AGPs as their clearance time was shorter.
- Site wide survey of all mechanically ventilated wards and to identify any issues and rebalance the ventilation system.
- Implemented a schedule of cleaning and maintenance of all mechanical ventilation systems.
- Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation.

Actions to resolve these areas for improvement are being undertaken with the key actions being within the ventilation components.

Next Steps

The Quality & Safety Executive has commissioned a survey of the Trust ventilation systems in order to determine next steps. This will be arranged by the Associate Director of Estates.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Note the methodology;
- Note the Executive oversight;
- Note the findings and areas where improvement is required;
- Note the ventilation review commissioned;
- Agree the findings of the commissioned ventilation review will be overseen by the Quality & Safety Executive meeting;
- Agree a further update will be received by the Quality & Safety Committee at a future meeting.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Health & Safety legal obligations

PREVIOUS CONSIDERATION:

The Trust Board received a verbal update on the proposed approach to the GAP analysis on 7th April 2021. The detailed GAP analysis was considered in full at the Quality & Safety Executive and Quality & Safety Committee on 20 April 2021 and 28 April 2021 respectively.

Health and Safety Executive

EPD OPST

Harvey Wild

Birmingham - Advantage House
9 Quinton Business Park
Birmingham
WTM
B32 1AL

http://www.hse.gov.uk/

Acting Deputy Director
John Rowe

To: Chief Executives of all NHS acute trusts,
foundation trusts and health boards

2 March 2021

Dear colleagues

HSE COVID-19 SPOT CHECK INSPECTION – FINDINGS

I would like to take this opportunity to thank you and your teams for your on-going commitment and dedication to maintaining high quality healthcare services throughout these incredibly challenging times.

The health and safety of workers is a priority and, as Britain's regulator for workplace health and safety, HSE has been supporting the national effort to tackle coronavirus in a number of ways, including through a COVID-19 spot inspection programme.

As part of this programme, 17 acute hospitals were inspected across Great Britain during December and January. We carefully analysed the outcomes from the inspections so that we could use this opportunity to share learning and enable you to swiftly identify any common areas that may need improvement.

I have therefore enclosed a summary of our findings along with a number of recommendations in anticipation that you will use it in a constructive way alongside your other quality improvement approaches to ensure your COVID -19 arrangements are robust as they can be.

Whilst the inspections were carried out in acute hospitals the common themes we identified may also be applicable across a variety other health and social care settings and services.

Should you need to clarify any of the content please send your enquiry to Public.Services-Sector@hse.gov.uk.

Yours faithfully



Harvey Wild
Head of Transport and Public Services Unit
Engagement and Policy Division
Health and Safety Executive

SUMMARY OF FINDINGS

HOSPITAL SPOT CHECK INSPECTIONS – COVID-19

Background

HSE inspected 17 acute hospitals, in 13 NHS Trusts in England and 2 NHS Health Boards in Scotland and Wales respectively as part of the national HSE COVID–19 spot check inspection programme. The inspections were led by an HSE Occupational Health Inspector and were carried out between December 2020 and January 2021. Each one focused on 7 key areas to assess the arrangements in place to manage risk arising from COVID-19, but where other matters of evident health and safety concern were identified they were also dealt with.

Executive summary

Overview

The NHS Trusts and Boards had all invested significant time and effort to implement a variety of COVID control measures in the hospitals inspected.

We saw a range of compliance both in terms of comparing the hospitals with each other but also within individual hospitals. Five were highly compliant; four were given advice and 8 required letters to be sent formally requiring remedial action to be taken. The contraventions of health and safety law included in the letters were:

Risk Assessment	Management arrangements Specific to COVID	Social Distancing	Cleaning and hygiene measures	Ventilation	Dealing with suspected cases	PPE
8	6	8	6	5	0	5

A detailed summary is provided in Annex 1 setting out examples of where we saw good practice and where remedial action was required. The common themes were:

Leadership

- Higher levels of compliance were seen where the leadership team were visible to staff on the front line and the Infection Prevention and Control (IPC) leads worked alongside health and safety teams.
- Lower levels of compliance were generally found where there were limited or no monitoring arrangements in place to ensure the control measures identified in the risk assessments were implemented and/or maintained.

Clinical and Non-clinical areas

- Higher levels of compliance were seen in patient facing clinical areas across most of the 7 areas inspected.
- Lower levels of compliance were frequently found in in non-clinical areas, even when adjacent to clinical areas. Reasonably practicable control measures were often available but not utilised in a variety of locations.
- Arrangements for staff who are displaying COVID -19 symptoms were well established.

Matters of evident concern unrelated to COVID are detailed in Annex 2.

Recommended action:

We strongly recommend NHS Trusts and Boards review the detailed findings of the inspections in Annex 1 and take the following action to reassure themselves that adequate COVID control measures are in place and remain so during the pandemic:

1. Review their risk management arrangements to ensure they are adequately resourced.
2. Consider how well the various parts of the risk management system coordinate with each other, including the health and safety team, departmental managers, infection control and occupational health colleagues and whether they could be improved.
3. Ensure compliance with their legal obligations to consult with trade unions and employee representatives by ensuring they are engaged in the risk assessment process. Worker engagement in this process is critical to establishing workable control measures.
4. Review all non-patient facing areas to ensure a suitable and sufficient risk assessment has been carried out and the control measures identified have been implemented – in line with relevant guidance, including - Making your workplace COVID-secure during the coronavirus pandemic (hse.gov.uk). Consider how well the risk assessments for these areas have applied the hierarchy of control and have they:

    - Identified the maximum room occupancy numbers and the optimum layout and seating arrangements in all areas? For example, in libraries, the laundry, porters lodge, clinical records, rest rooms, toilets, locker rooms, post rooms, changing rooms, offices, canteens, training rooms, doctors' common rooms
    - Considered how ventilation could be improved in all areas? Could windows be unsealed to open, are doors left open, how are rooms with no windows or air conditioning being ventilated?
    - Implemented mitigating measures where it is not possible to maintain social 2m distancing? For example, by proving physical barriers (screens), one-way systems or rearranging /modifying layout.
    - Checked the adequacy of their cleaning regimes in non–clinical areas? Have they consistently considered high touch surfaces, for example printers, vending machines, kettles, photocopiers, door handles etc?

5. Review the provision of lockers and welfare facilities to ensure they can accommodate the number staff on shift in a COVID secure manner.
6. Establish routine monitoring and supervision arrangements to ensure control measures identified in the risk assessment are implemented and are being maintained.
7. Review your arrangements regularly to ensure they remain valid and act on any findings.

24 February 2021

Annex 1

INSPECTION FINDINGS

This is the detailed summary of the 17 hospital inspections undertaken. It is broken down in to the 7 key areas that were covered in order to assess the arrangements in place to manage risk arising from COVID -19.

1.Management Arrangements

Examples of good practice:

- High level leadership provided during the pandemic with establishment of Gold and Silver commands, frequent leadership meetings and briefings provided to staff through a variety of routes including webinars, blogs and social media.
- Board and senior leadership team engaged with staff on the front line thanking them for their hard work and listening to issues they may want to raise.
- Incident command center - staffed 24/7 by senior management.
- Strong links between infection control, health and safety and occupation health.
- Procedures in place for concerns to be raised.
- Departmental managers had access to expert support provided by health and safety team with NEBOSH professional qualifications.
- IPC Board Assurance Framework used to monitor progress and identify risks
- Trade Unions (TUs) engaged and actively encouraged to attend Health, Safety & Environmental committee chaired by head of Occupational Health.

Examples where improvement was required:

- Monitoring arrangements were not in place to ensure policies and procedures were read and were followed.
- Compliance with risk assessment control measures were not being audited resulting in the non-compliance issues contained in this report.
- Staff behaviour was not being challenged when non-compliance was seen by managerial staff.
- Departmental managers were not aware of their responsibilities for monitoring and maintaining COVID controls.
- Poor consultation with recognised Trade Union Safety Representatives and/or employee representatives during the completion of COVID related risk assessments.
- Sharing of good practice did not occur indicating lack of coordination within the system.

2.Risk assessment

Examples of good practice:

- Those carrying out risk assessments had been provided with appropriate risk assessment training and were supported by the health and safety team.
- Risk assessments were updated and reviewed by the Health and Safety Committee and Risk Management Committee comprising both senior leaders and frontline staff.
- Risk assessments disseminated to work force via multiple routes - local managers, through intranet/email systems and notice boards.

Examples where improvement was required:

- Risk assessments were not carried out for all areas and did not assess all the issues required, for example ventilation requirements and maximum occupancy were often omitted.
- Risk assessments not being reviewed after; lockdowns, events, such as outbreaks, when guidance changed, or when areas were repurposed e.g. from offices to rest areas.
- Staff had not received training to carry out risk assessments.
- Not all staff had access to the risk assessments, for example some hospitals used their intranet but not all staff have access to computers or were computer literate; there was a reliance on verbal cascade and colleague to colleague communication where English is not the first language.

3.Personal Protective Equipment (PPE)

Examples of good practice:

- Fit testing of close fitting FFP3 respirators was being carried out by in house trained fit testers or by contractors at all sites inspected.
- Non-clinical workers required to work in red-zones were fit tested, for example, domestics, engineers and chaplains.
- PPE stocks were in good supply, with a variety of respirators available.
- Staff entering red zones checked to ensure respiratory protective equipment (RPE) fit testing record was available for the respirator being worn.
- RPE/PPE Co-Ordinator nominated to monitor usage and stock levels.
- Staff received training in changing cartridges, decontaminating and storing their reusable RPE, and donning and doffing procedures.
- Separate donning and doffing areas were created, whilst maintaining one-way systems with adequate storage accommodation for reusable RPE.
- Contingency planning in place, for example the NHS Trust Alliance in the North West allows sourcing and swapping of PPE/RPE if needed.
- Daily monitoring of wearing of PPE.
- PPE panel were meeting twice a week to discuss stock levels and consider other PPE for introduction or replacement of items no longer available.

Examples where improvement was required:

- Records were not readily available to ensure the worker was provided with the correct respirator they had been fitted for. Face-fit information was not stored centrally on the person's personal file.
- A buddy/mirror was not always available to ensure a fit check was carried out correctly.
- Records were not readily available at the time of the inspection to demonstrate that additional training had been provided in addition to the suppliers' introductory session on using the PortaCount machine used for face-fit testing.
- Whilst pre-use checks were being carried out reusable RPE was not always being checked at suitable intervals to ensure that defective equipment was not being used.
- Reusable RPE was not always labelled with the individual's name and not stored in an appropriate manner e.g. seen to be stacked on top of one another in a variety of settings.
- RPE was not always located close to the place of use.

- Alternative FFP3 respirators being used without additional face fit testing, where it had not been clearly established from the PPE supplier or manufacturer that the respirators were compatible and could be used without a further face fit test.

4.Social Distancing:

Variety of areas across the hospital

Examples of good practice:

- One-way systems introduced with linear marking on the floor and signage on walls.
- Separate entrances/exits for staff and patients in wards where possible.
- Plastic curtains in wards between beds, instead of fabric curtains to allow easy cleaning and disposal.
- Hand sanitiser at all entrances/exits for staff visitors, and outpatients.
- Staff member stationed at entrances to hand out masks, ensure hand gel was used, control numbers entering and provide directions.

Examples where improvement was required:

Surgical masks:

- Surgical masks were being worn as a control measure in lieu of social distancing arrangements, contrary to IPC guidance that states ' Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE'.

- Some workers assumed if they were wearing surgical masks they did not need to be socially distanced from their colleagues. For example, staff were seen walking and chatting along corridors within close proximity to each other.

Changing areas/locker rooms/toilets (clinical and non–clinical staff)

- Maximum occupancy numbers and systems for maintaining social distancing not displayed on entry.
- Where maximum occupancy was identified no arrangements were in place to ensure compliance was possible. For example, no information was available to explain how to achieve the stated maximum occupancy of 10 for a changing/locker room when 120 workers were on duty.
- Sinks adjacent to each other had not been taken out of use/taped over and/or no perspex screens provided to ensure separation.
- Floor markings were not provided to identify social distancing, for example to signpost foot traffic though a large changing facility.
- Congestion caused by staff having to queue in the corridor and requiring colleagues to pass by in a narrow corridor space.
- Storage of personal clothing outside of lockers indicating insufficient number of lockers available.
- Changing facilities and lockers not close to the place of work.

Rest areas/common rooms/doctor's mess/patholgy

- Many were multi-purpose, used for breaks, eating, locker storage and working, with inadequate social distancing. For example, a workstation was being used whilst others were eating within 1m.
- Maximum occupancy numbers not being provided.

- Where maximum occupancy numbers provided the number of seats exceeded the limit allowed. On one occasion the maximum was 5 but 14 chairs were available and were positioned close together.
- Tables too small to allow 2m separation e.g. 4 workers were sat around a 1m diameter table facing each other.
- Areas repurposed for rest facilities but were too small to allow social distancing, which was compounded by lack of ventilation.
- Employees seen not social distancing on several occasions including eating within 1m of each other; 15 members of staff sitting in close proximity to each other, and 5 staff sitting at a table for 2.
- Areas were too small to accommodate the number of staff needing to use them at any one time.

Specific to the education department:

Examples of good practice:

- Virtual training was undertaken where practicable.
- Videos produced to minimise classroom time.
- Seats arranged on a marked floor to ensure separation.
- Rooms ventilated before and after use and at break times.
- Maximum occupancy sign in place.

Examples where improvement was required:

- Chairs closer than 2m as they had been moved from marked position.
- Chairs arranged close together and side by side.

Specific to Offices (including in clinical areas)/post rooms/medical records

Examples of good practice:

- Rotas introduced to minimise staff attendance when working from home is not an option.
- Screens provided at receptions to provide separation between patients and staff and in some offices to provide separation between desks.
- Layouts redesigned to avoid face to face working by staggering workstations.

Examples where improvement was required:

- Maximum occupancy was not known or communicated.
- Maximum occupancy identified but the room was too small to accommodate the numbers.
- Occupancy exceeded at busy times due to lack of sufficient computers/workstations on a ward.
- Desks and workstations were not organised to ensure social distancing. For example, excess seating and chairs were not removed, workers sat side by side or opposite facing each other when additional space was available (in one case 3 computer desks were side by side),
- Screens were not provided where reasonably practicable to do so.
- Screens were not provided despite being required in the risk assessment. For example: failure to provide a screen to separate officer workers from employees accessing the printer.

- Redesigning tasks not considered. For example: a drop off point for post could have been introduced, reducing the need for the worker to enter a small work area; in the reception area in a medical records library the receptionist was handing records through an open sliding window when an alternative method of transfer was possible that would avoid handing records between people.

Specific to Canteens/kitchens

Examples where improvement was required:

- Failing to supervise controls. For example: staff repositioned tables and chairs for socialising and breaking social distancing controls.
- Failing to address and manage busy times with congestion and breakdown of social distancing measures.
- No mitigation measures in food preparation areas where sinks were provided side by side. For example: no separation screens provided; or adjacent sinks not taped over to indicate they had been taken out of use.

Specific to Facilities/engineers/domestics/laundry/library

Examples of good practice:

- Plastic screens provided to separate workstations in engineering
- Good social distancing in place in porters lodge i.e. maximum occupancy identified and allocated seats marked out.
- Estates workshop benches socially distanced and with staff being allocated their own workstation.
- Facilities staff deliver to 'ultra-green' wards via lift to avoid the need to enter in person.
- Lunch breaks and shifts staggered in the engineering/domestic department to reduce traffic flow through the building and numbers using the changing and toilet facilities at any one time.

Examples where improvement was required:

- Poor furniture layout reducing the ability to social distance.
- Reliance on surgical masks where it was reasonably practicable to provide screens at some fixed workstations. For example: 5 employees working around a conveyor belt in the laundry ‘classification’ area when it was reasonably practicable to stagger them and provide separation screens.
- Floor markings not used to indicate direction of travel and separation distances. For example, walkways in the main library.
-

Specific to corridors and open waiting areas /lifts

Examples of good practice:

- Seats in waiting areas taped over to manage separation and overflow arrangement in place to avoid over-crowding.
- Informative safety posters and directional floor signs provided.
- Wardens deployed to monitor numbers and ensure face masks/coverings were being worn.
- Portacabins provided to increase waiting area capacity.

Examples where improvement was required:

- In staff only areas a walk on the left side was policy introduced but with no marking or signage and lack of supervision it was not being adhered to.
- Signage not provided in a lift to communicate maximum occupancy.

5. Hygiene and cleaning regimes

Examples of good practice:

- Additional cleaning machines purchased to remove the need for transfer between departments /wards.
- Dedicated cleaning teams provided to individual wards.
- Deep clean teams provided and overseen by IPC team.
- Clear instructions of what is cleaned by the cleaning team and nurses respectively
- Enhanced cleaning in education and libraries with laminated 'action' cards provided to explain cleaning system.
- Instructions for cleaning arrangements of frequent touch points or multi-user equipment clear and monitored to ensure implemented
- Internal hygiene audits carried out to assess compliance.
- Toolbox talks provided twice monthly and safety bulletins to remind staff of IPC procedures and update on changes.
- Cleaning supervisor monitors cleaning daily and in turn this was monitored by a manager.
- Laminated cards used to identify areas that had been used and required cleaning.

Examples where improvement was required:

- Cleaning schedules were not comprehensive, leading to areas being missed. For example, they did not always include rest rooms, porters lodge, staff toilets, changing rooms, doctor's mess, medical records and libraries. In those areas high touch points were not being cleaned in between use, for example telephones, printers, computers, photocopiers, vending machines, kettles, microwaves, equipment in engineering workshops.
- Local instructions for cleaning not available at point of use.
- Cleaning material not available for local point of use cleaning.
- Cleaning after use not occurring despite suitable wipes being provided.
- Insufficient monitoring being carried out to ensure high touch points were cleaned regularly.

Specific to canteens:

- Limited information on cleaning regime for those using the facility.
- Lack of supervision and monitoring. This resulted in tables not being routinely cleaned between use by cleaning staff or those eating at the tables, despite a card system being in place to identify used tables.
- Cleaning material not always available.
- Single wipe being used for multiple tables.
- Surgical masks being placed on tables.

6. Ventilation

Examples of good practice:

- Maxillofacial department in the outpatient's department engaged a competent ventilation contractor to assess air changes in each treatment room. They then implemented a system to ensure those rooms with greatest number of air changes were used for AGPs as their clearance time was shorter.
- Modifications carried out to ventilation system to increase air flow in theatres and ICU.
- Ventilation was checked regularly including velocity, dilution, and dwell times.
- Site wide survey of all mechanically ventilated wards and to identify any issues and rebalance the ventilation system.
- Implemented a schedule of cleaning and maintenance of all mechanical ventilation systems.
- Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation.

Examples where improvement was required:

- Ventilation was not considered when the risk assessment was carried out.
- A room was repurposed as a rest facility but there were no windows or other means of ventilation provided.
- In non-clinical areas rooms were identified with no forced/mechanical ventilation and the windows were secured shut and the risk assessment did not consider whether the windows could have been unsealed to allow opening for ventilation where this was a possibility.
- In areas where AGPs were carried out the clearance time was not available.
- Not all opportunities to open doors and windows were being taken.

7. Dealing with Suspected Cases

- Arrangements for staff who are displaying COVID -19 symptoms were well established.

Annex 2

Other health and safety issues requiring enforcement action

Improvement Notice

Machinery guarding

Engineering machinery such as lathes and pillar drills in a workshop were not adequately guarded to prevent access to dangerous parts that could cause injury.

Letters of contravention

Transport

Workers were not walking in the designated pedestrian walkways and using designated crossing points exposing them to the risk of being injured by a moving vehicle. Consideration of improving the precautions was required along with additional monitoring and supervision arrangements to manage the on-going risk.

Risk of falling from windows

A window opened for ventilation purposes in a non-clinical room was not provided with a restraint to prevent a person inadvertently falling though the opening.

Provision of changing facilities

Changing facilities were not provided for workers in a “Red” ICU. Workers were required to change at work into their scrubs. The only facilities available were two small toilets near to the Manager’s office. In addition, they were not provided with suitable storage for their personal clothing so they stored them in bags and stacked them in an adjacent room as lockers were not provided.

Machinery guarding

A horizontal sawing machine located in a workshop was not adequately guarded. The machine was immediately taken out of service and electrically isolated in order to be decommissioned.

A hired waste compactor was in operation in a publicly accessible area with an unlocked entry panel; this meant that there was direct access to the compaction chamber, which could result in serious injury or death if the machine was operated. Immediate action was taken to secure the access door.

Note: as immediate action was taken to repair these machines or remove them from further use the issuing of enforcement notices was not considered necessary. If the matters had not been resolved immediately enforcement notices would have been served.

Thorough examination and testing of local exhaust ventilation (LEV)

The local exhaust ventilation systems (LEV) provided to reduce substances hazardous to health, namely, exposure to wood dust and welding fume in the workshops, did not have the legally required current record of thoroughly examination and test.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**The approach to the planning & redesign of talent management and succession planning**
SPONSOR:	**Jo Williams, Chief Executive**
AUTHOR:	**Sharon Malhi, Associate Director for Workforce & OD**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

Introduction
The attached slide pack provides overview of the current position in relation to the approach to talent management and succession planning at the Royal Orthopaedic Hospital NHS Foundation Trust and outlines the priority actions to be delivered within the next 6 months.

Context
Talent management seeks to attract, identify, develop, engage, retain and deploy individuals who are considered particularly valuable to the achievement of an organisation's goals and strategic objectives (CIPD, 2021).

There are numerous benefits in taking a strategic approach to managing talent in the NHS such as (but not limited to) creating meaningful work and growth opportunities for staff i.e. creating a sense of belonging and enhancing diversity and inclusion within the workplace and most importantly can enhance clinical outcomes for our patients.

Over recent years, the focus on and importance of talent management in the NHS has been steadily increasing.

The CQC Well-Led framework (2017) sets out expectations of provider organisations in relation to talent management, specifically ensuring that there is clear strategy in place, that there is a robust succession planning approach for senior leadership roles and that Trusts are proactively engaged with and involved in delivering local system talent agendas.

The recently published People Plan: We are the NHS (2020) and many preceding reports and frameworks including Developing People: Improving Care, Kerr, Kark and Rose reviews also refer to talent management as being a crucial in health and care settings to enable organisations to deliver high-quality, compassionate, inclusive and sustainable care for the future. NHS England and Improvement are set to provide clarity the national direction for talent management in coming months.

The Royal Orthopaedic Hospital NHS Foundation Trust aspires to become the 'First Choice for Orthopaedic Care' and the specialist provider of orthopaedic services within the Birmingham and

Solihull ICS. Fundamental to achieving this is a stable, high performing and diverse workforce. The specialist nature of the Trust and the under representation of senior managers from a BAME background further signifies the need for the Trust to be able to attract, identify, develop, retain and deploy individuals who have the skills and behaviours to support the achievement of the Trusts strategic priorities and ensure that that our workforce represents the diversity of patients within Birmingham and Solihull ICS footprint. In order to provide outstanding care, the Trust must be able to attract and retain outstanding people and Talent Management provides a structured framework by which organisations can achieve this.

REPORT RECOMMENDATION:

The Trust Board is asked to note the assurances provided in relation to developing the Trusts approach to talent management and succession planning.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

People element of the Trust's strategy

PREVIOUS CONSIDERATION:

None

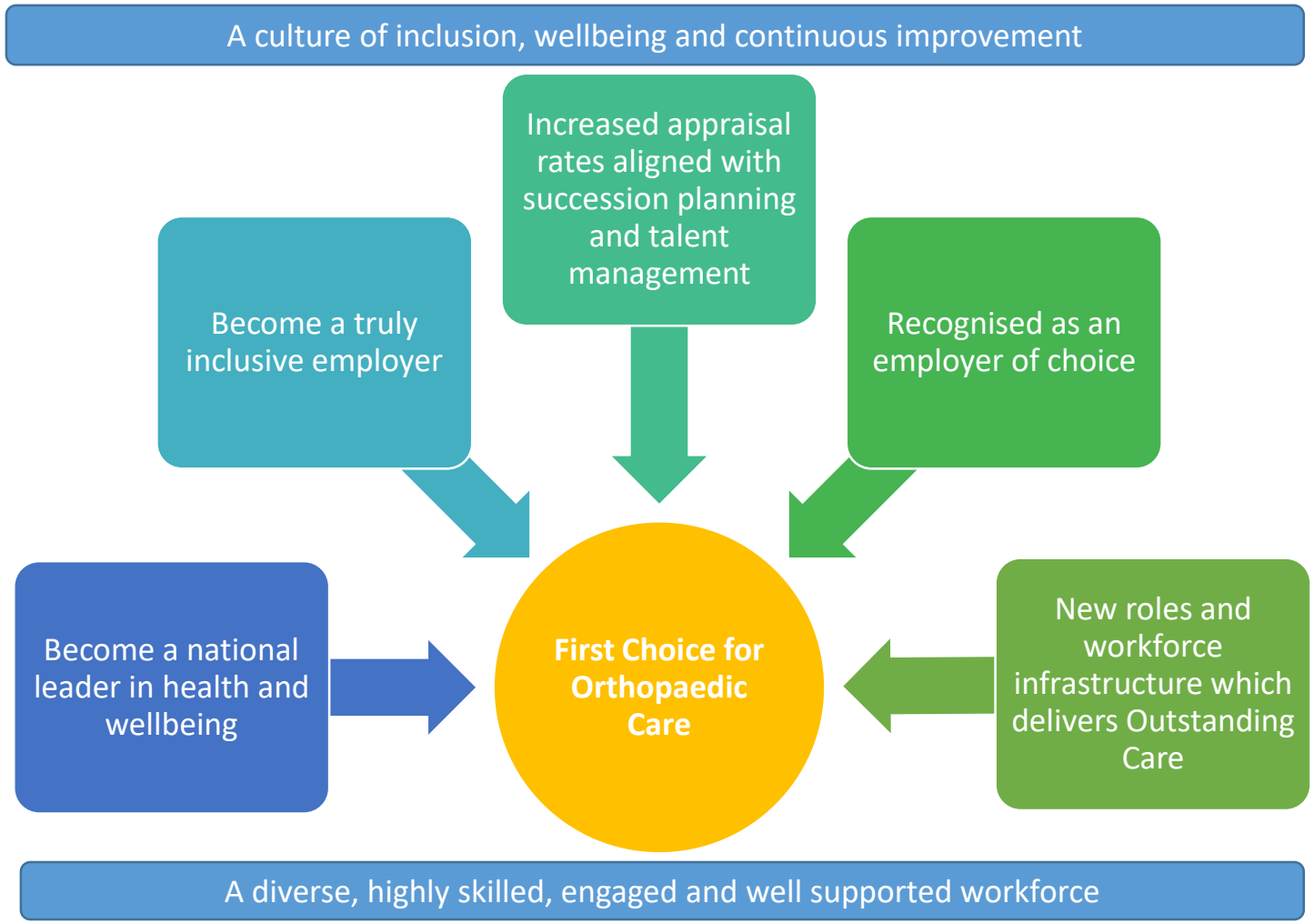
The approach to the planning & redesign of talent management and succession planning

Trust Board (for assurance) – May 2021, Sharon Malhi (AD for Workforce & OD)

Introduction

- Provide assurance to the Board in relation to our plans to develop our approach to Talent Management and Succession Planning
- Set out the national intentions in relation to talent management
- Outline progress to date
- Share key priorities for the next 6 months

Our strategic priorities



Laying the right foundations

- Refresh of the ROH People Strategy and Workforce Priorities:

  - Attracting and Recruiting the right people
  - Learning and Growing
  - Managing and Rewarding Performance
  - Enhancing Staff Experience
  - Effective workforce Planning and Strategy

- Ensure that Inclusive Talent Management practices underpin our approach across all elements of the employee life cycle

The National context

- Seeking to remove the 9-box grid (on the basis this is not an easy tool to roll out with large numbers, and it's not considered to be particularly inclusive)
- They are currently working on a 'talent review' tool – which is going to be a standardised conversation model called 'Scope for Growth' which they hope to roll out over a 3 year period commending in summer, targeting those in Band 8D roles and above in the first instance
- There will be a focus on understanding supply and demand (pipeline strengths and gaps), starting with Aspirant Directors in 2021/2022
- Work will continue in relation to the High Potential Scheme, Executive Director Pathway, programmes for aspirant chairs and CEOs, Ready Now and Stepping Up programmes
- There is an ask of all Trusts (from the national ED&I team) to create an action plan detailing how they will implement six high impact actions to support inclusive recruitment and promotion practices
- There is going to be greater emphasis on implementing talent practices at STP/ICS level. The KPMG STP/ICS Workforce Development Tool is being adapted into a System Workforce Improvement Model (SWIM) which describes what good looks like in 'thriving' systems

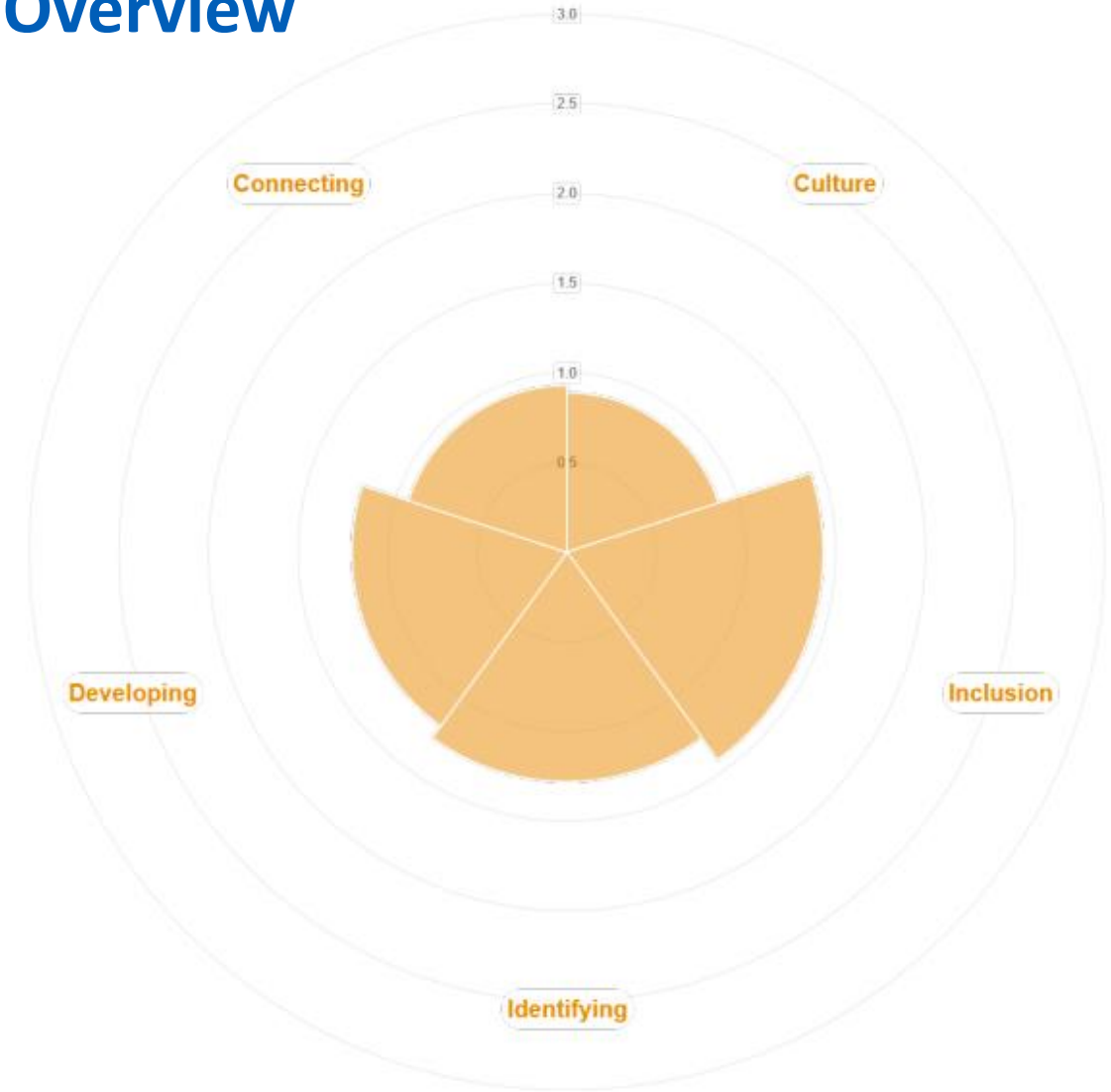
Key starting points/activities may include (but are not limited to)

- Examining culture/creating the right conditions for talent management
- Mapping existing approaches in relation to the employee/talent life-cycle/experience and prioritising how these can be strengthened/improved
- Developing inclusive talent practices which are accessible for staff at all levels/from all backgrounds
- Ensuring transparency of career pathways
- Ensuring appropriate offers to support career development are in place to support transitions from one level to another (e.g. vertical - individual, team, service, divisional, deputy, executive, and/or horizontal - from one internal service (or potentially organisation) to another))
- Introducing career conversations to explore the potential, aspirations, readiness and development needs of those with a desire to move
- Using data gathered from conversations to increase visibility of talent pipelines, understand strengths and gaps and support succession/workforce planning
- Track progress and ROI on key initiatives to support development and progression

Progress to date

- Undertaken Talent Diagnostic - indicators grouped into following key areas
  - Enabling a culture of talent management
  - Equality, diversity and inclusion in talent management
  - Identifying, managing and retaining talent
  - Developing and mobilising talent
  - Connecting talent interventions across local health and care systems
- Progress required in all areas

Our Diagnostic Overview



Key priorities for next 6 months

- Develop succession plans for business critical roles in the first instance – Band 8a and above & single points of failure
- Work with Education & Training colleagues and STP colleagues to review the quality of our development offerings for the above
- Train and develop leaders and managers to understand the benefits of inclusive talent management
- Develop and pilot the tools to support effective talent management and succession planning at all levels
- Review our policy, practice and training in relation to performance management and appraisal
- Deliver key actions on overhaul of recruitment and promotion
- Develop Strategic Workforce Planning capability and capacity across the organisation
- Develop a Talent & Succession Strategy

Questions/Comments

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Report into the Independent Inquiry into Paterson – Update Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revell, Executive Medical Director**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

The report into the Independent Inquiry into Paterson was published in February 2020. This paper outlines the Trust's present position in relation to the report findings, including an audit of consultant whole practice carried out by the Clinical Service Lead for Revalidation. This audit confirmed that all consultant practices in the private sector are aligned to current NHS practice. The paper describes the wider checks and balances within the governance framework to monitor practice and the controls in place. Work continues; future opportunities and the priorities for deepening assurances around consultant practice are set out.

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the update.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

Strategic Objectives: Patients, Process, Performance, Partnerships, People.

Safe, Timely, Efficient, Effective, Equitable, Patient Centred and Improving clinical care

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 28 April 2021.

QUALITY AND SAFETY MEETING ..... ERROR! BOOKMARK NOT DEFINED.
CARE THAT PEOPLE RECEIVED **3**
WIDER PATIENT CARE **3**
RESPONDING WHEN THINGS GO WRONG **3**
WORKING WITH OTHERS TO KEEP PATIENTS SAFE **3**
GOVERNANCE ACCOUNTABILITY & CULTURE **3**
CARE THAT PEOPLE RECEIVED **4**
Appropriate Treatment 4
Identifying and Challenging Poor Care 4
Identifying and Challenging Inappropriate Behaviour with Patients and Families 4
Care Given by Other Professionals 5
Emergency Care 5
WIDER PATIENT CARE **5**
Information given to patients & consent 5
Medical records and notes 5
Waiting times and referrals to independent sector 6
CHECKS AND BALANCES IN THE HOSPITALS **6**
Appraisal 6
Revalidation 6
Monitoring by hospitals 6
MDTs 6
Practising Privileges 6
RESPONDING WHEN THINGS GO WRONG **7**
Colleagues raising concerns 7
Recall of patients 7
Complaints 7
Claims 7
Insurers 8
WORKING WITH OTHERS TO KEEP PATIENTS SAFE **8**
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SUMMARY OF TRUST STATUS AGAINST THE MAIN RECOMMENDATIONS FROM THE PATERSON REPORT **9**
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What the Paterson Report Said

Patients expect healthcare professionals to provide care which is safe and of a good quality. They also expect hospitals to have systems in place to support patient safety. The Independent Inquiry into Paterson identified many ways in which patients care and the checks and balances that are meant to ensure high quality care had failed to trigger the appropriate corrective responses.

The areas that Rev James covered in the Paterson Independent Inquiry are summarised in Table 1.

Table 1: Key Areas Covered by The Paterson Inquiry

Care that people received	
1.1.	Appropriate Treatment
1.2.	Poor Care
1.3.	Inappropriate Behaviour
1.4.	Care Given by Other Professionals
1.5.	Emergency Care
Wider patient care	
2.1.	Information given to patients & consent
2.2.	Medical records and notes
2.3.	Wating times and referrals to independent sector
2.4.	Checks and balances in the hospitals
2.5.	Appraisal
2.6.	Revalidation
2.7.	Monitoring by hospitals
2.8.	MDTs
2.9.	Practising Privileges
Responding when things go wrong	
3.1.	Colleagues raising concerns
3.2.	Recall of patients
3.3.	Complaints
3.4.	Claims
3.5.	Insurers
Working with others to keep patients safe	
4.1.	Information sharing
Governance Accountability & Culture	
5.1	Corporate Accountability and Culture
5.2.	Culture

Our Approach

Our approach is set out in line with the Paterson Inquiry report summary in Table 1.

Care that people received

Appropriate Treatment

Operations That Are Safe and Necessary

Regional Measures and Supporting Commissioners

The Trust has supported the BSol commissioners in examining the evidence base and challenge around cases where regional or national guidance suggested that non-operative or alternative treatment might be available or that the evidence base behind a proposed intervention might be called into question.

Presently the Executive Medical Director attends a meeting every 4-6 weeks examining 4-6 cases per meeting over approximately the last 18 months.

The group is run as an MDT. It has seen an improvement in the quality of submissions from clinicians around these cases and has been able both to challenge and to compassionately support treatment plans in these areas of judgement.

The clinical service lead for arthroscopy has recently been engaged to support this meeting and it is intended that the clinical input from Birmingham providers will broaden and balance the group. At the same time, the group can apply some leverage on separate services within the region to meet and discuss difficult and rare cases, which can then come with broader clinical support and greater clarity if the underlying treatment strategy needs to be taken under review.

Internal Controls

The Modern Interventions Panel

The Trust now has a Modern Interventions Panel, reporting to AQILA. This has a medical chair with transformational and financial input. Its remit is twofold; approval recommendation and support. More specifically:

1) To examine the evidence base and financial case behind proposed new procedures
2) To guide clinicians in navigating the application process, the correct governance and follow up framework and help signpost anticipated resource and training needs.

A maturing MDT framework enhanced by combined clinical audit

All the surgical services and the anaesthetic services now have regular MDT meetings where difficult or controversial cases can be discussed.

Identifying and Challenging Poor Care

The divisional governance meetings are mature and stable with a multi-professional input.

There is a weekly Executive Governance meeting, chaired by the Executive Director for Nursing and Governance and attended by the Executive Medical Director and the Executive Director for Operations.

The Trust has recently added a monthly Executive Quality and Safety meeting attended by all of the Executive Team and chaired by the Chief Executive.

In the last two years the Trust has invited two external reviews, having a low threshold for asking for external scrutiny and objectivity. A third external review looked at the joint efforts to reconstruct the paediatric oncological surgery pathway between the ROH and BWCH.

Identifying and Challenging Inappropriate Behaviour with Patients and Families

The weekly Executive Governance meetings reviews complaints also. These are now accurately mapped to the relevant executive lead as part of tracking, so that any repeat or patterns of behaviours would be picked up at Unit, Divisional and Executive level.

The Head of Patient Experience has developed the reporting summaries to a point where they have now been included in a Patient Progress report at AQILA. This is the start of work to improve triangulation and monitoring of and with the medical body. The Head of Patient Experience confirms there are no individuals presently who would cause alarm by virtue of the number of complaints or their nature. Because incidents are tracked to the consultant for any aspect of their care, quantitative review can be misleading as a raw measure.

Surveillance by the Patient Experience department and the Executive Medical Director is supplemented by a third layer of assurance since all complaints are automatically entered into the consultants' appraisal pack for every appraisal. Each complaint therefore prompts and additional reflective piece as a minimum at annual appraisal.

Care Given by Other Professionals

The Trust is actively promoting and developing MDT working at unit level. There is also conscious effort and emphasis at Executive level to ensure that between professional groups there is equitable examination and treatment of any shortfalls in care across all disciplines.

Emergency Care

The Trust has an established "Boarding Card" system for managing emergency transfers from other Trusts. The Trust has a clear view against transferring patients who have received treatment and who run into complications in the private sector simply transferring to the NHS. This is applied proportionately and on a case-by-case basis with the options for the patient and the welfare of the patient in mind.

Wider patient care

Information given to patients & consent

"Paterson often failed to obtain consent from his patients, and then did not properly discuss their treatment with other healthcare professionals."

The consent policy was fully re-written and relaunched in 2019. New consent forms that encourage shared decision making in line with best practice were introduced in 2020.

Consent remains a mandatory refresher module as part of medical mandatory training. Recently the supplier of the module ceased to support the offering and a new supplier has been identified / gone live in Autumn 2020.

Quality of consent is a routine and consistent part of the review after any incident relating to invasive interventions as well as the Learning from Deaths process.

Division 1 have been asked to audit consent this year as part of their planned audit programme, particularly in the context of the start of virtual clinics and the quality of the consent.

Medical records and notes

The Trust still has a manual (paper) clinical record. The Trust is prioritising the introduction of Clinical Portal and, Covid response and recovery allowing, the intention is to introduce during 2021-2.

Waiting times and referrals to independent sector

Paterson was known to have exaggerated waiting times to receive care in the NHS when advising patients and is thought to have encouraged patients to transfer to private care in order to avoid a wait. Conversely, when complications were encountered, patients were transferred back to the NHS with few checks and balances.

The Trust has taken a clear stance against this type of practice both internally and regionally.

Checks and balances in the hospitals

"Checks and balances designed to ensure safety of care at the hospitals where Paterson practised were inadequate or were not followed, and this allowed him to continue with unsafe and unnecessary treatment which harmed patients."

Appraisal

The Clinical Service Lead for Revalidation has audited all consultant practices within the Trust and confirms that scope of private practice aligns with NHS practice in all cases. The audit also confirmed that whole practice had been reviewed with appraisers in 100% of cases.

Revalidation

Using the appraisal system and the GMC local advisory service, revalidation provides the formal mechanism through which doctors re-register every 5 years.

Monitoring by hospitals

The Trust communicates directly with other organisations through governance and through clinical leads where there are concerns. This can be around individual patient care (such as two cases where patients in very poor physical health were transferred to the Trust and feedback was shared at executive level) or about a clinician. There have been two cases in the last 2 years where the Trust has supported other Trusts in assessing clinicians at their hospitals. (See also "Colleagues Raising Concerns").

Presently there is minimal access for medical directors to national registry information. This is a theme that the Medical Directors at Robert Jones and Agnes Hunt Hospital and the ROH have started to challenge in the areas of Oncology and Arthroplasty in particular. This would be a fruitful area of inquiry for the National Orthopaedic Alliance to take up collectively. The Medical Director is also exploring access through partnership with the Midlands and Lancashire CSU.

MDTs

The Trust is proactively developing multi-professional and multidisciplinary working in al areas. This includes case planning, first tier of clinical governance and, more recently defining a role for clinical service units in patient prioritisation and harm prevention post-Covid second peak.

Practising Privileges

The Trust has audited the consultant body around practicing privileges. More consistent and open communication with other organisations around whole practice is planned as part of the Medical Directorate manager role.

In April 2021 the Trust began roll out of the National Consultant Information Programme for its surgeons. This scheme is in its early stages, but has been well received by surgeons as it provides individual surgeons with whole practice information, anonymised benchmarking against colleagues performance and unit level performance information. Scope is not universal, however Orthopaedics is relatively well represented. The Medical Director / Responsible Officer would also be able to access whole practice information about surgeons if it were to be needed in those areas that have been developed.

Responding when things go wrong

Colleagues raising concerns

The EMD/RO has received three concerns around individual clinical practice in the last 2.25 years.

Case 1: Verbal escalation from a consultant and another colleague in addition to an incident within the Trust. This resulted in a formal process and remediation under the Maintaining High Professional Standards framework.

Case 2: Written escalation from a clinical unit about a surgeon's practice outside the Trust. The EMD/RO gave advice to a DMD in another Trust who was managing an internal audit of the surgeons practice contemporaneously. The unit provided a formal report and a subsequent update which was escalated through the GMC. The EMD/RO will be a witness at the Tribunal hearing.

Case 3: Written escalation around complication rates outside the Trust as a service transferred from the Trust. Issues clarified and mitigations put in place as part of normal bilateral governance arrangements. The ROH provided enhanced support for cross-skilling of a clinician elsewhere as part of this. Accountability, escalation and monitoring all clarified.

Colleagues are also able to raise concerns through the Freedom to Speak framework and an open culture around raising concerns which may place either staff or patients at risk is promoted.

The Trust can therefore evidence a proactive approach to both engaging formal process and working with external organisations to escalate concerns and protect patients.

The Trust is also putting in place a Professional Practice Advisory Panel, specifically to advise the Responsible Officer / Executive Medical Director in cases where conduct, health, capability or confidence in a doctor is called into question. In addition, all staff have access to informal and formal pastoral support whether they have raised a concern or going through any process.

Recall of patients

The last major recall of patients was the Metal in Metal hip bearing.

Patients are routinely contacted after clinical incidents as part of professional and corporate duty of candour.

Where necessary, small cohorts have been recalled and informed of a group issue. This happened for example, when several cases of burns were found in patients who had undergone complex and lengthy arthroscopic procedures. The issue was eventually traced to the choice of two compatible light leads of different diameters, the narrower one of which had been intended for different arthroscopic procedures and was accumulating heat during these cases. Two surgeons had cases involved (one 4 cases and 1 a single case) and both cooperated fully and indeed eventually found the root cause of the problem. Each had accepted external observation of their operating as part of the investigation.

Complaints

As outlined above, complaints have divisional and executive sign off. They are tracked weekly at both the Divisional and the Executive Governance meetings. Work has started to include complaint numbers by consultant in regular reports to AQILA.

Claims

Claims are reviewed regularly by the Executive team and monitored for trends by the Corporate Governance team.

Insurers

There is no clear mechanism through which the Trust would have a direct dialogue with insurers about an individual practice. All consultants are encouraged to carry indemnity and required to have added indemnity if undertaking private practice at the ROH.

Working with others to keep patients safe

Information sharing

The medical director has quarterly meetings with the GMC through a local advisory service. This allows both the Trust and the GMC to triangulate in areas where they may not be fully sighted. For example a doctor who has not previously worked in the Trust and who raised a concern could be discussed either formally or informally allowing the GMC to use the national local advisor network and central record to intervene if there were recurrence of an issue that had been encountered elsewhere. Conversely, the mechanism has also been used recently to provide external assurance about a serious conduct allegation, which the GMC did not pursue due to lack of clear foundation.

Governance Accountability & Culture

The Trust places high emphasis on a transparent and learning culture from incidents. This has been positively identified by external bodies over the last 2-3 years. The Trust has committed to carrying out formal debriefs following serious disciplinary issues in order to capture both organisational learning and potential gaps in underpinning processes. This debrief enables the Trust to learn lessons and implement improvements.

Summary of Trust Status against the Main Recommendations from the Paterson Report

Recommendations	Comments / Progress where applicable
A single database of consultants across England, setting out their practising privileges, critical performance data, including the number of times they have performed a procedure and how recently. This would be publicly accessible and mandatory;	Not within the gift of the Trust but this information is available and has been audited within the revalidation team.
Doctors in the NHS and independent sector to write to patients outlining their treatment in simple language and copy this letter to the GP rather than the other way round;	The Trust has started initiatives around this before and many consultants do now write letters in this way. Outpatients is changing with the contact between clinician and patient becoming more open as a result of the convenience of virtual consultations. Once the clinical portal has been implemented, Patient Portal is the next phase of Digital development. Both this and the post covid recovery outpatient plan are drivers for more patient instigated consultations / direct access. The conversation between secondary clinicians and patients is therefore naturalising and rebalancing in a number of ways. A new clinical service lead role for outpatients has been advertised to lead on these transformational themes.
Differences between the organisation of NHS and independent sector care to be explained to patients in the independent sector (including those treated in the sector but funded by the NHS) to also encompass practicing privileges, indemnity and provision of emergency care;	The Trust has a clear view against transferring patients who have received treatment and who run into complications in the private sector simply transferring to the NHS. This is applied proportionately and on a case-by-case basis with the options for the patient and the welfare of the patient in mind.
All patients to be allowed a short period to reflect on diagnosis and treatment options before they consent to any treatment;	See consent policy and forms. The Trust is clear that all patients must have three distinguishable phases within the consent process: information sharing, reflection and confirmation.
Each patient with breast cancer to have their case discussed at an MDT, whether in the independent sector or the NHS, with the CQC to have responsibility for ensuring compliance;	All cancer patients and the majority of complex patients of any background are discussed in a specialty MDT.
Information about complaints pathways to be communicated more effectively in the NHS and independent sector and private patients to have the right to mandatory independent resolution of their complaint;	Any issues reported through complaints or formal governance that involve another health organisation are communicated at the appropriate level and through appropriate channel(s). Eg through the governance department and through the relevant medical lead. The Revalidation unit has mapped and audited private practice across the whole consultant body. The anticipated Medical Directorate Manager role includes developing and maturing both

	internal flow of information (eg around complaints) and links with external organisations (private providers) to strengthen the two way flow of information within and without the Trust when issues arise.
A national framework or protocol with guidance to address recall communication and management;	See Trust approach and track record above
Urgent Government reform of discretionary indemnity;	
The system for collaboration of regulators to be reviewed with the Government to ensure that it serves patient safety.	See Trust approach and track record above
Hospital investigation of a healthcare professional's behaviour to lead to suspension of the professional if any perceived risk to patient safety;	During the last two years the Trust can evidence early intervention to restrict practice in cases where there were perceived risks to patient safety. One case was resolved through informal process with no recurrence and one case has been resolved through formal MHPS process.
The Government to address the gap in responsibility and liability in the independent sector which remains unresolved;	
Apologies from hospitals to be made immediately when things go wrong;	The Trust applies corporate Duty of Candour in all cases of moderate harm and above and ensures professional duty of candour applies in all cases.
The Government to ensure that arrangements made in response to the recommendations are applicable across the whole of the independent sector (private, insured and NHS funded), as a qualifying condition for independent sector providers to do NHS work	

Conclusions and Future Opportunities

The lessons from the Paterson Inquiry Report are wide ranging. The challenges apply both to care and monitoring within organisations and to the communication between organisations. The Trust can demonstrate a proactive and insightful approach to both aspects of care provision. Enriching access to whole practice data through better communication links with other organisations and better access to databases and registries would facilitate both a culture of continuous feedback and improvement for all clinicians and provide more robust mechanisms for identifying outlier practices in the future. It is recommended that the Trust engage the National Orthopaedic Alliance amongst other partners to improve data sharing and access to such information sources.

Appendix A

Ian Paterson

Ian Paterson qualified in medicine at Bristol University in 1981. After he graduated, he worked for a time in Manchester before he came to the West Midlands to work at Good Hope Hospital in Sutton Coldfield. Paterson had been suspended for a time in 1996, while he was employed at Good Hope Hospital, after he had exposed a patient to harm in one of his operations. Good Hope Hospital arranged for Paterson's surgical work to be supervised until there was confidence that he could operate again without such oversight. 5 CHAPTER ONE – Introduction Paterson was trained as a general surgeon, initially specialising in vascular surgery, but was nonetheless appointed as a specialist breast surgeon in 1998 at Solihull Hospital, part of the Heart of England NHS Foundation Trust (HEFT). Paterson also practised as a surgeon in the independent sector. He treated patients at the Bupa Little Aston Hospital from 1993 and at the Bupa Parkway Hospital in Solihull from 1998. Both hospitals were taken over by Spire Healthcare (Spire) in 2007. Over time, Paterson increasingly treated most of his private patients at Spire Parkway Hospital. There were concerns about Paterson's clinical practice over many years. Clinical colleagues first raised serious questions about his surgical procedures and medical practice in 2003. Ultimately, he was suspended by HEFT in 2011 and Spire suspended his right to practise at its hospitals later that year. We discuss the concerns about Paterson in more detail in chapter five. In April 2017, Paterson was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man, whom he had treated as private patients between 1997 and 2011. Paterson was sent to prison for 15 years. His jail sentence was felt to be too lenient and was increased by the Court of Appeal to 20 years in August 2017

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual complaints report 2019/20**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing & Clinical Governance**
AUTHOR:	**Chris Ward, Acting Deputy Director of Nursing & Clinical Governance**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

The Trust deals with complaints in accordance with its PALS and Complaints Policy and the NHS Complaints Regulations of 2009.This report provides information with regards to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 01/04/2019 and 31/03/2020. It provides data in regard to the number of complaints received and identifies trends in relation to issues raised with the Trust.

In 2019/2020, ROH received 142 formal complaints. 5 were withdrawn leaving a total of 138 to be investigated and formally responded to.

The table below shows the total number of formal complaints received over a three-year period.

Formal Complaints	2017/2018	2018/2019	2019/2020
	148	137	138

Formal complaints experienced a 0.7% increase compared to the previous year

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the annual report and agree to its publication on the Trust's internet site.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

CQC compliance

PREVIOUS CONSIDERATION:
Quality & Safety Executive on 20 April 2020 and Quality & Safety Committee on 28 April 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2019/2020

1.0 Introduction

The Trust deals with complaints in accordance with its PALS and Complaints Policy and the NHS Complaints Regulations of 2009.This report provides information with regards to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 01/04/2019 and 31/03/2020. It provides data in regard to the number of complaints received and identifies trends in relation to issues raised with the Trust. The priorities for the complaints service during 2019/2020 were agreed as listed below:

- The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.
- Complaint investigation and report writing training will continue to be provided for staff that require it.
- The KPI of 80% of complaints completed within the agreed timescale will be achieved.
- The coding of PALS Concerns will be altered to the same system for complaints to allow for direct comparison of the data.

Progress against each of these priorities is covered in Appendix A

2.0 Definitions

Formal Complaint: Any expression of dissatisfaction, where the complainant wishes to have a fully investigated response in writing. These are likely to take longer than 2 working days to resolve, but may also include issues that are resolvable quickly, where the complainant expresses a wish for the complaint to be dealt with formally.

Informal Complaint: A concern that is raised by the complainant where the issue can be resolved either immediately or to the complainant's satisfaction within 48 hours. It also applies to issues raised verbally through the Patient Advice and Liaison Service or the Complaints Department where the complainant indicates he/she does not require a written response from the Trust or does not wish to proceed with the formal complaint, once resolved to their satisfaction. These are not formally reported via the complaints data.

PALS Enquiry: A general enquiry that does not raise any matters of concern, but the individual merely requires information. These are not formally reported and are resolved within 2 working days.

PALS Concern: An enquiry that requires contact with other staff to resolve and a response verbally or in writing to the individual providing answers to specified questions. There are not formally reported and are resolved within 5 working days.

3.0 The PALS and Complaints Team

The team comprises 2.0 WTE – Patient Services Manager (1.0 WTE) and Patient Experience Facilitator (1.0 WTE).

The Patient Services Manager is responsible for the day to day operational management and performance of both services.

The team reports directly to the Deputy Director of Nursing. The Executive Director of Nursing & Governance is the Executive Officer with overall responsibility.

4.0 Data Collection and analysis

All complaints data is now entered into the Customer Service Module within the Ulysses Safeguard system. Compliments, PALS Concerns and FFT Concerns are also entered on the same module. This has enabled more accurate and responsive trend and theme analysis across all Patient Experience data and allowed the team to work closely with the Divisional teams to improve the recording of actions and learning taken as a result of complaints.

However, the process is still heavily reliant on the Patient Services Team and the management and ownership of complaints within the Directorate will form part of the developmental work in 2020 /2021

5.0 Number of complaints

In 2019/2020, ROH received 142 formal complaints. 5 were withdrawn leaving a total of 138 to be investigated and formally responded to.

Table 1 below shows the total number of formal complaints received over a three-year period.

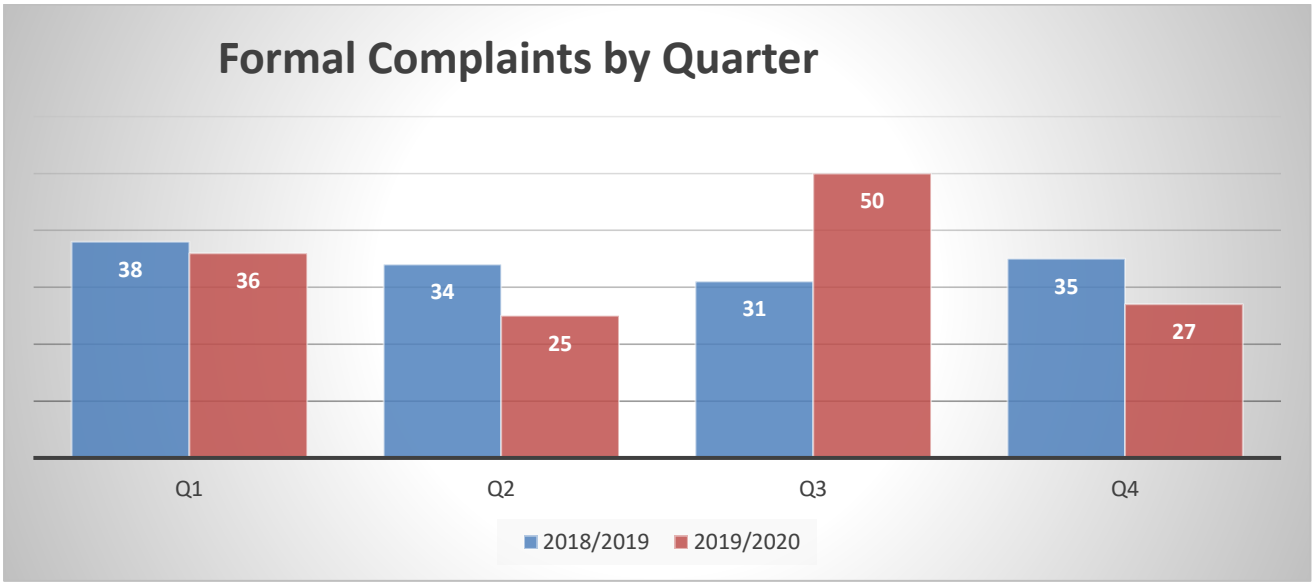
Table 1: Numbers of complaints received 2019/2020

Formal Complaints	2017/2018	2018/2019	2019/2020
	148	137	138

Formal complaints experienced a 0.7% increase compared to the previous year

Figure 1 details the number of complaints by quarter in 2018/19 with the previous year's data for comparison.

Figure 1: Number of complaints by quarter

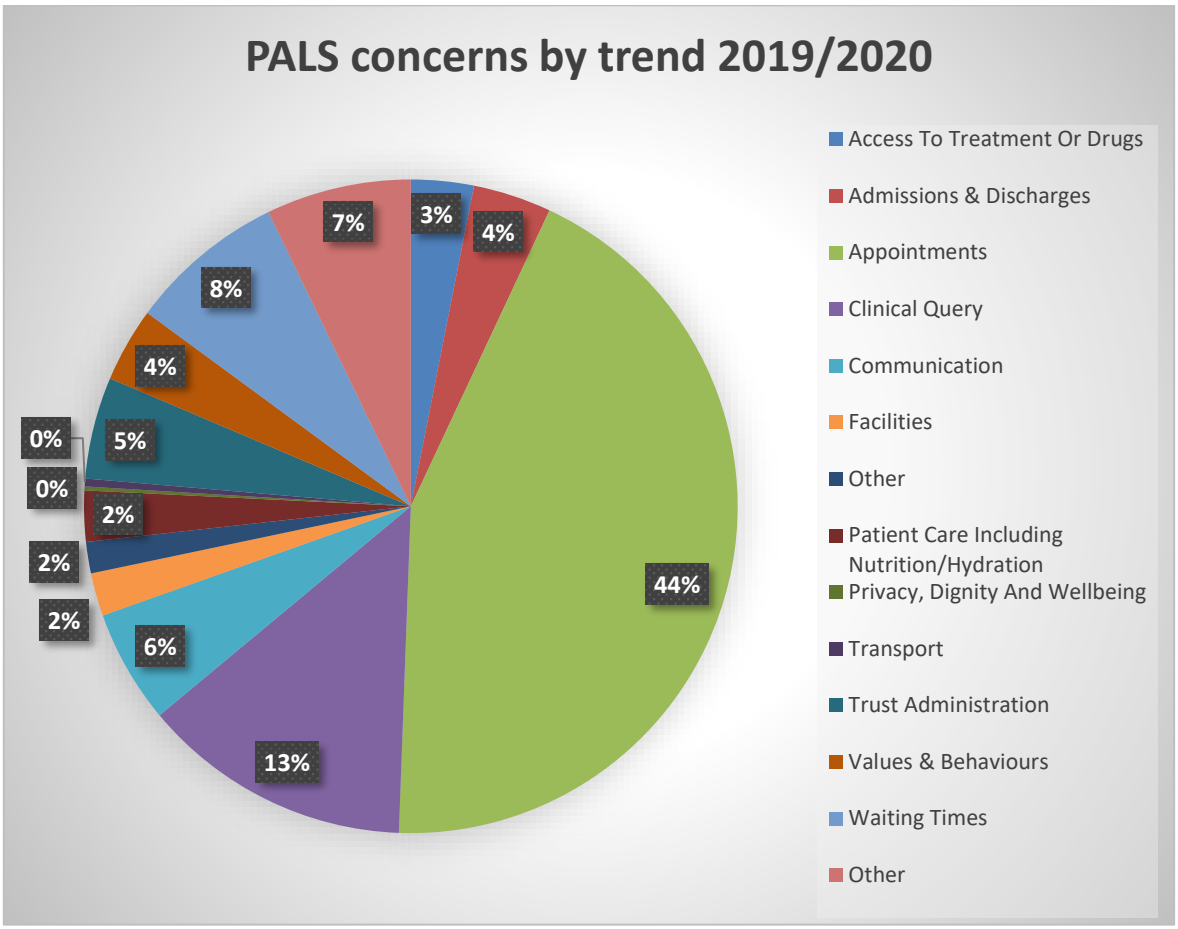


6.0 PALS Contacts during 2019/2020

The PALS department has handled 773 individual contacts from the 1st April 2019 to 31st March 2020, which has reduced 50% from last year, due to the removal of the PALS number from every letter leaving the Trust. This was identified as not helpful for patients as the majority of the calls were enquiries, which needed to be passed onto other departments, resulting in a less efficient service for patients. The letters were changed to ensure that patients are signposted to the right service for help, thereby streamlining their experience and leaving the PALS department to manage calls relating to concerns and assistance more effectively. This has been achieved; 51% of PALS calls this year were concerns that required more assistance, compared with 41% the previous year.

Figure 2 below shows the themes recorded for PALS Concerns in the year.

Figure 2: Number of PALS Concerns by Trend



The most common concerns expressed via PALS in 2019/2020 were:

- Appointments: including delay to be seen and cancellations
- Clinical advice: including pre and post- operative advice/questions
- Waiting times: including waiting time to be seen by doctor and waiting time for surgery

The PALS Service has also provided support to patients with identified needs to access appointments and treatment where this has been possible.

The department remains committed to supporting the work of the Learning Disabilities and Safeguarding Teams in the coming year.

7.0 Formal Complaints numbers measured against Trust activity

Table 2: Complaints against Trust Activity 2019/2020

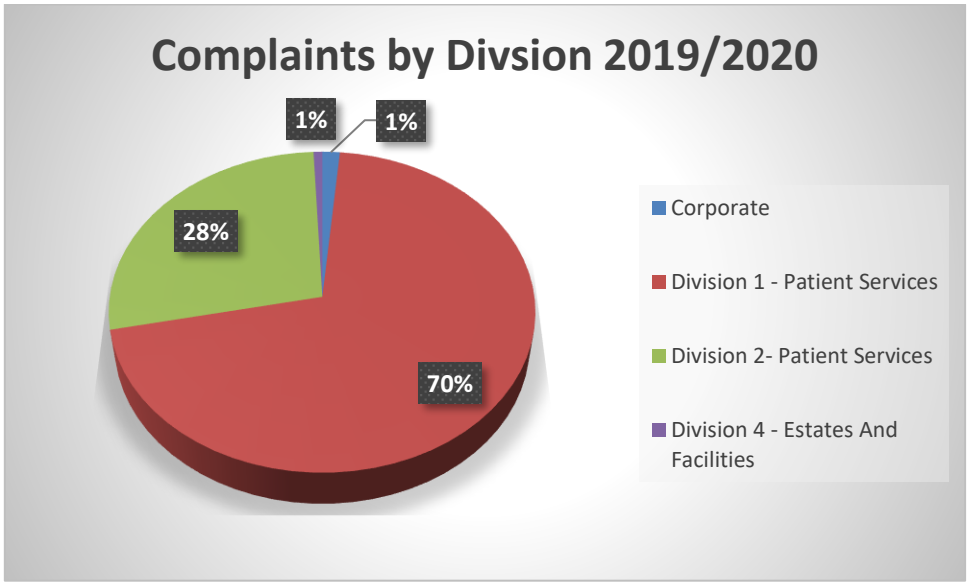
	2018/2019	2019/2020
Inpatient Attendances		
Inpatient Complaints	57	26
Inpatient Episodes	14,444	13,592
Complaints per 100 inpatient episodes	0.39%	0.19%
Outpatient Attendances		
Outpatient Complaints	81	112
Outpatient Episodes	70,735	99,940
Complaints per 1000 outpatient attendance	0.11%	0.11%

The Trust has seen a decrease in Inpatient Complaints and stayed the same in Outpatient Complaints over the year. It should also be noted however that a significant increase in outpatient appointments did not generate an increase in outpatient complaints.

8.0 Number of Complaints by Division

Figure 3 below illustrates the number of formal complaints by each Division in 2019/2020.

Figure 3: Number of Complaints by Division 2019/2020

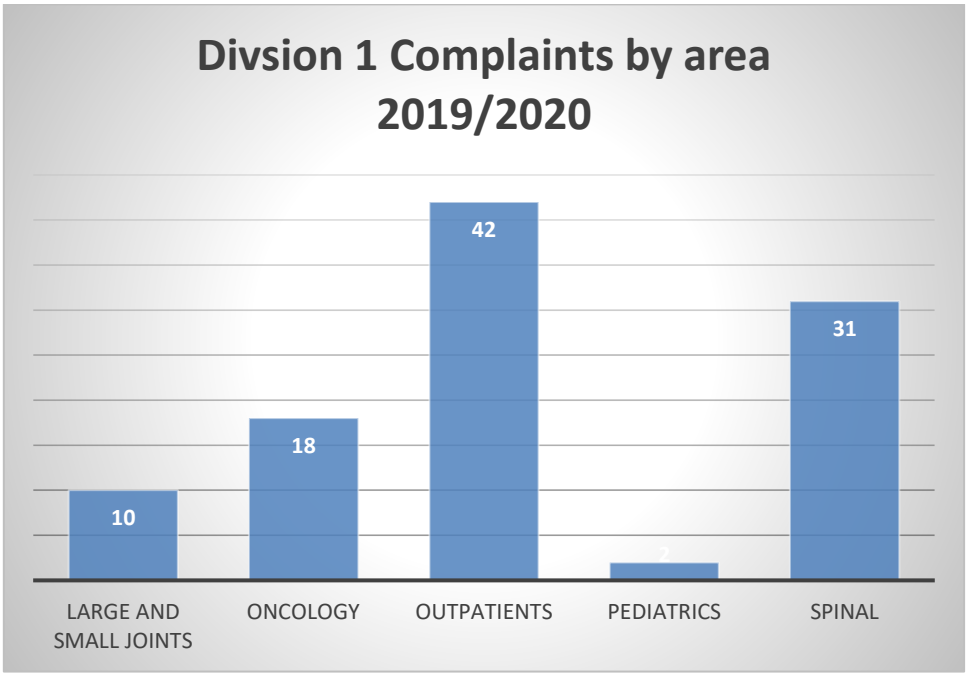


The majority of complaints (70%) relate to the Patient Services Division 1 which is to be expected since this Division 1 oversees all inpatient areas and outpatient departments, compared to Division 2 which oversees Theatres & HDU, the Admission and Day Care Unit, Pre-operative Assessment, all Therapy Services and all Imaging

Services. This is a slight increase from 67% last year. The two areas with the highest number of complaints in 2019/2020 were the Outpatient services (30%) following with Spinal Services (23%) and Therapy services (19%).

Figures 4 below provides an in-depth breakdown of complaints within Division 1

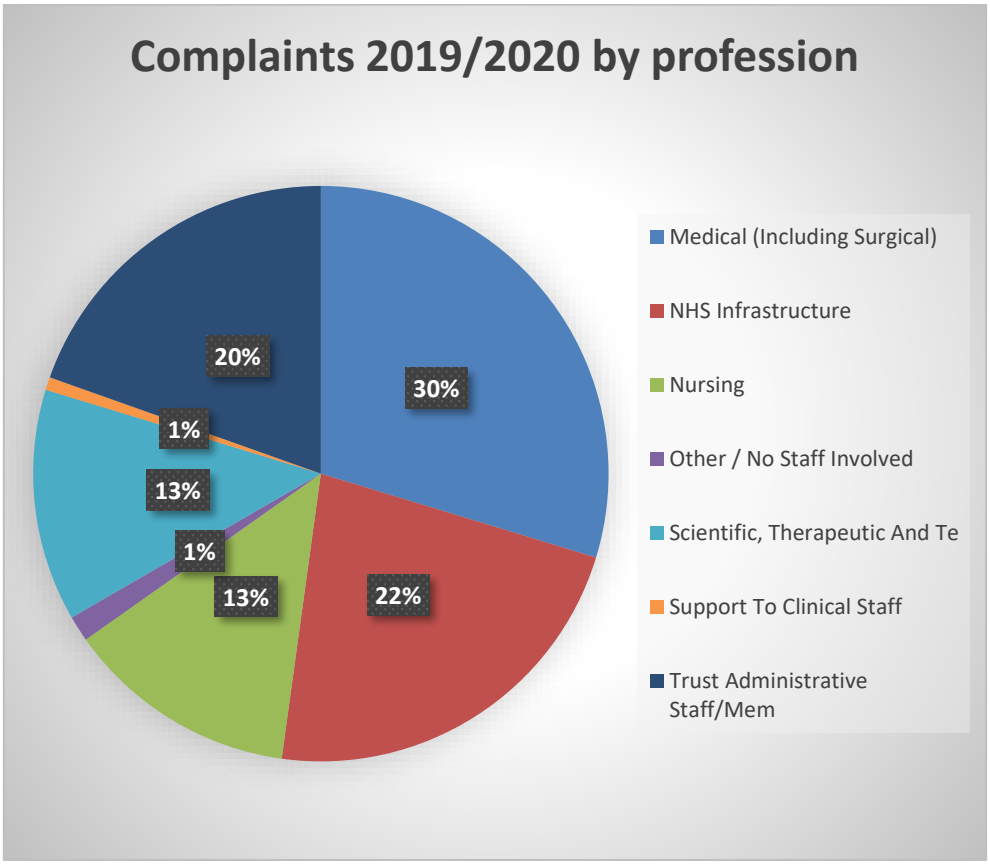
Figure 4: Number of Complaints by area in Division 1 2019/2020



The largest numbers of complaints in Division 1 related to concerns about the Outpatient and support services (30% of Div.1 complaints this year). These related to all aspects of the service, including clinical treatment, care provided and administration processes

9.0 Complaints by Profession

Figure 5: Number of Complaints by Profession 2019/2020



Medical Staff were the largest professional area complained about in 2019/2020. This is reflective of the more complex and specialist activity carried out in the Trust. The complaints received during this year raised concerns about surgical outcome (complications following surgery), attitude of medical staff and treatment options (e.g. wanting surgery but this is not an option).

This is like the last two years, although the number of complaints relating to infrastructure support within the hospital has continued to increase, such as the management of referrals and typing of clinic letters) It is believed that this is related to more accurate coding of complaints, whereby long waits for appointments or rescheduling are recorded under this area, rather than to the actions of a specific administrator or clinician.

10.0 Complaints by Subject

Figure 6: Complaints by Subject 2019/2020

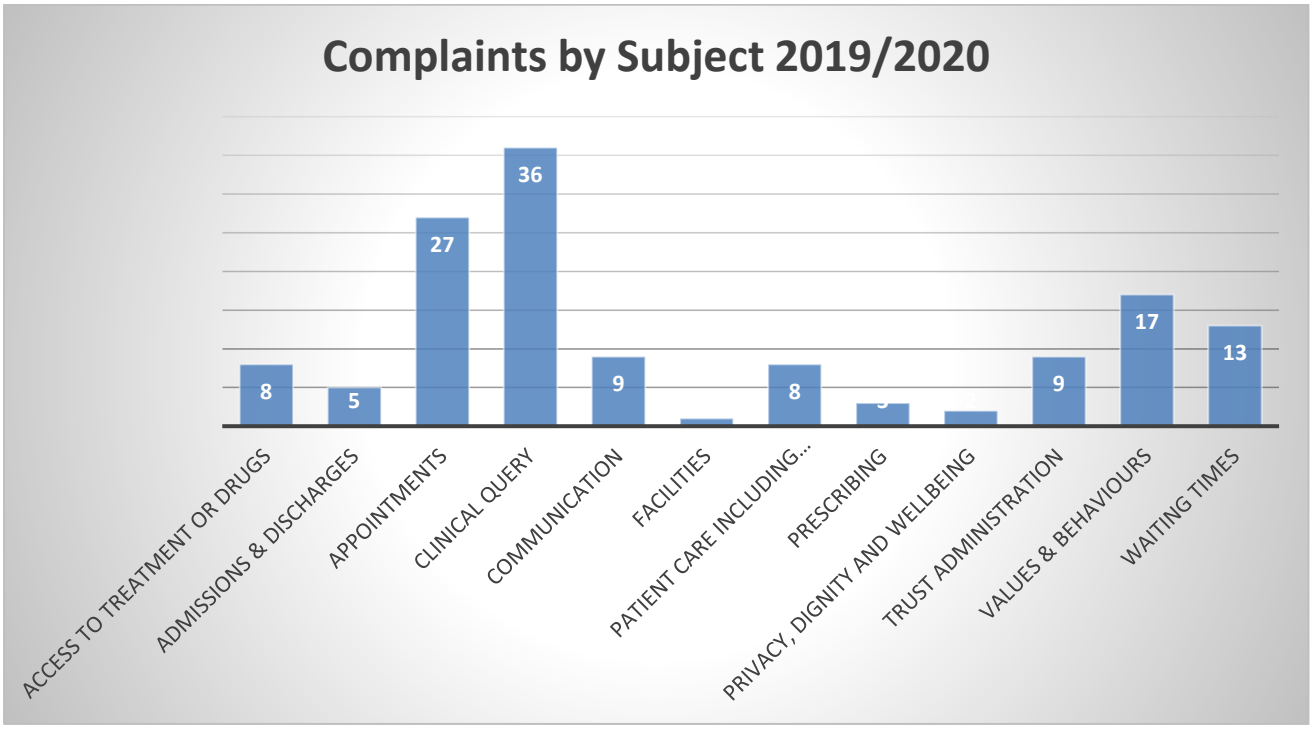
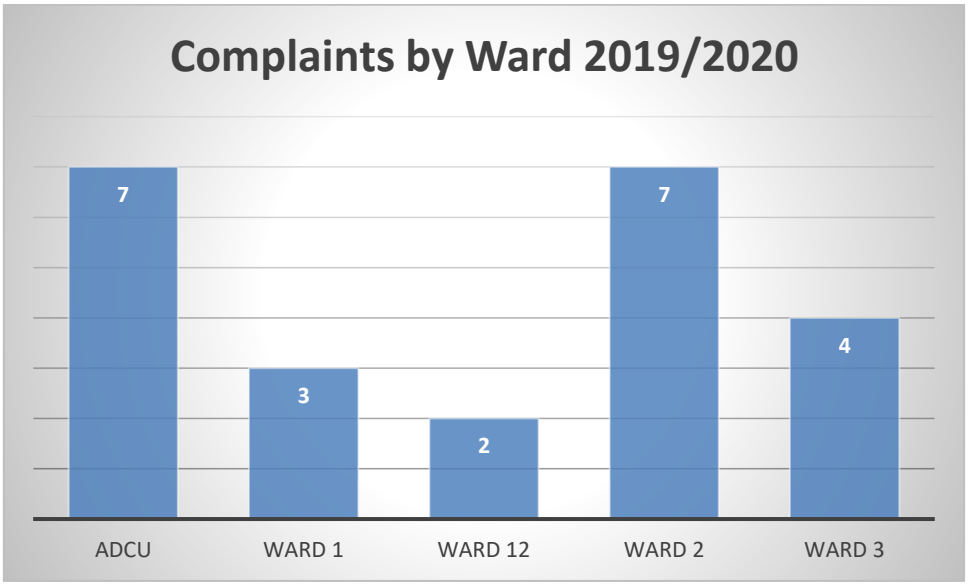


Figure 6 shows the main causes for complaints in 2019/2020, with dissatisfaction with clinical treatment, appointments and values & behaviours of staff being the highest reasons. These themes show changes from last year and as such provides some assurance that actions are being taken to address identified issues

A review of complaints mentioning values & behaviours of staff is being undertaken to identify any areas of commonality. Additional actions such as training or monitoring will be undertaken where appropriate.

11. Complaints by Ward during 2019/2020

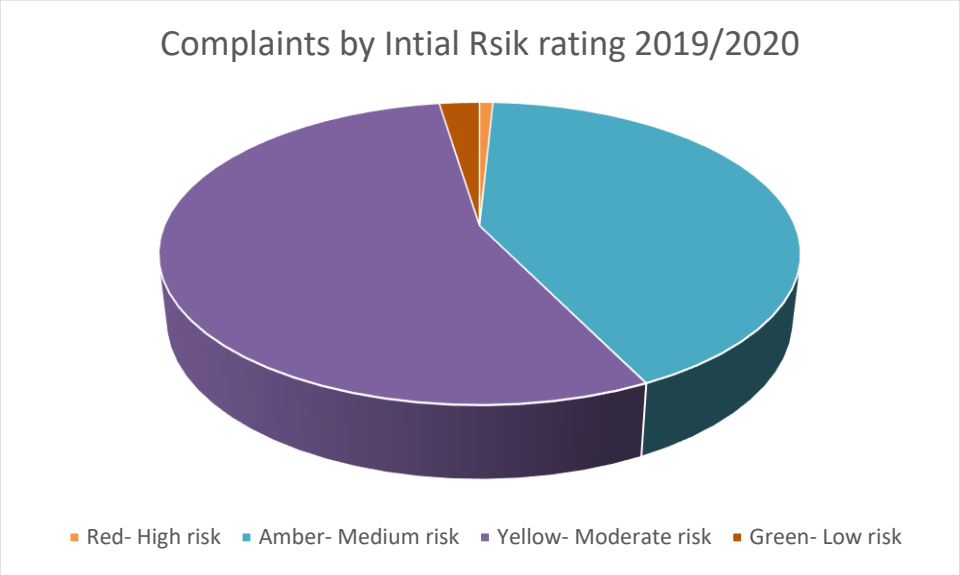
Figure 7 : Complaints by Ward 2019/2020



Concerns about aspects of ward care or treatment has been mentioned in 17.4% of complaints this year, which is same as year before (17.5%). This local indicator was implemented in 2015/2016 as there was a marked increase in the number of complaints about ward care in the final quarter of that year (45%). The data is scrutinised, together with other ward performance data in Clinical Quality Group meetings and forms part of the Quality Dashboard completed each month. These are also discussed with Senior Nurses and Ward Managers at their respective meetings. The Trust believes that the greater scrutiny has enabled any necessary changes to be made earlier thereby allowing the significant improvement to be maintained.

12. Risk Ratings of Complaints during 2019/2020

Figure 8: Initial Risk Rating of Complaints 2019/2020



The Trust has a robust system of tracking and monitoring complaints. Part of this tracking involves the logging of an initial risk rating. The Patient Services Manager monitors these risk ratings and the Deputy Director of Nursing reviews all complaints that are initially rated Red or High Amber, to ensure Duty of Candour requirements have been discussed and met where required. The Trust Risk Scoring Matrix can be found in Appendix B.

The results of this monitoring clearly shows that most of the complaints that represent a lower risk to the Trust are handled via different processes within the Trust, such as PALS or informally, as the number of complaints assessed as green or low risk are few (none this year). A review of the formal complaints assessed in the lower risk categories shows that in each case, the complainant had expressed a preference for their concerns to be made formal. This is indicative that the Trust is handling complaints in accordance with the Department of Health Complaint Regulations 2012 – that the complainant is able to determine how their concerns are managed.

13.0 Performance against Key Performance Indicators (KPI)

During 2019/2020 the Trust had 2 contractual complaints KPI's which were reported to the Trust Board, via the Quality Report and the Commissioners, via contractual reporting on a monthly basis. In addition, there were an additional 2 internal performance measures within the PALS and Complaints Policy. These are:

- Verbal acknowledgement within 2 days if possible (95%)
- Written Acknowledgement within 3 days (95%)
- Response within timescales agreed with complainant (80% KPI – contractual requirement)
- Response within timescales agreed with Commissioner for complaints that come via this route (100% KPI – contractual obligation)

Compliance against these KPI's is recorded in Sections 13.1 and 13.2

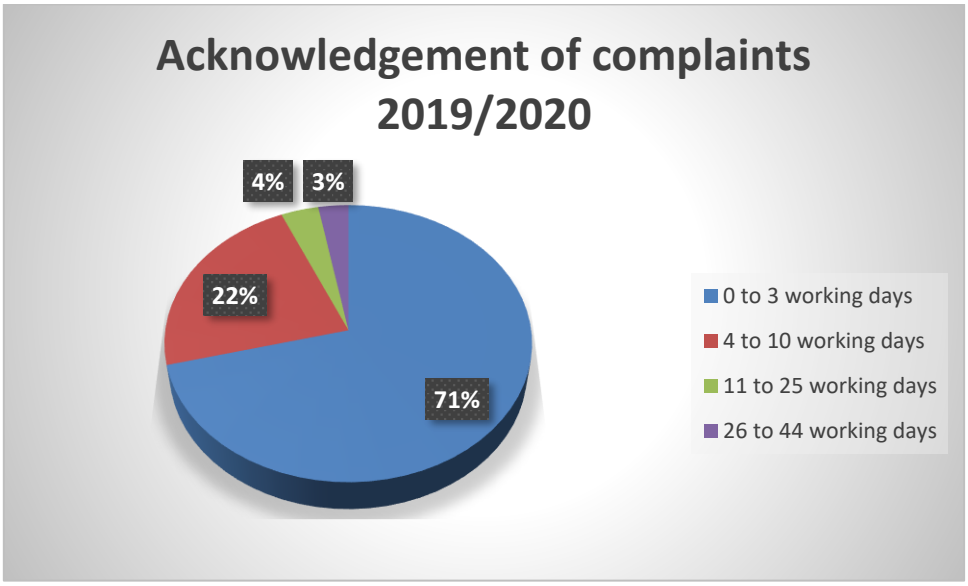
13.1 Acknowledging complaints

The ROH complaints procedure states that an acknowledgement should be made within three working days of receipt by any method.

The Trust's Policy states that all attempts should be made to contact the complainant by telephone within the first two days of receipt and this conversation informs the acknowledgement letter sent out by day three. If there is no telephone number available or the complainant does not answer/return the calls, then the letter is sent within the same timescale.

71% of complaint letters received during the 2019/2020 were acknowledged verbally or written within the correct timescale, thereby Trust did not meet internal KPI for acknowledging complaints.

Figure 9: Acknowledgement of complaints



13.2 Responding to complaints within the agreed timescale

The PALS and Complaints Policy states that the timescale for response should be agreed with the complainant. In the event of not being able to contact the complainant and speak to them directly, the Trust sets a provisional response date of 25 working days for routine/lower risk complaints and 40 working days for complex/higher risk complaints (dependant on discussion with the Deputy Director of Nursing, the Designated Complaint Investigator and the complainant as to the complexity of work required).

In line with ROH Policy, it is permissible to discuss an extension with the complainant. If they agree with the extension, the complaint will be deemed to have been completed within agreed timescales. Any complaint can only be extended once.

Annual Compliance with the contractual reporting requirement of 80% for the year was has not been met at 72.4%.

14.0 Outcome of complaints made in 2019/2020

Figure 10: outcome of complaints 2019/2020

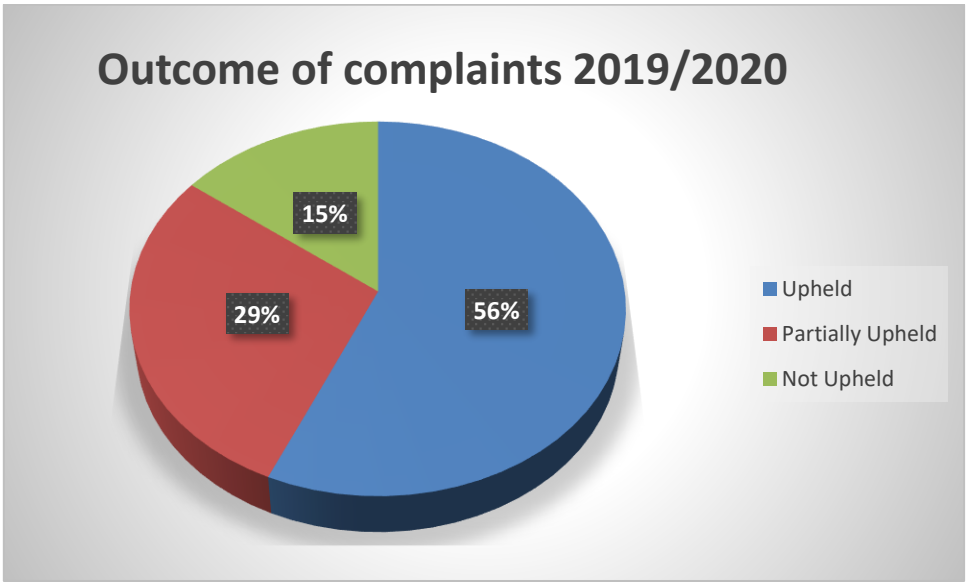


Figure 10 shows the outcome of complaints made in 2019/2020. The Trust upheld some aspects of 56% of the complaints made in this year, which is lower than 2018/2019 (71%). Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint. The decisions about whether to upheld or not are taken from the results of the investigation and discussion with the Investigation Lead if this is not explicitly clear in the report. The Trust believes that these figures show robust investigation and clearer expectations of good service provision across the Trust, which is being defined by the changes to the operational structure, the Transformation Agenda and the Quality Agenda priorities

15.0 Satisfaction with the Complaints Service

For the year 2019/2020 Complaints department was not able to recover data for the Complaints service survey due to change in staffing within department. Data for 2020/2021 will be collected and will be presented in Annual complaints report 2020/2021.

16.0 Complaints referred to the Parliamentary Health Service Ombudsman (PHSO)

We aim to resolve complaints by undertaking a thorough investigation, providing a comprehensive response and offering all complainants the opportunity to discuss further concerns with us. Generally, the Trust is successful with this, but sometimes it is not always possible to achieve a resolution which satisfies the complainant.

Under the NHS Complaint Regulations, any complainant who remains dissatisfied with the response has the right to request an independent review of their case with the PHSO. Every response contains this information together with the contact details for the PHSO.

During 2019/2020, the PHSO requested information about 1 complaint made to the Trust. On the 10th March 2021 PHSO confirmed that they have completed assessment and advised that they will not investigate the complaint and file will be closed.

17.0 Listening and Learning from Complaints

Patient Story

Ms X made a formal complaint about aspects of the care that she was receiving on a Ward. She was concerned about another patient opposite whom she felt was isolated and had no-one to speak up for her, which she also added into her complaint. She stated that other patients whom she had been in a bay with had the same concerns. This information was taken by the PALS Manager who had visited Ms X on the ward at her request.

The PALS Manager discussed all of the concerns with the Patient Services Manager and then contacted the Head of Nursing for Patient Services. He immediately went to the Ward concerned and discussed Ms X's concerns with her directly. He then took the opportunity to talk to all of the other patients in the same bay.

Together with the Ward Manager, the Head of Nursing took some immediate actions to offer assurance to all of the patients involved that their feedback had been taken seriously.

Ms X felt very happy that action had been taken so swiftly and was assured enough to accept that information about the other patients could not be shared with her.

As a result of Ms X's complaint and information taken from the other patients, a ward action plan was created and monitored by the Head of Nursing. This was shared with Ms X as part of her complaint response, together with an expression of thanks for sharing her concerns which enabled corrective action to be taken.

Complaints are reviewed and signed off at senior level within the Trust to ensure that:

- Complaints are well managed and contain accurate, helpful responses
- Any serious issues are identified and escalated appropriately
- Trends can be identified and acted upon

The Divisional Governance meetings are well established and provide an opportunity to discuss any complaints and matters of concern in more detail. Action Plans arising from complaints are also monitored and signed off in this group.

Individual Action plans are created for any actions that are specific to an individual complaint. Where actions form part of a larger work plan, patients are informed of this in their response. This ensures that complaint action plans remain targeted and relevant. Once actions have been completed, they are signed off at the meeting and a letter is sent to the complainant confirming that they have been completed.

In 2019/2020, 35 individual action plans were created. A further 34 complaints had actions that were completed prior to the response being sent

17.0 Looking ahead to 2020/2021

The Department continues to work with nursing and operational colleagues to identify more effective ways of working that benefit all and improve patient experience.

Improvements planned for 2020/2021:

- Work will be undertaken with Divisional Leads to further in-bed ownership of complaint investigation and action planning
- Complaint investigation and report writing training will be available in house for staff that require it
- The KPI of 80% of complaints completed within the agreed timescale will be achieved.
- The coding of compliments will be altered to the same system for complaints to allow for direct comparison of all Patient Experience data.

18.0 Conclusion

At the ROH, we remain committed to investigating, learning from and acting from complaints where it is confirmed that mistakes have been made or services can be improved. We recognise that the process of improvement is continual and that transparency and honesty are vital when things go wrong.

Appendix A

Progress against 2017/2018 and 2019/2020 priorities for the Complaints Department

Priority	Status	Detail
The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.	Partially Achieved	Thematic reporting is now pulled directly and information for Departments. KO41a is still not available and will be rectified in the coming year
Complaint investigation and report writing training will continue to be provided for staff that require it.	Achieved	All Directorate Leads and Senior Staff have received training.
The KPI of 80% of complaints completed within the agreed timescale will be achieved.	Achieved	Data is submitted monthly
The coding of PALS Concerns will be altered to the same system for complaints to allow for direct comparison of the data.	Achieved	All data is now coded and shared monthly with Departments

Appendix B

Trust Risk Rating Matrix

	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM riskRed = HIGH risk**

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Chairman and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**5 May 2021**

EXECUTIVE SUMMARY:

Attached is an updated Board Assurance Framework. Each risk has been reviewed and updated by the relevant risk owners.

Summary of proposals as follows:-

Proposed for Closure/De-escalation

- Covid-19 031 – Risk relating to patient harm for peri-operative patients testing positive for Covid-19 **- Proposed for closure**
- WF21 – Risk relating to Trust failing to attract & retain the skills & number of staff needed to secure financial stability and high quality care - **Proposed for de-escalation to Workforce & OD Committee risk register**
- FP7 – Risk relating to supply chain disruption – Risk on both BAF & CRR - **Proposed for closure from BAF and for CRR risk to be reframed**
- CE1 – Risk relating to financial plan to deliver sustainability in the medium to long term - Risk on both BAF & CRR - **Proposed for closure from BAF and for CRR risk to be reframed**
- WF20 – risk relating to tax liability in relation to consultant pension agreements - **Proposed for de-escalation to Workforce & OD Committee risk register**

Risks proposed for a reduction to their current mitigated risk score

- OP1 – Risk relating to suspension of paediatric oncology services at BCH – proposed **to reduce current risk score** from 16 to 4 (which is target risk score)
- 770 – Risk relating theatre engineering plant being beyond life expectancy – **proposed to reduce current risk score** from 15 to 12
- OP4 – Risk relating to further waves of Coviv-19 pandemic creating operational pressures – **proposed to reduce current risk score** from 16 to 12

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and NOTE the Board Assurance Framework
- CHALLENGE the risk scores (current and target)
- APPROVE the proposed changes.

- AGREE to receive an update on further details of any risks of particular interest to the Board at the next meeting

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	X

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

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

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

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

Aligns to all strategic objectives.

PREVIOUS CONSIDERATION:

The Trust Board last reviewed the Board Assurance Framework at its meeting in March 2021.

BOARD ASSURANCE FRAMEWORK

Risk Ref	Department	Executive Lead	Risk Statement	Risk category	Strategic Objective	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance (Internal, Peer or Independent)	Controlled			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Target risk			Date risk added
							Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating	
PATIENTS																					
1472	Infection Control	Director of Nursing & Clinical Governance/Medical Director	There is a risk that there could be cross contamination of patients that are Covid-positive or Covid-possible with non-Covid patients within clinical areas, causing the spread of the virus in a clinical setting	🔵 🟡	With safe and efficient processes that are patient centred	Quality & Safety Committee	4	5	20	Pre admission, patients are self isolating for two weeks along with their immediate household Patients are tested for Covid on two occasions pre-admission if they are an elective admission and live within a 30 mile radius of the Trust. Patients admitted from outside of the 30 mile radius are tested on admission. All patients are retested on day 7 of their inpatient stay. Patients admitted as an emergency are admitted into a single admissions area, tested and remain in this area for the duration of their stay. The hospital wards have been designated as 'Covid Protected' and 'Covid Managed', including a review of theatres and diagnostic pathways. National guidance has been reviewed and Trust-relevant local guidance has been produced for all staff to follow. All staff wear appropriate PPE as described in this guidance. Cleaning hours have been increased. All staff are screened on arrival at work for symptoms of Covid and are not allowed to enter the hospital of they are symptomatic. All beds are over two metres apart and shared bathrooms are cleaned with increased frequency. The infection prevention and control team carry out daily reviews of all patients in clinical areas to ensure appropriate isolation has occurred for symptomatic patients. Adherence to 'track and trace' guidance	Updates to Quality & Safety Committee Monthly quality reports Minutes and papers of the Infection Prevention and Control Committee and Infection Prevention Operational Group	3	5	15	↔	April 2021 - Medical Director update - Vaccination program having impact regionally and nationally at the same time as the January Covid peak falling off. The combined effect is that the prevalence in the community has fallen again (risk of bringing Covid into the hospital) and the risk of transfer within the Trust is lowered by PPE, vaccination and lateral flow testing. The Trust is moving to a position for pre-operative pathways in line with the NICE guidance and regional practice from a position of more stringent pre-operative (double swab) testing. Due to the small level of uncertainty that this change will introduce suggest the risk level remains unchanged but with evidence of effectiveness in the field over 2-3 months this risk could potentially be lowered further.	Ongoing	2	5	10	Apr-21
OPS	Operations	COO	There is a reluctance by patients to undergo scheduled treatment as a result of the uncertainty created by the Covid-19 pandemic	🟡 🟡	With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Consultants have been reviewing their waiting lists and clinically categorising patients using NHSI/Royal College of Surgeons criteria 1a/1b – urgent, 2 - treatment within 4 weeks, 3 – treatment within 12 weeks, 4 – treatment after 12 weeks. Consultants have subsequently contacted patients via telephone in virtual clinics with face to face appointments where clinically appropriate to discuss their current condition and based on medical history, latest scans etc., have clinically decided on when surgery will take place, all of which has been documented in the patients notes. Regular communication is in place with the CCG in a bi- weekly liaison call and a weekly communication update on restoration and recovery is in place for the GP bulletin from September 2020. Comprehensive Patient information leaflets are available and have been developed to help patients make a fully informed decisions regarding their treatment and to offer further reassurance of the changes that have been made to the Trust site to ensure government guidelines are being delivered . This information has been developed with the support of the patient carer forum and Health watch. The ROH website details the changes the Trust has made to maximise safety. The Trust has developed a 'Covid Protected' site, with appropriate zoning arrangements for Covid 'risk managed ' patients in line with government guidance. Keeping in touch calls and discussion between clinician and patient are taking place to provide an opportunity for patients to discuss the risks and make informed decisions documented in patient notes.	Papers from Executive Assurance Group; Recovery and Restoration presentation to Quality & Safety Committee and Finance & Performance Committee	3	4	12	↔	April 2021 - Chief Operating Officer update: The weekly Patient Tracking List will continue to review the progress of individual patient pathways and document patients who wish to defer treatment in line with RCS guidance to enable monitoring and review of those patients who want to defer treatment so bespoke conversations can be commenced to agree a suitable solution for the ongoing care of the patient. As part of the Trust Refresh and recovery programme patient engagement in developing patient information and education material will be embedded in all working groups.	Ongoing	2	4	8	Apr-21
Covid-19 - 031	Medicine	Medical Director	There is an increased risk of patient harm for peri-operative patients testing positive for COVID-19. Patients with COVID have a significant morbidity and mortality.	🔵 🟡	With safe and efficient processes that are patient centred	Quality & Safety Committee	5	5	25	Pre-operative individual assessment on the relative risks of surgical and non-surgical treatment. COVID testing and cohorting in place. Vaccination programme rolling out nationally according to plan for national coverage. Staff immunisation underway, with most staff having received the first dose of the vaccine which will reduce the risk of nosocomial transmission through a staff vector.	Learning from Deaths updates; monthly quality reports; minutes and papers from Clinical Audit and Effectiveness Committee	2	5	10	↔	April 2021 - Medical Director update: Proposed for closure.	Proposed for Closure/de-escalation	2	5	10	Apr-21

OP1	Operations	COO	The current suspension of the Paediatric Oncology service at BCH creates long delays for patients requiring surgery leading to poor patient experience, clinical outcomes and disenfrachisement of the oncology consultants		With safe and efficient processes that are patient centred	Quality & Safety Committee and Trust Board	5	4	20	System divert in place with patients referred to alternative centre within the Sarcoma network following the decision of the daily Multi Disciplinary Team (MDT) meetings. Bi-weekly calls with network partners chaired by Specialist Commissioning lead to monitor the divert process and ensure appropriate capacity is in place for patient cohort to be managed effectively. Root Cause Analyses around the paediatric cases treated at BCH prompted the decision to cease the service are being undertaken by BCH. Outcome of Root Cause Analyses concluded. External independent review into the oncology service commissioned. The service continues to be suspended as the host organisation continues to respond to the impact of the Covid-19 pandemic. Service resumption planned for April 19th 2021 Audit of patients due to undergo surgery conducted to review any harm experienced as a result of the delayed treatment. Results presented at July 2020 Quality and Safety meeting for assurance.	Weekly update to Executive Team. Minutes of private Trust Board meetings and Quality & Safety Committee meetings which include a regular update on status with the service. Minutes of Children's Board.	4	4	16	↔	April 2021 - Chief Operating Officer update: A Monthly Strategic Oversight meeting and weekly operational/risk group meetings are in place to monitor the ongoing service. Monthly Oversight Meetings continue in order to transition the service into business as usual, monitored by agreed KPIs going forward. Proposal to reduce the risk to target score.	Q1 21/22	1	4	4	Apr-21

PEOPLE																					
Covid-19 - 033	Workforce	Chief Executive	There is clear evidence that there is a disproportionate impact of COVID -19 on individuals who are from a BAME (Black & Ethnic Minority) background and those at higher risk due to age, gender, underlying health conditions and pregnancy ('vulnerable groups'). There is also evidence to suggest that BAME colleagues are less likely to speak up and raise concerns. There is a risk that BAME colleagues may unintentionally be placed at higher perceived/actual risk as they may not raise this. Additionally BAME staff and those deemed to be vulnerable may have higher rates of COVID related absence/illness.		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Risk assessments are currently being carried out for all BAME staff and those who fall into vulnerable groups 55% of the total number of BAE staff (297) have had a risk assessment and 82% of all staff with underlying health conditions. Managers have access to a briefing on how to effectively carry out risk assessments and additional support from HR Managers as required. Occupational Health providing support for any complex cases. There is ingoing corporate communications regarding the importance of risk assessment. The Trust achieved 100% compliance for the completion of risk assessments for BAME staff and /or those with underlying health conditions All managers are being reminded to undertake reviews of risk assessments for vulnerable staff and to undertake risk assessments with new/returning members of staff which has recently been underlined in a note to all staff around the need to undertake welfare meetings and revisit risk assessments where needed. The Trust is working with the system to develop a shared approach to embedding risk assessments into the employee wellbeing offer across BSol.	Report to Trust Board in July 20 on risk assessments; updates to Staff Experience & OD Committee; staff communication and 'Start of the Week messages	4	4	16	↔	April 2021 - Associate Director, Workforce and OD update: No change to risk score. Work across the system hasn't progressed in terms of having a shared risk assessment across BSOL. There is an electronic risk assessment which will be rolled out across the Trust by end of May 2021.	Ongoing	2	4	8	Apr-21
WF24	Workforce	Chief Executive	There is a risk that sickness absence may increase as a result of staff exhaustion or emotional strain due to different working patterns and exposure to emotional or stressful situations during the Covid pandemic		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Sickness absence rates are monitored on a monthly basis through the operational workforce dashboards and on a weekly basis through the Board Scorecard on a weekly basis. HR managers have regular 121s with local managers to review key hr metrics, to pro-actively address any HR concerns and signposting/seeking support from Occupational Health and/or the staff counselling service as appropriate. Staff have accessing to a free EAP service and can self-refer to the staff counselling service and this is promoted through comms and via line managers regularly. The national and regional offers regarding staff health and wellbeing have been promoted to all staff including in house support from trained mental health first aiders. There has been regular communications encouraging staff to take annual leave where business needs allow. There is now a cycle of reporting outstanding annual leave to Execs by directorate and highlighting those areas where no leave has been taken so that there can be targeted conversations about wellbeing, capacity and resourcing The psychological support offer for staff is being reviewed across BSol in response to the NHS People Plan in addition to the provision of a confidential staff counselling offer and Employee Assistance Programme being provided by the Trust. There is system wide psychological support, health checks and psychological first aid training available to staff in addition to Trust level interventions and support.	Weekly Board Scorecard Workforce Snapshot Data Intranet pages Communications briefings	4	4	16	↔	April 2021 - Associate Director, Workforce and OD update: No change to risk score. Ongoing reviews taking place. People Committee workshop in May 2021 will focus on supporting individuals with psychological wellbeing. Staff can now self-refer to counselling. Staff can also access support via EAP Vivup.	Ongoing	2	4	8	Apr-21
WF21	Workforce	Chief Executive	The Trust fails to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	4	16	Recruitment open days. Repositioning job advertisements to provide clarity on the ROH's unique offering. Health and Wellbeing programme. Introduction of 100 days on boarding process. New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for the pre-operative assessment centre. Potential future registration for PAs to be confirmed. Greater understanding of Nursing Associate role within Trust. NMC registration. Apprenticeships are being more widely adopted by managers	Staff Experience & OD Committee minutes and papers Health and Wellbeing week material Job adverts for key posts, including those for COO and CEO 100 induction 'road map'	3	4	12	↔	April 2021 - Associate Director, Workforce and OD update: Sharon Malhi agrees that risk should be closed from the BAF Risk Register and managed within the Workforce Risk Register..	Proposed for Closure/de-escalation	2	4	8	Apr-21
PARTNERSHIP																					

ST1	Strategy	Chief Executive	The Trust fails to exert influence in the STP and on the plans to develop an Integrated Care System, leading to loss of identity and brand, which could impact on the level of referrals, lowering of staff morale and loss of key skills		Developing services to meet changing needs, through partnership where appropriate	Trust Board	4	4	16	Attendance at STP Board meetings and Chairs/Chief Executives forums Ongoing work with the Birmingham Hospitals Alliance Development of a draft Memorandum of Understanding with University Hospitals Birmingham NHSFT to set out future working arrangements. Clinical strategy day held on 31 July 2020, which was well attended.	Trust Board minutes and papers Presentations from STP meetings	3	4	12	↔	April 2021 - Director of Strategy and Delivery update: The Trust is involved in supporting the developmentof the ICS Strategyand in assisting the Chair in the development of robust governance and recruitment of key Board level appointments. The CEO is fully engaged in the development of the ICS across the BSOL providers and the CCG. The Trust is fully represented at a Strategic, Operational, Financial and Clinical level. With key Executives attending the appropriate meeting regularly.	Ongoing	2	4	8	Apr-21
ST2	Strategy	Director of Strategy & Delivery	Innovation slows at the Trust as a result of reluctance to enter into commercial partnerships due to the uncertainty over the future influences of the Integrated Care System		Developing services to meet changing needs, through partnership where appropriate	Finance & Performance Committee	4	3	12	Trust is currently engaged with commercial partners to deliver JointCare initiative Active research programme is in place at ROH	Papers from R & D Committee and upward reports to the Quality & Safety Committee. 'Perfecting Pathways' programme board summaries to FPC Joint Care promotional material	3	3	9	↔	April 2021 - Director of Strategy and Delivery update: The Trust continues in developing new studies and there is no evidence of innovation slowing.	Mar-21	2	3	6	Apr-21

PROCESS																							
CE2	Corporate	Chief Executive	The effectiveness of the clinical governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience, potential harm and reputational damage.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	3	5	15	Elective surgery has been suspended. The ROH does not hold accountability for these patients, however any waiting for surgery above 40 weeks will be redirected to the clinical team for review monthly and trigger a harm review process. There has been a pause in the routine governance meetings with a resumption date to be agreed. Surgery on patients with cancer is currently directed to the Royal National Orthopaedic Hospital and the oversight of this service is robust.	Minutes of stakeholder oversight meeting	2	5	10	↔	April 2021 - Chief Operating Office update: Folllowing assurance to the ROH and BCH Trust Boards and in conjunction with NHSE/I, the resumption of service commenced on 22 February 2021 with the divert for referrals being lifted. The first OPA took place on 2 March 2021, the first biopsy list 3 March 2021, 11 April Clinical Safety Walkabout and first operating list on 19 April 2021. Joint risks have all been reviewed and all met the target scores prior to the first operating list taking place. Quality metrics have been defined to monitor the ongoing service and will be reviewed at the operational and governance meetings with a monthly upward report to the Strategic Oversight Meeting.	Apr-21	1	5	5	Apr-21
770	Operations	COO	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.		Safe and efficient processes that are patient-centred	Quality & Safety Committee	4	5	20	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	5	15	↔	April 2021 - Chief Operating Officer update: Phase 1 and Phase 2 of the theatre expansion programme have been handed over, the Trust have four additional operating theatres, however, activity is planned to increase beyong the current 12 theatre utilisation to 14. In relation to Theatres 1, 2 and 4 the risks remain unchanged, However, the consequence of failure is reduced as the 4 new theatres would be utilised for extended days and weekends in the event of failure to reduce the impact on patient cancellations. The risk still remains as the use of the 4 new theatres would not fully mitigate the consequence of failure in full, Proposal to reduce the consequence from 5 to 4, giving a current score of 12 (amber).	Mar-21	1	5	5	Apr-21
FP7	Finance	Exec Dir - F&P	The Trust may experience supply chain disruption resulting from a failure to agree a Free Trade Deal		With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Whilst a trade agreement has now been reached, the Trust has in place plans and contingencies developed in 2019 in response to the threate of a 'no deal' Brexit outcome, which are being revisted and refreshed.	Updates to Finance & Performance Committee	2	4	8	↔	April 2021 - Executive Director Finance and Performance update: to be closed from BAF risk register, and reframe Corporate risk.	Proposed for Closure/de-escalation	2	3	6	Apr-21
FP8	Digital	Exec Dir - F&P	There is a risk that the current IT capacity and functionality will not support the new ways of working developed during the Covid-19 response, such as virtual clinics, remote operation and videoconferencing		With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Trust use of thin clients and virtual desktop, with the addition of 80 mobile devices, allowed rapid remote access for 567 staff to work from home. Initial widespread use of Loopup videoconferencing and teleconferencing supported internal and external meetings. Business case for VDI hardware replacement proposal approved by the Executive Team on 27 October 2020. The new thick clients will strengthen the capability of the Trust's IT capability to support technology for videoconferencing and to maximise the functionality of Office 365.	Finance & Performance Committee	2	4	8	↔	April 2021 - Executive Director Finance and Performance update: Whilst most remote consultations have been done by phone, Video Conferencing is being piloted in Pain Management, MSK, Therapies, Foot and ankle and expected to be adopted much wider across the Trust. Attend Anywhere is the application being used (funded centrally for 12 months with a £20k grant to purchase appropriate equipment). Moreover, the Trust has now purchased laptop and desktops as part of the thin client replacement project. Rollout will continue into 21/22. Additionally, the HSCN line into the Trust is being upgraded. The secondary line has now been replaced and the primary line will be connected before the end of May 21.	Apr-21	2	3	6	Apr-21

OP4	Operations	COO	There is a risk of increased virus transmission and reproduction rates, leading to a second and further waves of the Covid-19 pandemic creating operational pressures in the hospital		Performance, People, Process, Partnerships and Patients	Trust Board	5	4	20	Flow & Cohorting and Testing & Scheduling processes have been implemented agreed Standard Operating Procedure and protocols implemented to minimise the transmission to staff and patients. Operational pathways have been reviewed to implement revised ways of working. Risk Assessments have been completed in all areas of the hospital and changes are in place to ensure staff safety whilst at work. Two pathways have been implemented to minimise the transmission of Covid 19. Protected Patient Pathways and a Risk Managed Pathway. The pathways are monitored through the three daily site office meetings. There is continued dialogue between PHE / Microbiology with learning from any outbreaks embedded in ongoing practice.	Papers from Executive Assurance Group; Recovery and Restoration presentation to Quality & Safety Committee and Finance & Performance Committee	4	4	16	↔	April 2021 - Chief Operating Officer update: Increase in performance in national vaccine rollout. National and local reduction in infection rates. High proportion of staff have had both vaccinations. Patients clinically triaged as part of pre-operative assessmentm vaccination status discussed with patients, Proposal to reduce risk to 4x3m to a current risk score of 12.	Ongoing	2	4	8	Apr-21
OP6	Operations	COO	There is a risk that there will be insufficient capacity to handle the activity from the new services being handled by the Trust as part of the restoration and recovery phase		Delivered by highly motivated, skilled and inspiring colleagues and Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	All 12 theatres operational. Phase 2 Theatre/Ward Expansion installed and scheduled to be commissioned by December 2020 adding two more theatres and an additional 8 beds on Ward 4. Bid for second MRI scanner to support Trust/System wide diagnostics approved and planning permission received. Enabling works commenced to increase ultrasound capacity in the imaging department. Additional mobile MRI 'van days' have been secured to maintain MRI activity and an increase in interventional/ CT capacity by providing extra lists Conversion of Ward 11 into an Adult ward or to increase pre operative assessment capacity. Theatre look back meeting re-instated to monitor any incident raised on a weekly basis. Theatre allocation reviewed monthly to monitor the delivery of the level 2/3 patients. 864 meeting will monitor theatre utilisation weekly.	Recovery and restoration update to Quality & Safety Committee and Finance & Performance Committee; demand and capacity analysis to Finance & Performance Committee	3	4	12	↔	April 2021 -Chief Operating Officer update: Ongoing system support to hand and ambulatory trauma and working as part of the wider system to provide orthopaedic elective capacity for P2 and P3 patients.	Ongoing	2	4	8	Apr-21
1298	Finance & Performance	Exec Dir - F&P	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Contractor Cyber Security Officer just been appointed at Band 6 for 3 months, so some progress to be made shortly with outstanding tasks. Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network.	IM&T programme board papers Presentation from CORS team to Audit Committee Audit Committee minutes Information Governance Group minutes	4	4	16	↔	APril 2021 - Executive Director Finance and Performance update: 1. Lack of patching/monitoring. Efforts underway to bring the patching to two weeks patching cycle to meet the DSPT requirements. Three weeks for theatres. VDI will be replaced May-Sep 2021- which will provide control over software deployment. SIEM solution has been purchased, the deployment time scale is around 3 months which should greatly enhance our monitoring capabilities. Load balancer Kemp - order has been placed and implementation will be May-June 2021 2. Presence of unsupported systems. This is still a significant risk, there is an increased need to find suitable alternatives and/or to work with vendors for update their provided solutions. Pathology will be moved out to UHB between June - July 2021, so unsupported systems will be moved out. Action Plan now agreed with Head of BI for Apple MACS. Pharmacy - Ascribe is being replaced by JAC, which will decommission the Win7 device, plan for implementation is between Apr-Jun 2021. 3. Poor Access and password audit. PICS teams rejected to move to local admin password due to lack of resources and time so no further progress until PICs teams resolve this issue. PICS password is linked to Active Directory (AD) so prevents us manually or automatically removing the AD account, which can be problematic because of duplication of accounts. Two factor authentication (2FA) for NHS Mail -currently in deployment using a phased approach. 4. MTI funding received by NHSD. Waiting for delivery of KIT to support the DR backup platform. The timeframe of this is May - Jul 2021 in collaboration with 3rd party support. 5 User awareness - Cyber Security Comms plan in place and in the process of being implemented including staff survey and new intranet page for resources. Being supported by the Comms Team	Ongoing	2	4	8	Apr-21

PERFORMANCE																						
1089	Operations	COO	**REFRAMED RISK:** The Trust fails to meet the national target of treating 92% and patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the Covid-19 pandemic		Delivering exceptional patient experience and world class outcomes	Finance & Performance Committee	5	5	25	The March Referral to Treatment position closed at 58.27% against the National Compliance target of 92%. There are 142 patients over 52 weeks. All of these patients are category 4 priority level. Patients waiting in excess of 52 weeksare all going through the Trust harm review process. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis. Refreshed post-Covid Trajectory is being developed in line with the system backog reduction working group is monitored by the Finance & Performance Committee monthly.	Weekly update to Exec Team & Ops Board; monthly finance overview	5	4	20	↔	April 2021: Chief Operating Officer update: Delivery of restoration and recovery plans as part of the wider system for P2 and P3 elective operating. Progression of second MRI Scanner - due to be operational August 2021. Phase two of theatre expansion delivered December 2020 - 14 theatres operational from 19 April 2021. Continued transformation of Outpatients services maximising the digital opportunities.	Dec-21	3	3	9	Apr-21
CE1	Corporate	Chief Executive	The Trust does not currently have a clear financial and operational plan in place that describes how the organisation will deliver sustainability over the medium to long term. The Trust is currently delivering consistent deficits and requires cash support to continue day to day operations		With safe and efficient processes that are patient centred	Trust Board	5	4	20	Whilst a two year financial and operational plan was signed off by the Trust Board in 2019/20, the Trust has been working with the STP to develop a longer term System Sustainability Plan (five years), although both for the Trust and the STP, this plan is different to the current set of performance improvement trajectories recently identified by NHSI The SSP reflects the Trust's 5 year strategy to become the first choice for orthopaedic care, which has recently been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. An initial Strategic Outline Case was developed and accepted by the Board outlining options for future growth. Discussions are taking place with partners in the STP to work through options for providing closer clinical integration between the ROH and other partners, which will built resilience and support the move towards financial sustainability The first phased of the theatre expansion work has been completed.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	3	4	12	↔	April 2021 - Executive Director Finance and Performance update: this risk can come off the BAF Risk Register and be reframed for the Corporate Risk Register.	Proposed for Closure/de-escalation	2	4	8	Apr-21

WF20	Workforce and Staff Experience/Finance	Associate Director of Workforce & OD/Director of Finance & Performance	There is a risk that as a consequence of the current tax liability associated with pension arrangements of some senior clinical individuals that there will be a reluctance to cover additional duty hours and therefore the Trust will fall short of its activity target and financial control total		Delivered by highly motivated, skilled and inspiring colleagues	Finance & Performance Committee and Staff Experience & OD Committee	5	4	20	Pension policy agreed to include additional payments for those staff who opt out of pension Trial of service contract for anaesthetic and surgical consultant services via LLP agreements. National solution published which has assisted to some degree. Demand and capacity modelling has been undertaken which if LLP may be needed as part of future restoration and recovery plans. Overall consultant reluctance to undertake additional activity has reduced and this capacity has been built into restoration and recovery plans. Successful recruitment of additional consultants over recent months.	Board meeting minutes. Finance & Performance overview. Minutes of Finance & Performance Committee.	2	4	8	↔	April 2021 update: proposed for de-escalation to Workforce Risk Register.	Proposed for Closure/de-escalation	2	4	8	Apr-21

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
- Patient safety
- Patient experience
- Workforce capacity, capability and engagement
- Systems, information and processes
- Regulatory compliance and national targets
- Equipment & estates
- Strategy and system alignment
- Reputation and brand

UPDATED: MARCH 2021

ROHTB (5/21) 012

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 27 April 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The risk around the funding of the theatre development was discussed. Given the change in funding arrangements from when it was agreed the scheme should proceed, discussions were needed with system colleagues about the arrangements going forward and the use of the facilities as an offering wider than just for the ROH. • The failure of the CT scanner was discussed and it was noted that this was an intermittent issue which was rapidly addressed and all patients delayed had been rescheduled. • The performance against the Referral to Treatment Time (RTT) target was at 58.27% against the national target of 92%, which was a slight deterioration from the position reported last month. There were 142 patients waiting in excess of 52 weeks, of which 100 admitted patients had been booked onto a theatre list and 42 non-admitted had clinic appointments or diagnostic procedures planned. • There was noted to be some delay with the turnaround of Pathology test results; a discussion was planned for the next meeting of the Quality & Safety Committee. • It was noted that Trust was currently operating under a degree of uncertainty in terms of financial and operational planning at present, however it was anticipated that this would be clarified over coming weeks.	• Update on incentive payments for activity at a system level to be presented at the next meeting. • The draft financial & operational submissions, including funding allocations for the ROH and the system would be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• It was reported that the unaudited year end position was to be reported as a deficit of £2.4m against a planned deficit of £2.6m. The expenditure was reported to be higher than expectations, however this would be offset in some areas such as for Personal Protective Equipment, annual leave accruals and pension contributions.	• None specifically.

• The Committee was advised that the Audit Committee had been briefed and was satisfied about any accounting treatment planned to arrive at the end of year position. • Activity levels had increased to 749 cases in March 2021 and there was anticipated to be a higher level of cases handled in April 2021. Fourteen theatres were now operating meaning that there would be a continued elevation of activity over coming months. • Outpatient activity was above plan, with 48% of appointments being delivered virtually, this being in excess of the target of 25% set by NHS Improvement. The virtual technology was reported to be working well. • Theatre utilisation and in-session utilisation had improved, with mainly Priority 2 and 3 patients being treated at present. • The preadmission isolation and swabbing regime was reported to have changed to meet guidelines set out by NICE. This was now three days prior to admission and one swab, which provided an opportunity to improve theatre utilisation given that patients could fill slots in theatre lists at short notice in the event of a planned cancellation. • Length of stay had reduced to 3.9 days, this being in line with usual expectations when the hospital was operating with its usual cohort of patients. Any patients staying in excess of 10 days were rigorously reviewed to ensure their stay was appropriate. • Clinic delays had reduced, being now only slightly above the Trust's target of 10%. • Most cancer targets had been met, apart from the 62-day target, where the breaches were reflective of the small number of patients being treated and the complexity of their pathways. • The Committee was pleased to note the significant improvement in the mandatory training position where a 10% increase had been reported since last month. • Good progress with the refresh and recovery workstreams was reported. A fifth workstream had been added to give oversight of the governance of the pathway that involved patients from University	

Hospitals Birmingham NHSFT (UHB). Consultants from UHB had been welcomed over recent weeks and the pathway was working well. • The outline planning assumptions for 2021/22 were outlined for the ROH; the system plan remained under development at present. • The Committee reviewed in detail the operational and financial risks on the Board Assurance Framework and provided an overview of additional mitigations that had been applied. These would be next considered at the Trust Board on 5 May as part of the full BAF.	

Chair's comments on the effectiveness of the meeting: It was noted that the issues with the virtual technology had impacted on smooth conversations at the meeting, however a good level of assurance had been provided by the papers and contributions from those members and those in attendance.

ROHTB (5/21) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 28 April 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Concerns over the lack of consistency with meeting the key performance indicators set out in the Pathology contract were discussed. Meetings would be held with the provider of the service to understand what national and regional support was needed to address the shortfalls. • There remained a shortfall in achieving the 24-hour VTE reassessment target and the Medical Director and Director of Nursing & Clinical Governance were reviewing the national guidance to understand if this was a requirement for every patient or was limited to only those where there had been a change to the clinical condition of the patient during their stay. • The key area of concern from the Health & Safety Executive inspection gap analysis related to ventilation. It was noted that in some areas it was impractical to arrange for natural ventilation given that there were mechanical systems that would be impacted. It was agreed that a full site ventilation survey would be commissioned and then agree the next steps once this has been completed. • The Committee chair suggested that in view of the additional initiatives and workload that consideration needed to be given to ensuring that it was adequately resourced.	• Further update on progress with addressing the current concerns over the performance against the Pathology service level agreement to be presented at a future meeting. • The new patient experience structures to be presented at a future meeting. • The Quality & Safety Executive to consider the work needed to address any work that needed to be addressed from the perspective of the Human Tissue Advisory Group. • Quality & Safety Executive to review the amber actions in the water safety action plan, in the event that there was insufficient progress reported to the Infection Prevention & Control Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Work had been undertaken to ensure that there was a more co-ordinated and structured approach to patient experience, including the recruitment into the Patient Advisory Liaison Service (PALS) and complaints department. • There was reported to have been an improvement in the performance against the clinic waiting time target. Diagnostic targets had been met and there had been few cancellations.	• It was agreed that the following reports should be presented to the Trust Board: annual complaints; Paterson Inquiry update; refreshed Board Assurance Framework. The support to the work with Robert Jones and Agnes Hunt NHSFT would also be presented.

• It was reported that the hospital remained free of COVID-19 infections, with the last being in February 2021. • A gap analysis against the key findings from the Health & Safety Executive spot check inspections was reviewed which overall showed good compliance. Where there were shortfalls identified then actions to address these would be set out for the Trust Board. • The Trust reviewed progress against the 2021/22 Quality Priorities that featured within the Quality Account. Four out of five would be closed, with the priority around spiritual welfare to be carried forward into the coming financial year. The new priorities for 2021/22 were set out and included a focus on volunteering and Children and Young People services. • The litigation update highlighted a number of cases where the predicted final settlement was expected to be lower than the initial estimate. The clinical negligence premiums for the coming year were reported to be set at c. £500k lower than the previous year. It was highlighted that there had been a positive cultural shift in terms of handling and responding to claims. • An update on the ROH's position statement in relation to the key findings of the Paterson Inquiry was received, including an audit of consultant whole practice. The audit confirmed that all consultant practices in the private sector were aligned to the current NHS practice. Further work is planned to strengthen the oversight of this work and to deepen the assurance. • The project charter, quality impact assessment and governance framework for the orthopaedics pathway for University Hospitals Birmingham NHSFT (UHB) were reviewed. The Operations team was thanked for its work to develop these processes so robustly. • The paediatric oncology service was reported to have resumed and was working well. • As part of the update from the Quality & Safety Executive, it was reported that there was a focus on delivery of customer care training, a piece of work being led by the Chief Operating Officer.	

• A report was presented from the Human Tissue Advisory Group which provided a high level of assurance that processes were in place to ensure that there was strong compliance with the HTA regulations. Further work had been undertaken to ensure that the HTA processes were strong and were working well. • There was noted to be strengthened processes in respect of cleaning and there was a plan to introduce a 'star' system to rate the cleanliness of the hospital areas. • There was reported to be good work to refresh the oversight of Surgical Site Infections and more closely focus on prevention.	

Chair's comments on the effectiveness of the meeting: The meeting was joined by Dr Wilson Thomas, Consultant Anaesthetist/Clinical Workforce Lead who was in attendance as an observer. It was agreed that the quality of reports was good and the discussions had been productive.

QUALITY REPORT – APRIL 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	***MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY***
3 Moderate Harms reported; 1 x Physio Outpatient Incident - patient lost to follow up from June 2020. The level of harm to be confirmed. This is under RCA and duty of candour has been undertaken 1 x Inpatient fall on Ward 4 – reported as a serious incident due to the level of harm and potential learning identified within initial review. Ward 4, unwitnessed fall, patient fell from shower chair (wrong equipment), moderate harm (non-surgical L3 Fracture), potentially avoidable, Duty of Candour and RCA are underway 1 x VTE on Ward 12 - RCA and Duty of Candour underway. ***3 deaths recorded in March 2021 –*** 1 x inpatient death (expected) Patient on enhanced observations and end of life care pathway 2 x out of hospital death (post 30 days discharge process) All deaths are currently under review via the learning from deaths process. ***VTE 24 hour re assessment*** Continued poor compliance with mandatory 24-hour re-assessment. This continues to monitored monthly and escalated to Medical Director and Consultants identified as responsible for Junior Doctor supervision. Audits are being undertaken to look at: • The accuracy of the data report provided by Informatics • The effect of the re-assessment on patient management plan • Clinical notes to compare what is documented regarding VTE reassessment/plan-this was the methodology used by the CQC at UHB.	*None*

3 grade 2 pressure ulcers reported – all deemed as unavoidable.	
POSITIVE ASSURANCES TO PROVIDE ***Ulysses Improvement*** Work on Trust structure and improved reporting in the system us completed. This will allow more detail reports to be undertaken and give the divisions greater oversight of speciality related incidents and improve divisional oversight. ***Increase in falls reported out of hospital -*** Review of falls incidents specifically related to ROCS undertaken, given increase in numbers. This shows there is no concern that patients are being inappropriately discharged, instead it reflects the current case mix of patients that are being seen. these patients were in poorer physical health, with a lower baseline mobility pre-op, potentially exacerbated by a delay in surgery and therefore predisposing them to falling. This is a theme which appears to be reflected across other hospitals in the region, as more readmissions are being seen into enhanced assessment beds following falls. ***Increase in falls with harm*** Review of an increase in falls with moderate harm over the last couple of months shows no specific links, again it appears to reflect the increased complexity of surgery currently being undertaken on patients with multiple co-morbidities ***Falls per 1000 bed days*** data showing at the lowest in year at 1.8 per 1000 bed days compared to the national acute setting average of 6.6 (RCP, 2015) **WHO Checklist 100 percent compliance**	***DECISIONS MADE*** ***None***

Quality Report - April 2021 (March 2021 Data) – Front Cover and Dashboard

	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	2020/2021	2019/2020 YTD
Incidents	247	225	260	399	361	323	346	284	274	270	297	417(↑)		
Serious Incidents	0	0	0	1	0	1	2	1	2	1	2	1(↓)	10	7(Total)
Internal RCA investigations	4	2	2	1	2	2	6	3	2	3	4	2(↓)		
VTEs (Avoidable)	0	0	1	0	0	0	0	0	0	0	1	0	1	3 (Avoidable)
Falls	6	5	4	2	5	9	12	6	6	10	6	5(↓)	76	100(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	2	0	0	1	2	2	0	0	1	2	0(↓)	10	7(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	1(Avoidable)
Complaints	4	5	1	5	7	6	7	3	3	7	3	6(↑)	57	132(Total)
PALS	13	38	39	65	95	76	95	63	62	41	35	52(↑)		
Compliments	3	11	9	9	6	15	4	12	6	5	5	4(↓)		
FFT Score %	NA	NA	97.9	98.7	92.9	95.3	95.3	93	95.1	90.5	89.8	94.8(↑)		
FFT Response %	NA	NA	41	52	23	12	65.5	47.3	36.5	32	24	25(↑)		
Duty of Candour	17	20	15	10	8	10	10	12	11	14	14	12(↓)		
Litigation	0	0	0	0	0	0	0	0	0	0	0	0		
Coroners	0	0	0	1	0	0	0	0	0	0	0	0		
WHO %	100	100	100	100	100	100	100	100	100	100	100	100		
Infections	1	0	0	1	0	0	0	0	0	0	1	0	3	4 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

April 2021 (March 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

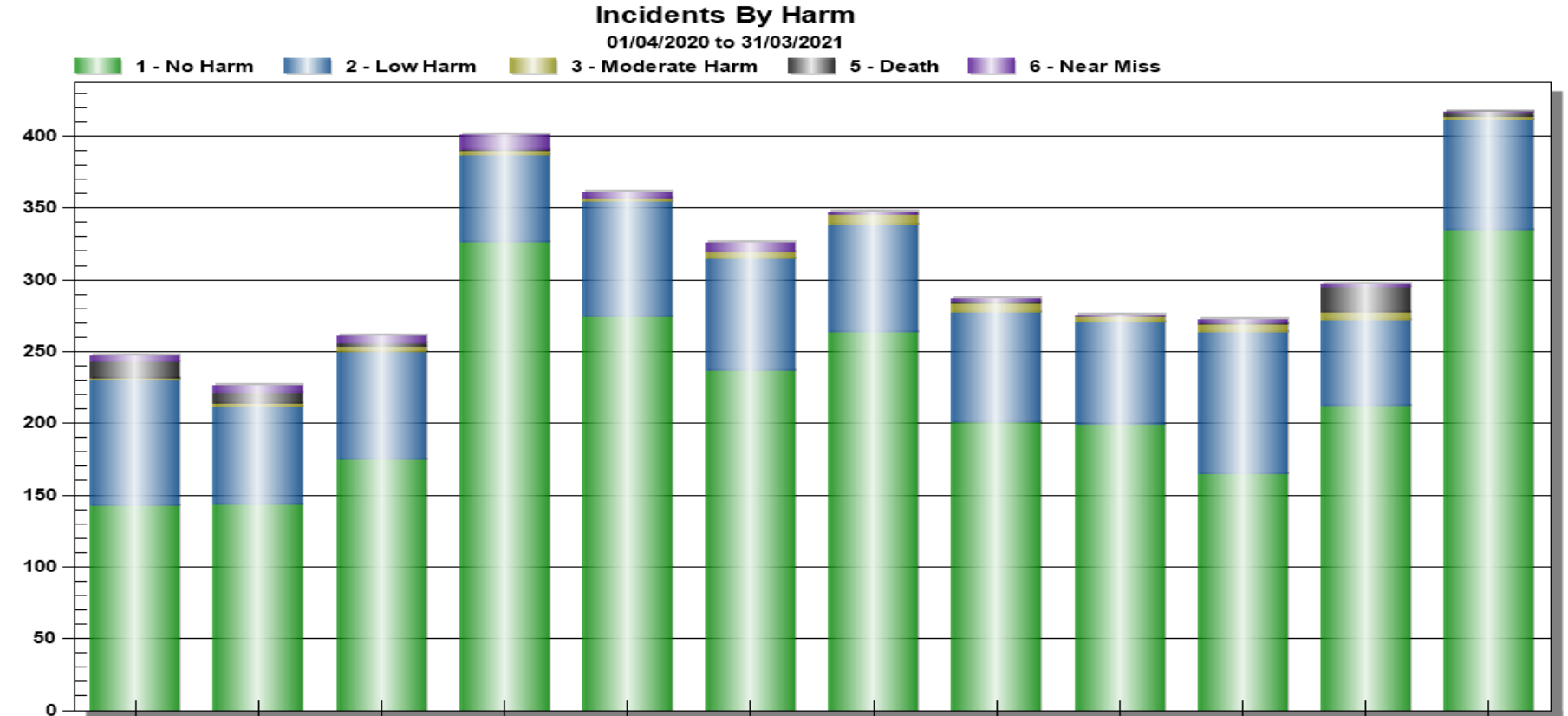
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55641)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
1 - No Harm	142	143	174	326	274	236	263	200	199	164	212	334
2 - Low Harm	88	68	75	60	80	78	75	77	71	99	59	77
3 - Moderate Harm	1	2	4	3	2	5	7	6	4	5	6	2
5 - Death	11	8	2	1	0	0	0	1	0	1	17	3
6 - Near Miss	5	5	6	11	5	7	2	3	1	3	3	1

Data source – Ulysses

INFORMATION

In March 2021, there were a total of 417 Incidents reported on the Ulysses incident management system. 2 out of 3 of the deaths were reported on the Ulysses system as part of a new process to review the deaths occurring within 30 days of patients being discharged from the ROH. All of these deaths occurred out of hospital in the last 12 months and will be reviewed within the learning from deaths process.

The breakdown of those incidents is as follows;

334 – No Harm
76 - Low Harm
2 - Moderate Harms
0 - Severe Harm
1 – Near Miss
3* – Death

Downgraded Incidents

Currently 0 of the reported harm in the Previous Quality report (February 2021) have been downgraded.

Patient Contacts

In March 2021, there were a total of 3364 patient contacts. There were 417 incidents reported, which amounts to 6.4 per cent of the total patient contacts. Of those 417 reported incidents, 82 incidents resulted in harm which is 2.4 per cent of the total patient contact.

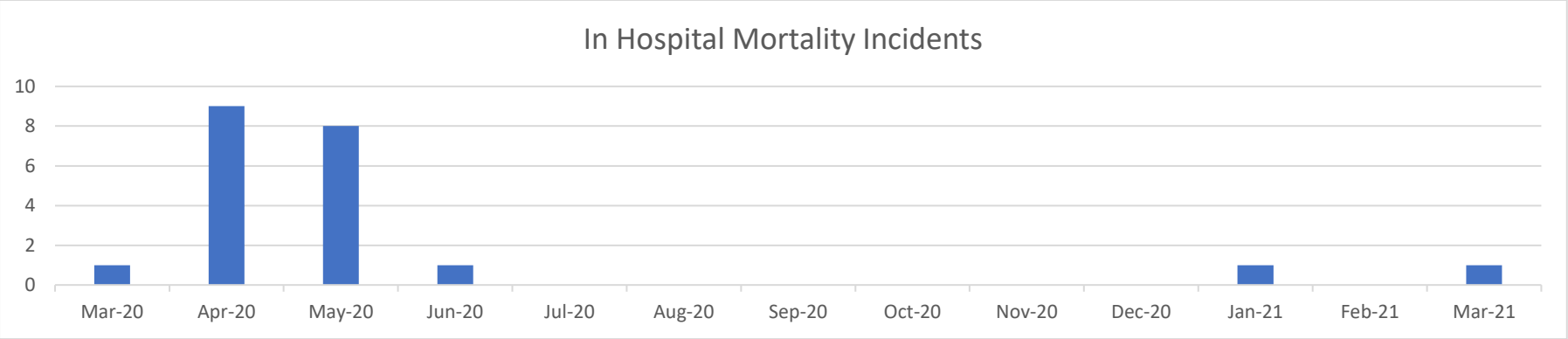
ACTIONS FOR IMPROVEMENTS / LEARNING

Ulysses upgrade has been completed on the Trust incident reporting structure and cause groups. This will improve the reporting on incidents and allow the Governance and the patient Experience team to break down the incidents and PALS concerns by speciality. Breakdowns of these incidents are now to be included in the speciality meetings within the division.

RISKS / ISSUES

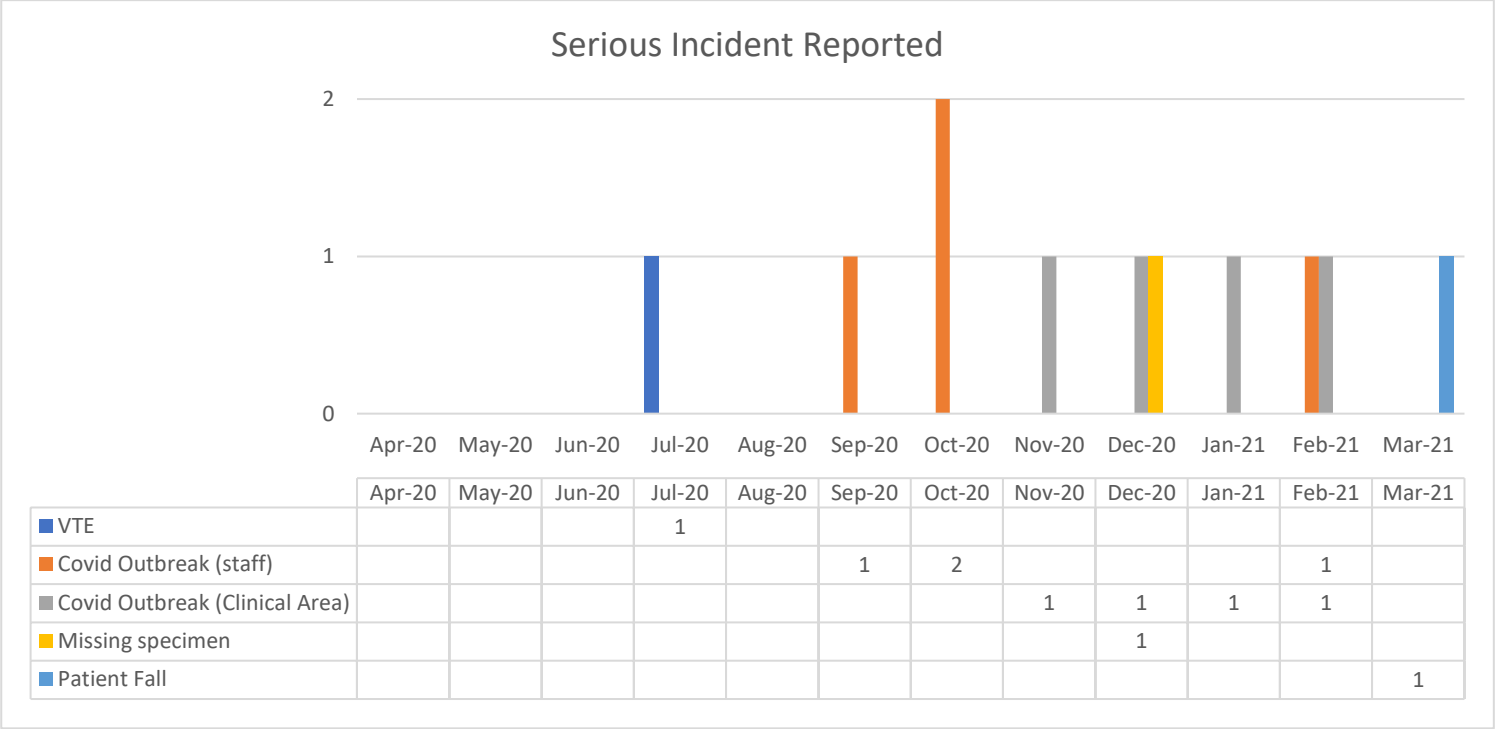
None

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
There was 1 In-hospital death reported in March 2021. The narrative is included on the incident page 9 and 10. 2 of the 3 deaths reported on the Ulysses system as part of a new process to review the deaths occurring within 30 days of patients being discharged from the ROH.
ACTIONS FOR IMPROVEMENTS / LEARNING
A new improved process is in place to review deaths within 30 days of ROH discharge from impatient services. This new process now includes an incident for each reported death. An increase in the reported deaths will be noticed in the next quality report data due to this. All deaths are currently going through the learning from deaths process.
RISKS / ISSUES
The data reported for the deaths occurring within 30 days is not always reliable due to a delay with the national system. This may cause a delay in the learning from deaths process. The Governance team is working with the Trust informatics team to improve the timeliness and accuracy of this data.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



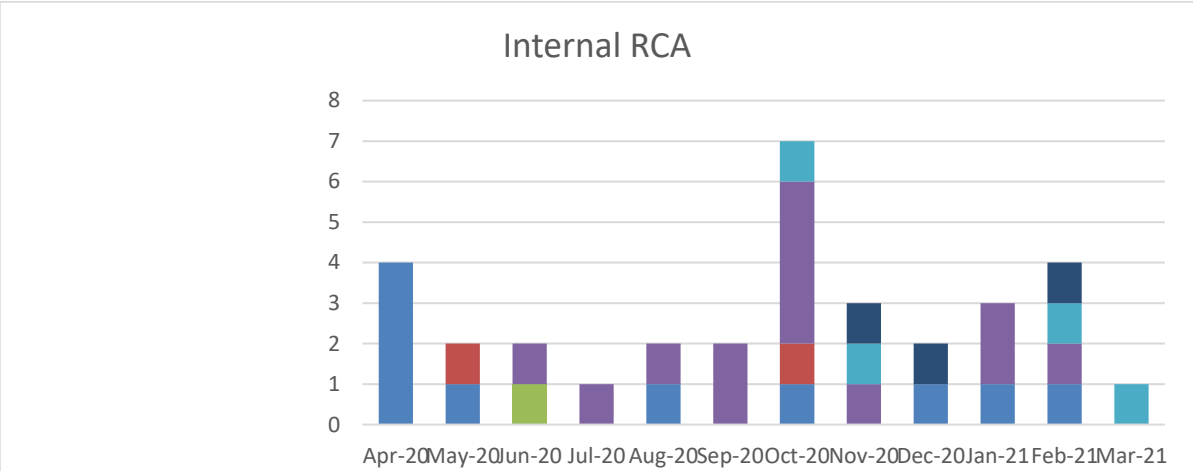
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
VTE				1								
Covid Outbreak (staff)						1	2				1	
Covid Outbreak (Clinical Area)								1	1	1	1	
Missing specimen									1			
Patient Fall												1

Year Totals	
19/20	7
20/21	11

Data Source – STEIS

INFORMATION
There was one Serious incident reported in March 2021. The Trust has submitted incident in relation to the missing specimen for closure to the CCG. The finding will be included within the quality report once closed.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in March 2021.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Falls								1	1		1	
Physio Discharge Process Issue							1	1			1	1
VTE			1	1	1	2	4	1		2	1	
Delay/Failure To Monitor			1									
Clinical Care		1					1					
Infection	4	1			1		1		1	1	1	

Data Source – Internal RCA tracker

INFORMATION

One internal RCA reported in March 2021 is currently underway within the divisions. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.

ACTIONS FOR IMPROVEMENTS / LEARNING

One Internal RCA was closed in March 2021 – two of these were unavoidable VTEs with no learning highlighted.

Background

Computed Tomography (CT) scan performed of the pelvis when the examination requested was an X-ray of the pelvis.
Initial investigation shows that that the patient's identity was not checked with the request form and that ID checks did not follow department or IR(ME)R (Ionising Radiation (Medical Exposure)Regulations) procedures.

Lessons Learnt

- Not following department and IR(ME)R patient identity checks prior to examination taking place
- Lack of adherence to World Health Organisation attendance
- Lack of clear communication between CT radiographer team across different days
- Distraction from picking up phone call, when focus should have been on the patient being scanned

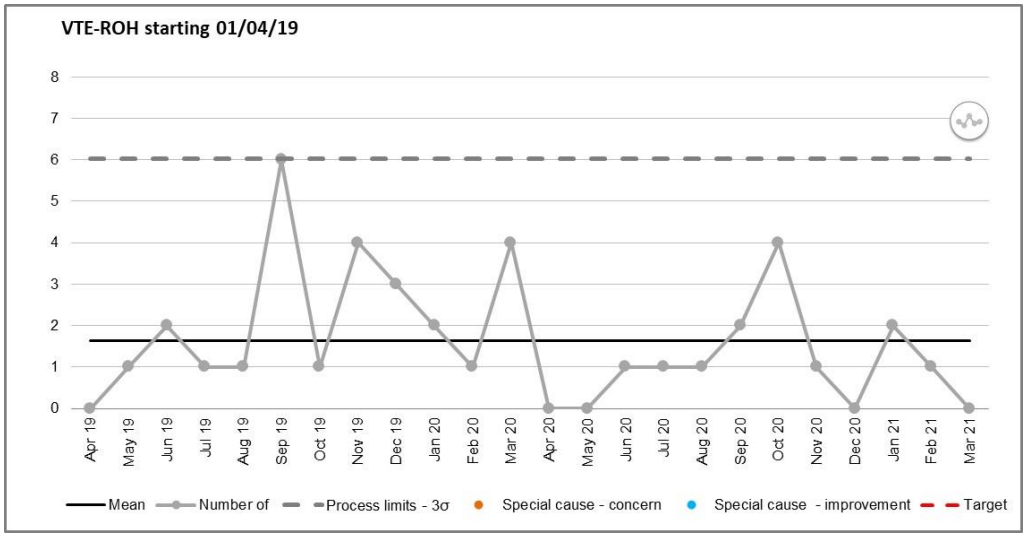
Recommendations

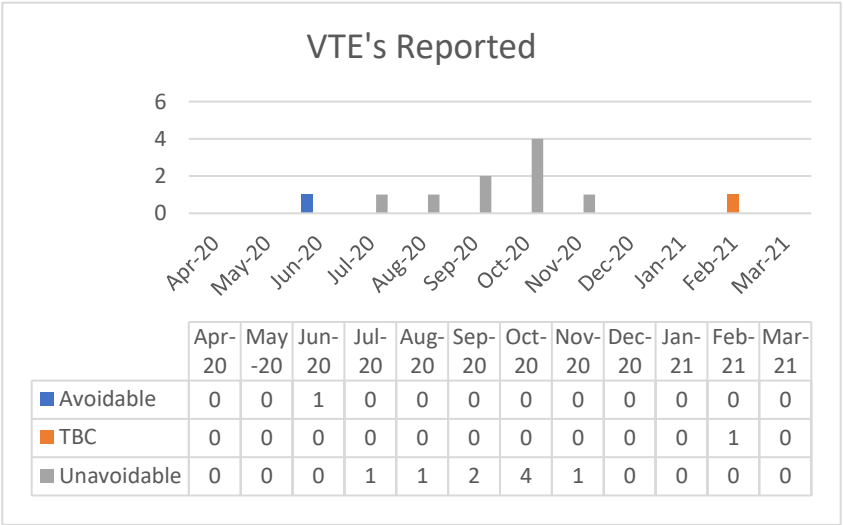
- CT radiographers to be supported by CT Team Leader and to work with support and all competencies reassessed and reviewed.
- Discuss RCA within the Imaging Team Meetings with ALL radiographers
- Support for the member of staff involved clinical supervision, Occupational Health and competency review
- Consider Return to Work touch-base meetings for staff absences other than annual leave.
- Radiographers to be supported within the informal stage of the Trust's competency policy
- Audit additional patients that are scanned during an interventional list
- Make sure that the wellbeing meetings are all up to date and documented
- IDA rotation through CT, to support CT radiographer during diagnostic lists

RISKS / ISSUES

None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Avoidable	0	0	1	0	0	0	0	0	0	0	0	0
TBC	0	0	0	0	0	0	0	0	0	0	1	0
Unavoidable	0	0	0	1	1	2	4	1	0	0	0	0

Avoidable Year Totals		Total including unavoidable
19/20	3	26
20/21	1	13

Data Source – Ulysses and VTE leads

INFORMATION

No ROH associated VTEs were reported in March 2021. The SPC chart on the previous page shows that reporting of VTEs is within the recognised threshold at the ROH.

24-hour reassessment:

4hr review	314
missed 24hr review	198
total	512
24hr %	61.32813

On admission assessment

total possible	593
total assessed	586
%	98.82%

ACTIONS FOR IMPROVEMENTS / LEARNING

Continued poor compliance with mandatory 24-hour re-assessment (see below). This continues to be escalated to and reviewed by the Medical VTE lead (JP) and Junior Dr Supervisors.

Audits are being undertaken by the VTE medical lead to look at:

- the accuracy of the data report provided by Informatics
- The effect of the re-assessment on patient management plan
- Clinical notes to compare what is documented regarding VTE reassessment/plan-this was the methodology used by the CQC at UHB.

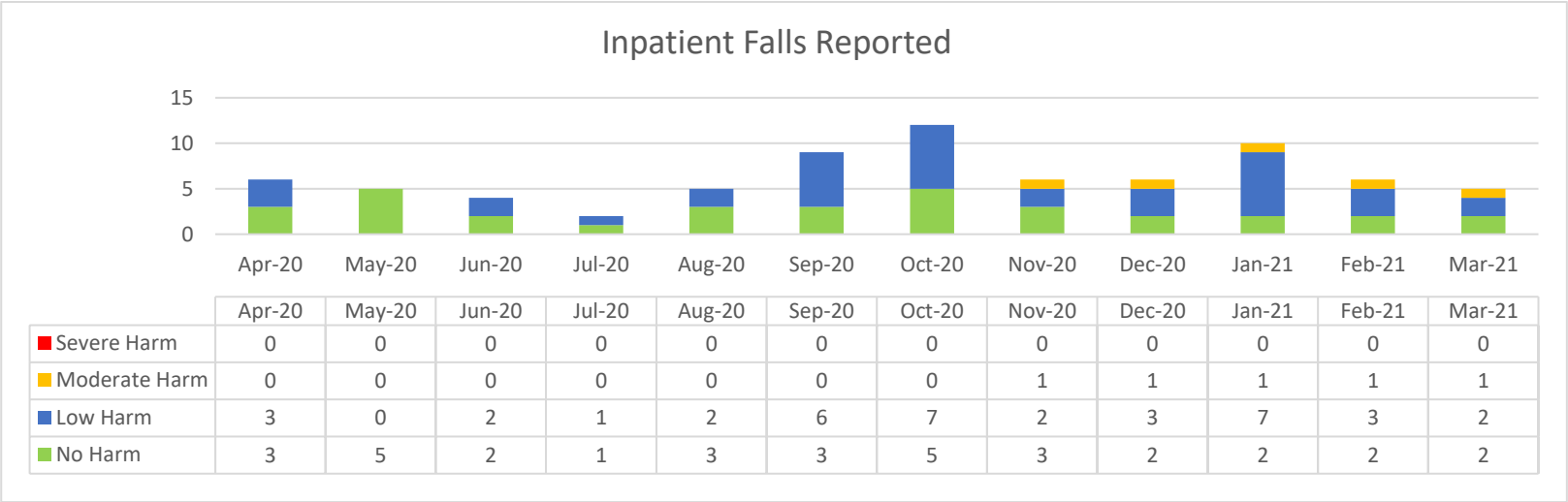
All results are expected to be available next month. This will then be reviewed by the VTE Advisory Group and presented at Clinical Audit and the Quality and Safety Committee. This will provide clarity re whether any changes to PICS and guidance is required/recommended or not.

The Trust Patient Safety Lead is finalising a review of VTE processes and management at ROH against new NICE Quality Standards QS29 .It has been confirmed that ROH VTE Guidance incorporates all requirements. A selection of notes will be audited to provide assurance this is occurring in practice.

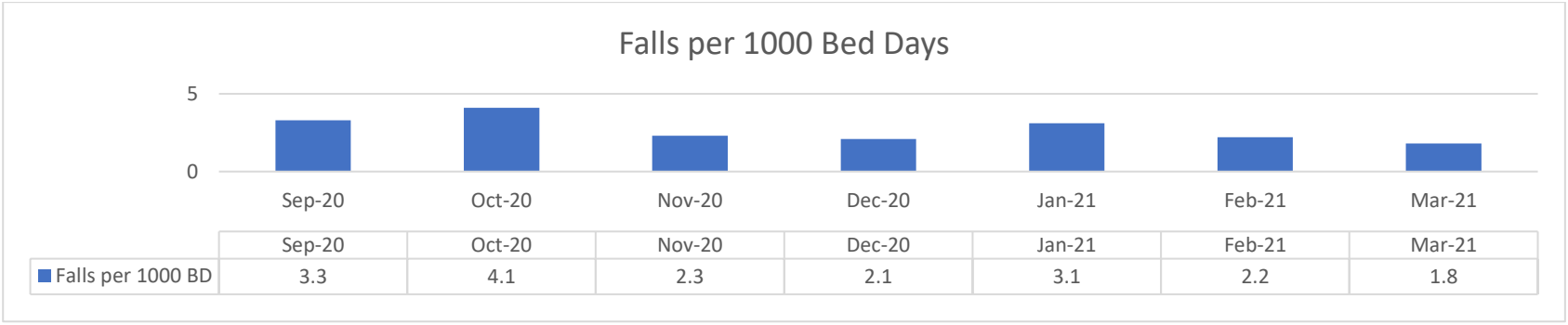
RISKS / ISSUES

Continued poor compliance with mandatory 24-hour re-assessment. This continues to monitored monthly and escalated to Medical Director and Consultants identified as responsible for Junior Doctor supervision. Medical Lead is undertaking a piece of work to look at data in more detail and addressing directly with individuals.

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

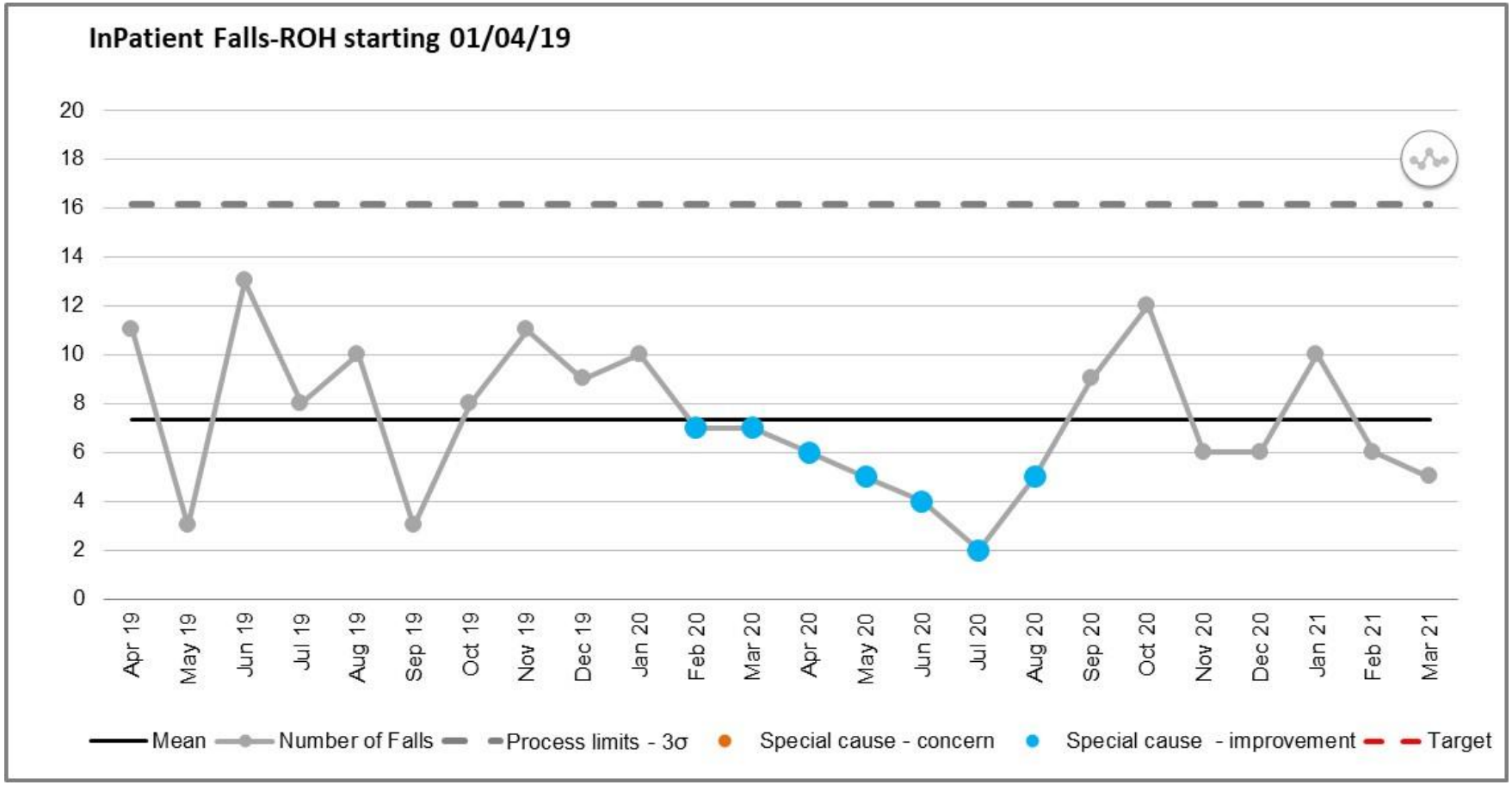


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	1	1	1	1	1
Low Harm	3	0	2	1	2	6	7	2	3	7	3	2
No Harm	3	5	2	1	3	3	5	3	2	2	2	2



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Falls per 1000 BD	3.3	4.1	2.3	2.1	3.1	2.2	1.8

Year Totals	
19/20	100
20/21	76



Data Source – Ulysses and Falls Group

INFORMATION

There were 5 reported inpatients across the Trust in March 2021 relating to Falls.

Further to these falls the following incidents were reported:

2 x Lowered to Floor Incidents
2 x Out-Patient Incidents
3 x ROCS/Patient Home Incidents

ACTIONS FOR IMPROVEMENTS / LEARNING

Areas for Learning:

Two avoidable falls identified on ward 1 highlight the need to ensure agency staff are aware of the correct use of equipment and that they gain an appropriate handover of patients, to ensure that patients are not inappropriately mobilised. This has been disseminated across the ward.

Further potential avoidable fall on ward 4 is awaiting the outcome of an RCA and has been declared as a serious Incident.

Positive Assurance

Review of falls incidents specifically related to ROCS undertaken, given increase in numbers. This shows there is no concern that patients are being inappropriately discharged, instead it reflects the current case mix of patients that are being seen. All of these patients were in poorer physical health, with a lower baseline mobility pre-op, potentially exacerbated by a delay in surgery and therefore predisposing them to falling. This is a theme which appears to be reflected across other hospitals in the region, as more readmissions are being seen into enhanced assessment beds following falls.

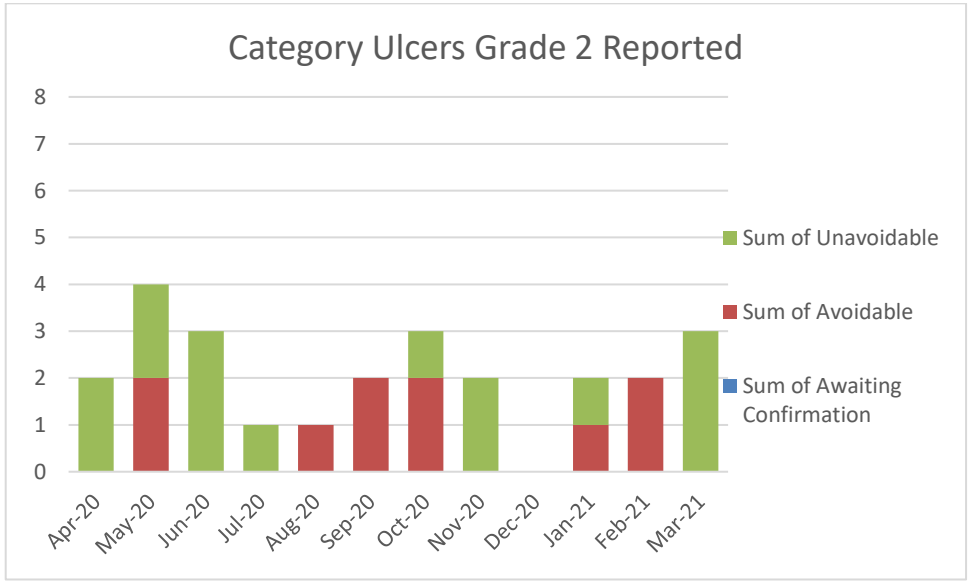
Review of an increase in falls with moderate harm over the last couple of months shows no specific links, again it appears to reflect the increased complexity of surgery currently being undertaken on patients with multiple co-morbidities.

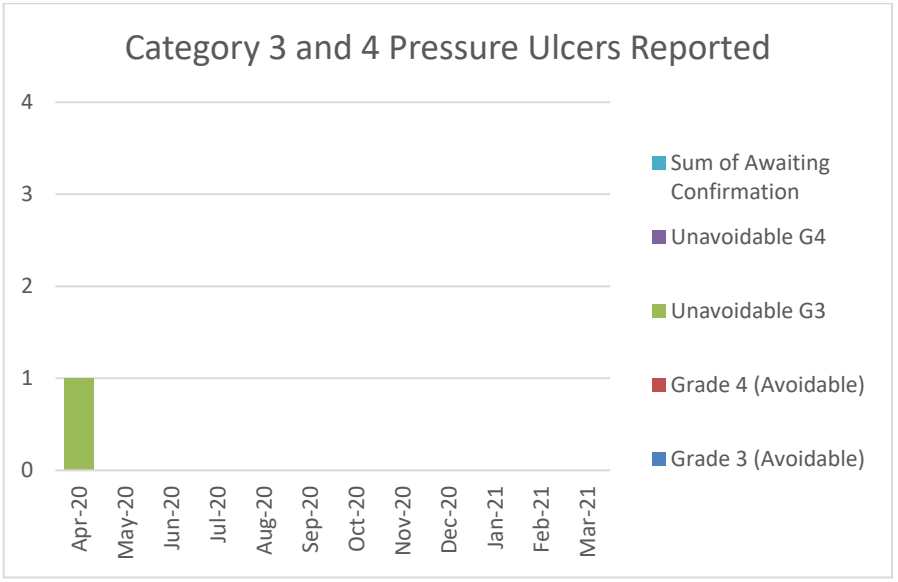
Shared learning around use of bedrails and appropriate supervision of patients will be emphasised at falls awareness sessions on clinical skills days

RISKS / ISSUES

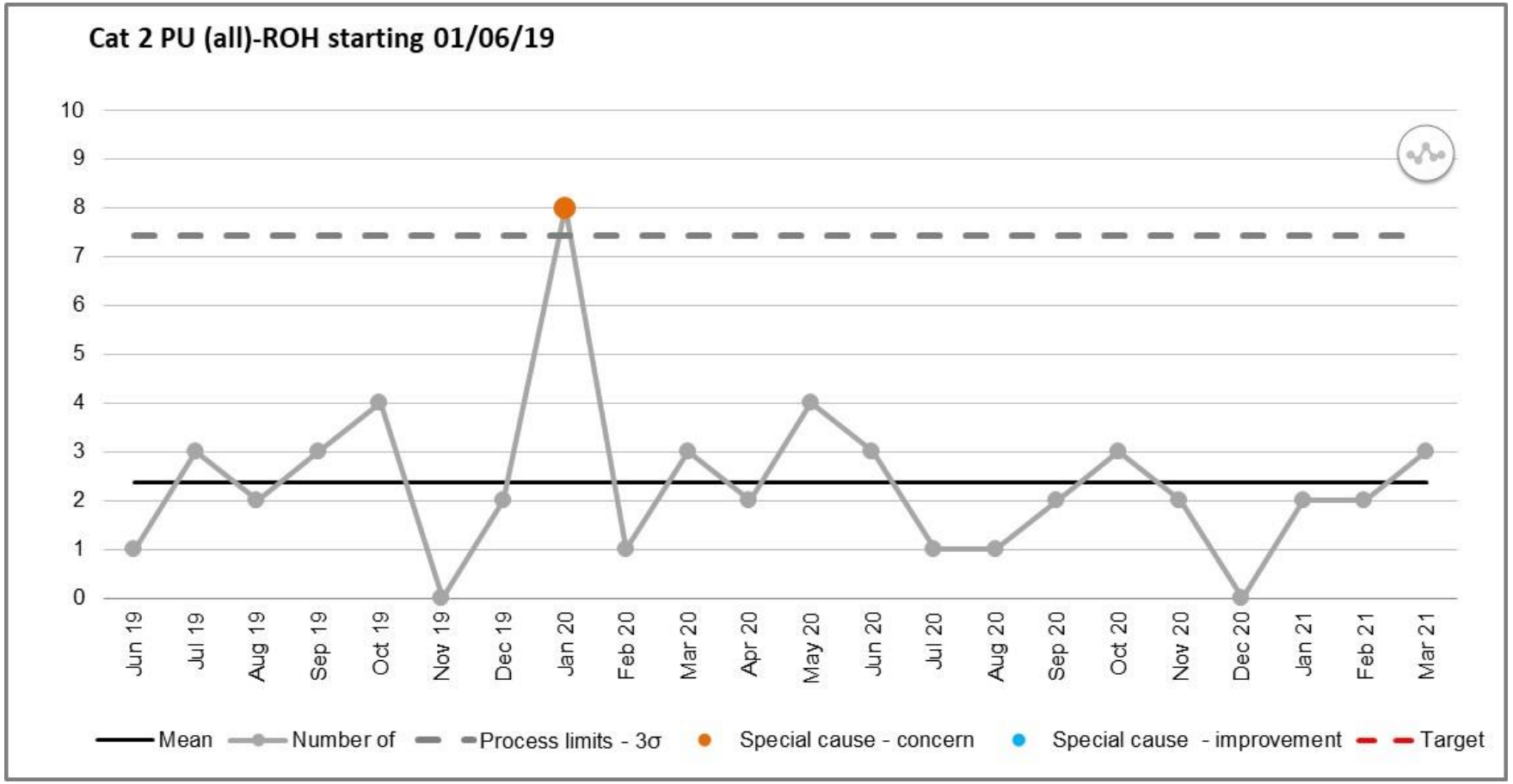
None

7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.





Year Total	Cat 2	Cat 3
19/20	27	3
20/21	25	1



Data Source – Ulysses and TV team

INFORMATION

March 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	2 (including one unavoidable)
Category – 2 (Device)	1 unavoidable
Category – 1	2 – none deteriorated
Suspected Deep Tissue Injury	None
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence x 1 MASD ROH Intertriginous dermatitis x Nil MASD admitted with Incontinence x 4 MASD admitted with Intertriginous dermatitis x 3

Patients admitted with PU's	PU admitted with Cat 1 x 3 None deteriorated PU admitted with Cat 2 x 3 PU admitted with Cat 3 x Nil PU admitted with Cat 4 DTI PU admitted with Cat UNGRADEABLE (at least a Cat 3) x 1 PU admitted with SDTI x Nil

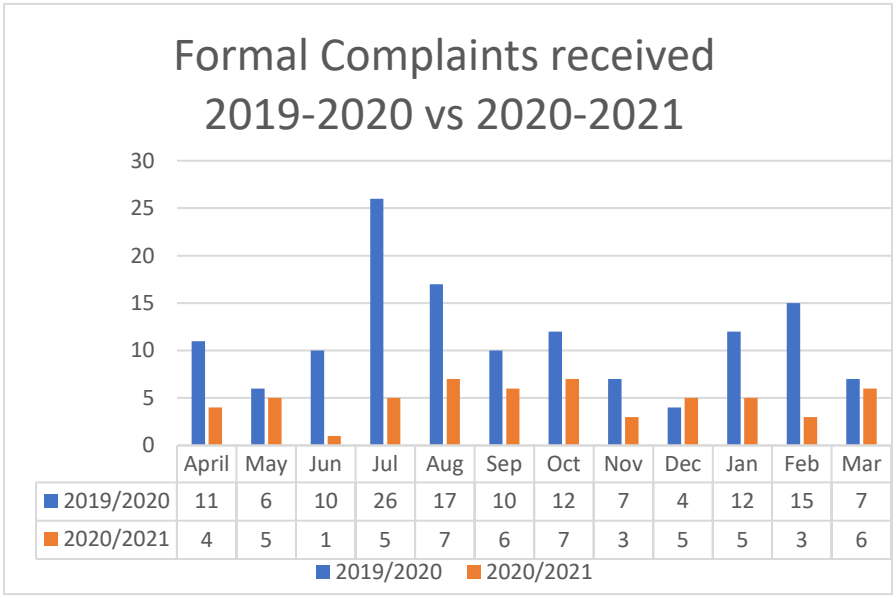
Avoidable only Pressure Ulcer CCG Contracts KPI

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

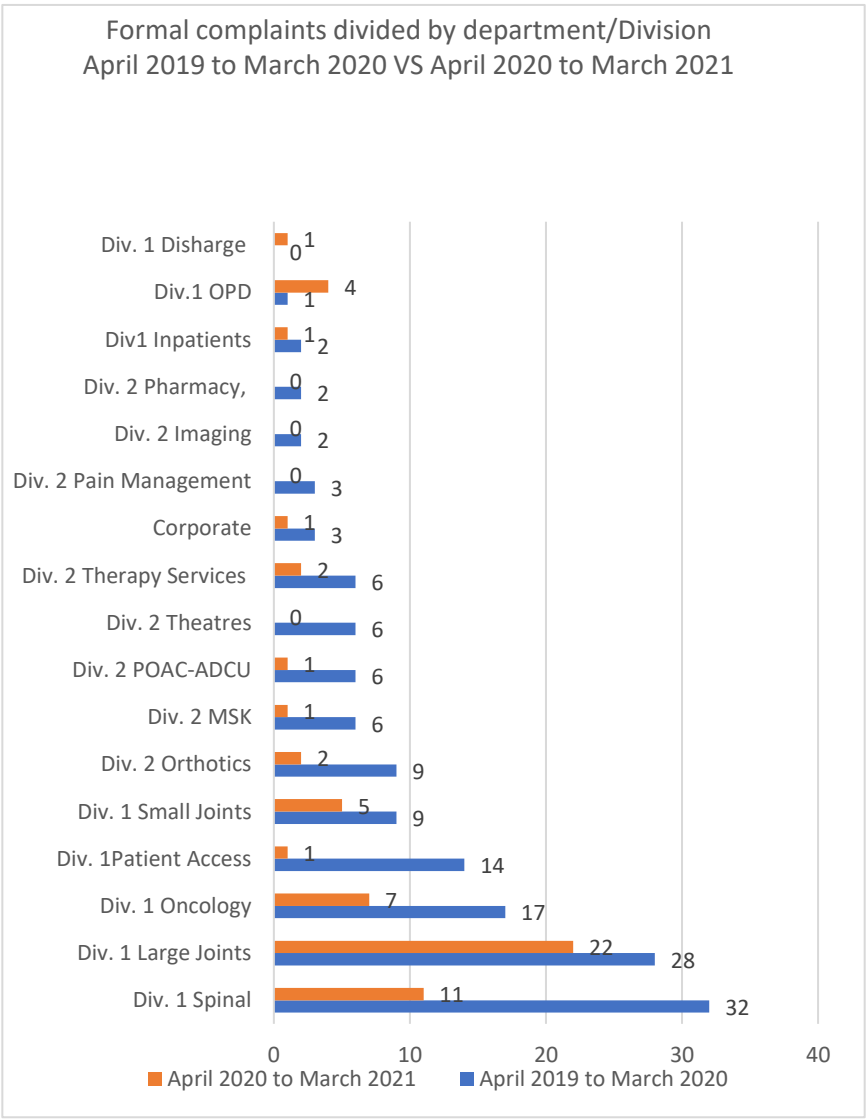
ACTIONS FOR IMPROVEMENTS / LEARNING
Increase in PU incidents from patients transferred to ROH from UHB. TV Lead noted that at ROH, deterioration did not occur. However, longer stay patients were at different risk of developing PU. They reported advice to Ward Managers for dissemination to staff around Pressure Relief and monitoring time patients spend sitting in a bedside chair. CQG group to continue monitoring to ensure the rate of PU returns to normal levels.
RISKS / ISSUES
None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



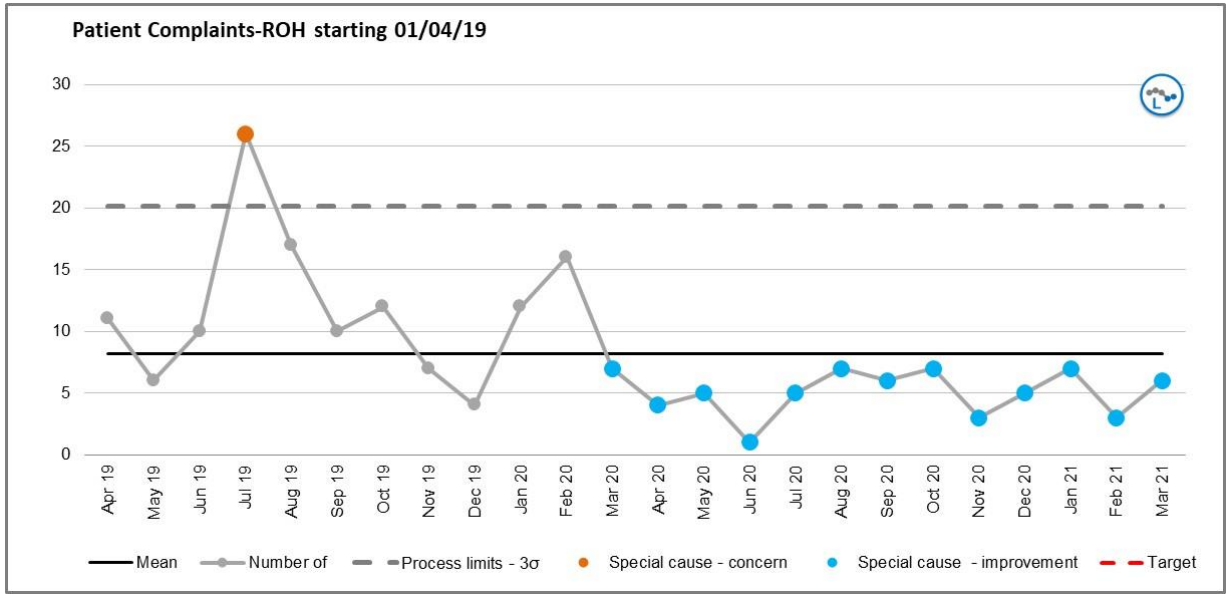
Data Source – Patient Experience team

Complaint Year Totals	
19/20	142
20/21	57



INFORMATION

Complaints

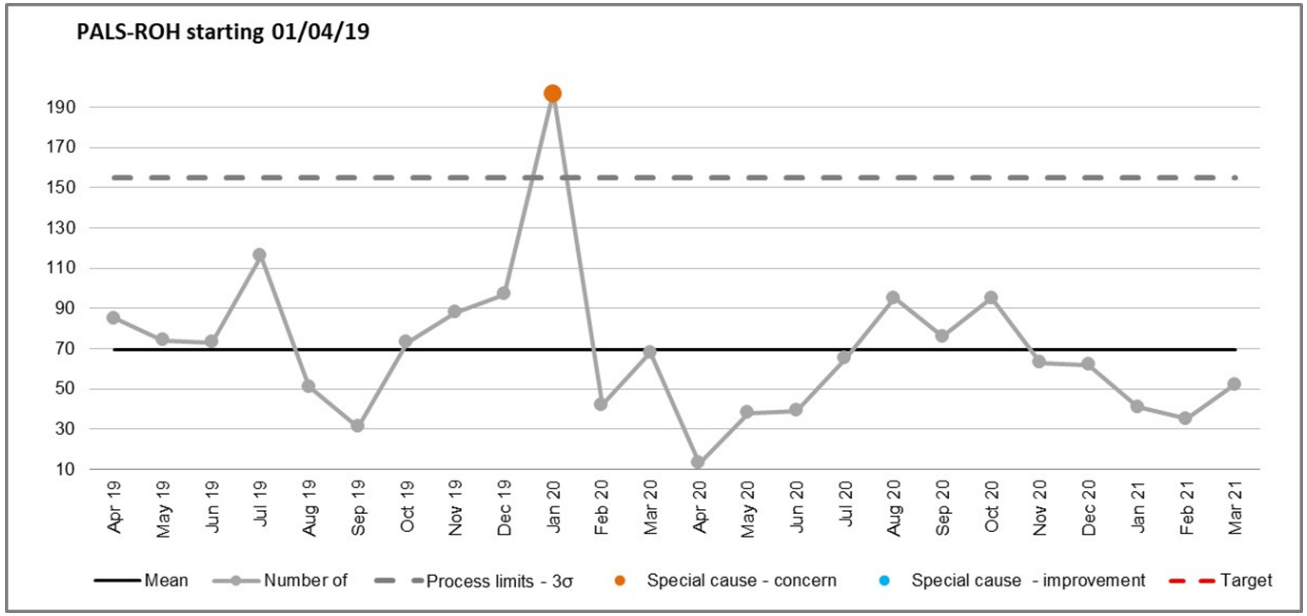


- There were 6 formal complaints acknowledged in March 2021 of which 6 were in relation to Division 1.
- Categories and subcategories of Formal complaints in March 2021 were

Category Type/Category	Count
Cancellation of Surgery	**1**
Surgery Cancellation on Day	1
Clinical Query	**4**
Complications Following Surgery	2
Delay/Failure to Act on Result	1
Dispute Over Diagnosis/Treatment	1
Values & Behaviours	**1**
Attitude of Staff - Medical	1

- In March 2021 – 3 formal complaints were closed within agreed date with patient. This gives an 100% completion on time rate and meet the KPI for the month. The average response to formal complaint was 21.3 days.
- There is currently (6th April 2021) 6 open complaints. 5 that are in relation with Division 1 and 1 in relation to Division 2.

Patient Advice and Liaison service - PALS



- In March 2021 PALS department handled 52 contacts of which 34 were classified as concerns and 18 as enquiries. This is decrease in contacts compared to the same time last year (68 contacts in March 2019 according to Ulysses). The main themes in the PALS data relate to queries about appointments.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In March 2021, 100% of enquires and 100% of concerns were handled within the agreed timescales with patient.

- Top 5 categories and Top 2 subcategories PALS contacts for March 2021

Top 4 Categories and top 2 subcategories for March 2021	
Clinical Query	**11**
Clinical Treatment	3
Injury Sustained During Treatment	2
Appointments	**21**
Appointment Availability	2
Referral - Delay In Authorising	8
Trust Administration	**4**
Unable to Contact Department	3
Communication	**7**
Communication/Info to Patients	4
Communication Failure Between	2
Values & Behaviours	**3**
Attitude of Staff – Medical	3

Patient experience KPI from April 2020 until March 2021

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-20	N/A	100	100
May-20	100	100	100
Jun-20	100	100	100
Jul-20	100	100	100
Aug-20	100	100	100
Sep-20	83.4	93.9	100
Oct-20	100	100	100
Nov-20	100	100	100
Dec-20	100	100	100
Jan-21	100	95.1	100
Feb-21	100	100	100
Mar-21	100	100	100

Compliments

There were 3 compliments recorded on Ulysses in March 2021.

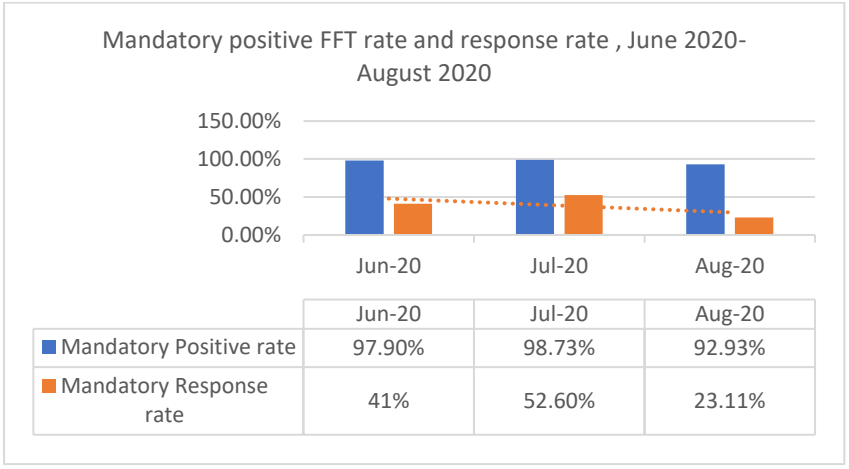
ACTIONS FOR IMPROVEMENTS / LEARNING

- All complaints, PALS concerns, enquiries and compliments from March 2020 have been logged on Ulysses system
- Data for Complaints is pulled from the Complaints trackers for 2019 as the Ulysses system was not fully utilised. From March 2020 the complaints team are adding the full details of Complaints onto the system.
- The Head of Patient Experience has improved the Ulysses system with new and improved categories, departments and Directories and this will be live from April 2021
- The Head of Patient Experience vacancy has been appointed and has commenced their role.
- Business case to improve the staffing for the Public Engagement team was approved by the Executive team. The team will look to consist of 1.0 WTE Head of Patient Experience 2.0 WTE Patient Experience Facilitators, 1.0 WTE Patent Experience Assistant and 1.0 WTE Volunteer Co-ordinator . Recruitment for 2 new post has started and 1.0 WTE Patient Experience Facilitator job role is awaiting ATR approval

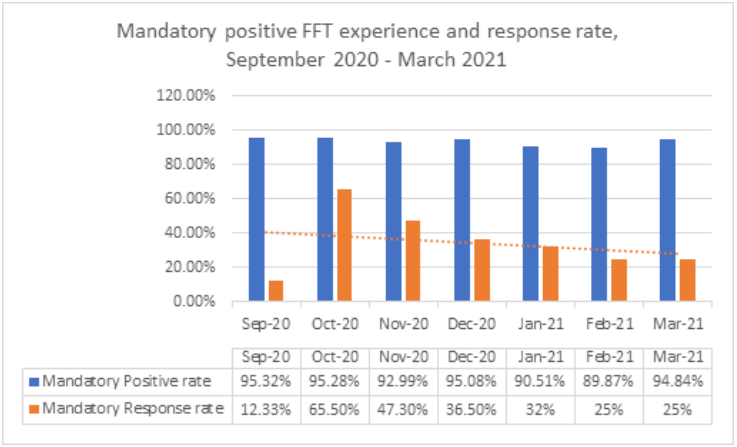
• The Head of Patient Experience has started to implement the Hello my name is campaign and will go live in the May 2021
RISKS / ISSUES
None
COMEBACK COMPLAINTS
There were no Comeback Complaints for March 2021

9. Friends and Family Test Results (collected in the iwantgreatcare system).

FFT Mandatory Reporting

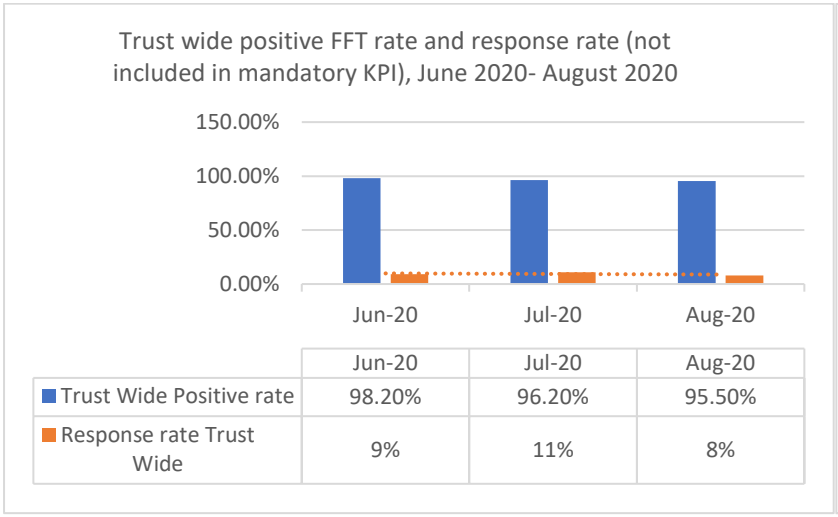


	Jun-20	Jul-20	Aug-20
Mandatory Positive rate	97.90%	98.73%	92.93%
Mandatory Response rate	41%	52.60%	23.11%

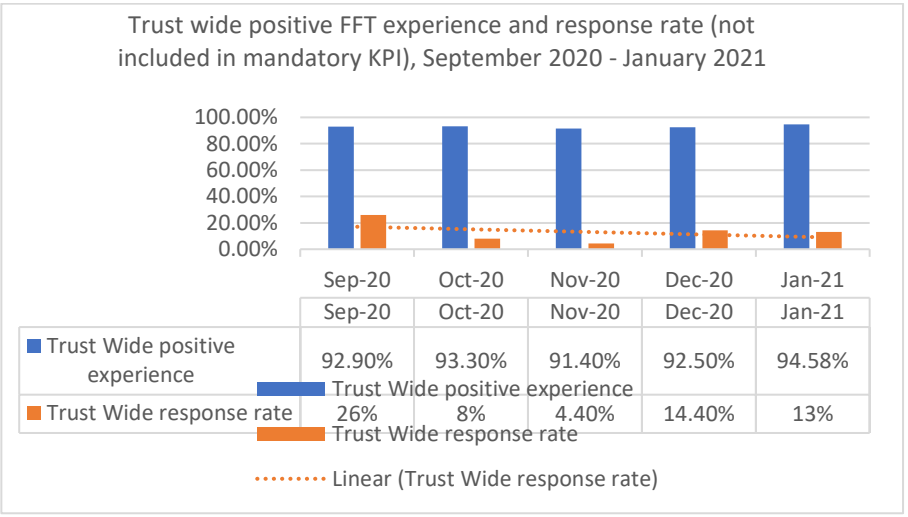


	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Mandatory Positive rate	95.32%	95.28%	92.99%	95.08%	90.51%	89.87%	94.84%
Mandatory Response rate	12.33%	65.50%	47.30%	36.50%	32%	25%	25%

FFT Non Mandatory Reporting

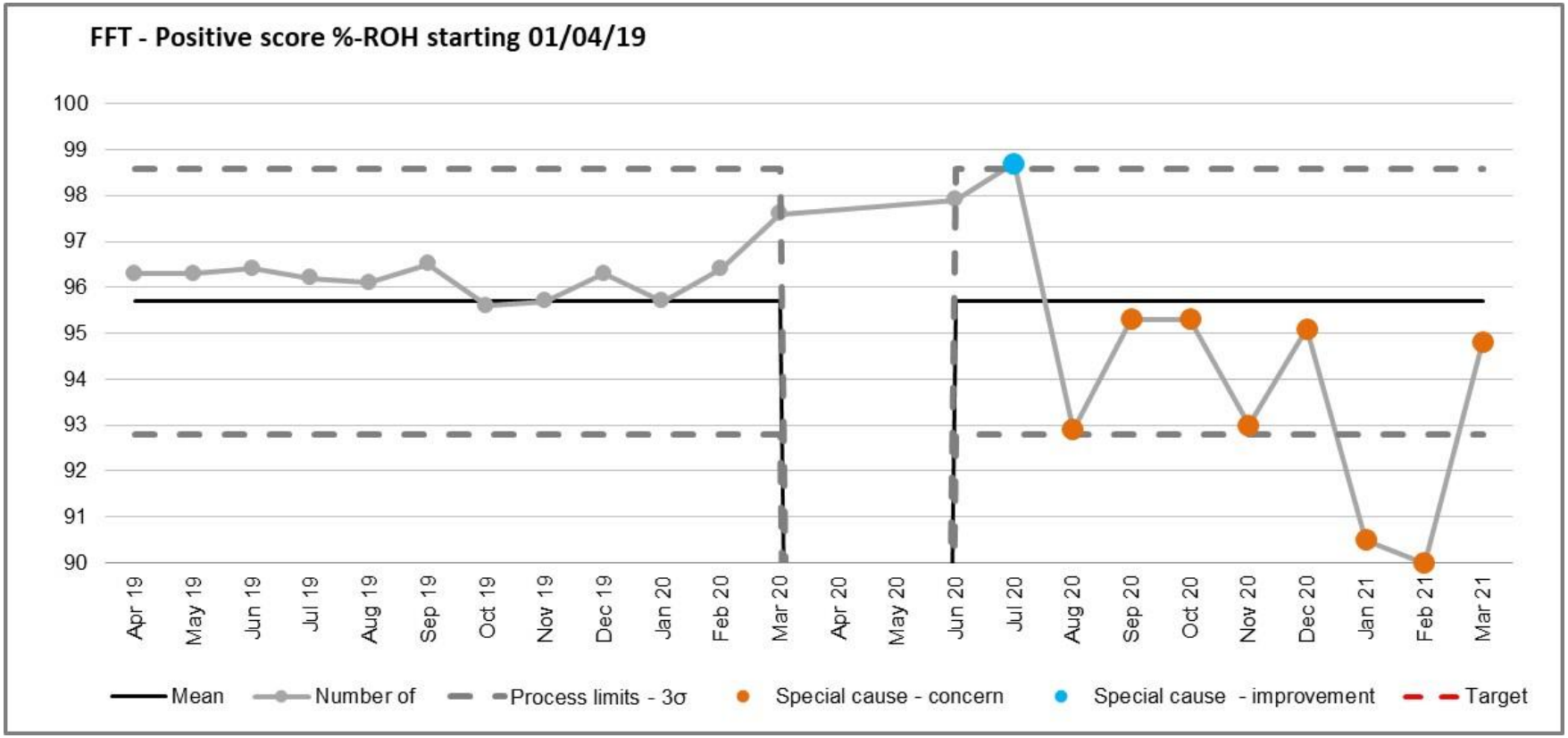


	Jun-20	Jul-20	Aug-20
Trust Wide Positive rate	98.20%	96.20%	95.50%
Response rate Trust Wide	9%	11%	8%



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Trust Wide positive experience	92.90%	93.30%	91.40%	92.50%	94.58%
Trust Wide response rate	26%	8%	4.40%	14.40%	13%

SPC chart showing the positive rate – In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison – April and May 2020 data was not collected due to the Covid 19 Pandemic.



INFORMATION
• There appears to be a disparity between data collection and results published. There is a plan to scale down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. The graphs above have been broken down by mandatory and non-mandatory areas to allow the Trust to focus on the mandatory areas. From February 2021 the Trust will not report on the non-mandatory areas until the data quality issues are resolved.

- In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. Therefore, the graphs above have been separated to allow a more accurate comparison.
- The Trust did not collect FFT during April and May 2020 due to COVID-19 pandemic, The Trust restarted the reporting and collection of FFT in June 2020,
- In February 2021 Trust received a confirmation email from IWGC that data from August 2020 and September 2020 was recovered. These are now included within the report
- Area Managers are receiving any compliments or concerns from patients in spreadsheet via the PALS team. This allows the areas to share with their staff for learning and improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The Public engagement team will look more closely on areas that do not fulfil mandatory 40% target in FFT response (return) rates.
- The Public engagement team reviewing possibility of sending web links for FFT in text messages to patients. This will help improve collection of the data.
- The Public Engagement team is in process of creating a template for compliment so they can be displayed to the public within departments.
- Trust is reviewing contract with the I Want Great Care software supplier
- The Public Engagement team is in process of creating a template for compliment so they can be displayed to the public within departments.

RISKS / ISSUES

- In October 2020 Public Engagement team received an email for IWGC that they have an issue with collecting data and that they did not formulate all FFT forms that have been sent to them during August 2020 nor September 2020.
- Public Engagement team recalled mandatory target data for August 2020 and did not issue mandatory target for September 2020, as IWGC did not find all forms that the ROH sent across, this is not patient identifiable data
- Data Quality issues with FFT data have been highlighted and work is underway with the software company and ROH to rectify. After collecting FFT data in-house for the March 2021 and auditing the FFT forms that were sent to IWGC, there seems again to be a difference in data. Work continues to rectify this issue.

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 12 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

0 new claims against the Trust were received in March 2021

On-going claims

There are currently 25 on-going claims against the Trust.

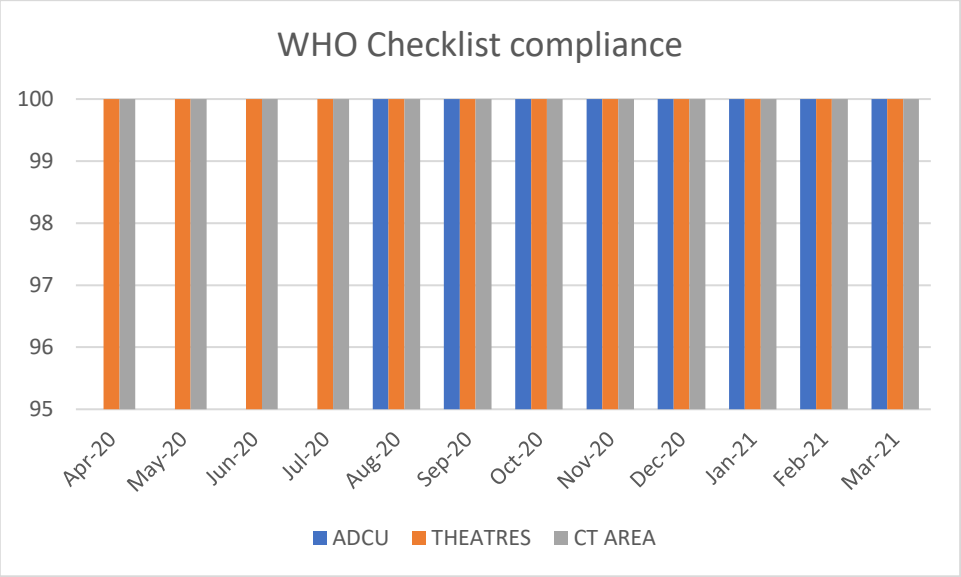
Pre-Application Disclosure

15 new requests for Pre-Application Disclosure of medical records were received in March 2021

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in March 2021

12. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 551

The total WHO compliance for Theatres in March 2021= 100%

CT area

Total cases = 103

The total WHO compliance for CT March 2021 = 100%

ADCU

The total WHO compliance for ADCU in March 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non-compliance will be reported back to the relevant clinical area.

The Theatre man system originally stated 3 incomplete patients on the Theatres lists, upon review all documentation and WHO Checklists for all patients complete and therefore compliant

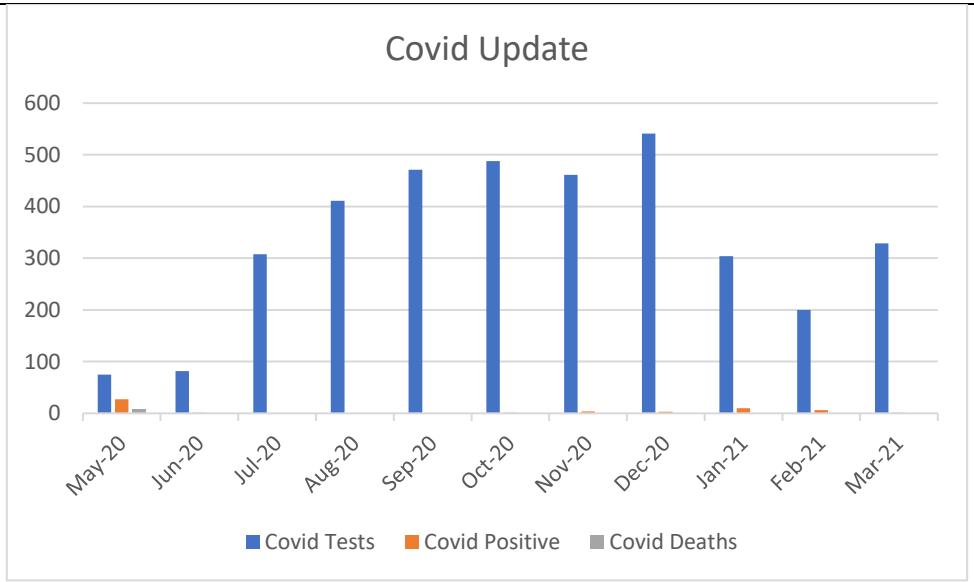
RISKS / ISSUES

None

13. Infection Prevention Control – Statutory requirement/Reportable Infections. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	March 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	1
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



ACTIONS FOR IMPROVEMENTS / LEARNING

1 patient had tested as positive for Covid-19 prior to admission to the ROH

RISKS / ISSUES

None

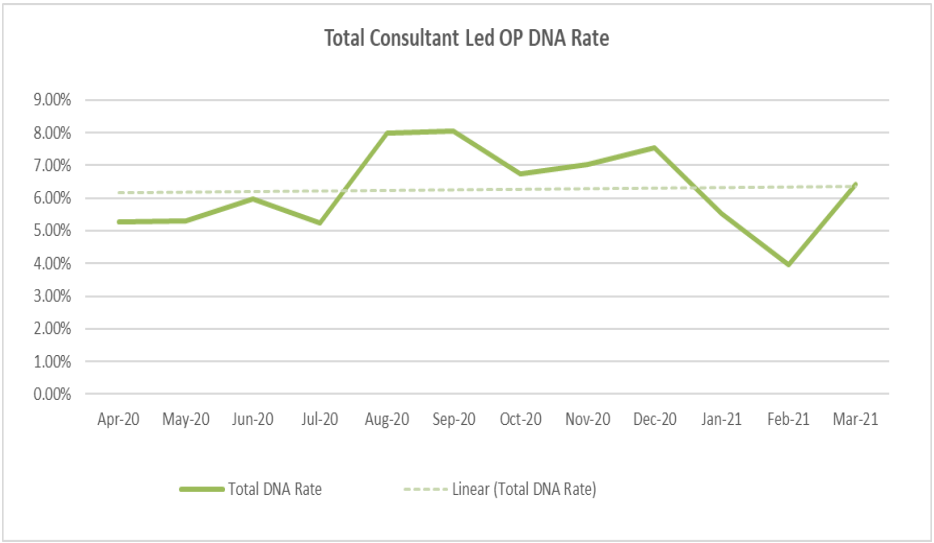
***Data Source – IPC team and Ulysses**

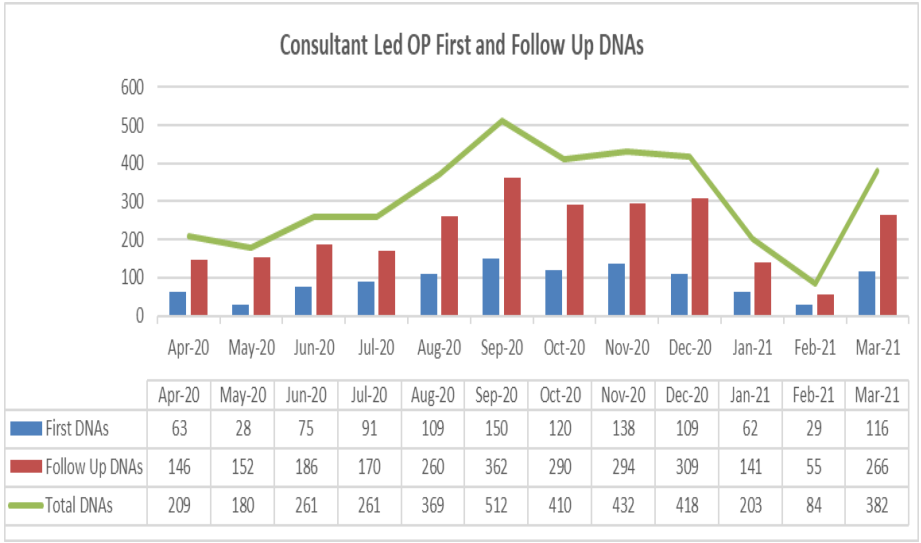
14. Safeguarding

	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
Safeguarding Adult Notifications	11	58	35	14	17	14	22	43	29	32	40	35	40
Safeguarding Children and Young People Notifications	17	3	1	5	4	6	8	22	18	27	19	12	29
Mental Health Incidents	6	3	4	8	17	29	52	51	25	15	7	11	20
LD Adult	5	2	0	3	2	7	3	3	7	5	5	3	10
LD Children	28	0	0	4	13	10	18	41	65	46	13	24	75
Adult Level 2	99.53	99.34%	99.23%	98.60%	98.32%	99.14%	99.14%	98.20%	98.2%	97.48%	98.12	98.33%	98.45%
Adult Level 3	71.86	68.69%	69.19%	75.25%	78.03%	81.78%	81.78%	85.24%	85%	85.75%	84.77	84.63	86.04%
Level 4	80.00	80.00%	75.00%	75.00%	75.0%	50.0%	50%	75.0$%	80%	80%	100	100%	100%
Child Level 2	99.34	99.15%	99.04%	98.31%	98.04%	98.95%	98.95%	97.99%	97.92%	97.30%	97.93	98.24%	98.27%
Child Level 3	74.88	71.88%	71.86%	77.48%	78.90%	82.75%	81.78%	86.46%	86.45%	86.71%	85.51	85.34%	86.56%
Mental Capacity Act MCA	100	99.44%	99.23%	97.95%	97.57%	97.90%	97.9%	96.59%	95.41%	93.93%	97.51	92.79%	95.65%
Deprivation of Liberty Safeguards DoLs	100	99.62%	99.60%	98.26%	97.87%	98.03%	98.03%	96.70%	95.27%	93.76%	97.44	95.68%	95.91%
Prevent WRAP	95.33	88.56%	87.66%	84.47%	86.63%	88.89%	88.89%	84.59%	85.96%	86.88%	83.68%	82.65%	84.14%
CE	0	0	0	0	0	0	0	1	0	0	0	0	0
FGM	0	0	0	0	1	0	0	0	0	1	0	0	2
DOLS	2	34	12	3	4	1	3	13	5	6	20	21	6
MCA	0	1	0	0	0	3	1	1	1	1	3	0	0

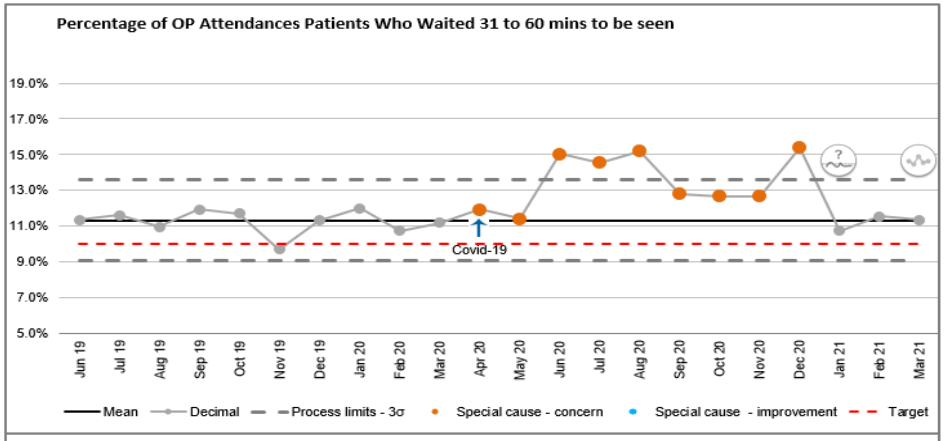
PIPOT cases	0	0	0	0	0	0	1	0	0	1		0	1
Domestic Abuse	3	4	1	2	2	0	2	3	4	3	1	2	3
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0
WNB	9	2	2	1	1	3	4	4	1	3	6	3	11
Child in Care	0	0	0	1	0	0	0	5	4	1	2	1	1
Early Help	0	0	0	0	0	0	0	6	2	0	1	4	4
DHR- scoping Reviews	1	0	1	1	0	0	2	0	0	2	0	0	0
SARs- scoping review **Or Rapid Reviews**	0	0	0	1	0	0	0	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0	1	0	0	0	0	0	0
Incidents	7	33	21	7	6	4	6	13	10	8	24	27	27
Open Cases					10	7	1	8	5	18	2	3	11
Closed Cases					10	8	29	57	42	41		44	58

15. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients

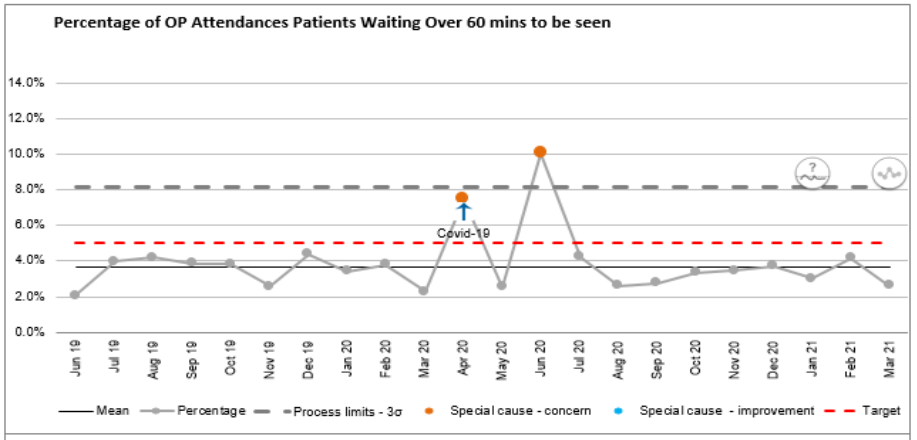


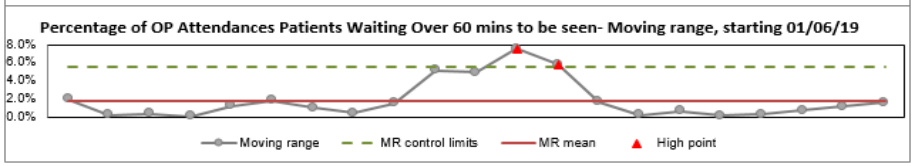


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
First DNAs	63	28	75	91	109	150	120	138	109	62	29	116
Follow Up DNAs	146	152	186	170	260	362	290	294	309	141	55	266
Total DNAs	209	180	261	261	369	512	410	432	418	203	84	382









INFORMATION

30 minute delays – Reduced in March to 11.3% compared to 11.5% in February. Trust Target is 10% -
60 minute delays – March 2.6% of patients were delayed compared to compared to 4.1% in February. Target is 5% therefore achieved

The position in March is an improvement compared to recent months however there is further work to be undertaken with Oncology clinic delays and patients waiting for imaging procedures.

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure our patients are seen on time for their appointments. This new escalation process has been working well in conjunction with the daily huddle which takes place at 14:30 in the outpatients department.

An audit of all delays in March to analyse any key issues and scope solutions is in progress and results will be reported next month.

ACTIONS FOR IMPROVEMENTS / LEARNING

The DNA rates for March are **6.42%** compared to **3.97%** in February and continues to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department.
An analysis of the increased DNA rate will take place in April to understand any themes and address as required .
Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

RISKS / ISSUES

Lack of space in outpatients continues to be a concern and currently solutions are being scoped. One of the options being explored is the use of an alternative location for virtual clinics and extending the working day further in OPS To meet capacity requirements .

16. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories

Referral to Treatment snapshot as at 31st March 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

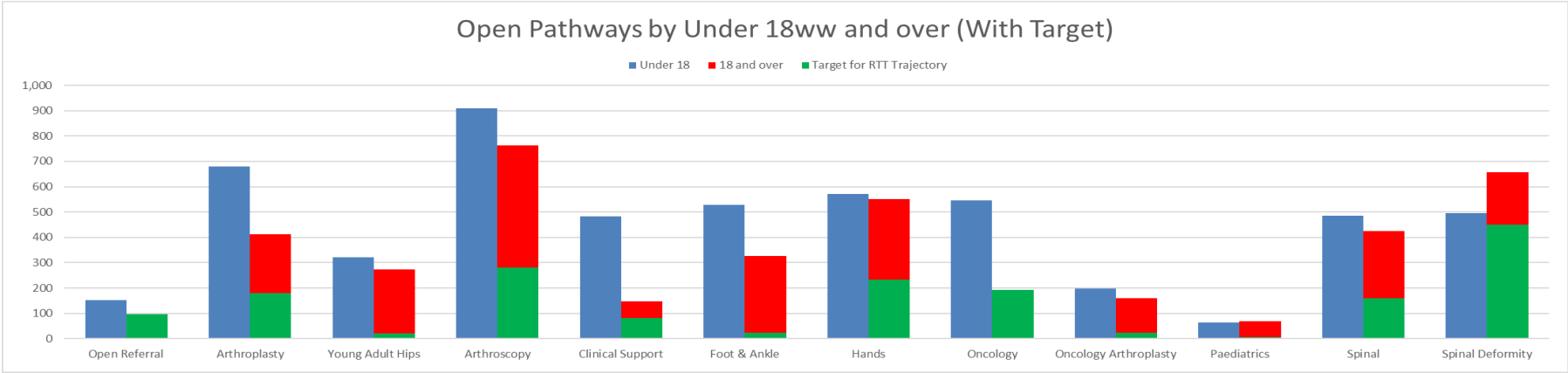
Est Over 18 Clock Stops Required		
To achieve	81.47%	3055
To achieve	71.13%	1939
To achieve	81.74%	3080

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,533**	100	290	135	441	239	232	229	316	127	19	214	191
7-13	**1,637**	32	230	99	255	136	163	182	165	30	27	144	174
14-17	**1,264**	20	160	88	213	107	133	159	66	41	19	128	130
18-26	**2,120**	2	237	162	415	125	200	321	68	91	31	190	278
27-39	**1,367**	0	148	99	243	19	115	186	28	61	26	161	281
40-47	**210**	0	19	7	50	2	6	28	1	6	10	31	50
48-51	**53**	0	3	1	11	0	2	1	4	0	2	13	16
52 weeks and over	**142**	0	5	5	45	1	3	14	3	1	1	31	33
Total	**9,326**	154	1,092	596	1,673	629	854	1,120	651	357	135	912	1,153

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,434**	152	680	322	909	482	528	570	547	198	65	486	495
18 and over	**3,892**	2	412	274	764	147	326	550	104	159	70	426	658
Target for RTT Trajectory	**1727**	96	181	21	281	81	23	232	194	24	5	159	449
Target for RTT 92%	**746**	**12**	**87**	**47**	**133**	**50**	**68**	**89**	**52**	**28**	**10**	**72**	**92**

Month End RTT %	**58.27%**	**98.70%**	**62.27%**	**54.03%**	**54.33%**	**76.63%**	**61.83%**	**50.89%**	**84.02%**	**55.46%**	**48.15%**	**53.29%**	**42.93%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	2,165	-94	231	253	483	66	303	318	-90	135	65	267	209
Variance from target 92%	3,146	-10	325	227	631	97	258	461	52	131	60	354	566



ROHTB (5/21) 014

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Referral to Treatment Snapshot as at 31st March 2021 – Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

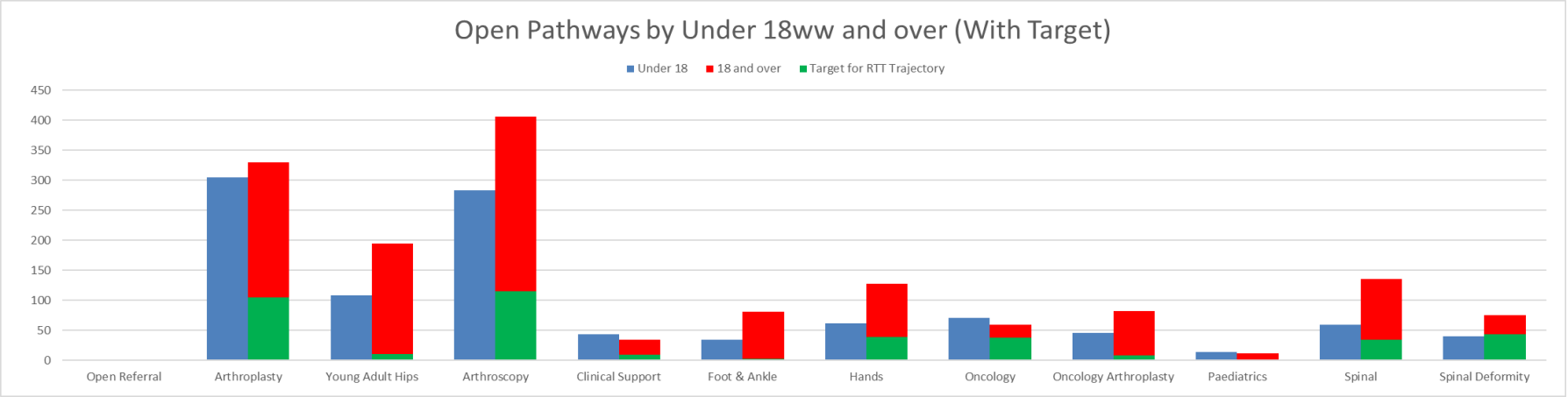
Est Over 18 Clock Stops Required		
To achieve	81.47%	1488
To achieve	71.13%	1269
To achieve	81.74%	1493

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**453**	0	108	43	137	23	14	24	50	21	3	20	10
7-13	**275**	0	90	26	64	10	6	16	16	9	6	16	16
14-17	**340**	0	107	39	82	11	15	22	5	16	5	24	14
18-26	**739**	0	184	111	188	21	43	61	28	39	2	42	20
27-39	**580**	0	124	75	137	13	31	50	23	37	8	53	29
40-47	**93**	0	15	4	38	0	2	9	1	5	1	10	8
48-51	**25**	0	2	1	8	0	2	0	4	0	1	7	0
52 weeks and over	**100**	0	5	4	35	0	3	8	3	1	0	23	18
Total	**2,605**	0	635	303	689	78	116	190	130	128	26	195	115

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,068**	0	305	108	283	44	35	62	71	46	14	60	40
18 and over	**1,537**	0	330	195	406	34	81	128	59	82	12	135	75
Target for RTT Trajectory	**482**	0	105	11	115	10	3	39	38	8	1	34	44
Target for RTT 92%	**208**	**0**	**50**	**24**	**55**	**6**	**9**	**15**	**10**	**10**	**2**	**15**	**9**

Month End RTT %	**41.00%**	**n/a**	**48.03%**	**35.64%**	**41.07%**	**56.41%**	**30.17%**	**32.63%**	**54.62%**	**35.94%**	**53.85%**	**30.77%**	**34.78%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,055	0	225	184	291	24	78	89	21	74	11	101	31
Variance from target 92%	1,329	0	280	171	351	28	72	113	49	72	10	120	66



Referral to Treatment Snapshot as 31st March 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

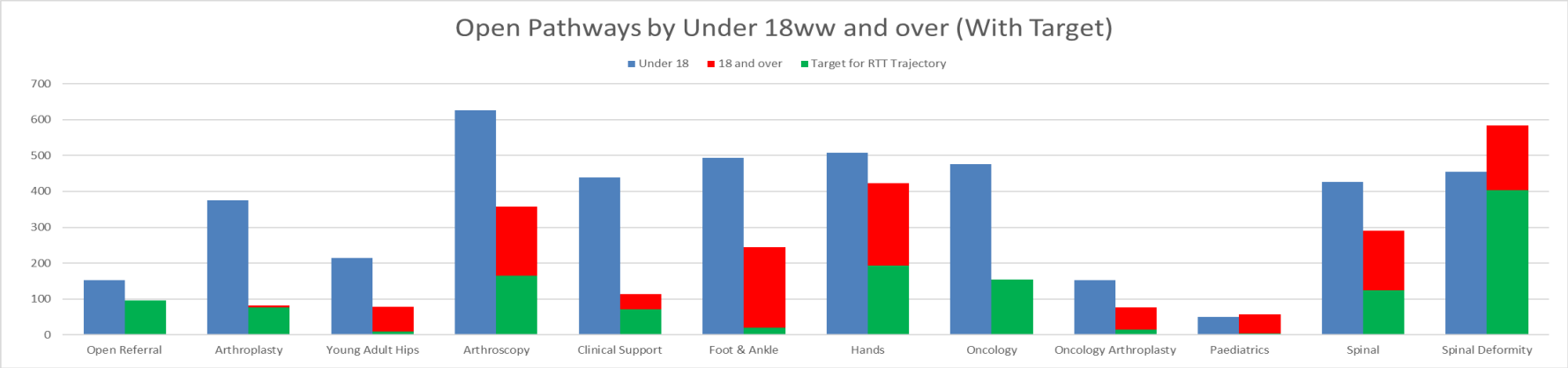
Est Over 18 Clock Stops Required		
To achieve	81.47%	1566
To achieve	71.13%	670
To achieve	81.74%	1587

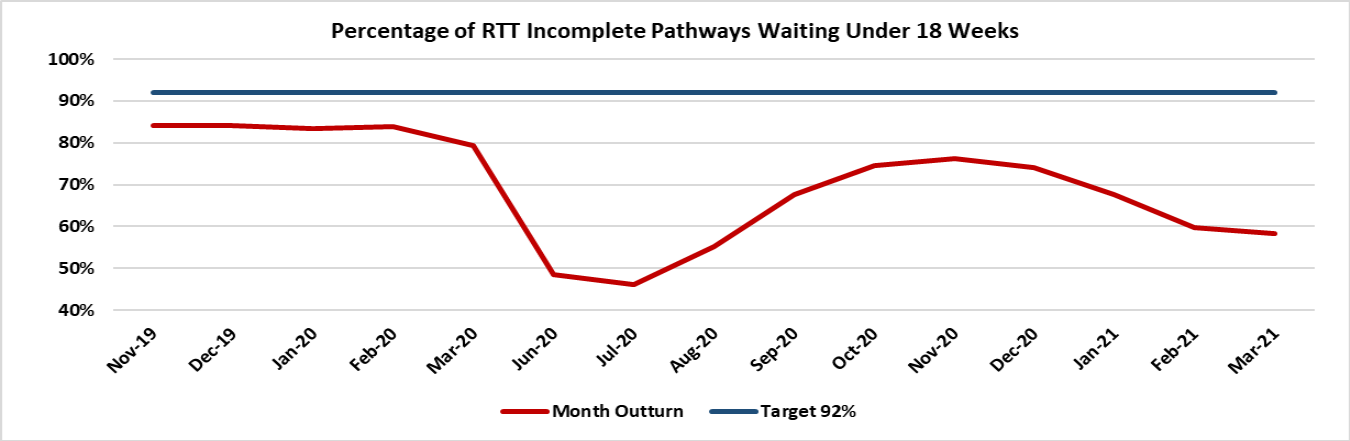
Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,080**	100	182	92	304	216	218	205	266	106	16	194	181
7-13	**1,362**	32	140	73	191	126	157	166	149	21	21	128	158
14-17	**924**	20	53	49	131	96	118	137	61	25	14	104	116
18-26	**1,381**	2	53	51	227	104	157	260	40	52	29	148	258
27-39	**787**	0	24	24	106	6	84	136	5	24	18	108	252
40-47	**117**	0	4	3	12	2	4	19	0	1	9	21	42
48-51	**28**	0	1	0	3	0	0	1	0	0	1	6	16
52 weeks and over	**42**	0	0	1	10	1	0	6	0	0	1	8	15
Total	**6,721**	154	457	293	984	551	738	930	521	229	109	717	1,038

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,366**	152	375	214	626	438	493	508	476	152	51	426	455
18 and over	**2,355**	2	82	79	358	113	245	422	45	77	58	291	583
Target for RTT Trajectory	**1245**	96	76	10	165	71	20	193	155	15	4	125	404
Target for RTT 92%	**537**	**12**	**36**	**23**	**78**	**44**	**59**	**74**	**41**	**18**	**8**	**57**	**83**

Month End RTT %	**64.96%**	**98.70%**	**82.06%**	**73.04%**	**63.62%**	**79.49%**	**66.80%**	**54.62%**	**91.36%**	**66.38%**	**46.79%**	**59.41%**	**43.83%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,110	-94	6	69	193	42	225	229	-110	62	54	166	179
Variance from target 92%	1,818	-10	46	56	280	69	186	348	4	59	50	234	500





The Referral To Treatment (RTT) position for March is 58.27% against the National compliance target of 92%. This is a slight decrease compared to February reporting at 59.72% and is reflective of the cessation of elective procedures in order to undertake core critical services. There are 142 patients over 52 weeks. There are 100 admitted patients, P2 and P3 patients are being booked onto theatre lists and 42 non admitted patients with face to face clinics or diagnostic investigations now planned.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. 263 patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

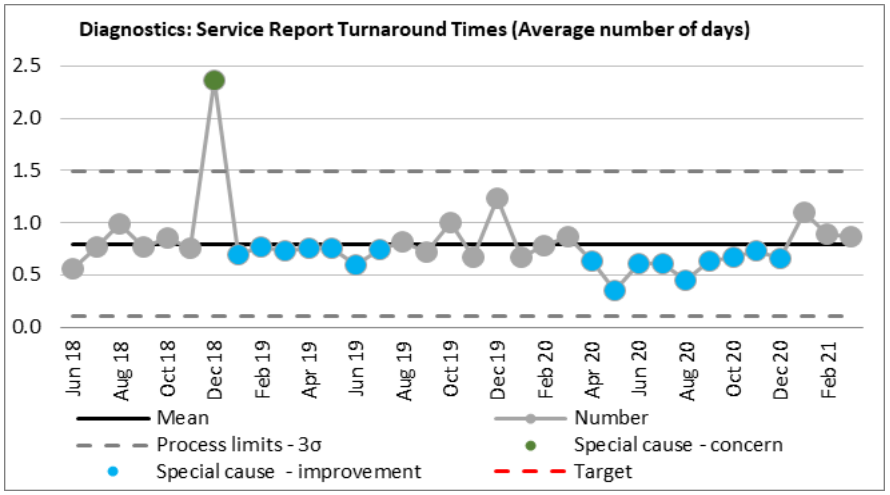
In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2605 patients are on the admitted waiting list (P1 – 7, P2 – 249 patients, P3 – 806 patients, P4 – 1540 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the harm prevention framework is standardised across all specialties to provide assurance that all patients are reviewed on a regular basis. At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority.

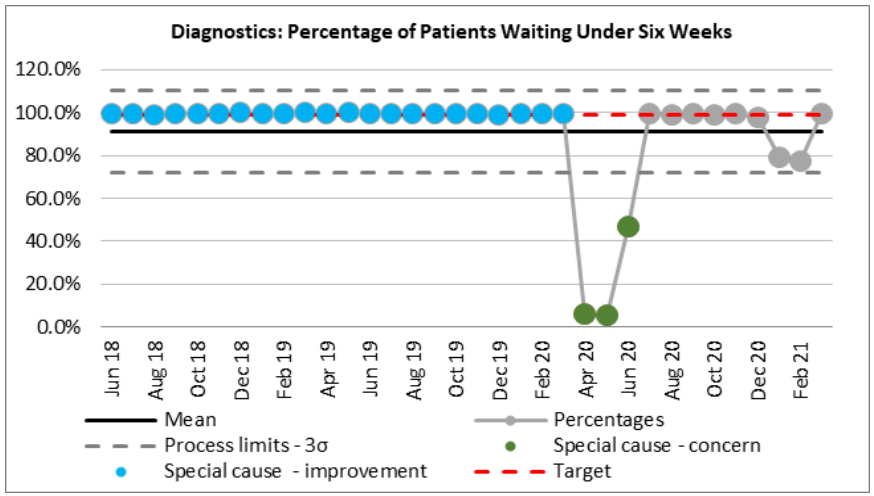
The total number of referrals into the Trust in March was 1899 which is low when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.

An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285





INFORMATION
Imaging recovered their backlog positon in March '21, achieving 99.03% of the diagnostic target. The department also continues to report consistently good performance for report turn around times. Following a process review of how specialities request PACS images identified an inconsistent approach in how requests were being sent to the imaging PAC's team resulting in potential delays. The process has now been standardised across all specialties, all now using one communication channel which has resulted in imaging requests being acted upon in a more timely and efficient way.
ACTIONS FOR IMPROVEMENTS / LEARNING
An additional 6 days of mobile MRI van capacity has been secured for April to support the maintaining of the overall targets.
RISKS / ISSUES
The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

Cancer Performance Targets

		Indicative	*Reported Month*											
Target Name	**National Standard**	***Mar-21***	***Feb-21***	***In Target***	***Breach***	***Total***	***Jan-21***	**In Target**	**Breach**	**Total**	***Dec-20***	**In Target**	**Breach**	**Total**
2ww	93%	**100%**	**100.0%**	**35.00**	**0.00**	**35.00**	**100.0%**	**40**	**0**	**40**	**100.0%**	**61**	**0**	**61**
31 day first treatment	96%	**100%**	**100.0%**	**16.00**	**0.00**	**16.00**	**100.0%**	**18**	**0**	**18**	**100.0%**	**12**	**0**	**12**
31 day subsequent (surgery)	94%	**100%**	**100.0%**	**5.00**	**0.00**	**5.00**	**91.0%**	**10**	**1**	**11**	**100.0%**	**4**	**0**	**4**
62 day (traditional)	85%	**70.0%**	**66.7%**	**4.00**	**2.00**	**6.00**	**76.5%**	**6.5**	**2.0**	**8.5**	**73.3%**	**5.5**	**2.0**	**7.5**
62 day (Cons Upgrade)	n/a	**81.2**	75.0%	3.00	1.00	**4.00**	100.00%	**7.5**	**0.0**	**7.5**	100.00%	**4.0**	**0.0**	**4.0**
28 day FDS REPORTED	75%	**79%**	**78.4%**	**40.00**	**11.00**	**51.00**	**65.0%**	**41**	**22**	**63**	**69.0%**	**50**	**22**	**72**
28 day FDS INTERNAL	75%						79%	50	13	63	73%	50	19	69
No. patients treated 104+ days														

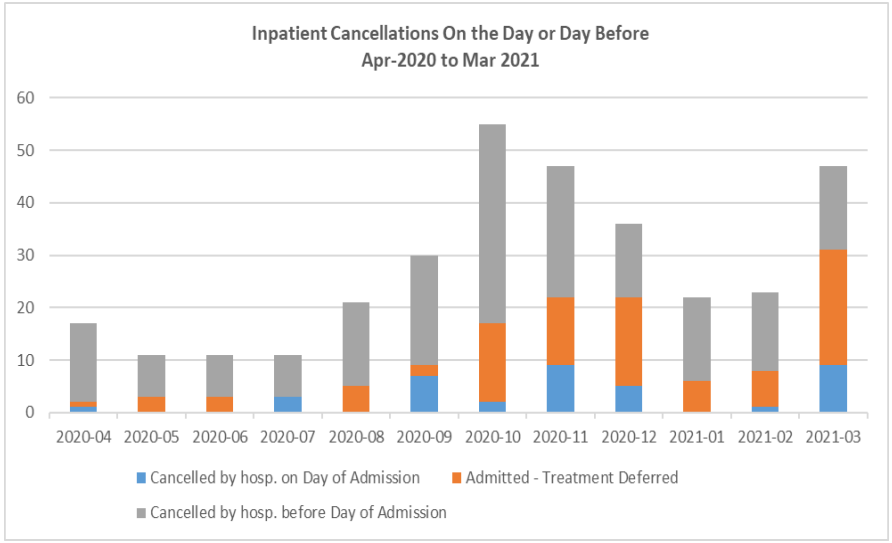
INFORMATION

he Trust's performance for the 62 day target in February 2021 is 66.7% with 4.0 treatments within target + 2 breaches (2 full breaches due to complex diagnostic pathway). Performance for the 31 subsequent target is 100% with all 5 treatments within target.
The Trust's performance for the 62 day target for March 2021 is currently predicted at 70.0% with 3.0 treatments within target + 1.5 breaches (Please note the breaches are being reviewed. (submission closes 30.04.21).
The faster diagnosis for February was 78.4% (new standard target is 75%). A total of 51 patients subject to FDS, 40 diagnosed within 28 days and 11 diagnosed outside target (3 patients received via late tertiary, 3 patients delayed histology, 1 patient covid-19 related, 2 patients complex pathway).
The Trust's Business Intelligence Service, with advice and help from the UHB Deputy Cancer Services Manager, are now currently developing specific data reports to enable a more detailed breakdown on key cancer waiting time targets to allow a better understanding of performance, trends, and highlighting areas where improvement is required. This work is currently being undertaken and anticipated mid-late April 2021.

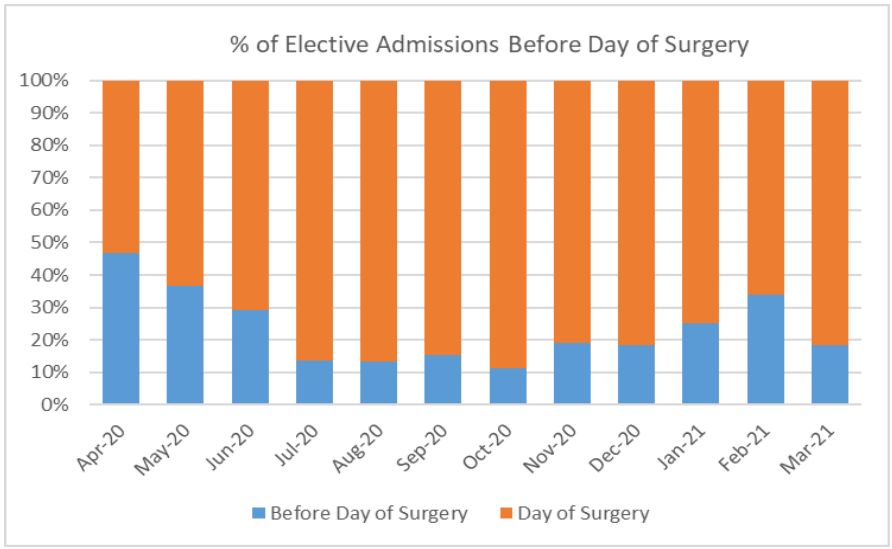
Risks

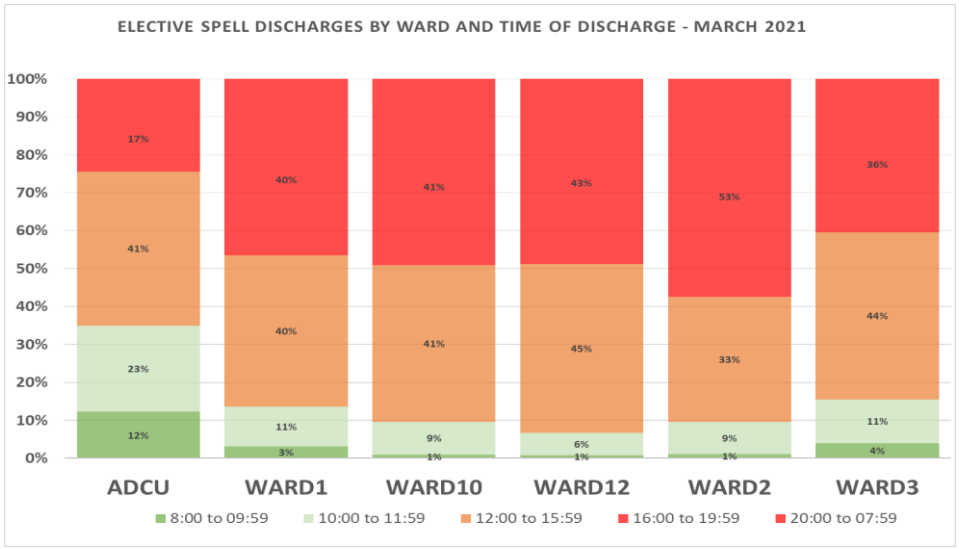
Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways, both of which are under current analysis and review. Recruitment issues remain an ongoing concern to appoint a specialist bone and soft tissue Pathologist at UHB . This is a national challenge across sarcoma centres and discussions are ongoing with UHB , Medical Director , Chief Operating Officer and the National Pathology network to source alternative solutions. This issue will be tabled for discussion at the Trust Quality and Safety Committee.

17. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



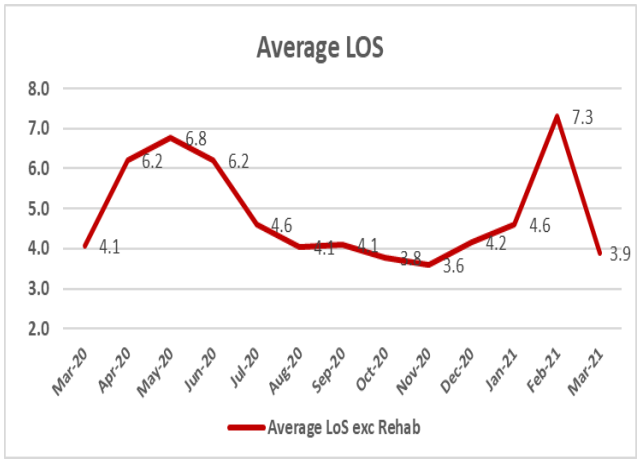
Sum of Total	Cancellation Category			
Year-Mth	Cancelled by hosp. On Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp.before Day of Admission	Grand Total
2020-04	1	1	15	17
2020-05	0	3	8	11
2020-06	0	3	8	11
2020-07	3	0	15	18
2020-08	0	5	16	21
2020-09	7	2	21	30
2020-10	2	5	48	55
2020-11	6	2	11	19
2020-12	4	6	14	24
2021-01	0	6	16	22
2021-02	1	7	15	23
2021-03	6	7	14	27
Grand Total	30	47	201	278

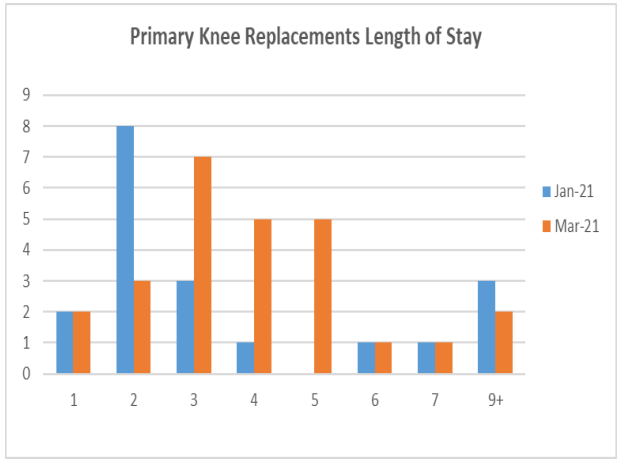


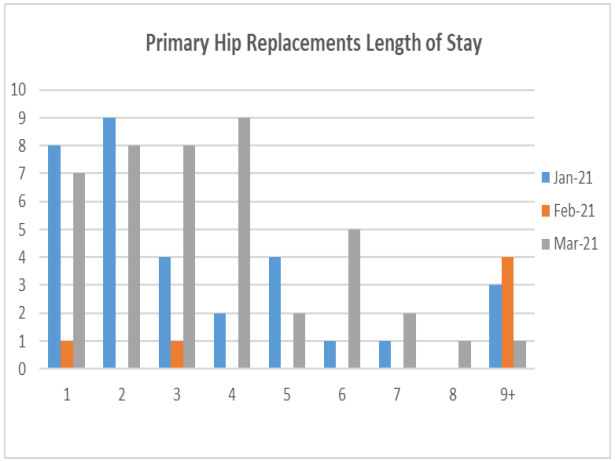


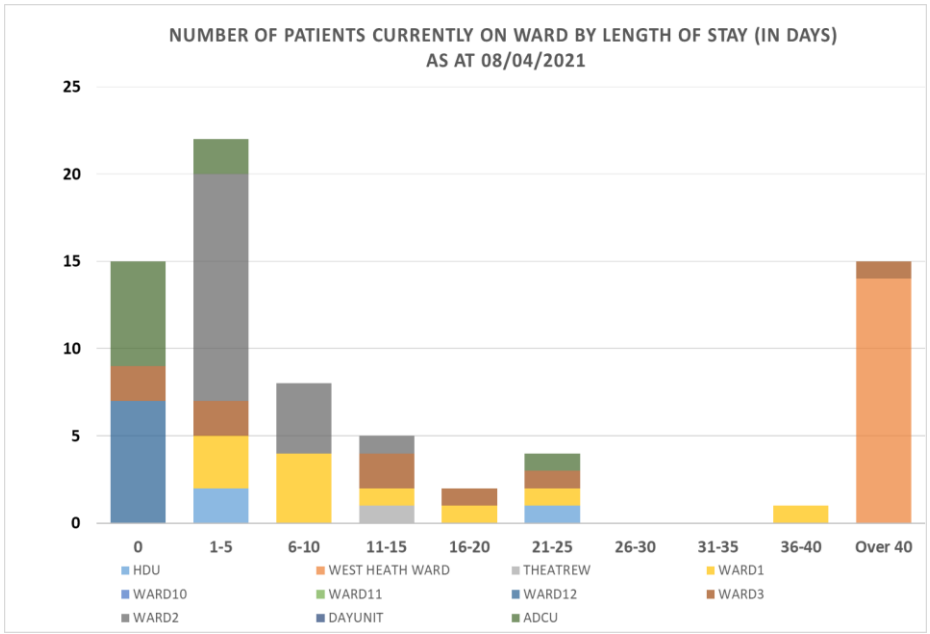
INFORMATION
There were 6 patients cancelled on the day of admission in March with reasons detailed as follows 4 x CT equipment failure (all patients subsequently treated) 2x Clinical reasons There were 7 patients admitted but where treatment was deferred, with reasons broken down as follows: 2 x Patient had COVID-19 vaccine recently –(this is now added to the 72 hour call questionnaire.) 3 x Patient medically unfit 1 x Not starved as instructed 1 x Patient no longer required procedure Cancellations prior to day of surgery for March were 14 as detailed below: 2 x Patients had not fully isolated / attend for covid swabs 4 x CT scanner broken 5 x TCI's rescheduled 2 x Patients requiring further tests / deferred by consultant following review 1 x Not suitable for op at ROH
ACTIONS FOR IMPROVEMENTS / LEARNING
6/4/2 scheduling meetings will be taking place instead of 8/6/4, as the isolation /swabbing rules have changed. The reinstatement from May of the 'theatre look back' meetings will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. System partners will now be attending these meetings to share best practice and learning
RISKS / ISSUES
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process .

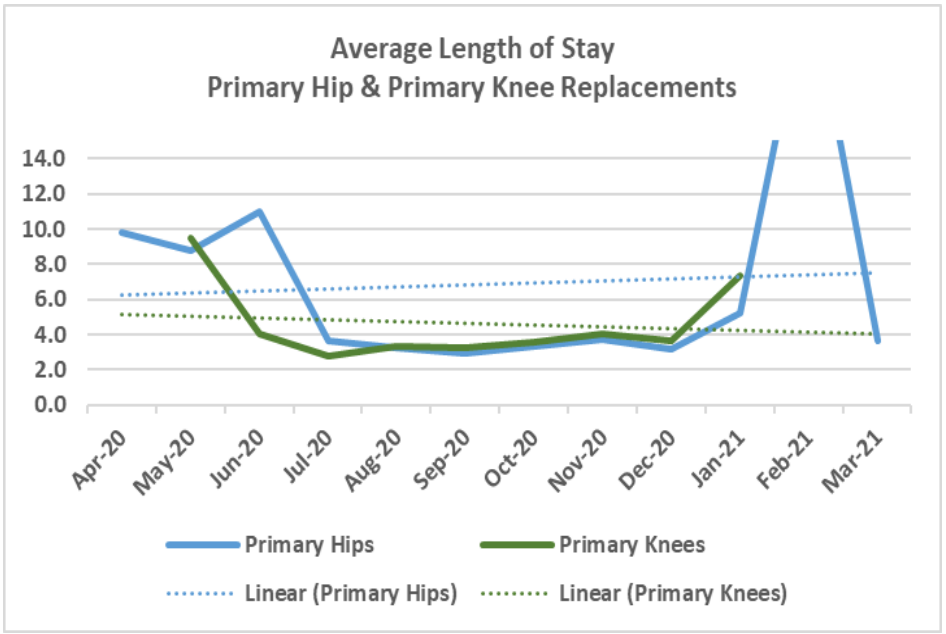
18. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION
The LOS Figures have reduced in month as anticipated as patients have been discharged from the rehabilitation pathway The Head of Nursing Division 1 has reviewed the average LOS data provided for March. All patients with a length of stay greater than 10 days have been reviewed. All of these patients had complex surgical needs together with infection and/or package of care/rehab requirements. All delays are reviewed on a daily basis and if the patient is medically fit for discharge and no movement is imminent this is escalated to the Matron and Head of Nursing. In March there were 7 patients with Delayed Transfer of Care: one for package of care, four delayed for on-going rehabilitation and two delayed for rehabilitation totalling a delay of 86 days.
ACTIONS FOR IMPROVEMENTS / LEARNING
The roaming discharge team continue to provide discharge support to the wards and actively manage any potential delayed discharges. The bed modelling is now added weekly to the SITREP , so that forecasting of bed capacity can be proactive and in line with activity requirements .
RISKS / ISSUES
Continued operating on more complex, high priority patient will retain risk of increased length of stay and possible impact on patient flow. This will be monitored on a weekly basis and managed daily by the site management team with executive oversight as required.

19. CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

OPEN CAS ALERTS 1 - 31 March 2021

NatPSA/2020/005/NHSPS	Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults. *The omission of steroids for patients with primary or secondary adrenal insufficiency can lead to adrenal crisis; a medical emergency which if left untreated can be fatal. If these patients become acutely ill or are subject to major body stressors, such as from trauma or surgery, they require higher doses of steroids to prevent an adrenal crisis.* *While substantial resources exist, clinical staff are not always aware of the risk of adrenal crisis, or the correct clinical response should one occur.* *The alert asks providers to ensure all eligible patients are issued with a Steroid Emergency Card; and to put processes in place to check if a patient has a Steroid*	National Patient Safety Alert - NHS England & NHS Improvement	13-Aug-20	**19 March 2021:** On-going.	13-May-21

	Emergency Card ahead of any emergency treatment, elective surgery, or other invasive procedures.				

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Finance and Performance Report

March 2020

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INTRODUCTION

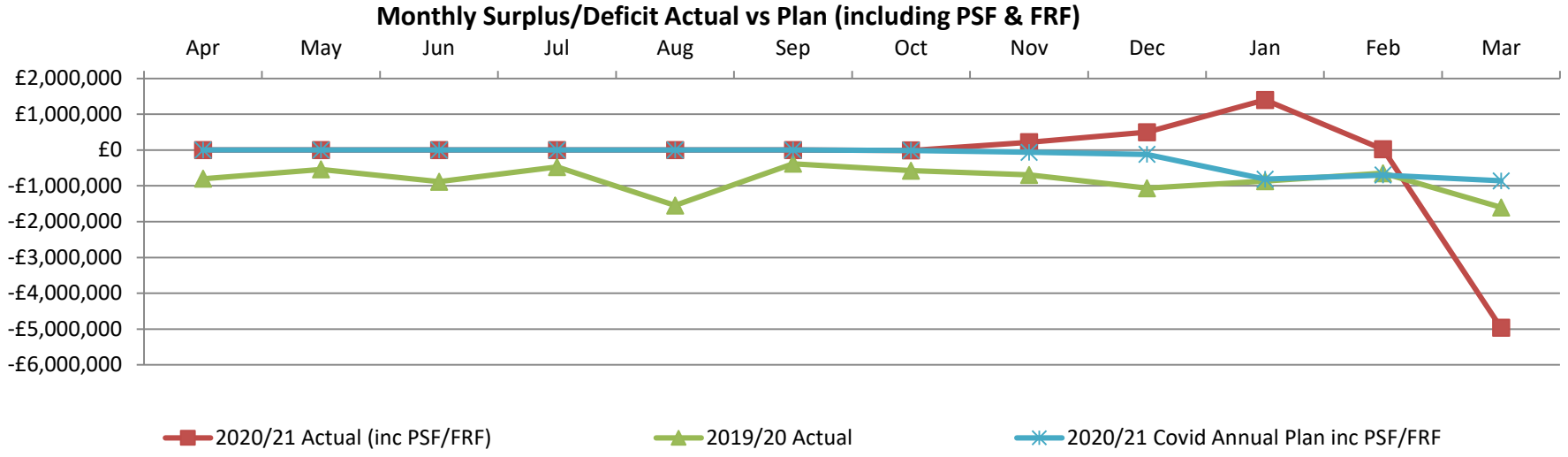
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

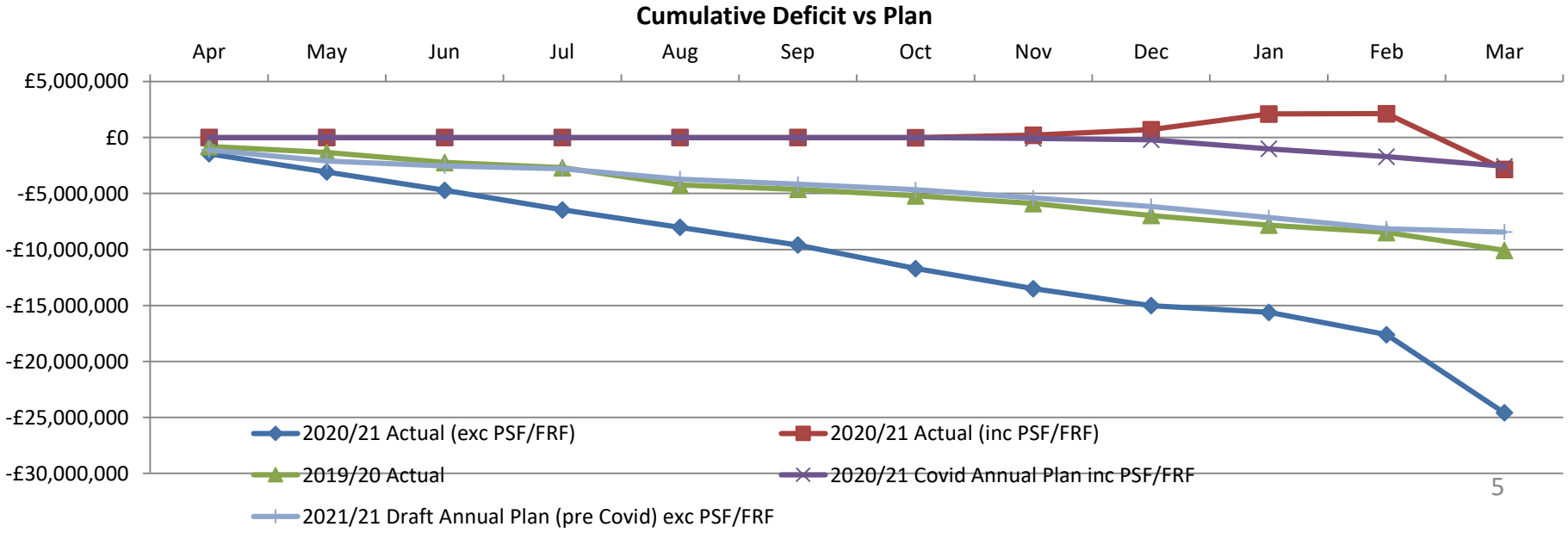
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	NHS I Plan M12 2020/21	Actual M12 2020/21	Variance
	£'000	£'000	£'000
Operating Income from Patient Care Activities (exc PSF & FRF)	88,457	93,676	5,219
Other Operating Income (Excluding top up)	3,185	6,121	2,936
Total Income	**91,642**	**99,797**	**8,155**
Employee Expenses (inc. Agency)	(56,618)	(58,818)	(2,200)
Other operating expenses	(45,985)	(53,155)	(7,170)
Operating Deficit	**(10,961)**	**(12,176)**	**(1,215)**
Net Finance Costs	(1,267)	(809)	458
Net deficit	**(12,228)**	**(12,985)**	**(757)**
Remove impairment impact	-	442	442
Remove donated asset I&E impact	65	65	-
Adjusted financial performance (exc PSF & FRF)	**(12,163)**	**(12,478)**	**(315)**
PRF/FRF monies	9,595	10,079	484
Adjusted financial performance surplus/(deficit) including PSF & FRF	**(2,568)**	**(2,399)**	**169**

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan on both a monthly and cumulative basis





INFORMATION

The full year performance is a deficit of £2,399k, which is £169k ahead of the planned deficit of £2,568k. The movement in position in month is as a result of year end adjustments, including the revaluation of the estate, year end stock count adjustments, and year end review of balance sheet areas such as prepayments and accruals.

Financial planning for 2021/22 has commenced and details will be shared separately on the agenda.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

There remains a risk, particularly as we move into H2 next year that the funding allocated to the Trust will not be sufficient to cover the increased costs the Trust is incurring in relation to the new theatres.

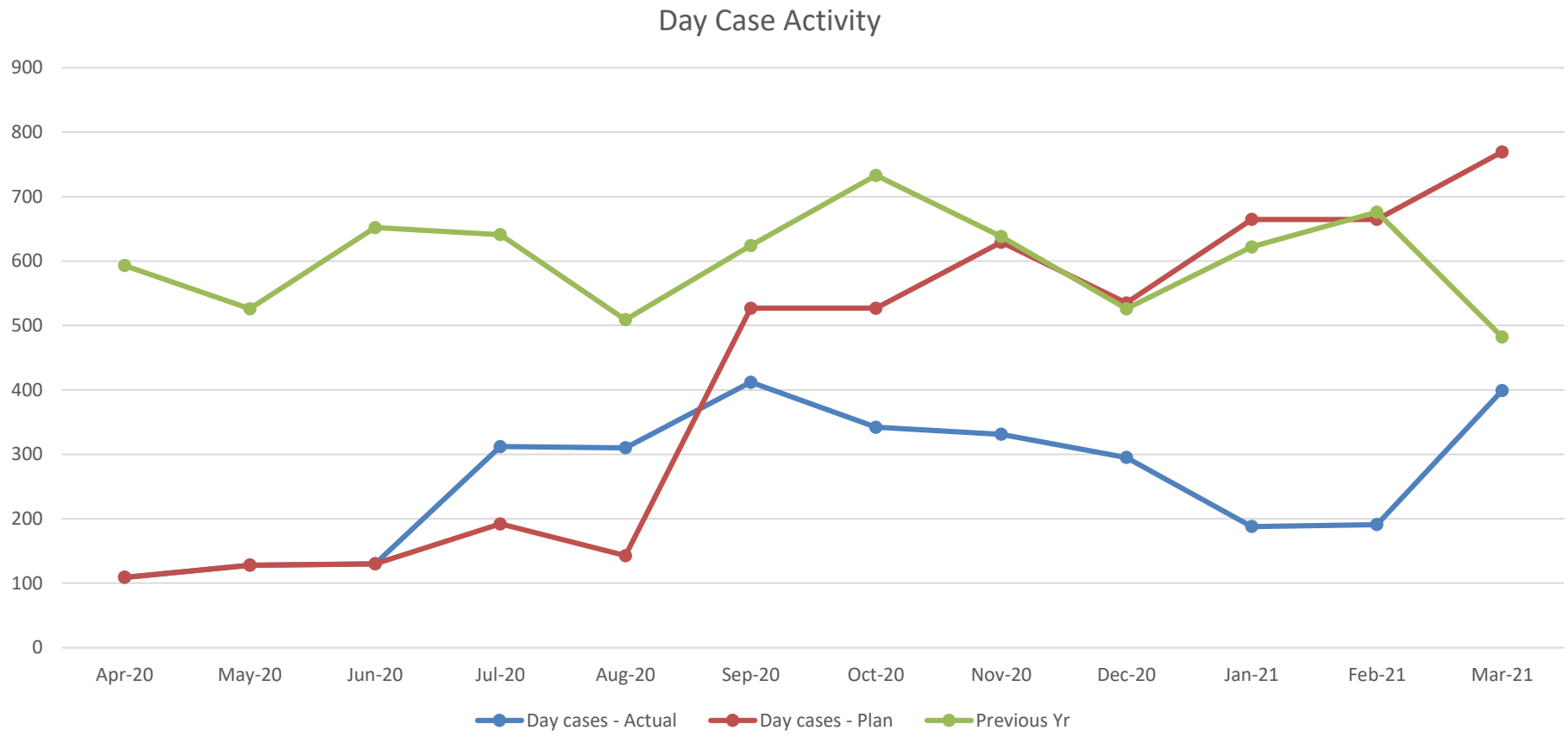
2. Income and Activity– This illustrates the total income generated by the Trust in 2020/21, in addition to the month's activity (Inc PSF & RFF)

Breakdown of Block Income Received year to date

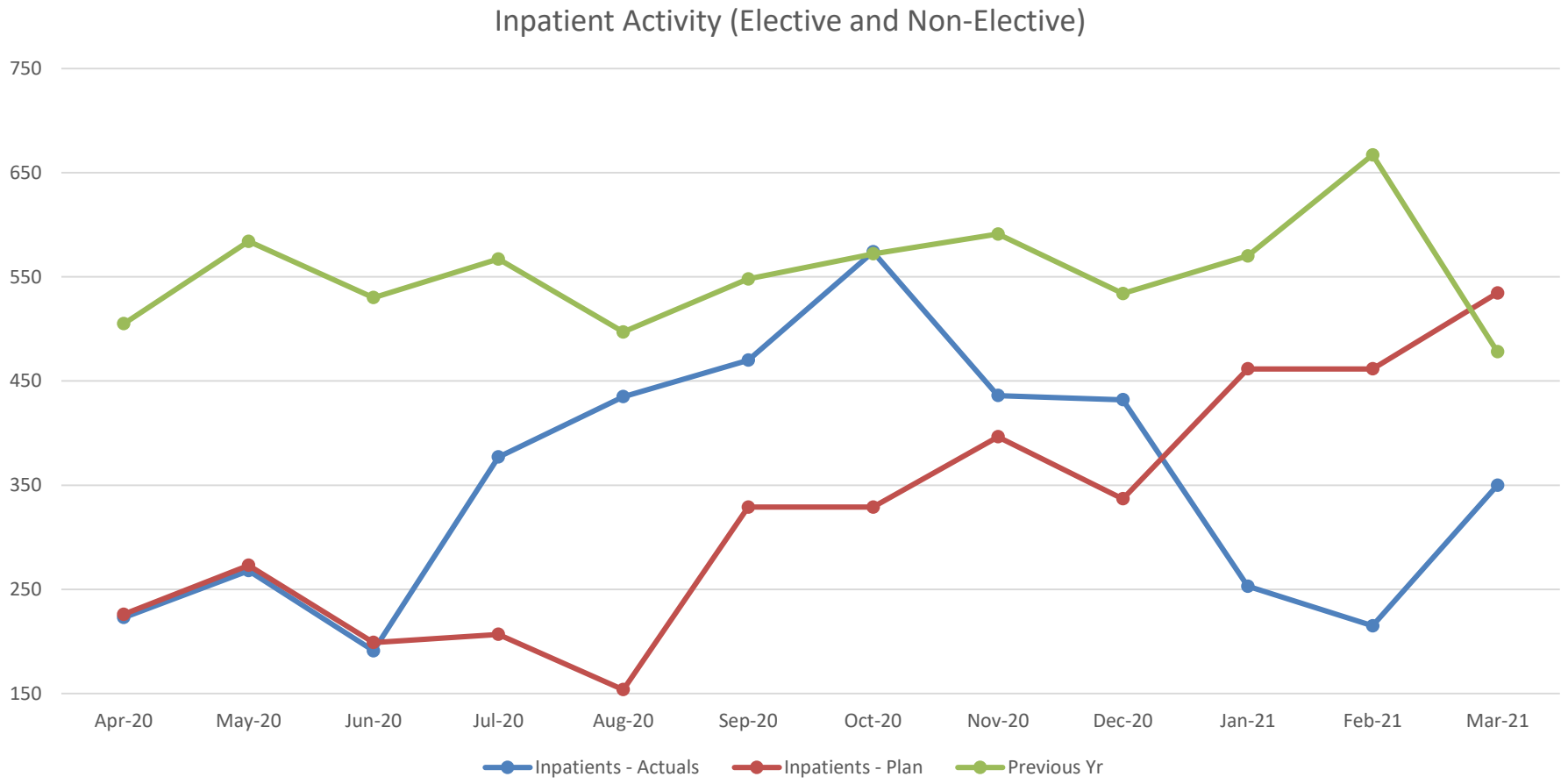
	Month 12 YTD (£000)		
	Plan	**Actual**	**Variance**
NHS England	23,076	27,519	4,443
Clinical commissioning groups	62,117	62,718	601
NHS Foundation Trusts	1,614	1,524	(90)
Private Patients	402	633	231
Research & Development	334	367	33
Education & Training	1,399	2,156	757
Other Income	2,700	2,492	(208)
Retrospective Top Up	9,594	9,514	(80)
	101,236	**106,923**	**5,687**

INFORMATION

Block contracts were in place for the whole financial year, and funding has been agreed for the first half of next year (H1), with funding envelopes for H2 to be received later in the year.

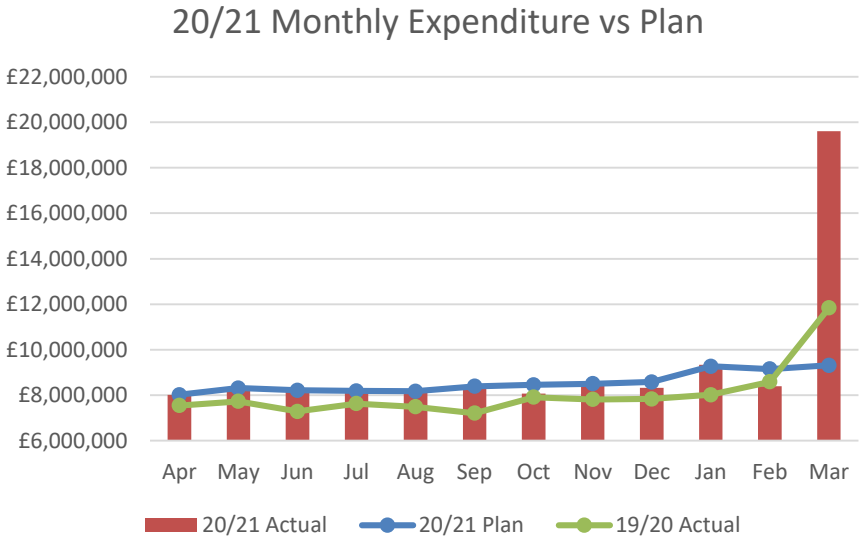


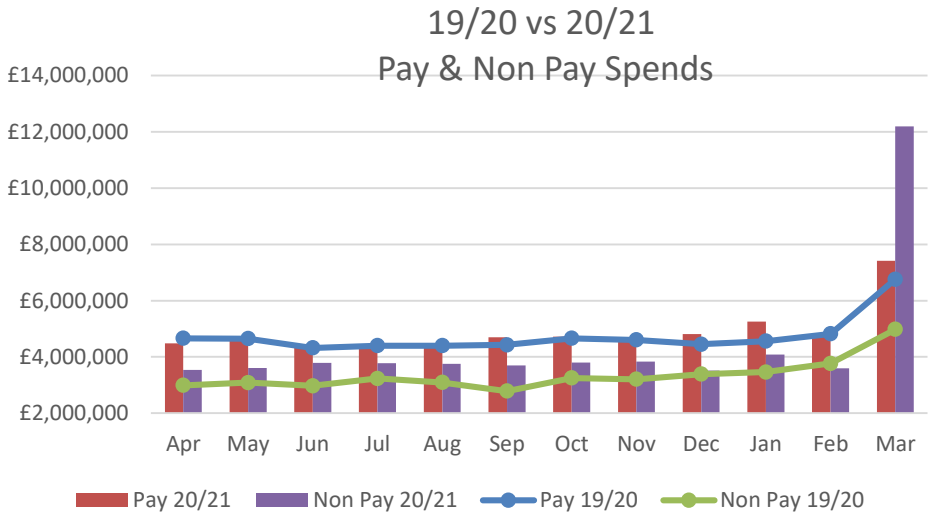
Daycase	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	109	128	130	311	321	411	341	330	293	188	191	399
Draft Plan				192	143	527	527	630	535	665	665	770
Previous Yr	593	526	652	641	509	624	733	638	563	675	676	482



Inpatient	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	226	273	199	365	428	468	568	436	431	253	215	350
Draft Plan				207	154	329	329	396	337	462	462	535
Previous Yr	505	584	530	567	497	548	572	591	534	568	666	478

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2020/21, compared to historic trends





COVID-19 related expenditure

Additional costs related to COVID	£'000s
Existing workforce additional shifts	1095
Backfill for higher sickness absence	245
Decontamination	63
Remote working	584
PPE and other associated costs	376
Segregation of patient pathways	470
Other	80

Reimbursement for this expenditure and income loss is funded through a retrospective top up process.
Across the Midlands and East region the average claim as % operating expenditure is 5.3% (Range 1% -13.2%), to Month 12 ROH claim was 2.6%.

INFORMATION

Performance against Plan

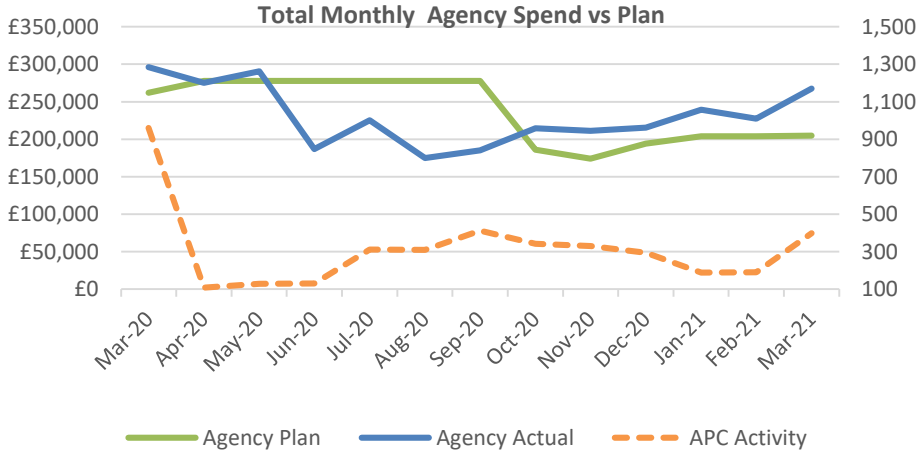
Expenditure in March was £19.6m. This includes year adjustments for areas such as the revaluation of the estate, pension adjustments (offset by a corresponding increase in income), recognition of the expenditure relates to donated PPE (again offset with income), a review of balance sheet areas such as prepayments and accruals, and year end stock count adjustments.

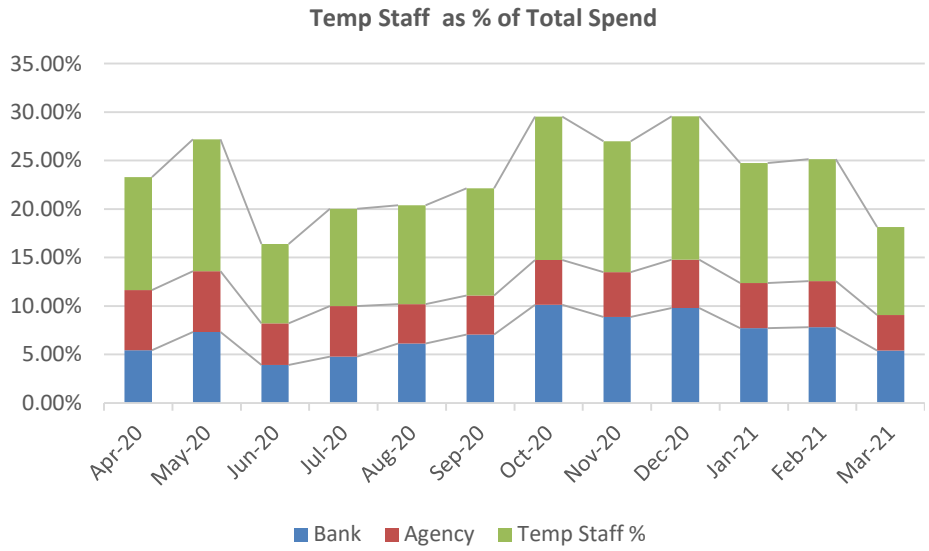
RISKS / ISSUES

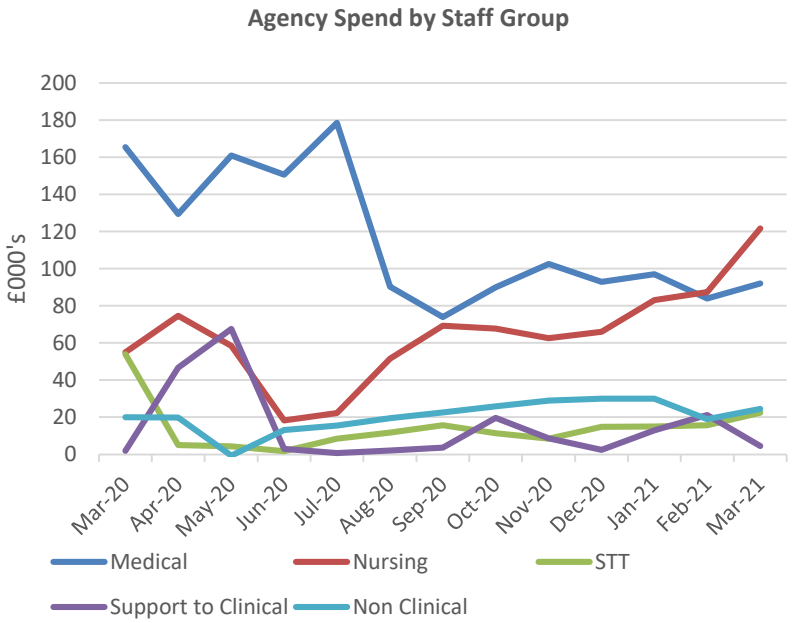
There remains a risk, particularly as we move into H2 next year that the funding allocated to the Trust will not be sufficient to cover the increased costs the Trust is incurring in relation to the new theatres.

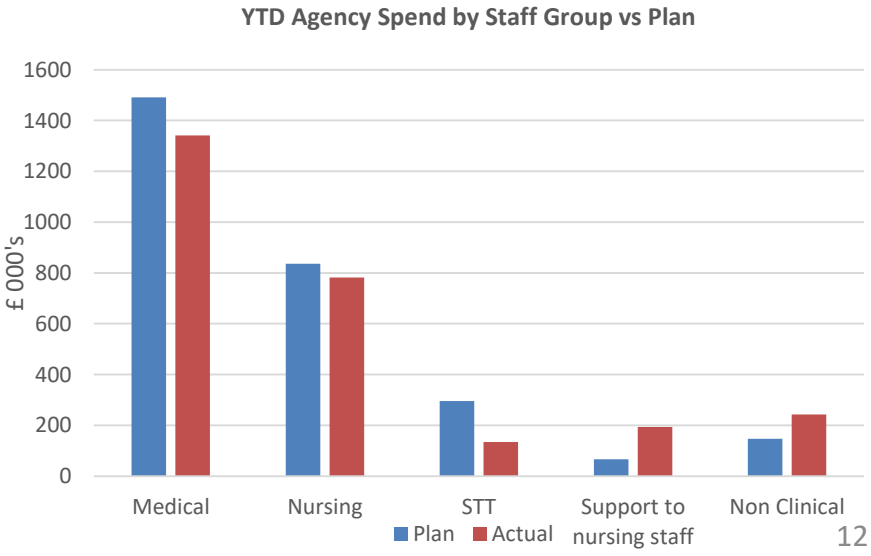
In addition, it should continue to be expected that expenditure in some particular areas, for example in temporary staffing, infection control measures will remain high over the next couple of months.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend for March was £267k.

A review of the detail shows the largest increase was within nursing agency, which correlates to the increase in day case and elective activity we have seen in month.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

RISKS / ISSUES

5.Cost improvement Programme Summary

INFORMATION

A CIP totalling £577,000 for the year has been achieved, equating to 0.73%.

Business planning sessions with services and departments has identified CIP schemes for 2021/22 totalling £1,615k . Many other schemes have been identified and require further work to identify the estimated savings.

The main schemes identified are;

- Digital Transformation – Expansion of paperless communications, text message reminders and partial booking for booking appointments
- Medical Workforce efficiencies –reduction in agency spend through collaborative bank set up, alternative roles and Direct Engagement
- Procurement initiatives – Continuation of work to review products, prices and contracts with suppliers of non pay goods & services.
- Service transformation – Implementation of a new spinal endoscopic service and a rationalisation of suppliers.
- Theatres Managed Service contract - VAT savings and economies of scale purchasing savings

Scheme	21/22 (£000s)
Div 1	**£521**
Digital transformation	£78
DNA Rate Reduction - OP	£50
Private Patients	£120
Procurement	£183
Spinal Service Transformation	£90
Div 1&2	**£264**
Medical Workforce	£264
Div 2	**£830**
DNA Rate Reduction - OP	£135
Managed Theatres Service	£696
Grand Total	**£1,615**

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	2019/20	Month 12 YTD (£000)		
	M12	Plan	Actual	Variance
Intangible Assets	1,326	872	1,255	383
Tangible Assets	43,980	43,975	45,931	1,956
Total Non-Current Assets	**45,306**	**44,847**	**47,186**	**2,339**
Inventories	6,690	3,683	1,800	(1,883)
Trade and other curent Assets	10,058	13,264	7,190	(6,074)
Cash	663	6,151	5,703	(448)
Total Current Assets	**17,411**	**23,098**	**14,693**	**(8,405)**
Trade and other payables	(13,967)	(16,676)	(10,173)	6,503
Borrowings	(21,246)	(703)	(3,524)	(2,821)
Provisions	(932)	(4,017)	(3,788)	229
Other liabilities	(250)	(480)	(1,567)	(1,087)
Total Liabilities	**(36,395)**	**(21,876)**	**(19,051)**	**2,825**
Total Net Assets Employed	**26,322**	**46,069**	**42,827**	**(3,242)**
Total Taxpayers and Others Equity	**26,322**	**46,069**	**42,827**	**(3,242)**

INFORMATION

The movement in the borrowings balance in year remains related to the transfer of historic revenue support loans from DHSC to issued public dividend capital. The total transfer was £19.8m and was physically actioned in September.

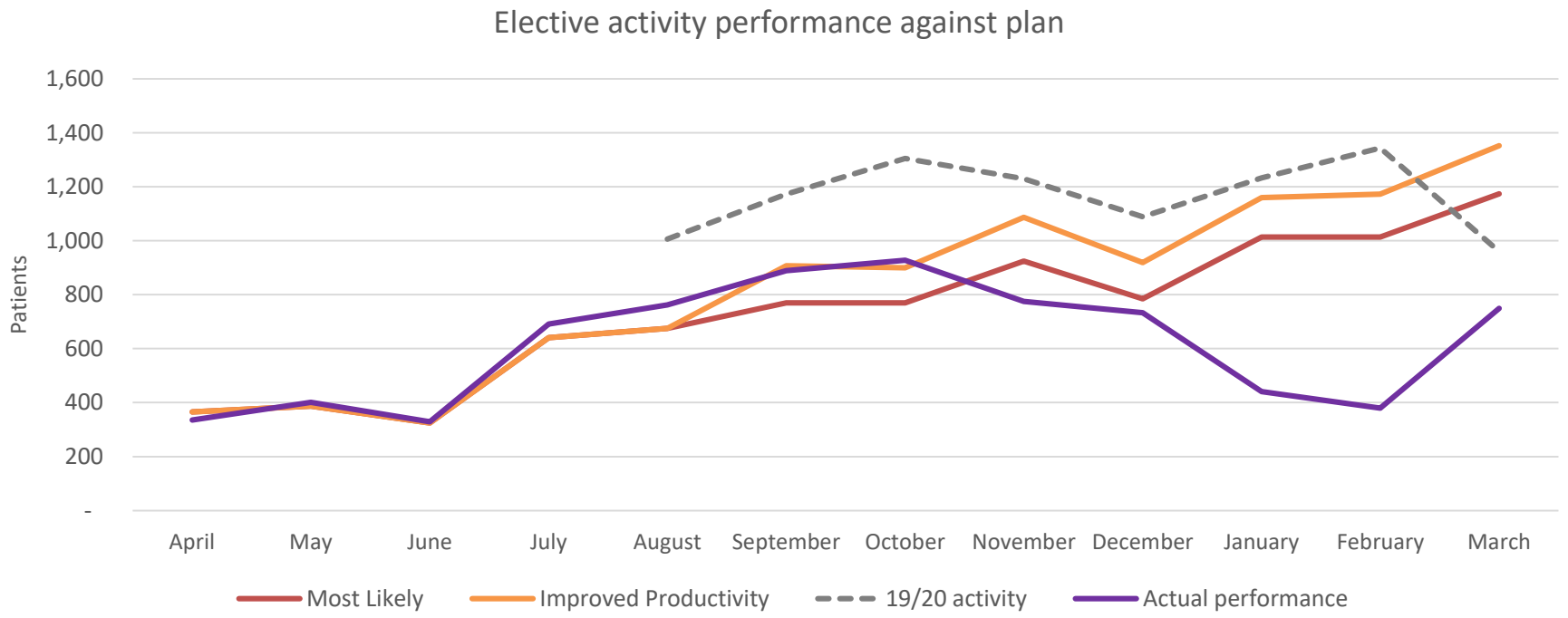
Cash in the bank at the end of the year was £5.7m which is an increase of £5m compared to March 2020, due to increased funding in the current year in addition to receipt of the funds for the equipment sold to Genmed as part of the managed service arrangement.

Inventories have also reduced as a result of the movement to theatre managed services as owned inventory is reduced.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

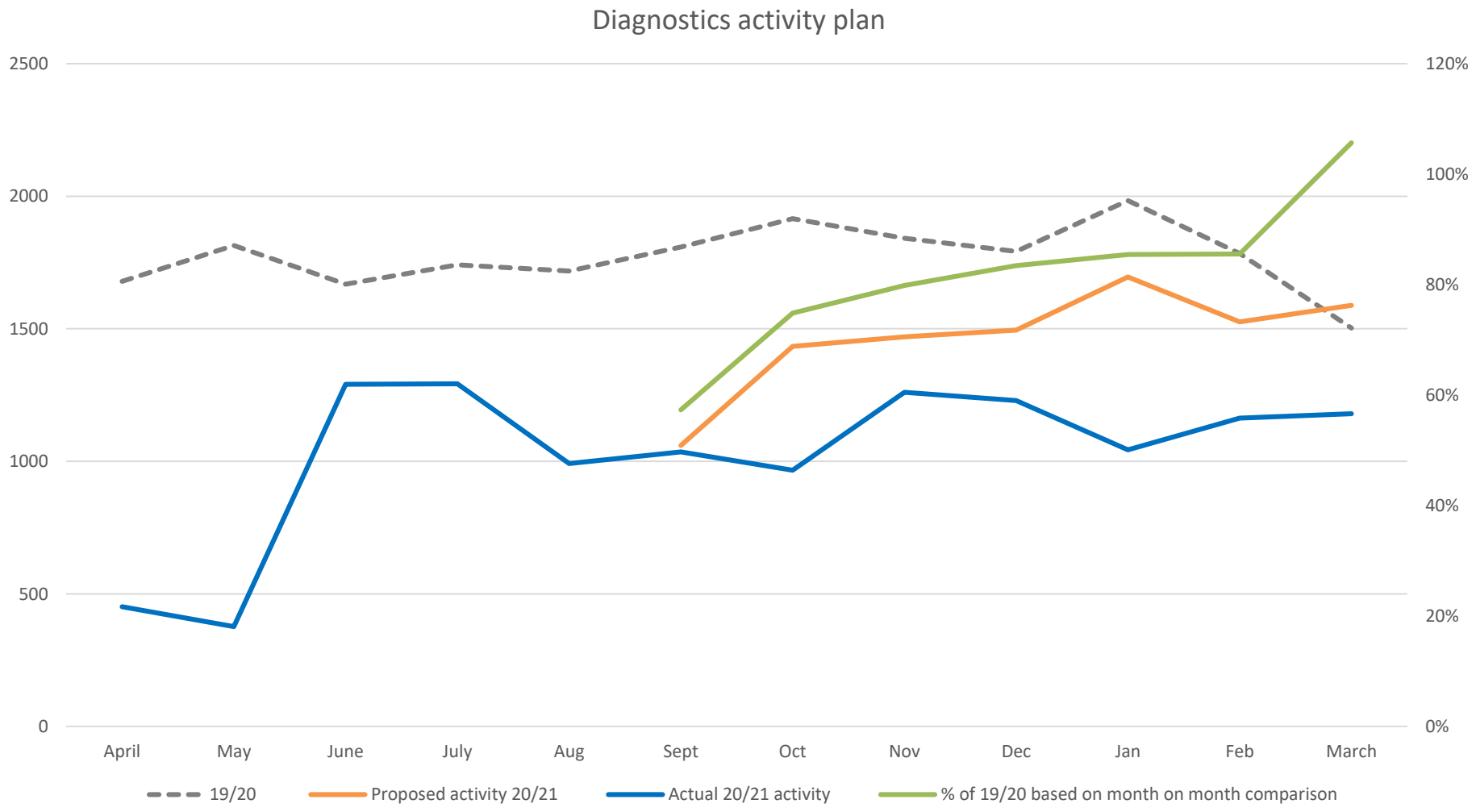
Performance against Activity plan – Elective Finance & Performance committee agreed plans



- February delivered 749 against a most likely plan of 1174, which is 78% of 19/20 activity for the same period
- Actual delivery and total booked activity for April totals 920 patients.

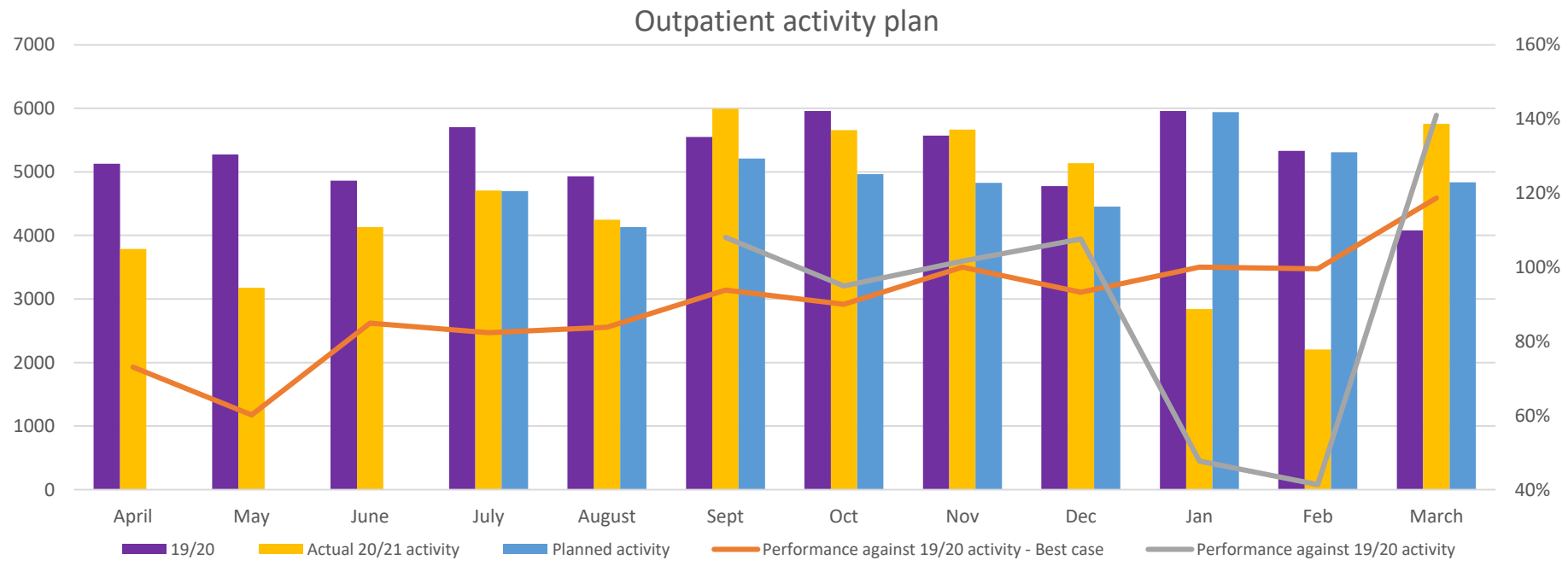
	April	May	June	July	August	September	October	November	December	January	February	March
Actual performance	335	401	329	691	762	889	927	775	733	441	380	749
Most Likely	366	387	325	641	675	770	770	924	785	1,014	1,014	1,174
Improved Productivity	366	387	325	641	675	907	900	1,087	919	1,160	1,173	1,352
19/20 activity					1006	1172	1305	1229	1089	1233	1343	960
Actual % delivery against 1920					71%	75%	70%	63%	67%	36%	28%	78%

Performance against Activity plan– Diagnostic STP final planning submission

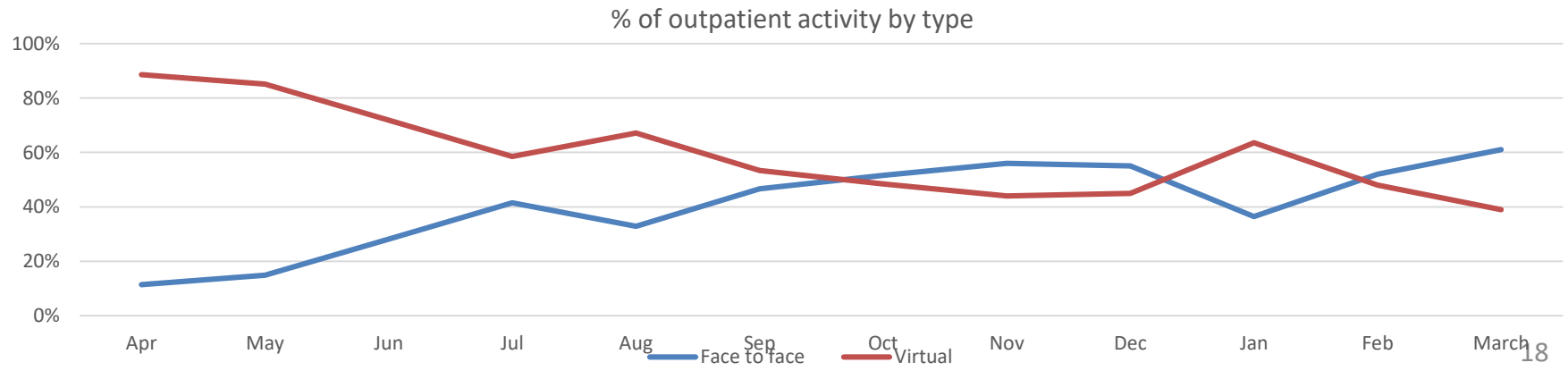


The diagnostic activity most likely projections are subject to forecasting of potential demand , however there is sufficient flexibility built into the operating model to enable expansion of capacity to ensure compliance with national diagnostic targets.

Performance against Activity plan– Outpatients STP final planning submission

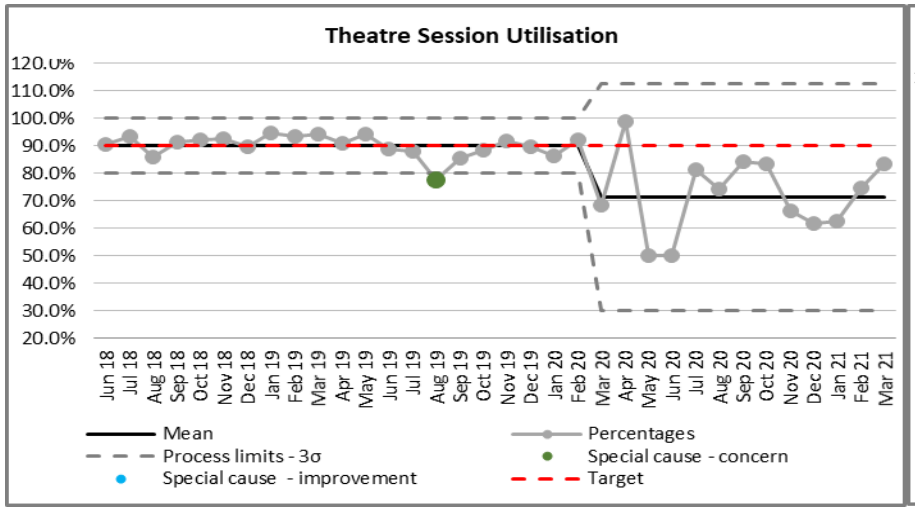


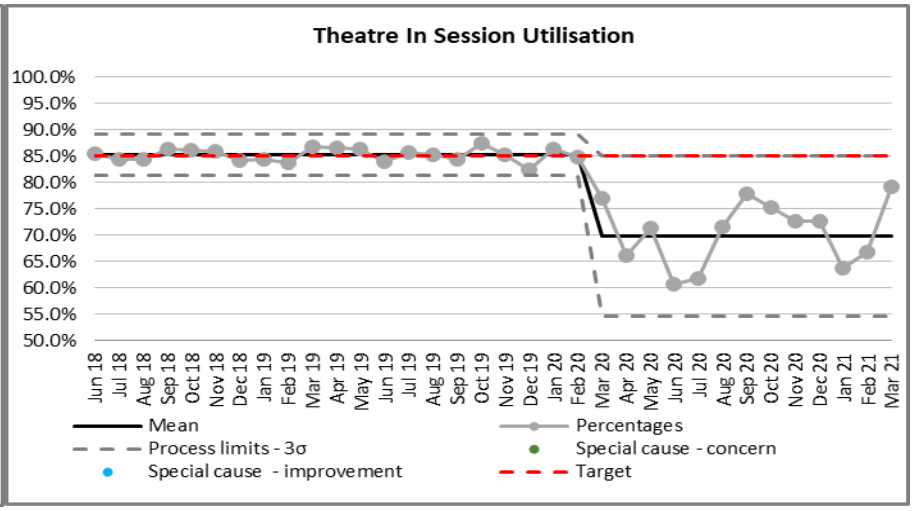
Activity in March was above plan and 19/20 activity levels. 48% of the activity delivered virtually.



Note: Plan figures here represent the final plan submitted to STP

1. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used





INFORMATION

The case mix prioritised during March remained that of urgent P2 / P3 and emergency work. Therefore out of the 10 theatres we had available 4 of these were allocated to support emergency workload which was predominantly from UHB, therefore utilisation is based on 6 elective theatres running.

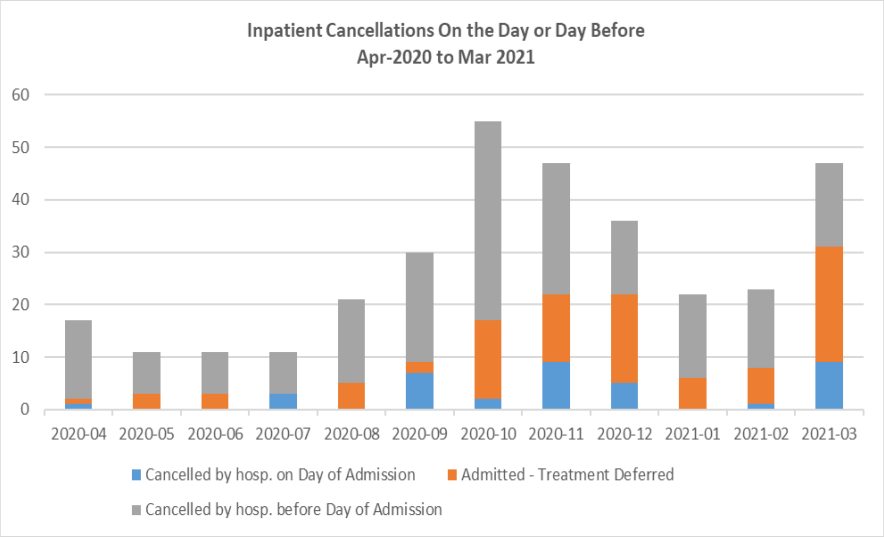
Theatre session utilisation for March was 83.44 % and 79.21% for in session utilisation, an increase on the previous month. The challenge still remained in respect of being unable to recycle lists when last minute cancellations occur due to the 14 day isolation rules that were in place throughout March. However, significant progress has been made in discussions to review this and changes to the isolation and swabbing protocols will come into effect from mid April, allowing more flexibility to maximise theatre capacity.

The main focus during April will be to ensure the opening of all 14 theatres to allow continuation of the system support being given to reduce the current orthopaedic backlog.

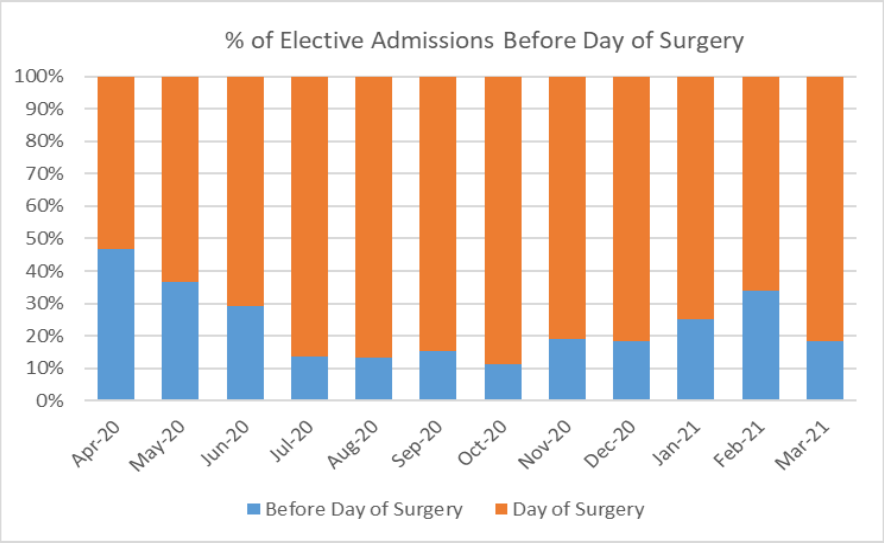
RISKS / ISSUES

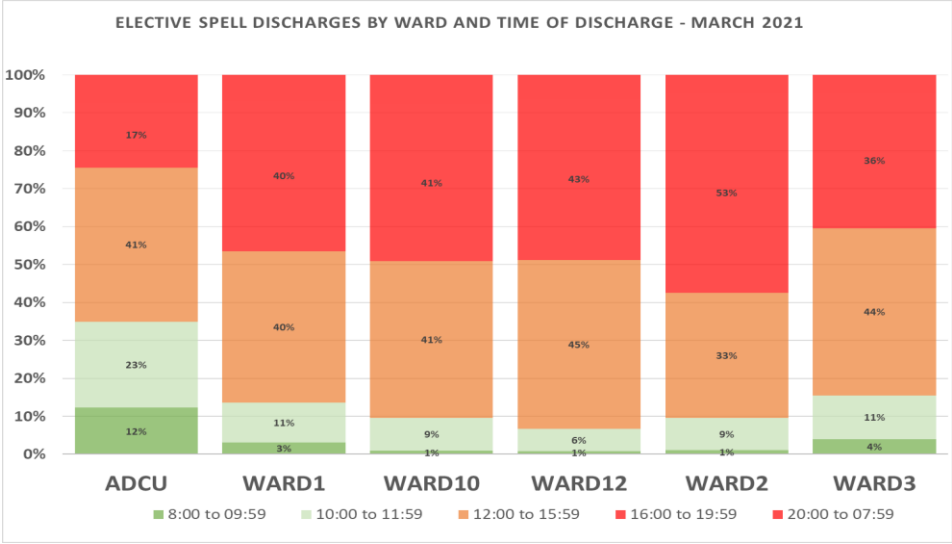
The utilisation of system lists will need to be improved in order to maximise resources and the ROH team are working closely with operational colleagues at UHB to ensure planning of lists is in place to improve efficiency overall.

2. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



Sum of Total	Cancellation Category			
Year-Mth	Cancelled by hosp. On Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp.before Day of Admission	Grand Total
2020-04	1	1	15	17
2020-05	0	3	8	11
2020-06	0	3	8	11
2020-07	3	0	15	18
2020-08	0	5	16	21
2020-09	7	2	21	30
2020-10	2	5	48	55
2020-11	6	2	11	19
2020-12	4	6	14	24
2021-01	0	6	16	22
2021-02	1	7	15	23
2021-03	6	7	14	27
Grand Total	30	47	201	278





There were 6 patients cancelled on the day of admission in March with reasons detailed as follows

4 x CT equipment failure (all patients subsequently treated)
2x Clinical reasons

There were 7 patients admitted but where treatment was deferred, with reasons broken down as follows:

2 x Patient had COVID-19 vaccine recently –(this is now added to the 72 hour call questionnaire.)
3 x Patient medically unfit
1 x Not starved as instructed
1 x Patient no longer required procedure

Cancellations prior to day of surgery for March were 14 as detailed below:

2 x Patients had not fully isolated / attend for covid swabs
4 x CT scanner broken
5 x TCI's rescheduled
2 x Patients requiring further tests / deferred by consultant following review
1 x Not suitable for op at ROH

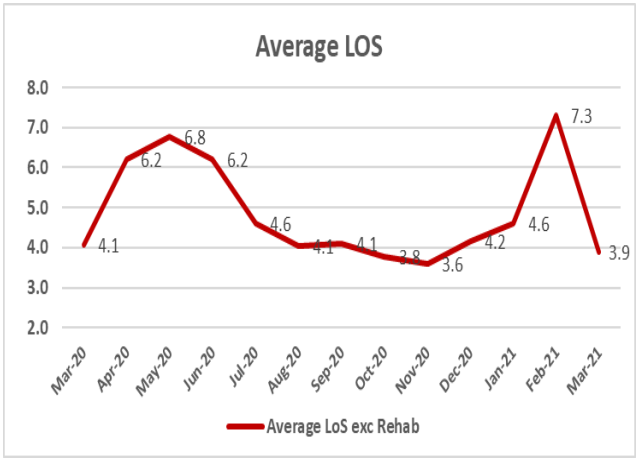
ACTIONS

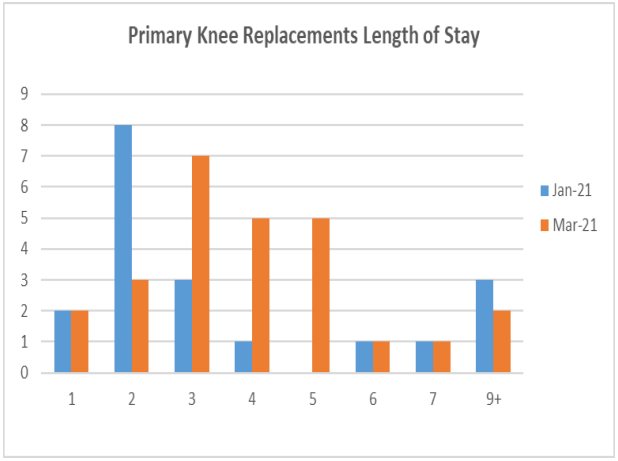
6/4/2 scheduling meetings will be taking place instead of 8/6/4, as the isolation /swabbing rules have changed. The reinstatement from May of the 'theatre look back' meetings will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. System partners will now be attending these meetings to share best practice and learning.

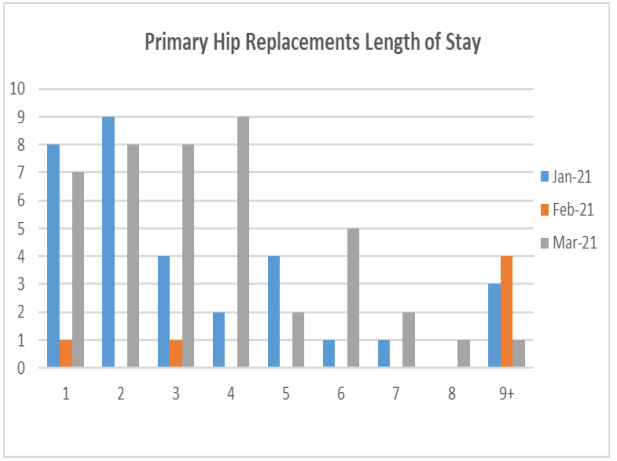
RISKS / ISSUES

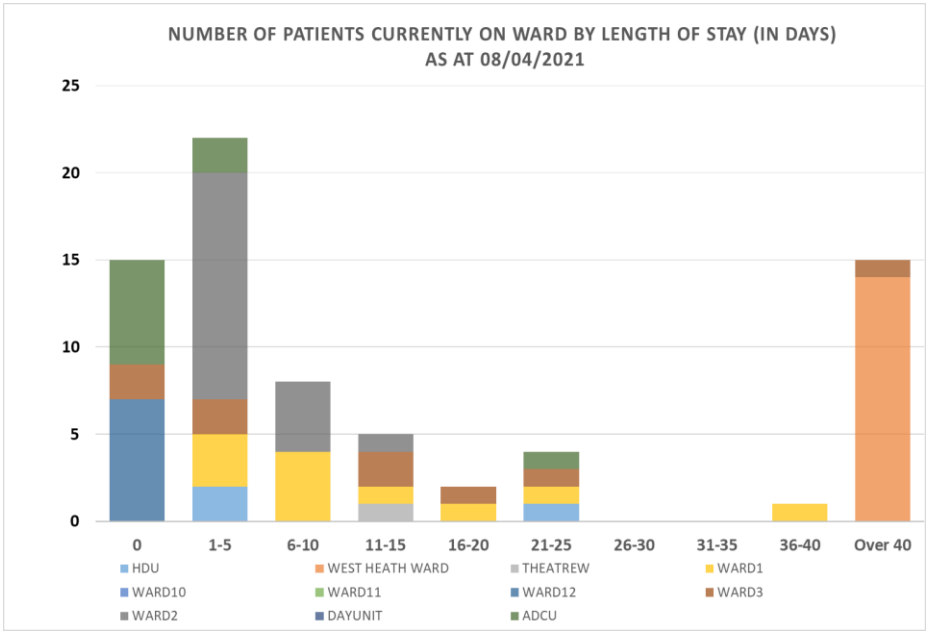
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process .

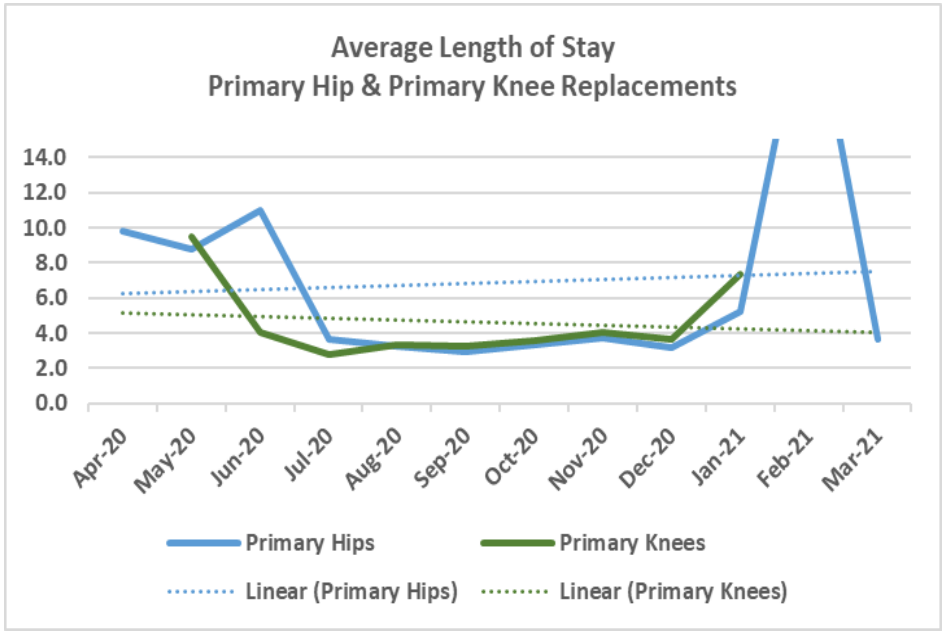
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

The LOS Figures have reduced in month as anticipated as patients have been discharged from the rehabilitation pathway
The Head of Nursing Division 1 has reviewed the average LOS data provided for March. All patients with a length of stay greater than 10 days have been reviewed. All of these patients had complex surgical needs together with infection and/or package of care/rehab requirements.

All delays are reviewed on a daily basis and if the patient is medically fit for discharge and no movement is imminent this is escalated to the Matron and Head of Nursing.

In March there were 7 patients with Delayed Transfer of Care: one for package of care, four delayed for on-going rehabilitation and two delayed for rehabilitation totalling a delay of 86 days.

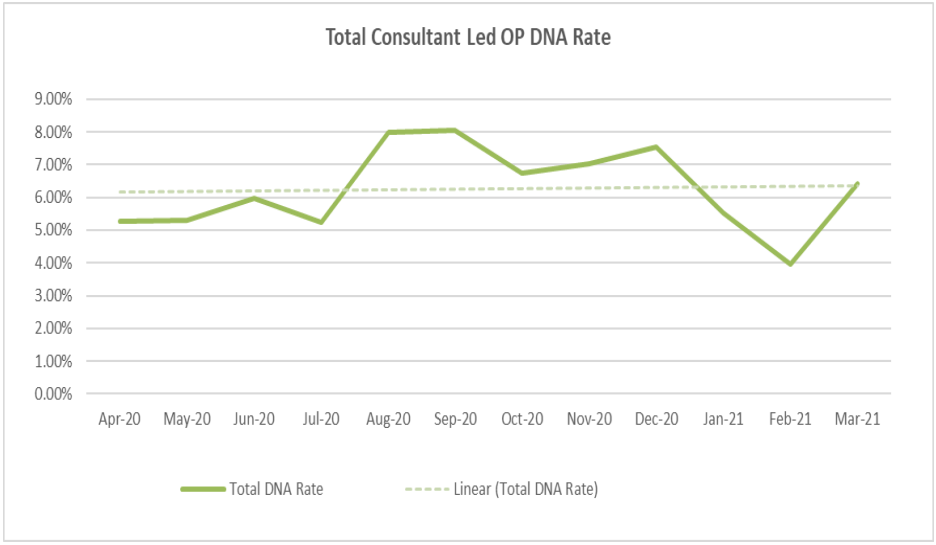
ACTIONS FOR IMPROVEMENTS / LEARNING

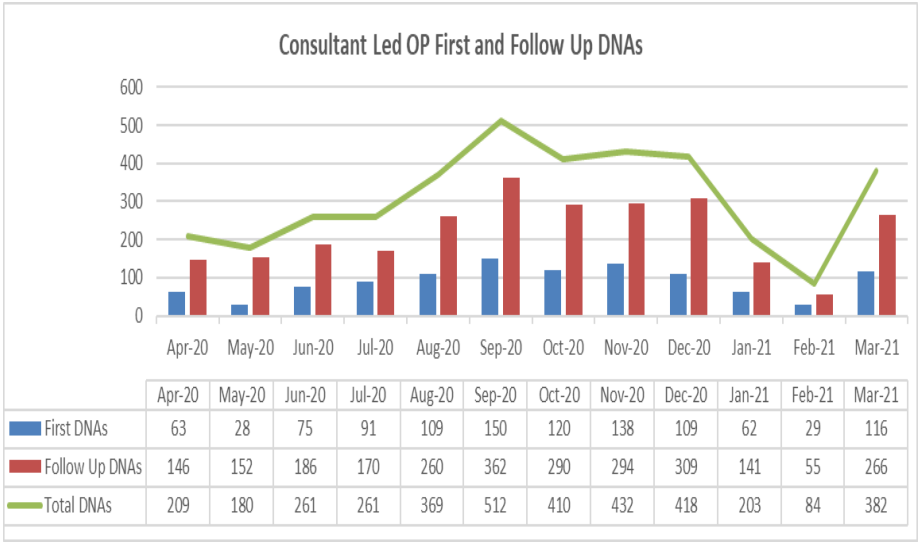
The roaming discharge team continue to provide discharge support to the wards and actively manage any potential delayed discharges.
The bed modelling is now added weekly to the SITREP , so that forecasting of bed capacity can be proactive and in line with activity requirements .

RISKS / ISSUES

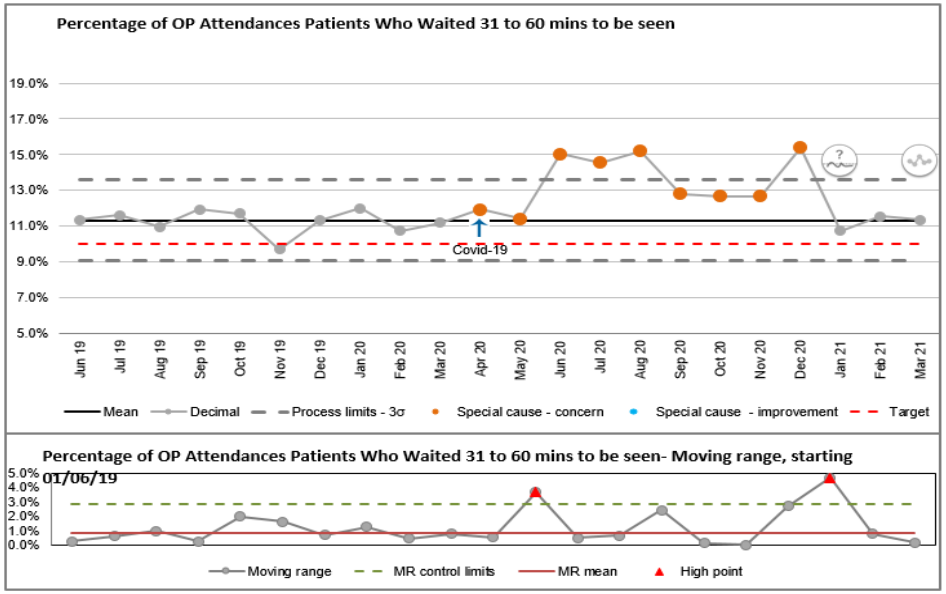
Continued operating on more complex, high priority patient will retain risk of increased length of stay and possible impact on patient flow. This will be monitored on a weekly basis and managed daily by the site management team with executive oversight as required.

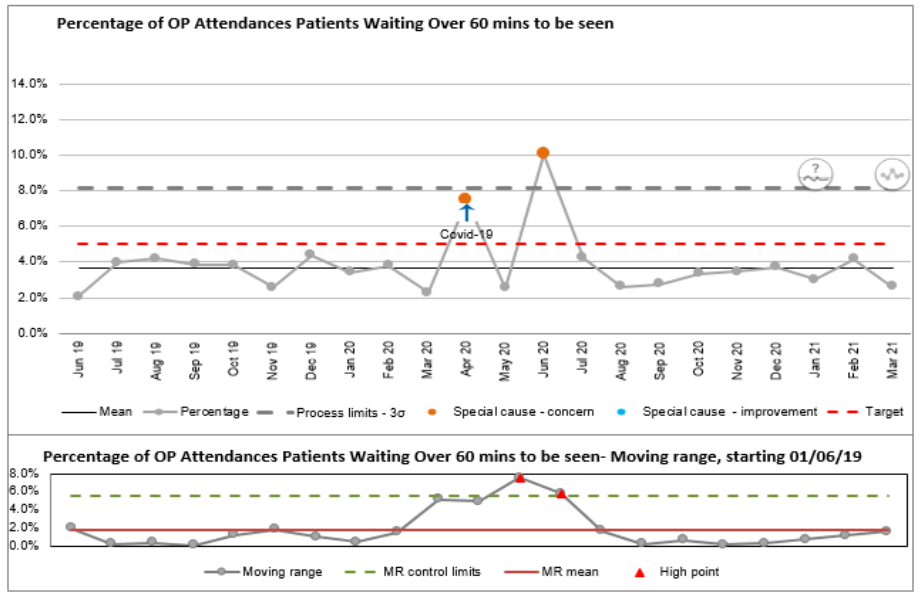
11. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
First DNAs	63	28	75	91	109	150	120	138	109	62	29	116
Follow Up DNAs	146	152	186	170	260	362	290	294	309	141	55	266
Total DNAs	209	180	261	261	369	512	410	432	418	203	84	382





INFORMATION

30 minute delays – Reduced in March to **11.3%** compared to **11.5%** in February. Trust Target is **10% -**
60 minute delays – March **2.6%** of patients were delayed compared to compared to **4.1%** in February. Target is 5% therefore achieved

The position in March is an improvement compared to recent months however there is further work to be undertaken with Oncology clinic delays and patients waiting for imaging procedures.

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure our patients are seen on time for their appointments. This new escalation process has been working well in conjunction with the daily huddle which takes place at 14:30 in the outpatients department.

An audit of all delays in March to analyse any key issues and scope solutions is in progress and results will be reported next month.

ACTIONS FOR IMPROVEMENTS / LEARNING

The DNA rates for March are **6.42%** compared to **3.97%** in February and continues to be below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department.
An analysis of the increased DNA rate will take place in April to understand any themes and address as required .

Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

RISKS / ISSUES

Lack of space in outpatients continues to be a concern and currently solutions are being scoped. One of the options being explored is the use of an alternative location for virtual clinics and extending the working day further in OPS To meet capacity requirements .

12. Referral to Treatment Snapshot as at 31st March 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

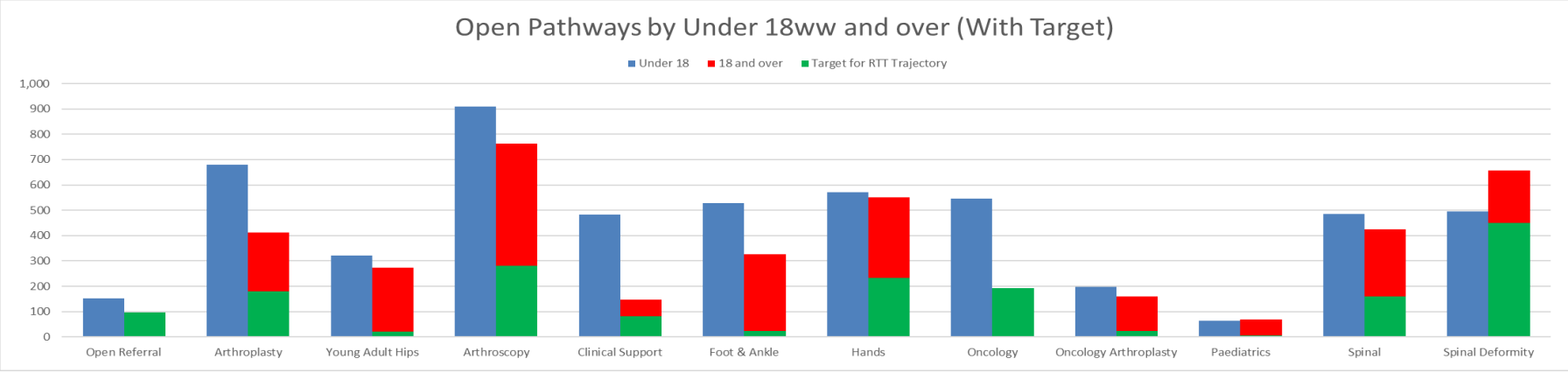
	Est Over 18 Clock Stops Required	
To achieve	81.47%	3055
To achieve	71.13%	1939
To achieve	81.74%	3080

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,533**	100	290	135	441	239	232	229	316	127	19	214	191
7-13	**1,637**	32	230	99	255	136	163	182	165	30	27	144	174
14-17	**1,264**	20	160	88	213	107	133	159	66	41	19	128	130
18-26	**2,120**	2	237	162	415	125	200	321	68	91	31	190	278
27-39	**1,367**	0	148	99	243	19	115	186	28	61	26	161	281
40-47	**210**	0	19	7	50	2	6	28	1	6	10	31	50
48-51	**53**	0	3	1	11	0	2	1	4	0	2	13	16
52 weeks and over	**142**	0	5	5	45	1	3	14	3	1	1	31	33
Total	**9,326**	154	1,092	596	1,673	629	854	1,120	651	357	135	912	1,153

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,434**	152	680	322	909	482	528	570	547	198	65	486	495
18 and over	**3,892**	2	412	274	764	147	326	550	104	159	70	426	658
Target for RTT Trajectory	**1727**	96	181	21	281	81	23	232	194	24	5	159	449
Target for RTT 92%	**746**	**12**	**87**	**47**	**133**	**50**	**68**	**89**	**52**	**28**	**10**	**72**	**92**

Month End RTT %	**58.27%**	**98.70%**	**62.27%**	**54.03%**	**54.33%**	**76.63%**	**61.83%**	**50.89%**	**84.02%**	**55.46%**	**48.15%**	**53.29%**	**42.93%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	2,165	-94	231	253	483	66	303	318	-90	135	65	267	209
Variance from target 92%	3,146	-10	325	227	631	97	258	461	52	131	60	354	566



Referral to Treatment Snapshot as at 31st March 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

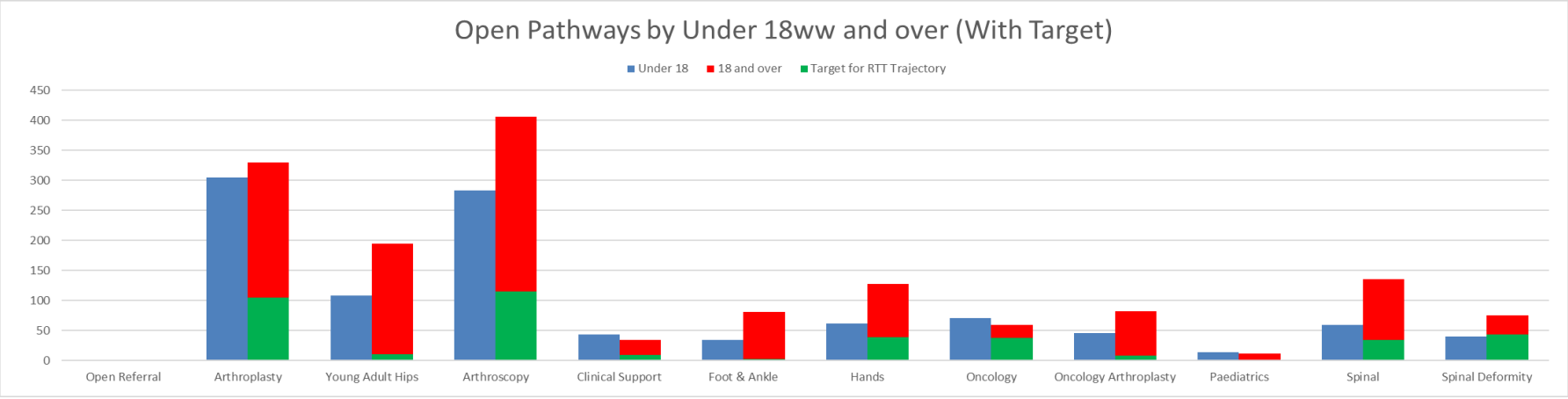
Est Over 18 Clock Stops Required		
To achieve	81.47%	1488
To achieve	71.13%	1269
To achieve	81.74%	1493

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**453**	0	108	43	137	23	14	24	50	21	3	20	10
7-13	**275**	0	90	26	64	10	6	16	16	9	6	16	16
14-17	**340**	0	107	39	82	11	15	22	5	16	5	24	14
18-26	**739**	0	184	111	188	21	43	61	28	39	2	42	20
27-39	**580**	0	124	75	137	13	31	50	23	37	8	53	29
40-47	**93**	0	15	4	38	0	2	9	1	5	1	10	8
48-51	**25**	0	2	1	8	0	2	0	4	0	1	7	0
52 weeks and over	**100**	0	5	4	35	0	3	8	3	1	0	23	18
Total	**2,605**	0	635	303	689	78	116	190	130	128	26	195	115

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,068**	0	305	108	283	44	35	62	71	46	14	60	40
18 and over	**1,537**	0	330	195	406	34	81	128	59	82	12	135	75
Target for RTT Trajectory	**482**	0	105	11	115	10	3	39	38	8	1	34	44
Target for RTT 92%	**208**	**0**	**50**	**24**	**55**	**6**	**9**	**15**	**10**	**10**	**2**	**15**	**9**

Month End RTT %	**41.00%**	**n/a**	**48.03%**	**35.64%**	**41.07%**	**56.41%**	**30.17%**	**32.63%**	**54.62%**	**35.94%**	**53.85%**	**30.77%**	**34.78%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,055	0	225	184	291	24	78	89	21	74	11	101	31
Variance from target 92%	1,329	0	280	171	351	28	72	113	49	72	10	120	66



Referral to Treatment Snapshot as 31st March 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/03/2021

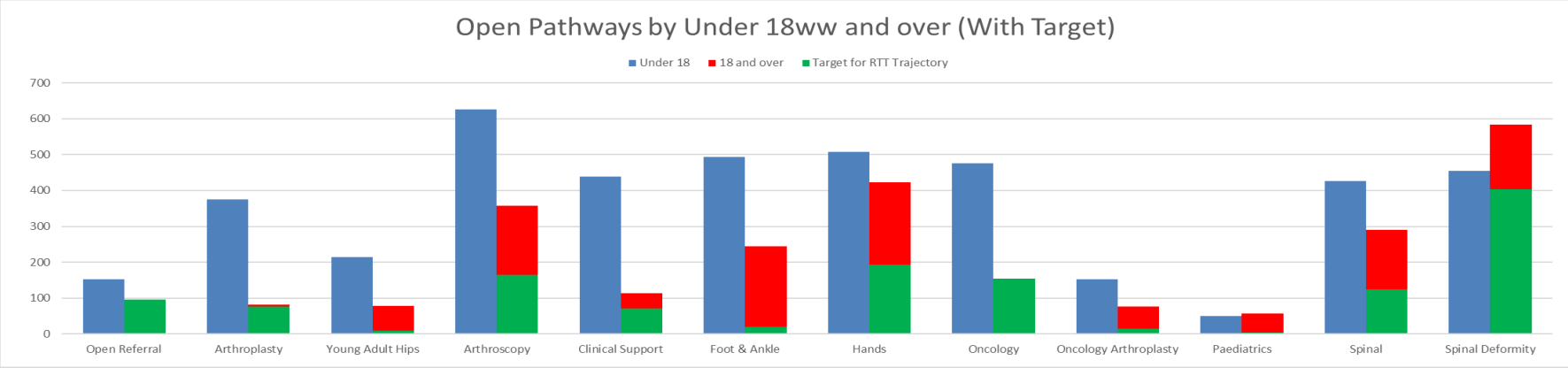
Est Over 18 Clock Stops Required		
To achieve	81.47%	1566
To achieve	71.13%	670
To achieve	81.74%	1587

Select Pathway Type: Non Admitted

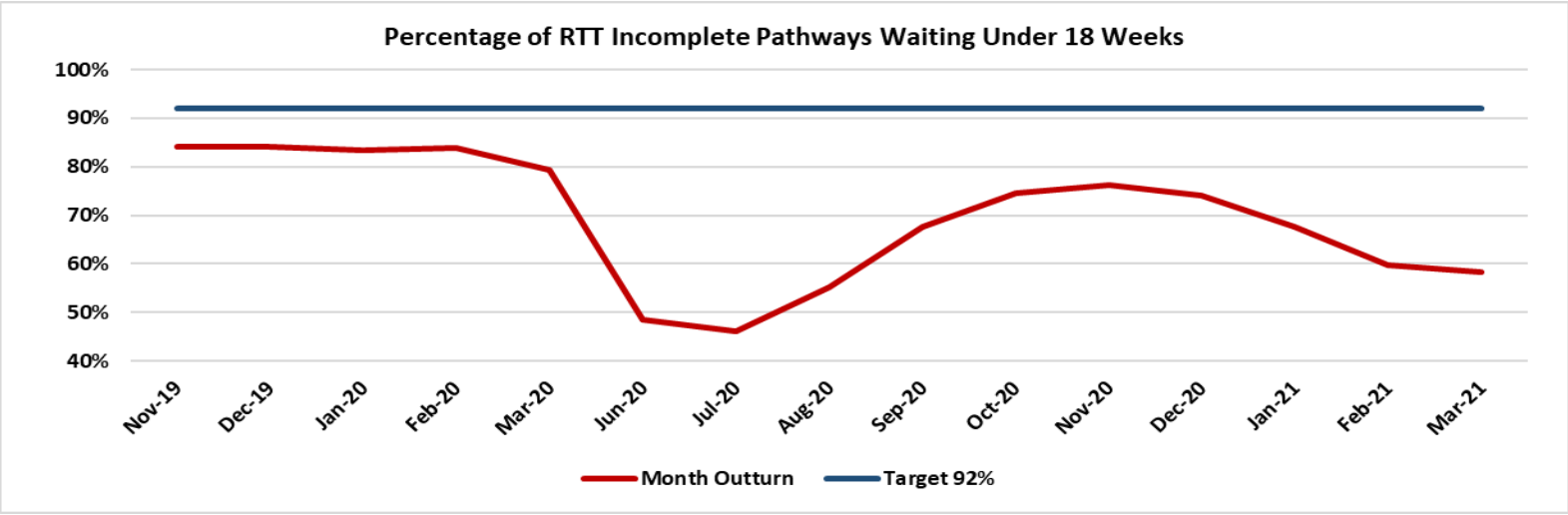
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,080**	100	182	92	304	216	218	205	266	106	16	194	181
7-13	**1,362**	32	140	73	191	126	157	166	149	21	21	128	158
14-17	**924**	20	53	49	131	96	118	137	61	25	14	104	116
18-26	**1,381**	2	53	51	227	104	157	260	40	52	29	148	258
27-39	**787**	0	24	24	106	6	84	136	5	24	18	108	252
40-47	**117**	0	4	3	12	2	4	19	0	1	9	21	42
48-51	**28**	0	1	0	3	0	0	1	0	0	1	6	16
52 weeks and over	**42**	0	0	1	10	1	0	6	0	0	1	8	15
Total	**6,721**	154	457	293	984	551	738	930	521	229	109	717	1,038

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,366**	152	375	214	626	438	493	508	476	152	51	426	455
18 and over	**2,355**	2	82	79	358	113	245	422	45	77	58	291	583
Target for RTT Trajectory	**1245**	96	76	10	165	71	20	193	155	15	4	125	404
Target for RTT 92%	**537**	**12**	**36**	**23**	**78**	**44**	**59**	**74**	**41**	**18**	**8**	**57**	**83**

Month End RTT %	**64.96%**	**98.70%**	**82.06%**	**73.04%**	**63.62%**	**79.49%**	**66.80%**	**54.62%**	**91.36%**	**66.38%**	**46.79%**	**59.41%**	**43.83%**
31/03/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,110	-94	6	69	193	42	225	229	-110	62	54	166	179
Variance from target 92%	1,818	-10	46	56	280	69	186	348	4	59	50	234	500



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for March is **58.27%** against the National compliance target of 92%. This is a slight decrease compared to February reporting at **59.72%** and is reflective of the cessation of elective procedures in order to undertake core critical services. There are **142** patients over 52 weeks. There are 100 admitted patients, P2 and P3 patients are being booked onto theatre lists and 42 non admitted patients with face to face clinics or diagnostic investigations now planned.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. 263 patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

In line with the national guidance for clinical prioritisation of patients awaiting surgery, 2605 patients are on the admitted waiting list (P1 – 7, P2 – 249 patients, P3 –806 patients, P4 – 1540 patients P5 – 2 patients and P6 – 1 patient). A working group is in place to ensure the harm prevention framework is standardised across all specialties to provide assurance that all patients are reviewed on a regular basis. At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority.

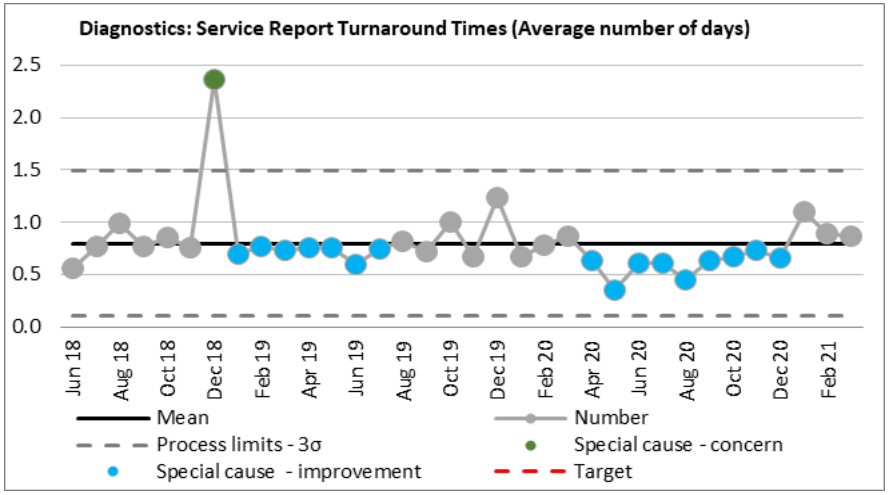
The total number of referrals into the Trust in March was 1899 which is low when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

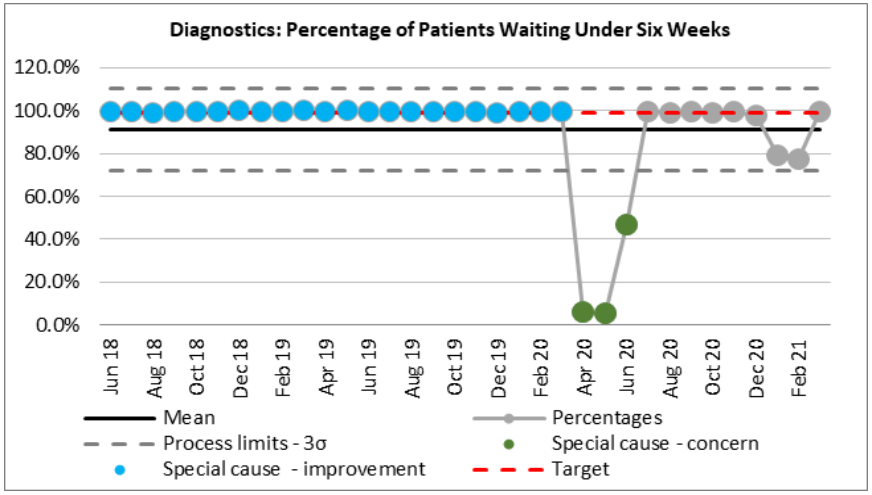
Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.
National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Mar-20	411	98	84	593	2	591	99.7%	911	218	315	1444
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION

Imaging recovered their backlog positon in March '21, achieving 99.03% of the diagnostic target. The department also continues to report consistently good performance for report turn around times.

Following a process review of how specialities request PACS images identified an inconsistent approach in how requests were being sent to the imaging PAC's team resulting in potential delays. The process has now been standardised across all specialties, all now using one communication channel which has resulted in imaging requests being acted upon in a more timely and efficient way.

ACTIONS FOR IMPROVEMENTS / LEARNING

An additional 6 days of mobile MRI van capacity has been secured for April to support the maintaining of the overall targets.

RISKS / ISSUES

The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

13. Cancer Performance Targets

		Indicative	*Reported Month*											
Target Name	**National Standard**	***Mar-21***	***Feb-21***	***In Target***	***Breach***	***Total***	***Jan-21***	**In Target**	**Breach**	**Total**	***Dec-20***	**In Target**	**Breach**	**Total**
2ww	93%	**100%**	**100.0%**	**35.00**	**0.00**	**35.00**	**100.0%**	**40**	**0**	**40**	**100.0%**	**61**	**0**	**61**
31 day first treatment	96%	**100%**	**100.0%**	**16.00**	**0.00**	**16.00**	**100.0%**	**18**	**0**	**18**	**100.0%**	**12**	**0**	**12**
31 day subsequent (surgery)	94%	**100%**	**100.0%**	**5.00**	**0.00**	**5.00**	**91.0%**	**10**	**1**	**11**	**100.0%**	**4**	**0**	**4**
62 day (traditional)	85%	**70.0%**	**66.7%**	**4.00**	**2.00**	**6.00**	**76.5%**	**6.5**	**2.0**	**8.5**	**73.3%**	**5.5**	**2.0**	**7.5**
62 day (Cons Upgrade)	n/a	**81.2**	75.0%	3.00	1.00	**4.00**	100.00%	**7.5**	**0.0**	**7.5**	100.00%	**4.0**	**0.0**	**4.0**
28 day FDS REPORTED	75%	**79%**	**78.4%**	**40.00**	**11.00**	**51.00**	**65.0%**	**41**	**22**	**63**	**69.0%**	**50**	**22**	**72**
28 day FDS INTERNAL	75%						79%	50	13	63	73%	50	19	69
No. patients treated 104+ days														

PERFORMANCE/IMPROVEMENTS/LEARNING

The Trust's performance for the 62 day target in February 2021 is 66.7% with 4.0 treatments within target + 2 breaches (2 full breaches due to complex diagnostic pathway). Performance for the 31 subsequent target is 100% with all 5 treatments within target.

The Trust's performance for the 62 day target for March 2021 is currently predicted at 70.0% with 3.0 treatments within target + 1.5 breaches (Please note the breaches are being reviewed. (submission closes 30.04.21).

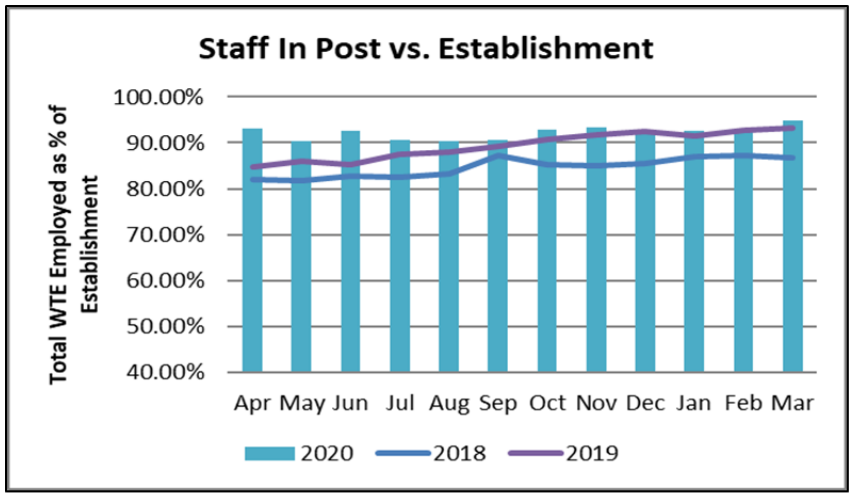
The faster diagnosis for February was 78.4% (new standard target is 75%). A total of 51 patients subject to FDS, 40 diagnosed within 28 days and 11 diagnosed outside target (3 patients received via late tertiary, 3 patients delayed histology, 1 patient covid-19 related, 2 patients complex pathway).

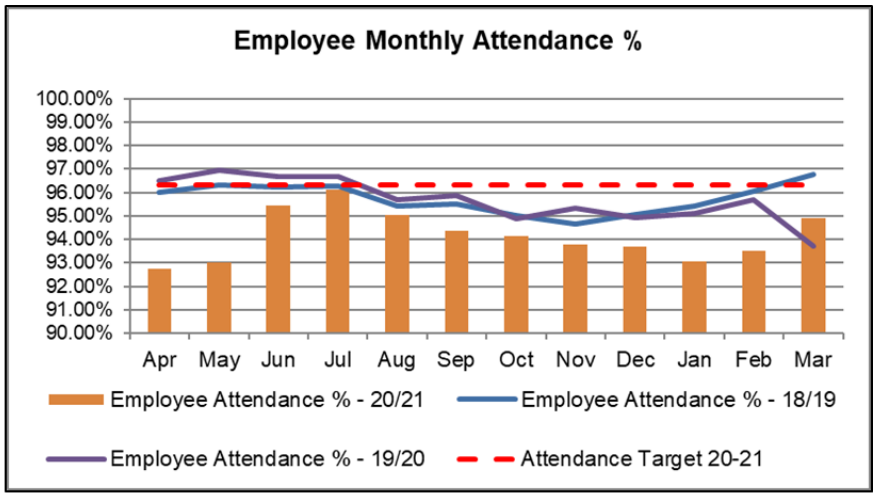
The Trust's Business Intelligence Service, with advice and help from the UHB Deputy Cancer Services Manager, are now currently developing specific data reports to enable a more detailed breakdown on key cancer waiting time targets to allow a better understanding of performance, trends, and highlighting areas where improvement is required. This work is currently being undertaken and anticipated mid-late April 2021.

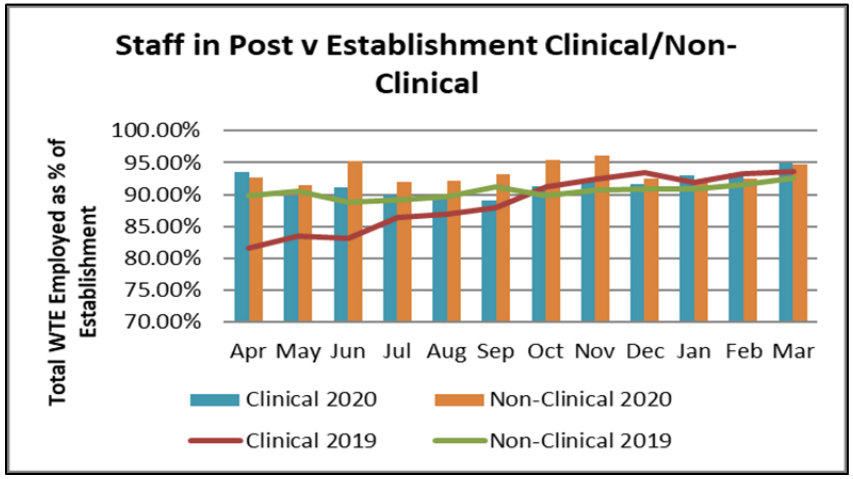
RISKS / ISSUES

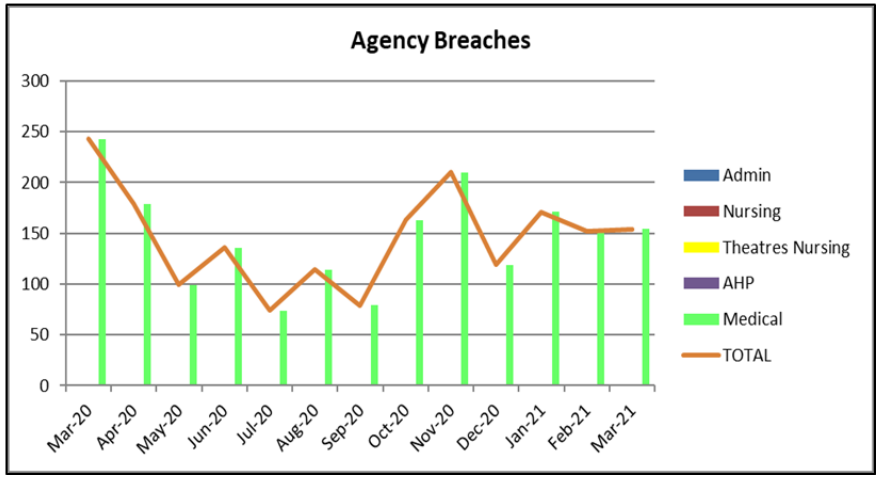
Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways, both of which are under current analysis and review. Recruitment issues remain an ongoing concern to appoint a specialist bone and soft tissue Pathologist at UHB . This is a national challenge across sarcoma centres and discussions are ongoing with UHB , Medical Director , Chief Operating Officer and the National Pathology network to source alternative solutions. This issue will be tabled for discussion at the Trust Quality and Safety Committee.

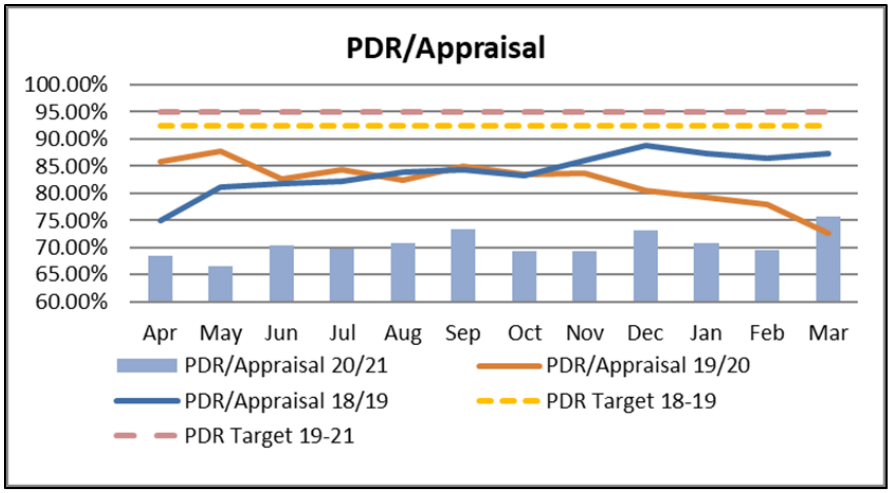
2. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

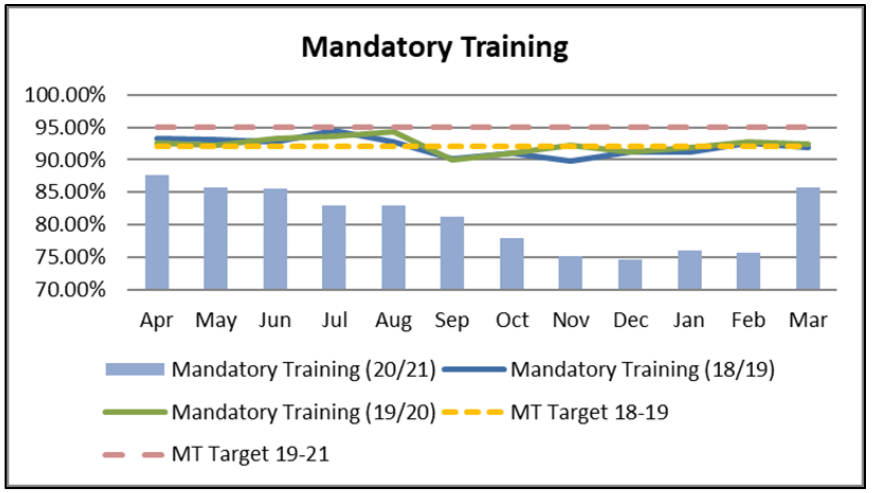


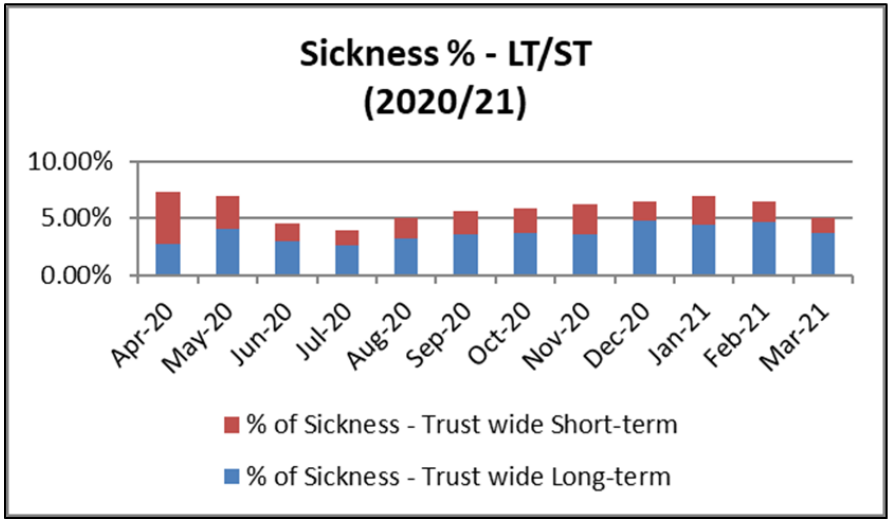


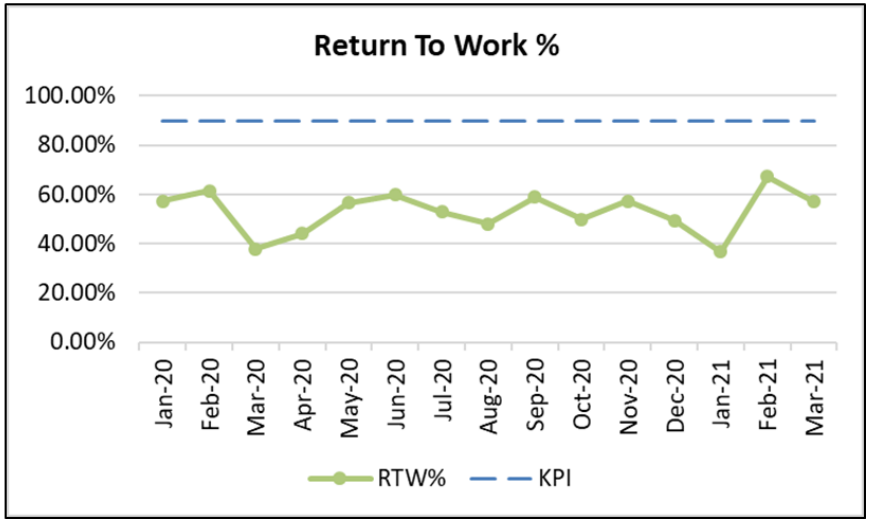





PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal 20/21
PDR/Appraisal 19/20
PDR/Appraisal 18/19
PDR Target 18-19
PDR Target 19-21


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (20/21)
Mandatory Training (18/19)
Mandatory Training (19/20)
MT Target 18-19
MT Target 19-21


Sickness % - LT/ST
(2020/21)
10.00%
5.00%
0.00%
Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Return To Work %
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
RTW%
KPI

ROHFP (01-20) 002 Finance & Performance Report

Overall Headlines

March 2021 saw a significant improvement in the Trust's overall appraisal and mandatory training figures rates. March saw the biggest improvement and highest figures in the last 12 months for those two areas. Vacancy rates also increased in all areas with non-clinical vacancies retaining a red status against the Trust KPI. Monthly attendance figures also slightly improved, whilst turnover and agency breaches remained constant with February 2021.

Vacancy

The number of staff on the payroll in March stood at **1206** (**1066.47 - WTE)**, an increase of **17.24 WTE**.

- The Trust vacancy position improved by **1.84%** to **94.85%**, maintaining a green status against the Trust's target of **93%.**
- The number of clinical staff vacancies decreased by **1.56%** to **94.96%,** also retaining it's green status against the Trust's target of **92%.**
- The number of non-clinical vacancies also increased by **2.11%** to **94.67%,** moving to the amber status against to the Trust's target of **96%.**

Monthly Attendance

- Monthly attendance increased by **1.43%** to **94.92%,** retaining it's red status against the Trust's target of **96.3%.**
- The underlying 12-month average attendance figure also slightly increased by **0.13%** to **94.04%** retaining it's red status against the Trust's target of **96.3%.**
- Long term sickness data slightly decreased by **0.45%** to **3.67%**

The figures have been quite similar over the past 3 months and we are expecting the continue improving following the COVID vaccination programme. Covid-19 absence data is still being reported daily to NHS England and weekly figures are being submitted to the BSOL STP

. **Appraisals**

- Appraisals completions increased by 6.09% to **75.73%,** and retains it's red status against the Trust target of **95%**

March 2021 saw the biggest increase in appraisal completion within the last 12 months since February 2020. The ESR & HR Teams are continuing to liaise directly with teams where there is continual non-compliance and also support managers with ensuring the information is accurately recorded on ESR in a timely manner. Medical appraisals are starting to be re-scheduled again where possible following the suspension of medical appraisals last year which was uplifted in September 2020.

Mandatory Training

- Mandatory training increased by **10.18%** to **85.79%** in March, moving to the amber status against the Trust revised target of **95%**

March 2021 saw a significant improvement in mandatory training completion and staff are still actively being encouraged to complete their mandatory training via e-Learning. New starters are also being supported with completing their mandatory training prior to starting.

Turnover Figures

- Unadjusted Turnover (all leavers except Junior Doctors) decreased slightly to **9.04%,** and retaining a green status against the Trust's target of **11.5%.**
- Adjusted Turnover (substantive staff leavers excluding flexible retirements) also decreased slightly by **0.19%** to **6.62%,** retaining a green status against the Trust's revised target of **11.5%.**

Agency Breaches

Agency Breaches increased slightly from **152** shift breaches in February 2021 to **154** shift breaches in March 2021. The entirety of this shift breaches were medical usage. There were no AHP, Nursing or Admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Re-introducing the appraisal preliminary report to encourage managers to record their completed appraisals on the system.
- Manager Dashboard to be finalised in the upcoming months to support managers with viewing their own workforce data

RISKS / ISSUES

- Turnover figures should be monitored, specifically unadjusted turnover as this is now more than 9%

	Feb-21	Mar-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	9.07%	9.04%	-0.03%	⇩	<=11.5%
Staff Turnover (%) - Adjusted	6.81%	6.62%	-0.19%	⇩	<=11.5%
Total WTE Employed as % of Establishment	93.01%	94.85%	1.84%	⇩	>=93%
Total WTE Employed as % of Establishment - Clinical	93.40%	94.96%	1.56%	⇩	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	92.56%	94.67%	2.11%	⇩	>=96%
% of Attendance	93.49%	94.92%	1.43%	⇧	>=96.3%
% of 12 mth MAA Attendance	94.09%	94.22%	0.13%	⇧	>=96.3%
% Staff received mandatory training last 12 months	75.61%	85.79%	10.18%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	69.64%	75.73%	6.09%	⇧	>=95%
% of Sickness - Trust wide Long-term	4.65%	3.67%	-0.98%	⇩	-
% of Sickness - Trust wide Short-term	1.86%	1.41%	-0.45%	⇩	-
Return To Work Completion %	67.26%	57.01%	-10.25%	⇩	>=80%

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday 5 May 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 5 May 2021 commencing at **0900h**. This will be a remote meeting facilitated using videoconferencing technology.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 5 May 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mr Matthew Corden	CQC relationship manager	(MC)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0920h	1	Apologies	Verbal	Chair
0922h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	3	Minutes of Board meeting held in Public on 7 April 2021: *for approval*	ROHTB (4/21) 026	Chair
	3.1	Actions from previous meetings in public: *for assurance*	ROHTB (4/21) 026 (a)	SGL
0925h	4	Questions from members of the public	Verbal	Chair
0927h	5	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (5/21) 001 ROHTB (5/21) 001 (a) ROHTB (5/21) 001 (b)	TP/JW
0950h	6	Refresh & recovery update: *for assurance*	ROHTB (5/21) 002	MP
1000h	7	**Inequalities**		
	7.1	Birmingham & Solihull system and ROH approach: *for assurance*	ROHTB (5/21) 003 ROHTB (5/21) 003 (a) ROHTB (5/21) 003 (b)	GM

	7.2	Children & Young People inequalities workstream: *for assurance*	ROHTB (5/21) 004 ROHTB (5/21) 004 (a)	GM
	7.3	Children & Young People inequalities case study: *for information*	Presentation	GM
1030h	8	Infection Prevention and Control & response to the Covid-19 pandemic		
	8.1	Health & Safety Executive COVID-19 spot check: *for information*	ROHTB (5/21) 007 ROHTB (5/21) 007 (a) ROHTB (5/21) 007 (b)	GM
1040h	9	Staff Experience and Health & Wellbeing		
	9.1	Strategic workforce plan – the approach to planning, redesign, talent management and succession planning: *for assurance*	ROHTB (5/21) 008 ROHTB (5/21) 008 (a)	SM
1050h	10	Governance & compliance		
	10.1	Paterson Inquiry update: *for assurance*	ROHTB (5/21) 009 ROHTB (5/21) 009 (a)	MR
	10.2	Annual complaints report: *for approval*	ROHTB (5/21) 010 ROHTB (5/21) 010 (a)	GM
	10.3	Board Assurance Framework: *for assurance*	ROHTB (5/21) 011 ROHTB (5/21) 011 (a)	ALL
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
1105h	11	Exception assurance reports from the Board Committees: • Finance & Performance – assurance report • Staff Experience & OD workshop – key highlights • Quality & Safety – assurance report	ROHTB (5/21) 012 Verbal ROHTB (5/21) 013	
1115h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance	ROHTB (5/21) 014 ROHTB (5/21) 015	

CONFIDENTIAL SESSION				
1130h	13	Exclusion of the press and public	Verbal	Chair
1235h	14	Any Other Business	Verbal	ALL
1245h	15	Meeting effectiveness	Verbal	ALL
Date of next meeting: Wednesday 2 June 2021 @ 0900h				

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 – UPDATED TO APRIL 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓										1/1
Kathryn Sallah	✓										1/1
Richard Phillips	✓										1/1
David Gourevitch	✓										1/1
Simone Jordan	✓										1/1
Gianjeet Hunjan	✓										1/1
Ayodele Ajose	✓										1/1
Les Williams	✓										1/1
Jo Williams	✓										1/1
Matthew Revell	✓										1/1
Garry Marsh	✓										1/1
Phil Begg	✓										1/1
Marie Peplow	✓										1/1
Stephen Washbourne	✓										1/1
Sharon Malhi	✓										1/1
Simon Grainger-Lloyd	✓										1/1

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 2 June 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: End of Life audit	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 7 April 2021: *for approval*	ROHTB (5/21) 026	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (5/21) 026 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/21) 001 ROHTB (6/21) 001 (a)	TP/JW
0950h	7	Refresh & recovery update: *for assurance*	ROHTB (6/21) 002	MP
1000h	8	Carbon strategy: *for assurance*	ROHTB (6/21) 003 ROHTB (6/21) 003 (a)	PB

1020h	9	**Staff Experience and Health & Wellbeing**		
	9.1	Staff survey 2020 results and organisational action plan: *for assurance*	ROHTB (6/21) 007 ROHTB (6/21) 007 (a)	SM
	9.2	Inclusion strategy: *for assurance*	ROHTB (6/21) 008 ROHTB (6/21) 008 (a)	SM
1045h	10	**Governance & compliance**		
	10.1	Declaration to NHS Improvement – General Condition 6 – systems for compliance with licence conditions: *for approval*	ROHTB (6/21) 009 ROHTB (6/21) 009 (a) ROHTB (6/21) 009 (b)	SGL
	10.2	Board responsibilities: *for information*	ROHTB (6/21) 010 ROHTB (6/21) 010 (a) ROHTB (6/21) 010 (b) ROHTB (6/21) 010 (c)	SGL
		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1050h	11	Assurance reports from the Board Committees: • Finance & Performance • Staff Experience & OD • Quality & Safety • Audit Committee	ROHTB (6/21) 011 ROHTB (6/21) 012 ROHTB (6/21) 013 ROHTB (6/21) 014	
1100h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance • Workforce	ROHTB (6/21) 015 ROHTB (6/21) 016 ROHTB (6/21) 017	
		CONFIDENTIAL SESSION		
1115h	13	Exclusion of the press and public	Verbal	Chair
	14	Declarations of interest on any matters in the private session	Verbal	ALL
	15	Minutes of the previous meeting in private held on 7 April 2021: *for approval*	ROHTB (5/21) 026 (P)	Chair
	15.1	Actions from previous meetings in private: *for assurance*	ROHTB (5/21) 026 (a) (P)	SGL
1120h	16	Chair and Chief Executive update on any confidential matters: *for information and assurance*	ROHTB (6/21) 018 (P) ROHTB (6/21) 018 (P) (a)	TP/JW

1135h	17	System plan 2021/22 update: *for information*	ROHTB (6/21) 019 (P) ROHTB (6/21) 019 (P) (a) ROHTB (6/21) 019 (P) (b) ROHTB (6/21) 019 (P) (c)	SW
1150h	18	Joint working: • Update on Robert Jones & Agnes Hunt oncology service • University Hospital Birmingham orthopaedic pathway	Verbal	MP
1205h	19	Modernising, Maintaining and Imagining the Future of the Trust Estate	Presentation	PB
1230h	20	Committee minutes and summaries: *for information*	ROHTB (6/21) 020 (P) ROHTB (6/21) 021 (P) ROHTB (6/21) 022 (P) ROHTB (6/21) 023 (P)	ALL
1235h	21	Any Other Business	Verbal	ALL
	22	Meeting effectiveness	Verbal	ALL
	Date of next meeting: Friday 18 June 2021 @ 0930h to sign off the Annual Report & Accounts and on Wednesday 7 July 2021 @ 0900h in public			

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.

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ATTENDANCE REGISTER – UPDATED TO MAY 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓									2/2
Kathryn Sallah	✓	✓									2/2
Richard Phillips	✓	✓									2/2
David Gourevitch	✓	✓									2/2
Simone Jordan	✓	✓									2/2
Gianjeet Hunjan	✓	✓									2/2
Ayodele Ajose	✓	✓									2/2
Les Williams	✓	✓									2/2
Jo Williams	✓	✓									2/2
Matthew Revell	✓	✓									2/2
Garry Marsh	✓	✓									2/2
Phil Begg	✓	✓									2/2
Marie Peplow	✓	✓									2/2
Stephen Washbourne	✓	✓									2/2
Sharon Malhi	✓	✓									2/2
Simon Grainger-Lloyd	✓	✓									2/2

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board - DRAFT Version 0.3

Venue Remote via videoconferencing **Date** 5 May 2021: 0900h – 1300h

Members attending:

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing and Clinical Governance	(GM)

In attendance:

Mr Matthew Corden	CQC relationship manager	(MC)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
No apologies for absence were received. The Board welcomed Matthew Corden, CQC Inspector and the Trust's relationship manager.	
2 Declarations of interest	**Verbal**
It was noted that the Register of Interests was available on request from Company Secretary.	
3 Minutes of Board Meeting held in Public on 7 April 2021: *for approval*	**ROHTB (4/21) 026**
The minutes of the previous meeting were accepted as a true and accurate	

reflection of discussions held.	
3.1 Actions from previous meetings in public: *for assurance*	**ROHTB (4/21) 026 (a)**
It was noted that several actions had been removed from the action log given that they were now covered by the strategic Board & Development Plan.	
4 Questions from members of the public	**Verbal**
There were none.	
5 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (5/21) 001** **ROHTB (5/21) 001 (a)** **ROHTB (5/21) 001 (b)**
The Chief Executive advised that 84% staff had been vaccinated again Covid-19 to date and thanks were given to Director of Finance, Steve Washbourne and his team for this achievement. The vaccine booster would be administered when appropriate and available which was likely to be in the autumn. There remained some further work to encourage staff to take up the vaccine, however there remained a small cohort of staff that either could not or were reluctant to have the vaccine. Mandatory training rates had improved to c.86%, up from 75% in the previous month. The good progress was echoed by Richard Phillips who noted that there had been significant challenges that needed to be overcome and the Head of Education & Training, David Richardson was thanked for his efforts. The 'ROH Life' newspaper had been prepared and had been circulated in digital and hard copy formats. The Chairman noted that this was an excellent publication and would be created seasonally. The Trust had participated in the AccessAble initiative and there had been good feedback. There has been much further national guidance around the Covid-19 response. All staff were thanked for their resilience and adaptability during this challenging time. The guidance for pre-operative assessment processes would be amended to fall back in line with the national standard set by NICE, given the low infection rates. Gratitude was given for the guide prepared for staff to support colleagues appropriately through Ramadam. Falon Paris-Caines had been appointed as the Chair of the Multi Minority Ethnic	

Group which it was agreed was an excellent appointment. The 'Check and Chat' walkabout had been held at the end of April and had been really well received. A well led assurance inspection by the CQC was noted to be planned shortly. It was noted that Sir Simon Stevens was stepping down as Chief Executive of the NHS shortly. The Chairman advised that he had been spending time dedicated to the development of the Integrated Care System (ICS). He had joined a 'round table' with Jeremy Hunt, former Secretary of State for Health, recently where there had been discussions about moving the NHS forward over future years. The Chairman had visited the Infection Control team and the good work of Head of Infection Prevention & Control, Victoria Clewer, was acknowledged. He had also spent some time with the HR team and with the kitchens and with staff in Café Royale. He had met with Falon Paris-Caines and was impressed with the individual and her ideas.	
6 Refresh and recovery update: *for assurance*	**ROHTB (5/21) 002**
The Chief Operating Officer presented the refresh and recovery update, which included lessons learned from the pandemic. There had been a new testing and preadmission protocol implemented which allowed some patients to be brought in at short notice. A theatre risk assessment and recovery plan had been delivered to allow all 14 theatres to be opened. The visitors' policy had been revisited and the use of the discharge lounge would be reviewed to maximise the flow; bed modelling was included in the daily situation report as a weekly forecast. A well supported communications launch had been delivered for the preadmission protocol. In terms of Outpatients, there was much work underway and subgroups were looking at capacity and video conferencing was being used. A virtual clinic environment would be implemented, this being separate from face to face clinics to maximise the use of Outpatients for face to face appointments. The welcome back meeting had been attended for redeployed staff. More work on workforce and wellbeing was being delivered including armchair yoga and meetings of the 'Admin Matters' group. A workforce planning baseline had been set. A fifth group had been introduced to the programme which looked at the system	

governance for the University Hospitals Birmingham NHSFT (UHB) pathway. Honorary contracts were in place for all clinicians coming across from UHB and there was a full induction for these staff. On 19 April, the UHB pathway had commenced and the feedback from Clinical Service Leads was positive and the pathway was working well. The Hospital Management Group had been reinstated. Some additional key highlights were shared, including the relocation of the Pre-Operative Assessment Centre and implementation of theatre recovery plans. The 6-4-2 meetings had been reinstated and a look back on theatre lists and lessons learned would recommence. The workstreams would be reviewed going forward. The Chief Executive noted that there continued to be no patients who had contracted Covid-19 and the UHB pathway was well managed. Kathryn Sallah thanked the Executive Team for all the work to orientate the new surgeons and to provide the oversight of this. In terms of the welcome back event, thanks were given to the staff who had undertaken different roles and had been flexible with their support. It was noted that attention needed to be considered around the wards as well as theatres, in addition to an eye on discharge rates and length of stay. All patients were being pre-operatively assessed at the ROH regardless of pathway used. The Chief Executive agreed to reflect the thanks of the Board through her weekly message. The Chairman noted it was pleasing to see the elevated numbers of cases now being handled.	
7 Inequalities	
7.1 Birmingham & Solihull system and ROH approach: *for assurance*	**ROHTB (5/21) 003** **ROHTB (5/21) 003 (a)** **ROHTB (5/21) 003 (b)**
The Director of Nursing & Clinical Governance presented a contextual report on the system and ROH approach to inequalities. The list of requirements that the Trust was required to consider in the planning guidance had been reviewed including data sets and consideration to equality of access. It was also mandated that the Trust had an understanding that the	

difference in approach over the pandemic did not exclude any patient groups, such as those who could not afford technology for activities such as virtual appointments. Within the ICS, there had been a working group established looking at Health Inequalities, this being led by Richard Kirby, Chief Executive of Birmingham Community NHS FT. This would now feed into the main ICS Board and the terms of reference for this group were considered. The main priorities of the Inequalities Board were highlighted, of which mental health and maternity (on the basis of infant mortality rate) were included. It was noted that health inequalities was wider than the NHS and it was suggested that this needed to be widened to public health and Local Authority. The responsibilities around strengthening leadership and accountability would be achieved by the Director of Nursing & Clinical Governance and Kathryn Sallah representing the ROH on the ICS Inequalities Board. An internal health inequalities group would be developed and the terms of reference would be set once the ICS terms of reference had been agreed. Some of the work in the ROH could be widened beyond the organisation, such as that around mental health first aiders. An annual physical health check also needed to be introduced to check any physical deterioration given that there was a link to mental health conditions. Learning disabilities were also being considered. Children and Young People's healthcare access was noted to be contingent on the support of adults. Access to good food was a key priority and how this was addressed for those needing to follow a particular nutritional regime; access to good food was noted to be less likely for those living in poverty. In terms of procurement, it was suggested that purchasing should take into account the local offerings. Finally, the green space agenda would also be supported and work underway continued. Key staff around these areas had been engaged to support the work. There was a plan to report into the Quality & Safety Committee which would sight the Board on this work through the usual upward report framework. The Chief Executive noted that there was some work around education and training around prevention. Making health inequalities real to staff was also planned. In terms of data quality, data related to health inequalities would be strengthened to allow the Director of Nursing & Clinical Governance to do what	

he and the team was required to do to meet the obligations.

In terms of analytical capability, Simone Jordan asked for an indication as to how sound business intelligence was at the ROH to be able to develop useful insights. The Director of Finance & Performance advised that following set up, the data analysis needed to be automated. The set up would need to be prioritised against work of the Business Intelligence team.

It was also noted that this the inequalities agenda was additional work and it was questioned whether there was capacity to deliver this. The Director of Nursing & Clinical Governance provided assurance that there was a plan to utilise existing forums where possible, such as a Children's and Young Person's Board. It was acknowledged that there was potentially an additional workload associated with the plan however this would be reviewed. The Chairman asked that discussions be held around whether new or different resources were needed to support this. The Chief Executive noted that inequalities needed to run through all the work of the ROH and potentially a public health skill set may be needed, possibly from a University Undergraduate. It was noted that the joint funding for inequalities work through the ICS would be critical.

Richard Phillips noted that health inequalities was gaining traction across the globe and the Director of Nursing & Clinical Governance was asked what the ambition of the work was given the unique make-up of the Birmingham population. He was advised that this would be set by the ICS Inequalities Board, however it was suggested that the ROH had the capability to set the ambition and had strength in its own right. It was noted that Birmingham had tried to tackle the issue multiple times but had gained little headway and progress. It was suggested that some measurable targets would also need to be set to drive the ambition. The Chairman agreed that definition and quantification of success and ambition was needed. Ayodele Ajose noted that care was needed to capture all the key pieces of information given the breadth of the work. It was reported that this would evolve as the governance structure developed. It was noted that there was an inextricable link between health and wealth.

It was noted that from 1 June 2021, the Clean Air zone would come into force in Birmingham which had the potential to create a financial pressure for some lower paid individuals who could not afford to change their car. A system wide policy would be developed, but the ROH would support staff in the absence of this, albeit there was likely to be a small cohort of staff affected.

Gianjeet Hunjan asked whether additional finances had been identified as part of the national funding mechanisms for the work. The Director of Finance & Performance noted that this was a discussion by the ICS Board although the system reserve may not be available to cover this.

It was agreed that a further update would be provided in September 2021.	
ACTION: **SGL to schedule a further update on inequalities for the September 2021 Board meeting**	
7.2 Children & Young People inequalities workstream: *for assurance*	**ROHTB (5/21) 004** **ROHTB (5/21) 004 (a)**
The Director of Nursing & Clinical Governance highlighted that the young person's transition into adulthood had an impact on health inequalities later in life, up to the age of 25. The index of multiple deprivation was highlighted. The concept and role of an anchor organisation was discussed and it was suggested that the ROH was one such body. It was noted that there was currently absence of recognition of vocational qualifications and flexibility of roles in the Trust. The impact of the pandemic on young people was noted to be severe as a result of the hospitality industry impact and the transition through life journey had been impeded due to lockdown. The importance to the ROH of this workstream was outlined. The ROH was highlighted to be 1.5% above the typical rate of employment of Young People however. A document toolkit to undertake a risk assessment against a set of criteria to ensure that the work was prioritised moving forward had been developed. There was a list of benefits with progressing the work, particularly in terms of workforce for the wider NHS. It was noted in terms of the demographic in the ROH, there appeared to be an issue in terms of the quantity of the workforce approaching retirement and therefore effort needed to be directed to securing employment of young people and apprenticeships. The key driver was to address the inequalities between the ROH workforce and the local demographic. There was a need to secure younger people to help open up conversations with younger patients. The need to build life skills as part of employment also needed to be considered. There was noted to be a real benefit of talent management and developing the brand so that the ROH was attractive to Children and Young People. The Director of Strategy & Delivery noted that the Trust had done well to attract apprentices who had gone on to secure permanent roles. There also needed to be attention to University schools in terms of support and the links to creating a level of prosperity in the city.	
7.3 Children & Young People inequalities case study: *for information*	**Presentation**

A presentation was delivered by the Director of Nursing & Clinical Governance around a case study in relation to child inequalities. This related to an individual who had suffered family hardship during the teenage years and the plan for a sound education had been compromised as a consequence, leading to employment opportunities being restricted to a trade job and a poor choice of housing and access to good food. The friends and social life of the individual were also impacted in a negative way. Once the individual secured employment in the NHS a number of opportunities in terms financial, network and housing opened up however. This also brought an opportunity to develop qualifications and gain a pension. It was suggested that given the local demographic a realistic ambition needed to be set. It was noted that the judgement of capabilities in the NHS and the background of the individuals joining the NHS needed to be reviewed to ensure that there was equity of opportunities for individuals from different backgrounds. It was agreed that for some roles, there needed to be an understanding that previous experience of the NHS may not be needed. The power of the case study was noted by all Board members and the Director of Nursing & Clinical Governance was thanked and encouraged to think through how this may be shared further.	
8 Infection Prevention and Control & response to the Covid-19 pandemic	
8.1 Health and safety Executive COVID-19 spot check: *for information*	**ROHTB (5/21) 007** **ROHTB (5/21) 007(a)** **ROHTB (5/21) 007 (b)**
A gap analysis against the key findings from a set of inspections undertaken by the Health & Safety Executive over the Covid-19 period was reviewed. The Quality & Safety Committee was noted to have scrutinised this recently. It was highlighted that there was an absence of consistent evidence around some of the policies and procedures and risk assessments and in terms of the audit methodology for non-clinical areas there was little evidence. There was also a range of issues identified associated with ventilation. The output was noted to be that a review would be commissioned which would be considered by the Quality & Safety Executive. The risks would also be added to the estates risk register. There were noted to be limitations based on the age of the estate. The Associate Director of Estates was reported to be undertaking the assessment and this would be completed within the next 6-8 weeks. There were noted to be no immediate concerns regarding ventilation that needed to be highlighted.	

It was noted that this was a significant amount of work and there was a concern regarding the available capacity to deliver this. In terms of Health & Safety capacity, it was agreed that there did need to be some consideration to broadening the team. It was suggested by Kathryn Sallah that this review needed to be extended to all Executive Team members.	
9 Staff Experience and Health & Wellbeing	
9.1 Strategic workforce plan – the approach to planning, redesign, talent, management and succession planning: *for assurance*	**ROHTB (5/21) 008** **ROHTB (5/21) 008 (a)**
The Acting Associate Director for Workforce & OD advised that there was a greater focus on talent management nationally and systemwide. Talent management in the system was embryonic and there was discussion planned shortly with the South East region to review their progress and approach. Talent management and succession planning for the ROH would be aligned to other pieces of work such as health inequalities and the refresh of the People Plan. Talent management would also feature in the life cycle of individuals at the ROH including within career conversations. Nationally, there was noted to be a focus on Band 8d individuals, however for the ROH it was suggested that this should be Band 8a individuals and above, as there were few people in the organisation at an 8d level. A talent diagnostic had been undertaken which showed some progress had been achieved but more needed. The process would be applied on a risk-based approach. The tools to progress the talent management approach would be developed. The policies also needed to be robust enough to be able to support this work and to align this though the strategic workforce planning. Plans were in place to secure the necessary capacity for the work. It was suggested that a plan and resource analysis was needed given its ambition. Simone Jordan supported the proposals and commended the Trust in moving this to a proactive approach. She suggested that the processes needed to be designed so it was a responsibility for all. It was noted that there was an opportunity to undergo training and some individuals in the Trust would be useful to engage.	

The Chairman suggested that Board succession planning also needed to be considered as part of this work.	
ACTION: SM/SGL to progress Board succession planning	
10 Governance & compliance	
10.1 Paterson Inquiry update: *for assurance*	**ROHTB (5/21) 009** **ROHTB (5/21) 009 (a)**
It was noted that the origin of the Paterson Inquiry and subsequent report was the investigation of a clinician who was found guilty of a number of intents to harm. The gap analysis against the key findings and recommendations in the report was considered. Kathryn Sallah noted that the paper had been discussed at Quality & Safety Committee. It was suggested that it was key that there was confidence that all staff would feel able and confident to speak up. There needed to be certainty that there was commitment to addressing the actions and to eliminate the tolerance and not withstand wilful blindness. In terms of writing to GPs and ensuring that a copy of the letter was sent to patients there was a renewed focus to be compliant. David Gourevitch noted that the work underlined the importance of medical appraisal. It also underlined the link between private and NHS practice and the needed to be subject to audit. There was also a workforce process that needed to support the work. Health and safety of individuals needed to be the key driver for the processes. It was suggested that a 'Just Culture' framework needed to be borne in mind and a balanced approach was needed.	
10.2 Annual Complaints report: *for approval*	**ROHTB (5/21) 010** **ROHTB (5/21) 010 (a)**
It was noted that the annual complaints report related to the 2019/20 financial year. The number of complaints during the year had remained static and the Patient Advisory Liasion Service (PALS) contacts had been most notably around appointment waiting times and clinical advice. There had been some challenges with achieving the key performance indicators for complaints handling, this being	

linked with a single points of failure, although this had now been addressed. It was noted that the 2020/21 report would be developed and the detail of the common themes would be included.	
10.3 Board Assurance Framework: *for assurance*	**ROHTB (5/21) 011** **ROHTB (5/21) 011 (a)**
The refreshed Board Assurance Framework was reviewed and it was noted that there were a number of changes proposed. It was suggested that the plan to de-escalate the financial sustainability onto the Corporate Risk Register needed to be reconsidered given that there was not currently clarity around the long term financial position of the organisation given the recent changes to the national and system-wide financial regime. The matter would be discussed further at the next Finance & Performance Committee meeting. The proposal to close the risk an increased risk of patient harm for peri-operative patients testing positive for COVID-19 as a result of patients with Covid-19 having a significant morbidity and mortality was not agreed given that this remained an ongoing feature of the pandemic. This would be discussed further by the Quality & Safety Committee.	
11 Exception assurance reports from the Board Committees: • **Finance & Performance – assurance report** • **Staff Experience & OD workshop – key highlights** • **Quality & Safety – assurance report**	**ROHTB (5/21) 012** **Verbal** **ROHTB (5/21) 013**
Richard Phillips noted that in terms of the Finance & Performance Committee update the main points had already been covered on the Board agenda. It was noted that the number of virtual appointments conducted was pleasing. There had been good progress with achievement of the diagnostics targets. The end of financial year was reported to be a deficit of £2.4m against a plan of £2.6m. Length of stay had reduced, however there may be an impact in coming months as a result of the University Hospitals Birmingham NHS FT orthopaedics pathway. It was noted that there would be separate reporting for this pathway, therefore any impact would be clarified. In terms of the Quality & Safety Committee, Kathryn Sallah reported that there had been a concern raised around the performance against the Key Performance Indicators within the Pathology contract; this was a local and regional issue and the impact on patients needed to be understood. It was noted that there was lots	

of positive assurance provided at the meeting. Simone Jordan noted that the Staff Experience & OD Committee workshop had focussed on metrics and observed the importance of the data as this had been mentioned in several of the Board discussions. It was suggested that the HR business partner model needed to underpin the ownership of this across the Trust.	
12 Performance reports: *for assurance* • **Quality & Safety** • **Finance & Performance**	**ROHTB (5/21) 014** **ROHTB (5/21) 015**
The Director of Nursing & Clinical Governance highlighted the increase in the use of agency staffing and reported that the position was being investigated. The time of discharge was also being reviewed to ensure that this information was meaningful. In terms of staff absences, six staff were currently absent due to Covid-related conditions, a significant reduction from the previous position.	
13 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
The next meeting is scheduled for Wednesday 2 June 2021 @ 0900h.	

PUBLIC SESSION

Next Meeting: 2 June 2021, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 28.05.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 091	Update from the Guardian of Safe Working Hours	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	06/11/2019	Arrange for the Guardian of Safe Working to present an update to the Trust Board	JWI	~~01/07/2020~~ ~~13/01/2021~~ ~~7~~/07/2021	New individual appointed and will join the Board in ~~January~~ July 2021	C-19
ROHTBACT.105	~~Health & wellbeing~~ update including the role of the Wellbeing Guardian	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	07/04/2021	Identify the Health and Wellbeing Guardian	TP/SGL	15-May-21	Approach made to Non Executive colleagues. Discussed within the 'Roles & Responsibilities' paper included on the public agenda for the June 2021 meeting	
ROHTBACT.103	Staff survey 2020 results and action plan	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	07/04/2021	Present the Staff Survey action plan at the June 2021 meeting	SM	02-Jun-21	Included on the agenda of the June 2021 meeting	
ROHTBACT.104	Diversity, equality, respect and inclusion update	ROHTB (4/21) 008	07/04/2021	Present the equality and diversity action plan in June 2021	SM	02-Jun-21	Inclusion strategy which includes equality & diversity interventions included on the agenda for the June 2021 meeting	
ROHTBACT.106	Health & wellbeing update including the role of the Wellbeing Guardian	ROHTB (4/21) 009 ROHTB (4/21) 009 (a)	07/04/2021	Prepare a summary of the statutory roles that Non Executives were expected to undertake	SGL	02-Jun-21	Discussed within the 'Roles & Responsibilities' paper included on the public agenda for the June 2021 meeting	
ROHTBACT.107	Learning Lessons to Improve our People Practice	ROHTB (4/21) 010 ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)	07/04/2021	Present the revised disciplinary policy at a future meeting	SM	07-Jul-21	ACTION NOT YET DUE	
ROHTBACT.109	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the IT Programmes of work at the July 2021 meeting	SW	07-Jul-21	ACTION NOT YET DUE	
ROHTBACT.110	Strategic workforce plan – the approach to planning, redesign, talent, management and	ROHTB (5/21) 008 ROHTB (5/21) 008 (a)	05/05/2021	Progress Board succession planning	SM/SGL	31-Jul-21	Initial discussions helds with Trust Chairman and a plan will be constructed for each Board role by the end of July 2021	

ROHTBACT. 092	Trust's response to the Paterson Report	ROHTB (3/20) 012 ROHTB (3/20) 012 (a)	04/03/2020	Arrange a briefing session on the Paterson Report	MR	07-Apr-21	Included on the agenda of the May 2021 meeting	
ROHTBACT. 100	Board Assurance Framework	ROHTB (3/21) 005 ROHTB (3/21) 005 (a)	03/03/2021	Refresh the IT risk on the Board Assurance Framework	SW	05-May-21	Included in the refreshed BAF due to be considered by the Board in May 2021.	
ROHTBACT.108	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the system IT approach to the Finance & Performance Committee	SW	25-May-21	Presented to the Finance & Performance Committee in May 2021	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (6/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board in Public on 2nd June 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 5th May 2021 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 It is encouraging to see that in April our elective activity was in line with the planned trajectories agreed across Outpatients, Inpatients and Day cases. I know that this has been delivered at a time when the Trust still has a number of capital programmes underway, so I would like to thank everyone for their continued commitment and effort.

2.2 On Monday 17th May we opened our new purpose-built Pre-Operative Assessment Centre (POAC) which increases our capacity and has given us the opportunity to improve the pathway. The facilities look fantastic and I am very grateful to all the team who came in over the weekend to get the area ready. It was also a busy weekend as the Paediatric Outpatient Team also moved into their new accommodation and my thanks again to all the team who worked over the weekend.

2.3 The CQC Well-led assurance assessment using the Transitional Monitoring Approach (TMA) has been arranged for 22nd June 2021, which as updated previously will be virtual. We look forward to meeting with the team and sharing with them the progress and sustainable improvements we have made since our last inspection.

2.5 We have received a complaint from a member of the public via one of our Governors regarding staff smoking outside of the Trust premises on the Bristol Road. We have apologised to the individual and we are currently working through a number of actions to help to try and alleviate the issue. We also acknowledge that whilst it is not on the Trust premises we do have responsibility to uphold and protect the image of our Trust and its staff, so we will use this opportunity to review the policy which will be in consultation with staff and our staff side partners alongside support such as smoking cessation for staff.

2.6 On Thursday 27th May we successfully appointed to both Divisional Head of Nursing posts. Congratulations to Karen Hughes who is currently the interim Head of Nursing for Division 1 and we look forward to welcoming a new member of staff to the ROH team over the coming months into Division 2.

2.7 On the 24th June we are interviewing six candidates for the Freedom to Speak up Guardian role following a telephone interview shortlisting process which was required due to very high interest in the role.

2.8 The annual appraisal and objective setting process has been concluded for the Executive Team and a summary of the process and outcome will be discussed at the next Nominations and Remuneration Committee.

3 Birmingham & Solihull (BSol) Integrated Care System (ICS) Update

3.1 An Extraordinary ICS Board took place on Friday 28th May to sign off the system H1 (Months 1 – 6) plan which is due to be submitted to NHS Improvement on 6th June 2021 and was approved. We also received a draft of the system priorities for 2021/2022 which had been developed with the ICS Chief Executives. There was positive support for the priorities with minor additions to the plan. It is expected that this will be discussed with the Chief Executives who will also review what resource is required to now develop the implementation plans alongside the narrative and metrics to ensure that we review and monitor progress.

3.2 Recruitment is current underway for the appointment of Chief Executive for the ICS Board.

3.3 It is proposed a small expert group with independent legal and change management expertise in this area commence the work to propose what a provider collaborative could look like. They will build on the work already undertaken, developing the following options:

a. The leadership models for the provider collaborative(s) (including the governance implications for individual Boards, non-executives and executives of each of the options). The advantages and disadvantages of each should be explored and a simple assessment against a set of agreed criteria undertaken.
b. The legal mechanisms that could be deployed to support the leadership models, the advantages and disadvantages of each and a simple assessment.

The group will report through to Professor Sir Bruce Keogh, who it has been agreed will chair the overall ICS provider collaborative and in turn to the ICS Board. The ambition is that a full decision will be made at the ICS Board on the 12th July, before then a further round table debate of the key players (Chief Executives and Chairman) would allow time for more detailed debate and discussion. This is an important decision for the health and care system and does warrant an appropriately planned time for discussion and debate.

4 NHSI/E National updates

4.1 Fortnightly briefing calls remain in place with NHSI, with the focus being on the vaccination programme and restoration & recovery of elective activity across the Midlands and East region.

4.2 On Thursday 20th May 2021, Steve Washbourne attended the Birmingham & Solihull quarterly performance meeting with NHS Improvement on behalf of the ROH.

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, there have been no policies presented to the Chief Executive, on the advice of the Executive Team for approval.

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams

Chief Executive

28th May 2021

F&P | UPWARD REPORT

PROGRAMME:	**Restoration and Recovery Phase 2: Refresh and Recover**	**PROGRAMME MANAGER:**	**Alicia Stanton**	**DATE:**	**20/05/2021**
PROJECTS:	**Preop and Scheduling / Inpatients / Outpatients / Workforce and Wellbeing / ROH-UHB System**	**EXEC SPONSOR:**	**Marie Peplow Matt Revell**		

MILESTONES ACHIEVED (OVER LAST MONTH)

- New elective preadmission testing protocol running well – now BAU
- Theatre Recovery plan implemented
- POAC re-located to old ward 11
- 6-12 month extension of on-site testing facility agreed
- Bed modelling ongoing – built into Sitrep weekly
- Robust OP Physiotherapy plan in place
    - COVID screening information agreed by IPC to enable a reduction in patient phone calls
    - Waiting list 'validation day' arranged
    - Gym classes re-started
    - Physio recruitment successful
- Activity at Lordswood re-commenced
- New OPD-Imaging process designed and 1 month trial commenced (to improve flow)
- Successful virtual Health and Wellbeing week
- Regular Managers support calls ongoing
- All UHB patients going through ROH POAC from 17/05/21
- Systems group move to BAU – operational, governance and oversight meetings in place

ISSUES/CONCERNS/RISKS IDENTIFIED

- Physiotherapy backlog (planning in progress)
- Lack of space to accommodate virtual clinic rooms (to be discussed at Accommodation Review Committee)
- Concerns over Imaging flow due to waiting room restrictions (secondary to social distancing) – New OPD-Imaging process currently being trialled
- UHB surgeons operating in an unfamiliar environment (review and mitigation in place)
- Reduced capacity for ROH surgeons to operate (increase to 14 theatres, and scoping additional weekend sessions)

DECISIONS / SUPPORT REQUIRED

- Decisions and support undertaken via R&R Board

WORK PLANNED (MONTH AHEAD)

- Assurances around new preadmission testing protocol to go to R&R Board (e.g. no. of COVID positive results, no. of theatre cancellations etc.)
- Review results of trial of patient flow between OPD and Imaging
- Scoping of virtual clinic space – to go to the Accommodation Review Committee
- Virtual clinics sub-group to recommence, led by Matt Payne
- OP Physiotherapy waiting list 'validation day' (all patient's contacted by phone to establish need) 22/05/21
- Programme Manager to attend System oversight meetings regularly for ongoing 'lessons learnt'
- Closure meetings for every group, to discuss transition into BAU and lessons learnt

KEY BENEFITS: MEASURING SUCCESS OF THE PROGRAMME

- All outpatient services restarted
- Elective surgery restarted (including ROH and UHB patients) – treatment of priority patients at risk of potential harm
- Effective partnership working (integrated and standardised pathways)
- Reduced system waiting times

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Carbon Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Stuart Lovack, Associate Director of Estates and Emma Lenegan-Edwards, Emergency Planning & Sustainability Officer**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

The Trust's strategy from 2009 has been to work towards meeting the Government's target for carbon reduction by reducing its carbon footprint from the base year in 2006.

This paper provides an update to the current position and present recommendations for the next 12 months.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the paper.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Compliance with national carbon strategy.

PREVIOUS CONSIDERATION:

None.

CARBON STRATEGY UPDATE

REPORT TO THE TRUST BOARD ON 2 JUNE 2021

1.0 Summary/Background

1.1 The Trust's strategy from 2009 has been to work towards meeting the Government's target for carbon reduction by reducing its carbon footprint from the base year in 2006.

1.2 Different targets have been published during this time ranging from 10% reduction by 2015, recently rising to a 34% reduction by 2020.

1.3 The recently published 'NHS Green Agenda' is gathering momentum, all Trust's will need to have a Board Approved 'Green Plan' by April 2022 which aligns to the ambitions in delivering a 'Net Zero NHS'.

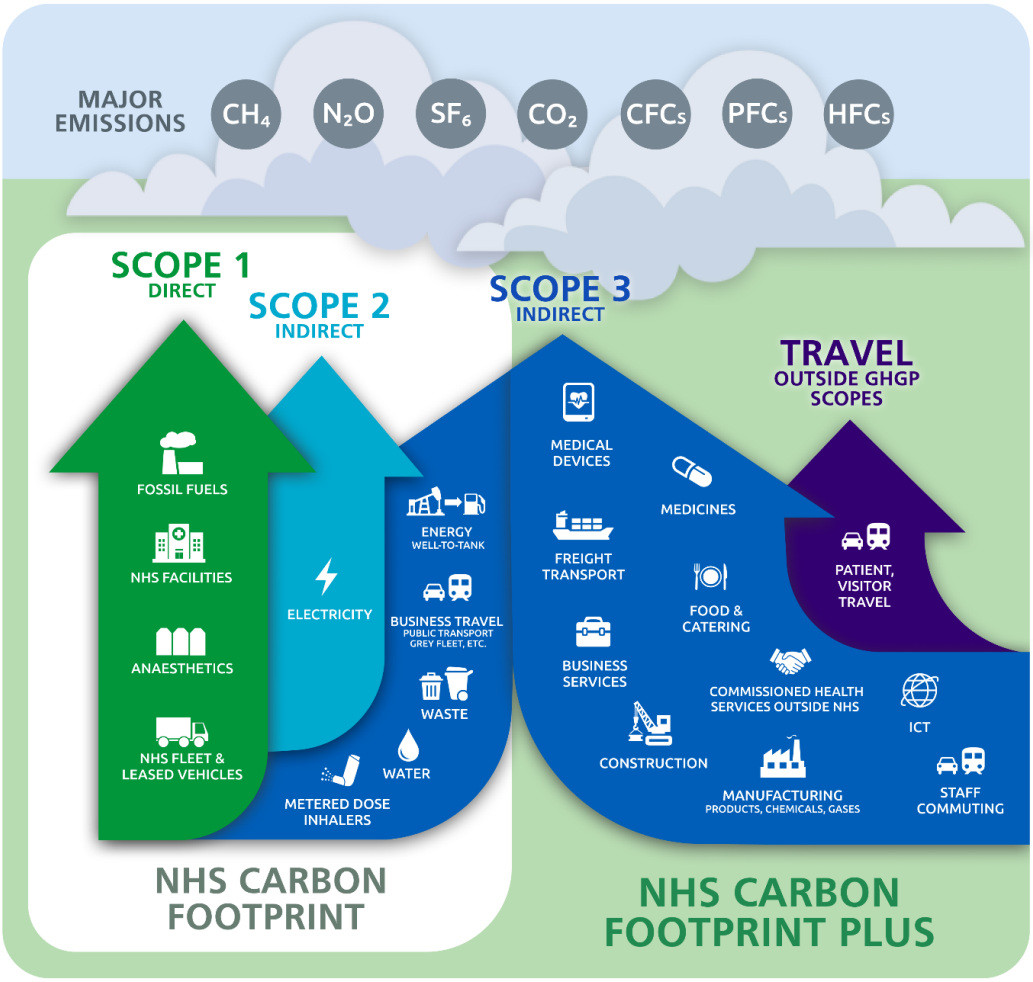
1.4 A revised NHS target was published in October 2020, which will see:

- NHS Carbon Footprint be at 'Net Zero' by 2040 with an ambitious interim target of an 80% reduction by 2028/2032.
- NHS Carbon Footprint Plus (including the Supply Chain) to be at 'Net Zero' by 2045, with an ambitious interim target of 80% by 2036/2039.

1.5 The overall Greenhouse Gas Protocol (GHGP) scope covers a wider set of emissions such as:-

Scope 1	Direct Emissions – Fuels and Heating sources
Scope 2	Indirect Emissions – Electricity
Scope 3	Indirect Emissions – All goods and Services

1.6 As illustration overleaf, patient and visitor travel falls outside of the GHGP scope processes but is a key element of overall NHS emissions.



1.7 Birmingham City Council declared a Climate Emergency on 11th June 2019 and has committed to reduce the city's carbon emissions with an ambition for the city to become 'Net Zero Carbon' by 2030.

1.8 The Clean Air Zone (CAZ) is being introduced in June 2021 which aims to see air quality improvements within the city centre, where there are currently dangerous levels of air pollution.

2.0 Current Situation

2.1 As a Trust, a forum called the Good Corporate Citizen Group (GCCG) was formed a number of years ago to look at areas of improvements that would reduce the overall impact the Trust has on the environment. The GCCG is chaired by the Associate Director - Estates and Facilities and is scheduled to meet quarterly.

2.2 Overall attendance at the meetings has been a challenge with competing priorities, and is perhaps indicative of the green agenda being seen as a lower priority alongside clinical priorities and of course the recent pandemic effect.

2.3 The Trust has a named Sustainability Officer. The postholder is contracted to work 25 hours per week which includes other designated roles in Emergency Planning and Car Park Management.

2.4 The Sustainability Officer is a member of National Performance Advisory Group Sustainable Leads Network, the group meet quarterly with the lead officer for Sustainability and Estates and Facilities Management Workforce Lead at NHSI/E.

2.5 The Trust also has a working relationship with the West Midlands Green Travel Network via Transport for West Midlands and Birmingham City Council.

2.6 The main focus has been looking at Scope 1 and Scope 2, where technology and new equipment offer a reduction in the overall usage saving.

2.7 Recently this has been:

- Existing boilers in the Admin Plant room are 15 year old Hamworthy boilers (capacity 450 kW) these have been replaced with high efficiency Hoval Ultra Gas boilers which are 98% efficient (related to Net Calorific value).
- The Existing 15+ years old cold-water booster set serving the site has been replaced with an efficient inverter driven 3 stage booster set.
- Lighting in corridor link areas are provided with LED lights with auto switching.
- LED Lighting with manual switching is provided in Boiler Room area to replace existing fluorescent lights.
- Investment in replacement Trust Fleet Vehicles from diesel to electric.

2.8 Through campaigns and events staff have been encouraged to participate in all aspects of good housekeeping, which has made a small contribution in driving down the Trust's overall energy usage and carbon footprint.

2.9 In 2019/20 as per previous years, ambitious targets were set to continue to move towards and achieve the then 'National Target' for a carbon footprint saving of 20% reduction.

2.10 Progress is as follows:

By Tonne	Baseline 2006/07	Actual 15/16	Actual 16 /17	Actual 17/18	Actual 18/19	Actual 19/20	Actual 20/21	National Target 2020
Gas * (Scope 1)	1420	1677	1478	1161	1221	1461	1406	1136
Electricity ** (Scope 2)	1539	1612	1608	1607	1608	1018	1076	1231
Staff travel	1100	1006	1006	1006	1006	1006	1006	880
Water (Scope 1)	29,374	27000	22430	28514	28522	28539	TBC	23459

*Calculation Change from 19/20 – fossil fuel levy (usage not increased)

**Calculation Change from 19/20 - more 'green' sourced electricity used (usage not decreased)

2.11 Unfortunately, despite the work that has been undertaken, the Trust has not achieved the 20% saving in Scope 1 emissions. This may be in part because of increased footprint of buildings on site and an increase in the overall staffing establishment at the Trust.

2.12 As a Trust we have been able to procure 'greener' electricity, Scope 2 reduction has been achieved but the overall usage has not reduced.

2.13 Since the targets were originally set we have seen:

- The size of the Trust's Estate has increased by over 18%;
- An additional mobile MRI scanner on-site twice a month;
- The completion of the Phase 2 Theatre/Ward Development;
- Increased footprint of POAC;
- Increased footprint of Pharmacy;
- Increased footprint of the Knowledge Hub;
- The permanent second MRI scanner installation which is due to complete in 2021, this will see the overall usage on site increase further.

2.14 Whilst there is a balancing off, between the new developments and reductions in other areas of the Trust, there is significant modernisation of the site. These will continue to put further pressure on the Trust's ability to meet the national targets specifically for electricity (Scope 2) and water usage.

2.15 The Trust continues to segregate its waste stream and has introduced the Non-Infectious or 'Tiger' waste stream into all Wards, POAC, ADCU and Outpatients.

2.16 The table below shows waste information for the period 1st April 2019 to 31st March 2020:

Health Care Related Waste	**Tonnes**
Soft Bagged Healthcare Waste(Alternative Treatment)	106.78
Sharps Waste (Incineration)	8.68
Pharmacy (Non-Haz Meds)	1.19
Anatomical Waste	2.28
Gypsum Waste (incineration)	0.24
Non-Infectious Waste	20.00
Commercial Waste	
General Waste (Baseline 2006/07 139 tonnes)	97.716
Dry Mixed Recycling	30.923
Cardboard	34.21
Inert Waste (Non-Hazardous, Skip)	11.30
Metal Only (Skip)	0.7
Glass Only	2.7
Confidential Waste	39.4

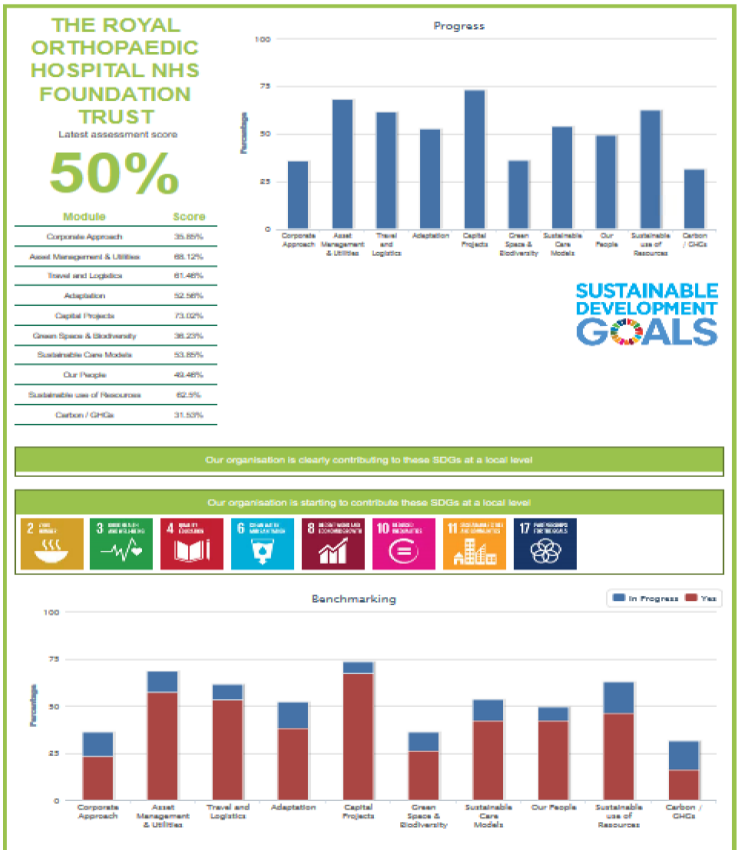
2.17 The staff travel aspect has not changed since last year due to the demand for car parking with both on-site and off-site waiting lists increasing.

2.18 Currently, there is no facility to report on business mileage as the information is not captured by payroll.

2.19 Sustainability reporting in the NHS has been mandatory from 2012/13; the NHS Manual for Accounts has been updated to reflect this. The Trust reports on sustainability both nationally and in its Annual Report.

2.20 The Sustainable Development Assessment Tool was undertaken in March 2020, whereby the Trust received an overall score of 50%, see table below.

2.21 The assessment has 296 questions covering 10 categories: Corporate Approach; Asset Management and Utilities; Travel and Logistics; Adaptation; Capital Projects; Green Space and Biodiversity; Sustainable Care Models; Our People; Sustainable Use of Resources; Carbon/GHGs.



3.0 Timescale

3.1 Following the NHS Net Zero Carbon being published in October 2020, we are developing our Green Plan using the Sustainability Development Unit (SDU) Benchmarking Tool which is based on the suggested format by NHSI/E.

3.2 This will identify areas that we are doing well and not so well in, and assist in formulating a Green Plan for the next five years.

3.3 The following workplan for the next 12 months will be:

- Staff Travel Survey using the ModeShift STARS Travel Planning System – access provided by Birmingham City Council. This will also look at travel mode changes since March 2020 and help the Trust to set targets in this area.
- Sustainable Travel Campaign – linking in with Birmingham's Clean Air Zone (CAZ) and National Clean Air Day campaigns.
- Cyclist/Walking events – Dr Bike (provided by Bike UK), linking in with national campaigns and promoting health benefits.
- Advertise for Departmental Green Champion.
- Explore using SALIX (Government backed loan scheme) to fund schemes where a reduction in usage and cost saving can be achieved.

4.0 Financial Considerations

4.1 There has been no published information on any financial penalties. It is likely it will form part of the future audits by NHSI/E and/or CQC and more information requested via the Estates Return Information Collection (ERIC) annual reporting system.

5.0 Revenue Consequence Implications

5.1 Further work is required on reducing our carbon footprint as this will have a direct effect on revenue savings for the Trust.

5.2 An investment on available technologies to reduce usage and the re-introduction of staff awareness training at Mandatory Training should be considered by the Trust in order to raise the profile, reduce usage, improve efficiency and potentially achieve cost savings.

5.3 Salix Funding (Government funding via the Department for Business, Energy and Industrial Strategy) is available for hospital projects where a clear cost saving and reduction in energy usage can be achieved. Any funding received must be repaid within five years and cost less than £191 to save one tonne of carbon over the lifetime of the technology being installed.

5.4 The cost associated with the Green Impact (behavioural change) programme is approximately a one-off cost of £9,500. Cost for annual reviews can vary depending on the hospital's requirements.

5.5 An additional Artificial Intelligence (AI) tool supplied by CO2 Analysis to determine the Trust's Scope 1 to 3 emissions would be a benefit as this would identify not only our total carbon emissions, but also identify costs savings going forward.

5.6 The study has a one-off cost of £10,000 which would include processing the data, producing an analysis report and support workshops. Other local Trusts are looking to use this tool to identify Scope 3 emissions and achieve overall cost savings. This could be used to fund other green agenda projects.

5.7 Investment in dedicated shower and changing facilities for staff that cycle to work. This could help with a modal change of travel for staff commuting as 48% of staff live within 5 miles and 75% live within 10 miles. This could be considered during improvement works to the hospital estates and fits in well with the Health and Wellbeing agenda.

6.0 Risk Considerations

6.1 Failure to meet the 2020 National target currently does not incur financial penalties however this may change as the NHS commit to achieving 'Net Zero'.

6.2 Birmingham Clean Air Zone will be implemented in June 2021. This will impact on staff commuting to work and also those that travel to clinics and patient's homes.

6.3 There is time limited input into Sustainability. One member of the Estates Team has responsibility in this area, however other duties compete again this time limited resource. To ensure the Trust works towards its obligations in this area, it is suggested additional hours are allocated to this post.

6.4 The Trust needs to develop a 'Green Plan' and have it in place by April 2022.

6.5 There is a lack of engagement with the Good Corporate Citizen Group by teams who work throughout the Trust. A re-launch of the proposed.

7.0 Consultation

7.1 The work of the Good Corporate Citizen Group endeavours to keep 'Carbon Reduction' in everybody's minds and promotes/consults with a wide audience across the Trust.

8.0 Conclusion and Recommendations

8.1 The Trust Board is asked to note the below plans for the development of a Trust Green Plan for the reduction of our carbon emissions and working towards the NHS Net Zero ambition:

- Invest in the 'Behaviour Change Programme' using the National Union of Students Green Impact campaign to encourage staff to make small changes to reduce our overall impact on the environment. It has proven successful at other NHS Trust's and Universities who have seen a marked reduction.

- Investment in Trust-wide sub-metering to monitor areas where there could be an energy saving.

- Formulate a Green Procurement Strategy, looking at requesting life cycle assessments from all suppliers, sourcing 'Net Carbon' products where possible.

- Nomination of a Lead Clinician to look at medical devices, anaesthetic gas usage on-site and other sustainable care models. This would provide a crucial link for the GCCG.

- Invest in the use of AI technology from CO2 Analysis to identify all of issues/opportunities in Scope 1 to 3 hospital emissions.

- Further funding for Electric Vehicle charging points on site.

- Carbon literacy training for all staff as part of mandatory training, including online toolkits.

- Dedicated cyclist changing, showering and storage facilities for staff to encourage using this mode of travel to commute to work. Currently eight lockers available in the Nurses Home and the use of one shower.

- Increase sustainability hours by making the Emergency Planning and Sustainability Officer role full time. (Currently 25 hours to 37 hours).

- Invest in 'Alternative Technology' such as Photo Voltaic, Solar Panels, etc.

Phil Begg
Executive Director of Strategy & Development

28 May 2021

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Staff Survey Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

This report gives an overview of actions as a result of the work that has been undertaken to analysis and share the information for the National Staff survey with staff members. This includes a draft organisational action plan.

Work will continue during June to confirm staff survey action plans at Directorate level. Once these are completed final actions at organisational and directorate level will be communicated to all staff members. Progress and completion of actions will be monitored on a regular basis.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		x

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

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

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

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

Recruitment and retention of staff.

PREVIOUS CONSIDERATION:

Updates on Staff survey results and formally consider by the Executive Team in May 2021.

National Staff Survey (NSS) – Organisational Plan 2021/2022

What you told us and why it's important		Action	Lead/Champion	Target Date	Progress	Completion Date
Health, Wellbeing and Safety						
1	Staff receiving Health and Wellbeing messages and information	Build a network of Wellbeing champions in all areas of the Trust to help with sharing information	Health and Wellbeing Team Support from departments			
2	Continue and improve practice for incidents in relation to learning and feeding back	Establish ways to disseminate learning from incidents	Governance			
Bullying and Harassment						
3	Continue with work around zero tolerance, civility and respect	Introduce e learning training material on micro aggression accessible for all staff	Learning and Development Inclusion			
4	Communicate to all staff updated policies aimed at tackling bullying and harassment	Revise the Trust Induction Bullying and Harassment policy	Policy holders Inclusion Line Manager briefings			

Staff Engagement						
5	Ensure staff are able to contribute and speak up	Staff network celebration and listening session to understand other networks staff would like to join	Network leads Staff and Line Managers			
6	Establish new Freedom to Speak up approach	Development network of Freedom to Speak up champions	Freedom to Speak up Guardian			
7	Enable teams to introduce themselves to each other	Introduce 'Quick guide' to each department using visuals and photos	Comms team Inclusion Departments			
8	Create a seamless patient journey through one team approach	Opportunities for staff to visit/work in other departments to understand better the patient journey	Comms team Departments			
9	Enhance current approach for induction to include working together across teams	Update 100 day programme to highlight the importance of working together for the patients	Learning and Development Inclusion Comms team			
10	Engaging staff with Staff Survey actions and progress	Poster and marketing collateral showing action plan (including each Directorate)	Comms team Health and Wellbeing Inclusion			
11	Establish ways for non-clinical staff to understand their impact on patient care	Non clinical staff attending Coffee and catch up session and other similar patient facing interventions	Wellbeing Inclusion Coffee catch project team			

			Line Manager and Team working			
12	Campaign to promote an all equal approach for colleagues in line with a sense of belonging	Educate line managers on promoting a 'non banding' conversation approach to communication in departments				
13	Support line managers in communicating with staff	Rolling out key programmes including 'Me as Manager' and refreshed Management Skills programme (MSP) with toolkit and key skill development messaging to team	Learning and Development Comms Team Inclusion team			
			Career progression and Retention			
14	Provides session to promote opportunities for all staff to progress and develop	Career and development focussed event to be run as a drop-in session in central location as well as in specific departments. To include Career Path Finder Tool	Learning and Development OD and Inclusion			
			Engagement with senior managers			
15	Looking ahead to how senior managers can now visit departments post-COVID	Mirror Check and Chat and staff walkabout principles to be used by managers at difference levels	OD and Inclusion Managers			
16	Provide clear engagement tools for managers at all levels	Easy formats for managers to distribute key information and	OD and Inclusion Comms All Managers			

		enhance different ways to communicate within teams				

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to NHS Improvement – General Condition 6 – systems for compliance with licence conditions**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive & Tim Pile, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

The Board of Directors is required to make a set of declarations on an annual basis.

The attached (main appendix) presents the proposed declaration to confirm or otherwise that the Trust has in place systems to enable compliance with its licence conditions.

On this basis of the commentary and evidence base behind the statement of compliance for each condition, it is proposed that the Trust states 'CONFIRMED' to the following:

'***Following a review for the purpose of Paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in order the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and had regard for the NHS Constitution***'

The requirements of the declaration stipulate that it must have 'had regard to the views of governors' and therefore the proposed declaration and evidence base has been circulated to governors for comments.

The remaining declarations due for submission at the end of June will be presented to the Board at its 18 June meeting.

REPORT RECOMMENDATION:

The Board is asked to approve the G6 declaration.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Compliance with the Self-certification: guidance for NHS FTs and specifically compliance with the Trust's licence to operate.
PREVIOUS CONSIDERATION:
Circulated to the Council of Governors for comments

Self-Certification Template - Conditions G6 and CoS7

The Royal Orthopaedic Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

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

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

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

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

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

EITHER:

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

OR

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

OR

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

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

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

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

Signature		**Signature**	
Name	Jo Williams	**Name**	Tim Pile
Capacity	Chief Executive	**Capacity**	Chairman
Date	02 June 2021	**Date**	02 June 2021

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

A

ROHTB (6/21) 009 (b) - Evidence for ROH Compliance with Monitor Licence Conditions 2020-21

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1 Section 1 – General Conditions

1.1 *Condition G1 – Provision of information*

1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence, the Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require for any of the purposes set out in section 96(2) of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as NHS Improvement may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading; (b)

   in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	All NHS Improvement returns have been prepared in the required format and delivered on time. There has been no adverse comment from NHS Improvement re late or incomplete returns. A copy of the audited annual reports and accounts for 2019/20 was submitted by the required deadline. All returns are reviewed buy at least one other person than the author.	• NHS Improvement monthly performance reports • Confirmation receipts of declarations & AR & Accts from NHSI portal

1.2 *Condition G2 – Publication of information*

1. The Licensee shall comply with any direction from NHS Improvement for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.

2. For the purposes of this condition "publish" includes making available to the public, to any section of the public or to individuals.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	FT Code of Governance requirements to publish on the website have been complied with, largely in the form of the Trust's annual report	• Screen shot of licence included on the Trust's internet • Screen shot of annual report on website

1.3 *Condition G3 – Payment of fees to NHS Improvement*

1. The Licensee shall pay fees to NHS Improvement in each financial year of such amount as NHS Improvement may determine for each such year or part thereof in respect of the exercise by NHS Improvement of its functions for the purposes set out in section 96(2) of the 2012 Act.

2. The Licensee shall pay the fees required to be paid by a determination by NHS Improvement for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No fees have been levied by NHS Improvement during 2020/21.	None

1.4 *Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions) -*

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of NHS Improvement.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS Improvement.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS Improvement.

4. If NHS Improvement has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify NHS Improvement promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is: (a)

an individual;

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub- paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	The Trust has continued the annual review of those who are required to meet the FPPT, and to apply the Trust policy. All required members of the Board completed a self-declaration in 2020 and new starter Mrs Gianjeet Hunjan and Mr Leslie Williams completed pre-employment check and the self-declaration in regard to FPPT. The annual round of self-declarations is underway as of June 2021. DBS checks for Board members have been refreshed during the year. The CQC did not find any omissions in the FPPT requirements when they inspected in Autumn 2019.	• FPPT policy • FPPT declarations • Personal files • CQC inspection report

ROHTB (6/21) 009 (b) - Evidence for ROH Compliance with Monitor Licence Conditions 2020-21

1.5 *Condition G5 – NHS Improvement guidance*

1 Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS Improvement for any of the purposes set out in section 96(2) of the 2012 Act.

2 In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS Improvement of the reasons for that decision.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	FT Code of Governance requirements have been complied with except as detailed in the annual report in the "comply or explain" section. The Trust adheres to the requirements of the Single Oversight Framework. There has been a reduction in the overall spend against agency staffing as the Trust has undertaken a successful medical and nurse staffing recruitment exercise during the year.	• Annual report 2019/20 • Finance & Performance Report, and Quality & Safety Report • Agency staffing information included in Finance & Performance papers and the Workforce Overview

1.6 *Condition G6 – Systems for compliance with licence conditions and related obligations*

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHS Improvement in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Lead Exec	Compliant	Comment	Evidence
PART 1			
SW/SGL/GM re (a) and (b)	Y	(A) Controls relating to this are described in the whole of this appendix (B) The Trust is registered with the CQC and the HTA as per the NHS Acts. The Director of Strategy & Delivery holds the post of HTA designated individual. (C) The Board is not aware of any other significant requirements under the NHS Acts.	• This appendix • CQC registration certificate • HTA registration certificate
CEO	Y	The NHS constitution establishes the principles and values of the NHS in England. The constitution can be broken down into 6 key areas, 4 of which apply to requirements for the organisation: guiding principles, NHS values, rights of patients & public and rights for staff. The Trust's five year strategy, approved in Autumn 2019, echoes the **guiding principles** in the NHS constitution including putting the patient at the heart of everything the organisation does, working across organisational boundaries and aspiring to achieve the highest standards of excellence & professionalism. The strategy also provides a set of **values** that are consistent with those in the NHS constitution including promoting respect &	• Five year forward strategy and strategy refresh • Finance & Performance overview • Quality & Patient Safety report • Workforce overview • Annual complaints report • National Staff Survey results

Lead Exec	Compliant	Comment	Evidence
		dignity, commitment to quality of care and being compassionate. The measurement of the outcomes of these indicators is through consideration of a suite of reports received by the Board and its Committees and at an Executive level by reports to the weekly Executive meeting.	• Quality Account • Quality & Safety Committee meeting papers • Finance & Performance Committee meeting papers • Staff Experience & OD Committee papers
		In terms of compliance with the constitutional requirements relating to the **rights of the public and patients**, compliance is demonstrated through performance against the range of nationally commissioned targets set out in the Quality Account & Annual Report. The specific relating to confidentiality & consent are monitored respectively by an IG Group and by the Quality & Safety Committee. The Quality & Safety Committee has during the year sought assurance on the consent process, particularly in line with the impact of the Covid-19 pandemic and the introduction of virtual appointments. In terms of complaints and redress, the Trust has made improvements to its processes for complaints handling during the year and strengthened adherence to Regulation 20: Duty of Candour guidance. A spot audit undertaken during the year shows complete compliance with cases reviewed. The right to drugs and treatments can be demonstrated by the Joint Formulary available on the internet. The Trust was inspected by the CQC in Quarter 3 2019/20 and maintained its regulatory rating as 'Good' across all domains. The procedure for the transfer of the paediatric services out of the trust, agreed by the Trust Board ensured that this was done in line with the requirements of the NHS Constitution and involved all necessary stakeholders and regulators. The Trust has seen a deterioration in the performance against the national Referral	• Quality Account 2019/20 • Annual Report 2019/20 • Data security toolkit toolkit submission and internal audit report • Minutes of Quality & Safety Committee • Annual complaints reports to Quality & Safety Committee and Trust Board • Duty of Candour updates as part of Quality & Patient Safety report Quality & Safety Committee • CQC report and CQC action plan • Screenshot of joint formulary • Duty of Candour audit • NICE guidance internal audit and action plan • Performance against access targets included in the Finance and Performance report

Lead Exec	Compliant	Comment	Evidence
		to Treatment Time standards as a result of the cessation of elective activity in line with the national response to the Covid-19 pandemic and the need to support system partners with restoration & recovery. As elective activity resumes it is anticipated that the position will improve. There has been no regulatory enforcement action during the year or any undertakings imposed. Regarding the **rights of staff**, the Trust has policies and procedures in place to support staff and ensure that their needs are met appropriately. The Trust has a Freedom to Speak Up policy in place and has undertaken an assessment against the WRES and WDES standards which has flagged some work to do to improve the Trust's regard for equality & diversity matters. An equality and diversity network and a Multi Minority Ethnic Group (MMEG) are in place in addition to a 'BeMySelf' forum and a Disability forum. The Trust has in place a Freedom to Speak Up Guardian who reports to the Director of Corporate Affairs/ Company Secretary. The Trust Board is supported by a Committee, the Staff Experience &OD Committee, which seeks assurance on the Trust's adherence to staff-related policies, workforce matters and organisational development	• Workforce policies, including Freedom to Speak Up • Establishment of the Equality & Diversity network • Schwartz Round information • WRES assessment to Staff Experience & OD Committee • Freedom to Speak Up presentation to Trust Board • Freedom to Speak Up Guardian role description • Staff Experience & OD Committee terms of reference • National staff survey results
PART 2			
SGL	Y	The Trust has further improved its risk management processes over 2020/21, including a refresh of some of the risk registers of the Trust's major committees and groups. Further work is underway to improve the framework further which is set out in a risk improvement plan which is monitored by the Audit Committee and Executive Team. The Annual Governance Statement for 2020/21 sets out the framework of risk management within the Trust and provides an assessment of the effectiveness of these systems and processes. The Head of Internal Audit Opinion for 2020/21 confirms that the Trust has adequate internal control	• Annual Governance Statement • Board Assurance Framework • Corporate Risk Register • Ulysses action plan • Risk management policy • HOIA 2019/20

Lead Exec	Compliant	Comment	Evidence
		mechanisms, however there is further work to do. The CQC inspection and the external well led inspection did not highlight any weaknesses in the Trust's risk management framework.	
PART 3			
SGL	Y	The approval publication of the 2020/21 declaration will meet the required timetable.	• Trust Board paper which is published on the Trust's website in readiness for the Board meeting on 2 June.

1.7 *Condition G7 – Registration with the Care Quality Commission*

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.

2. The Licensee shall notify NHS Improvement promptly of:

   (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or

   (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.

3. A notification given by the Licensee for the purposes of paragraph 2 shall: (a)

   be made within 7 days of:

   (i) the making of an application in the case of paragraph (a), or

   (ii) becoming aware of the cancellation in the case of paragraph (b), and

   (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for:

   (i) the making of an application in the case of paragraph (a), or

   (ii) the cancellation in the case of paragraph (b).

Lead Exec	Compliant	Comment	Evidence
GM	Y	The ROH was registered with CQC throughout the financial year. The ROH is registered without conditions currently. The Executive Lead for the CQC is the Director of Nursing & Clinical Governance.	• Screenshot of CQC website • CQC insight reports • CQC inspection reports from 2019

1.8 *Condition G8 – Patient eligibility and Selection criteria*

1. The Licensee shall:

   (a) set transparent eligibility and selection criteria,

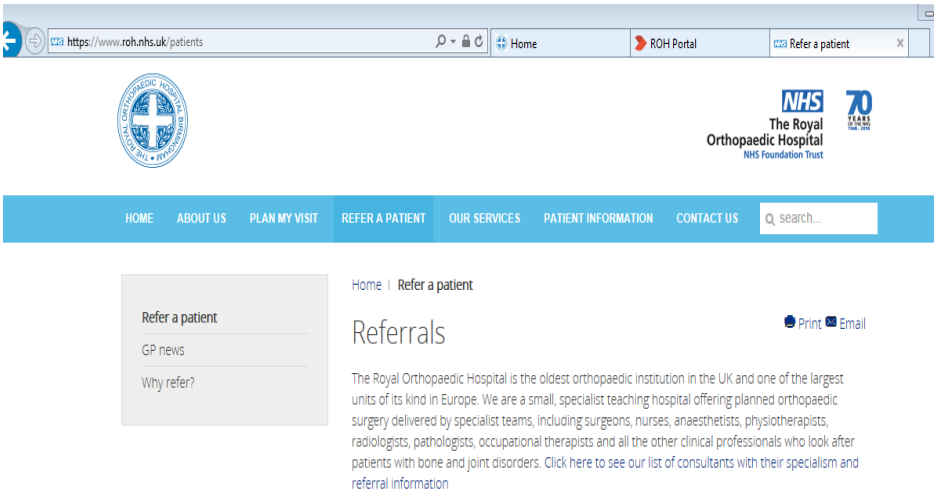
   (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and

   (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.

2. "Eligibility and selection criteria" means criteria for determining:

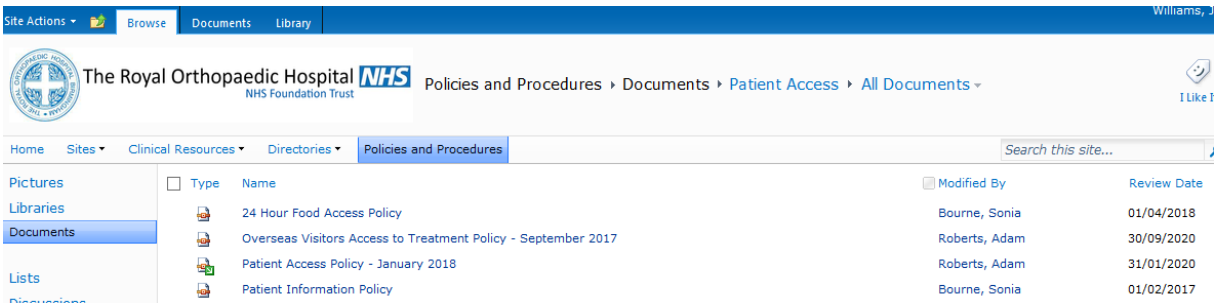
   (a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and

   (b) if the person is selected, the manner in which the services are provided to the person.



Lead Exec	Compliant	Comment	Evidence
JW	Y	The Trust has in place a policy for patient access which has been approved both internally and by the CCG). Application of this policy is overseen by the Clinical Services Manager	• Patient Access policy • Screen shot of patient access policy on intranet • Screens shot of referral page on internet site

		(Patient Access, Performance and Outpatients Department) who reports directly to the Chief Operating Officer (COO). The Trust has also implemented the Royal College of Surgeons 'Clinical guide for surgical prioritisation during the Coronavirus pandemic' when triaging patients for surgery.	Patient Access Policy - June 18.pdf



1.9 *Condition G9 – Application of Section 5 (Continuity of Services)*

1. The Conditions in Section 5 shall apply:

   (a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and

   (b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which:

      (i) was not subject to such an obligation on commencement of this Licence, and

      (ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b);

for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).

2. A service is a Commissioner Requested Service if, and to the extent that, it is:

   (a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by NHS Improvement immediately prior to the commencement of this Licence, or

   (b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or

   (c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.

3. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2:

(a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and

(b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either

(c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or

(d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to NHS Improvement and to the Licensee a notice in accordance with paragraph 4, and NHS Improvement, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.

4. A notice in accordance with this paragraph is a notice: (a)

in writing,

(b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

(c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service

5. A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.

6. The Licensee shall give NHS Improvement not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

7. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS Improvement issues either:

(a) a direction of the sort referred to in paragraph 8, or

(b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.

8. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, NHS Improvement issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.

9. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by NHS Improvement given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.

10. A service shall cease to be a Commissioner Requested Service if:

(a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS Improvement has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

(b) NHS Improvement has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

(c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or

(d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or

(e) the contractual obligation pursuant to which the service is provided has expired and NHS Improvement has issued a notice pursuant to paragraph 7(b) in relation to the service; or

(f) the period specified in a direction by NHS Improvement of the sort referred to in paragraph 8 in relation to the service has expired.

11. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

12. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS Improvement in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

13. Unless it is proposes to cease providing the service, the Licensee shall not make any application to NHS Improvement for a determination in accordance with paragraph 10(b):

(a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or

(b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.

14. In this Condition "NHS contract" has the meaning given to that term in Section 9 of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SW	Y	As a result of Covid, NHS commissioners and NHS Trusts/NHS Foundation Trusts were not required to sign contracts between them for 2020/21. The nationally mandated terms of the NHS Standard Contract for 2020/21 applied instead.	• NHS Finance and Contracting Guidance 2020/21

2 Section 2 – Pricing

2.1 *Condition P1 – Recording of information*

1. If required in writing by NHS Improvement, and only in relation to periods from the date of that requirement, the Licensee shall:

   (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and

   (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information,

   as are necessary to enable it to comply with the following paragraphs of this Condition.

2. From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.

3. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.

4. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS Improvement the Licensee shall procure that each of those sub-contractors:

   (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and

   (b) provides that information to NHS Improvement in a timely manner.

5. Records required to be maintained by this Condition shall be kept for not less than six years.

Section 3 – Choice and Competition

6. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by NHS Improvement;
"Approved Reporting Currencies"	means such categories of cost and other relevant information as may be published by NHS Improvement;
"other relevant information"	means such information, which may include quality and outcomes data, as may be required by NHS Improvement for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The annual National Cost Collection (NCC) is now implemented and Mandated replacing the previous Reference Cost collection. The Trust is adhering to the National Costing Guidance and providing detailed Patient level information to NHSE/I achieving a 92% score within NHSI's costing assurance tool against a national average of 81%. The direction of travel from NHSE/I is to implement quarterly collections to understand the complex costs of services within the NHS during the Covid-19 pandemic and future state. The Trust continues to develop and improve the way in which costs are being reported and allocated in conjunction with Clinicians.	• NCC return

2.2 *Condition P2 – Provision of information*

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as NHS Improvement may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has completed all required information with regards to monthly, quarterly and annual performance data. In addition, the Trust has provided ad-hoc information as requested.	• Confirmatory emails from NHS Improvement

2.3 *Condition P3 – Assurance report on submissions to NHS Improvement*

1. If required in writing by NHS Improvement the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.

2. The descriptions of submissions in relation to which a report may be required under paragraph 1 are:

(a) submissions of information furnished to NHS Improvement pursuant to Condition P2, and

(b) submissions of information to third parties designated by NHS Improvement as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.

3. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met:

(a) it is prepared by a person approved in writing by NHS Improvement or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act;

(b) it expresses a view on whether the submission to which it relates:

(i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1;

(ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and

(iii) provides a true and fair assessment of the information it contains.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has complied fully with an externally commissioned audit of our costing and coding systems and outputs that took place in January / February 2015. No similar reviews since.	• Audit report • E-mail exchanges confirming externally commissioned audit occurred

2.4 *Condition P4 – Compliance with the National Tariff*

1. Except as approved in writing by NHS Improvement, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by NHS Improvement, in accordance with section 116 of the 2012 Act.

2. Without prejudice to the generality of paragraph 1, except as approved in writing by NHS Improvement, the Licensee shall comply with the rules, and apply the methods, concerning

charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement in accordance with, section 116 of the 2012 Act, wherever applicable.

Lead Exec	Compliant	Comment	Evidence
SW	Y	Due to Covid the NHS introduced block payments for all Trusts to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract. This minimised the burden of formal contract documentation and contract management processes, so that staff could focus fully on the COVID-19 response. The Trust has continued throughout 2020-21 to submit accurate activity and tariff submissions to Commissioners.	• Standard contract

2.5 *Condition P5 – Constructive engagement concerning local tariff modifications*

1. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No additional changes have been requested locally for 2020/21.	• Standard contract • NHSE contract for specialised services

3 Section 3 – Choice and Competition

3.1 *Condition C1- The right of patients to make choices*

1. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.

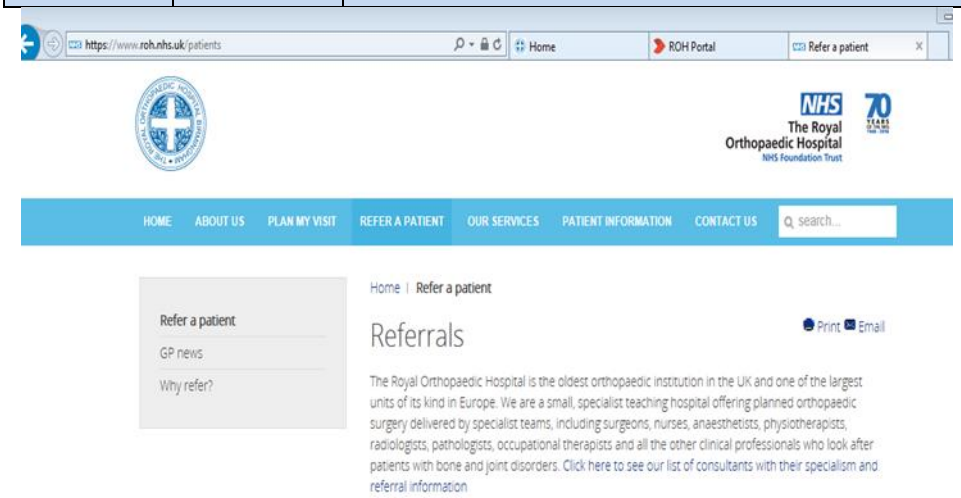
2. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.

3. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.

4. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Lead Exec	Compliant	Comment	Evidence
MP	Y	Pre-Covid 19 pandemic all patients accessing services are offered two reasonable dates with three weeks' notice as part of their referral process, and subsequently a choice of operation date where applicable. As a routine part of our consenting documentation a record of clinical procedural options is made and narrative discussion recorded, determined by consultant. In response to the Covid 19 pandemic elective surgery was ceased. Patient choice in regards to outpatient appointments was therefore limited to virtual appointments. Post Covid, processes have been developed to offer face to face & virtual appointments (via telephone and/or via the attend anywhere digital platform) with the aim of ensuring those patients who are not digitally enabled remain able to choose how to	• Referral page on internet • Consent policy • Access policy Patient Access Policy - June 18.pdf Consent to Examination or Trea

		access Trust services in a way that suits their preferences and personal requirements. The Trust offer virtual appointment via telephone or its video platform, Attend Anywhere. This means that virtual appointments are available event to patients who are not digitally enabled to undertake video consultation. There is work underway to see if old IT equipment held by the Trust could be used to bridge any gaps created by digital poverty. Virtual appointment are the default consultation media where ever clinically appropriate. This is to ensure the Trust is working towards the Department of Health target of virtual appointments. If a patient would rather be seen face to face for whatever reason their needs would be accommodated by the Trust where ever possible.	



3.2 *Condition C2 – Competition oversight*

1. The Licensee shall not:

   (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or

   (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS,

   to the extent that it is against the interests of people who use health care services.

Lead Exec	Compliant	Comment	Evidence
MP	Y	The ROH has never knowingly done anything anti-competitive. As a result of the Covid 19 Pandemic and as part of an ICS agreed response to the provision of health services in the region, ROH was the only choice of health care provider for patients requiring orthopaedic treatment.	• None

4 Section 4 – Integrated care

4.1 *Condition IC1 – Provision of integrated care*

1. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

2. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

3. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.

4. The objectives referred to in paragraphs 1, 2 and 3 are:

   (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,

   (b) reducing inequalities between persons with respect to their ability to access those services, and

   (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

5. The Licensee shall have regard to such guidance as may have been issued by NHS Improvement from time to time concerning actions or behaviours that might reasonably be regarded as

against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.

Lead Exec	Compliant	Comment	Evidence
MP/GM	Y	The Trust has an Accessible Information Standard policy and has a forum that monitors its ongoing compliance with the standard. The Trust has access to interpreting services 24/7. At our outpatient desks the Trust has the loop up system for individuals with hearing loss. For patients with complex needs the Trust has; A dementia strategy; A Learning Disability strategy; A Mental health policy Staff are trained in a range of forums to empire compliance against theses polices. The Trust has in place a Patient Engagement & Experience Group and regularly holds 'Coffee Catch Up' events to aid patient engagement, for which the scope, which currently includes joint care services, is to be expanded to include all orthopaedic specialties. Work is also planned over the coming year to refresh and reinvigorate the Patient Engagement framework in the Trust which will be supported by the new Deputy Director of Nursing. The Trust has in place a Learning Disability User Group. The Trust has worked in partnership with AccessAble to create Detailed Access Guides to facilities, wards and departments at the ROH. The Guides are 100% facts, figures and photographs and give patients useful information to plan their visit to the hospital and assure them that we are accessible and have considered their needs. The free Accessibility Guide is for staff and visitors and is available at www.roh.nhs.uk and www.AccessAble.co.uk and on the AccessAble App. Throughout the pandemic there was positive patient engagement on a range of matters but most notably on virtual clinic appointments. The Safeguarding team were intimately involved in designing the service to ensure that those most vulnerable	• Accessible Information Standard • Learning Disabilities Strategy • Dementia Strategy • Mental Health policy • Patient Experience & Engagement Strategy • ICS development documents • Governance documents supporting the UHB restoration and recovery pathway • Citizen engagement summary • Business case for investment into Complaints and PALS

		patients and clinically urgent patients were provided with face to face appointments as a priority. The Trust is a key member of the developing Integrated Care System to allow the shaping of seamless services within the City and is working collaboratively particularly with University Hospitals Birmingham NHSFT to deliver region wide restoration and recovery. The Trust has a joint governance forum with BWCH & RJAH to oversee patients cared on pathway between the two providers.	

5 Section 5 – Continuity of Services

5.1 *Condition CoS1 – Continuing provision of Commissioner Requested Services*

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.

2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), NHS Improvement issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.

3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

   (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or

   (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or

   (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS Improvement for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to NHS Improvement notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery

or provision of that service in a manner which differs from the manner specified and described in:

(a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or

(b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or

(c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not had cause to cease to provide, or materially alter the specification or means of delivery of any Commissioner Requested Services. Any issues with regards to existing services, or proposals for new services, are discussed constructively through the Joint Clinical Commissioning Group meetings or other such key stakeholder meetings which include clinical and managerial representation from the Trust and its commissioners. This was the case for example with the transfer of paediatric inpatient services to Birmingham Women's and Children's NHS Foundation Trust as part of health economy supported transfer of services.	• Schedule of commissioning meetings • Minutes of commissioning meetings

5.2 *Condition CoS2 – Restriction on the disposal of assets*

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")

2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.

3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.

4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS Improvement has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

   (a) with the consent in writing of NHS Improvement, and

   (b) in accordance with the paragraphs 6 to 8 of this Condition.

6. The Licensee shall furnish NHS Improvement with such information as NHS Improvement may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.

7. Where consent by NHS Improvement for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.

8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

   (a) NHS Improvement has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:

      (i) transactions of a specified description; or

      (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and

   the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is

subject; or the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licences and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS Improvement regarding:

(a) the manner in which asset registers should be established, maintained and updated, and

(b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust maintains an up-to-date asset register, which is audited as part of the annual audit of the accounts. The Trust has a policy in place regarding the disposal of all assets, which includes the process for the disposal of relevant assets. Asset disposal forms are completed and authorised for any asset disposals.	• Asset register • Asset disposal policy • Asset disposal forms • Annual accounts – asset disposal

5.3 *Condition CoS3 – Standards of corporate governance and financial management*

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

   (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

   (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:

   (a) such guidance as NHS Improvement may issue from time to time concerning systems and standards of corporate governance and financial management;

   (b) the Licensee's rating using the risk rating methodology published by NHS Improvement from time to time, and

   (c) the desirability of that rating being not less than the level regarded by NHS Improvement as acceptable under the provisions of that methodology.

Lead Exec	Compliant	Comment	Evidence
SW for financial management	Y	The Trust has a range of financial policies and controls in place to meet this licence condition. These policies and controls are audited annually by our Internal Auditors and recommendations and actions are monitored by Audit Committee. The Trust was subject to a block contract arrangement during the year in line with the national response to the global Covid-19 pandemic.	• Financial policies • Internal audit reviews of financial management • Audit Committee minutes • Annual Report
SGL for corporate governance	Y	The Trust's segmental rating remained at 2 during the year. The Trust during the year implemented some interim governance arrangements in line with the mandate from NHS England issued at the start of the last financial year.	• Single Oversight Framework segment correspondence from NHSI • Annual Governance Statement

5.4 *Condition CoS4 – Undertaking from the ultimate controller*

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS Improvement, that the ultimate controller ("the Covenantor"):

   (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and

   (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

   (a) deliver to NHS Improvement a copy of each such undertaking within seven days of obtaining it;

   (b) inform NHS Improvement immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

   (c) comply with any request which may be made by NHS Improvement to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

(a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and

(b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:

(a) a health service body, within the meaning of section 9 of the 2006 Act;

(b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;

(c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or

(d) a trustee of the Licensee and the Licensee is a charity.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	The ROH is a health service body so this is not applicable	• None

5.5 *Condition CoS5 – Risk pool levy*

1. The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.

2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS Improvement.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not been required to make any risk pool levies during 2020/21.	• None

5.6 *Condition CoS6 – Co-operation in the event of financial stress*

1. The obligations in paragraph 2 shall apply if NHS Improvement has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

2. When this paragraph applies the Licensee shall:

   (a) provide such information as NHS Improvement may direct to Commissioners and to such other persons as NHS Improvement may direct;

   (b) allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and

   (c) co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not received any such notice from NHS Improvement during the financial year.	• Finance and performance overview

5.7 *Condition CoS7 – Availability of resources*

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

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

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

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust Board has approved the Trust's financial and operational plan for 2020/21 that evidences that the financial resources and working capital required to deliver sustainable services are in place. The Board also approved the 2020/21 capital plan which reviewed the physical assets required for this purpose. With regard to the availability of sufficient personnel there remain some risks in relation to sufficient clinical staffing, although this is an improving position, and this risk is not believed to be sufficiently serious to impact upon NHS Improvement's license requirements as arrangements are in place to ensure sufficient safe staffing.	• Operational plan considered by the Finance & Performance Committee

6 Section 6 – NHS Foundation Trust Conditions

6.1 *Condition FT1 – Information to update the register of NHS foundation trusts*

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:

   (a) the current version of Licensee's constitution;

   (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and

   (c) the Licensee's most recently published annual report,

   and for that purpose shall provide to NHS Improvement written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

3. Subject to paragraph 4, the Licensee shall provide to NHS Improvement written and electronic copies of any document that is required by NHS Improvement for the purpose of Section 39 of the
   2006 Act within 28 days of the receipt of the original document by the Licensee.

4. The obligation in paragraph 3 shall not apply to:

   (a) any document provided pursuant to paragraph 2; (b)

   any document originating from NHS Improvement; or

   (c) any document required by law to be provided to NHS Improvement by another person.

5. The Licensee shall comply with any direction issued by NHS Improvement concerning the format in which electronic copies of documents are to be made available or provided.

Section 6 – NHS Foundation Trust Conditions

6. When submitting a document to NHS Improvement for the purposes of this Condition, the Licensee shall provide to NHS Improvement a short written statement describing the document and specifying its electronic format and advising NHS Improvement that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	There were some amendments to the Constitution proposed to the Council of Governors at their meeting in January 20. The majority of these were cosmetic or updated names & titles, however one of significance was the update to the membership of the Appointed Governors cadre, where the local MP was replaced by a representative from the Northfield Community. These changes were approved by the Trust Board in March 2020. The audited annual report and accounts for 2019/20 were provided to NHSI by 25 June 2020 as required according to this year's timetable	• Annual report & accounts • Paper to Council of Governors proposing changes to the Constitution.

6.2 *Condition FT2 – Payment to NHS Improvement in respect of registration and related costs*

1. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. Whenever NHS Improvement determines in accordance with section 50 of the 2006 Act that the Licensee must pay to NHS Improvement a fee in respect of NHS Improvement's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to NHS Improvement within
28 days of the fee being notified to the Licensee by NHS Improvement in writing.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No fees have been levied by NHS Improvement during 2020/21	• None

6.3 *Condition FT3 – Provision of information to advisory panel*

1. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	No request for a referral to the advisory panel was received from members of the Council in the financial year.	• None

6.4 *Condition FT4 – NHS foundation trust governance arrangements*

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

   (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) if required in writing by NHS Improvement, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	The corporate governance framework is set out within the Trust's annual report and specifically within the Annual Governance Statement. The Director's report within the Accountability Report outlines the Board composition and skills and also references the architecture of the Board & its committees. The Quality Report section outlines the performance against a range of quality metrics. The safe staffing report seen at Staff Experience & OD Committee provides assurance to the Board that there is adequate nurse staffing cover to maintain a safe level of care for patients.	• Annual Report (including Quality Account) • Safe staffing reports

Section 6 – NHS Foundation Trust Conditions

		The Corporate Governance Declaration will be signed off by the Board by 30 June 2021 as required and will be presented at the Board meeting on 18 June for consideration. The Trust has not received any regulatory enforcement action or undertakings applied during the year. During the year, the Trust underwent an external assessment against the NHS Improvement well led framework which presented a positive view of the Trust's compliance, a matter which was reported back to NHS Improvement. The end of year assessment from the Head of Internal Audit was that there were no mattes of significance to include within the section of the annual report concerning lapses in internal control.	

7 Section 7 – Interpretation and Definitions

7.1 *Condition D1 – Interpretation and Definitions*

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table.

"the 2006 Act"	the National Health Service Act 2006 c.41;
"the 2008 Act"	the Health and Social Care Act 2008 c.14;
"the 2009 Act"	the Health Act 2009 c.21;
"the 2012 Act"	the Health and Social Care Act 2012 c.7;
"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;
"clinical commissioning group"	a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act;
"Commissioner Requested Service"	a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition;
"Commissioners"	includes the NHS Commissioning Board and any clinical commissioning group;
"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, or (ii) a company constituted under the Companies Act 2006;
"Governor"	includes any person who, in any organisation, performs the functions of, or functions equivalent or

	similar to those of, a Governor of an NHS foundation trust as specified by statute;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act;
"NHS Commissioning Board"	the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

3. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board roles and responsibilities**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Chairman and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

Given the recent appointment into the Vice Chair and Senior Independent Director (SID) positions, the attached paper sets out the respective responsibilities & remit of each and provides a job description for the SID which is aligned to the requirements of the Code of Governance for foundation trusts.

Also provided is a list of nominated responsibilities for the Non Executives and Executive Team members, which have been assigned based on national guidance, legislation or an area of particular focus for the Trust at a point in time.

REPORT RECOMMENDATION:

The Board is asked to receive and note the update.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Compliance with legislation and the Code of Governance for FTs.

PREVIOUS CONSIDERATION:

None.

NON EXECUTIVE DIRECTOR LEAD ROLES

Report to the Trust Board in public on 2 June 2021

1 BACKGROUND

1.1 There have been a number of changes in the Non Executive cadre of the Board over the past few months, most notably the departure of the previous Chair, a post taken on by Tim Pile in January 2021.

1.2 The decision was taken to split the Senior Independent Director role and the Vice Chair position, both of which had previously been occupied by Tim Pile. In agreement with the Council of Governors, Kathryn Sallah took on the role of the SID, while Simone Jordan assumed the role of Vice Chair from April 2021.

1.3 In addition to these key roles, the Board is required to have nominated Non Executives to support specific areas of oversight, in accordance with national guidance, legislation or to fulfil the requirements of the Code of Governance for foundation trusts.

1.4 This paper aims to provide a refresh of the role of the Senior Independent Director, set out the remit of the Vice Chair and to provide an overview of the areas of responsibility and oversight of the other Non Executives.

2 SENIOR INDEPENDENT DIRECTOR

2.1 When it developed its Code of Governance for foundation trusts, Monitor, the independent regulator of NHS foundation trusts, drew on best practice from the private sector and included an entry which required the appointment of a Senior Independent Director (SID), a matter which the Trust is required to declare compliance with, along with adherence to the other provisions in the Code, within the annual report.

2.2 The relevant provision is that of A.4.1: *'In consultation with the Council of Governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson'*.

2.3 Within provision A.4.2 the responsibility of the SID to lead the appraisal process of the Chair is also set out *'Led by the senior independent director, the non-executive*

directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.'

2.4 Given the change in Non Executive responsibility for the SID role, the opportunity has been taken to develop a job description for this role, which sets out the key duties of the post in line with the requirements of the Code of Governance. This is attached as Appendix A.

3 VICE CHAIR

3.1 Unlike the Senior Independent Director, there is no mandate in the Code of Governance to appoint a Vice or Deputy Chair. The role however, provides recognised contingency in the case of unexpected absence of the Chairman and strengthens the leadership of the Board and therefore the decision was taken a number of years ago to include this responsibility within the remit of one of the Non Executive Directors at the Royal Orthopaedic Hospital NHSFT.

3.2 The Vice Chair acts as a key sounding board for the Chairman, in addition to providing contingency cover when required. In the case of the current Chairman and Vice Chair, the leadership of the Board is enhanced by the different expertise and remits of the individuals in post. The Chairman is largely experienced in private sector and commercial matters, whereas the nominated Vice Chair has a skill set in workforce, continuous improvement and has a background seated in the NHS.

4 OTHER NON EXECUTIVE RESPONSIBILITIES

4.1 From time to time national guidance or legislation emerges which includes a directive to nominate or appoint a Non Executive or Executive lead to provide oversight of a particular area of interest or concern. In addition to these, the Trust at its discretion may also request the support of a Non Executive Director with the oversight of a particular piece of work or area of interest to strengthen the level of assurance being provided up to the full Board and Council of Governors. The participation of Kathryn Sallah in the oversight of the paediatric services transition is a particular recent and relevant example of this.

4.2 Attached at Appendix B is a list of the responsibilities that are currently assigned to the various Board members. Executive Team members have been included for completeness. There are a number of additional Non Executive roles that have been identified through some work undertaken through the Company Secretary network which will be assigned over the coming month. To minimise any additional burden associated with these current and further responsibilities, is proposed that this oversight is predominantly aligned to the Board Committee which has the most relevant remit. For instance, the Non Executive champion for Counterfraud would

naturally fall within the remit of the Chair of the Audit Committee and Non Executive lead for Complaints would fall within the remit of the Chair of the Quality & Safety Committee.

5 RECOMMENDATION

5.1 The Trust Board is asked to:

RECEIVE and ACCEPT this report

SUPPORT the plan for the proposed allocation of additional Non Executive responsibilities and oversight arrangements being principally through the relevant Board subcommittees

Simon Grainger-Lloyd
Director of Corporate Affairs & Company Secretary

27 May 2021

ROLE DESCRIPTION

TITLE	Senior Independent Director
REPORTS TO	The SID seeks to be independent in all matters and does not have one route of reporting; this will depend on the nature of the matter
ACCOUNTABLE TO	Board of Directors and Council of Governors

1. JOB SUMMARY

The Senior Independent Director (SID) will be a non-executive director (NED) with all the general duties of a NED in common with other NEDs, but with the enhanced duties of the SID as set out in section 4 below.

In summary the SID will be available to directors, governors or members if they have concerns which have not or cannot be resolved through normal contact with the Chair of the Trust, the Chief Executive, or the Company Secretary or where such contact is considered to be inappropriate.

2. CRITERIA FOR ELIGIBILITY

The SID is to be a NED who is appointed by the Council of Governors and who is considered to fulfil the criteria of 'independent' as set out by Monitor in the NHS Foundation Trust Code of Governance.

The Chair of the Trust is not eligible to be the SID. The Vice Chair whilst eligible to be the SID, cannot carry out this role when acting as Chair of the Trust, due to the need to be independent of the Chair role. The Senior Independent Director does not have to be the chair of the Audit and Assurance Committee.

The Council of Governors will review the appointment normally every two years, and may re-appoint the incumbent SID or choose another person from amongst the independent non-executive directors as it sees fit. For clarity the appointment period for the SID will normally be two years unless there are operational reasons as to why the Board may wish to vary the term of appointment.

3. WORKING RELATIONSHIPS

The SID will be appointed by the Council of Governors.

The SID will have the normal working relationships of a NED, however with specific reference to the role of the SID the main working relationships will be with:

- Governors
- Members
- Directors (Executive & Non Executive)
- The Council of Governors
- Chair of the Trust
- Company Secretary

4. PRINCIPAL DUTIES AND AREAS OF RESPONSIBILITY

In addition to the general duties of a NED, the SID will have the following specific duties:

- Be available to directors (executive and non-executive) if they have concerns about the performance of the Board or the welfare of the Trust, where contact through the normal channels of Chair of the Trust, the Chief Executive, or the Company Secretary has failed to resolve or for which such contact is inappropriate
- Be available to governors and members if they have concerns about: the performance of the Board of Directors; the Trust's compliance with the terms of its licence or the welfare of the Trust; where contact through the normal channels of Chair of the Trust, the Chief Executive, or the Company Secretary has failed to resolve or for which such contact is inappropriate
- Help resolve any disagreements that may arise between the Council of Governors and Board of Directors, in accordance with any procedures agreed by the Trust and set out in the Constitution
- Maintain sufficient dialogue with governors in order to develop a balanced understanding of their issues and concerns
- When appropriate ensure that the issues and concerns of members and governors are communicated to the other non-executive directors and, as necessary, the Board as a whole
- Carry out the annual appraisal of the Chair of the Trust and make a report to the Council of Governors on the outcome

- Meet with the non-executive directors, in the absence of the Chair of the Trust, at least annually to discuss his/her performance as part of the annual appraisal process (or for any other reason which may require the NEDs to meet without the Chair of the Trust)

- Working jointly with the Vice Chair, to support the Chair of the Trust in leading the Board of Directors, acting as a sounding board and source of advice for the chair.

5. TIME COMMITMENT

The Senior Independent Director should ensure they will have sufficient time to meet the rigours of the role and the additional responsibilities.

May 2021

Additional roles of Board members

Non Executive Directors	
Tim Pile, Chair	
Simone Jordan, Vice Chair	Vice Chair and Chair of the Staff Experience & OD Committee and Chair of the Nominations & Remuneration Committee
Kathryn Sallah, Non Executive Director	Senior Independent Director; Chair of the Quality & Safety Committee; Safeguarding Champion; Board lead for Schwartz Rounds
Gianjeet Hunjan, Non Executive Director	Chair of the Audit Committee; Freedom to Speak Up/Whistleblowing Board champion; Procurement Champion
David Gourevitch, Non Executive Director	Chair of the Charitable Funds Committee; Infection Control Champion
Richard Phillips, Non Executive Director	Chair of the Finance & Performance Committee; Equality & Diversity Champion
Ayodele Ajose, Non Executive Director	
Les Williams, Non Executive Director	
Executive Team	
Jo Williams, Chief Executive	Lead Chief Executive for the National Orthopaedics Alliance (NOA)
Garry Marsh, Director of Nursing & Clinical Governance	Director of Infection Prevention & Control; Board Lead for Inequalities
Steve Washbourne, Director of Finance & Performance	Senior Information Risk Owner (SIRO); ICS support for specialised commissioning
Phil Begg, Director of Strategy & Delivery	Accountable Emergency Officer
Marie Peplow, Chief Operating Officer	Responsible Officer for PAS
Matt Revell, Medical Director	Responsible Officer, Board lead for Stonewall accreditation
Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary *	Freedom of Information Lead; Data Protection Officer (DPO); ICS governance support
Sharon Malhi, Acting Associate Director of Workforce & OD *	Joint ICS Lead for Leadership & Inclusion

* Non voting

To assign:

- NED Champion for Learning from Deaths (Learning from Deaths Report 2017; NHS England)
- NED Champion for Health & Safety (Health & Safety Act Work Act 1974)
- NED Champion for Emergency Planning (EPRR, NHS 2009)
- NED Champion for Counter Fraud (Directions to NHS Bodies on Counterfraud 2004)
- Guardian for Health & Wellbeing (NHS People Plan)
- NED Champion for End of Life Care (More Care, Less Care Report 2013)
- NED Champion for Complaints (NHS Complaints Regulations)

ROHTB (6/21) 011

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 25 May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The funding regime for the current year was discussed and it was noted that for the second half of the year, income would be more challenging and there was likely to be a requirement for the delivery of a significant efficiency target. • It was noted that there was currently little opportunity for the ROH to receive any Elective Recovery Funding despite meeting the requirements as an organisation to trigger this. This was noted to be as a result of the system activity position overall, which was not at a level that attracted the funding. • The risk around the funding to support the theatres complex was discussed, given the change in the financial regime from a Payment by Results model to a cost reimbursement model. This would be reflected in the relevant risk on the Board Assurance Framework.	• An assessment of the risk to the delivery of the Cost Improvement schemes to be included in the finance pack for the future. • The finance overview was reported to be being revised with the draft version to be presented in June. • Develop a meaningful comparison for length of stay between UHB and ROH patients. • Provide details of GP referrals on a month on month basis. • Schedule a further update on IT developments into the agenda of a future meeting of Finance & Performance Committee or Trust Board.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• It was noted that £1.6m of Cost Improvement savings had been identified, the majority of which were recurrent schemes. There had been good engagement with divisions as part of this. • Outpatient activity was reported to be above plan. • Theatre utilisation was reported to be good at 84.3%, with in session utilisation being 81.58%. The in session utilisation for the pathway involving patients from University Hospital Birmingham NHS FT (UHB) was lower at 64.55%. • Length of stay was reported to be 3.7 days for ROH patients. • The diagnostics target had been met and the second MRI scanner would be commissioned in August. • There was continued good progress with the refresh and recovery work and there was a plan to close a number of the workstreams where objectives had been completed. There was a plan to repatriate ambulatory trauma and hands work shortly.	• None specifically.

• The Committee received a presentation around the plans for digital and IT on a system basis, which was supplemented by an update on the various schemes underway at the ROH. A significant scheme across the system was a shared telephony and communications system. • It was noted that additional investment in the IT team had created additional capacity and support for the work to achieve compliance with the Data Security and Protection Toolkit. • The Committee received for information an update in the progress with the Perfecting Pathways Programme Board.	

Chair's comments on the effectiveness of the meeting: It was agreed that the presentation on digital and IT was useful to demonstrate good system working. All were thanked for the ongoing good work on the plans for refresh and recovery.

ROHTB (6/21) 012

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 26 May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was noted to be a heightened level of absence in respect of anxiety and stress. A gap analysis against the provision of support for these conditions was underway. • Turnover was noted to have increased slightly and would be kept under review. It was agreed that there needed to be further understanding around the reasons for staff leaving within a year of commencement. • There was noted to be a risk in terms of the number of imminent retirements from the nurse staffing group.	• Draft revised workforce report to be presented in June. • Split out the end of fixed term contract cases within the cohort of staff leaving within a year of commencement. • Mandatory training rates to be presented at the next meeting. • Benchmark absences, including those associated with Covid-19, against other organisations. The circulation of the regional Situation Reports would be organised to provide this information. • Further discussion on the Professional Practice Advisory Group terms of reference was agreed to be needed and in particular the awareness of the responsibilities of the Responsible Officer role in this context.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was joined by Julie Gardner, Associate Director of Finance, who described her experience of participating in the Birmingham and Solihull system training programme. It was acknowledged that the learning from the course had translated into a different style and approach for Julie and that the experience had been positive and was a platform for development of the system in coming months. • The next steps from the metric workshop held in April were to include the development of a revised workforce report, which would include a set of indicators across all protected characteristics. • There was reported to be further work to do to attract good quality candidates from a minority background and to brand the ROH as an employer of choice. • The draft inclusion strategy was reviewed which set out the future journey for colleagues and also reflected the work undertaken over the past few months. The Committee noted the proposed governance framework for inclusion. Overall, it was agreed that the	• The revised terms of reference for the People & OD Group were approved (circulated virtually for approval outside of the meeting).

document was a sound piece of work and good progress had been made on this agenda. • The feedback from the staff survey focus groups was discussed which would feed into the organisation action plan developed in response to the survey. It was agreed that there was further work to do to ensure that staff in non-clinical areas understood the way in which their role contributed to patient care. Staff from different areas shadowing each other was suggested as a useful means of achieving this.	

Chair's comments on the effectiveness of the meeting: The Committee had been chaired by Richard Phillips in place of the usual chair, Simone Jordan. There were some significant discussions at the meeting which created pressure given the time allocated for the meeting.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 26 May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there had been a Never Event; the investigation into this was underway and would be presented back to the Quality & Safety Committee. • The completion of the Friends and Family Test surveys was reported to be low at present. It was anticipated that the position would improve as the process became more embedded, following the recent pause which had been taken to ensure that the quality of the data collection was robust. • There was reported to be an outstanding Central Alerting System (CAS) alert around steroid prescription, however this would be addressed shortly and presented a low risk in the meantime. • There was noted to be an elevated level of absence among some nurse staffing groups; work was underway to understand the reasons for this, particularly whether the cases of stress and anxiety were related to work or influences outside of work. • Due to social distancing requirements there had been some impact on the Outpatients processes as a result of the limitations within the Imaging areas. A new process would be piloted.	• VTE Group to present an update on VTE assessment compliance in June 2021. • Comments on the Quality Account were invited. • The refresh and recovery workstream leads to be invited to the next meeting. • It was agreed that a letter of thanks and best wishes would be sent to Christian Ward, former Deputy Director of Nursing & Clinical Governance.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was reported to have been good progress with resolving the issues concerning performance against the Pathology contract and there was work underway to develop a network of support for this work, this initially being led by the ROH Deputy Chief Operating Officer. • There had been an improvement in mandatory training and appraisal rates across ward areas. • A comprehensive assurance report was provided on the situation and actions being taken around the ongoing post-admission VTE assessment. It was noted that the national guidance had changed in	• None specifically.

respect of this, removing this activity as 'exemplar practice'. There had been no harm identified in cases where the assessments had not been undertaken. The VTE Group was taking a lead role in the work and would present an update in June. • There remained good compliance with completion of the WHO checklist. • A valuable update on performance against the 15 key indicators being used to measure the effectiveness of the Primary Malignant Bone Tumour service (PMBTS) was received. This demonstrated that the pathway was working well and was good evidence of sound system working. • The draft Quality Account was received which would be presented to the Trust Board at its special meeting on 18 June 2021. The Committee was guided through the new quality priorities. • There was reported to be continued good progress with the refresh and recovery workstreams and there was a plan to close a number of these where the objectives had been achieved and move the work into business and usual. The pathway used by surgeons visiting from University Hospitals Birmingham NHSFT was noted to be working well. • Support to the Robert Jones and Agnes Hunt NHS FT was discussed and the governance structure for the work was being finalised. • An overview of the Patient Reported Outcome Measures (PROMS) was provided. There had been improvements to the process, including the linkage to the Amplitude system. Discussions around areas for improvement on specific outcomes measures were noted to be happening and there was good clinical engagement. • The Committee received an update from the Audit, Quality, Improvement, Learning & Analysis (AQILA) panel. It was noted that the panel had discussed the movement of Joint Registry information from a paper-based to an electronic system. • An update on the strategic approach to clinical quality improvement was discussed which included the development of a combined	

dashboard and clinical key performance indicators as part of the work. • The 'Patients' extract of the Board Assurance Framework was discussed and it was agreed that some changes to the scores for the existing risks would be proposed to the Trust Board. • The Committee chair reported that she had undertaken a walkabout around the hospital site to view the new building development and had noted that the excellent work had resulted in improved access for patients. She had also joined the Safeguarding meeting.	

Chair's comments on the effectiveness of the meeting: It was agreed that the discussions had been productive, however there should be a balance on the agenda in terms of guest presenters vs. Executive reports.

ROHTB (6/21) 014

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 7 May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee was concerned over the delayed completion of some actions on the recommendation tracker. It was noted that some of the delay was attributed to the need to respond the pandemic, however it was agreed that effort would be directed into improving the position before the July meeting of the Committee. • An advisory report into risk management was received which highlighted some weaknesses at a divisional and local level. There was confidence that the issues would be addressed by the risk improvement strategy that was in place. • Performance against the Pathology contract was noted to be a concern raised at the Quality & Safety Committee meetings.	• Improvements to the recommendation tracking position to be achieved by the July 2021 meeting. • Circulate the annual governance statement and associated year-end papers for comment. • Circulate the latest assessment of compliance against the Data Security and Protection Toolkit.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received reports into Procurement and Freedom to Speak Up, both of which reported positive opinions. • The Head of Internal Audit's Opinion concluded that there was an adequate framework of internal control in place, notwithstanding there being room for enhancement. There were no matters of significant weakness that needed to be reflected in the Annual Governance Statement. • Thanks were given to RSM UK for their support to the ROH over the past years. KPMG LLP was welcomed as the Trust's new internal auditors. • The initial internal audit plan was reviewed. This included a Covid-19 backlog review which would be undertaken on a systemwide basis. • It was reported that there was good progress with the external audit plan and annual audit. • The workplan for counterfraud was discussed and supported. An antifraud champion would be identified. There was some good work	• The Audit Committee approved the internal audit plan for 2021/22.

reported to be underway to weave counterfraud into the overall work of the Trust. • The Committee was joined by the Deputy Director of Nursing & Clinical Governance who presented the proposed new quality account priorities. • The draft governance statement was considered which highlighted a strong internal control framework. • There were noted to be no concerns over losses and special payments made. The breaches and waivers of Standing Financial Instructions provided some assurance on the process but there may be a need to further review aspects in relation to registered invoice dates and order dates.	

Chair's comments on the effectiveness of the meeting: It was agreed by all present that the meeting was productive and there had been sufficient time for discussions on key items, particularly given the complexity of the agenda.

QUALITY REPORT – MAY 2021 (APRIL DATA)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	***MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY***
1 x Never Event reported (SERIOUS INCIDENT) - Retained foreign body post-surgery. This has been reported as a Serious Incident/Never Event to the CCG via the STEIS system. ***5 x Moderate Harms reported*** **1 x Death reported** **VTE 24-hour re-assessment** Continued poor compliance with mandatory 24-hour re-assessment. This continues to monitored monthly and escalated the Consultants identified as responsible for Junior Doctor supervision. Medical Lead for VTE is undertaking a piece of work to look at data in m detail and addressing directly with individuals. ***6 Inpatient falls reported –*** *Falls per 1000 bed days (2.1) remains under the national Benchmark(6.0)* **FFT** Trust did not meet Mandatory internal completion KPI for mandatory areas (inpatients) for several months. This will be discussed on Divisional management board meetings in May 2021 **1 Overdue CAS alert** Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults. Guidance being drafted via DTC in order to comply with Alert.	***None***
POSITIVE ASSURANCES TO PROVIDE	***DECISIONS MADE***
1 closed RCA **No Category 2, 3 or 4 Pressure ulcers reported in month** **Patient experience KPI have been met within month**	***None***

WHO Checklist compliance 100% ***No reportable infections recorded***	

Quality Report - May 2021 (April 2021 Data) – Front Cover and Dashboard

	April 2021	2021/2022	2020/2021 YTD
Incidents	391		
Serious Incidents	1	1	10(Total)
Internal RCA investigations	5		
VTEs (Avoidable)	0	0	1(Avoidable)
Falls	6	6	76(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0	10(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0(Avoidable)
Complaints	3	3	57(Total)
PALS	47		
Compliments	5		
FFT Score %	97		
FFT Response %	22		
Duty of Candour	10		
Litigation	0		
Coroners	0		
WHO %	100		
Infections	0	0	3 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

May 2021 (April 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

CONTENTS

1	Introduction
2	Incidents and Mortality
3	Serious Incidents
4	Internal RCA investigations
5	VTEs
6	Falls
7	Pressure Ulcers
8	Patient Experience
9	Friends & Families Test and Iwantgreatcare
10	Duty of Candour
11	Litigation and Coroners Inquests
12	WHO Surgical Safety Checklist
13	Infection Prevention Control + Covid update
14	Safeguarding
15	Open CAS alerts

1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

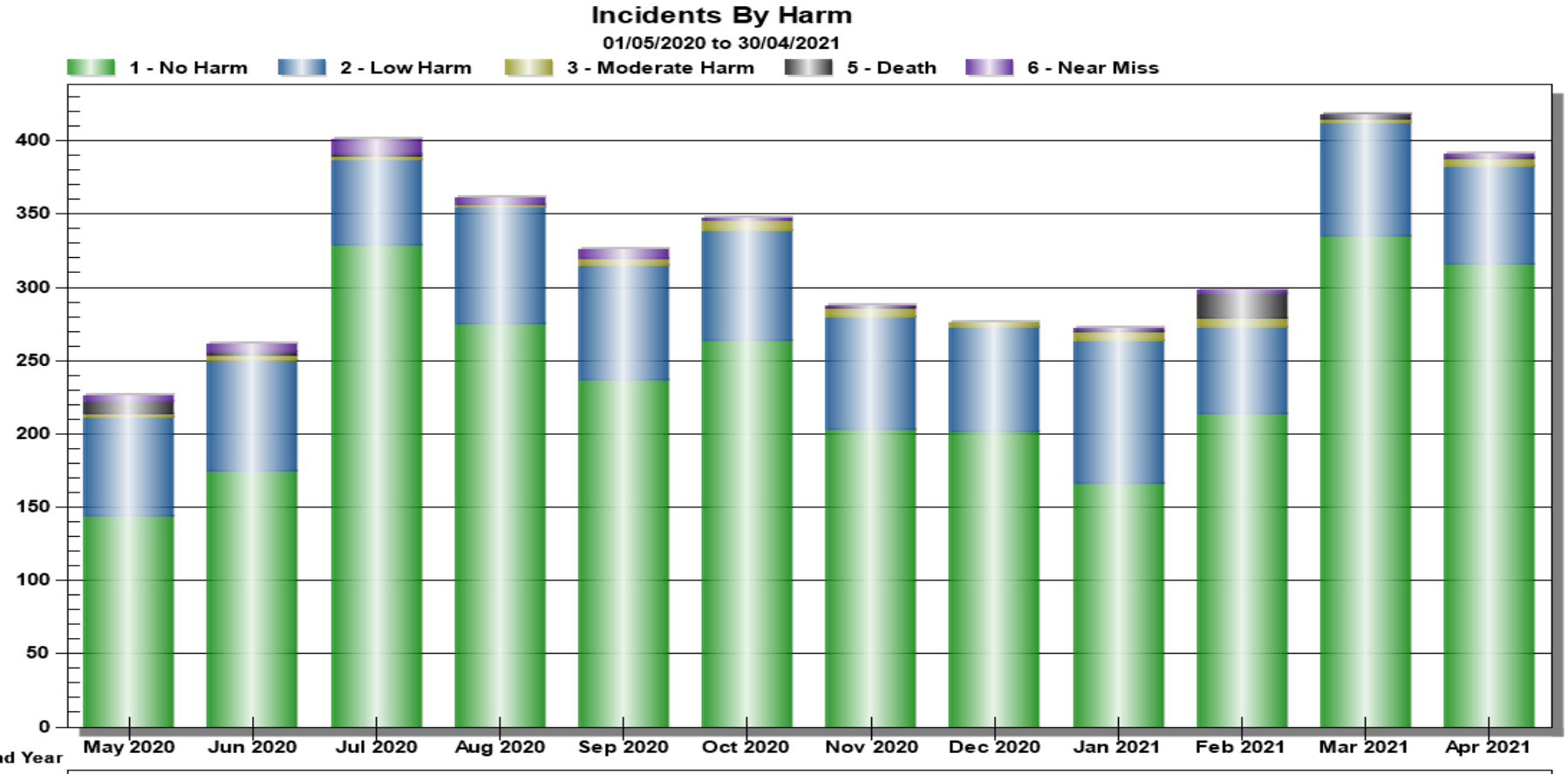
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55216)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021
1 - No Harm	143	174	328	274	236	263	202	201	165	213	334	315
2 - Low Harm	68	75	58	80	78	75	77	71	98	59	78	67
3 - Moderate Harm	2	4	3	2	5	7	6	4	6	6	2	5
5 - Death	8	2	1	0	0	0	1	0	1	17	3	1
6 - Near Miss	5	6	11	5	7	2	1	0	2	3	1	3

Data source – Ulysses

INFORMATION

In April 2021, there were a total of 391 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

315 – No Harm
68 - Low Harm
4 - Moderate Harms
0 - Severe Harm
3 – Near Miss
1 – Death

Downgraded Incidents

Currently 0 of the reported harm in the Previous Quality report (April 2021) have been downgraded.

Patient Contacts

In April 2021, there were a total of 7576 patient contacts. There were 391 incidents reported, which amounts to 5.1 per cent of the total patient contacts. Of those 319 reported incidents, 73 incidents resulted in harm which is 1 per cent of the total patient contact.

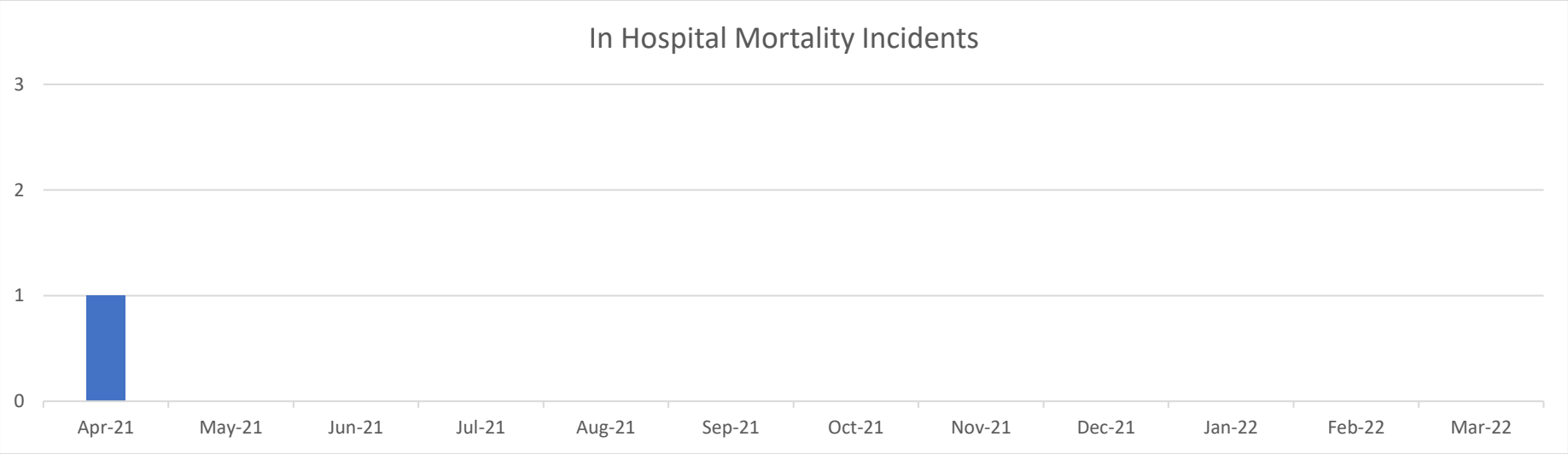
ACTIONS FOR IMPROVEMENTS / LEARNING

Ulysses upgrade has been completed on the Trust incident reporting structure and cause groups. This will improve the reporting on incidents and allow the Governance and the patient Experience team to break down the incidents and PALS concerns by speciality. Breakdowns of these incidents are now to be included in the speciality meetings within the division.

RISKS / ISSUES

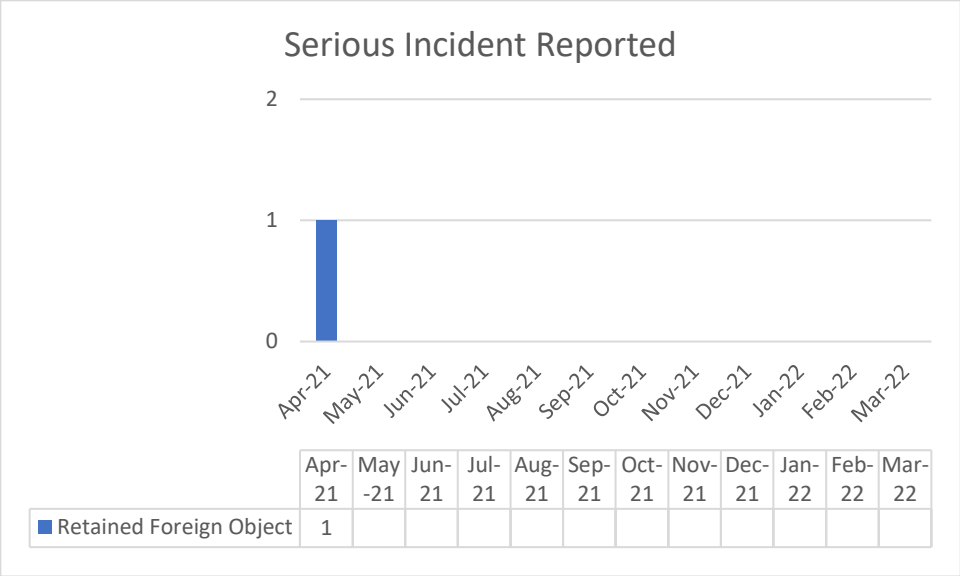
None

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
There was 1 In-hospital death reported in April 2021. Referred on to Medical Examiner and Learning from deaths underway
ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
The data reported for the deaths occurring within 30 days is not always reliable due to a delay with the national system. This may cause a delay in the learning from deaths process. The Governance team is working with the Trust informatics team to improve the timeliness and accuracy of this data.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**

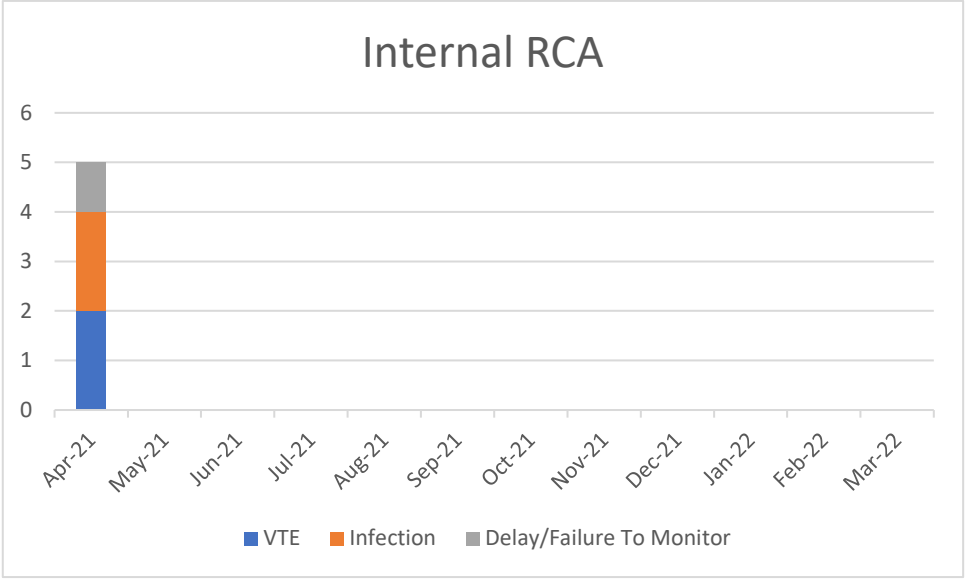


Year Totals	
20/21	11
21/22	1

Data Source – STEIS

INFORMATION
There was one Serious incident (NEVER EVENT) reported in April 2021. The Trust currently have two open Serious Incidents. Incidents 35417 – retained foreign object and 35090. Both incidents are currently under investigation within the agreed CCG timeframes.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in April 2021.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



Data Source – Internal RCA tracker

INFORMATION

4 internal RCAs were reported in April 2021 are currently underway within the divisions. This is also detailed on the incident page. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.

ACTIONS FOR IMPROVEMENTS / LEARNING

Lessons learned

- Care needs to be taken in terminology offered to patients – service suspension vs discharge with a view to self-refer back.
- A clear agreed treatment plan needs to implemented, to ensure all post-operative patients have appropriate level of input should service be reduced. If post-operative patients are discharged then this needs to be clearly documented and justified in the patient notes.
- A clear criteria for the management of post-operative patients during any disruption to physiotherapy services should be given to guide staff.
- If services are withdrawn/reduced in the future then the surgical teams need to be made aware in advance, where possible, being advised of the plan to follow up their post-operative patients. Instructions given to patients on return to sport need to be clear and documented following an appropriate assessment.
- Assessment and review of milestones through ACL pathway should be completed as per protocol and documented thoroughly in their notes.

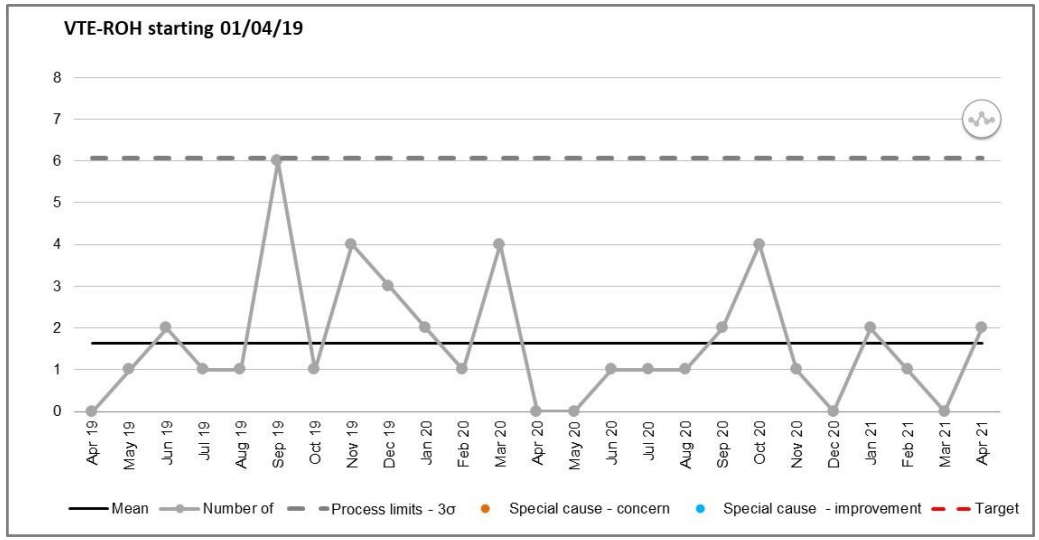
Recommendations

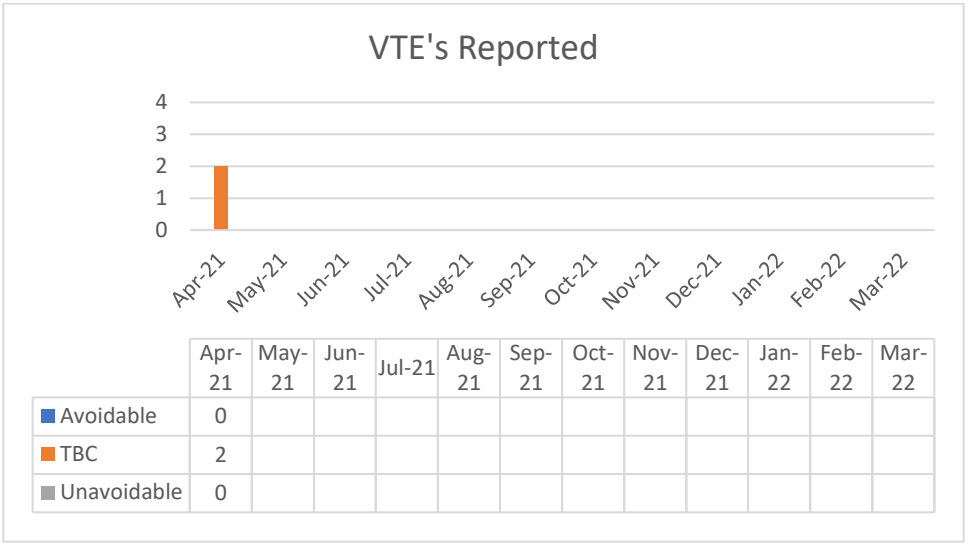
- Clear documentation of clinical assessment to demonstrate progression through the pathway.
- The treating clinician should be responsible to ensure that follow up appointments are booked and the review is completed.
- A clear criteria in place to plan for any future reduction in physiotherapy service to ensure appropriate management of post op patients' rehabilitation.
- Feedback to the physiotherapy team on the issues identified as part of the RCA.
- There should be an option for the patient to contact the physiotherapy department should they have any concerns with their post-operative rehabilitation.
- Consider creating a return to sport 'passport' to formally inform the patient of their progress.

RISKS / ISSUES

None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Avoidable	0											
TBC	2											
Unavoidable	0											

Avoidable Year Totals		Total including unavoidable
20/21	1	13
21/22	0	0

Data Source – Ulysses and VTE leads

INFORMATION

Two ROH associated VTEs were reported in April 2021. The SPC chart on the previous page shows that reporting of VTEs is within the recognised threshold at the ROH.

24-hour reassessment:

4hr review	410
missed 24hr review	203
total	613
24hr %	66.88418

On admission assessment

total possible	760
total assessed	748
%	98.42%

ACTIONS FOR IMPROVEMENTS / LEARNING

Continued poor compliance with mandatory 24-hour re-assessment (see below). This continues to be escalated to and reviewed by the Medical VTE lead (JP) and Junior Dr Supervisors.

Audits are being undertaken by the VTE medical lead to look at:

- the accuracy of the data report provided by Informatics
- The effect of the re-assessment on patient management plan

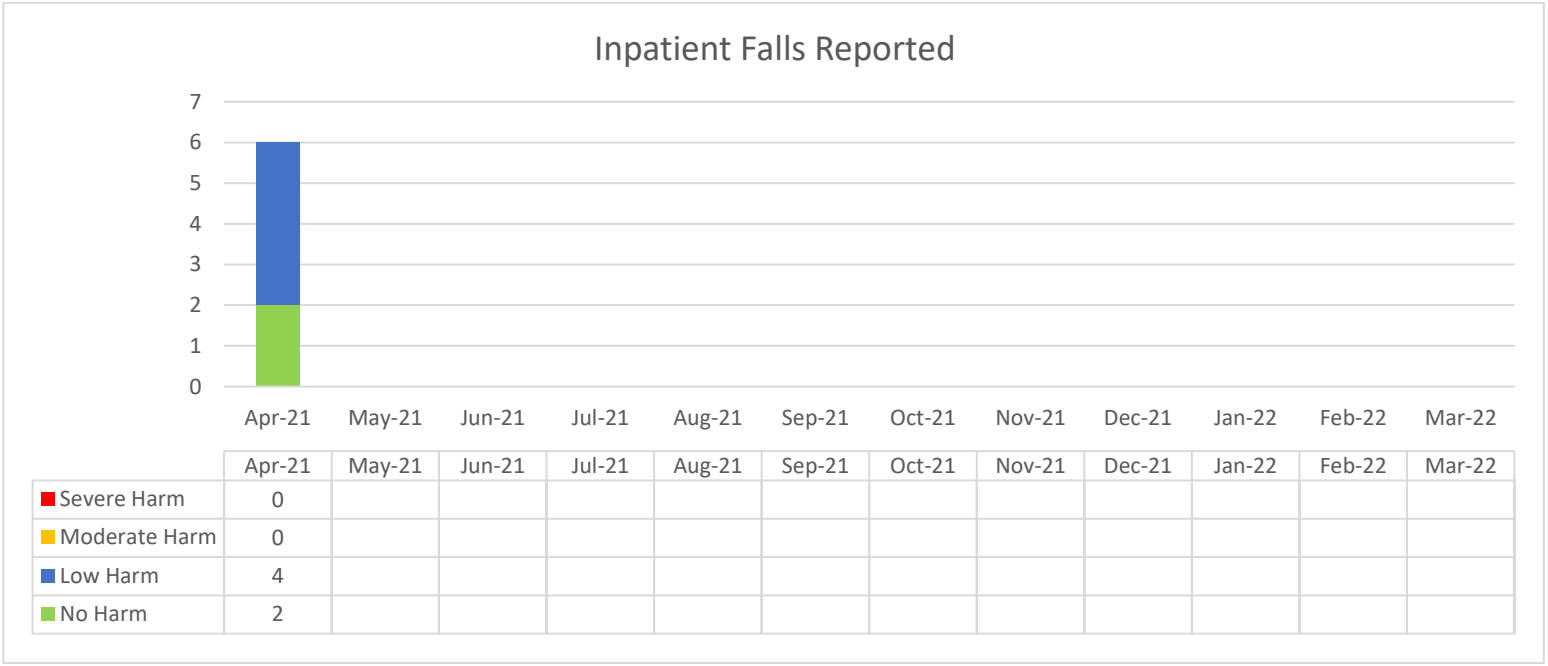
- Clinical notes to compare what is documented regarding VTE reassessment/plan-this was the methodology used by the CQC at UHB.

All results are expected to be available this month. This will then be reviewed by the VTE Advisory Group and presented at Clinical Audit and the Quality and Safety Committee. This will provide clarity re whether any changes to PICS and guidance is required/recommended or not.
The Trust Patient Safety Lead is finalising a review of VTE processes and management at ROH against new NICE Quality Standards QS29 .It has been confirmed that ROH VTE Guidance incorporates all requirements. A selection of notes will be audited to provide assurance this is occurring in practice.

RISKS / ISSUES

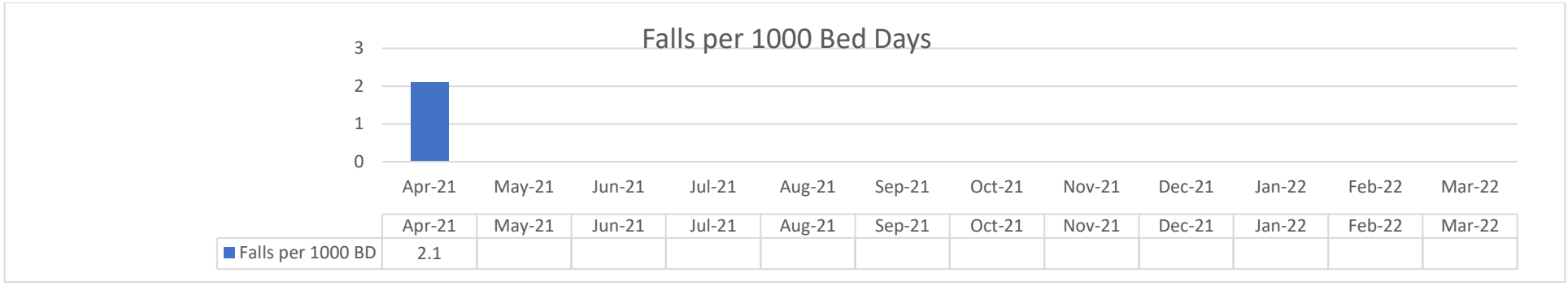
Continued poor compliance with mandatory 24-hour re-assessment. This continues to monitored monthly and escalated to Medical Director and Consultants identified as responsible for Junior Doctor supervision. Medical Lead is undertaking a piece of work to look at data in more detail and addressing directly with individuals.

6. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.

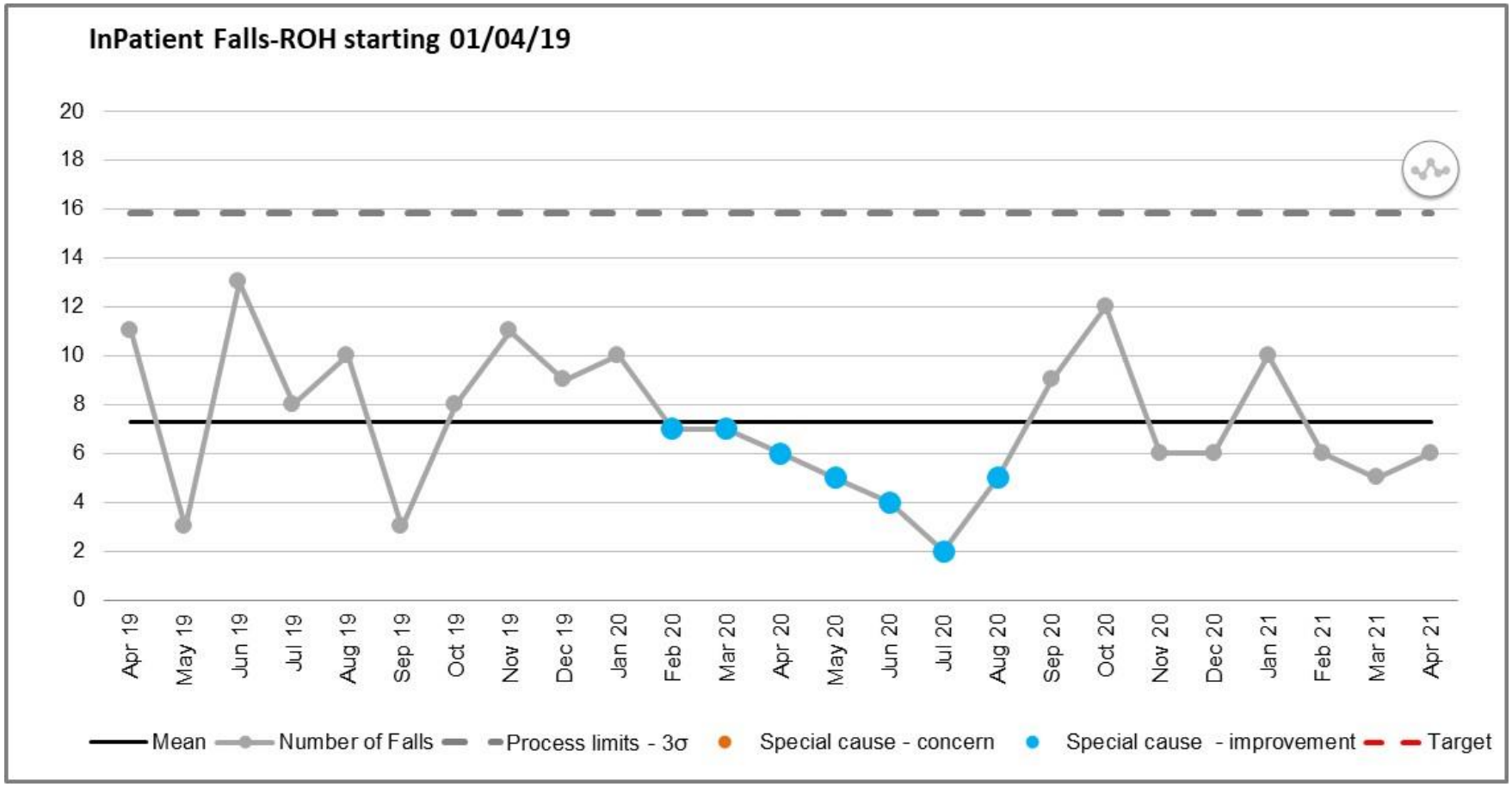


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Severe Harm	0											
Moderate Harm	0											
Low Harm	4											
No Harm	2											

Year Totals	
20/21	76
21/22	6



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Falls per 1000 BD	2.1											



Data Source – Ulysses and Falls Group

INFORMATION

There were 9 incidents reported across the Trust in April 2021 relating to Falls:

6 x In-Patient Falls Incidents

1 x Lowered to Floor Incidents:

2 x ROCS/Patient Home Incidents

ACTIONS FOR IMPROVEMENTS / LEARNING

Positive Assurance

Review of falls incidents specifically related to Ward 4 undertaken, given an increase in numbers. The potential concern, being the recent opening of beds in phase 2 of the ward, these are more isolated and comprise of side rooms only. The review shows that most of the falls occurred in the original section of the ward, ruling out the concern of patients falling due to being more isolated in the new section. All but 1 of the patients had multiple co-morbidities, and a number of them suffered from hypertension, although observations prior to the fall were within normal parameters. In view of this, training is to be provided to the ward 1 team around anti-hypertensive medication post-surgery.

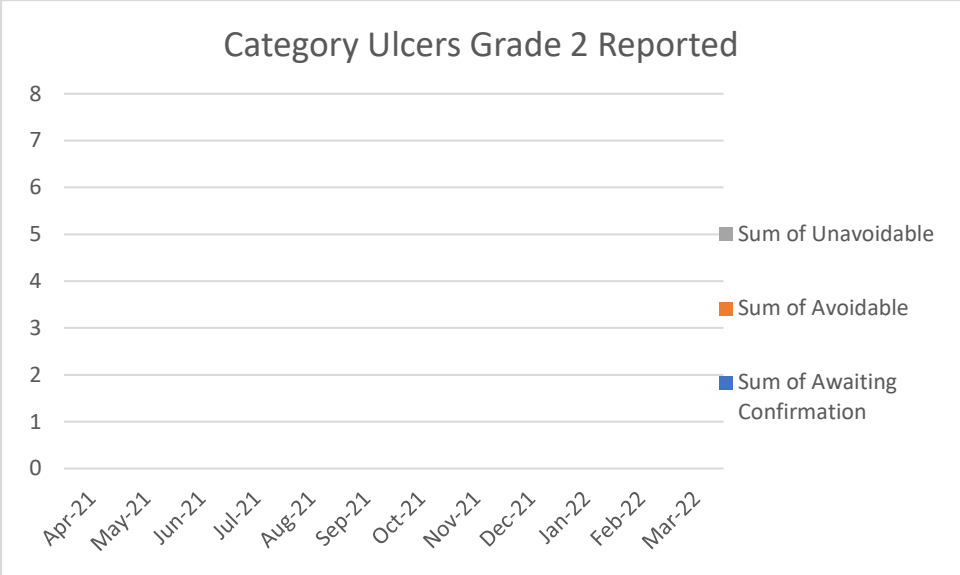
New falls information boards arrived, currently being distributed to wards/departments.

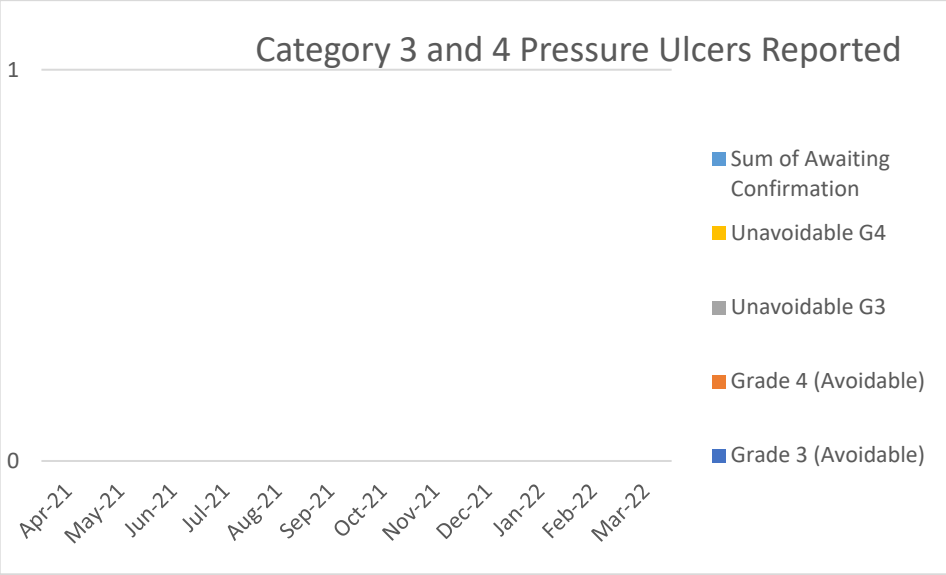
Benchmarking against WMQRS now complete, no gaps in standard.

RISKS / ISSUES

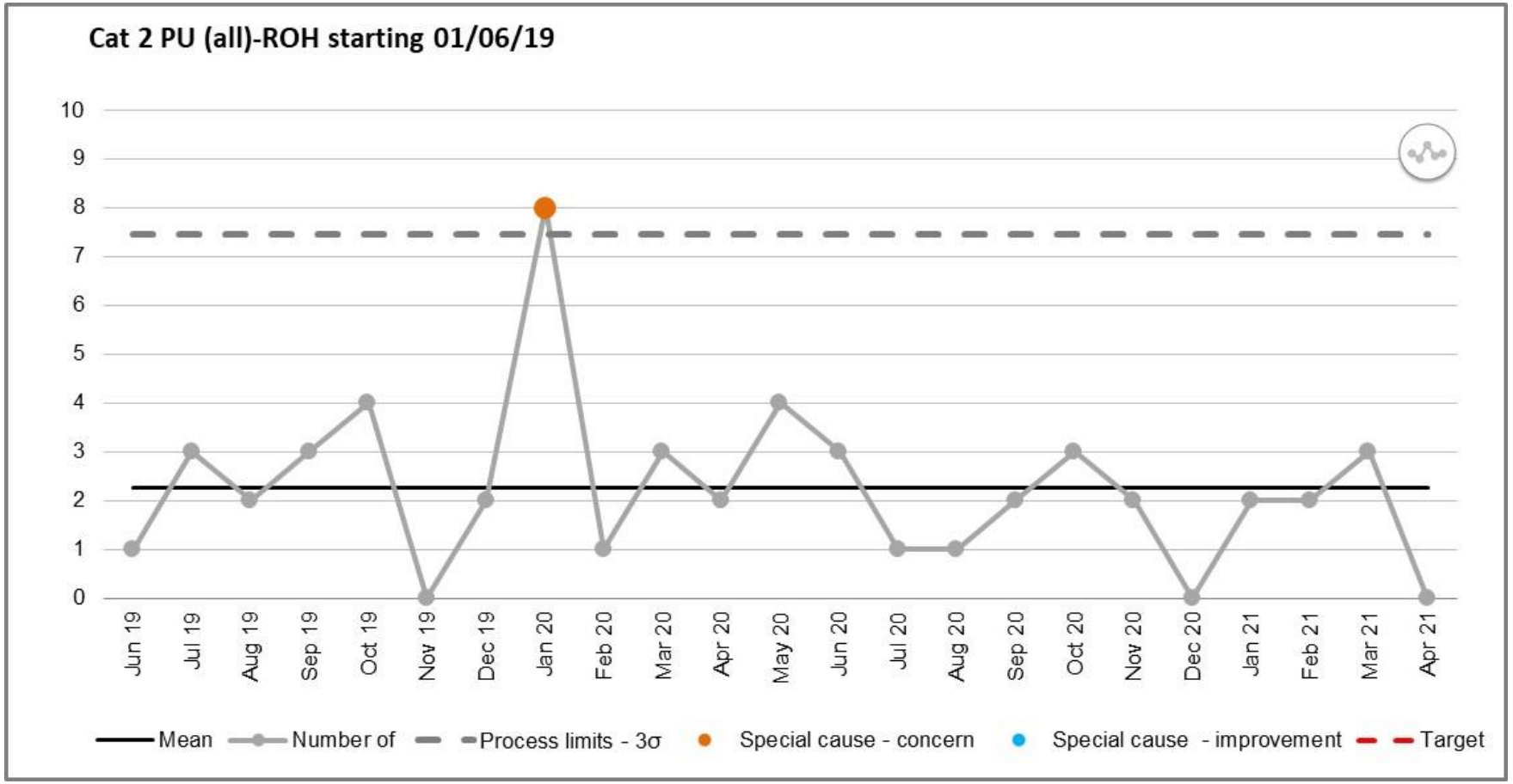
None

7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.





Year Total	Cat 2	Cat 3
20/21	25	1
21/22	0	0



Data Source – Ulysses and TV team

INFORMATION

April 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	0
Category – 2 (Device)	0
Category – 1	1
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence - Nil MASD ROH Intertriginous dermatitis – 2 MASD admitted with Incontinence x 2 MASD admitted with Intertriginous dermatitis x 1

Patients admitted with PU's	PU admitted with Cat 1 x 1 – Did not deteriorate PU admitted with Cat 3 – Nil PU admitted with Cat 4 DTI x 1 – Admitted from home PU admitted with Cat Ungradeable - Nil PU admitted with SDTI – Nil

Avoidable only Pressure Ulcer CCG Contracts KPI

2021/2020 – Contract to be confirmed.

2021/2022	
Avoidable Grade 2 pressure Ulcers	0
Avoidable Grade 3 pressure Ulcers	0
Avoidable Grade 4 pressure Ulcers	0

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

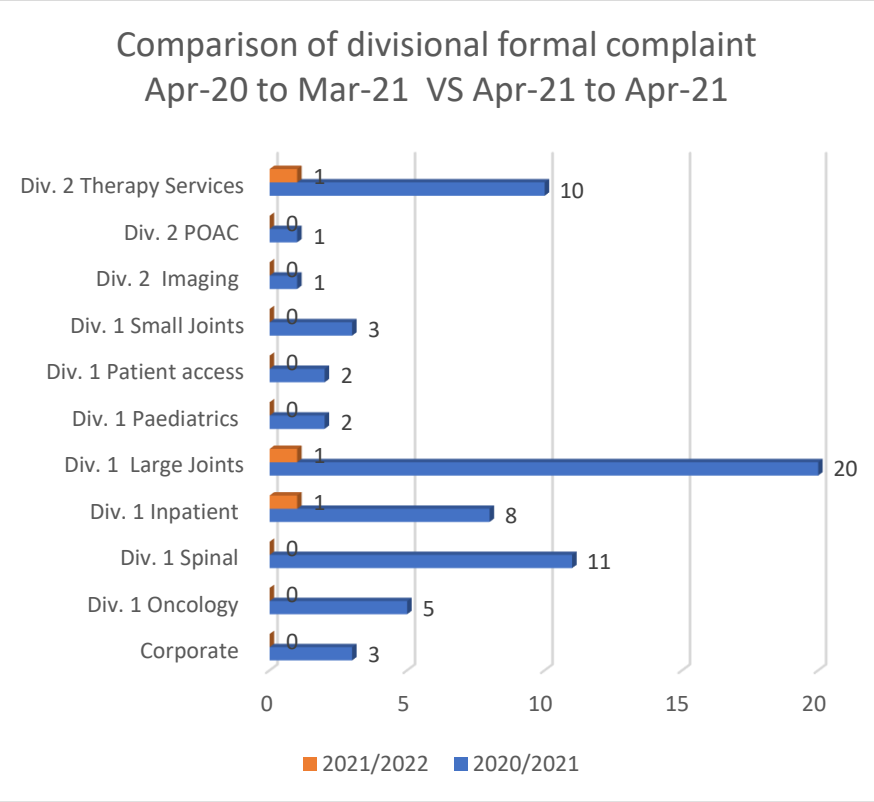
Increase in PU incidents from patients transferred to ROH from UHB. TV Lead noted that at ROH, deterioration did not occur. However, longer stay patients were at different risk of developing PU. They reported advice to Ward Managers for dissemination to staff around Pressure Relief and monitoring time patients spend sitting in a bedside chair. CQG group to continue monitoring to ensure the rate of PU returns to normal levels.

RISKS / ISSUES

None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
20/21	49
21/22	3

Data Source – Patient Experience team

INFORMATION

Complaints

- There were 3 formal complaints acknowledged in April 2021; 2 were in relation to Division 2 and 1 in relation to Division 1.
- Categories and subcategories of Formal complaints in April 2021:

Row Labels	Count
Admissions	**1**
Delayed Admission	1
Cancellation Of Surgery	**1**
Surgery Cancelled At Pre-Op	1
Clinical Query	**1**
Injury Sustained During Treatment	1
Grand Total	**3**

- In April – 1 Formal Complaint were closed within agreed date with patient. This gives an 100% completion on time rate and meet the KPI for the month. The average response to formal complaint was 8 days.
- At the time of producing this report there was 1 open complaint and it is Corporate, in relation to the vaccination hub.
- There were no comeback complaints in April 2021

Patient Advice and Liaison service - PALS

- In April 2021 the PALS department handled 47 contacts of which 31 were classified as concerns, 3 as informal complaints and 13 as enquiries. This is an increase in contacts compared to the same time last year when COVID-19 pandemic started (14 contacts in April 2020 according to Ulysses). The main themes in the PALS data relate to queries about appointments with 25 contacts in relation to them.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In April 2021, 100% of enquires and 99.69% of concerns were handled within the agreed timescales with patient.
- Top 3 categories and 2 Top subcategories PALS contacts for April 2021

Top 3 PALS categories and top 2 subcategories for April 2021	
Appointments	**26**
Appointment Cancelled	5
Availability	6
Clinical Query	**9**
Clinic Letter Not Received	1
Clinical Treatment	2
Referral	**2**
Referral- Not Actioned	2

Patient experience KPI from April 2021

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-21	100	99.69	100

Compliments

There were 5 compliments recorded on Ulysses in April 2021.

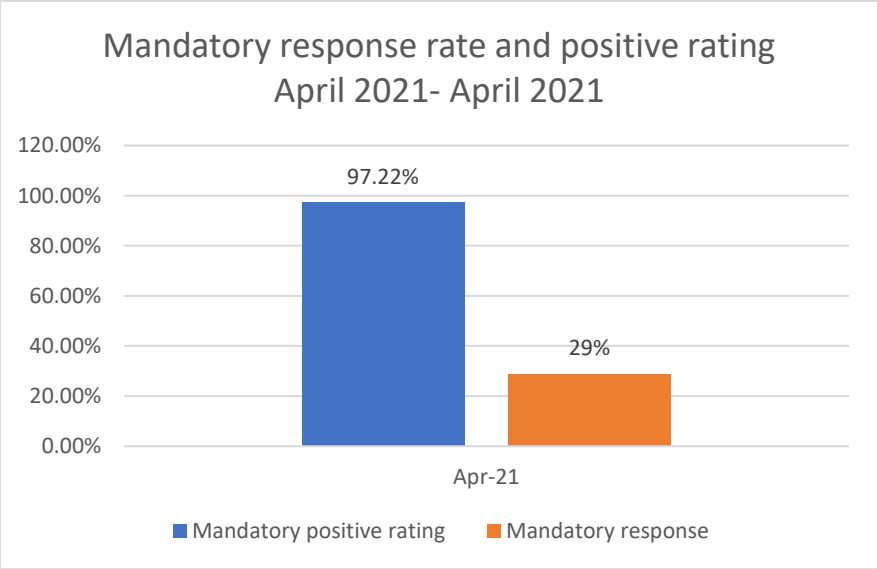
ACTIONS FOR IMPROVEMENTS / LEARNING

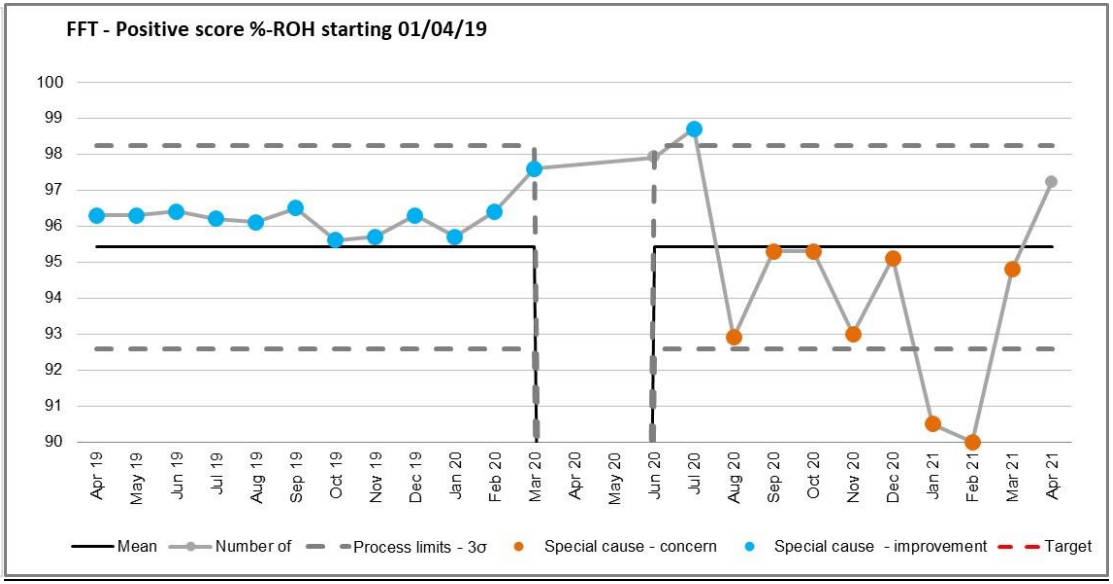
- The Head of Patient Experience has improved the Ulysses system with new and improved categories, departments and Directories and this is live from April 2021
- The vacant 1.0 WTE Band 5 Patient Experience Facilitator was advertised in April 2021 and interviews will take place in May 2021
- The Head of Patient Experience has started to implement the Hello my name is campaign and this will go live in June 2021. Samples of the new badges have been received. The Co-founder of #HelloMyNameIs campaign will be involved in the introduction of this campaign at the ROH in June 2021

RISKS / ISSUES
Team will be left without Patient Experience Facilitator in June 2021, due to end of secondment. Bank staff will be put in the place to cover the role
COMEBACK COMPLAINTS
None

9. Friends and Family Test Results (collected in the iwantgreatcare system).

FFT Mandatory Reporting





INFORMATION
• There appeared to be a disparity between data collection and results published. In February 2021, Trust scaled down the collection to just the mandatory element to allow the position to be better understood. The issue has been flagged to the CQC and the Executive Quality and Safety meeting with work underway to rectify issues. From February 2021 the Trust will not report on the non-mandatory areas until the data quality issues are resolved. • In September 2020 the Focus of the FFT questions changed to focus on the patients experience at the Trust rather than the previous focus on how highly they would recommend the Trust. • Area Managers are receiving any compliments or concerns from patients via a report from the PALS team. This allows the areas to share with their staff for learning and improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The Public engagement team will look more closely on areas that do not fulfil mandatory 40% target in FFT response (return) rates.
- The Public engagement team reviewing the possibility of sending text messages to all outpatients after their appointment to ask them how was their experience (1-5) and why did they give that answer. Once every quarter area will have in depth patient survey which will be generated by heads of department.
- Business case that was approved for Public Engagement team will allow us to bring FFT collection, reports and ownership of data back in the Trust.
- Contract with I Want great care will cease at the end of June 2021.
- The Public Engagement team is in process of creating a template for compliments so they can be displayed to the public within departments.

RISKS / ISSUES

- Trust collect patient feedback form non-mandatory areas within the hospital, capturing data on internal spreadsheet and sends any concerns, feedback or compliments back to the Ward managers.
- Trust did not meet Mandatory internal completion KPI for mandatory areas (inpatients) for several months. This will be discussed on Divisional management board meetings in May 2021

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

0 new claims against the Trust have been received so far in May 2021

On-going claims

There are currently 25 on-going claims against the Trust.

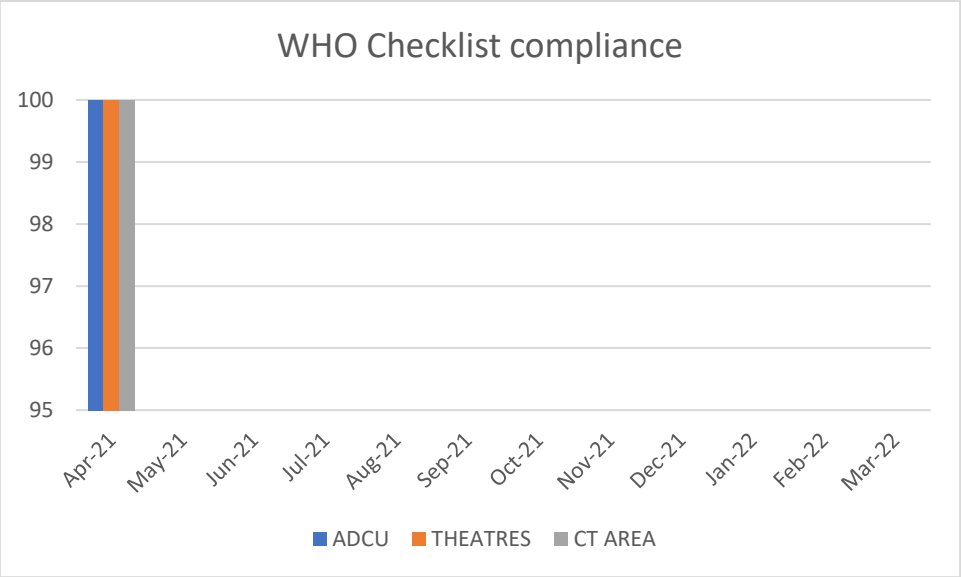
Pre-Application Disclosure

1 new request for Pre-Application Disclosure of medical records has been received so far in May 2021

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' have been held or are listed to be heard in May 2021

12. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 668

The total WHO compliance for Theatres in April 2021= 100%

CT area

Total cases = 75

The total WHO compliance for CT April 2021 = 100%

ADCU

The total WHO compliance for ADCU in April 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non-compliance will be reported back to the relevant clinical area.

The Theatre man system originally stated 3 incomplete patients on the Theatres lists, upon review all documentation and WHO Checklists for all patients complete and therefore compliant

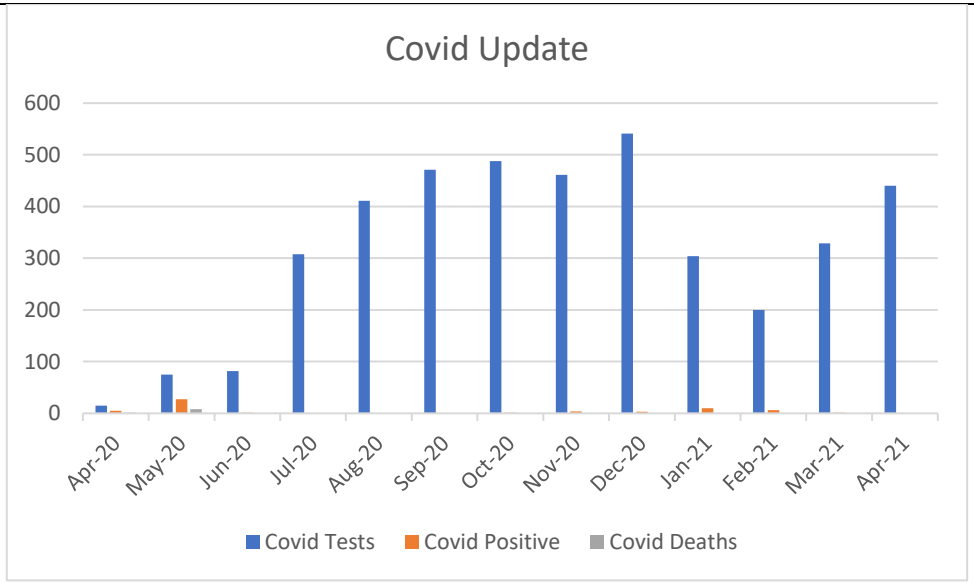
RISKS / ISSUES

None

13. Infection Prevention Control – Statutory requirement/Reportable Infections. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	April 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	0
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



ACTIONS FOR IMPROVEMENTS / LEARNING

0 patients tested positive for Covid-19 prior to admission to the ROH

RISKS / ISSUES

None

***Data Source – IPC team and Ulysses**

14. Safeguarding

	Apr-21
Safeguarding Adult Notifications	37
Safeguarding Children and Young People Notifications	43
Mental Health Incidents	22
LD Adult	6
LD Children	73
Adult Level 2	98.09%
Adult Level 3	87.07%
Level 4	100&
Child Level 2	97.91%
Child Level 3	87.38%
Mental Capacity Act MCA	96.23%
Deprivation of Liberty Safeguards DoLs	96.50%
Prevent WRAP	82.92%
CE	0
FGM	0
DOLS	4
MCA	0
PIPOT cases	0
Domestic Abuse	3
PREVENT Notifications	0
WNB	15
Child in Care	2
Early Help	3
DHR- scoping Reviews	1
SARs- scoping review Or Rapid Reviews	0
Modern Slavery	0
Incidents	5
Open Cases	12
Closed Cases	69

15. CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

OPEN CAS ALERTS 1 - 31 April 2021

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
NatPSA/2020/005/NHSPS	Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults. *The omission of steroids for patients with primary or secondary adrenal insufficiency can lead to adrenal crisis; a medical emergency which if left untreated can be fatal. If these patients become acutely ill or are subject to major body stressors, such as from trauma or surgery, they require higher doses of steroids to prevent an adrenal crisis.* *While substantial resources exist, clinical staff are not always aware of the risk of adrenal crisis, or the correct clinical response should one occur.* *The alert asks providers to ensure all eligible patients are issued with a Steroid Emergency*	National Patient Safety Alert - NHS England & NHS Improvement	13-Aug-20	**19 May 2021:** **Chief Pharmacist:** Reviewing processes. Guidance being drafted via DTC in order to comply with Alert. On-going.	13-May-21

	Card; and to put processes in place to check if a patient has a Steroid Emergency Card ahead of any emergency treatment, elective surgery, or other invasive procedures.				

Finance and Performance Report

April 2021

CONTENTS

1	Overall Financial Performance	
2	Income and Activity	
3	Expenditure	
4	Cost Improvement Programme	
5	Liquidity & Balance Sheet analysis	
6	Theatre Sessional Usage	
7	Theatre In-Session Usage	
8	Process & Flow Efficiencies	
9	Length of Stay	
10	Outpatient Efficiency	
11	Treatment Targets	
12	Workforce Targets	

INTRODUCTION

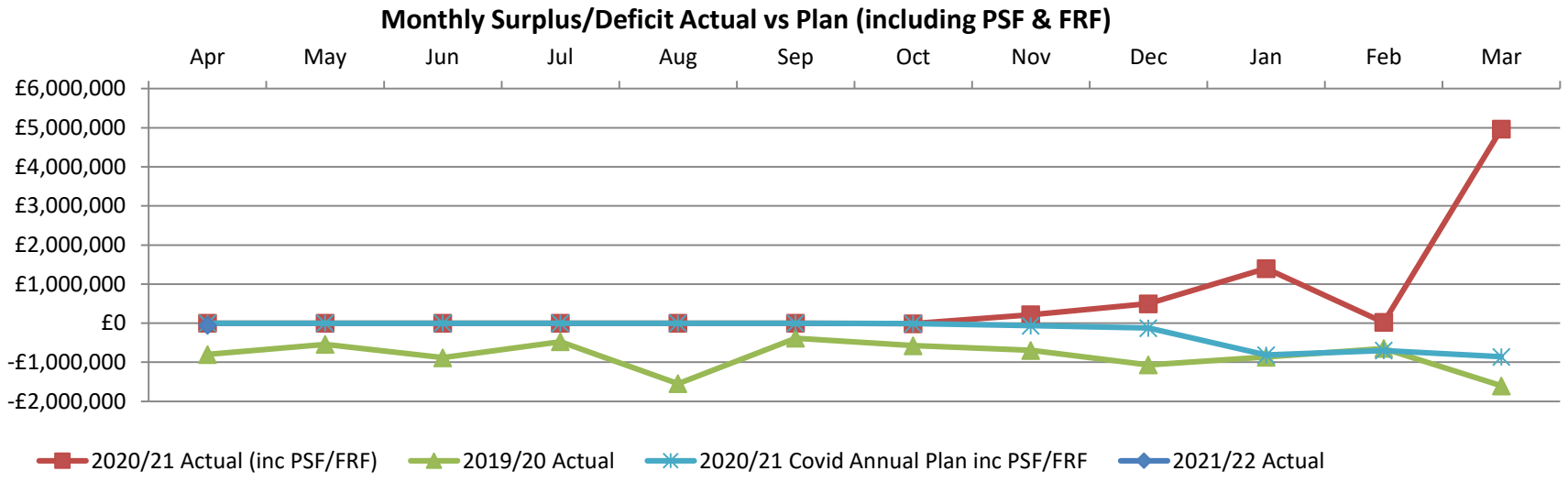
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

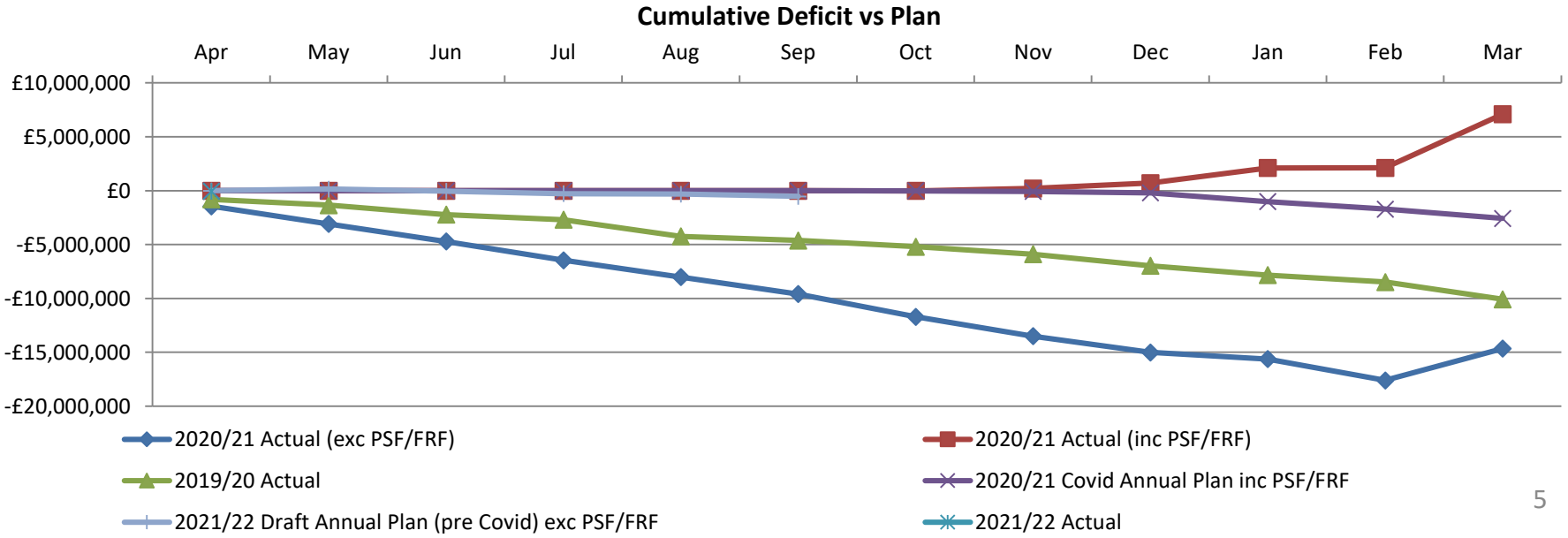
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	H1 Plan 2021/22	Actual M1 2021/22
	£'000	£'000
Operating Income from Patient Care Activities	53,787	8,212
Other Operating Income	1,925	331
Total Income	**55,712**	**8,543**
Employee Expenses (inc. Agency)	(29,947)	(4,803)
Other operating expenses	(25,915)	(3,732)
Operating Deficit	**(150)**	**9**
Net Finance Costs	(412)	(69)
Net deficit	**(562)**	**(60)**
Remove donated asset I&E impact	34	6
Adjusted financial performance surplus/(deficit)	**(528)**	**(54)**

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan on both a monthly and cumulative basis





INFORMATION
The performance in month 1 is a small deficit of £54k. The plan for H1 is a deficit of £528k over the six months, and therefore this position is approximately in line with expectations for the month. No assumption has been made for ERF income within this financial position. Work is ongoing at present to consider the H1 plans as a system, which will be further described later in the agenda.
ACTIONS FOR IMPROVEMENTS / LEARNING
RISKS / ISSUES
There remains a risk, particularly as we move into H2 next year that the funding allocated to the Trust will not be sufficient to cover the increased costs the Trust is incurring in relation to the new theatres.

2. Income and Activity– This illustrates the total income generated by the Trust in 2021/22 by category of income;

Breakdown of Block Income received in month against the plan for H1 (April'21 – September'21

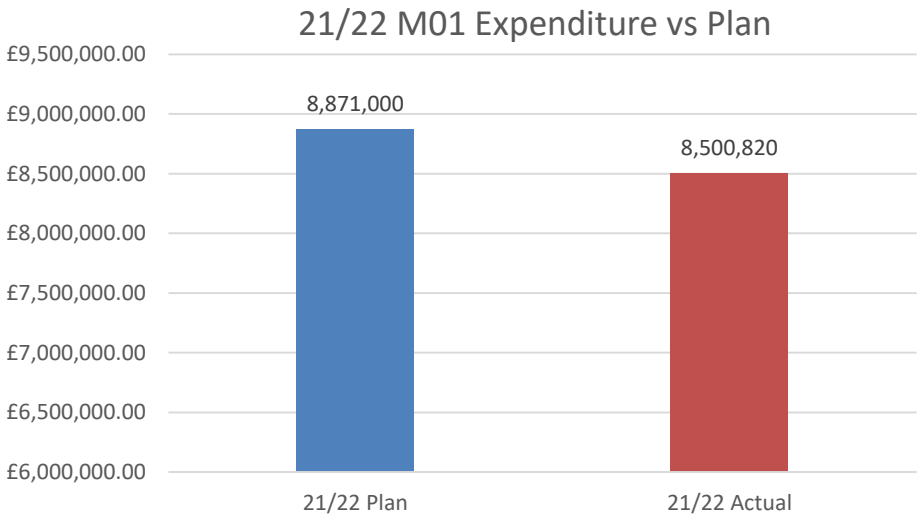
	H1 2021/22 Plan	M1 Actual
NHS England	14,058	1,974
Clinical commissioning groups	36,091	6,015
NHS Foundation Trusts	762	127
Private Patients	375	0
Research & Development	214	36
Education & Training	942	157
Other Income	1,370	234
Elective Recovery Fund	1,900	0
	55,712	**8,543**

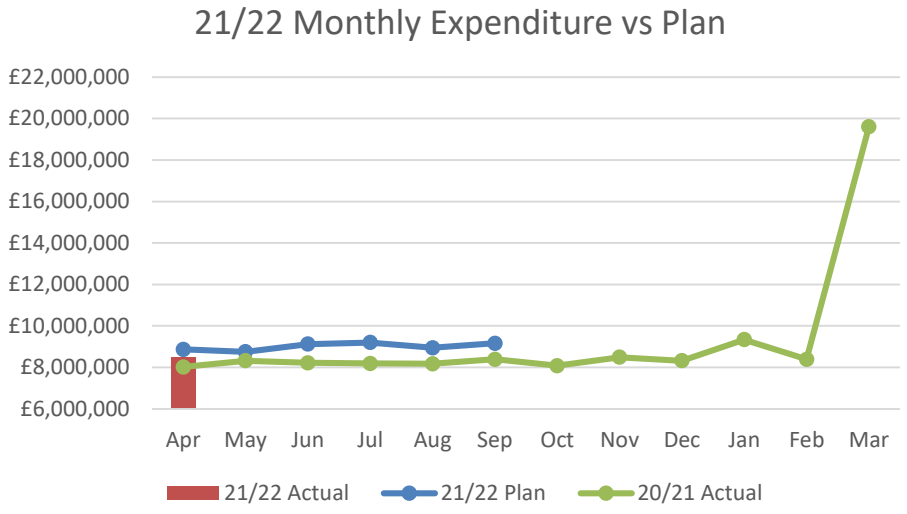
INFORMATION

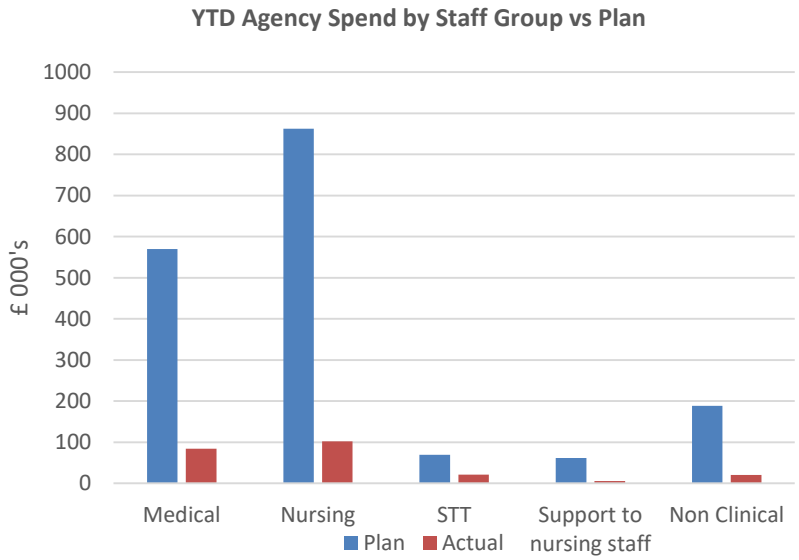
Block contracts have been agreed for the first six months of the financial year (H1), with funding envelopes for H2 to be received later in the year.

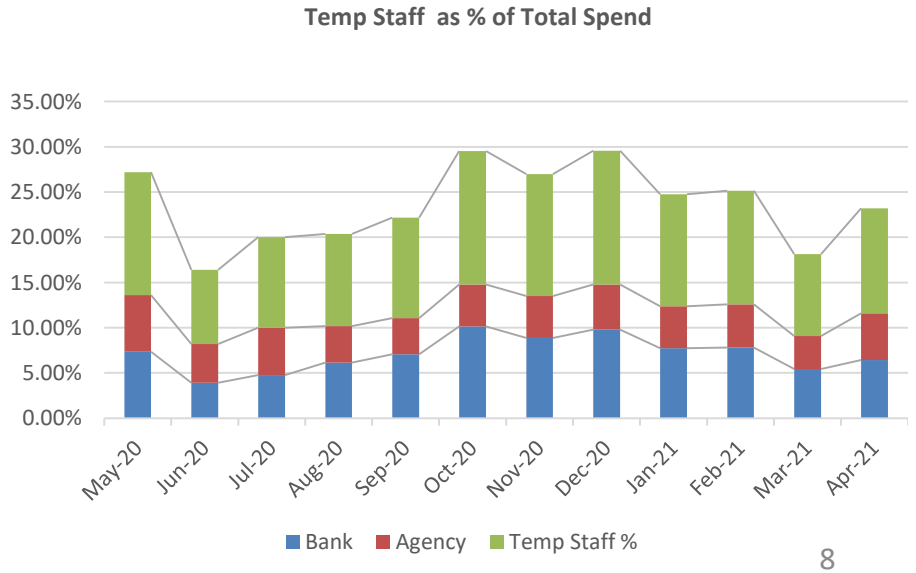
An estimate of the income expected as a result of the Elective Recovery Fund (ERF) has been made based on the draft activity plan. The ERF target is based on recovering income from patient care activities (Elective, day case and outpatient activity) to a percentage of 2019/20 levels.

3. Expenditure – This illustrates the total expenditure incurred by the Trust, compared to historic trends









INFORMATION

Performance against Plan

Expenditure in April was £8.5m, and improvement against the planned position of £8.9m.

Agency spend in month was well controlled at £228k, down from £267k in March.

RISKS / ISSUES

There remains a risk, particularly as we move into H2 next year that the funding allocated to the Trust will not be sufficient to cover the increased costs the Trust is incurring in relation to the new theatres.

In addition, it should continue to be expected that expenditure in some particular areas, for example in temporary staffing, infection control measures will remain high over the next couple of months.

4.Cost improvement Programme Summary

INFORMATION

CIP plans totalling £1,615k have been identified to date.

The main schemes identified are;

- Digital Transformation – Expansion of paperless communications, text message reminders and partial booking for booking appointments
- Medical Workforce efficiencies –reduction in agency spend through collaborative bank set up, alternative roles and Direct Engagement
- Procurement initiatives – Continuation of work to review products, prices and contracts with suppliers of non pay goods & services.
- Service transformation – Implementation of a new spinal endoscopic service and a rationalisation of suppliers.
- Theatres Managed Service contract - VAT savings and economies of scale purchasing savings

Scheme	21/22 (£000s)
Div 1	**£521**
Digital transformation	£78
DNA Rate Reduction - OP	£50
Private Patients	£120
Procurement	£183
Spinal Service Transformation	£90
Div 1&2	**£264**
Medical Workforce	£264
Div 2	**£830**
DNA Rate Reduction - OP	£135
Managed Theatres Service	£696
Grand Total	**£1,615**

5. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	2020/21	Month 1 (£000)	
	M12	Actual	Variance
Intangible Assets	1,255	1,230	(25)
Tangible Assets	45,798	45,666	(132)
Total Non-Current Assets	**47,053**	**46,897**	**(156)**
Inventories	1,800	1,819	19
Trade and other curent Assets	7,190	6,824	(366)
Cash	5,703	7,449	1,746
Total Current Assets	**14,693**	**16,093**	**1,400**
Total Liabilities	**(17,413)**	**(20,345)**	**(2,932)**
Total Net Assets Employed	**44,333**	**42,645**	**(1,688)**
Total Taxpayers and Others Equity	**(44,333)**	**(42,645)**	**1,688**

INFORMATION

Cash in the bank at the end of April was £7.4m, which is largely due to timing differences in the payment of cash between year end and Month 1. This is also the reason for the movement on liabilities.

ACTIONS FOR IMPROVEMENTS / LEARNING

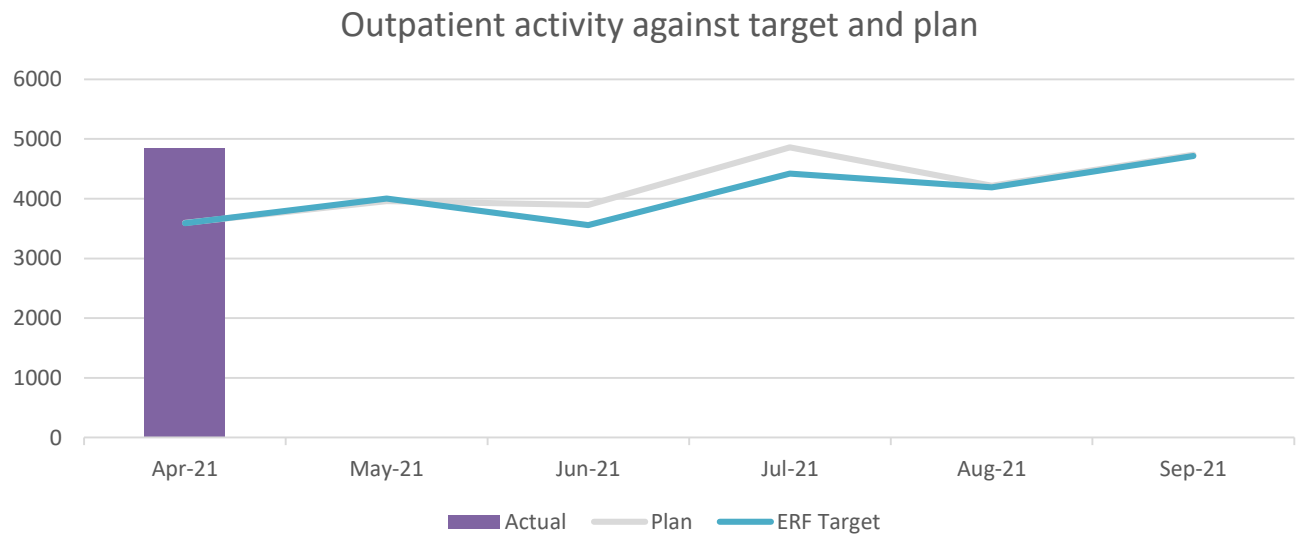
RISKS / ISSUES

Performance against Activity plan

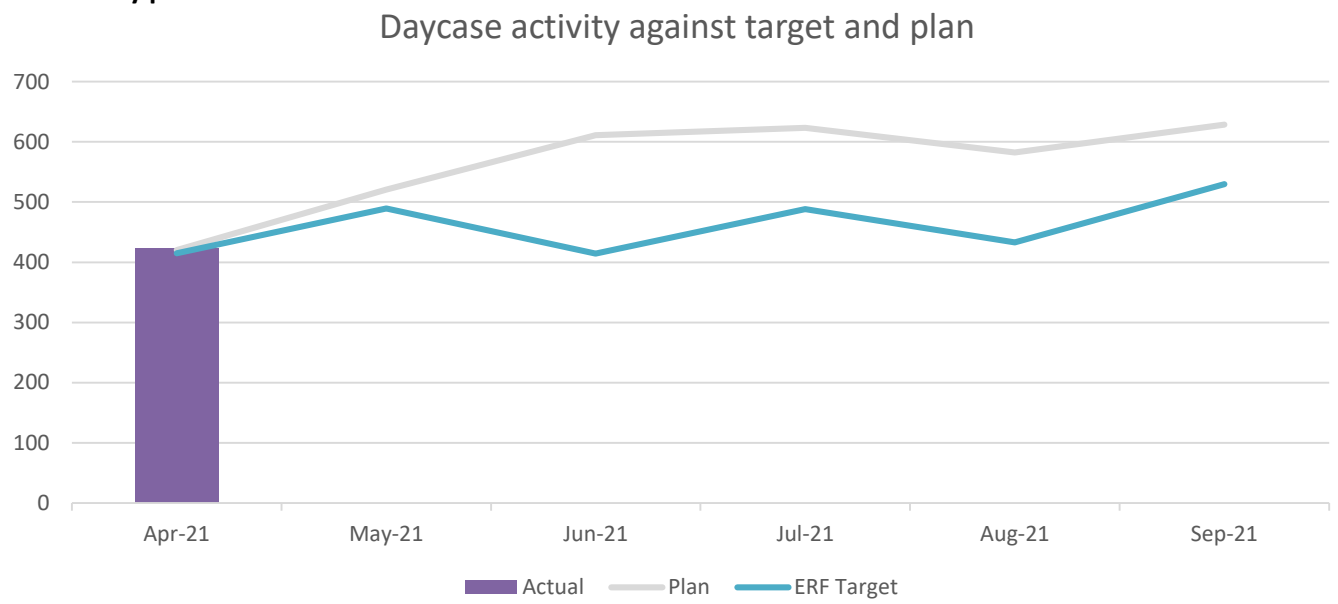
An elective recovery fund target (ERF) has been set based on achieving a percentage of 2019/20 income. The target has been calculated by applying 2021/22 tariff prices to the 2019/20 activity baseline. An increasing trajectory has then been applied, starting at 70% for April increasing in 5% intervals to 85% in July.

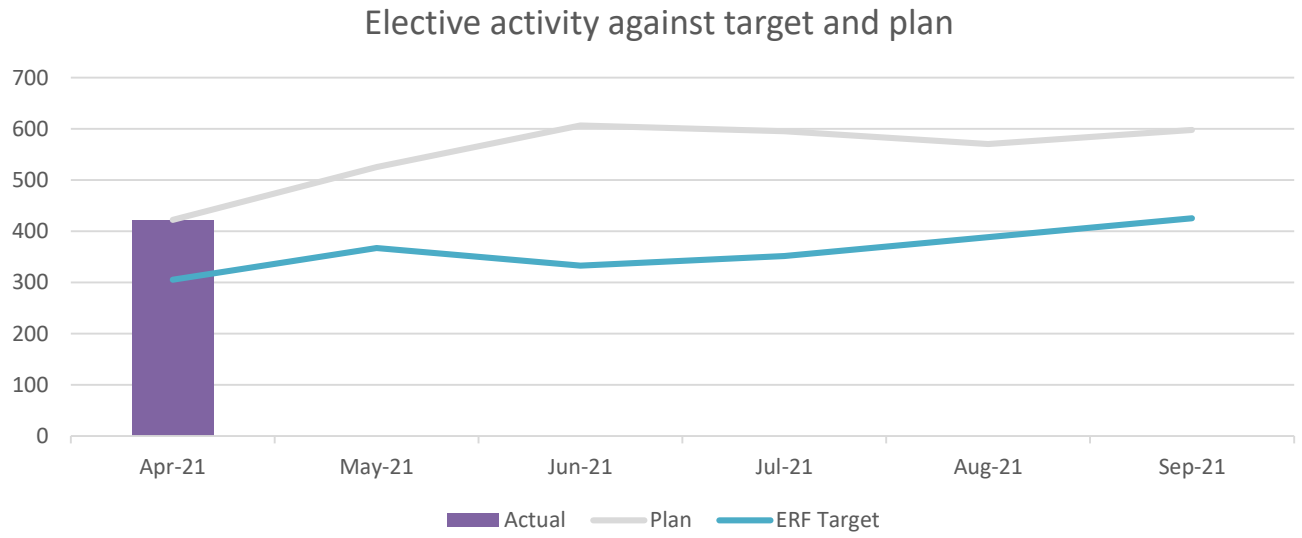
An estimated activity target has been set calculated on the expected case mix and tariff of activity planned.

A draft activity plan has been produced pending final amendments, so note the plan figures could alter before final activity plan submission on 3rd June.

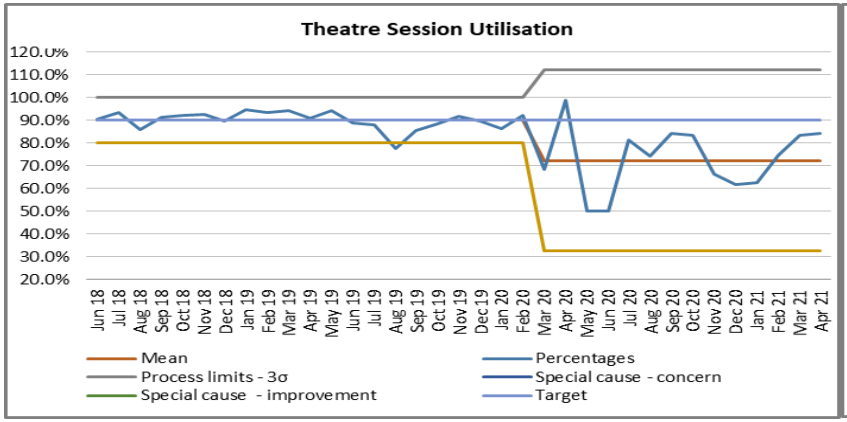


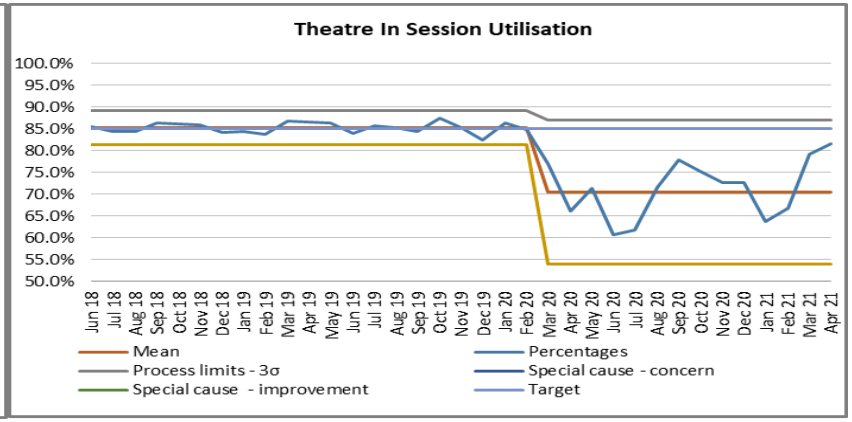
Performance against Activity plan





6. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used





INFORMATION

The case mix prioritised during April remained that of urgent P2 / P3 and emergency work. There was a phased reopening of theatres, with 10 open from the 1st – 11th April, expanding to 12 theatres from 12th April and then to 14 theatres from the 19th April. During this time there was an allocation of emergency theatres which equated to 3 theatres per day on average.

Elective theatre session utilisation for April was 84.39% and 81.58% for in session utilisation, an increase on the previous month. The challenge still remained in respect of being unable to recycle lists when last minute cancellations occur due to the 14 day isolation rules that were in place until the 19th April, it then changed to 14 days strict social distancing and 3 days isolation with 1 negative swab .

The main focus during May will be to ensure maximisation of elective theatre lists in conjunction with UHB to allow continuation of the system support being given to reduce the current orthopaedic backlog.

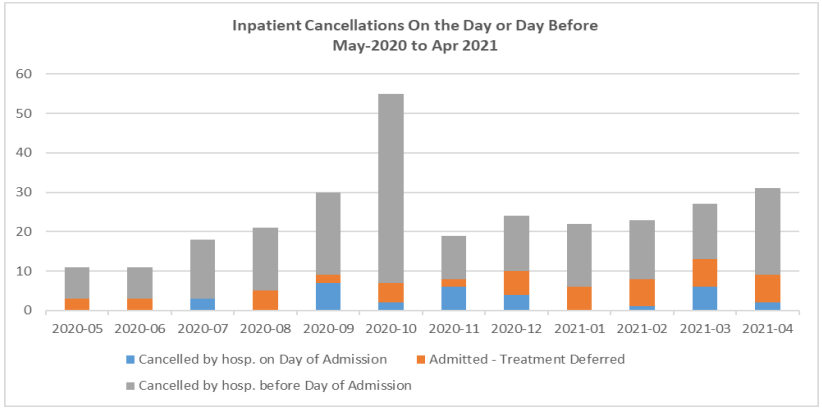
Elective Session Utilisation Apr 21				
Trust	Planned Lists	Utilised Lists	Unused Lists	% Utilisation
ROH	324	275	49	84.88%
UHB	54	44	10	81.48%
Totals	378	319	59	84.39%

Elective In Session Utilisation Apr 21				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1232	1039	193	84.34%
UHB	200	129	71	64.55%
Totals	1432	1168	264	81.58%

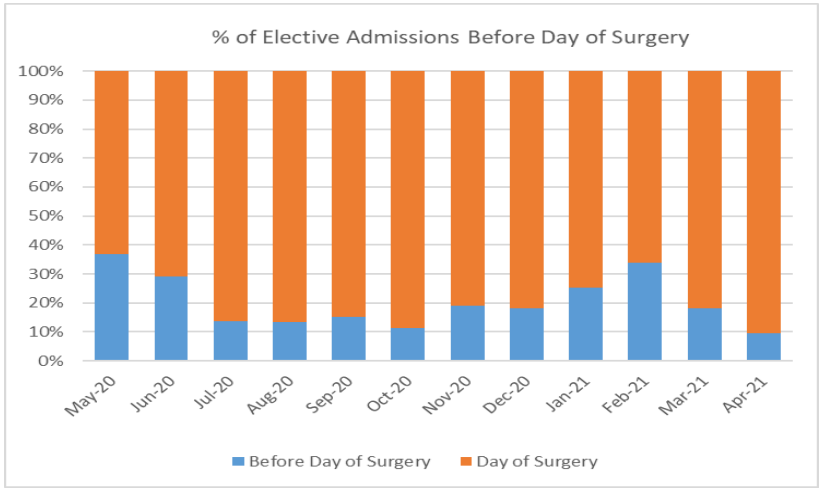
RISKS / ISSUES

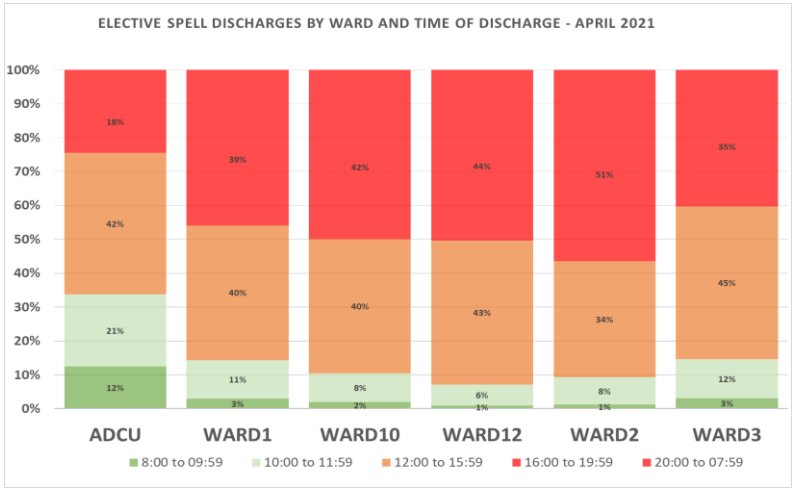
The utilisation of system lists will need to be improved in order to maximise resources and the ROH team are working closely with operational colleagues at UHB to ensure planning of lists is in place to improve efficiency overall.

7. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



Sum of Total	Cancellation Category			
Year-Mth	Cancelled by hosp. On Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp.before Day of Admission	Grand Total
2020-05	0	3	8	11
2020-06	0	3	8	11
2020-07	3	0	15	18
2020-08	0	5	16	21
2020-09	7	2	21	30
2020-10	2	5	48	55
2020-11	6	2	11	19
2020-12	4	6	14	24
2021-01	0	6	16	22
2021-02	1	7	15	23
2021-03	6	7	14	27
2021-04	2	7	22	31
Grand Total	31	53	208	292





There were 2 patients cancelled on the day of admission in April with reasons detailed as follows

1 x procedure no longer required
1 x further tests required

There were 7 patients admitted but where treatment was deferred, with reasons broken down as follows:

1 x surgical procedure not required - converted to CT
1 x procedure no longer required
2 x further tests required
2 x patient not stopping their medications
1 x patient declined surgery

Cancellations prior to day of surgery for April were 22 as detailed below:

3 x Consultant self isolating
7 x patients had recent covid vaccine
3 x patients not fit
2 x covid positive
1 x no covid test / isolation
5 x TCI's rearranged
1 x procedure no longer required

The number of cancellations / deferrals detailed above does not include those who were either emergency or urgent cases as these are more difficult to avoid due to the very short notice as most are booked 48hrs after being seen. For example of number of patients booked as an emergency may have their procedures cancelled on the day/deferred due to their injury being too swollen or a decision made to treat conservatively or they were not fit (10 in total)

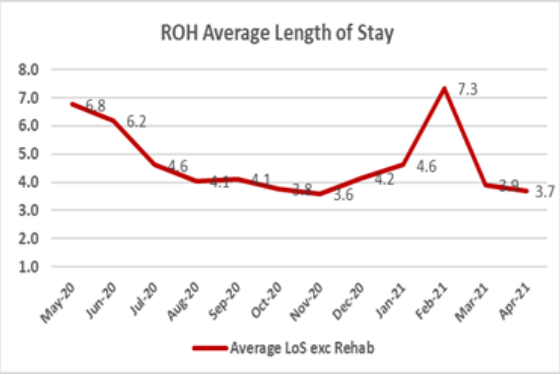
ACTIONS

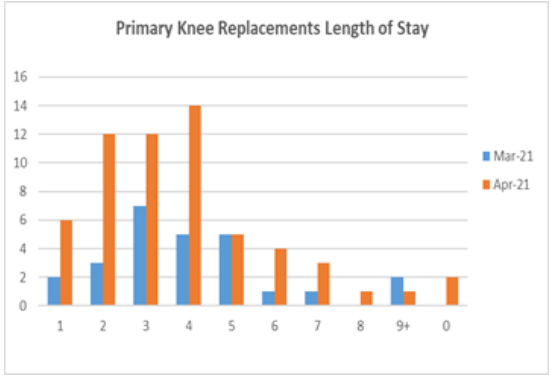
6/4/2 scheduling meetings have been reinstated as have the 'theatre look back' meetings which will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. System partners will now be attending these meetings to share best practice and learning.

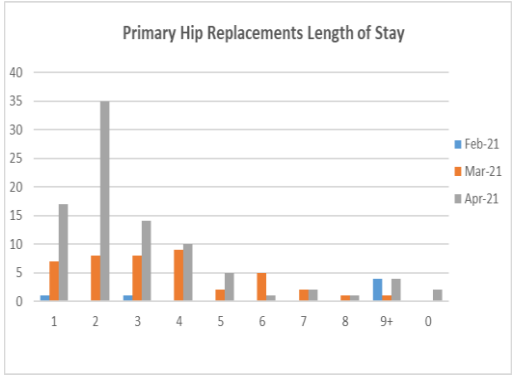
RISKS / ISSUES

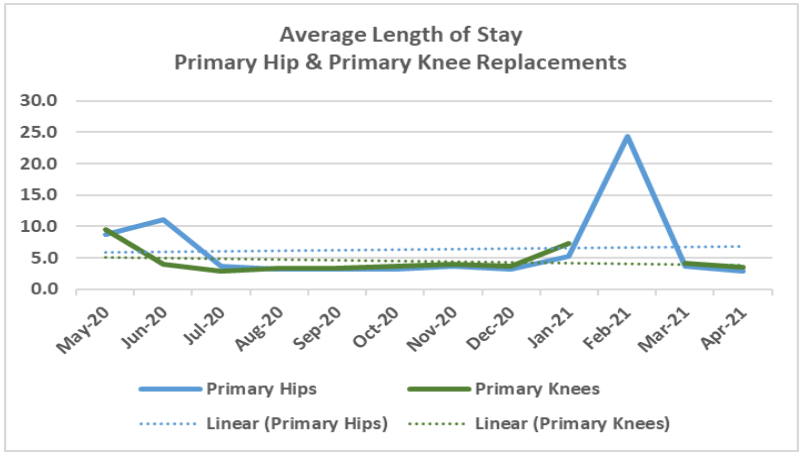
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process .

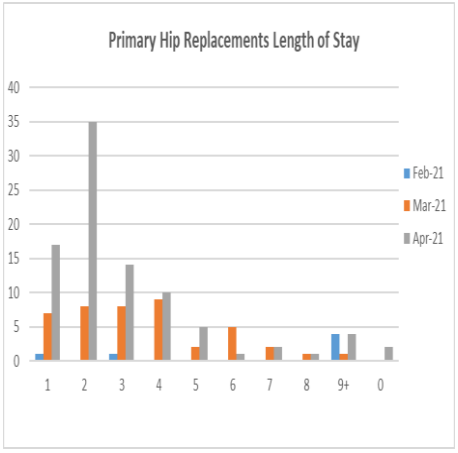
8. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways

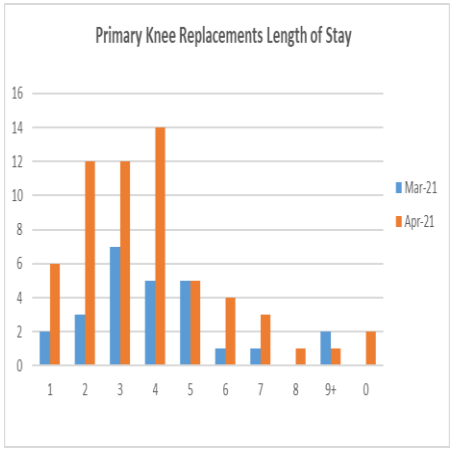












INFORMATION

The average length LOS for ROH patients has reduced slightly in month from 3.8 to 3.7.

The PICS records of all patients with a length of stay greater than 7 days, of which there were 11 in March/April have been reviewed by the Divisional Head of Nursing. All of these patients had clinically evident reasons for extended stay delays. The increased complexity and lower start point for rehabilitation of the waiting list patients has been confirmed by the Physiotherapy Lead. The longest length of stay during this period was 13 days.

All potential delayed discharges are discussed at the 1pm staffing meeting Monday to Friday and if the patient is medically fit for discharge and no movement is imminent this is escalated to the Matron and Head of Nursing.

In April there were 6 patients with Delayed Transfer of Care: three for package of care and three delayed for on-going rehabilitation totalling a delay of 30 days, which is a reduction from 86 days previous month.

ACTIONS FOR IMPROVEMENTS / LEARNING

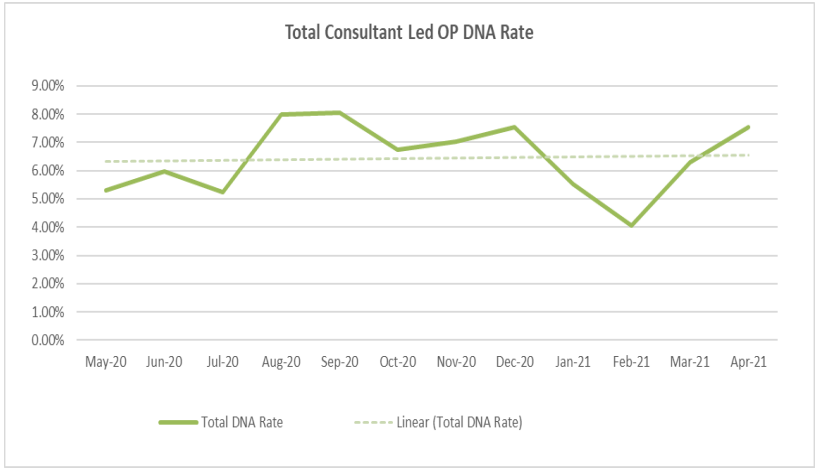
The roaming discharge team continue to provide discharge support to the wards and actively manage any potential delayed discharges. In addition, the wards are proactively managing discharges plans and escalating any potential physiotherapy/imaging delays which may impact

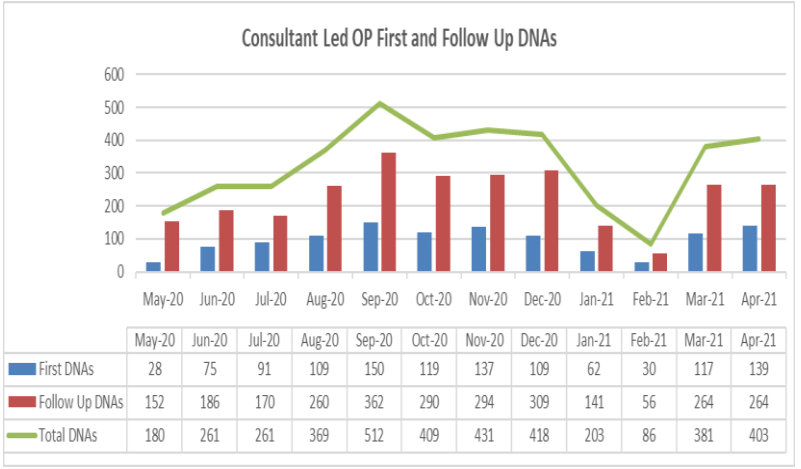
Process to ensure timely discharging of patients from WHH being agreed with Discharge Liaison Sister.

RISKS / ISSUES

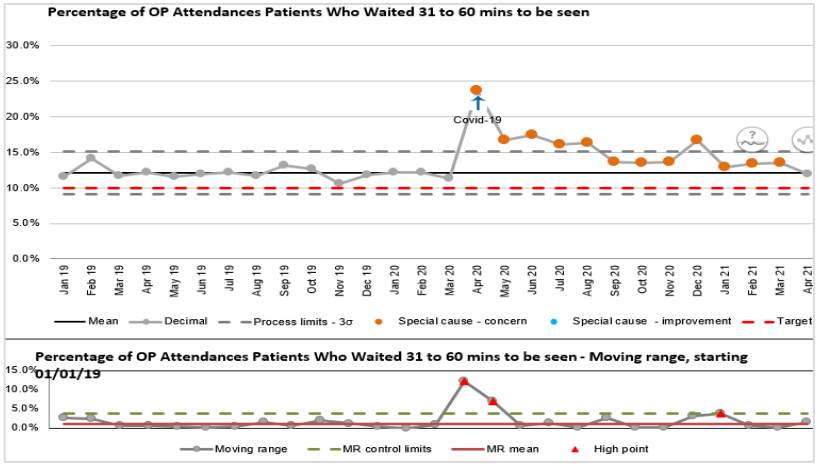
Continued operating on more complex, high priority patient will retain risk of increased length of stay and possible impact on patient flow. Physical discharge lounge is unavailable as space has been allocated to ROCS/IPC and Tissue Viability. This may present an issue as activity increases and has been escalated. Decision awaited regarding where and when these teams will move to a new permanent home.

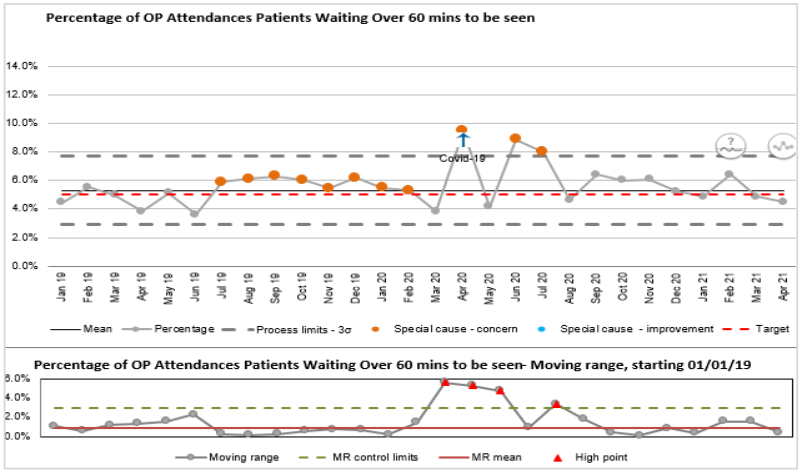
9. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients





	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
First DNAs	28	75	91	109	150	119	137	109	62	30	117	139
Follow Up DNAs	152	186	170	260	362	290	294	309	141	56	264	264
Total DNAs	180	261	261	369	512	409	431	418	203	86	381	403





INFORMATION

30 minute delays – Reduced in April to **11.9%** compared to March to **13.5%**. Trust Target is **10%**
60 minute delays – Reduced in April to **4.5%** compared to March **4.9%**. Target is **5%** therefore achieved this was achieved

The position in April is an improvement compared to recent months however there is further work to be undertaken with Oncology clinic delays and patients waiting for imaging procedures. A separate imaging working group has been created and a new report has been made available to the imaging team to help them book x-rays at an appropriate time in relation to a patient's clinic appointment.

An escalation process is in place for delays in outpatients approaching 30 minutes and the Operational and Nursing Team will continue to identify and resolve the issues in order to ensure our patients are seen on time for their appointments. This new escalation process has been working well in conjunction with the daily huddle which takes place at 14:30 in the outpatients department.

ACTIONS FOR IMPROVEMENTS / LEARNING

The DNA rate for April has increased to 7.53% from 6.3% in March however it remains below the target for the Trust of 8%. Operational Management presence is now based in Outpatients to work alongside the Nursing Team and the CSM and CSSM have a dedicated office in the department.

An analysis of the increased DNA rate will take place in May to understand any themes and address as required.

Mitigations are in place to ensure a safe environment for patients who are asked to attend alone where possible and if necessary that their relative/friend wait outside until the time of their appointment to allow the department to maintain safe distancing measures.

RISKS / ISSUES

Lack of space in outpatients continues to be a concern and currently solutions are being scoped. One of the options being explored is the use of an alternative location for virtual clinics and extending the working day further in OPS To meet capacity requirements.

10. Referral to Treatment Snapshot as at 30th April 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/04/2021

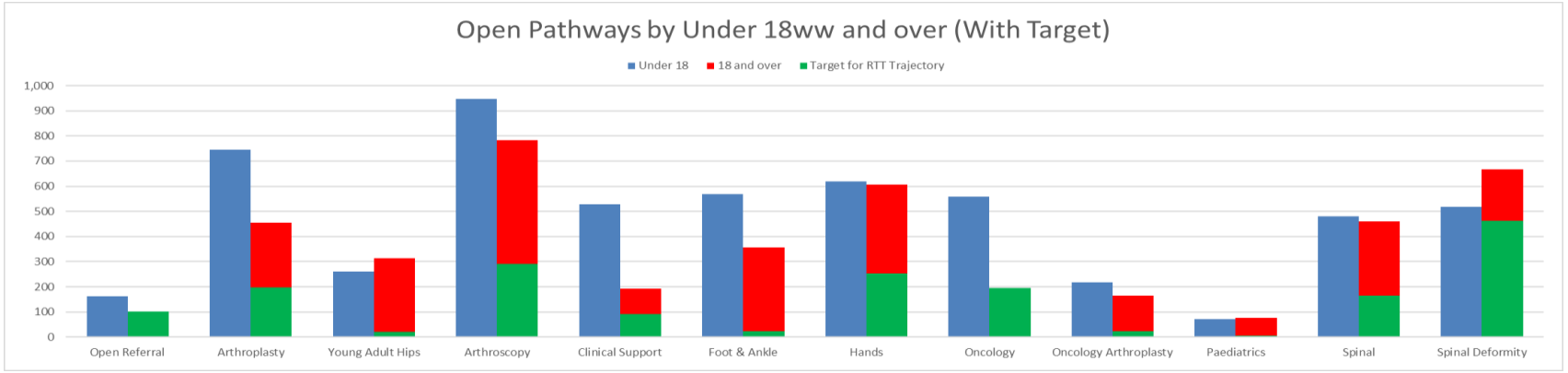
Est Over 18 Clock Stops Required		
To achieve	81.47%	3327
To achieve	71.13%	2161
To achieve	81.74%	3354

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**3,070**	128	409	120	515	306	305	326	287	144	37	249	244
7-13	**1,802**	26	230	88	303	164	182	192	215	56	25	148	173
14-17	**808**	8	105	53	130	59	82	101	56	19	9	84	102
18-26	**2,081**	3	240	165	389	151	185	333	53	77	36	197	252
27-39	**1,653**	0	187	137	294	42	156	224	38	76	31	176	292
40-47	**280**	0	22	9	59	1	13	37	5	8	8	44	74
48-51	**47**	1	3	2	13	0	1	4	0	1	1	9	12
52 weeks and over	**124**	0	3	1	28	0	1	9	6	3	1	35	37
Total	**9,865**	166	1,199	575	1,731	723	925	1,226	660	384	148	942	1,186

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,680**	162	744	261	948	529	569	619	558	219	71	481	519
18 and over	**4,185**	4	455	314	783	194	356	607	102	165	77	461	667
Target for RTT Trajectory	**1827**	103	199	21	291	93	25	254	196	25	5	164	462
Target for RTT 92%	**789**	**13**	**95**	**46**	**138**	**57**	**74**	**98**	**52**	**30**	**11**	**75**	**94**

Month End RTT %	**57.58%**	**97.59%**	**62.05%**	**45.39%**	**54.77%**	**73.17%**	**61.51%**	**50.49%**	**84.55%**	**57.03%**	**47.97%**	**51.06%**	**43.76%**
30/04/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	2,358	-99	256	293	492	101	331	353	-94	140	72	297	205
Variance from target 92%	3,396	-9	360	268	645	137	282	509	50	135	66	386	573



Referral to Treatment Snapshot as at 30th April 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/04/2021

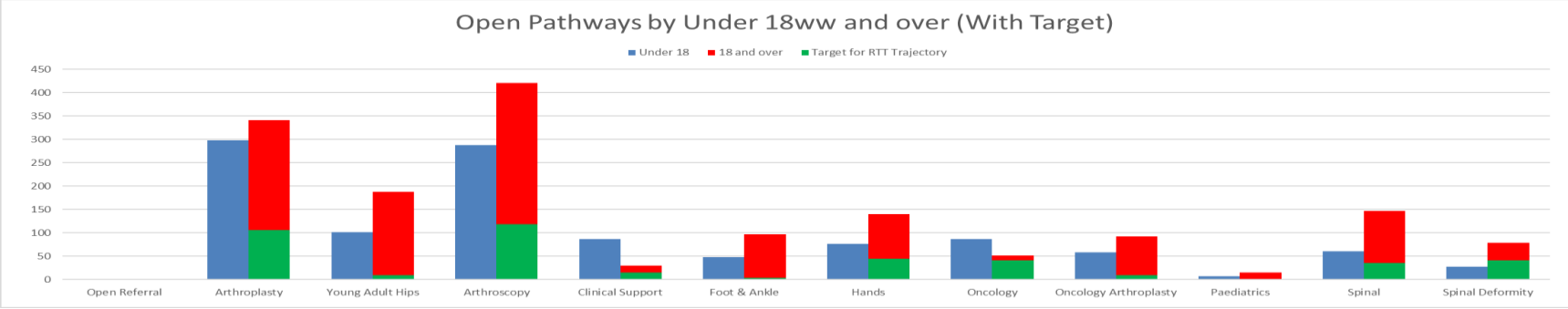
Est Over 18 Clock Stops Required		
To achieve	81.47%	1544
To achieve	71.13%	1310
To achieve	81.74%	1549

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**616**	0	137	51	159	57	26	51	56	27	4	40	8
7-13	**329**	0	102	29	80	14	15	15	28	20	3	11	12
14-17	**196**	0	59	22	49	16	7	11	3	11	0	10	8
18-26	**665**	0	172	88	181	11	38	49	18	37	6	44	21
27-39	**724**	0	153	97	168	18	55	71	27	45	7	60	23
40-47	**122**	0	13	3	41	1	3	14	4	8	2	15	18
48-51	**18**	0	1	0	10	0	0	0	0	0	0	3	4
52 weeks and over	**73**	0	2	0	21	0	1	6	3	2	0	25	13
Total	**2,743**	0	639	290	709	117	145	217	139	150	22	208	107

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,141**	0	298	102	288	87	48	77	87	58	7	61	28
18 and over	**1,602**	0	341	188	421	30	97	140	52	92	15	147	79
Target for RTT Trajectory	**508**	0	106	10	119	15	4	45	41	10	0	36	41
Target for RTT 92%	**219**	**0**	**51**	**23**	**56**	**9**	**11**	**17**	**11**	**12**	**1**	**16**	**8**

Month End RTT %	**41.60%**	n/a	**46.64%**	**35.17%**	**40.62%**	**74.36%**	**33.10%**	**35.48%**	**62.59%**	**38.67%**	**31.82%**	**29.33%**	**26.17%**
30/04/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,094	0	235	178	302	15	93	95	11	82	15	111	38
Variance from target 92%	1,383	0	290	165	365	21	86	123	41	80	14	131	71



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Referral to Treatment Snapshot as 30th April 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/04/2021

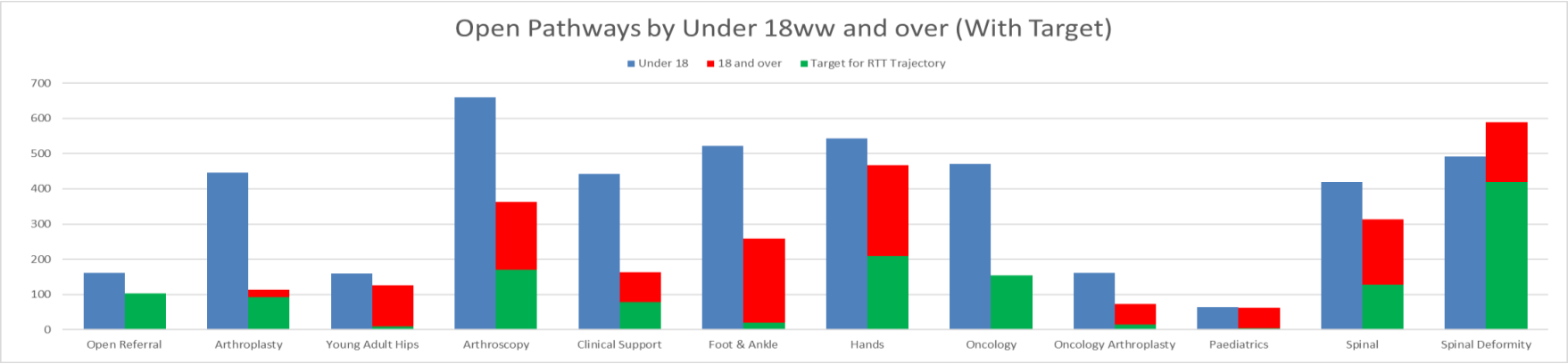
Est Over 18 Clock Stops Required		
To achieve	81.47%	1783
To achieve	71.13%	851
To achieve	81.74%	1804

Select Pathway Type: Non Admitted

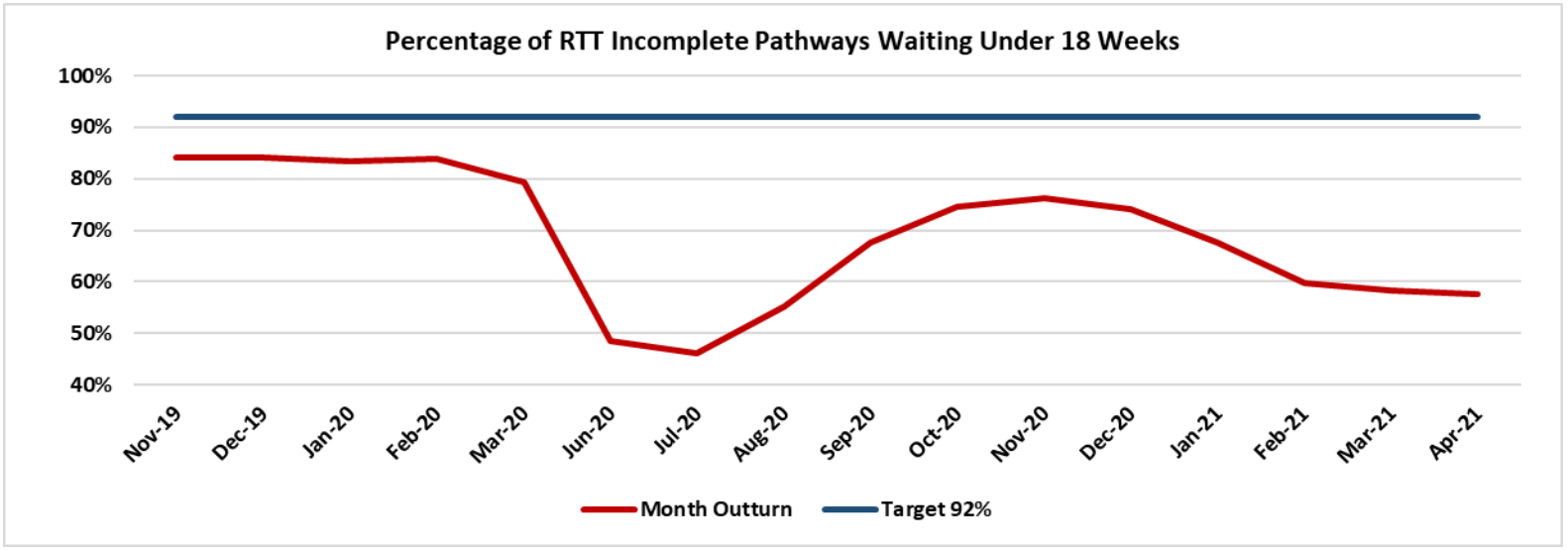
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,454**	128	272	69	356	249	279	275	231	117	33	209	236
7-13	**1,473**	26	128	59	223	150	167	177	187	36	22	137	161
14-17	**612**	8	46	31	81	43	75	90	53	8	9	74	94
18-26	**1,416**	3	68	77	208	140	147	284	35	40	30	153	231
27-39	**929**	0	34	40	126	24	101	153	11	31	24	116	269
40-47	**158**	0	9	6	18	0	10	23	1	0	6	29	56
48-51	**29**	1	2	2	3	0	1	4	0	1	1	6	8
52 weeks and over	**51**	0	1	1	7	0	0	3	3	1	1	10	24
Total	**7,122**	166	560	285	1,022	606	780	1,009	521	234	126	734	1,079

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**4,539**	162	446	159	660	442	521	542	471	161	64	420	491
18 and over	**2,583**	4	114	126	362	164	259	467	50	73	62	314	588
Target for RTT Trajectory	**1319**	103	93	10	171	78	21	209	155	15	5	128	420
Target for RTT 92%	**569**	**13**	**44**	**22**	**81**	**48**	**62**	**80**	**41**	**18**	**10**	**58**	**86**

Month End RTT %	**63.73%**	**97.59%**	**79.64%**	**55.79%**	**64.58%**	**72.94%**	**66.79%**	**53.72%**	**90.40%**	**68.80%**	**50.79%**	**57.22%**	**45.51%**
30/04/21 Trajectory RTT %	81.47%	37.57%	83.35%	96.32%	83.18%	87.06%	97.23%	79.22%	70.17%	93.23%	95.97%	82.51%	61.03%
Variance from Target to meet Trajectory	1,264	-99	21	116	191	86	238	258	-105	58	57	186	168
Variance from target 92%	2,014	-9	70	104	281	116	197	387	9	55	52	256	502



Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories



The Referral To Treatment (RTT) position for April is **57.58%** against the National compliance target of 92%. This is a decrease compared to March 21 reporting at **58.27%** and is reflective of the cessation of elective procedures in order to undertake core critical services. There are **124** patients over 52 weeks a decrease from **142** in March, 73 admitted and 51 non-admitted with plans or actions in place.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. **451** patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority in line with the national guidance for clinical prioritisation of patients awaiting surgery, **2743** patients are on the admitted waiting list **(P1 – 15, P2 – 256 patients, P3 –936 patients, P4 – 1464 patients P5 – 2 patients and P6 – 0 patients).** A working group is in place to ensure the harm prevention framework is standardised across all specialties to provide assurance that all patients are reviewed on a regular basis.

The total number of referrals into the Trust in April was 2067 which is low when compared to the average number of referrals per month is 2,706 during 19/20. We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Fortnightly CCG/ROH Liaison Meetings are in place, to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

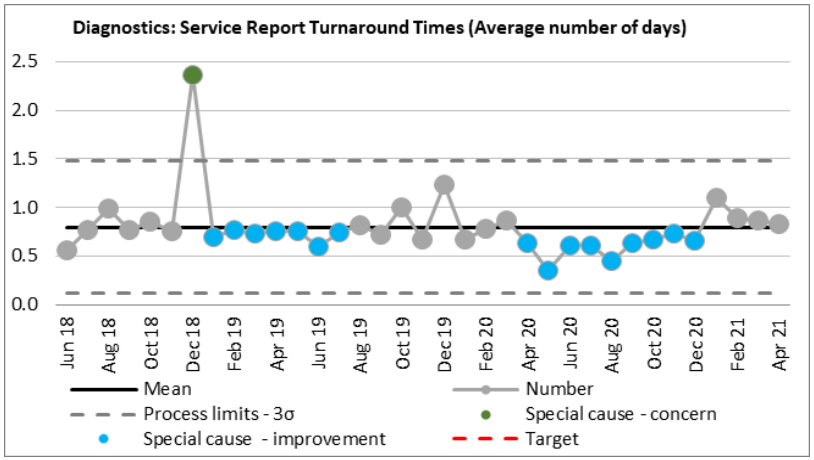
Treatment targets – This illustrates how the Trust is performing against national treatment target –

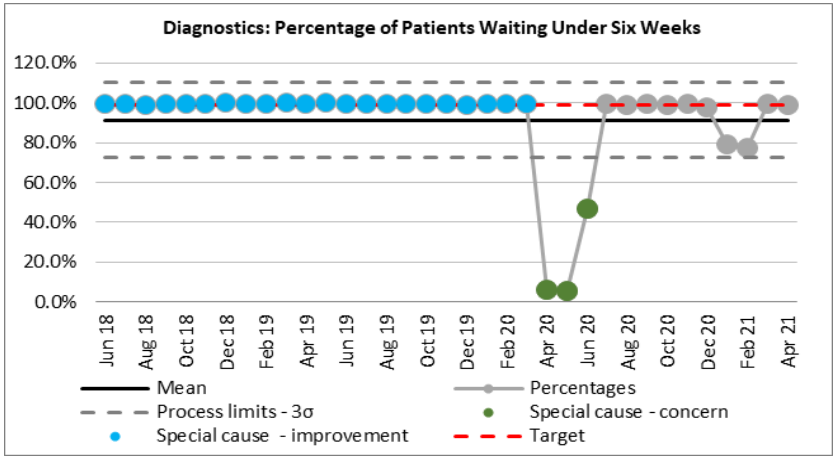
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Apr-20	1040	110	247	1397	1310	87	6.2%	258	86	97	441
May-20	952	109	200	1261	1193	68	5.4%	217	95	56	368
Jun-20	454	54	35	543	287	256	47.1%	875	184	320	1379
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285
Apr-21	776	68	182	1026	8	1018	99.2%	770	233	298	1301

Treatment targets – This illustrates how the Trust is performing against national treatment target





INFORMATION

Imaging achieved their diagnostic target in April, reporting 99.22%. The department also continues to report consistently good performance for report turn around times.

A review of patient flows between outpatients and the imaging department is underway with the aim to reduce delays as a result of reduced waiting room capacity in imaging and outpatients. Pre-booking of patients will be encouraged to improve efficiencies so to that end the department will be working closely with specialties to support pre-booked appointments as much as possible.

ACTIONS FOR IMPROVEMENTS / LEARNING

An additional of mobile MRI van capacity has been secured to compensate for the loss of capacity due to the bank holidays in May.

RISKS / ISSUES

The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.

11. Cancer Performance Targets

		Indicative	Reported Month															
Target Name	National Standard	Apr-21	Mar-21	In Target	Breach	Total	Feb-21	In Target	Breach	Total	Jan-21	In Target	Breach	Total	Dec-20	In Target	Breach	Total
2ww	93%	100%	100%	53.00	0.00	53.00	100.0%	35.00	0.00	35.00	100.0%	40	0	40	100.0%	61	0	61
31 day first treatment	96%	100%	100%	13.00	0.00	13.00	100.0%	16.00	0.00	16.00	100.0%	18	0	18	100.0%	12	0	12
31 day subsequent (surgery)	94%	100%	100%	9.00	0.00	9.00	100.0%	5.00	0.00	5.00	91.0%	10	1	11	100.0%	4	0	4
62 day (traditional)	85%	80%	56%	2.50	2.00	4.50	66.7%	4.00	2.00	6.00	76.5%	6.5	2.0	8.5	73.3%	5.5	2.0	7.5
62 day (Cons Upgrade)	n/a	95%	91%	9.50	1.00	10.50	75.0%	3.00	1.00	4.00	100.00%	7.5	0.0	7.5	100.00%	4.0	0.0	4.0
28 day FDS REPORTED	75%	78%	74%	39.00	14.00	53.00	78.4%	40.00	11.00	51.00	65.0%	41	22	63	69.0%	50	22	72
No. patients treated 104+ days																		

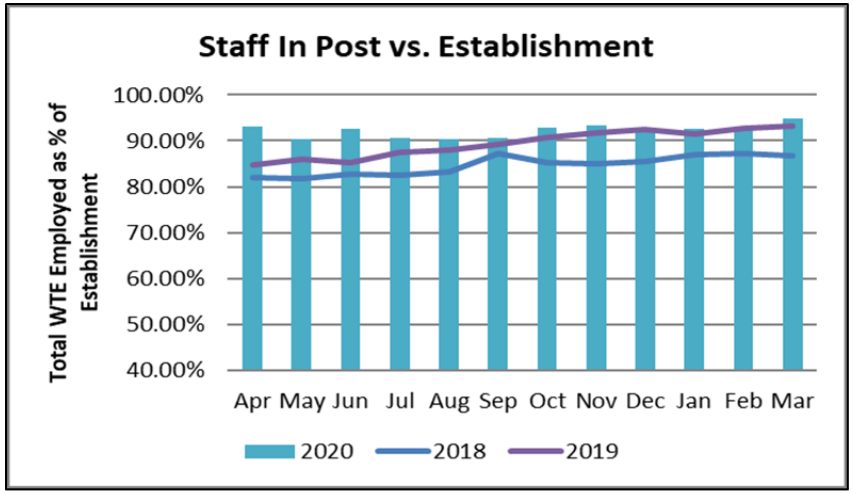
PERFORMANCE/IMPROVEMENTS/LEARNING

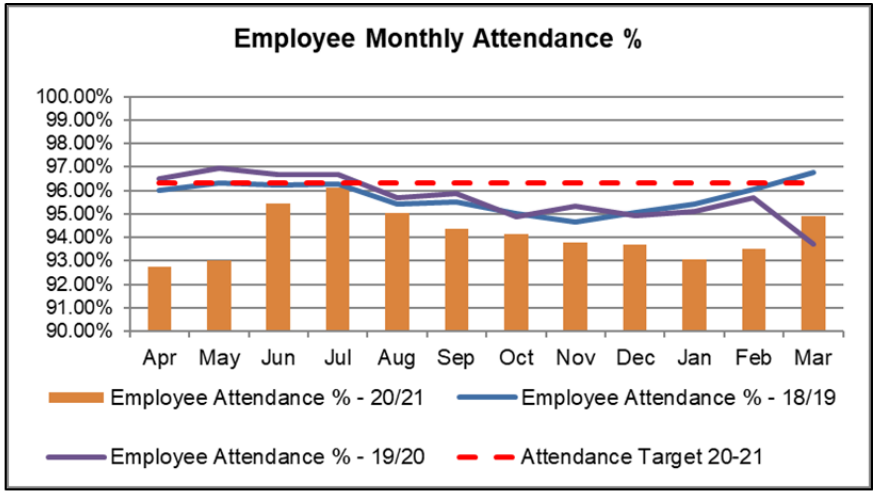
- The Trust's performance for the 62 day target in March 2021 is 56% (about the predicted 54.5 % in April Cancer board paper)with 2.5 treatments within target + 2 breaches (2 full breaches due to complex diagnostic pathway). Performance for the 31 subsequent target is 100% with all treatments within target.
- The Trust's performance for the 62 day target for April 2021 is currently predicted at 75% with 2.5 treatments within target + 0.5 breaches (Please note the number of breaches may increase due to awaiting histology report from 9th *April) (submission closes 02.06.21).*
- The faster diagnosis for March was locked down at 74% against a target of 75%). A total of 53 patients subject to FDS, 39 diagnosed within 28 days and 14 diagnosed outside target (3 patients received via late tertiary, 6 patients delayed histology, 2 patients complex pathway).
- The Trust's Business Intelligence Service, with advice and help from the UHB Deputy Cancer Services Manager, are now currently developing specific data reports to enable a more detailed breakdown on key cancer waiting time targets to allow a better understanding of performance, trends, and highlighting areas where improvement is required. This work is currently being undertaken and anticipated late May/June2021.
- From initial referral to key milestones process is currently under review with the intention of improving the administrative pathway across the oncology department. This review is continuing with a deep dive into the service, with a new Oncology SOP is being produced.

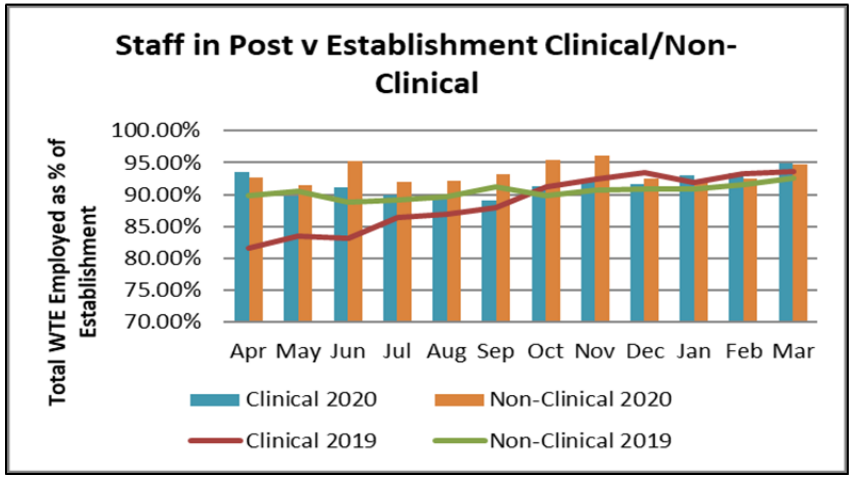
RISKS / ISSUES

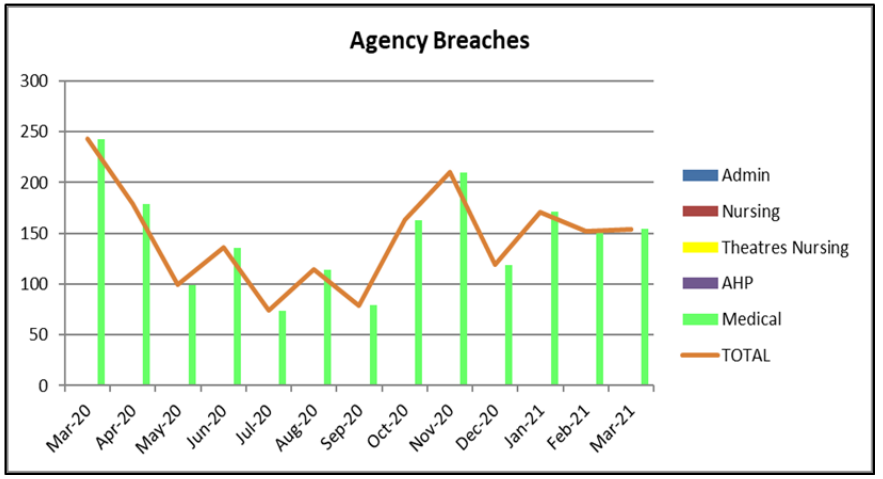
- Increase of referral numbers and additional work from RJAH
- Histology reporting continues to have cases report outside the suggested "7-10 day turnaround".

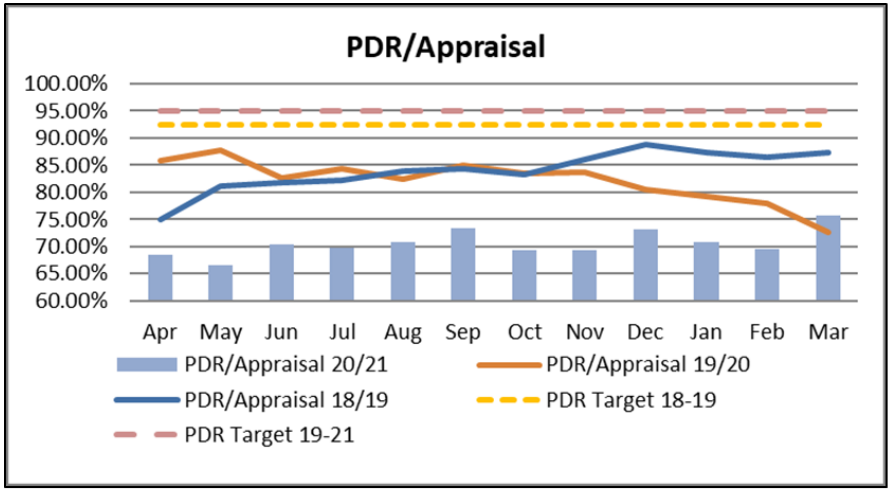
12. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

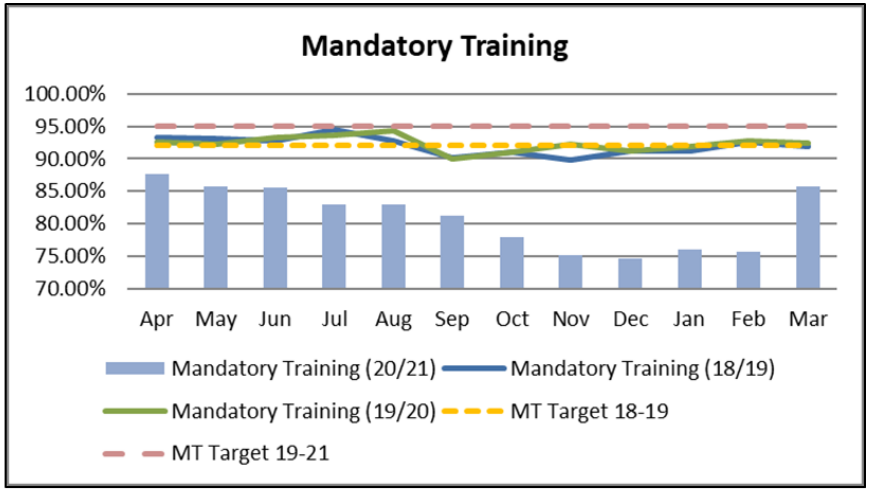


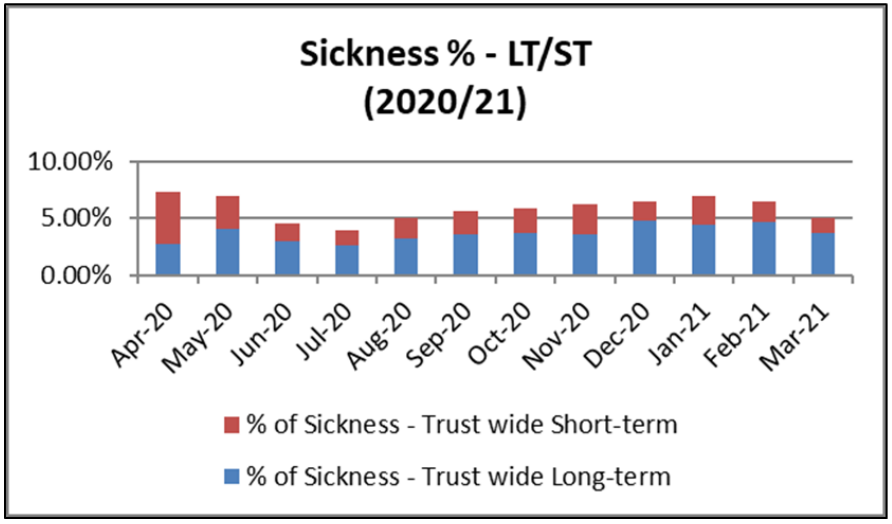


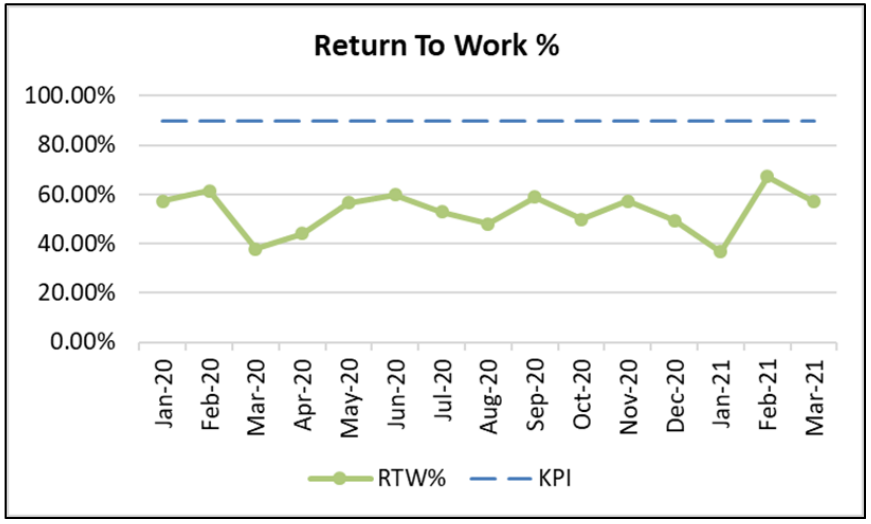


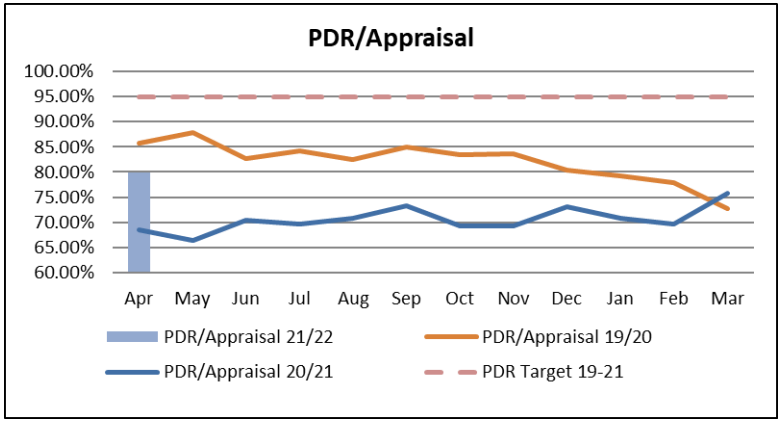


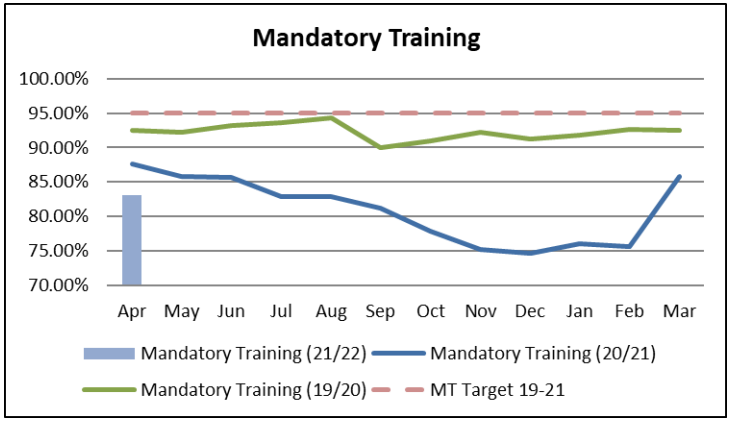

PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal 20/21
PDR/Appraisal 19/20
PDR/Appraisal 18/19
PDR Target 18-19
PDR Target 19-21

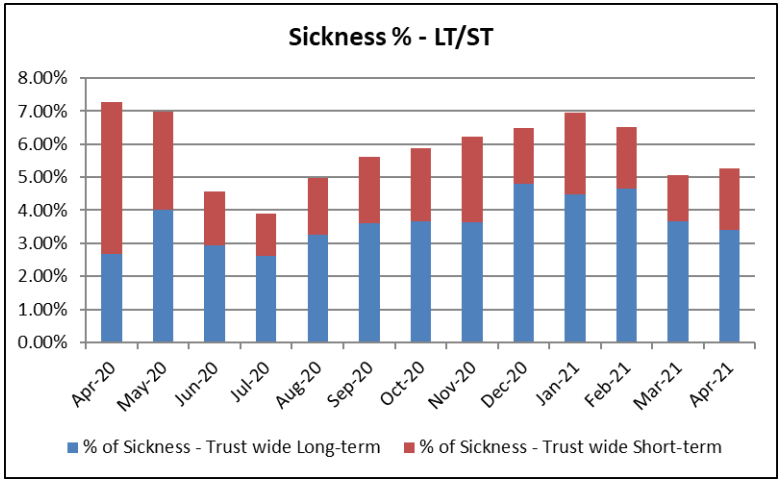

Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (20/21)
Mandatory Training (18/19)
Mandatory Training (19/20)
MT Target 18-19
MT Target 19-21

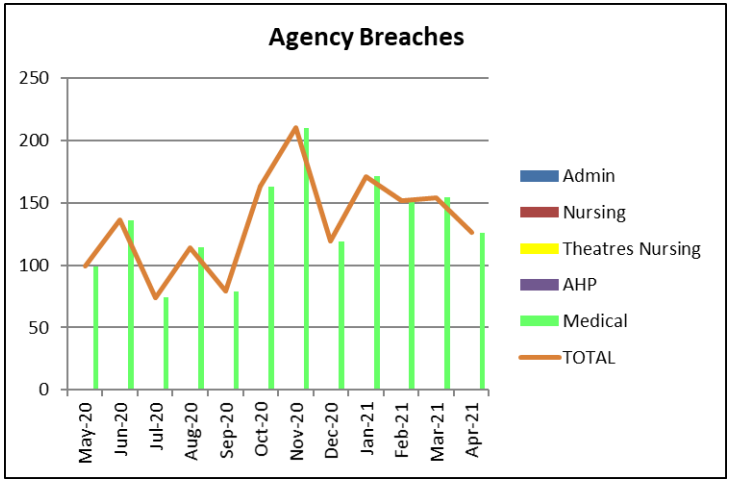

Sickness % - LT/ST (2020/21)
10.00%
5.00%
0.00%
Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Return To Work %
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
RTW%
KPI


PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal 21/22
PDR/Appraisal 19/20
PDR/Appraisal 20/21
PDR Target 19-21


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (21/22)
Mandatory Training (20/21)
Mandatory Training (19/20)
MT Target 19-21


Sickness % - LT/ST
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Agency Breaches
250
200
150
100
50
0
May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21
Admin
Nursing
Theatres Nursing
AHP
Medical
TOTAL

Overall Headlines

April 2021 saw a large increase in appraisal completion within the last 12 months seeing the highest figure since December 2019. Mandatory training completion within the last 12 months and agency breaches decreased in April 2021 compared to March 2021 and turnover and attendance figures remained relatively consistent with March 2021.

Vacancy vs. Establishment

The number of staff on the payroll in April stood at **1210** (**1071.40 - WTE)**, an increase of **4.93 WTE**.

In this report, we are currently unable to confirm the current the Trust vacancy position due to the starting point budgets of the financial year still being confirmed.

Attendance

- Monthly attendance slightly decreased by **0.19%** to **94.73%,** retaining it's red status against the Trust's target of **96.3%.**
- The underlying 12-month average attendance figure also slightly increased by **0.17%** to **94.38%** retaining it's red status against the Trust's target of **96.3%.**
- Long term sickness data slightly decreased by **0.28%** to **3.39%.** This is the lowest figure since August 20

The figures have been quite similar over the past 3 months and we are expecting the continue improving following the COVID vaccination programme. Covid-19 absence data is still being reported daily to NHS England and weekly figures are being submitted to the BSOL STP

Appraisals

- Appraisals completions increased by 4.25% to **79.98%,** and retains it's red status against the Trust target of **95%**

Appraisal completion within the last 12 months has shown an increase of almost 10% over the past two months which is positive in reaching the Trust KPI of 95%. The ESR & HR Teams are continuing to liaise directly with teams where there is continual non-compliance and also support managers with ensuring the information is accurately recorded on ESR in a timely manner.

Mandatory Training

- Mandatory training decreased by **2.71.%** to **83.08%** in March, moving to the red status against the Trust revised target of **95%.**

Though this figure has decreased since last month, the last two months are still the highest figures since August 2020 which is showing positive progress. Staff are still actively being encouraged to complete their mandatory training via e-Learning. New starters are also being supported with completing their mandatory training prior to starting.

Turnover Figures

- Unadjusted Turnover (all leavers except Junior Doctors) increased slightly by **0.07%** to **9.11%,** and retaining a green status against the Trust's target of **11.5%.**
- Adjusted Turnover (substantive staff leavers excluding flexible retirements) also increased slightly by **0.20%** to **6.82%,** retaining a green status against the Trust's revised target of **11.5%.**

Agency Breaches

Agency Breaches increased slightly from **154** shift breaches in March 2021 to **126** shift breaches in April 2021. The entirety of this shift breaches were medical usage. There were no AHP, Nursing or Admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Continuation of the appraisal preliminary report to encourage managers to record their completed appraisals on the system in a timely manner
- The Manager Dashboard to be finalised in the upcoming months to support managers with viewing their own workforce data

RISKS / ISSUES

- Turnover figures should be monitored, as both adjusted and unadjusted turnover have slightly passed 9%

	Mar-21	Apr-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	9.04%	9.11%	0.07%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	6.62%	6.82%	0.20%	⇧	<=11.5%
% of Attendance	94.92%	94.73%	-0.19%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.22%	94.38%	0.17%	⇧	>=96.3%
% Staff received mandatory training last 12 months	85.79%	83.08%	-2.71%	⇩	>=95%
% Staff received formal PDR/appraisal last 12 months	75.73%	79.98%	4.25%	⇧	>=95%
% of Sickness - Trust wide Long-term	3.67%	3.39%	-0.28%	⇩	-
% of Sickness - Trust wide Short-term	1.41%	1.88%	0.47%	⇩	-
Return To Work Completion %	57.01%	67.54%	10.53%	⇧	>=80%

Workforce Performance Report

As at 30th April 2021

Please be aware that the information included in this report relies upon the timely update of information into ESR and Healthroster, this report is based on data as at the 7th working day in May, please note the figures are likely to change if information is input into the systems after the cut-off date.

Please also be advised that this report does not include any updated workforce learning and development data due to staff absence, and also does not include any planned vs. actual staffing costs and establishment vs. vacancy information due starting budgets for the financial year still being finalised.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

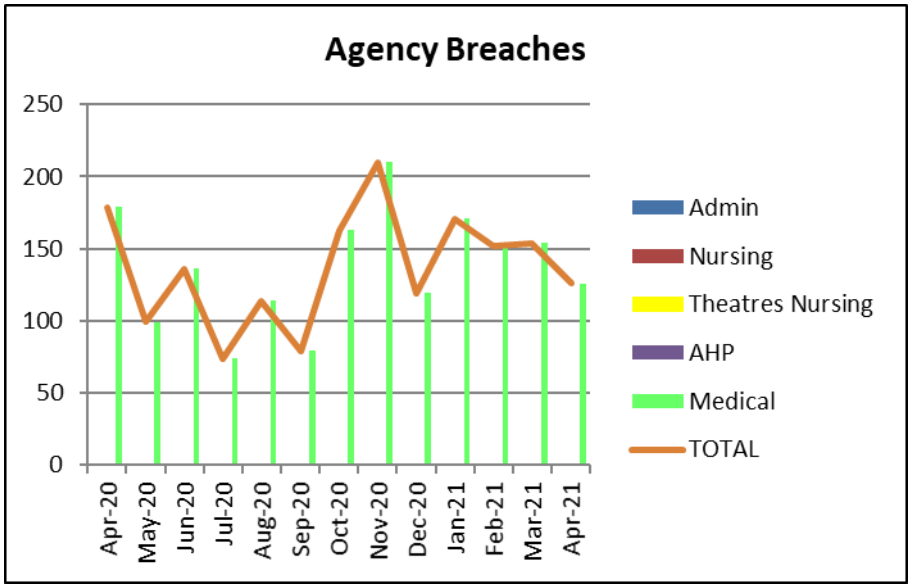
CONTENTS

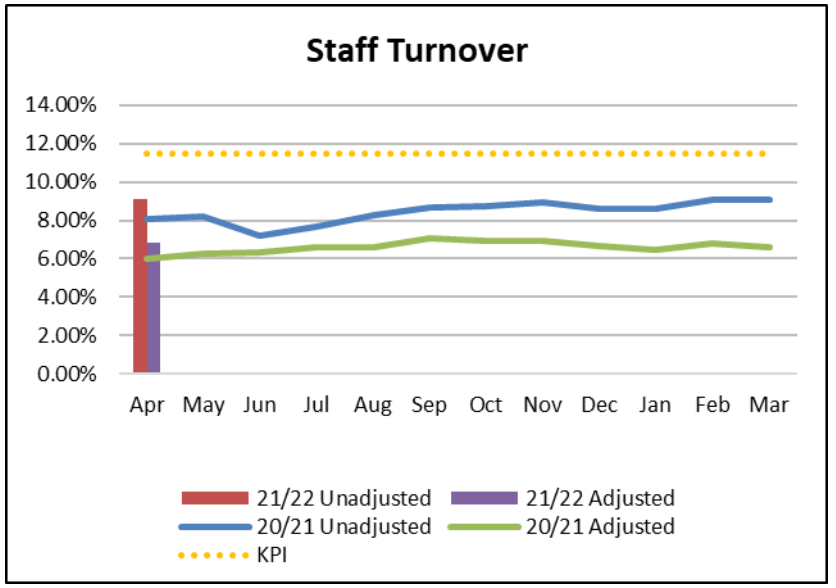
		RAG Rating	Page
1	Workforce Composition, Resourcing and Cost		3
1b	Trust Overall Performance Summary & Temporary Staffing		3
1b	Starters & Leavers Data (inc. Exit Questionnaires Data)		4-7
1c	WRES Indicator 2		8
1d	Workforce Profile		9
2	Workforce Performance		11
2a	Monthly Sickness Absence		12-13
2b	Staff Attendance		14-16
2c	Longer Term Absence Monitoring		17-19
2d	Formal Disciplinary Processes		20
4	Workforce – Experience and Engagement		21
4a	Engagement and Job Satisfaction		22
4b	Workforce Race Equality Standard (WRES) Indicators		23

1 Workforce Composition, Resourcing and Cost

1a Trust Overall Performance Summary

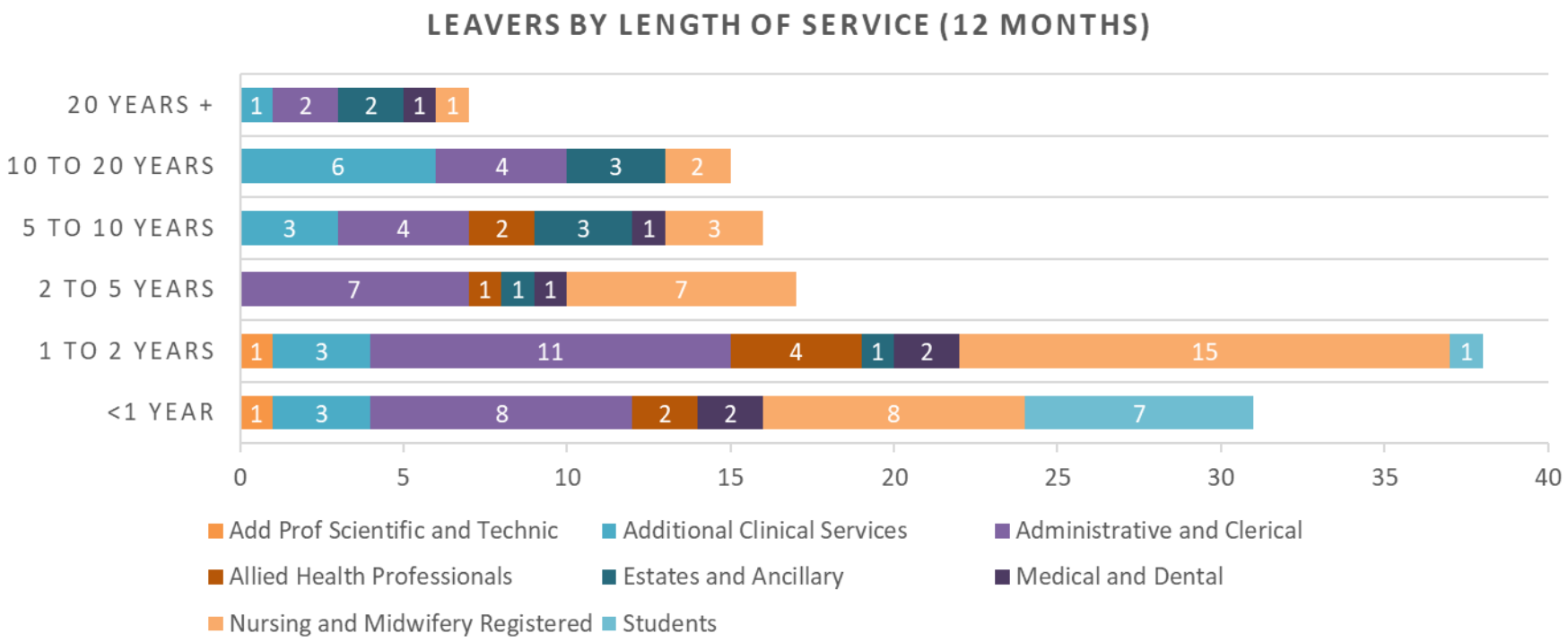
	Mar-21	Apr-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	9.04%	9.11%	0.07%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	6.62%	6.82%	0.20%	⇧	<=11.5%





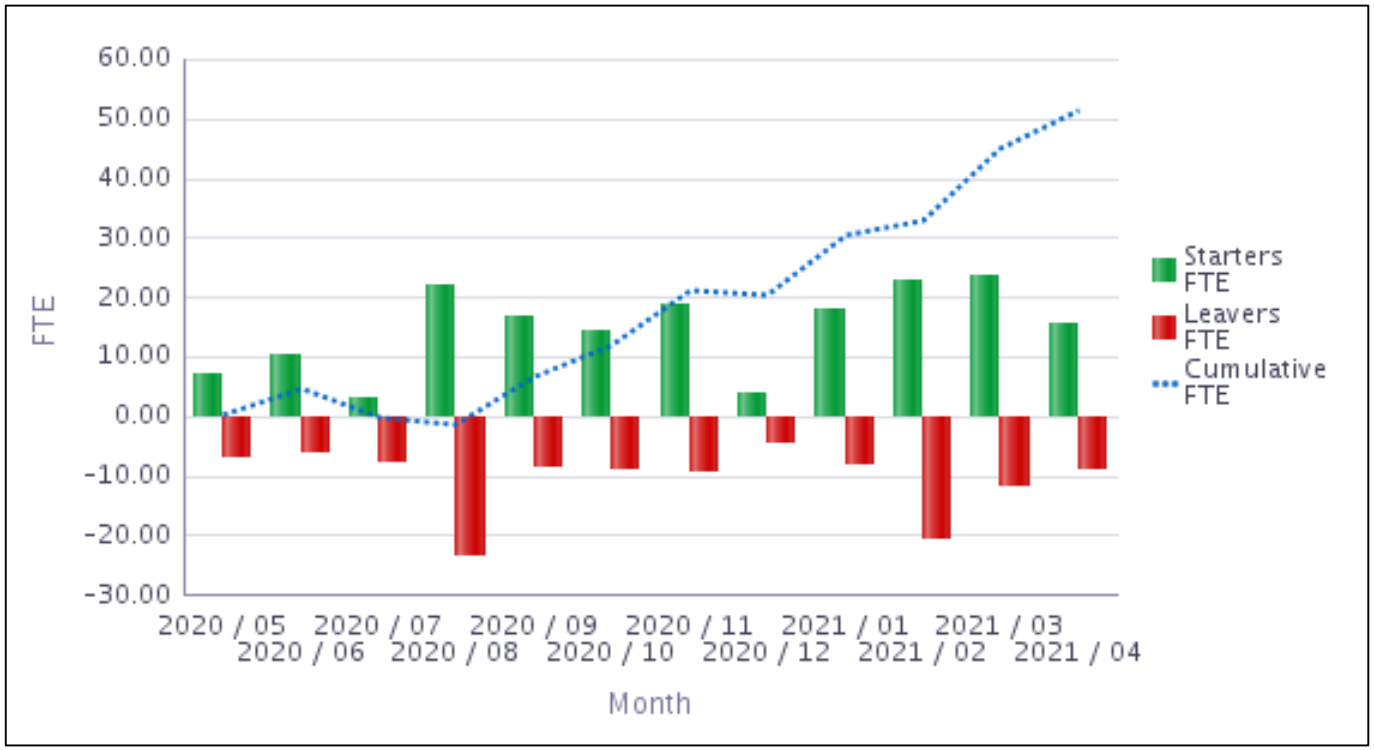
*Adjusted Turnover (substantive leavers exc. flexible retirements
*Unadjusted Turnover (all leavers excluding Junior Doctors)

1	Workforce Composition, Resourcing and Cost
1b	Leavers Data – Length of Service



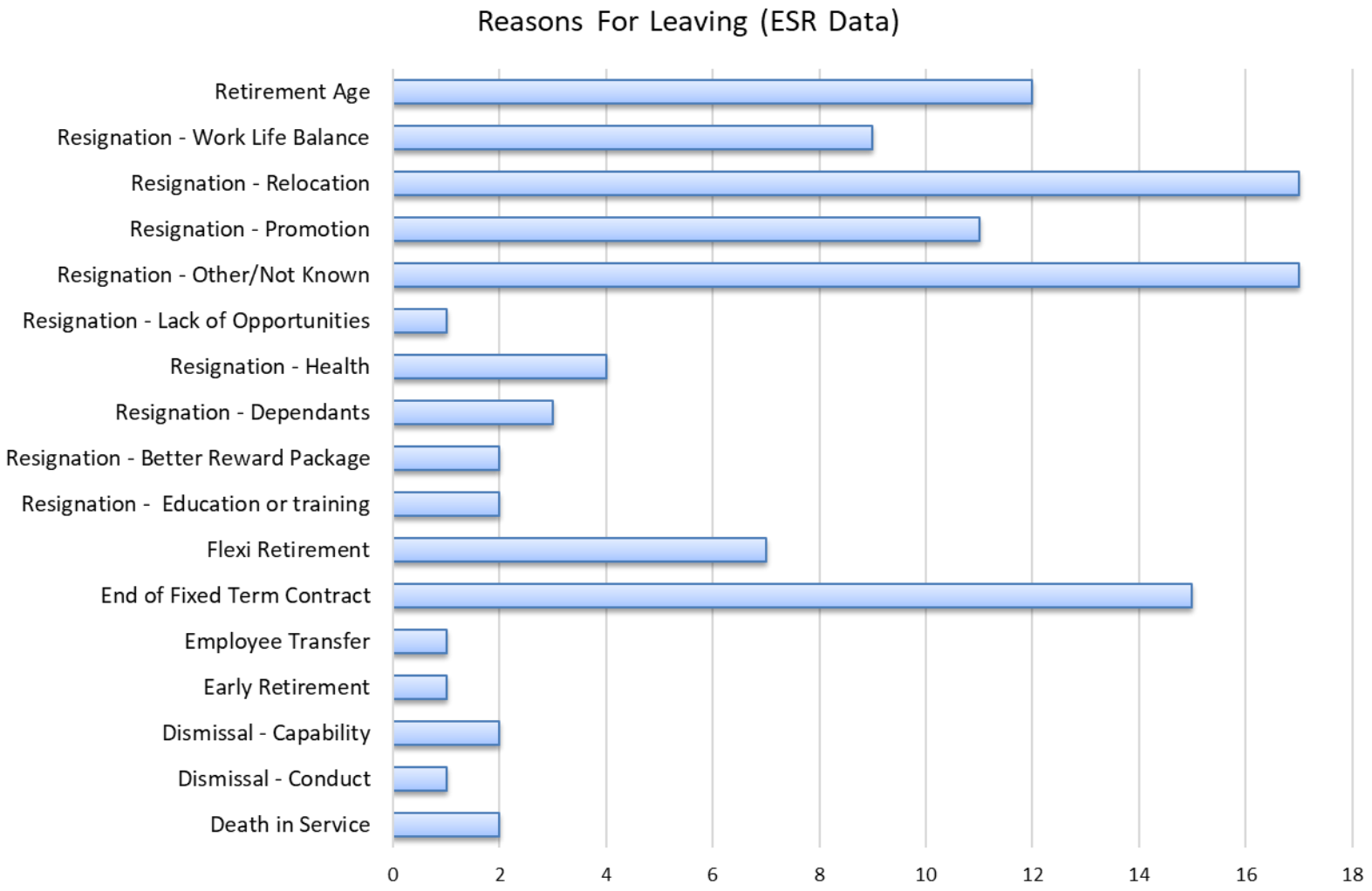
May 20 – Apr 21

1	Workforce Composition, Resourcing and Cost
1b	Leavers Data – Starters & Leavers



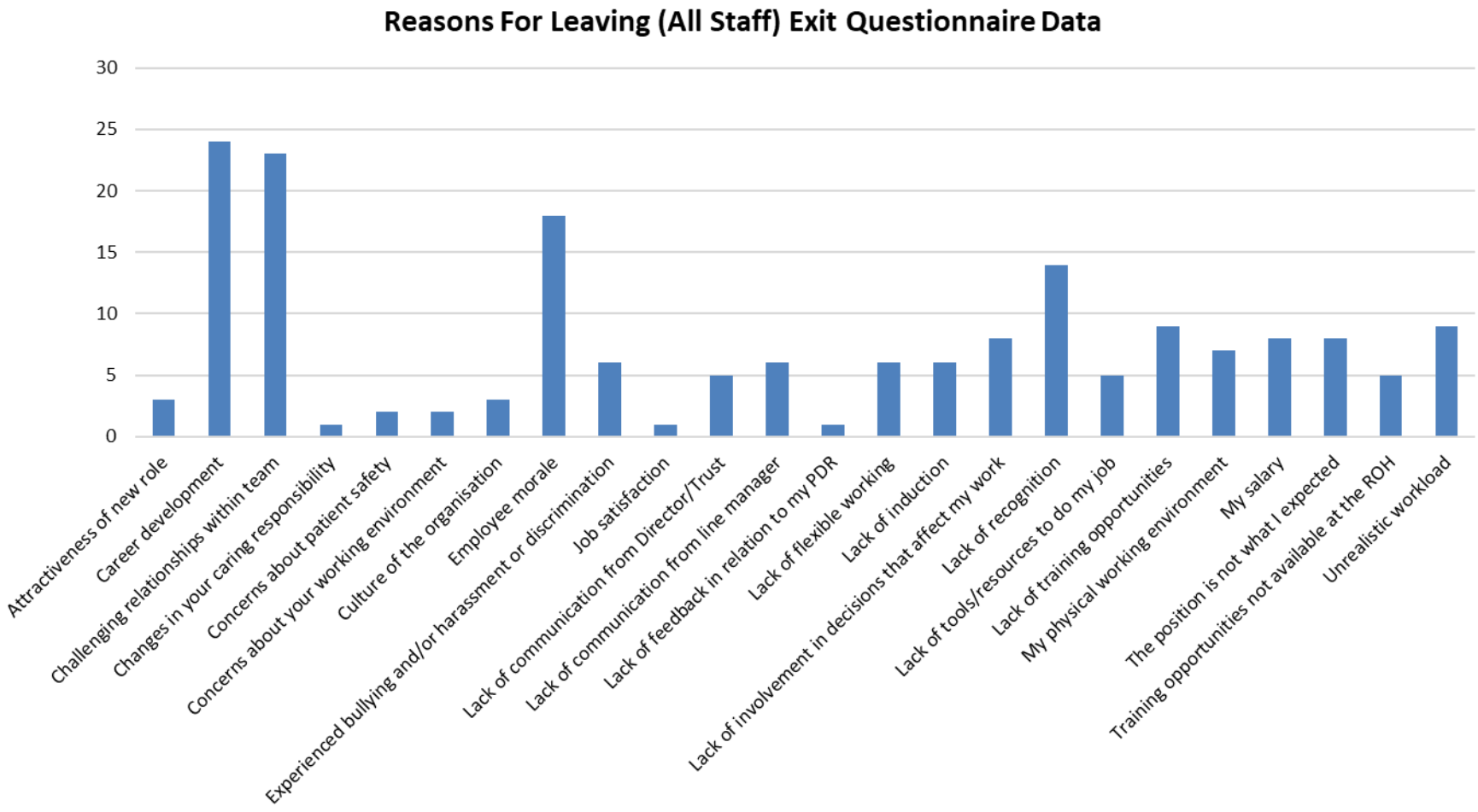
May 20 – Apr 21

1	Workforce Composition, Resourcing and Cost
1b	Leavers – ESR Data



May 20 – Apr 21

1	Workforce Composition, Resourcing and Cost
1b	Leavers – Exit Questionnaire Data

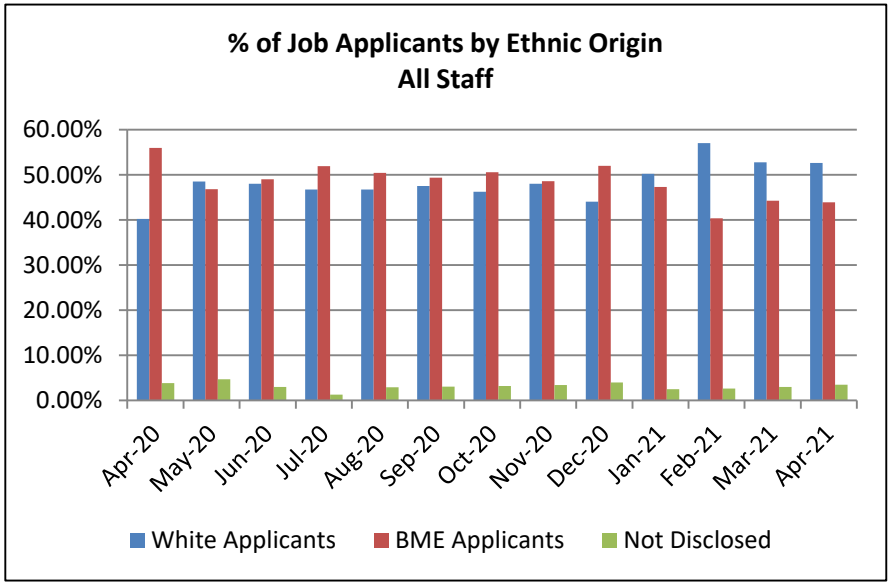


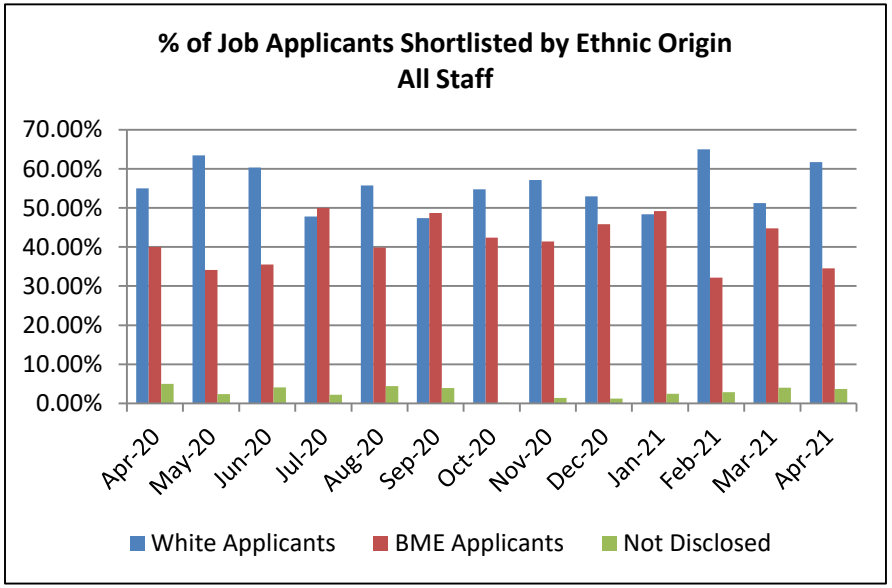
April 20 – March 21

1	Workforce Composition, Resourcing and Cost
1c	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





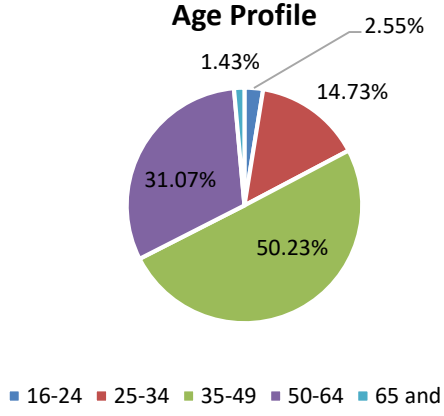
Rolling Twelve month	Trend compared to last report	Variance to National benchmark	Variance to Last Annual Return	2020	2019	2018	2017	2016	National Benchmark
1.65	↑	+0.05	0.05	1.36	1.70	1.64	1.45	1.99	1.60

May 20 – Apr 21

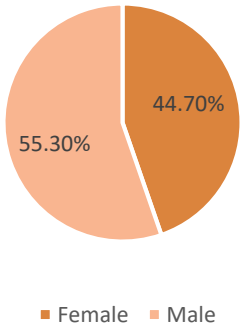
1	Workforce Composition, Resourcing and Cost
1f	Workforce Profile Breakdown

NHS Workforce Diversity Snapshot 2020 – *figures form the NHS Annual Inclusion Report 2019-2020*

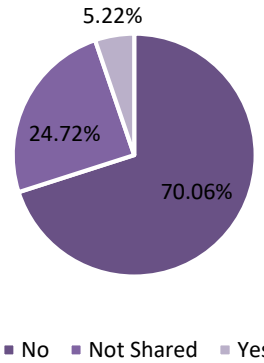
Age Profile



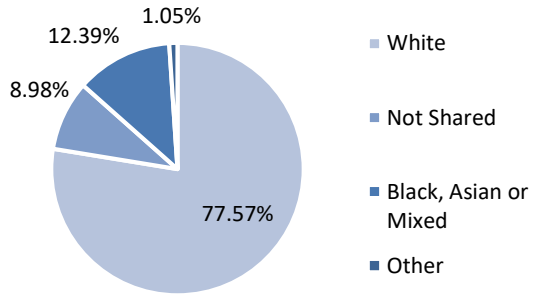
Gender



Disability status

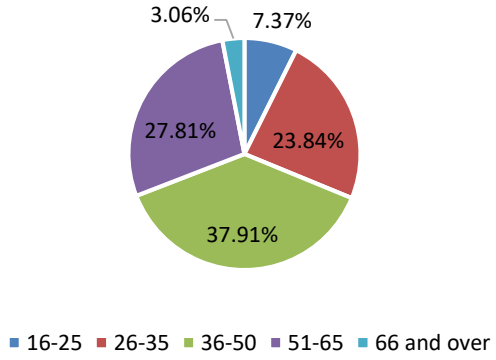


Ethnic Group

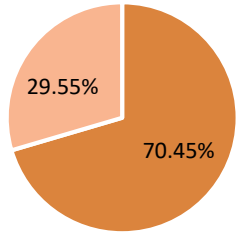


The Royal Orthopaedic Hospital NHS Foundation Trust – *out of 1208 employee's excluding bank staff*

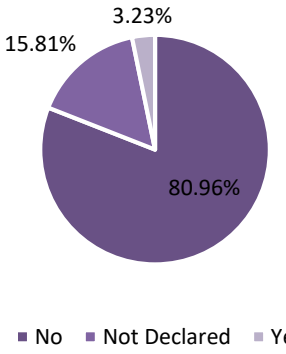
Age Profile



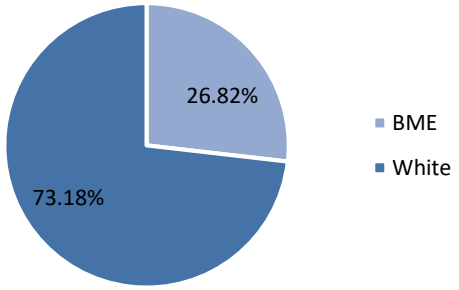
Gender Workforce %



Disability Status



Ethnic Group



Information

Staff Turnover

- The unadjusted turnover figure (all leavers except junior doctors) decreased from 9.04% in March 2021 to **9.11%** in April 2021. This continues to sit below the Trust's KPI of 11.5%.

Exit Data

- During the past 12 months, the top 3 reasons for staff leaving the organisation according to our exit questionnaire and ESR Data:

	TOP 3 LEAVING REASONS	
	Exit Questionnaire	**ESR Data**
1	Career development	Relocation
2	Challenging relationships within team	Other/Not known
3	Employee morale	End Of Contract

Staff in Post

- The number of staff on the payroll in April stood at **1210** (1071.40 - WTE), an increase of 4.93 WTE.

Recruitment and Selection - Streamlining

- The team are continually looking at streamlining systems and processes to ensure that they are effective and reliable for both managers and candidates. KPI's are due to be finalised shortly and introduced to the team, as well as development of the ATR Tracker to allow for monitoring of team performance and to identify any areas where issues may be arising

WRES Indicator 2 monitoring

- The number of BME applicants and BME applicants shortlisted has slightly reduced in April 2021 compared to March 2021. The number of BME applicants appointed into post over the last 12 months (May 2020 – April 2021) was 8.80% compared to 9.93% in the 12 months period of April 2020 – March 2021. Following the graphs on page 9, there were less BME applicants in April 2020 compared to April 2021, which in turn reduced how many BME applicants were shortlisted and hence recruited into post.

ACTIONS FOR IMPROVEMENTS / LEARNING

Workforce Profile Demographics

- The Communications to be sent out to all staff to encourage them to declare their equality and diversity information on ESR so that we can understand more about the diversity of our workforce

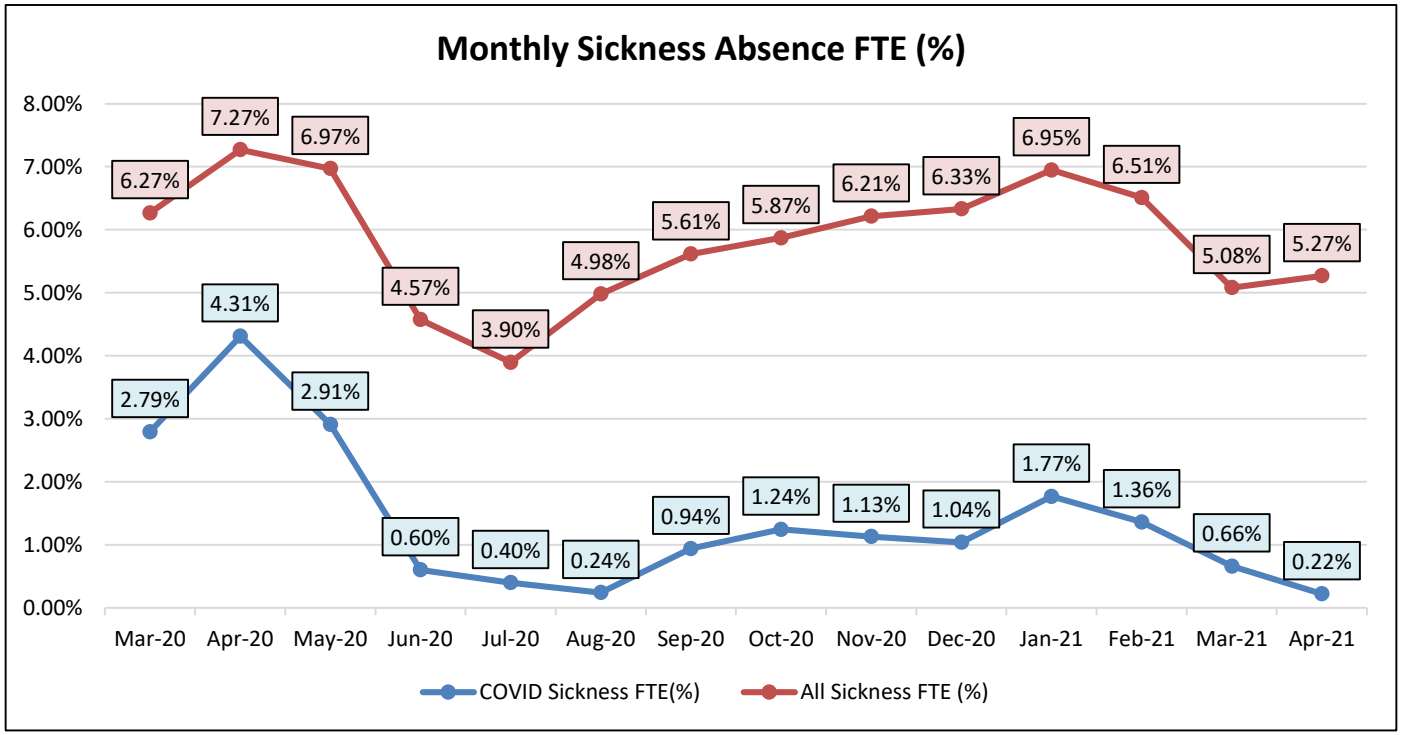
RISKS/ISSUES

- BME applicants being recruited into post is currently slightly over the national average for the last 12 month period

2	Workforce Performance
2	Trust Overall Summary

	Mar-21	Apr-21	This Month vs Last Month	Trend	KPI
% of Attendance	94.92%	94.73%	-0.19%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.22%	94.38%	0.17%	⇧	>=96.3%
% Staff received mandatory training last 12 months	85.79%	83.08%	-2.71%	⇩	>=95%
% Staff received formal PDR/appraisal last 12 months	75.73%	79.98%	4.25%	⇧	>=95%
% of Sickness - Trust wide Long-term	3.67%	3.39%	-0.28%	⇩	-
% of Sickness - Trust wide Short-term	1.41%	1.88%	0.47%	⇩	-
Return To Work Completion %	57.01%	67.54%	10.53%	⇧	>=80%

2	Workforce Performance
2a	Monthly Sickness Absence – COVID Related & Non-COVID Sickness Absence



As at 30th April 2021

2	Workforce Performance
2a	Monthly Sickness Absence – COVID Related & Non-COVID Sickness Absence

All Sickness Absence (Monthly)

Month	Sickness Absence FTE (%)	Sickness Absence Monthly Estimated Cost
Apr-20	7.27%	£220,982.08
LAST 12 MONTHS		
May-20	6.97%	£214,079.76
Jun-20	4.57%	£127,097.34
Jul-20	3.90%	£110,123.36
Aug-20	4.98%	£135,973.44
Sep-20	5.61%	£147,390.73
Oct-20	5.87%	£171,708.41
Nov-20	6.21%	£180,007.50
Dec-20	6.33%	£182,434.49
Jan-21	6.95%	£196,600.78
Feb-21	6.51%	£167,353.02
Mar-21	5.08%	£139,862.84
Apr-21	5.27%	£147,818.75
12 Month Total	5.62%	£1,920,450.42

COVID Related Sickness Absence (Monthly)

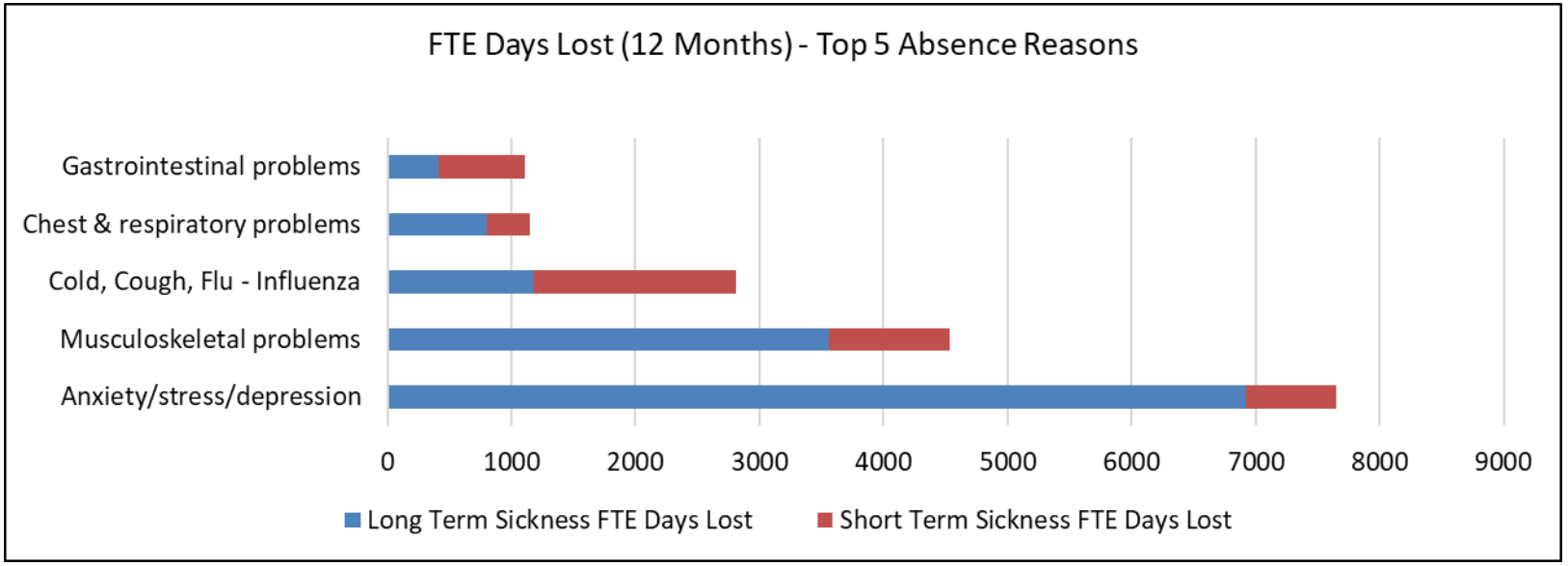
Month	Sickness Absence FTE(%)	Sickness Absence Estimated Cost
Mar-20	2.79%	£92,987.59
Apr-20	4.31%	£120,138.33
May-20	2.91%	£69,823.14
Jun-20	0.60%	£16,659.69
Jul-20	0.40%	£9,135.48
Aug-20	0.24%	£8,182.28
Sep-20	0.94%	£21,987.24
Oct-20	1.24%	£32,471.85
Nov-20	1.13%	£28,841.64
Dec-20	1.04%	£31,547.90
Jan-21	1.77%	£54,699.03
Feb-21	1.36%	£44,399.94
Mar-21	0.66%	£26,418.06
Apr-21	0.22%	£19,198.33
Total Sickness Absence Estimated Cost		£576,490.49

As at 30th April 2021

2 Workforce Performance

2b Staff Attendance – Top 5 Absence Reasons (12 Months)

Absence Reason	Amount of Episodes	FTE Days Lost	Absence Estimated Cost (12 Months)
Anxiety/stress/depression	187	7651.99	£691,058.34
Musculoskeletal problems	240	4531.01	£368,517.95
Cold, Cough, Flu - Influenza	300	2811.09	£276,771.13
Chest & respiratory problems	58	1149.35	£124,766.27
Gastrointestinal problems	239	1109.57	£96,567.82
Total	**1024**	**17253.01**	**£1,557,681.51**



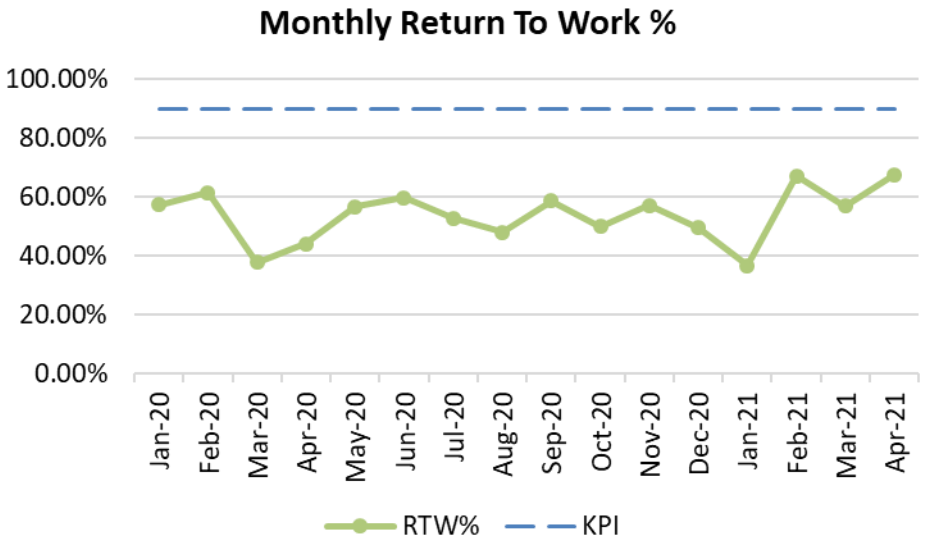
As at 30th April 2021

2	Workforce Performance
2b	Staff Attendance – Absence Management & Return To Work

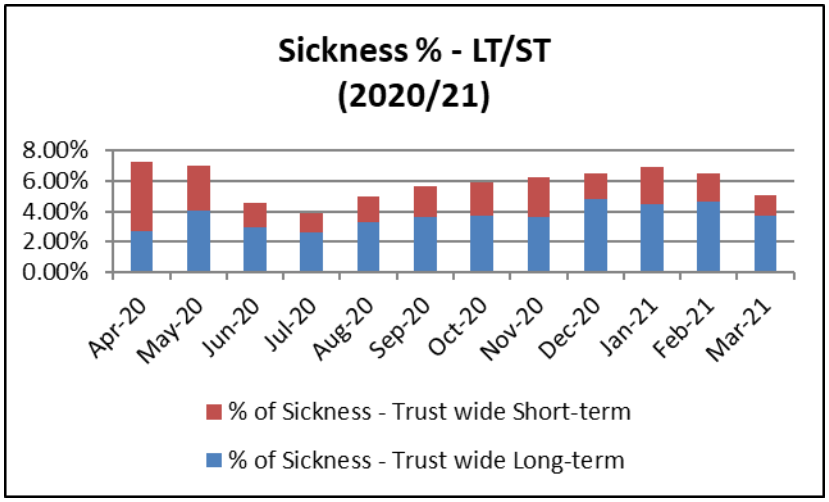
Return to Work Process Completion Rate
(12 months) *April 2021

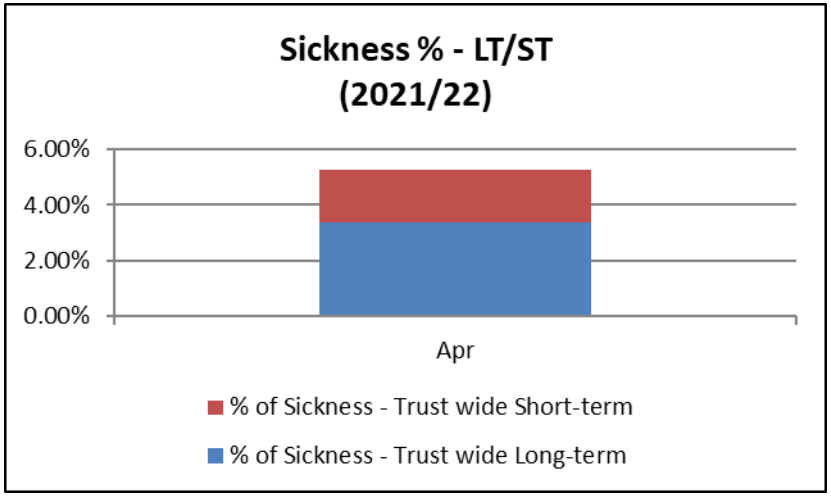
ALL STAFF

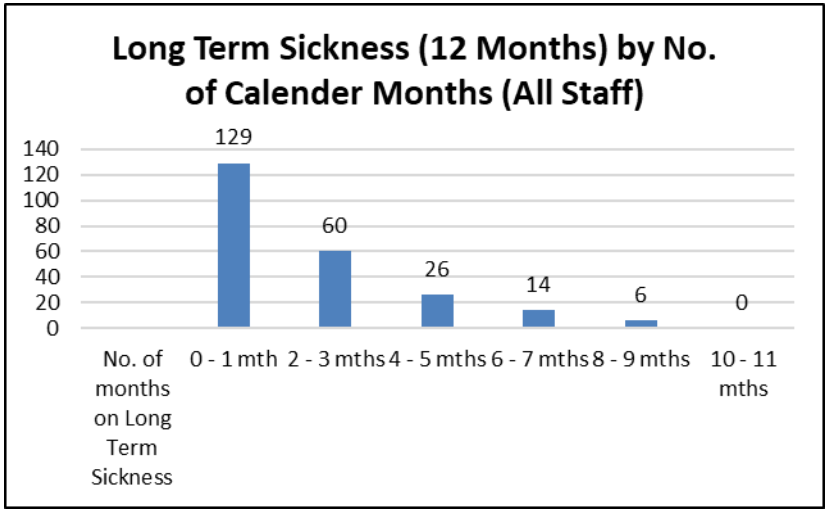


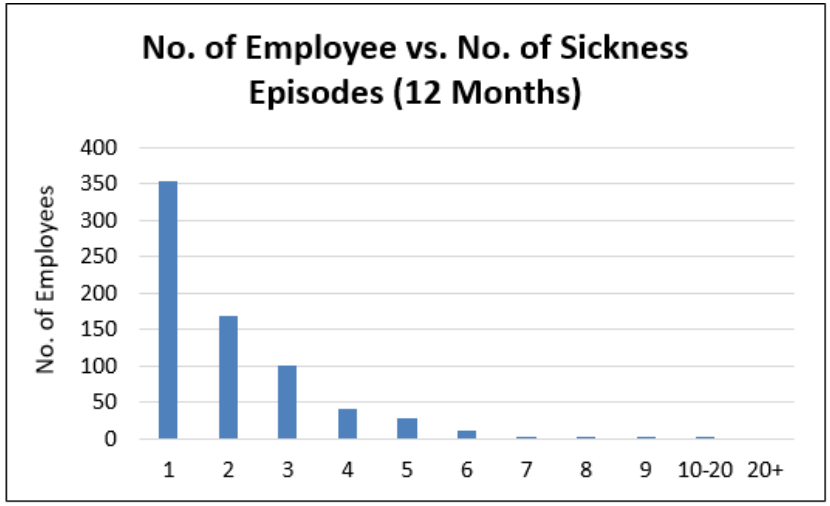


2	Workforce Performance
2b	Staff Attendance - Episodes & Duration

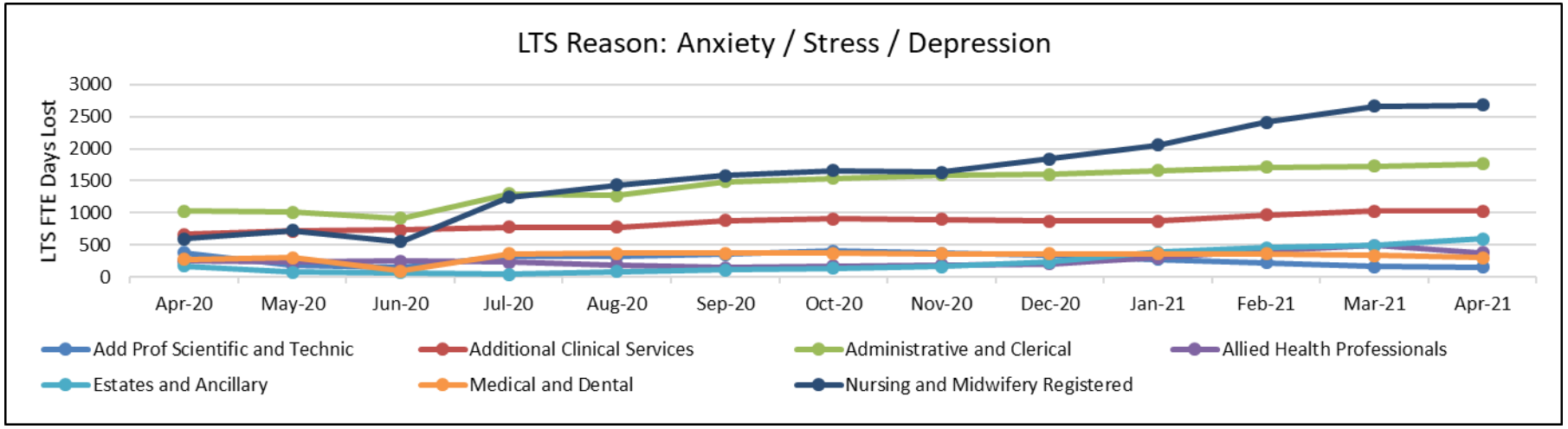


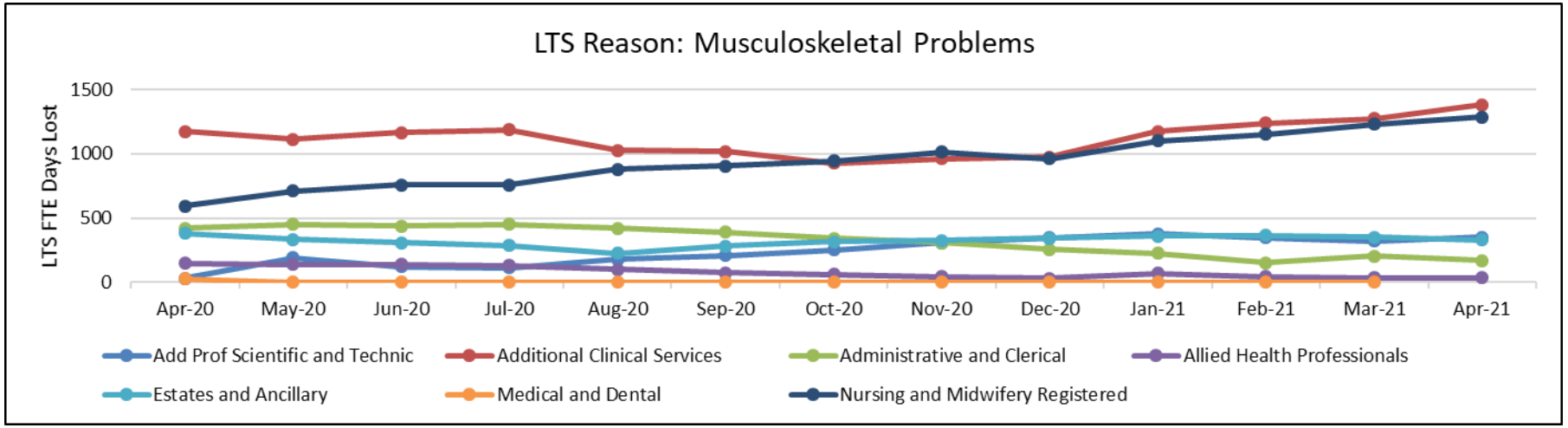




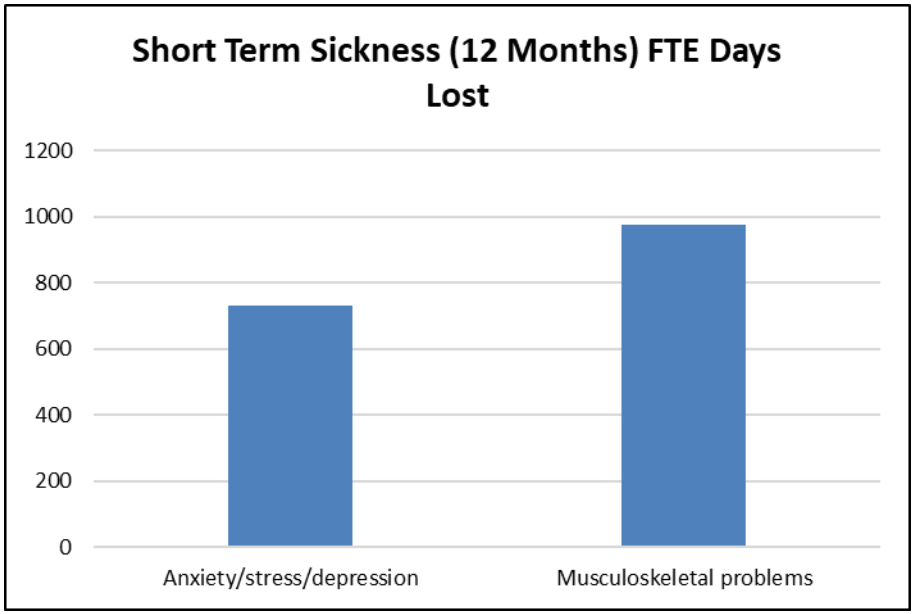


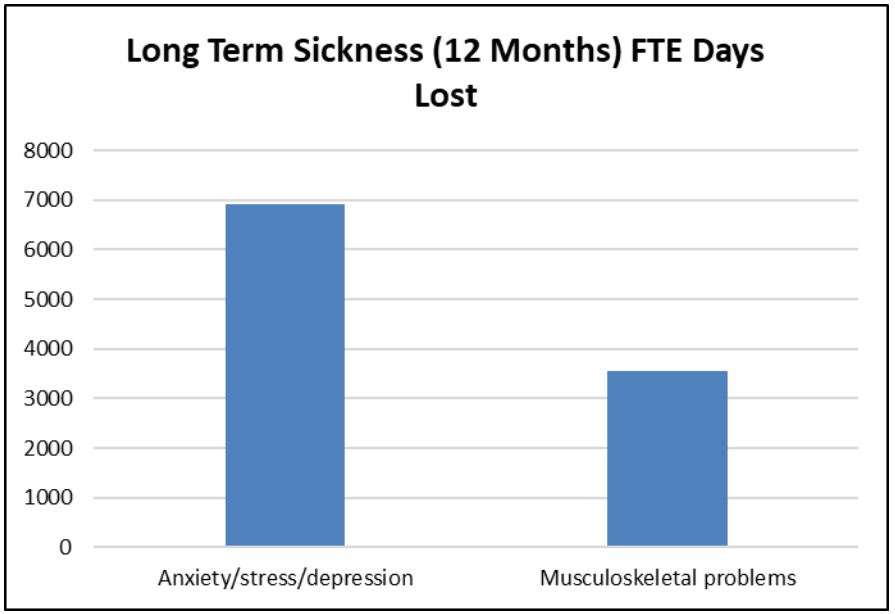
2	Workforce Performance
2c	Longer Term Staff Absence Monitoring





2	Workforce Performance
2c	Longer Term Staff Absence Monitoring





As at 30th April 2021

2	Workforce Performance
2d	Employee Relations – Conduct and Capability

Information

Formal Disciplinary and Capability

- As at the end of April 2021, there were no formal capability cases and 3 formal on-going conduct cases. There are currently no staff under suspension.
- Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being kept informed of any informal processes to ensure we can anticipate potential future formal cases and appropriate action/measures that needs to be considered.

Ethnicity Overview of Conduct Cases:

- One case is a Black British colleague and the 2 others are White British Colleagues.

	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	0	0	3	3

Overview of Conduct Cases	Case 1	Case 2	Case 3
Allegation	AWOL, failure to report absence and follow reasonable management instructions	Failure to follow Trust and national guidelines in regards to COVID and wearing of PPE	Misuse of power through means to humiliate / bully a member of staff they manage

Information

Staff Attendance
The rolling 12 month attendance figures for all staff slightly from **94.22%** in March 2021 to **94.38%** in April 2021 showing a difference of 1.92% to the Trust KPI of 96.30%

Return To Work
Monthly Return to Work completion saw an increase from **57.01%** in March 2021 to **67.54%** in April 2021 against the Trust KPI of 80%. The 12 monthly Return to Work completion rate was 59.09% in April 2021.

Risk Assessments
Trustwide compliance for Tier 2 COVID Risk Assessments currently stands at **92.66%** which is an increase of 1.13% since last month. Managers are reminded to continue reviewing risk assessments on a monthly basis and also staff are reminded to review their own individual circumstances monthly and to arrange a Tier 2 Risk Assessment which their line manager if their circumstances have changed

ACTIONS FOR IMPROVEMENTS / LEARNING

- Action is being taken to ensure managers are completing Tier 2 COVID Risk Assessments for new staff who fit into the criteria as the guidance on 'vulnerable staff' is regularly updated. Managers are also being supported to send the completed risk assessments to HR where additional support or guidance can be offered in terms of working arrangements for vulnerable staff. Any outstanding risk assessments which have not been sent to HR as actively being requested.

RISKS/ISSUES

- There is a risk that Return to Work interviews are not being completed and recorded properly. HR will continue to support and encourage line managers to record completed return to work interviews in a timely manner and ensure that these are updated on the relevant systems

4	Workforce – Experience and Engagement
4a	Employee Engagement and Job Satisfaction



OVERALL STAFF ENGAGEMENT

The most recent National staff survey (NSS) results for 20/21 have seen a move on the overall staff engagement score from 7.4 to 7.3. The score is made up of the questions shown below. The completion rate has also increased from 51% to 56%. The initial results for NSS 2020 have been shared within the Trust. There will be an overall organisational action plans as well as local directorate plans.

Plans are now in place for the next staff survey to start in October 2020

	Questions linked to Engagement score	2020 %	2019 %	2018 %	2017 %	2016 %
21a	Care of patients is top priority for ROH		89	86	79	69
21b	ROH acts on concerns raised by patients		86	83	79	73
21c	Recommend as place to work	74	77	73	62	56
21d	Recommend as place for treatment	90	92	91	83	77

INFORMATION

Friends and Family Test (FFT) – This survey is currently on hold. NHS England is engaging with NHS Trust to agree on the future format

Progress is being made with the **National NHS survey (NSS)** action plan. The results for the Trust were received in full in February and information was then communicated at Trust level and also at Directorate level. Six themes have been identified for focus in 2021:



The communication plan for NSS has included posters, information on the intranet and Team brief. Each Executive Director is also leading on sharing information across their Directorates and finalising a local action plan. The final action plans will be confirmed in June.

The work around **Health and Wellbeing** is now focussed on supporting staff through the recovery phase for Covid-19. Information is currently available through information packs on the intranet, one to one meetings and manager calls. The Trust has recently run a virtual Health and Wellbeing week and an evaluation is currently being undertaken.

Equality and Diversity –Work is progressing to finalise the Inclusion Strategy. Progress in recent months has been made in forming a Multi Minority ethnicity network and electing a Chair, working on the funded WDES project and AccessAble being implemented across the Trust. The LGBTQ+ network (Be Myself) is also developing with new members joining the Whatsapp group. The Equality & Diversity network and the Disability Forum have also continued to meet and run awareness activities virtually. The Disability Forum has also supporting AccessAble.

Work on data collection and action plans for Workforce Race Equality Standard (WRES) and Workforce Disability Equality standard (WDES) is now underway

ACTIONS FOR IMPROVEMENTS / LEARNING

Ongoing evaluation on all interventions
Continue to ensure all staff are able to participate in Inclusion activities

RISKS/ISSUES

Supporting staff post Covid -19

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Inclusion strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**2 June 2021**

EXECUTIVE SUMMARY:

This report shows the final iteration of the ROH Inclusion strategy 2021-2023. This document has been written following discussions and feedback at previous SE & OD committees, consultation with key colleagues, patient information, guidance from National NHS colleagues and support from external partners.

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this strategy document

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

Supports the ambition to be the Wellbeing Hospital and ensures that the Trust is compliant with Equality & Diversity legislation.

PREVIOUS CONSIDERATION:

Executive Team and Staff Experience & OD Committee in May 2021.

EVERY VOICE MATTERS

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Inclusion Strategy 2021-23
The Royal Orthopaedic Hospital


PHARMACIST

Contents

04 Links to Inclusion strategy across the NHS
05 Our inclusion vision
06 How we will deliver our vision
08 Our progress in 2020/2021
09 Inclusion roadmap
11 Key ambassador involvement
12 National measurements
15 Our partners
16 Governance for ROH inclusion
17 Inclusion action plan 2021 - 2023

Foreword

TBC

Glossary

TBC

Links to Inclusion strategy across the NHS

The ROH Inclusion strategy will continue to align to the National NHS Inclusion agenda through the work of the NHS People Promise and also the core principles for the creation of the regional ICS. Descriptions of these are given below.

NHS People Plan

The People Promise in the NHS People plan is 'Our People Promise are what we should all be able to say about working in the NHS, by 2024'. A pledge has been made to ensure that colleagues, line managers, employers and central bodies work together to make these ambitions a reality for all of us, within the next four years.

The ROH Inclusion strategy will continue to align to the People Promise, particularly around 'We each have a voice that counts'. At the Trust, our staff, patient and visitors voice is very important to us and there are a number of interventions undertaken to promote the voice for all. In addition, our value of Compassion aligns with the People Promise of 'We are compassionate and inclusive'.

Creation of the ICS

Again the four core purposes for an ICS and the outcomes for our people are observed in the ROH Inclusion strategy particularly around purpose No 2 which aligns with the ROH Inclusion Objective 1: Tackling and removing all forms of discrimination in order to promote equality for all

The four core purposes for the Integrated Care System (ICS) are:

1. Improving population health and healthcare
2. Tackling unequal outcomes and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development



Our inclusion vision

Refining the vision

Building on feedback from members of the ROH team, we have decided to refresh this vision. The following quotes are from our colleagues who we asked to explore what 'inclusion' means to them.

- Being able to be my whole self to work
- Inclusion is everybody's business
- Somewhere I feel I belong and valued
- Recognising we are all emotional beings requiring love, friendship, support and growth
- Regardless of who I am, my contribution is recognised and valued, and I can feel a sense of pride in what I do
- A place where I feel my employers' policies and procedures protect me if I'm a victim of discrimination
- A place where the services offered are suitable to my needs e.g. domestic abuse support services are tailored to male/male relationships
- My lived experience is important and should be recognised

Our values

Our values are more than words, they define how we treat one another and how we deliver care. Positive values are the bedrock of our culture. Our values inform how we understand and practice inclusion at ROH. They are respect, compassion, excellence, pride, openness and innovation.

Our refreshed vision for 2021

Our vision is to nurture a connected culture of belonging where we bring our authentic selves to work and visitors experience an inclusive environment, ready to meet their needs.

How we will deliver our vision



Our vision

Our vision is to nurture a connected culture of belonging where we bring our authentic selves to work and visitors experience an inclusive environment, ready to meet their needs.

Equality objectives

We will achieve our ambition to be an inclusive organisation (in line with the NHS People Plan) through a clear set of strategic objectives and an action plan which will work across all areas of the trust.

Overall the strategic objectives are to create a truly inclusive environment at the ROH which will continue to improve the patient and colleague experience through:

- **Objective 1:** Tackling and removing all forms of discrimination in order to promote equality for all
- **Objective 2:** Creating an inclusive and healthy ROH culture through Trust values
- **Objective 3:** Giving colleagues and patients a voice to speak up and ask for access to opportunities
- **Objective 4:** Ensuring out Leaders, Managers and colleagues role model in a compassionate and inclusive way
- **Objective 5:** Being recognised as a Top Inclusive Employer externally through best practice approach
- **Objective 6:** Ensure the Equality and Diversity work plan delivers on the required objectives

Each objective has been translated in one of the six high impact areas. Each of these impact areas have key outcomes which are documented in the Inclusion action plan.

High impact areas

1: Proactive ambassadors at all levels of the Trust

- Embed effective mentoring approach
- Embed NHS Partners Programme

2: Accessible through the ROH culture lens

- Inclusive approach to attracting and retaining staff
- Embed a respect and civility approach

3: Building staff/patient voice through feedback and networks

- Development of staff networks including participation and governance
- Redevelop the Freedom to Speak Up Guardian (DTSU) approach
- Embed best practice through external partners

4: Education and awareness for all around cross culture

- Implement programmes for all staff levels including senior leaders
- Embed a culture of inclusive thinking
- Strengthen the importance of our staff network voice
- A well communicated Inclusion calendar

5: Best practice through accreditation

- Ensure continued focus on accreditation through external best practice providers
- Develop evaluation tool for the Inclusion strategy
- Establishment of links with regional and national NHSeagues to share best practice

5: Using data and metrics research to promote change

- Embed an approach for staff and patients to access key inclusion data and information
- Developing further NHS compliance data
- Analysis of feedback from patients and staff interventions is well defined
- Embedded approach to Equality Impact Assessments across all departments

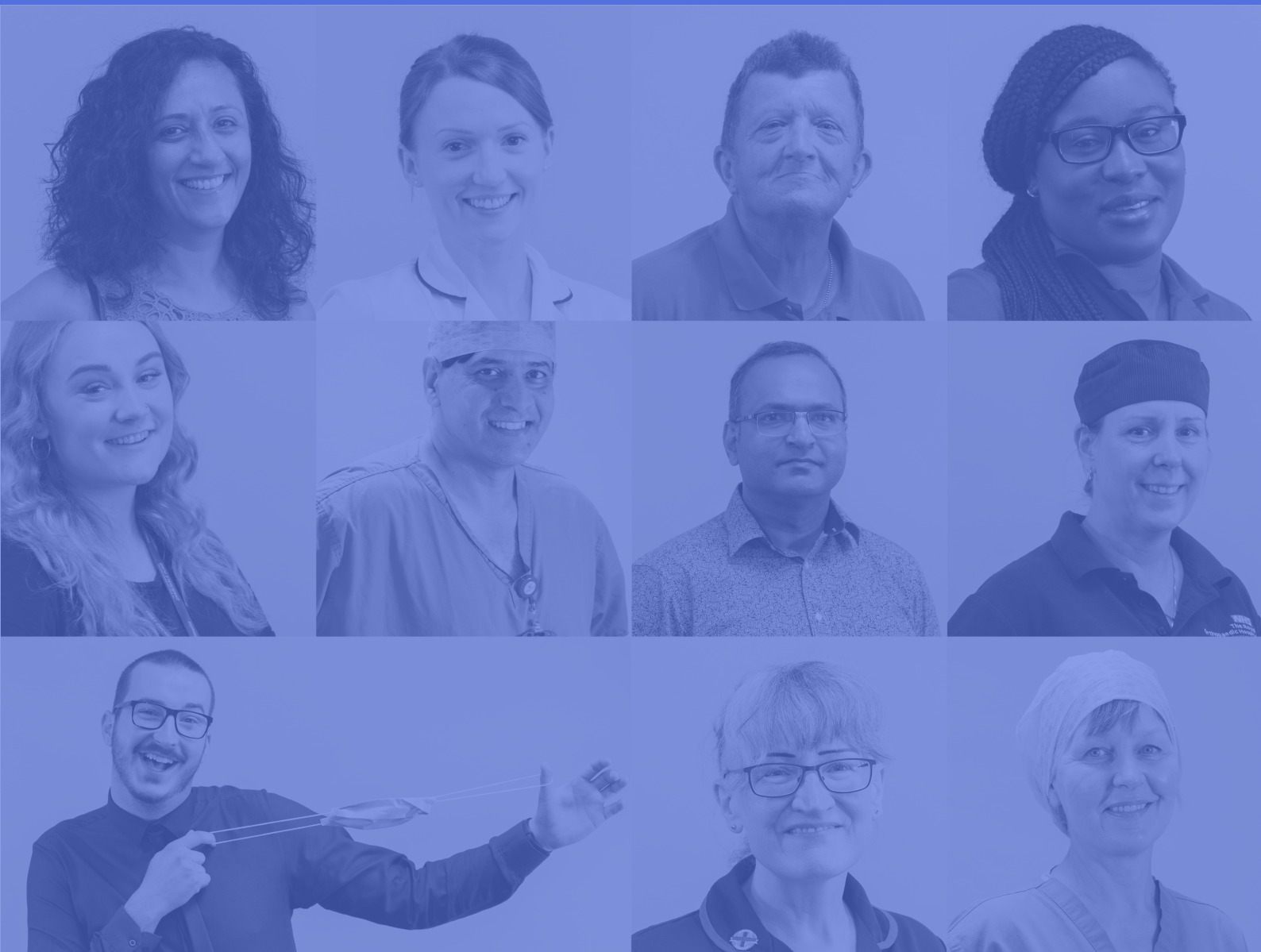
Action plan (see page 15)

Our progress in 2020 / 2021

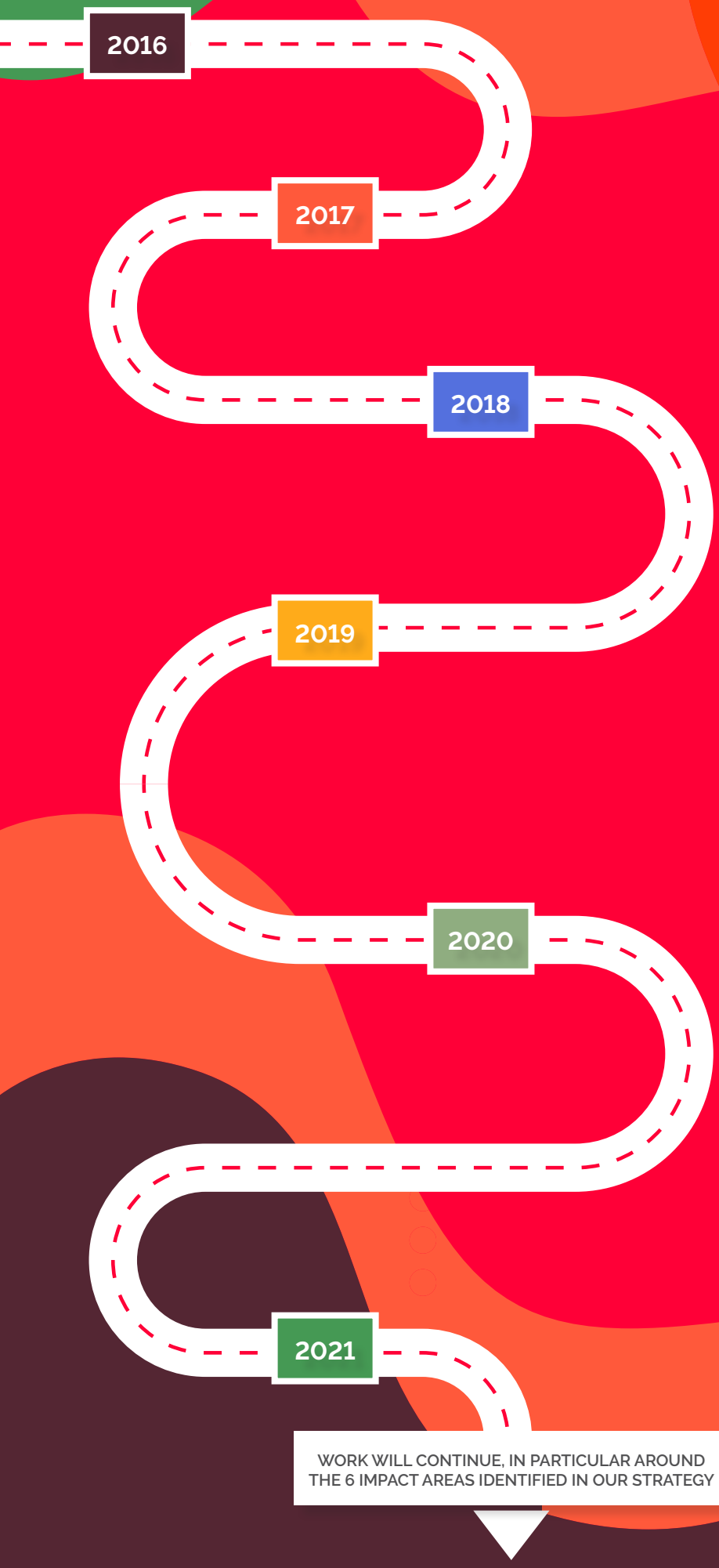
- Ranked in the top 50 inclusive companies in the UK
- Successful listening sessions with the MMEG group
- Highlighted in the WRES annual report
- Joined Stonewall organisation
- Phase 1 recruitment project complete
- Selected for NHS partners programme
- AccessAble project completed for patients and visitors
- EPIC workshop launched for colleagues across different disciplines
- Collaborated on first regional virtual LGBTQ+ conference
- Successful WDES Project bid

During the pandemic, the Trust has also focussed on supporting different diverse groups in the Trust with specific interventions including:

- Ethnic minorities
- Shielding staff
- Menopause
- Initial Long Covid support



Inclusion roadmap



SEPT 2016	VALUES CARDS LAUNCHED
JUNE 2017	PARTNERS IN NATIONAL COM-PASSION AWARD BADGES
OCT 2017	FIRST ANTI-BULLYING AWARENESS EVENT
OCT 2017	ROH NOTED IN NATIONAL WRES REPORT
OCT 2017	FIRST E&D EVENTS
JAN 2018	ENGAGEMENT WITH PATIENT CARER FORUM STARTED
JULY 2018	PARTNERSHIP SUPPORT FROM BRAP
JULY 2018	SCHWARTZ ROUNDS STARTED
AUG 2018	FIRST COLLEAGUES ACCEPTED ONTO STEPPING AHEAD
NOV 2018	ACCESSIBLE INFORMATION STANDARD COMMITTEE STARTED
NOV 2018	E&D NETWORK WAS SET UP
NOV 2018	MHFA TRAINING STARTED
JAN 2019	EQUALITY AND DIVERSITY AWARENESS EVENTS LAUNCHED
MAR 2019	LGBTQ+ FLAG RAISED
MAR 2019	LGBTQ+ AWARENESS WEEK
APR 2019	E&D BRANDING LAUNCHED BY E&D GROUP
APR 2019	INVOLVED WITH BIRMINGHAM PRIDE
APR 2019	SPEAK-UP MOBILE APP LAUNCHED
APR 2019	WDES REPORTING STARTED
APR 2019	DISABILITY FORUM STARTED
APR 2019	MENOPAUSE AWARENESS
JAN 2020	E&D LEAD APPOINTED TO BOARD
APR 2020	BAME LISTENING SESSION
JUNE 2020	BAME CONVERSATIONS STARTED
JUL 2020	LGBTQ+ AND STONEWALL
JUL 2020	1ST MMEG MEETING
AUG 2020	DISABILITY CONFIDENT ACCREDITATION
AUG 2020	AUGUST 2020 FIRST BE MYSELF LISTENING SESSION
OCT 2020	OCTOBER 2020 PILOT ANTI-RAC-IST WORKSHOP
DEC 2020	DECEMBER 2020 WDES SUC-CESSFUL FUNDING BID
DEC 2020	RANKED 34TH IN TOP 50 FOR IN-CLUSIVE COMPANIES ACROSS UK
FEB 2021	FIRST MENOPAUSE SUPPORT GROUP
MAR 2021	REGIONAL LGBTQ + CONFERENCE
APR 2921	MMEG CHAIR APPOINTED
APR 2021	VIRTUAL HEALTH & WELLBEING WEEK
APR 2021	ACCESS ABLE LAUNCH

WORK WILL CONTINUE, IN PARTICULAR AROUND THE 6 IMPACT AREAS IDENTIFIED IN OUR STRATEGY



In order to deliver the Inclusion strategy, it is important that the Trust supports and promotes the involvement of ambassador groups

Key ambassador involvement

In order to deliver the Inclusion strategy, it is important that the Trust supports and promotes the involvement of ambassador groups at different levels. These groups include involvement from staff, senior leaders, unions, staff networks, Foundation Trust members and patients. More information about these networks is shared below:

Staff involvement

All staff are given the opportunity to learn more about the importance of equality, diversity and inclusion. This is done through, mandatory training, learning opportunities and regular feedback sessions to capture staff thoughts. Sessions are run across the Trust and also in specific departments. Future interventions will continue to balance the advantages of using online medium and classroom formats.

Senior Leaders

Our Executive Directors and Non Executive Directors (NEDs) are very involved in the Inclusion work undertaken at the Trust with Richard Phillips being appointed as E&D Lead in January 2020. Through Trust Board meeting and sub board committees, members are given updates on progress and future plans. In addition, Trust Board members from the sub committee of Staff Experience and OD (SE&OD) are active participants in interventions including E&D sessions, Listening sessions and network meetings.

Staff networks

The Trust has a growing number of networks run by colleagues to promote the voice of our diverse staff groups. The Trust recognises the strength of supporting our network groups. Equality and Diversity was the first network formed in November 2018 with the remit of raising awareness and promoting Inclusion across the Trust. Since then other diverse networks have formed as shown below. These networks have their own identity and focus, and are aligned to the overall Inclusion plan. The ambition is for the diversity of staff voice to be increased over the coming years as either stand alone networks or as part of the Equality and Diversity group. Here are the current groups with active conversations now starting in the Trust around Health Inequalities and Women's Matters.

BE MYSELF LGBTQ+

EQUALITY & DIVERSITY

MMEG MULTI MINORITY ETHNIC GROUP

Seeing beyond the stigma

National measurements

As a Trust we will continue to work to the regulatory NHS measures required. Each of these is highlighted below with a brief overview. We will also ensure that we look beyond the data and national benchmarking to understand the key actions that are required to have the best impact for Inclusion at the Trust.

National NHS staff survey

All Trusts are required to undertake the staff survey which is completed during October and November on an annual basis. Key information can highlight issues and opportunities not just in different departments or directorates but also in diverse groups. There is an annual organisation action plan as well as Directorate plans. The staff survey information is used across the Trust in many different ways. Over the past five years the Trust has improved the completion rate. This means the data is valid and gives good representation across the Trust.

National NHS Frameworks

The Trust is required to work under the Public Sector Equality Duty (PSED) of the Equality Act 2010. One of these requirements is for the Trust to share the content of this report with the public through our ROH website. This information includes:

- Workforce Race Equality standards (WRES)
- Workforce Disability Equality standards (WDES) standards
- Gender Pay gap
- Equality data for staff and patients
- EDS 2 framework

By working to the PSED standards, this enables us to:

- deliver on the NHS Outcomes Framework and the NHS Constitution
- meet the Care Quality Commission's "Essential Standards of Quality and Safety"

The Trust works closely with CCG to ensure that inclusion standards are met on an annual basis.

Workforce Race Equality Standards (WRES)

The aim of the Workforce Race Equality Standard (WRES) is to improve the experience of ethnic minority staff in the workplace. This includes employment, promotion and training opportunities. It also applies to people from ethnic minorities whose ambition is to work in the NHS.

Workforce Disability Equality Standards (WDES)

The NHS Workforce Disability Equality Standard (WDES) came into force on 1 April 2019 and is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information is used by the Trust to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

Gender Pay Gap

Gender pay reporting is different to equal pay which deals with the right for men and women to be paid the same when doing the same, or equivalent, work. The gender pay gap shows the difference in average pay of all men and average pay of all women within one organisation. It is therefore possible to have genuine equality of pay but still have a pay gap between genders. As a trust ROH, uses the Agenda for Change job evaluation framework to benchmark appropriate pay bandings to our roles, this in turn provides a process for paying staff equally for the same or equivalent work. Progression through pay steps under the Agenda for Change framework is based on time in post and satisfactory performance irrespective of gender.

Equality data for staff and patients

This information is included annually in the Equality and Diversity annual report which is published on the internet.

EDS 2 Delivery System 2

The Equality Delivery System 2 (EDS 2) is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse.

The EDS 2 framework which is represented by an action plan, is split into 18 areas under the four following outcomes. It links directly to the Inclusion Action Plan, included as part of this strategy:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership at all levels

One of the key areas of focus for the EDS2 plan is around health inequalities for both patients and staff members which continues to be a key focus.

Access Information Standard (AIS)

In addition, the AIS standard and policy is implemented across the Trust to support patients and visitors receiving key information in understandable formats. This work is undertaken through an AIS committee.

Our partners

The Trust also works with a number of external partner organisations which enables ROH to be assessed and accredited against independent standards. It also gives the Trust access to national and international support, advice, networking and resources.

Inclusive Companies top 50
The Inclusive Top 50 UK Employers is a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within their organisation. The Trust submits an application annually to be assessed for the top 50 ranking.

Disability Confident
Recently the Trust has been awarded Level 2 Disability Confident Employer accreditation. This means ROH is recognised as being actively committed to attracting and recruiting disabled people to join the ROH team.
There is a paragraph on the NHS Jobs website for our Trust which welcomes applicants with Disabilities "Our organisation is disability confident and we are committed to offering equal opportunities for all. We welcome applications from disabled people and value their life experience"

The Trust has recently completed a recruitment project to review key areas to focus to ensure a diverse workforce. This will support work in achieving Disability Confident Level 3.

Thrive at Work
Thrive at Work is a workplace commitment from West Midlands Combined Authority with criteria and guidelines on creating a workplace that promotes employee health and wellbeing. There are four accreditation levels for Thrive at Work, Foundation, Bronze, Silver and Gold, each have commitment themes.

The themes are Enablers of Health, Mental Health, Musculoskeletal Health, Lifestyles and External Risks to Health which we use alongside ROH's five ways to wellbeing Connect, Be Active, Mindfulness, Give and Keep Learning. Using this framework, promoting and reinforcing wellbeing will help with a happier, more productive and healthier workforce.

Other key partners supporting the Inclusion work at the ROH include:

- NHSE/I Team
- National, STP and Regional NHS networks
- EPIC Facilitators– Culture and Inclusion programme
- BRAP (Birmingham Race Action Partnership)
- Northfield Community Partnership

Links to other ROH Strategies

The Inclusion strategy does not sit independently and is linked most importantly to the following strategies:

- The ROH five year strategy for excellence
- The ROH Clinical Strategy
- The Education and Training strategy
- The Patient Engagement strategy

Patient engagement

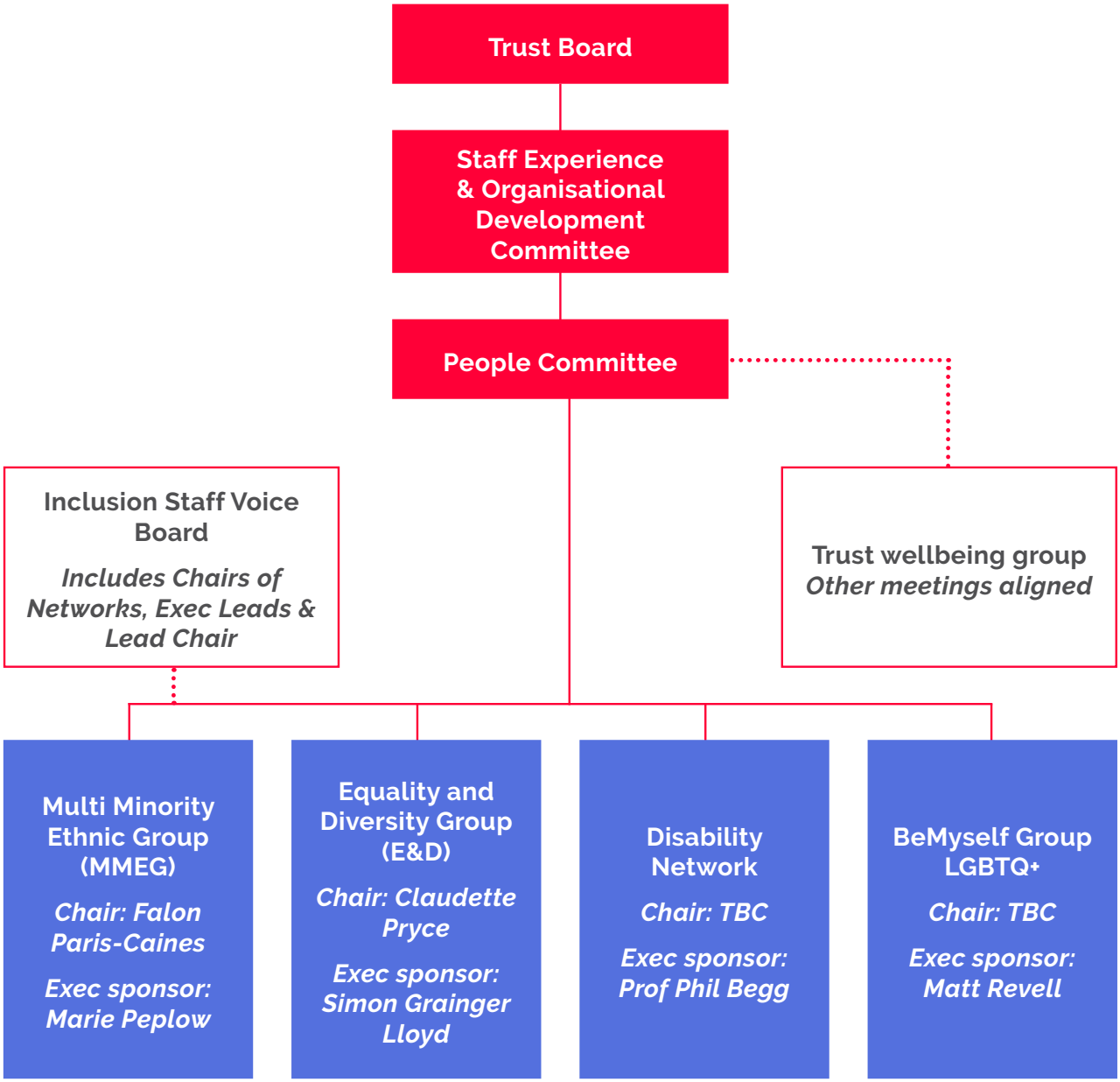
It is important to provide a forum for our patients to be heard. This enables us to track how we are performing as a Trust and to ensure we continue to build patient pathways that are inclusive for everyone. There are two key elements that enable us to focus on our patients views:

- Ensure our work aligns to our Patient Engagement strategy that is managed by the PALS departments and supported across the Trust
- Elements of the NHS EDS 2 system action plan that focus on Patient Access and Engagement

Part of the focus for patient engagement work will be clear plan in reducing health inequalities. Progress in this area will be supported by work undertakenby national and regional teams in the NHS.

Governance for ROH inclusion

The Trust has a clear governance and support structure from staff and patients. This enables all parties to be involved and work together to ensure there is a clear strategy for Inclusion.



Please note: Inclusion Staff Voice Board is still to be implemented which is defined by a dashed line

Inclusion action plan: 2021 - 2023

This plan gives an overview of the key areas of work that will be undertaken in Year 1 and Year (starting April 2021)

Outcome	Action	Target date
Impact area: Ambassadors		
Embed effective Mentoring approach	Define overall Mentoring Framework • MMEG Mentoring Programme • Disability Buddy Scheme • Reverse mentoring	Year 1 and year 2
Embed NHS Partners programme	Review programme completed by Senior Leaders to produce a plan of actions	Year 3
Impact area: Culture		
Inclusive approach to attracting and retaining staff	Build on recommendations from recruitment project • Different methods of attracting candidates • Best practice for interviews and selection • Effective on-boarding • Disability confident	Year 2
Embed a respect and civility approach	• Development of Behavioural framework • Development of Staff Charter • Re-launch of values	Year 2
Impact area: Staff and patient voice		
Development of staff networks including participation	Confirm structure and action plan for individual networks • Equality & Diversity Network (E & D) • Disability Network • Multi Minority Ethnic Group (MMEG) • Be Myself (whatsapp group) Development of further staff networks through staff feedback	Year 1 and year 2
Redevelop the Freedom to Speak Up Guardian (FTSU) approach	Develop the FTSU brand through • Establishment of a network of FTSU champions across the Trust • Review of internal communications and reporting to highlight progress and future plans • Improved visibility of Guardian role through a Trust wide campaign	Year 1
Confirm governance structure for Staff Voice	Plan to ensure Staff Voice is effective through staff networks and is reported effectively through to senior leaders	Year 1
Build support for staff networks to include staff, patients and senior leaders	Interventions to include • Senior leadership sponsorship on staff networks to be confirmed • Support collaboration across different staff and patient networks • Listening sessions for different staff groups	Year 1 and year 2
Embed best practice through external partners	Ensure key projects such as AccessAble and translation are well embedded in the Trust for the benefit of patients	Year 2
Improvement of declaration rates	With support from staff networks encouraging staff to declare diversity information	Year 1

Continued overleaf...

Outcome	Action	Target date
Impact area: Education		
Embed effective Mentoring approach	• Regular updates to be provided for SE&OD committee and Trust Board • Scheduled education sessions for Trust Board members to be established	Year 1 and year 2
Implement programmes for all staff levels	• Anti-Racist Workshop • Inclusion toolbox for all staff • Raise awareness on national NHS development programmes • Integrate with Apprenticeship Programmes	Year 1 and year 2
Embed a culture of inclusive thinking through the EPIC Programme	• 1st cohort staff members and trainers to complete programme • Further cohorts of the EPIC Programme to be embedded in the Trust • EPIC champions network established	Year 1 and year 2
Strengthen the importance of our staff network voice	Organise and run staff network conference	Year 2
Inclusion calendar	• Calendar communicated annually to show key dates recognised in celebrating Inclusion • Action plan in place to highlight specific dates recognised in each staff network	Year 1 and year 2
Impact area: Best practice		
Ensure continued focus on accreditation through external best practice providers	Build on recommendations from recruitment project • Different methods of attracting candidates • Best practice for interviews and selection • Effective onboarding	Year 1 and year 2
Develop Evaluation tool for Inclusion strategy	• Work with partners	Year 1
Establishment of links with regional and national NHS colleagues to share best practice	• Working with the organisations above in the partners section • Leading on regional and national projects where appropriate	Year 1 and year 2
Model hospital improvement tool integrated into ongoing inclusion agenda	• Regular review of model hospital system to align with inclusion actions	Year 1 and year 2

Outcome	Action	Target date
Impact area: Data and metrics		
Embed an approach for staff and patients to access key inclusion data and information	• Establish a resource of information accessible for staff including intranet and ROH mobile app • To re-instate more regular staff E & D forums to share information • Review and maintain internet site	Year 1
Developing further NHS compliance data	Ensure NHS metrics and analysis is made visible for all staff and patients through reporting work in: • WRES • WDES • Gender Pay Gap • EDS2 • AIS	Year 1 and year 2
Analysis of feedback from patients and staff interventions is well defined	• To further develop the staff survey action plan to incorporate the voice of the patient	Year 2
Evaluation of programmes and interventions to review impact and effectiveness	Undertake full review of key programmes using different methods. Programmes include: • NHS Partners programme • EPIC Programme • MMEG Mentoring programme	Year 1 and year 2
Embedded approach to Equality impact Assessments across all departments	• Recommended documentation guidance and monitoring is embedded and understood within the Trust	Year 2



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Notice of Trust Board Meeting in Public on Wednesday 2 June 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 2 June 2021 commencing at **0900h**. This will be a remote meeting facilitated using videoconferencing technology.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (IN PUBLIC)

Venue Remote via videoconferencing **Date** 2 June 2021: 0900h – 1100h

Members attending

Mr Tim Pile	Chairman	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Ms Simone Jordan	Non Executive Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: End of Life audit	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 7 April 2021: *for approval*	ROHTB (5/21) 026	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (5/21) 026 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/21) 001 ROHTB (6/21) 001 (a)	TP/JW
0950h	7	Refresh & recovery update: *for assurance*	ROHTB (6/21) 002	MP
1000h	8	Carbon strategy: *for assurance*	ROHTB (6/21) 003 ROHTB (6/21) 003 (a)	PB

1015h	9	**Staff Experience and Health & Wellbeing**		
	9.1	Staff survey 2020 results and organisational action plan: *for assurance*	ROHTB (6/21) 007 ROHTB (6/21) 007 (a)	SM
	9.2	Inclusion strategy: *for assurance*	ROHTB (6/21) 008 ROHTB (6/21) 008 (a)	SM
1040h	10	**Governance & compliance**		
	10.1	Declaration to NHS Improvement – General Condition 6 – systems for compliance with licence conditions: *for approval*	ROHTB (6/21) 009 ROHTB (6/21) 009 (a) ROHTB (6/21) 009 (b)	SGL
	10.2	Board responsibilities: *for information*	ROHTB (6/21) 010 ROHTB (6/21) 010 (a) ROHTB (6/21) 010 (b) ROHTB (6/21) 010 (c)	SGL
		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1050h	11	Assurance reports from the Board Committees: • Finance & Performance • Staff Experience & OD • Quality & Safety • Audit Committee	ROHTB (6/21) 011 ROHTB (6/21) 012 ROHTB (6/21) 013 ROHTB (6/21) 014	
1100h	12	Performance reports: *for assurance* • Quality & Safety • Finance & Performance • Workforce	ROHTB (6/21) 015 ROHTB (6/21) 016 ROHTB (6/21) 017	
		CONFIDENTIAL SESSION		
1115h	13	Exclusion of the press and public	Verbal	Chair
	Date of next meeting: Friday 18 June 2021 @ 0930h to sign off the Annual Report & Accounts and on Wednesday 7 July 2021 @ 0900h in public			

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 – UPDATED TO MAY 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓									2/2
Kathryn Sallah	✓	✓									2/2
Richard Phillips	✓	✓									2/2
David Gourevitch	✓	✓									2/2
Simone Jordan	✓	✓									2/2
Gianjeet Hunjan	✓	✓									2/2
Ayodele Ajose	✓	✓									2/2
Les Williams	✓	✓									2/2
Jo Williams	✓	✓									2/2
Matthew Revell	✓	✓									2/2
Garry Marsh	✓	✓									2/2
Phil Begg	✓	✓									2/2
Marie Peplow	✓	✓									2/2
Stephen Washbourne	✓	✓									2/2
Sharon Malhi	✓	✓									2/2
Simon Grainger-Lloyd	✓	✓									2/2

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 1 September 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Ms Ali Gray	Charity Manager	(AG)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Pre-Operative Assessment Centre	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 7 July 2021: *for approval*	ROHTB (7/21) 020	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (7/21) 020 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (9/21) 001 ROHTB (9/21) 001 (a)	TP/JW
		STRATEGY		
0945h	7	Progress with delivery of the five year strategy: *for assurance*	ROHTB (9/21) 002 ROHTB (9/21) 002 (a)	RL

0955h	8	Charity Strategy update: *for assurance*	ROHTB (9/21) 003 ROHTB (9/21) 003 (a)	AG
1005h	9	IT & Digitisation plans update: *for assurance*	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	SW
1015h	10	National patient strategy update: for information	Verbal	GM
		PATIENT EXPERIENCE AND OUTCOMES		
1020h	11	COVID-19 update: *for assurance*	Presentation	GM
1025h	12	Learning from Deaths quarterly update: *for assurance*	ROHTB (9/21) 005 ROHTB (9/21) 005 (a) ROHTB (9/21) 005 (b)	MR
1035h	13	Quantifying and evidencing excellence, using quality outcome measures: *for assurance*	ROHTB (9/21) 006 ROHTB (9/21) 006 (a)	MR
		STAFF EXPERIENCE AND HEALTH & WELLBEING		
1045h	14	Responsible Officers annual report: *for assurance*	ROHTB (9/21) 007 ROHTB (9/21) 007 (a)	MR
1055h	15	Staff survey action plan update: *for assurance*	ROHTB (9/21) 008 ROHTB (9/21) 008 (a) ROHTB (9/21) 008 (b)	SM
		BREAK		
		GOVERNANCE & COMPLIANCE		
1115h	16	Annual reports: *for approval* • Fire safety • Safeguarding • Infection Prevention and Control	ROHTB (9/21) 009 ROHTB (9/21) 009 (a) ROHTB (9/21) 009 (b) ROHTB (9/21) 009 (c)	PB GM GM
1130h	17	Updated Board Assurance Framework: *for assurance*	ROHTB (9/21) 010 ROHTB (9/21) 010 (a)	ALL
		FINANCIAL AND OPERATIONAL PERFORMANCE		
1135h	18	Finance and Performance monthly report: *for assurance*	ROHTB (9/21) 011	SW/ MP

		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1145h	19	Assurance reports from the Board Committees: • Audit • Finance & Performance • Staff Experience & OD • Quality & Safety	ROHTB (9/21) 012 ROHTB (9/21) 013 ROHTB (9/21) 014 ROHTB (9/21) 015	
1155h	20	Performance reports: *for assurance* • Quality & Safety • Workforce	ROHTB (9/21) 016 ROHTB (9/21) 017	
		BREAK		
		CONFIDENTIAL SESSION		
1210h	21	Exclusion of the press and public	Verbal	Chair
	22	Declarations of interest on any matters in the private session	Verbal	ALL
	23	Minutes of the previous meeting in private held on 2 June and 24 June 2021: *for approval*	ROHTB (7/21) 018 (P)	Chair
	23.1	Actions from previous meetings in private: *for assurance*	ROHTB (7/21) 018 (a) (P)	SGL
1215h	24	Chair and Chief Executive update on any confidential matters: *for information and assurance*	ROHTB (9/21) 019 (P)	TP/JW
1230h	25	Joint working: • Update on Robert Jones & Agnes Hunt oncology service • University Hospital Birmingham orthopaedic pathway	Verbal	MP
1240h	26	Committee minutes: *for information*	ROHTB (9/21) 020 (i) (P) ROHTB (9/21) 020 (ii) (P) ROHTB (9/21) 021 (P) ROHTB (9/21) 022 (P) ROHTB (9/21) 023 (P)	Ctte Chairs
1245h	27	Any Other Business	Verbal	ALL
	28	Meeting effectiveness	Verbal	ALL
	Date of next meeting: Thursday, 7 October 2021 @ 0900h			

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 – UPDATED TO JULY 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓	✓	✓							4/4
Kathryn Sallah	✓	✓	✓	✓							4/4
Richard Phillips	✓	✓	✓	✓							4/4
David Gourevitch	✓	✓	✓	✓							4/4
Simone Jordan	✓	✓	✓	✓							4/4
Gianjeet Hunjan	✓	✓	✓	✓							4/4
Ayodele Ajose	✓	✓	✓	✓							4/4
Les Williams	✓	✓	✓	A							3/4
Jo Williams	✓	✓	✓	✓							4/4
Matthew Revell	✓	✓	✓	✓							4/4
Garry Marsh	✓	✓	✓	✓							4/4
Phil Begg	✓	✓	✓	✓							4/4
Marie Peplow	✓	✓	✓	✓							4/4
Stephen Washbourne	✓	✓	✓	✓							4/4
Sharon Malhi	✓	✓	✓	✓							4/4
Simon Grainger-Lloyd	✓	✓	✓	✓							4/4

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (in public) - DRAFT Version 0.3

Venue Remote via videoconferencing **Date** 7 July 2021: 0900h – 1300h

Members attending:

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing and Clinical Governance	(GM)

In attendance:

Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mr Jamie McKenzie	Guardian of Safe Working Hours	(JM)	
Mrs Sandra Milward	Head of Imaging	(SM)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story: Pre-operative Assessment Centre	**Presentation**
The story was deferred to the September meeting of the Trust Board.	
2 Apologies	**Verbal**
Apologies were received from Les Williams. The Board was joined by Mark Davies, a member of the public and by Alex Gilder, Deputy Director of Finance.	

3 Declarations of Interest	**Verbal**
It was noted that the register was available on request from the Company Secretary.	
4 Minutes of Board Meeting held in Public on 2 June 2021: *for assurance*	**ROHTB (6/21) 025**
The minutes of the Board meeting in public were accepted as a true and accurate reflection of discussions held on 2 June 2021.	
4.1 Actions from previous meetings in public: *for assurance*	**ROHTB (5/21) 025 (a)**
The Board received and accepted the updated action tracker, noting that a number of items had been removed given that they now formed part of the strategic workplan.	
5 Questions from members of the public	**Verbal**
The Chief Operating Officer provided an update to the question asked by a patient at the last meeting regarding the plan to achieve the 92% Referral to Treatment Time (RTT) standard within 18 weeks. She advised that there was expanded capacity being arranged to meet the unprecedented demand in services. She suggested that it was appropriate to develop a recovery trajectory for RTT and at the next meeting of the Finance & Performance Committee the best case, most likely and worst case scenarios would be presented. It was looking likely at present that the position would be achieved by September 2022. The Trust's performance was reported to be made up of an aggregated position of all specialities and patients had been triaged according to clinical need. The Trust was reported to have a robust harm prevention framework in place and this would be invoked when a patient exceeded a waiting time of 52 weeks. It was noted that the patient had asked about prevention and it was reported that the musculoskeletal (MSK) transformation programme had been launched which was being led by the ROH with system partners. In summary, there were plans to reduce waiting times as soon as practical and as effectively as possible. There was awareness of the mental health issues associated with the current state of health provision nationally. It was noted that the Elective Recovery Fund was a systemwide fund with required approved access from the system, despite the ROH being in a position to exceed the plan to trigger the benefit of the funds.	

It was noted that the patient who had raised the concerns would be an advocate and participate as part of patient safety forum.	
6 Chairman's and Chief Executive's update: *for information and assurance*	**ROHTB (7/21) 001** **ROHTB (7/21) 001 (a) – ROHTB (7/21) 001 (c)**
The Chief Executive reported that there had been much activity over the last month. It was noted that there had been a good presentation to the CQC as part of the Transitional Monitoring Approach well led assessment. A new Freedom to Speak Up Guardian had been appointed. The disability project was noted to have been discussed at the Staff Experience & OD Committee which had been emotional and where individuals had discussed their hidden disabilities. The 'Hello My Name Is…' badges had been delivered and had been well received. There had been a positive day to celebrate key worker day and to mark the award of the George Cross to the NHS. A virtual meeting with Saffron Cordery, Deputy Chief Executive of NHS Providers had been held which had provided a good opportunity to showcase the work of the ROH. Ambulatory trauma had returned to University Hospitals Birmingham NHSFT (UHB), which had released theatre capacity. The Chief Executive had attended the senior nurses, clinical governance and facilities away day and had shared the experience as to how COVID-19 had impacted on staff. It had also provided an opportunity to share with staff what the development of the Integrated Care System (ICS) meant. Richard Phillips asked whether there were further plans to undertake protected time for teams away from the organisation. It was noted that there had been difficulties with gathering together due to social distancing regulations and the nursing away day had been a good opportunity to introduce new people who had started during COVID-19. It was also the first time that people had been seen without a mask for some time. The feedback from the away day indicated that staff had not understood the pressure that the Executive Team had been under during the pandemic. A level of trust had been built as a result of the discussion around the ICS, which had also provided assurance that a merger was not	

planned. Ayodele Ajose noted the new health and social bill included removing the influence of the Competition and Markets Authority (CMA) and asked for further details. The Director of Finance advised that at present the CMA could get involved in issues where mergers were involved. The Chair advised that he had continued to participate in the systemwide meetings including the ICS Board on 14 June and had joined the ICS Internal Programme Board meeting on 7 June 2021. On 22 June, the Chair had attended a Provider Collaborative governance options meeting. In terms of internal visits, the Chair had met with the Operations Department, the Knowledge Hub and the Stores staff since the last meeting. He had also participated in the CQC Engagement Call on 22 June 2021 and the meeting with Saffron Cordery as described earlier by the Chief Executive.	
7 Refresh & Recovery update: *for assurance*	**ROHTB (7/21) 002**
The Chief Operating officer presented the routine report for 'Refresh and Recovery'. She advised that this was the penultimate report as three out of five workstreams had now closed. Both the target for plan for activity and the Elective Recovery Fund trigger had been exceeded. The new elective admissions audit had been completed and there were no new risks identified. There was much work being undertaken with Imaging to address the issues with social distancing and a new trial process was underway. It was noted that the workstream leads would present their work to the Quality & Safety Committee in August. In terms of issues and concerns, a day had been dedicated to validating the patient waiting list. The Birmingham Community Healthcare NHSFT had low waiting times at present so there was some work to do share the list. The Griffin Brook GP practice was also being opened which would be used for treating some patients. There was reported to be a permanent governance bridge between services provided with University Hospitals Birmingham NHSFT (UHB). There was a good joint working model.	

All Outpatient services had restarted and 5000 patients had been seen this month. The Chief Executive noted that one patient had tested positive for COVID-19 who had been treated in a side room and was discharged the following day. With the numbers of patients being treated there would be continued vigilance from an Infection Prevention and Control perspective. Thanks was given to the team for all the work that had been undertaken. This had been a significant team effort.	
8 Musculo-skeletal (MSK) Transformation Programme update: *for assurance*	**Presentation**
The Chief Executive reported that there had been a good turnout at the Musculo Skeletal (MSK) services workshop and there had been some good energy in terms of how the work would impact in a positive way on patients. There was excitement now that the clinical strategy had been developed and this would bring this work to life. Rebecca Lloyd, Deputy Director of Strategy, joined the Trust Board and advised that the programme had been anticipated for some time. In terms of the drivers for this work, this related to the need for system wide transformation. In terms of context, in April, there were 685,000 patients awaiting treatment for orthopaedics. GP colleagues saw a large number of patients presenting with MSK conditions. Only 22% patients were reported to be physically active in Birmingham & Solihull region and so part of the work included a plan to support patients to get them active. There were also multiple referral pathways at present and there was inequity in access. This work was supported by the foundations of the clinical strategy around empowering people to access the right advice and guidance and being able to achieve a high quality standard of living. The need for Osteoarthritis treatment may double in the next few years. There had been 45 people attending the MSK workshop and there was enthusiasm around the work including by GP colleagues. The day was framed by Andrew Bennett, the National Clinical Director for MSK and Nighat Hussain RightCare Delivery Partner from NHS England & Improvement. Prevention was also added into the programme to empower people to manage their condition on a proactive basis. There was reported to have been a set of programme commitments made and they had informed the governance structure for the work. The MSK Transformation Programme Board would report to the ICS Board and was supported by five task and finish groups and a case for change would be	

developed. It was noted that there were some key partnerships that needed to be developed including with public health; digital innovators and sports/physical activity partners. Kathryn Sallah commented that the work was exciting. She suggested that the inequalities lens needed to be applied to work to address for instance, the discrepancy around referrals and to support the part of the population who could not afford to take three months off work post recovery. Richard Phillips noted how central MSK was to the quality of life. He also highlighted the opportunity that the Commonwealth Games presented to the work, particularly around encouraging physical mobility. The Chair agreed with this and noted that he was also on the Board overseeing the Commonwealth Games. The economic benefit of the work was also underlined, particularly from a prevention perspective. Mark Davies echoed the previous comments about the initiative and noted the inequity of access and that there would be increased demand for MSK support in the future, which would lead to a capacity issue. He asked, in terms of funding to make this accessible, whether this this was available. The Medical Director agreed that there was a need to prepare for the 'long haul' and that there should be a focus on harm prevention. The Clinical Strategy included an acknowledgment of the volume of demand. The Chief Operating Officer added that there were a number of initiatives which would support the work and extra capacity had been developed through the pandemic. Business cases were also being developed to fund the additional capacity. In terms of the funding, the ERF also had the potential to help support the additional demand, providing it could be accessed through the system. It was agreed that this was an exciting area and a further update would be presented to the Board at a future meeting.	
ACTION: SGL to schedule in a further update on the MSK transformation work to the agenda of a future meeting	
9 Staff Experience and Health & Wellbeing	
9.1 Update from the Guardian of Safe Working Hours: *for assurance*	**ROHTB (7/21) 003** **ROHTB (7/21) 003 (a)**
The Board was joined by Jamie McKenzie, Guardian of Safe Working Hours. He was welcomed to the Board and thanked for his support to junior doctors. Mr McKenzie noted that there was a benefit in that the Trust was small and there	

was a high degree of familiarity with the junior doctors. They enjoy the work with the hospital and were generally happy. There was noted to be an inherent tension between the work that the trainees put in to make the hospital run, against providing the required experience to help them develop into more senior doctors. It was noted that the Guardian of Safe Working Hours was available to trainees to discuss working hours outside the contract, however there were few instances of this. Any issues raised had all been resolved so far. There was noted to be a good team supporting them and the Junior Doctor forum was working well. The trainees were open and able to express a range of opinions. Simone Jordan thanked Mr McKenzie for the report. She suggested that it would be useful to see the range of the concerns raised and asked if they met with the Non Executive Directors. Simone was advised that the update would be a quarterly report to the Board which would contain this detail in future. As a separate point, it was noted that the snagging list for the Junior Doctors common room needed to be addressed.	
ACTION: **JMc to present the range of concerns raised by the Junior Doctors at a future meeting** **ACTION:** **PB to resolve the snagging issues with the Junior Doctors common room**	
9.2 Board walkabouts and engagement: *for assurance*	**ROHTB (7/21) 004** **ROHTB (7/21) 004 (a)**
The Director of Corporate Affairs presented a report summarising the way in which the Board has engaged with staff over the course of the pandemic. The paper also proposed some ideas for future engagement, post September when social distancing requirements had been lifted which the Board supported. It was suggested that lessons and learning needed to be captured from the engagement work. It was also suggested that there needed to be a balance between familiarity created by the 'Hello, My Name Is…' initiative against professional regard for individuals. The Chairman noted that the initiative would be helpful to break down barriers. The Chief Executive added that it was also concerned with equity in terms of addressing individuals particularly those in a clinical setting. It was noted that there had been a staff engagement piece of work undertaken which informed what staff wanted to have displayed on their badges.	

10 Governance & Compliance	
10.1 CQC inspection of Imaging: *for assurance*	**Presentation**
The Board was joined by Sandra Milward, Head of Imaging and Anish Patel, Consultant who presented a summarised version of the presentation delivered to the CQC in May 2021 which had been well received. The presentation set the context for the area, discussed how it had operated during the COVID-19 pandemic, key risks and issues and any matters of innovation that were worthy of highlighting. The Chair thanked Sandra and Anish for the presentation and for their work. Richard Phillips noted that innovation was a key theme and asked if there was anything further that could be done better to adopt innovation. Sandra suggested that the standing CT needed to be considered as a routine service and an imaging system for spinal surgeons would be helpful. It was noted that this was costly however and some equipment upgrades to the more modern technology may also be needed. The Board was advised that the Radiology team was keen to extend the boundaries and keep at the forefront of Imaging. There was a need to listen to the clinicians to guide the future direction. Gianjeet Hunjan thanked Sandra for the update and asked as the country emerged from the pandemic, what continued precautions were needed to keep patients and staff safe. The Board was advised that the department would continue to abide by national guidance and until there were changes to this there would be continuation of existing practice. There may be a move away from social distancing requirements. The Chief Operating Officer commented that she was proud of the team and even though the ROH was small, it was mighty. The innovation outlined was emphasised as being incredibly important. The Chief Executive noted that any revised national guidance was awaited and the use of social distancing and mask wearing would be discussed by the Quality & Safety Committee, which would in turn report to the Trust Board the outcome and recommended decision.	
10.2 CQC well led inspection using the Transitional Monitoring Approach: *for assurance*	**ROHTB (7/21) 020** **ROHTB (7/21) 020 (a)**
The presentation that had been delivered to the CQC as part of the recent Well Led assessment was received and noted. The Board was reminded that the self-assessment against the relevant Key Lines of Enquiry had been received and	

noted at the Board meeting in April 2021. The Chairman reported that he was proud of the amount of good work that the team had been able to discuss and the information had been well conveyed and outlined the key challenges. There was no formal feedback expected as the conclusion to the call had been that the CQC had not identified any key risks which would prompt a more detailed assessment. Gianjeet Hunjan noted that the information pack was impressive and thanked the team for all the work that had been done. The Medical Director noted that it was important to note the expertise that the Director of Nursing & Clinical Governance brought back into the organisation through his own CQC work giving a foundation to the discussions at the Executive level in particular.	
10.3 Progress and next steps towards delivering a 'net zero' NHS: *for discussion*	**ROHTB (7/21) 005** **ROHTB (7/21) 005 (a)**
It was agreed that engagement with the work to support the ambition to achieve a 'net zero' NHS needed to be raised and required mainstreaming in terms of Executive and Non Executive attention. A quality improvement approach was agreed to be valuable for this purpose. It was suggested that consideration needed to be given to branding the work. Although there was already some work underway there was more work to do to tailor it to the organisation. The Chairman suggested that 'net zero' needed to include environmental sustainability, including plastic reduction which met the challenge and requirements set out in the plans. He emphasised that it needed to embrace social, governance and environmental responsibilities. This also needed to be aligned to the intention set out by David Attenborough. The Director of Strategy & Delivery noted that there was a large staff engagement and culture change piece needed to support the work. This would be discussed through Finance & Performance Committee and there was also a link to Staff Experience & OD. The strategy would be developed by the end of the calendar year.	
ACTION: PB to present the 'net zero' strategy at the January 2022 meeting	
10.4 NHS England IPC Board Assurance Framework: *for assurance*	**ROHTB (7/21) 006** **ROHTB (7/21) 006 (a)**
The Director of Nursing & Clinical Governance presented Version 6 of the NHS England Infection Prevention and Control (IPC) Board Assurance Framework. He advised that there had been some work undertaken to determine the	

evidence base behind the housekeeping practices. There were three residual amber statements, the first of these being audit of Personal Protective Equipment (PPE) and process where there was noted to be a shortfall in audit for non-clinical matters. There was a suite of risk assessments undertaken however covering a range of staff areas. There was also noted to be a culture of challenging non-compliance should PPE breaches be identified which was reassuring. In terms of the audit programme, this would wait until national guidance was received and then an audit would be designed. Assurance against the use of FFP3 masks was also noted be an amber risk. These masks were noted to not be routinely used in the organisation. They were used principally for aerosol generating procedures, mainly in theatres and high dependency areas for non-invasive ventilation. When these were rolled out, supply was a challenge and staff were trained in the use of a variety of masks, but there were instances where staff had failed fit testing. In this case there should be an individual conversation documented which was not evident. A hood was used in place of FFP3 masks in some cases. Nationally, there was narrative around the need to move to UK produced FFP3 products, which the ROH was not currently using. The process would be refreshed to ensure there were no gaps and new materials would be rolled out in a planned way. There was no evidence of transmission of the virus due to the current position and no staff had vocalised difficulties. The third gap was reported to be around ventilation and a peer review would be commissioned. Until the Health Technical Memoranda (HTM) requirements were satisfied then this would remain open. A risk scoring would be added and these areas added to the relevant risk registers where appropriate.	
10.5 Updated Board Assurance Framework: ***for assurance***	**ROHTB (7/21) 007** **ROHTB (7/21) 007 (a)**
The Board Assurance Framework was noted to have been fully refreshed. In terms of risks 1472 and Cov-19 031, it was questioned whether the lifting of the COVID-19 restrictions would impact on the decision-making. It was suggested that the impact on staffing levels needed to be considered as a risk. The Director of Nursing & Clinical Governance advised that the risks were at the given time and when the national guidance was received they would be reviewed. It was noted that the mask wearing may not impact on healthcare settings but there may be a return to conditions at the beginning of the pandemic. Lateral Flow testing, temperature checking and meeting & greeting would continue.	

In terms of staffing, people were having to isolate due to children coming into contact with others. There was no expectation that sickness absence may increase however. Kathryn Sallah noted that the community spread would impact on staff if infection rates increased. In terms of the IPC arrangements on site, the Board could reach a local decision as discussed under an earlier item. In terms of risk CE1, this would be closed and replaced by CE1(2) with a reframed risk. This was agreed. The Director of Nursing & Clinical Governance challenged the proposed reduced score for risk 1089, this being the risk around RTT where the likelihood would reduce from 5 to 4. Given that there was continued non-compliance with the RTT target it did not feel appropriate to reduce this risk score. The Chief Operating Officer advised that there was a robust trajectory to achieve the target and some specialities would achieve 92% shortly. *NB: The Executive Team when it discussed this subsequently, agreed that the score should not be altered for now.* In terms of risk 770, the engineering plant, it was noted that the action needed to resolve it needed to be clarified in the narrative. It was reported that the extended plant was now in place and the consequences and impact would reduce as the assets would be maximised. It was agreed that the framing of the risk needed to be discussed offline between the Chief Operating Officer and the Director of Strategy & Delivery and the narrative updated for the next version.	
ACTION: **MP/PB to discuss the framing of risk 770 around the engineering plant**	
MATTERS TO BE TAKEN BY EXCEPTION ONLY	**ROHTB (5/21) 009** **ROHTB (5/21) 009 (a)**
11 Assurance reports from the Board Committees: • **Finance & Performance** • **Staff Experience & OD** • **Quality & Safety**	**ROHTB (7/21) 008** **ROHTB (7/21) 009** **ROHTB (6/21) 010**
The assurance reports were received and noted. No comments were made.	
12 Performance reports: *for assurance* • **Quality & Safety** • **Finance & Performance** • **Workforce**	**ROHTB (7/21) 011** **ROHTB (7/21) 012** **ROHTB (7/21) 013**
The performance reports were received and noted. It was reported that the annual report and accounts had been submitted within	

the required timeframe. Thanks were given to the team for their efforts in achieving this.	
CONFIDENTIAL SESSION	
13 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
Date of next meeting: Wednesday 1 September 2021 @ 0900h	

PUBLIC SESSION

Next Meeting: 1 September 2021, Virtual via MS Teams

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 27.08.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT.103	Staff survey 2020 results and action plan	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	07/04/2021	Present the Staff Survey action plan at the June 2021 meeting	SM	02-Jun-21	Presentation of the full action plan deferred to the September meeting.	
ROHTBACT.107	Learning Lessons to Improve our People Practice	ROHTB (4/21) 010 ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)	07/04/2021	Present the revised disciplinary policy at a future meeting	SM	07-Jul-21	Circulated to the Board with comments now reflected in the updated verison.	
ROHTBACT.109	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the IT Programmes of work at the July 2021 meeting	SW	07-Jul-21	Deferred to the September 2021 meeting.	
ROHTBACT.110	Strategic workforce plan – the approach to planning, redesign, talent, management and	ROHTB (5/21) 008 ROHTB (5/21) 008 (a)	05/05/2021	Progress Board succession planning	SM/SGL	31-Jul-21	Discussions helds with Trust Chairman on 31 August and a plan constructed.	
ROHTBACT.116	Musculo-skeletal (MSK) Transformation Programme update	Presentation	07/07/2021	Schedule in a further update on the MSK transformation work to the agenda of a future meeting	SGL	03-Nov-21	ACTION NOT YET DUE	
ROHTBACT.117	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Present the range of concerns raised by the Junior Doctors at a future meeting	JMc	03-Nov-21	ACTION NOT YET DUE	
ROHTBACT.118	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Resolve the snagging issues with the Junior Doctors common room	PB	30-Sep-21	ACTION NOT YET DUE	

ROHTBACT.119	Progress and next steps towards delivering a 'net zero' NHS	ROHTB (7/21) 005 ROHTB (7/21) 005 (a)	07/07/2021	Present the 'net zero' strategy at the January 2022 meeting	PB	12-Jan-22	ACTION NOT YET DUE	
ROHTBACT.112	Refresh & Recovery update	ROHTB (6/21) 002	05/06/2021	Ensure that the performance against the constitutional standards is emphasised in the new integrated dashboard	MP	01-Sep-21	Included in the revised financial and operational pack.	
ROHTBACT.114	Board responsibilities	ROHTB (6/21) 010 ROHTB (6/21) 010 (a) ROHTB (6/21) 010 (b) ROHTB (6/21) 010 (c)	05/06/2021	Present the paper outlining the Board members' responsibilities to the Council of Governors	SGL	30-Jun-21	Presented to the governors on 16 June 2021,	
ROHTBACT.115	Board responsibilities	ROHTB (6/21) 010 ROHTB (6/21) 010 (a) ROHTB (6/21) 010 (b) ROHTB (6/21) 010 (c)	05/06/2021	Check with NHS Providers on the progress with rationalising the Non Executives championships and additional responsibilities	SGL	30-Jun-21	Update provided at the July 2021 meeting.	
ROHTBACT.120	Updated Board Assurance Framework	ROHTB (7/21) 007 ROHTB (7/21) 007 (a)	07/07/2021	Discuss the framing of risk 770 around the engineering plant	MP/PB	01-Sep-21	Discussed and reflected in the revised BAF considered at the September 2021 meeting	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (09/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board in Public on 1st September 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 7th July 2021 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Due to the pressures across the BSol (Birmingham and Solihull) region which our partners are experiencing, the Trust continues to focus on our role in supporting our system restoration and recovery. System calls have been re-instated with all system partners, three times per week. The Chief Operating Officers (COOs) across all providers also continue to meet three times a week to agree the operational changes required to address the system backlog for adults across BSol.

We continue to support the backlog reduction for the system for Orthopaedic Surgery whilst we are also currently supporting spinal patients who require surgery after attending at the Emergency Department of the Queen Elizabeth Hospital. The Trust continues to work through the complexity of a system waiting list concentrating primarily on patients categorised as P2 and P4.

2.2 On the 20th August the Trust submitted its annual application to Inclusive Companies which will be assessed by their judging panel for inclusion in this year's Top 50 Inclusive Companies Awards with the outcome due out later this year. The team has continued to work on our inclusion agenda over the last 12 months and it is hoped that we improve on last year's positon of 34th most inclusive company in the UK.

2.3 On Friday 27th the CQC held an on-site focus group for staff from a Black Asian & Minority Ethnic background. The event was attended by a good number of staff. The focus of the group was as part of the CQC's ongoing engagement with its providers and was to gain views on the experience of our staff at the ROH. Thanks to the network chairs for their support to this event.

2.4 On Tuesday 24th August the Trust was notified that it had been shortlisted for NHS Acute/Specialist Trust of the Year. Finalists include:

- Croydon Health Services Trust
- Frimley Health FT
- Guy's and St Thomas' Hospital FT
- Newcastle upon Tyne Hospitals FT
- Royal Papworth Hospital FT
- South Central Ambulance Service FT
- Surrey and Sussex Healthcare Trust
- University Hospitals Coventry and Warwickshire Trust

It was a fantastic surprise to yet again be a shortlisted organisation and we look forward to being part of the process and celebrating with staff over the coming months.

2.5 Planning is well underway for our rescheduled Staff awards which is due to take place on Friday 1st October at Edgbaston Cricket Ground with invitations going out week commencing 16th August to 350 colleagues attending the event.

2.6 After being introduced to Ruth Evans MBE, CEO of the Patient Experience Network (PEN) Home - Patient Experience Network, I have commissioned them to work with the ROH on a number of themes. The first is to invest some time on site, observing, shadowing and interviewing colleagues around the organisation. This will allow them an opportunity to immerse themselves in the ROH culture and understand how the patient (and staff) experience is lived and breathed across the Trust.

The second is to invite people to take a short assessment. There are several resources available that they may use, for example the NHSI Patient Experience Improvement framework tool, an assessment from Ipsos Mori or PEN's own assessment but the principle is to invite key people to undertake a self-assessment to help PEN to understand what people feel are the areas being done well and also the areas to improve.

The work will therefore be twofold, a understand the "real" experience as it is today and understand what is already being done well and explore the areas to improve and know where the "energy" is in terms of priorities. PEN will then make recommendations and present their feedback to Garry Marsh who is the Executive Lead for patient experience, with progress being updated and monitored via Quality and Safety Committee.

Ruth has already started working with the Trust as she attended the MSK workshop as we are keen to ensure that we capture the patient voice and ensure that services are designed with patients.

2.7 On the 30th July 2021, we held a virtual JointCare reunion meeting with 15 patients attending the events and a further 22 who feed back to the Trust following their surgery. Colleagues from across the Trust attended the meeting including Pharmacy, Advanced Nurse Practitioners and members of the Patient Advisory Liaison Service (PALS). The format of the session was:

- Welcome and introductions from the staff, including importance of patient feedback, and how it is used to shape further improvement
- Discussion of the pre-set questions in small groups of 4-5 (including 2 members of staff per group), using 'break-out rooms'
- Discussion as a whole group
- Question and answer session
- Discussion of a new research project around hip and knee replacement 'prehab' led by Research Physiotherapist Gareth Stephens, and the hospital signage improvement project led by Ryan McComb

Following the feedback a report has been produced and disseminated to all relevant departments/staff with the finding being shared at the Patient Experience and Engagement

Group. Reviewing the report it is great to see such positive feedback from our patients and we will also act upon the comments from patients. Reading the report it is acknowledged that some of our patients are anxious about visiting the site and I am very grateful to all our patients who have been extremely supporting of our visiting policy which we clearly had to adapt in line with national guidelines due to COVID-19 pandemic. We will keep this under constant review and when it is safe to do so we look forward to welcoming back visitors to the site. The next 'Coffee Catch Up' is being arranged for September 2021.

2.8 At the end of July 2021, I attended the last session of the EPIC (Enabling Productive Inclusive Culture) training and development session. It has been a real privilege for me to be part of Cohort 1, learning and listening to colleagues talk about their aspirations and plans for the Trust to continue to be a more inclusive organisation. As part of the session we also presented our project for the coming months and it was fantastic to hear colleagues share their projects and share their learning from the programme. I wish them all the very best with their project and thank them for allowing me to listen and learn alongside you, it was one of the most enjoyable learning experiences I have had in some time and made all the more enjoyable by the delegates from across the Trust.

2.9 The Chairman and I held a scheduled meeting with our Consultant colleagues and the Executive team on 22nd July as agreed and we updated the team on the restoration and recovery plan for the system, with an update on the development of the BSol ICS. The meeting was positive and the updates were well received and we will continue to meet on a bi-monthly basis.

2.10 On 3rd August, the Executive Team undertook the third of its 'Chat and Check' walkabouts, with the following areas receiving visits: HR House; Theatres; Therapies; and Corporate Governance. As with previous visits, the Team was well received and gained some illuminating feedback on staff experience of working at the ROH. Picking up on one of the themes from the Staff Survey, the opportunity was taken to emphasise the way in which staff working in corporate functions play a role in creating an excellent quality of care for patients.

2.11 On Thursday 15th July we launched our 'Beyond the Stigma' new photography exhibition, an exhibition about people at The Royal Orthopaedic Hospital and their experiences of disability, both visible and unseen. The stories we showed are all different but the common thread between them all is the need to be kind, the need to see the individual beyond the disability and the importance of taking the time to understand. I am extremely proud of the team both those who bravely shared their lived experience and those who made this exhibition a reality following our successful bid for Workforce Disability Equality Standards (WDES) funding. It was also pleasing to see Prerana Issar, Chief People Officer (NHSE/) share an update about our exhibition in her monthly briefing which goes out to all NHS HR professionals. Thank you to colleagues across the Trust and Board colleagues who joined us on site as part of the official unveiling of the exhibition.

2.12 The impact of the current crisis in Afghanistan is heart-breaking to see and I recognise that this may be an especially challenging time for those affected including ROH colleagues from the region or veterans who once served and those currently serving in Afghanistan and their families. We will continue to support any staff requiring assistance and our website has been

updated with contact details of various agencies offering help. We will of course support our system partners across BSol as requested.

3 BSol ICS (Integrated Care System) UPDATE

3.1 On 22nd July the first of a series of meetings planned were held for all Provider Chairs and Chief Executives to discuss and agree the potential options for a Provider Collaborative. On 19th August NHSI/I published several integrated care guidance documents and supporting resources to aid the transition ahead of April 2022, these include:-

i).Interim guidance on the functions and governance of the ICB

ii).The model ICB constitution and supporting notes (NHSE/I ICS implementation hub)

iii).A list of statutory clinical commissioning group (CCG) functions to be conferred on ICBs (NHSE/I ICS implementation hub)

iv).Building strong ICSs everywhere: guidance on the ICS people function

v).Other guidance, including: an HR framework for developing ICBs, an ICB readiness to operate statement, and due diligence guidance (NHSE/I ICS implementation hub)

3.2 Recruitment is current underway for the appointment of the BSol ICS Chief Executive. A national advert will go out on 1st September until 26th September for all 40 ICS Chief Executives which will be part of the national programme to recruit to all the established ICSs across the country.

4 NHS England/Improvement (NHSE/I) National updates

4.1 Fortnightly briefing calls remain in place with NHS Improvement with the focus being on the vaccination programme and restoration & recovery of elective activity across the Midlands and East region.

4.2 NHSE/I is preparing for the autumn and awaiting further updates regarding the requirement to provide staff with a COVID-19 booster vaccination. The seasonal 'flu vaccination campaign will run in parallel and is planned to commence September/October with a performance target of 85%.

4.3 The nationally agreed pay award for all on the Agenda for Change (AfC) framework and doctors has been agreed at 3% which will be paid in September 2021 and back dated to April 2021.

4.4 Mark Mansfield, Regional Finance Director of NHS Improvement (Midlands and East) is due to retire on 31st August 2021. Mark has been very supportive of the ROH and he will be missed by his colleagues at the Trust.

4.5 Planning guidance for the second half of the year is due out in early September with a system submission required in November 2021. It is expected that the pay award will be funded with 3% efficiency target for the remainder of the year.

5 POLICY APPROVAL

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

- Electrical safety
- Flexible Working
- Job Matching
- Revised disciplinary policy

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

23rd August 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Progress with delivery of the five-year strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Rebecca Lloyd, Deputy Director of Strategy**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

The Trust's five-year strategy was launched in 2019, incorporating the Board's vision document developed in 2018. The strategy is centred on the 5P model, and specific priorities were set for years one and two.

The attached document provides a summary of:

- Performance against the Board's vision set in 2018 and 9 key measures of success over the past three financial years
- How the five year strategy evolved from this vision document
- Priorities that have been achieved over years one and two, and those which remain incomplete and therefore a key focus for year three (please note: this summary does not include all key achievements and progress made over the past 2-3 years, rather a direct summary of those priorities specifically articulated in the Trust's five year strategy)
- Gaps that have emerged, with particular reference to the impact of Covid and the evolution of the Integrated Care System

Finally, the proposed next steps are as follows:

- Given the impact of Covid on the Trust's ability to deliver the five year strategy, it is proposed that 2021-22 is seen as 'year 2' (rather than year 3) of the five year strategy, acknowledging that we are still under significant pressure post Covid
- The hope is that 2022-23 will give us the opportunity to return to some semblance of normality, and the expectation is that we make clear improvement progress against all priorities within the five year strategy
- The Trust's Clinical Strategy provides ambitious measures of success which underpins the Trust's five year strategy, and articulates the role of the ROH as a 'leader' regionally and nationally
- In quarter 4 of 2022-23 (January-March 2023), a full strategy refresh will take place, including:
    - Evaluation of performance data to assess progress made against each of the 5Ps between 2019-2022
    - Defining the ROH offer, as a specialist orthopaedic centre of excellence and a leader in the Birmingham and Solihull ICS
    - Articulation of our plans to address the gaps identified on the previous slide
    - Quantifiable measures of improvement for the next five years

REPORT RECOMMENDATION:

The Board is asked to receive and note the update against the Trust's five year strategy (years 1 & 2), and discuss the proposed next steps for years 3-5

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		X

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

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

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

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

Full alignment to Trust objectives and performance metrics

PREVIOUS CONSIDERATION:

Board workshop held in October 2020

ROH Trust Five Year Strategy (2019-2024)

Update to Trust Board | 1 September 2021

Accountable Director: Executive Director of Strategy & Delivery

Presented by: Rebecca Lloyd, Deputy Director of Strategy & Delivery

Trust Board defined 9 key measures of success in 2018 (prior to five year strategy 2019-24):

1. **Exceptional patient outcomes**: We will continue to be in the top 10% for positive Patient Reported Outcome Measures (PROMs)

2. **Increased activity**: We will treat enough patients each year to reach our 50% growth target by 2022

3. **Improved Referral To Treatment compliance**: 92% target achieved in all sub-specialties

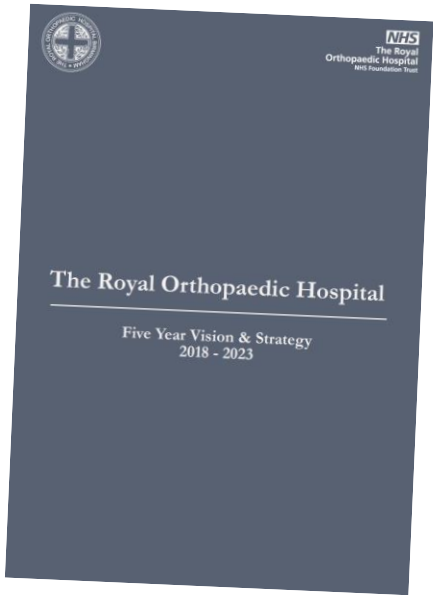
4. **Increased theatre productivity:** A 20% increase in cases per theatre session

5. **Reduced length of stay:** A 30% reduction in overall average length of stay

6. **Highly recommended:** Positive 'Friends & Family Test' scores in the top 10%

7. **Engaged workforce:** Improvement in staff survey responses

8. **Financial stability:** Breakeven by 2019/20, Surplus by 2021/22



9. **Positive regulatory position:** Rated 'Outstanding' by the CQC NHS Improvement will class us as 'Segment 1' in their Single Oversight Framework, a rating which assures that we require minimal oversight

1. PROMS (target – top 10% nationally)

2018-19 ⬆ national average (6/6)
2019-20 ⬆ national average (1/6)
2020-21 (TBC)

2. Total activity (target – 50% increase by 2022)

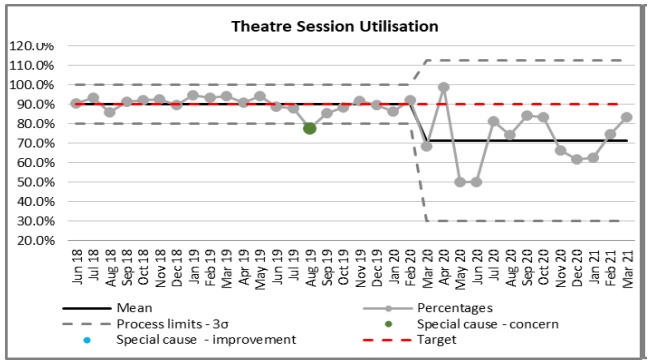
2018-19 ⬆ **OP** 4.5% ⬇ **IP** 1.6%
2019-20 ⬇ **OP** 12.3% ⬇ **IP** 5.6%
2020-21* ⬇ **OP** 66.4% ⬇ **IP** 47.2%

**Measured against previous year's activity (actual)*

3. Referral to Treatment (RTT) compliance (target – 92%)

2018-19 86.85% (Q4)
2019-20 82.29% (Q4)
2020-21 58.27% (Q4)

4. Theatre productivity (target – 20% increase)



5. Length of stay (target – 30% overall reduction)

2018-19 4.2 day (12 month average)
2019-20 4.2 day (12 month average)
2020-21 5 day (12 month average)

6. Friends & Family Test (target – top 10% nationally)

2018-19 96.4%
2019-20 96.1%
2020-21 96.5%

7. Staff survey response rate

2018-19 41% ⬆
2019-20 51% ⬆
2020-21 56% ⬆

8. Financial position (target – break even 2019-20 / surplus 2021/22)

2018-19 -£6.115m
2019-20 -£10.214m
2020-21 -£1.102m

9. CQC Rated 'Outstanding'

2018-19:

Inspected and rated
Good
CareQuality Commission

Trust strategy 2019-24

- Based on Board vision set the previous year
- 9 key measures of success integrated into ‘What success looks like’ section/s
- Strategy centred around ‘5Ps’
- Specific goals set for years 1 & 2 (2019-20 and 2020-21)
- Series of underpinning strategies developed
- Significant progress with developing Estate
- Strategy pre-dates formal transition to Integrated Care System, and the impact of Covid



PATIENTS: SAFE HIGH QUALITY PATIENT CARE

Priority theme	Completed priorities (defined by the Trust 5 year strategy) (2019-20 / 2020-21)	Incomplete priorities / focus for 2021-22	Monitoring
Improved patient pathways	• JointCare hip & knee pathway embedded • Day case uni-knee pilot successful – rollout planned for hips • ROH Metastatic Bone Disease pathway implemented – 640 referrals from across UK (June 19 – July 21)	• Sustained reductions in length of stay • Develop new POAC pathway	• F&P • PPP Board
Improved clinical outcomes	• Year on year reduction in avoidable harm quality metrics • Maintained extremely low mortality rates • 97% consent rate for National Joint Registry • Increase in clinical specialties using Amplitude	• Improved PROMS data across all performance indicators	• AQILA • Quality & Safety Committee
Improved patient access	• 1000+ virtual clinic consultations have taken place, totalling over 280 consultation hours • Increased First Contact Practitioners across BSOL • Additional outreach clinics with Our Health Partnership	• 7 day access to Physiotherapy services, Imaging & Pharmacy • RTT compliance in all specialties • Extended opening hours	• Operational Management Board
Increased research & participation portfolio	• Established Regenerative Medicine Laboratory • New research programmes developed in areas with low research activity • Regular submission of grant applications		
New ways of working	• Outpatient modernisation programme has delivered digitisation of patient letters, full implementation of partial booking, rollout of Referral Management System (see 'Process') • Transition to Adult Care Nurse appointed • Training of 100+ Mental Health First Aiders		

PEOPLE: A DIVERSE, HIGHLY SKILLED AND SUPPORTED WORKFORCE

Priority theme	Completed priorities (defined by the Trust 5 year strategy) (2019-20 / 2020-21)	Incomplete priorities / focus for 2021-22	Monitoring
Focus on engagement and wellbeing	• Rolling programme of Trust-wide wellbeing initiatives in place (linked to Inclusion action plan) • Increased response to staff survey (56%)	• Establish a new recognition scheme based on Trust values • New, innovative communication channels to reach all staff within the ROH	• People Committee
Developing our workforce	• Exceeded National Apprenticeship target (2019/20) • Management Skills Programme mapped to Level 3 Team Leader/Supervisor apprenticeship (12 month programme)	• Workforce planning / modelling skills developed across the organisation	• People Committee
Diverse and inclusive place to work	• Embedded Equality & Diversity network with rolling programme of inclusive activities for all staff • Staff networks launched, with national recognition • Top 100 Inclusive Employers	• Produce & implement a Values Behaviour Framework – in line with BSol ICS Values & Behaviours workstream • EQIA Policy refresh	• ICS Board • Staff Experience & OD
Managing performance	• Career development framework established for all staff • Effective use of workforce development funding from HEE	• New performance management and appraisal approach - on hold awaiting national guidelines • Achieve mandatory training compliance of 91%	• People Committee
New ways of working	• 18 of 24 Theatre Nurse Associates recruited, remaining 6 to commence in October 2021 • Recruited and trained 3 Theatre Assistant Practitioners and 3 ODP degree level apprenticeships	• Establish revised middle grade model • Develop a clear ROH ‘employer brand’ which aligns to the BSOL approach to workforce • Develop joint appointments across BSOL providers	• People Committee • Staff Experience & OD

PARTNERSHIPS: IMPROVED AND INTEGRATED SERVICES

Priority theme	Completed priorities (defined by the Trust 5 year strategy) (2019-20 / 2020-21)	Incomplete priorities / focus for 2021-22	Monitoring
Birmingham Hospitals Alliance	• ICS Digital Enablement Group clear digital roadmap to integrate clinical systems • Develop new guidelines for referring to specialised orthopaedic services (Spinal & Oncology)	• Lead the standardisation of large joint pathway across ROH & UHB (through MSK Transformation Programme)	• MSK Transformation Programme Board
Public and patient involvement	• JointCare Coffee Catch Ups – over 500+ attendees • Proactively addressing themes from complaints	• Increase the number of patients who are involved with, and make demonstrable impact on, key improvements projects and changes to services	• PEEG
MSK expansion	• Lead role in the redesign of Muscular Skeletal (MSK) pathways across BSol ICS • Expansion of FRP • First Contact Practitioners	• 5 workstreams established for MSK Transformation Programme: 1) Standardised procedure pathways 2) Patient Information and Advice & Guidance 3) Digital support for self-management 4) Public Health & Health Inequalities 5) Workforce planning, development and skills academy	• MSK Transformation Programme Board
Academic partnerships	• New undergraduate teaching programme for Aston University medical students in place • 5 Consultants joined ROH from Birmingham Orthopaedic Training Programme in last 2 years	• Develop Aston University Management graduate scheme placement programme • MSK Academy plan	• Training & Development Group • PPP Board
Commercial relationships	• MAKO Robotic Arm • Stryker / MyRecovery app development • Increased income through Woodlands Suite	• Intellectual Property developed • Private Patient Strategy development	• ROH Keystone • PPP Board • F&P
New ways of working	• System approach to transformation i.e. Long Covid • Partnership work with GIRFT • Robotic Process Automation 'FX' forms in use across Trust	• MyRecovery app implementation • Full use of RPA • GIRFT / Midlands Elective Delivery Programme action plan	• PPP Board • MSK Transformation Programme Board

PROCESS: PRODUCTIVE AND EFFICIENT PROCESSES

Priority theme	Completed priorities (defined by the Trust 5 year strategy) (2019-20 / 2020-21)	Incomplete priorities / focus for 2021-22	Monitoring
Digital organisation	• Referral Management System fully implemented • Robotic Process Automation form development • PICS Phase 2 completed – March 2020 • Synertec/DrDoctor digitisation	• Clinical Portal (due for completion Dec 2021) • Dr Doctor – Phase 2 (Radiology, Therapy Services Appointment SMS) (commenced May 2021) • PICS Phase 3 (due for completion Dec 2021) • Rollout of Office 365 (commenced May 2021)	• PPP Board
Outpatient modernisation	• All appointment/clinic letters available electronically • Partial booking implemented to minimise waiting times • Attend Anywhere (virtual clinics) commenced • Access Able guides launched	• Seamlessly integrated Radiology and Outpatient appointments	• PPP Board
Theatre efficiency and productivity	• Cancellations on the day reduced from total of 75 in 2018/19 to 30 in 2020/21 • Bar coding implemented	• Lockdown lists 2 weeks before surgery	• Theatre scheduling – confirm & challenge • OMB • F & P
Robust financial processes	• Benefits of shared procurement system across ICS evidenced during COVID pandemic • Cost Improvement Programme developed using outputs from Model Hospital Club	• Online monitoring tools to support cost improvement programme	• Model Hospital Club • F & P
New ways of working	• Total of 30 staff have completed QSIR Practitioner training (38 more currently in training) • Perfecting Pathways Programme Board embedded	• Increase the organisation's awareness and appetite for risk management • Integrated Performance Dashboard in development 2021-22 • Updated Perfecting Pathways Programme e.g. Joimax Endoscopic Surgery	• PPP Board • Modern Interventions Panel • AQILA • Amplitude (Joimax)

PERFORMANCE: A SUSTAINABLE FUTURE THROUGH GROWTH & FINANCIAL SUSTAINABILITY

Priority theme	Completed priorities (defined by the Trust 5 year strategy) (2019-20 / 2020-21)	Incomplete priorities / focus for 2021-22	Monitoring
Treating more patients	• Provided significant mutual aid to ICS partners to treat more patients during COVID pandemic • Recruited additional consultants	• Develop ADCU into a 23-hr length of stay unit • Collaborate with UHB over growth opportunities • Further development of JointCare • Plan to recover activity (post COVID)	• Operational Management Board • Perfecting Pathways Programme Board • F&P Committee
Reconfiguring and investing in our estate	• Knowledge Hub development – Sept 2020 • Phase 1 & 2 Theatres Modular Build - Dec 2020 • CYP, POAC, Pharmacy relocation • Investment in 2nd MRI scanner	• Relocation of Outpatient Physiotherapy, Physio Gym, MSK, Orthotics, Spinal Topography	• Perfecting Pathways Programme Board
Achieving and exceeding our performance targets	• Rescheduled outpatient appointments decreased by 73% as a result of partial booking rollout • OP DNA reduction of 2% • Consistent performance against Cancer & Diagnostic standards	• Achieve a minimum 95% patients treated within 18 weeks in all sub-specialties– (currently at 65%) • Achieve average wait for first OP appointments to 6 weeks	• F&P Committee
Financial sustainability across medium-long term	• Medium-term financial plan developed as an ICS • Model Hospital Club embedded • Demand & capacity planning aligned to business planning cycle • System agreement on funding allocations (including capital investment)		• F&P Committee
New ways of working	• Shortlisted for HSJ Trust of the Year 2019 & 2021 • Significant increase in charitable income	• UK Premier site for Stryker Performance Solution clinical pathways	• PPP Board • F&P Committee

Reflections on the 5 year strategy: where are the gaps?

Patients

- Focus on population health / health inequalities
- Health promotion – maintaining & restoring wellness and independence
- Taking us from Good to Outstanding ('Outstanding Care Every Time')
- System prioritisation of patients & elective recovery planning

People

- Updated workforce transformation programme (post NHS People Plan)
- MSK Academy

Partnerships

- Role as Integrated Care System leader
- Mutual aid provided to system partners
- Further detail on BSol MSK Transformation Programme

Process

- Perfecting Pathways major transformation programmes e.g. Knee Revision Hub
- Expanded Digital Transformation Programme

Performance

- Establish brand aspirations, supported by Branding & Marketing strategy
- Expansion into community (Griffins Brook, ExtraCare)
- Private patient suite development
- Commercial opportunities
- Defining our international ambition
- Diversifying our offer

Proposed plan

- Given the impact of Covid on the Trust's ability to deliver the five year strategy, it is proposed that 2021-22 is seen as 'year 2' (rather than year 3) of the five year strategy, acknowledging that we are still under significant pressure post Covid

- The hope is that 2022-23 will give us the opportunity to return to some semblance of normality, and the expectation is that we make clear improvement progress against all priorities within the five year strategy

- The Trust's Clinical Strategy provides ambitious measures of success which underpins the Trust's five year strategy, and articulates the role of the ROH as a 'leader' regionally and nationally

- In quarter 4 of 2022-23 (January-March 2023), a full strategy refresh will take place, including:
    - Evaluation of performance data to assess progress made against each of the 5Ps between 2019-2022
    - Defining the ROH offer, as a specialist orthopaedic centre of excellence and a leader in the Birmingham and Solihull ICS
    - Articulation of our plans to address the gaps identified on the previous slide
    - Quantifiable measures of improvement for the next five years

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Charity Strategy: Three Year Plan Summary**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Ali Gray, Charity Manager**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

Charity Strategy Summary – The attached presents a summary and proposed plan of action for the ROH Charity Strategy, presented to the Trust Board for approval in March 2021. This summary document is intended to provide a condensed version of the full strategy document, and highlights key metrics and income generation targets between 2021-24.

Progress against year one of the Strategy is already underway, and has been summarised below for information:

Achieved in Quarter One of 2021-2022

Developed a compelling Charity Strategy, aligned to the 2019-2024 Strategy for Excellence:
Highlights achieved within each main priority of strategy;

Priority 1; Establish a compelling case for support and programme of events to increase donor motivation and grown income

- Identified income generation growth potential
- Reviewed all appeals and sustainable giving
- Forecasted income target and expenditure budget across all income streams, set from April 2021 with a set % increase per year

Priority 2; Raise the profile of the ROH Charity across Birmingham, Solihull and beyond

- Refreshed ROH Charity website
- Project group established and brand reviewed. New brand concepts designed ahead of September's Charitable Funds Committee
- Developed an inclusive programme of general events, fundraising activities and staff engagement including Cricket match, sporting/challenge events, Christmas Ball etc for the year ahead
- Regularly attend local and national networking forums such as 'Institute of Fundraising' and 'NHS Charities Together'

Priority 3; Implement effective and efficient processes to ensure the charity operates to its maximum potential

- Ensured the ROH is fully compliant with all governance measures in place

- Created and developed the job roles within the Charity team
- Ensured process is 'lean' from fundraising enquiry through to acknowledgement of donation
- Developed improved processes for capturing funding ambitions to ensure the funds raised are used effectively
- Strengthened the governance and reporting to Executive and Board committees

Priority 4; Identify new projects and partnerships to develop the Charity and increase opportunity for income

- Database implemented
- Prepared and submitted strong bids for applications for funding such as a total of £265k received from NHS Charities Together

On presentation of the Charity Strategy Summary document, the Charity Manager will lead a brief discussion with Board members about a 'call to action' for the year ahead.

REPORT RECOMMENDATION:

The Board is asked to:

- DISCUSS and APPROVE the Charity Strategy Summary alongside a verbal discussion regarding the 'call to action', to ensure the priorities are delivered with full support from the Board.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	X

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

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

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

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

Aligned to the Charity Strategy previously presented to the Trust Board

PREVIOUS CONSIDERATION:

Charity Strategy discussed by the Board in March 2021

The Royal Orthopaedic Hospital Charitable Fund

Three year plan summary



Purpose

We exist to enhance the care and experience of patients and their loved ones, and support the wellbeing, development and training of staff and students at The Royal Orthopaedic Hospital.

Our aims

- Improving patient, visitor and staff experience of the hospital surroundings through major development projects
- Funding additional equipment to enhance the level of care the hospital can give to patients
- Supporting medical and health research in orthopaedics to drive patient care
- Encouraging specialist teaching and learning to further clinical knowledge and promote innovation

Examples of where we are making a difference



Mental Health First Aid Training
Supporting the wellbeing of our team



Children and Young People's Outpatients
Creating a fantastic new environment for patients

AccessAble initiative
Supporting inclusive services for all

Our strategic priorities 2021 - 2024

Priority 1
Establish a compelling case for support and programme of events to increase donor motivation and grown income

Priority 2
Raise the profile of the ROH Charity across Birmingham, Solihull and beyond

Priority 3
Implement effective and efficient processes to ensure the charity operates to its maximum potential

Priority 4
Identify new projects and partnerships to develop the Charity and increase opportunity for income

Support

Our key stakeholders support, sustain and benefit from the work of our charity.

Public: Module Co
"We've established a fantastic relationship with the ROH Charity and thrilled that our contribution has helped and it's clear that fundraising is great way to improve the patient experience"

Patient: Autumn Robinson
"I have scoliosis and go to the ROH for my braces, x-rays and MRI scans. I decided to have a birthday fundraiser and raise money for the charity who has helped me"

Staff: Phil Vinnicombe
"I've only been here a short while but I feel I could do some good for our hospital...I'm running The Great Birmingham Run for myself, staff and all patients."

Student: Medical Student
"The Knowledge Hub and The Max Harrison Lecture Theatre are great places to learn. We acknowledge how fortunate we are to have the Charity's support in transforming this special place"

How we will deliver our priorities in the next three years

Priorities	Year 1 / 2021-22	Year 2 / 2022-2023	Year 3 / 2023-2024
Priority 1 Establish a compelling case for support and programme of events to increase donor motivation and grown income	• **Total income target for 2021-22: £95,000 (25% increase on 2019-20)** • Additional income generation stream – Grants & Trust Fund applications – target: £15,000 • Increased focus on community and general donations	• **Total income target for 2022-23: £195,000 (51% increase on 2020-21)** • Additional income generation stream – Major Giving – target: £5,000 • Additional income generation stream – Regular Giving – target: £2,000	• **Total income target for 2023-24: £325,000 (40% increase on 2021-22)** • Ambitious stretch targets set for all income generation streams (including £100,000 target for Grants & Trust Fund applications
Priority 2 Raise the profile of the ROH Charity across Birmingham, Solihull and beyond	• Increase internal presence • Increase external profile resulting in new partnership opportunities and income generation • Charity re-brand completed • Database installed • Ambassador volunteer group embedded • Stakeholder mapping exercise completed	• Market/launch regular giving Increase: • Face to face / Business to Business networking • Legacy marketing/ partnerships • Trust applications • ICS sustainable and strategic partnerships (inc. commercial and academic research)	• Research for and partner with major donors Increase: • Trust applications • NOA; showcasing joint clinical innovation, joint bids and partnership working • Continue ICS sustainable and strategic partnerships (including commercial and academic research)
Priority 3 Implement effective and efficient processes to ensure the charity operates to its maximum potential	• Governance improvement plan approved • Framework/scoring pre bid application process in operation • Evidence of Charitable support for innovation, cutting edge equipment and an enhanced robotics portfolio	• Enforced expenditure plans per fund • 12 month trustee development programme in action	• Consolidation of internal departmental funds and fund holders
Priority 4 Identify new projects and partnerships to develop the Charity and increase opportunity for income	• Staff Health and wellbeing projects complete (Year 1) • Catering facilities plan approved • Patient Entertainment System implemented	• MSK patient information and digital self-management application launched across ICS • Clinical leadership and innovation programme developed • Expansion of JointCare	• ROH Charity shop/hub in place • MSK Academy formally launched • QSIR Innovation Awards embedded

Leading Lights STAFF AWARDS

KNOWLEDGE HUB

Registered with FUNDRAISING REGULATOR

AccessAble Accessibility information

JOINTCARE Hip and Knee Centre of Excellence at The Royal Orthopaedic Hospital

CENTRE FOR MUSCULOSKELETAL MEDICINE

NHS CHARITIES TOGETHER

ROH BE WELL STAFF WELLBEING

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**IT & Digitisation plans update**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Executive Director of Finance & Performance**
AUTHOR:	**Paul Jennings, ICS Digital Lead & Matthew Maycock, Acting Head of IT**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

The attached presentation was delivered to the Finance & Performance Committee earlier in the year and provides an overview of the key projects and workstreams underway both at a system level and local to the ROH from and IT & digital perspective.

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this presentation.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

CQC 'Should Do' around harmonising disparate IT systems

Compliance with Data Protection & Security Toolkit

PREVIOUS CONSIDERATION:

Finance & Performance Committee in May 2021.

BSOL Integrated Care System Digital Enablement Group

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

The current digital vision

There will be a **single digital front door for patients** no matter what care they need using the NHS login, providing advice and guidance through a symptom checker to navigate to services that patients need. This will provide the opportunity to **direct patients to the relevant healthcare professional at the right time for the right reason** as well as **providing care professionals with real time data for their citizen journey with a shared care record** and providing patients with access to their record, support for self-care and greater choice with the ability to book appointments directly.

ICS Objectives

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Build smart digital and data foundations

- Have board accountability for digital and named SRO on ICS Board
- 3 year digital transformation plan
- Build digital skills and capacity
- Invest in infrastructure and shared systems and platforms i.e. EPRR with single ICS allocation

Connect health and care services

- Develop a shared care record
- Enable collaborative working and staff to move around the system, across organisation boundaries, i.e shared booking, referral management, pathology/radiology reporting

Digital and data to transform care

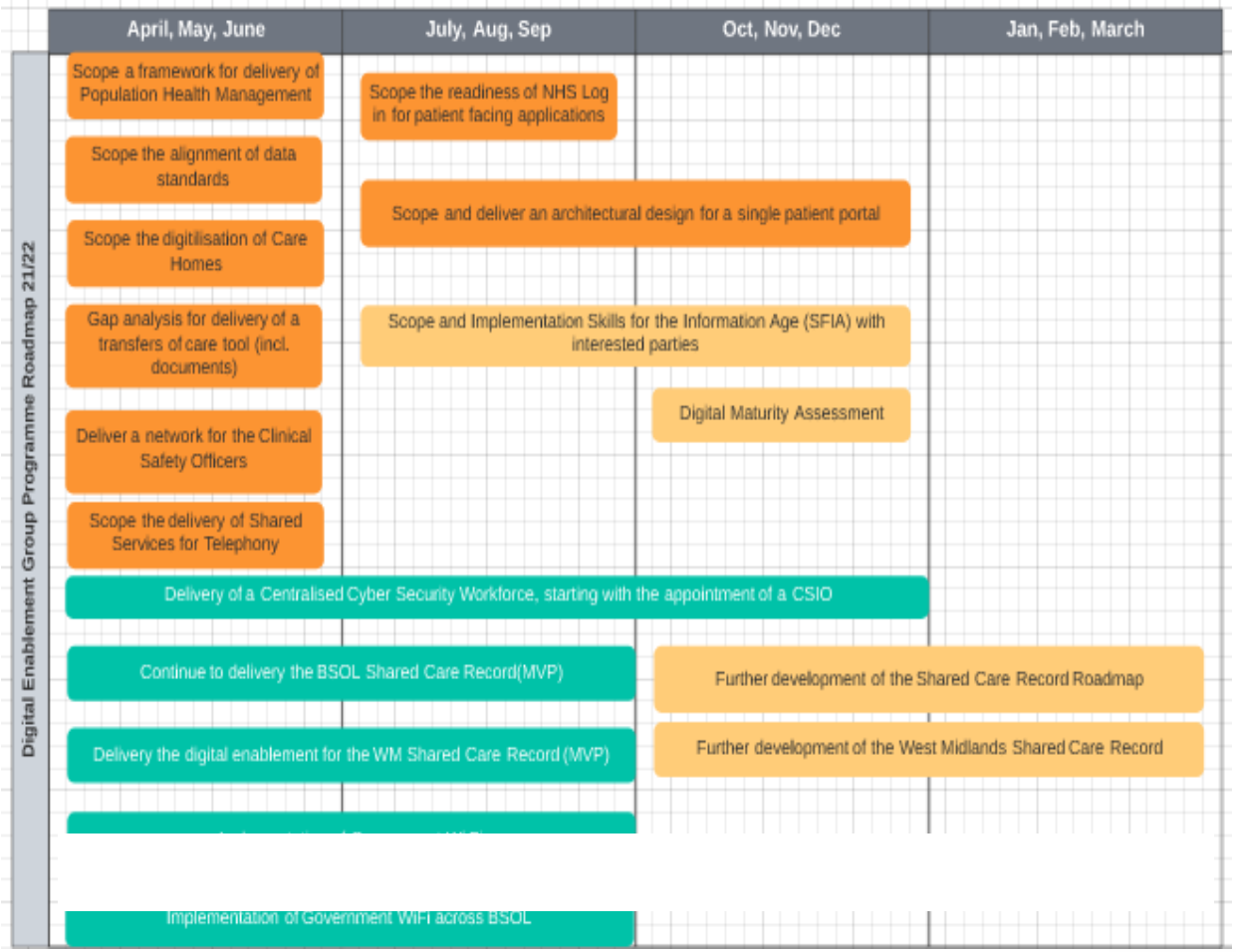
- Use digital technology to transform services, pathways
- Develop cross system intelligence and analytical functions
- Enable the transparency of information to support Decision Making

Citizen at the centre of their care

- Develop a Road map for Digital Centred citizen care
- Roll out remote monitoring
- Legislative changes to support data sharing

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Current Roadmap 21/22



Legend

- Scoping
- In Progress
- Not confirmed

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

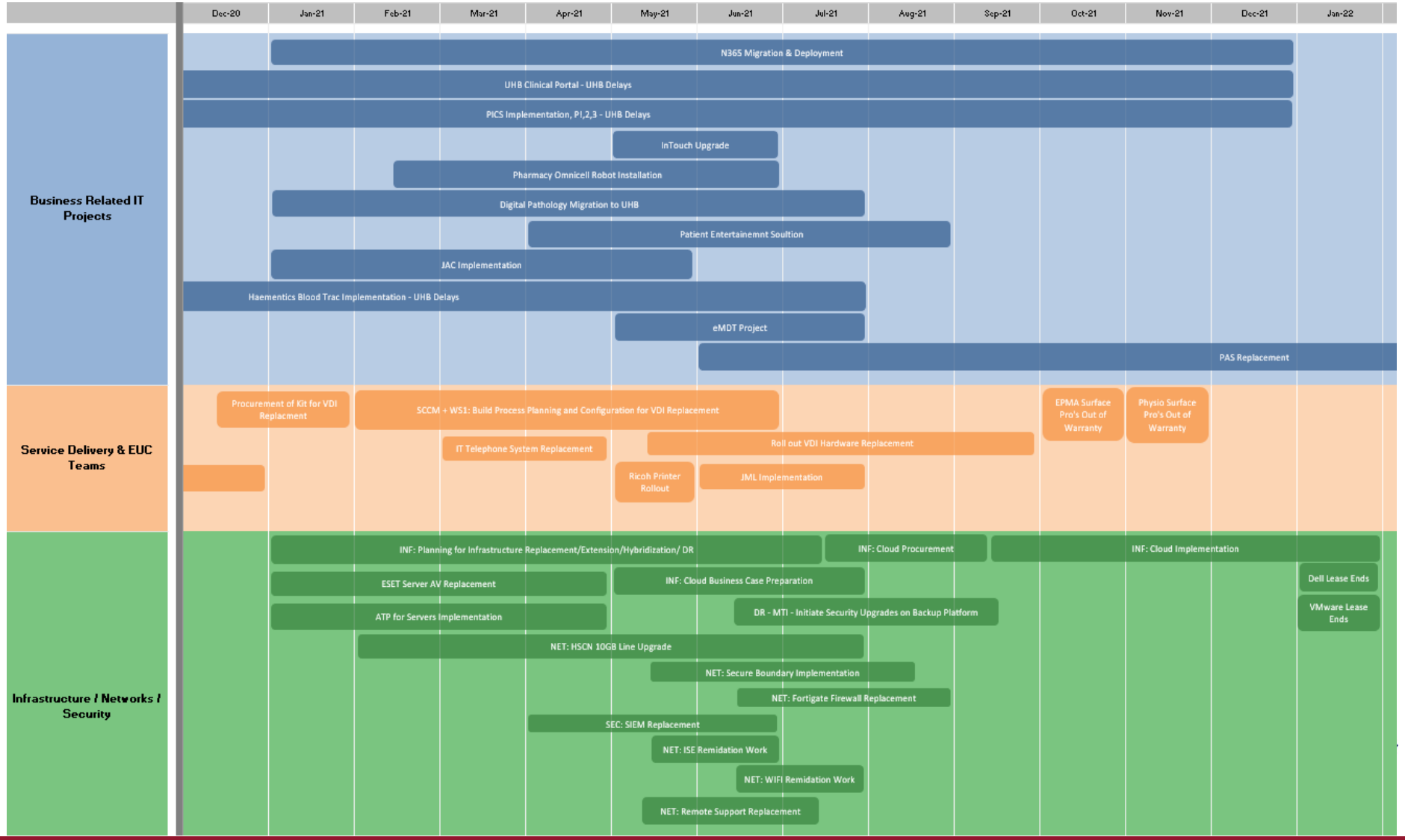
In Flight Programmes and Projects

To deliver digital maturity for Care Homes by implementing 1. NHS Mail 2. An MDT Platform / POC 3. Remote Monitoring pilot 4. A digital education platform and 5. access to health and care information through the local Shared Care Record
To consolidate video solutions where possible as an STP utilising combined procurement opportunities
To implement the use of Government WiFi (Gov Roam) acros BSOL
To develop a shared Cyber Security Service starting by sharing best practice, building knowledge and appointing a CSIO
To seek opportunities to procure as an STP based on Unified Communications starting Telephony and O365
To deliver a shared cared record across the West Midlands footprint
To deliver the digital enablement for the Covid Vaccination Programme
To delivery an architectural framework for the Population Health Management
To deliver a digital gateway for citizens with access through NHS Login
To deliver a Health Information Exchange (Shared Care Record) across BSOL
To carry out a digital maturity assessment to see the shift from 2018 to now
To implement NHS111 online and Care Connect
To transition digital services to an ICS model (Deloitte shared services review)
To deliver a workforce that can freely move around utilising the SFIA tool
The establishment of the Clinical Safety Officer Network and the CNIO Network

ROH IT Roadmap / Programme of Work

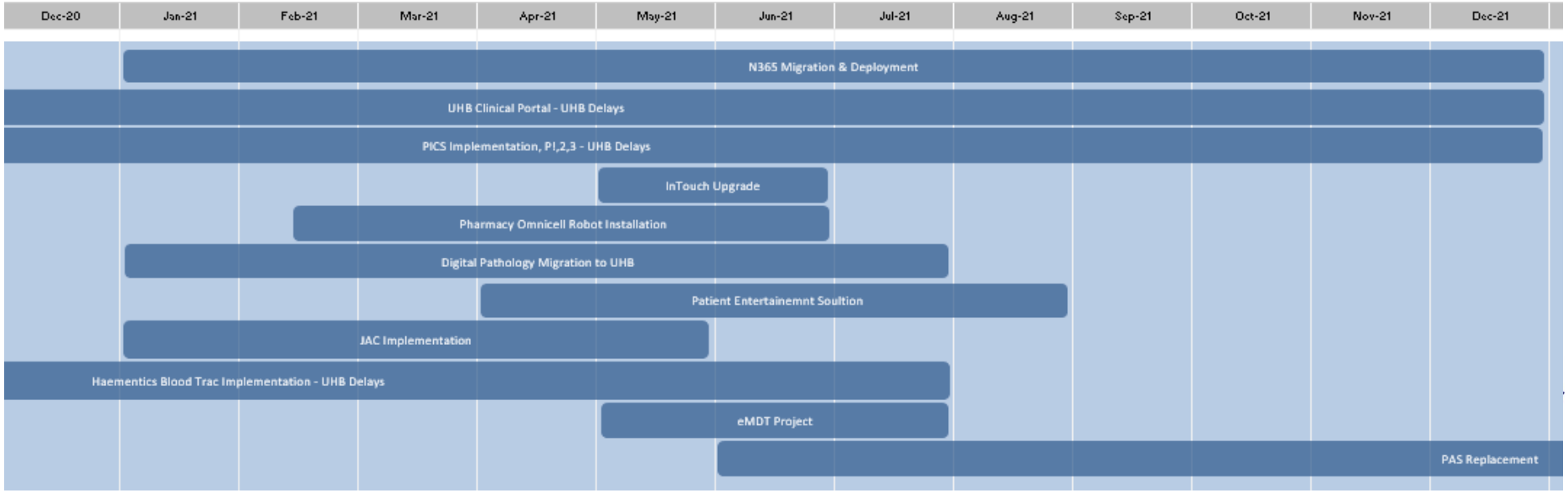
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2021 IT Program



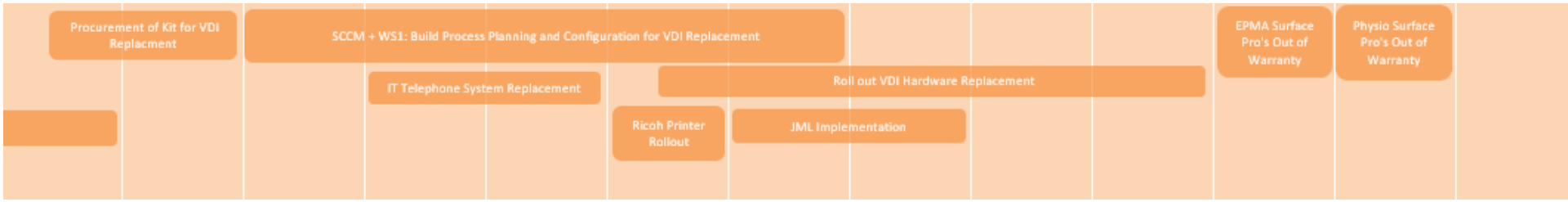
Key Business IT Projects

- **N365** – First on boarding areas identified. Joint work between Strategy and IT to onboard departments as new replacement devices are available to allocate to replace the VDI/Thin client. Any new department will then be able to take advantage of a full Microsoft Teams experience initially. Rollout will be over the course of 2021.
- **Clinical Portal** – Now set to reconvene with delivery of the current CP4 version being delivered. Re scoping exercise being conducted this during April/May. Reinstatement of Portal Project meetings and Joint Portal/PICS meetings in May.
- **PICS** – We now have a timeline agreed to deliver the next phase of PICS. Over the remainder of 2021 we will be seeing a host of additional functionality arriving within our PICS environment including inpatient noting, operation notes, alcohol/tobacco assessment , outpatient module, outpatients noting, clinician e-handover and more.
- **Pharmacy Omnicell Robot** – Robot located in the new pharmacy department, configuration is being configured to enable connectivity between JAC.
- **Patient Entertainment Solution** – Expected to kick off in May 2021 – Improve patient experience by enabling providing patients with an entertainment solution to watch tv, contact family/ friends, access recovery information following surgery.
- **JAC –** Ascribe is being replaced by JAC in pharmacy, Ascribe was insufficient and wasn't provided full capabilities required. JAC will be implemented by May
- **PAS Replacement** – PAS is due to be replaced in August 2022. Paper has been produced of potential options and next steps. A project team will put together in due course.



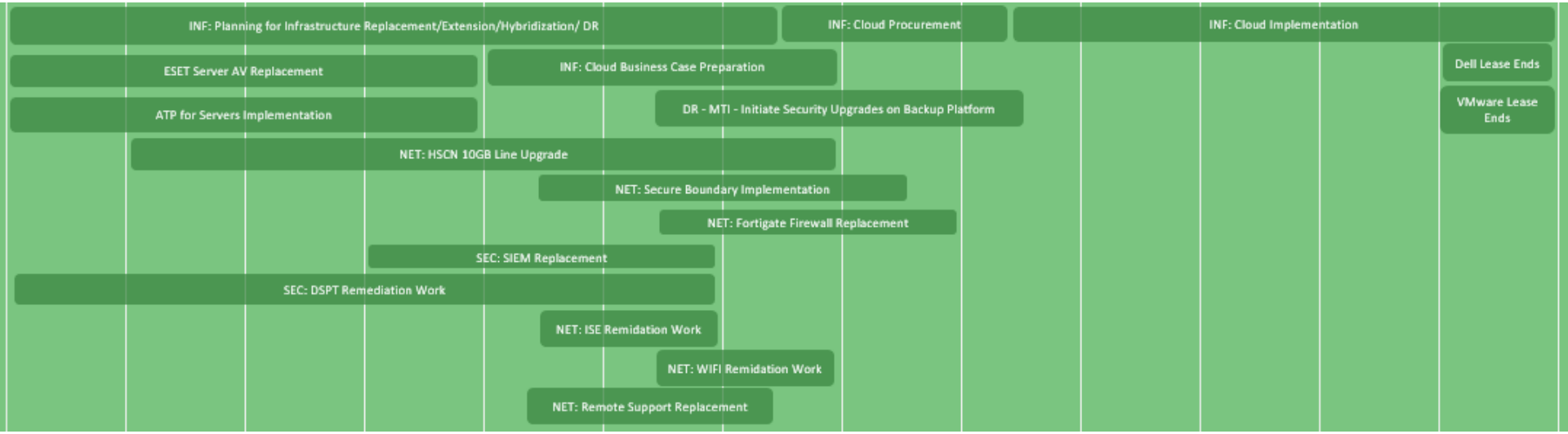
Key Service Delivery / EUC Teams

- **VDI Hardware Replacement** – All VDIs to be replaced by physical All In Ones and Laptops. Laptops will support the flexible working for staff and we are utilising the single device policy route. Extensive work over the last 2 months has been conducted to ensure the platform is ready for deployment. This will improve user expereince and future proof us for the next 5 years. Rollout throughout May – September 2021.
- **Ricoh Printer Refresh –** Joint contract with BWCH to replace our existing Ricoh printers. Will be rolled out during May 2021.



Infrastructure/Networks/Security

- **Infrastructure Replacement** – ROH Infrastructure is due for replacement in January 2022. Extensive work has been happening over the past 4 months to review the future of our infrastructure. The IT department is looking to move to next step in cloud infrastructure technologies and will be proposing a business case in the next 2 months to trust for our potential options.
- **10GB Internet Line** – Due to the increase in digital cloud technologies the trust is in the process of upgrading its internet lines from 1GB to 10GB, this will enable better speeds and enable us to access more online systems with acceptable speeds and performance.
- **NHS Secure Boundary** – This provides a perimeter security solution offering us protection against security threats. The solution uses next gen firewalls and Web application protection to protect internet from digital and cloud based threats.
- **SIEM –** Implementation of Rapid7, which will collect, naturalise and correlating log data from ROH. The Siem tool will help reduce security breaches with proactive security.
- **DSPT –** We are still working to meet out Data Security and Protection Toolkit (DSPT) targets by NHS Digital. We are working to the next key milestone which is June 2021.



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TRUST BOARD	
DOCUMENT TITLE:	**Learning from Deaths Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revel – Executive Medical Director** **John Va Faye – Associate Medical Director (Corporate)** **Amirul Haque (Clinical Governance)**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

This report outlines the progress made and main themes for the Learning from Deaths team for the year 2020-2021.
The learning from deaths process has continued to mature and develop, enhanced by the input from and dialogue with of the regional Medical Examiners. The learning from deaths team have presented the Trusts approach regionally with positive feedback from the CCG. The Covid pandemic impacted the Learning from Deaths team along with all others and the Medical Director has thanked the team on behalf of the Trust for the huge effort to maintain the register at a high standard in the context of those considerable challenges. The learning from deaths dashboard is maintained by the clinical governance team on the Trust website.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the update.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Aligned to national guidance around reporting lessons learned from deaths

PREVIOUS CONSIDERATION:

March 2021



NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Introduction

Clinical Context

The Royal Orthopaedic Hospital is a stand-alone specialist orthopaedic Trust. The clinical work varies from high-volume / low-complexity procedures to highly complex tertiary and quaternary referral work. The Trust is a designated regional centre for revision arthroplasty, the management of joint infections, spine infections and oncological work, including both axial and appendicular sarcoma.

During the Covid-19 pandemic, our urgent and emergency work, oncology and acute spine work continued. The Trust also supported the needs of the wider BSol integrated care system. During the first (Spring 2020) peak, we undertook regional trauma for the city in the form of fracture neck of femur and ambulatory trauma. Hand surgery, spinal surgery and retroperitoneal sarcoma services were also welcomed in greater numbers with clinical colleagues from University Hospital Birmingham coming across to the Royal Orthopaedic Hospital site and working more closely with the Royal Orthopaedic Hospital teams. Later, during the second peak, the trust accommodated orthopaedic surgeons from neighbouring University Hospital Birmingham in an elective context to continue with their urgent work.

About the Learning from Deaths Framework

Learning from Deaths is a national initiative designed to screen cases where patients have died and identify those where there would be material to support wider learning. The methodology involves a review of care along 5 domains outlining the patient pathway (see table 1). Reviewers are encouraged to use judgment statements and terms such as “good”, “poor”, “adequate”, “excellent” etc. These can then be collated to support a quantitative evaluation of the care delivered at each stage of care.

Table 1 Five Domains for Learning from Deaths Reviews

1.	Prehospital/pretransfer care and care within the first 24 hours
2.	Ongoing care
3.	Care during a procedure
4.	Perioperative and procedure care
5.	End of life discharge care

Many large trusts select a random sample of deaths for review and from these the quantitative score that Learning from Deaths provides can then be used to triage cases for further attention and root cause analysis. At the Royal Orthopaedic Hospital, our policy requires that we review all deaths within 30 days of surgery, be they in hospital or outside. The Covid pandemic and the change in case mix described above put significant strain on the Learning from Deaths process and the team because of the

dramatically increased numbers. As part of the tracking, incident forms were used in to provide a failsafe and a single reference point for each event. Thankfully, the number of deaths has since renormalized.

The 3 to 5 stage process involves preliminary screening, first stage review and, if required, the structured judgement review elements. As stated above, the output is a numerical score used to inform a decision as to whether a root cause analysis will be necessary or helpful.

For deaths in hospital, this forms part of a dual review as all cases are also referred to an external independent medical examiner. The patient family is involved in the process wherever necessary and staff and doctors involved are provided with pastoral support when needed.

Notable positives, improvements and initiatives

Notable positives, improvements and initiatives include:

- An update of the Learning from Deaths policy with addition of provision for patients with learning difficulties if that, should ever be needed.

- An update to the workflow to reflect addition of external medical examiner service for inpatient deaths. The External medical examiner uses a validated checklist for a standardised review of all cases referred and provides a recommendation for referral to the coroner, establishing a cause of death.

- The development of summary report back to consultant and CSL by the AMD for inclusion in appraisal document and discussion for both individual, team and organizational learning.

- Learning is presented at hospital wide audit meeting further confirming dissemination and organizational learning. Our findings have also been shared with the CCG for wider system learning.

- The AMD and representative from governance team attend the regional Learning from Deaths meeting.

Themes Identified for the Year

During the pandemic, while the Trust undertook trauma work, the data collected and presented reflected a better than average death rates for this cohort of patient benchmarked against the national hip fracture database.

A review of last year's entire Learning from Deaths output was recently presented to the Clinical Commissioning Group and at the trust wide hospital audit by the Associate Medical Director. The slides are available on request through Mr John Va Faye.

There was evidence of good decision making in highly complex patients notably in the oncology and sarcoma services.

For patients with serious and life threatening conditions a visible and constant need to make sound assessments about the balance between how a service adds "life to the days" or "days to life", or both. There are circumstances, for instance, where clinicians, patients and families feel that surgery is justified to maintain comfort and dignity near the end of life. The risks are higher here, and the benefits in these circumstances will be shorter lived, but those closely involved continue to advocate the value and meaningfulness of these interventions. Examples encountered in our reviews is palliation of a fungating tumour for local control and decompression of an advanced tumour to prevent paralysis rather than to aim for cure. Both these types of intervention are by their nature features of treating advanced disease with finely balanced judgements about the appropriateness and the timing of surgical intervention. There continues to be a very fine balance about the thresholds for such decisions, highlighted in both the Learning from Deaths and Medical Examiner reviews of admission for palliative treatment in this way.

Quality of care, perioperative care and end of life care were all judged to have been to be good to excellent. Documentation, again has been a concern in some cases. This again has been raised in both the Learning from Deaths and Medical Examiner reviews. In the main, this has been a reflection of paper health records - now near the end of life - and the need for electronic noting (project in progress).

There was one death which was judged to have aspects of avoidability and two Trusts were involved in care (please refer to the handout attachment).

Results of the Reviews

A summary analysis of the Royal Orthopaedic Hospital tracker collected by the governance team is included below:

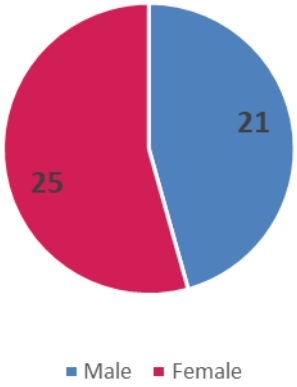


Figure 1: Gender of Learning from Deaths Cases Apr 2020 – Apr 2021

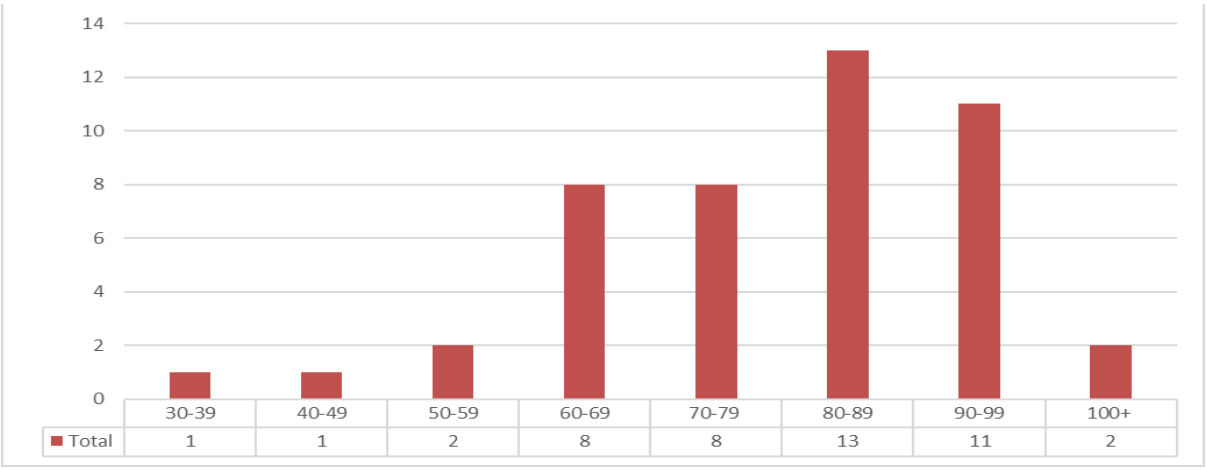


Figure 2 Age Distribution of Learning from Deaths Cases Apr 2020 – Apr 2021

Age range depicted a peak at 80-89 and 90-99 as expected.

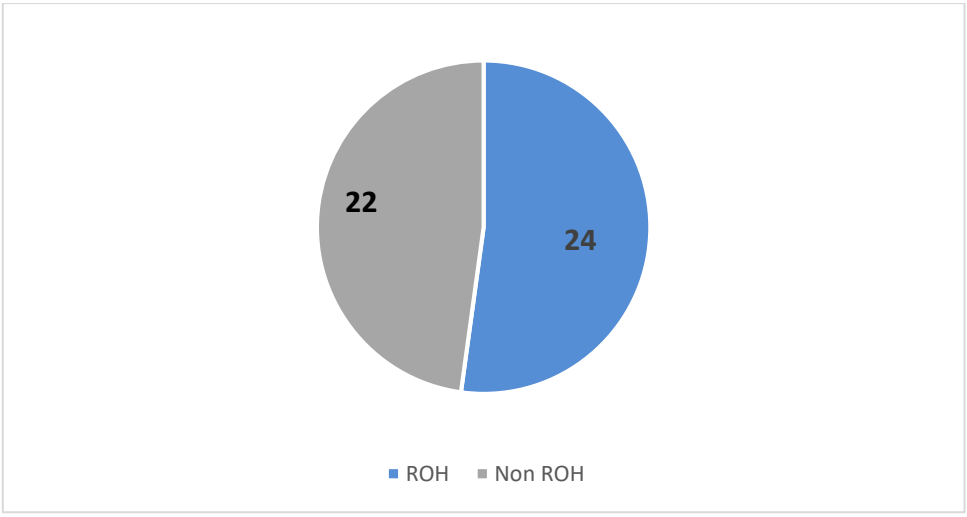


Figure 3 Place of Death for Learning from Deaths Cases

Place of death showed a near 50/50 split.

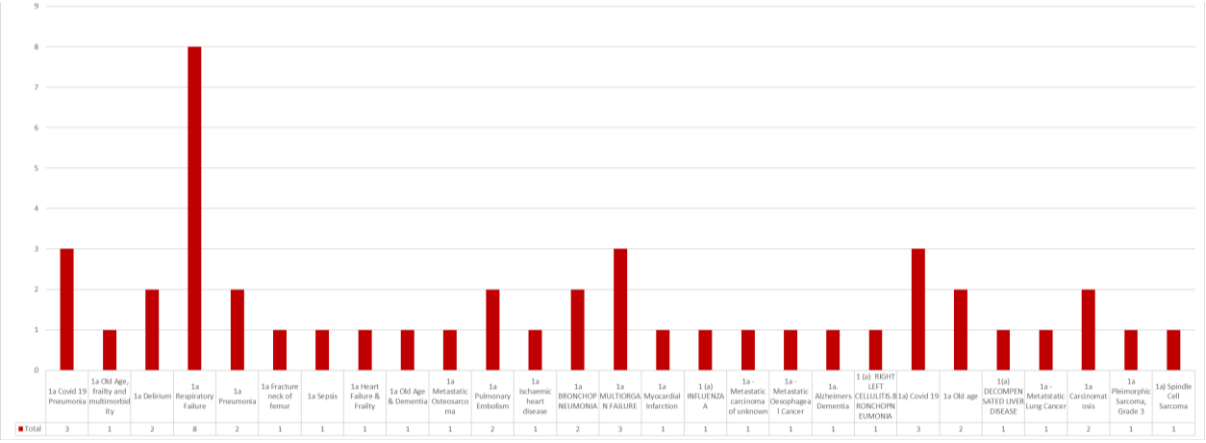


Figure 4 Causes of Death for Learning from Deaths Cases Apr 2020 – Apr 2021

Causes of death depicted in this busy figure. The peak causes of death has been respiratory cause during the Covid pandemic.

Table 2 Cause of Death in Tabular Form Apr 2020 – Apr 2021

Cause Of Death	
1a Covid 19 Pneumonia	**3**
1a Old Age, frailty and multimorbidity	**1**
1a Delirium	**2**
1a Respiratory Failure	**8**
1a Pneumonia	**2**
1a Fracture neck of femur	**1**
1a Sepsis	**1**
1a Heart Failure & Frailty	**1**
1a Old Age & Dementia	**1**
1a Metastatic Osteosarcoma	**1**
1a Pulmonary Embolism	**2**
1a Ischaemic heart disease	**1**
1a BRONCHOPNEUMONIA	**2**
1a MULTIORGAN FAILURE	**3**
1a Myocardial Infarction	**1**
1 (a) INFLUENZA A	**1**
1a - Metastatic carcinoma of unknown	**1**
1a - Metastatic Oesophageal Cancer	**1**
1a. Alzheimers Dementia	**1**
1 (a) RIGHT LEFT CELLULITIS.BRONCHOPNEUMONIA	**1**
1a) Covid 19	**3**
1a Old age	**2**
1(a) DECOMPENSATED LIVER DISEASE	**1**
1a - Metatstatic Lung Cancer	**1**
1a Carcinomatosis	**2**
1a Pleimorphic Sarcoma, Grade 3	**1**
1a) Spindle Cell Sarcoma	**1**
Total	**46 Patient Mortalities**

Table 3 Royal Orthopaedic Hospital Outcomes and Comments across Learning from Deaths domains

Table 2: Five domains for Learning from Deaths Reviews with Royal Orthopaedic Hospital Outcomes and Comments	
1. Prehospital/pretransfer and care delivered in the first 24 hours.	Patent notes were found to be of lower standard with regards to file management, however the quality of medical entry and reviews were excellent.
2. Ongoing care.	Good to excellent
3. Care during a procedure.	Good to excellent
4. Perioperative and procedure care.	Good to excellent
5. End of life discharge care.- this revealed	Good to excellent

The overall quantitative assessment bands based on scoring the qualitative reviews for the year April 20-21 were:

- Excellent 23
- Good 2
- Adequate 2
- N/A: 15 (did not fulfil SJR criteria)

Conclusions

The learning from deaths process has continued to mature and develop, enhanced by the input from and dialogue with of the regional Medical Examiners. The learning from deaths team have presented the Trusts approach regionally with positive feedback from the CCG. The Covid pandemic impacted the Learning from Deaths team along with all others and the Medical Director has thanked the team on behalf of the Trust for the huge effort to maintain the register at a high standard in the context of those considerable challenges. The learning from deaths dashboard is maintained by the clinical governance team on the Trust website.

The Royal Orthopaedic Hospital NHS Foundation Trust

Table 4 Learning from Deaths Tracker Dashboard 2020-2021

The Royal Orthopaedic NHS Foundation Trust : Learning from Deaths Dashboard - February 2020-21

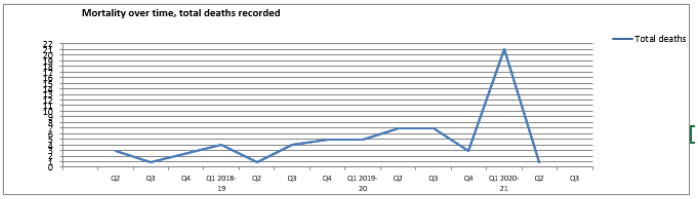
Department of Health

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	1	1	1	0	0
his Quarter (QTI	Last Quarter	his Quarter (QTI	Last Quarter	This Quarter (QTD	Last Quarter
2	3	2	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
24	22	24	22	0	1

Time Series: Start da 2017-18 Q2 End date 2020-21 Q4



Total Deaths Reviewed by RCP Methodology Score

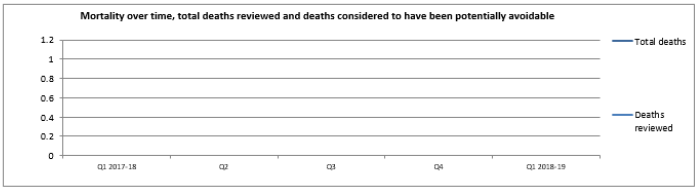
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (G	0	-	This Quarter (C	0	-	This Quarter (QT	0	-	This Quarter (QTD	0	-	This Quarter (QTD	0	-	This Quarter (C	0	-
This Year (YTD	0	0.0%	This Year (YTC	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	4.8%	This Year (YTD)	0	0.0%	This Year (YTC	20	95.2%

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

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

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

Time Series: Start da 2017-18 Q1 End date 2018-19 Q1



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quantifying and Evidencing Excellence**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revell, Executive Medical Director**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

This paper sets out the rationale and strategic approach for the Patient Progress project – the part of the Audit, Quality Improvement, Learning & Analysis Panel (AQILA) quality improvement programme that looks at moving clinical information into public, committee and clinical domains in ways it can be most useful.

The design concept and outline structure are described along with some of the challenges anticipated.

REPORT RECOMMENDATION:

The Board is asked to:

- RECEIVE and ACCEPT the paper for information.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	X

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

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

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

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

Strategic Objectives: Patients, Process, Performance, Partnerships, People.

Safe, Timely, Efficient, Effective, Equitable, Patient Centred and Improving clinical care

PREVIOUS CONSIDERATION:

ROH Clinical Strategy – AQILA Autumn 2020

QUANTIFYING AND EVIDENCING EXCELLENCE USING QUALITY OUTCOME MEASURES

Report to the Trust Board on 1 September 2021

Introduction

Excellence can be defined as the state or quality of being outstanding or extremely good, of having great merit or worth.

For the purposes of this paper the scope will be taken as that of *clinical* excellence.

Clinical excellence includes providing high quality of care in both outcome and experience.

The Trust has put Clinical Quality at the centre of our Clinical Strategy (Autumn 2021). The Clinical Outcomes and Effectiveness Committee was renamed the AQILA group in late 2020 to reflect our approach for how clinical excellence will be achieved and maintained. This will be using Audit, Quality Improvement projects, all opportunities for learning, and analysis of our performance data.

Within the AQILA group's monthly agenda there are improvement loops working to improve quality on several scales. These start at various points of an improvement cycle as well; integration of national standards, measurements of performance, questions arising when we have seen deviations from our expectations or the norm. Part of the work of the Audit and Outcomes team is to ensure that continuous improvement in clinical practice is fully understood; that the concepts and tools are embedded throughout the clinical body.

The quantitative elements of the AQILA agenda centre around patient outcomes. The Patient Progress report each month has been the vehicle through which we seek to better define, expand and broadcast our outcomes - to deliver excellence and provide the basis though which we can communicate it and celebrate it. The Trust is supporting a project collaboration with the MLCSU to develop a dashboard and reporting capability which is automated and available to those who can benefit from it.

Starting with Why?

Providing excellent clinical care for patients in the field of musculoskeletal medicine and orthopaedic surgery is the central activity, core capability and primary mission of the Trust. The Trust has developed its reputation for excellent patient care and we aim to exceed patients' expectations for their experience and their outcome every time.

Why be excellent?

The Trust needs to achieve and demonstrate excellence in clinical care for reputational, market position and financial reasons.

Clinical outcomes are likely to be better in a centre where confidence of patients and staff is high.

Why measure excellence?

Quantifying quality is necessary to drive improvement cycles and inform the baseline for improvement projects. Measurement tends to induce improvement through individual application and improved teamwork as famously described by the Hawthorne effect. Information that shows performance below an anticipated standard is just as useful as positive feedback in driving improvement; it can support reflective change to practice, encourages clinicians to gravitate towards areas where they see personal success and permits active management intervention where needed. Therefore, good

information about clinical performance is not only needed to describe the current status quo but to reach and maintain excellence.

Who needs to see evidence of clinical excellence?

For the purposes of the Patient Progress project, the intended audience has been defined on three broad levels.

1 Patients and Public

Patients and the public need accessible information about clinical performance as they select provider, research a clinician, or share decision-making with their clinical team about their care. This information is the foundation from which conversations about treatment options can take place. It complements the individual nature of the clinical relationship, where perspectives, needs and anxieties can be addressed in more detail and at a human level. It helps to boundary and bind rational informed decisions by clinical and patient partners.

2 Trust Committees

Trust committees need to have good information about performance in order to monitor and manage it. Here, trends over time and benchmarking are important common tools for interpretation. Using these instruments, a snapshot for a single point / period can be understood better in its fuller context. Further value being added from discussion among peers and from lay perspective. Variations from random chance or cyclical causes can be drawn out and sensible hypotheses around special cause variation can be made. Increasingly, good clinical data is of use to regulators in their assessments and, with care, it can be exchanged as valuable with supply chain partners as well to mutual benefit of all.

3 Clinicians and Clinical Units

Clinical units and clinicians need to review the cases that they have provided care for objectively as part of reflective learning practice. Good data can support publications and academic progress as well – of benefit at all levels of this stakeholder hierarchy.

A Patient Progress stakeholder engagement event over July/August 2021 has provided verification that this three-level structure is a reasonable way to underpin our approach.

Getting to How? The AQILA / Patient Progress Approach

The Patient Progress approach is based on supplying meaningful information at the three levels outlined above. There is awareness at the outset that meeting the quality information needs at all these three levels requires quite varied techniques. It will involve experimentation and ongoing consultation as to what information is accessible to different stakeholders. We have set ourselves the challenge of finding the right format and the right channels to reach each meaningfully. This can only be done through a multi-professional team whose focus is around communication as much as data. From a patient perspective, a new group will be tasked with supporting Shared Decision Making. It will include patients and draw together the expertise to reach out to service users. In this way, the mobilisation of our performance data will complement the planned work in other areas of the clinical strategy. In particular, the drive for decision support document and descriptive information about treatment choices that we hope will be authored by teams within the anticipated MSK Academy.

Our definition of quality has been set broadly. We have used a historical description of quality from the Health Foundation which sets out 6 domains, listed in Table 1.

Table 1 Our Chose Quality Domains

Quality Domain
Safety
Timeliness
Efficacy
Efficiency
Equitability of provision and access
Patient centred

At the same time, across all these areas, we will want to ensure that we are demonstrating excellence through improvement trajectories, learning and communicating our information well.

Within these Quality Domains our candidate outcome measures can now be mapped onto a structure (table 2). Care will be taken across the Trust to avoid duplication of effort and to ensure a single version of the truth where subject areas fall more naturally into other portfolios or will be covered more effectively in the Trust's integrated dashboard.

Table 2 Candidate Metrics for the Patient Progress Suite

DOMAIN	SUBJECT AREA	TOPIC
SAFE CARE		
	Readmissions	
	Mortality	
	Reoperations	Theatre logs / registries
	Infections	
	VTE	
	Transitions in Care	
		Emergency admissions to the Trust
		Rapid Response Team Reviews
		Unplanned admissions to HDU
		Transfers out of the hospital
	Clinical Incidents	
TIMELY CARE		
	RTT	
	Theatre starts	
	Wheels in and out / Touch time utilisation	
EFFICIENT CARE		
	Theatre utilisation	
	Outpatient metrics	
	Length of stay	
	Day case rates	
EFFECTIVE CARE		
	National PROMs	
EQUITABLE CARE		
	Protected characteristics	

	BMI
PATIENT CENTRED CARE	
	PALS contacts
	Complaints
	Friends & Family
	I want great care

We now have our basic template from which the dashboard and reporting work is based.

Design Principles

Patients and Public

Patient and public directed reports will need to prioritise accessibility and take account of the need to reassure as well as to inform service users.

Trust Committees

Within Trust committees, reports and dashboard views will use some common tools recurringly. Most figures and screens will centre on a single outcome measure. In general, we will usually want to know how we have performed over time. For this, the Statistical Process Control methodology will be the standard. We will also want to know how we rate compared with sister organisations. This can be done by direct comparison based on site – so that the other two stand-alone Orthopaedic trusts are our obvious comparators. More difficult is to control by the procedures patients have had – this will be needed when we want to compare performance about the procedures themselves. It will also be necessary when we want to compare with large trusts who provide orthopaedic care as part of a wider offering. We may want to see timeline comparisons or single period in time comparisons that show the spread of outcomes (eg box and whisker). Experimentation and pilot reporting during the year has demonstrated the usefulness of highlight tables / heat maps to spot patterns –early examples of changes in clinical practice were described in the 2020 Quality report.

Sometimes, we will want to look at the raw outcomes themselves, sometimes we may need to look as well at the value our care has added. We will always need to have some handle on the substrate and starting conditions from which we work. We will need, therefore, to break down our analysis in many cases and look at the input factors that may affect outcome (such as our patient demographics and comorbid conditions). We will also want to examine our process factors – which procedure, which team, which theatre, which ward, etc?

There are other representations that have proved helpful in specific situations – some of which are shown for interest in appendix 1.

Clinical

At clinician level there is the need to see individual performance in much the same way as at organisation level – time series and useful comparators. In addition, relevant highlight and summary reports and short patient precis can support MDT discussions and individual reflective practice alike.

During 2020-2021, the Patient Progress report has followed a work plan exploring ways of representing data for committees and for units. Lighter digests have been piloted on a monthly basis at team brief to explore their utility and accessibility.

We have found too, how valuable data can be in bringing together clinical leaders who care passionately about the quality of the services they provide, want them to be the best they can be and want objective feedback as they build their services. Well-presented information brings people together across disciplines and professions, encourages ownership and supports a solution focus.

Pitfalls – and the need to commit and communicate.

At the outset, there is an understanding that no data is perfect and its use is in generating the right thoughts and discussions in the right context. Evidence is different from a verdict; often our verdict will need to return to narrative rather than direct action on a single figure or a single perspective.

The team are conscious that the Trust's specialist status brings opportunities and challenges. In some areas (for example mortality) we have small numbers and specialist inputs that disqualify is from being able to use widely available comparison indicator tools (HSMR,SHMI). In other areas, such as joint replacement, we are national leaders in terms of numbers. The amount of movement we have around the mean is small (we are strong influencers of the average). We will need therefore to be conscious of scale as we design and build reports.

Despite of these potential restrictions there are still a myriad of perfectly valid ways of looking at many of our outcomes. Figure 1 shows the Trusts current position (accessed August 2021) on available mortality measures.

Indicator	Current	Previous	Change	Peer	National	Position
Number of mortalities (12 mth rolling) HES Inpatients (Jul 2021)	120 (Jun 2020 - May 2021)	160 (May 2020 - Apr 2021)	-40 →	3,783*	2,978*	
Number of in-hospital mortalities (12 mth rolling) HES Inpatients (Jul 2021)	7 (Jun 2020 - May 2021)	17 (May 2020 - Apr 2021)	-10 →	1,888*	1,423*	
Number of out-of-hospital mortalities (12 mth rolling) HES Inpatients (Jul 2021)	113 (Jun 2020 - May 2021)	143 (May 2020 - Apr 2021)	-30 →	1,895*	1,527*	
HSMR (monthly) HES Inpatients (Jul 2021)	-	-	No Change	98.30	99.62	Within expected range
HSMR (12 mth rolling) HES Inpatients (Jul 2021)	85.19 (Jun 2020 - May 2021)	149.01 (May 2020 - Apr 2021)	-63.82 →	100.39	97.08	Within expected range
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Jul 2021)	67.93 (Jun 2020 - May 2021)	124.32 (May 2020 - Apr 2021)	-56.39 →	98.73	96.48	Within expected range
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Jul 2021)	78.49 (Jun 2020 - May 2021)	163.95 (May 2020 - Apr 2021)	-85.46 →	98.74	95.44	Within expected range
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Jul 2021)	108.30 (Jun 2020 - May 2021)	102.37 (May 2020 - Apr 2021)	5.93 ←	105.33	102.00	Within expected range
Average co-morbidity score (HSMR) - all conditions (12 mth rolling) HES Inpatients (Jul 2021)	1.8806 (Jun 2020 - May 2021)	1.9274 (May 2020 - Apr 2021)	-0.0468 →	5.3103	5.1359	
NRLS - Incidents resulting in severe harm or death (biannual) NRLS (Sep 2020)	0.00 (Oct 2019 - Mar 2020)	0.16 (Apr 2019 - Sep 2019)	-0.16 →	0.15	0.23	
Deaths in low-risk diagnosis groups (12 mth rolling) HES Inpatients (Jul 2021)	0.00% (Jun 2020 - May 2021)	0.00% (May 2020 - Apr 2021)	No Change	0.06%	0.06%	
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2021)	0.09% (Jun 2020 - May 2021)	0.23% (May 2020 - Apr 2021)	-0.14 →	1.68%	1.52%	
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2021)	1.46% (Jun 2020 - May 2021)	2.12% (May 2020 - Apr 2021)	-0.66 →	3.36%	3.19%	
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2021)	0.38% (May 2021)	0.37% (Apr 2021)	0.01 ←	2.25%	2.11%	
Crude out-of-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2021)	1.37% (Jun 2020 - May 2021)	1.89% (May 2020 - Apr 2021)	-0.52 →	1.68%	1.66%	

Figure 1 Mortality Metrics Available

In fact, Figure 1 starts to illustrate another issue to navigate in narrowing down the choice of metrics. In the case of mortality, what time window is relevant and how far back do we want to go? Are we worried about patients who die in hospital, those that die within 30 days, 90 days, beyond that? Who do we want to compare to? When we compare, can we make any correction for the complexity or co-morbidities in the cases? When we look at small numbers there is a lot of variation month to month – can we find a way of smoothing that out fairly and scientifically? Then, how can we communicate a figure meaningfully without raising anxiety?

Clearly, part of the skill will be to commit to and communicate the most relevant measures. By design, by consulting and by experimenting.

When?

The project team aims to have minimum viable product that can be put to practical use and shared with provider partners regionally and nationally within 12 months.

The approach will be modular and largely outcome measure by outcome measure. The need for continuing to report clinical outcomes in real time and to consult as we move information out into the public domain will mean that output will be visible in certain contexts earlier in 2022.

Conclusions

This report has outlined the ambition, philosophy and main building blocks of the AQILA programme and the Patient Progress project. Some examples of visualisations are included for interest in appendix 1. Project initiation documentation is included in appendix 2.

Appendix 1 – Visualisation Examples

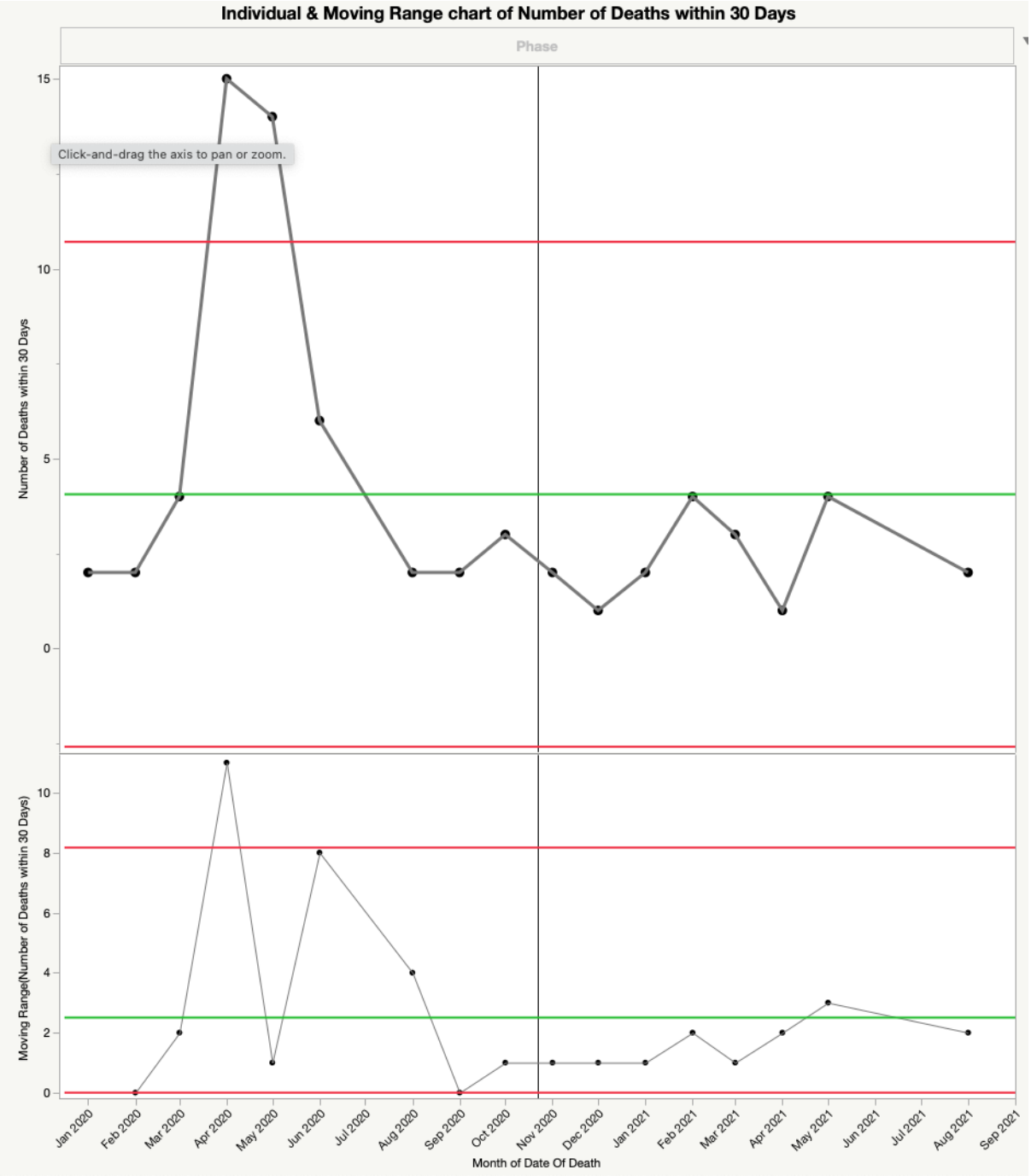


Figure 2 Example of SPC Chart - current position on 30 day mortality

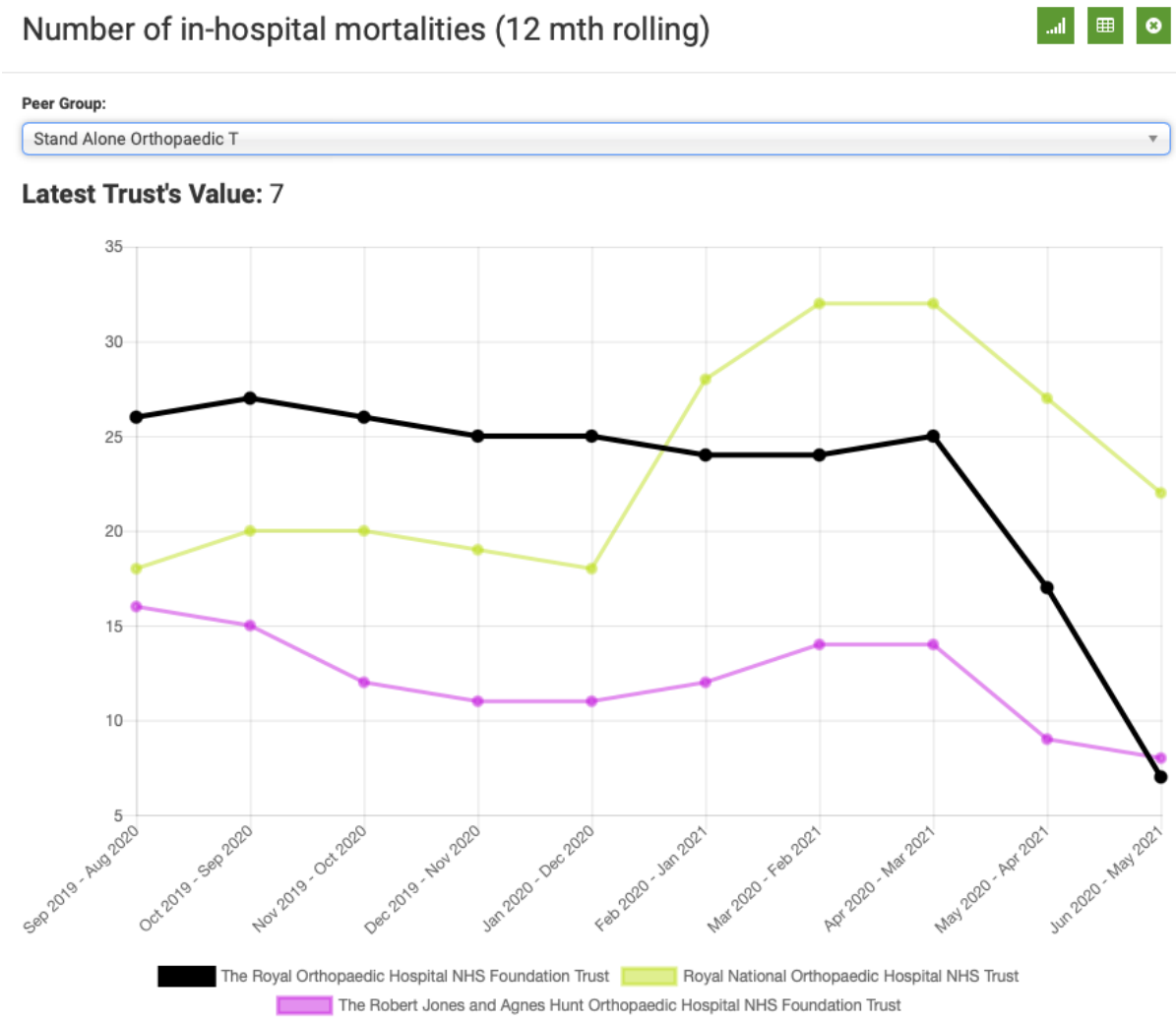


Figure 3 Time Series Benchmarking of Inpatient Mortality

Deaths within 30 days by Unit April 2017 to June 2021

Service Unit	Mortality Outcome	Date of Death 2017	2018	2019	2020	2021	Grand To..
Null	1-7 DAYS					1	1
	8-30 DAYS					2	2
	DEATHS IN HOSPITAL				1		1
	Total				1	3	4
Arthroplasty	1-7 DAYS				1		1
	8-30 DAYS	2		5	5		12
	DEATHS IN HOSPITAL	2	1		10	1	14
	Total	4	1	5	16	1	27
Arthroscopy	1-7 DAYS		3	1	2		6
	8-30 DAYS	4	1		2		7
	DEATHS IN HOSPITAL				10		10
	Total	4	4	1	14		23
Null	8-30 DAYS	2	4	2			8
	Total	2	4	2			8
Oncology	1-7 DAYS	2	2	3	3		10
	8-30 DAYS	6	6	5	7	2	26
	DEATHS IN HOSPITAL		2	1	2	2	7
	Total	8	10	9	12	4	43
Paediatrics	8-30 DAYS			1	1		2
	Total			1	1		2
Plastic Surgery	DEATHS IN HOSPITAL		1				1
	Total		1				1
Radiology	1-7 DAYS	2					2
	8-30 DAYS				1		1
	Total	2			1		3
Small Joints	8-30 DAYS					3	3
	DEATHS IN HOSPITAL				1		1
	Total				1	3	4
Spines	1-7 DAYS	2	3		1		6
	8-30 DAYS	8	12	5	6		31
	DEATHS IN HOSPITAL	2	3	2	1		8
	Total	12	18	7	8		45
Trauma	1-7 DAYS					2	2
	8-30 DAYS					1	1
	Total					3	3
Grand Total		32	38	25	54	14	163

Figure 4 Use of Hightlight Tables / Heatmaps to Look for Patterns at Unit and Clinician Level

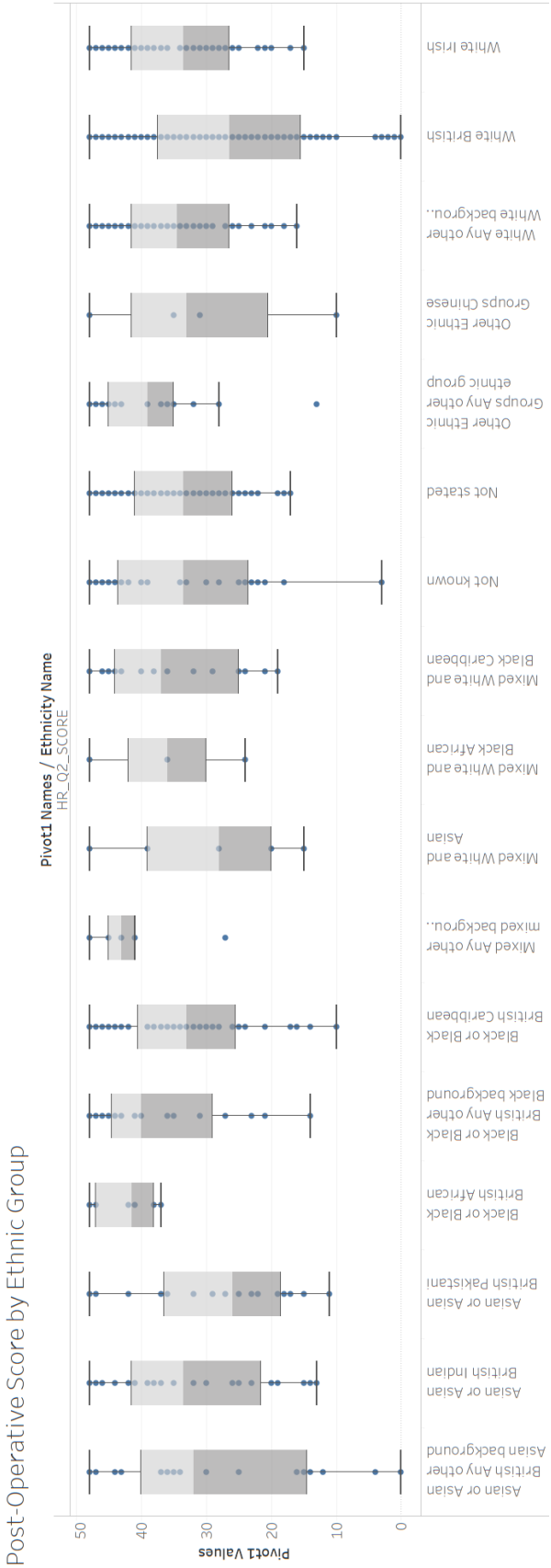


Figure 5 Using Box and Whisker Plots to Compare Outcome between Different Groups (Can be patients, clinicians, teams etc)

Figures 6 onwards – innovative ways of displaying complex information – Patient reported outcome measures for hips contain 12 questions each scoring 0-4. A score of 48 is full hip health. In these diagrams the bigger the circle – the healthier the hip! The following some pilot work exploring equitability of access to good clinical outcomes.

Pre and Post Op

Domain	Pre-Op or Post Op: Pre-op	Post-op
WASHING	2.223	3.478
WALKING	1.884	3.447
TRANSPORT	1.851	3.301
STAIRS	1.871	3.259
STANDING	1.715	3.432
SHOPPING	1.741	3.171
SUDDEN_PAIN	1.402	3.467
DRESSING	1.529	2.904
WORK	1.261	3.330
NIGHT_PAIN	1.013	3.281
LIMPING	0.692	3.143
PAIN	0.604	2.970

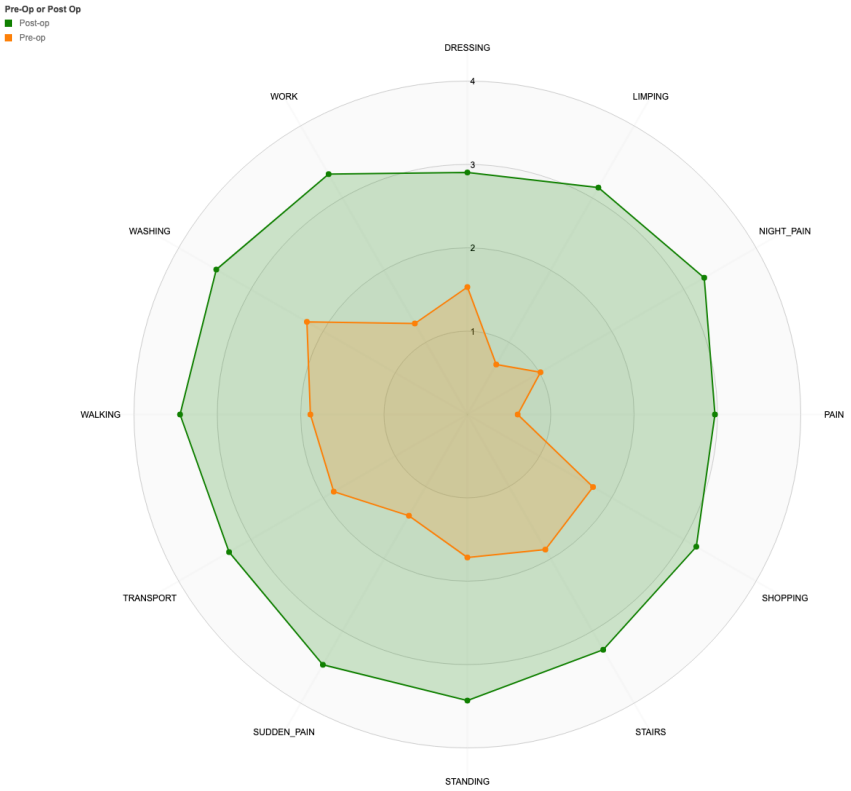


Figure 6 The Difference Between Pre-operative and Post Operative Scores for Hip Replacement

Pre-Op Scores by Ageband

	AGE (bin)		
Domain	30-60	60-90	>90
DRESSING	1.576	1.509	1.000
LIMPING	0.685	0.705	0.366
NIGHT_PAIN	0.841	1.093	1.203
PAIN	0.628	0.594	0.351
SHOPPING	1.958	1.657	0.767
STAIRS	2.063	1.789	0.918
STANDING	1.771	1.688	1.451
SUDDEN_PAIN	1.222	1.495	1.486
TRANSPORT	1.916	1.826	1.192
WALKING	2.015	1.837	1.169
WASHING	2.165	2.262	1.716
WORK	1.226	1.288	0.712

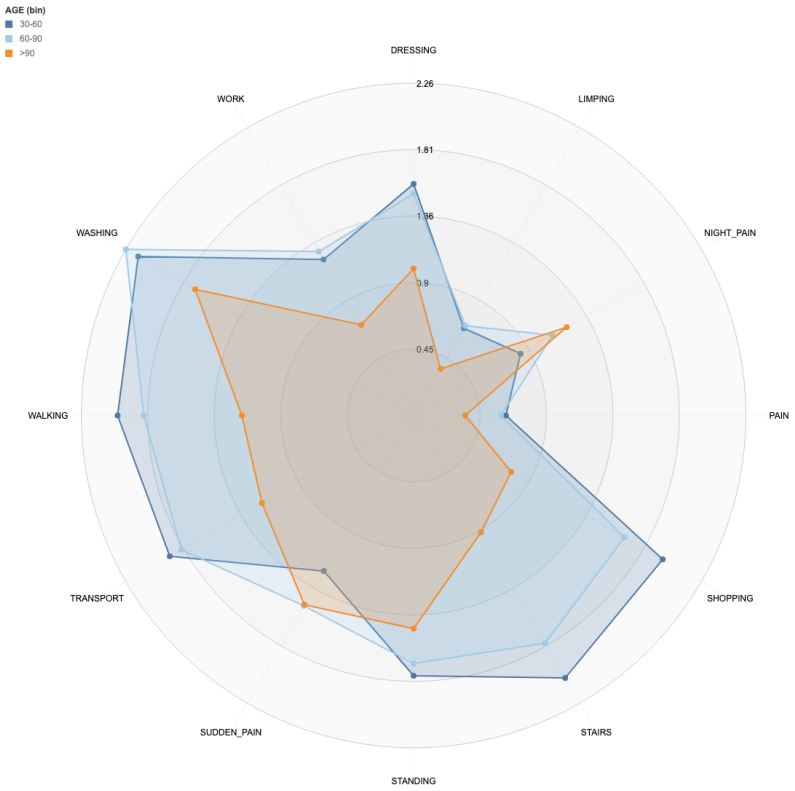


Figure 7 Pre-Operative Differences in Hip Replacement outcome by age

Post-Op Scores by Ageband

	AGE (bin)		
Domain	30-60	60-90	>90
DRESSING	3.004	2.870	2.705
LIMPING	3.155	3.143	3.068
NIGHT_PAIN	3.232	3.299	3.682
PAIN	2.969	2.970	2.955
SHOPPING	3.367	3.112	1.955
STAIRS	3.428	3.205	2.455
STANDING	3.449	3.425	3.455
SUDDEN_PAIN	3.349	3.513	3.705
TRANSPORT	3.372	3.276	3.045
WALKING	3.537	3.422	2.841
WASHING	3.440	3.494	3.364
WORK	3.316	3.336	3.295



Figure 8 Post Operative Difference in Hip Replacement by Age

Preoperative

Domain	Gender	
	Female	Male
DRESSING	1.478	1.597
LIMPING	0.701	0.679
NIGHT_PAIN	0.903	1.160
PAIN	0.540	0.689
SHOPPING	1.514	2.044
STAIRS	1.712	2.085
STANDING	1.606	1.861
SUDDEN_PAIN	1.362	1.455
TRANSPORT	1.758	1.975
WALKING	1.775	2.027
WASHING	2.187	2.272
WORK	1.175	1.375



Figure 9 Pre-operative Differences in Hip Health by Gender

Postoperative

Domain	Gender	
	Female	Male
DRESSING	2.8954	2.9157
LIMPING	3.1042	3.1989
NIGHT_PAIN	3.1929	3.4092
PAIN	2.8715	3.1120
SHOPPING	3.0157	3.3964
STAIRS	3.1420	3.4294
STANDING	3.3929	3.4885
SUDDEN_PAIN	3.4263	3.5261
TRANSPORT	3.2493	3.3763
WALKING	3.4016	3.5127
WASHING	3.4828	3.4720
WORK	3.2761	3.4061

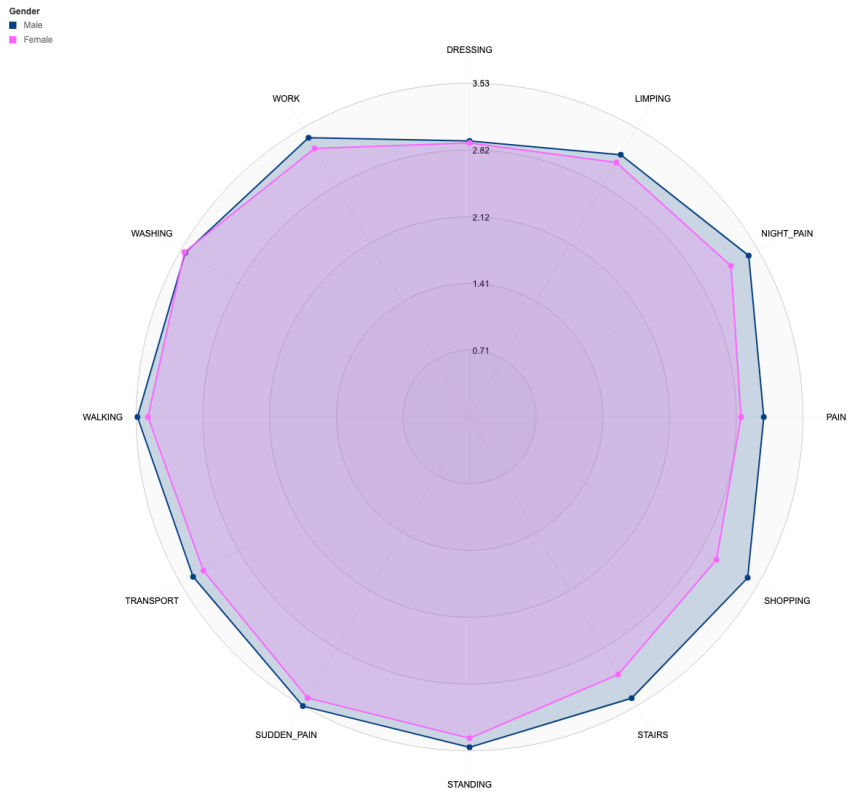


Figure 10 Post Operative Differences in Hip Health by Gender - Men are better self reported shoppers?!

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Designated Body Annual Board Report 2021**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director / Responsible Officer**
AUTHOR:	**Matthew Revell, Jamie McKenzie, Alison Newman**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

The Trust was not required to and did not submit a report last year due to the COVID-19 pandemic.

This year's review documents stable delivery of appraisal and revalidation over the pandemic period, evidences incremental gains and improvements, emphasises the pastoral elements of the appraisal process and sets out the key priorities for next year, when a medical directorate manager will be in a position to support projects to improve audit (quality assurance) and whole practice review of appraisal.

REPORT RECOMMENDATION:

The Board is asked to:

- NOTE the report and check and challenge as appropriate.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

People, Patients elements of the Trust's strategy

PREVIOUS CONSIDERATION:

2019. Annually henceforth.

RESPONSIBLE OFFICER'S ANNUAL REPORT 2021

Contents

Designated Body Annual Board Report 2
Section 1 – General: 2
Section 2a – Effective Appraisal 4
Section 2b – Appraisal Data 6
Section 3 – Recommendations to the GMC 7
Section 4 – Medical governance 8
Section 5 – Employment Checks 11
Section 6 – Summary of comments, and overall conclusion 12
Section 7 – Statement of Compliance: ..... **Error! Bookmark not defined.**

Designated Body Annual Board Report

Section 1 – General:

The Trust Board of Royal Orthopaedic Hospital NHS Foundation Trust can confirm that:

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

Action from last year: -
Comments: **Yes. The current Responsible Officer has been in post since February 2019 and completed Responsible Officer training on 25 and 26 June 2019.**
Action for next year: **Inclusion of Deputy Medical Director as part of resilience and succession planning.**

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: **Directorate manager appointment to provide further support**
Comments: **Further support for the medical directorate agreed in 2020, now advertised and will be in place before early 2022**
Action for next year: **Directorate manager to improve intelligence around whole practice by liaising with local private providers. Increased capacity for audit / quality assurance of appraisals.**

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:
Comments: **Yes. This is triangulated with GMC Connect and the Equiniti appraisal system**
Action for next year: **Appraisals electronic system contract review**

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:
Comments: **Yes. Policies are in place and are reviewed by the Responsible Officer as required.**

Action for next year:

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year Comments: **Peer review not undertaken in 2020 due to Covid-19 pandemic** Action for next year: **Peer review to be undertaken in 2022**

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

Action from last year: Comments: **Junior doctors forum now 4-6 weekly. Additional MD meetings with GP trainees x3 per placement. Identified clinical lead for locum doctors. New Clinical Service Lead for Medical Workforce in post. Guardian of Safe Working lead new post holder.** Action for next year: **Medical Workforce meeting commencing under CSL Medical Workforce to commence 2021 reporting in to People Committee. Will included as members representatives from all doctors and relevant allied professionals.**

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year:
Comments: **Following national guidance appraisals for medical staff in the Trust were suspended during the peak of the Coronavirus pandemic. Appraisals were restarted by popular consent and with the agreement of JLNC for medical. However, some appraisals may take place over 12 months since the previous appraisal**
Action for next year: Full realignment of appraisal schedules.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:
Comments: **Yes all appraisals are reviewed on an individual basis and advice taken when necessary.**
Action for next year:

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

Action from last year:
Comments: **There is an Appraisal and Revalidation Policy in place which has recently been reviewed by the Responsible Officer**
Action for next year:

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Comments: **A further 6 appraisers have been appointed and training has been completed.** Action for next year:

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

Action from last year: Comments: **The Appraisal Lead reviews all appraisal outputs. Feedback is received regarding all appraisers as part of the electronic appraisal system. Support is provided by the Appraisal Lead and Revalidation Support Assistant.** Action for next year:

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Paterson report review and gap analysis presented to Board 2021. Comments: **Professional Practice Advisory Panel instigated and first meeting held (Responsible Officer Advisory Group). Annual Board report** Action for next year: Mature advisory panel.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	95
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	55
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	40
Total number of agreed exceptions	-

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:
Comments: **Yes. No issues have been raised at the GMC Liaison meetings**
Action for next year:

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:
Comments: **All recommendations, including reasons for deferral, are recorded**
Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Comments: **Incident reporting, complaints, learning from deaths and key risks discussed regularly at weekly exec triumvirate governance meeting with the divisions and monthly Executive Quality and Safety meeting. Improved audit and outcomes team visibility. Monthly combined clinical audit and monthly model hospital club.** Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Comments: **Some improvement in SSI and litigation data still to be identified. Improved feedback around mortality and readmissions at clinician level. New information available to clinicians through early adopter of the National Consultant Information Scheme.** Action for next year: **To include Friends and Family and I Want Great Care data**

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: **MHPS policy (completed). Refreshed disciplinary policy.** Comments: **Responding to Concerns Policy in place. Professional Practice Advisory Group meeting established.**

Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: Comments: **Quarterly Professional Practice Advisory Group meetings established 2021. All events above threshold discussed and documented with HR.** **GMC Liaison Meetings now include invitations to the Deputy Medical Director and Head of Human Resources** Action for next year: **PPAG to include BMA input as well as HR**

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: Comments: **Use of MPIT forms and direct contact with other Responsible Officers if necessary. Evidenced escalation of cases when raised at ROH. Improved regional contact between medical directors with regular meeting.** Action for next year: **BSol ICS will further enhance and mature inter-organisational links.**

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: **Professional Practice Advisory Panel – discussed with BMA and will include access. Associate Director of HR is a member.** Action for next year:

Section 5 – Employment Checks

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

Action from last year: **Consultant appointments policy (complete). Improved HR support and process.**
Comments: **New appointment in 2021 of dedicated and experienced medical staff manager in HR. Breach in early 2020 reported to GMC – failure of internal controls was human error.**
Action for next year: **New medical HR manager commencing**

Section 6 – Summary of comments, and overall conclusion

Difficult year for doctors to keep up with appraisal and revalidation and indeed to interpret in reflection all the events and experiences of the Covid pandemic.

As per the national guidance appraisal has emphasised the pastoral element of annual review.

Appraisal and revalidation were recommenced quite early – during autumn 2020. This was because of the number of requests for appraisal and followed an internal consultation. The move was actively encouraged by the JLNC.

Overall conclusion:

Satisfactory maintenance and continuing to exploit marginal gains. The hope is that there will be key projects possible during 2022 with the arrival of the new directorate manager to support links with the private sector and audit of whole practice.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body J Williams

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

J Williams (CEO)

Official name of designated body: The Royal Orthopaedic Hospital (ROH)

Name: J Williams Signed: J Williams

Role: CEO.

Date: 23/8/21.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Staff Survey Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Sharon Malhi (AD Workforce & OD)/Clare Mair (Head of OD & Inclusion)**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

This report provides an update with regards to the staff survey action plan and provides a brief summary of plans for the 2021 staff survey.

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

People element of the Trust's strategy

PREVIOUS CONSIDERATION:

Draft action plan considered by the Board in June 2021

National staff survey update

Trust Board September 2021

Sharon Malhi
Associate Director of Workforce and OD

Engagement plan - update

Phase 1: Analysis, Interpretation, Message refinement and development – by end of April 21

Share results infographic with organisation
Engagement with Exec Team, Individual Execs, key staff members and groups e.g. Staff side, People Committee, SE&OD, Trust Board and also You Said, We Did
Communication packs using different formats

Phase 2: Sharing organisation action plan – by end of May 21

Full review of results and development **of organisational action plan**
Messaging across comms channels including intranet page
Exec to develop actions plans in Directorates
Focus group to inform action planning
Listening sessions with Staff network groups

Phase 3 : Message delivery – by end of June 21

Infographics around key areas
Launch of action plan with theme of You Said, We did
Integration into business planning
Reporting back to Trust Board

Key themes – linked to Action plans

- HEALTH WELLBEING AND SAFETY
- BULLYING AND HARASSMENT
- STAFF ENGAGEMENT
- LINE MANAGERS AND TEAM-WORKING
- CAREER PROGRESSION AND RETENTION
- ENGAGEMENT WITH SENIOR MANAGERS

Key outcomes from Staff survey results data

- Good engagement from Directorates supported by Executive Directors and senior leaders
- Improved engagement with staff members at focus groups and team meetings to understand the results and focus on improvements
- Progress made on Organisational Action plan based on key themes
- Some progress on Directorate plans (again using key themes)
- Key themes emerging across the Directorates
  - Communication
  - Time/Support with Manager

Planning for 2022

- Planning started for next survey cycle with start on October 4th at the latest
- Quality Health (QH) will partner on project for Trust in 2022 – one year contract
- Follows Capita Business Systems ceasing service and review of approved suppliers
- One year contract only with QH due to regional work across ICS
- Requirement for data cleanse to enhance reporting on results (ESR tidy up)
- Metrics/impact work will be completed in January
- New Quarterly staff survey results will start in January 2022

National Staff Survey (NSS) – Organisational Plan 2021/2022

What you told us and why it's important		Action	Lead/Champion	Target Date	Progress
1	Staff receiving Health and Wellbeing messages and information	Build a network of Wellbeing champions in all areas of the Trust to help with sharing information	Health and Wellbeing Team Support from departments	November 2021	Good progress is being made to recruit champions from different departments including clinical and non clinical areas` Work will continue as part of the Health and Wellbeing (H&WB) week in September Non Executive Director appointed to Wellbeing Guardian role
2	Continue and improve practice for incidents in relation to learning and feeding back	Strengthen ways to disseminate learning from incidents	Governance	Ongoing	All Execs have received a refresher on the current process for disseminating learning Divisional level meetings have been strengthened and speciality meetings are being established Clinical audit presents key learning from incidents which ensures engagement with medical colleagues Nurse development programme will be re-introduced with a particular focus on learning from incidents

					Work planned to ensure that all wards and departments ensure that 'learning from incidents' is a standing agenda item Work underway with comms to ensure that learning rom incidents features in key mediums such as ROH Life and a plan to reintroduce 'Learning Leaflets' for staff
3	Continue with work around zero tolerance, civility and respect	Introduce e learning training material on micro aggression accessible for all staff	Learning and Development Inclusion	October 21	Topic to be included on the restarted Mandatory training as part of the Inclusion sessions. October review date to allow for feedback HR, OD and FTSU Guardian to meet with National Civility and Respect team in September
4	Communicate to all staff updated policies aimed at tackling bullying and harassment	Revise the Trust Induction Bullying and Harassment policy	Policy holders Inclusion Line Manager briefings	December 21	To align with Point 3 above
5	Ensure staff are able to contribute and speak up	Staff network celebration and listening session to understand other networks staff would like to join	Network leads Staff and Line Managers	Ongoing	Staff network celebration to take place in September to include survey on ideas for other staff networks Staff networks will be part of Health and Wellbeing week (H&WB) – September 21

					Current network leads linking in with system and regional networks Scoping options to restart face to face meetings
6	Establish new Freedom to Speak up approach	Development network of Freedom to Speak up champions	Freedom to Speak up Guardian	November 21	FTSU Guardian has been recruited and will start in September 21. Freedom to Speak Up champions to be recruited through September and October and will be in place by November 21.
7.	Enable teams to introduce themselves to each other	Introduce 'Quick guide' to each department using visuals and photos	Comms team Inclusion Departments	December 21	Not started but planned for completion in December 21
8	Create a seamless patient journey through one team approach	Opportunities for staff to visit/work in other departments to understand better the patient journey	Comms team Departments	January 21	Not due to be started until October 21
9	Enhance current approach for induction to include working together across teams	Update 100-day programme to highlight the importance of working together for the patients	Learning and Development Inclusion Comms team	TBC	Delay to restart of 100 day programme due to restrictions
10	Engaging staff with Staff Survey actions and progress	Poster and marketing collateral showing action plan (including each Directorate)	Comms team Health and Wellbeing Inclusion	August 2021	Initial information has been shared with colleagues and work is now started on the final poster to show progress – delay in completion but will be communicated by September 2021

11	Establish ways for non-clinical staff to understand their impact on patient care	Non clinical staff attending Coffee and catch up session and other similar patient facing interventions	Wellbeing Inclusion Coffee catch project team	January 2021	Not due to be started
12	Campaign to promote an all equal approach for colleagues in line with a sense of belonging	Educate line managers on promoting a 'non banding' conversation approach to communication in departments	Inclusion with departments to support	To be defined by national project team	Trust selected to be part of national pilot scheme to review non banding language and approach across the NHS organisations. Initial meeting in September
13	Support line managers in communicating with staff	Rolling out key programmes including 'Me as Manager' and refreshed Management Skills programme (MSP) with toolkit and key skill development messaging to team	Learning and Development Comms Team Inclusion team	Ongoing with review in October 2021	Next cohort for MSP to start in January 2022 Nursing programme due to restart in January 2022 Fortnightly Health and Wellbeing calls continue managers with information being sent out
14	Provide session to promote opportunities for all staff to progress and develop	Career and development focussed event to be run as a drop-in session in central location as well as in specific departments. To include Career Path Finder Tool	Learning and Development OD and Inclusion	September 2021	Sessions being run in individual departments by Clare Felkin Career development session to be run as part of the Health and Wellbeing week The Career Pathfinder tool will also be shared on the intranet
15	Looking ahead to how senior managers can now visit departments post-COVID	Mirror Check and Chat and staff walkabout principles to be used by managers at difference levels	OD and Inclusion Managers	December 2021	Work has started informally but not due to be started until October 21

16	Provide clear engagement tools for managers at all levels	Easy formats for managers to distribute key information and enhance different ways to communicate within teams	OD and Inclusion Comms All Managers	Ongoing	HR & OD team started work scoping Team Engagement Diagnostic (TED) tool with support from Lancashire NHS Trust Training for project to commence by November 21

ROHTB (9/21) 009 & 009 (a)

TRUST BOARD

DOCUMENT TITLE:	**Annual governance reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Phil Begg, Director of Strategy & Delivery** **Garry Marsh, Director of Nursing & Clinical Governance**
AUTHOR:	**Various**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

The following annual reports have been considered as part of the routine cycle of business for the Quality & Safety Committee, where the operational leads/authors have presented them for scrutiny and approval to submit to the Trust Board for approval.

The reports, with the Board's approval will be published on the Trust's internet site as evidence that there is compliance with key pieces of legislation and national guidance.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the annual reports
- AGREE to their publication of the Trust's internet site

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

Compliance with key pieces of legislation.

PREVIOUS CONSIDERATION:

Quality & Safety Committee in June and August 2021.

Annual Fire Safety report for the year 2019/20

Sponsor (Executive Director): Professor Phil Begg Director of Strategy and Delivery

Author: Stuart Lovack Associate Director of Estates and Facilities

1. Fire Incidents:

Fires:

In the year April 2019 – March 2020, we experienced no fires within the site at The Royal Orthopaedic Hospital.

False alarms:

The Trust experienced a record low number of 18 false alarm calls last year, with only two attendances by the Fire and Rescue Service. During the previous year we experienced 43 false alarms to which the Fire and Rescue Service attended 24 times.

There are extensive practices and procedures in place to reduce the potential for ignition and false alarms.

2. Governance:

Fire safety policy:

The Trust has a detailed fire safety policy, setting aims and objectives for the management of fire safety and fire safety standards, outlining the role and responsibilities for all staff, and setting standards for fire safety.

Fire risk assessments and audits:

The Trust fire risk assessment and audits are up-to-date. All areas are audited annually by the fire safety advisor. All clinical areas are provided with local fire safety manuals which include the procedures for a local response to fire.

The standard of fire safety management identified through the audits is generally very good. Some departments struggle with a lack of storage space which can lead to the storage of equipment and materials in corridors.

The Estates Department continues to work closely with department leads where necessary to overcome these difficulties, setting standards for storage in these areas where it simply cannot be relocated.

Fire Safety Group:

The Trust has an active fire safety group, which meets every 3 months.

Reporting:

A fire safety report is a standing item and presented at the Trusts Health and Safety Committee meetings.

External Scrutiny:

The Trust has not been subject to audit or inspection by the Fire and Rescue Service during the past year. However, past inspections have expressed satisfactions with our practices and procedures.

3. Training:

Fire safety training

The regular face-to-face fire safety training sessions were suspended last year due to the need for social distancing and the COVID-19 epidemic; staff have been accessing an on-line fire safety training presentation.

Fire safety training is kept under constant review, and although face-to-face sessions are due to restart in September, recommendations will be made for ward-based training for senior clinicians who will have to take charge of the local response to fire incidents.

Separate sessions (currently subject to social distancing restraints) are provided for Fire Safety Wardens and Trust Duty Managers who take hospital wide responsibility for the response to fire incidents.

4. Ongoing Plans:

In recent years the Trust has supported improvements to the estate, upgrading structural fire precautions, such as:

- Replacing walls and floors that have been penetrated or damaged;
- Making improvements and updating the site fire alarm system;
- Ongoing commitment to general maintenance of all other preventative and protective measures.

Recommendations will be made for the provision of ‘fire scene manager’ training to senior clinicians in their area of work.

Undertake a review of the current Fire Safety Management Policy, in line with good practice.

5. Conclusions:

The overall performance in the past year, has been one of the best, and displays an awareness by all staff in the importance of fire safety.

The Trust continues to promote the importance of fire safety awareness, and ensure that there is no place for complacency.

Stuart Lovack
Associate Director of Estates and Facilities

The Royal Orthopaedic Hospital NHS Foundation Trust

Safeguarding Annual Report

2020 – 2021



Safeguarding Annual Report - 2020-2021

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1. Introduction

1.1 This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within The Royal Orthopaedic NHS Foundation Trust for the period April 2020 to March 2021. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of Safeguarding Accountability and Assurance Framework (SAAF) (2015 updated 2019), Section 11 Children Act (2004), Working Together to Safeguard Children (2018) and the Care Act (2014).

1.2 In addition, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance, respectively.

1.3 The report highlights areas of priority and activity and those areas requiring further focus and development in order to strengthen the safeguarding processes within the Trust, and meet the increasing complexities of the national and local safeguarding agenda.

1.4 The Safeguarding team's vision supports that of the Trust vision and strategy which is:

"To be the first choice for orthopaedic care". The team provide advice and support and we are dedicated to ensuring that we listen to the voices of the vulnerable and act upon what we hear.

1.5 The Trust employs 1095 substantive staff and has 83 volunteers, with 179 bank staff.

1.6 Safeguarding is an increasingly complex and challenging environment. For vulnerable adults at risk there is the need to balance the rights and choices of an individual, with the Trust's duty to act in their best interest and protect them from harm. Children and young people continue to experience abuse from within and outside their families, including criminal and sexual exploitation, gang related abuse and radicalisation. This is an area of multi-faceted abuse which is often hidden and can be difficult to identify and monitor.

2. National and Local Safeguarding Context, Guidance and Key Legislation

2.1 Key Legislation

- Children Act 1989 and 2004
- Human Rights Act 1998
- Sexual Offences Act 2003

- Female Genital Mutilation Act 2003
- Data Protection Act 2018
- United Nations Conventions on the rights of the child 1990
- Children Act 2004; statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11
- Children and Social Work Act 2017
- Mental Health Act 2007
- Human Rights Act 1998
  Article 5 - Right to Liberty and Security
  Article 8 - Respect for Private and Family Life
- Mental Capacity Act 2005 and Mental Capacity Amendment Act 2019
- Health & Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Crime and Disorder Act 1998
- Care Act 2014
- Counter Terrorism and Security Act 2015
- Serious Crime Act 2015
- Children and Families Act 2014
- Convention of the Rights of a Person with Disabilities 2006
- Modern Slavery Act 2015
- United Nations Convention on the Rights of the Child 1989

2.2 **National Guidance**

- Working Together to Safeguard Children Statutory Guidance 2018
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019
- Adult Safeguarding :Role and Competencies for Health Care Staff 2018
- PREVENT Duty Guidance 2015
- CQC Fundamental Standards Statement on CQC's Roles and Responsibilities For
- Safeguarding Children, Young People and Adults at Risk in the NHS – Safeguarding Accountability and Assurance Framework (SAAF) - June (2015 updated 2019)
- FGM Enhanced Data Set 2015
- RCN 2018 Intercollegiate Document - Safeguarding Adults: Roles and Competencies for Healthcare Staff
- Child Death Review - Statutory and Operational Guidance 2018
- RCN 2019 Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Accountability and Assurance Framework updated in 2019.
- Promoting the Health of Looked After Children Statutory Guidance 2015

3. Impact of COVID-19

3.1 COVID-19 has brought with it many challenges, but at the forefront of our service delivery has been ensuring the safeguarding of all our patients, visitors and staff.

3.2 The COVID-19 Prioritisation with Community Services Guidance, The COVID-19 2020 Act, Changes to the Care Act 2014 and the various COVID-19 related Guidance, have

all emphasised that safeguarding children and adults is as critical during the pandemic as at any other time, and that all statutory requirements still stand.

3.3 The global COVID-19 pandemic is unprecedented and the impact for individuals, families, communities and wider society is significant and will be long lasting. Due to the restrictions in place, many children and adults have become at increased risk of harm such as Exploitation, Domestic Abuse and Financial Abuse, scamming. The most vulnerable and at risk in our society have been hidden from day to day services that would normally have provided a protective shield.

3.4 The safeguarding team have continued throughout the pandemic to provide a responsive service to staff who were under increasing pressure:

- Practical support from the safeguarding team across the Trust to complete safeguarding activities where staff lacked the time or resources to do this; especially in the first wave of patient activity with Trauma Pathway care in terms of completion of capacity assessments and deprivation of liberty safeguards requests for authorisation. Complex discharge planning and best interest meetings.
- Support to discharge liaison team regarding safe and efficient discharges for patients with safeguarding concerns.
- Regular liaison with external agencies and CCG designate nurses around local and national safeguarding updates.
- Daily telephone calls to departments to offer support and to find out concerns and give support on complex cases.
- Supporting staff in day to day practice through the delivery of high-quality training has been essential, underpinned by case management advice and supervision to promote the philosophy that Safeguarding is “everyone’s business”.

3.5 The safeguarding team continue to work in partnership with both the adults (BSAB), and Children Safeguarding Partnership (BCSP) boards. Focussing on increasing collaborative working with other agencies such as Housing, Age Concern, Police, Fire Service and Third Sector Agencies. Networking at board training events, and subgroups providing the opportunity to build relationships and information sharing and learning.

3.6 **Birmingham Safeguarding Adults Board(BSAB) Vision**

“That people with care and support needs in Birmingham are able to live their lives free from harm because we have a city that does not tolerate abuse or neglect; the community works together to prevent abuse and neglect and people know what to do when it happens”.

3.7 Table 1 below showing BSAB strategic priority

Strategic Priority 1	Communication & Involvement
Strategic Priority 2	Prevention & Early Intervention
Strategic Priority 3	Empowerment & Enablement
Strategic Priority 4	Learning Through Development & Assurance

3.8 **Birmingham Safeguarding Children Partnership (BSCP) Vision**

"Birmingham is a family city where children will flourish, feel safe, listened to, learn and grow up able to actively contribute to society".

3.9 The BSCP published a two-year Improvement Plan for 2019-2021. These priorities support the statutory functions of the BSCP and the partnership response to protecting vulnerable children and young people, preventing harm and promoting their welfare.

3.10 Table 2 below showing the key priority areas:

Priority 1	Strong Leadership and Strong Partnership demonstrating effective Accountability
Priority 2	Continuously Improve Child Safeguarding Practice across the system and in all agencies
Priority 3	Developing an effective multi-agency response to Child and Adolescent Neglect
Priority 4	Evaluating and addressing the consequences of the COVID-19 pandemic on safeguarding children

3.11 The work of the Trust safeguarding team has reflected these priorities for safeguarding adults and children via training, learning events, supervision and in the support provided to patients and staff.

3.12 Safeguarding activity across the Trust has continued to intensify in volume and complexity despite a decrease in physical footfall throughout the Trust due to COVID-19 pandemic. This is also reflected both nationally and regionally.

4. The Trust Safeguarding Team

4.1 Below is table 3 showing the composition of the Trust Safeguarding Team

Safeguarding Team - April 2020 – March 2021	
Designation	**WTE**
Lead Nurse for Safeguarding	1.0 WTE
Named Nurse for Safeguarding Children and adults - (commenced into post January 2020)	1.0 WTE
Safeguarding Nurse – Band 6 – Secondment – Development opportunity from August 2020 (6-month secondment initially)	1.0 WTE
Named Doctor for Safeguarding Children	1 PA
Administrative support- bank	0.6 WTE

4.2 The safeguarding team are supported externally by the CCG Designated Doctor for Safeguarding along with the CCG Designated Safeguarding Nurse and Deputy Designated Nurses.

5. Governance

5.1 The safeguarding team are led by the Safeguarding Lead Nurse, with line management from the Executive Director for Nursing and Clinical Governance; who is the Trust Executive Lead for Safeguarding, providing Board oversight of safeguarding arrangements.

5.2 The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business'.

5.3 The Trust oversees the governance arrangements through bi-monthly Safeguarding Committee, which is chaired by the Safeguarding Lead Nurse . The Safeguarding Committee gains assurance on behalf of the Trust Board that its legal and statutory duties are met in relation to Safeguarding of Adults, Young People and Children.

5.4 The Trust Safeguarding Committee is attended by a Safeguarding representative from the Designated Nurse Team in the Birmingham and Solihull Clinical Commissioning Group (BSOL CCG) and senior leaders of Trust departments whose role is to offer reporting, scrutiny, challenge and cascade learning to their areas. The terms of reference are reviewed annually. Areas for escalation from the Safeguarding Committee are reported to the Trust Quality and Safety Committee with the Lead Nurse attending quarterly.

5.5 The Safeguarding Committee monitors progress against :

- Activity reporting , concerns and external referrals
- Risk register
- Annual work and audit plan
- Incident reporting and learning
- Local and National learning from Domestic Homicide Reviews (DHR), Safeguarding Adult Reviews (SAR) and Child Safeguarding Practice Reviews(CSR)
- Performance against statutory standards and guidance
- CCG key performance indicators and contractual standards

5.6 The minutes of the Safeguarding Committee meetings are received and monitored through the Quality and Safety Committee, quarterly reports are submitted.

5.7 The Safeguarding Team provide a monthly Safeguarding Quality Report which is reviewed at Safeguarding Committee. This Quality Report aims to provide a Trust-wide overview and assurance relating to the safeguarding of patients at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to (BSOL CCG) to satisfy contractual information requirements and for routine engagement visits.

6. Partnership Working

6.1 During 2020/21 the Trust has contributed to engagement and effective partnership working with agencies across Birmingham and the wider footprint; as COVID-19 restrictions have allowed.

6.2 The Safeguarding Lead and Named Nurse actively contribute to Adult Safeguarding Reviews (SARs), Domestic Homicide Reviews (DHR); and Child Safeguarding Practice Reviews (SCRs), both in terms of scoping and Individual Management Reviews.

6.3 The Named Nurse and Named Doctor attends Birmingham Safeguard BSCP partnership meetings and actively participate with multi-professionals with regard to risks for Children and Young People in Birmingham area, and sub-group committees.

6.4 The Executive Lead attends the Leaders Assembly, and has been visible and vocal in this group discussion and work.

6.5 The Trust also provides representation by the Safeguarding Team at the forums, sub-groups and operational groups whom report to the statutory boards.

6.6 Partnership events have been attended by staff during the year, these events are held quarterly and have covered a range of areas in line with the local boards key target areas for improvement.

7. Safeguarding Training

7.1 The Trust is responsible for ensuring all staff are given Adult Safeguarding training that supports their role and responsibilities towards adults that they come in contact with during their work. The training delivered at the Trust is regularly updated by the Named Nurse/ Lead Nurse to reflect needs of the staff through evaluation and local and national changes in policy/guidance. Safeguarding Training within the Trust is compliant with the intercollegiate document Adult and Children Safeguarding: Roles and Competencies for Health Care Staff (2018)

7.2 Adult safeguarding training for the majority of staff is delivered with children's safeguarding training; and is included in the Trust's mandatory training programme.

7.3 Following the introduction of Liberty Protection Safeguards (LPS) further training for staff will be required. Pending the Code of Practice being released, due later this year 2021.

7.4 **Safeguarding Training Compliance**

Table 4: Percentage of staff trained at the end of quarter 4 for 2020/2021.

Safeguarding Training	Adult Safeguarding	Children Safeguarding	Target Compliance %
Level 1			90.0%
Level 2	98.45%	98.27%	85.0%
Level 3	86.04%	86.56%	85.0%
Level 4	100%	100%	90.0%

Training	Compliance %	Compliance Target %
Mental Capacity Act (MCA)	95.65%	85.0%
Deprivation of Liberty Safeguards (DoLS)	95.91%	85.0%
Prevent Awareness	88.86%	90.0%
Prevent Health WRAP	84.14%	90.0%

7.5 **Adult and Children training Level 2**

All staff need to complete level 2 training. Pre COVID-19 pandemic training was delivered as part of the mandatory training day face to face by the Safeguarding Team. Since March 2020 this training has been undertaken by completion of eLearning package.

7.6 **Adult and Children training Level 3**

Level 3 training face to face (F2F) training was suspended between the period from the end March 2020 to the end of May 2020, due to COVID-19 restrictions numbers of available spaces were limited. Trust Executive Lead prioritised Safeguarding training to recommence.

7.7 The training is delivered by the Named Nurse/ Safeguarding Nurse with support from Children and Young Persons (CYP) OPD Sister. Based on evidence from NSPCC recommending that due to the sensitive and emotive nature of children's safeguarding training, two presenters should be available in order to meet any emotional needs of the participants from possible trauma triggers.

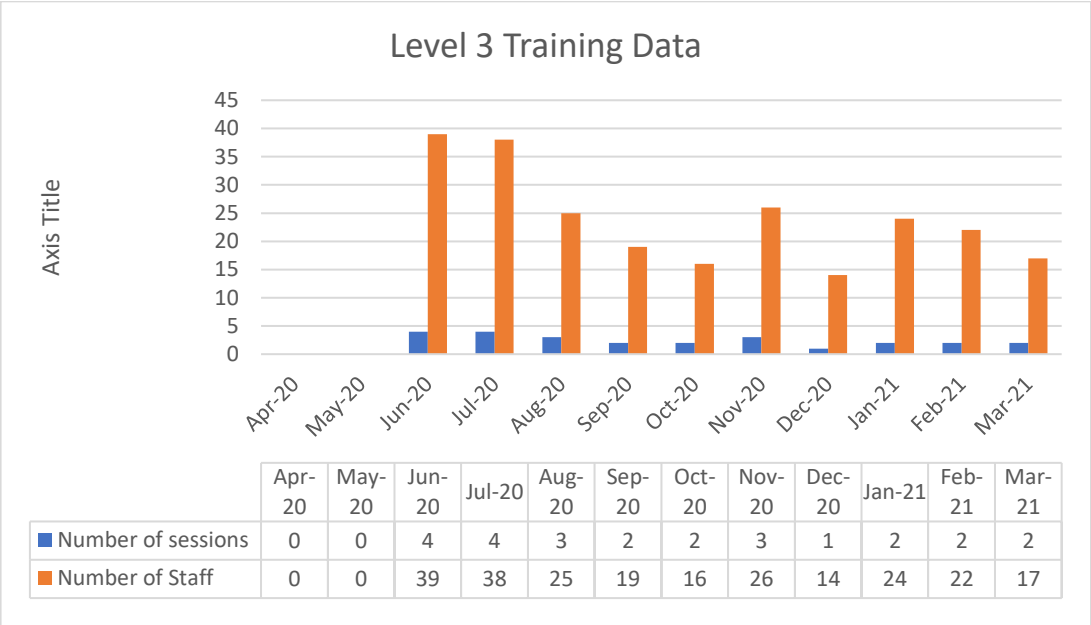
7.8 In 2020 and 2021 the training package for Level 3 for Children and Adult has been updated by the Safeguarding Named Nurse to reflect national and local recommendations.

7.9 In addition, the safeguarding team will be looking for new ways of providing and increasing access to safeguarding training working with the Trust Learning and Development Team; for example, Microsoft Teams in recognition of the growing trend towards virtual access to training and information, blended learning.

7.10 All staff including students and volunteers and junior doctors receive Level 1 Basic Awareness in Safeguarding and PREVENT via the Trust Safeguarding Booklet, this is available in electronic and hard copy version for staff. The leaflet will be updated in the next year.

7.11 The Safeguarding team have provided a total of 25 out of the scheduled 31 sessions this year with a total of 240 staff attending.

7.12 Table 5: Level 3 staff trained per month this year



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of sessions	0	0	4	4	3	2	2	3	1	2	2	2
Number of Staff	0	0	39	38	25	19	16	26	14	24	22	17

Data source -Record of attendance

8. Safeguarding Champions Training

8.1 The Trust this year continued to support the Safeguarding Champion forum day. These are scheduled quarterly throughout the year; due to COVID-19 pandemic the March 2020 and June 2020 sessions were not held. The sessions in September 2020 and December 2020 covered the following:-

- Bespoke Domestic Abuse training and DASH risk assessment training for all clinical and non-clinical staff, champions and managers; provided by the Named Nurse and Safeguarding Nurse in October and November 2020. A total of 80 Domestic Abuse Champions trained and available to support patients and staff experiencing Domestic Abuse in the Trust. This was in line with the planned launch of the Domestic Abuse pathway and Staff Domestic Abuse Policy.
- First Contact Forms – How to use and when to use the documentation and reason behind information being required for children and young people.

8.2 Participants then disseminate learning to their wards and departments.

8.3 Evaluation of sessions held are gained; below is some examples of staff feedback who attended the sessions:-

- *The Domestic Abuse Care Pathway is helpful*
- *Scenarios really useful and very informative*
- *Ability to ask questions freely, group discussion with other professionals*
- *Purple Ribbons (national symbol for domestic abuse DA) to show which staff member is the DA Champion*
- *'We are not afraid to ask' cards to attach ID badges - visual prompt*
- *The session was in depth*
- *Trainers went above and beyond to explain everything*
- *Domestic Abuse Policy and how the Domestic Abuse Care Pathway ties in with the policy*

9. Safeguarding Supervision

9.1 The Trust is committed to ensuring that all staff have access to advice and support from competent safeguarding professionals and that staff working with children, Young People, Adults and Families receive safeguarding supervision appropriate to their level of contact and responsibility with children and families, in accordance with national and local standards and requirements.

9.2 Supervision offered is provided 1:1, group sessions, learning lessons and case debriefs.

9.3 Safeguarding supervision is a priority for the safeguarding team moving forward. Staff have been identified to receive specialist supervision which also includes restorative supervision training.

9.4 Children and Young People Outpatient Department (CYPOD) receive weekly SG case supervision, led by the Safeguarding Named Nurse.

9.5 The Named Nurse has put considerable effort, since joining the Trust in December 2020, to ensure staff have access and undertake supervision, and continues to promote this with all staff. Safeguarding Supervision Policy to be reviewed in June 2021, the Named Nurse has already identified areas for improvement; these include documentation and access by teams and staff being evidenced.

10. Audit and Inspection Activity

10.1 An audit undertaken by an external practitioner for Mental Capacity Assessment MCA. Report of findings have been discussed at March 2021 Safeguarding meeting, along with recommended actions. The areas where further improvement being :-

- Staff to document updates of Mental Capacity Assessments and Deprivation of liberty on purple paper.
- Strengthen staff knowledge of the role of the Independent Mental Capacity Advocate (IMCA) within DoLS
- Improve Deprivation of Liberty Safeguards (DoLS) documentation especially clear reason for the deprivation, and how the deprivation is occurring the level /type of restriction.
- Improve communication of MCA and DoLS applications on transfer documentation both in to and out of the Trust.

10.2 Improvement in the use of the MCA assessment tool has been seen over the year, however it remained an area requiring further focus, increasing staff knowledge of use and review of the assessment and recording outcomes for patients.

10.3 First contact form audit-The safeguarding champions were asked to complete in December 2020 undertook an audit of the use and completion of this documentation. The Trusts First Contact form should be given to every patient under the age of 18. This form has allowed staff to capture key information about agencies that are already working with the family and whether there are any current safeguarding concerns being addressed. Also ensures that the accompanying adults have parental responsibility. Overall the results demonstrate positive usage of First Contact Forms although there are areas of practice that require improvement.

10.4 Following this audit there has been focused work by the Children and Young People team to ensure staff were fully aware of the documentation, when it should be completed.

10.5 Mental Health -A spot audit of notes was completed in February 2021 using the complex care audit template. These were selected at random from the list of Mental Health Notifications received in the previous 3 months. Findings gave assurance that

Mental Health conditions are being identified and managed. All learning identified has been fed back to the notifying individual for learning.

10.6 There have been no assurance visits undertaken by the CCG during 2020/21.

10.7 The Trust has continued to support BSAB and BSCP with external audits and is committed to meeting its statutory and regulatory requirements in this area.

10.8 The audit plan for 2021-22 has been prepared and presented at Safeguarding Committee for agreement in March 2021. See Appendix 1.

11. Section 11 Audit

11.1 The Children Act (2004) places on a statutory footing the obligation for named agencies and individuals to co-operate to Safeguard Children and promote their welfare. Section 11 of the Act makes clear to whom this duty applies and indicates that they must make arrangements for ensuring that:

> *' their functions are discharged having regard to the need to safeguard and promote the welfare of children'*

11.2 The same Act established the roles and responsibilities of the Local Safeguarding Children Board (now Partnerships) BSCP.

11.3 This 'Section 11 Audit' tool is designed to allow the LSCP to monitor, and evaluate the compliance of partner agencies. To assure itself that agencies are fulfilling their responsibilities. Chapter 2 of 'Working Together' July 2018 details the common features which must be demonstrated by agencies. This has been used as the source document for the key standards defined within the audit document.

11.4 In a self-assessment process, each agency or organisation must ensure that any statements made within the tool are backed by evidence for each of the standards.

11.5 The audit template key standards being:-

1. Leadership and Accountability
2. Policies and Procedures
3. Recruitment and Selection Introduction
4. Training and Development
5. Policies and procedures
6. Information Sharing
7. Listening to Children and Young People

11.6 The tool had been delayed this year, as the BSCP were looking to launch this on a national platform. It was released for upload in February 2021. The Self-Assessment tool for 2020-2021 has been submitted to the BSCP, and areas for improvement identified were: -

- Evaluation of practice from the perspective of the child or young person. Increase evidence of listening to children through patient stories, engagement of children and evidence of their ideas and view being acted upon. This to be addressed by patient engagement forum for children and young people. Section 7.3
- Annual audit plan- a programme of internal audit and review, and outcomes/ findings from reviews - Section 4.4 and 6.4
  Annual work plan submitted to March 2021 safeguarding meeting for approval.
- Safer Recruitment training/ standards - This is outstanding action from the previous year. Human Resources Team to undergo training initially, and then roll out - scheduled for May 2021 - Section 3.1
- Develop and implement an effective method of evaluating the impact of training on practice - Section 3.2
- Standard Operating Procedure SOP for Virtual clinics for safeguarding, and promoting the wellbeing of children in light of COVID-19 and these are accessible to all staff - Section 2.2

11.7 The Trust action plan progress for this audit tool will be reviewed at the safeguarding committee, and is included in the Committee workplan.

11.8 The annual peer review and challenge for the section 11 audit was not undertaken due to COVID-19 pandemic and the late release of the tool for upload by the BSCP.



12. Domestic Abuse

12.1 There has been increase in the number of concerns and referrals being raised to the safeguarding team; from 16 to 28 during this year. It is likely that the true incidents/ concerns of domestic abuse not being recorded this year, due to COVID-19 Pandemic restrictions and lockdowns. It is anticipated domestic abuse incidents will increase in line with local and national intelligence, after lockdown measures are fully eased.

12.2 The Named Nurse is encouraging staff to use the national risk assessment tool (DASH) for Domestic Abuse to identify high-risk victims, in line with Birmingham Domestic Abuse Strategy. The tool is recognised across all organisational sectors and will provide evidence to how the Trust should respond when supporting victims of Domestic Abuse. The team has supported staff face to face to complete the DASH risk assessment tool.

One case a patient provided with one-one support over two days discussing risk factors within the home environment, living with a perpetrator of domestic abuse whilst empowering patient to report incidents to police.

12.3 Bespoke Domestic Abuse training had been offered to all staff clinical and non-clinical staff who had requested to become Domestic Abuse Champions for their departments. This year 80 Domestic Abuse champions have been trained ensuring all understand their roles and responsibilities for their departments as Champions.

12.4 The Trust Domestic Abuse integrated pathway has been designed by Named Nurse to support the Trust's Domestic Abuse Policy and procedures; including safety planning and signposting to organisations for support.

12.5 Staff have been reminded to ensure they ask "direct" questions, when a disclosure or a concern has been identified with a possible risk of harm to a patient. The new amended SG level 3 training should provide staff with the confidence and skills to manage "difficult" conversations and use "direct" questions incorporating the use of the Domestic Abuse, Stalking and Harassment risk assessment tool (DASH).

12.6 Posters have been designed to support routine enquiry implementation which included "Seen alone" poster in key areas identified, adult and paediatric posters in Outpatients Department (OPD), Admissions and Day Case Unit (ADCU), and Pre-Operative Assessment Clinic (POAC). Resources provided to staff are "Ask Me" cards for signposting to external services, "we are never afraid to ask" routine enquiry cards, and Domestic Abuse Champions badges.

12.7 A new Staff Domestic Abuse Policy has been implemented. The policy aims to support staff who are experiencing Domestic Abuse and the Trust ensures the safety of its employees.

12.8 Developing staff's skills and confidence in asking direct questions around Domestic Abuse will be part of ongoing work next year.

12.9 The Trust continues to benchmark our Domestic Abuse response against national and local standards, to identify areas which require improvement.

12.10 Domestic Homicide Reviews (DHR)

A DHR must be conducted where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom the victim was related, or with whom the victim was or had been in an intimate personal relationship, or a member of the same household.

12.11 There is a statutory requirement to participate and respond to DHR requests. The focus is a multi-agency approach with the purpose of identifying learning.

12.13 The Safeguarding Team have had a total of 6 scoping requests received for internal management scoping, all of these were a nil return, and information provided to DHR panel.

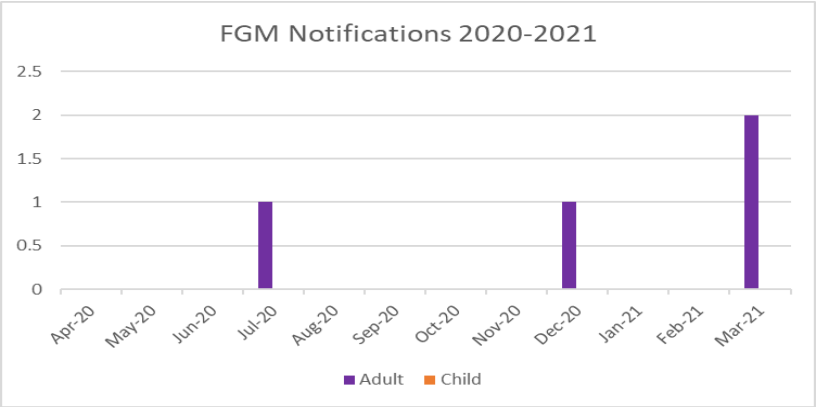
12.14 Learning from local and national DHR is incorporated into training for both Level 2 and Level 3 training.

13. Female Genital Mutilation (FGM)

13.1 FGM is a violation of the human rights of girls and women. NHS national statistics state there were 6,590 individual women and girls who had an attendance where FGM was identified in the period April 2019 to March 2020.

> *"1 in 3 women and 1 in 4 men have experienced some form of physical violence by an intimate partner. This includes a range of behaviours (e.g. slapping, shoving, pushing) and in some cases might not be considered "domestic violence." 1 in 7 women and 1 in 25 men have been injured by an intimate partner".*
> *National Statistics Domestic Violence - NCADV*

13.2 During the year a total of 4 FGM concerns raised compared with 3 in the previous year all adults. Table 6:



13.3 Patients disclosed that they had been subject to FGM as a child, patient supported and given time to talk and offered referral to FGM clinic. Mandatory reporting completed by SG team and information sharing to GP. Mandatory reporting for FGM

requires health professionals to identify FGM and follow their internal safeguarding procedures whilst recognising any 'at risk' children or adults within the home.

13.4 Learning from cases has shown staff need to ensure that they use independent interpreters when having "difficult conversations" to discuss safeguarding concerns such as FGM. Staff have followed internal procedure well by identifying FGM and reporting, whilst ensuring that other members of household are not "at risk".

13.5 SG level 3 Children's training updated including pictorial information on how to identify the four types of FGM and staffs' responsibilities with mandatory reporting. Training updated to included case scenario and learning for staff.

13.6 Due to minimal cases of FGM being identified at the Trust due to orthopaedic speciality and reliance on patient's disclosure on admission, staff require support from the Safeguarding team when FGM is identified.



14. Safeguarding Adults Activity 2020/2021

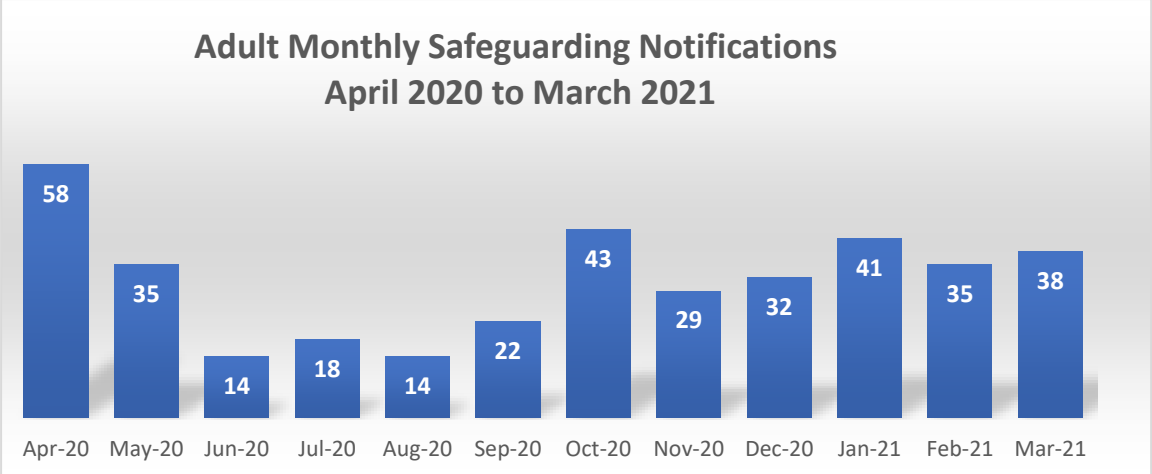
14.1 What does adult Safeguarding mean?

14.2 Safeguarding Adults means stopping or preventing abuse or neglect of adults with care and support needs. Adults with care and support needs are aged 18 and over and may:

- have a learning disability
- have a mental health need or dementia disorder
- have a long or short-term illness
- have an addiction to a substance or alcohol; and/or are elderly or frail due to ill health, disability or a mental health illness

14.3 A total of 379 concerns have been raised for adult safeguarding. Below is table showing monthly breakdown during 2020/21 for adults concerns and contacts internal notifications.

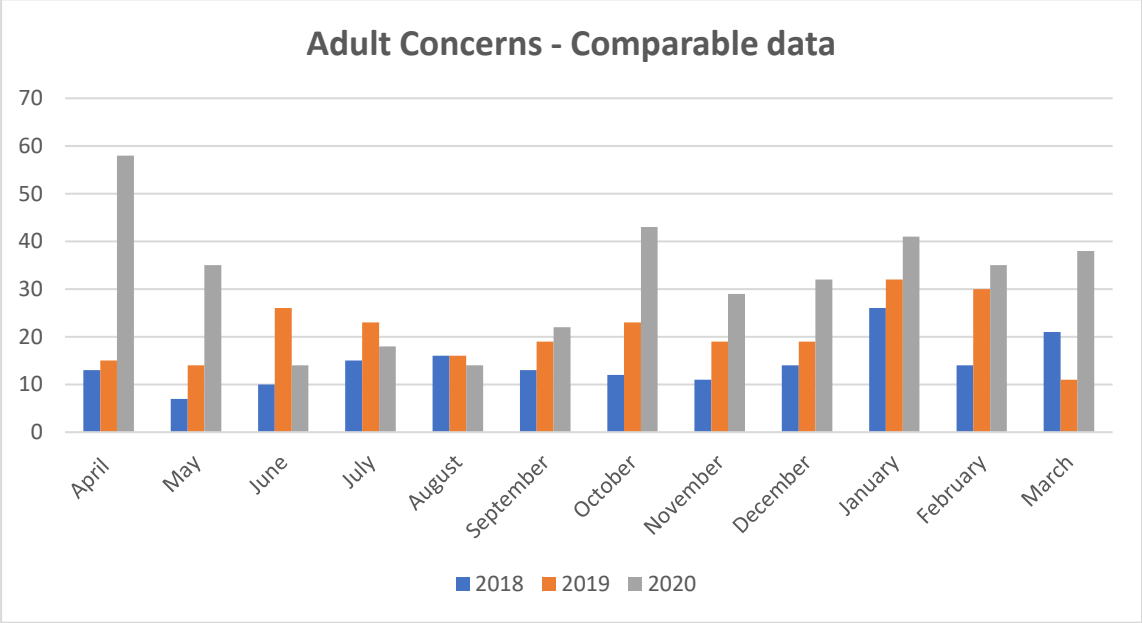
14.4 Table 7: Number of adult safeguarding notifications per month April 2020 to March 2021



Data source – ROH internal Access Database

14.5 Despite a reduced footfall through the hospital during the majority of 2020 due to the COVID-19 pandemic; there has been an increase in safeguarding concerns. Many of the concerns raised have been very complex cases and required a proactive approach to safeguarding by liaising with key professionals externally.

14.6 Table 8 below shows the comparative data 2018-2021 per month



Data source – ROH internal Access Database

14.7 This provides positive assurance that staff are growing in confidence with identifying safeguarding risks, and are taking responsibility for keeping our patient's safe. Noting reduced activity during reduction in Trust activity due to COVID-19 distribution of services.

14.8 It is important to note that during the first and second wave of the pandemic, the Trust supported the wider NHS service, working with UHB-ROH trauma centre and Rehabilitation pathways from January 2021. With the Trust caring for a different cohort of patients, it needed an ability to adapt and transform to meet patient needs and complexity of some cases, in particularly the trauma cases in terms of safeguarding concerns raised. There was an increase in the number of patients with cognitive impairment, for example Dementia.

14.9 Table 9 shows the Top 4 categories of the adult contacts and referrals



14.10 The highest contacts being the Deprivation of Liberty Safeguards (DoLS) applications - total number of 132 contacts. This was due to a significant increase of patients transferring from other acute trusts, predominately University Hospital Birmingham(UHB), with fractured neck of femurs.

14.11 Mental Health themes from contacts relate to patients with history of Mental Health, these being depression; along with a history of suicide attempts and self-harm concerns also. This may also have increased in line with staff receiving Mental Health First Aid Training raising awareness and knowledge. As a Trust we acknowledge the impact of COVID-19 restrictions “lock down” on patients who are isolating and shielding seeing a decline in Mental Health,

14.12 There have been 32 contacts regarding risks, these cases show the importance of identifying risks and sharing with other agencies.

14.13 **External referral activity**

Table 10 below summarises the external referrals the Safeguarding Team have made following concerns raised:-

Area of Referral submitted to:	Yearly Total
Adult Social Care	17
Adult Social Services for care and support needs	9
Substance misuse	2
Community Mental Health Team	17
GP for follow up and support for safeguarding concerns	75
Police WMPS safe and well fare check	2
Drug and Alcohol Services GCL	8
Educational Services	1
Female Genital Mutilation (FGM) Services	2
West Midlands Ambulance Service (WMAS)	4
Multi-Agency Risk Assessment Conference (MARAC) for DA high-risk cases	4
Substance Abuse	1
Food Bank Service	2
Volunteer Befriending Service	1
PiPoT (external)	1
Independent Mental Capacity Advocate (IMCA) Pohwer	1
Child Social Services (Adult concern)	2
Red Thread	1
Rough Sleeper Team	1
Community Service Hoarding Addition Service	1

14.14 **Case Studies – Adult Safeguarding**

Case A -Mental Health/Complex care and support needs
Patient admitted for investigation procedure. Patient unable to communicate, required the support of an Independent Mental Capacity Advocate (IMCA) for best interest decisions. Patient's surgery cancelled due to administering of regular medication by care home. Patient admitted until investigations complete. Staff identified trauma injuries whilst an inpatient. Multi-agency referrals completed by the SG team and escalation of concerns to external authorities for investigation, to ensure the patient received support with all care and support needs. (November 2020)

Case B- Vulnerable adult with care and support needs
Medical secretary raised concerns to Deputy Director of Nursing regarding a vulnerable adult with physical disabilities who has not seen her carers for three days. Secretary was concerned that the patient was unable to take care of their personal hygiene and dietary requirement without support from carers. Deputy Director of Nursing contacted Named Safeguarding Nurse, and shared concerns. Named Safeguarding Nurse contacted patient and arranged for her family member to support her and GP over the Christmas period, and agreed to speak to patient and arrange a long-term plan of care when she attended outpatients later that week. The Safeguarding Nurse spoke to patient in OPD and arranged for a befriending service; to organise food shopping for patient and completed a referral to adult social services for long term support in the community.

Patient needs met and proactive plan to ensure patient wishes considered , along with information shared with professionals. Staff escalation of concerns for the patient and joint working to support the patient. (December 2020)

Case C- Self Neglect

Patient attended clinic appointment where staff immediately escalated concerns regarding patient's health and well-being, regards to his appearance and care and support needs. Patient had a number of communication concerns in particular hearing. Staff addressed concerns effectively and made reasonable adjustments so the patient could use a different method of communication, in this incident the use of paper and pen was provided to the patient to express concerns and also allow staff to ask the patient questions.

Patient health concerns identified and addressed as an immediate action prior to patient returning home using information sharing with specialist teams to treat the patient. An external referral was made to social services to raise safeguarding concerns and share information. A full assessment was carried out on the patient within 72 hours in the community and care and support needs were addressed and level of care input updated.

Case D-Hoarding- Corvid

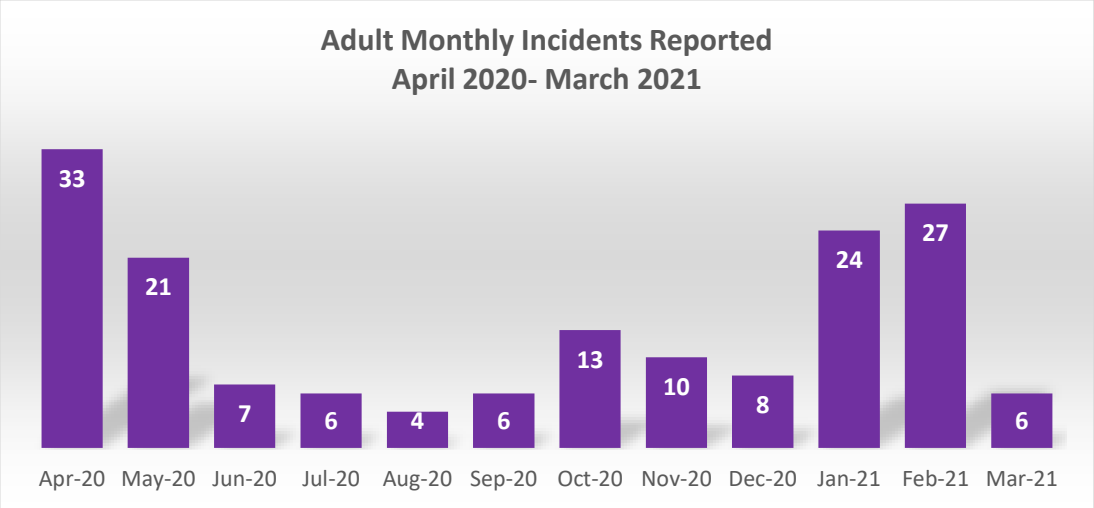
Trusts swabbing team reported concerns regarding hoarding with a patient due to be admitted for surgery. Safety plan developed to protect staff for further swabs that needed to be taken. Patient given the opportunity on admission to disclose any home/ living conditions concerns. Being open and honest with the patient concerns regarding hoarding were addressed. Patient refused any support regarding concerns but gave consent for the information to be shared with appropriate staff within the Trust in order to develop a safe discharge plan. Patient also gave consent for information to be shared with next of kin to ensure patient had a level of support on discharge.

Case E- Partnership working information sharing

Safeguarding concern initially raised by West Midlands Ambulance Service regarding poor home conditions the patient lived in. Staff worked well to build relationship with patient which resulted in a disclosure of self-harm and a hoarding addiction. SG Nurse signposted patient to community services for family to access to support with hoarding addiction. Staff referred out to wider NHS services to support mental health needs.

14.15 **Safeguarding Adults Incident Reporting (Internal reporting Ulysses System)**

Table 11 below shows the number of adult incidents reported per month; total for this period of reporting being 165.



Data Source – Ulysses Monthly Incident – Governance Department

14.16 **Safeguarding Adult Review (SAR)**

The purpose of a SAR case review is to establish whether there are lessons to be learnt from the case, identify what those lessons are, how they will be acted on and what is expected to change. The consequence of this should be to improve interagency working and better safeguard and promote the welfare of vulnerable adults.

14.17 A total of 2 SAR review scoping requests were requested during the year. A nil return for Trust with involvement with any patients in requests.

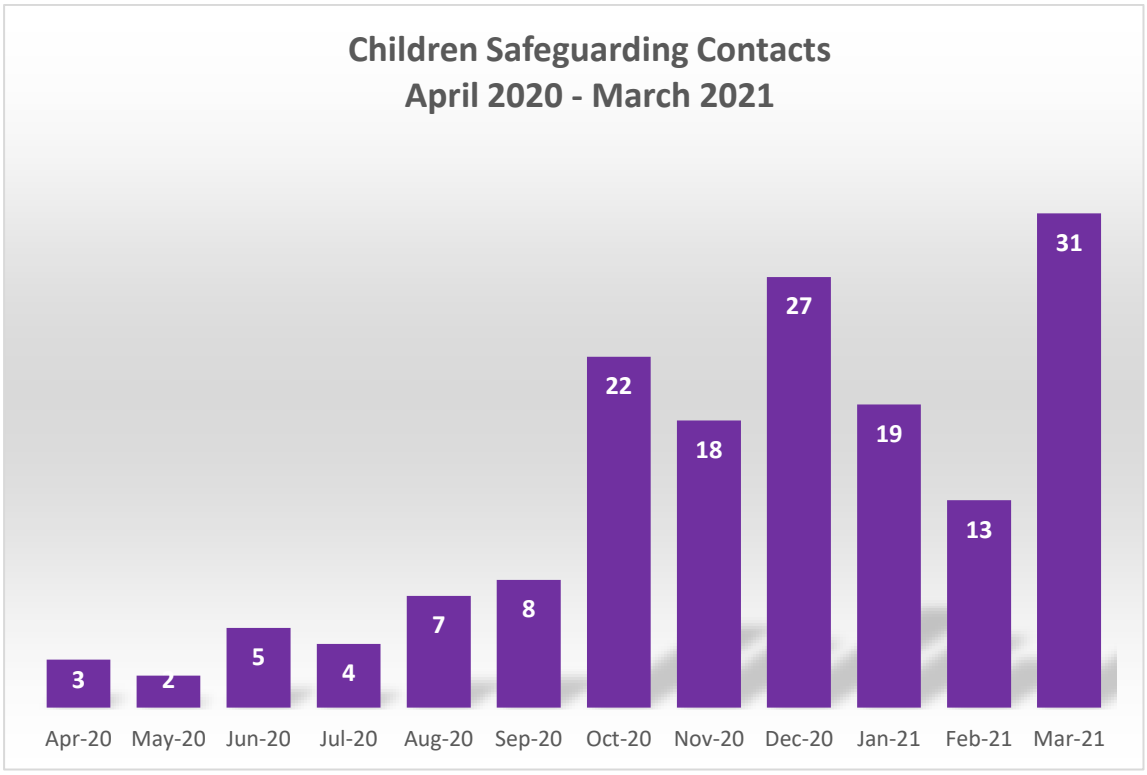
14.18 Learning from local and national SAR are included in safeguarding training to also ensure learning is shared and embedded within the Trust.

15. Safeguarding Children and Young People Report - Activity 2020/21

15.1 The Trust has a statutory duty to safeguard and promote the welfare of children and young people (the Children Act, 2004). The Safeguarding Policy outlines corporate and individual responsibilities in accordance with legislation, guidance and standards. Working closely with local safeguarding board Birmingham Safeguarding Children Partnership (BSCP).

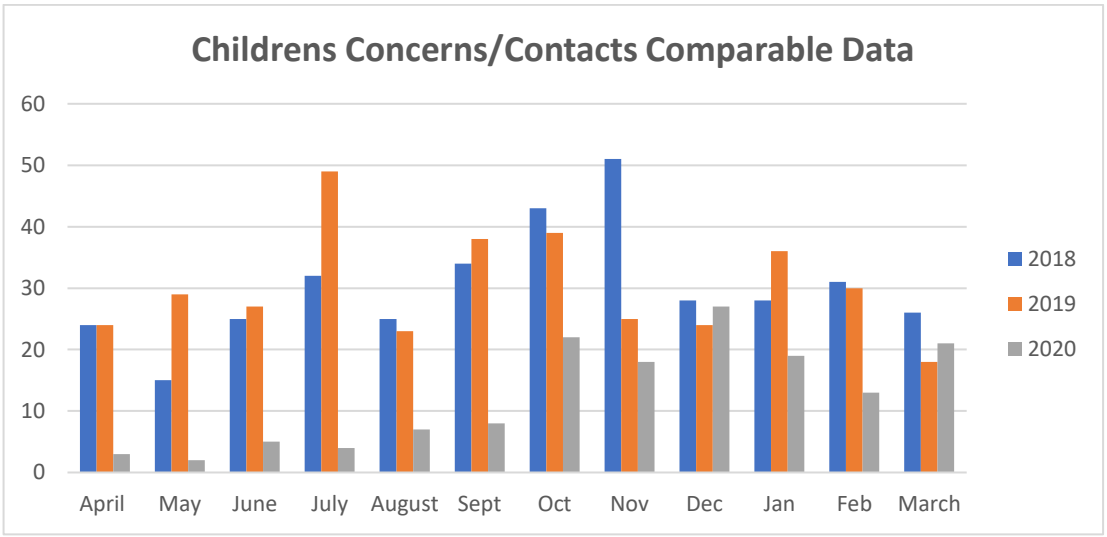
15.2 A total of 149 contacts/ concerns have been raised for children safeguarding to the Named and Lead Nurse. There has been a reduction compared with the previous year total of 362. This is in line with the reduced Trust activity, due to the COVID-19 pandemic, and the ceasing of services in the first wave of lockdown.

15.3 Below is table 12 showing monthly breakdown during 2020/21 for children concerns and contacts internal notifications



Data source – ROH internal Access Database

15.4 The chart below shows comparative data for the number of safeguarding children referrals made over the last 3 years.



Data source – ROH internal Access Database

15.5 Children and Young People Department (CYPD) temporarily closed due to COVID-19 hence the significant decline in child SG notifications April 2020. It should be noted that the Trust had a children's inpatient ward in 2018.

15.6 The majority of Safeguarding notifications received were identified as "was not brought" and social services involvement indicated on first contact forms.

15.7 There is a continuing need in the coming year for the Safeguarding Team to provide focus on the Safeguarding needs of young people aged 16 years and over who are cared for within adult services.

15.8 Due to COVID-19 restrictions virtual clinics commenced for children and young people. This identified potential risks as hidden children and young people, no longer have a safe space in a hospital environment to disclose safeguarding concerns, and staff are unable to use professional curiosity due to possible safeguarding risks within home environment. Safeguarding Lead nurse and CYPOD manager met with Medical Associate Director to discuss the importance of medical team implementing safeguarding criteria in risk assessing clinic appointments.

15.9 Due to COVID-19 and remote working for external agencies, staff reported difficulties to contacting professionals when completing lateral checks, to establish ongoing risks or concerns and ensure these patients are seen or can access care and support need services. Cases were reported to be often taking 1-2 weeks longer to complete lateral checks and establish external safeguarding concerns due to professional remote working. This was escalated to CCG and Children Social Services along with following external escalation procedures for information sharing.

15.10 Notifications had remained open longer, this being due to awaiting outcome of lateral checks from partnership agencies. Due to multiple school closures Designate Safeguarding Leads were not available to share any safeguarding information during April to September 2020. Concerns raised locally and nationally regarding the lack of professional oversight for children.

15.11 **Safeguarding Children Case studies**

Case A
Child in care with severe learning disabilities was not brought to an appointment. Staff contacted child foster carer and social worker who explained that they do not feel that Botox injection are benefiting child's health needs and child becomes extremely distressed attending hospital. Best interest meeting arranged which was attended by Social Worker, foster carer, patient, Transitions Nurse, CYP OPD manager, Safeguarding Named Nurse and consultant. All options were discussed and it was decided that it would not be in the child's best interests to proceed with treatment. Good example of listening to the "child's voice" and multi-agency working. (September 2020)

Case B
First contact form indicated patient is home schooled. Following recommendations from SCR's regarding lack of professional oversight for children not in education, CYP OPD staff contacted education department to ensure they are aware that child is not in education and an education officer is assigned to family. (October 2020)

Case C
Child in Need plan indicated on first contact form. Staff contacted Social Worker who explained child in need plan in place due to parent's mental health concerns which impacts on the child's well-being. Child scheduled for a procedure at ROH and reasonable adjustment put in place by Transitions CNS to support child and mother. Transitions CNS contacted mother's mental health team to support ROH staff if mental health declines due to child's procedure. A good example of "whole family" approach. (October 2020)

Case D
Patient was found in outpatients department, distressed and lost. Patient referred to the Trust Ambulatory care by UHB for reconstruction day case surgery following trauma injury to hand. Patient attended unaccompanied with a number of version of incidents. Lateral Checks completed by Safeguarding Nurse which highlighted concerns with GP and home-schooling. Referral made to Children Social Services (CASS) with the support of GP as mental health risks identified within the family home. Patient was supported through the admission, theatre and discharge process. Patient was discharged into the care of an adult sibling and followed up by CASS and GP for professional oversight in the community. (February 2021)

15.12 Staff have worked well to share and update external multi agency services to establish ongoing risks or concerns and ensure these patients are seen or can access care and support services.

15.13 The Trust's first contact form have been reviewed and amended by CYPOD department in June 2020.

15.14 Staff reminded to not assume parental responsibility and to complete checks thoroughly. Parental responsibility training has been provided to staff and information updated.

15.15 The Named Nurse has ensured that complex cases that require escalation are reviewed, as per external safeguarding escalation procedures.

15.16 Monthly meetings and case discussion dates booked for Named Doctor for Children Safeguarding and the Named and Lead Nurse for Safeguarding .

15.17 **Serious Case Reviews (SCR)**
A SCR takes place after a child is seriously injured and abuse or neglect thought to be involved. The Local Safeguarding Children Partnership (BSCP) follows statutory

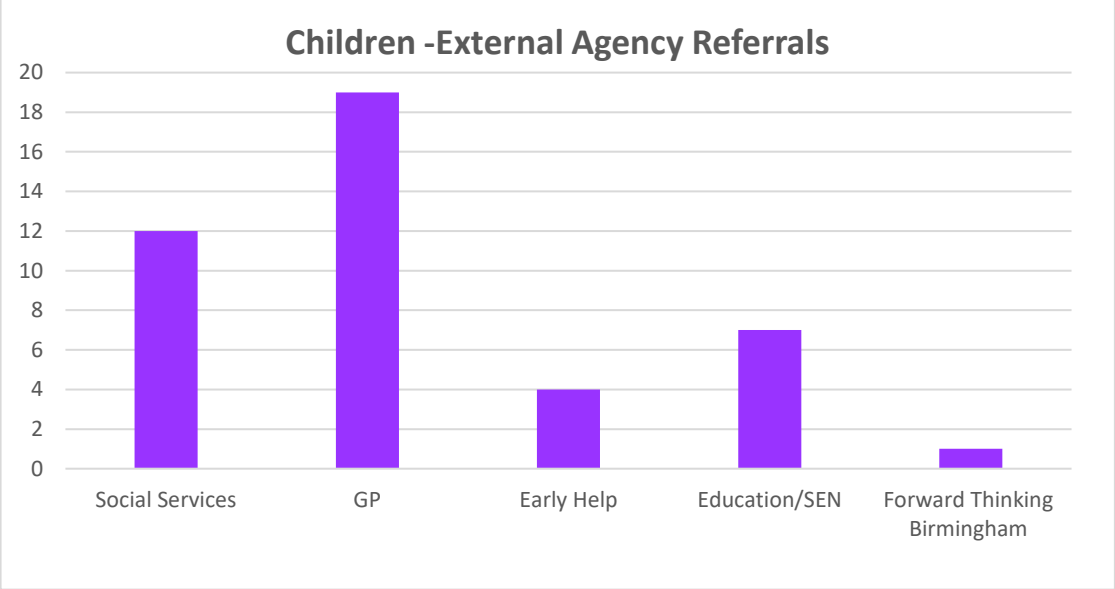
guidance on when conducting a SCR and partner agencies are required to participate if involved.

15.18 Over the past 12 months the Trust has received a total of 3 requests for scoping for SCR.

15.19 Only 1 SCR request received for scoping known to the Trust through the OPD service. Information provided to the SCR panel.

15.20 **External Agencies Referrals**

Total number of referrals 43, below is table 13 summarising the professional agencies, following concerns and notifications being raised about children and young people.



15.21 **Early Help**

Staff have been made aware and included in children safeguarding training that teams are now up and running and targeting specific areas in Birmingham. Trust intranet page updated with local and national information, guidance and contact details along with the Early Help handbook.

15.22 During supervision standard item agenda is Early Help to encourage staff to offer families in need to Early Help services.

15.23 Early Help will continue to be a focus for the next year including the importance of proactive, protective care to prevent crisis and abuse. Staff are encouraged to complete the new E-Learning "Right Help, Right Time" package produced by Birmingham Children's Partnership.



16. Child Exploitation (CE)

16.1 CE encompasses sexual and criminal exploitation, trafficking, modern slavery and other forms of adolescent vulnerability.

16.2 The aim is to highlight issues around child exploitation, encourage everyone to think, spot and speak out against abuse and adopt a zero-tolerance stance on adults developing inappropriate relationships with children, or children developing inappropriate relationships with other children.

16.3 Awareness Day National Child Exploitation Awareness day in line with The National Working Group to show our support for their "Helping Hands" campaign, and this was also shared on social media using #CEADAY21 and #Helping Hands.

16.4 Safeguarding intranet has been updated to reflect local services available to support such as Empower U.

16.5 Child Exploitation tool, and issues surrounding contextual safeguarding has been included into Level 3 training.

17. Person in Position of Trust (PiPoT)

17.1 The Safeguarding Lead Nurse is the identified PiPoT Lead for the Trust. The safeguarding team works closely with Human Resources team to monitor activity in this area. Issues relating to staff that hold a professional registration are reviewed against the professional registration requirements and onward referrals to professional bodies are made when necessary.

17.2 The PiPoT framework and process applies to concerns and allegations about:

- A person who works with adults with care and support needs in a position of trust, whether an employee, volunteer or student (paid or unpaid); and
- Where those concerns or allegations indicate the person in a position of trust poses a risk of harm to adults with care and support needs.

17.3 These concerns or allegations could include, for example, that the person in a position of trust has:

- Behaved in a way that has harmed or may have harmed an adult or child;

- Possibly committed a criminal offence against, or related to, an adult or child;
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

17.4 The CCG Designated Lead Safeguarding Nurse informed of all cases, along with relevant professional governing bodies as required.

18. Prevent Activity

18.1 The Trust recognises that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

18.2 The Safeguarding Lead is the Prevent Lead, Operational Prevent Lead; with the Executive Director of Nursing and Governance being the Executive Lead. The Operational Lead and Safeguarding Lead attended the regional Prevent Forums, and receives local intelligence from the Counter Terrorism Unit (CTU) officers. Local mandatory training is updated as required to reflect new information.

18.3 No Prevent concerns had been reported during the year.

18.4 The Home Office expectation is that all organisations party to the NHS Standard Contract will, as a minimum, achieve 95% compliance for Basic Prevent training and 90% for WRAP. Unfortunately, with the suspension of training on 25th March 2020 due to COVID-19 the WRAP compliance figures had reduced. Trust has submitted the required quarterly national returns.

18.5 Training is now delivered by both face to face training sessions since the end of June 2020, and an on-line package for both mandatory, and induction training.

18.6 Additional face to face training sessions were provided by the Operational Lead to address the training shortfall. E learning training is being encouraged to ensure that staff training compliance is maintained.

18.7 The Prevent folder to support staff on the intranet has been updated.

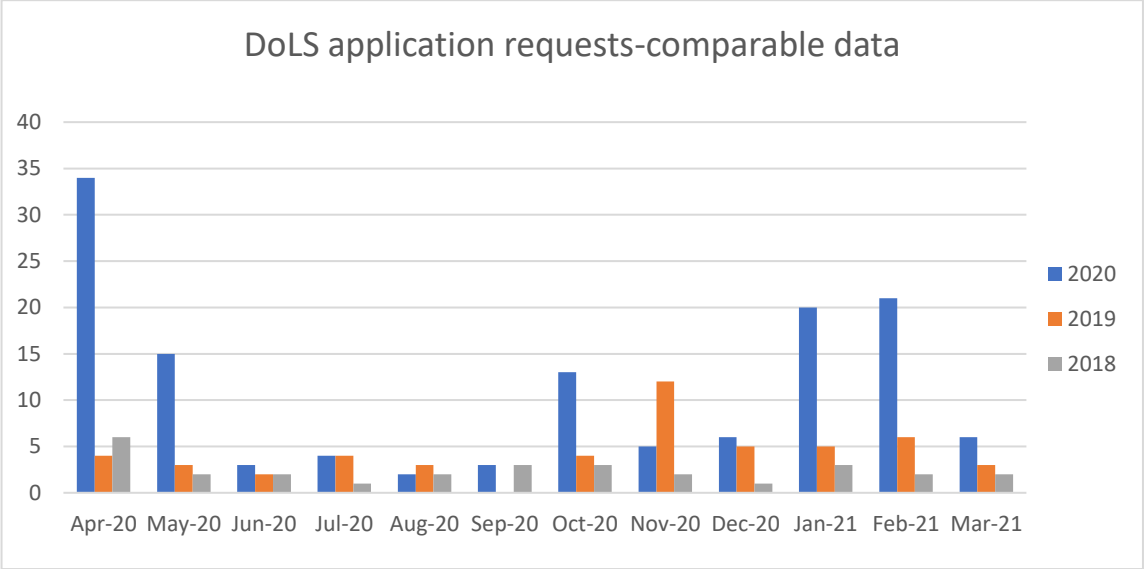
18.8 The Operational Lead for Prevent is retiring in March 2022, preparation for this role is being undertaken.

18.9 The Trust aims to embed Prevent into mainstream safeguarding. Training encourages staff to focus on our professional responsibility to understand and recognise that radicalisation is a real risk which could affect any of us.

19. Deprivation of Liberty Safeguarding (DOLS) and Mental Capacity Act (MCA)

19.1 Where patients are under continuous supervision, would not be allowed to leave if they wanted to and lack the capacity to stay in hospital, they are determined under the Mental Capacity Act 2005 to be Deprived of their Liberty. In order for this to be a legal deprivation, the Trust must make an application to the Local Authority to have this deprivation authorised. This process is a safeguard for patients to ensure they are not unlawfully deprived of their liberty and failure to make this application puts the Trust at risk of litigation, reputational damage and allegations of organisational abuse.

19.2 Table 14 below shows the DoLS applications by the Trust - comparable data



Data source – ROH internal Access Database

19.3 The increase in patients requiring DoLS application requests total 132 in the year compared with 51 in the previous year. The increase due to the care group of patients being treated, the trauma patients from UHB. This increase has impacted on staffing requirements to meet patient needs, with bank and agency staff used for the increased/enhanced observation and recorded on safe care staffing record.

19.4 A focused area of work has been undertaken with the Lead Nurse providing monthly training session as staff lacked the confidence to appropriately implement the Mental Capacity and Mental Health Act and understand the interface between the two, particularly around detaining or depriving patients of their liberty within a legal framework and utilising the Mental Capacity Assessment for patients, along with the need to evidence review has been undertaken and recorded.

19.5 Staff requested to complete an internal notification when undertaking MCA assessment to allow for review, follow up and monitoring by the team and managers.

19.6 Improvement in the use of the MCA assessment tool has been seen over the year, however it will need to continue to be an area requiring further focus, increasing staff knowledge of use and review of the assessment, and recording outcomes for patients in preparation for the introduction of Liberty Protection Safeguards (LPS) in 2022.

19.7 Training has been reviewed and updated with further case studies for staff in Level 2 and Level 3.

20. Liberty Protection Safeguards (LPS)

20.1 Liberty Protection Safeguards (LPS) are due to replace Deprivation of Liberty Safeguards (DOLS) in April 2022. These new safeguards will radically alter who can authorise the deprivation of liberty and as NHS Trusts will be “Responsible Bodies” it is essential that staff have the confidence, skills and knowledge to implement the Mental Capacity Act. Its introduction signifies an opportunity within the Trust to review the management of MCA and liberty safeguards including resources required to fulfil statutory duties. Preparation, training and strategies for these changes must begin as soon as possible following the Code of Practice release to ensure the Trust is ready to fulfil new statutory obligations. This will be a focused area of work in the next year for the team, regarding its introduction and the process and procedure for the staff required.

20.2 The Health and Social Care Bill. The White Paper 'Integration and Innovation: working together to improve health and social care for all' has been published with the Government setting out its intention to establish statutory Integrated Care Systems (ICSs). It is anticipated that the Responsible Body function under LPS will transfer to ICSs, as they take over core functions of Clinical Commissioning Groups. This means three Responsible Bodies in England being the local authority, NHS Trusts, CCG/ICS.

20.3 The date for implementation of LPS remains April 2022 although much speculation remains as to whether this may change.

20.4 At present the legislation gives us a clear framework regarding the role of the three Responsible Bodies and we know the assessments required, we also know of the role of clinicians however the code of practice has much to add to help clarify how we use AMCPs, how LPS impacts on those 16 plus etc.

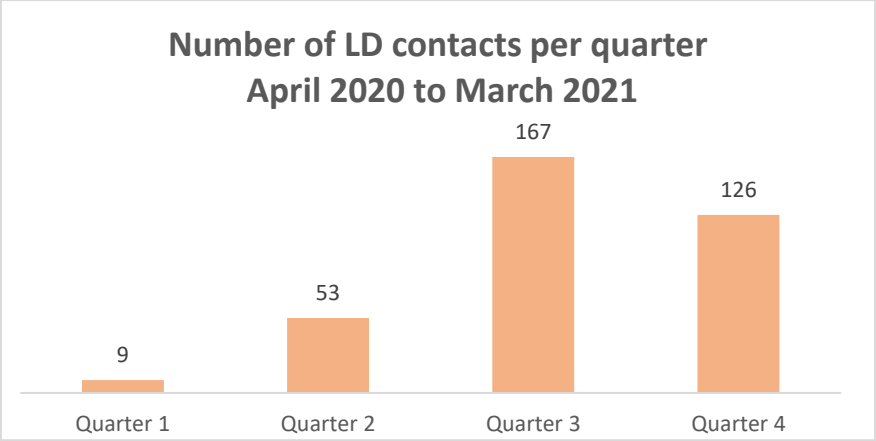
20.5 The LPS MCA code of practice is reportedly progressing and will be made available for public consultation. An updated version of the MCA Code of Practice will contain detailed information about LPS in dedicated sections. The expectation is that the updated MCA Code of Practice will run to 25 chapters including 'What is the Overall LPS Process, the interface between LPS and the MHA and LPS Challenging Arrangements. One code of practice rather than two aims to embed LPS in MCA.

21. Learning Disabilities (LD)

21.1 The Learning Disability Service is part of the Safeguarding Team and aims to respond to the additional needs of people with Learning Disabilities (LD), and the quality of assessment and care people with LD received when accessing our services.

21.2 A total of 355 contacts were reported by the Trust's LD Nurse during the year.

21.3 The table 15 below showing the quarterly number of contacts:



Data source SG internal database and LD excel spread sheet of notifications

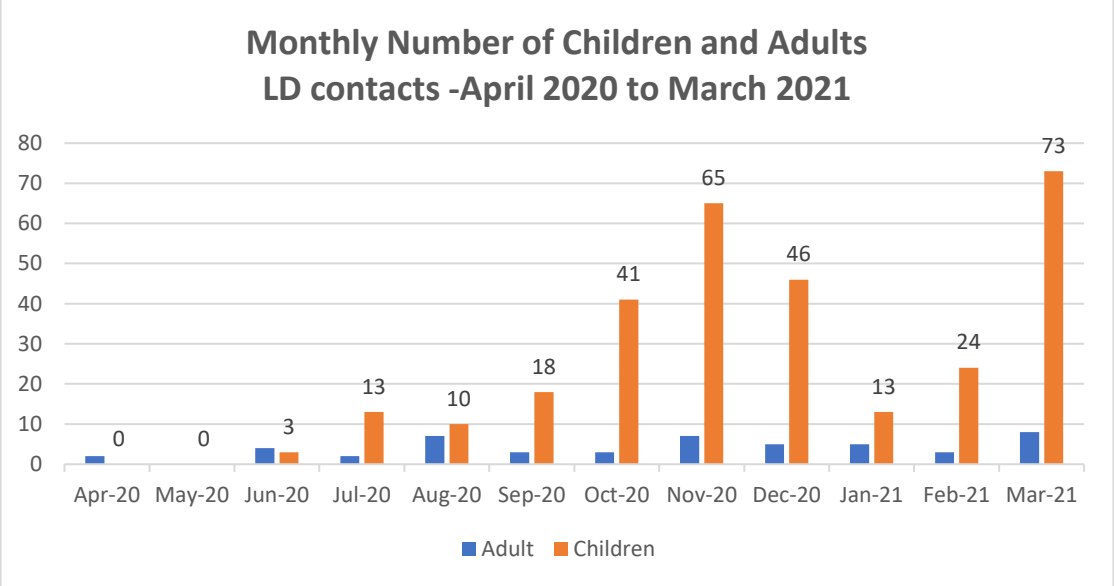
21.4 The previous year total contacts reported was 615, a total reduction over 50%. This is in line with reduced activity inpatient and outpatients due to COVID-19 pandemic.

21.5 The LD Nurse left the Trust at the end of April 2020, and the new LD Nurse commenced into post in November 2020. During the period of vacancy of the Trust LD specialist; the CNS for Transition has provided support, advice and guidance for patients and family and carers pre and during their hospital admission. The Safeguarding Team provided telephone advice and support to staff including best interest meetings.

21.6 The Trust Lead Nurse has sort support and advice as required, from Birmingham Women and Children's Hospital (BWCH) LD Lead Nurse; who also participated in the interview panel for the LD staff member.

21.7 Monthly reports of the contacts/ activity, along with the themes and trends are presented to Trust Safeguarding Committee for discussion review and escalation, by the LD nurse. The activity summary of contacts with LD Nurse reported via the Safeguarding Quality report .

21.8 The table 16 below showing the number of learning disability children and young people and adults contacts monthly reported.



21.9 Learning took place around the importance of ensuring families are contacted to ascertain the reason for not attending an appointment prior to categorising it as a Did Not Attend (DNA). In one case there had been lack of reasonable adjustments in terms of communication method. This was discussed and practice altered accordingly.

21.10 Staff are reminded to:-

- Continue to submit a learning disability notification when they come into contact with a patient with learning disabilities. Staff are encouraged to include as much information as possible, and to contact the learning disability nurse if support is required.

21.11 **Learning Disability Case Studies**

Case A-
Outpatient planning – Oncology Clinical Nurse Specialist who had identified that a patient with learning disabilities was due in clinic. LD Nurse provided support by informing the staff in oncology, outpatients and ultrasound who were expecting to see the patient of relevant support needs. Liaising with different departments involved with the patient ensured appropriate sharing of information and enabled the appointment to run smoothly with relevant reasonable adjustments being made.

Case B
Understanding behaviour – LD nurse requested to see young man with ADHD who was displaying verbally aggressive behaviour toward staff following admission and surgery. A conversation was had with the patient who explained he was in pain, was constipated and was struggling to communicate his needs. Discussion regarding pain management and laxative options was had with the patient and ward Senior House Officer (SHO). The patient understood it wasn't appropriate to be aggressive towards staff and alternative ways of expressing his needs were discussed as well as any required adjustments.

Case C
27-year-old male patient with Downs syndrome with dislocated hip. Patient lacked capacity so best interests meeting organised with key people and Involvement of Independent Mental Capacity Advocate (IMCA). Agreement made regarding surgical decision and patient has undergone surgery and has had extended inpatient episode to facilitate physio and mobilisation. Patient has LD passport which has been utilised by ward staff.

Case D
Multidisciplinary working - A 16-year-old with autism, ADHD and scoliosis has been on the waiting list for anterior and posterior surgery and presented with declining mental health. Collaborative working between LD Nurse, Transitions Nurse, Spinal Nurse and Community Mental Health Team to develop a plan to progress care and to support the patient and family whilst waiting for surgery. Transition Nurse and LD Nurse have worked with the family to determine their support needs and liaised with the safeguarding team to make a referral for early help.

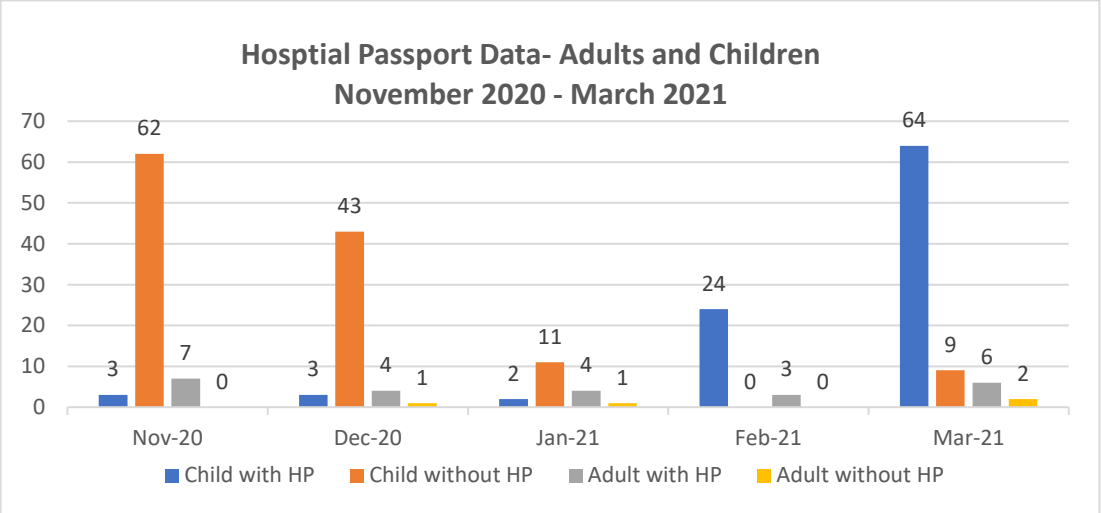
21.12 **Hospital Passport Compliance**

A hospital passport is an essential document which a person with learning disabilities should have to take with them to all appointments throughout their life. It is an evolving document containing information all about the individual, not just health and care needs. It is a communication tool and highlights reasonable adjustments required to support an individual.

21.13 Since commencing in post November 2020, the LD nurse has been monitoring hospital passport. This previously had not been regularly reported on. Excellent progress has been made, and this will continue to be monitored. This was following

focused work, and education of staff about the importance of hospital passports and how they must be offered to all patients with a learning disability as gold standard.

21.14 Below table 17 demonstrates the improvement:



21.15 Below is example of the actions agreed to help with compliance:-

- Staff must explain what the passport is and how it can assist them
- If a patient doesn't think they want one, it can be offered to take home with them
- If patient doesn't want a hospital passport or if it is not deemed applicable then justification must be noted on the learning disability notification and clear documentation in the patients notes.
- If diagnosis or need is picked up following an appointment passport to be sent out with an accompanying letter. The LD Nurse has created an easy read letter which can be posted out with a hospital passport.
- Entry in the OPD section of notes must be completed following an appointment containing if the first contact form was completed/ reviews and any outstanding actions, completion of LD notification along with details about diagnosis, support needs and whether a passport was issued (if not, reasons documented).

21.16 **Learning Disability Training**

Learning Disability training for induction of staff had been reviewed and updated by the LD Nurse prior to leaving the Trust, Tier 1. As this was provided on the mandatory training day which was The Oliver McGowan's Story, and what are reasonable adjustments

21.17 The Oliver McGowan Mandatory Training on learning disability and autism is currently being developed, trialled and undergoing evaluation by the trial partners. The Trust had put itself forward to undertake the trail, however was not selected.

The evaluation process aims to be completed by February 2022. The training will cover tier 1 and tier 2 of the Core Capability Frameworks for supporting people with Learning Disabilities and Autism. Stakeholder meetings are being held every few months which the LD Nurse attends and provide updates.

21.18 **Trust LD strategy**

Trust LD strategy was launched May 2018. An annual review was undertaken and summary report presented at the May 2020 Safeguarding Committee to identify where the Trust was two years into the three-year life of the Strategy which expired in March 2021.

21.19 In March 2021 a summary report was presented of what has been achieved over the three years since its implementation, whilst also reviewing and updating the strategy ready for a relaunch.

21.20 Staff and patients are key stakeholders in the development and delivery of the Learning Disability Strategy. The plan is to use a questionnaire to scope awareness and understanding of the current strategy with staff across the Trust. This audit will be conducted by identifying an appropriate time with managers for a variety of staff to take a few minutes to complete the questions independently.

21.21 The plan for the new strategy is that it will cover both learning disabilities and autism. This is due to the fact that the Trust does not currently have any specific strategy relating to autism, as highlighted in the data collection exercise for this year's NHS benchmarking submission. As well as this, the creation of the Oliver McGowan Mandatory Training in Learning Disability and Autism highlights the importance of healthcare staff being aware of both learning disabilities and autism and how to make reasonable adjustments to support both of these populations.

21.22 **Learning Disability Electronic Flagging**

In relation to the Learning Disability Electronic Flagging System, an update has been made to the current electronic patient administration system. Whilst this does not meet the Flagging requirements set out in the improvement standards, there is evidence that in some cases having an alert/ patient needs details (not flag) on a patient record does have some benefit to the patient experience. This remains on the Trust risk register number 1383, and remains ongoing with the Trusts IT and analytics department on how we can improve our current systems to achieve the required standards. An ongoing challenge for the Trust as in reality it requires a larger scale project where all computer systems within the Trust are either merged into one or synchronised so they are all able to feed into each other, at present this is not possible.

21.23 Forward Look 'Patient Needs Summary Report' – Discussed at the Accessible Information Standards meeting in February 2021. Clinical Service Manager requested to Informatics that this report is updated to reflect inpatient information as well as outpatient appointments.

- To submit learning disability under 'patient need' on PAS rather than as a safeguarding alert. A flow chart has been developed to explain how to do this. This is available in outpatients and will be available on the intranet.

21.24 The Trust has supported the refurbishment and upgrade of reflection room in OPD, support obtained from BWCH LD Lead regarding equipment lighting to source for the room from sensory point of room, to provide a more tranquil environment for patients with LD.

21.25 **The Learning Disabilities Mortality Review (LeDeR) Programme**
LeDeR programme is one of the recommendations from the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD).

21.26 An initial review of the death takes place. Purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who had died, and if any further learning could be gained from a multiagency review of the death that would contribute to improving practice

21.27 Learning from lives and deaths – People with a learning disability and autistic people (LeDeR).

21.28 The first LeDeR Policy was published in March 2021 and makes some significant changes to the LeDeR process. The LD Nurse, Safeguarding Lead, and Assistant Medical Director met to discuss how this is reflected in the Learning From Deaths Policy, which required update and to ensure the Trust complies with new policy and the new LeDeR reporting.

21.29 LD Nurse attended multi-agency panel meeting at the end of February 2021. Three completed reviews were discussed. Themes that arose included discussion around supporting access to screening programmes, ensuring the individual has a voice and confirming the understanding of the individual or family.

21.30 LD Nurse has completed the LeDeR reviewer training to ensure that the Trust can contribute effectively to the LeDeR programme, along with Trust Learning from deaths process and procedures.

21.31 **NICE Guidance and Standards**
The following NICE standards relating to LD were reviewed. Full assessment reports have been sent to the Clinical Audit Committee in December, for review in March 2021 by the Trust Audit Committee.

- Care and support of people growing older with learning disabilities – NG96
- learning disability: care and support of people growing older – QS187
- Learning Disability: behaviour that challenges – QS101)

21.32 The review found that as a hospital we are mainly compliant areas for action have been identified in assessment report. Progress on areas for action will be reported to the Safeguarding Committee.

21.33 **NHS England & NHSI Improvement Learning Disabilities Improvement Standards**
The Trust submitted the required data return in January 2021. This data covers the period between April 2019 and March 2020. It is collected through distribution of patient surveys, staff surveys and data collected in response to specific questions set by the NHS England and NHS Improvement Learning Disability Standards Review document. We are currently still awaiting publication of last year's report.

21.34 Publication of the NHS England & NHS Improvement Learning Disabilities Improvement Standards with NHS Benchmarking report is expected later in May 2021

21.35 Once the official report is published this action plan will be updated to reflect the outcomes and will be monitored quarterly at the Safeguarding Committee.

21.36 **Challenges LD**
There is no official learning disability database. Safeguarding Admin and LD Nurse are working with a monthly excel spreadsheet to record notifications, which is time consuming and not fit for purpose. This has been previously raised with IM&T Manager. Safeguarding Lead has submitted a request for the creation of this. A Learning Disability patient database would hold accurate numbers of patients, better data collation and increased accountability. To support its creation the LD Nurse has review the current Learning Disability notification to ensure all data required is being collected.

Publication in November 2020 of analysis of findings from LeDeR COVID-19 reviews and subsequent Action from Learning Report highlights the vulnerabilities of a person with learning disabilities throughout the COVID-19 pandemic. The publications highlight that people with Learning Disabilities are likely to die at a younger age from COVID-19 than that of the general population, inappropriate use of DNACPR, access to healthcare was problematic and diagnostic overshadowing played a part in delayed treatment as well as lack of identification of deteriorating health.

One of the main recommendations listed included application of reasonable adjustments (e.g. allowing carers/ parents to accompany the patient) and encouraging the uptake of annual health checks. These two areas the Trust is actively addressing and can demonstrate reasonable adjustments made for patients,

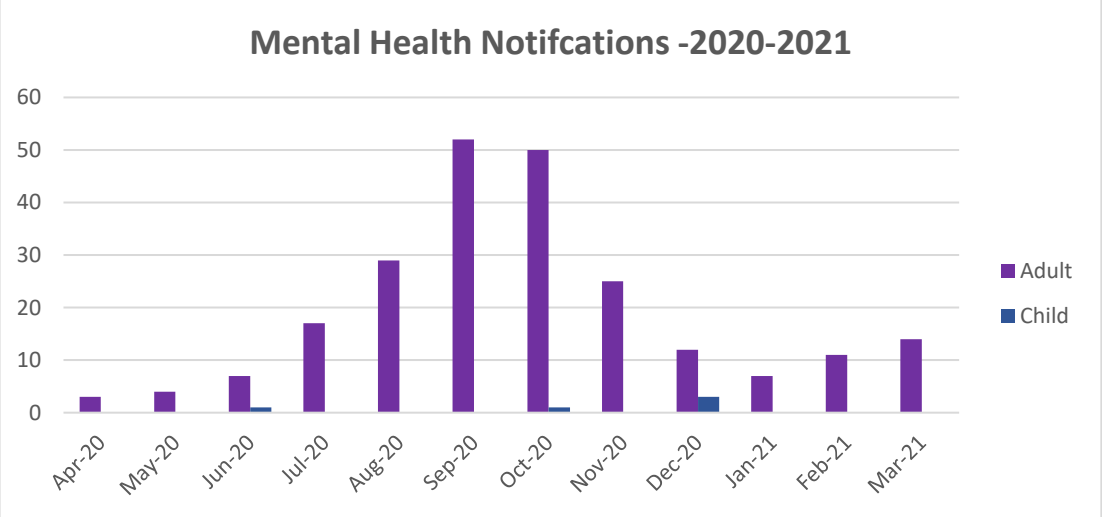
and the update of patients having annual health checks by GP's on discharge correspondences, will be area of work next year

22. Mental Health (MH) and Mental Health First Aid (MHFA)

22.1 Mental Health update –"*Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to his or her own community".* (World Health Organisation).

22.2 The Trust has an obligation to maintain patient safety and in a Mental Health Crisis need to be able to provide immediate first aid and organise transfer to a suitable provider.
As a Trust we do not treat/diagnose Mental Health conditions.

22.3 Table 18 below showing the number of notifications received by the Safeguarding Team per month adult and children. A total of 93 contacts reported via the safeguarding internal notification system. Total of 236 contacts.



Data source Trust Internal Database

22.4 Of these 231 were adults and 5 were for children. This activity is representative of the number of patients being seen in the Trust during this period, due to the impact of COVID-19 and Trust activity during this period.

22.5 Themes/trends

- Increase in numbers of notifications coming through, due to higher incidence and greater awareness
- Patient voice listened to and their wishes considered
- Good evidence of Multi-Disciplinary Team (MDT) working with GP, Community Psychiatric Nurse (CPN), and appropriate information sharing

- Good signposting to appropriate professionals and other support via intranet/health minds
- Staff generally more empowered to have Mental Health conversations, and understand escalation route
- Staff take expressions of suicide seriously and see it as a medical emergency, and have professional curiosity to question patient about intentions (current plan/ previous suicide attempts/ access to resources)
- Some staff still keen to hand over concern to Safeguarding Team/MH lead, these staff are supported and steered to own the issue and manage it.

22.6 Numbers of Mental Health contacts rising significantly in OPD, however whilst MH prevalence is increasing it should also be noted that the MH questions in the revised Integrated Care Pathway (ICP) document are now routinely completed and therefore more MH concerns are identified.

22.7 Input provided by the Safeguarding team has been signposting to support organisations, GP informed, Crisis Team, Community Psychiatric Nurse (CPN) contacted when required patients transferred for liaison psychiatry assessment. Most importantly supporting the staff in dealing with concerns raised to them. Continual reminder to staff with regard to the role of MHFA and how they support patients, fully utilising training undertaken.

22.8 In terms of the mental health conditions being reported these included most commonly the following

- Anxiety /Stress
- Psychosis
- Psychosis (Schizophrenia)
- Depression
- Self-Harm
- Suicide

22.9 **Mental Health Case Studies-**

Case A
Patient ticked self-harm/suicide within preoperative document. Staff worked well and used their professional curiosity to engage with patient to gain more information. Patient risk assessed following immediate mental health first aid assessment and was agreed using a multi-disciplinary approach the patient would benefit from external referrals being made. Patient consented to external referral to be completed for support within the community. Patient received help and support for mental health concerns within the community managed by GP and now has regular contact with a community psychiatric nurse (October 2020)

Case B
A patient in December 2020 required implementation of section 5.2 (Drs holding power) due to psychosis, patient however was later discharged with community psychiatric support. This patient also disclosed Domestic Abuse.

Alerts that were being logged onto the Trust Patient Administration System (PAS) Lorenzo, stating Mental Health conditions, that as this is visible to all it is inappropriate, and should only be shared with those who need to know. Re-education was undertaken with teams about alerts and that if they feel an alert is necessary should record 'see notes for detail' this way information can be shared sensitively and is not visible to those externally.

22.10 **Mental Health First Aider (MHFA) Training**
Mental Health First Aid (MHFA) Training which commenced in Oct 2108. MHFA training was initially targeted at departmental senior staff, bleep holders and clinical site coordinators. There has been a total of 166 MHFAs within the Trust. Further training dates at planning stages for new year pending pandemic status and recruitment of band 7 MH lead for Trust.

22.11 The training had been led by the Matron Inpatient Services - Division 1, who was leading on mental health as corporate role. Supported by the LD Nurse prior to leaving the Trust in April 2020, who had Mental Health experience, and undertook the MHFA train the trainer programme along with the Matron initially. During September 2020 and October 2020, a further 4 training session were provided, face to face in line with social distancing.

22.12 Mental Health will remain within the remit of the Safeguarding team, noting the impact of growing Mental Health portfolio on Safeguarding team resources.

22.13 The Trust has a Service Level Agreement (SLA) with Birmingham and Solihull Mental Health Foundation Trust (BSHMHFT) and this will remain in place.

22.14 The Trust approved the appointment of a Dementia /Mental Health specialist practitioner band 7. Unfortunately, we were unsuccessful in appointing to this post. We are now reviewing alternative recruitment avenues. The selection and recruitment being supported by a senior staff member from (BSHMHFT).

22.15 Mental Health working group, had been set up by the Matron Lead for Mental Health, however cancelled due to national lockdown and staffing demands in clinical areas.

22.16 Mental Health Buddies - Mental Health first aiders (MHFA) are supporting the Health and wellbeing campaign, by 'buddying' anyone in the Trust that requires their help and support with their Mental Health, this will be monitored and reviewed.

22.17 All staff complete Mental Health Awareness e-learning on induction to the Trust. This presentation has been reviewed and updated by the Matron with corporate lead for Mental Health. This package has been implemented with the support of Senior Web and Systems Developer; whilst we continue to resolve access to the server to enable us to upload our own content onto Electronic Staff Record (ESR).

22.18 **Youth Mental Health First Aider**
A business case for Youth MHFA was approved in relation to under 18's Mental Health provision in Trust. Two staff members in the Trust have completed their 2-day youth Mental Health First Aid course and are scheduled to attend a training course to become instructors to deliver course to ROH staff in the new year. This course will be applicable to all those involved with patients under the age of 18 (including transition patients on Adult wards). (Sept/Oct 2020)

22.19 Risk in relation to under 18's Mental Health Provision in Trust remains on register (risk 1416) as Youth Mental Health First Aider's training has been delayed due to COVID-19 pandemic.

22.20 **Staff Mental Health support - Florence Nightingale Foundation**
The Executive Director of Nursing recognised the impact that Corvid has had on front line nursing staff, and secured charitable funds to purchase places on support sessions offered via the Florence Nightingale Foundation, who provide sessions for:-

- Ward managers/ Team Leaders
- Senior Leaders
- Staff Nurses
- Newly Registered Nurses

22.21 Sessions were delivered in small groups via a virtual learning platform. Expert facilitators provided a psychologically safe learning space. Nurses were able to connect with others from across the country to coach each other and benefit from sharing experiences and receiving reciprocated support. Sessions were 3 hrs long and had a maximum of 6 participants per session.

22.22 23 staff utilised the support sessions, the feedback from the sessions has been very good with the sessions equipping staff with the knowledge and resources to look after themselves better, and also how to support their teams. Additionally, there is clinical supervision providing staff an opportunity to debrief and learn from one another's experiences.

23. Achievements for Adults and Children's Safeguarding – 2020-2021

- Support to colleagues during COVID-19 pandemic
- Maintaining quality of safeguarding practice throughout COVID-19 pandemic
- Group and 1 to 1 supervision sessions for Children and Young People outpatients' team.
- Recruitment to:-
    - Learning Disability Nurse – commenced in post November 2020
    - Band 6 Safeguarding Nurse Secondment and development opportunity (initial 6-month period)
    - Safeguarding Administrator (commenced mid-March 2021)
- Increase in safeguarding recognition and reporting across the Trust
- New Staff Domestic Abuse Policy, and care pathway for Domestic Abuse
- Inputted into the Virtual Clinic Standard Operating Procedure (SOP).
- Domestic Abuse Champions training total of 80 staff attended internal training provided by the Named Nurse and Safeguarding Nurse.
- Improvement in completion of MCA Assessment and from audit undertaken, staff understanding of the MCA .

24. Summary of the areas for focus and improvement identified for 2020/2021

Areas of Focus	Outcome	Rating Achieved Yes or No
Trust Safeguarding Strategy Review Strategy updated for Safeguarding -previous one expired 2019	Work undertaken in 2020 One-page strategy and staff handbook to support the strategy Review and new strategy presented to Trust Board March 2021	**Yes**
Named Doctor for Paediatric Safeguarding Staff member to be identified- in line with national compliance, as replacement required; as the current Named Doctor stepped down. The risk register updated to reflect current assurances	Named Doctor appointed and reporting to Trust Safeguarding Committee. Supervision undertaken – virtually due to COVID-19	**Yes**

supported by the Paediatrician Service level agreement.		
Voice and Choice and Engagement To ensure that the voice of the children and adults is included in service development	Staff asked to ensure when completing notification or incident to ensure what the patient wishes/ outcome are recorded. Due to COVID-19 restrictions limited opportunity due to lack of direct contact. Area of focus for the C&YP Group going forward next year. Adults Patient Forum and Patient and Public Engagement Strategy to launched later 2021	**Not fully**
16- 18-year olds Ensuring smooth transition of young people from children and young people to adult services and ensuring adult focused staff have the understanding, skills and confident to identify and act upon children's safeguarding issues	Transition to Adults Clinical Nurse specialist was redeployed during COVID-19 first wave impacting on plan delivery. CNS moved to part of Safeguarding Team as from 01 April 2021	**Not Fully**
Co-ordination of Safeguarding between ROH and Birmingham Women's and Children Hospital (BWCH) Ensure robust communication and joint working practices are in place to safeguarding children and young people across both Trusts	No incidents or issues raised Trust has a governance arrangement with BWCH. Children and Young Peoples Manager close links with BWCH.	**Yes**
Direct Questioning Undertake further training for staff, to increase confidence	Direct questions being asked in ADCU and POAC. Staff Domestic Abuse Policy now approved.	**Yes**

	Focus for 21/22 Trust wide roll out.	
Liberty Protection Safeguards (LPS) Preparing for the introduction of the Amended Bill, due to come into force in May 2019, now proposed date of April 2022	Awaiting Government DOH Code of Practice , delay in introduction. Working in partnership with other providers and CCG Leads to plan for preparation and introduction, risks and implications to practice	**NO** **Outside of Trust control**
Department and Ward Self-Reporting and Audit of Safeguarding To develop departmental and ward ownership of Safeguarding including identification of best practice and areas of challenge to inform the Trust safeguarding agenda	Upward reporting on scheduled plan from areas undertaken Completion of complex care audits monthly.	**Yes**
Safeguarding Supervision Embed supervision within the Children and Young People Services and evaluate how it has influenced practice and training	Team supervision by Named Nurse and Safeguarding Nurse	**Yes**
Outcomes for Children and Young People Improved evidence of the impact that safeguarding practice in the Trust has on the outcomes of the children and young peoples and adults who use our services/care.	Further work is required here. There is some evidence of Early Help referrals and SG Team referrals to demonstrating proactive rather than reactive safeguarding and support has been evident.	**Not fully**
Mental Capacity Assessment Tool Review and update and embed staff understanding	Audit undertaken by external provider Monthly training offered by Lead Nurse.	**Yes** **Work continues in preparation for LPS implementation**

Safeguarding Documentation Care Pathway to review and update safeguarding care plans for patients, with staff involvement and learning from cases/ concerns.	Outstanding	**Focus for 21/22**
Restrictive Physical Intervention Policy and training review to be undertaken by the Lead Nurse	Policy reviewed and updated, Training Needs Analysis undertaken.	**Yes**
Information collection and monitoring Review and update of Trust internal safeguarding database	Request to IM&T for update on categories and subcategories in light of national and local changes i.e. Hate Crime , Contextual Safeguarding LD database remains outstanding	**No** **IT support and investment required Carried forward to 21/22**
Staff Domestic Abuse Policy New Policy Staff awareness and confidence in direct routine questioning	Completed and DASH tool training and, DA care pathway developed and staff trained.	**Yes**

25. Trust Safeguarding Strategy

25.1 The strategy presented to the Trust Safeguarding Committee and Quality and Safety Committee for approval. This is aligned with Trust objectives and values, and those of the local Safeguarding Boards BSAB and the BSCP.

Our 7 Safeguarding priorities for 2021-2025	
1	To hear the voice of adults, young people and children
2	To make safeguarding a priority
3	To improve awareness and practice
4	Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) are understood and embedded , implementation of Liberty Protection Safeguards (LPS)
5	To work in partnership
6	To have a safe and effective reporting workforce
7	To ensure a focus on transition from child to adult services

25.2 The priorities have been set out in 'Strategy on a page'. This will form part of the communication of the strategy in terms of poster and internet/ intranet update. Also workshops and roadshow events.

25.3 To achieve our key priorities an action plan has been developed. This will be reviewed and updated quarterly to ensure delivery of this strategy. The work action plan will form part of the annual reporting. The Trust Safeguarding Committee will monitor and review progress and will report to the Quality and Safety Committee which is a subcommittee of the Trust Board.

26. Challenges for 2021-2022

- Preparation for introduction of Liberty Protection Safeguards, due to be introduced in April 2022.
- Compliance with Safeguarding training
- Resources within the Safeguarding Team to meet growing Safeguarding agenda.
- Implementation of the Domestic Abuse Policies and routine enquiry.
- The continued virtual working/ home working of partner agencies delays in responding and closing cases.
- E Training fit for purpose with assurance of understanding, and impact – IT support required to ensure modules are deliverable due to different system needs.
- Virtual clinics due to COVID-19 restrictions, patients no longer have a safe space in a hospital environment to disclose SG concerns and staff are unable to use professional curiosity due to potential SG risks within home environment. Standard Procedure being embedded.
- Information collection and monitoring - Review and update of Trust internal safeguarding database to ensure categories and outcomes captured.
- To ensure data for LD and MH and Transition can be collected as currently no database system available.

27. Key objectives for 2021-2022

27.1 **Areas for focus and improvements for the Safeguarding Team to include:- See Appendix B**

Preparation for the implementation of Liberty Protection Safeguards LPS in the Trust One area for example - Produce a Q&A document which will be able to answer specific questions to aid implementation and staff awareness. The paperwork/care plan to be familiar unlike DoLS; LPS are not confined to one

setting.
Increase staff and public awareness of local and national safeguarding agenda and priorities across the Trust- purple paper using divisional meetings and forums. Road show /events.
Evidence that learning and training is having a positive impact on safeguarding practice- audit
Improve safeguarding practice for older children and young people across the Trust-Transition
Improve safeguarding documentation systems- care plans
Improve opportunities for patients to be heard and give feedback regarding their experiences. Via patient experience groups and induvial contacts, patient case stories
Safeguarding team review and business case development to meet the growing safeguarding agenda for children, young people and adults at risk – Health Inequalities
Raising profile of Domestic Abuse direct questioning across the Trust to increase disclosure and support provided by the Trust
Safeguarding Supervision being further imbedded into the Trust
Evidencing , recording of Safeguarding refresher training compliance for staff.
Evidence of activity - Review and update for Trust in house Access Database for SG, and ensure that MH , LD and Transition data is also able to be inputted, and extracted for reporting internal and external also trend analysis .
Develop and update Level 2 and Level 3 training in house to meet the changing needs for training delivery, on line platform training.
Youth Mental Health First Aid Training carried out by the Trust two trainers,- sessions scheduled delayed due to COVID-19 restrictions
Internal audits programme schedule delivered and shared learning of findings and areas for improvement (see Appendix A).
Review and update external website to include information and support around safeguarding for public to access

27.2 The Safeguarding Team are constantly seeking ways to improve how we work together to ensure the best outcomes for all those who use or come into contact with our services.

27.3 Trust Board are asked to receive this report and endorse the safeguarding areas of focus for 2021-2022. These have been developed in line with the local Safeguarding Boards priorities and actions, as well as the organisational requirements to ensure a culture of good safeguarding practice is maintained within the Trust.

For Board and Board Committees:	Trust Board
Report supported and authorised by	Mr Garry Marsh – Executive Director of Nursing and Clinical Governance and Facilities / Executive Lead for Safeguarding
Paper Authored by	Evelyn O'Kane -Lead Nurse Safeguarding
Organisational Risk Register considerations:	The Trust fails to safeguard children and adults appropriately
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Safeguarding Committee
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate agenda planning	Annual Report

Appendix A

Safeguarding Audit Schedule Workplan 2021-2022 Audits- Internal spot checks and reviews - programme workplan	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Domestic Abuse *							x					
Restrictive Interventions/ physical intervention						x						
Person in Position of Trust - Managing Allegations				x								
Mental Capacity Act - MCA assessments	x											
Deprivation of Liberty Safeguards -DoLs	x											
Training -evaluation of effectiveness/ impact		x			x			x			x	
Child Exploitation - CE*								x				
Safeguarding Documentation Audit - C&YP				x								
Safeguarding Documentation Audit - Adults				x								
Prevent -Radicalisation						x						
Transition			x									
Clinical Holding - Children								x				
Chaperone Policy			x									
Safeguarding Supervision						x						
Patient Assessment Documentation (first contact form) for CYP patients- use in the Trust									x			
FGM*										x		
Referrals - children and adult				x								

Trust Intranet Page Icons for focus work for 2021-2022 Appendix B

Icons used on the Trusts intranet page to provide support guidance and process for staff , these will be further developed as part of the focus work for the Safeguarding team in 2021-2022.



Self-Neglect – Understanding , risk enablement and support and guidance for patients and staff . Complexity and need to build trust.



Mental Capacity – we need to get it right, and fully understand and implement this, in preparation for the impact of the LPS being introduced.



Modern Day Slavery and Human Trafficking – for us to support the Government aims to tackle the issues and work collaboratively



Domestic Abuse – Taking this forward imbed the direct questions and the pathway Trust wide and Domestic Abuse Bill (2021)

ROHTB (9/21) 009 (c)

The Royal Orthopaedic Hospital NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2020/21

Author: Garry Marsh
Role: Executive Director of Nursing and Clinical Governance

Approved at: Infection Prevention and Control Committee
Date of approval: September 2021

Introduction from the Director of Infection Prevention and Control

Infection Prevention and Control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (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 Director of Infection Prevention and Control's annual report for 2020/2021

The work of the IPC team and the Trust was significantly impacted by the COVID-19 pandemic from mid-January 2020, initially with the management of potential cases of SARS-CoV-2 infection as a high consequence infectious disease (HCID), and then as significant numbers of cases were managed in the Trust in March 2020 onwards. Further to this the NHS continues to experience unprecedented challenge clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centred and safety-focused. Our vision is to constantly provide the highest possible standards of care across our healthcare economy. You can learn all about the challenges faced by the ROH during the pandemic within this report.

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. During the pandemic we continued this work to the standard we have always worked to.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (see table of criteria on following page). The IPC agenda has continued to be strengthened with a highly visible Infection Prevention Team and a new IPC Matron. The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors and volunteers across ROH, Clinical Commissioning Groups (CCG) and Public Health England (PHE) in relation to the prevention of avoidable HCAIs.

Garry Marsh
Executive Director of Nursing and Clinical Governance
Director of Infection Prevention and Control



This report demonstrates how the Trust has systems in place for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this there are two principles:

• to deliver continuous improvements of care

• it meets the need of the patient

Compliance with the Health Act is judged against 10 criteria which we will look at in detail in the next section.

Criterion	**Detail**
Criterion 1	There are systems to monitor the prevention and control of infection. These systems use risk assessments & consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infectious to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide or secure adequate isolation facilities
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Hygiene Code Criteria and Contents of report

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
   - **a. The Director of Infection Prevention and Control**
   - **b. The Infection Prevention and Control Team**
   - **c. Committee Structures and Assurance Processes**
   - **d. Trust Board**
   - **e. Quality and Safety Committee**
   - **f. Infection Prevention and Control Committee**
   - **g. Surveillance of Healthcare Associated Infection (HCAI)**
   - **h. Methicillin resistant *staphylococcus aureus* blood stream infections (MRSA)**
   - **i. Methicillin-sensitive *staphylococcus aureus* blood stream infections (MSSA)**
   - **j. *Clostridiodies difficile* Infection (CDI)**
   - **k. Preventing and controlling the spread of CDI**
   - **l. Gram negative – bloodstream infections – *Escherichia coli* (E-*coli*)**
   - **m. Vancomycin/glycopeptide resistant *enterococci* (VRE/GRE)**
   - **n. Carbapenemase producing *enterobateriaceae* (CPE)**
   - **o. Tuberculosis (TB)**
   - **p. Norovirus outbreaks**
   - **q. COVID-19**
   - **r. Audit programme to ensure key policies are implemented**
   - **s. Audits of hand hygiene practice**
   - **t. Staff information and training**
   - **u. Seasonal Staff Influenza Vaccination Campaign**
   - **v. IPC Link Practitioners**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.
   2.1 Providing a clean safe environment
   2.2 Water Systems Management
   2.3 Management of Decontamination
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
   5.1 Surgical Site Infection (SSI)
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.

8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections.
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.

COVID-19 and this data

It is clear that the global pandemic of COVID-19 is having an effect on the number of cases reported to the surveillance of BSI and CDI. From an analysis of voluntary microbiology surveillance, there has also been a reduction in the number of cases of other bloodstream infections, not only those covered by the mandatory surveillance. In response to the pandemic, many elective procedures in hospitals were cancelled. Hospital patient populations changed dramatically in their composition; in order for us to understand the true incidence rate of infections, we will need to consider closely these changes. Section 1Q of this report will detail the Trusts response to the COVID-19 pandemic.

Compliance criterion 1

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

1a) The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable HCAIs at all levels in the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.
The DIPC will offer commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice. At the ROH the Executive Director of Nursing and Governance holds the role of DIPC.

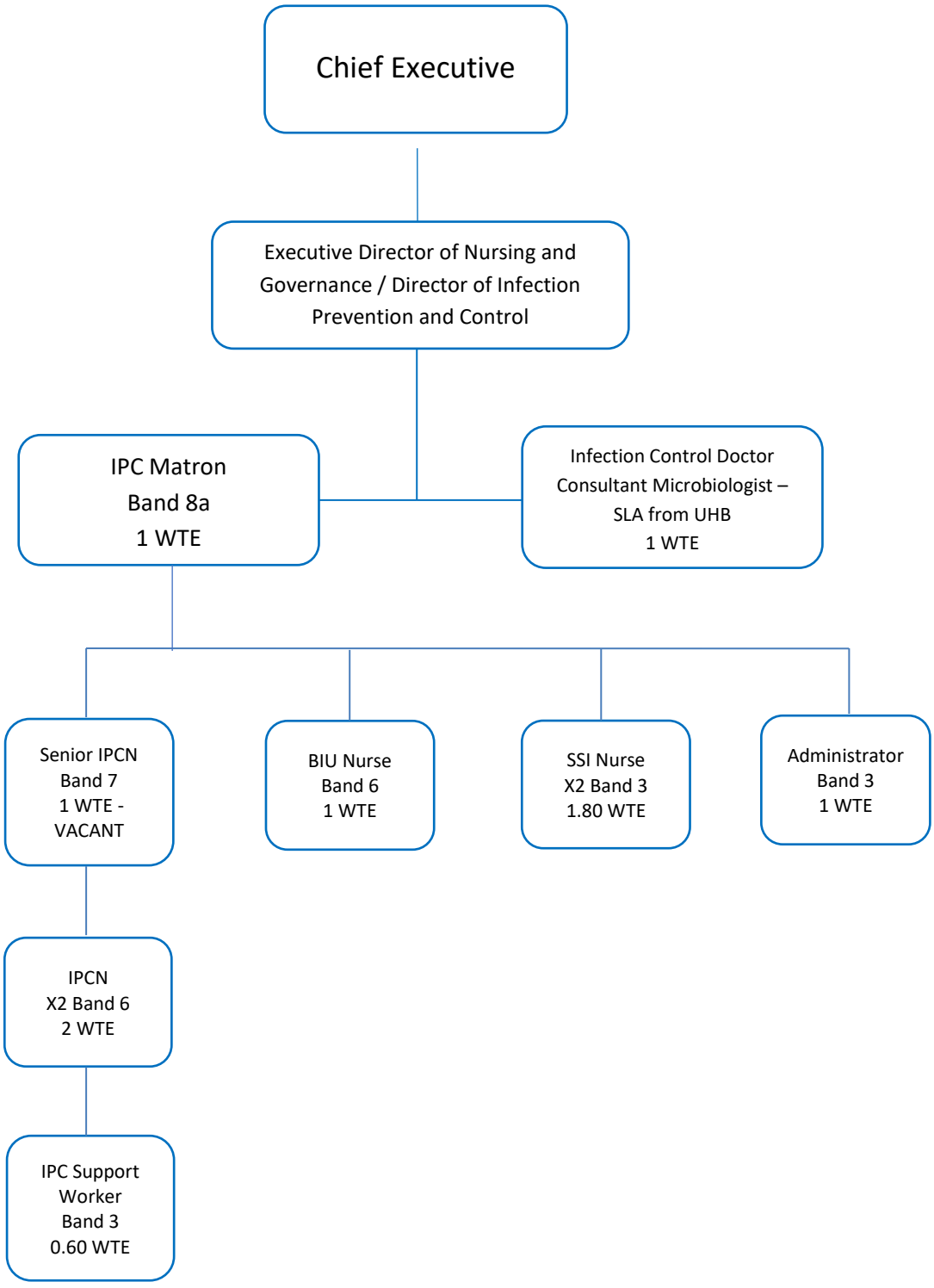
1b) The Infection Prevention and Control Team

The IPC Team is led by the Matron for IPC and is supported by Infection Prevention Nurse Specialists, Surgical Site Surveillance Health Care Assistants and an Administrator.

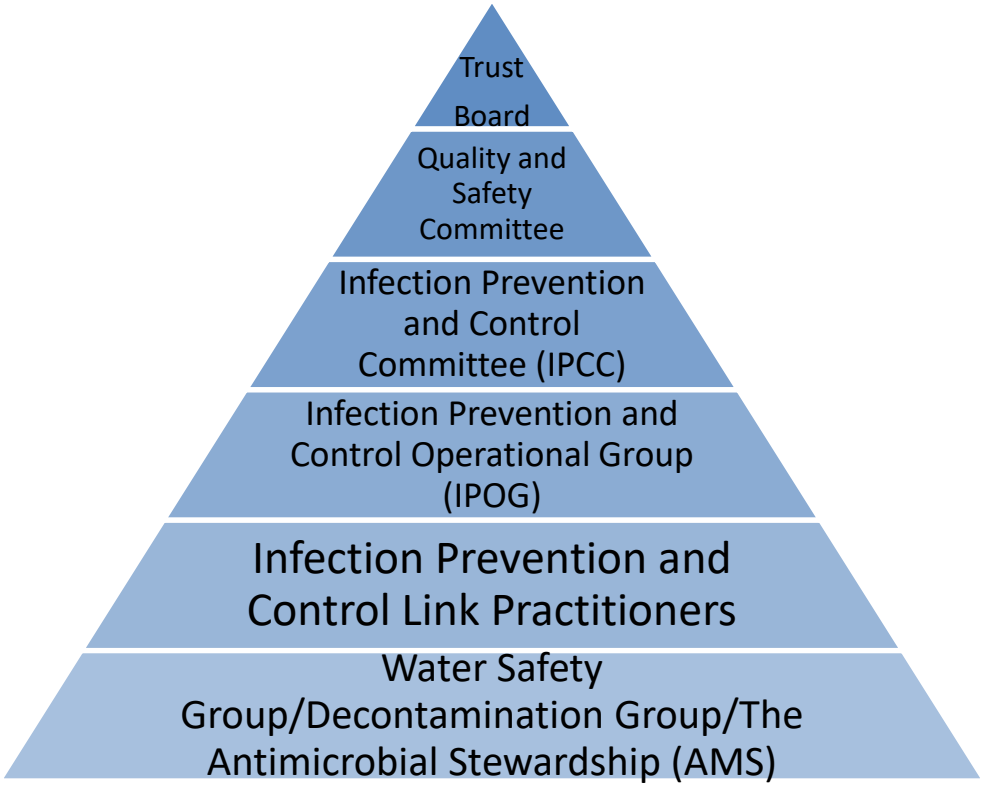
The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

The DIPC has overall responsibility for the IPC Team that works collaboratively alongside the front-line clinical leaders at the Trust.

IPC Team Structure



1c) Committee Structures and Assurance Processes



1d) Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive Officer (CEO) has overall responsibility for the prevention and control of infection at ROH.

1e) Quality and Safety Committee

The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety and continuous monitoring and improvement in relation to IPC. The QSC receives assurance from the IPCC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report on surveillance and outbreaks within the Quality Account.

1f) Infection Prevention and Control Committee

IPCC, chaired by the DIPC, provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to HCAIs. The Committee has a designated Non-Executive Director.

1g) Surveillance of Healthcare Associated Infection (HCAI)

Surveillance is undertaken on a number of alert organisms and mandatory reporting to PHE is undertaken. Performance is monitored by Birmingham and Solihull Clinical Commissioning Group (CCG). Overall performance at ROH is excellent.

1h) Methicillin resistant *staphylococcus aureus* blood stream infections

S. aureus is an organism harmlessly carried by around 30% of the healthy population. Its importance is that it is a leading cause of surgical site infection (post-operative wound infection).

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality. The risk of prosthetic joint infection and other orthopaedic implants is a particular concern in the patient population that ROH treats.

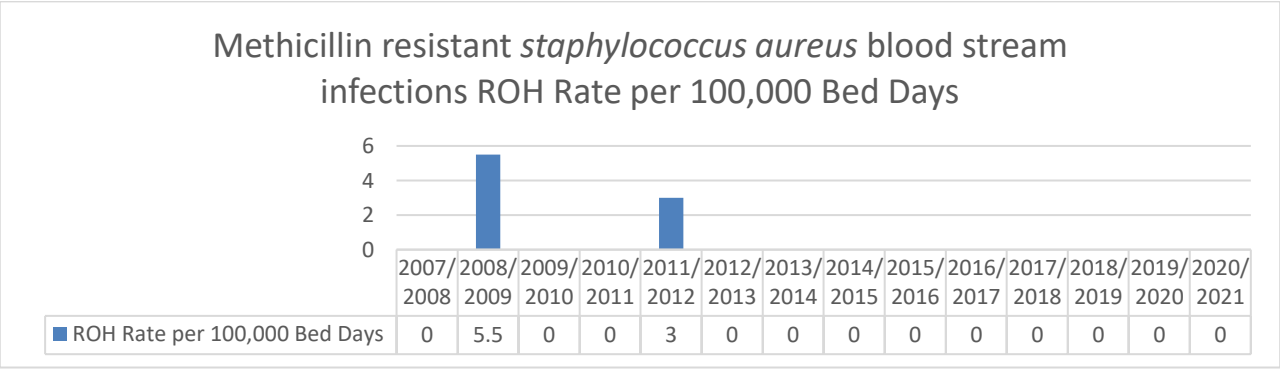
MRSA is a type of *S. aureus* that is resistant to the most commonly used group of antibiotics for perioperative prophylaxis i.e. prevention of post-operative wound infection. It is less commonly carried than the more sensitive strains.

ROH continues to mitigate the risk of MRSA infection by active pre-admission screening and isolation of colonised patients, in keeping with national guidance. Screening results also enables effective use of appropriate prophylactic antibiotics in colonised patients.

The ROH also comply with national guidance to reduce the risk of blood stream infection. Low rates of blood stream infection therefore offer assurance of:

- Effective screening strategies
- Management and care of devices
- Antibiotic prophylaxis
- Compliance with national guidance

For the period covered by this report 2020 - 2021 there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous 8 years;



	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
ROH Rate per 100,000 Bed Days	0	5.5	0	0	3	0	0	0	0	0	0	0	0	0

Figure 4a: Quarterly rates of all reported MRSA bacteraemia: April to June 2007 to October to December 2020

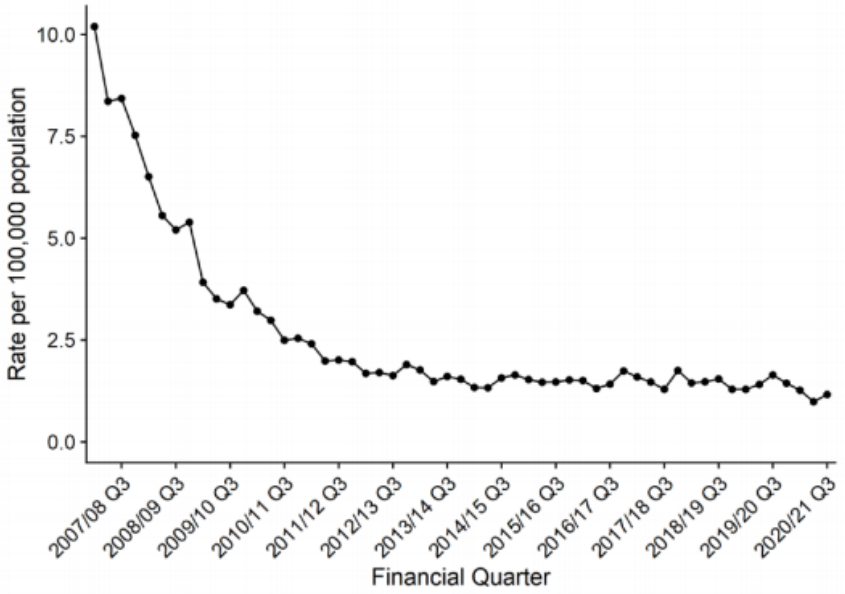
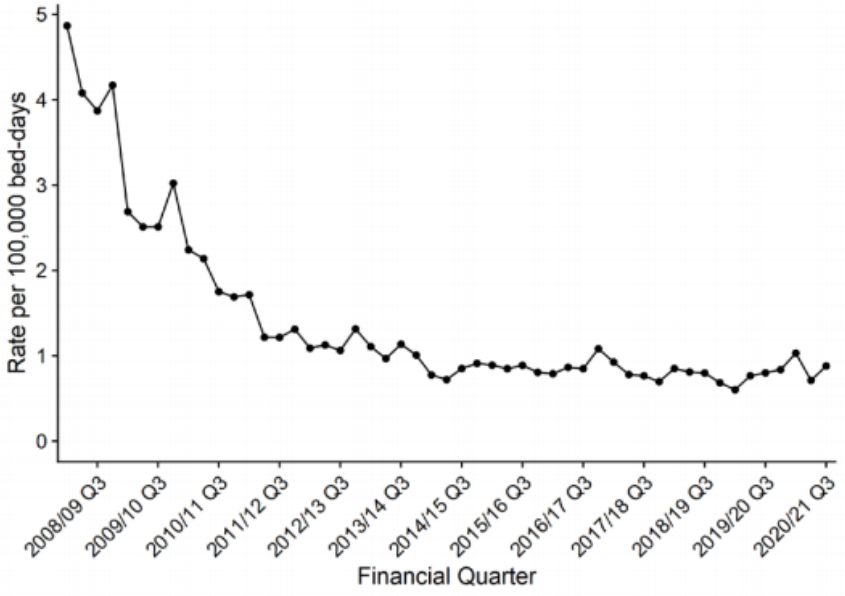


Figure 4b: Quarterly rates of hospital-onset MRSA bacteraemia: April to June 2008 to October to December 2020



Epidemiological analyses of *Staphylococcus aureus* bacteraemia data

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007 (Figures 4a, Table S4a). The incidence rate of all reported cases fell by 85% from 10.2 cases per 100,000 population in April to June 2007 to 1.5 cases per 100,000 in January to March 2014. The rate has subsequently decreased to 1.2 cases per 100,000 population between January to March 2014 and October to December 2020.

A similar trend was observed with the incidence rate of hospital-onset cases. There was a steep decrease of 79.0% from 4.9 cases per 100,000 bed-days in April to June 2008 to 0.9 January to March 2014.

Subsequently, between January to March 2014 and October to December 2020, the rate has decreased to 0.9 cases per 100,000 bed-days.

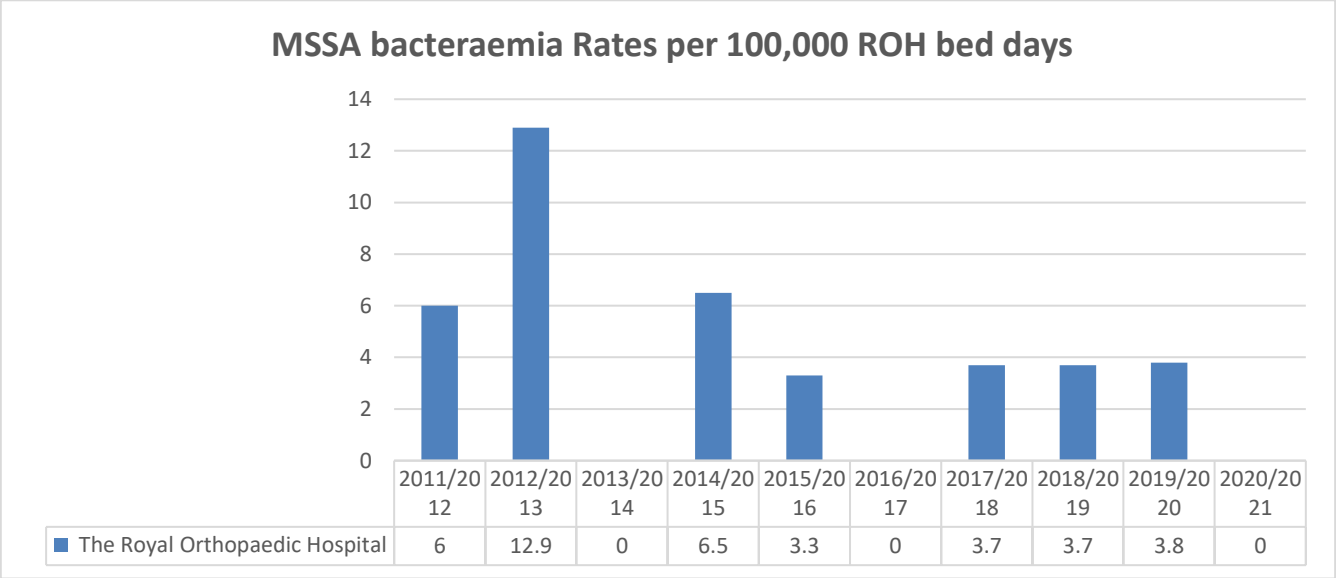
The effect of the COVID-19 pandemic on MRSA incidence is evident when comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) which shows a 29.2% decrease in counts and rates of all reported cases from 233 to 165, and 1.6 to 1.2 cases per 100,000 population, respectively. Community-onset MRSA bacteraemia cases and rates decreased 38.9% from 162 to 99 and from 1.1 to 0.7 cases per 100,000 population. The count of hospital-onset MRSA bacteraemia cases decreased 7.0% from 71 to 66 with a corresponding increase in the incidence rate of 8.8% from 0.8 to 0.9 per 100,000 bed days.

1i) Methicillin-sensitive *staphylococcus aureus* blood stream infections

Methicillin-sensitive *Staphylococcus aureus* is a type of bacterium which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.
MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

For the period covered by this report 2020 - 2021 there have been zero cases of MSSA.



Since the mandatory reporting of MSSA bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates of cases. The count of all reported cases of MSSA bacteraemia increased by 34.0% from 2,199 to 2,947 between January to March 2011 and October to December 2020. This was accompanied by a 23.7% increase in incidence rate from 16.8 to 20.8 per 100,000 population (Figure 5a, Table S5).

These increases are primarily driven by the increase in community-onset cases. Between January 2011 and October to December 2020, the count and the incidence rate of community-onset cases increased by 40.4% and 29.6% respectively from 1,464 to 2,055 cases and from 11.2 to 14.5 cases per 100,000 population. Over the same period, the count of hospital-onset cases increased by 21.4% from 735 to 892 cases, while the incidence rate increased 41.1% from 8.4 to 11.8 cases per 100,000 bed-days (Figure 5a and 5b, Table S5a). Since the beginning of the COVID-19 pandemic there has been a decrease in all reported cases and a contrasting increase in hospital-onset cases. The overall reduction is, in part a result of reduced hospital activity, although the increase in hospital-onset cases is still under investigation.

Comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) shows this disparity between the total counts and rates of MSSA and hospital-onset counts and rates of MSSA. There was a 5.9% decrease in the counts and rates of all reported cases from 3,132 to 2,947 cases and from 22.1 to 20.8 cases per 100,000 population. Hospital-onset MSSA bacteraemia cases however, increased 5.4% from 846 to 892 which corresponds to a sharp incidence rate increase of 23.5% from 9.5 to 11.8 per 100,000 bed-days. Community onset MSSA bacteraemia cases decreased 10.1% from 2,286 to 2,055, while the community-onset incidence rate decreased 10.1% from 16.1 to 14.5 per 100,000 population. This large rate increase in hospital-onset has been present since April to June 2021 and can broadly be explained due to similar counts of cases combined with the reduction of hospital activity as a result of COVID-19 pandemic

Figure 5a: Quarterly rates of all reported MSSA bacteraemia: January to April 2011 to October to December 2020

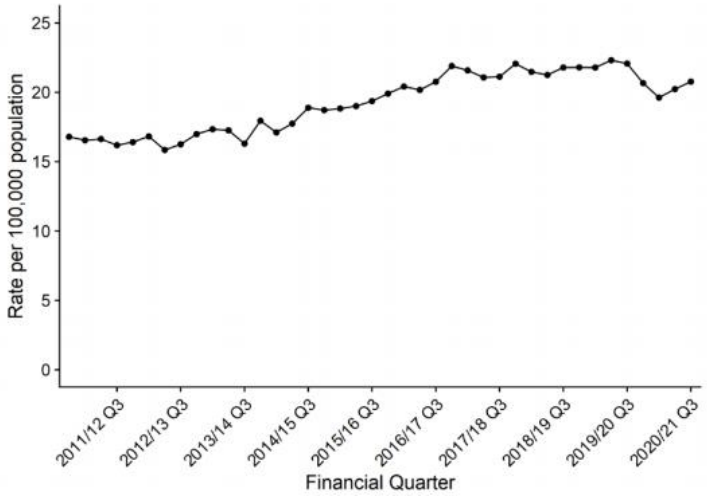
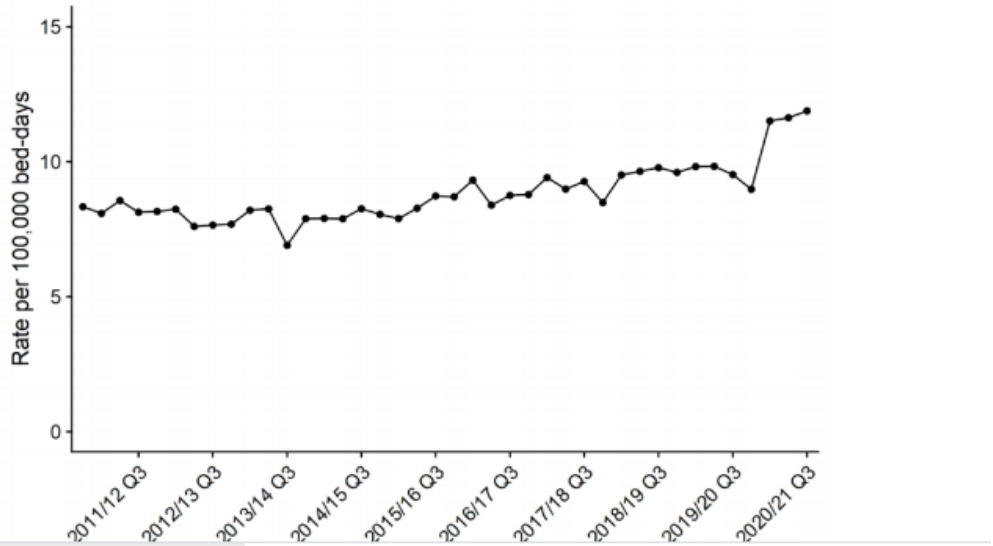


Figure 5b: Quarterly rates of hospital-onset MSSA bacteraemia: January to April 2011 to October to December 2020



1j) *Clostridiodies difficile* Infection (CDI)

Up to and including 2020/21, NHS organisations have continued to be required to demonstrate year on year reductions in *Clostridiodies difficile* Infection (CDI) cases. However, as published data shows, the rate of improvement for CDI has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors, including the biology and epidemiology of the *Clostridiodies difficile* (*C. difficile*) organism.

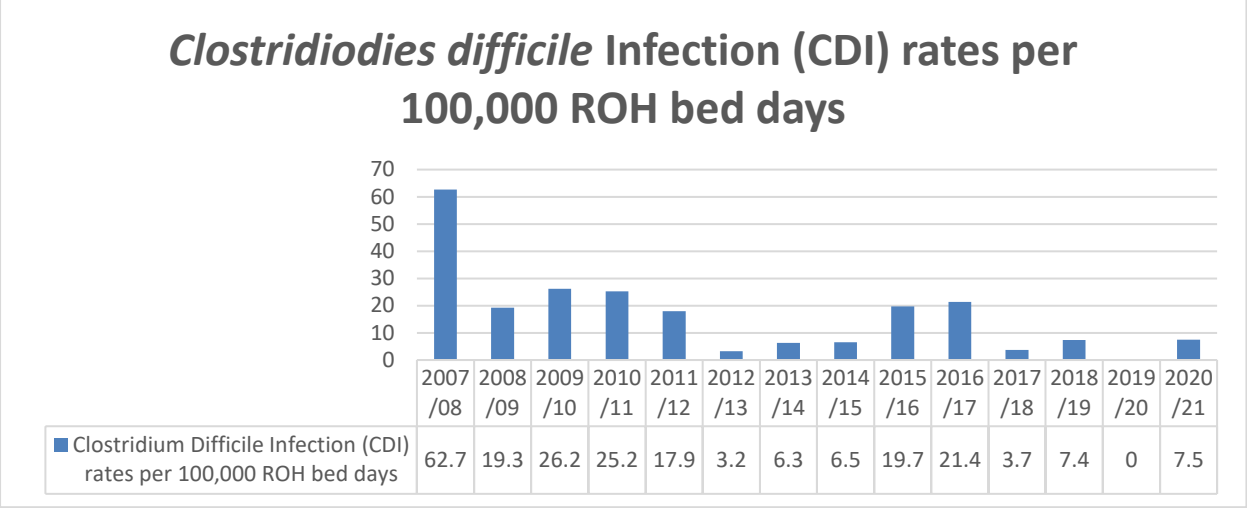
There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry *C. difficile* in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

Cases of CDI that are considered to have been acquired in the Trust are defined as a sample taken “on or after 48 hours of admission”.

Three cases were apportioned to the ROH in 2020/2021. In two of the cases it was noted there were lapses in the quality of care provided and responsive actions plans were put into place. After review it was noted there were lapses in quality around recognition and response to symptoms of CDI – (not sending stool sample on first episode, not completing D&V risk assessments). The Care of the patients once the CDI diagnosis was made was good and as per guidance.

The cohort of patients we were having at this time were elderly undergoing surgery and were already predisposed to CDI given their age, exposure to antimicrobials, exposure to

other healthcare settings (high rate of CDI at University Hospitals Birmingham whom we had a joint pathway with). Some patients had additional risk factors such as recent/current chemotherapy, use of proton pump inhibitors and laxatives.



Epidemiological analyses of *Clostridiodies difficile* infection data (England)

Since the initiation of *C. difficile* infection (CDI) surveillance in April 2007, there has been an overall decrease in the count and associated incidence rate of both all-reported and hospital-onset cases of CDI (Figure 6a, 6b and Table S6). Most of the decrease in the incidence rate occurred between April to June 2007 and January to March 2012 with a 78% decrease in all-reported cases of CDI from 16,864 to 3,711 cases and an associated 79% reduction in incidence rate from 131.6 cases per 100,000 population to 27.9. Subsequently, between January to March 2012 and October to December 2020, the count of all-reported cases decreased 13.0% from 3,711 to 3,227 cases and the incidence rate reduced by 18.5% from 27.9 to 22.7 cases per 100,000 population. There were similar, but greater, reductions among hospital-onset CDI cases with an 85.0% reduction in count of cases between April to June 2007 and January to March 2012 from 10,436 to 1,613 cases and 84.0% reduction in the incidence rate from 112.5 to 18.2 per 100,000 bed-days. This was followed by a further 27.7% decrease in the count of cases from 1,613 to 1,167 cases and a decrease of 14.9% in the incidence rate from 18.1 cases per 100,000 bed-days to 15.4 between January to March 2012 and October to December 2020.

Comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) shows a 5.3% decrease in the count of all reported cases from 3,407 to 3,227, while the incidence rate decreased 5.3% from 24.0 cases per 100,000 population to 22.7. Hospital-onset CDI cases decreased 8.8% from 1,279 to 1,167 which corresponds to an incidence rate increase of 6.8% from 14.4 cases per 100,000 bed-days to 15.4. Community-onset CDI cases decreased 3.2% from 2,128 to 2,060, while the community-onset incidence rate decreased 3.2% from 15.0 to 14.5 per 100,000 population.

Figure 6a: Quarterly rates of all reported *C. difficile*: April to June 2007 to October to December 2020

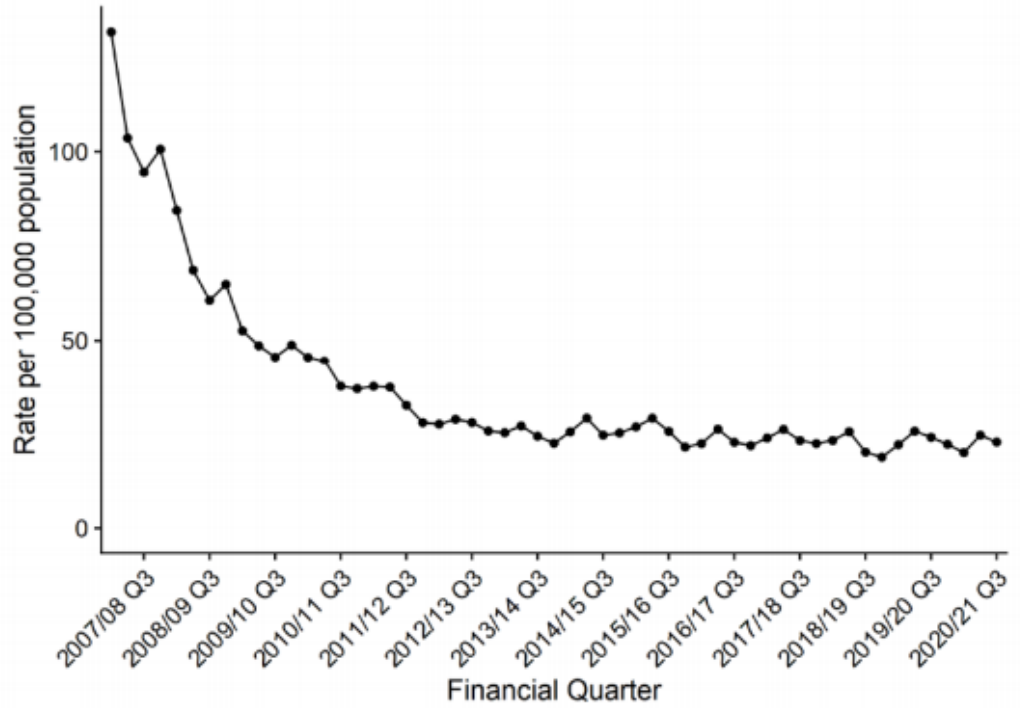
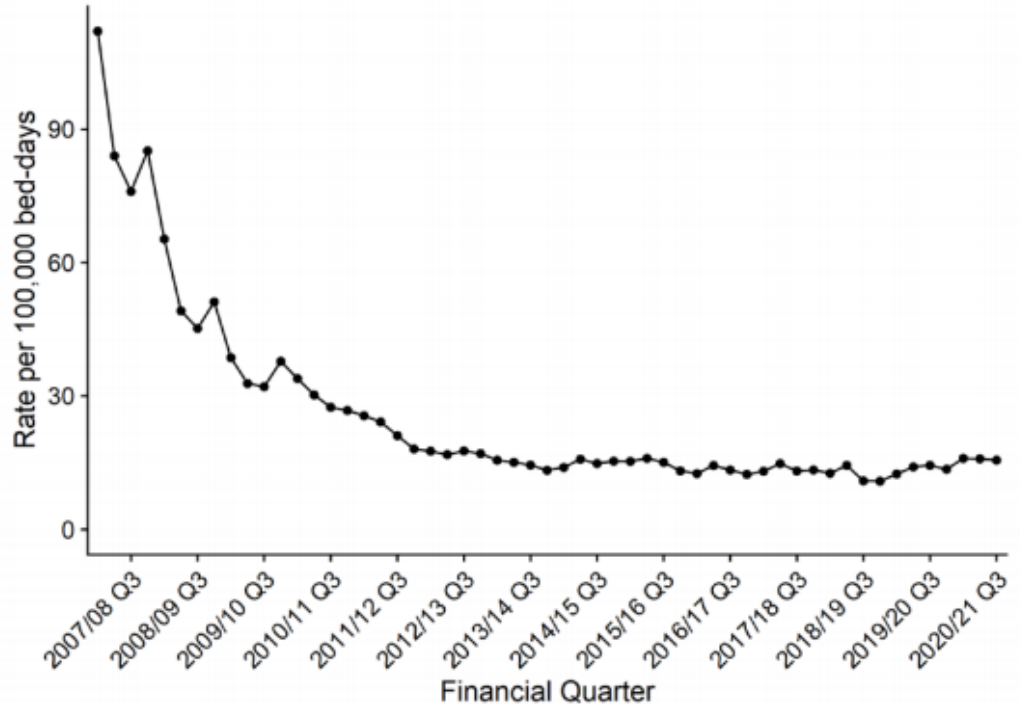


Figure 6b: Quarterly rates of hospital-onset *C. difficile*: April to June 2007 to October to December 2020



1k) Preventing and controlling the spread of CDI at the ROH

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Service (BIS) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors.

Pre Covid, all HCAI CDI cases are subject to a post infection review and each case is discussed with the Lead IPC Nurse at Birmingham and Solihull Clinical Commissioning Group (Bsol/CCG) to determine the avoidability (lapses in care) with feedback given to IPCC and relevant Divisions. This has not been taking place during the pandemic. The CCG has continued to attend all of the Trusts PIR meetings . The Divisions action Duty of Candour where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic *C. difficile* in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic *C. difficile* within a period of 28 days and associated with stay in the same ward or area. Should this occur samples are obtained and submitted to Public Health England for ribotyping. Samples with the same ribotypes are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

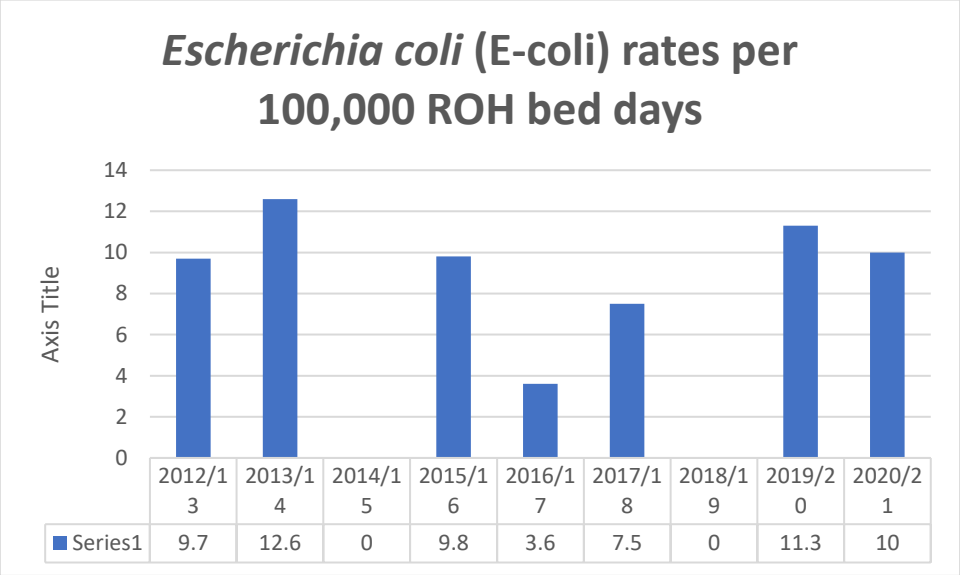
1l) Gram negative – bloodstream infections – *Escherichia coli* (E. *coli*)

Gram negatives (GN) are a group of organisms that form part of the normal gut flora. They are particularly associated with urinary tract infection (UTI) which may also lead to blood stream infection (BSI). This risk may be increased by inappropriate care and use of urinary catheters. The very nature of orthopaedic surgery entails uses of urinary catheters and therefore the stringent management of catheters is paramount to clean safe care. *E. Coli* is the most commonly seen representative in this group.

E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is excreted in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021. Gram-negative BSIs are believed to have contributed to 5,500 NHS patient deaths in 2015. The initial focus to support this ambition is on *E-coli* BSI reduction. Enhanced surveillance of *E. coli* BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE.

Two cases were apportioned to the Trust in 2020/2021. It was noted that there were no lapses in care or quality highlighted after investigation.



Epidemiological analyses of Gram- negative bacteraemia data (England) *E. coli* bacteraemia

The incidence rate of all reported *E. coli* bacteraemia has increased each year since the initiation of the mandatory surveillance of *E. coli* bacteraemia in July 2011 to the start of the COVID-19 pandemic in April to June 2020 (Figure 1a). This was primarily driven by the increase in the rate of community-onset cases (Table S1a). Since the start of the pandemic, the total cases and rates and community-onset cases and rates have fallen but are still higher than the start of the period. In contrast, the incidence rate of hospital onset cases has remained relatively stable within the same period (Figure 1b).

Between July to September 2011 and October to December 2020, the count of cases and the incidence rate of all reported cases of *E. coli* bacteraemia increased by 12.1% from 8,275 cases to 9,275 and from 61.8 to 65.4 cases per 100,000 population. Similarly, over the same period, the count of community-onset cases increased by 19.1% from 6,279 to 7,479, while the incidence rate increased by 12.4% from 46.9 cases per 100,000 population to 52.7. Between July to September 2011 and October to December 2020, the count of hospital onset cases decreased by 10.0% from 1,996 to 1,796. In contrast, there has been an increase

in the incidence rate of hospital-onset cases of 0.5% between July to September 2011 and October to December 2020 from 23.6 per 100,000 bed-days to 23.7. This contrast between the change in counts and rates of hospital-onset infections can, in part be explained through the reduction of hospital activity as a result of the COVID-19 pandemic.

When comparing the most recent quarter (October to December 2020) to the same period in the previous year (October to December 2019) there is a 13.2% decrease in the count of all reported cases from 10,685 to 9,275, while the incidence rate also decreased by 13.2% from 75.3 per 100,000 population to 65.4. Community-onset *E. coli* bacteraemia cases decreased by 13.9% from 8,690 to 7,479, with the community-onset incidence rate decreasing by the same percentage (13.9% from 61.3 per 100,000 population to 52.7, Figures 1a and 1b, Table S1).

Furthermore, hospital-onset *E. coli* bacteraemia cases decreased by 10.0% from 1,995 to 1,796. However, incidence rate increased by 5.4% from 22.5 to 23.7 per 100,000 bed days. It is important that these figures be interpreted with caution. Since the start of the COVID-19 global pandemic, the total count and rate of *E. coli* bacteraemia cases declined due to reduced hospital activity but the rate of hospital-onset case has increased compared to the previous year. In previous years, there is a strong seasonality to the incidence of all-reported *E. coli* bacteraemia cases, with the highest rates observed between July to September of each year. Care is required in interpreting 2020 to 2021 as we have seen a reduction in cases and hospital activity.

Figure 1a: Quarterly rates of all reported *E. coli* bacteraemia: July to September 2011 to October to December 2020

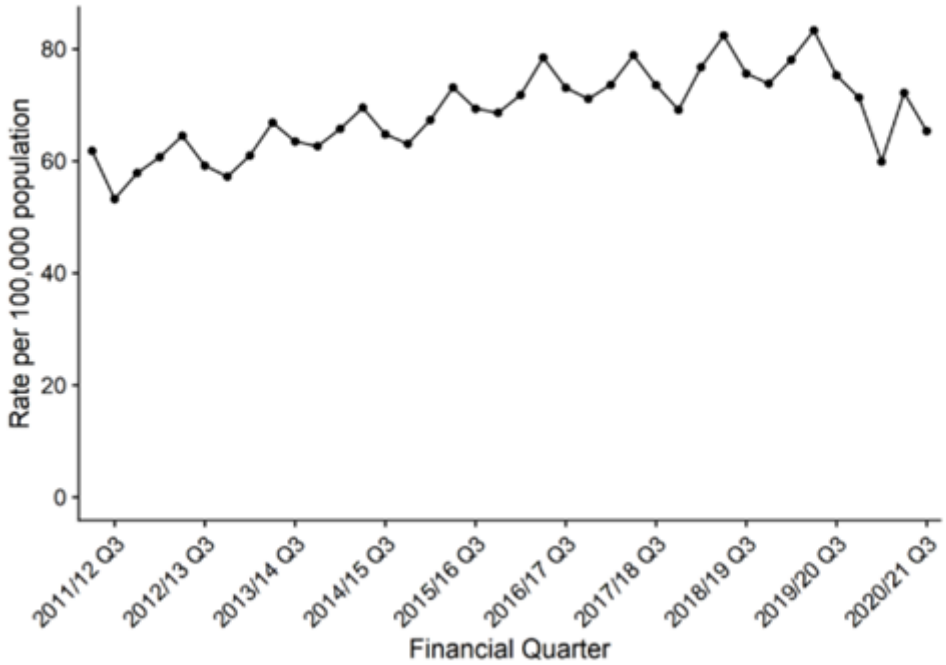
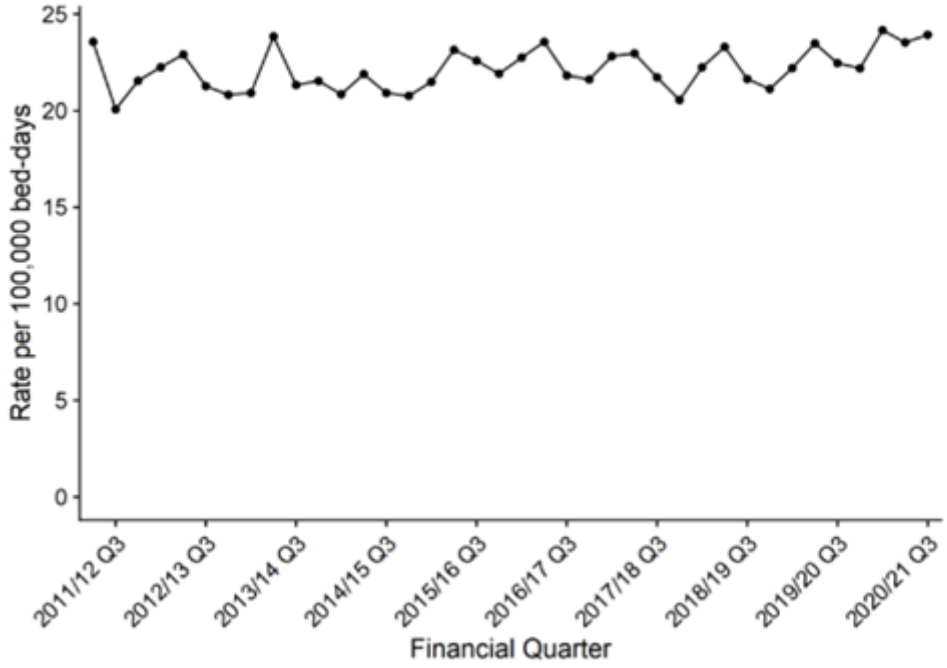


Figure 1b: Quarterly rates of hospital-onset *E. coli* bacteraemia: July to September 2011 to October to December 2020



1m) Vancomycin/Glycopeptide resistant *enterococci* (VRE/GRE)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.
VRE/GRE may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Although mandatory surveillance was discontinued in 2013, the Trust continue to monitor and report internally. For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

1n) Carbapenemase producing *enterobateriaceae* (CPE)

These are a sub-set of gram negatives (see above section) which are particularly resistant to antibiotics. They are seen commonly in the Indian subcontinent and in some Mediterranean countries which have historically had a poor record of antimicrobial stewardship and IPC.

There is an increasing concern nationally about their spread in healthcare. PHE published a toolkit in 2013 to control the spread in healthcare and onwards in the community. ROH adheres to the toolkit.

For the period covered in this report there have been zero cases of CPE at ROH which is the same compared to the previous year.

1o) Tuberculosis (TB)

Tuberculosis (TB) is an infection caused by a bacterium belonging to the Mycobacterium tuberculosis complex. TB is a notifiable disease in the UK. Suspected and confirmed diseases must be notified within three working days. It is a serious disease that can affect most organs but often presents as a lung infection. In the context of ROH practice it can also cause joint, bone and spinal infection. For the period covered in this report ROH had zero cases of TB infection.

1p) Norovirus outbreaks

Norovirus causes diarrhoea and vomiting and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or from their environment through contamination. In hospital this environmental risk is considerable and outbreaks are common. Management therefore relies on prompt recognition of symptoms, robust isolation and IPC precautions as well as fastidious environmental cleaning. For the period covered in this report ROH had no confirmed cases of Norovirus

1q) COVID-19

The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases in the UK were confirmed in late January 2020. COVID-19 surveillance in the UK has been on-going since January 2020. The work of the IPC team was significantly impacted by the COVID-19 pandemic from mid-January 2020, initially with the management of potential cases of SARS-CoV-2 infection as a high consequence infectious disease (HCID), and then as significant numbers of cases were managed in the Trust from March 2020 onwards

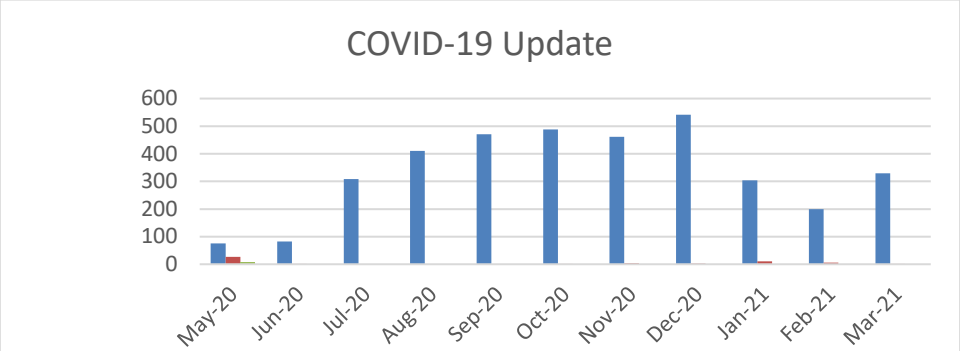
COVID-19 has been very different to anything the IPC team have had to manage before and was a massive challenge for the team. However, it was an extremely good example of cross-healthcare system working. The IPC team attended multiple meetings about COVID-19 via Microsoft Teams including daily operational meetings both internal to the trust and also with external partners.

The NHS England IPC board assurance Framework has been reported to both private and public board when released. NHS England developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

Other work for the IPC team and the Trust included:

- Frequent updates of the COVID-19 IPC policies were required as PHE issued new guidance regularly as more information about the virus became available. It was a steep learning curve and initial assumptions had to be corrected e.g. that only symptomatic patients were infectious;
- The IPC Team were heavily engaged in PPE training as increased mask, glove and gown wearing was introduced to protect staff. Staff also needed advice on social distancing from one another during breaks during which staff were at risk of infecting each other;
- The IPC team worked with the operational teams to introduce new Patient Pathways to separate infected, potentially exposed or unknown status patients from negative patients. These had to be changed again as elective activity was reintroduced. They also worked closely with the site management team in placing patients to reduce cross infection;
- The IPC team was also involved along with Estates staff in reviewing environmental issues;
- The Risk of COVID-19 was assessed in all staff areas with risks added to the risk register;
- All staff, patients and the public are screened for COVID-19 on entrance to hospital. Their temperature is taken and PPE issued;
- The Trust has adhered to National Guidance at all times;
- The Trust set up a vaccine centre in main outpatients to provide all staff and some of the surrounding community with both doses of the COVID-19 Vaccine.

The graph below details the number of COVID-19 testing, positives and deaths since May 2020. To be noted there were no staff deaths linked to COVID-19 in the Trust.



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Covid Tests	75	82	308	411	471	488	461	541	304	200	329
Covid Positive	27	1	0	0	0	1	4	3	10	6	1
Covid Deaths	8	0	0	0	0	0	0	0	0	0	0

There were 8 outbreaks identified in the Trust since April 2020, 4 of which were in clinical areas and involved patients. Every outbreak was investigated fully with the involvement of NHSEI, PHE and CCG, culminating in twice weekly reviews. During the first wave and the start of the second wave, any outbreaks identified had to be reported to NHSEI at a regional level on a daily form sent via email. Towards the end of the second wave, NHSEI introduced an electronic reporting system to replace the manual system of reporting outbreaks.

When reviewing patients and attributing their infection, in May 2020 PHE provided four classifications:

- Day 0-2: Community-Onset (CO)
- Day 3-7: Hospital-Onset Indeterminate Healthcare-Associated (HOHA)
- Day 8-14: Hospital-Onset Probable Healthcare-Associated (HOPHA)
- Day 15+: Hospital-Onset Definite Healthcare-Associated (HODHA)

The outbreaks have been within the following areas:

Area/Dept.	Date Outbreak Declared	Date Outbreak Closed	Total № of +ve Staff	Total № of +ve Patients	Total number of Patients diagnosed at 3 - 7 days (Indeterminate)	Total № of Patients diagnosed at 8 - 14 days (probable)	Total № of Patients diagnosed at 15+ days (definite)
Pharmacy	03/09/2020	01/10/2020	3	N/A	N/A	N/A	N/A
Imaging	17/10/2020	14/11/2021	9	N/A	N/A	N/A	N/A
Oncology	19/10/2020	16/11/2021	9	N/A	N/A	N/A	N/A
Ward 1	15/11/2020	13/12/2021	1	2	1	0	1
Ward 2	09/12/2020	09/01/2021	1	4	3	0	1
Ward 3 (10/12)	11/01/2021	08/02/2021	9	7	3	3	1
Ward 3	05/02/2021	04/03/2021	0	2	2	0	0
Pharmacy	19/02/2021	20/03/2021	2	0	N/A	N/A	N/A

1r) Audit programme to ensure key policies are implemented

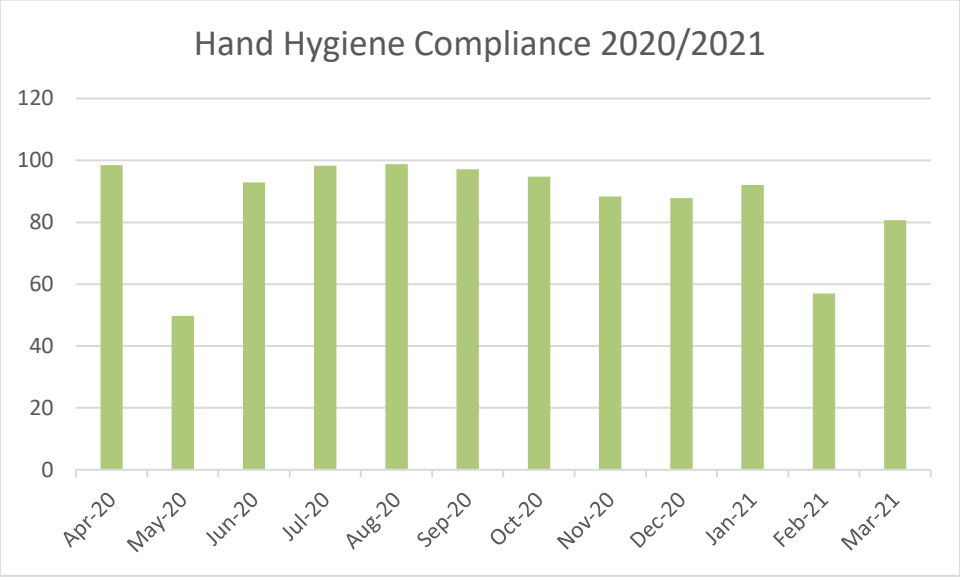
The ROH has a programme of audits in place undertaken in all the clinical areas and the IPC team to provide assurance around practice and consistent compliance with evidence-based practice and policies. Where a period of increased incidence occurs / risks are identified the IPC Team undertake additional audits in accordance with risk requirement. Action plans are devised by areas where issues are highlighted and these are managed and monitored within the divisions and escalated to IPCC and upwardly reported through the robust ROH Governance structure. Increased PPE audits were undertaken during the pandemic in clinical areas.

1s) Audits of hand hygiene practice

Hand hygiene continues to be included in the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas utilising UV glow boxes specifically for hand hygiene training.
Hand hygiene is audited across all wards and departments, on a monthly basis, following the WHO 5Moments of Hand Hygiene.

The Trust continues to focus on four main components:

- Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view;
- Audit of hand washing practice at least monthly.
- Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
- Raised awareness of hand hygiene and the 'Bare below the elbow' dress code





1t) Staff information and training

- The IPC team has ongoing PPE training, staff are able to book onto these sessions via ESR.

- The IPC Team has provided mandatory hand hygiene training for all ROH employees through induction days, mandatory study days, and ward-based enhanced training.

- The IPC Team facilitate bi-monthly meetings for infection prevention link practitioners(from each ward and department) During the pandemic these meetings were held virtually via Microsoft Teams.

- The IPC Team facilitate an annual study day for all interested employees from ROH.

- Grab Packs for hand hygiene, Influenza, MRSA, personal protective equipment and CPE have been developed and implemented across ROH to support staff with effective application from theory to practice within their areas of work.

- The IPC Team continues to work collaboratively with suppliers and Estates and Facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment or processes.

- ROH hand hygiene provider, DEB UK, have standardized products, posters, dispensers across the Trust and continue to provide training and audit at operational level for all clinical areas.

- The induction IPC training package was updated to reflect the requirements of new employees to ROH. IPC mandatory training is split into level 1 for clinical and non-clinical staff and level 2 for clinical staff only. These were provided via e-learning modules during the height of the pandemic where face to face sessions were not appropriate.

- Communication of key messages via a number of media methodologies including social network, newsletters and emails.

- The World Health Organisation (WHO) 'Five Moments of Hand Hygiene' is in use across ROH with the support from Communications. This campaign continues to be communicated both internally and externally with the support from social media.

- Additional on-going infection prevention surveillance and support continues across ROH with daily infection prevention visits to all inpatient areas.

- Bespoke infection prevention training has been developed, in line with HBN 00-09, for all preferred contractors coming into ROH.

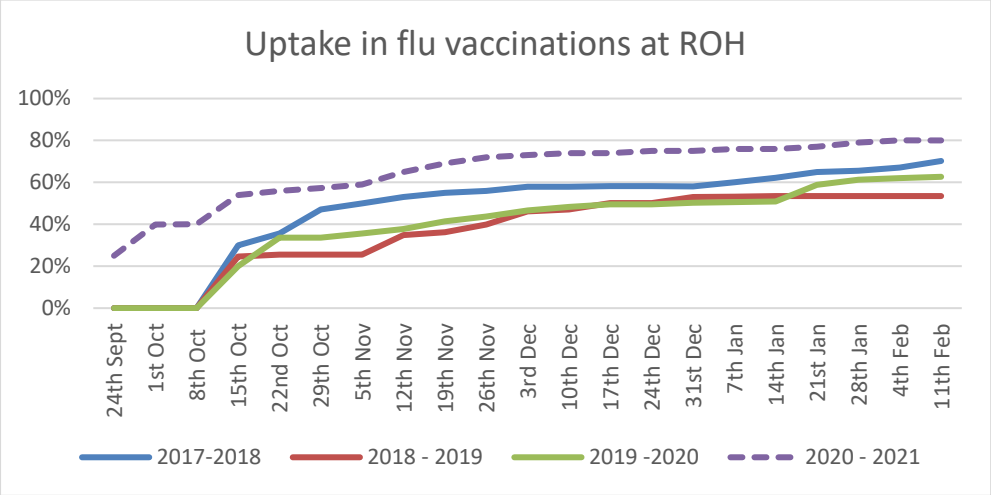
- The IPC Team continue to work with clinical staff and support clinical site managers with safe bed utilisation.

- The IPC Team facilitated the national antibiotic awareness and hand hygiene days across ROH, this is in addition to promotional activities that they have supported throughout the year.

- The IPC team provided training in relation to COVID-19 and PPE use in conjunction with the ROH Clinical Education Team.

1u) Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2020 with a wealth of information available to staff on the Trust intranet, information boards across the site and locally based influenza champions. The uptake for 2020/2021 was 80.02%. The graph below shows the update for the last 4 years



1v) IPC Link Practitioners

ROH, within each clinical area, has in place dedicated IPC Link Practitioners these include registered nurses, healthcare assistants and allied health care professionals. These staff are supported by the IPC Team and attend bi-monthly meetings alongside education / study days to support them in their roles. They provide advice, support, education and training to operational staff as well as monitoring compliance with the IPC agenda.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

2.1 Providing a clean safe environment

- There is a designated Facilities Manager for cleaning services that are managed in house.
- The IPC Team support ROH bed management / clinical staff to ensure efficient / appropriate bed utilisation
- IPC Team are involved in capital planning schemes to support the needs of IP across ROH in refurbishments and new builds.
- The IPC Team oversees assurance of standards and reduction of risk in partnership with Divisional Management teams through audit, monitoring of standards, and shared learning.
- ROH use Bioquell (hydrogen peroxide vapour), a specialised decontamination method, for the removal of environmental contaminants to ensure a safe, clean environment.
- Domestic staff continue to provide cover in all patient areas from 6am until 9pm. (Monday – Friday) and 8.30am – 7pm (weekends and bank holidays). The Trust also

undertake cleaning throughout the night – mainly in public areas and lower risk patient facing locations i.e. Hydrotherapy department

- Training for domestic staff continues to be provided by British Institute for Cleaning Standards and is refreshed annually.

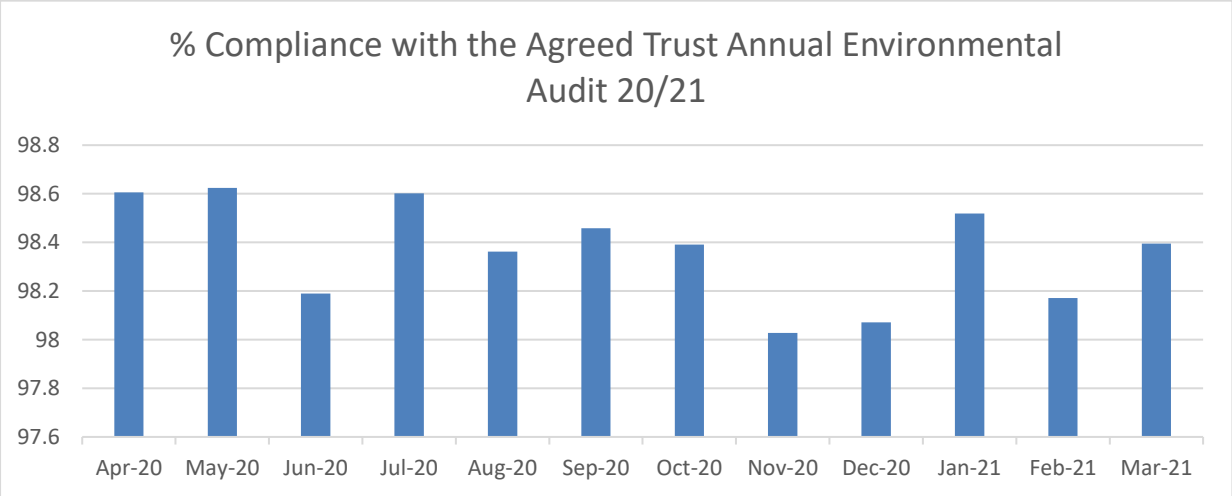
- The Matron for IPC meets on a monthly basis with Head of Estates / Facilities to review cleanliness standards and any issues identified by monthly audits. Issues are discussed at IPOG and escalated, as required to IPCC.

- ROH contract out to an accredited facility for decontamination services.

- ROH theatres had a scheduled partial shutdown to enable essential maintenance and Deep cleans were undertaken

- ROH participate in the annual Patient Led Assessments of The Care Environment (PLACE).

- Below details the Trust Compliance with the agreed Trust Annual Environmental Audit 20/21. ROH has been exceeding the threshold of 95% set by the Commissioners in 2020/21.



2.2 Water Systems Management

- ROH Water Safety Group, which includes a dedicated Authorised Engineering Officer (AEO)for water, is responsible for the oversight of water safety and continue to meet on a quarterly basis.

- The Water Safety group is a sub group of the IPCC and reports directly to IPCC. The group is chaired by the Associate Director of Estates & Facilities.

- Estates and Facilities, Consultant Microbiologists, and the IPC Team support the water management process across ROH. The Trust has a Water Safety Action Plan that was developed based on the peer review and reflects the current status. This is monitored at the Water Safety Group.

2.3 Management of Decontamination

The management and compliance currently fall into three distinct areas;

- Estates – for medical device reprocessing equipment / scheduled maintenance where required,
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies,
- User – to comply with Trust Policies and to ensure that decontamination of equipment is fit for use and subject to periodic testing and maintenance as advised by the manufacturer / contractual agreement.

No decontamination is undertaken on site – ROH contract out to BBraun, accredited decontamination service, for full management of surgical instrumentation.

3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

The Antimicrobial Stewardship (AMS) Group formed in 2017/18 has produced an Antimicrobial Stewardship Strategy to outline the roles and responsibilities of all members of staff within the Trust at tackling Antimicrobial Resistance. The AMS strategy provides an overview of the planned AMS activities to be completed to encourage responsible use of antimicrobials.

Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Lead Antimicrobial Pharmacist. A number of audits have been completed to assess appropriateness of antimicrobial usage and also the review of antibiotics used within the Trust. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with Microbiologists.

The antimicrobial guidelines were updated by the Lead Antimicrobial Pharmacist and Microbiologists at the University of Hospitals Birmingham Trust. These were uploaded to the Trust's intranet and launched within the Trust; a summary card was produced to improve staff awareness and compliance with the guidelines.

The Trust utilise the 'Start Smart, then Focus' approach for initiating and reviewing antimicrobial prescriptions which aims to avoid inappropriate antimicrobial prescribing. A Antimicrobial Prescribing sticker was launched to prompt review of IV antibiotics at 72 hours and improve documentation around antimicrobial usage.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.

- The IPC Team work collaboratively with ROH Communications team who support dissemination of IPC communications both internally and externally as required.

- The IPC Team meet monthly to update each other on areas of work and plan ahead.

- All wards / departments have an IPC information board for patients / visitors which is updated monthly.

- IPC information stalls are used across site quarterly with time specific information for staff, patients and visitors to the Trust.

- All Infection Prevention Nurses undergo an annual appraisal.

- The IPC Team utilise social media that enables communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating to a wider health economy.

- The ROH Weekly Message from the CEO supports and cascades messages from the IPC Team across the organization and gives prominence to Executive leadership and support of IPC activities, supporting “Board to Ward”.

- The IPC Team have dedicated space on the Trust Intranet and on the Trust Internet site.

- The Trust Intranet promotes infection prevention issues and guides users to information on MRSA, *Clostridiodies difficile* and other organisms.

In the past 12 months the IPC and Communications Teams have worked together to:

- Develop information for patients and staff regarding visiting restrictions and requirements,

- Develop eye catching, easy to read, clear instructional PPE guidance which has changed as per PHE guidance throughout the pandemic.

- To share COVID-19 updates including policy change/SOP development,

- Shared IPC improvement news e.g. the introduction lessons learnt from outbreaks information and hand washing facilities improvements, social distancing and mask adherence communication,
- Update the Trust website and intranet,
- Issue social media statements during outbreaks,
- Support the annual flu vaccination campaign.

4.1 Trust Website and Information Leaflets

A dedicated COVID-19 information page was developed early on in the COVID-19 pandemic and continues to be regularly updated with trust wide communications, COVID-19 policy changes and advice for staff on working through the pandemic, including information for patients and visitors. This included topics such as volunteering, symptoms of COVID-19, how to keep healthy and avoid infection, how to get tested and visiting.

This continues to be updated by the Communications Team with advice from IPC as new information becomes available. The Trust website also promotes the IPC information page for general IPC issues and guidance including link practitioner information, information on MRSA, *Clostridiodies difficile* and other organisms. This is also the media area to review a range of information leaflets on various organisms and access the regularly updated policies and guidance.

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-Associated Infection (HCAI) because they can increase a patient's length of stay in hospital and "are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI.

However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).

Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	✓
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	✓
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	Glucose control	+	✓
Post-operative	Wound management	+ / -	✓
	Surveillance and feedback of rates	+	✓

Many of these actions are in place, with the addition of others exceeding the National Guidance, at ROH. ROH have in place an established wound care helpline that can offer the patient an appointment at the SSI clinic, on the same day, should it be required This allows the review of patients by specialist staff allowing rapid treatment / admission where required avoiding visits to the GP and unnecessary prescribing of antibiotics.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

- hip replacement
- knee replacement
- repair of neck of femur
- reduction of long bone fracture

Primary arthroplasty surgery is constantly reviewed and monitored as part of the SSI surveillance programme at ROH. SSI surveillance is routinely carried out according to Public Health England protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30-day surveillance was introduced.

The data presented below is a combination of Mandatory surveillance data for Surgical Site Infections identified following hip and knee replacement surgery carried out and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in- house surveillance scheme conducted by the IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding

of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.

SSI Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hips	3.5%	3.8%	2.9%	2.0%	1.0%	1.5%	1.2%	2.4%	1.4%	2.3%	2.2%	1.8%
Knees	6.7%	5.8%	6.9%	4.4%	2.6%	2.9%	1.8%	2.3%	2.0%	3.2%	2.0%	1.0%
No. of SSI	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hips	37	44	33	26	13	21	15	31	17	11	24	19
Knees	65	52	61	41	23	25	17	23	21	14	21	9
No. of procedures	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hips	1063	1144	1153	1274	1240	1371	1261	1271	1189	487	1075	1062
Knees	974	896	880	932	887	875	956	992	1071	433	1028	899

During 2018 we did not participate in all four quarters, hence the lower number of procedures in comparison to other years.

We have only begun carrying out Surgical Site Infection Surveillance on Spines in July 2020. Therefore, unfortunately we do not have a large amount of data available at present.

A vast majority of our spinal patients included in surveillance do not have an implant inserted, and therefore as per Public Health England's Protocol, surveillance is stopped at 30 days post surgery. However, for those who do have an implant inserted, surveillance continues for 1 year, which coincides with the process for hip/knee patients.

SSI Rate	**2020**
Spines	2.8%
No of SSI	
Spines	8
No of procedures	
Spines	286

The number of SSI's also include patient reported infections. However, it is important to note that National Benchmarks do not consider patient reported infections, only those detected as an inpatient/at readmission.

We have recently created a patient wound information leaflet which we are distributing to those included in surveillance on the wards prior to discharge. This is to help inform them of the service, to make them aware of the signs and symptoms of infection and to call our wound care helpline should any issues arise. We anticipate that educating patients with this information will facilitate the prompt notification of any potential infections to us sooner rather than later. Follow up calls are also being carried out at 3 months following surgery to assess the patients wound healing and if any issues have risen so that these can be promptly addressed by the consultant.

MRSA:

The Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections stipulates the requirement for an MRSA policy to be in place to help prevent and control infection.

The Government considers it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. The zero- tolerance approach to MRSA has been re-iterated in Everyone Counts: Planning for Patients 2014/15 to 2018/19.

The purpose of pre-operatively screening for MRSA is to:

- Minimise the transmission of MRSA within ROH
- Protect patients from infection or colonisation with MRSA
- Ensure that patients who are colonised or infected with MRSA are managed appropriately, and receive adequate information about their condition

All admissions to ROH must be screened for MRSA, using the MRSA Screening tool, unless they are day case patients for:

- injections only
- biopsy
- manipulation under anaesthetic (MUA)

Pre-operative screening for MRSA is valid for 12 weeks from the date of the samples being taken.

All ‘long stay’ inpatients (>4 weeks) are screened for MRSA on a 4-weekly basis (to monitor acquisition). If the result is MRSA positive then the patient must be isolated and commenced on decolonisation treatment. All patients not known to be MRSA positive in HDU will be screened weekly.

All patients who test positive for MRSA and those who are considered to be ‘high risk’ i.e. multiple invasive devices, skin conditions causing open wounds etc. are prescribed decolonisation therapy with the goal of reducing the bacterial load or ‘bio-burden’ on the skin to a level that is no longer considered a risk – poses no risk of transmission.

COVID-19:

Prior to the vaccination programme, evidence on the mortality rates of patients contracting COVID-19 in the perioperative period raised very significant concern, and there was an absolute need to ensure that patients are not admitted for surgery with the virus (both asymptomatic in the incubation period or with symptoms), and were protected from the virus in the perioperative and post-operative period. The period of preoperative isolation was, and continues to be the mainstay of protecting patients, along with the vaccination programme.

The ideal length of isolation and quarantining is 14 days however, with the emergence of new mutations of the virus this might increase or decrease as evidence becomes available. Household isolation is recognised as the most effective form of quarantining although shielding within a household is found to be more convenient, but with higher risks of viral exposure.

The Trusts pre-operative COVID-19 process describes what should be followed for the pre-operative management of all patient groups due to undergo any elective surgery, including high risk surgery, during the COVID-19 Pandemic. The protocol has been developed in order to mitigate the recognised risk of exacerbated respiratory complications and associated mortality when undertaking major surgery on undetected COVID positive patients.

The protocol applies to all patients about to undergo any of the below surgical interventions

- Major oncology surgery >2hrs or patient receiving pre-op chemotherapy
- Spinal surgery with surgical time >2hrs
- Revision arthroplasty with surgical time >2hrs
- Any other surgical interventions at the ROH that requires the patient to attend or pass through ADCU or theatres
- This is inclusive of patients undergoing an injection in these departments (for further details on this patient group, please see the 'Pre-Procedure Management of Injection Patients during the COVID-19 Pandemic SOP')

Ref: Pre-Operative COVID-19 Screening SOP

COVID-19 Screening of Inpatients

All inpatients in the Trust are screened daily for symptoms, throughout their stay. If there are any concerns, a PCR test is completed at the time the concerns are raised to the clinical team and IPC team.

If patients remain asymptomatic for COVID-19, the following protocol is followed:

1) For Elective patients (1 PCR tests have been completed prior to admission)

- PCR Test completed weekly on all patients, for the duration of their stay
- PCR Test completed 48 hours prior to discharge for all patients being discharged to another health or care facility e.g. hospital, nursing home, care home.

2) For Emergency patients (No PCR tests have been completed prior to admission)

- First PCR Test completed on admission

- Second PCR Test completed at 48 hours
- PCR Test completed weekly on all patients, for the duration of their stay
- PCR Test completed 48 hours prior to discharge for all patients being discharged to another health or care facility e.g. hospital, nursing home, care home

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions.

All clinical staff receive training and education in optimum infection prevention practices during induction and mandatory training and Link practitioner teaching sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.

All staff included volunteers receive mandatory IPC training.

8. Provide or secure adequate isolation facilities

Isolation Rooms

Wards

51 isolation rooms with en-suites.

3 isolation rooms without en-suite.

HDU

3 Adult Side Rooms without en-suites.

2 paediatric isolation rooms with en-suite.

The Number of isolation rooms has been a challenge during the COVID pandemic which resulted in operational challenges on a few occasions. It is to be noted that no patient harm or outbreaks occurred due to these pressures and challenges.

Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose-built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full (UKAS) accreditation ISO Standard 15189. ROH has electronic access to results to facilitate patient care.

9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, procedures and manuals are available for staff to view on the Trust Intranet. There is a formal Governance structure in place for reviewing and ratifying such documents within the Trust and Governance has produced a directory of documents alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated. All polices are agreed at the Trust IPC Committee and Executive team (if the changes are major or new policy).

10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participates in mandatory updates for all staff groups (clinical and non-clinical). A representative from the Occupational Health Service is a member of the IPCC.

Occupational Health services are provided to staff via an SLA with the University Hospitals Birmingham (UHB). Occupational Health staff travel from UHB to ROH to provide one session (1 day) per week to support the Occupational Health requirements.

A report from the Occupational health service is provide to the IPC Committee 3 times a year.

Summary

Giving the COVID-19 Pandemic declared in March 2020, 2020-21 was one of the most challenging years for ROH and the NHS with Infection prevention and control playing the vital role of maintaining services at the ROH and ensuring our patients and staff are safe.

Produced by: Ash Tullett – Head of Clinical Governance
Date: August 2021
Email: ashleightullett@nhs.net

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive and Tim Pile, Chairman**
AUTHOR:	**Executive Team**
DATE OF MEETING:	**1 September 2021**

EXECUTIVE SUMMARY:

Attached is the refreshed Board Assurance Framework.

All risks have been reviewed and updated or proposed for closure where indicated by the grey entries.

Risks proposed for closure:

- ST2
- ST1

Open risks that have had scores changed:

- 770 – re-escalated following a discussion between the Chief Operating Officer and Director of Strategy & Delivery outside of the meeting.
- 1089 – re-escalated following discussion at the last meeting.

There are no new risks proposed for addition.

REPORT RECOMMENDATION:

The Board is asked to:

- APPROVE the proposed changes to the Board Assurance Framework

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

Aligns to all strategic objectives.

PREVIOUS CONSIDERATION:

July 2021.

BOARD ASSURANCE FRAMEWORK

Risk Ref	Department	Executive Lead	Risk Statement	Risk category	Strategic Objective	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance (Internal, Peer or Independent)	Controlled			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Target risk			Date risk reviewed
							Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating	
PATIENTS - there are currently no risks identified for escalation to the BAF for this section of the Risk Register																					
PEOPLE																					
Covid-19 - 033	Workforce	Chief Executive	There is clear evidence that there is a disproportionate impact of COVID -19 on individuals who are from a BAME (Black & Ethnic Minority) background and those at higher risk due to age, gender, underlying health conditions and pregnancy ('vulnerable groups'). There is also evidence to suggest that BAME colleagues are less likely to speak up and raise concerns. There is a risk that BAME colleagues may unintentionally be placed at higher perceived/actual risk as they may not raise this. Additionally BAME staff and those deemed to be vulnerable may have higher rates of COVID related absence/illness.		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Risk assessments are currently being carried out for all BAME staff and those who fall into vulnerable groups 55% of the total number of BAE staff (297) have had a risk assessment and 82% of all staff with underlying health conditions. Managers have access to a briefing on how to effectively carry out risk assessments and additional support from HR Managers as required. Occupational Health providing support for any complex cases. There is ingoing corporate communications regarding the importance of risk assessment. The Trust achieved 100% compliance for the completion of risk assessments for BAME staff and /or those with underlying health conditions All managers are being reminded to undertake reviews of risk assessments for vulnerable staff and to undertake risk assessments with new/returning members of staff which has recently been underlined in a note to all staff around the need to undertake welfare meetings and revisit risk assessments where needed. The Trust is working with the system to develop a shared approach to embedding risk assessments into the employee wellbeing offer across BSol. Work across the system hasn't progressed in terms of having a shared risk assessment across BSOL. There is an electronic risk assessment which will be rolled out across the Trust by end of May 2021. System wide Risk Assessment Group now meeting. E J DaSilva running drop ins for ethnic minority staff to ask questions about vaccines to encourage uptake.	Report to Trust Board in July 20 on risk assessments; updates to Staff Experience & OD Committee; staff communication and 'Start of the Week messages	4	4	16	↔	August 2021 - Associate Director of Workforce and OD update: Risk has been reviewed and no change to be noted.	Ongoing	2	4	8	Aug-21
WF24	Workforce	Chief Executive	BAF and CRR There is a risk that sickness absence may increase as a result of staff exhaustion or emotional strain due to different working patterns and exposure to emotional or stressful situations during the Covid pandemic		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	4	5	20	Sickness absence rates are monitored on a monthly basis through the operational workforce dashboards and on a weekly basis through the Board Scorecard on a weekly basis. HR managers have regular 121s with local managers to review key hr metrics, to pro-actively address any HR concerns and signposting/seeking support from Occupational Health and/or the staff counselling service as appropriate. Staff have accessing to a free EAP service and can self-refer to the staff counselling service and this is promoted through comms and via line managers regularly. The national and regional offers regarding staff health and wellbeing have been promoted to all staff including in house support from trained mental health first aiders. There has been regular communications encouraging staff to take annual leave where business needs allow. There is now a cycle of reporting outstanding annual leave to Execs by directorate and highlighting those areas where no leave has been taken so that there can be targeted conversations about wellbeing, capacity and resourcing The psychological support offer for staff is being reviewed across BSol in response to the NHS People Plan in addition to the provision of a confidential staff counselling offer and Employee Assistance Programme being provided by the Trust. There is system wide psychological support, health checks and psychological first aid training available to staff in addition to Trust level interventions and support. People Committee workshop in May 2021 will focus on supporting individuals with psychological wellbeing. Staff can now self-refer to counselling. Staff can also access support via EAP Vivup. Messages being reterated re staff annual leave and wellbeing day. HRMs working with divisional managers to support wellbeing and absence management. Deep diving into flagged areas where absence is high.	Weekly Board Scorecard Workforce Snapshot Data Intranet pages Communications briefings	4	4	16	↔	August 2021 - Associate Director of Workforce and OD update: continuing to reiterate the message around rest and recuperation. Slight increase in wellbeing day taken. Exact figure to be confirmed. Action around this risk is ongoing.	Ongoing	2	4	8	Aug-21
PARTNERSHIP																					

ST1	Strategy	Chief Executive	The Trust fails to exert influence in the STP and on the plans to develop an Integrated Care System, leading to loss of identity and brand, which could impact on the level of referrals, lowering of staff morale and loss of key skills		Developing services to meet changing needs, through partnership where appropriate	Trust Board	4	4	16	Attendance at STP Board meetings and Chairs/Chief Executives forums Ongoing work with the Birmingham Hospitals Alliance Development of a draft Memorandum of Understanding with University Hospitals Birmingham NHSFT to set out future working arrangements. Clinical strategy day held on 31 July 2020, which was well attended. The Trust remains very connected to the development of the emerging ICS as before. The Trust was instrumental in leading a strategic away day to determine an overall plan and strategy for MSK, ensuring that all partners across the BSOL footprint were engaged in the co-production of how MSK services will develop and be delivered going forward. THe organisation continues to be fully engaged in all aspects of the ICS development with key Executives and Senior Managers present at the relevant meetings and planning session.	Trust Board minutes and papers Presentations from STP meetings	3	4	12	↔	August 2021 - Director of Strategy and Delivery update: No change to risk. Discussion at next meeting to determine whether this risk should remain on the risk register.	Ongoing	2	4	8	Aug-21
ST2	Strategy	Director of Strategy & Delivery	Innovation slows at the Trust as a result of reluctance to enter into commercial partnerships due to the uncertainty over the future influences of the Integrated Care System		Developing services to meet changing needs, through partnership where appropriate	Finance & Performance Committee	4	3	12	Trust is currently engaged with commercial partners to deliver JointCare initiative Active research programme is in place at ROH As the Trust and the wider NHS emerges from the pandemic, more conversations are taking place in regard to collaborations with commercial and higher education establishments including Smith and Nephew (Prof Snow) and University of Toledo in USA with Mr Mehta. We continue to explore other opportunities for collaborative working.	Papers from R & D Committee and upward reports to the Quality & Safety Committee. 'Perfecting Pathways' programme board summaries to FPC Joint Care promotional material	3	3	9	↔	August 2021 Director of Strategy and Delivery update: No change to risk. This risk related to when Covid-19 appeared and the impact it had on innovation and research has not been as negative as the Trust thought it might be. Proposed for closure.	Mar-21	2	3	6	Aug-21
PROCESS																							
CE2	Corporate	COO	The effectiveness of the clinical governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience, potential harm and reputational damage.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	3	5	15	Elective surgery has been suspended. The ROH does not hold accountability for these patients, however any waiting for surgery above 40 weeks will be redirected to the clinical team for review monthly and trigger a harm review process. There has been a pause in the routine governance meetings with a resumption date to be agreed. Surgery on patients with cancer is currently directed to the Royal National Orthopaedic Hospital and the oversight of this service is robust. Folllowing assurance to the ROH and BCH Trust Boards and in conjunction with NHSE/I, the resumption of service commenced on 22 February 2021 with the divert for referrals being lifted. The first OPA took place on 2 March 2021, the first biopsy list 3 March 2021, 11 April Clinical Safety Walkabout and first operating list on 19 April 2021. Joint risks have all been reviewed and all met the target scores prior to the first operating list taking place. Quality metrics have been defined to monitor the ongoing service and will be reviewed at the operational and governance meetings with a monthly upward report to the Strategic Oversight Meeting.	Minutes of stakeholder oversight meeting	2	5	10	↔	August 2021 - Chief Operating Office update: Monitoring continues at Trust QSC. 13 Patients have now undergone surgery since resumption of service. All metrics in line with agreed tolerance. Service will continue to be monitored.	Apr-21	1	5	5	Aug-21
770	Operations	COO	BAF and CRR Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.		Safe and efficient processes that are patient-centred	Quality & Safety Committee	4	5	20	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible. April 2021 - Chief Operating Officer update: Phase 1 and Phase 2 of the theatre expansion programme have been handed over, the Trust have four additional operating theatres, however, activity is planned to increase beyond the current 12 theatre utilisation to 14. In relation to Theatres 1, 2 and 4 the risks remain unchanged. However, the consequence of failure is reduced as the 4 new theatres would be utilised for extended days and weekends in the event of failure to reduce the impact on patient cancellations. A significant risk still remains as the use of the 4 new theatres would not fully mitigate the consequence of failure in full.	Estates maintenance schedule	4	5	20	↑	August 2021 Executive Chief Operating Officer and Director of Strategy and Delivery update: Updates to be provided once the Estates Strategy discussions have taken place and on conclusion of other potential solutions, led by Director of Estates to develop a full strategy for replacement of the theatre estate to provide full resilience and future proofing. Current risk score has increased. Agreeing a Theatre maintenance plan to enable work to proceed and plan accordingly. Theatre maintenance project group being set up. Risk score to be reviewed once the project group is in place.	Mar-21	1	5	5	Aug-21

FP8	Digital	Exec Dir - F&P	There is a risk that the current IT capacity and functionality will not support the new ways of working developed during the Covid-19 response, such as virtual clinics, remote operation and videoconferencing		With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	Trust use of thin clients and virtual desktop, with the addition of 80 mobile devices, allowed rapid remote access for 567 staff to work from home. Initial widespread use of Loopup videoconferencing and teleconferencing supported internal and external meetings. Business case for VDI hardware replacement proposal approved by the Executive Team on 27 October 2020. The new thick clients will strengthen the capability of the Trust's IT capability to support technology for videoconferencing and to maximise the functionality of Office 365. Whilst most remote consultations have been done by phone, Video Conferencing is being piloted in Pain Management, MSK, Therapies, Foot and ankle and expected to be adopted much wider across the Trust. Attend Anywhere is the application being used (funded centrally for 12 months with a £20k grant to purchase appropriate equipment). Moreover, the Trust has now purchased laptop and desktops as part of the thin client replacement project. Rollout will continue into 21/22. Additionally, the HSCN line into the Trust is being upgraded. The secondary line has now been replaced and testing is continuing prior to the connection of the primary line.	Finance & Performance Committee	2	4	8	↔	August 2021 - Executive Director Finance and Performance update: Whilst most remote consultations have been done by phone, Video Conferencing is being piloted in Pain Management, MSK, Therapies, Foot and ankle and expected to be adopted much wider across the Trust. Attend Anywhere is the application being used (funded centrally for 12 months with a £20k grant to purchase appropriate equipment). Moreover, the Trust has now purchased laptop and desktops as part of the thin client replacement project. Rollout will continue into 21/22. Additionally, the HSCN line into the Trust is being upgraded. The secondary line has now been replaced and testing will continue prior to replacement of the the primary line.	Apr-21	2	3	6	Aug-21
OP4	Operations	COO	There is a risk of increased virus transmission and reproduction rates, leading to a second and further waves of the Covid-19 pandemic creating operational pressures in the hospital		Performance, People, Process, Partnerships and Patients	Trust Board	5	4	20	Flow & Cohorting and Testing & Scheduling processes have been implemented agreed Standard Operating Procedure and protocols implemented to minimise the transmission to staff and patients. Operational pathways have been reviewed to implement revised ways of working. Risk Assessments have been completed in all areas of the hospital and changes are in place to ensure staff safety whilst at work, ongoing assurance and monitoring provided at Trust Quality and Safety Committee. Two pathways have been implemented to minimise the transmission of Covid 19. Protected Patient Pathways and a Risk Managed Pathway. The pathways are monitored through the three daily site office meetings. There is continued dialogue between PHE / Microbiology with learning from any outbreaks embedded in ongoing practice. Increase in performance in national vaccine rollout. National and local reduction in infection rates. High proportion of staff have had both vaccinations. Patients clinically triaged as part of pre-operative assessmentm vaccination status discussed with patients.	Papers from Executive Assurance Group; Recovery and Restoration presentation to Quality & Safety Committee and Finance & Performance Committee	3	4	12	↔	August 2021 - Chief Operating Officer update: risk to be retained at 12 due to continued prevelance in the community and associated system challenges.	Ongoing	2	4	8	Aug-21
OP6	Operations	COO	There is a risk that there will be insufficient capacity to handle the activity from the new services being handled by the Trust as part of the restoration and recovery phase		Delivered by highly motivated, skilled and inspiring colleagues and Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	All 12 theatres operational. Phase 2 Theatre/Ward Expansion installed and scheduled to be commissioned by December 2020 adding two more theatres and an additional 8 beds on Ward 4. Bid for second MRI scanner to support Trust/System wide diagnostics approved and planning permission received. Enabling works commenced to increase ultrasound capacity in the imaging department. Additional mobile MRI 'van days' have been secured to maintain MRI activity and an increase in interventional/ CT capacity by providing extra lists Conversion of Ward 11 into an Adult ward or to increase pre operative assessment capacity. Theatre look back meeting re-instated to monitor any incident raised on a weekly basis. Theatre allocation reviewed monthly to monitor the delivery of the level 2/3 patients. 864 meeting will monitor theatre utilisation weekly. The repatriation of hand and ambulatory trauma back to UHB has been agreed with effect from 5 July 2021. Ongoing system support continues including support for Robert Jones Agnes Hunt.	Recovery and restoration update to Quality & Safety Committee and Finance & Performance Committee; demand and capacity analysis to Finance & Performance Committee	3	4	12	↔	August 2021 Chief Operating Officer update: continued support to Robert Jones Agnes Hunt and system (3.5 theatres) for elective surgery capacity monitored at Divisional level and Cancer Board to assess impact and any constraints. Risk remains unchanged.	Ongoing	2	4	8	Aug-21
1298	Finance & Performance	Exec Dir - F&P	BAF AND CRR There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyber attack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training.		Safe, efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Contractor Cyber Security Officer just been appointed at Band 6 for 3 months, so some progress to be made shortly with outstanding tasks. Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network.	IM&T programme board papers Presentation from CORS team to Audit Committee Audit Committee minutes Information Governance Group minutes	4	4	16	↔	August 2021 - Executive Director Finance and Performance update: 1. Lack of patching/monitoring. Efforts underway to bring the patching to two weeks patching cycle to meet the DSPT requirements. Three weeks for theatres. VDI will be replaced May-Sep 2021- which will provide control over software deployment. SIEM solution has been purchased, the deployment time scale is around 3 months which should greatly enhance our monitoring capabilities. Load balancer Kemp - order has been placed and implementation is currently ongoing. 2. Presence of unsupported systems. This is still a significant risk, there is an increased need to find suitable alternatives and/or to work with vendors for update their provided solutions. Pathology is being moved out to UHB, so unsupported systems will be moved out. Action Plan now agreed with Head of BI for Apple MACS. Pharmacy - Ascribe has now been rpelaced by JAC, which will decommission the Win7 device. 3. Poor Access and password audit. PICS teams rejected to move to local admin password due to lack of resources and time so no further progress until PICs teams resolve this issue. PICS password is linked to Active Directory (AD) so prevents us manually or automatically removing the AD account, which can be problematic because of duplication of accounts. Two factor authentication (2FA) for NHS Mail -currently in deployment using a phased approach. 4. MTI funding received by NHSD. Waiting for delivery of KIT to support the DR backup platform which is now imminent. 5 User awareness - Cyber Security Comms plan in place and in the process of being implemented including staff survey and new intranet page for resources. Being supported by the Comms Team. DSP Toolkit submitted in June 2021 with further action plan to mitigate remaining risks.	Ongoing	2	4	8	Aug-21
PERFORMANCE																								

1089	Operations	COO	BAF and CRR **REFRAMED RISK: The Trust fails to meet the national target of treating 92% and patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the Covid-19 pandemic**		Delivering exceptional patient experience and world class outcomes	Finance & Performance Committee	5	5	25	The March Referral to Treatment position closed at 58.27% against the National Compliance target of 92%. There are 142 patients over 52 weeks. All of these patients are category 4 priority level. Patients waiting in excess of 52 weeksare all going through the Trust harm review process. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis. Refreshed post-Covid Trajectory is being developed in line with the system backog reduction working group is monitored by the Finance & Performance Committee monthly. Delivery of restoration and recovery plans as part of the wider system for P2 and P3 elective operating. Progression of second MRI Scanner - due to be operational August 2021. Phase two of theatre expansion delivered December 2020 - 14 theatres operational from 19 April 2021. Continued transformation of Outpatients services maximising the digital opportunities. ongoing system working for elective orthopaedics for P2, P3 Weekly Elective Care Board in place to monitor and track performance. Restoration and recovery plans now business as usual. All 14 theatres operational and scoping thress session days and weekend working.	Weekly update to Exec Team & Ops Board; monthly finance overview	5	4	20	↑	August 2021 Chief Operating Officer update: in the previous report the COO proposed to reduce the risk score to a Likelihood of 4 but following Exec discussion, it was identified that non-compliance with RTT target is currently continuing and it did not feel appropriate to reduce this score. COO has advised that there is a robust trajectory to achieve the target score and some specialities will achieve 92% shortly. Exec team agree the score should not be reduced at this time, so the current risk score has been re-increased to 20 (5Lx4C). Agreed trajectory in place to deliver RTT target: May 60.50% June 65.56% July 66.75% Trajectory on target as of 24.08.2021. Restoration and recovery plans now business as usual. All 14 theatres operational and scoping three session days and weekend working. July RTT position in line with refreshed trajectory.	Dec-21	3	3	9	Aug-21
CE1	Corporate	Chief Executive	**Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years**		With safe and efficient processes that are patient centred	Trust Board	5	4	20	The ICS has identified a signifiacnt run-rate pressure from 2022 onwards Further work is being undertaken by each Provider to understand the nature of their individual pressure, and the degree to which this is being generated by an expected reduction in Income post COVID, an increase in the cost base of delivering services post COVID, increased costs of service restoration and backlog reduction, or a combination of all of these things. Additionally the ROH is leading system work on the MSK pathway in prepartion for the production of a case-for change document.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	4	4	16		Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned August 2021 Executive Director Finance and Performance update: no change to risk.	Proposed for Closure/de-escalation	3	4	12	Aug-21

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
- Patient safety
- Patient experience
- Workforce capacity, capability and engagement
- Systems, information and processes
- Regulatory compliance and national targets
- Equipment & estates
- Strategy and system alignment
- Reputation and brand

UPDATED: AUGUST 2021

Finance and Performance Report

July 2021

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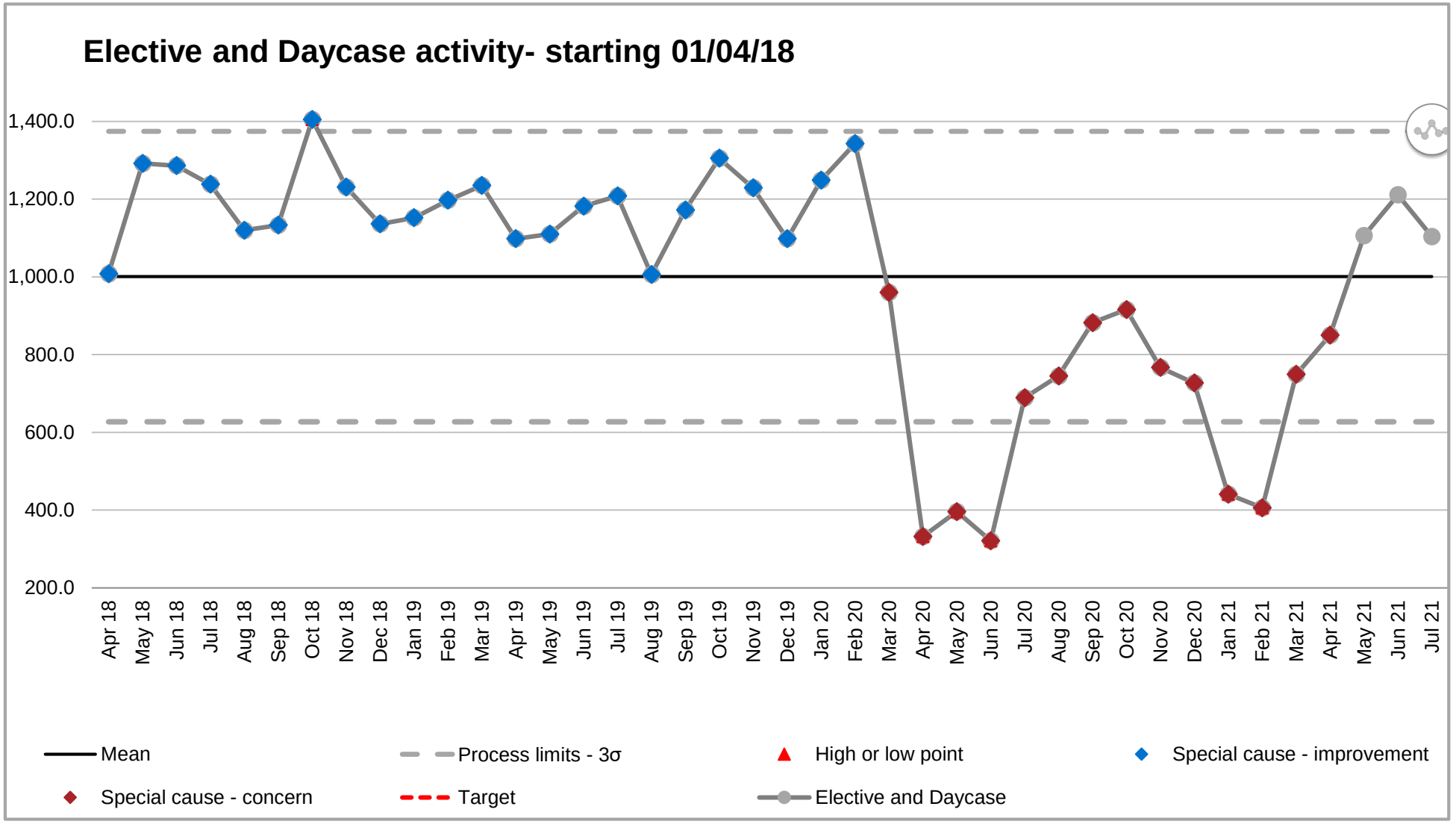
	Introduction
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Introduction

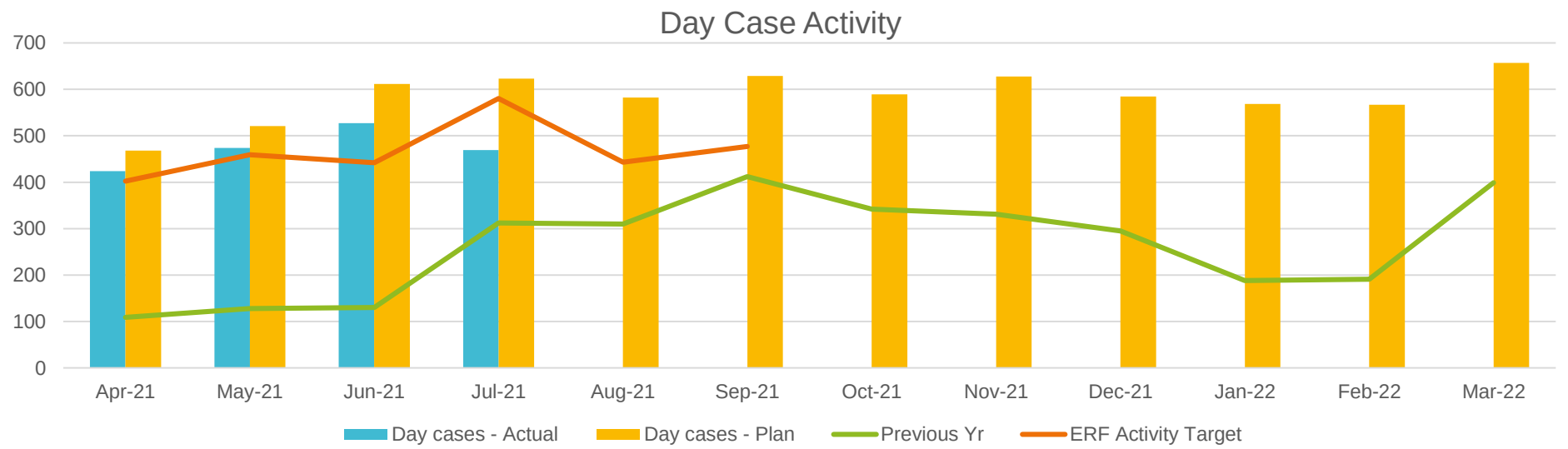
The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

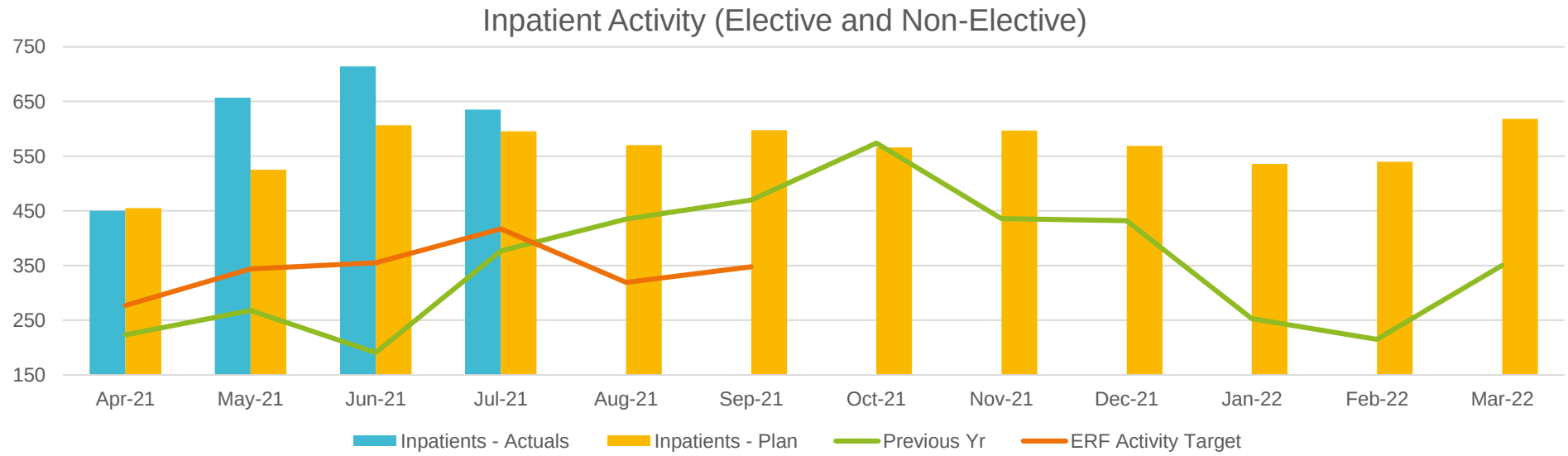
A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues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

1. Activity Summary

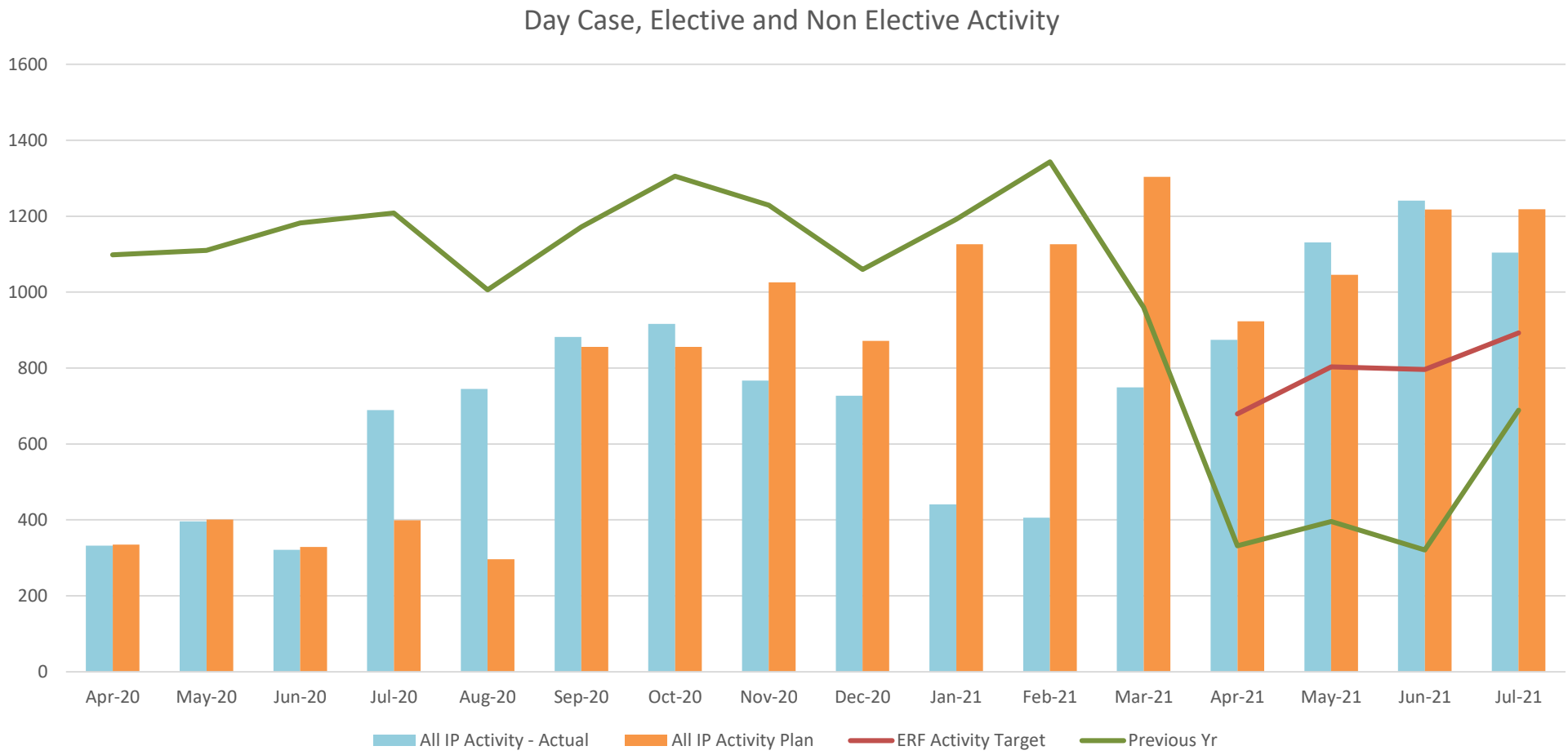


1. Activity Summary

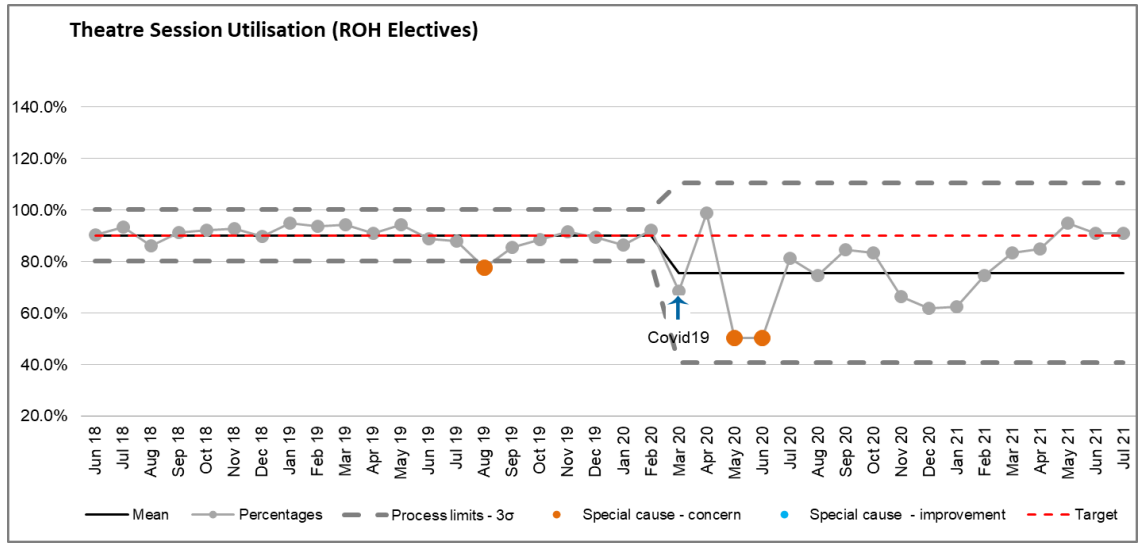


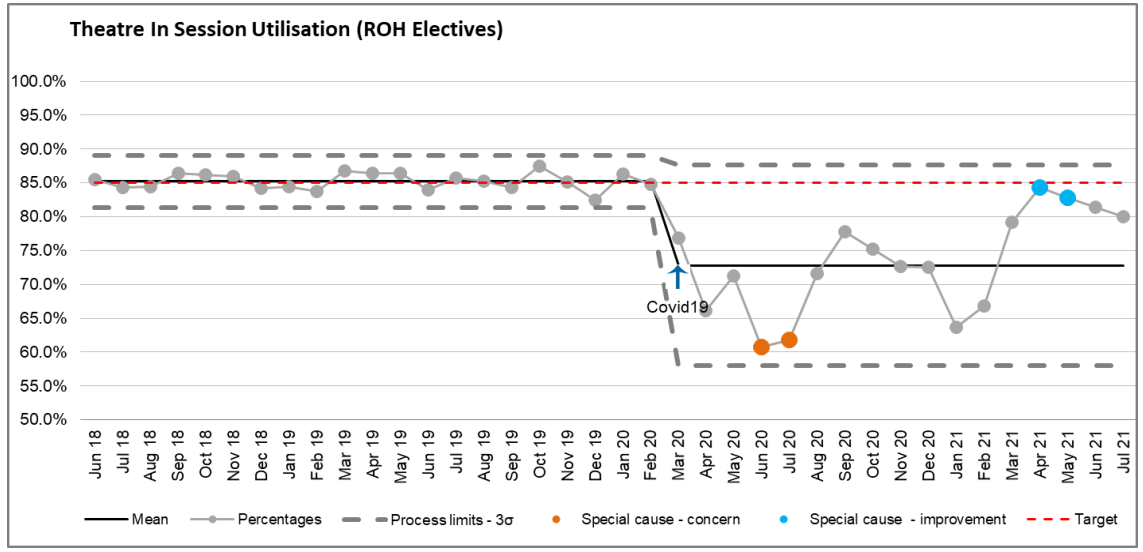


1. Activity Summary



2. Theatre Utilisation





Elective Session Utilisation (July-21)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	395	360	17	91.14%
UHB	149	109	18	73.15%
Totals	544	469	35	86.21%

Elective In Session Utilisation (July-21)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1649	1320	330	80.02%
UHB	513	362	151	70.57%
Totals	2162	1681	480	77.78%

2. Theatre Utilisation

SUMMARY

Overall theatre utilisation was 86.21% a reduction when compared to June which was 94.71%. The main area of reduction in utilisation was in UHB lists (73.15% compared to 94.68%). The reason for this was driven by an increase in trauma activity at UHB throughout July and the need to prioritise Consultant availability to carry out emergency/urgent theatre lists across their theatre footprint. Previously some of this activity would have been undertaken at ROH.

Elective ROH theatre session utilisation for July was 91.14% compared to 94.33% and in session utilisation was 80.02% compared to 81.46% , a slight drop on the previous month. This was mainly due to the impact of staff and patients being 'pinged', to which there has been a reduction of such incidents more recently.

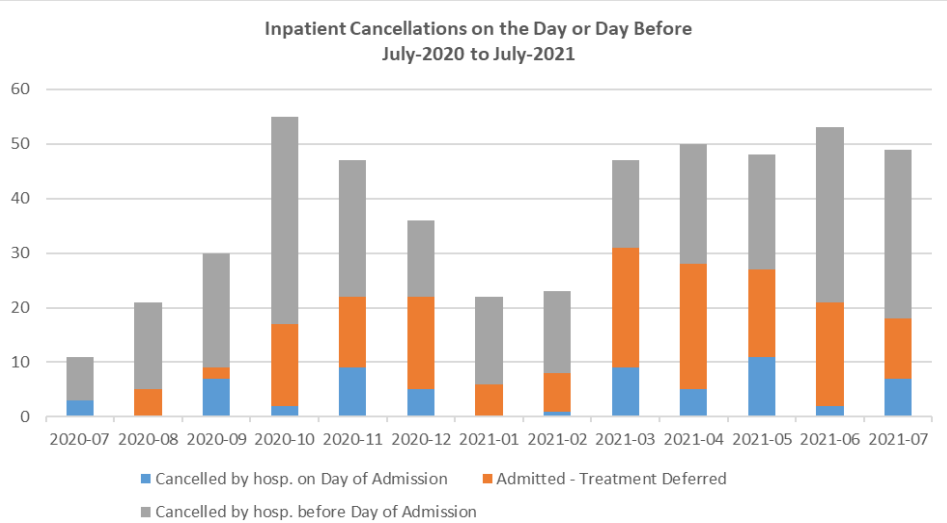
AREAS FOR IMPROVEMENT

Pre-populating of theatre lists at least 4 weeks in advance. with contingency patients now being actively sort from September 2021.

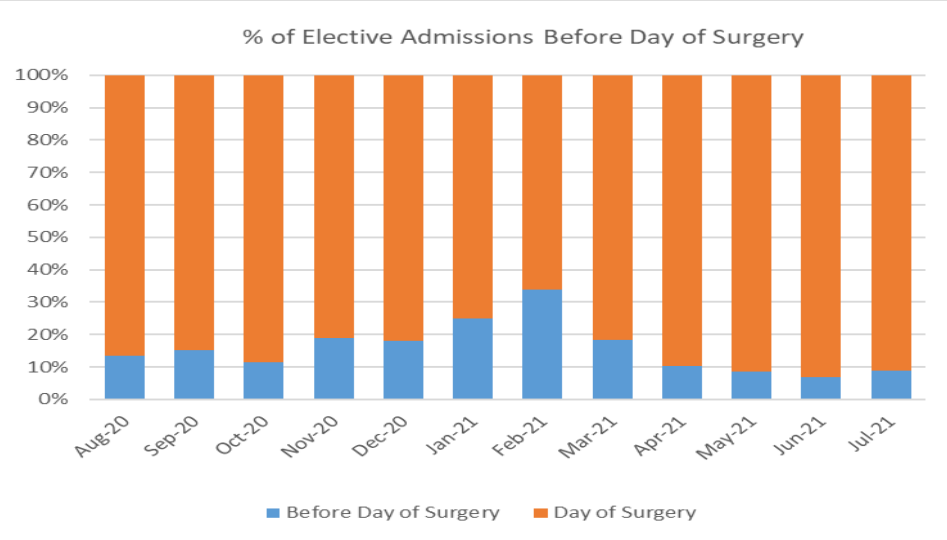
RISKS / ISSUES

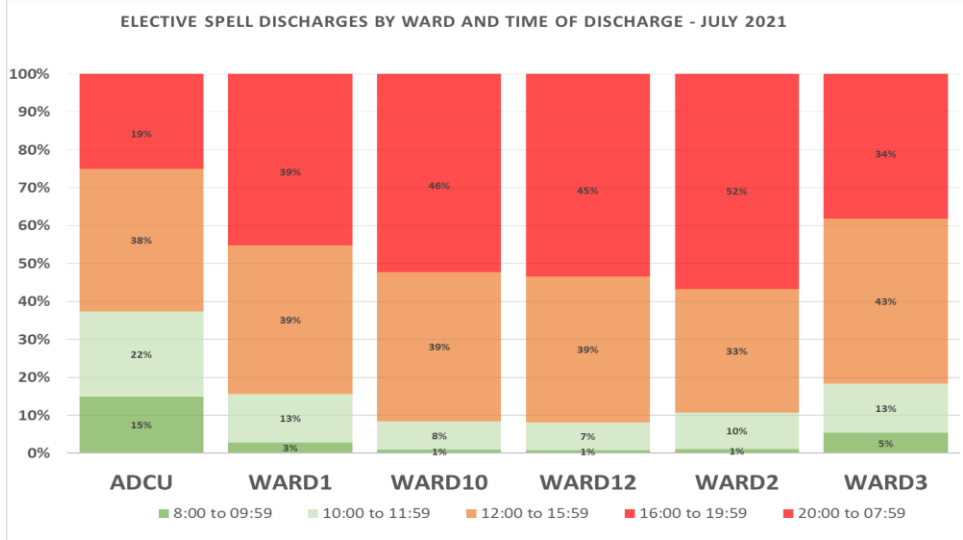
The utilisation of system lists will need to be improved in order to maximise resources and the ROH team are working closely with operational colleagues at UHB to ensure planning of lists is in place to improve efficiency overall

2. Theatre Utilisation/ Hospital Led Cancellations



Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2020-07	3		8	11	0
2020-08		5	16	21	0
2020-09	7	2	21	30	0
2020-10	2	15	38	55	0
2020-11	9	13	25	47	1
2020-12	5	17	14	36	0
2021-01		6	16	22	0
2021-02	1	7	15	23	0
2021-03	9	22	16	47	0
2021-04	5	23	22	50	0
2021-05	11	16	21	48	0
2021-06	2	19	32	53	0
2021-07	7	11	31	49	0
Total	**61**	**156**	**275**	**492**	**1**





2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed does not include those who were either emergency or urgent cases as these are more difficult to avoid due to the very short notice of being booked.
There were 7 patients cancelled on the day of admission in July with reasons detailed as follows;
1 x DNA
1 X Medically unfit
1 x no covid swab
1 x lack of theatre staff
2 x procedure deferred
1 x admin error.

There were 12 patients admitted but where treatment was deferred, with reasons broken down as follows:
5 x Medically unfit / Clinical change in condition
1 x Patient declined surgery
1 x Consultant absence
1 x No covid swab
1 x Patient did not isolate
1 x procedure deferred
1 x Lack of theatre time
1 x No HDU bed

There were 31 patients cancelled by the hospital prior to date of admission with reasons detailed below:

10 x Medically unfit to proceed with surgery, 5 x Patient cancellation, 4 x Covid + , 12 x rescheduled POAC dates due to staff sickness or TCI dates changed

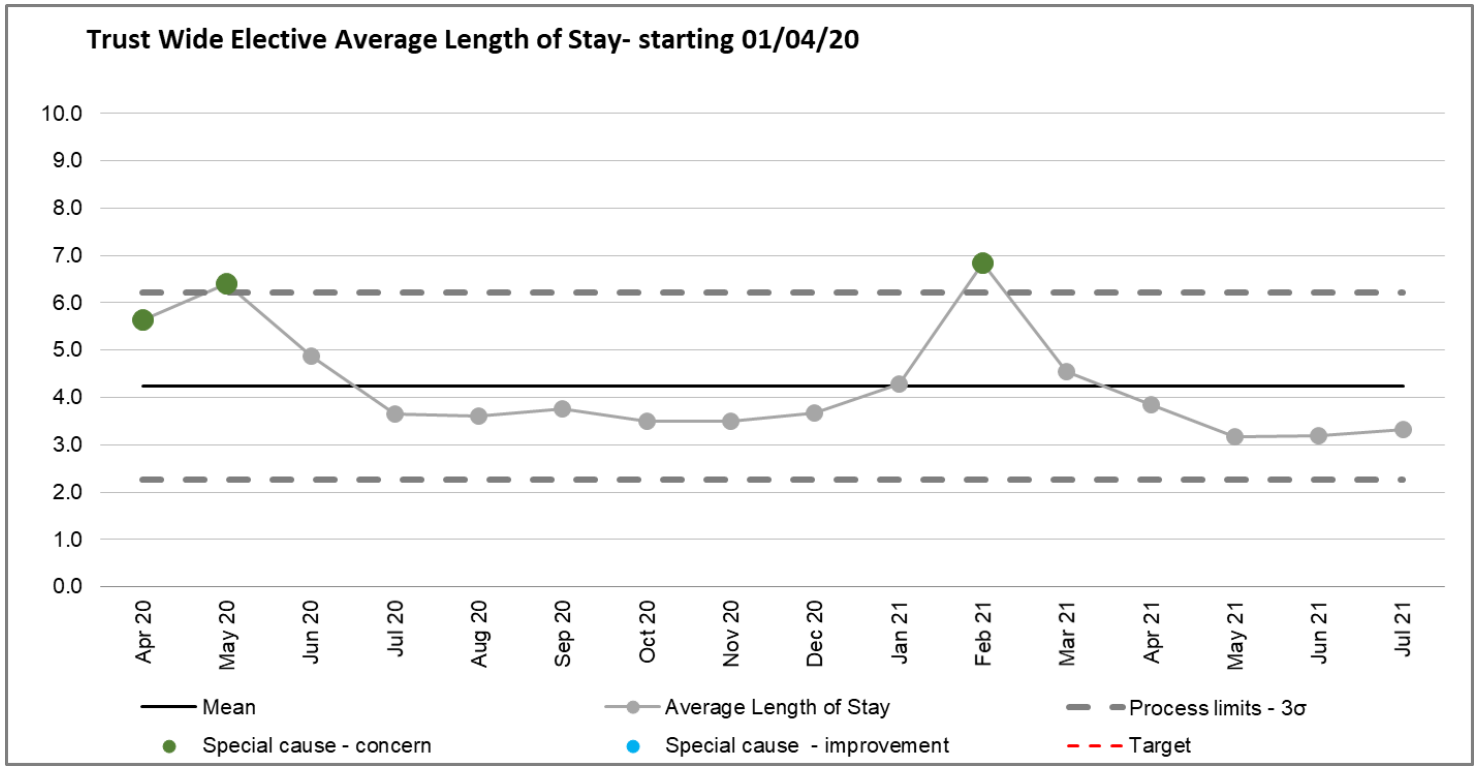
AREAS FOR IMPROVEMENT

6/4/2 scheduling meetings have been reinstated as have the 'theatre look back' meetings which will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. System partners will now be attending these meetings to share best practice and learning. An initiative with NHSE/I looking at Theatre Productivity will be commencing with site visits commencing in June to view current processes / pathways. Feedback expected mid August

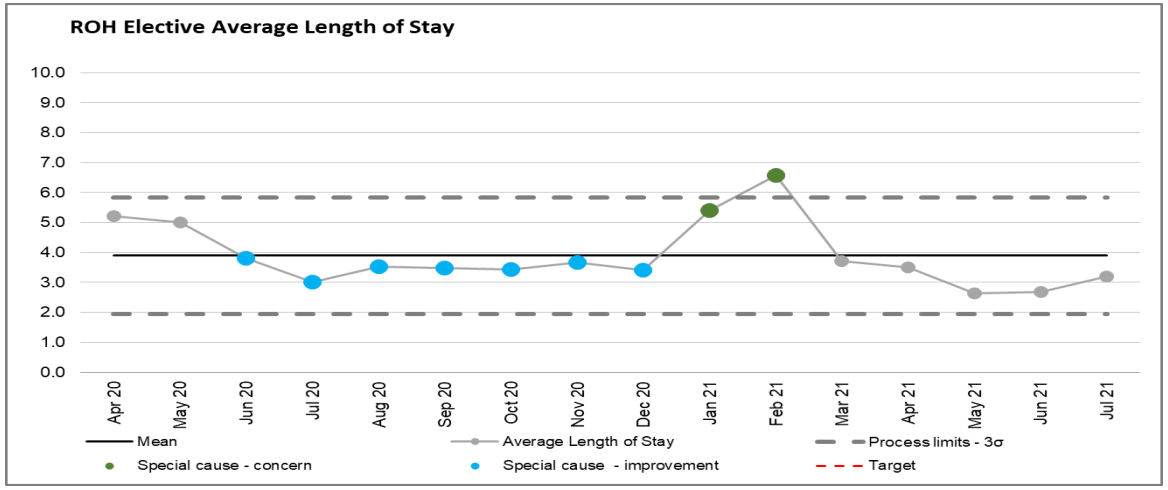
RISKS / ISSUES

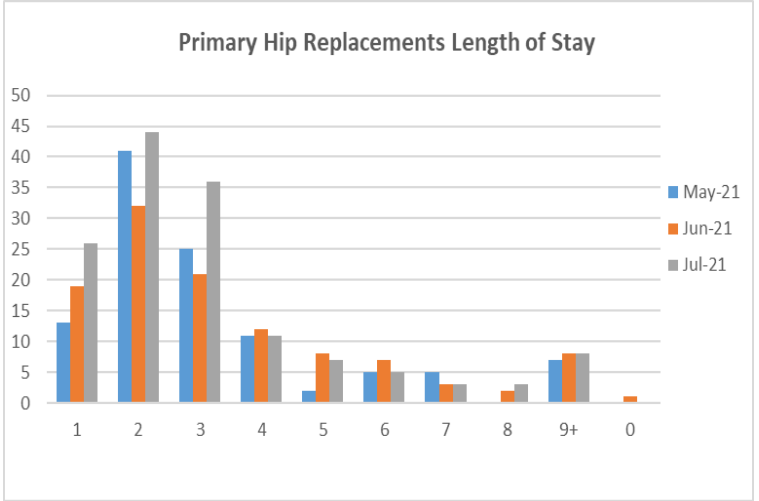
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process.

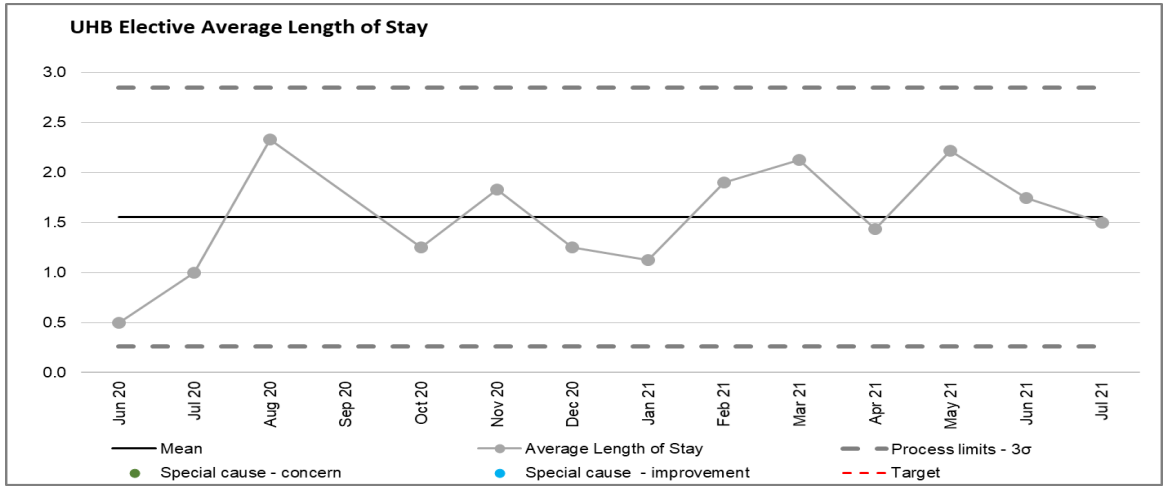
3. Length of Stay

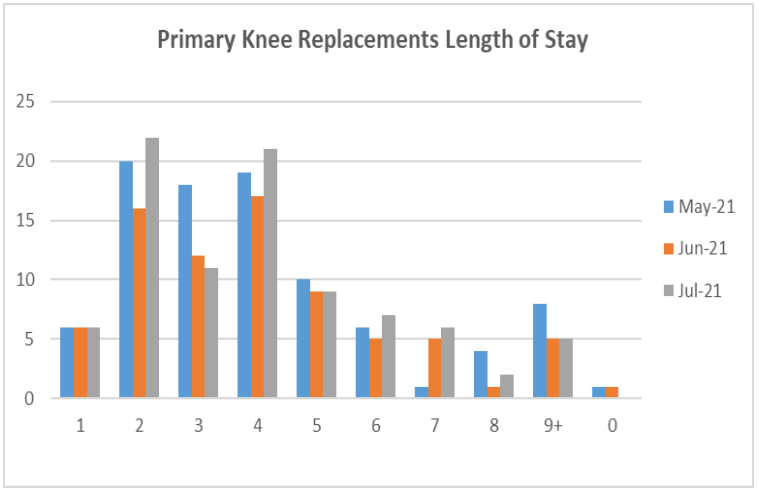


3. Length of Stay









3. Length of Stay

SUMMARY

The average length LOS for ROH patients from *all* specialities is 3.32 (3.21 from June).
The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is 3.18 (2.73 in June)
The average length of stay for UHB patients at ROH is 1.52 (1.60 in June)

June length of stay data produced for UHB and ROH, all specialities (excluding day cases) have been reviewed and the following observations made:

- 26 UHB patients with LOS greater than 5 days. 8 with a length of stay grater than 7 days. (excludes Rehab). Those patients with stays greater than 7 days were due to complexity of surgery and clinically justified reasons.

- Data and review of PICs information demonstrated that ROH surgeons are undertaking surgery on significantly larger numbers of complex patients, particularly within Oncology. These patients due to the nature of the surgery have a longer length of stay. Of the PICS records reviewed all length of stays were justifiable due to on-going clinical or complex discharge needs

The comparison between ROH and UHB LOS will be skewed by the fact that ROH operate on more complex patients that can result in a longer stay, e.g. EPR procedures carried out oncology arthroplasty.

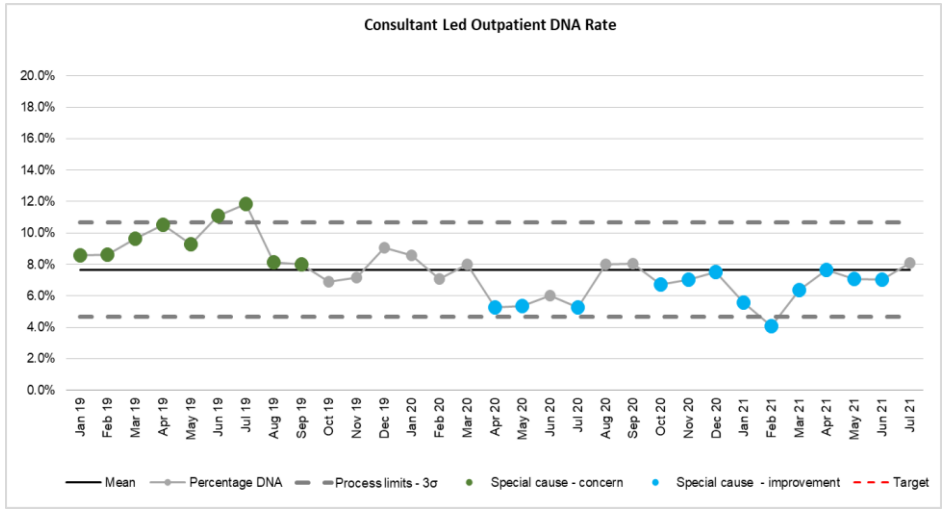
AREAS FOR IMPROVEMENT

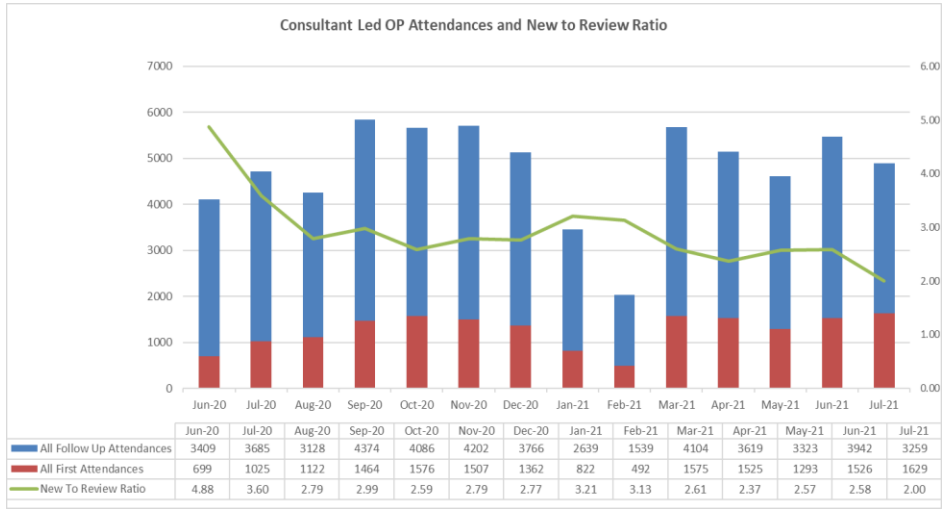
The roaming Discharge Team continue to provide discharge support to the wards and actively manage any potential delayed discharges. In addition, the wards are proactively managing discharges plans and escalating any potential physiotherapy/imaging delays which may impact

RISKS / ISSUES

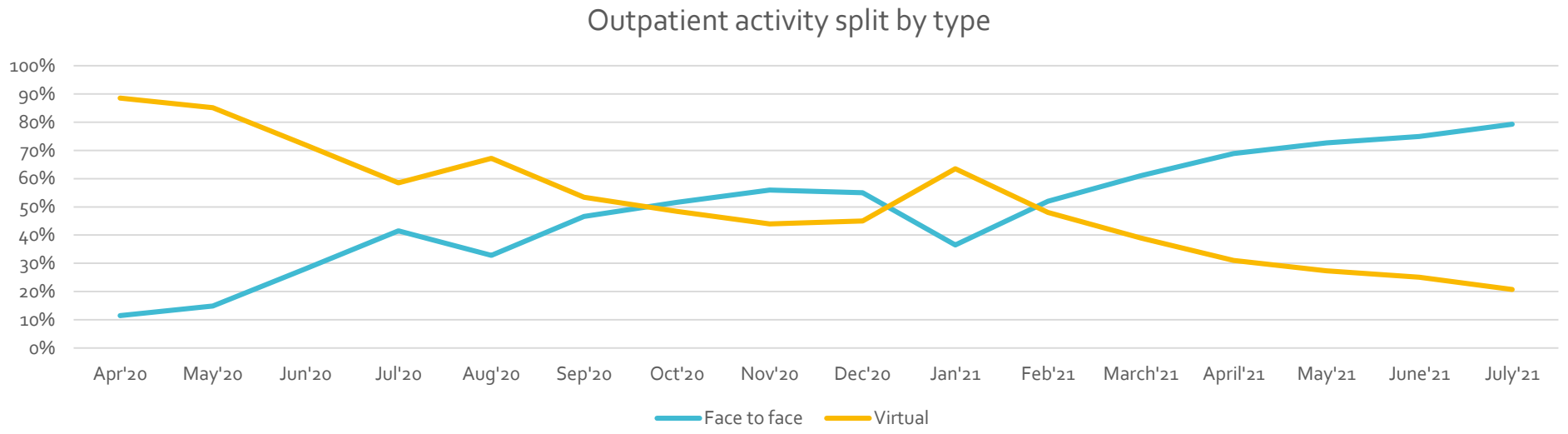
Continued operating on more complex, high priority patient will retain risk of increased length of stay . The Discharge Lounge continues to be used by the ROCS/IPC and Tissue Viability Teams, as activity increases, this facility needs to be in place . Scoping options for where these teams will move to a new permanent location with support from the estates team.
There is a reliance on temporary staffing to support the discharge team due to vacancies, however this is being actively managed.

4. Outpatient efficiency

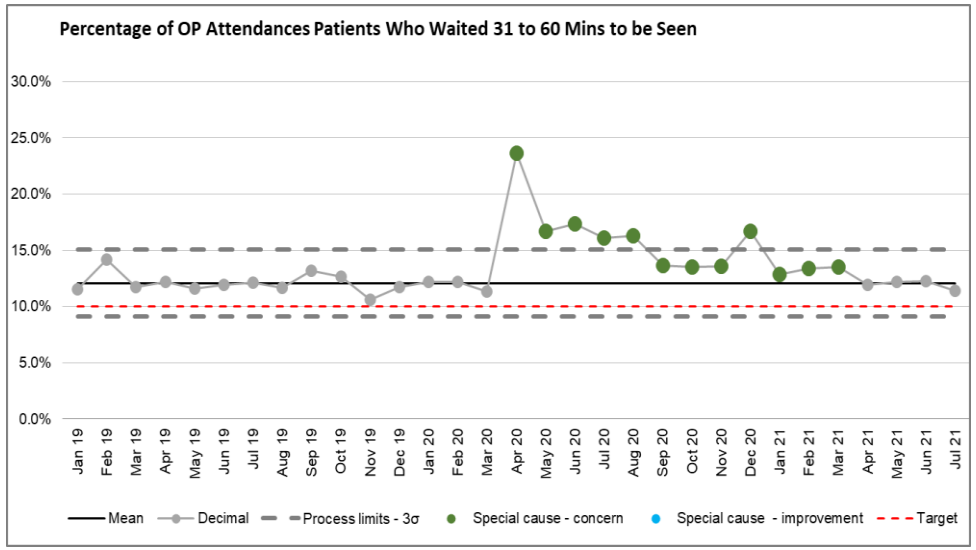


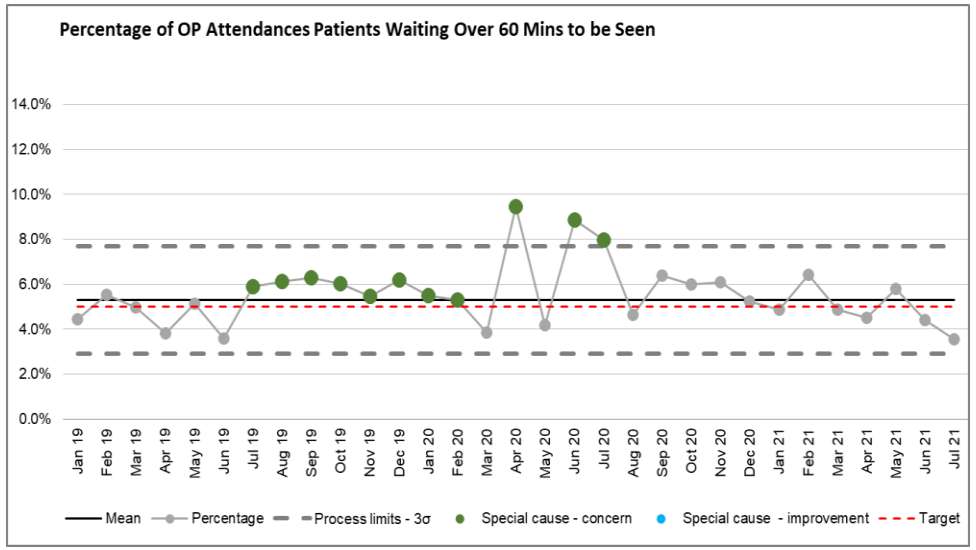


	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
All Follow Up Attendances	3409	3685	3128	4374	4086	4202	3766	2639	1539	4104	3619	3323	3942	3259
All First Attendances	699	1025	1122	1464	1576	1507	1362	822	492	1575	1525	1293	1526	1629
New To Review Ratio	4.88	3.60	2.79	2.99	2.59	2.79	2.77	3.21	3.13	2.61	2.37	2.57	2.58	2.00



4. Outpatient efficiency





4. Outpatient efficiency

SUMMARY

30 minute delays – Decreased in July to **11.4%** from June which was **12.3%**. Trust Target is **10%**
60 minute delays – Decreased in July to **3.6%** from June which was **4.4%**. Target is **5%**

The position in July has improved from the previous month. Work is being undertaken with Oncology to review the clinic templates to address the current clinic delays. The new templates will be operational from September.

Imaging delays have significantly reduced due to the improvements in the booking process and with the repatriation of the ambulatory trauma work to UHB, this has increased staffing capacity in x-ray.

An escalation process is in place for delays in outpatients approaching 30 minutes between the Operational and Nursing Team and is working well.
The Outpatient Huddle continues to take place daily and is having a positive impact on processes and the flow within the department as well as improving communication between the nursing and operational teams.

There were 3747 (79%) face to face and 1001 (21%) virtual appointments carried out in July. The virtual clinics undertaken fell short of the national % target attributed to patients needing to be seen face to face as we continue to restore and recover.

New appointment waiting times have reduced through the OPWL PTL meetings being held by the appointments team.

AREAS FOR IMPROVEMENT

The DNA rate for July is 8.09% which is an increase from 7.02% in June. Trust target is 8%.

A DNA audit is undertaken each month to understand the issues and an action plan is in place to ensure the issues are resolved going forward. The comparison appears to suggest a seasonal trend and the findings from the July audit support this with patients missing their appointments due to being on holiday. Letters ad texts are sent to remind patients of the appointment date and time.

RISKS / ISSUES

A business case for the use of Griffins Brook Medical Centre has been approved and will provide additional outpatient capacity for Clinical Support Services.

5. Referral to Treatment

Referral to Treatment Snapshot as at 31st July 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/07/2021

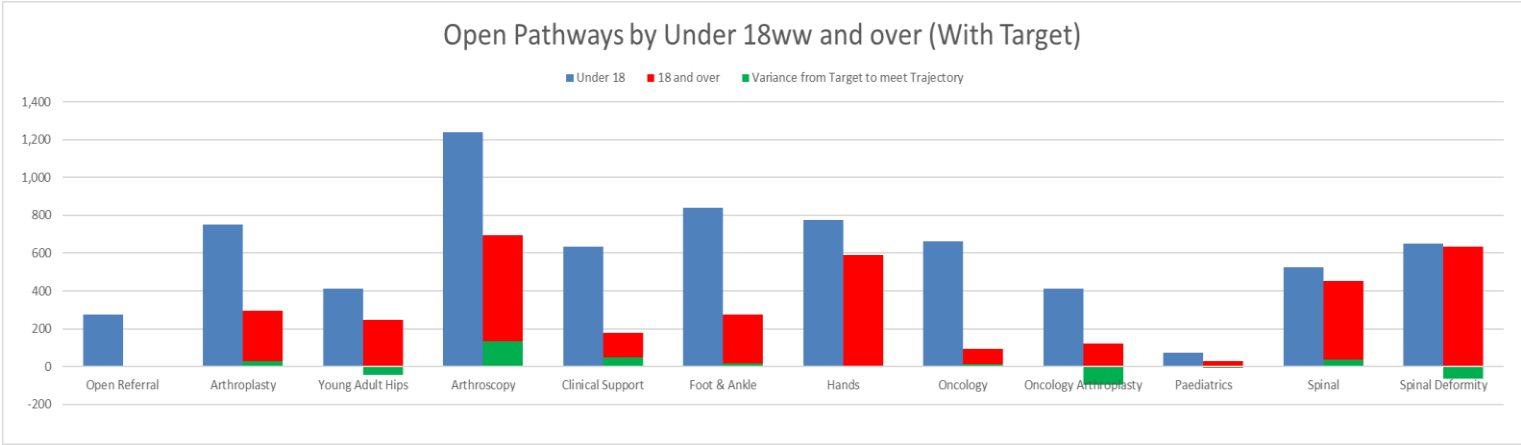
Est Over 18 Clock Stops Required		
To achieve	66.71%	-9
To achieve	75.72%	1476
To achieve	79.91%	2052

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**3,359**	269	352	181	506	220	412	312	357	197	36	245	272
7-13	**2,736**	7	274	173	527	308	301	301	215	159	24	196	251
14-17	**1,148**	0	123	58	207	105	126	161	90	57	11	84	126
18-26	**1,399**	1	138	86	281	119	106	217	57	47	10	139	198
27-39	**1,484**	0	113	141	274	49	114	266	21	50	9	187	260
40-47	**478**	0	29	18	96	6	46	76	10	20	6	79	92
48-51	**117**	0	11	0	22	2	7	17	4	3	2	19	30
52 weeks and over	**128**	0	2	2	23	0	2	13	2	1	1	28	54
Total	**10,849**	277	1,042	659	1,936	809	1,114	1,363	756	534	99	977	1,283

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,243**	276	749	412	1,240	633	839	774	662	413	71	525	649
18 and over	**3,606**	1	293	247	696	176	275	589	94	121	28	452	634
Current Month End RTT %	**66.76%**	**99.64%**	**71.88%**	**62.52%**	**64.05%**	**78.24%**	**75.31%**	**56.79%**	**87.57%**	**77.34%**	**71.72%**	**53.74%**	**50.58%**

31/07/21 Trajectory RTT %	66.71%	100.00%	73.88%	58.44%	68.84%	83.22%	76.42%	56.75%	88.89%	65.34%	66.35%	55.85%	48.12%
Target for RTT Trajectory	3,614	0	265	293	561	128	259	590	83	219	36	415	700
Variance from Target to meet Trajectory	-8	1	28	-46	135	48	16	-1	11	-98	-8	37	-66



5. Referral to Treatment

Referral to Treatment Snapshot as at 31st July 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/07/2021

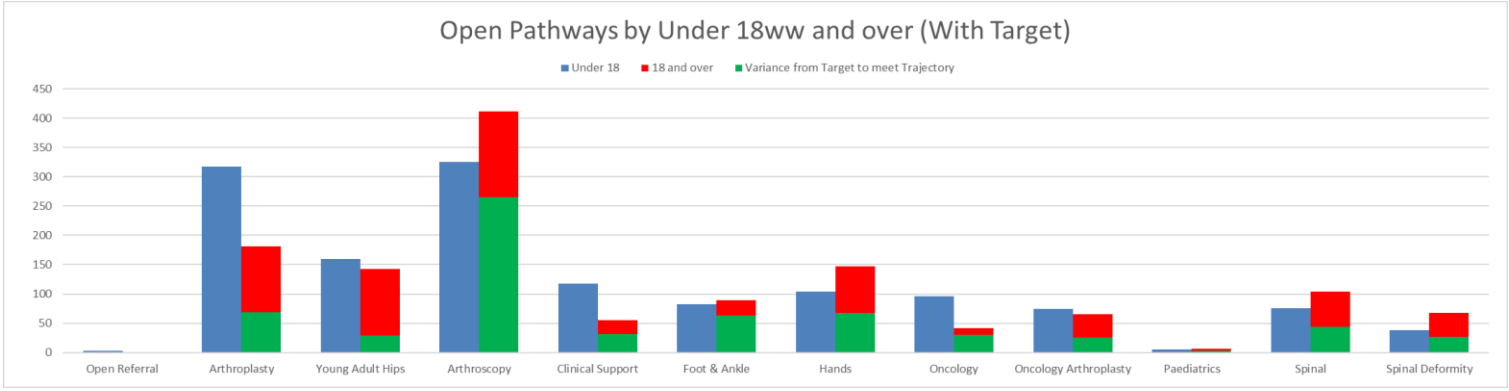
	Est Over 18 Clock Stops Required	
To achieve	66.71%	707
To achieve	75.72%	993
To achieve	79.91%	1105

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**505**	3	108	52	91	41	26	49	62	21	3	31	18
7-13	**592**	0	141	81	142	57	36	36	22	37	2	23	15
14-17	**301**	0	68	27	92	20	20	19	12	16	0	22	5
18-26	**386**	0	75	38	141	32	19	17	14	19	2	16	13
27-39	**583**	0	75	94	174	18	39	76	15	32	1	38	21
40-47	**222**	0	24	10	68	3	26	35	9	13	2	25	7
48-51	**53**	0	7	0	12	2	4	7	3	1	1	11	5
52 weeks and over	**68**	0	0	1	17	0	1	12	1	0	0	14	22
Total	**2,710**	3	498	303	737	173	171	251	138	139	11	180	106

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,398**	3	317	160	325	118	82	104	96	74	5	76	38
18 and over	**1,312**	0	181	143	412	55	89	147	42	65	6	104	68
Current Month End RTT %	**51.59%**	100.00%	**63.65%**	**52.81%**	**44.10%**	**68.21%**	**47.95%**	**41.43%**	**69.57%**	**53.24%**	**45.45%**	**42.22%**	**35.85%**

31/07/21 Trajectory RTT %	66.71%	100.00%	73.88%	58.44%	68.84%	83.22%	76.42%	56.75%	88.89%	65.34%	66.35%	55.85%	48.12%
Target for RTT Trajectory	698	0	112	114	147	24	25	79	12	39	3	60	41
Variance from Target to meet Trajectory	614	0	69	29	265	31	64	68	30	26	3	44	27



5. Referral to Treatment

Referral to Treatment Snapshot as 31st July 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/07/2021

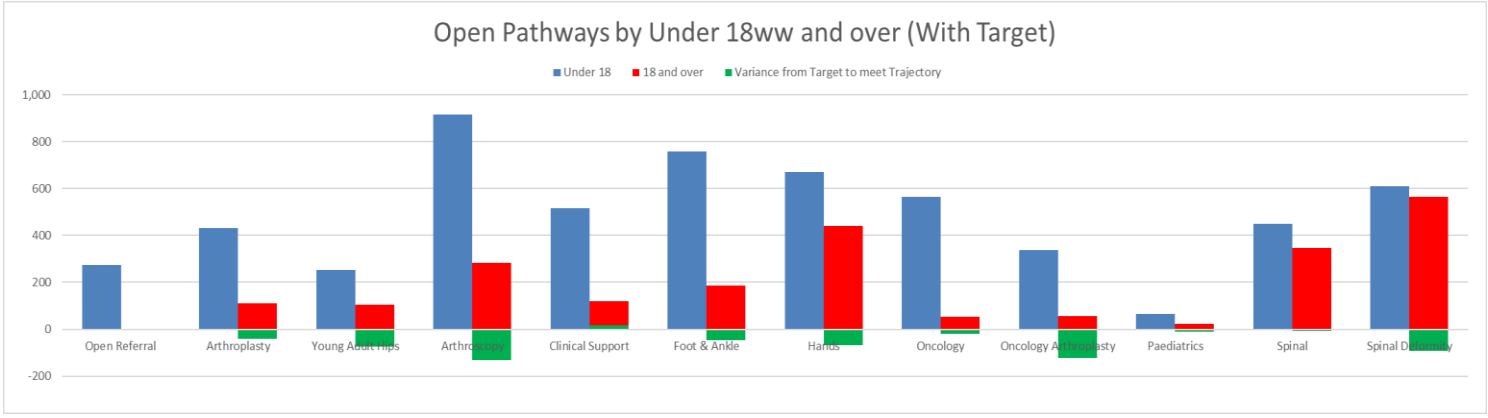
Est Over 18 Clock Stops Required		
To achieve	66.71%	-716
To achieve	75.72%	482
To achieve	79.91%	948

Select Pathway Type: Non Admitted

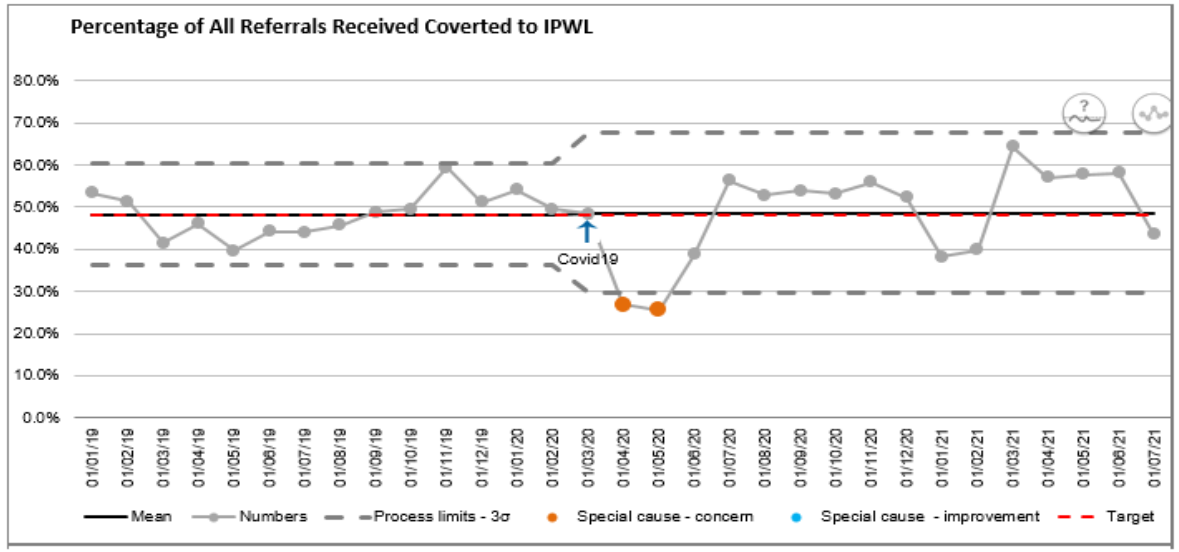
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,854**	266	244	129	415	179	386	263	295	176	33	214	254
7-13	**2,144**	7	133	92	385	251	265	265	193	122	22	173	236
14-17	**847**	0	55	31	115	85	106	142	78	41	11	62	121
18-26	**1,013**	1	63	48	140	87	87	200	43	28	8	123	185
27-39	**901**	0	38	47	100	31	75	190	6	18	8	149	239
40-47	**256**	0	5	8	28	3	20	41	1	7	4	54	85
48-51	**64**	0	4	0	10	0	3	10	1	2	1	8	25
52 weeks and over	**60**	0	2	1	6	0	1	1	1	1	1	14	32
Total	**8,139**	274	544	356	1,199	636	943	1,112	618	395	88	797	1,177

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,845**	273	432	252	915	515	757	670	566	339	66	449	611
18 and over	**2,294**	1	112	104	284	121	186	442	52	56	22	348	566
Current Month End RTT %	**71.81%**	99.64%	**79.41%**	**70.79%**	**76.31%**	**80.97%**	**80.28%**	**60.25%**	**91.59%**	**85.82%**	**75.00%**	**56.34%**	**51.91%**

31/07/21 Trajectory RTT %	66.71%	100.00%	73.88%	58.44%	68.84%	83.22%	76.42%	56.75%	88.89%	65.34%	66.35%	55.85%	48.12%
Target for RTT Trajectory	2,917	0	153	179	414	104	234	511	71	180	33	355	659
Variance from Target to meet Trajectory	-623	1	-41	-75	-130	17	-48	-69	-19	-124	-11	-7	-93

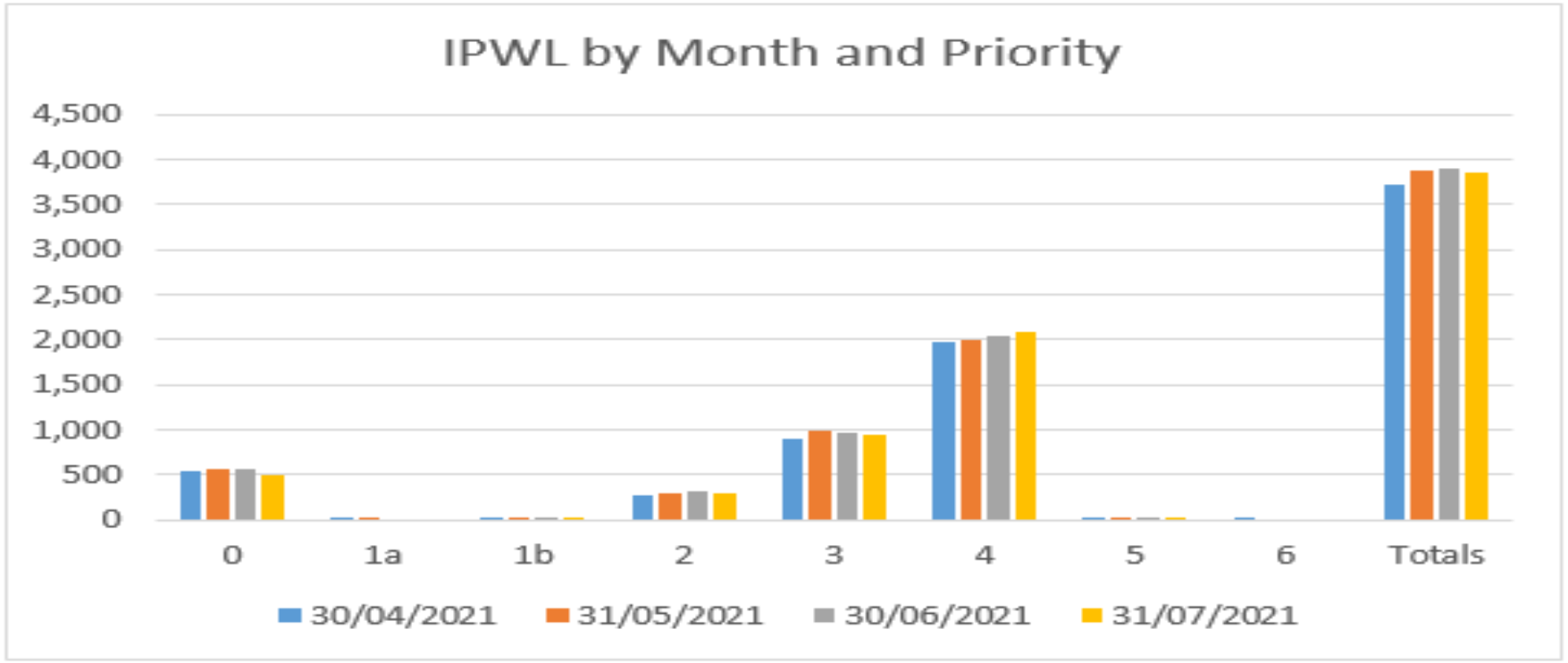


5. Referral to Treatment

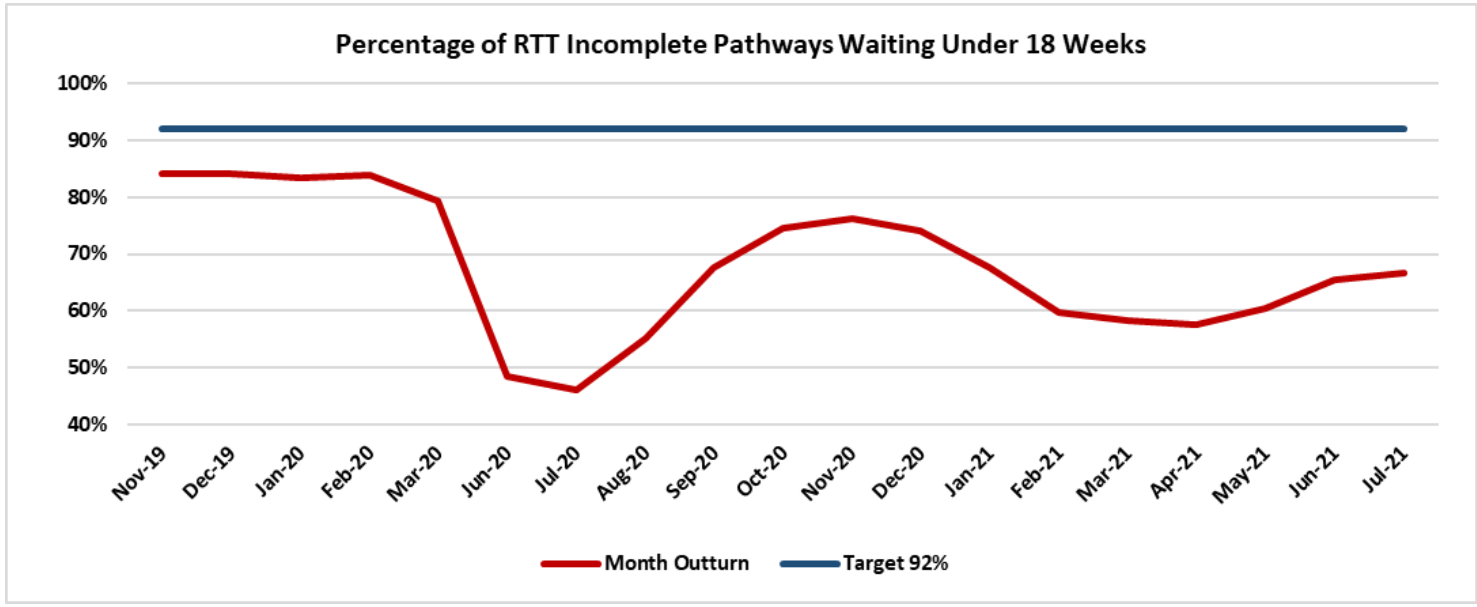


Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Number of Referrals	996	1154	1212	1575	1521	2030	2018	1796	1700	1556	1426	1939	2331	2281	2555	2351
Number of IPWL Additions	268	295	470	885	804	1094	1072	1004	887	595	568	1247	1327	1316	1483	1021
Percentage of All Referrals Received Coverted to IP	26.91%	25.56%	38.78%	56.19%	52.86%	53.89%	53.12%	55.90%	52.18%	38.24%	39.83%	64.31%	56.93%	57.69%	58.04%	43.43%

5. Referral to Treatment



5. Referral to Treatment



ALL Pathways	RTT Trajectory as at:																	
	31/07/2021	31/08/2021	30/09/2021	31/10/2021	30/11/2021	31/12/2021	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	31/11/2022	31/12/2022
Under 18 Weeks	6,747	6,861	7,420	7,832	8,143	8,423	8,749	9,033	9,282	9,375	9,448	9,523	9,578	9,605	9,625	9,629	9,639	9,648
18 Weeks and Over	3,367	3,227	2,966	2,644	2,288	1,967	1,774	1,533	1,318	1,147	1,057	964	902	859	821	798	778	768
Total ALL Pathways	10,114	10,087	10,386	10,476	10,431	10,391	10,523	10,567	10,601	10,522	10,505	10,487	10,479	10,463	10,446	10,427	10,417	10,416
ALL RTT %	66.71%	68.01%	71.45%	74.76%	78.07%	81.07%	83.14%	85.49%	87.56%	89.10%	89.94%	90.81%	91.40%	91.79%	92.14%	92.35%	92.53%	92.63%
Month % Movement	3.30%	1.30%	3.43%	3.31%	3.31%	3.00%	2.08%	2.35%	2.07%	1.54%	0.84%	0.87%	0.59%	0.40%	0.35%	0.20%	0.18%	0.10%

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for July is **66.76%** against the National compliance target of 92%. This is an increase compared to June 21 reporting at **65.56%** and is reflective of the increase in elective procedures in month. There are **128** patients over 52 weeks, an increase from **108** in June - **68** admitted and **60** non-admitted with plans or actions in place to progress these pathways or patients.
All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. **595** patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority in line with the national guidance for clinical prioritisation of patients awaiting surgery, **2710** patients are on the admitted waiting list **(P2 – 282 patients, P3 –869 patients, P4 – 1511 patients, P5 – 2 patients, P6 – 0 patients**.

Referrals continue to move towards Pre-Covid levels with 2,351 referrals received in July 2021, the average monthly referrals received Pre-Covid (2,704)

IPWL as at 31/07/2021 is 18% higher than the Last Pre-Covid Position (3,297 as at 28/02/2020)

We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

AREAS FOR IMPROVEMENT

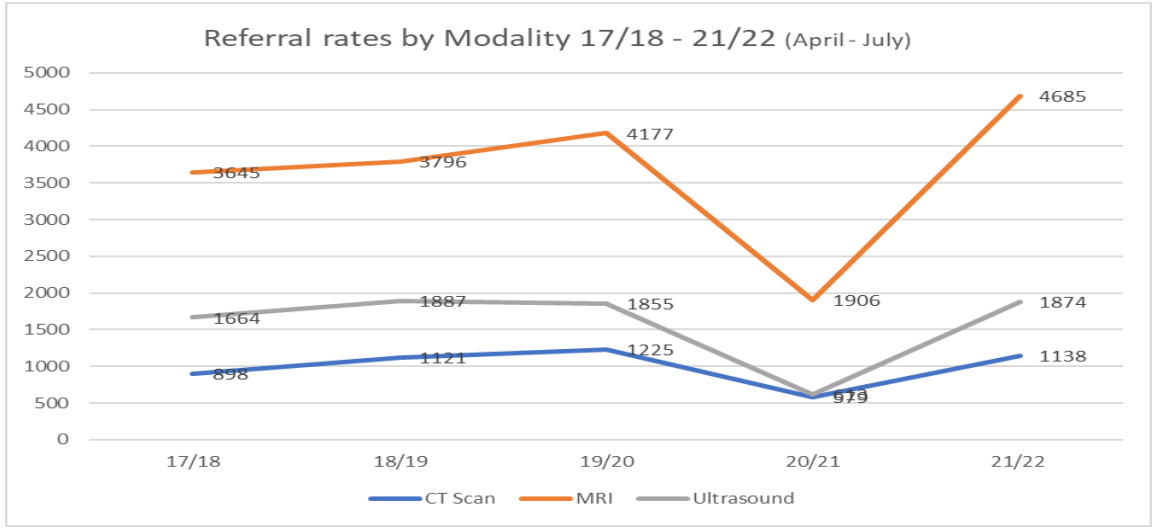
A weekly Elective Care Confirm and Challenge meeting is in place together with a weekly PTL meeting to monitor compliance with RTT and to ensure we are actively progressing patients through their pathways.

RISKS / ISSUES

6. Diagnostic Performance

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

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285
Apr-21	776	68	182	1026	8	1018	99.2%	770	233	298	1301
May-21	956	93	353	1402	14	1388	99.0%	599	166	299	1064
Jun-21	1268	64	287	1619	201	1418	87.6%	807	248	391	1446
Jul-21	1390	53	317	1760	324	1436	81.6%	911	212	318	1441



6. Diagnostic Performance

SUMMARY

Imaging failed to achieved their diagnostic target in July reporting 81.59%. Reporting times remain consistently good.

Overall referrals for diagnostics increased to 102% in July when compared to the same period in 19/20 (pre-covid levels), with referrals for MRI at 113% in July when also compared to July 19/20. This is against a backdrop of decreased capacity due to the IPC restrictions currently in place. The current waiting time for routine MRI is 8 weeks, and all patients have an appointment date.

The 2nd MRI scanner was craned into position on the 8th August and is due to be operational from the 13th September and will have a positive impact on current waiting times.

Continued use of the mobile MRI van will be sourced as far as availability of the mobile unit allows and the maximisation of all slots will continue.

AREAS FOR IMPROVEMENT

An additional mobile MRI van capacity is being sourced for the next 3 months to meet the increasing demand for MRI, however based on current rates of referrals, more capacity will be required but is proving challenging to secure due to competing demands from other Trusts / centres. The independent sector have also been approached to ascertain if any MRI capacity is available, but they are unable to help at this time due to their own increasing demands.

RISKS / ISSUES

The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.
With the increasing level of referrals and disruption due to installation works until September when the 2nd scanner becomes operational there is a risk to delivering the diagnostic target for MRI which is being monitored closely by the team to mitigate where possible.

7. Cancer Performance

		June 2021 (complete)				May 2021 (Submitted)			
Target Name	National Standard	%	In target	Breach	Total	%	In target	Breach	Total
2ww	93%	98%	55.00	1.00	56.00	100%	40.00	0.00	40.00
31 day first treatment	96%	100%	10.00	0.00	10.00	92%	11.00	1.00	12.00
31 day subsequent (surgery)	94%	100%	4.00	0.00	4.00	100%	5.00	0.00	5.00
62 day (traditional)	85%	88%	3.50	0.50	4.00	92%	5.50	0.50	6.00
62 day (Cons Upgrade)	n/a	75%	3.00	1.00	4.00	84.60%	5.50	1.00	6.50
28 day FDS REPORTED	75%	74%	48	17	65	86%	47	8	55

7. Cancer Performance

SUMMARY

Performance against cancer targets continued in a positive trajectory in June, with one patient having breached against the 62 day target (0.5 breach attributed to ROH), however forecasted performance for Quarter 2 demonstrates a deterioration for the following reasons:

- Increased complexity of patients
- Increased numbers of patients requiring repeat biopsies or complex analysis of pathology
- Late tertiary referrals
- Capacity in Oncology and supporting services (e.g. radiology, pre-op, pathology)
- Increased numbers of patients unfit for surgery or testing as C19 +ve in pre-op screening

The Trust slightly underperformed against the 28 day FDS target due to a high number of complex patients requiring repeat biopsies.
22 patients have been referred from RJAH as part of the SLA.
Joint working with supporting services continues (e.g. Pre-op, Radiology, Pathology and Theatres)

AREAS FOR IMPROVEMENT

Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways, both of which are under current analysis and review.

RISKS / ISSUES

Currently one nursing post is vacant with a start date confirmed for September.

There are currently four vacancies at fellow and training grade with two start dates confirmed and two candidates undergoing pre-employment checks with start dates to be confirmed.

Oncology Department move has been confirmed – project meetings in place going forward.

8. Overall Financial Performance

SUMMARY

The Trust delivered a year to date deficit of £619k against a plan of £49k surplus, creating a variance of £668k underperformance against plan.

Income year to date against plan is underperforming by £205k. This is a deterioration on last month.

In previous months there was an element of ERF funding recognised for initial planned activity, alongside an expectation of additional ERF for over performance. The planned ERF has been confirmed for the system, but whilst the ROH continue to over perform at a provider level, there is insufficient additional activity at a system level to achieve as much ERF as previously anticipated.

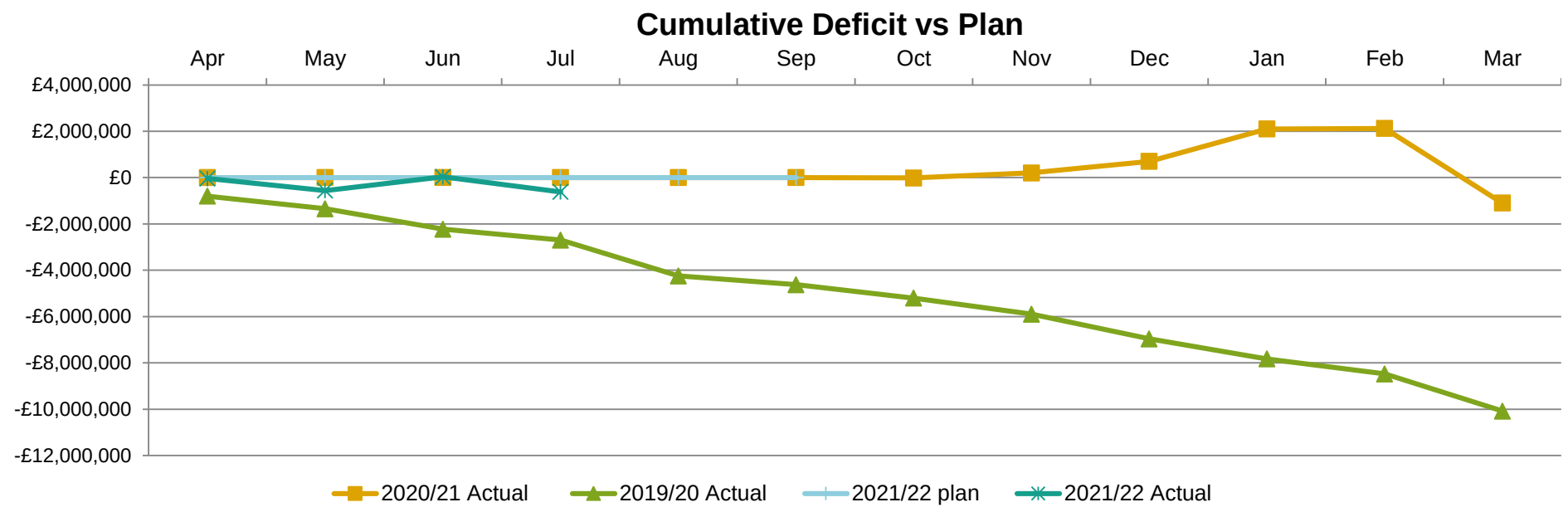
Pay and non pay expenditure overspent year to date by £476k.

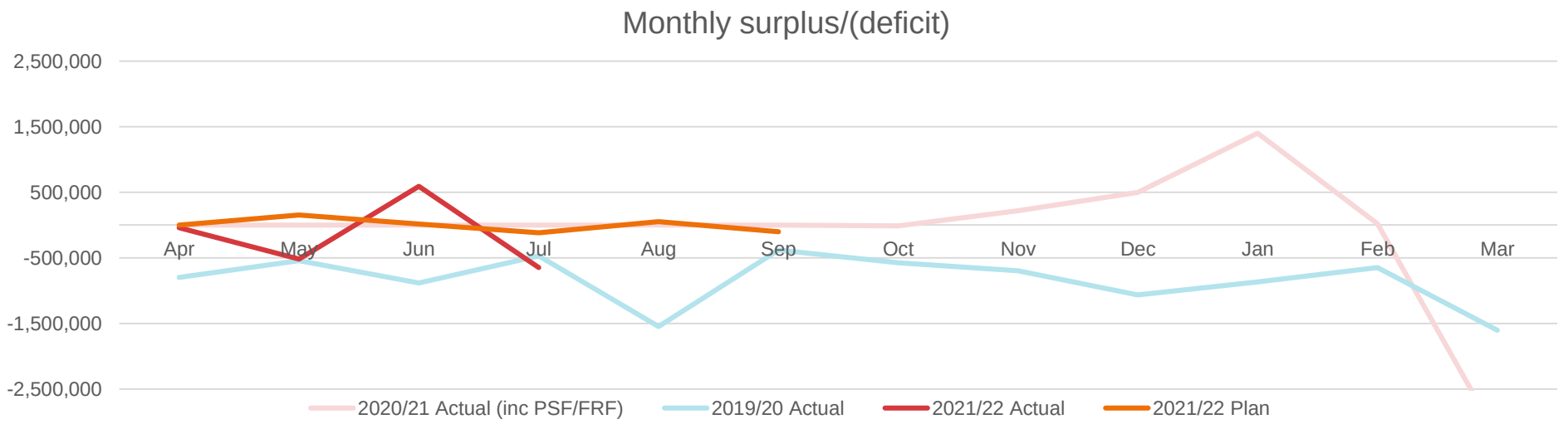
	£'000s			
	Income	Pay	Non Pay	Total
Year to date Variance	(205)	(365)	(98)	(668)
Year to date plan	35,177	(19,464)	(15,686)	49
Year to date actual	34,972	(19,829)	(15,785)	(619)
Actual compared to previous month	▼	▲	▼	▼
Forecast Variance	1,854	(921)	(933)	0

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	33,863	33,531	(332)
Other Operating Income (Excluding top up)	1,314	1,441	127
Total Income	**35,177**	**34,972**	**(205)**
Employee Expenses (inc. Agency)	(19,464)	(19,829)	(365)
Other operating expenses	(15,411)	(15,522)	(111)
Operating Deficit	**301**	**(380)**	**(681)**
Net Finance Costs	**(275)**	**(262)**	**13**
Net deficit	**26**	**(642)**	**(669)**
Remove donated asset I&E impact	23	23	0
Adjusted financial performance	**49**	**(619)**	**(668)**

8. Overall Financial Performance





9.Income

SUMMARY

Income year to date against plan is overperforming by £336k as a result of £1.4m of Elective Recovery Fund (ERF) income being recognised. This is a reduction of £305k year to date following an increase to the trajectory resulting in the system ERF target not being met in month.

In previous months there was an element of ERF funding recognised for initial planned activity, alongside an expectation of additional ERF for over performance. The planned ERF has been confirmed for the system, but whilst the ROH continue to over perform at a provider level, there is insufficient additional activity at a system level to achieve as much ERF as previously anticipated.

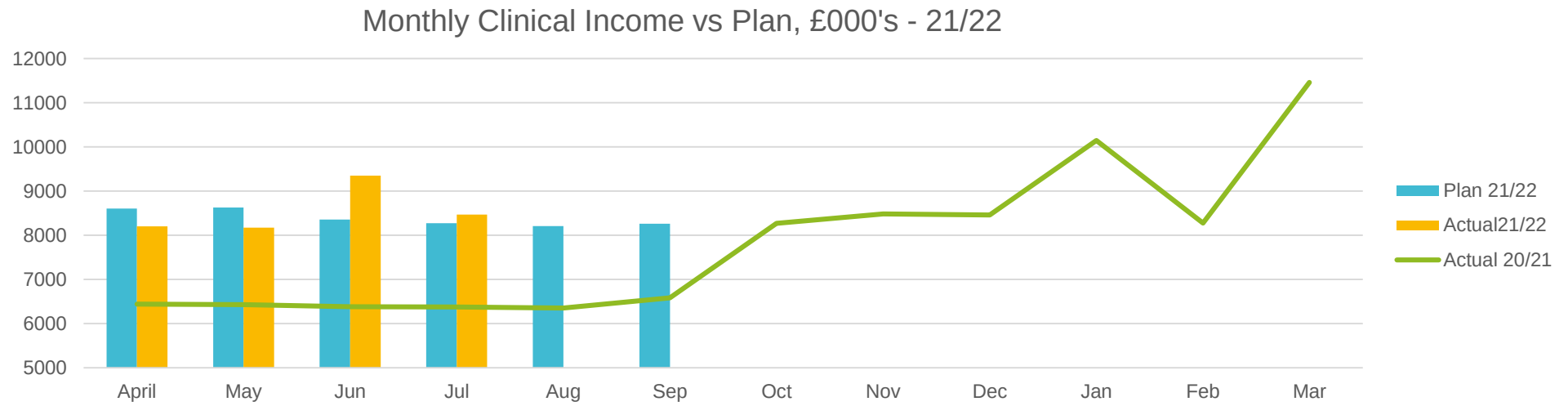
AREAS FOR IMPROVEMENT

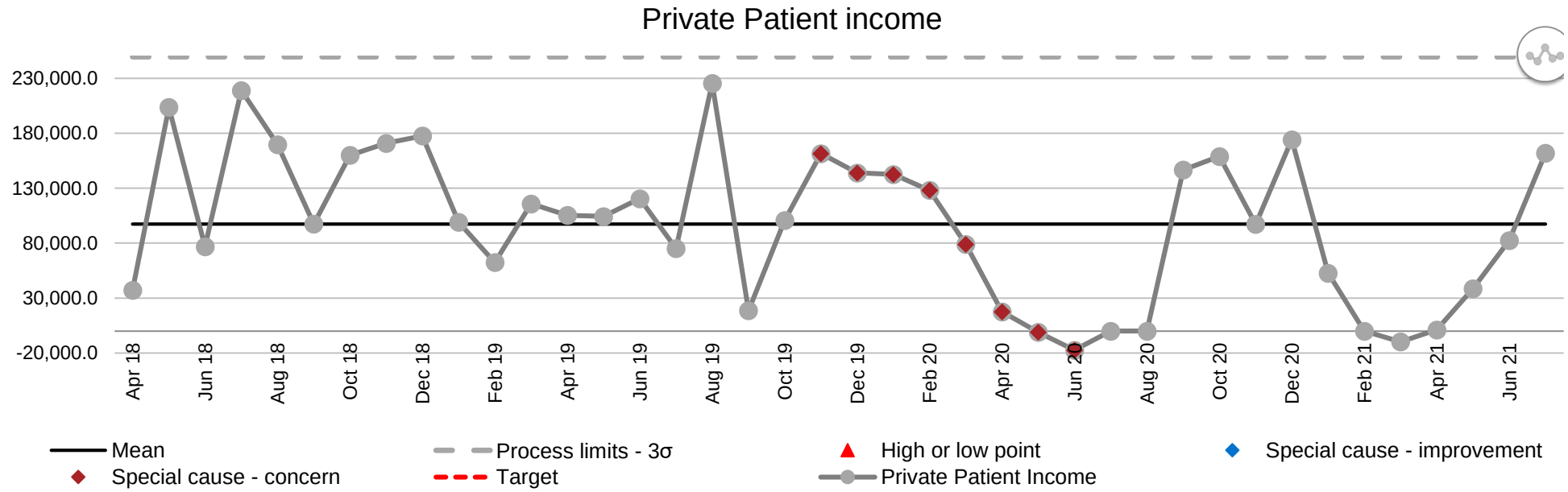
Private patient income is below average, but is steadily improving.

RISKS / ISSUES

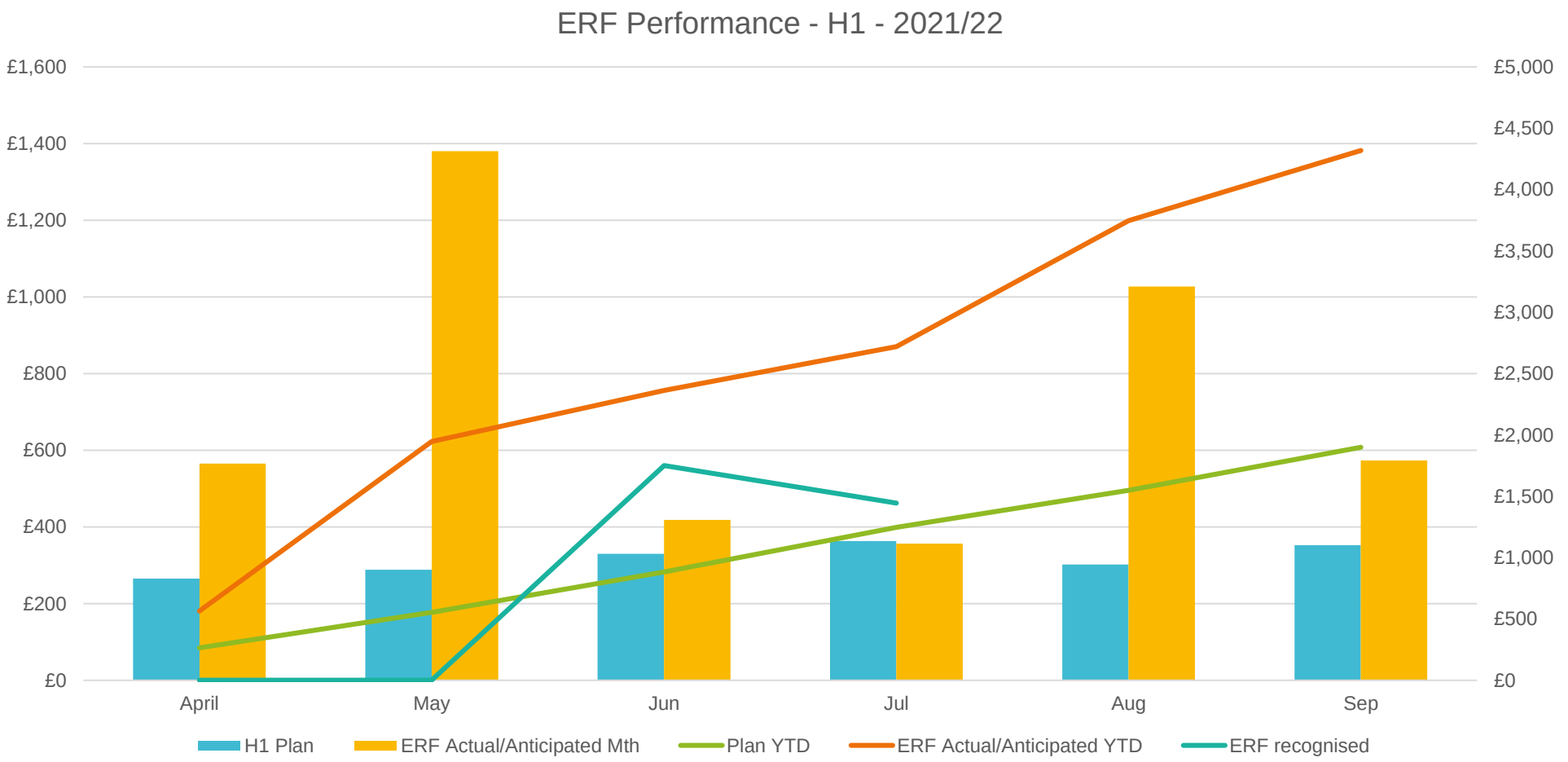
Elective Recovery Fund (ERF) income of £1.9m is currently included within the plan. ERF is a value based target set on system level performance rather than provider level. In the month, a revised, significantly more challenging trajectory for ERF was provided by NHS E/I. The revised targets are for elective inpatient, day case and outpatient activity to recover to a % of 2019/20 levels;
April = 70%, May = 75%, June = 80% July = 95% (previously 85%).

9. Income


Monthly Clinical Income vs Plan, £000's - 21/22
12000
11000
10000
9000
8000
7000
6000
5000
April
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan 21/22
Actual21/22
Actual 20/21


Private Patient income
230,000.0
180,000.0
130,000.0
80,000.0
30,000.0
-20,000.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

9. Income


ERF Performance - H1 - 2021/22
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
£5,000
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
April
May
Jun
Jul
Aug
Sep
H1 Plan
ERF Actual/Anticipated Mth
Plan YTD
ERF Actual/Anticipated YTD
ERF recognised

9. Expenditure

SUMMARY

Pay and non pay expenditure overspent year to date by £464k, which has been driven by increased activity.

As previously described, budgets have now been released for the first half of 2021/22 (H1).

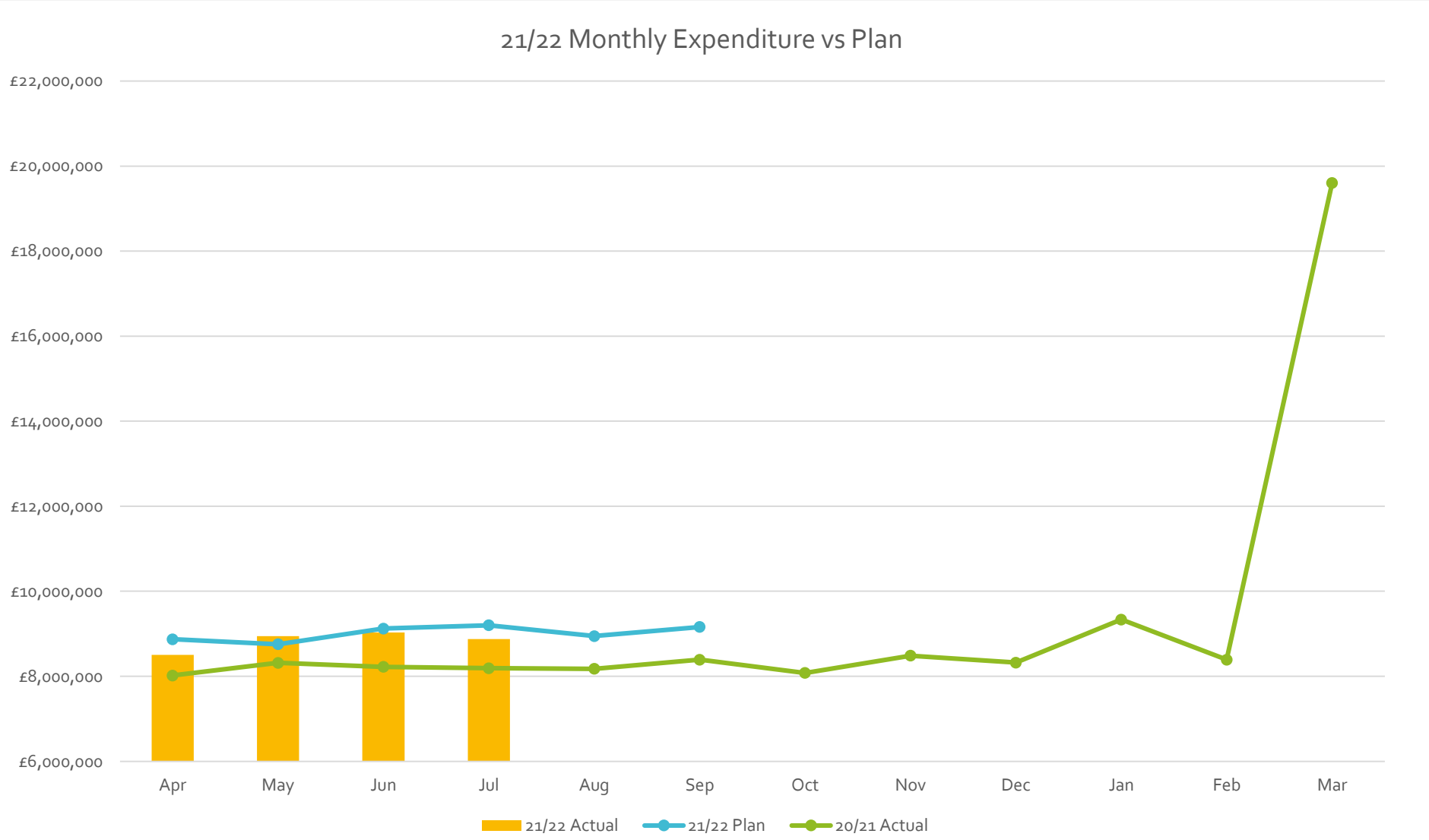
AREAS FOR IMPROVEMENT

Agency spend is slightly above plan with a year to date overspend of £76k. Agency costs as a percentage of total staff costs has reduced slightly from Month 3 to 6.1%. This is an increase from 4.6% in 2020/21, and is above planned levels of 5.8%.

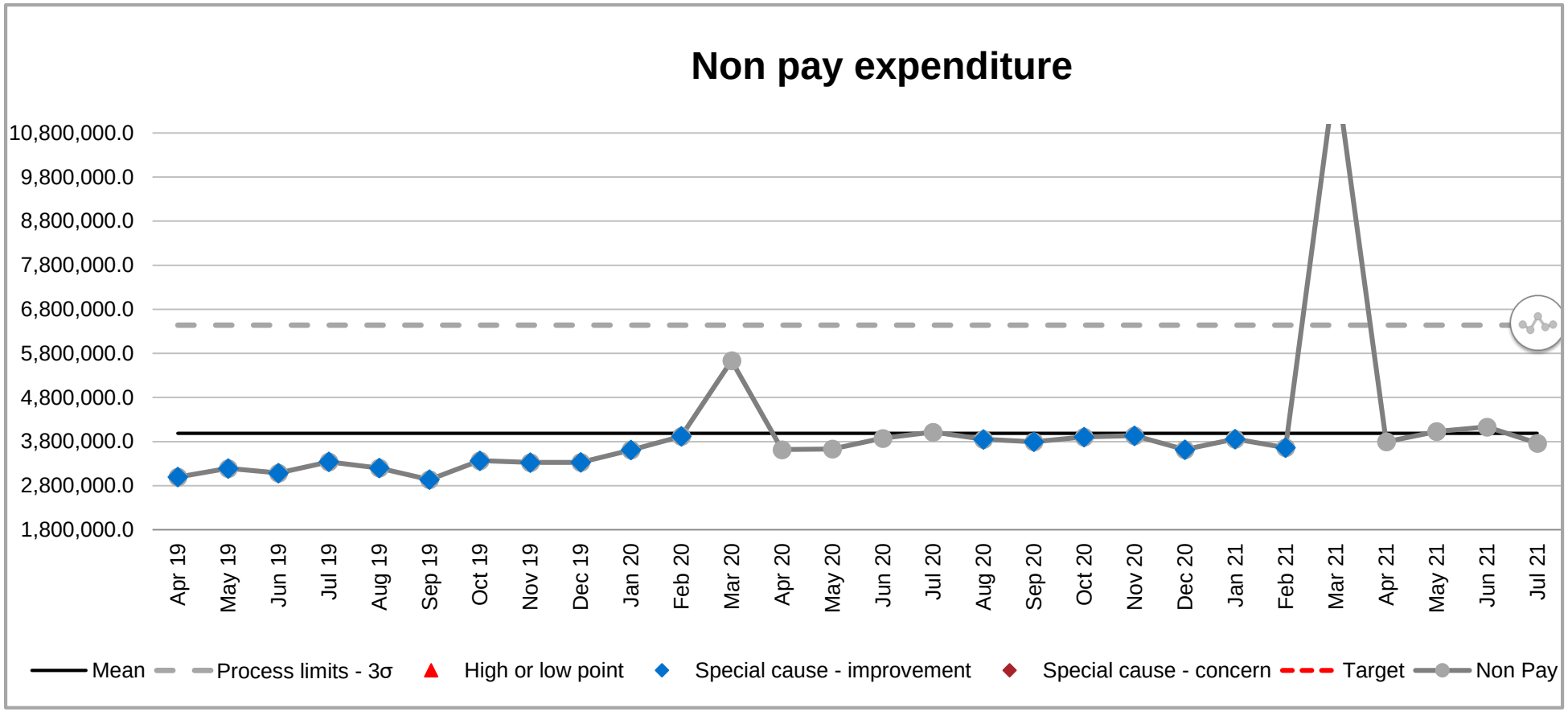
RISKS / ISSUES

H2 financial plan not yet been agreed as funding envelop has not been allocated to the ICS.

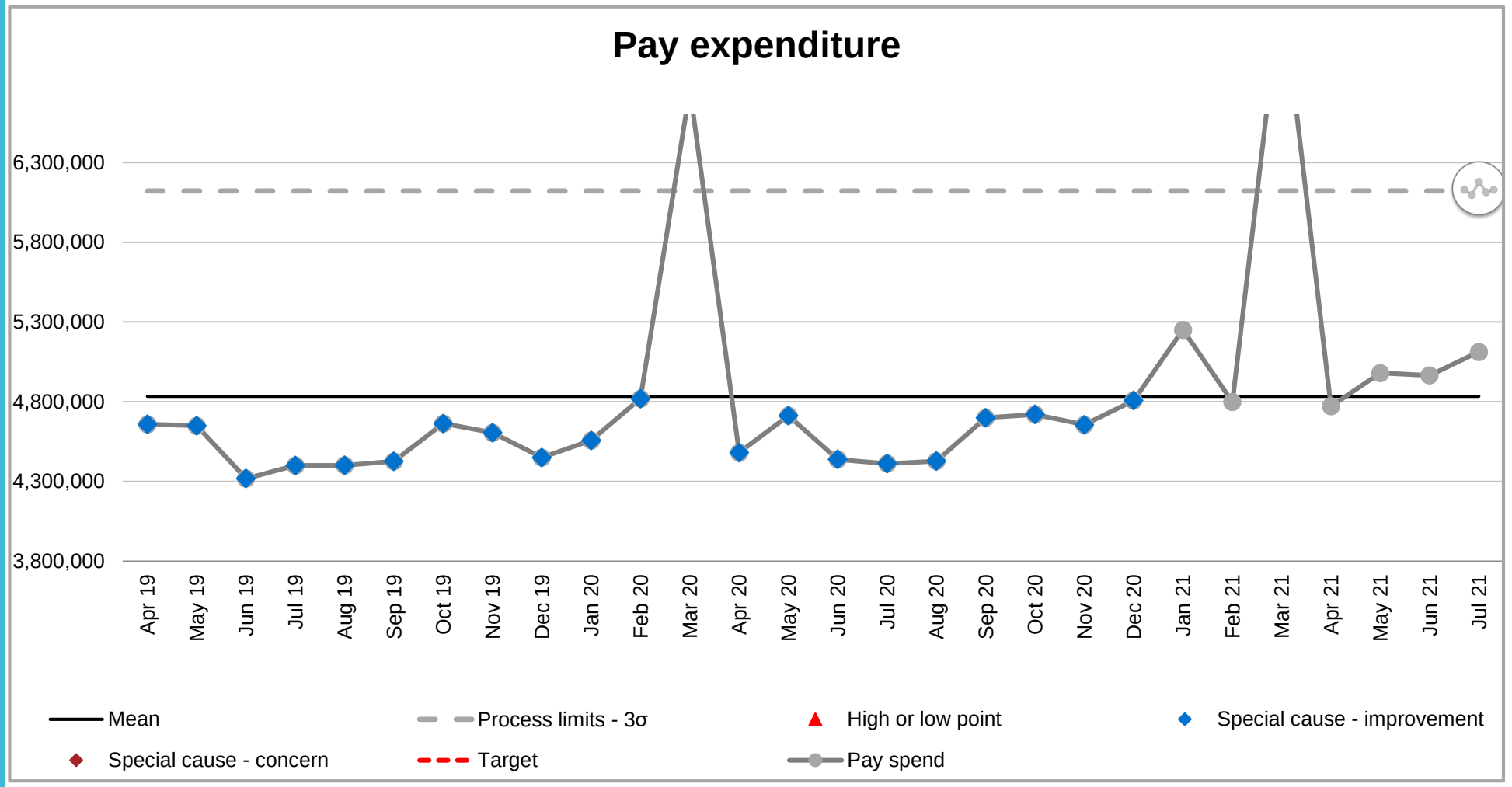
9. Expenditure



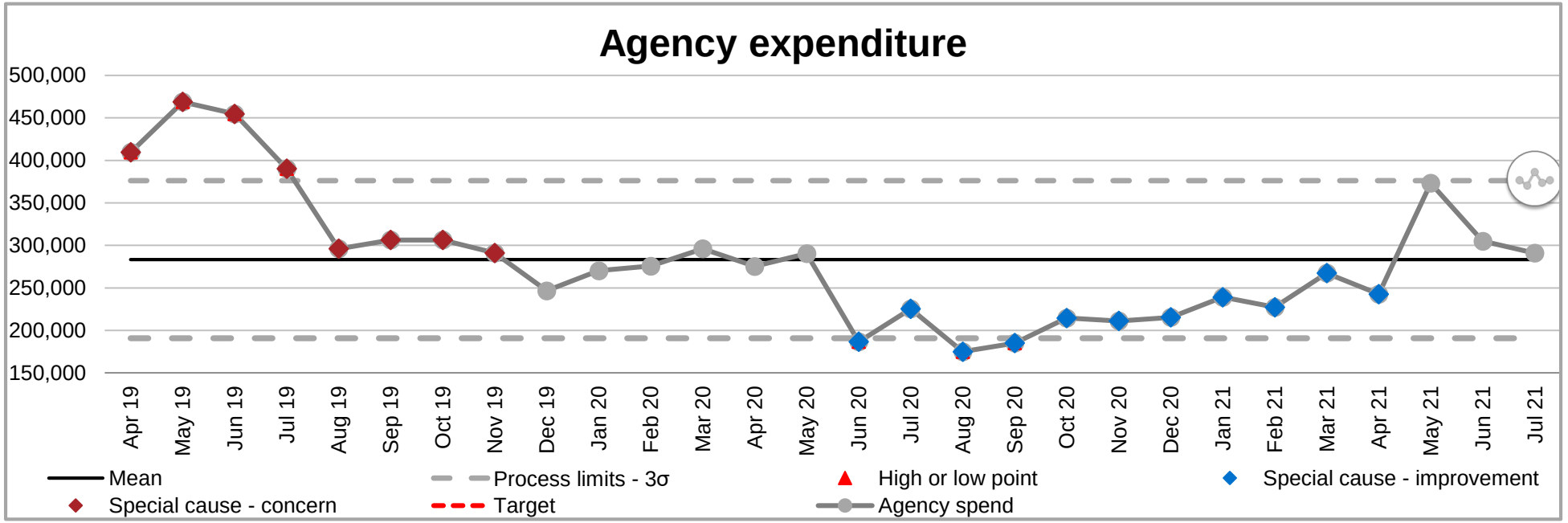
9. Non Pay Expenditure



9. Pay Expenditure

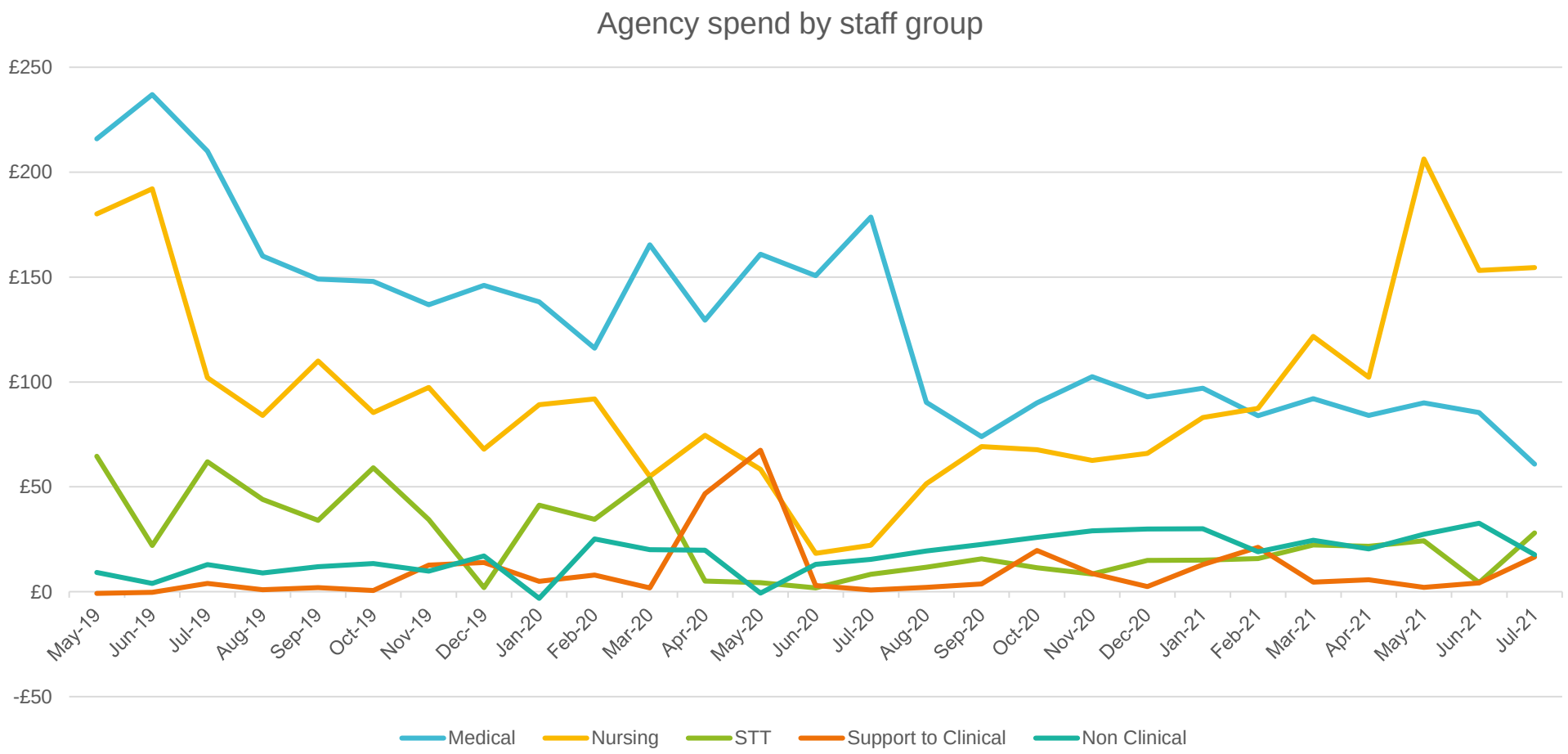


11. Agency Expenditure



	Year to date Spend (£'000s)			
	Agency	Bank	Substantive	Total
Medical staff	320	163	4,909	5,392
Clinical Staff (exc medical staff)	718	815	7,354	8,887
Non clinical staff	174	456	4,852	5,482
Total	1,212	1,433	17,115	19,761

11. Agency expenditure



12. Cost Improvement Programme Summary

SUMMARY

CIP plans totalling £1,917k have been identified to date.

The main schemes identified are;

- Digital Transformation – Expansion of paperless communications, text message reminders and partial booking for booking appointments
- Medical Workforce efficiencies –reduction in agency spend through collaborative bank set up, alternative roles and Direct Engagement
- Procurement initiatives – Continuation of work to review products, prices and contracts with suppliers of non pay goods & services.
- Service transformation – Implementation of a new spinal endoscopic service and a rationalisation of suppliers.
- Theatres Managed Service contract - VAT savings and economies of scale purchasing savings

CIP Category	Full year Plan	Plan year to date	Actual year to date	Variance
Pay	290	0	0	0
Non Pay	1,627	0	0	0
Income	0	0	0	0
Total	1,917	0	0	0

13. Statement of Financial Position

SUMMARY

The cash balance has increased in comparison to the year end, largely due to an expected credit note being received from a supplier.

	2020/21 M12	2021/22 M4	Movement
	(£'000)		
Intangible Assets	1,255	1,214	(41)
Tangible Assets	45,798	45,646	(152)
Total Non Current Assets	**47,053**	**46,860**	**(193)**
Inventories	1,800	1,818	18
Trade and other current asset	8,492	6,120	(2,372)
Cash	5,703	8,035	2,332
Total Current Assets	**15,995**	**15,973**	**(22)**
Trade and other payables	(11,396)	(10,437)	959
Borrowings	(877)	(622)	255
Provisions	(2,758)	(3,301)	(543)
Other Liabilities	(344)	(833)	(489)
Total Current Liabilities	**(15,375)**	**(15,192)**	**183**
Borrowings	(1,009)	(951)	58
Provisions	(1,029)	(1,029)	-
Total Non Current Liabilities	**(2,038)**	**(1,980)**	**58**
Total Net Assets Employed	**45,635**	**45,660**	**25**
Total Taxpayers' and Others' Equity	**45,635**	**45,660**	**25**

ROHTB (9/21) 012

UPWARD REPORT FROM AUDIT COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board met: 23 July 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee revisited the complications around the sign off of the accounts at the year end and particularly the issue concerning stock. It was agreed that this would be discussed in the audit debrief and reported back at the next meeting as part of the lessons learned. • The items rated red and amber in the Counter Fraud assessment were discussed and there were noted to be plans identified to address any shortfalls. • It was agreed that it was a healthy discipline to ensure that it was known across the Trust that having no purchase order in place could mean difficulties with making payment. • In terms of the Data Security and Protection Toolkit, it was noted that of the 146 indicators, the Trust was unable to meet 12 of the requirements. There was an action plan to address this shortfall however and this had been agreed by NHS Digital. The linkage of the work with the wider system discussions around IT and digitisation was noted.	• Narrative to be provided in future to highlight when it was appropriate or had been necessary to raise a purchase order after an invoice was received rather than before. • Lessons learned on the process for appointing audits to be presented at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was noted to be positive progress with clearing audit recommendations, with 57 of the 83 planned for closure. There was further work planned to refine the action tracker as the new internal audit function began reporting on reviews. • The scope of work for some of the key audits and reviews had been developed. • The annual accounts were reported to have been signed prior to the deadline set and the outstanding Value for Money work would be completed by 20 September 2021 which would allow the annual report and accounts to be laid before Parliament. • The Counterfraud return was reported to have been submitted by the due date.	• Contingency days in the internal audit plan to be used to reaudit some areas previously audited where lower levels of assurance had been provided and to provide an overview of sustainability of closed recommendations. • The suggested amendment to the terms of reference for the Audit Committee was supported, which suggested that the Director of Nursing & Clinical Governance be removed from the regular attendees given that the Medical Director now joined each meeting.

• Alex Gilder, Deputy Director of Finance was reported to have been nominated as the Trust's Counter Fraud champion. • Ongoing work was in place to review contracts to ensure that services procured delivered best value for money and therefore minimised the number of breaches and waivers of Standing Financial Instructions. • The Committee noted the ongoing work to improve the risk management framework across the Trust through enhanced training, system improvements and links to business planning. • The Committee received the updated Board Assurance Framework, noting that it was discussed at nearly each meeting of the Trust Board.	

Chair's comments on the effectiveness of the meeting: The Committee agreed that there had been good challenge around the areas where there had been shortfall or improvement identified. Private meetings between the auditors and members would be held in future after each meeting.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 27 July 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There had been an increase in the number of 30 and 60 minute waits for Outpatient clinics. This reflected the lengthier discussions required in the Oncology clinic appointments. An audit was planned to identify where improvements could be made. • There had been a significant increase in MRI referrals which had meant that the diagnostic target had not been met. This also reflected that some patients having undergone a diagnostic procedure previously required a refresh of their Imaging. Whilst the second MRI scanner was expected to be operational shortly, the Trust was continuing to use the mobile scanner and looking to book additional days where possible. • In terms of virtual appointments, there was noted to be a ceiling on the number that could be undertaken as they were not well received by some patients. • It was noted that the change in the Elective Recovery Funding (ERF) threshold from 85% to 95% presented a risk to the delivery of the financial plan as a benefit from this had been assumed when the plan had been developed. • The proposed financial regime for the second half of financial year was noted to present some future challenges for organisations. • There was noted to be some higher than expected long term staff absence. Turnover was also noted to have increased and the reasons behind this were being reviewed. • At a system level, the financial position was noted to be a deficit at present. The end of year forecast was also likely to be impacted negatively by the change in the ERF threshold.	• Quarterly summary of the JointCare performance to be prepared for the Committee. • The 'Wheel of Improvement' work to be presented to the Committee periodically. • Provide a risk assessment as to the deliverability of the Cost Improvement Plan at the next meeting. • Plan to address the sickness absence position to be presented to the Staff Experience & OD Committee.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• There was reported to be continued strong performance against the activity plan. This was also above the level that would trigger the Elective Recovery Fund and was above the prior year's plan. • The Trust was currently benefiting from the support of the NHS Improvement Productivity Lead who would offer advice as to improvements that could be made, particularly within the theatres processes. • Length of stay had stabilised at 3.18 days (excluding Oncology patients). Length of stay for patients on a University of Birmingham NHSFT pathway was higher due to the complexity of patients handled. • The JointCare 'Coffee Catch Up' meetings had been reinstated. • In terms of the 'Did Not Attend' rate, this was below the 8% Key Performance Indicator. The objective was to reduce this to 4% or below. • There had been an increase in performance against the 18 weeks Referral to Treatment Time target to 65.6%. • Referrals had increased and would continue to rise as more GP appointments were held. • Performance against the cancer targets was noted to be good. • A positive update on the progress of the 'Perfecting Pathways' programme was provided. A new structure was in place for project support which was working well.	• None specifically.

Chair's comments on the effectiveness of the meeting: The meeting had run to time and had focussed on the items requiring most important discussion. There would be no meeting in August.

ROHTB (9/21) 014

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 28 July 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Turnover was reported to be at 9.9% which was higher than usual. Work was underway to review the exit questionnaires to understand the reasons for staff leaving. • There was currently a higher than usual level of sickness absence. Work was planned to ensure that return to work discussions were undertaken by managers routinely. • There was reported to remain some reluctance by some staff to take the opportunity to be vaccinated against COVID-19, particularly those from a Black, Asian & Minority Ethnic (BAME) background. Drop in sessions and communicating key messages were being arranged. It was noted that should vaccination become nationally mandated for healthcare staff then this had the potential to cause some difficulties in terms of managing staff discontent and the impact on terms and conditions.	• A systemwide workforce summit was held which commissioned some work to develop a reservist bank and international recruitment. • There was reported to be work to do to revise the Trust's policies to accommodate the new flexible working requirement under the Agenda for Change framework. • Work was underway to encourage staff to take annual leave, given that many staff were still carrying a high reserve of leave accumulated from the previous year. • The action plan for the staff survey would be presented to the Trust Board in September. • An update on the current position regarding mandated staff vaccination to be presented in September. • A student is to be invited to a future meeting to describe their experience of training at the ROH.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A new resourcing manager had been recruited to strengthen the time to hire process and further key posts would be filled in the HR team over coming months. • The Trust planned to make an application to Inclusive Companies and hoped to improve on its current ranking of 34 out of 50. • A Health and Wellbeing week is planned for September and an initial meeting had been held with Ayodele Ajose, the Board's Health & Wellbeing Guardian to agree her approach to this role. • An update on the new race disparity ratio was presented. The position aligned to the current Workforce Race Equality Standards and the work underway to improve diversity and inclusion was expected to impact on the ratio.	• None specifically.

• The process for signing off apprentice levy applications was discussed; this was working well and there was a set of new apprentices who would join the ROH in Autumn. • A positive update on medical education at the ROH was presented. The update on the plans to further develop the Knowledge Hub was provided. • Although the current mandatory training rates were lower than desired there was reported to be confidence that the position would improve by the end of the calendar year through work undertaken to amend the required frequency of some courses. • It was noted that the 'Beyond the Stigma' campaign had been well received and received national attention from the Chief People Officer.	

Chair's comments on the effectiveness of the meeting: It was noted that it had been challenging to cover all the material on the agenda within the allocated time.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 25 August 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The performance against the key performance indicators in the Pathology Service Level Agreement remain below expectations, although assurance was provided that any impact on patient outcomes as a result of any delays would be identified through robust monitoring by the Cancer Board. The matter was also captured on the divisional risk register. • The Quality Report highlighted two areas where improvement was planned, including VTE reassessment rates and Friends and Family Test compliance. In terms of VTE reassessment, work was underway to agree the most meaningful presentation of this information given the changes to the NICE guidance around this. • There was reported to have been a set of notifiable infections recorded, these being associated with the admissions ward. It was noted that the leadership of the area had improved and an 'away day' had been held to discuss the operation of the ward and the plans to ensure it provided as safe and effective environment as possible. • It was noted that the lateral flow tests were now distributed centrally rather than from individual organisations, therefore there was a potential risk of a deterioration in reporting results by individuals. • The CQC action plan had been reviewed where it had been determined that a number of previously closed actions needed to be reopened. The Committee agreed that it was a positive step to reaudit the sustainability of the action plan and encouraged work to be taken promptly to address the actions.	• Assurance to be sought from the host organisation on the pipeline of recruitment and development of individuals to support the Pathology work. • The various services involving the support of or for a third party to be discussed by the Executive Team to agree how and where they have oversight. • Work to be undertaken to communicate the Trust's position in terms of safety accessible to public and patients. • Overview of the new Liberty Safeguards to be presented to the Trust Board.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was joined by the workstream leads for the Refresh and Recovery Programme who presented an overview of the key focus of their workstream, reflections on the work and any matters still continuing or outstanding. The workstreams covered: pre-	• The Quality & Safety Committee received the annual reports on Safeguarding and Infection Prevention and Control and approved their onward transit to Trust Board for approval.

operating care, testing and scheduling; inpatients; outpatients; wellbeing & OD; and system work. The Committee was particularly impressed by the degree of continuous improvement evident from the work and on the multidisciplinary delivery of the tasks. • Work to triangulate the compliance with the WHO checklist in terms of the audit using Theatreman and the visual audit was reported to be underway. • The pathway for paediatric patients being treated on the Primary Malignant Bone Tumour Service continues to work well and is effective. • The Committee received an update on the classification of incidents from a harm perspective. The process for categorising, escalating, reviewing, reporting and distilling lessons learned was discussed, which it was agreed provided sound positive assurance. • An overview of the evidence base behind the Trust's position against the Key Lines of Enquiry in the CQC's 'Safe' domain was presented. This showed that there had been positive improvement on a range of quality metrics including VTEs (particularly avoidable), falls, Pressure Ulcers and complaints. • It was highlighted that in terms of the National Joint Registry data, the Trust's culture allowed transparent discussion and comparison of these results between functions and at an individual level. Processes were in place to identify and address any outliers if needed. It was agreed that this information was useful to describe the impact and effectiveness of medical care at the ROH. • The annual report on Infection Prevention and Control provided a high level of assurance that the Trust met its requirements under the Hygiene Code. There was a particular note that the upward assurance from the water safety group had been strengthened and the risk around lack of assurance raised previously had been closed. • An update on the COVID-19 outbreak in the portering team was presented which showed that there had been robust handling and reporting of the situation.	• Agreed that only the summary reports of outbreaks be considered by the Committee in future as all outbreak reports to the Committee had provide excellent assurances on systems and processes.

• Upward reports were received from the Infection Prevention & Control Committee; the Quality & Safety executive; and the Audit Quality Improvement, Learning and Analysis panel. • Much work was reported to be underway to improve compliance with mandatory training rates and there was a move to a hybrid approach, with a combination of e-learning and face to face delivery.	

Chair's comments on the effectiveness of the meeting: It was agreed that the initial presentation had been interesting and allowed a number of staff to showcase the good work that had occurred to support the Restoration and Recovery plans. There was some key items received which had provided positive assurance of improvement in quality of care and demonstrated that quality processes were working well. A stocktake of the operation of the Committee is planned for October. The Trust Chairman was in attendance at the meeting.

QUALITY REPORT – AUGUST 2021 (JULY 2021 DATA)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	***MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY***
4 x Moderate Harms reported **1 Avoidable Cat 2 Pressure Ulcer recorded** ***FFT completion target*** *The Trust has not met the Mandatory internal completion rate for FFT. This will be discussed at Divisional Management Board (DMB) meetings.*	Friends & Family test fully recommenced after data quality issues further improvement work underway to improve compliance. Extra Prevent training courses underway and slight increase in compliance at 88.5%
POSITIVE ASSURANCES TO PROVIDE	***DECISIONS MADE***
VTE 24-hour re-assessment Audit to review the compliance with the mandatory 24-hour re-assessment was presented to the VTE Advisory Group on 20/07/2021 and Quality and Safety Committee on 28/07/2021.The audit demonstrated that in 39/40 cases there was evidence of VTE prevention discussions/decisions documented which provided some assurance. It was noted that clinical noting within Prescribing Information and Communications System (PICS) will help when implemented. Recommendations from the audit included: • Review wording of the standard. NICE ng89 2018 states Reassess all medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes opposed to specifically 24 hours. • PICS alert gives option to acknowledge (by ticking accept responsibility for having completed) or Ignore (not done now so will keep alerting) need for re-assessment-current PICS report methodology to be reviewed to ensure this is reflected in the data collection (not currently).	None

• Retain re-assessment as in 5-6% of patient prophylaxis need did change from assessment by cease reporting until above recommendations are complete to accuracy. • Re-audit in 3-6 months • Risk 43: re 24 hour re-assessment to remain on the risk register until above recommendations complete ***WHO checklist 100% compliant*** **No Serious Incidents reported** **Never Event** – has now been submitted to the CCG for closure – the findings will be presented to the Quality and Safety Executive meeting in August 2021 and will be included in next month's Quality Report. ***No deaths reported***	

Quality Report - August 2021 (July 2021 Data) – Front Cover and Dashboard

	April 2021	May 2021	June 2021	July 2021	2021/2022	2020/2021 YTD
Incidents	391	345	376	317(↓)		
Serious Incidents	1	0	0	0	1	10(Total)
Internal RCA investigations	5	1	3	4 (↑)		
VTEs (Avoidable)	0	0	0	0	0	1(Avoidable)
Falls	6	8	8	7(↓)	29	76(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0	0	1 (↑)	1	10(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0(Avoidable)
Complaints	3	4	7	4(↓)	18	57(Total)
PALS	47	62	68	90(↑)		
Compliments	5	5	5	7 (↑)		
FFT Score %	97	96	98	98		
FFT Response %	29	33	28	22(↓)		
Duty of Candour	10	12	16	20 (↑)		
Litigation	0	0	1	0		
Coroners	0	0	0	0		
WHO %	100	100	100	100		
Infections	0	1	1	0	2	3 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

August 2021 (July 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

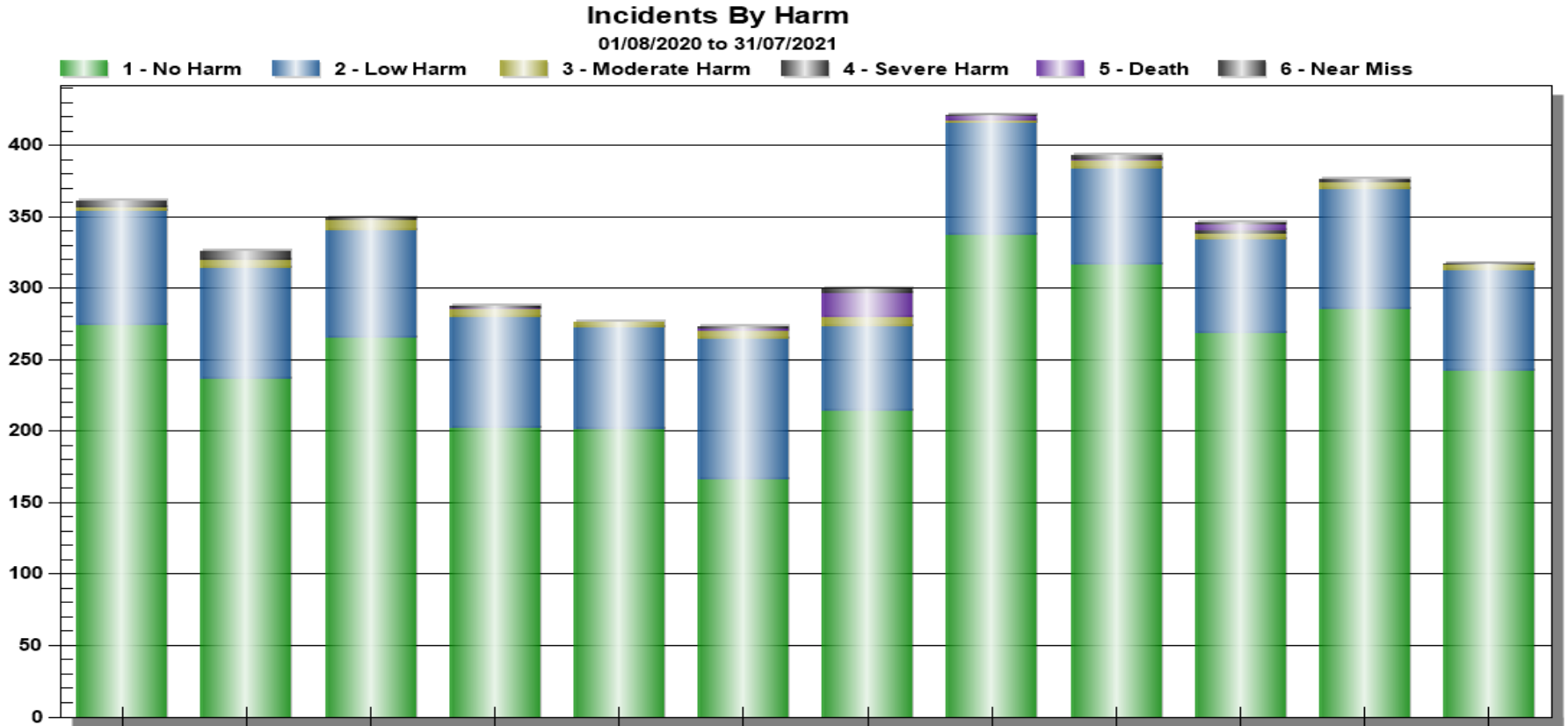
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55216)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021
1 - No Harm	274	236	265	202	201	166	214	337	316	268	285	242
2 - Low Harm	80	78	75	77	71	98	59	78	67	66	84	70
3 - Moderate Harm	2	5	7	6	4	6	6	2	6	4	5	4
4 - Severe Harm	0	0	0	0	0	0	0	0	0	2	0	0
5 - Death	0	0	0	1	0	1	17	3	1	4	0	0
6 - Near Miss	5	7	2	1	0	2	3	1	3	2	2	1

Data source – Ulysses

INFORMATION

In July 2021, there were a total of 317 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

242 – No Harm
70 - Low Harm
4 - Moderate Harms
0 - Severe Harm
1 – Near Miss
0 – Death

Downgraded Incidents

Currently 0 of the reported harm in the Previous Quality report (July 2021) have been downgraded.

Patient Contacts

In July 2021, there were a total of 8071 patient contacts. There were 317 incidents reported, which amounts to 309 per cent of the total patient contacts. Of those 317 reported incidents, 74 incidents resulted in harm which is 0.9 per cent of the total patient contact.

ACTIONS FOR IMPROVEMENTS / LEARNING

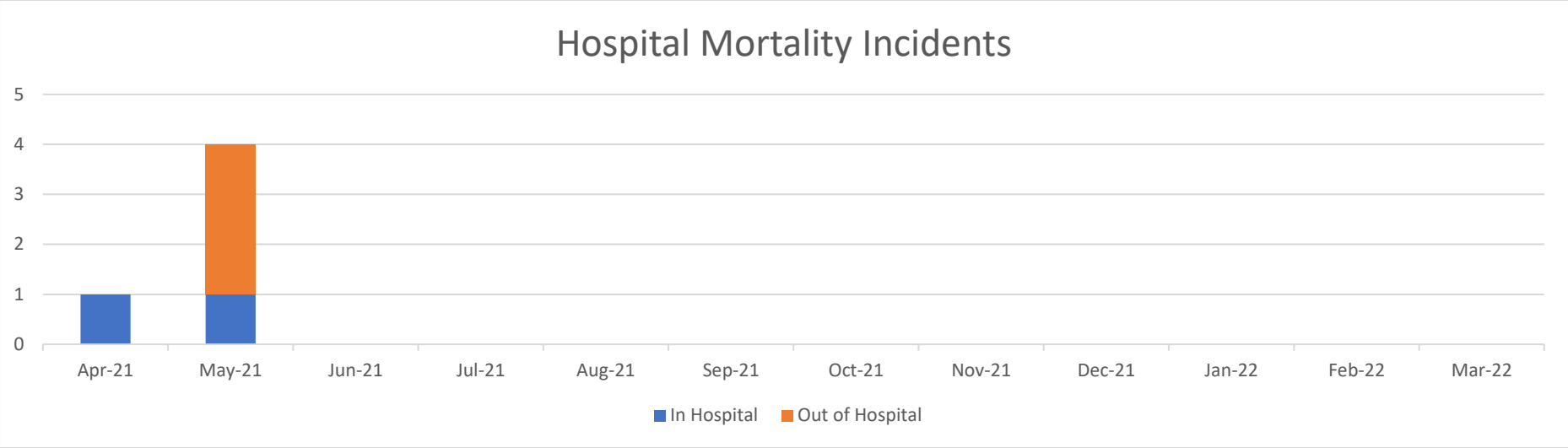
Grading of Harm

A presentation on the grading of harm is on the agenda for Quality and Safety in August 2021. Grading the degree of harm to a patient resulting from a patient safety incident can be a challenge for reporters, but by grading patient safety incidents or prevented incidents according to the impact or harm they cause patients, local organisations can ensure consistency and comparability of data. The presentation will look to provide the assurance that the Trust has a consistent approach and processes that locally support the national reporting and Duty of Candour regulation 20.

RISKS / ISSUES

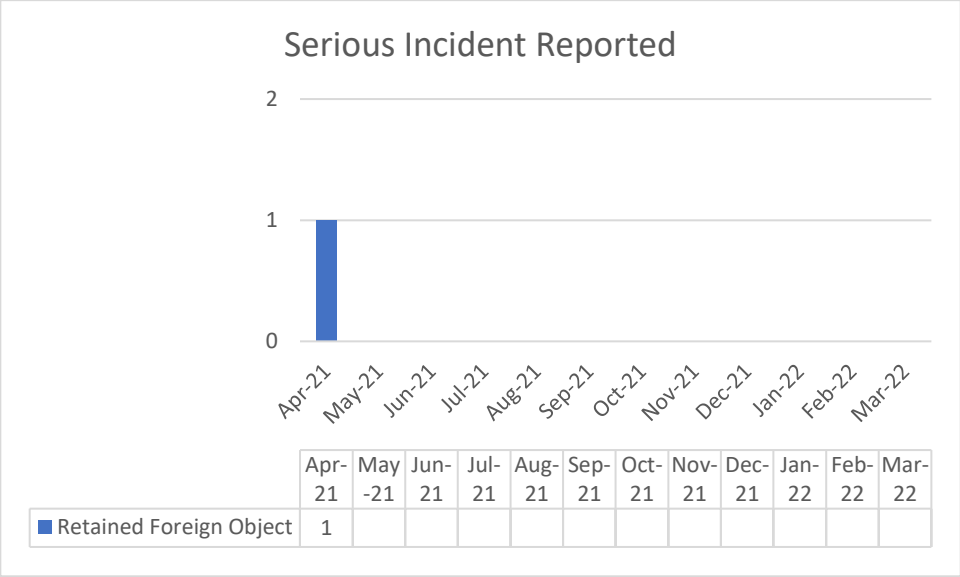
None

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
0 deaths were reported in July 2021
ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
None

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



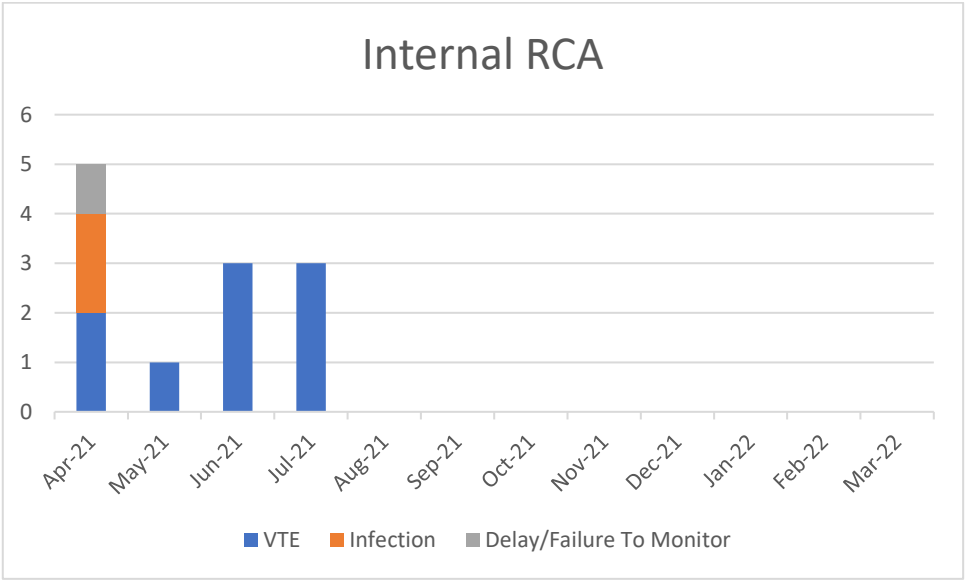
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Retained Foreign Object	1											

Year Totals	
20/21	11
21/22	1

Data Source – STEIS

INFORMATION
No Serious Incidents were reported in July 2021.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in June 2021. The Never Event has now been submitted to the CCG for closure – the findings will be presented to the Quality and Safety Executive meeting in August 2021 and will be included in next month's quality report.
RISKS / ISSUES
None

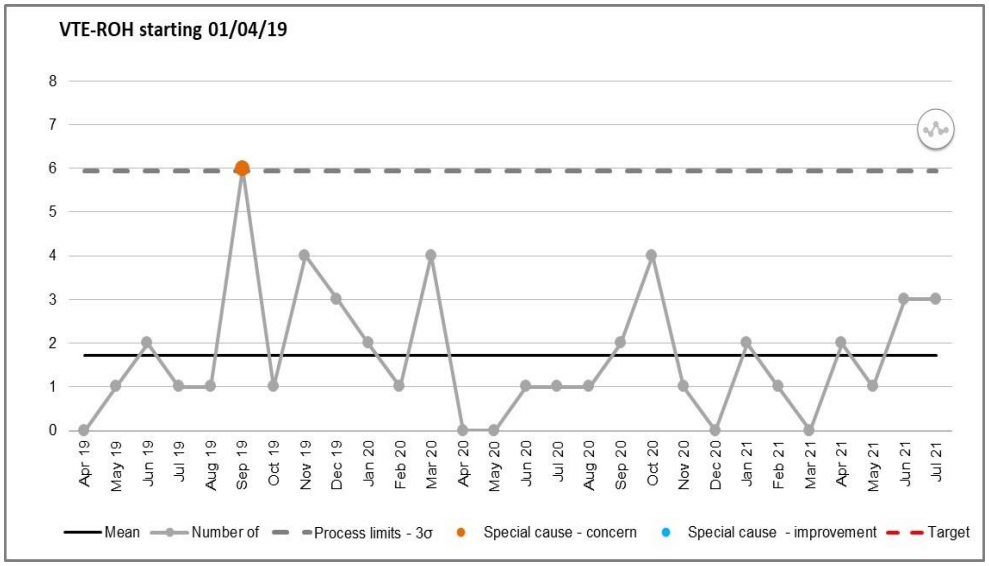
4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**

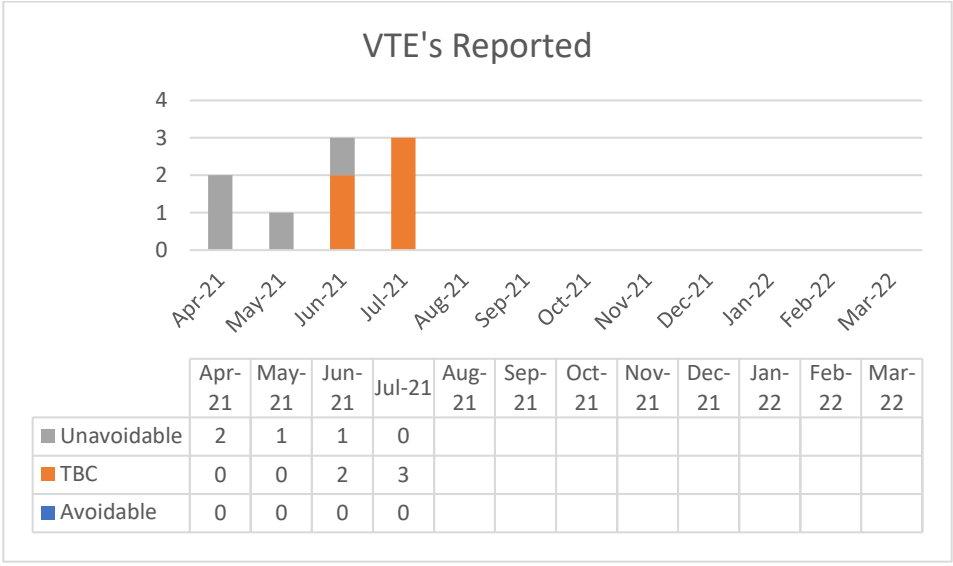


Data Source – Internal RCA tracker

INFORMATION
Four internal RCAs reported in July 2021 and are currently underway within the divisions. This is also detailed on the incident page within this report. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.
ACTIONS FOR IMPROVEMENTS / LEARNING
One RCA was closed in July 2021 – This was an unavoidable VTE with no learning highlighted.
RISKS / ISSUES
None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Unavoidable	2	1	1	0								
TBC	0	0	2	3								
Avoidable	0	0	0	0								

Avoidable Year Totals		Total including unavoidable
20/21	1	13
21/22	0	9

Data Source – Ulysses and VTE leads

INFORMATION

3 ROH associated VTE's were reported in July 2021. The SPC chart on the previous page shows that reporting of VTE's is within the recognised threshold at the ROH.

24-hour reassessment: need for re-assessment-current PICS report methodology to be reviewed – please see narrative below

24hr review	450
missed 24hr review	289
total	739
24hr %	60.8931

On admission assessment

total possible	895
total assessed	887
%	99.11%

ACTIONS FOR IMPROVEMENTS / LEARNING

Compliance with mandatory 24-hour re-assessment

An audit was undertaken by VTE leads to review :

- The accuracy of the data report provided by Informatics
- The effect of the re-assessment on patient management plan
- Clinical notes to compare what is documented regarding VTE reassessment/plan-this was the methodology used by the CQC at UHB.

The findings of this audit were presented to the VTE Advisory Group on 20/07/2021 and Quality and Safety Committee on 28/07/2021.

The audit demonstrated that in 39/40 cases there was evidence of VTE prevention discussions/decisions documented which provided some assurance. It was noted that clinical noting within PICS will help when implemented.

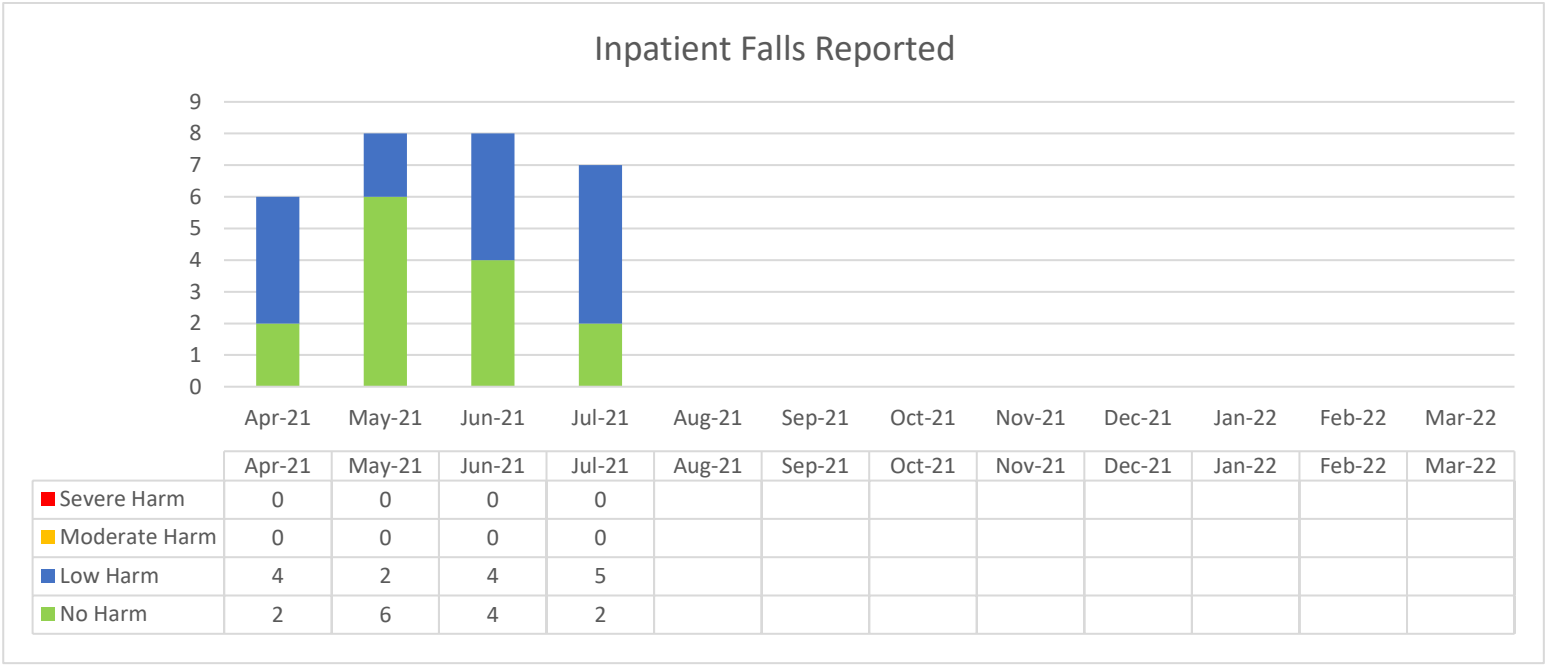
Recommendations:

- Review wording of standard. NICE ng89 2018; states Reassess all medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes opposed to specifically 24 hours.
- PICS alert gives option to acknowledge (by ticking accept responsibility for having completed) or Ignore (not done now so will keep alerting) need for re-assessment-current PICS report methodology to be reviewed to ensure this is reflected in the data collection (not currently).
- Retain re-assessment as in 5-6% of patient prophylaxis need did change from initial assessment by cease reporting until above recommendations are complete to ensure accuracy.
- Re-audit in 3-6 months

RISKS / ISSUES

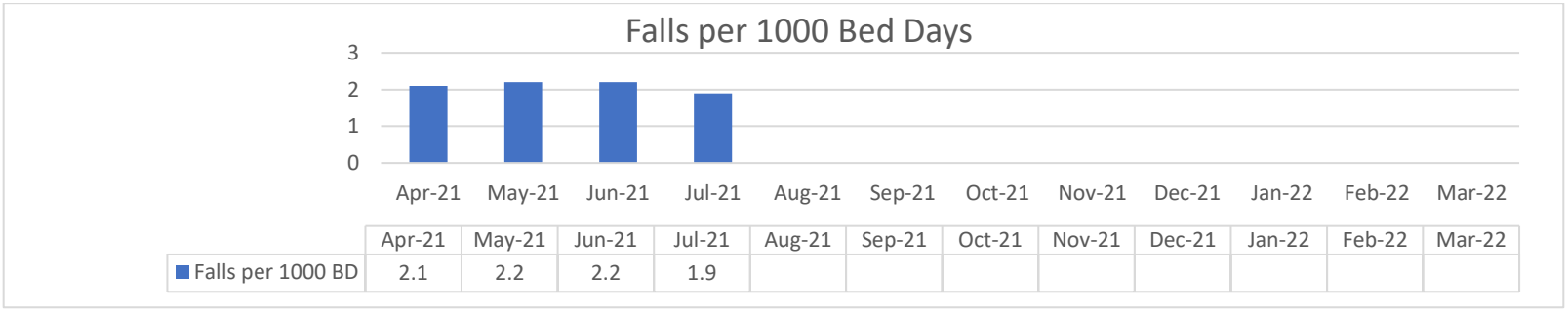
Risk 43: re 24 hour re-assessment to remain on the risk register until above recommendations complete

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

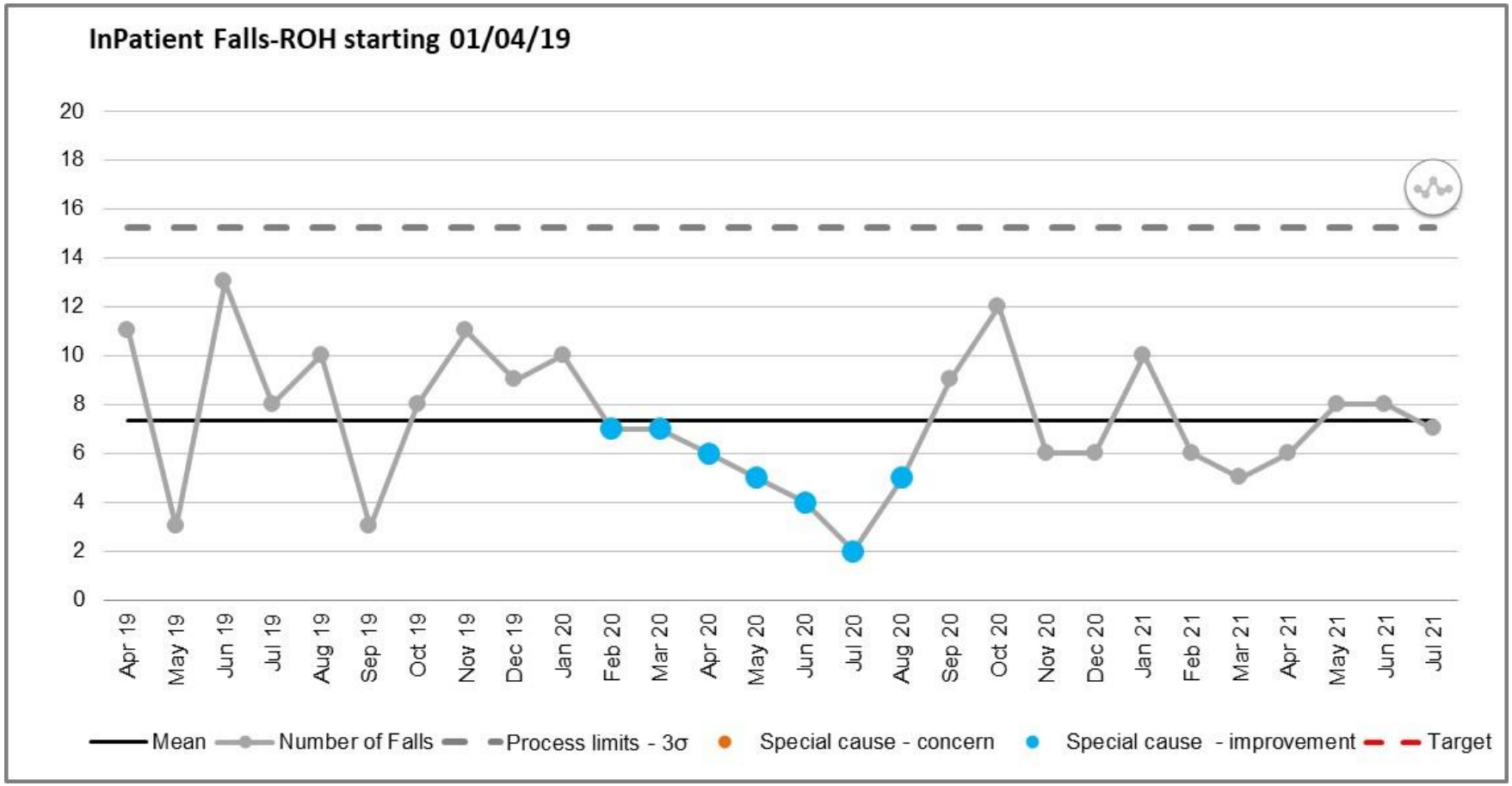


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Severe Harm	0	0	0	0								
Moderate Harm	0	0	0	0								
Low Harm	4	2	4	5								
No Harm	2	6	4	2								

Year Totals	
20/21	76
21/22	29



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Falls per 1000 BD	2.1	2.2	2.2	1.9								



Data Source – Ulysses and Falls Group

INFORMATION

There were 9 incidents reported across the Trust in July 2021 relating to Falls:

7 x In-Patient Falls Incidents: One no harm; Six low harm

1 x Lowered to Floor Incident: No harm.

1 x Staff Member Incident: Low harm

The number of in-patient falls remains low, with no consistent pattern to the falls. It can be seen that there is a continued theme of some patients mobilising against advice. Although it is worth noting, that some of these patients present with dementia and post-op confusion/delirium so would not necessarily be able to follow advice.

ACTIONS FOR IMPROVEMENTS / LEARNING

Positive Assurance

- Falls/dementia working group met on 2nd August 2021.
- Awareness of falls medical review form post-fall, to be raised to doctors starting new rotation in the Trust, with advice & teaching in filling out the form by Dr Goodman.
- The number of in-patient falls remains consistent compared to the previous months. There is still an identifiable theme this month of patients mobilising against advice.
- A review of moderate harm incidents due to be reported to the Quality & Safety Executive Committee.

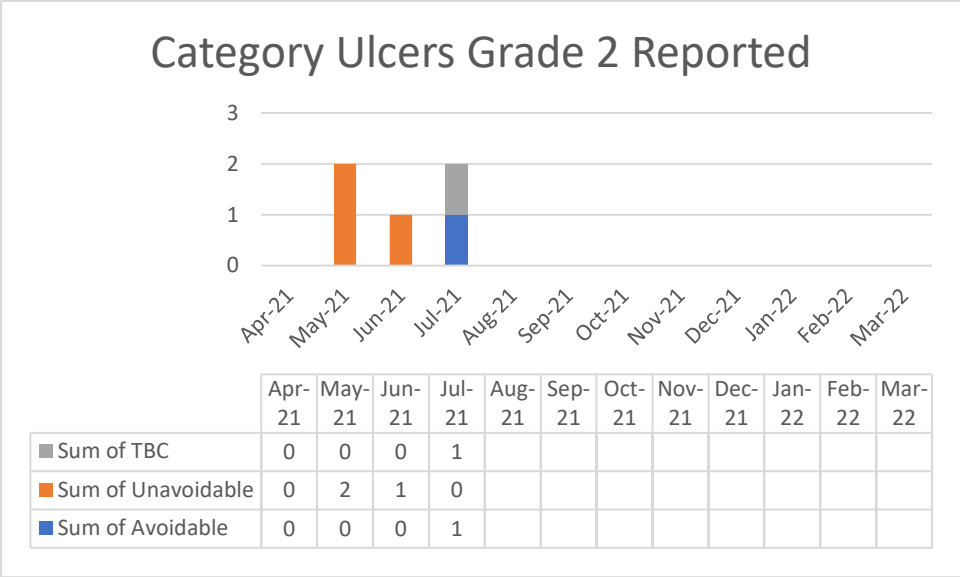
Actions

- To look at rolling out screening patients for delirium across all wards, so that those patients that may potentially mobilise against advice can be more readily identified and placed in a bed where closer supervision can be provided.

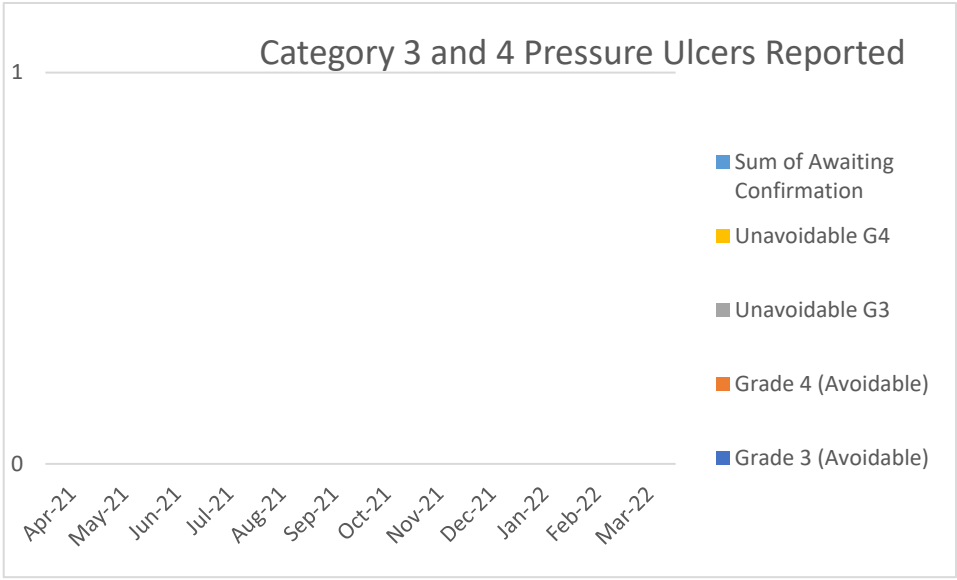
RISKS / ISSUES

None

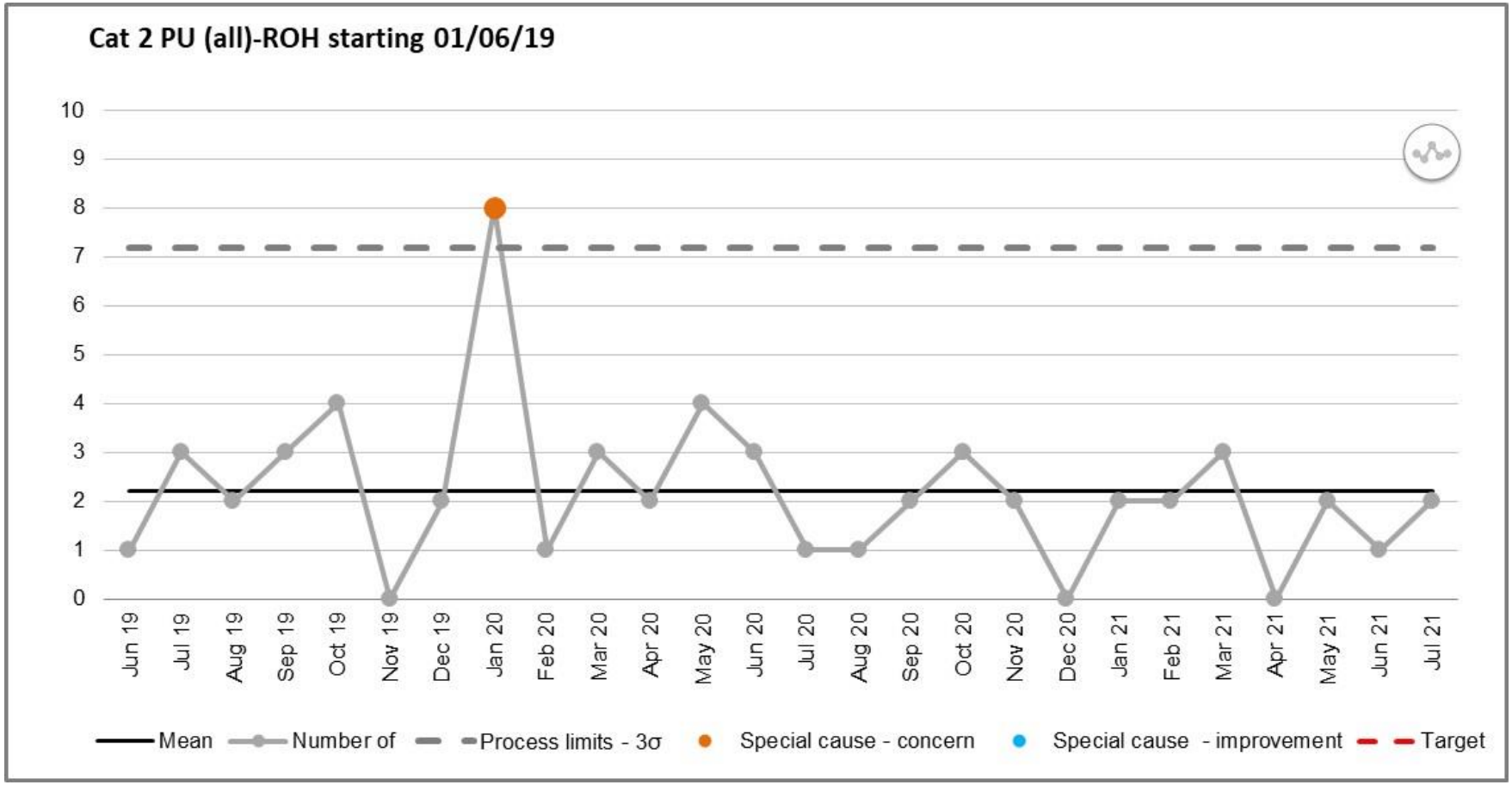
7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Sum of TBC	0	0	0	1								
Sum of Unavoidable	0	2	1	0								
Sum of Avoidable	0	0	0	1								



Number of PU reported total		
Year Total	Cat 2	Cat 3
20/21	25	1
21/22	4	0



Data Source – Ulysses and TV team

INFORMATION

July 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	1
Category – 2 (Device)	1 x – Unavoidable
Category – 1	2
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence – 2 MASD ROH Intertriginous dermatitis – 0 MASD admitted with Incontinence – 2 MASD admitted with Intertriginous dermatitis – 5

Patients admitted with PU's	PU admitted with Cat 1 x 1 – Did not deteriorate PU admitted with Cat x 3 all from home PU admitted with Cat 3 – Nil PU admitted with Cat 4 DTI - Nil PU admitted with Cat Ungradeable - Nil PU admitted with SDTI – Nil PU admitted with SDTI – Nil

Avoidable only Pressure Ulcer CCG Contracts KPI

2021/2022 – Contract to be confirmed.

2021/2022	
Avoidable Grade 2 pressure Ulcers	1
Avoidable Grade 3 pressure Ulcers	0
Avoidable Grade 4 pressure Ulcers	0

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

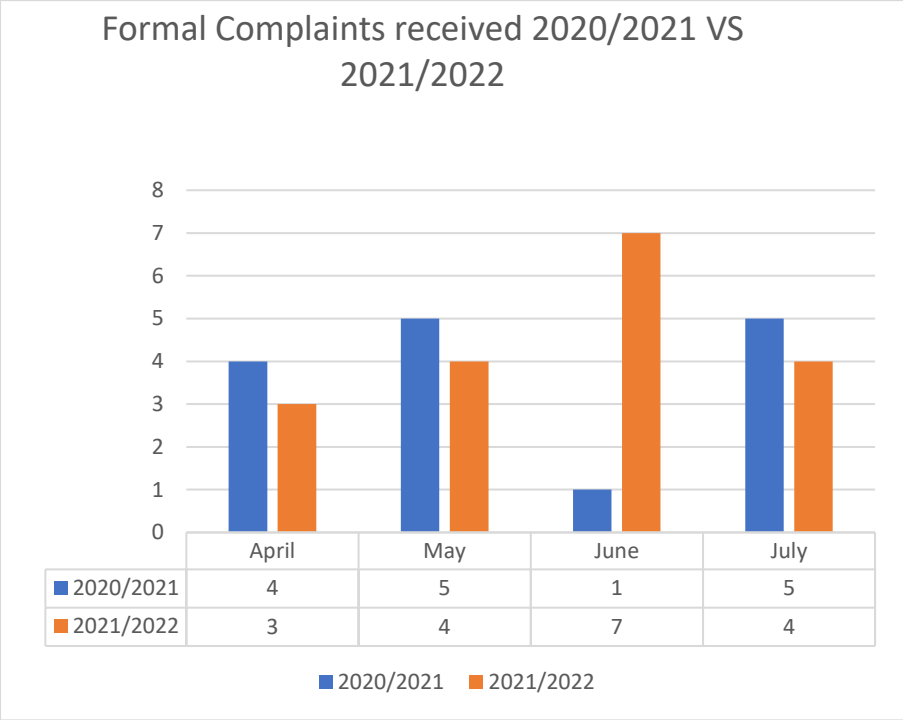
ACTIONS FOR IMPROVEMENTS / LEARNING

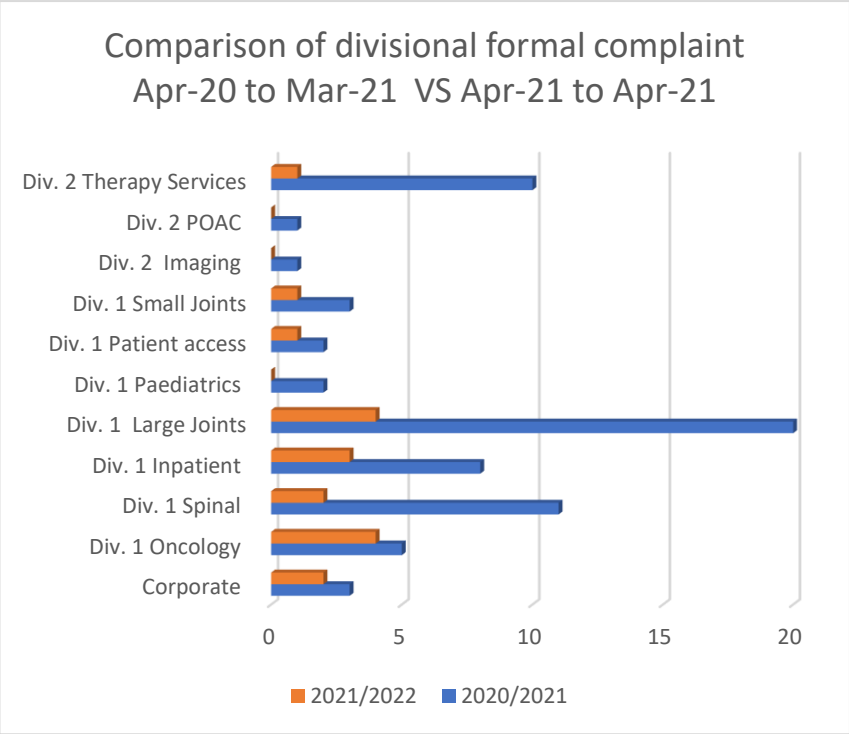
Tissue Viability Competency document being reviewed as part of Outstanding Care Every Time programme;

RISKS / ISSUES

None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
20/21	49
21/22	18

INFORMATION

Complaints

- There were 5 formal complaints received in July 2021 of which 3 were in relation to Division 1, and 1 in relation to Corporate and 1 which was later redirected to the Queen Elizabeth Hospital – therefore the department received 4 complaints in total. 1 Complaint have been received from private patient and this is not recorded in categories below.
- Categories and subcategories of Formal complaints received in July 2021.

Categories and Subcategories	Count
Attitude Of Staff - Nursing	**1**
Values & Behaviours	1
Car Park - Charges/Fines	**1**
Car Parking	1
Discrimination - Disability	**1**
Protective Characteristics	1
Dispute Over Diagnosis/Treatment	**1**
Clinical Query	1

- In July 2021 – 1 Formal Complaint was closed within the agreed date with patient. This gives a 100% completion on time rate and meets the KPI for the month. The average response for formal complaints was 23 days.
- At the time of producing this report there are 5 open complaints.
- There were no comeback complaints in July 2021.
- In May 2021 Complaints received a meeting request to discuss complaint from March 2021, this meeting will be held on the 16th August 2021. Complainant did not want this complaint to be reopened as they want to talk to consultant

Patient Advice and Liaison service - PALS

- In July 2021 the PALS department handled 90 contacts of which 50 were classified as concerns, 2 as informal complaints and 38 as enquiries. This is an increase in contacts compared to the same time last year (39 contacts in June 2020).
- The main themes in the PALS data relate to Appointments and Admissions, with over 30 contacts between both categories.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In June 2021, 89% of enquires and 94% of concerns were handled within the agreed timescales with patient and we did not breach any KPI's in the month.
- Top 3 categories and 2 Top subcategories PALS contacts for July 2021.

Top 3 PALS Categories and top 2 PALS Subcategories

PALS Contacts	Count
Appointments	**33**
Appointment Cancelled	10
Availability	6
Clinical Query	**14**
Delay in Obtaining Results	4
Inadequate Pain Management	3
Communication	**8**
Communication with Relatives/Carer	1
Communication/Info to Patients	5

Patient experience KPI from April 2021

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-21	100	99.69	100
May-21	100	100	100
Jun-21	100	100	100
Jul-21	100	94	89

Compliments

There were 7 compliments recorded on Ulysses in July 2021.

ACTIONS FOR IMPROVEMENTS / LEARNING

- WTE Band 5 Patient Experience Facilitator was appointed in May 2021 and started in August 2021 and team is waiting for one more band 4 to be recruited

- The Public Engagement department have designed the PALS posters to now have the translation of the 5 most common languages spoken within our patients. The Posters include a contact for patient to text the Public Engagement team with their preferred language and the time/date for a PALS call back. This will encourage more patents to provide feedback, raise concerns or complaints.

RISKS / ISSUES

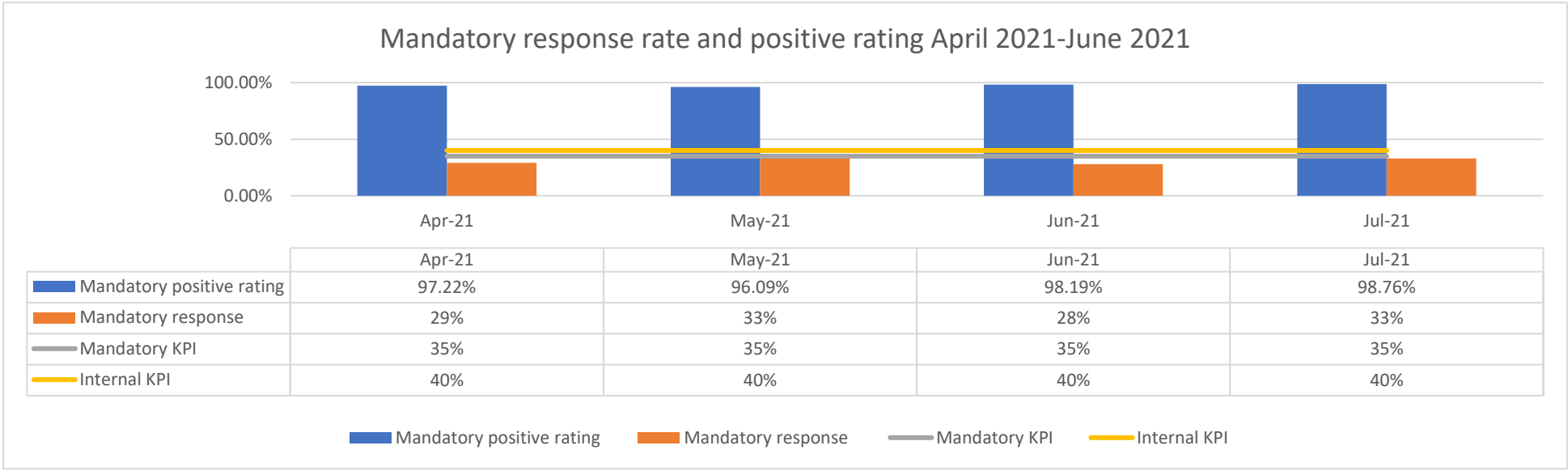
- 7 breached PALS cases were recorded in July 2021- this was due to the COVID related absence, sick leave and annual leave within the Trust and has been discussed between Head of Patient Experience and Deputy Chief operating officer

COMEBACK COMPLAINTS

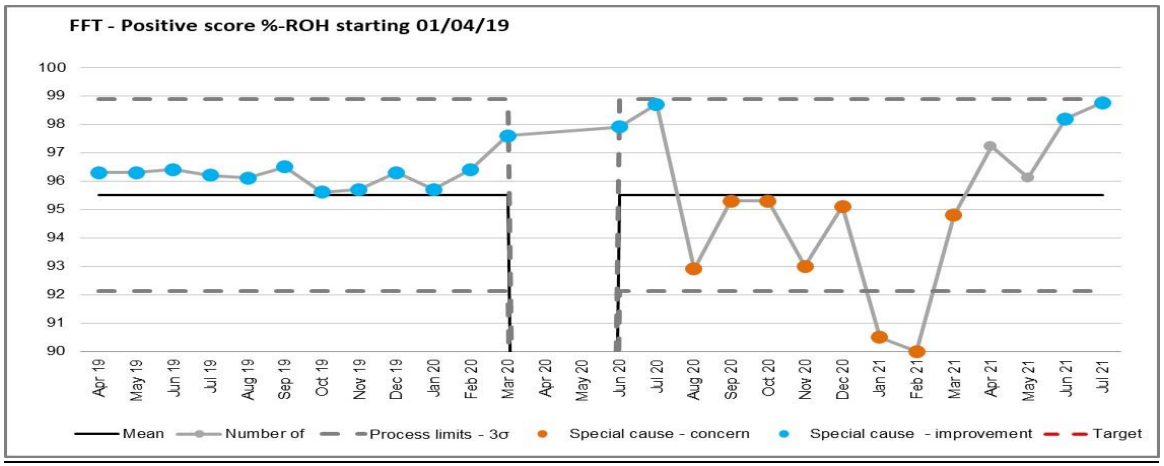
None

9. Friends and Family Test Results (collected in the iwantgreatcare system).

FFT Mandatory Reporting



	Apr-21	May-21	Jun-21	Jul-21
Mandatory positive rating	97.22%	96.09%	98.19%	98.76%
Mandatory response	29%	33%	28%	33%
Mandatory KPI	35%	35%	35%	35%
Internal KPI	40%	40%	40%	40%



INFORMATION
• Via the PALS team, area Managers are receiving any compliments or concerns from patients in a spreadsheet and scanned copies of forms that have staff names or are concerns that are immediate risk to the other patients. This allows the areas to share with their staff for learning and improvements.
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Public engagement team will look more closely on areas that do not meet the mandatory 40% target in FFT response (return) rates. • Meeting undertaken between Head of Patient Experience and Finance department in the QE to discuss the possibility of using their texting service. • The contract with "I Want great care (IWGC)" did not stop at the end of June 2021 due to a late termination note. Head of Patient Experience has had a meeting with the new account manager form IWGC and still wait for them to complete their actions. For now, the ROH is not using IWGC as all internal processes work perfectly. • The Public Engagement team are creating a template to display compliments to the public within departments. • Trust collect patient feedback from non-mandatory areas within the hospital, capturing data on internal spreadsheet and sends any concerns, feedback or compliments back to the departmental managers.
RISKS / ISSUES
• Trust did not meet mandatory nor internal completion rate for mandatory areas (inpatients) for several months. This will be discussed on Divisional management board meetings - this has been discussed on the DMB in May 2021 and managers have been asked to encourage staff to hand FFT out

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 20 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

0 new claim against the Trust was received in July 2021

On-going claims

There are currently 26 on-going claims against the Trust.

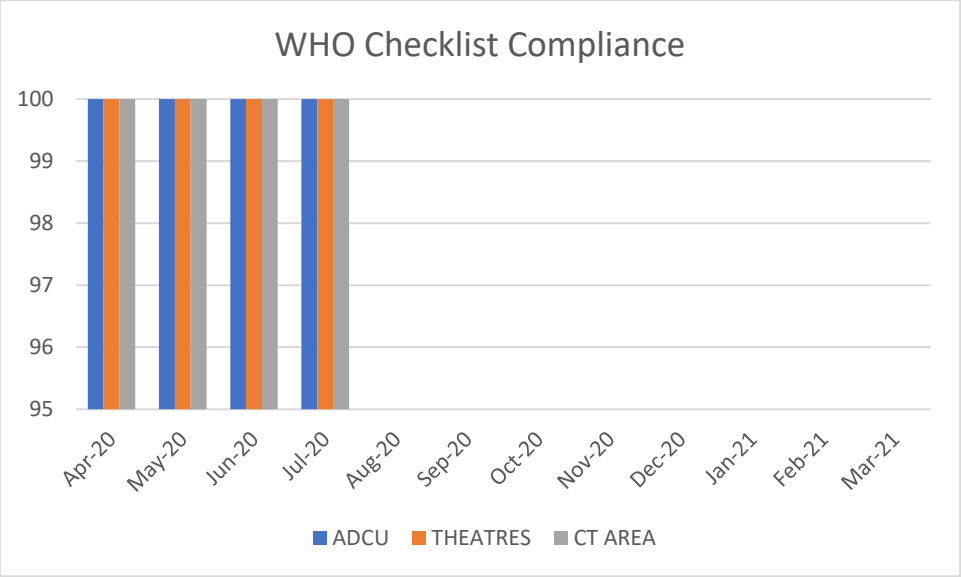
Pre-Application Disclosure

5 new request for Pre-Application Disclosure of medical records were received in July 2021

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in July 2021

12. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 837

The total WHO compliance for Theatres in July 2021= 100%

CT area

Total cases = 80

The total WHO compliance for CT July 2021 = 100%

ADCU

The total WHO compliance for ADCU in June 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Visual WHO in Theatres

In total 12 audits were completed during July 2021. 6 audits scored 96% and 6 audits scored 100%.

Trends throughout July are as follows:

WHO Team Brief:

1 x Core team member – sending for patient

WHO Sign In:

1 x Sign in Not Read Aloud

2 x Patient Not Seen by Surgeon

WHO Team Debrief:

1 x Surgeon had left

1x No Anaesthetist

Overall Compliance: 98%

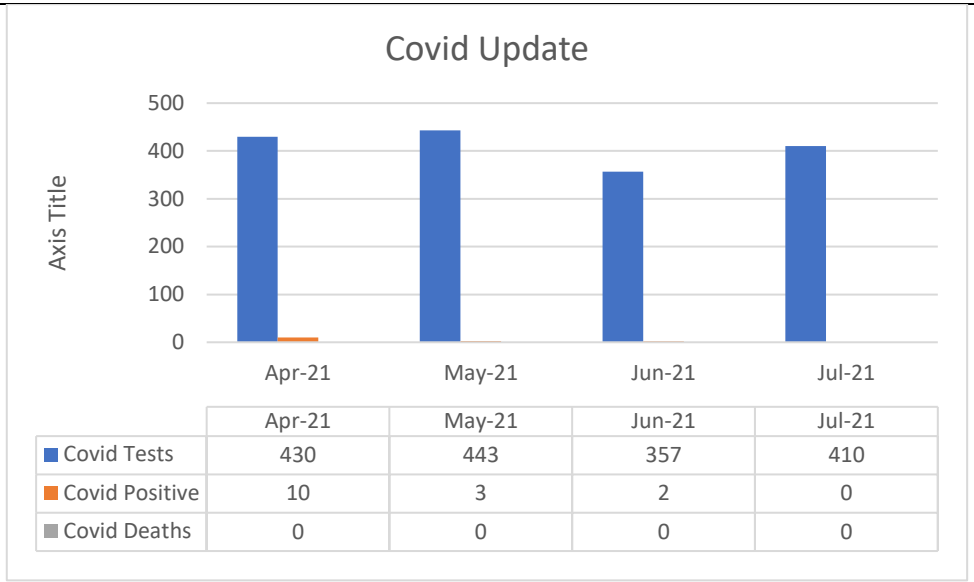
RISKS / ISSUES

None

13. Infection Prevention Control – Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	July 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



	Apr-21	May-21	Jun-21	Jul-21
Covid Tests	430	443	357	410
Covid Positive	10	3	2	0
Covid Deaths	0	0	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

None

RISKS / ISSUES

None

***Data Source – IPC team and Ulysses**

14. Safeguarding – Below details the Key perfomance indicators and metrics in relation to Safeguarding compliance within the Trust. The KPIS below are disucssed in detail at the Safeguarding Committee and are included within this report for awareness

	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Safeguarding Adult Notifications	40	37	36	49	22
Safeguarding Children and Young People Notifications	29	43	45	49	40
Mental Health Incidents	20	22	18	13	5
LD Adult	10	6	11	0	1
LD Children	75	73	61	1	0
Adult Level 2	98.45%	98.09%	97.84%	97.49%	97.35
Adult Level 3	86.04%	87.07%	86.88%	85.65%	84.45
Level 4	100%	100%	100%	85.71%	80
Child Level 2	98.27%	97.91%	97.66%	97.40%	97.08
Child Level 3	86.56%	87.38%	87.41%	85.91%	84.67
Mental Capacity Act MCA	95.65%	96.23%	96.65	96.45%	96.34
Deprivation of Liberty Safeguards DoLs	95.91%	96.50%	96.75	96.72%	96.43
Prevent **WRAP**	84.14%	82.92%	88.48%	87.50%	88.52%
CE	0	0	1	0	0

FGM	2	0	0	0	0
DOLS	6	4	6	8	4
MCA	0	0	5	2	5
PIPOT cases	1	0	0	0	0
Domestic Abuse	3	3	5	6	3
PREVENT Notifications	0	0	0	0	0
WNB	11	15	8	16	11
Child in Care	1	2	1	1	3
Early Help	4	3	0	0	1
DHR- scoping Reviews	0	1	0	0	0
SARs- scoping review **Or Rapid Reviews**	0	0	0	0	0
Modern Slavery	0	0	0	1	0
Incidents	6	5	13	12	6
Open Cases	11	12	11	20	20
Closed Cases	58	69	65	78	42

15. CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

ALL CAS ALERTS (1 July 2021 - 30 July 2021)

ALERTS FROM PREVIOUS MONTHS

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
SDA/2021/008	Tinzaparin sodium (10,000 IU/ml) 3,500 units in 0.35ml and 4,500 units in 0.45ml pre-filled syringes – supply disruption. Organisations who use tinzaparin for both prophylaxis and treatment of venous thromboembolism will need to consider if they wish to switch to an alternative low molecular weight heparin (LMWH) for all indications or just for prophylaxis.	DHSC & NHS England and Improvement: Supply disruption alert.	29-Jul-21	Issued to Pharmacy Response Not Required	n/a
NatPSA/2021/006/NHSPS	Inappropriate anticoagulation of patients with a mechanical heart valve. Early in the Covid-19 pandemic, published guidance supported clinical teams to review patients treated with a vitamin K antagonist (VKA) and where appropriate change their medication to an alternative	National Patient Safety Alert - NHS England & NHS Improvement.	14-Jul-21	29 July 2021: *'Aimed at GP's and anticoagulant*	28 July 2021

	anticoagulant (e.g a low molecular weight heparin (LMWH) or a direct oral anticoagulant (DOAC)). This was partly to reduce the frequency of clinic attendance for monitoring, and thus reduce the risk to patients. The guidance listed exceptions where specific patients should not be switched from a VKA, including patients with a mechanical heart valve. However, incidents have been reported of patients with a mechanical heart valve being switched to a LMWH or a DOAC. This alert asks GPs and other NHS providers of anticoagulation services to identify any patients who have a record of a mechanical heart valve and are receiving a DOAC, and to urgently review these patients to ensure they are on the most appropriate anticoagulation therapy and monitoring.			*clinics. Not relevant to us'*.	

ALERTS FROM PREVIOUS MONTHS

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
NatPSA/2021/003/NHSPS	Eliminating the risk of inadvertent connection to medical air via a flowmeter	National Patient Safety Alert - NHS		**5 July 2021.**–	21 Nov 2021

	Due to the proximity of the piped medical air and oxygen outlets at the bedside, and the similarity in design of flowmeters, there is a significant risk when using air flowmeters that patients may be inadvertently connected to medical air instead of oxygen. The alert asks providers to purchase alternative devices that do not require medical air to be delivered via an air flowmeter. Following this, all medical air flowmeters except those tethered to equipment for niche use should be discarded, and all medical air outlets no longer required should be reversibly capped off.	England & NHS Improvement		all 1-5 actions detailed in alert complete. Revise SOP by 21 Nov (deadline for alert). **3 Aug 2021.** *'SOP for the air flowmeters and disseminated to my recovery lead, Recovery band 6 team leaders, Theatre band 7s, Theatre matron and the recovery clinical lead for their input and comments. allowed 10 days for this prior to the SOP going live'.* **Actions complete.**	

The Royal Orthopaedic Hospital NHS Foundation Trust

Workforce Performance Report Month End June 2021

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Please be aware that the information included in this report relies upon the timely update of information into ESR and Healthroster, this report is based on data as at the 7th working day in July, please note the figures are likely to change if information is input into the systems after the cut-off date. Due to staff absence, training and developmental information has been omitted from this report.

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

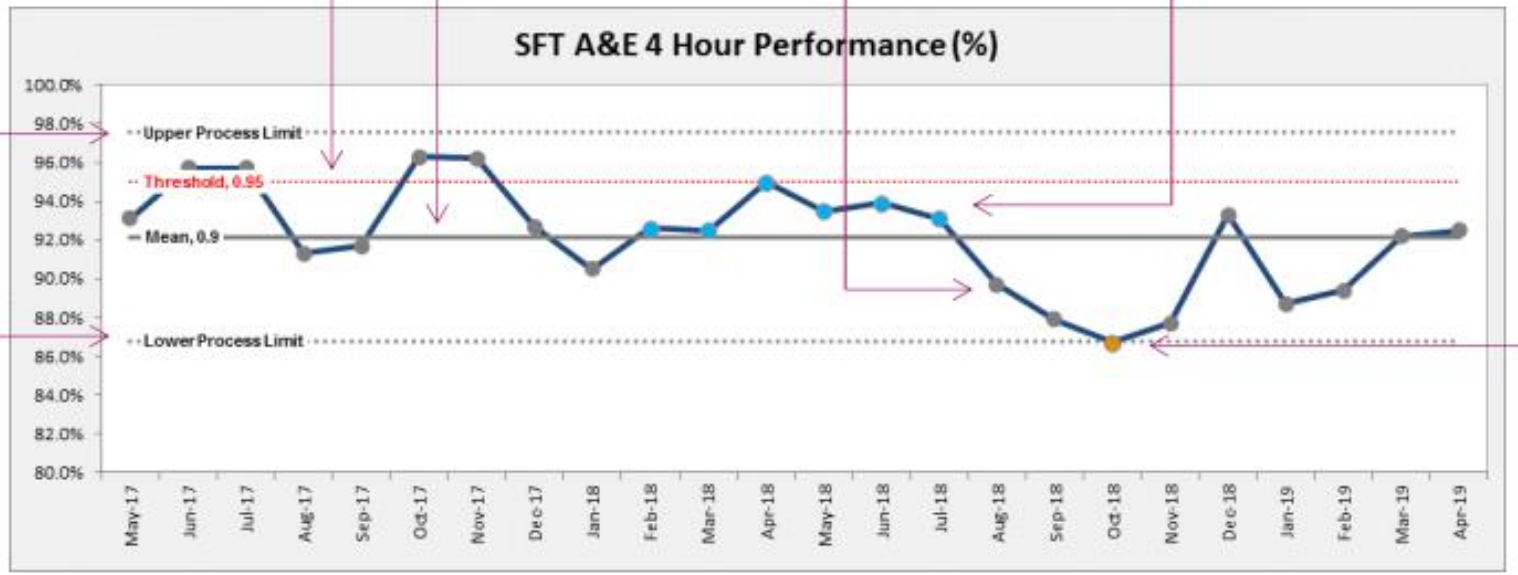
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

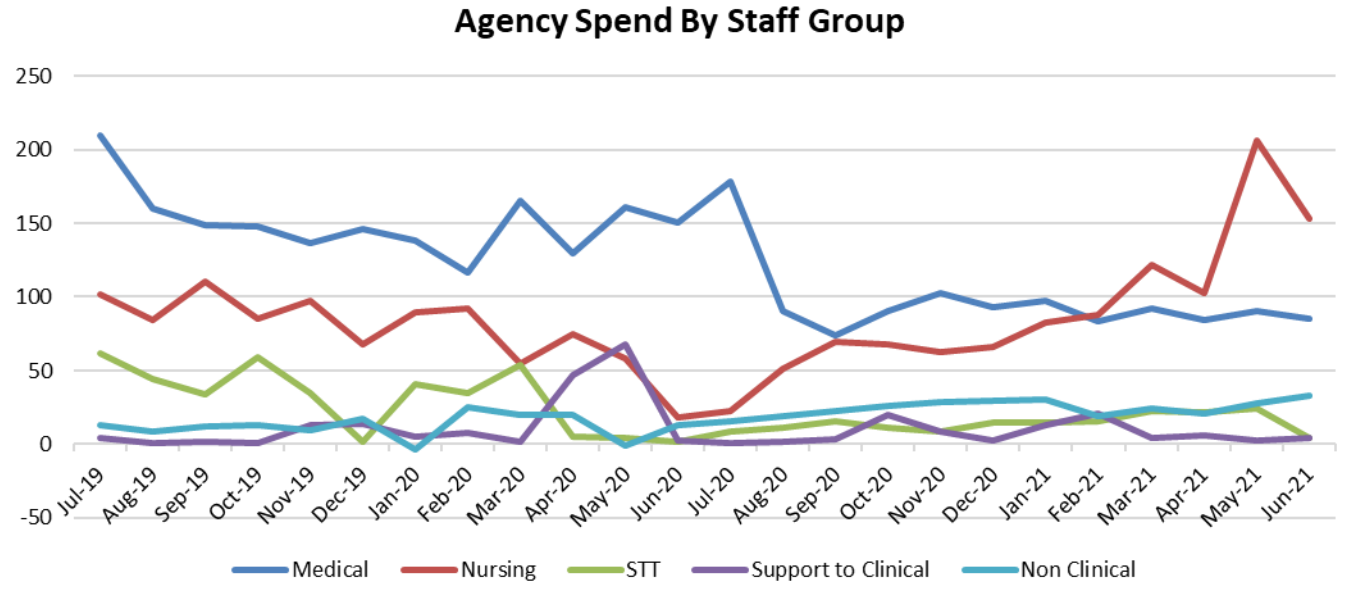
Workforce Monthly Snapshot Overview

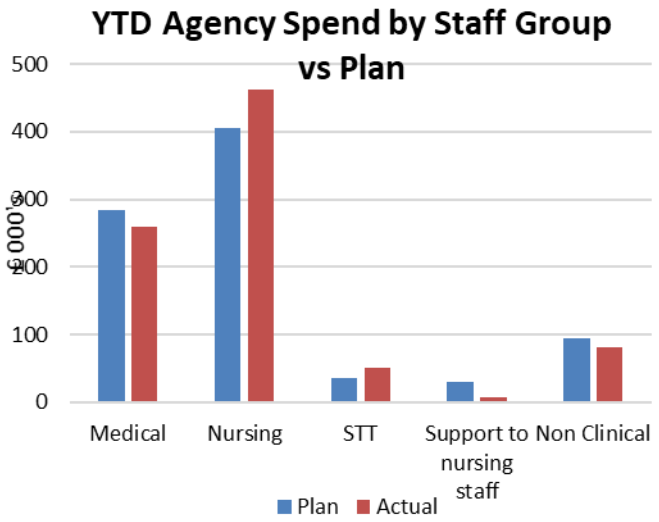
NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

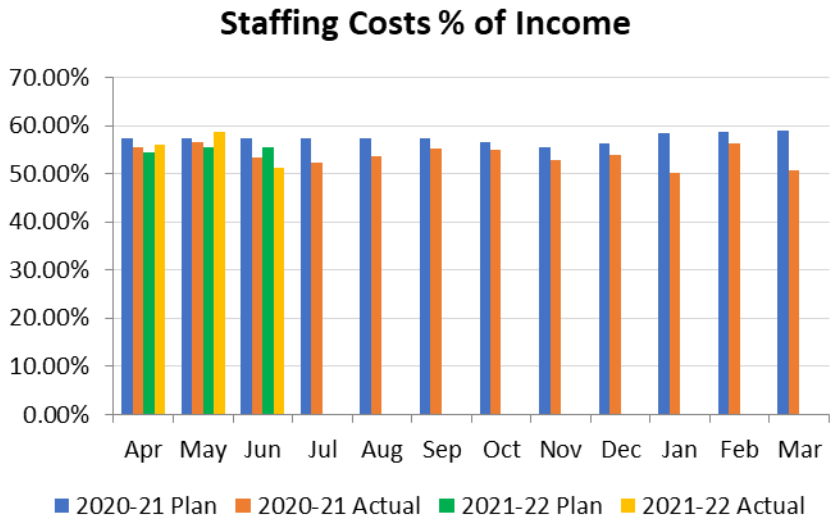
	May-21	Jun-21	This Month vs Last Month	Trend	KPI
Staff Turnover (%) - Unadjusted	9.57%	9.91%	0.34%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	7.32%	7.11%	-0.21%	⇩	<=11.5%
Total WTE Employed as % of Establishment	82.77%	83.69%	0.92%	⇧	>=93%
Total WTE Employed as % of Establishment - Clinical	81.10%	81.47%	0.37%	⇧	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	85.85%	87.76%	1.91%	⇧	>=96%
% of Attendance	95.07%	94.38%	-0.69%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.44%	94.31%	-0.13%	⇩	>=96.3%
% Staff received mandatory training last 12 months	82.73%	82.45%	-0.28%	⇩	>=95%
% Staff received formal PDR/appraisal last 12 months	80.30%	79.90%	-0.40%	⇩	>=95%
% of Sickness - Trust wide Long-term	2.72%	3.93%	1.21%	⇧	-
% of Sickness - Trust wide Short-term	2.47%	1.69%	-0.78%	⇩	-
Return To Work Completion %	77.44%	65.89%	-11.55%	⇩	>=80%

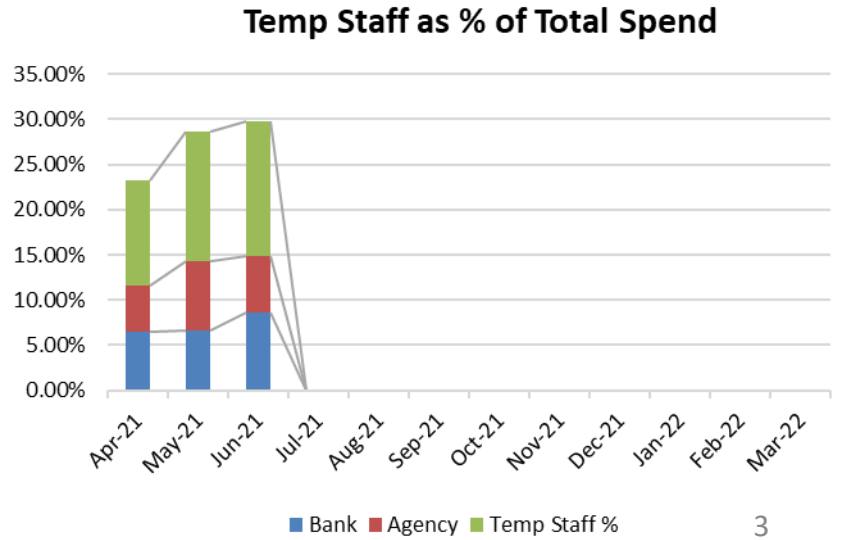
Workforce Composition & Cost

Jun-21		
Pay Cost Analysis		
	£'000's	Variance
Planned Income YTD	26570	
Actual Income YTD	26683	100.43%
Planned Pay Staffing Costs (YTD)	14636	
Actual Pay Staffing Costs (YTD)	14717	101%
Planned Substantive Pay Costs (YTD)	12704	
Actual Substantive Pay Costs (YTD)	12676	100%
Planned Bank Pay Costs (YTD)	1038	
Actual Bank Pay Costs (YTD)	1068	103%
Planned Agency Pay Costs (YTD)	844	
Actual Pay Costs (YTD) Agency Staff	921	109%
Planned Agency Pay Costs as % of total Pay costs (YTD)		5.77%
Actual Agency Pay Costs as % of total Pay costs (YTD)		6.26%



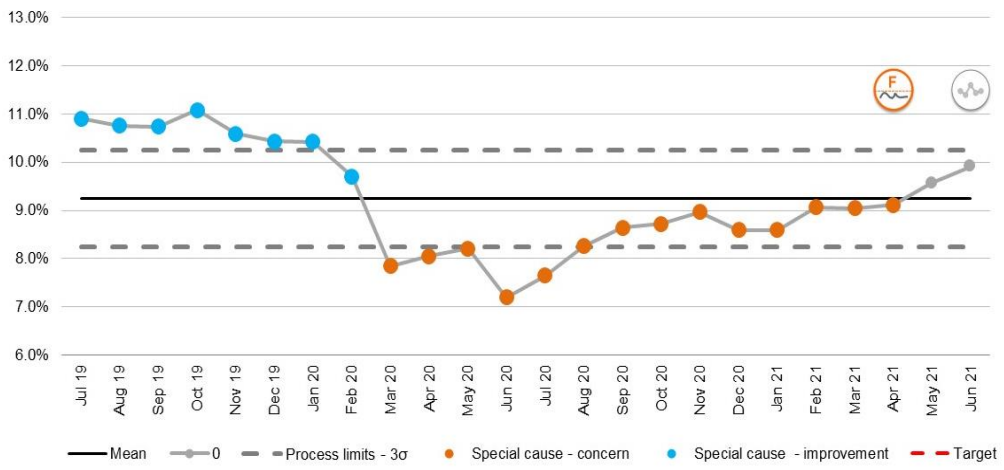




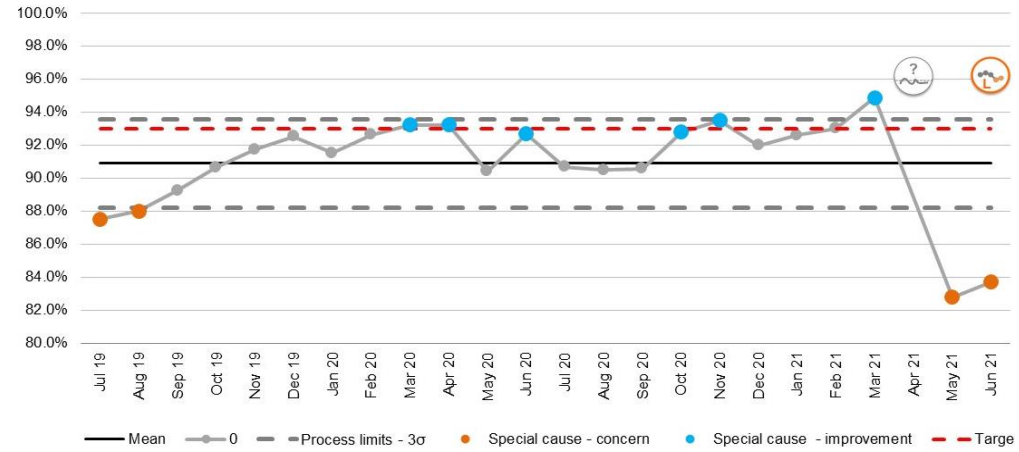


Workforce Establishment & Turnover

Staff Turnover Unadjusted (%)



Total WTE Employee as a % of Establishment



Summary and Actions

The Royal Orthopaedic Hospital NHS Foundation Trust

Turnover

Unadjusted turnover (all leavers excluding rotational doctors) for this month was **9.91%** which rests below the Trust target of 11.5%. This month there were 15.63 (WTE) new starters (17 headcount) and 8.04 (WTE) leavers (9 headcount) (this excludes any rotational doctors).

The Corporate Division had the highest turnover of all divisions this month at **16.05%** and has been the only division for the past six months where turnover has exceeded the Trust target. Admin staff also have the highest turnover rate of **11.87%** which may coincide with the turnover figures for the Corporate Division as a whole. The Trust does hold an Admin Matters forum and feedback from this group in future may help to understand more about any issues in particular that the admin staff group are experiencing.

Leaving Reasons

Over the last 12 months, the main reasons for staff leaving (according to ESR data) were relocation, promotion and an other / unknown reason. HR will continue to encourage managers to select more specific leaving reasons when doing terminations through ESR.

From the exit questionnaires, over the last 3 months, the most common leaving reason was unrealistic workload. This is closely followed by employee morale and lack of recognition which were also two of the most common leaving reasons over the last 12 months. The HR department will continue to send out exit questionnaires to staff to collate their feedback.

66% of leavers have been with the Trust for less than 5 years and 70% of these leavers were with the Trust for less than 1 year.

Establishment & Vacancy

At the end of June, the number of staff on payroll stood at 1225 (WTE 1085.78), n increase of **13.76 WTE** from May. The Total WTE Employed as a % of the Establishment this month was **83.69%** which rests below the Trust Target 93%. It should be noted since Feb 2021, the Trust was on target at over 93%, however in April 2021, the start point budgets were reset which has impacted the vacancy rates.

Workforce Attendance & Sickness Absence

The Royal Orthopaedic Hospital NHS Foundation Trust

Summary and Actions

COVID Related Absence

This month COVID-related sickness made up **0.25%** of all sickness absence within the Trust. Compared to this time last year, the figures are slightly lower which suggests positive impact of measures to reduce the spread of infection e.g. vaccinations.

Furthermore, over the last 12 months, COVID related sickness absence has cost the Trust approximately £296,665.69. COVID-related absence data is reported daily to NHS England and weekly to the BSOL STP.

Attendance & Sickness Absence

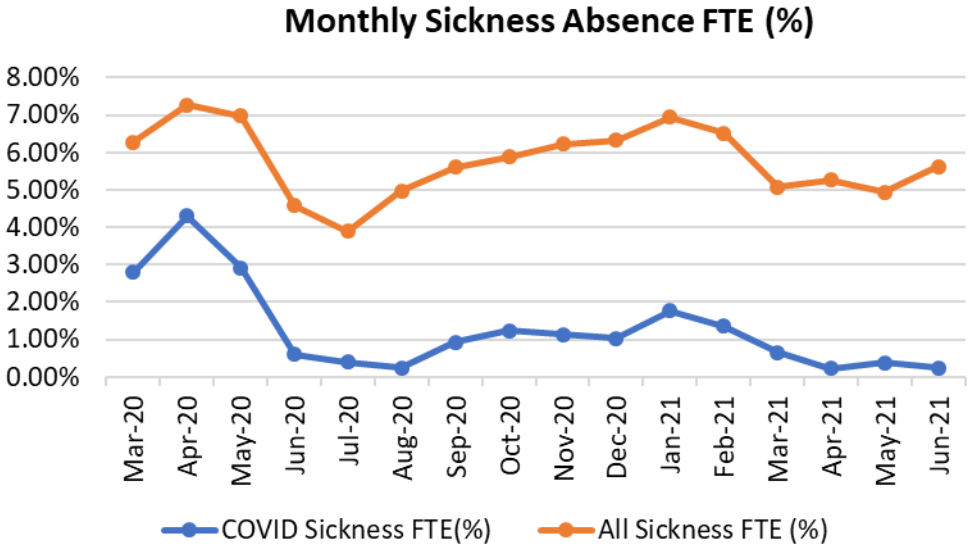
Attendance for this month was **94.38%** (sickness absence % = 5.62%) and Attendance for the rolling past 12 months was **94.31%.** These currently sit below the Trust target of 96.3%, but have remained fairly consistent over the past few months.

Over the last 12 months, sickness absence has cost the Trust approximately **£1,912,211.90**. The top reasons for sickness absence include gastrointestinal problems, musculoskeletal problems or cold cough or flu like symptoms (including COVID-19).

At the end of June 2021, there were 43 staff on long term sickness, where 3 of these staff have been absent for longer than 6 months. HR are continuing to support managers with ensuring that absence meetings are taking place and staff are being supported throughout their absence.

Return To Work Discussion Meetings Following Sickness Absence

Trustwide Return To Work (RTW) interviews decreased this month to **65.89%** which below the Trust Target of 80%. RTW non-compliance is predominately happening within clinical areas and HR are encouraging line managers to complete these interviews within a timely manner. On-going support is being offered to Division 2 – Patient Support on a weekly basis to ensure that these meetings are completed as soon as possible. The Workforce Information team are also supporting managers with recording these meetings onto the relevant absence system.



Top 5 Absence Reasons (Last 12 Months) *Jul20-Jun21

Absence Reason	Amount of Episodes	FTE Days Lost	Estimated Absence Cost
Gastrointestinal problems	258	1026	£93,729.77
Musculoskeletal problems	258	5211	£409,750.29
Cold, Cough, Flu - Influenza	250	2250	£227,885.26
Anxiety/stress/depression	187	7972	£713,857.09
Headache / migraine	136	487	£49,075.92

Formal Capability / Disciplinary Processes

The Royal Orthopaedic Hospital NHS Foundation Trust

Summary and Actions

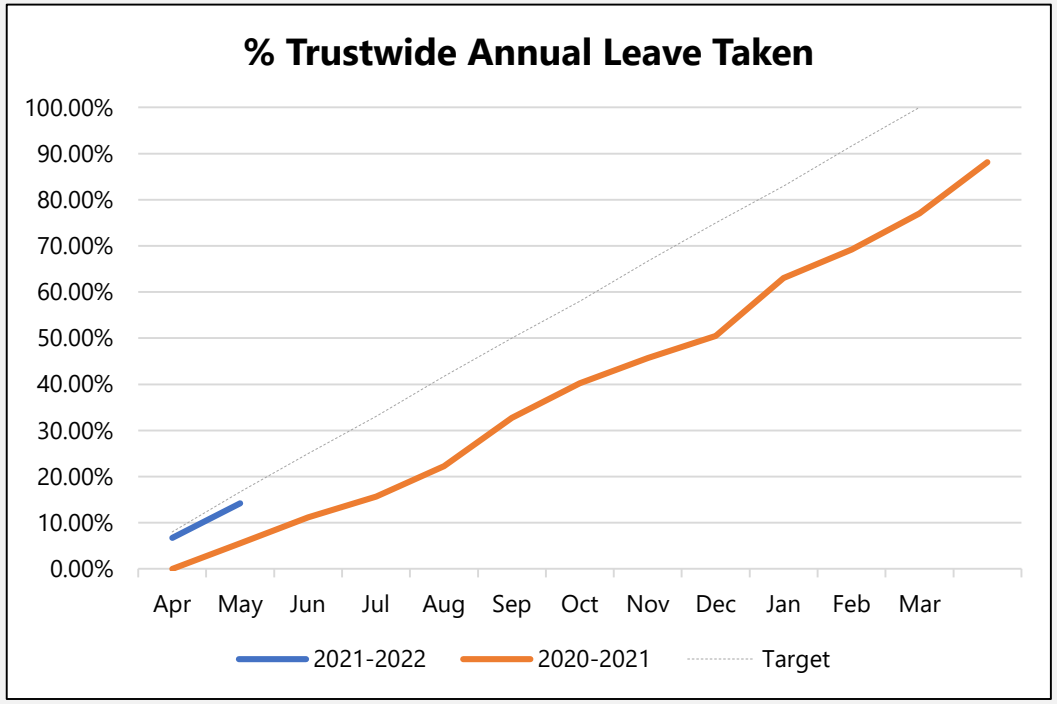
At the end of June, there were no formal capability cases and **2** formal on-going conduct cases. Since May, one formal conduct case was closed.

Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being kept informed of any informal processes to ensure we can anticipate potential future formal cases and appropriate action/measures that needs to be considered.

For the on-going conduct cases, one is a Black British Colleague and the other case is a White British

Open Cases – June 2021

	Case 1	Case 2
Allegation	AWOL, failure to report absence and follow reasonable management instructions	Failure to follow Trust and national guidelines in regards to COVID and wearing of PPE



Workforce Wellbeing

Annual Leave

At the end of Q1 (June 21) for the financial year, AfC staff have taken 19.83% of their annual leave entitlement. The target for each quarter of the year is for staff to have taken 25% of their annual leave entitlement to support staff in having regular rest breaks.

% Leave Taken as at 30th June 2021

Division	% Annual Leave Taken
Corporate Directorate	18.18%
Covid-19 Division	5.09%
Division 1 - Patient Services	19.81%
Division 2 - Patient Support	21.73%
Division 4 - Estates & Facilities	17.26%
Trust Total	**19.83%**

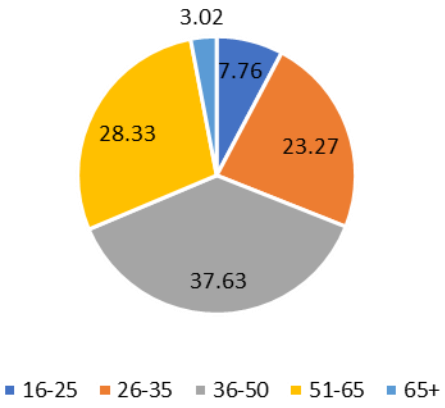
Wellbeing Day

At the end of June, 20% of staff have taken their wellbeing day. There are a further 13% of staff so far who have this booked in the coming financial year

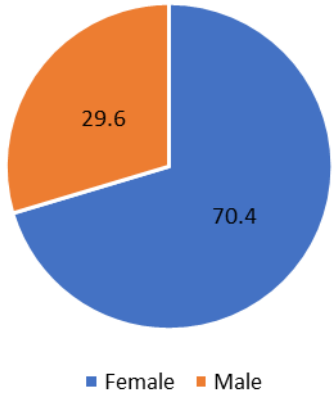
Workforce & Resourcing Demographics

The Royal Orthopaedic Hospital NHS Foundation Trust

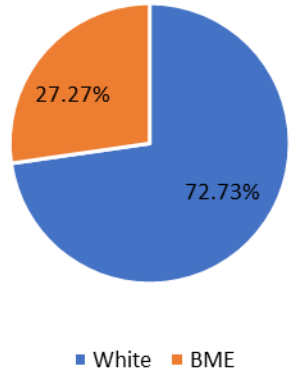
Age Band of Workforce (%)



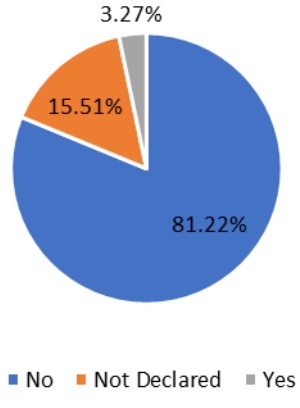
Gender of Workforce (%)



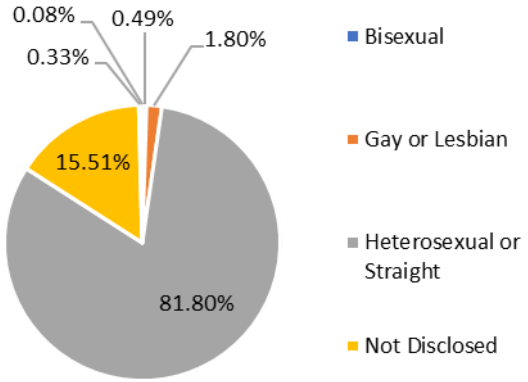
Ethnic Group of Workforce (%)



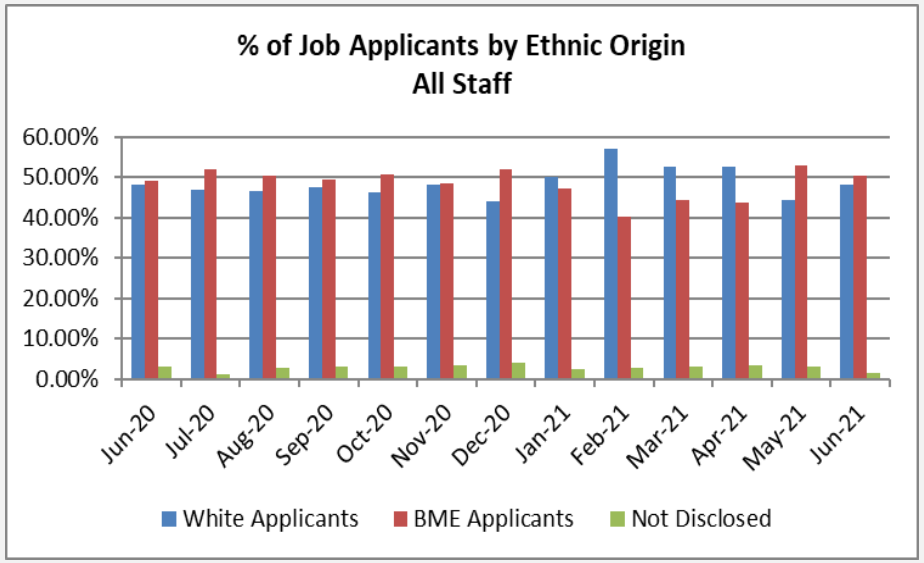
Disability of Workforce (%)

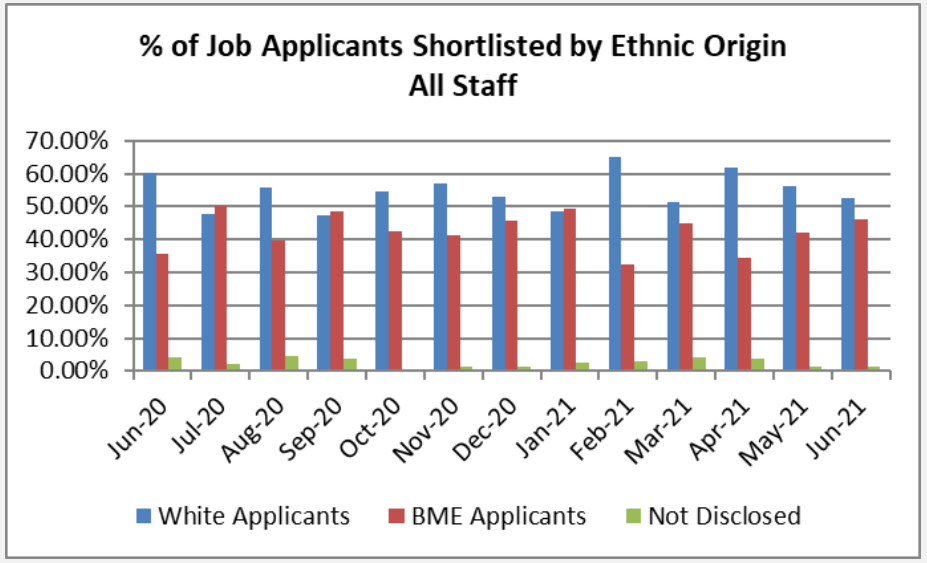


Sexual Orientation of Workforce (%)



WRES Indicators – Resourcing Ethnic Origin





WRES Indicator 2 Monitoring

Over the last two months, there have been more BME applicants than White applicants and also an increase in BME applicants being shortlisted.

Workforce – Experience and Engagement

The Royal Orthopaedic Hospital NHS Foundation Trust

Quarterly NHS Staff survey (previously Friends and Family Test (FFT))

A new staff survey format has been launched by NHS England. Most recent Information confirms that the Trust will be required to start the survey at ROH in January 2022.

Progress is being made with the **National NHS survey (NSS)** action plan. Each Executive Director is leading on sharing information across their Directorates and finalising a local action plan. The final organisational action plans will be confirmed in June and communicated across the Trust in July.

Inclusion Work

The Workforce Disability Equality standard (WDES) photography and video exhibition has now been launched as a physical display outside Outpatients and online. There was good representation from across the Trust at the launch and positive feedback from staff members, regional and national partners. The next phase of the project will be to develop awareness session and also a Buddy scheme in line with the mentoring work continuing across the Trust.

The BeMyself LGBTQ+ team are working with regional teams to co-ordination an NHS float at Birmingham Pride in September. However at the latest regional meeting on July 21st it has been agreed to scale back this project due to current Covid numbers and possible cancellation of the event

Network meeting have taken place in June and July for Equality and Diversity, Disability Network and Multi Minority Ethnic Group (MMEG). Key focus for the networks is planning for events in the future to engage staff across all departments. There a discussion on an election for the Disability network chair.

Work on **data collection** and action plans for Workforce Race Equality Standard (WRES) and Workforce Disability Equality standard (WDES) continues and data is due to be submitted to NHS England in August 2021. A report on the new Disparity Ratio standard which is linked to WRES data and the Model Employer was submitted to NHS England in June 2021 All actions will be linked to the Inclusion action plan.

Workforce – Experience and Engagement

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Health and Wellbeing

The work around **Health and Wellbeing** is now focussed on supporting staff through the recovery phase for Covid-19. Information is currently available through information packs on the intranet and in departments, one to one meetings and manager calls. Key work to support staff includes:

- Thrive at work – continue with Bronze Accreditation, collecting information from key staff members and uploaded evidence to the dashboard.
- Health and Wellbeing Room, refurbishment is underway, the room has been cleared and prepared, new windows and doors have been fitted.
- Bid submitted to BSol for additional funding for an outdoor wellbeing space at ROH
- New Menopause Support Posters to be distributed
- Revised Heath and Wellbeing Conversations within a 1:1 format currently being developed
- Health and Wellbeing Champions working with national and regional colleagues
- TWIG (Trust Wellbeing and Implementation Group Meeting) – worked needed to review members of group

Future Events

- Health and Wellbeing Week 13th-17th September, working with key colleagues to gather ideas and support
- Completion of H&WB Room beginning of September
- Start work on outdoor wellbeing spaces
- Continue to work with individual teams to support team culture and colleagues wellbeing
- Stand at Juniors Doctors Induction

Support has been offered to a number of department across the Trust to facilitate **team building** and a high performance team culture with sessions which have taken place in July with some key actions confirmed for improvement

We recognise that some staff may not be able to participate in all activities where there are work pressures and fatigue across staff groups, but we continue to ensure all staff are make aware of support available and events upcoming within the Trust

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Date: 27 August 2021

Notice of a meeting of the Board of Directors

Notice is hereby given to all of the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held remotely via videoconference on 1 September 2021:

Meeting	**Timing**
Non Executives pre-meet	0800h – 0900h
Public Board meeting	0900h – 1200h
Private Board meeting	1200h – 1300h

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

Signed



Tim Pile
Chairman

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday 1 September 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 September 2021 commencing at **0900h**. This will be a remote meeting facilitated using videoconferencing technology.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

Venue Remote via videoconferencing **Date** 1 September 2021: 0900h – 1130h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Ms Ali Gray	Charity Manager	(AG)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Pre-Operative Assessment Centre	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 7 July 2021: *for approval*	ROHTB (7/21) 020	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (7/21) 020 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (9/21) 001 ROHTB (9/21) 001 (a)	TP/JW
		STRATEGY		
0945h	7	Progress with delivery of the five year strategy: *for assurance*	ROHTB (9/21) 002 ROHTB (9/21) 002 (a)	RL

0955h	8	Charity Strategy update: *for assurance*	ROHTB (9/21) 003 ROHTB (9/21) 003 (a)	AG
1005h	9	IT & Digitisation plans update: *for assurance*	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	SW
1015h	10	National patient strategy update: for information	Verbal	GM
		PATIENT EXPERIENCE AND OUTCOMES		
1020h	11	COVID-19 update: *for assurance*	Presentation	GM
1025h	12	Learning from Deaths quarterly update: *for assurance*	ROHTB (9/21) 005 ROHTB (9/21) 005 (a)	MR
1035h	13	Quantifying and evidencing excellence, using quality outcome measures: *for assurance*	ROHTB (9/21) 006 ROHTB (9/21) 006 (a)	MR
		STAFF EXPERIENCE AND HEALTH & WELLBEING		
1045h	14	Responsible Officers annual report: *for assurance*	ROHTB (9/21) 007 ROHTB (9/21) 007 (a)	MR
1055h	15	Staff survey action plan update: *for assurance*	ROHTB (9/21) 008 ROHTB (9/21) 008 (a)	SM
		BREAK		
		GOVERNANCE & COMPLIANCE		
1115h	16	Annual reports: *for approval* • Fire safety • Safeguarding • Infection Prevention and Control	ROHTB (9/21) 009 ROHTB (9/21) 009 (a) ROHTB (9/21) 009 (b) ROHTB (9/21) 009 (c)	PB GM GM
1130h	17	Updated Board Assurance Framework: *for assurance*	ROHTB (9/21) 010 ROHTB (9/21) 010 (a)	ALL
		FINANCIAL AND OPERATIONAL PERFORMANCE		
1135h	18	Finance and Performance monthly report: *for assurance*	ROHTB (9/21) 011	SW/ MP

		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1145h	19	Assurance reports from the Board Committees: • Audit • Finance & Performance • Staff Experience & OD • Quality & Safety	ROHTB (9/21) 012 ROHTB (9/21) 013 ROHTB (9/21) 014 ROHTB (9/21) 015	
1155h	20	Performance reports: *for assurance* • Quality & Safety • Workforce	ROHTB (9/21) 016 ROHTB (9/21) 017	
		BREAK		
		CONFIDENTIAL SESSION		
1210h	21	Exclusion of the press and public	Verbal	Chair
	Date of next meeting: Thursday, 7 October 2021 @ 0900h			

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 – UPDATED TO JULY 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	6/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓	✓	✓							4/4
Kathryn Sallah	✓	✓	✓	✓							4/4
Richard Phillips	✓	✓	✓	✓							4/4
David Gourevitch	✓	✓	✓	✓							4/4
Simone Jordan	✓	✓	✓	✓							4/4
Gianjeet Hunjan	✓	✓	✓	✓							4/4
Ayodele Ajose	✓	✓	✓	✓							4/4
Les Williams	✓	✓	✓	A							3/4
Jo Williams	✓	✓	✓	✓							4/4
Matthew Revell	✓	✓	✓	✓							4/4
Garry Marsh	✓	✓	✓	✓							4/4
Phil Begg	✓	✓	✓	✓							4/4
Marie Peplow	✓	✓	✓	✓							4/4
Stephen Washbourne	✓	✓	✓	✓							4/4
Sharon Malhi	✓	✓	✓	✓							4/4
Simon Grainger-Lloyd	✓	✓	✓	✓							4/4

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Trust Board Meeting in Public on Thursday 7 October 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Thursday 7 October 2021 commencing at **0900h**.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Lecture Theatre, Knowledge Hub **Date** 7 October 2021: 0900h – 1300h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Chief Nurse	(GM)

In attendance

Ms Claire Hinwood	Clinical Nurse Specialist	(CH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RLl)	
Mr Matthew Maycock	Acting Head of IT	(MM)	
Mr Liam Maiden	Technical Projects Manager	(LM)	
Mr Adam Whitehouse	Digital Architect	(AW)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Transition to Adult Services	Presentation	CH
0920h	2	Apologies - Ayodele Ajose	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 1 September 2021: *for approval*	ROHTB (9/21) 024	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (9/21) 024 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (10/21) 001 ROHTB (10/21) 001 (a)	TP/JW
		STRATEGY		
0945h	7	Musculo Skeletal Services development: *for assurance*	Presentation	RLl

PATIENT EXPERIENCE AND OUTCOMES				
1005h	8	COVID-19 update: *for assurance*	Presentation	GM
1015h	9	NHS England Infection Prevention and Control Board Assurance Framework: *for assurance*	ROHTB (10/21) 002	GM
STAFF EXPERIENCE AND HEALTH & WELLBEING				
1025h	10	Gender pay gap submission: *for assurance*	Verbal	SM
GOVERNANCE AND COMPLIANCE				
1030h	11	CQC Action Plan: *for assurance*	ROHTB (10/21) 003 ROHTB (10/21) 003 (a)	GM
1035h	12	2021 NHS Emergency Preparedness Resilience and Response Core Standards: *for assurance*	ROHTB (10/21) 004 ROHTB (10/21) 004 (a)	PB
COMMITTEE UPDATES				
1040h	13	Finance and Performance: • Upward assurance report • Terms of Reference	ROHTB (10/21) 005 ROHTB (10/21) 005 (a) ROHTB (10/21) 005 (b)	RP/ SW/ MP
	14	Quality & Safety: • Upward assurance report • Terms of Reference	ROHTB (10/21) 006 ROHTB (10/21) 006 (a) ROHTB (10/21) 006 (b)	KS/ GM
	15	Staff Experience & OD: • Upward assurance report • Terms of Reference	ROHTB (10/21) 007 ROHTB (10/21) 007 (a) ROHTB (10/21) 007 (b)	SJ/ SM
	16	Audit: • Terms of Reference	ROHTB (10/21) 008 ROHTB (10/21) 008 (a)	GH
	17	Nominations and Remuneration (Executive Directors) • Terms of Reference	ROHTB (10/21) 009 ROHTB (10/21) 009 (a)	SJ
MATTERS TO BE TAKEN BY EXCEPTION ONLY				
1055h	18	Performance reports: *for assurance* • Finance & Performance • Quality & Safety • Workforce	ROHTB (10/21) 010 ROHTB (10/21) 011 ROHTB (10/21) 012	

BREAK				
CONFIDENTIAL SESSION				
1115h	19	Exclusion of the press and public	Verbal	Chair
	20	Declarations of interest on any matters in the private session	Verbal	ALL
	21	Minutes of the previous meeting in private held on 1 September 2021: *for approval*	ROHTB (9/21) 024 (P)	Chair
	21.1	Actions from previous meetings in private: *for assurance*	ROHTB (9/21) 024 (a) (P)	SGL
1120h	22	Chair and Chief Executive update on any confidential matters: *for information and assurance*	Verbal	TP/JW
1130h	23	Cloud business case: *for approval*	ROHTB (10/21) 013 (P) ROHTB (10/21) 013 (a) (P) Presentation	MM/ LM/ AW
1150h	24	Private patient strategy update: *for discussion*	Verbal	MP
1205h	25	Serious incident report: *for assurance*	ROHTB (10/21) 014 (P) ROHTB (10/21) 014 (a) (P)	GM
1215h	26	Joint working: • Update on Robert Jones & Agnes Hunt oncology service • University Hospital Birmingham orthopaedic pathway	Verbal	MP
1220h	27	Committee minutes: *for information*	ROHTB (10/21) 015 (P) ROHTB (10/21) 016 (P) ROHTB (10/21) 017 (P)	Ctte Chairs
1225h	28	Any Other Business	Verbal	ALL
	29	Meeting effectiveness	Verbal	ALL
	Date of next meeting: Wednesday, 3 November 2021 @ 0900h			

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 – UPDATED TO SEPTEMBER 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	7/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓	✓	✓	✓						5/5
Kathryn Sallah	✓	✓	✓	✓	✓						5/5
Richard Phillips	✓	✓	✓	✓	✓						5/5
David Gourevitch	✓	✓	✓	✓	✓						5/5
Simone Jordan	✓	✓	✓	✓	✓						5/5
Gianjeet Hunjan	✓	✓	✓	✓	✓						5/5
Ayodele Ajose	✓	✓	✓	✓	✓						5/5
Les Williams	✓	✓	✓	A	✓						4/5
Jo Williams	✓	✓	✓	✓	✓						5/5
Matthew Revell	✓	✓	✓	✓	✓						5/5
Garry Marsh	✓	✓	✓	✓	✓						5/5
Phil Begg	✓	✓	✓	✓	A						4/5
Marie Peplow	✓	✓	✓	✓	✓						5/5
Stephen Washbourne	✓	✓	✓	✓	✓						5/5
Sharon Malhi	✓	✓	✓	✓	✓						5/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓						5/5

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board - DRAFT Version 0.3

Venue Remote via videoconferencing **Date** 1 September 2021: 0900h – 1300h

Members attending:

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing and Clinical Governance	(GM)

In attendance:

Mrs Sharon Gardner	Acting Matron	(SG)	[Item 1]
Ms Ali Gray	Charity Manager	(AG)	[Item 8]
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story: Pre-operative Assessment Centre	**Presentation**
The Board welcomed Sharon Gardner, Acting Matron, who described the care of a patient who had been treated through the Pre-Operative Assessment Centre. The individual had required the intervention of the Safeguarding team. The patient had been experiencing anxiety as a result of a reduction in benefits they were able to claim. The individual was subsequently referred to University Hospitals Birmingham NHSFT for a medication review and a review of their benefits entitlement had also been undertaken. The Medical Director asked how the needs of the patient and the need to	

maintain staff safety had been prioritised. He was advised that precautions had been taken to ensure that the nurse caring for the patient remained visible and accessible through the appointment and that she had been asked to confirm that she was content to continue to care for the patient, which had been the case. Mrs Gardner also advised that she had personally supervised the care and had sought the support of a male nurse colleague. Other members of the team had also supported the care and ensured that the patient was given all the dedicated time they needed to be comfortable. Kathryn Sallah thanked Mrs Gardner for the story and commented that this highlighted very clearly the safeguarding challenges. The Mental Health First Aid (MHFA) training delivered at the Trust was noted to be good for giving staff the confidence to handle the situation in a calm way. It was noted that the individual recognised their own issues and it was suggested that the patient could present their own story to staff if they wished. The Chairman echoed the benefit of training. He asked with what frequency a Mental Health patient was encountered by the Trust. He was advised that this was c. 1 to 2 patients per week, plus others with safeguarding issues. It was noted that the nurses were in a position of privilege to be able to handle this. The Chairman asked if support had been given to staff. Mrs Gardner noted that there had been a debrief and the team had recognised the benefit that they had achieved for the patient and felt motivated by the experience. The Director of Nursing & Clinical Governance noted that the Safeguarding Committee heard stories of staff experience and the learning from their cases. Despite having good quality plans of care, the difference for the nurses was that the plans for this type of patient were varied and patients deviated from the plans of care set for them. There was however good confidence with handling with conversations and handling the whole person rather than just their orthopaedic care. Kathryn Sallah noted that there had been a previous trend for organisations to have mental health trained nurses and asked whether this was needed in the future as part of employment opportunities. The Director of Nursing & Clinical Governance noted that there had been a business case for dementia nurse already approved. The balance between use of MHFA training versus training in Mental Health was noted. Lisa Newton, Matron, was recognised for her work leading Mental Health work. Thanks were expressed to Mrs Gardner. It was agreed that the compassion that she had conveyed was a testimony to hers and her team's work.	

2 Apologies	**Verbal**
Apologies were received from Phil Begg.	
3 Declarations of Interest	**Verbal**
It was noted that the register was available on request from Company Secretary.	
4 Minutes of Board Meeting held in Public on 7 July 2021: *for assurance*	**ROHTB (7/21) 020**
The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held.	
4.1 Actions from previous meetings in public: *for assurance*	**ROHTB (7/21) 020 (a)**
The Director of Corporate Affairs & Company Secretary talked through the action log. There were no concerns highlighted which needed Board attention.	
5 Questions from members of the public	**Verbal**
There were none.	
6 Chairman's and Chief Executive's update: *for information and assurance*	**ROHTB (9/21) 001** **ROHTB (9/21) 001 (a)**
The Chief Executive reported that the Trust remained supporting the system with a divert for spinal cases, given that the number of COVID positive patients across the system remained high. Despite this, there was strong steer from NHS Improvement for the ROH to remain as a 'green' (COVID-free) site. The application for a place in the Top 50 inclusive companies had been submitted. The Trust had been shortlisted for Health Service Journal (HSJ) 'Trust of the Year' which the Board agreed was an incredible achievement. The interviews were week commencing 27 September, which would be virtual. The Staff Awards were reported to be planned for 1 October 2021. Staff attending would be asked to undergo a lateral flow test and provide vaccination confirmation. The plan would be to cross check the vaccination status held by individuals. There was a plan to provide staff with a third dose of the COVID vaccination, which would need to be delivered alongside the annual 'flu vaccination. Work was underway with the Patient Experience Network (PEN) around collecting	

patient information and garnering the lessons learned from this. The Chairman supported the work and asked that it involved wide Board representation and be shared at a Board meeting. The Director of Nursing & Clinical Governance reported that the PEN was coming in to undertake observations of care initially and the Trust would also be given the opportunity to self-assess. The patient experience team was noted to be a new cohort of staff and the PEN had been asked to support the development of this team. There would be a workshop planned at the end of October at the Quality & Safety Committee meeting around patient experience. The work would focus on the governance of patient experience so the Board was sighted adequately. It was suggested that the voice of the patient into the Board needed to be strengthened. The outside of hospital processes also needed to be strengthened and also picked up patient outcomes. There was reported to have been a meeting with the consultants on 22 July 2021 and they had recognised the importance of the work undertaken across the system. The workstreams underway had been reviewed. The next meeting would be established shortly. In terms of the work within the Integrated Care System (ICS), there had been a quieter period. There had been a meeting about the development of the Provider Collaborative, which the Chief Executive and Chairman had joined. Kathryn Sallah noted that there was work to support the Afghanistan refugees and suggested that the skills that they were bringing into the area could be used, particularly in terms of filling vacancies. It was noted that this had been discussed, more specifically around the use of interpreting skills. Nursing and Allied Health Professionals (AHPs) had already connected with the national work to access healthcare qualifications held by refugees. The Chairman advised that he had undertaken a number of visits within the Trust. He had also joined the Provider Collaborative work, which was positive. He had attended the ICS transition meeting, at which there had been evident realisation that the work needed to accelerate in readiness for April 2022.	
ACTION: **GM to arrange for the Board to be update on the patient experience work at a future meeting**	
7 Progress with delivery of the five year strategy: *for assurance*	**ROHTB (9/21) 002** **ROHTB (9/21) 002 (a)**
The Deputy Director of Strategy, reported that the Trust's strategy had been developed in 2019 and much had happened since then including the advent of system working. The vision had been set in 2019, this being framed by nine key measures of success.	

A brief overview of the data that sat behind the measures of success was reviewed. The COVID pandemic was noted to have influenced performance in some cases. The staff survey results were noted to be improving and CQC had rated the ROH as 'Good'. The 'Five Ps' were reported to have been translated into the operational work of the Trust such as business planning, capital programs and quality impact assessments. In terms of 'Patients', the completed priorities were reviewed, some of which had been overshadowed by Restoration and Recovery. The list of initiatives was discussed. There were some ongoing transformation schemes and the MusculoSkeletal (MSK) transformation work was a key part of this. Regarding the 'People' element, there was work planned around workforce transformation. The 'Partnerships' work was discussed which included some of the digital projects and programmes. 'Performance' was outlined which picked up the development of services, supported by project management. In terms of gaps, it was suggested that the work needed to better reflect health inequalities and the MSK vision. The mutual aid to the system would be ongoing and this needed to be reflected. There were new schemes planned which needed to be included. The ambition that the Board discussed in October 2020 was noted to include the brand aspirations and some commercial discussions. Chronologically it was highlighted that the strategy was in Year 3, however with the impact of the COVID pandemic, it was suggested that this should be regarded as Year 2. It was suggested that a full strategy refresh should be planned in Spring 2022 to reflect the position with the ICS. Simone Jordan noted that the strategy was a good framework and commented that there had been a seismic shift since it had been developed. She supported the refresh of the strategy but urged that this be undertaken earlier than suggested. The Director of Nursing & Clinical Governance noted that there was some delay with the engagement of frontline staff and suggested that the strategy refresh needed to be sooner to include this. Kathryn Sallah noted that the reflections and gaps were a useful view and these represented the future direction. She suggested that work was needed to address	

the gaps as a priority and this should be the basis of the new strategy. Richard Phillips agreed with this point. The Chief Operating Officer agreed that the 'Five Ps' framework worked well. She urged that the refresh needed to be sooner rather than later, notwithstanding the need for staff to recover from the effect of the pandemic. The Chief Executive suggested that the work achieved needed to be shared with staff. The Chairman suggested that the majority of the work in the strategy remained appropriate. However, the impact of the COVID pandemic, the development of the clinical strategy, the work with the ICS and the new MSK focus all needed to be reflected. It was suggested that the progress needed to be celebrated and reflected back to the organisation as suggested by the Chief Executive. He suggested that strategy should not be reinvented and that it needed to be expressed to reflect the offer to the system. This offer needed to be outlined with great clarity and precision. The Chairman proposed that the first draft should be shared early in the new year, with the timing agreed by the Executive. The Director of Finance & Performance agreed and suggested that the refresh needed to be in the final quarter of the year, by which time the strategy could reflect the financial settlement of the NHS and looking into the final quarter of the year.	
ACTION: PB to present the revised strategy during Quarter 4 2021/22	
8 Charity Strategy update: *for assurance*	**ROHTB (9/21) 003** **ROHTB (9/21) 003 (a)**
The Board was joined by Ali Gray, Charity Manager. She advised that following the Charity strategy that had been signed off in March 2021 a meeting had been held with the Chairman. It had been agreed that a summary needed to be presented as a condensed version, which included some key deliverables for the priorities. Quotes from some of the key stakeholders were noted to be included. There was more work to do internally around making the charity tailored to the various departments of the Trust. The summary was to be used externally. Financial targets for the income streams had been developed, although these remained to be signed off by Trustees. The cover sheet of the report was noted to include the achievements for Quarter 1. Questions and observations were requested. Thanks were given to Ali for her work and for the energy delivered. The Chairman agreed that this was transformed from the position previously. Les Williams noted that the targets	

were ambitious. Ms Gray suggested that the targets were conservative and focused on the income streams under the remit of the Charity and in the coming year, grants and foundations would be of focus. Post 2024, a strategic 20% increase was planned. The use of Major Giving was planned but some sustainable income streams would be of focus for opportunity. The Chairman suggested that there were opportunities around the Commonwealth Games for 2022. Ms Gray was thanked for her work and for the precision by which the strategy had been presented. David Gourevitch echoed this point.	
9 IT & Digitisation plans update: *for assurance*	**ROHTB (9/21) 004** **ROHTB (9/21) 004 (a)**
The presentation on IT & Digitisation delivered by the Director of Finance & Performance was noted to have been presented previously to the Finance & Performance Committee and included the ICS vision and then an update of the ROH projects and schemes. The ICS work was noted to focus on the development of a shared care record, unified communications and telephony. There had been some work undertaken by Deloitte to support the work. The list of schemes undertaken or planned shortly by the ROH were discussed including Officer 365, clinical portal, OrderComms, Prescribing Information and Communication System (PICS), pharmacy Omnicell robot, a patient entertainment solution, JAC pharmacy system and Patient Administration System (PAS) replacement. A business case would be presented around Cloud transition at the October Board meeting. This provided benefits in terms of resilience and cyber security protection. It was also more cost effective. The ROH would be the first Trust in the system to move into the Cloud. In terms of national initiatives, NHSX had published some guidance on success measures on achievements that systems should meet and making sure they were designed for users. The proposals for the funding of the digital transition had also been set out. A unified technology fund had also been created. A digital maturity index had been set which was based on a peer self-assessment. David Gourevitch asked whether there were plans to implement a unified PICS and PACS given that from a clinical perspective there was significant appetite as this would improve efficiency and patient care. The Director of Finance & Performance noted that PICS had been a frustrating scheme deployment. The parts that would be of benefit to the ROH would be maximised however. There	

was joint benefit in adding UHB and ROH on a single platform. PAC would be interoperable supporting image transfer across the system. The Chief Operating Officer noted that PACS was stable and the right option for the ROH would be chosen for the new version. The Chief Executive noted that each organisation was moving at a different pace but there was confidence that the modalities for the ROH were appropriate. Kathryn Sallah noted that there had been a number of issues with system glitches flagged as part of the daily communication bulletins issued and asked what the impact was on clinicians and whether these would be resolved by the implementation of the new systems. The Director of Finance noted that downtime was limited and the system was overall very stable. The Medical Director noted that there were some sequencing plans to make the experience positive. There had not been patient harm evident as a result of any downtime. Simone Jordan commented that it was difficult to see sequencing of the systems and suggested that the systems' influence on quality needed to be clearer. She also suggested that a summary of the costs, timing, risks and a straightforward set of deliverables were needed. It was agreed that this detail would be provided at a different time. Gianjeet Hunjan asked for progress on the Data Protection and Security Toolkit (DPST) action plan. The Director of Finance & Performance advised that this would be considered as part of the Cloud business case.	
ACTION: **SW to arrange for the Cloud business case to be presented to the Trust Board** **ACTION:** **SW to arrange for a high level summary of the IT projects to be presented at a future meeting**	
10 National patient strategy update: *for information*	**Verbal**
The Director of Nursing & Clinical Governance reported that the national patient strategy had been launched in January 2019, however the advancement of this has been delayed due to the COVID pandemic. The strategy was designed to give consistency in terms of how harm was reviewed across the NHS. Some national syllabi were planned around training. This would also pick up the safety culture and its impact on harm and learning. There was an expectation that patients would be identified as patient safety champions who would be used within the fabric of organisations. In terms of the requirements of the Board, this was to agree the appointment of a patient safety specialist and one of the matrons had been identified for this. This	

was an interim role at present and the role description was being developed. An Executive Lead was nominated, this being the Director of Nursing & Clinical Governance. A letter had been received which discussed the need to dedicate time for the Board to understand the patient safety priorities being developed and progressed.	
11 COVID-19 update: *for assurance*	**Presentation**
The Director of Nursing & Clinical Governance delivered an update on the response to the COVID pandemic, including the work pre-operatively in terms of swabbing and isolation. Cancellations linked to COVID were discussed; there had been 10, including patients breaking isolation. The detail of red, amber and green pathways was outlined. There had been an increase investment in housekeeping which mostly supported wards and theatres, this also supported the higher number of terminal cleans during the period. There had been no mortality over the last quarter. There remained good levels of compliance with the use of Personal Protective Equipment (PPE) and a high level of audits undertaken. There had been one staff outbreak in the portering team, which had been handled according to usual processes. Simone Jordan suggested that a presentation from the cleaning team should be organised. She asked if the additional costs and number of staff were understood. The Director of Nursing & Clinical Governance advised that cost was not fully understood at present. In terms of the investment, most part time workers had been offered increased additional hours over this period. Some full time opportunities had also been offered. Work on retention was underway.	
ACTION: GM to arrange for the cleaning team to present their staff story to the Board or a Board Subcommittee	
12 Learning from Deaths quarterly update: *for assurance*	**ROHTB (9/21) 005** **ROHTB (9/21) 005 (a)**
The Medical Director drew attention to the fact that team managing the Learning from Deaths processes had coped well with the spike in activity over the pandemic. As well as all deaths within 30 days, all inpatients were now viewed by the Medical Examiner. There had been no Serious Incidents and the cases were presented in Clinical Audit sessions for dissemination of any lessons learned.	

Gianjeet Hunjan noted that the learning from the cases was important. She suggested that the involvement of families in the process could be considered. It was noted that the bereavement team would present to the Staff Experience & OD Committee at the October 2021 meeting to summarise the challenges on them during the period. The feedback from relatives had been positive to date. In terms of clinical staff, the arrival of the temporary mortuary had impacted on staff, including porters who had showed compassion and humility when dealing with the remains of loved ones.	
13 Quantifying and evidencing excellence, using quality outcome measures: *for assurance*	**ROHTB (9/21) 006** **ROHTB (9/21) 006 (a)**
The Medical Director noted that the Audit Quality Improvement Learning & Analysis (AQILA) panel had been set up for quantifying and evidencing excellence. The information available needed to be shared with a number of audiences, including patients as part for treatment choices, the Quality & Safety Committee and for reflecting back to clinicians. The latter was poorer than desired at present, however the main outcome measures and trajectory for improvement had been defined. The next 12 months would be supported by a Medical Manager to work through a suite of information to satisfy the various audiences. The information would be aligned with the Getting It Right First Time (GIRFT) and Model Hospital information. The Medical Director was thanked for his commitment to exposing what the Board agreed was a valuable set of information. The Chairman asked about the timing of the development of a dashboard. He was advised that this would be c. 12 months. The most meaningful metrics needed to be defined and drawn from a range of internal and external data sources.	
STAFF EXPERIENCE AND HEALTH & WELL BEING	
14 Responsible Officers annual report: *for assurance*	**ROHTB (9/21) 007** **ROHTB (9/21) 007 (a)**
The Medical Director presented the annual Responsible Officers report, which was accepted for assurance. It was reported that the General Medical Council (GMC) had suspended the report last year but there had been good progress with appraisal this year. Audit would be supported by the new Medical Manager and fed into the appraisal process and to strengthening quality. Gianjeet Hunjan asked whether there was a window in which the appraisals needed to be completed. She was advised that there should be four appraisals for an individual within a five-year schedule. These were usually around an	

individual's birthday.	
15 Staff survey action plan update: *for assurance*	**ROHTB (9/21) 008** **ROHTB (9/21) 008 (a)**
The Acting Associate Director of Workforce & OD advised that the staff survey action plan highlighted that there had been good progress. The outline engagement plan was reviewed and it was noted that there had been a loss of traction centrally led but divisions had led the work independently. A 'You Said, We Did' action plan was in place and would be communicated by the time that the current year's staff survey was launched. The Chairman emphasised the need for this work to be completed prior to the launch of next year's survey. It was noted that the work had fed into the business planning work. In terms of the key themes from action plans, these included communication and support from line managers, which would be enhanced by the reintroduction of 'Me as a Manager'. In terms of planning for the current year's staff survey, a new provider would be used: Quality Health. Historically there had been issues with the use of the Electronic Staff Record (ESR) to ensure that individuals were in the correct category however this was being worked through. The quarterly pulse survey had been launched by the national team and this would be launched at the ROH. Simone Jordan supported the excellent work and noted that the Directors would present progress in turn to the Staff Experience & OD Committee. The Chief Executive asked whether there were any system discussions around the planned approach. She was advised that this year would be used by the system to agree a co-ordinated approach.	
GOVERNANCE & COMPLIANCE	
16 Annual reports: *for approval* • **Fire safety** • **Safeguarding** • **Infection Prevention and Control**	**ROHTB (9/21) 009** **ROHTB (9/21) 009 (a)** **ROHTB (9/21) 009 (b)** **ROHTB (9/21) 009 (c)**
The Deputy Director of Strategy presented the Fire Safety annual report, which it was noted had been considered previously by the Quality & Safety Committee. The Board was advised that the fire policy had been refreshed. The report was approved. The Director of Nursing & Clinical Governance reported that in terms of the	

Safeguarding annual report, there had been an increase in demand and variance of Safeguarding matters. There had been an increase in adult referrals linked to the different cohort of patients handled. The size of the team had been increased to support the demand. There had been a Named Doctor for Safeguarding appointed. The Safeguarding Committee was attended by the Clinical Commissioning Group's Lead Nurse and a system Safeguarding medic. There was a Non Executive champion in place who was linked into the Safeguarding Nurse Lead. Training levels were positive throughout the pandemic. Of the Safeguarding priorities, there were 5 out of the 15 that had been partially delivered, one of which was around disparity in IT systems which as discussed previously was being handled at a system level. The legislation that would replace Deprivation of Liberty standards was delayed. Kathryn Sallah noted that the team was dependent on services into which they linked such as Mental Health but the team handled the cases with great sensitivity. The report was approved. Thanks were given to Ashleigh Tullett, Head of Clinical Governance, for the preparation of the Infection Prevention and Control annual report. From a notifiable infection perspective, the Board was advised that there had been three *C. Difficile* infections, these being reflective of the different cohort of patients treated over the past few months. There had been eight outbreaks all of which had been managed appropriately. The hand hygiene audit did not show 100% compliance, which it was noted, suggested an accurate reflection of the position. In terms of 'flu vaccinations, c. 80% had been achieved. The cleaning for credits position showed a positive view of cleanliness. The governance of water safety had improved and the risk on the risk register had been closed. There had been an increase in antibiotic prescribing, however there was good oversight of this and this reflected the change in the activity. The Surgical Site Infection (SSI) processes had rolled into the spinal service and a SSI subgroup had been developed which focussed on prevention rather than a reactive response. Cohort nursing in bays had been used but there had been no outbreaks highlighted. Kathryn Sallah noted that the Director of Infection Prevention and Control (DIPC) role was statutory and she thanked Garry Marsh for his work in this capacity during the pandemic. The Chairman added his thanks. The Board approved the report.	
17 Updated Board Assurance Framework: *for assurance*	**ROHTB (9/21) 010** **ROHTB (9/21) 010 (a)**
The updated version of the Board Assurance Framework (BAF) was presented. The Chief Operating Officer reported that there had been re-escalation of the risk around the theatre estate given the linkage between some theatres, which presented a significant risk of failure if one became dysfunctional. The other risk was re-escalated was noted to be around the achievement of the 92% Referral to	

Treatment Time (RTT) target performance. There were two risks proposed for closure, which were agreed from the strategy portfolio. The proposed changes were approved.	
FINANCIAL AND OPERATIONAL PERFORMANCE	
18 Finance and Performance monthly report: *for assurance*	**ROHTB (9/21) 011**
The Chief Operating Officer reported that there had been a reduction in activity against the plan due to patient choice and staff isolation. There had been a decrease in day cases and increase in the inpatient plan. It was highlighted that there was an expectation that activity would settle in September and the operations teams would be able to fill vacant appointments. Many staff had been taking holidays, which has also affected utilisation, although there was good work to ensure that the use of the assets was maintained by ROH and UHB surgeons. The 6-4-2 process was noted to remain sound, a process echoed by Richard Phillips who had attended the meeting. There was good discussion between peers. Cancellations were reported to be stable and length of stay was also static. UHB was treating less complex patients, which reflected the lower length of stay. In terms of Outpatient efficiency, there had been an increase in 'Did Not Attend' cases and there had been an increase in face-to-face appointments. Outpatient delays continued to be reduced. The Griffin Brook facility had been secured for additional capacity and this would come on line in December 2021. There had been an improved performance against the 18 weeks Referral to Treatment Time (RTT) target. Last month there had been 128 patients waiting over 52 weeks for treatment, although this had now reduced to under 100. The total backlog had decreased. The diagnostic target had not been met, this performance being 81.6%, reflecting the increased demand in Imaging. This would improve from October. The longest wait was eight weeks. Cancer performance against the national standards was good, apart from against the 62-day performance due to complexity of the cases on this pathway. Gianjeet Hunjan asked for details of the private patients work. It was reported that this was above plan and cases were gradually increasing in line with the NHS	

clinical prioritisation. There had been 16 patients treated in August 2021 and 18 booked in September 2021. The Director of Finance & Performance reported that in terms of the financial position, at the end of July there was a £600k deficit. The underlying position element of this was £100-200k, the rest being a correction based on the Elective Recovery Fund (ERF) income, where the threshold was now set at 95% from an initial position of 85%. Elective activity had been pared back and was impacted by patient choice. The ROH had over achieved against the ERF plan, although could not benefit fully from this given that the ERF was based on a system approach. The position had been corrected in the ROH finance plan. It was reported that it was expected that there would be greater pressure in the second half of the year (H2). Kathryn Sallah asked whether there were any other risks from a financial perspective that had the potential to materialise. The Director of Finance & Performance advised that there was fundamental uncertainty around H2. The Chief Executive noted that there was a system meeting between system Chief Finance Officers to close the system deficit. The Finance & Performance Committee would be updated around this at its next meeting. In terms of the Cost Improvement Programme, it was suggested that the actual benefits needed to be validated. Tax relief on managed theatre services was under discussion with HMRC.	
MATTERS TO BE TAKEN BY EXCEPTION ONLY	
19 Assurance reports from the Board Committees: • **Audit** • **Finance & Performance** • **Staff Experience & OD** • **Quality & Safety**	**ROHTB (9/21) 012** **ROHTB (9/21) 013** **ROHTB (9/21) 014** **ROHTB (9/21) 015**
These reports were received and noted.	
20 Performance reports: *for assurance* • **Quality & Safety** • **Workforce**	**ROHTB (9/21) 016** **ROHTB (9/21) 017**
These reports were received and noted.	
CONFIDENTIAL SESSION	

21 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
Date of next meeting: Thursday 7 October 2021 @ 0900h	

PUBLIC SESSION

Next Meeting: 7 October 2021, Lecture Theatre, Knowledge Hub

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 1.10.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT.118	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Resolve the snagging issues with the Junior Doctors common room	PB	30-Sep-21	Verbal update at meeting.	
ROHTBACT.116	Musculo-skeletal (MSK) Transformation Programme update	Presentation	07/07/2021	Schedule in a further update on the MSK transformation work to the agenda of a future meeting	SGL	03-Nov-21	Included on the agenda of the October 2021 meeting.	
ROHTBACT.117	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Present the range of concerns raised by the Junior Doctors at a future meeting	JMc	03-Nov-21	ACTION NOT YET DUE	
ROHTBACT.119	Progress and next steps towards delivering a 'net zero' NHS	ROHTB (7/21) 005 ROHTB (7/21) 005 (a)	07/07/2021	Present the 'net zero' strategy at the January 2022 meeting	PB	12-Jan-22	ACTION NOT YET DUE	
ROHTBACT.120	Chairman's and Chief Executive's update	ROHTB (9/21) 001 ROHTB (9/21) 001 (a)	01/09/2021	Arrange for the Board to be update on the patient experience work at a future meeting	GM	01-Dec-21	ACTION NOT YET DUE	
ROHTBACT.121	Progress with delivery of the five year strategy	ROHTB (9/21) 002 ROHTB (9/21) 002 (a)	01/09/2021	Present the revised strategy during Quarter 4 2021/22	PB	31-Mar-21	ACTION NOT YET DUE	
ROHTBACT.122	IT & Digitisation plans update	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	01/09/2021	Arrange for the Cloud business case to be presented to the Trust Board	SW	07-Oct-21	Included on the agenda of the October 2021 meeting.	

ROHTBACT.123	IT & Digitisation plans update	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	01/09/2021	Arrange for a high level summary of the IT projects to be presented at a future meeting	SW	01-Dec-21	ACTION NOT YET DUE	
ROHTBACT.124	COVID-19 update	Presentation	01/09/2021	Arrange for the cleaning team to present their staff story to the Board or a Board Subcommittee	GM	24-Nov-21	ACTION NOT YET DUE	
ROHTBACT.103	Staff survey 2020 results and action plan	ROHTB (4/21) 007 ROHTB (4/21) 007 (a)	07/04/2021	Present the Staff Survey action plan at the June 2021 meeting	SM	02-Jun-21	Presentation of the full action plan deferred to the September meeting.	
ROHTBACT.107	Learning Lessons to Improve our People Practice	ROHTB (4/21) 010 ROHTB (4/21) 010 (a) - ROHTB (4/21) 010 (d)	07/04/2021	Present the revised disciplinary policy at a future meeting	SM	07-Jul-21	Circulated to the Board with comments now reflected in the updated verison.	
ROHTBACT.109	Annual cycle of business and strategic board work & development plan	ROHTB (4/21) 012 ROHTB (4/21) 012 (a) ROHTB (4/21) 012 (b)	07/04/2021	Present an update on the IT Programmes of work at the July 2021 meeting	SW	07-Jul-21	Deferred to the September 2021 meeting.	
ROHTBACT.110	Strategic workforce plan – the approach to planning, redesign, talent, management and	ROHTB (5/21) 008 ROHTB (5/21) 008 (a)	05/05/2021	Progress Board succession planning	SM/SGL	31-Jul-21	Discussions helds with Trust Chairman on 31 August and a plan constructed.	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (10/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Private Trust Board on 7th October 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 1st September 2021 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 We continue to support our partners across the BSol (Birmingham and Solihull) region with the Trust focusing on our role supporting the system restoration and recovery. System strategic calls continue three times per week. The Chief Operating Officers (COOs) across all providers also continue to meet twice a week to agree the operational changes required to address the system backlog for adults across BSol. We continue to support spinal patients who require surgery after attending at the Emergency Department (ED) of the Queen Elizabeth Hospital.

2.2 On Monday 27th September, alongside Marie Peplow (Chief Operating Officer) and Falon Paris-Cane (Communication and Engagement Manager), the Trust presented to a panel of five judges as part of the shortlisting process for the Health Service Journal's NHS Acute/Specialist Trust of the Year. We shared our three reasons for wanting to win the award. It will be no surprise our statement for winning this accolade was around our people, our patients and our population. We acknowledged the daily commitment with which our teams rise to the challenges without fear, favour and fanfare, however on this occasion we were unapologetic for championing our amazing hospital, team and patients and our passion and commitment to Orthopaedic care. The awards ceremony is in November and we look forward to taking part in the event.

2.3 Following the cancellation of the Staff Awards ceremony on 1st October 21 due to concerns over the ability to hold the event safely in the current climate, we are currently finalising the details of the day for a smaller on site celebration of the awards. I recognise that it is disappointing that we are not able to celebrate together but we will make sure that the event showcases our fabulous nominees and services nevertheless.

2.4 On 30th September the 2021 staff survey was launched with both electronic and paper copies being distributed across the organisation. This year's questionnaire has been updated to align with the NHS People Promise and I hope that colleagues take part and join in to help us to continue to understand what it is really like to work at the ROH so we can continue to improve the experience of working at the Trust - every voice matters.

2.5 Our seasonal flu campaign is due to commence on 8th October 21 with a performance target of 85%, with our COVID booster vaccination programme planned to run throughout November. The team is currently working through the new protocols and procedures as this time we will be administering the Pfizer vaccination.

2.6 October is Black History Month (BHM), which is a national celebration to recognise the contributions of NHS staff from Black backgrounds. I look forward to the events which are planned across the Trust which are opportunities for everyone across the organisation to celebrate the contributions of our colleagues, to educate one another and further develop our inclusive and diverse culture ensuring that it is supportive and welcoming for all working at the ROH.

2.7 The ROH led team, including Mr Andrew Thomas, based in the Department of Chemical Engineering at the University of Birmingham, has been nominated as a finalist in the Life Sciences section of the prestigious HPC Wire high-performance computing awards. HPC wire is a California-based news website that reports on the world of high-performance computing. We were nominated by the team that runs the BlueBear supercomputer at the University of Birmingham. The nomination is in recognition of our work on tracking bacteria carrying particulates expelled from the surgical gowns in ultraclean operating theatres. The work is a combination of experimental measurements carried out in our operating theatres and complex computer simulations to track the distribution of particles in the operating theatre air.

2.8 On Wednesday 29th September the Trust welcomed Her Royal Highness, the Princess Royal, who was met by Dr Abdullah Shehu MBE, Deputy Lieutenant for the West Midlands, the Lord Mayor of Birmingham, Cllr Muhammad Afzal, the Lady Mayoress, Mrs Tazeem Afzal and the High Sheriff of the West Midlands, Mrs Louise Bennett OBE DL, to officially open our new Theatres and Ward 4. The visit included many parts of the Trust and it was lovely to see so many colleagues welcoming our visitors so warmly to the site.

It is hard to fully describe just how proud I am of the entire team - the site looked amazing and everyone that took part in the visit spoke of their pride for the Trust. A huge thank you to everyone who made the site shine on the day whether that was cleaning the site or our fantastic catering team who baked for all the staff. We have had some great feedback from Her Royal Highness and the civic dignitaries about the Trust, the site and our achievements over the last two years. It was an absolute privilege to represent the Trust and memories of the day and the team supporting the visit will fondly stay with me for many years.

3 BSol ICS (Integrated Care System) Update

3.1 The ICS Board meeting was held on 13th September and it was great to see members of the ROH team present the MSK system transformation programme detailing the aims, the work to date and the ambition of the programme. The programme continue to make good progress and the team will be at the October Board to present the programme.

3.2 A second meeting is planned for 5th October 21 for all BSol Provider Chairs and Chief Executives to discuss and agree the potential options for a Provider Collaborative.

3.2 The recruitment process continues for the appointment of the BSol ICS Chief Executive. The national advert closed on 26th September 21 and the appointment process will be concluded at the end of October 21.

4 NHS England/Improvement (NHSE/I) National updates

4.1 Fortnightly briefing calls remain in place with NHS Improvement with the focus being on the vaccination programme and restoration & recovery of elective activity across the Midlands and East region.

4.2 At the time of writing this report the planning guidance has been issued by NHSE/I for the second half of the year (H2). The document will be reviewed and a summary of the guidance will be presented to the Finance & Performance Committee in October 21 with the timelines and work which will now need to be delivered across our system for submission in November 21.

5 POLICY APPROVAL

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

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

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

1 October 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention and Control Board Assurance Framework - Brief**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Chief Nurse**
AUTHOR:	**Ash Tullett, Head of Clinical Governance and Garry Marsh**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

NHS England developed a framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to Trust Boards that organisational compliance has been systematically reviewed.

In September 2021 the full gap analysis was submitted and scrutinised at the Infection Prevention and control Committee

The Gap analysis has been undertaken by the Head of Clinical Governance, Executive Chief Nurse/The Director of Infection Prevention and Control (DIPC) and the IPC Matron against the Infection Prevention and Control Board Assurance framework (version1.6) As part of the Gap analysis each statement was 'RAG' rated by the following criteria. To update the Trust Board, only the open Red and Amber actions are included in this brief.

Compliance	Green
Non-Compliance with mitigation	Amber
Non-Compliance with no mitigation	Red

From the new sections, 2 were deemed as amber;

10i	For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health		For those that fail the fit test an alternative powered hood is available for use. More evidence is needed to see if this is recorded correctly on peoples individual record or risk assessment. A new FFP3 standard has been released and will need to be implemented. Records and training will need to be repeated and refreshed as part of the new standard. On the 17 June 2021 all Trusts received a letter from the Department of Health which outlined FFP3 resilience in the acute setting

			with a number of actions to implement. In summary four main principles need to be delivered and five next steps. Compliance is monitored. The range of FFP3's onsite has now extended to six different models with three of those being UK made. The date of all fit tests is recorded for each member of staff on the department breakdown provided to managers. All staff that have passed on at least two masks will be provided with a training record; which should be given to their Manager and included in the staff members personal file. The compliance figure for staff trained on two masks (new UK standard) is low. The data is currently showing a discrepancy between the centrally held database and the locally held records. Work needs to be undertaken to review this central database to ensure it reflects the true position. It is to be noted that FFP3 masks are not routinely used outside of the Theatre departments amber/red Covid-19 pathways. The Deputy Director of Nursing, FFP3 lead and Head of Nursing are meeting to discuss a plan going forward to ensure the Trust meet the new UK standard for FFP3 masks and staff training. There is a further requirement for the Trust to use ESR to record all fit testing outcome and usage data at an individual level. The Trust is still awaiting guidance from the national team regarding this function on ESR; it is not currently available and it is unclear how the Trust upload this information.	
2n	Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air		ROH have two systems of ventilation operating in admissions/waiting areas throughout the Trust, these being: •Natural ventilation – openable windows are available, in above ground patient areas these windows are restricted to 100mm opening •Mechanical ventilation – we have a number of separate supply and extract air conditioning systems operating in admissions/waiting areas throughout the	

			Trust which supply filtered air. The system is maintained on a regular basis. There is an action in place for the Trust to review its ventilation against the HTM current guidance. This is monitored in the Health and Safety Committee. The trust has been in contact with IOM Consulting Limited about the role of AE Ventilation. The Trust are in the process of appointing IOM Consulting and arranging a date to carry out a ventilation review and provide the Trust with a 'Status report'.

Since the last report to IPCC and the Trust Board – One section has been closed as compliance has been met.

1d	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice Staff adherence to hand hygiene? staff social distancing across the workplace staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting		IPCT audit patient and staff FRSM use in clinical areas. Audit data is fed back to department managers and upwardly reported at Divisional meetings and the Infection Prevention Operational Group (IPOG) meeting bi-monthly during the pandemic. IPCT undertake weekly hand hygiene and PPE assurance audits. Department monitor their own hand hygiene compliance weekly or monthly at present. Clinical areas showed 96% compliance (August 2021) The Trust are now undertaking audits in non-clinical areas with an agreed template. Compliance will be reported to the Trusts IPOG/IPCC meetings/Committee.

Evidence and Assurance

The Head of Clinical Governance with support from the IPC Matron have undertaken a review of the evidence that supports the gap analysis. This has given greater assurance that the Trust meets the Infection prevention and control board assurance framework. This piece of work was undertaken with oversight from the DIPC and will be presented to the IPC committee.

Conclusion

The Trust have a multi professional group that approved the new IPC BAF and a gap analysis against the IPC BAF

The conclusion of the Gap analysis was that the Trust has a clear pathway, processes, and policies in place around infection prevention and control during the Covid-19 Pandemic and that all training detailed within the gap analysis is supported by attendance and/or competency sign off sheets. It is to note that none of the gaps were rag rated 'Red' and just two ambers ref 10i and 2n with the narrative included above.

REPORT RECOMMENDATION:

To note and accept update

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

CQC KLOE/NHS England Assurance Framework

PREVIOUS CONSIDERATION:

IPCC Committee

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**The Care Quality Commission (CQC) action plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Chief Nurse**
AUTHOR:	**Ashleigh Tullett, Head of Clinical Governance**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

This paper sights the Trust Board on the action plan from the Care Quality Commission (CQC) report.

The Care Quality Commission (CQC)

The Care Quality Commission (CQC) last inspected The Royal Orthopaedic Hospital (ROH) in October 2019. Between the 15th and 17th October 2019, the CQC inspected the core services of surgery and critical care at the ROH. The well led review was undertaken on the 12th November 2020. The rating for the ROH remained the same and was rated 'good'.

A report was published on the 20th of December 2019 detailing the findings of the inspection. The inspection team found 28 things that the Trust should improve to comply with minor breaches.

It is to be noted that all of the actions were 'SHOULD' rather than 'MUST' do actions. Action the Trust MUST take is necessary to comply with its legal obligations.

Action the Trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Ongoing Monitoring

The CQC action plan was formed from the concerns raised by the CQC. There are actions within the plan that remain open and in a state of 'ongoing'. These ongoing actions are detailed in the attached report. The closed actions within the action plans also have ongoing monitoring and are reviewed to ensure the improvements are being sustained.

The action plan was reviewed at the Quality and Safety Executive meeting in August 2021.

In addition, the action plan is monitored at the;

- Clinical Quality Group
- HDU management Board
- The Executive Quality and Safety Meeting

CQC action plan exceptions

The Head of Clinical Governance has undertaken a review of the CQC action plan to ensure the actions remained embedded and closed. As a result of this review a number of actions have reopened and further assurance is needed.

The following actions are ongoing or reopened and are mainly centred on:

7 Reopened	***The trust should ensure staff respond to patient call bells promptly. (Regulation 10.2 (b) Dignity and respect)*** October 2020 - The Trust had an audit to measure the response that showed good results. Further Audits have showed further good compliance and no further issues have been raised. This was originally monitored at the outstanding care every time group but going forward an audit plan will need to be created to ensure ongoing assurance. August 2021 - Reopened as further work and assurance is needed. Not currently reported in the Divisional Condition report and no longer monitored. The Matron for Division 1 is preparing an engagement piece of work with staff to further improve the Trust process and provide assurance of staff being responsive to call bells.
8 Reopened	***The trust should ensure wards are adapted to the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3.(b) Person-centred care)*** There is a Trust wide dementia environmental improvements action plan. PLACE assessments are also undertaken. The assessment criteria included in the dementia section of the PLACE assessment are drawn from environmental assessments produced by The King's Fund and Stirling University. Generally, from a dementia point of view the environments scores are good compared to the national average October 2020 - Enhanced observation record sheet revised and Care plan designed for patients under direct and enhanced observation designed. Dementia boxes introduced for patients to aid distraction therapy. August 2021 – Reopened - PLACE assessment with results presented at CQG with a number of actions that remain open on the dementia environmental improvements action plan. The Trust Dementia Strategy was due for review in 2019, it was put on hold for the new dementia lead nurse to come into post, unfortunately there have not been any suitable applicants to date so recruitment is still ongoing. The strategy will be refreshed and the GAP analysis against the WMQRS will be revisited as part of this work. It has been confirmed the 'jog boxes' (dementia boxes) have been introduced to all ward areas. The Matron is currently reviewing whether the organisational objectives of the dementia strategy were delivered and this will be presented at the Clinical Quality Group.

9 Reopened	***The trust should ensure patients are not moved at night. (Regulation 10.2. (a) Dignity and respect)*** October 2020 - Snap shot audits show that this does not occur and the Trust does not have an issue with moves at night. This raises a query with the data provided to the CQC from PAS in the original data request. The paper reviewed at the Senior nurses meeting in December 2020 concluded that from review of the data it appears to be inaccurate and not reflective of the patients journey through the Trust. Data quality appears to be the issue, and we need to move our focus to address the data issue. September 2021 - After review it was agreed this action would reopen. Although we can evidence that patients are not moved at night via the audits undertaken. The data provided from informatics (same data provided to the CQC data request) still shows patients are moved. This is currently monitored at the data quality group with actions in place to rectify. This includes a new monthly report to allow timely review of any issues and a review of the process around discharging and admitting patients on the PAS system.
12	***The trust should provide formal training on breaking bad news.*** Training package/lecture identified. This has been delivered to staff on the Band 6 Development days. Further work is needed to highlight staff groups that would require the training. A meeting is to be arranged with staff on Ward 12 to feedback the learning from the deaths that occurred during Covid pandemic. The lead reviewed what the Trust has in place in relation to End of Life care and an evaluation of the end of life plan already in place. Online eLearning modules regarding Breaking bad news to be scoped to be part of mandatory training for every registered nurse training and other departments such as Medical Secretary and to be implemented on to ESR. the online package to be Piloted with staff that carried out End of Life Care. January 2021 - Breaking bad news training has been added to ESR . All clinical staff should complete e-learning modules on ESR. Modules can be accessed via ESR by searching: 303 Breaking Bad News. Managers/team leaders should identify this training in individual PDR's and record on completion. February 2021 - Training has been communicated to all staff via ROH comms. Compliance reports will need to be generated to demonstrate completion August 2021 - 7 members of staff have completed training. Further work is needed within divisions to ensure the band 6 and 7's have undertaken the training September 2021 - Further to the work undertaken to address the issues raised by the CQC in relation to breaking bad news, the Trust has now made some amendments to the care certificate to further educate staff in the care of end of life patients. An audit of the End of life care was presented at the nurse away day and the Trust Board.

14	***The trust should continue to develop solutions to overcome its fragmented information systems*** The Trust has a ROH digital Roadmap of ongoing projects to improve the information systems used for both staff and patients. A Project committee is established in the Trust to monitor the completion of these projects with a target date of March 2022. These projects include; • MS office 365 • Clinical Portal - Full access to Patient clinical documentation, results and reports and access applications from one portal. • PICS Phase 3 • H.I.E/ShCR - Health Information Exchange allows access to all patient records via the Clinical Portal from other Trusts, Social Care, Primary care across STP • RMS - Referral Management platform for staff to manage all tertiary and ERS referrals digitally from within a portal • Digital PreOp - Full digitisation of the PreOp Process. Patients can complete their preassessment via A Web based portal. Clinicians can view/manage results via a separate portal • RPA - Robotic Process Automation allows resource intense processes to be automated via bots thus saving resource hours. • Attend Anywhere - Continued expansion of Video Consultations to aid Outpatient clinics. Potential to save patient time and travel cost and aid social distancing policies • Clinical Comms - Replace current bleep/pager system with a digitized solution to incorporate workflows and secure messaging, data sharing • Speech Rec - Dragon Medical Workflow Manager. Utilize Speech recognition across the ROH site thus reducing outsourcing. Integrate with other applications to enable data entry via voice. Future plans also include • PAS replacement – New PAS system • Electronic Outcomes – Optims/Intouch • Patient Portal – Patient accessed viewer for Health Records/Appointments etc.	

15	***The trust should maintain the pace of its engagement work and develop an approach to consulting spinal patients*** The Trust has a Patient Experience Engagement Group. The group is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement and experience. The key objective of the Group is to ensure that there is a clear Involvement, Experience and Volunteering Strategy in place across the Trust. The strategy and workplan will help support the engagement work across all speciality and patients of the Trust. This action is monitored via the PEEG group There is a risk (1604)that the patient engagement strategy has not been forwarded, causing regulatory compliance concerns and due to the patient carers forum and patient experience and engagement group not meeting during the COVID 19 pandemic. Mandate from NHSI during the first wave of the Covid-19 Pandemic that NHS trusts should cancel non urgent meetings. Additional pressure of the Pandemic has also caused staffing pressures/issues as staff were unable to be released from clinical areas. Patient experience activities have still continued and the Trust can provide evidence of this. The PEEG meeting is now in place and meet regularly. A Working group has been established in the Trust to roll out the 'joint care - coffee catch up" methodology of engaging with patients. The spinal service is to be piloted first in September 2021 with a plan to further roll this out to each service/speciality. This was delayed due to staff availability. A meeting is arranged to rearrange the pilot.
19 Reopened	***The service should ensure consultant reviews are appropriately recorded to show they have been conducted within 12 hours of patient admission. (Regulation 12. 2 (a) (b) Safe care and treatment).*** Email has been sent to all Consultants regarding the importance of their patient reviews within 12 hours of being admitted onto High Dependency Unit. August 2021 - An Audit will need to be undertaken to ensure compliance - to be raised in HDU MDT meeting in August 2021. This will be added to the Condition report for Division 2 for assurance.

REPORT RECOMMENDATION:

The Board is asked to RECEIVE and NOTE the update on the delivery of actions arising from the CQC reviews.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

CQC compliance

PREVIOUS CONSIDERATION:

Quality & Safety Executive

ROH ACTION PLAN
August/September 2021 - V4

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	MONITORING COMMITTEE	ACTION	FINAL DEADLINE	COMMENTS	RISK REGISTER	ONGOING ASSURANCE
Trust wide										
1	The trust should consider the way in which challenge is documented within minutes to be reflective of the discussions taken place	Additional attributable comments to be added into minutes as the norm to reflect when there is significant challenge.	Jo Williams - Chief Executive Officer (CEO)	Simon Grainger Lloyd - Director of Corporate Affairs & Company Secretary and Data Protection Officer (DPO)	Trust Board	Challenge to be documented within minutes to be reflective of the discussions taken place	Closed	Additional attributable comments to be added into minutes as the norm to reflect when there is significant challenge.		Board and Committee minutes
2	The trust should consider a review of the corporate risk register to include date of entry to the register, frequency of update and a review of the control measures in place.	The refreshed corporate risk register and BAF for 2020/21 will include the dates that risks were added	Jo Williams - Chief Executive Officer (CEO)	Simon Grainger Lloyd - Director of Corporate Affairs & Company Secretary and Data Protection Officer (DPO)	Trust Board	Corporate risk register to include date of entry to the register, frequency of update and a review of the control measures in place.	Closed	To be included in the New BAF		Corporate Risk Register BAF Ulysses status
3	The trust should review the systems in place to manage staff anxieties regarding the future of the trust and potentially losing its identity as an orthopaedic specialist trust.	Positive staff experience and feedback	Jo Williams - Chief Executive Officer (CEO)	Sharon Mahli - Head of HR Operations	Staff and OD Committee	Systems in place to manage staff anxieties regarding the future of the trust	Closed	The Trust has a number of systems in place to support staff. The Trust has regular team briefs to keep staff updated with regards to the operations of the Trust Staff are able to raise concerns/anxieties directly with the CEO The Trust is currently going through a Theatre Expansion programme investing in the organisation as a specialist orthopaedic Trust. August 2021 - The Trust is working collaboratively as part of the Integrated Care System - ICS (Birmingham & Solihull (BSol)). As part of the ICS and its strategic goals the ROH is looking to Refresh and Recover with further investment and expansion in it s services.		Staff Feedback and Staff surveys
4	The trust should ensure all staff complete their safeguarding training. (Regulation 12.2 (c) Safe care and treatment)	All staff trained to Level 2 Safeguarding	Garry Marsh - Executive Director of Nursing and Clinical Governance	Evelyn Okane - Matron for Safeguarding	Safeguarding Committee and Quality & Safety	All staff to receive level 2 training on Mandatory Training	Closed	Level 2 training is delivered on core mandatory training – Presentation clearly indicates this at the beginning of the session for all staff Level 2 is the min level received by all staff updated annually Confirmed -and CQC provided with training presentation.	Yes	ESR data SG upward report to QandS

4a		All staff trained to Level 2 Safeguarding	**Phil Begg - Executive Director of Strategy**	**David Richardson - Head of Education and Training**	**Safeguarding Committee and Quality & Safety**	Certificate of attendance for core mandatory will clearly indicate the Level of SG training.	Closed	Completed - Certificate of attendance for core mandatory changed to reflect February 2021 compliance -substantive staff •Level 2 Children's =98.33% •Level 2 Adults = 98.24% Level 2 as per core mandatory training is being on line due to no face to face training, due to restart ? New Year (L+D dept) to confirm this narrative.	Yes	ESR data SG upward report to QandS
4b		All staff trained to Level 2 Safeguarding	**Phil Begg - Executive Director of Strategy**	**David Richardson - Head of Education and Training**	**Safeguarding Committee and Quality & Safety**	Add a Question to core mandatory training regarding level of training – to monitor staff response each session.	Closed	New Named Nurse for SG has updated Level 2 training package	Yes	ESR data SG upward report to QandS
4c		All staff trained to Level 2 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	Trust wide communication to reinforce to staff the levels of training offered and why and how these are achieved.	Closed	All staff informed as part of core mandatory training. Staff also given booklet which explains training on induction. ROH comms message was sent to all staff Purple news letter for this quarter to have section on training. Ward Managers and Heads of department have had update and requested to provided trajectory for compliance with required training.		ESR data SG upward report to QandS
4d		All staff trained to Level 2 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Division 1 and 2 Heads of Nursing**	**Safeguarding Committee and Quality & Safety**	Ward/Departmental Managers to ensure as part of PDR review that the Level of SG training required and obtained is discussed and recorded as required per job role. Also confirmed on appointment to post as part of local induction and recorded.	Closed	The Learning and Development team had requested via comms team to raise awareness. Evelyn and I have had two meetings with LD regarding this issue in July and August. Currently ESR does not have the facility to record SG refresher training over 3 years (6 hours) which should be evidenced in a PDR. Work will be undertaken on the trust intranet over the next couple of months to add refresher training that staff can access, which will be signposted on ESR and by LD (mitigating the risk). This is not currently audited for compliance.		ESR data SG upward report to QandS
4e		All staff trained to Level 3 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	An on-site Clinical Site Coordinator, trained at level 3, available 24 hours a day, 7 days a week for advice, knowledge and support.	Closed	All Band 6 and 7 Nursing staff trained to level 3 prior to commencing on the Clinical Site Coordinator rota. Forms part of Trust Induction for this staff group. The compliance for training is monitored via ESR.		ESR data SG upward report to QandS
4f		All staff trained to Level 3 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	TNA for Level 3 training increase in staff eligible due to adult intercollegiate document, August 2018 (all registered nurses) Focusing on front door service areas: - •ED •POAC •ROCS •ADCU and HDU Target to have all registered nurses trained to Level 3 by end of March 2020 Agreed with CCG for 19/20 contracting.	Closed	The Level 3 compliance target was met for the target date for 85% •May 2021 compliance Children Level 3- 87.41% and Adults Level 3 – 86.88% •Monthly data report on compliance shared with Lead by L+D dept and outstanding staff identified and targeted •Training data included monthly in SG Trust quality report •Risk on SG risk registered to be closed if agreed at SG meeting July 21- risk no- 1439 •Monthly training sessions available f2f off site venue social distancing requirement being met , max capacity 12 per session •Schedule of training for the year available on training calendar and booked via ESR •Level 3 updated May 2021 new programme in line with national , local changes and skills for health •Trust has supported f2f training and resourcing facility for delivery off site		ESR data SG upward report to QandS
4g		All staff trained to Level 3 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	Additional children only sessions have been scheduled; Total of 7 session Targeting in patient ward registered nurses (Ward 1,2,3,12).	Closed	Staff being released for training as health roster rota already completed – staff being reassigned to attend sessions booked by managers. Staff being released for training. Two sessions Level 3 per month on offer – limited by room availability working with L+D dept		ESR data SG upward report to QandS

4h		All staff trained to Level 3 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	Increase in the training sessions to 2 full days per month for all staff requiring level 3 (Adults and Children).	Closed	This action has been sustained - Trust are now compliant with level 3		ESR data SG upward report to QandS
4i		All staff trained to Level 3 Safeguarding	**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Evelyn Okane - Matron for Safeguarding**	**Safeguarding Committee and Quality & Safety**	Compliance % to be monitored monthly and reported via Trust Safeguarding Quality report, and via workforce reports to divisional meetings, and variances actioned.	Closed	Monitored via safeguarding committee and reported in Quality Report. Mandatory training is reported at a divisional level in the management boards. Agenda, minutes and paper can evidence this.		ESR data SG upward report to QandS
5	The trust should ensure that staff understand its policies on locking medical records and resuscitation trolleys. (Regulation 17.2 (d) Good governance)		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	All wards and departments to have key coded lockable notes trollies to store patient records securely.	Closed	Completed with the delivery of last lockable trolley.		Audits in condition report - Confirmed by Head of Clinical Governance August 2021
5a			**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Reminder regarding secure storage of patient records to be sent out via: • Communication weekly email • Team Brief	Closed	Communication email sent out to all staff. Audits are undertaken in the departments to ensure patient records are stored correctly		Audits in condition report - Confirmed by Head of Clinical Governance August 2021
5b			**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Auditing of notes trollies to be introduced into the Matron daily walkabout, with exception reporting to form part of the Matron monthly Condition report to the Head of Nursing.	Closed	Will need continued monitoring and reinforcement to get compliance. Found that locks become damaged over time, compliance not always therefore linked to deliberate divergence from policy This was originally monitored at the outstanding care every time group but going forward a audit plan has been created to ensure ongoing assurance - this will be included within the condition report		Audits in condition report - Confirmed by Head of Clinical Governance August 2021
6	The trust should ensure staff complete patient records fully including fluid charts and malnutrition universal screening tools. (Regulation17.2 (d) Good governance)		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Staff to complete patient records fully including fluid charts and malnutrition universal screening tools. (Regulation17.2 (d) Good governance)	Closed	October 2020 A review of Patient management for fluid balance monitoring completed and background research completed to ascertain best practice. A tool kit of posters, patient information leaflets and a training package has been designed. Branding of a fluid balance logo for control boards and PICs created to prompt completion. compliance is included within the condition report		Audits in condition report - Confirmed by Head of Clinical Governance August 2021
7	The trust should ensure staff respond to patient call bells promptly. (Regulation 10.2 (b) Dignity and respect)		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Ensure staff respond to patient call bells promptly. (Regulation 10.2 (b) Dignity and respect)	reopened October 2021	The trust should ensure staff respond to patient call bells promptly. (Regulation 10.2 (b) Dignity and respect) October 2020 - The Trust had an audit to measure the response that showed good results. Further Audits have showed further good compliance and no further issues have been raised. This was originally monitored at the outstanding care every time group but going forward an audit plan will need to be created to ensure ongoing assurance. August 2021 - Reopened as further work and assurance is needed. Not currently reported in the Divisional Condition report and no longer monitored. The Matron for Division 1 is preparing an engagement piece of work with staff to further improve the Trust process and provide assurance of staff being responsive to call bells.		Audit

8	The trust should ensure wards are adapted to the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3.(b) Person-centred care)		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Sharon Gardner- Division 2 Matron**	**Clinical Quality Group and Quality & Safety**	Should ensure wards are adapted to the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3.(b) Person-centred care)	reopened October 2021	The trust should ensure wards are adapted to the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3.(b) Person-centred care) There is a Trust wide dementia environmental improvements action plan. PLACE assessments are also undertaken. The assessment criteria included in the dementia section of the PLACE assessment are drawn from environmental assessments produced by The King's Fund and Stirling University. Generally, from a dementia point of view the environments scores are good compared to the national average October 2020 - Enhanced observation record sheet revised and Care plan designed for patients under direct and enhanced observation designed. Dementia boxes introduced for patients to aid distraction therapy. August 2021 – Reopened - PLACE assessment with results presented at CQG with a number of actions that remain open on the dementia environmental improvements action plan. The Trust Dementia Strategy was due for review in 2019, it was put on hold for the new dementia lead nurse to come into post, unfortunately there have not been any suitable applicants to date so recruitment is still ongoing. The strategy will be refreshed and the GAP analysis against the WMQRS will be revisited as part of this work. It has been confirmed the 'jog boxes' (dementia boxes) have been introduced to all ward areas. The Matron is currently reviewing whether the organisational objectives of the dementia strategy were delivered and this will be presented at the Clinical Quality Group.		PLACE assessment with results presented at CQG
9	The trust should ensure patients are not moved at night. (Regulation 10.2. (a) Dignity and respect)		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Ensure patients are not moved at night.	reopened October 2021	The trust should ensure patients are not moved at night. (Regulation 10.2. (a) Dignity and respect) October 2020 - Snap shot audits show that this does not occur and the Trust does not have an issue with moves at night. This raises a query with the data provided to the CQC from PAS in the original data request. The paper reviewed at the Senior nurses meeting in December 2020 concluded that from review of the data it appears to be inaccurate and not reflective of the patients journey through the Trust. Data quality appears to be the issue, and we need to move our focus to address the data issue. September 2021 - After review it was agreed this action would reopen. Although we can evidence that patients are not moved at night via the audits undertaken. The data provided from informatics (same data provided to the CQC data request) still shows patients are moved. This is currently monitored at the data quality group with actions in place to rectify. This includes a new monthly report to allow timely review of any issues and a review of the process around discharging and admitting patients on the PAS system.		paper to Senior Nurses stored on file
10	The trust should remind staff to record cleaning jobs done and action taken on fridge temperature variation.		**Phil Begg - Executive Director of Strategy**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	Remind staff to record cleaning jobs done and action taken on fridge temperature variation.	Closed	Review has been undertaken on the current systems in place in different areas. From this review a new standardised cleaning Rota has been designed and will be reported within the condition report		Audits in condition report - Confirmed by Head of Clinical Governance August 2021
11	The trust should share its surgery safety thermometer performance with patients and visitors.		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	**Clinical Quality Group and Quality & Safety**	No action required	Closed	As of April 2020 the Safety Thermometer is no longer in use. Patient safety information can be found on the Ward Boards in each area. Once the replacement data set is released the Trust will consider promoting it to patients and visitors		No action required

12	The trust should provide formal training on breaking bad news.		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Anita Killingworth - Macmillan Oncology Nurse Consultant & Lead Cancer Nurse**	**Clinical Quality Group and Quality & Safety**	Formal training on breaking bad	reopened October 2021	The trust should provide formal training on breaking bad news. Training package/lecture identified. This has been delivered to staff on the Band 6 Development days. Further work is needed to highlight staff groups that would require the training. A meeting is to be arranged with staff on Ward 12 to feedback the learning from the deaths that occurred during Covid pandemic. The lead reviewed what the Trust has in place in relation to End of Life care and an evaluation of the end of life plan already in place. Online eLearning modules regarding Breaking bad news to be scoped to be part of mandatory training for every registered nurse training and other departments such as Medical Secretary and to be implemented on to ESR. the online package to be Piloted with staff that carried out End of Life Care. January 2021 - Breaking bad news training has been added to ESR . All clinical staff should complete e-learning modules on ESR. Modules can be accessed via ESR by searching: 303 Breaking Bad News. Managers/team leaders should identify this training in individual PDR's and record on completion. February 2021 - Training has been communicated to all staff via ROH comms. Compliance reports will need to be generated to demonstrate completion August 2021 - 7 members of staff have completed training. Further work is needed within divisions to ensure the band 6 and 7's have undertaken the training September 2021 - Further to the work undertaken to address the issues raised by the CQC in relation to breaking bad news, the Trust has now made some amendments to the care certificate to further educate staff in the care of end of life patients. An audit of the End of life care was presented at the nurse away day and the Trust Board.		Attendance register for training
13	The trust should minimise in-clinic wait time for day surgery patients.		**Marie Peplow - Chief Operating Officer**	**Sharon Gardner; Matron ; Clinical Services Manager**	**Clinical Quality Group and Quality & Safety**	An average waiting time per speciality report to be shared via the divisional operational groups on a monthly basis for review and monitoring. Where possible this report should also contain PALs information and results from the pre-operative water hydration audits.	Closed	Reports now available from Informatics. Data is now discussed and reviewed at Joint Operations Meeting with CSMs. This includes the 643 meeting, daily huddle and OPD operations group		Data from Informatic and minutes for the operations meetings
13a			**Marie Peplow - Chief Operating Officer**	**Sharon Gardner; Matron ; Clinical Services Manager**	**Clinical Quality Group and Quality & Safety**	Clinical service managers to review individual speciality booking processes. It would be beneficial for each speciality to provide guidance on best practice for staggering admissions.	Closed	CSMs provided guidance to booking staff.		Trust Guidance
13b			**Marie Peplow - Chief Operating Officer**	**Sharon Gardner; Matron ; Clinical Services Manager**	**Clinical Quality Group and Quality & Safety**	To implement a two-time admission process for patients on diagnostic lists – trials of how this can be achieved are currently being undertaken between ADCU and CT. Work is required to progress.	Reopened 31 December 2021	August 2021 - Due to the Covid 19 pandemic the CT lists have been going through ward 1. Once they are fully reintroduced to ADCU this will need to be monitored September 2021- CT lists are now back onto ADCU and working to a two time admission process previously agreed pre Covid		
13c			**Marie Peplow - Chief Operating Officer**	**Sharon Gardner; Matron ; Clinical Services Manager**	**Clinical Quality Group and Quality & Safety**	Extend the two-time admission process to the injection lists undertaken in ADCU.	Closed	Injection lists are now running through OPD with staggered admission times.		

14	The trust should continue to develop solutions to overcome its fragmented information systems		**Steve WASHBOURNE - Director of Finance**	**Gavin Newman/Mark Bemrose**	IM&T Board	Develop solutions to address the fragmented IT systems.	~~01/09/2021~~ March 2022	The trust should continue to develop solutions to overcome its fragmented information systems The Trust has a ROH digital Roadmap of ongoing projects to improve the information systems used for both staff and patients. A Project committee is established in the Trust to monitor the completion of these projects with a target date of March 2022. These projects include; • MS office 365 • Clinical Portal - Full access to Patient clinical documentation, results and reports and access applications from one portal. • PICS Phase 3 • H.I.E/ShCR - Health Information Exchange allows access to all patient records via the Clinical Portal from other Trusts, Social Care, Primary care across STP • RMS - Referral Management platform for staff to manage all tertiary and ERS referrals digitally from within a portal • Digital PreOp - Full digitisation of the PreOp Process. Patients can complete their preassessment via A Web based portal. Clinicians can view/manage results via a separate portal • RPA - Robotic Process Automation allows resource intense processes to be automated via bots thus saving resource hours. • Attend Anywhere - Continued expansion of Video Consultations to aid Outpatient clinics. Potential to save patient time and travel cost and aid social distancing policies • Clinical Comms - Replace current bleep/pager system with a digitized solution to incorporate workflows and secure messaging, data sharing • Speech Rec - Dragon Medical Workflow Manager. Utilize Speech recognition across the ROH site thus reducing outsourcing. Integrate with other applications to enable data entry via voice. Future plans also include • PAS replacement – New PAS system • Electronic Outcomes – Optims/Intouch • Patient Portal – Patient accessed viewer for Health Records/Appointments etc.		IM&T /Health records Group
15	The trust should maintain the pace of its engagement work and develop an approach to consulting spinal patients		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Alicia Stanton - Project team/Patient Experience team**	IM&T Board		~~01/09/2020~~ Dec 21	The trust should maintain the pace of its engagement work and develop an approach to consulting spinal patients The Trust has a Patient Experience Engagement Group. The group is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement and experience. The key objective of the Group is to ensure that there is a clear Involvement, Experience and Volunteering Strategy in place across the Trust. The strategy and workplan will help support the engagement work across all speciality and patients of the Trust. This action is monitored via the PEEG group There is a risk (1604)that the patient engagement strategy has not been forwarded, causing regulatory compliance concerns and due to the patient carers forum and patient experience and engagement group not meeting during the COVID 19 pandemic. Mandate from NHSI during the first wave of the Covid-19 Pandemic that NHS trusts should cancel non urgent meetings. Additional pressure of the Pandemic has also caused staffing pressures/issues as staff were unable to be released from clinical areas. Patient experience activities have still continued and the Trust can provide evidence of this. The PEEG meeting is now in place and meet regularly. A Working group has been established in the Trust to roll out the 'joint care - coffee catch up" methodology of engaging with patients. The spinal service is to be piloted first in September 2021 with a plan to further roll this out to each service/speciality. This was delayed due to staff availability. A meeting is arranged to rearrange the pilot.		PEEG group and patient feedback (FFT or Patient Survey)
16	The trust should continue to develop its management information to monitor pre-assessment recalls, surgical site infections for spinal or other complex surgery.		**Matt Revell - Executive Medical Director**	**Andrew Young - Spinal Clinical Service Lead/IPC team**	IM&T Board		Closed	The Spinal service has now contributed to the GIRFT data set. There is a Trust wide review of the SSI Data collection being undertaken. There is 2 WTE SSI surveillance workers now in post.		
Critical Care										

17	The service should ensure staff are up-to-date with all mandatory and safeguarding training. (Regulation 12.2 (c) Safe care and treatment).		**Phil Begg - Executive Director of Strategy**	**David Richardson - Head of Education and Training**	HDU Management Board	Monitor monthly compliance via the ESR training records report at the HDU management meeting	Closed	Completed - Recorded in the monthly HDU condition report, which is shared at the HDU MM. As of March 2021 - all staff are trained on level 2 and 3 (100%)		ESR data
18	The service should ensure the flooring in the dirty utility can be cleaned effectively and does not present as a slip and trip hazard. (Regulation 15 (a), (c) Premises and equipment).		**Phil Begg - Executive Director of Strategy**	**Stuart Lovack - Director of Estates**	HDU Management Board	Estates to replace sluice flooring	Closed	The sluice floor is on the risk register. This is monitored in the HDU management meeting. The Trust have currently looking into the laying of a new floor when the work in theatres is being carried out. HDU are liaising with Estates. October 2020- New floor completed on the 17th September Risk register updated and risk closed.	Risk 1374 - now closed	
19	The service should ensure consultant reviews are appropriately recorded to show they have been conducted within 12 hours of patient admission. (Regulation 12. 2 (a) (b) Safe care and treatment).		**Matt Revell - Executive Medical Director**	**Clinical Service Leads**	HDU Management Board	Ensure consultant reviews are appropriately recorded to show they have been conducted within 12 hours of patient admission	reopened to ensure compliance September 2021	The service should ensure consultant reviews are appropriately recorded to show they have been conducted within 12 hours of patient admission. (Regulation 12. 2 (a) (b) Safe care and treatment). Email has been sent to all Consultants regarding the importance of their patient reviews within 12 hours of being admitted onto High Dependency Unit. August 2021 - An Audit will need to be undertaken to ensure compliance - to be raised in HDU MDT meeting in August 2021. This will be added to the Condition report for Division 2 for assurance.		
20	The service should ensure they implement local Safety Standards for Invasive Procedures (LocSSIPs) and assess the need for these against all invasive procedures carried out. (Regulation 12. 2 (a) (b) Safe care and treatment).		**Matt Revell - Executive Medical Director**	**Tony Sutherland - Clinical Service Lead for anaesthetics**	HDU Management Board	Standard Operating Procedure (SOP) – Safe Invasive Procedures on the High Dependency Unit in draft; circulation for comments and ratification via the HDU Management meetings and to Clinical Quality Group.	Closed	SOP reviewed and approved following November 2019 HDU Management Meeting and December 2019 CQG SOP currently on the HDU reference manual on the Trust intranet.		HDU guide
20a			**Matt Revell - Executive Medical Director**	**Simran Minhas - Clinical Service Lead for anaesthetics**	HDU Management Board	Dissemination of approved SOP to clinical teams.	Closed	SOP on the HDU Reference Manual on the Trust intranet.		SOP
21	The service should ensure they conduct regular simulation and emergency drills for the unit to be able to assess what went well and where improvements were needed. (Regulation 17. 2 (a) (b) Good Governance).		**Phil Begg - Executive Director of Strategy**	**Stuart Lovack - Director of Estates**	HDU Management Board	Simulations to be undertaken by the resus officer and the emergency planning team	Closed	Simulations are emergency drills are undertaken by the resus officer and the emergency planning training – these are trust wide and not bespoke to HDU – but HDU staff do attend them. HDU CPF scoping information from the Critical Care Network – planning in progress across division 2. August 2021 = Attendance register First simulation was put on for HDU staff in HDU with great feedback Sim doll has been purchased. Waiting for newly recruited Resus officer to come into post for trust wide simulations to commence.		Attendance register
22	The service should ensure all policies and procedures are up-to-date to accurately reflect the types of patients admitted to the unit. (Regulation 17 (1) Good Governance).	Quality Priority around ensuring that no more that 5% of policies are beyond their review date will address this and work will be undertaken with the clinical area to ensure that the requirement is met	**Jo Williams - Chief Executive Officer (CEO)**	**Simon Grainger Lloyd - Director of Corporate Affairs & Company Secretary and Data Protection Officer (DPO)**	HDU Management Board	Policies and Procedures specific to HDU should be monitored and reviewed via the HDU Management Meeting – to become a standard agenda item.	Closed	List of most up to date policies and procedures was shared at the HDU Management meeting December 2019 and is a regular agenda item within HDU management board. All clinical policies are reviewed at the CQG meeting		Policy update reports Intranet status

23	The service should ensure the design of the unit meets the needs of patients living with dementia. (Regulation 9.1 (a) (b) (c) 3. (b) Person-centred care).		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Sharon Gardner - Division 2 Matron**	HDU Management Board	Action covered in the Dementia environmental action plan	Closed	There is a dementia environmental improvements action plan – which covers trust wide. PLACE assessments are also undertaken. The assessment criteria included in the dementia section of the PLACE assessment are drawn from environmental assessments produced by The King's Fund and Stirling University. Generally, from a dementia point of view the environments scores are good compared to the national average October 2020 - Enhanced observation record sheet revised and Care plan designed for patients under direct and enhanced observation designed. Dementia boxes introduced. August 2021 – Reopened - PLACE assessment with results presented at CQG with a number of actions that remain open on the dementia environmental improvements action plan. The Trust dementia strategy was due for review in 2019, it was put on hold for the new dementia lead nurse to come into post, unfortunately there have not been any suitable applicants to date so recruitment is still ongoing. The strategy will be refreshed and the GAP analysis against the WMQRS will be revisited as part of this work. It has been confirmed the 'jog boxes' (dementia boxes) have been introduced to all ward areas.		PLACE assessments
24	The service should ensure all current risks for the service are recorded on the local risk register. (Regulation 17.2 (b) Good Governance).	All current risks for the service are recorded on the local risk	**Marie Peplow - Chief Operating Officer Jo Williams - Chief Executive Officer (CEO)**	**Divisional Operations teams and Simon Grainger Lloyd - Director of Corporate Affairs & Company Secretary and Data Protection Officer**	HDU Management Board	All current risks for the service are recorded on the local risk register	Closed	Risk team provide the templates and risk management framework, it is up to the clinical area to identify the risk that relate to them. Probably needs to be the divisional governance lead or area manager. The risk Registers are standing agenda at both Governance and Divisional Meetings. HDU has a current risk register, unaware of any missing risks. This is reviewed in the HDU management meeting		Risk Policy and Risk Registers
25	The service should consider displaying the results of the safety thermometer, so they are visible to patients and visitors.		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Lisa Newton - Division 1 Matron**	HDU Management Board	Display the safety thermometer on the HDU information board.	Closed	As of April 2020 the Safety Thermometer is no longer in use. Patient safety information can be found on the Ward Boards in each area. Once the replacement data set is released the Trust will consider promoting it to patients and visitors		NA
25	The service should consider providing access to a speech and language therapist during weekends.		**Garry Marsh - Executive Director of Nursing and Clinical Governance**	**Karen Hughes - Head of Nursing Division 1**	**Clinical Quality Group and Quality & Safety**	No action required	Closed	ROH SLT service is provided via SLA from QE Hospital Birmingham. QE themselves do not have a 24/7 service with no cover evenings, nights or weekends. Therefore this is not something that is available. ROH SLA proves 2 days on site SLT and access to the service at QE for advice within their working hours. We have Dietetic SLA which covers 3 days on site which again provides access to advice and urgent support from QE within their working hours. We have approved policies and guidelines regarding management of dysphagia, enteral feeding and starter enteral feeding regimes if required. These would enable safe management of a patient outside of working hours. August 2021 - it is confirmed the narrative is still correct. Urgent advice out of hours would be available via the QE GI team on call if necessary. The bleep holder can support staff out of hours in making contact with UHB. For further assurance the ROH has requested data from UHB to see how many times per year the service is used. It is anticipated that the number is very low		
27	The service should consider clearly displaying in the unit that information and leaflets are available in other languages.		**Marie Peplow - Chief Operating Officer**	**Matt Payne - Clinical Service Manager – Patient Access, Performance and Outpatients Department**	**HDU Management Board**	Posters to be displayed – Comms to support.	Closed	The Trust has the Accessible Information Standard and aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. The Standard looks to make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in accessible formats and that people should get support from a communication professional if they need it. The Trust has an ongoing group that reports compliance into the patient experience group of the Trust. leaflets and information are available in different languages		

ROHTB (10/21) 004

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2021 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Prof Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Mr Stuart Lovack, Associate Director of Estates & Facilities**
DATE OF MEETING:	**7 October 2021**

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 2021 NHS Core Standards profile.

The review process has identified 3 areas of partial compliance against the 2021 EPRR Core Standards and 1 area of partial compliance against the Medical Gas Deep Dive.

The 3 areas of partial compliance against the 2021 EPRR core standards are:

- Duty To Maintain Plans – Mass Casualty - Patient Identification
- Business Continuity – Data Protection & Security Toolkit
- CBRN – HAZMAT/CBRN Risk Assessment

In relation to the 'Medical Gas Deep Dive' the area of partial compliance is:

- Risk Assessment review against sections 6.134 & 6.6 of HTM 02-01

The Trust through the self-assessment process has been graded as 'Partially Compliant'.

An 'action plan' forms part of the EPRR Core Standards spreadsheet for the area identified as partially compliant.

The overall timescale identified for completion of these areas is six months; a project lead has been nominated.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which has been assessed against the 2021 NHS Core Standards, noting in particular the actions being taken to address the areas where compliance needs to be strengthened.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*: The receiving body is asked to receive, consider and:		
Note and accept	**Approve the recommendation**	**Discuss**
x		

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental	**x**	Communications & Media	**x**
Business and market share		Legal & Policy	**x**	Patient Experience	
Clinical		Equality and Diversity		Workforce	**x**
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Safe, efficient processes that are patient centred. 'Process' element of Trust strategy.

PREVIOUS CONSIDERATION:
Annual consideration by the Trust Board

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England and NHS Improvement Region	NHS England and NHS Improvement National	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance																							
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	The organisation has appointed an Accountable Emergency Officer (AEO - Professor Philip Begg) responsible for Emergency Preparedness Resilience and Response (EPRR) The individual is a Board Director and has appropriate authority, resources and budget to direct the EPRR portfolio. The Trust has appointed an Emergency Planning Lead (Stuart Lovack). The role is further supported by an Emergency Planning Officer (Emma Leregan-Edwards). The Trust has a Non-Executive Director identified to support this role.		Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	The Trust has an EPRR Strategy, Memorandum of Understanding for Mutual Aid agreed with neighbouring local Trusts. Trust is part of the LHRF and LHRP. Work plans and 'Best Practice Assessments' are in place, current up-to-date documentation has been received. An Emergency Planning budget has been established for the organisation. Emergency Planning support has been identified and agreed. Organisation committed to supporting EPRR process.		Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	The 2021 Core Standards for the ROH will be reported to the Trust Board on Wednesday 6th October 2021.		Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning aspects embedded in the Trust. Annual work plan developed and monitored, work plan covers annual exercising , communication cascade, Business Continuity and risk management. Regular attendance at the LHRP and LHRF in normal circumstances. Additional reporting implemented during COVID Pandemic.		Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Continuous improvement forms part of our Emergenct Planning policies/philosophies. Training programmes are cascaded to our staff in the form of Decision Logging, The Context & Personal Awareness of EBRR, The Role of the ICT & PCT Staff, Tabletop Exercise with Rework		Fully compliant				
Domain 2 - Duty to risk assess																							
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Risk Register developed for the Trust, risks are reviewed on a regular basis, any significant risks are escalated to the Corporate Risk Register.		Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR risks are considered in the organisation\'s risk management policy. Reference to EPRR risk management is in the organisation's EPRR policy document.		Fully compliant				
Domain 3 - Duty to maintain plans																							
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust has processes and procedures in place to manage 'Critical Incidents'. Incident Response Plan up-to-date.		Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust has processes and procedures in place to manage 'Major Incidents'. Incident Response Plan up-to-date.		Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Trust Heatwave Plan and Heatwave Plan for England is available on the Emergency Planning Portal on the Trust's Intranet site. Heatwave checklist available and guidance on medications likely to provoke or increase the severity of heatstroke. Met office reports received during hot weather period.		Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Cold Weather Plan for England available on the Emergency Planning Portal on the Trust's Intranet site. Met Office reports received during cold weather period.		Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Trust is part of the LHRP and LHRF, the Trust has fostered good relationships with other local Trusts and EPRR locality Leads. Specialist Elective Orthopaedic Trust has the ability to flex clinical services to meet the demands of 'Mass Casualty' for the treatment of Orthopaedic Patients.		Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y												A patient identification system exists on the Trust however this needs reviewing to ensure it is robust and will cover mass casualty situations.		Partially compliant	Patient Identification System to be revelwed.	Emergency Planning Lead/Officer	Three months	
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Hospital Evacuation and Shelter Plan in place. Part of resilience network for the West Midlands.		Fully compliant				
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Y	Y	Y			Y					Y	Y	Hospital has an established 'Lockdown' procedure in place, portering and security staff are available 24/7.		Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	Plans are in place to cater for high profile individuals, clinical areas have been identified on site for the treatment of high profile individuals/VIP's.		Fully compliant				
Domain 4 - Command and control																							
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Processes described in the Trust's Emergency Preparedness Resilience and Recovery Strategy document. Escalation process detailed in 'Bleep Holder Pack'. EPRR and Executive Director's On-call arrangements in place 24/7.		Fully compliant				
Domain 5 - Training and exercising																							
Domain 6 - Response																							
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has a 'Primary Incident Co-ordination Centre' and a 'Secondary Incident Co-ordination Centre' located in two different areas of the site.		Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Documentation covers 'Business Continuity' arrangements. Business Continuity Plan up-to-date and available to staff. Local 'Business Impact Assessments' undertaken and local BC plans developed.A central repository has been established for all the BC Plans. Focussed work is		Fully compliant				

34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Trust process in place for the submission, escalation and sign-off of SitReps. Incident Management Team Meeting structure in place.		Fully compliant					
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y													Not applicable to Specialist Trust.							
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y													Not applicable to Specialist Trust.							
Domain 7 - Warning and informing																								
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has an active Media Policy which covers aspects of communication. The Trust has three social media accounts. (Twitter, YouTube and Facebook) The communication strategy is linked to the Trust's 'Major Incident Plan'. The Trust maintains active channels of communication with local groups/organisations.		Fully compliant					
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The 'Media Policy' also deals with wider communication. The Trust has a number of communication modes to ensure staff, patients, visitors and the wider public are warned and informed.		Fully compliant					
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust's 'Media Policy' also covers its communication strategy and intervention/links with the general public/media.		Fully compliant					
Domain 8 - Cooperation																								
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	A regional Mutual Aid Handbook has ben developed amongst partner organisations and has recently been updated.		Fully compliant					
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y				Y	Not applicable to Specialist Trust.							
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					Not applicable to Specialist Trust.							
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Memorandum of Understanding document has been signed by the Trust. Open protocol arrangements with Emergency Planning organisations are in place.		Fully compliant					
Domain 9 - Business Continuity																								
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity Management Policy active and in place. Policy statement included.		Fully compliant					
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity Management Policy incorporates scope and objectives, policy details a risk management approach. The information is disseminated throughout the organisation.		Fully compliant					
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The IT Department are working towards achieving full compliance, action plan developed and being monitored by Head of IT.		Partially compliant	Head of IT and Governance Manager to work towards full compliance.	Head of IT	Six months		
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The departments in the Trust have Business Continuity Plans in place, these plans are being actively reviewed. A central repository has been established for all the BC Plans. Focussed work is underway on the local testing of the BC Plans.		Fully compliant					
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Business Continuity process is audited and outcomes are recorded.		Fully compliant					
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity systems are reviewed Bi-annually, lessons learnt are incorporated to foster a system of continuous improvement.		Fully compliant					
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	Y	Y	Y	Y	Y	Y	n	Y	Y	Y	Y	Y	Assurance is provided via the Procurement Department for key suppliers to have Business Continuity systems in place. Specifications/documnetation includes for Business Continuity Plans to be in place via framework agreements.		Fully compliant					
Domain 10: CBRN																								
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements, information contained in CBRN Plan.		Fully compliant					
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							The Trust has a Chemical, Biological, Radiological and Nuclear (CBRN) Plan which incorporates external agency contact numbers, how to deal with potentially contaminated casualties including 'Action cards'.		Fully compliant					
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							A risk assessment needs to be completed for the potential issues of a CBRN Incident.		Partially compliant	Risk assessment to be completed.	Emergency Planning Lead/Officer	Three months		
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													Not applicable to Specialist Trust.							
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							As a Specialist Trust we do not have an Emergency Department however we have appropriate 'Personal Protective Equipment' (PPE) to ensure safe delivery of care to potentially contaminated persons. We have CBRN Plan and the Public Health England documentation 'Chemical, biological, radiological and nuclear incindets: clinical management and health protection' available in our emergency planning documentation.		Fully compliant					
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks.	Y													Not applicable to Specialist Trust.							
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													Not applicable to Specialist Trust.							

64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y													Not applicable to Specialist Trust.		
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y													Not applicable to Specialist Trust.		
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y													Not applicable to Specialist Trust.		
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							The Trust have approved documents in place for the protection of staff and the control of contaminated patients. Documents include RCH Covid-19 Infection Prevention and Control Guidance, Loose Fitting Hood Policy, etc.	Fully compliant	
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y							Key staff have been trainined in the use of FFP3 masks and related PPE equipment. A document has been produced instructing staff on the requirements for Infection Prevention and Control.	Fully compliant	

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y	N/a					
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y	N/a					
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	N/A					
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y	N/a					
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y	N/a					
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans	Y	N/a					
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y	N/a					
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y	N/a					
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y	N/a					
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	N/a					
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	N/a					
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y	N/a					

Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y	N/a					
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y	N/a					
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y	N/a					
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y	N/a					
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y	N/a					
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	N/a					
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	N/a					
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y	N/a					
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y	N/a					
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y	N/a					
Domain: Response time standards										
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y	N/a					
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y	N/a					
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y	N/a					
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y	N/a					
Domain: Logistics										
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y	N/a					
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	N/a					

H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y	N/a					
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y	N/a					
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y	N/a					
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	N/a					
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y	N/a					
MTFA **Domain: Capability**										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y	N/a					
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y	N/a					
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y	N/a					
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	N/a					
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y	N/a					
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y	N/a					
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y	N/a					
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans	Y	N/a					
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y	N/a					
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y	N/a					
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y	N/a					
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	N/A					

M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	N/a						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y	N/a						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y	N/a						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y	N/a						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y	N/a						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	N/a						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	N/a						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y	N/a						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y	N/a						
Domain: Response time standards											
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y	N/a						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y	N/a						
Domain: Logistics											
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y	N/a						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y	N/a						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y	N/a						
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y	N/a						
M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment)	Y	N/a						
CBRN Domain: Capability											

B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y	N/a					
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y	N/a					
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y	N/a					
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y	N/a					
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y	N/a					
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y	N/a					
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y	N/a					
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y	N/a					
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y	N/a					
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y	N/a					
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y	N/a					
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y	N/a					
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y	N/a					
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y	N/a					
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y	N/a					
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y	N/a					
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y	N/a					
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y	N/a					
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y	N/a					
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y	N/a					

B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y	N/a					
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y	N/a					
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y	N/a					
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y	N/a					
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	N/A					
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y	N/A					
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y	N/a					
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y	N/a					
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	N/a					
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y	N/a					
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y	N/a					
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y	N/a					
Mass Casualty Vehicles **Domain: Administration**										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y	N/a					
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y	N/a					
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y	N/a					
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y	N/a					
Domain: NHS England Mass Casualties Concept of Operations										
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* .	Y	N/a					
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y	N/a					
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y	N/a					
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y	N/a					

V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y	N/a					
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y	N/a					
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y	N/a					
Command and control **Domain: General**										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y	N/a					
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y	N/a					
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y	N/a					
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y	N/a					
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y	N/a					
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y	N/a					
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	N/a					
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y	N/a					
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y	N/a					
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y	N/a					
Domain: Decision making										

C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y	N/a					
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y	N/a					
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y	N/a					
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y	N/a					
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y	N/a					
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y	N/a					
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y	N/a					
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	N/a					
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y	N/a					
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	N/a					
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	N/a					
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	N/a					
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	N/a					
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y	N/a					

C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y	N/a						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y	N/a						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y	N/a						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y	N/a						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y	N/a						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y	N/a						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	N/a						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y	N/a						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y	N/a						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y	N/a						
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y	N/a						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y	N/a						

Domain: Embedding doctrine										
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y	N/a					
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y	N/a					
J3	**JESIP**	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y	N/a					
J4	**JESIP**	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y	N/a					
J5	**JESIP**	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y	N/a					
J6	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y	N/a					
J7	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y	N/a					
Domain: Training										
J8	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y	N/a					
J9	**JESIP**	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y	N/a					
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y	N/a					
J11	**JESIP**	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y	N/a					
J12	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y	N/a					
J13	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y	N/a					
J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y	N/a					
J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y	N/a					
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y	N/a					
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y	N/a					
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y	N/a					
Domain: Assurance										
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y	N/a					

J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y	N/a					
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y	N/a					
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y	N/a					
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y	N/a					

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**													
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable	Medical Gas Group in place, Bi-monthly meetings scheduled, TOR's in place, escalation process in place reporting to 'Drugs & Therapuetic Committee', Authorised Person is a momber of the group, AE reports received.	Fully compliant				
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable	Meidcal Gas Schematic drawings available, Permit To Work on medical gas systems in place, lockdown procedures in place, SOP in place for cylinder management, training in place for key staff.	Fully compliant				
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable	Medical Gas Policy in place, Service Contract in place for maintenance of medical gas systems, call-out service in place, site covered by two VIE's with BOC linked telemetry.	Fully compliant				
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable	Authorised Person(AP) in place for Medical Gases, secondary person currently being trained, AE in place for site.	Fully compliant				
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable	Medical Gas Policy in place, SOP in place for cylinder management and distribution.	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable	Annual report produced by our external Authorising Engineer.	Fully compliant				
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable	Risk Assessment to be reviewed in accordance with section 6.6 and 6.134 of HTM 02-01.	Partially compliant	Risk assessment to be reviewed.	Estates Manager / Officer	Three months	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 28 September 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was reported to have been a dip in activity during August, this being reflective of a combination of staff holiday and the rotas for the University Hospital Birmingham NHSFT (UHB) pathways settling. There was anticipation that the situation would recover in September. • There was reported to have been a deterioration in theatre utilisation, given some short notice cancellations due to patients and staff testing positive for COVID-19 and some patients not adhering to the pre-operative self-isolation requirements. • There was reported to be a higher number of patients presenting who were not fit for surgery due to comorbidities that had developed during the past few months. There was also an overall higher level of acuity of patients being treated leading to more complex cases being handled. • Length of stay had increased due to patient complexity and also due to the differences in the cohort of patients being treated on the UHB pathway. • There had been a reduction in the number of virtual outpatient appointments being delivered, this being now below the national target. Much work was underway with the consultant body to encourage them to use the virtual platform when clinically appropriate to do so. • The diagnostics performance target had not been met due to the delay in commissioning the second MRI scanner and non-availability of the mobile facilities. • The Trust's financial position was c. £1m below the original plan, with the key reason being the inability to fully recognise the Elective Recovery Fund that had initially been assumed. There had also been	• The theatre productivity review by NHS Improvement was reported to be ongoing and the report from this would be presented in November 2021. • Length of Stay to be presented by speciality in the future. • A detailed overview of the Cost Improvement Programme and risks to the delivery of the schemes to be prepared.

an increase in expenditure due to higher agency costs and the higher levels of activity handled. • Performance against a range of Key Performance Indicators and targets at a system level was reported to be very poor. The system was reported to be unable to achieve the Elective Recovery Fund threshold, this being driven by underperformance of some of the key system partners.	
POSITIVE ASSURANCES TO PROVIDE • The Outpatient 'Did Not Attend' rate remained stable and work was underway with a third party to review the efficiency of Outpatient processes. • Clinic waiting times had improved and further work was planned to reduce any delays caused by the interface with Imaging. • The performance against the 18 weeks Referral to Treatment Time target had improved and there was a reduction in the number of patients waiting in excess of 52 weeks for treatment to 85. • There was reported to have been an improvement in the levels of referrals being seen. • In excess of £600k of Cost Improvement savings had been recognised at the end of August 2021. The key risks with achievement of some schemes were discussed. • Cash position remained strong. • Good progress with the delivery of some of the initiatives in the Perfecting pathways Programme was highlighted. • The Committee received a detailed overview of the plans to move the Trust's IT and digital infrastructure onto a Cloud-based platform. The key benefits related to improved resilience and cyber security. The move would also reduce the Trust's carbon footprint. The Trust would be one of the early adopters of this approach.	**DECISIONS MADE** • The Committee agreed that the revised terms of reference should be presented to the Trust Board at the next meeting. • The Cloud business case to be presented to the next Trust Board meeting.
Chair's comments on the effectiveness of the meeting: The meeting had run to time and had focussed on the items requiring most important discussion.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Committee terms of reference**
SPONSOR:	**Richard Phillips, Finance & Performance Committee chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

The attached present some proposed changes to the terms of reference for the Finance & Performance Committee, these being:

- To reflect the Committee's role in reviewing the system wide financial plan and assessing its contribution to that
- To reflect that the IT project work is included in the wider Perfecting Pathways Programme
- Change in the Chairmanship of the Committee from the Vice Chair to a Non Executive Director
- To reflect that the work of the Estates Strategy & Delivery Group is now encompassed within the Perfecting Pathways Programme

REPORT RECOMMENDATION:

The Trust Board is asked to :

- Approve the proposed amendments to the terms of reference

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Provides oversight and assurance to the Board on financial performance and performance against key national & local targets.

PREVIOUS CONSIDERATION:

Finance & Performance Committee on 28 September 2021.

ROHTB (10/21) 005 (b)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee will operate independently of the Trust's Audit and such other Committees that the Board creates, but will work to avoid duplicating discussion of issues.

3 PURPOSE

3.1 The Committee, within the framework of the Trust's strategy and annual corporate and financial plans, shall undertake detailed oversight and scrutiny of the Trust's financial and activity performance, including contractual performance and performance against key national performance targets to provide assurance to the Board on its financial stewardship, the robustness of its financial forecasts and on its regulatory returns.

3.2 The Committee shall also take responsibility on behalf of the Board, for oversight of the Trust's project management and Information Governance frameworks.

Deleted: Technology (including Information

Deleted:)

3.2 The Committee shall have oversight of the delivery of the Trust's estates strategy.

4 MEMBERSHIP

4.1 The Committee will comprise of three Non-Executive Directors, the Chief Executive, the Executive Director of Finance & Performance, the Executive Director of Strategy & Delivery and the Chief Operating Officer.

4.2 A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.3 The Chair of the Committee will be the a Non Executive Director and if the Chair is absent from the meeting then another Non-Executive Director shall preside.

Deleted: Vice Chairman

5 ATTENDANCE

5.1 Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chair of the Committee.

5.2 Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.3 The Director of Corporate Affairs & Company Secretary shall be secretary to the Committee and will provide administrative support and advice. The duties of the Director of Corporate Affairs & Company Secretary in this regard are:

Deleted:

Deleted: .

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly, with the exception of August and December.

7 DUTIES

The Committee shall, on behalf of the Board, monitor and where appropriate review in greater detail the information within the Finance & Performance Overview and on any other information which it requires on finance and activity, financial forecasts and regulatory returns in order to:

7.1 Assess progress on the Trust's financial position and commissioned activity to provide assurance to the Board.

7.2 Monitor progress with performance against key national performance metrics, such as Referral to Treatment Time and cancer waiting time targets

7.3 Keep the Board informed on the robustness of plans and proposals which focus on improvement or recovery to address material deviation from the long term delivery plan or areas where poor performance against national or local targets are identified.

7.4 Assess the level of any key financial and performance risks to the Trust and to assess that the mitigating actions to manage these risks are sufficient to inform the Board appropriately.

7.5 Benchmark Trust performance through trend analysis and comparative data in order to highlight any specific concerns to the Board.

7.6 Scrutinise in greater detail the proposed annual budgets for revenue and capital and to recommend their adoption by the Board.

7.7 Monitor the development and delivery of the Cost Improvement Programme and recommend to the Board any concerns or opportunities for improved efficiencies or cost savings.

7.8 Look at detailed forecasts on the Trust's short and medium term financial position and financial plans to feed into the Board's implementation of its Strategy.

7.9 Review the Integrated Care System's financial and operational position, discussing contribution that the Trust may make to any improvement plans set.

Deleted: progress with the development of the Trust's Strategic Outline Case

7.10 Ensure the Board is drawing upon suitable sources of information which are timely, reliable and comprehensive in relation to finance and performance.

7.11 Oversee the submission of returns to NHS Improvement after these have been discussed and agreed at the Board taking into account the Board timetable and any other responsibilities.

7.12 To seek assurance on any additional matter referred to the Committee from the Board

7.13 Keep oversight of key financial and operational risks on behalf of the Board, seeking assurance on adequacy of mitigating actions where needed.

7.14 Review the framework for the management of Trustwide projects and programmes and receive detailed reports on the benefits realisation from initiatives according to the timetable of delivery and implementation.

7.15 Receive upward assurance reports from the Information Governance Group, seeking assurance on behalf of the Board that there is compliance with connected legislation and regulatory requirements.

7.16 Review progress with the delivery of the Trust's estates strategy.

Deleted: , through a routine upward assurance report from the Estates Strategy & Delivery Group

8 REPORTING

8.1 The minutes of all meetings of the Committee shall be recorded and submitted, together with recommendations where appropriate, to the Board at its private session. A summary of the key matters discussed, including any action commissioned will be presented by the Chair of the Committee in public.

8.2 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate Trust Board meeting for information.

8.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8.4 The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

9 REVIEW

9.1 The terms of reference of the Committee shall be reviewed by the Board annually.

Date of adoption: October 2021

Deleted: November 2019

Date of review: October 2022

Deleted: November 2020

ROHTB (10/21) 006

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 29 September 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Length of Stay was reported to have increased, this being reflective of the higher complexity of patients that were being treated at the Trust. It was reported that the Head of Nursing undertook a review of all patients with long lengths of stay to ensure that they were appropriate. • The diagnostic target had not been met due to some temporary capacity issues while the second MRI scanner was commissioned and the higher level of referrals seen at present. • The update from the Research and Development Committee noted that there were some gaps in key position within the department at present, although there was confidence in the plans in place to fill these. • Mandatory training compliance remained below the desired position but there was confidence that over the next few months the position would be addressed. Face to face training had recommenced. • The Safe Staffing update reported some challenges with staffing on Ward 1, however targeted support was being provided to the team as they adjusted to the new pathway for which they were responsible.	• It was agreed that some metrics and associated performance around readmissions would be included in the Quality Report in future. • Provide an update to highlight how the lessons learned from the Safeguarding incident have been embedded at the next meeting. • Prepare an update on the extent to which Trust consultants were undertaking private practice and the methods by which this information was reported. • Prepare a briefing of the Cost Improvement Programme schemes and processes that would be jointly suitable for the Quality & Safety Committee and the Finance & Performance Committee. • The plan for the nursing workforce to be brought back to a future meeting. • Work was planned to analyse the new national guidance issued around pre-operative isolation and COVID precautions in healthcare settings. The Trust's position would be clarified at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on performance against the Service Level Agreement for the Pathology service was provided, which highlighted improvements in terms of discussions and plans to achieve a higher degree of compliance with the Key Performance Indicators. There was work locally and nationally underway. There was noted to be no impact identified on patient harm as a result of the current position. • Although there had been an in hospital death, the feedback from the Coroner and Medical Examiner identified good quality of care of the	• The Committee supported the changes to its terms of reference and agreed that they should be presented to the Trust Board for approval.

patient at the Trust. The patient's family was also praiseworthy of the care the individual had received. • The requirements of the Friends and Family Test (FFT) data collection had been met, this being the first time for a number of months. • There had been a reduction in the number of patients waiting in excess of 52 weeks for treatment, this being contrary to the local and national position. • A positive assurance paper was presented concerning the harm review process, which remained sound and relevant cases were reviewed through the Cancer Board. • An update on the open claims position was presented. It was noted that there had been eight new claims registered and nine closed since the last update. The higher number was reported to be associated with increased legal activity as the country emerged from the pandemic. All cases closed were settled at or below the predicted level. • An assurance report was presented by the Head of Imaging. It was noted that the level of incidents reported was less than that of other similar sized trusts when benchmarked. • There was reported to be good progress with the delivery of the priorities set out for the current year in the Quality Account 2020/21. • The joint work with the Robert Jones & Agnes Hunt NHSFT was reported to be progressing well. • There were noted to be some promising and significant opportunities for Research in Development identified for the next few months. • It was reported that a new designated individual to oversee compliance with the requirements of the Human Tissue Authority had been recruited and was creating a very positive impact. No compliance issues were highlighted. • The safe staffing papers presented a positive overview of the Care Hours delivered, particularly in comparison to other organisations locally and nationally. There was some good benchmarking through the Model Hospital Club. To alleviate reliance on temporary staffing	

the work underway to secure international resources and apprentices would help and there was also work across the system.	

Chair's comments on the effectiveness of the meeting: Members agreed that the discussions had been balanced and there was sufficient time on the agenda for the number if items included.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Proposed revisions to the terms of reference of the Quality & Safety Committee**
SPONSOR:	**Kathryn Sallah, Chair of the Quality & Safety Committee & Non Executive Director**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Quality & Safety Committee in line with the requirement for them to be reviewed annually.

The changes proposed are predominately minor in nature, reflecting:

- The revised title of the Director of Nursing & Clinical Governance to Chief Nurse
- Additional responsibility of the Committee to review the governance arrangements for jointly delivered services
- Revised set of groups to report up to the Committee in line with the Committee's workplan
- Revised set of annual reports to be considered by the Committee according to its workplan

REPORT RECOMMENDATION:

The Board is asked to consider and approve the proposed revisions to the terms of reference.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

None specifically

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 29 September 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of Reference

1 Constitution

The Constitution of the Trust provides that the committees and sub-committees established by the Board of Directors are:

(i) Nominations & Remuneration Committee;
(ii) Quality & Safety Committee; and
(iii) Audit Committee
(iv) Staff Experience & OD Committee
(v) Finance & Performance Committee

The Constitution states that "Quality & Safety Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

2 Delegated Authority

The Committee has the following delegated authority:

2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;

2.1.2 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.

2.1.3 The authority to establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

Oversight and scrutiny of all aspects of quality, patient safety, clinical

outcomes, effectiveness and experience

To assure the board that robust systems, clinical policies and processes are in place to enable the Trust to:

5.1.1 Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,

5.1.2 Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 **Contract management & Commissioning**

6.1.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**

6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of skills to lead efforts across the organisation to drive continuous quality improvement.

6.2.2 The committee will review the Trust's quality reports and approve the annual Quality Account for inclusion in the Annual Report

6.3 **Regulatory Assurance** – NHS Improvement and CQC (review of guidance, CQC outcome assurance report,)

6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by NHS Improvement.

6.3.2 The Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of services and for driving continuous quality improvement.

6.3.3 The Committee will review performance against constitutional targets on a monthly basis from the perspective of impact on quality and patient experience as part of the routine consideration of the Quality & Patient Safety report.

6.4 **Clinical Audit of outcomes and effectiveness**

6.4.1 The committee will oversee the annual programme of clinical audit – this will include surgical audit, anaesthetic audit, histopathology audit, radiology audit, participation in national audits and locally determined audits

6.5 **Risk management**

6.5.1 The committee will regularly review clinical risk - in particular, Board

Assurance Framework clinical risks, Corporate Risk Register and those risks owned by executive committees providing assurance to the Quality & Safety Committee.

6.6 **Upward governance reports**

The committee will review reports from other committees as outlined below:

6.6.1. Committee reports at agreed intervals from ~~drugs and therapeutics,~~ infection control, Safeguarding Committee, Children's Board, ~~Health & Safety Committee,~~ Research & Development Committee, Cancer Board, ~~Clinical Audit & Effectiveness Committee~~ Audit Quality Improvement Learning & Analysis panel (AQILA), Radiation Safety Advisory Group, Human Tissue Act Group.

6.6.2 The Committee will receive annual reports from the ~~Infection Prevention and Control Committee and an annual complaints report for review prior to Trust Board approval~~ covering the following areas:

- Health & Safety
- Fire Safety
- Radiation Safety
- Lessons learned
- Medical Directors portfolio
- Medicines Safety
- Controlled Drugs Accountable Officer
- Complaints
- Infection Prevention and Control
- Safeguarding

The Committee will review these reports prior to them being sent to the Trust Board for formal approval.

6.6.3 The Committee will consider feedback from the Trust's patient groups through a routine upward report from the Patient Experience & Engagement Group and from peer reviews.

6.6.4 The Committee will receive updates on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

6.7 **Other**

6.7.1 The Committee will assure the Board that the Trust's research activity complies with necessary regulations and supports the Trust's strategy.

6.7.2 The committee will assure the Board that the Trust's medical and clinical education meets the required standards.

6.7.3 The Committee will review the adequacy of the clinical governance frameworks for services being delivered jointly with partner organisations.

7 Permanency

The Committee is permanent

8 Membership

The Committee membership will comprise no fewer than three Non Executive Directors and the Chair of the Committee will be a Non Executive holding a clinical background.

The Vice Chair of the Committee will be a Non Executive with a clinical background and will take on the Chair's duties in their capacity as chairman of the Quality & Safety Committee if the Chair is absent for any reason.

Executive members

- ~~Executive Director of Nursing & Clinical Governance~~ Chief Nurse
- Medical Director
- Chief Executive
- Chief Operating Officer

9 Quorum

At least two NEDs (including an Associate Non Executive Director if required) and one from Executive Medical Director or Executive ~~Director of Nursing & Clinical Governance.~~ Chief Nurse

10 Secretariat

Director of Corporate Affairs & Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing & ~~Clinical Governance~~ Facilities
Others relevant to the agenda of the meeting such as chairs of advisory groups, Heads of Nursing, the Head of Clinical Governance, Clinical Service Leads and the Corporate Governance Manager ~~and successor roles~~
A representative from the Council of Governors may attend in a non-participative, observatory capacity

12 Internal Executive Lead
Executive Director of Nursing & Clinical Governance

13 Frequency of meetings
At least 8 meetings per annum

14 Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee.

15 Review of terms of reference

This should be undertaken annually.

Date of adoption **October 2021**
Date of next review **October 2022**

ROHTB (10/21) 007

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 29 September 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The staff story highlighted some issues with the administration of pay for medical trainees. It was reported that as part of the recruitment into the HR function, expertise around medical staffing and terms & conditions was being arranged which would resolve this issue. • There were some difficulties reported with the arrangements for SAS doctors, however the issues were being worked through. • Turnover was reported to have increased steadily and work was underway to establish the reasons for this and review exit questionnaires. • Sickness was noted to have increased and it was noted to be likely to be challenging over the coming months, with the potential for the vaccination programme to cause short term absences. • The position against some of the Workforce Race Equality Standards (WRES) indicators was noted to be below where the organisation wished to be and below the national average. It was anticipated that the work with the Multi Minority Ethnic Group would help to improve the position. Likewise, it was noted that the position against the Workforce Disability Equality Standards (WDES) was below that desired.	• Update on gender pay gap to be considered by the Trust Board on 7 October 2021. • Workforce performance report to include an analysis of the position against some of the Key Performance Indicators and trends in future. • Aims and actions associated with each theme from the staff survey to be clarified in future reports. • Identify outcome measures for the wellbeing interventions in terms of finance, productivity and efficiency. • The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plan to be presented next month. • Present a summary of all workforce initiatives at the next meeting. • Provide an update on the EPIC programme next month.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a staff story from a senior trainee anaesthetist. He reported that in his experience the Trust was friendly and well organised. Facilities in terms of parking and those for on call duties were also well provided. There was also a good opportunity for trainees to facilitate service improvement during their time at the ROH. • Work was underway to make the gender pay gap data submission to the required timeline.	• The Committee supported the changes to its terms of reference and agreed that they should be presented to the Trust Board for approval. • The Committee approved the final version of the Inclusion strategy.

• The Trust's application to join the Top 50 Inclusive Companies had been submitted. • Work was reported to be underway to 'right size' the HR/Workforce function and to restructure it to strengthen the skills of the team. There was also some work underway to exploit digital technology to support some of the processes that were currently manually handled. • Work was underway to address the feedback from the last staff survey and to prepare for the next which commenced on 30 September 2021. Good progress on the delivery of actions was noted. Target completion rate for the staff survey is to remain at 90%. • An overview of the recent wellbeing week was provided. There had been good engagement from many parts of the Trust. It was noted to be anticipated that bronze accreditation for the Thrive at Work programme would be achieved in November 2021. • There was work underway to introduce a programme of flexible working into the Trust and the Trust was participating in a national programme around this.	
Chair's comments on the effectiveness of the meeting: It was noted that the agenda had been well balanced and the staff story had been good.	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Staff Experience & OD Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Simone Jordan, Chair of Staff Experience & OD Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

In line with the requirement to review the Committee's terms of reference on an annual basis, the attached are the latest version with some minor changes suggested:

- Include a specific duty to review the Trust's inclusion plans (to cover statutory requirements and returns)
- Add an additional duty to reflect the requirement to consider the system wide plans and the impact & Trust contribution to these.
- Minor formatting and numbering issues.
- Revised membership to remove an Associate Medical Director and to add in the Chief Nurse

The Trust Board is invited to note that there has been sound compliance with the terms of reference during the year through the delivery of the Committee's annual workplan.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the changes to the terms of reference

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

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

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

Comments:

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

Delivered by highly motivated, skilled and inspiring colleagues

The Royal Orthopaedic Hospital NHS Foundation Trust

PREVIOUS CONSIDERATION:
Staff Experience & OD Committee on 29 September 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE AND ORGANISATIONAL DEVELOPMENT (OD) COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Staff Experience and OD Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 The purpose of the Committee is to provide the Board with assurance concerning the Trust's performance against a range of workforce-related metrics, indicators and targets. It shall also seek assurance as to the robustness of the Trust's strategic workforce planning arrangements, organisational development framework and progress with developing a learning and improvement culture within the ROH.

4 MEMBERSHIP

4.1 The Committee will comprise of not less than three Non-Executives, the Chief Executive, Chief Operating Officer, the Associate Director of Workforce, HR & OD and the Chief Nurse.

4.2 The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. If the Chair is absent from the meeting then another Non-Executive Director shall preside.

4.3 A quorum will be three members, of which there must be at least one Non-Executive Director and one Executive Director.

4.4 Members should make every effort to attend all meetings of the Committee

5 ATTENDANCE

5.1 Other Executive Directors or any other individuals deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

5.2 The Director of Corporate Affairs & Company Secretary shall be secretary to the Committee and will provide administrative support and advice.

The duties of the Director of Corporate Affairs & Company Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and the lead director, this being the Associate Director of Workforce & OD and organises the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly, with the exception of August and December, with additional meetings where necessary.

Deleted: Directors (including the Associate Non Executive Director)

Deleted: the Director of Strategy & Delivery,

Deleted: ,

Deleted: Deputy Director of Nursing & Clinical Governance

Deleted: and an Associate Medical Director.

Deleted: Chief Executive

7 REPORTING AND ESCALATION

7.1 Following each committee meeting, the minutes shall be drawn up and presented at the next Committee meeting where they shall be considered for accuracy and approved. The approved minutes will be presented to the next immediate private Trust Board meeting for information.

7.2 The Chair of the Committee will provide an assurance report to the next Trust Board after each Committee meeting, highlighting the key points of the discussions at the meeting, any matters of concern or risk and matters of positive assurance for the Board.

7.3 The Committee will provide an annual report to the Trust Board on the effectiveness of its work and its findings, which is to include an indication of its success with delivery of its work plan and key duties.

7.4 In the event that the Committee is not assured about the delivery of the work plan within its domain, it may choose to escalate or seek further assurance in one of five ways:

(i) insisting on an additional special meeting;
(ii) escalating a matter directly to the full Board;
(iii) requesting a chair's meeting with the Chief Executive and Chairman;
(iv) asking the Audit Committee to direct internal, clinical or external audit to review the position

7.5 The Committee will receive routine upward reports from workforce-related fora, the People Committee being the principal conduit. These will report in rotation, the frequency being set out in the Committee's workplan.

8 REVIEW

8.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 To seek assurance on the robustness of the plans to deliver the Trust's key workforce strategy, including but not limited to:

- Talent Management
- Leadership
- OD and Staff Engagement
- Inclusion

- Reward and recognition
- Succession planning

9.2 To receive progress updates on the delivery of the above

9.3 To seek assurance on the robustness of workforce planning, education, training and development to meet the needs of the Trust's overall strategy

9.4 To ensure that workforce plans are adequately connected to financial, quality and capacity/demand planning in ROH

9.5 To review plans for developing new roles, skill mix and where needed, new job plans, to meet the evolving needs of the Trust

9.6 To review data and trends against key workforce metrics, including but not limited to:

- Numbers of starters, leavers and staff turnover
- Staff in Post and vacancy rates
- Pay spend (fixed and variable) overall and by staff group
- Appraisal rates and mandatory training position
- Sickness absence and other absence
- Numbers of formal procedures
- Staff satisfaction
- Benchmarking data
- Agency and locum usage

And to seek assurances that where there are trends of concern, that plans are in place that will deliver improvement in an effective and timely way

9.7 To seek assurance on the Trust's position against the NHS People Plan, NHS Improvement and CQC Well Led Frameworks and any plans to strengthen compliance or address shortfalls against the requirements of any dimension

9.8 To review key trends and themes from staff feedback, through mechanisms including the national staff survey, internal 'pulse checks', 360 degree feedback, exit interviews, Freedom to Speak up data and whistleblowing concerns raised and seek assurance that where improvement is required that plans are sufficiently robust and timely

9.9 To review plans for developing the Trust's education and training framework, and to scrutinise income and expenditure from Health Education West Midlands

9.10 To seek assurance on the quality of health and wellbeing offerings to staff.

9.11 To have oversight of culture change across the Trust, including the development of an Improvement culture among the workforce and equipping staff with the knowledge and skills to make improvements happen at the front line

9.12 To review workforce-related internal audits and monitor progress and the impact of the delivery of any recommendations within these reports.

9.13 To seek assurance on behalf of the Board that the key risks to the delivery of the of the workforce strategy, frameworks or plans are adequately mitigated.

9.14 To receive updated on the systemwide approach to workforce matters, evaluating the Trust's contribution to and impact of such plans.

Date of adoption: October 2021

Date of review: October 2022

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Audit Committee Terms of Reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Gianjeet Hunjan, Chair of Audit Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Audit Committee in line with the requirement for them to be reviewed annually.

The amendments are minor in nature and propose that the Director of Nursing & Clinical Governance be removed from the routine attendance list. The Medical Director will instead provide oversight of clinical audit matters where relevant.

REPORT RECOMMENDATION:

The Trust Board is asked to consider and approve the proposed revisions to the terms of reference and agree that the revised terms of reference are presented to the Trust Board for approval at the next available opportunity.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

None specifically – supports good governance.

PREVIOUS CONSIDERATION:

Audit Committee on 23 July 2021.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust

Audit Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Audit Committee. The Committee is a non-executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2 Delegated Authority

The Committee has the following delegated authority:

2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;

2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,

2.1.3 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.

2.1.4 The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3 Accountability

The Committee is accountable to the Trust Board.

4 Reporting Line

The Trust Board and Council of Governors (for specific matters)

5 Objective

To provide independent oversight and scrutiny of compliance and effectiveness across the whole organisation and all its functions. Internal and external auditors are a key means to providing that assurance**.**

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 <u>Internal control and risk management</u>

6.1.1 To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

6.1.2 To maintain an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.

6.1.3 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

6.1.4 To review the adequacy of the foundation trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

6.1.5 To review the adequacy of underlying assurance processes that indicate the degree of

achievement of corporate objectives and the effectiveness of the management of principal risks.

6.1.6 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2 Internal audit & counter fraud

6.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Its co-ordination with external audit
- Meeting mandatory Public Sector Internal Auditing Standards.
- Providing adequate independent assurances;
- Meeting the internal audit needs of the foundation trust.
- Delivering the agreed internal audit programme.

6.2.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.2.4 To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

6.2.5 To conduct an annual review of the internal audit function and market test at least every 5 years.

6.2.6 To ensure that appropriate processes and resources are in place to support the detection and prevention of fraud.

6.2.7 To consider the major findings of counter fraud investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.3 External audit

6.3.1 To make recommendations to the Council of Governors in respect of external auditors covering:

- Appointment
- Reappointment
- Removal

To the extent that recommendations are not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendations were not adopted.

In support of the above the Audit Committee will make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the Council of Governors to consider whether or not to re-appoint them.

The Audit Committee will approve the remuneration and terms of engagement of the external auditor. Consideration should be given to assessing the auditors work and fees on an annual basis, and there should be a market testing exercise at least once every 5 years.

6.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

6.3.3 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.3.4 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.4 **Review of Annual Report & Accounts, incorporating the Quality Account**

6.4.1 To review the annual statutory accounts, before they are presented to the board of directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is

not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgment has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- The Trust's going concern status and any disclosures associated with this

6.4.2 To review the annual report and statement of internal control before they are submitted to the board of directors to determine completeness, objectivity, integrity and accuracy.

6.4.3 To receive the Annual report and associated annual opinion from the HOIA and to consider the AGS is consistent with this opinion.

6.4.4 To review the annual quality account before it is submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

6.5 Standing orders, standing financial instructions and standards of business conduct

6.5.1 To review on behalf of the board of directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3 To review the scheme of delegation.

6.6 Other

6.6.1 To review performance indicators relevant to the remit of the audit committee.

6.6.2 To examine any other matter referred to the audit committee by the board of directors and to initiate investigation as determined by the audit committee.

6.6.3 To annually review the accounting policies of the foundation trust and make appropriate recommendations to the board of directors.

6.6.4 To develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

6.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6 To review the work of all other foundation trust committees in connection with the audit committee's assurance function.

6.6.7 To produce an annual report for Trust Board covering the activity and effectiveness of the Audit Committee.

6.6.8 To report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

7 Permanency

The Committee is permanent.

8 Membership

Chair
A suitably qualified non-executive Director. Members of the committee have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman.

Other members
At least two other NEDs

9 Quorum
The Chair and one other NED.

10 Secretariat
Director of Corporate Affairs & Company Secretary

11 In attendance, by invitation
Regular attendance
Director of Finance and Performance
~~Director of Nursing and Clinical Governance~~
Medical Director
Internal Auditors
External Auditors

Occasional attendance
Chief Executive
Chairman

The Committee may request the attendance of any director or manager to seek assurance on progress of key pieces of work or plans to address audit recommendations.

12 Internal Executive Lead
Director of Finance & Performance

13 Frequency of meetings
Not less than five times per annum

14 Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes.

15 Review of terms of reference
This should be undertaken annually.

16 Date of adoption
23 July 2021.

17 Date of next review

July 2022.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Nominations & Remuneration Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Simone Jordan, Chair of the Nominations & Remuneration Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**7 October 2021**

EXECUTIVE SUMMARY:

In line with the requirement to review the Committee's terms of reference on an annual basis, the attached are the latest version with some minor changes suggested, these being mainly cosmetic to address grammar errors.

The clause related to the need to make an exclusion from a meeting should anyone in attendance have an interest in relation to any agenda item has been expanded to clarify that this including the Secretariat to the meeting, this being the Director of Corporate Affairs & Company Secretary.

An additional entry has been added to the 'Purpose' section at the request of the Committee to ensure that there is clarity that the remit of the body is confined to Executive Directors, with an equivalent Committee being in place for the Council of Governors overseeing Non Executive matters.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the minor changes to the terms of reference

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

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

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

Comments:

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

Delivered by highly motivated, skilled and inspiring colleagues

The Royal Orthopaedic Hospital NHS Foundation Trust

PREVIOUS CONSIDERATION:
Nominations & Remuneration Committee on 15 September 2021

NOMINATIONS AND REMUNERATION COMMITTEE (EXECUTIVE DIRECTORS)

Terms of Reference

1. Purpose

The Nomination and Remuneration Committee (Executive Directors) is constituted as a standing Committee of the Trust Board.

The Committee is authorised by the Trust Board to act within its terms of reference, as set out below, subject to amendments at future meetings of the Trust Board.

The Committee is authorised by the Trust Board to obtain such internal information as it considers necessary for or expedient to the exercise and fulfilment of its functions. All members of staff of the Trust are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to exercise its functions.

For the sake of clarity, it should be noted that an equivalent Committee of the Council of Governors exists, with a remit to oversee a similar set of responsibilities which pertain to the Non Executive element of the Board.

2. Duties/Responsibilities

2.1 Nominations

- To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust Board and make recommendations to the Board with regard to any changes. To receive results of annual audit of Board skills, knowledge and experience and advise accordingly
- To give consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed in future.
- Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
- Before an appointment is made, to evaluate the balance of skills, knowledge and experience on the Trust Board and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall use open advertising or the

services of external advisors to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

- To consider any matter relating to the continuation in office of the Chief Executive and any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.
- Receive the annual declaration from the Chief Executive in respect of the Trust's compliance with the Fit and Proper Persons regulation and receive evidence-based assurance that all newly appointed executive Directors, including the Chief Executive are deemed Fit and Proper
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons Regulation

2.2 Remuneration

- To decide upon and review the terms and conditions of office of the Trust's Chief Executive and Executive Directors in accordance with all relevant Trust policies, including:
  - salary
  - provision for other benefits
  - allowances
- To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate the Chief Executive and Executive Directors whilst remaining cost effective.
- To advise upon and oversee contractual arrangements for the Chief Executive and Executive Directors, including but not limited to termination payments.
- To determine arrangements for annual salary review for all staff on Trust contracts.

2.3 Performance, development and succession planning

- To monitor and evaluate the performance of the Chief Executive and Executive Directors
- To receive and approve the annual objectives for the above
- To receive and consider the outcome of annual appraisals for the above
- To receive and consider annually the Talent Management and Succession Plans for the above, along with that for other identified business critical senior leader posts

3. Accountable to

The Committee is accountable to the Trust Board

4. Reports to and Method (including minutes circulation)

The minutes of all meetings of the Committee shall be formally recorded and shall be retained by the Company Secretary, on behalf of the Chairman, and shall not be shared with the Executive Directors or Chief Executive in relation to matters pertaining to that postholder.

The Committee shall report to the Trust Board after each meeting of the Committee via an assurance report. This shall be limited to an overview containing items and matters appropriate to be shared in a public forum.

The Company Secretary, on behalf of the Chairman, shall ensure that the work of the Committee is accurately reported in the Annual Report and Accounts in accordance with any direction from NHS Improvement

5. Membership

Chair
The Chair of the Committee will be a Non Executive Director nominated by the Trust Chairman.

Members
All Non Executive Directors (including the Associate Non Executives) shall be members.

In attendance by invitation

- Chief Executive (to be excluded during matters pertaining to that postholder)
- Associate Director of HR, Workforce and Organisational Development

Serviced by
Director of Corporate Affairs and Company Secretary (with the exception of matters pertaining to themselves)

6. Quorum

A quorum shall be three members.

7. Meeting Frequency and Procedures (minimum if applicable)

Meetings shall be held as and when required, but at least twice per year.

- Papers are to be circulated five working days in advance
- Meetings can be held virtually if necessary and members can attend virtually if necessary
- Agendas are to be created based on the agreed workplan and order of business
- Declaration of interests are to be registered with any item on the agenda and members are to be excluded from the meeting where this is the case

8. Process for Reviewing Effectiveness

The effectiveness of the Committee will be monitored on an annual basis via the following:

- Annual review of the Terms of Reference by the Trust Board
- Report of Committee's work and attendance register in Annual Report and Accounts in accordance with direction.

10. Reporting Structure (list of Groups/Committees which report to this Committee)

None.

11. Review Terms of Reference

Undertaken at least annually or as required.

12. Date of adoption

September 2021

13. Date of Review

September 2022

Finance and Performance Report

August 2021

CONTENTS

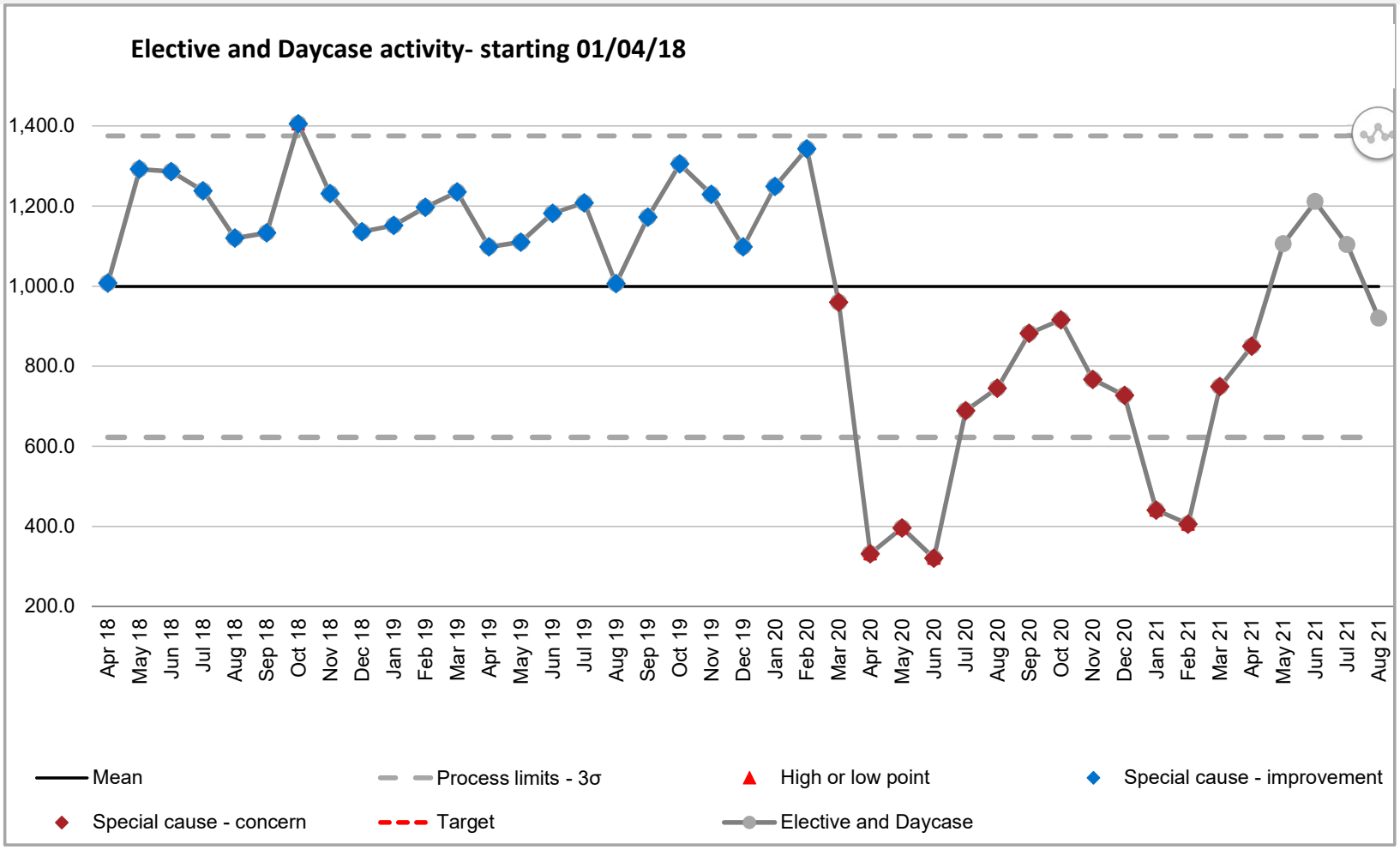
	Introduction
1	Activity Summary
2	Theatre Utilisation
3	Length of Stay
4	Outpatient Efficiency
5	Referral to Treatment Targets (RTT)
6	Diagnostic Performance
7	Cancer Performance
8	Overall Financial Performance
9	Income
10	Expenditure
11	Agency Expenditure
12	Cost Improvement Programme
13	Liquidity & Balance Sheet analysis
14	Workforce

Introduction

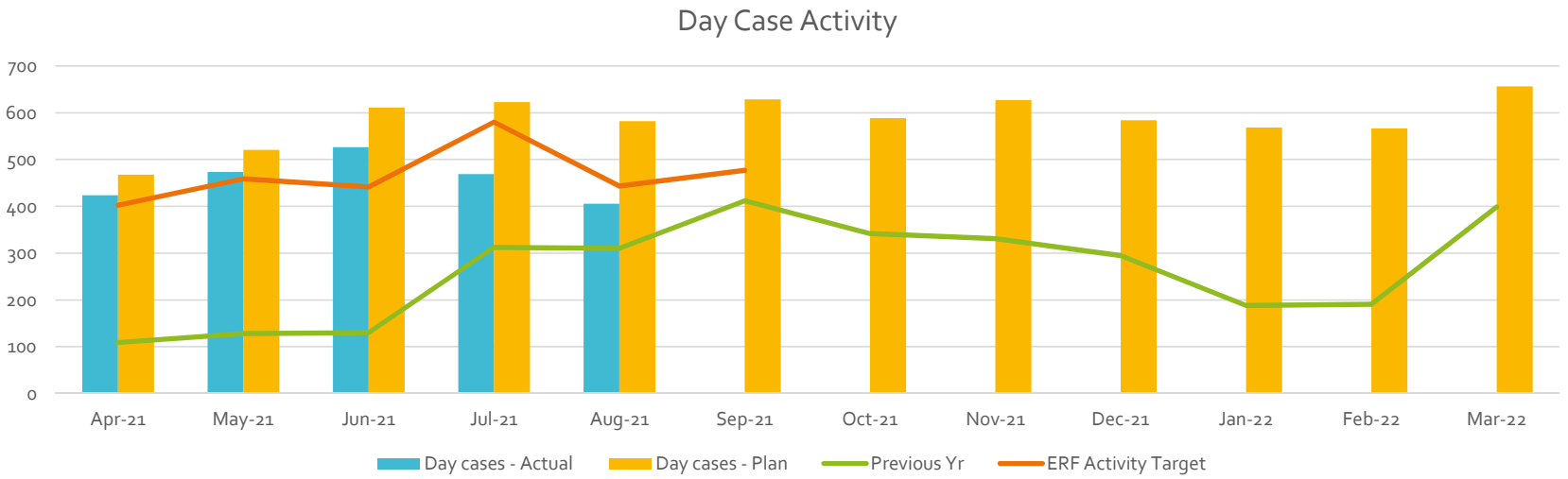
The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

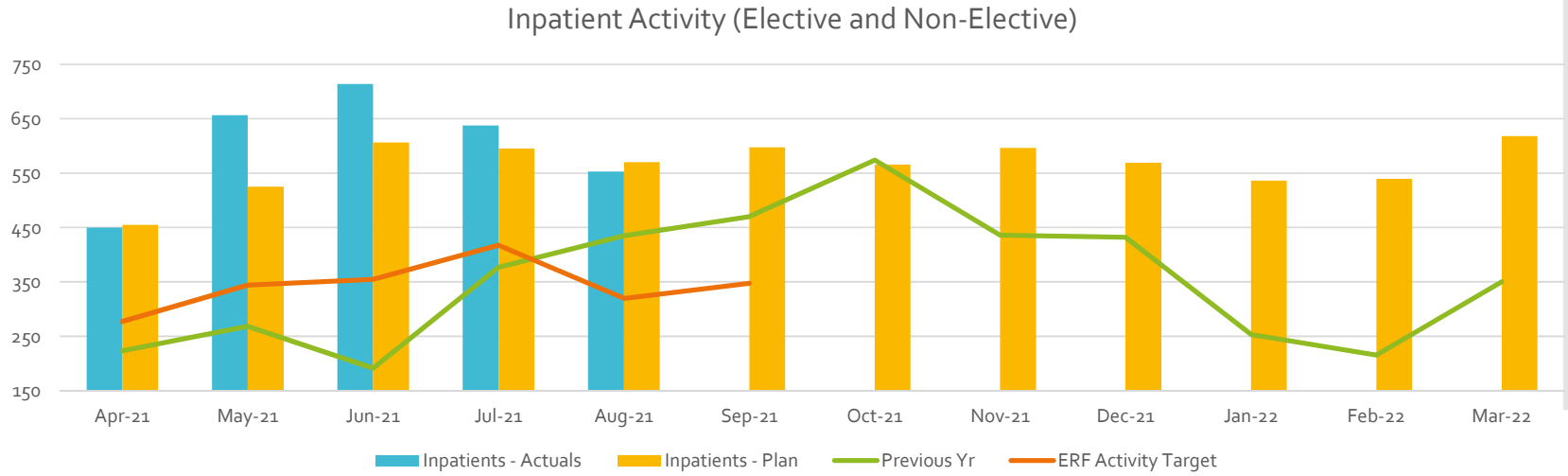
A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues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

1. Activity Summary

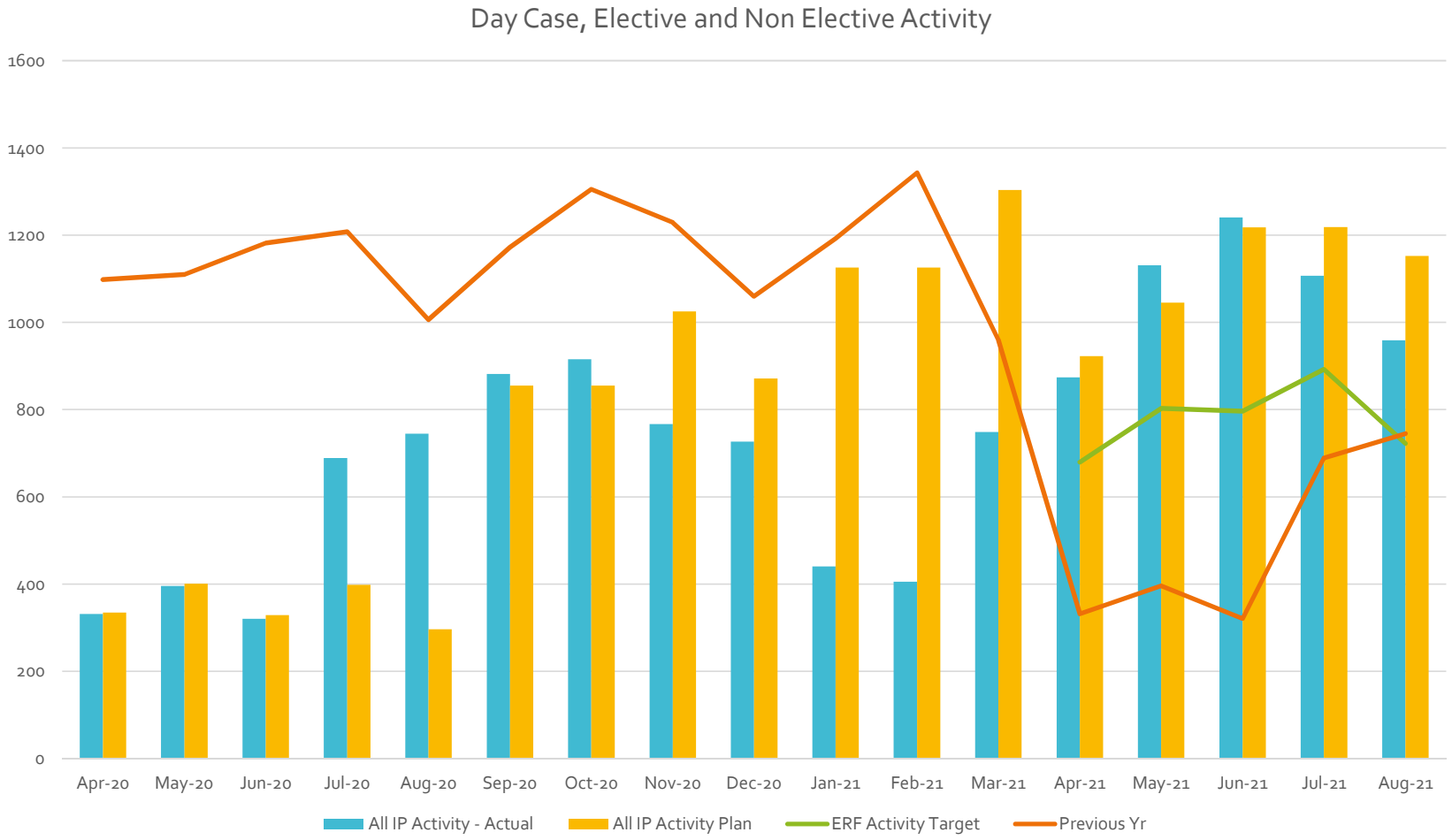


1. Activity Summary

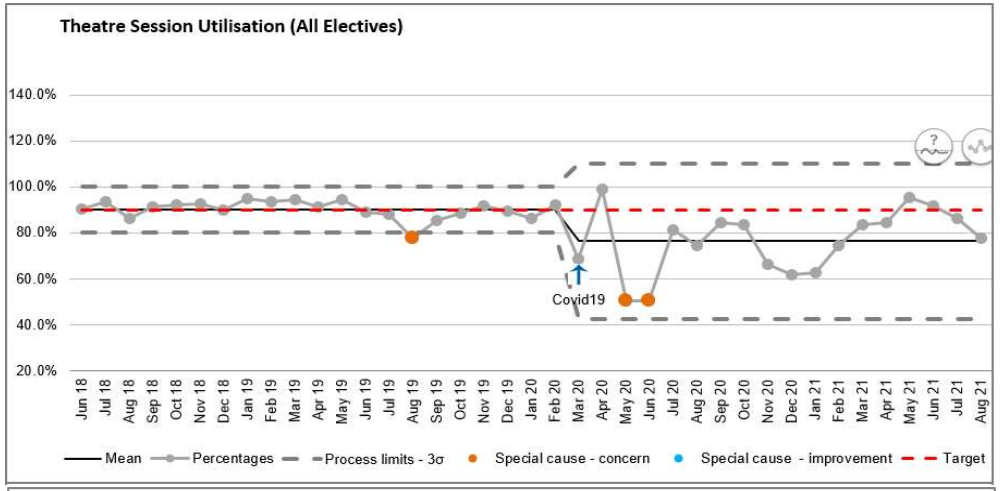


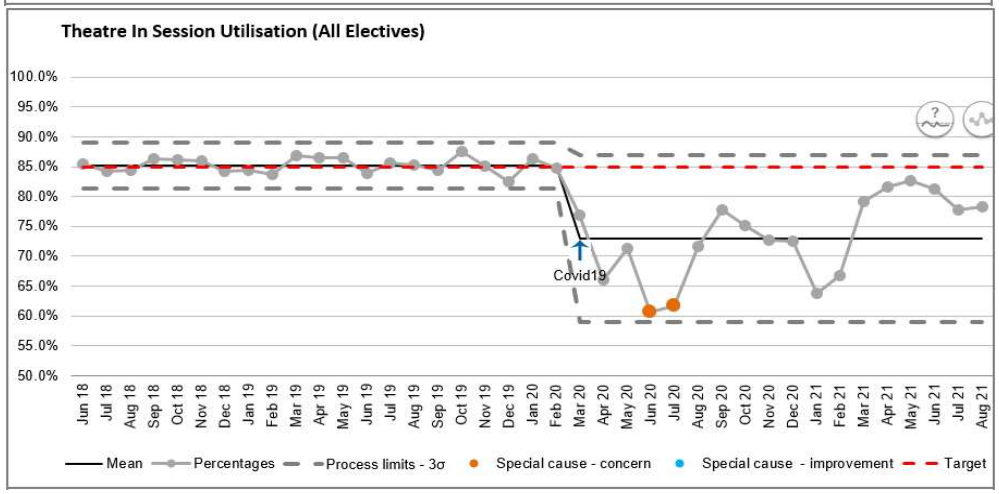


1. Activity Summary



2. Theatre Utilisation





Elective Session Utilisation (August-21)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	400	305	17	76.25%
UHB	136	111	18	81.62%
Totals	536	416	35	77.61%

Elective In Session Utilisation (August-21)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1358	1075	283	79.14%
UHB	493	376	117	76.31%
Totals	1851	1451	400	78.39%

2. Theatre Utilisation

SUMMARY

Overall theatre utilisation was 77.61% compared to 86.21% the previous month. Total in session utilisation was 78.39% a slight increase on the month before.

The main reason for the reduction in list utilisation was due to a high numbers of Consultants across both Trusts on annual leave throughout August and the continuing need for UHB Consultants to support trauma lists across UHB theatres sites. However we expect to see an improvement in utilisation during September as Consultants return back to work.

In session utilisation remained a challenge which is mostly due to cancellations of patients due to either being unfit or testing positive / isolating due to covid.

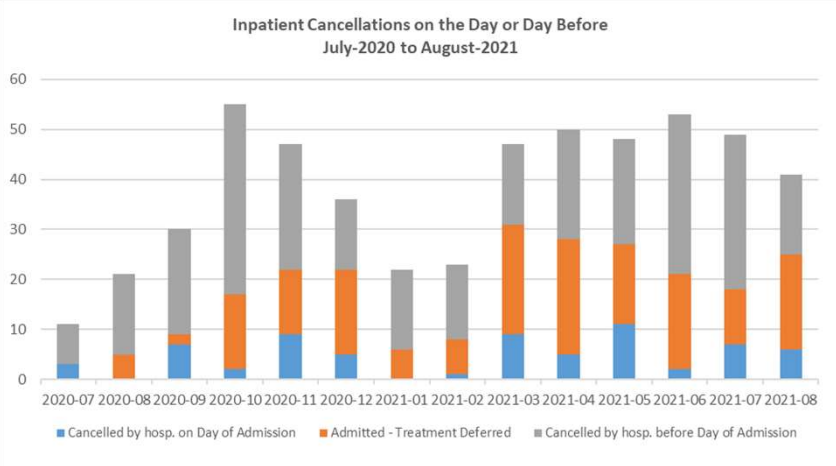
AREAS FOR IMPROVEMENT

Pre-populating of theatre lists at least 4 weeks in advance with contingency patients now being actively sort from September 2021.

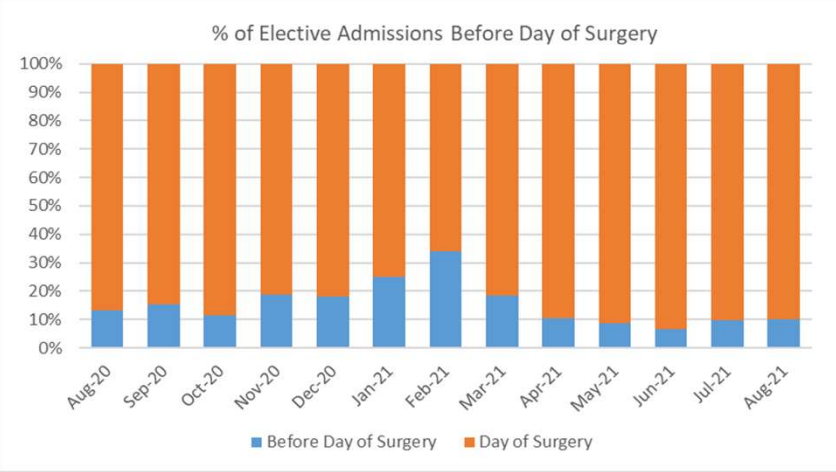
RISKS / ISSUES

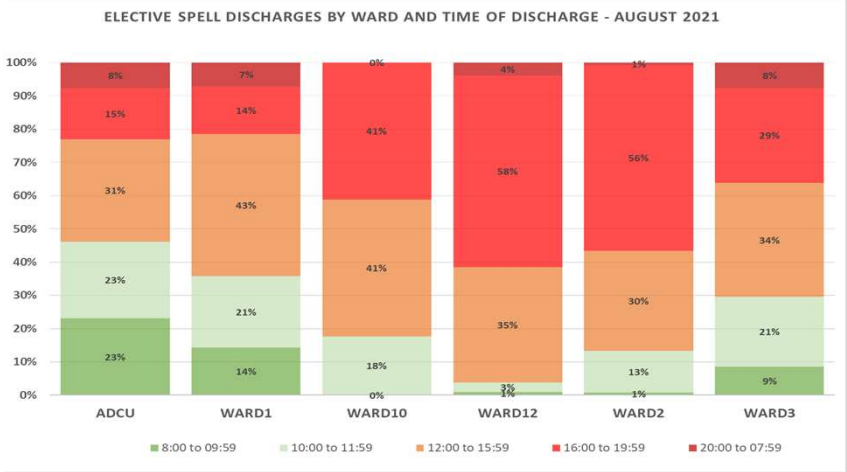
The in sessions utilisation of system lists will need to be improved in order to maximise resources and the ROH team are working closely with operational colleagues at UHB to ensure planning of lists is in place to improve efficiency overall

2. Theatre Utilisation/ Hospital Led Cancellations



Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2020-07	3		8	11	0
2020-08		5	16	21	0
2020-09	7	2	21	30	0
2020-10	2	15	38	55	0
2020-11	9	13	25	47	1
2020-12	5	17	14	36	0
2021-01		6	16	22	0
2021-02	1	7	15	23	0
2021-03	9	22	16	47	0
2021-04	5	23	22	50	0
2021-05	11	16	21	48	0
2021-06	2	19	32	53	0
2021-07	7	11	31	49	0
2021-08	6	19	16	41	0
Total	67	175	291	533	1





2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed does not include those who were either emergency or urgent cases as these are more difficult to avoid due to the very short notice of being booked.

There were 6 patients cancelled on the day of admission in August with reasons detailed as follows;

6 x Surgeon availability/unwell

There were 19 patients admitted but where treatment was deferred, with reasons broken down as follows:

9 x Medically unfit / Clinical change in condition
5 x Procedure no longer required / declined surgery
4 x Covid + / broke isolation rules
1 x Lack of technical staffing (cord monitoring)

There were 16 patients cancelled by the hospital prior to date of admission.

2 x surgeon availability
1 x patient self cancelled
2 x replaced by more urgent/emergency case
1 x change in TCI date
10 x not fit / more tests required

As detailed above, the main driver for cancellations are patients presenting as unfit for surgery e.g. poorly managed diabetes due to being unable to access services during the pandemic

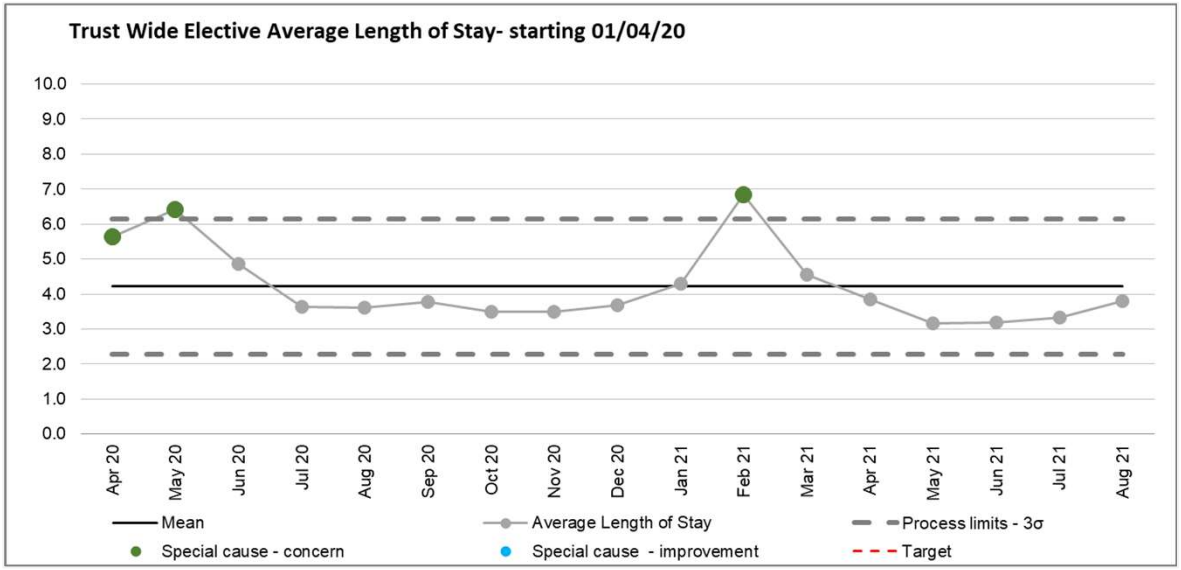
AREAS FOR IMPROVEMENT

6/4/2 scheduling meetings have been reinstated as have the 'theatre look back' meetings which will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. System partners will now be attending these meetings to share best practice and learning. An initiative with NHSE/I looking at Theatre Productivity has commenced with visits planned throughout September.

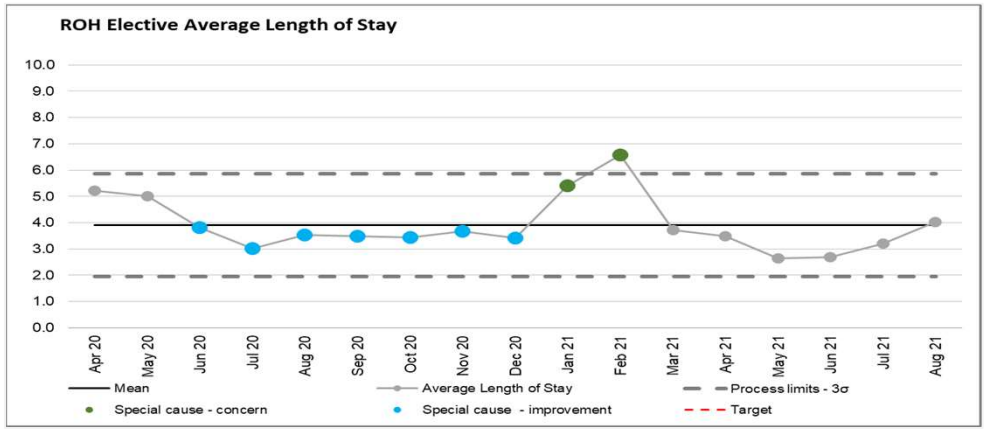
RISKS / ISSUES

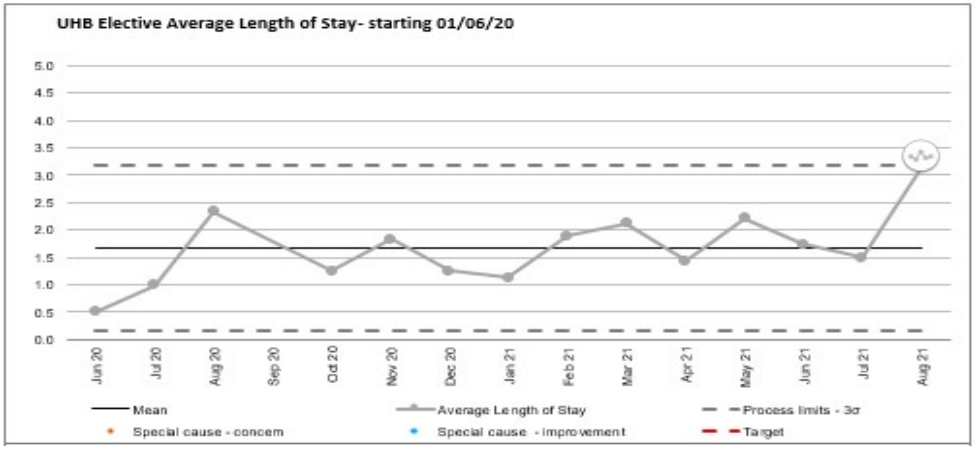
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process.

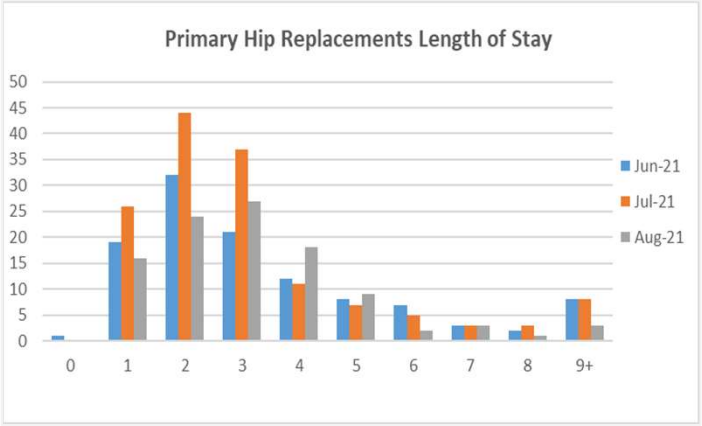
3. Length of Stay

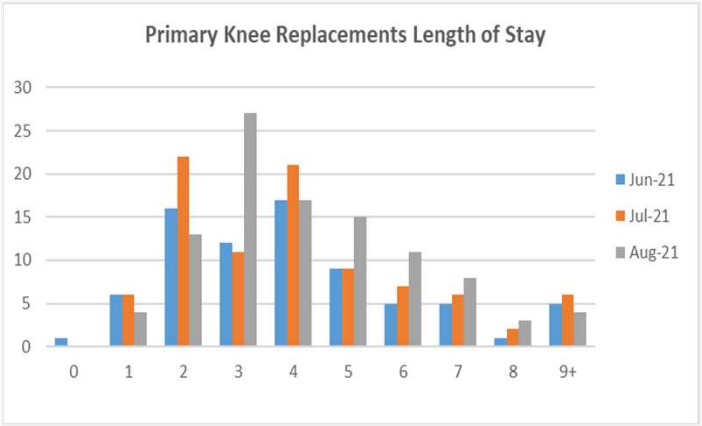


3. Length of Stay









3. Length of Stay

SUMMARY

The average length LOS for ROH patients from *all* specialities is 3.81 (3.32 from July).
The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is 4.02 (3.18 in July)
The average length of stay for UHB patients at ROH is 3.14 (1.52 in July)

August length of stay data produced for UHB and ROH, all specialities (excluding day cases) have been reviewed and the following observations made:

- 15 UHB patients with LOS greater than 5 days – there were 4 patients with a length of stay greater than 7 days. (excludes Rehab) this was due to the complexity of surgery, clinically justified reasons or specific discharge needs e.g. package of care. One patient had a LOS of 13 days due to clinical reasons.

- Data and a review of the PICs information continues to demonstrate that ROH Surgeons are undertaking surgery on a significantly larger number of complex patients, particularly within Oncology. These patients due to the nature of the surgery have a longer length of stay. Of the PICS records reviewed all length of stays were justifiable due to on-going clinical or complex discharge needs

The ROH Surgeons operate on more complex patients that result in a longer stay, e.g. EPR procedures carried out oncology arthroplasty a direct comparison is not an accurate reflection. A further deep dive will be undertaken for September's LOS to review the data and be able to accurately compare LOS for ROH and UHB

Due to capacity pressure in other Trusts there have been delayed transfers of care requiring escalation

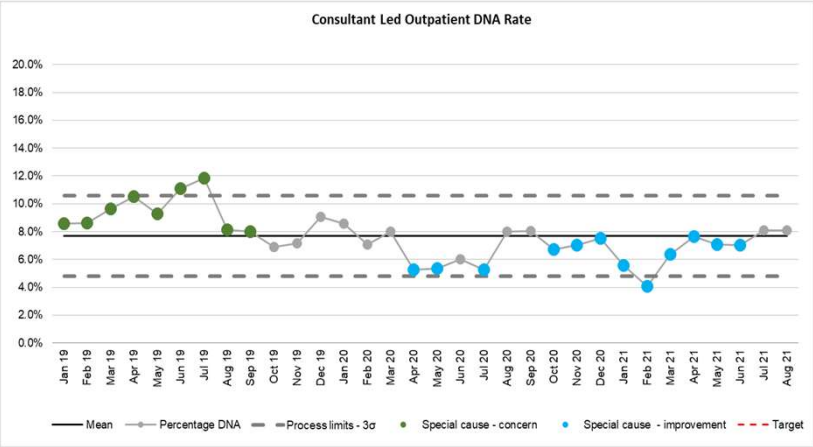
AREAS FOR IMPROVEMENT

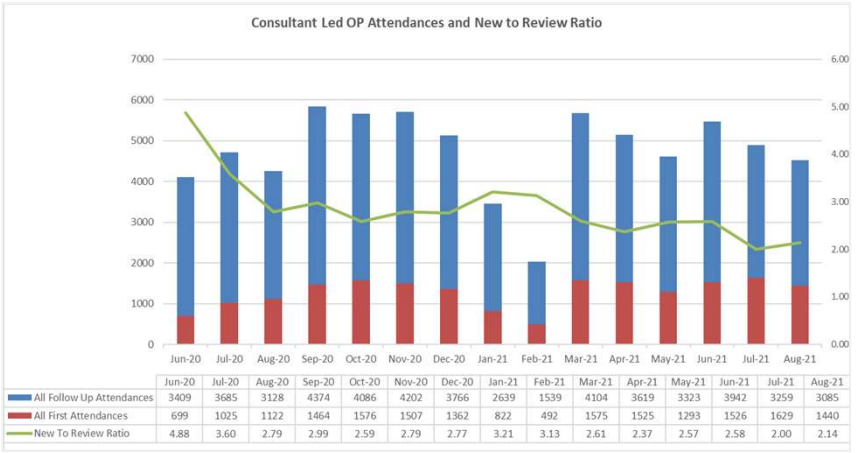
The roaming Discharge Team continue to provide discharge support to the wards and actively manage any potential delayed discharges. In addition, the wards are proactively managing discharges plans and escalating any potential physiotherapy/imaging delays which may impact

RISKS / ISSUES

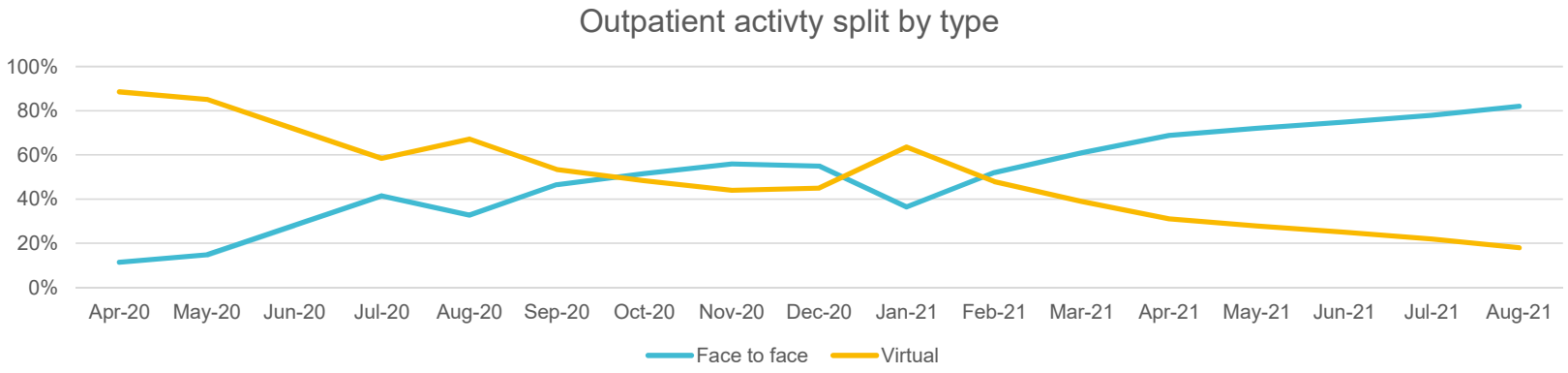
Continued operating on more complex, high priority patient will retain risk of increased length of stay . The Discharge Lounge continues to be used by the ROCS/IPC and Tissue Viability Teams, as activity increases, this facility needs to be in place . Scoping options for where these teams will move to a new permanent location with support from the estates team.
There is a reliance on temporary staffing to support the discharge team due to vacancies, however this is being actively managed.

4. Outpatient efficiency

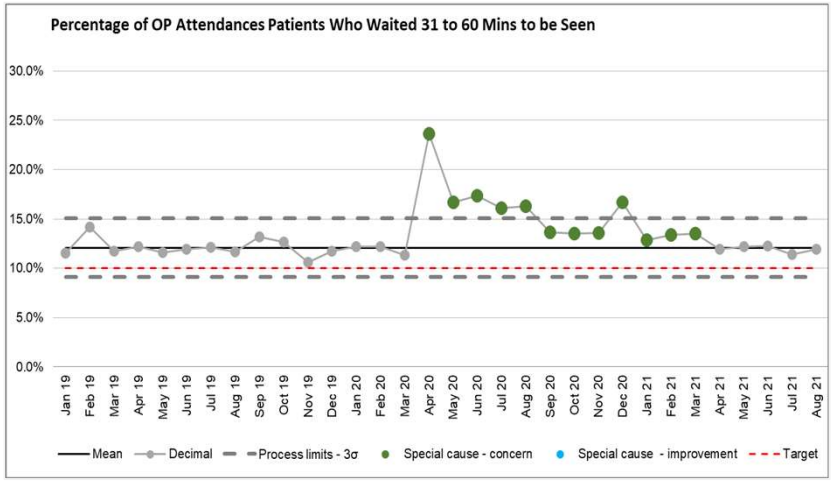


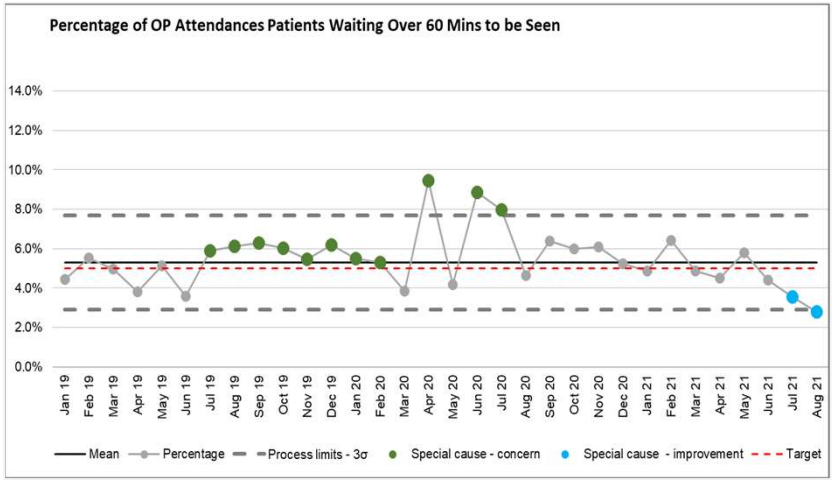


	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
All Follow Up Attendances	3409	3685	3128	4374	4086	4202	3766	2639	1539	4104	3619	3323	3942	3259	3085
All First Attendances	699	1025	1122	1464	1576	1507	1362	822	492	1575	1525	1293	1526	1629	1440
New To Review Ratio	4.88	3.60	2.79	2.99	2.59	2.79	2.77	3.21	3.13	2.61	2.37	2.57	2.58	2.00	2.14



4. Outpatient efficiency





4. Outpatient efficiency

SUMMARY

30 minute delays – Increased in August to **11.9%** from July which was **11.4%**. Trust Target is **10%**
60 minute delays – Decreased in August to **2.8%** from July which was **3.6%**. Target is **5%**

Imaging delays have significantly reduced due to the improvements in the booking process and with the repatriation of the ambulatory trauma work to UHB, this has increased staffing capacity in x-ray. A new electronic form has been produced to manage the patient flow from outpatients to imaging and acts as a communication tool for the clinical team to send down patients from the pods and manage the waiting list of patients to be sent down to imaging.

An escalation process is in place for delays in outpatients approaching 30 minutes between the Operational and Nursing Team and is working well.
The Outpatient Huddle continues to take place daily and is having a positive impact on processes and the flow within the department as well as improving communication between the nursing and operational teams.

There were 3718 (82%) face to face and 812 (18%) virtual appointments carried out in August. The virtual clinics undertaken fell short of the national 25% target and is attributed to patients needing to be seen face to face. A virtual consultation room has now been made available and the CSM for Outpatients and Patient Access is working with the Clinical Service Leads to better define virtual pathways and encourage greater uptake by the clinical teams.

New appointment waiting times continue to reduce through the OPWL PTL meetings being held by the appointments team.

AREAS FOR IMPROVEMENT

The DNA rate for August is 8.10% which is an very small increase from 8.09% in July. Trust target is 8%.

A DNA audit is undertaken each month to understand the drivers for patients not attending. The comparison suggests a seasonal trend for July and August and the findings from the August audit support this with patients missing their appointments due to being on holiday. Letters and texts are sent to remind patients of the appointment date and time.

RISKS / ISSUES

A business case for the use of Griffins Brook Medical Centre has been approved and will provide additional outpatient capacity for Clinical Support Services for Q4.

5. Referral to Treatment

Referral to Treatment Snapshot as at 31st August 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2021

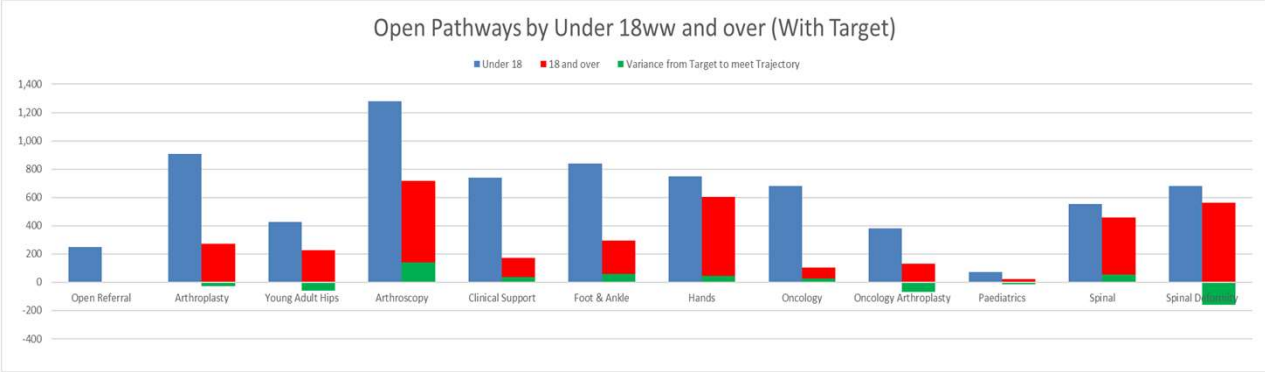
Est Over 18 Clock Stops Required		
To achieve	68.01%	-1
To achieve	75.72%	1300
To achieve	79.91%	1902

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**3,299**	216	432	163	533	304	386	262	330	131	33	231	278
7-13	**2,862**	30	332	174	478	294	298	326	233	193	28	220	256
14-17	**1,400**	1	142	89	270	141	155	162	119	58	13	103	147
18-26	**1,657**	0	145	98	343	129	157	263	66	73	10	159	214
27-39	**1,149**	1	99	93	217	32	87	218	23	30	6	138	205
40-47	**524**	0	19	35	117	10	39	96	7	19	3	96	83
48-51	**140**	0	7	2	26	1	10	20	5	8	2	34	25
52 weeks and over	**85**	0	1	0	13	0	1	4	3	0	0	30	33
Total	**11,116**	248	1,177	654	1,997	911	1,133	1,351	786	512	95	1,011	1,241

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,561**	247	906	426	1,281	739	839	750	682	382	74	554	681
18 and over	**3,555**	1	271	228	716	172	294	601	104	130	21	457	560
Current Month End RTT %	**68.02%**	**99.60%**	**76.98%**	**65.14%**	**64.15%**	**81.12%**	**74.05%**	**55.51%**	**86.77%**	**74.61%**	**77.89%**	**54.80%**	**54.88%**

31/08/21 Trajectory RTT %	68.01%	100.00%	75.28%	59.61%	68.96%	84.30%	78.12%	57.35%	89.97%	65.77%	67.74%	57.86%	48.57%
Target for RTT Trajectory	3,556	0	297	289	577	138	235	558	76	199	35	404	721
Variance from Target to meet Trajectory	-1	1	-26	-61	139	34	59	43	28	-69	-14	53	-161



5. Referral to Treatment

Referral to Treatment Snapshot as at 31st August 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2021

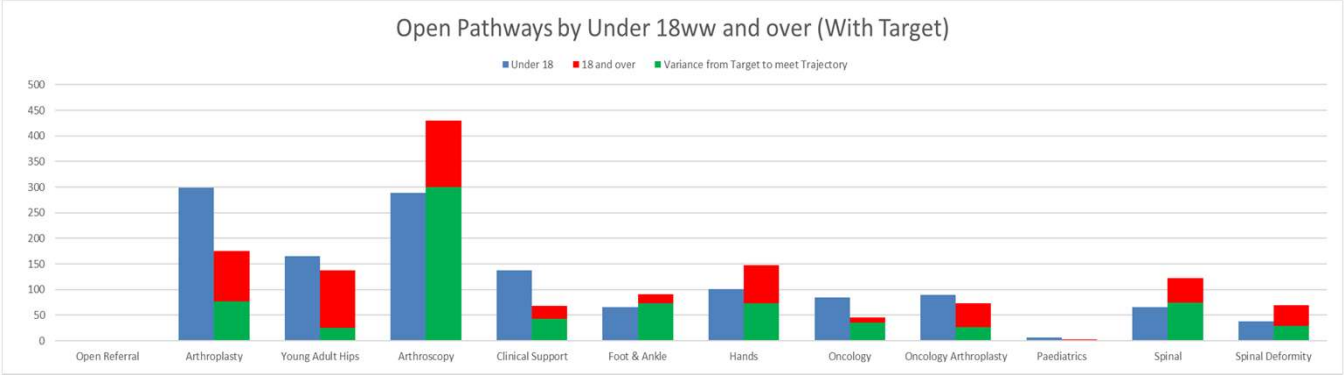
Est Over 18 Clock Stops Required		
To achieve	68.01%	839
To achieve	75.72%	1070
To achieve	79.91%	1177

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**457**	1	93	55	87	41	13	45	48	36	2	27	9
7-13	**531**	0	130	62	106	59	28	40	27	36	3	22	18
14-17	**354**	0	76	48	96	37	24	16	10	18	1	17	11
18-26	**560**	0	92	53	192	46	34	45	17	33	2	33	13
27-39	**450**	0	69	60	130	16	24	60	14	21	0	29	27
40-47	**241**	0	12	23	83	5	25	39	7	13	0	23	11
48-51	**67**	0	2	1	20	1	7	3	4	6	1	16	6
52 weeks and over	**43**	0	0	0	5	0	1	1	3	0	0	21	12
Total	**2,703**	1	474	302	719	205	156	249	130	163	9	188	107

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,342**	1	299	165	289	137	65	101	85	90	6	66	38
18 and over	**1,361**	0	175	137	430	68	91	148	45	73	3	122	69
Current Month End RTT %	**49.65%**	**100.00%**	**63.08%**	**54.64%**	**40.19%**	**66.83%**	**41.67%**	**40.56%**	**65.38%**	**55.21%**	**66.67%**	**35.11%**	**35.51%**

31/08/21 Trajectory RTT %	68.01%	100.00%	75.28%	59.61%	68.96%	84.30%	78.12%	57.35%	89.97%	65.77%	67.74%	57.86%	48.57%
Target for RTT Trajectory	631	0	98	112	130	26	18	75	9	47	3	48	40
Variance from Target to meet Trajectory	730	0	77	25	300	42	73	73	36	26	0	74	29



5. Referral to Treatment

Referral to Treatment Snapshot as 31st August 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2021

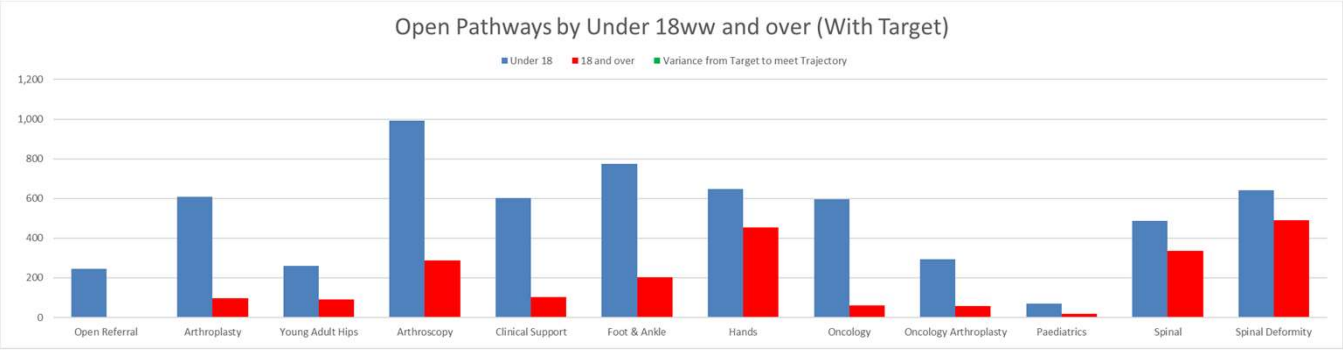
Est Over 18 Clock Stops Required		
To achieve	68.01%	-840
To achieve	75.72%	230
To achieve	79.91%	725

Select Pathway Type: Non Admitted

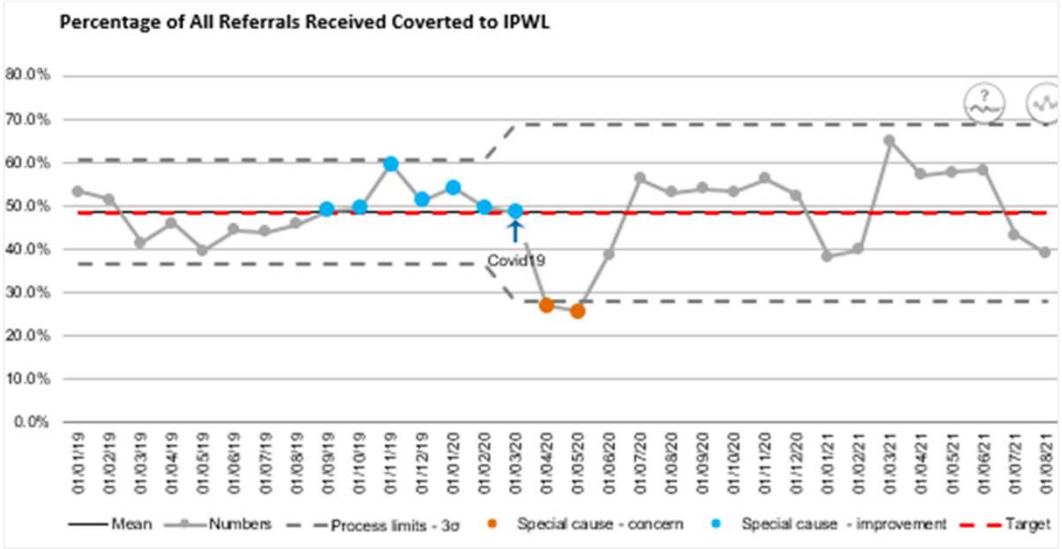
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,842**	215	339	108	446	263	373	217	282	95	31	204	269
7-13	**2,331**	30	202	112	372	235	270	286	206	157	25	198	238
14-17	**1,046**	1	66	41	174	104	131	146	109	40	12	86	136
18-26	**1,097**	0	53	45	151	83	123	218	49	40	8	126	201
27-39	**699**	1	30	33	87	16	63	158	9	9	6	109	178
40-47	**283**	0	7	12	34	5	14	57	0	6	3	73	72
48-51	**73**	0	5	1	6	0	3	17	1	2	1	18	19
52 weeks and over	**42**	0	1	0	8	0	0	3	0	0	0	9	21
Total	**8,413**	247	703	352	1,278	706	977	1,102	656	349	86	823	1,134

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,219**	246	607	261	992	602	774	649	597	292	68	488	643
18 and over	**2,194**	1	96	91	286	104	203	453	59	57	18	335	491
Current Month End RTT %	**73.92%**	99.60%	**86.34%**	**74.15%**	**77.62%**	**85.27%**	**79.22%**	**58.89%**	**91.01%**	**83.67%**	**79.07%**	**59.30%**	**56.70%**

31/08/21 Trajectory RTT %	68.01%	100.00%	75.28%	59.61%	68.96%	84.30%	78.12%	57.35%	89.97%	65.77%	67.74%	57.86%	48.57%
Target for RTT Trajectory	2,925	0	199	177	447	112	217	483	67	152	32	355	681
Variance from Target to meet Trajectory	-731	1	-103	-86	-161	-8	-14	-30	-8	-95	-14	-20	-190

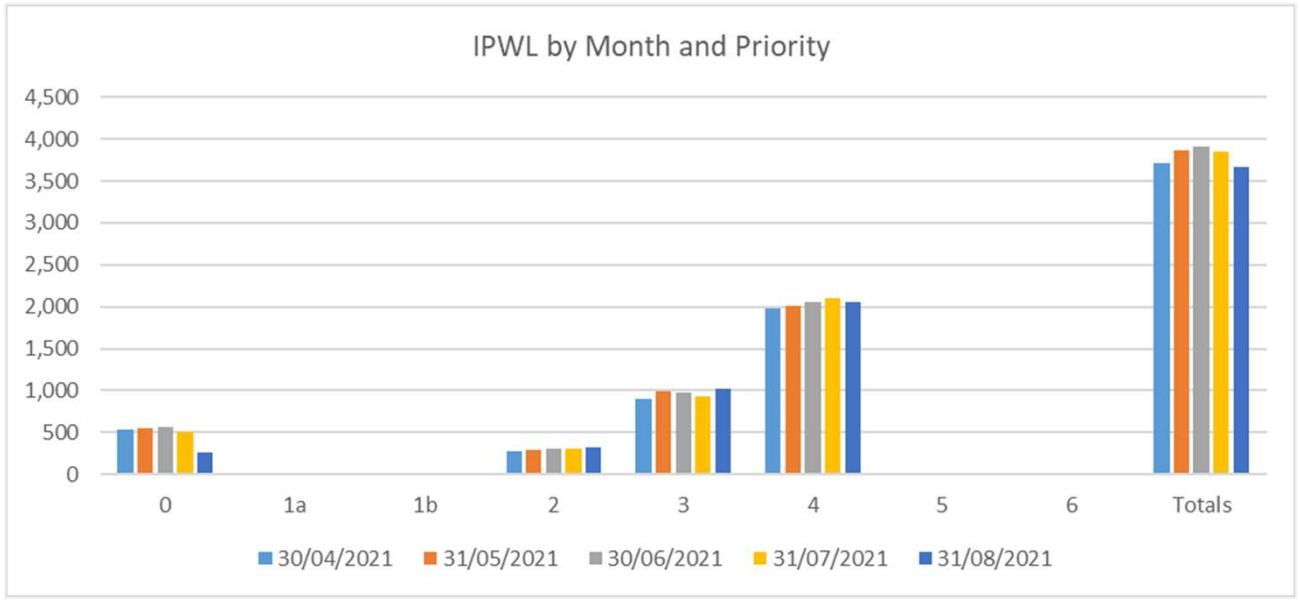


5. Referral to Treatment

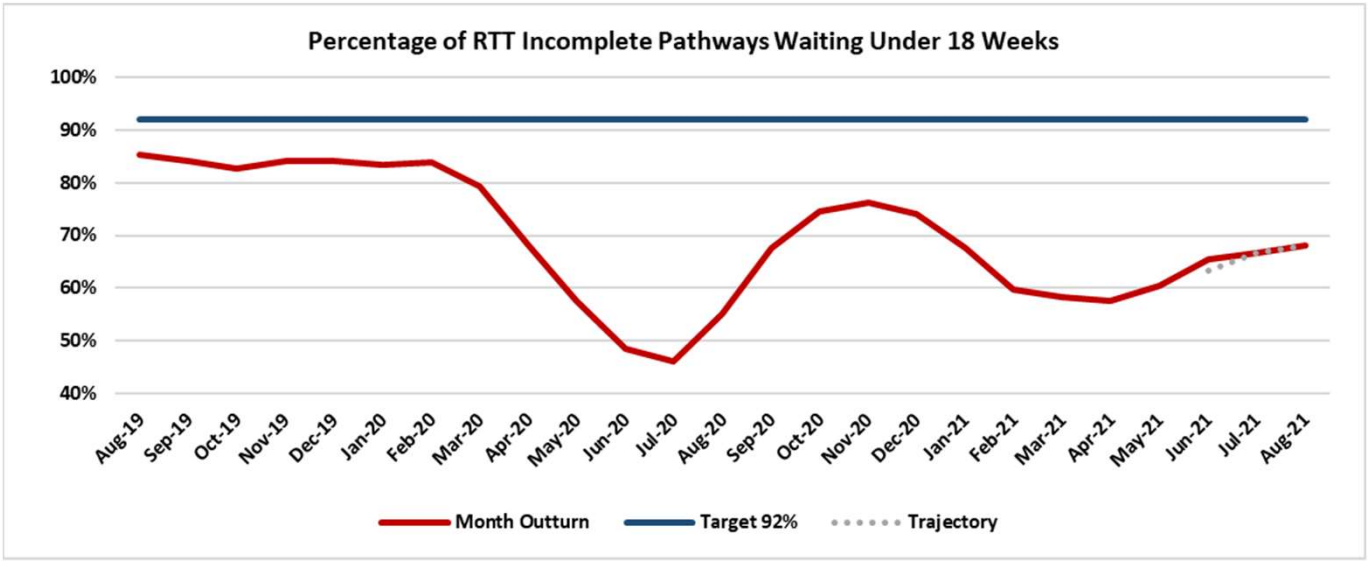


Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Number of Referrals	996	1154	1212	1575	1521	2030	2018	1797	1700	1558	1429	1942	2333	2287	2572	2461	2361
Number of IPWL Additions	268	295	470	885	806	1095	1073	1008	890	595	568	1258	1332	1321	1495	1062	921
Percentage of All Referrals Received Coverted to IPWL	**26.91%**	**25.56%**	**38.78%**	**56.19%**	**52.99%**	**53.94%**	**53.17%**	**56.09%**	**52.35%**	**38.19%**	**39.75%**	**64.78%**	**57.09%**	**57.76%**	**58.13%**	**43.15%**	**39.01%**

5. Referral to Treatment



5. Referral to Treatment



ALL Pathways	RTT Trajectory as at:																		
	31/07/2021	31/08/2021	30/09/2021	31/10/2021	30/11/2021	31/12/2021	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	31/11/2022	31/12/2022
Under 18 Weeks	6,747	6,861	7,420	7,832	8,143	8,423	8,749	9,033	9,282	9,375	9,448	9,523	9,578	9,605	9,625	9,629	9,639	9,648
18 Weeks and Over	3,367	3,227	2,966	2,644	2,288	1,967	1,774	1,533	1,318	1,147	1,057	964	902	859	821	798	778	768
Total ALL Pathways	10,114	10,087	10,386	10,476	10,431	10,391	10,523	10,567	10,601	10,522	10,505	10,487	10,479	10,463	10,446	10,427	10,417	10,416
ALL RTT %	66.71%	68.01%	71.45%	74.76%	78.07%	81.07%	83.14%	85.49%	87.56%	89.10%	89.94%	90.81%	91.40%	91.79%	92.14%	92.35%	92.53%	92.63%
Month % Movement	3.30%	1.30%	3.43%	3.31%	3.31%	3.00%	2.08%	2.35%	2.07%	1.54%	0.84%	0.87%	0.59%	0.40%	0.35%	0.20%	0.18%	0.10%

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for August is 68.02**%** against the National compliance target of 92%. This is an increase compared to July 21 reporting at **66.76%** and is reflective of the increase in elective procedures in month. There are **85** patients over 52 weeks, a decrease from **128** in July - **43** admitted and **42** non-admitted with plans or actions in place to progress these pathways or patients.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. **664** patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority in line with the national guidance for clinical prioritisation of patients awaiting surgery, **2703** patients are on the admitted waiting list **(P2 – 291 patients, P3 –922 patients, P4 – 1428 patients, P5 – 2 patients, P6 – 0 patients**.

Referrals continue to move towards Pre-Covid levels with 2,361 referrals received in August 2021, the average monthly referrals received Pre-Covid (2,704)

IPWL as at 31/08/2021 is 11% higher than the Last Pre-Covid Position (3,297 as at 28/02/2020)

We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

AREAS FOR IMPROVEMENT

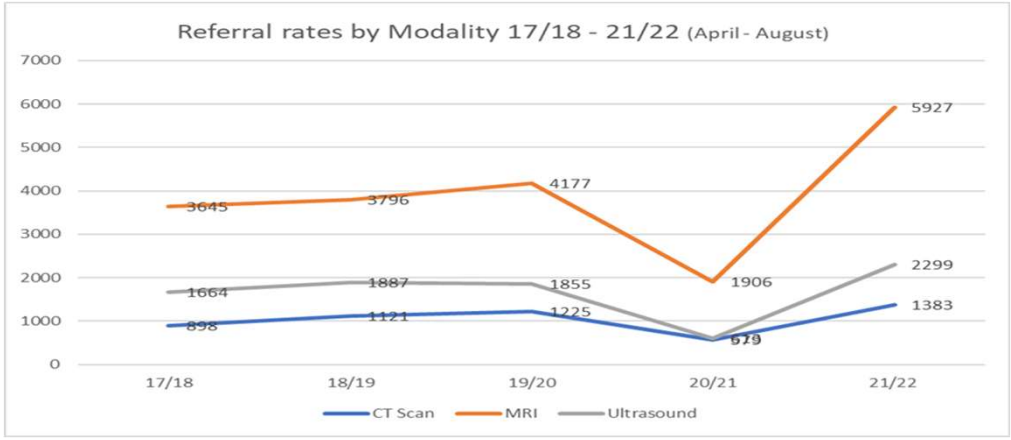
A weekly Elective Care Confirm and Challenge meeting is in place together with a weekly PTL meeting to monitor compliance with RTT and to ensure we are actively progressing patients through their pathways.

RISKS / ISSUES

6. Diagnostic Performance

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

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Jul-20	237	50	82	369	2	367	99.5%	974	195	312	1481
Aug-20	412	66	110	588	5	583	99.1%	655	181	257	1093
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285
Apr-21	776	68	182	1026	8	1018	99.2%	770	233	298	1301
May-21	956	93	353	1402	14	1388	99.0%	599	166	299	1064
Jun-21	1268	64	287	1619	201	1418	87.6%	807	248	391	1446
Jul-21	1390	53	317	1760	324	1436	81.6%	911	212	318	1441
Aug-21	1492	54	376	1922	613	1309	68.1%	768	186	277	1231



6. Diagnostic Performance

SUMMARY

Imaging did not meet the diagnostic target in August reporting 68.11%. Reporting times remain consistently good.

The department continued to see significant increases in referrals in August, with MRI at 125% and Ultrasound at 95% when compared to the same period in 19/20

Additional mobile MRI van capacity has been secured with an additional 6 weeks booked from mid October until the end of November. This along with the 2nd MRI scanner becoming operational from the 13th September will positively start to improve the current positon with the expectation that MRI will be back on track by the end of October.

An extra list per week will become available from October to support the increases in Ultrasound activity and Consultant Radiologists have been approached to provide additional lists. Capital funding has also been approved to purchase a 2nd ultrasound machine (delivery date tbc) which will maximise the throughput of activity in both ultrasound rooms going forward.

AREAS FOR IMPROVEMENT

The independent sector have been approached to ascertain if any MRI capacity is available, but they are unable to help at this time due to their own increasing demands.

RISKS / ISSUES

The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.
With the increasing level of referrals there is a risk to delivering the diagnostic target for MRI and Ultrasound for September which is being monitored closely by the team to mitigate where possible.

7. Cancer Performance

		August 2021 (Incomplete)				July 2021 (complete)				June 2021 (complete)			
Target Name	National Standard	%	In target	Breach	Total	%	In target	Breach	Total	%	In target	Breach	Total
2ww	93%	98%	46.00	1.00	47.00	95%	61.00	3.00	64.00	98%	55.00	1.00	56.00
31 day first treatment	96%	100%	6.00	0.00	6.00	100%	15.00	0.00	15.00	100%	10.00	0.00	10.00
31 day subsequent (surgery)	94%	100%	4.00	0.00	4.00	100%	5.00	0.00	5.00	100%	4.00	0.00	4.00
62 day (traditional)	85%	67%	2.00	1.00	3.00	30%	1.50	3.50	5.00	88%	3.50	0.50	4.00
62 day (Cons Upgrade)	n/a	86%	3.00	0.50	3.50	69%	5.50	2.50	8.00	75%	3.00	1.00	4.00
28 day FDS REPORTED	75%	81%	59	14	73	89%	81	10	91	74%	48	17	65

7. Cancer Performance

SUMMARY

Performance against 2 week wait, 31 day first and subsequent surgery and 28 day FDS performance continued in a positive trajectory, with a 40% increase in the number of qualifying patients for 31 day targets.
There was a drop in performance against the 62 day traditional and consultant upgrade targets in July which is predicted to continue into August. All patients were tracked and escalated appropriately and the appropriate clinically led decision made. Contributing factors include:

- Increased numbers of patients requiring repeat biopsies or complex analysis of pathology
- Late tertiary referrals
- Capacity in Oncology and supporting services (e.g. radiology, pre-op, pathology) due to an increase in referrals in June and July on average 80 referrals per month compared to 19/20 & 20/21 where we saw an average of 60 referrals per month. August referrals have decreased and we are continuing to monitor the referral pattern going forwards. The increase in referrals and acuity of patients being referred into the service are in line with national trends due to the impact of C19 restriction relaxation
- Conflicting demands for cancer target patients with similar deadlines
- Increased numbers of patients unfit for surgery or testing as C19 +ve in pre-op screening

27 patients have been referred from RJAH as part of the SLA.

AREAS FOR IMPROVEMENT

There is increased surveillance on the Oncology and Cancer PTLs through additional weekly reviews with the team to anticipate issues in a more proactive manner.
Estates move has been confirmed – floor plan sign off pending before procurement process commences.
RMS pathways and implementation continues – system issues have delayed the 6th September start date, however this gives further opportunity to test the new pathway with an anticipated 'go live' date in October
Pathology database transition work ongoing – Jon Stevenson is the Consultant Lead

RISKS / ISSUES

There are two gaps in Fellow and Trainee grades following the August 2021 rotation. The vacancies have been appointed into and pre-employment checks are underway with start dates to be confirmed. The senior CNS post holder is due to start at the end of September 2021 and the nursing compliment will be fully established.

8. Overall Financial Performance

SUMMARY

The Trust delivered a year to date deficit of £932k against a plan of £102k surplus, creating a variance of £1,034k underperformance against plan.

Income year to date against plan is over performing by £201k. This is an improvement on last month.

ERF income recognised to date is £1,898k against a year to date plan of £1,548k.

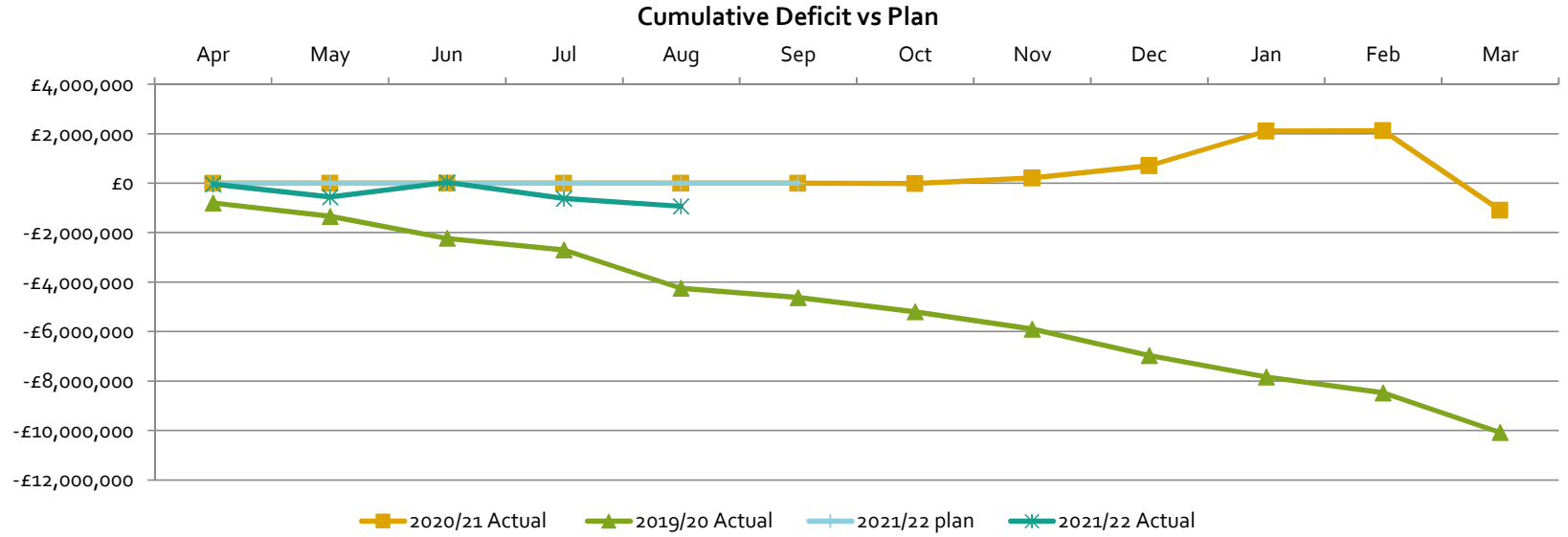
Pay and non pay expenditure overspent year to date by £1,235k.

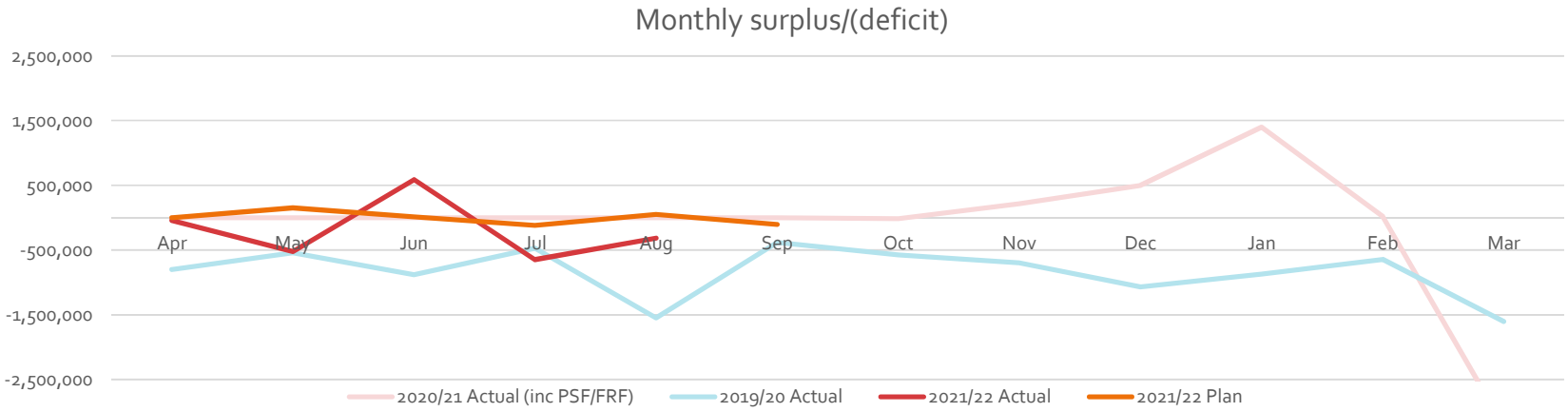
	£'000s			
	Income	Pay	Non Pay	Total
Year to date Variance	201	(556)	(678)	(1,034)
Year to date plan	43,720	(24,298)	(19,348)	102
Year to date actual	43,920	(24,854)	(20,027)	(932)
Actual compared to previous month	▲	▼	▼	▼
Forecast Variance	477	(921)	(933)	(1,034)

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	42,075	42,112	37
Other Operating Income (Excluding top up)	1,645	1,808	163
Total Income	**43,720**	**43,920**	**201**
Employee Expenses (inc. Agency)	(24,298)	(24,854)	(556)
Other operating expenses	(19,004)	(19,687)	(683)
Operating Deficit	**417**	**(621)**	**(1,039)**
Net Finance Costs	**(344)**	**(340)**	**4**
Net surplus/(deficit)	**73**	**(961)**	**(1,034)**
Remove donated asset I&E impact	29	29	-
Adjusted financial performance	**102**	**(932)**	**(1,034)**

8. Overall Financial Performance





9.Income

SUMMARY

Income year to date against plan is overperforming by £201k, largely as a result of £1,898k of Elective Recovery Fund (ERF) income being recognised against a year to date plan of £1,548k.

ROH performance would have generated £3,423k in ERF income if the system target had been achieved. The system are currently underperforming against the ERF target so the system are not expected to achieve further ERF funds during H1.

AREAS FOR IMPROVEMENT

Private patient income is below average, with a reduction in August considered to be due to staff availability over the summer period.

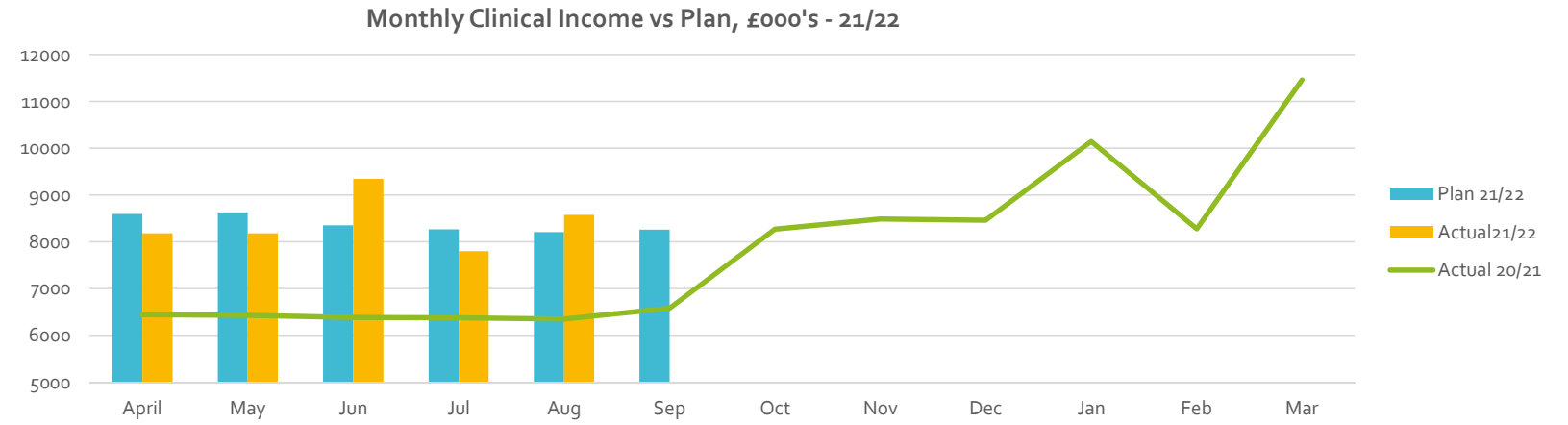
RISKS / ISSUES

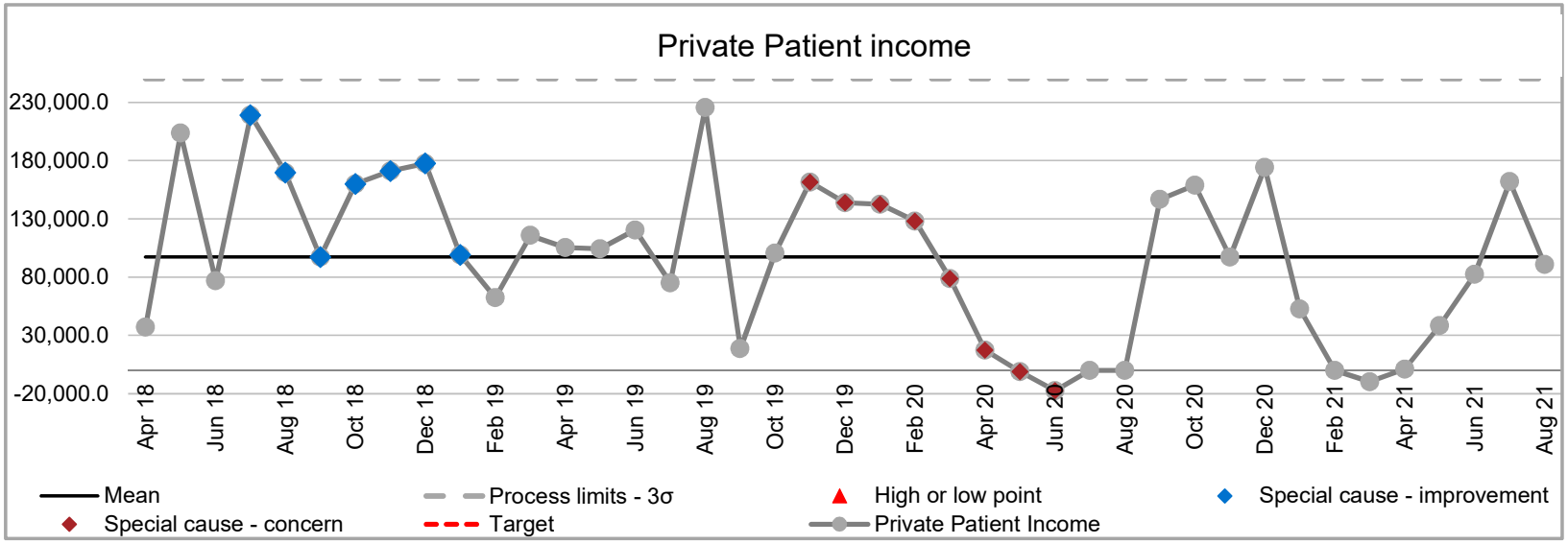
Elective Recovery Fund (ERF) income of £1.9m is currently included within the plan, although this is now forecast to be £2.3m due to over performance in previous months against the system target.

ERF is a value based target set on system level performance rather than provider level. In the month, a revised, significantly more challenging trajectory for ERF was provided by NHS E/I of 95% from July onwards (previously 85%).

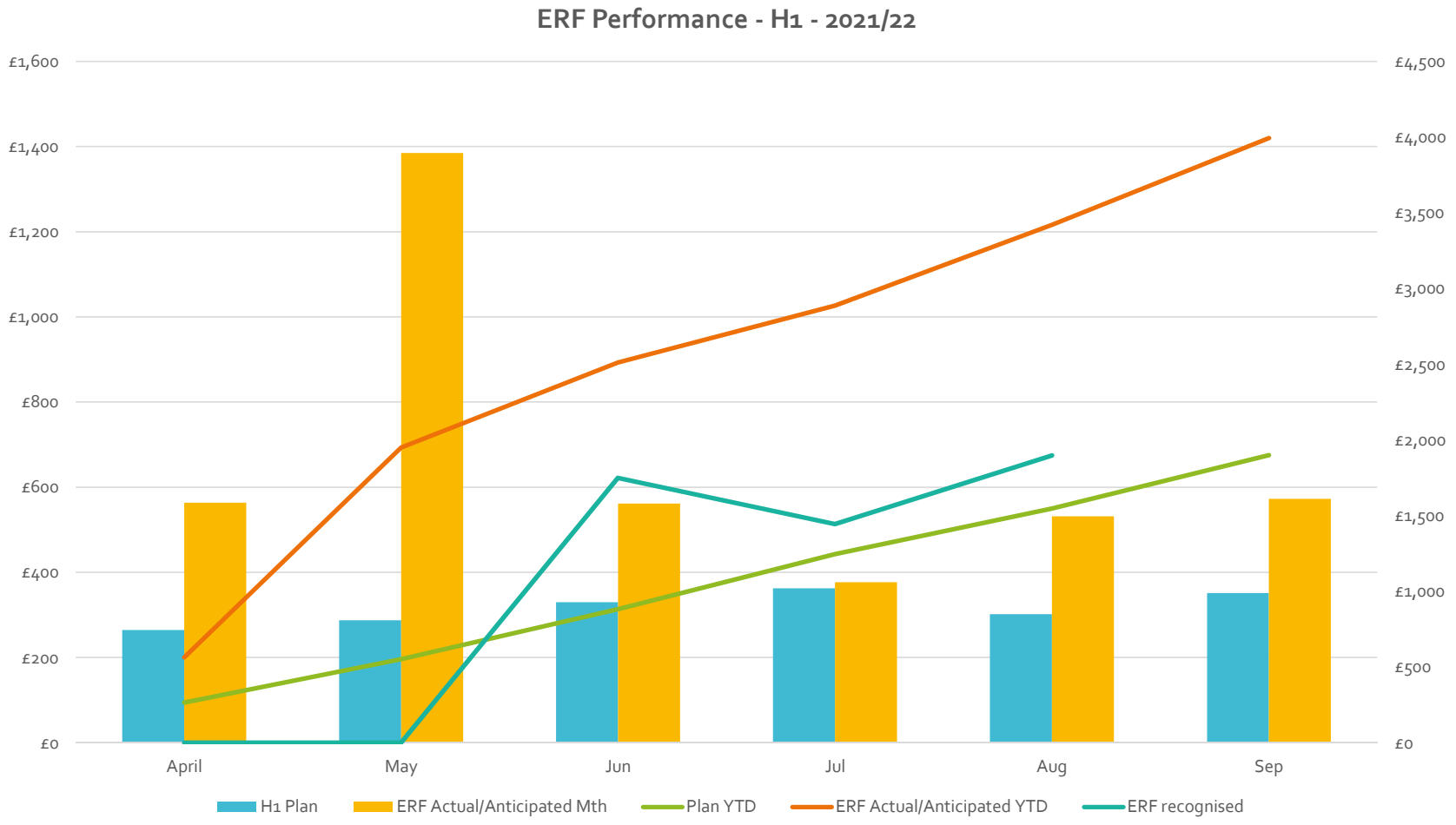
The Trust is not yet clear on the expectations in H2, but is expecting this to be made clear imminently as part of the H2 offer publication.

9. Income


Monthly Clinical Income vs Plan, £000's - 21/22
12000
11000
10000
9000
8000
7000
6000
5000
April
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan 21/22
Actual21/22
Actual 20/21


Private Patient income
230,000.0
180,000.0
130,000.0
80,000.0
30,000.0
-20,000.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

9. Income


ERF Performance - H1 - 2021/22
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
April
May
Jun
Jul
Aug
Sep
H1 Plan
ERF Actual/Anticipated Mth
Plan YTD
ERF Actual/Anticipated YTD
ERF recognised

9. Expenditure

SUMMARY

Pay and non pay expenditure overspent year to date by £1,234k, which has been driven by increased activity against original plan.

The Trust are expecting to receive H2 allocations imminently, and will update the F&P Committee on the key impacts if received before the meeting. Once the allocations have been made available, budgets will be able to be allocated for H2.

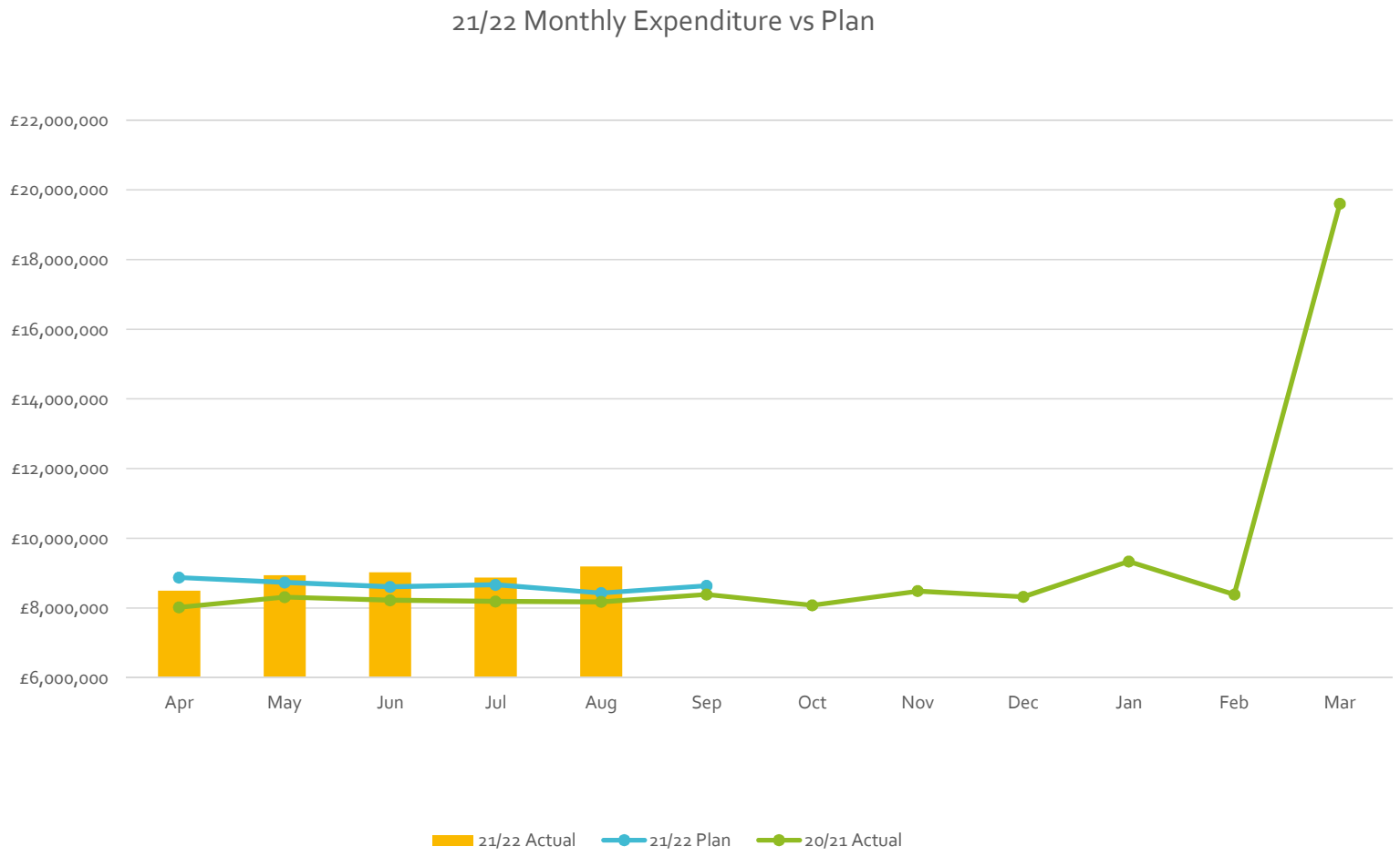
AREAS FOR IMPROVEMENT

Agency spend is slightly above plan with a year to date overspend of £103k. Agency costs as a percentage of total staff costs has remained almost static at 6.2%. This is an increase from 4.6% in 2020/21, and is above planned levels of 5.8%.

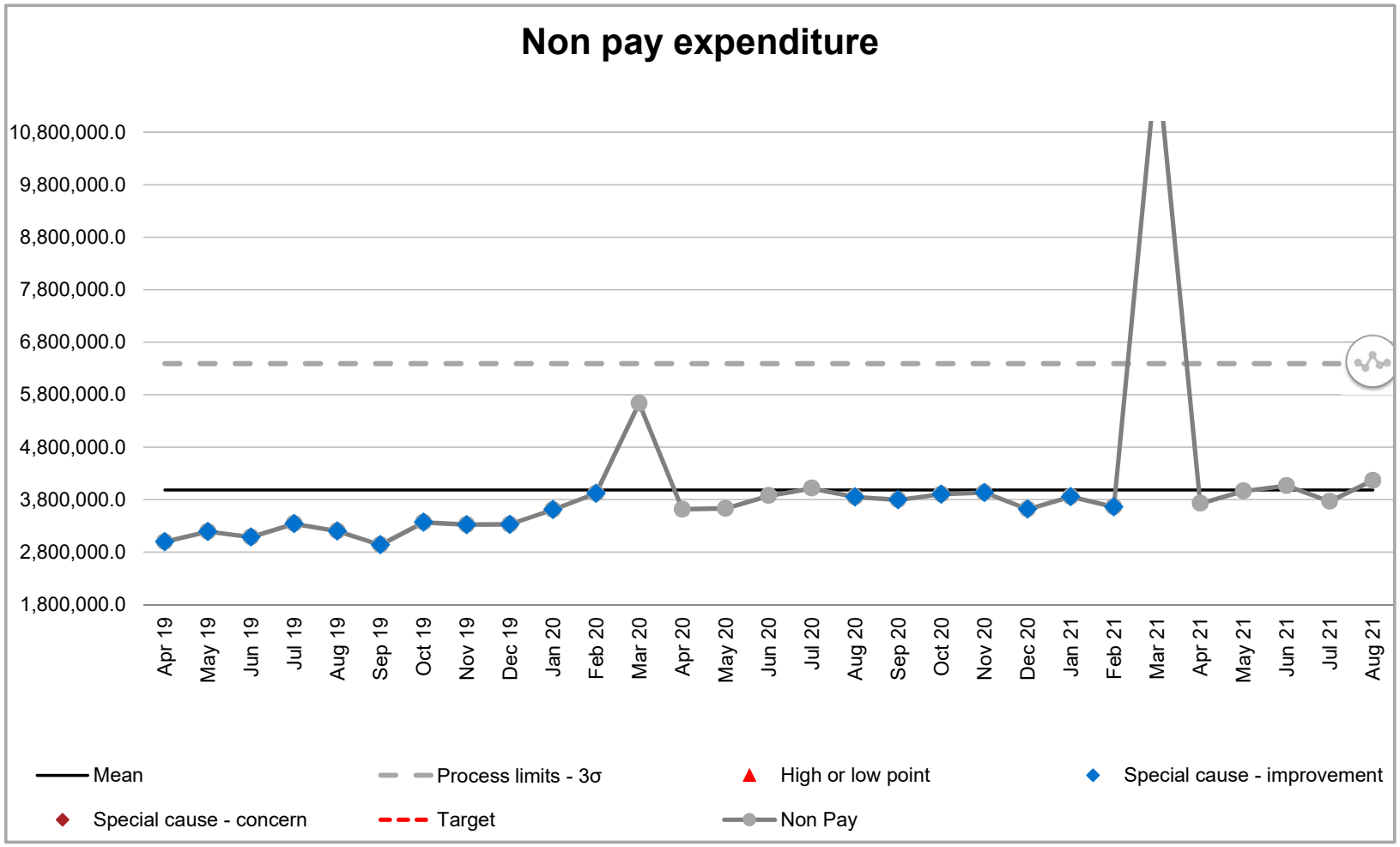
RISKS / ISSUES

As described above, the H2 financial plan not yet been agreed as the funding envelope has not yet been allocated to the ICS, although this is expected to occur imminently.

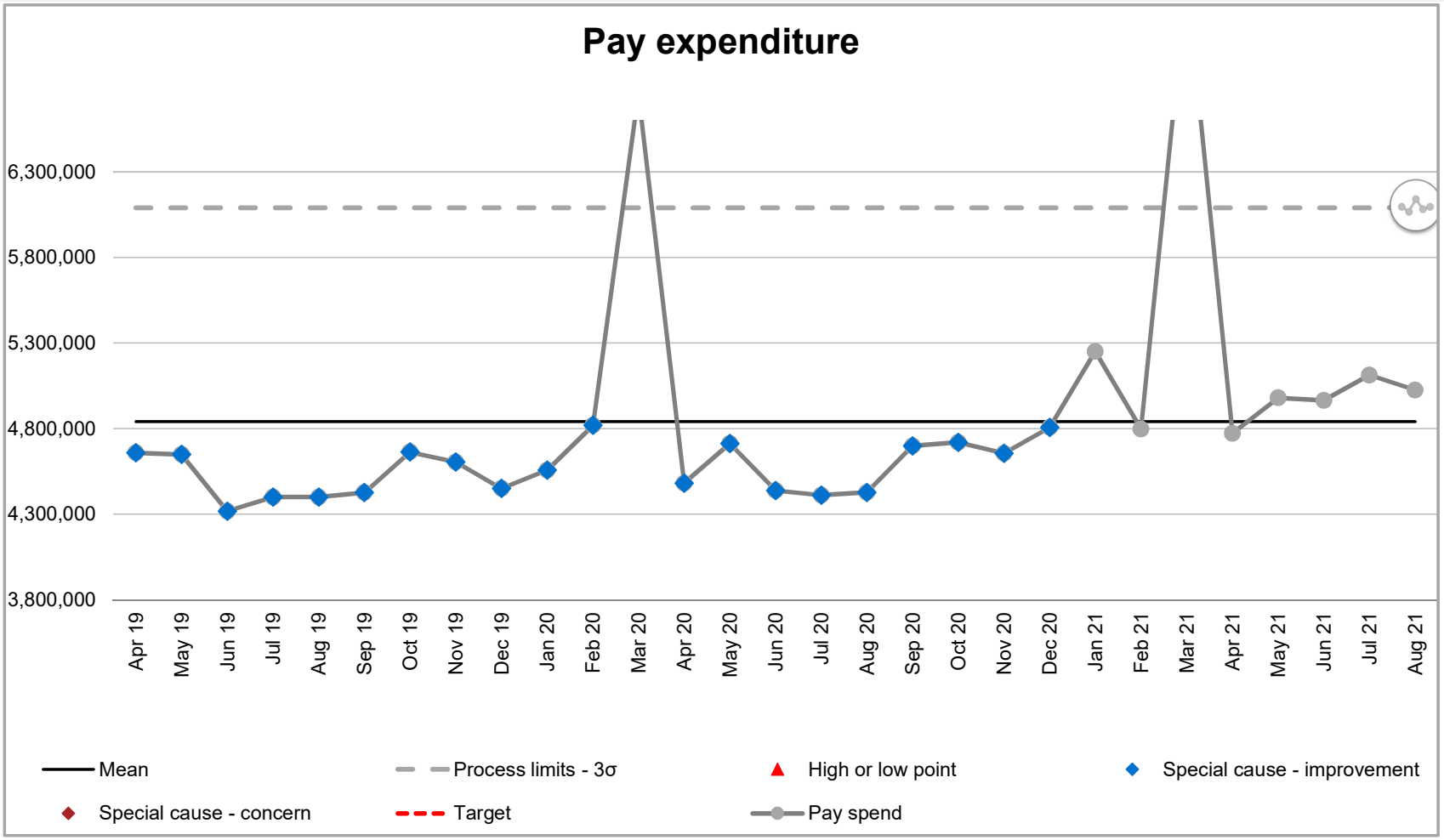
9. Expenditure



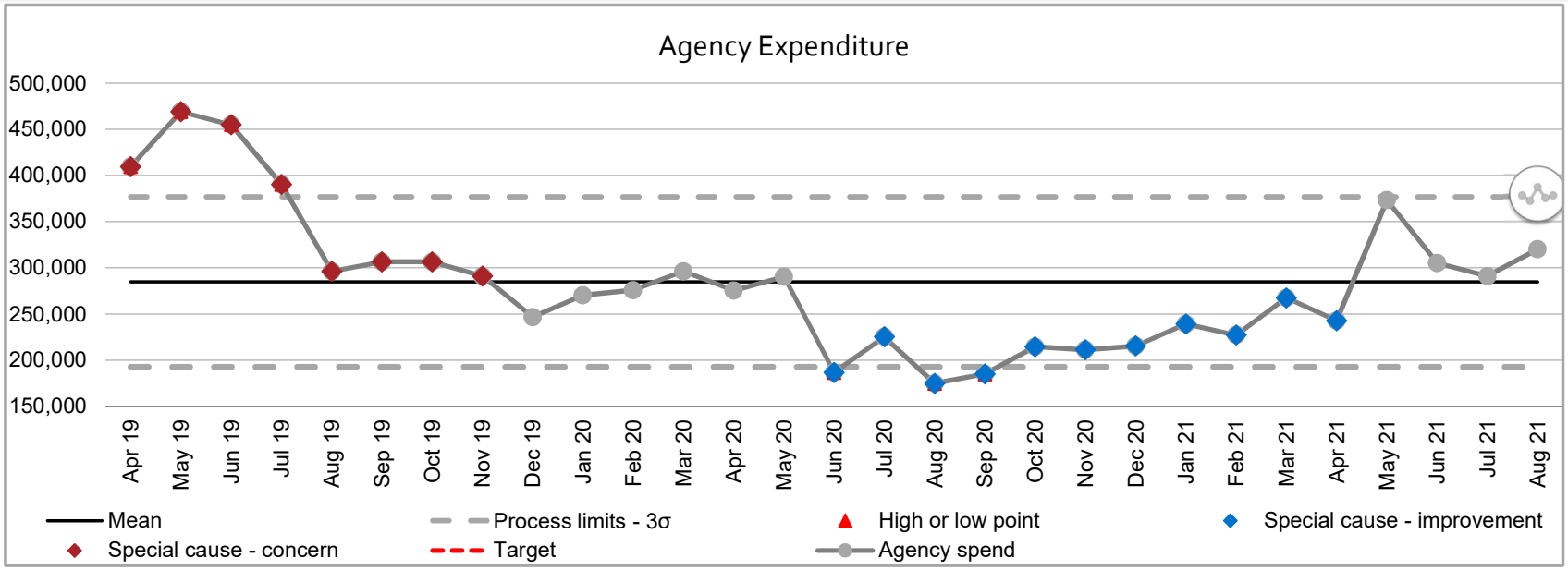
9. Non Pay Expenditure



9. Pay Expenditure

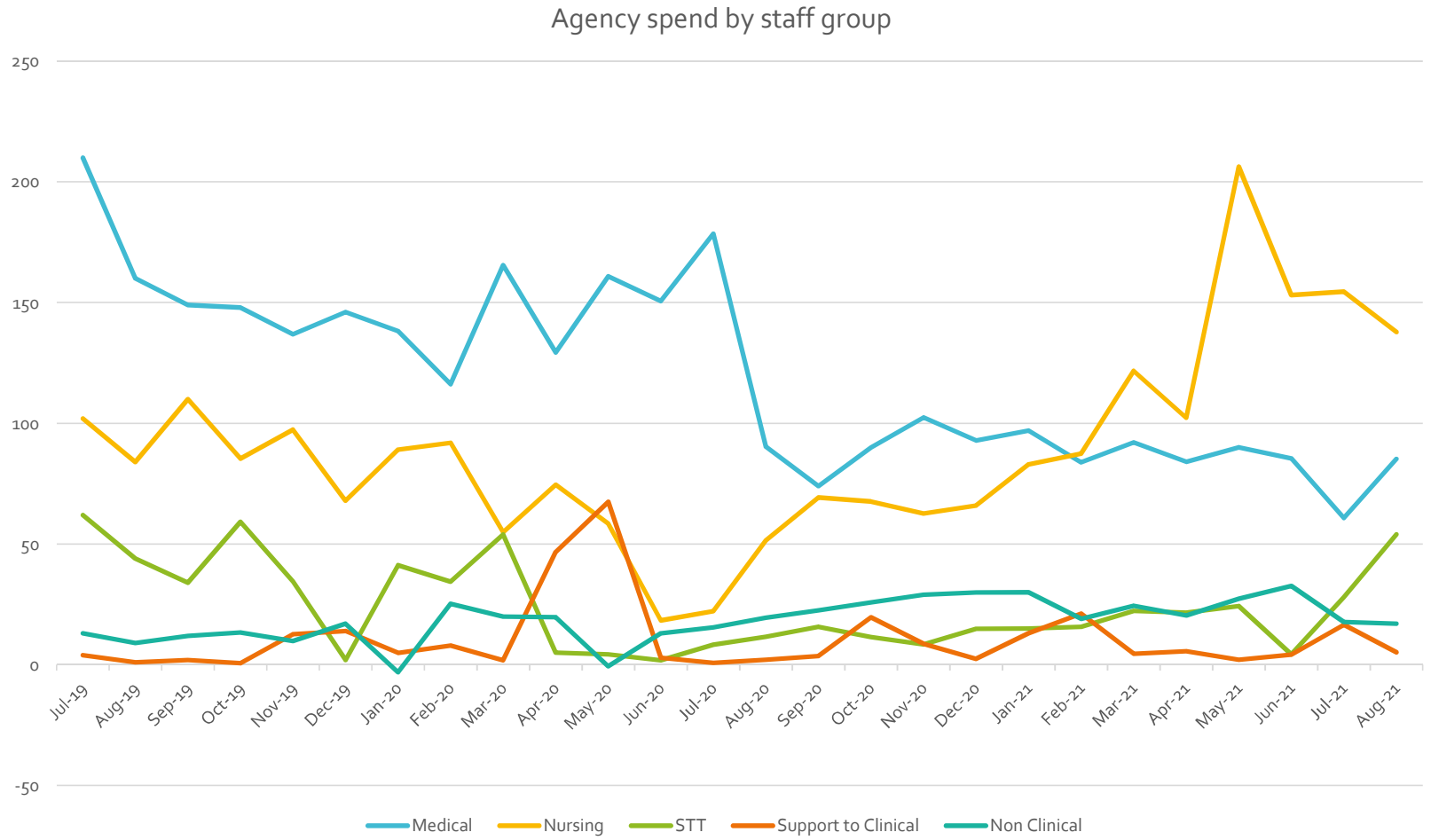


11. Agency Expenditure



	Year to date Spend (£'000s)			
	Agency	Bank	Substantive	Total
Medical staff	406	248	6,135	6,789
Clinical Staff (exc medical staff)	915	1,003	9,204	11,122
Non clinical staff	212	574	6,072	6,858
Total	1,532	1,824	21,411	24,767

11. Agency expenditure



12. Cost Improvement Programme Summary

SUMMARY

Efficiencies totalling £562k have been recognised year to date with £2,748k expected to be delivered in total during 2021/22. The most significant scheme delivering savings to date is non pay procurement savings. The planning assumptions for H1 expected CIP of 2.15%, £1,236k to be delivered. H2 it is expected to be 3%.

CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£110	£64	-£46	£64
Non Pay	£897	£474	-£423	£2,490
Income	£104	£25	-£79	£195
Total	**£1,111**	**£562**	-£549	**£2,748**

Scheme	Confidence level of delivery	Year to Date (£'000s)		
		Plan	Actual	Forecast
Theatres MSC - VAT recovery on Consumables and Prosthesis	Low	£580	£0	£1,391
Procurement - Birmingham Hospital Alliance Collaborative	Med	£191	£447	£738
Private patient service expansion	High	£50	£25	£145
Diagnostics and Therapies - Synertec paperless	High	£56	£0	£135
Spinal Implant Rationalisation & Modernisation	Med	£38	£0	£90
Substantive Medical recruitment - reduce agency spend and Direct Engagement saving	Med	£110	£64	£64
Enhanced Voice Recognition - Digital Dictation	Med	£25	£0	£60
Microsoft 365 Licence review	High		£26	£58
DNA Rate Reduction - Outpatients	Med	£21	£0	£50
Interpreting via telephone	Med	£8	£0	£18
Employee benefits scheme - VIVUP scheme	Med		£2	£2

13. Statement of Financial Position

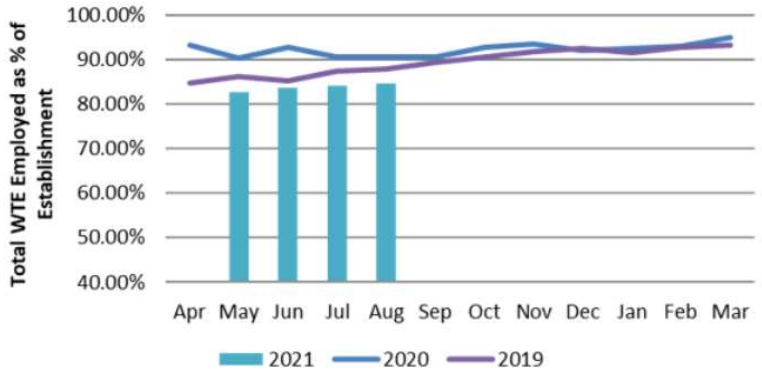
SUMMARY

The cash balance has increased in comparison to the year end, largely due to an expected credit note being received from a supplier, in addition to timing differences at the month end on payables.

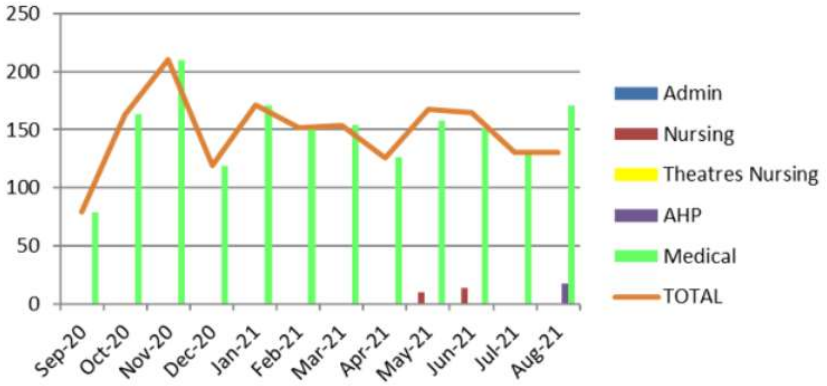
	2020/21 M12	2021/22 M5	Movement
	(£'000)		
Intangible Assets	1,255	1,191	(64)
Tangible Assets	45,798	46,005	207
Total Non Current Assets	**47,053**	**47,196**	**143**
Inventories	1,800	1,818	18
Trade and other current assets	8,492	5,120	(3,372)
Cash	5,703	10,284	4,581
Total Current Assets	**15,995**	**17,223**	**1,228**
Trade and other payables	(11,396)	(13,528)	(2,132)
Borrowings	(877)	(567)	310
Provisions	(2,758)	(3,155)	(397)
Other Liabilities	(344)	(457)	(113)
Total Current Liabilities	**(15,375)**	**(17,707)**	**(2,332)**
Borrowings	(1,009)	(1,009)	-
Provisions	(1,029)	(1,029)	-
Total Non Current Liabilities	**(2,038)**	**(2,038)**	**-**
Total Net Assets Employed	**45,635**	**44,674**	**(961)**
Total Taxpayers' and Others' Equity	**45,635**	**44,674**	**(961)**

14. Workforce

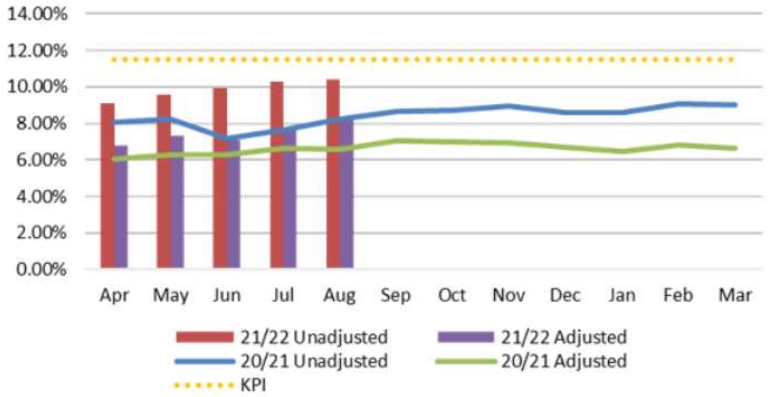
Staff In Post vs. Establishment



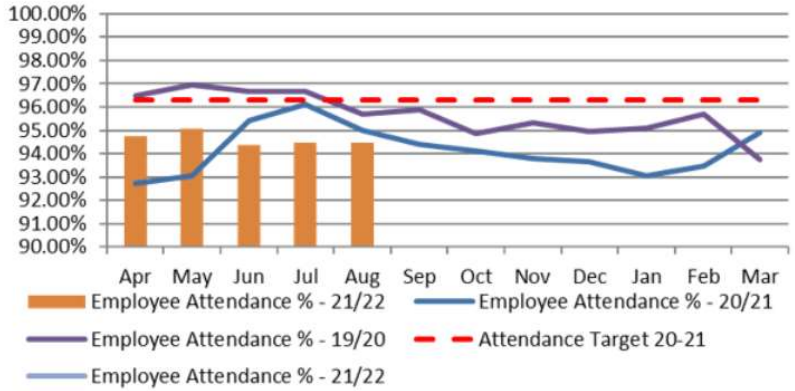
Agency Breaches



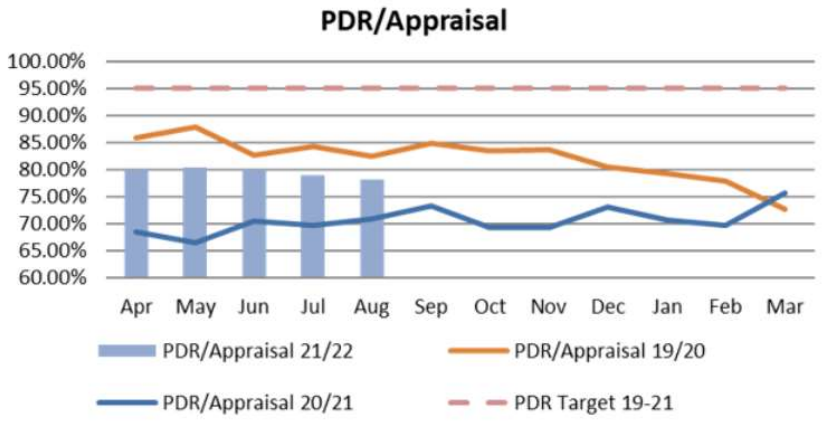
Staff Turnover



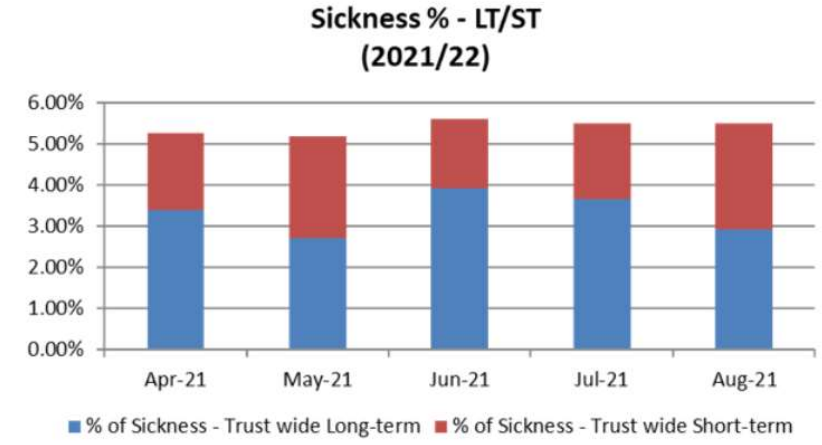
Employee Monthly Attendance %

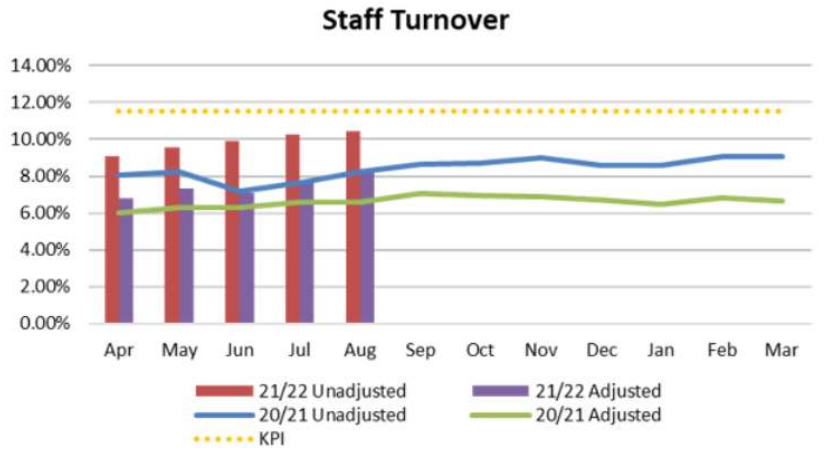


14. Workforce









14. Workforce

Trust Workforce Metrics	Jun-21	Jul-21	Aug-21	This Month vs Last Month	Trend	KPI
Staff in Post - Headcount	1225	1233	1238	5	-	-
Staff in Post - Full Time Equivalent	1085.78	1093.82	1099.95	6.13	-	-
Staff Turnover (%) - Unadjusted	9.91%	10.27%	10.42%	0.15%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	7.11%	7.75%	8.23%	0.48%	⇧	<=11.5%
Total WTE Employed as % of Establishment	83.69%	84.23%	84.67%	0.44%	⇧	>=93%
Total WTE Employed as % of Establishment - Clinical	81.47%	82.03%	82.11%	0.08%	⇧	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	87.76%	88.25%	89.37%	1.11%	⇧	>=96%
% of Attendance	94.38%	94.49%	94.48%	0.00%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.31%	94.15%	94.13%	-0.02%	⇩	>=96.3%
% Staff received mandatory training last 12 months	82.45%	83.93%	84.11%	0.17%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	79.90%	79.05%	78.24%	-0.80%	⇩	>=95%
% of Sickness - Trust wide Long-term	3.93%	3.66%	2.94%	-0.72%	⇩	-
% of Sickness - Trust wide Short-term	1.69%	1.85%	2.57%	0.72%	⇧	-
Return To Work Completion %	65.89%	53.50%	51.66%	-1.85%	⇩	>=80%

QUALITY REPORT SEPTEMBER 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	*MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY*
6 Moderate Harms reported **1 In hospital death recorded** **One Serious Incident was reported** **4 x Grade 2 Pressure ulcers reported** **10 x In-Patient Falls Incidents** **Prevent training** - Remains under the 90% KPI at 88.37% **The Trust Annual Complaints report** It was agreed that the annual report for Complaints will go for approval on the October 2021 Quality and Safety Executive meeting with final approval at the Trust Board on the 2nd November 2021	**Screening patients for delirium** To look at rolling out screening patients for delirium across all wards, so that those patients that may potentially mobilise against advice can be more readily identified and placed in a bed where closer supervision can be provided. **Bed rails policy** Review of bed rails policy is underway. **Compliments** The Public Engagement department is looking into the collection of compliments as the number reported is low. **Compliance with mandatory 24-hour re-assessment** Actions are underway to: • Review wording of standard. NICE Ng89 2018; states Reassess all medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes opposed to specifically 24 hours. • PICS alert gives option to acknowledge (by ticking accept responsibility for having completed) or Ignore (not done now so will keep alerting) need for re-assessment-current PICS report methodology to be reviewed to ensure this is reflected in the data collection (not currently). • Retain re-assessment as in 5-6% of patient prophylaxis need did change from initial assessment by cease reporting until above recommendations are complete to ensure accuracy. • Re-audit in 3-6 months

	Gap analysis of the CQC Regulation for receiving and acting on complaints. Gap analysis of the CQC Regulation 16.1 (Receiving and acting on complaints) is currently being undertaken by the Head of Patient Experience and will be presented on the next Patient Experience and Engagement Group
POSITIVE ASSURANCES TO PROVIDE **Breaking bad news** Further to the work undertaken to address the issues raised by the CQC in relation to breaking bad news, The Trust has now made some amendments to the care certificate to further educate staff. The CQC action plan will be updated to reflect this update. **Friends and Family completion rates** FFT – Both the External 35% and internal 40% compliance rate for completion was met. Although the Trust has hit mandatory response rate of 35% there were four inpatient areas that did not hit the mandatory completion rate in August 2021. These four areas did show improved compliance so work will be undertaken to ensure they meet the KPI target next month. **Safeguarding level 3** Now above the 85% KPI target **New PALS posters** The Public Engagement department has designed new PALS posters that have been translated to the five most common languages spoken by our patients. The Posters include a contact for patient to text the Public Engagement team with their preferred language and the time/date for a PALS call back. This will encourage more patients to provide feedback, raise concerns or complaints.	***DECISIONS MADE*** **Serious Incident policy and Incident management policy** Both polices have been reviewed by the Head of Clinical Governance. No changes are judged to be needed and the policy review date will be extended with approval from the Executive Director of Nursing and Clinical Governance.

CAS alerts No overdue CAS alerts	

Quality Report - September 2021 (August 2021 Data) – Front Cover and Dashboard

	April 2021	May 2021	June 2021	July 2021	August 2021	2021/2022	2020/2021 YTD
Incidents	391	345	376	317	208 (↓)		
Serious Incidents	1	0	0	0	1(↑)	2	10(Total)
Internal RCA investigations	5	1	3	4	3(↓)		
VTEs (Avoidable)	0	0	0	0	0	0	1(Avoidable)
Falls	6	8	8	7	10(↑)	39	76(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0	0	1	1	2	10(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0(Avoidable)
Complaints	3	4	7	4	3(↓)	18	57(Total)
PALS	47	62	68	90	61(↓)		
Compliments	5	5	5	7	3(↓)		
FFT Score %	97	96	98	98	99(↑)		
FFT Response %	29	33	28	33	41(↑)		
Duty of Candour	10	12	16	20	15(↓)		
Litigation	0	0	1	0	0		
Coroners	0	0	0	0	0		
WHO %	100	100	100	100	100		
Infections	0	1	1	0	1(↑)	3	3 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

September 2021 (August 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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2	Incidents and Mortality
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8	Patient Experience
9	Friends & Families Test and Iwantgreatcare
10	Duty of Candour
11	Litigation and Coroners Inquests
12	WHO Surgical Safety Checklist
13	Infection Prevention Control + Covid update
14	Safeguarding
15	Outpatient efficiency
16	Treatment targets
17	Process & Flow efficiencies
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1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

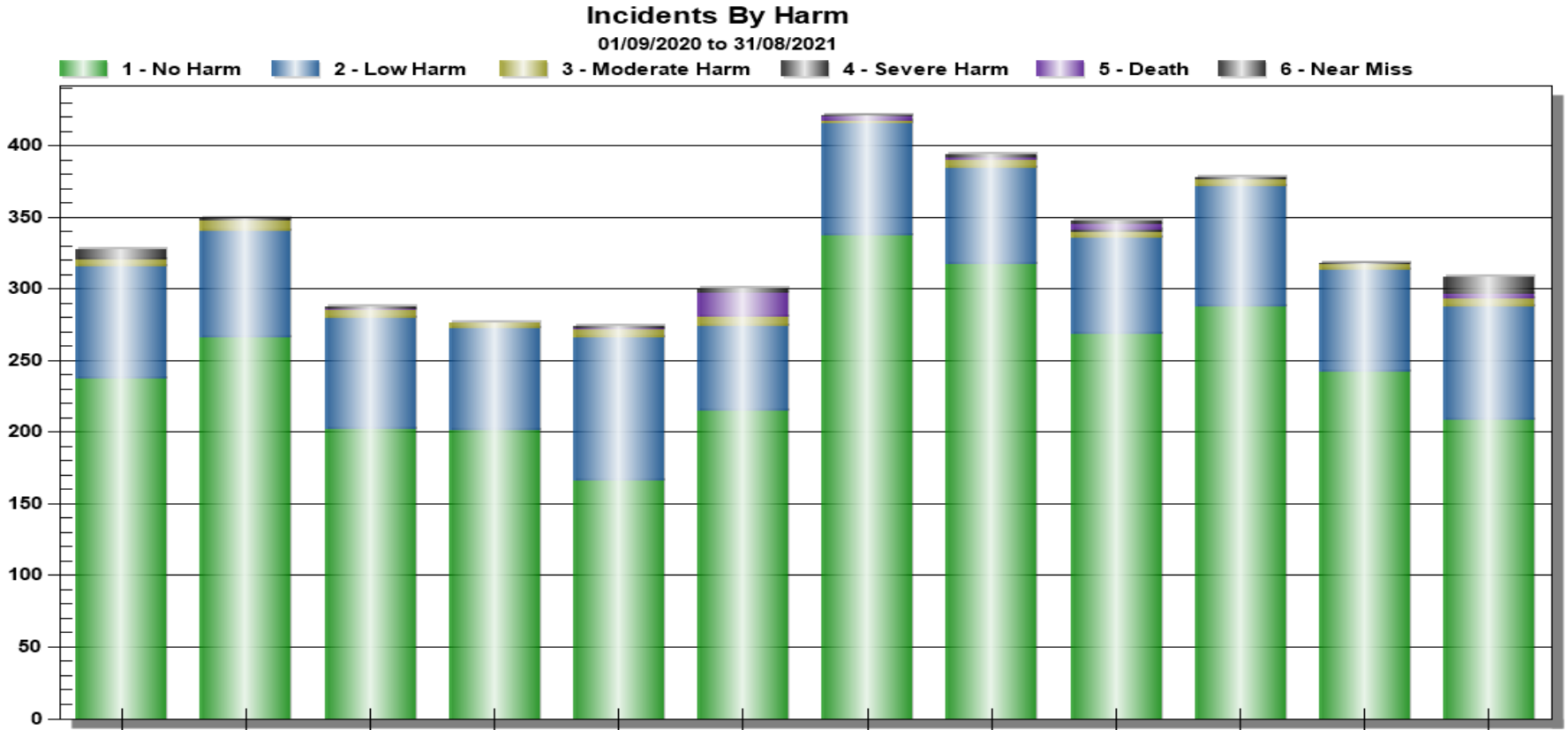
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55216)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**



Month and Year	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021
1 - No Harm	237	266	202	201	166	215	337	317	268	287	242	208
2 - Low Harm	78	74	77	71	100	59	78	67	67	84	71	79
3 - Moderate Harm	5	7	6	4	5	6	2	6	4	5	4	6
4 - Severe Harm	0	0	0	0	0	0	0	0	2	0	0	0
5 - Death	0	0	1	0	1	17	3	1	4	0	0	3
6 - Near Miss	7	2	1	0	2	3	1	3	2	2	1	12

Data source – Ulysses

INFORMATION

In August 2021, there were a total of 308 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

208 – No Harm
79 - Low Harm
6 - Moderate Harms
0 - Severe Harm
12 – Near Miss
3 – Death (1 In hospital and 2 out of hospital)

Downgraded Incidents

Currently 0 of the reported harm in the Previous Quality report (August 2021) have been downgraded.

Patient Contacts

In August 2021, there were a total of 7484 patient contacts. There were 308 incidents reported, which amounts to 4.1 percent of the total patient contacts. Of those 308 reported incidents, 88 incidents resulted in harm which is 1.2 per cent of the total patient contact.

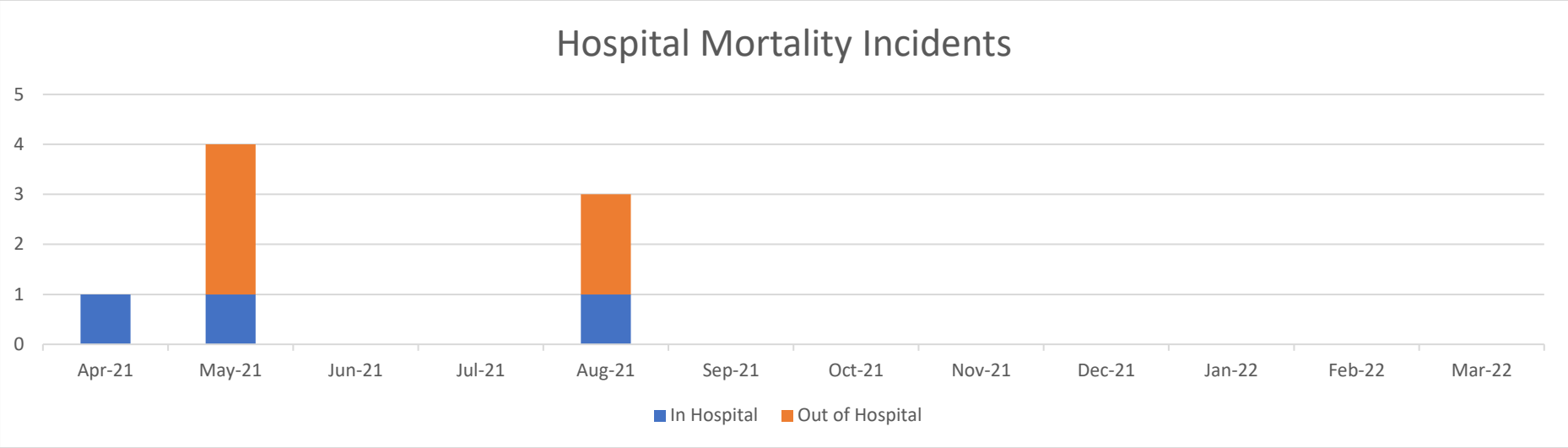
ACTIONS FOR IMPROVEMENTS / LEARNING

Serious Incident policy and Incident management policy are been reviewed by the Head of Clinical Governance. No changes are judged to be needed and the policy review date will be extended with approval from the Executive Director of Nursing and Clinical Governance.

RISKS / ISSUES

None

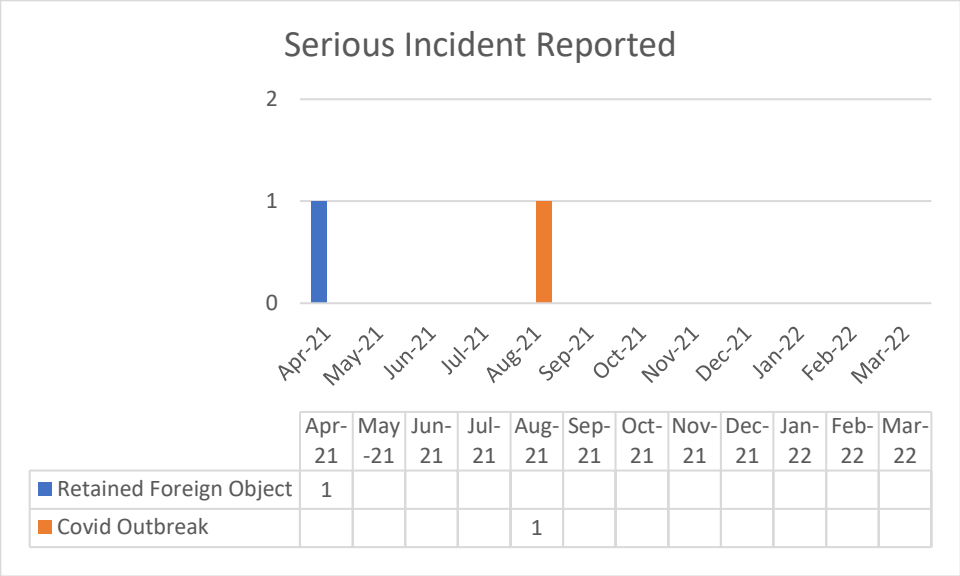
In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
3 deaths were reported in August 2021. One Death occurred in hospital. Two deaths were reported as part of the Learning from deaths process reviewing out of hospital deaths within 30 days of discharge from the ROH.
ACTIONS FOR IMPROVEMENTS / LEARNING
Further to the work undertaken to address the issues raised by the CQC in relation to breaking bad news, The Trust has now made some amendments to the care certificate to further educate staff. The CQC action plan will be updated to reflect this update. A Mortality report was presented to the Trust Board in September 2021.

RISKS / ISSUES
None

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



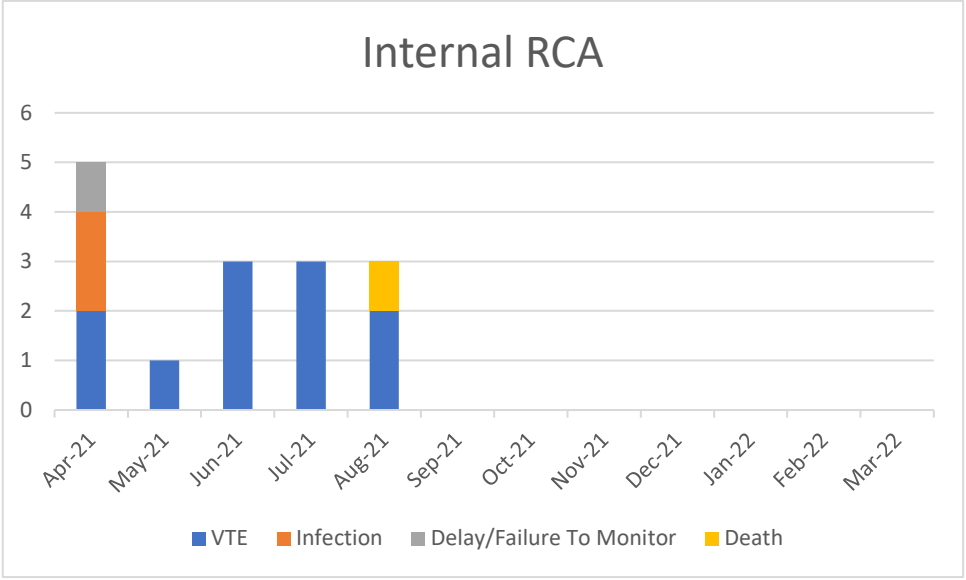
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Retained Foreign Object	1											
Covid Outbreak					1							

Year Totals	
20/21	11
21/22	2

Data Source – STEIS

INFORMATION
One Serious Incident was reported in August 2021 – a COVID outbreak in a staff area. **Status of investigation** Root Cause Analysis is underway with a draft submitted to Clinical Governance Outbreak meeting held with NHS England and improvement, Clinical Commissioning Group (CCG) and Public Health England A brief detailing the outbreak was presented to the Quality and Safety Committee and Trust Board in August 2021 and September 2021.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no serious incidents closed by the CCG in August 2021.
RISKS / ISSUES
None

4. **Internal Root Cause Analyses (RCAs) - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



Data Source – Internal RCA tracker

INFORMATION

There were 3 internal RCAs reported in August 2021 and are currently underway within the divisions. This is also detailed on the incident page within this report. If any learning is highlighted within these reports the learning will be shared within this report and Trust wide.

ACTIONS FOR IMPROVEMENTS / LEARNING

One RCA was closed in August 2021.

Lessons learned

1. The referral and booking of an appointment for out-patient physiotherapy from the ward is an essential piece of work, responsibility for this lies with the ward physiotherapist.
2. There should be a process in place to ensure, a referral to out-patient physiotherapy is made when necessary and not missed, especially if the workload is busy on the ward.
3. It is important that out-patient physiotherapy referrals are triaged for urgency within 48hrs of being registered by the therapies department, this should not be delayed by other processes.
4. Systems need to be put into place in order to prevent physiotherapy patients being lost to follow up, especially if members of staff leave the Trust. This needs to be developed alongside the system administrators for the Tiara system, and ensure that alerts/notifications are received by the appropriate staff.
5. Safeguarding alerts - no assumptions should be made by therapists working in the out-patient department when a patient on their caseload has a safeguarding alert. All staff must take responsibility for acting on a safeguarding alert, regardless of grade.
6. Safeguarding checks in physiotherapy out-patients need to be robust and completed without any omissions.
7. Adequate time must be taken to ensure all staff are trained and understand new procedures, especially when implemented during times of change in working practices.

Recommendations

- Out-patient physiotherapy referral process - the referral from the in-patient team must be completed as a priority. Training and systems should be put in place to ensure that this happens, especially where there is a risk of it being missed i.e. at times of particular increased workload or short staffing.
- Ideally, for those patients due to receive out-patient physiotherapy at the ROH, an appointment should be booked before the patient is discharged from the ward.
- Referrals received into out-patient physiotherapy should be triaged for urgency within 48hrs, note – this has already been actioned.

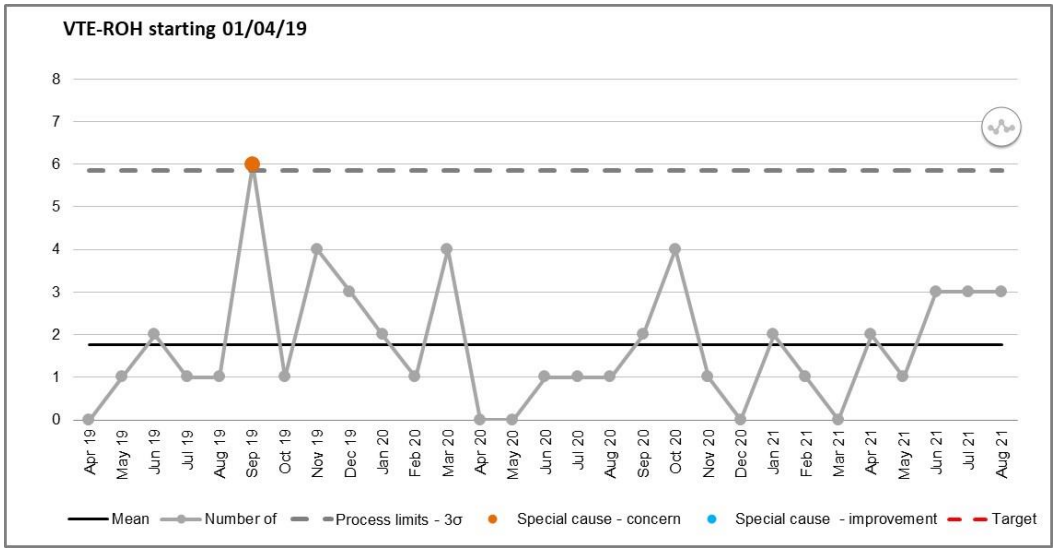
• A review of the process for referrals being sent from out-patient consultant clinics should be undertaken, to ensure the most effective method and minimise the likelihood of delays between the two departments.
• Continuity of care - systems need to be reviewed to ensure that physiotherapy patients are not lost to follow up. A process needs to be put in place to ensure Tiara alerts are checked by another member of staff if someone has left the Trust. Particular importance needs to be placed on both post-operative patients and those with a safeguarding alert attached to their notes due to the potential risk of harm in these groups of patients.
• A review of the safeguarding process in physiotherapy out-patients. The process needs to be more robust and ensure that the correct information is read and documented by the out-patient staff.
• A review of safeguarding mandatory training within therapies should be undertaken. Checks should be made to ensure all staff members are up to date and that they have the appropriate level of training – level 2 vs level 3.

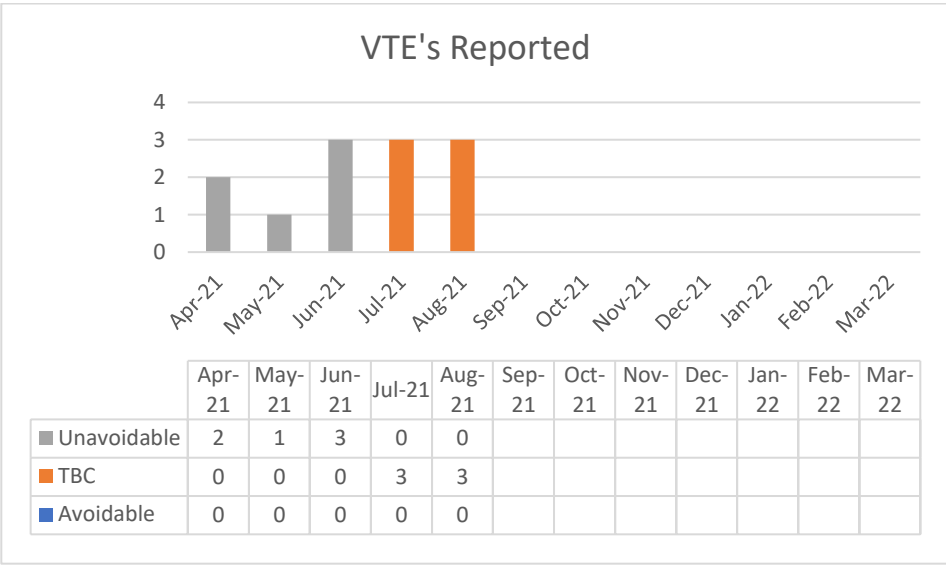
Patient story was presented by the Physiotherapist to Safeguarding Committee in September 2021, further action are to follow:
Updated Patient story to include the safeguarding actions and good practice.

RISKS / ISSUES

None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Unavoidable	2	1	3	0	0							
TBC	0	0	0	3	3							
Avoidable	0	0	0	0	0							

Avoidable Year Totals		Total including unavoidable
20/21	1	13
21/22	0	12

Data Source – Ulysses and VTE leads

INFORMATION

There were three ROH associated VTEs reported in August 2021. The SPC chart on the previous page shows that reporting of VTEs is within the recognised threshold at the ROH.

24-hour reassessment: need for re-assessment-current PICS report methodology to be reviewed – please see narrative below

24hr review	393
missed 24hr review	280
total	673
24hr %	58.4

On admission assessment

total possible	790
total assessed	775
%	98.10

ACTIONS FOR IMPROVEMENTS / LEARNING

Compliance with mandatory 24-hour re-assessment

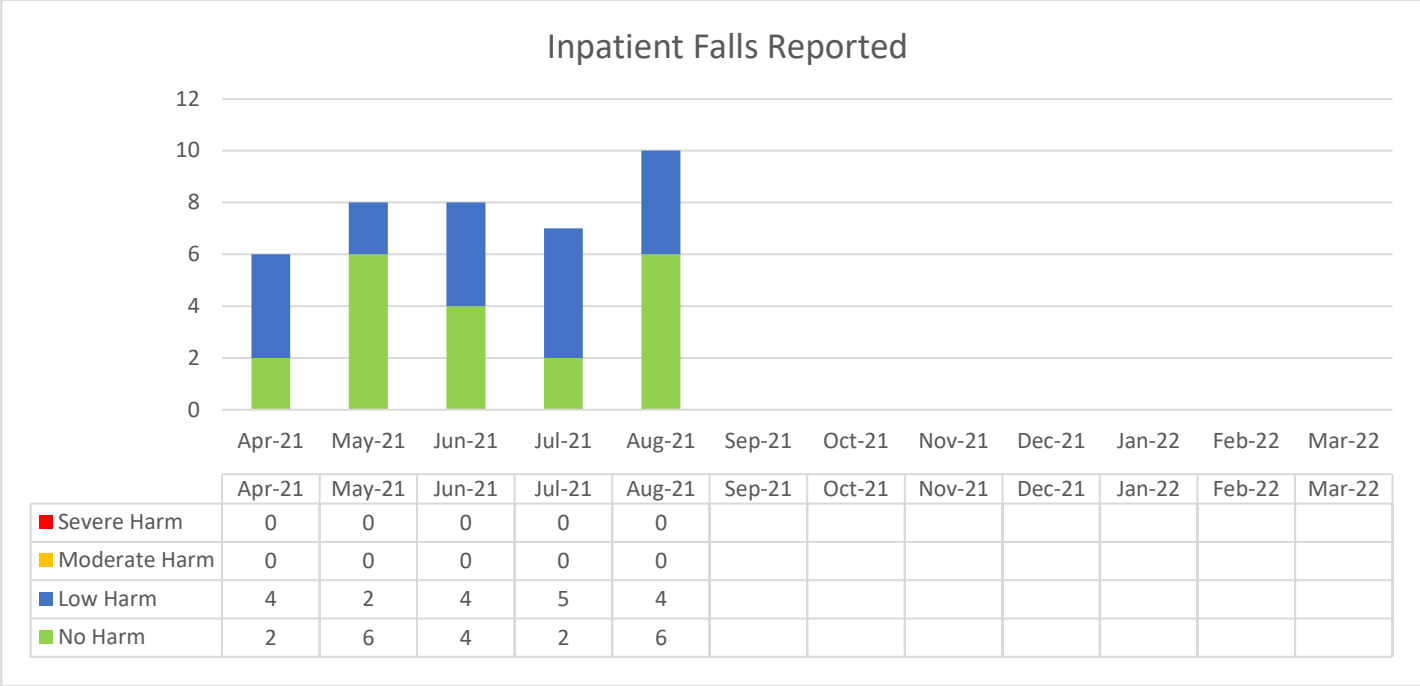
Actions are underway to:

- Review wording of standard. NICE ng89 2018; states Reassess all medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes opposed to specifically 24 hours.
- PICS alert gives option to acknowledge (by ticking accept responsibility for having completed) or Ignore (not done now so will keep alerting) need for re-assessment-current PICS report methodology to be reviewed to ensure this is reflected in the data collection (not currently).
- Retain re-assessment as in 5-6% of patient prophylaxis need did change from initial assessment by cease reporting until above recommendations are complete to ensure accuracy.
- Re-audit in 3-6 months

RISKS / ISSUES

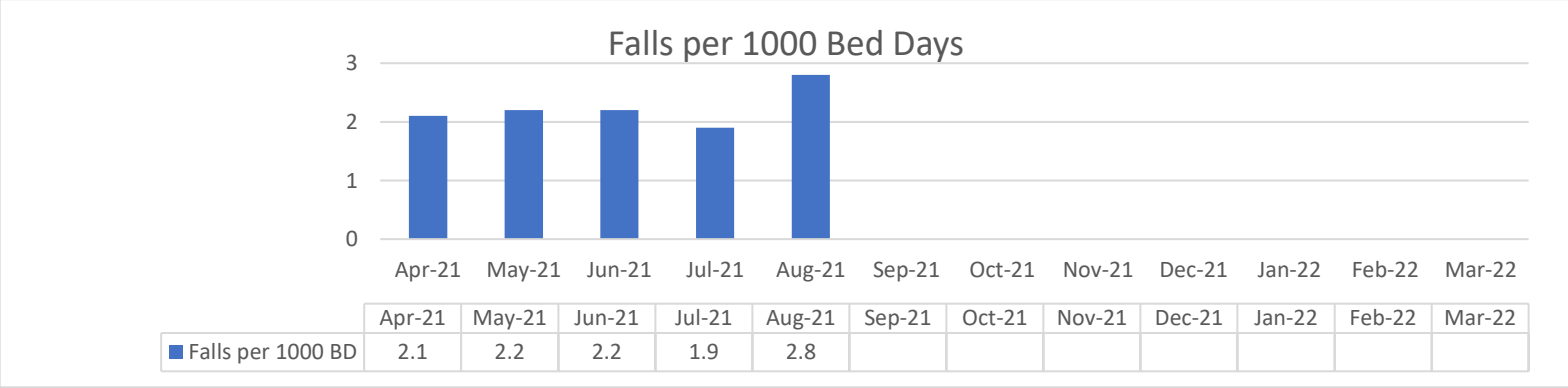
Risk 43: re 24 hour re-assessment to remain on the risk register until above recommendations complete. This month's compliance was 58.4%

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

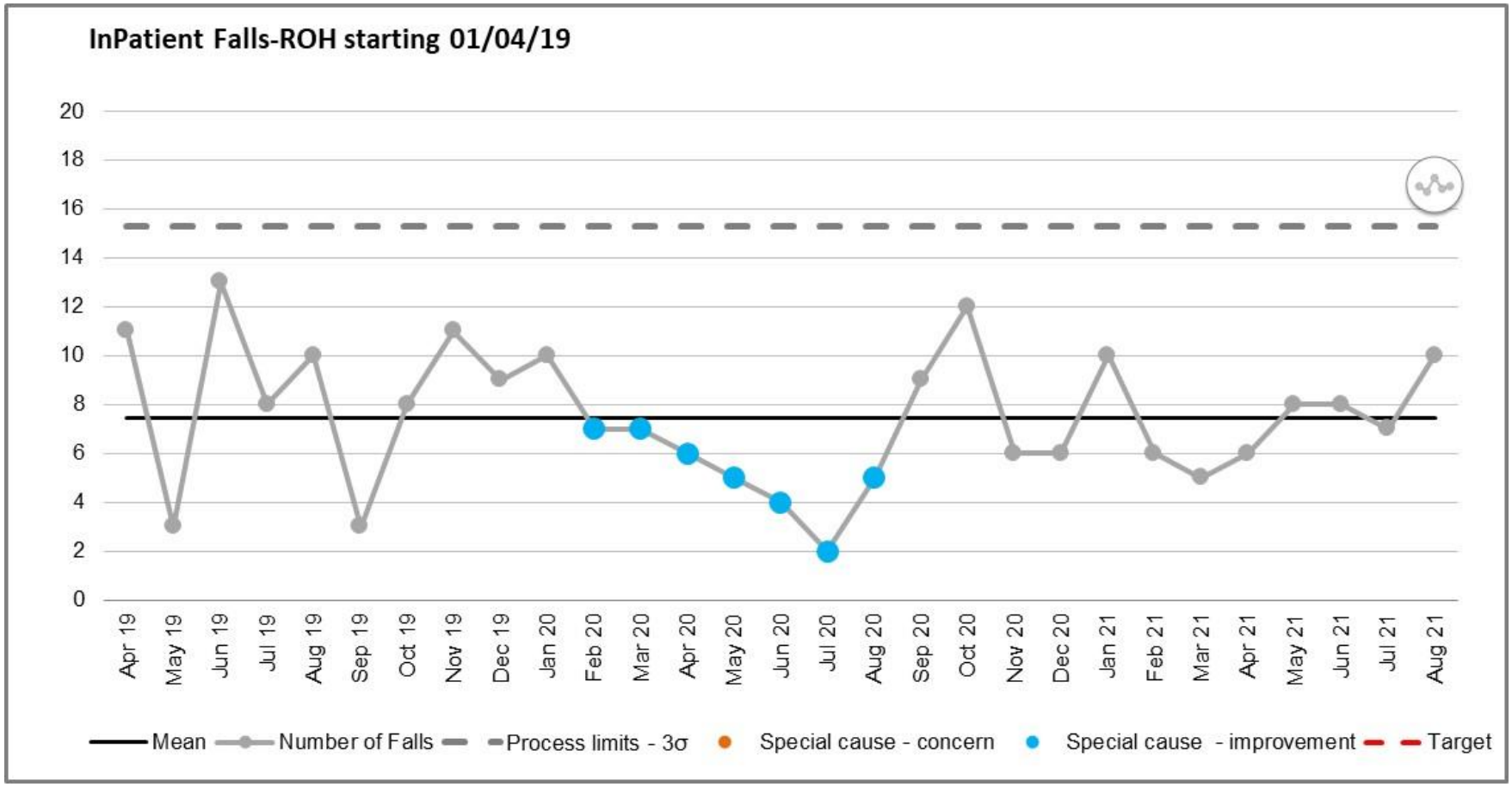


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Severe Harm	0	0	0	0	0							
Moderate Harm	0	0	0	0	0							
Low Harm	4	2	4	5	4							
No Harm	2	6	4	2	6							

Year Totals	
20/21	76
21/22	39



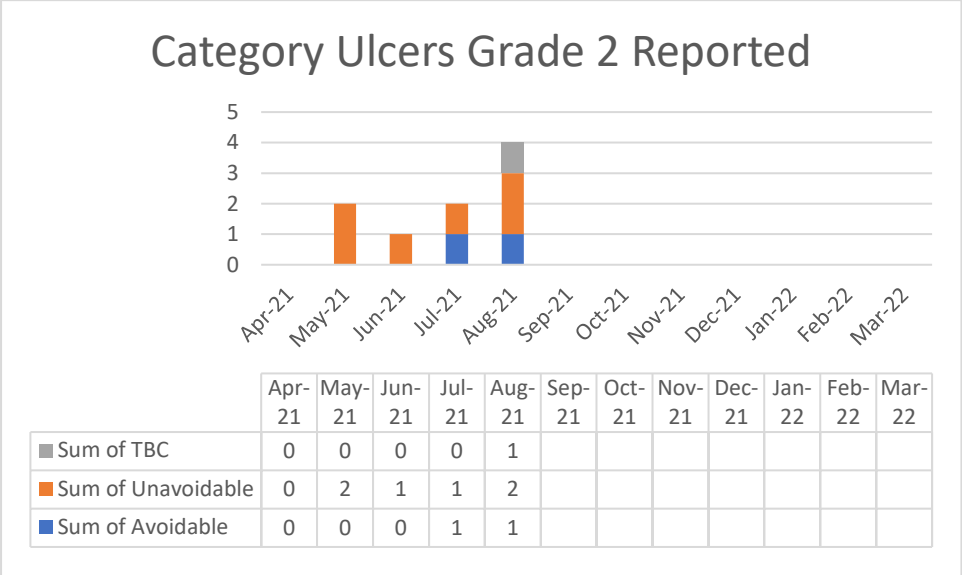
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Falls per 1000 BD	2.1	2.2	2.2	1.9	2.8							



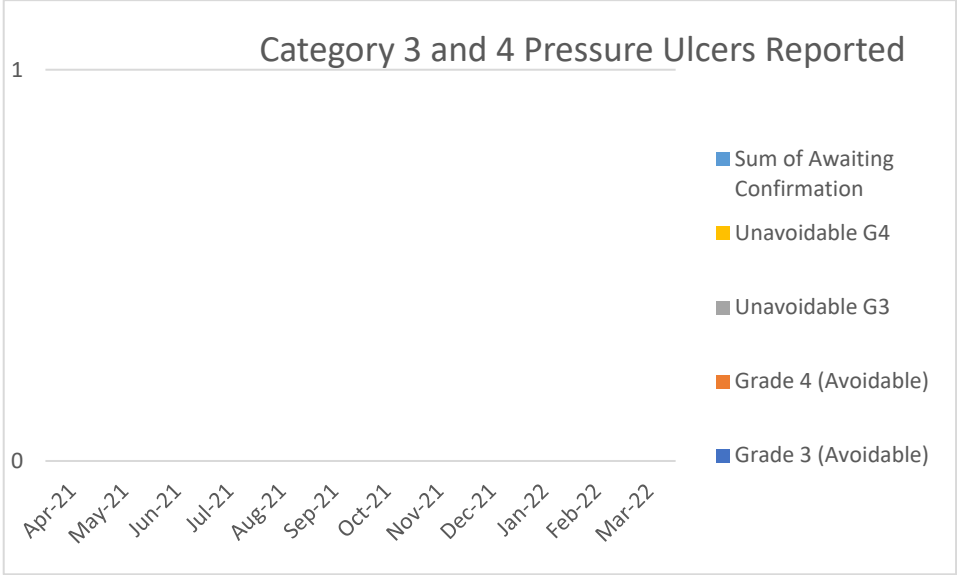
Data Source – Ulysses and Falls Group

INFORMATION
There were 15 incidents reported across the Trust in August 2021 relating to Falls: 10 x In-Patient Falls Incidents. 2 x Lowered to Floor Incidents. 1 x Out-Patient Falls Incident. 2 x Near Miss Incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
Positive Assurance Awareness of falls medical review form post-fall, raised to doctors who started new on rotation in the Trust, with advice & teaching in filling out the form given. The number of in-patient falls remains consistent compared to the previous months. There is an identifiable theme of patients with dementia or post-operative confusion/delirium who have either fallen or had a near miss. **Actions** To look at rolling out screening patients for delirium across all wards, so that those patients that may potentially mobilise against advice can be more readily identified and placed in a bed where closer supervision can be provided. Review of bed rails policy.
RISKS / ISSUES
None

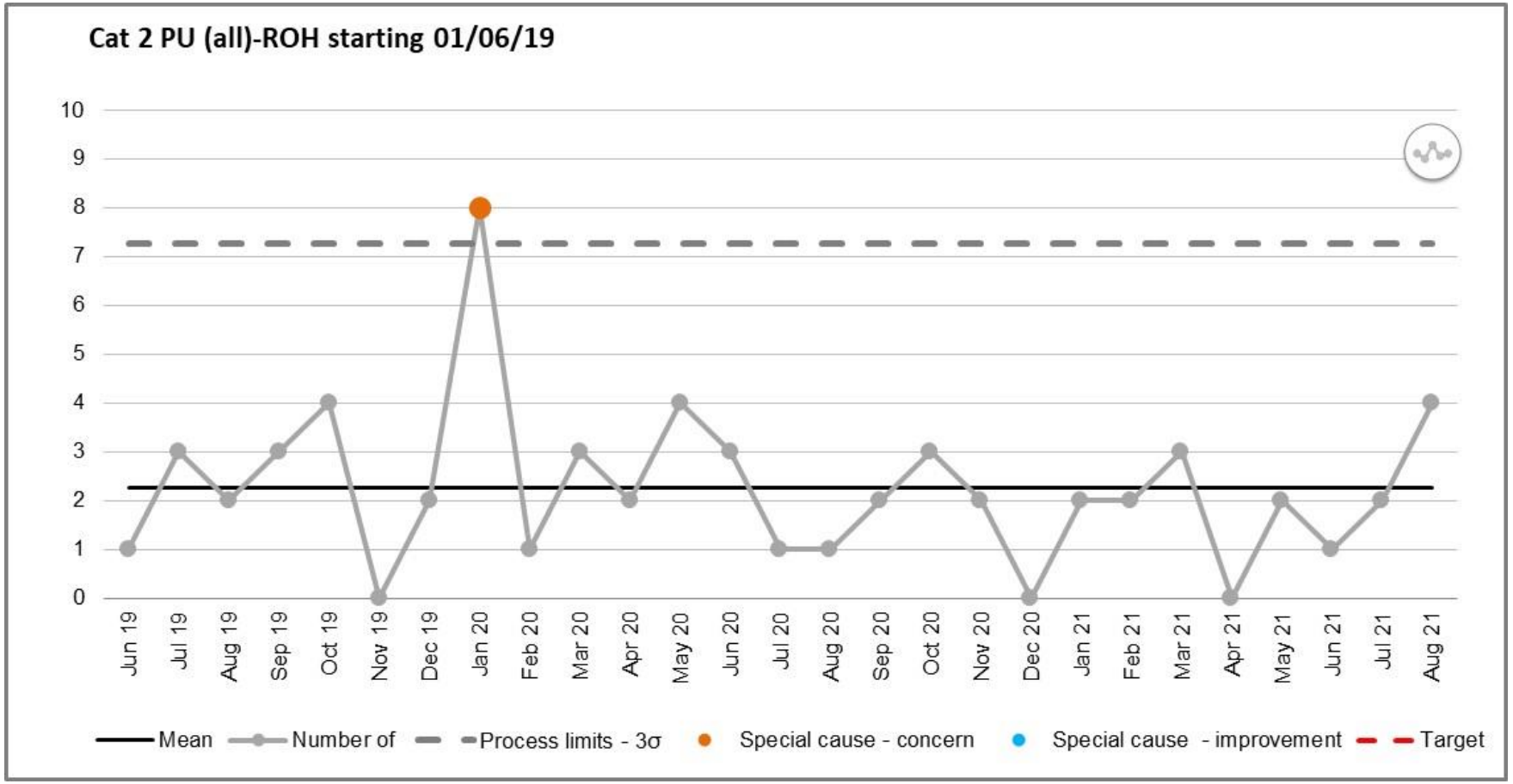
7. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Sum of TBC	0	0	0	0	1							
Sum of Unavoidable	0	2	1	1	2							
Sum of Avoidable	0	0	0	1	1							



Number of PU reported total		
Year Total	Cat 2	Cat 3
20/21	25	1
21/22	9	0



Data Source – Ulysses and TV team

INFORMATION

August 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	4
Category – 2 (Device)	0
Category – 1	x 2 – None deteriorated
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence – 0 MASD ROH Intertriginous dermatitis – 0 MASD admitted with Incontinence x 3 MASD admitted with Intertriginous dermatitis x 4

Patients admitted with PUs	PU admitted with Cat 1 - Nil PU admitted with Cat 2 - Nil PU admitted with Cat 3 x 4 UHB x 1 Pt's home x 3 PU admitted with Cat 4 DTI - Nil PU admitted with Cat Ungradable x 1 Home The Trust aims to contact all external Trusts Governance teams in relation to the "admitted with" pressure ulcers.

Avoidable only Pressure Ulcer CCG Contracts KPI

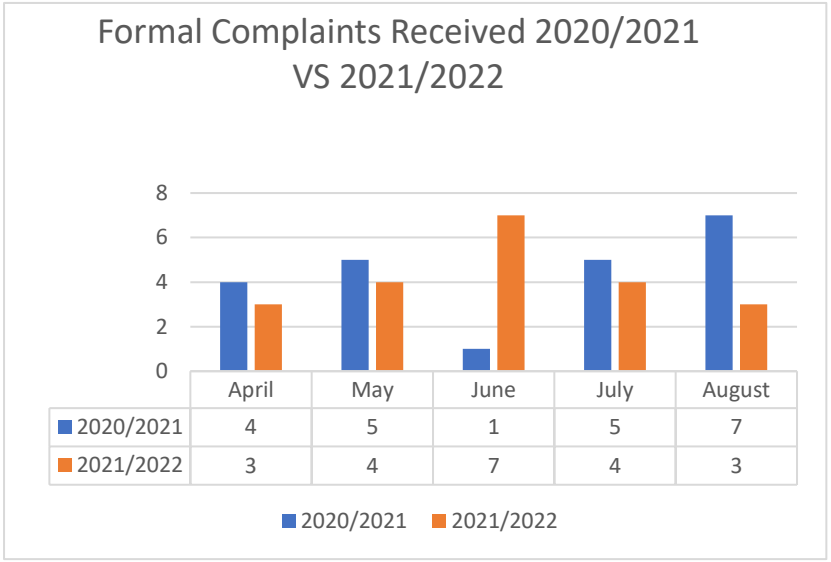
2021/2022 – Contract to be confirmed.

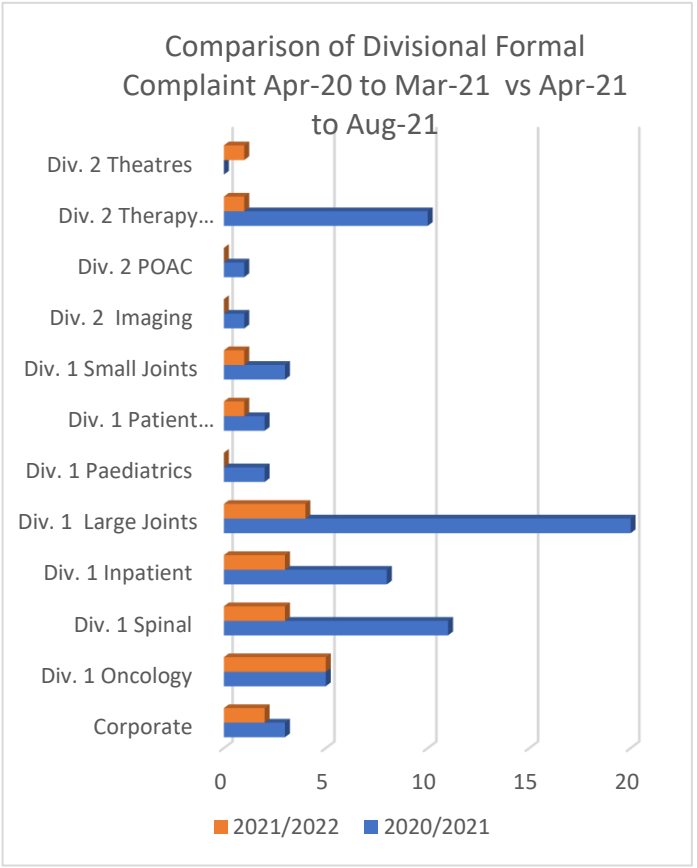
2021/2022	
Avoidable Grade 2 pressure Ulcers	2
Avoidable Grade 3 pressure Ulcers	0
Avoidable Grade 4 pressure Ulcers	0

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING
Tissue Viability Competency document being reviewed as part of Outstanding Care Every Time programme;
RISKS / ISSUES
None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
20/21	49
21/22	21

INFORMATION

Complaints

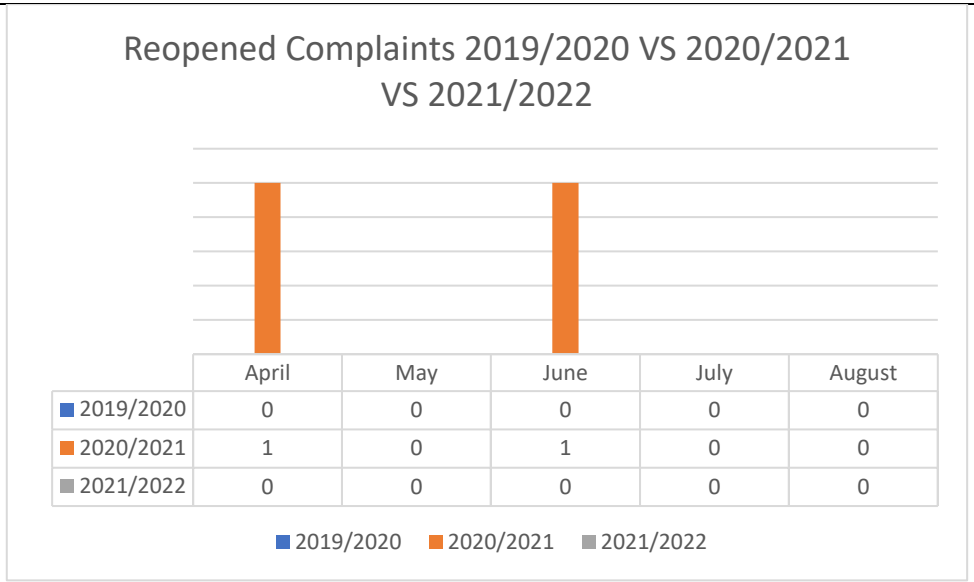
- There were 3 formal complaints received in August 2021 of which 1 were in relation to Division 1, and 1 in relation to Division 2 and 1 was in relation to both divisions
- Categories and subcategories of Formal complaints received in August 2021.

Categories and Subcategories	Count
Appointment Not Satisfactory	**1**
Clinical Query	1
Dispute Over Diagnosis/Treatment	**1**
Clinical Query	1
Injury Sustained During Treatment	**1**
Clinical Query	1
Grand Total	**3**

- In August 2021 – Two Formal Complaints were closed within the agreed date with patient. This gives a 100% completion on time rate and meets the KPI for the month. The average response for formal complaints was 25 days.
- At the time of producing this report there are 4 open complaints.

Reopened Complaints

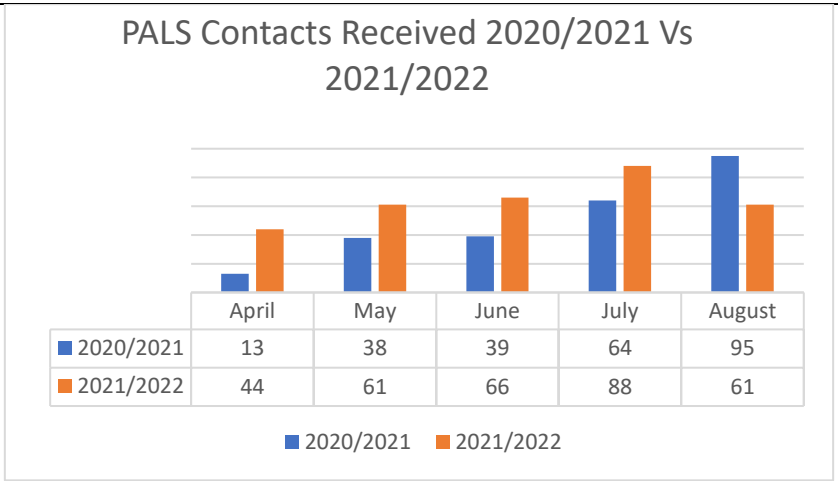
- In August 2021 Trust did not reopen any complaint on the request of the complainant
- From April 2021 Trust did not have any reopened complaints, 1 complainant has requested to meet with the investigation lead to discuss complaint, but complaint was not reopened
- In May 2021 Complaints received a meeting request to discuss complaint from March 2021, this meeting was held on the 16th August 2021. Complainant did not want this complaint to be reopened as they wanted to talk with consultant.



	April	May	June	July	August
2019/2020	0	0	0	0	0
2020/2021	1	0	1	0	0
2021/2022	0	0	0	0	0

Patient Advice and Liaison service - PALS

- In August 2021 the PALS department handled 61 contacts of which 41 were classified as concerns, and 20 as enquiries. This is a decrease in contacts compared to the same time last year (65 contacts in August 2020)



- The main themes in the PALS data relate to Appointments and Communication, with over 38 contacts between both categories.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In August 2021, 99.8% of enquires and 100% of concerns were handled within the agreed timescales with patient and we did not breach any KPI's in the month.
- Top 3 categories and 2 Top subcategories PALS contacts for August are Appointments, Clinical Queries and Communications

Top 3 PALS Categories and top 2 PALS Subcategories

PALS Contacts	Count
Appointments	**25**
Appointment Cancelled	8
Availability	6
Clinical Query	**9**
Appointments not satisfactory	3
Operation-outcome not as expected	2
Communication	**13**
Communication failure between departments	3
Communication/Info to Patients	8

PALS and Complaints KPI's were hit for all months with an KPI of 100%, for complaints, and average of 98% for PALS concerns and 95% for PALS enquiries

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-21	100	99.69	100
May-21	100	100	100
Jun-21	100	100	100
Jul-21	100	94	89
Aug-21	100	100	99.8

Compliments

There were 3 compliments recorded on Ulysses in August 2021.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The team have a vacant patient experience assistant (Band 4). ATR to be completed.
- The Public Engagement department have designed new PALS posters that have been translated to the 5 most common languages spoken by our patients. The Posters include a contact for patient to text the Public Engagement team with their preferred language and the time/date for a PALS call back. This will encourage more patents to provide feedback, raise concerns or complaints.
- The Public Engagement department is looking into the collection of compliments as the number of reported is low to the department.
- A new external internet page is under construction for the Public Engagement Department and its focus will be on the PALS, Complaints and Patient Experience
- Head of Patient Experience will arrange Ulysses training for team members
- Gap analysis of the CQC Regulation 16.1 (Receiving and acting on complaints) is currently being undertaken by the Head of Patient Experience and will be presented on the next Patient Experience and Engagement Group
- The PALS department handled 55% more contacts this year (449) in comparison to the same time last year (249); this is due to the COVID-19 pandemic which started last year in April, which resulted in less activity and PALS team did not log general enquiries in 20/21

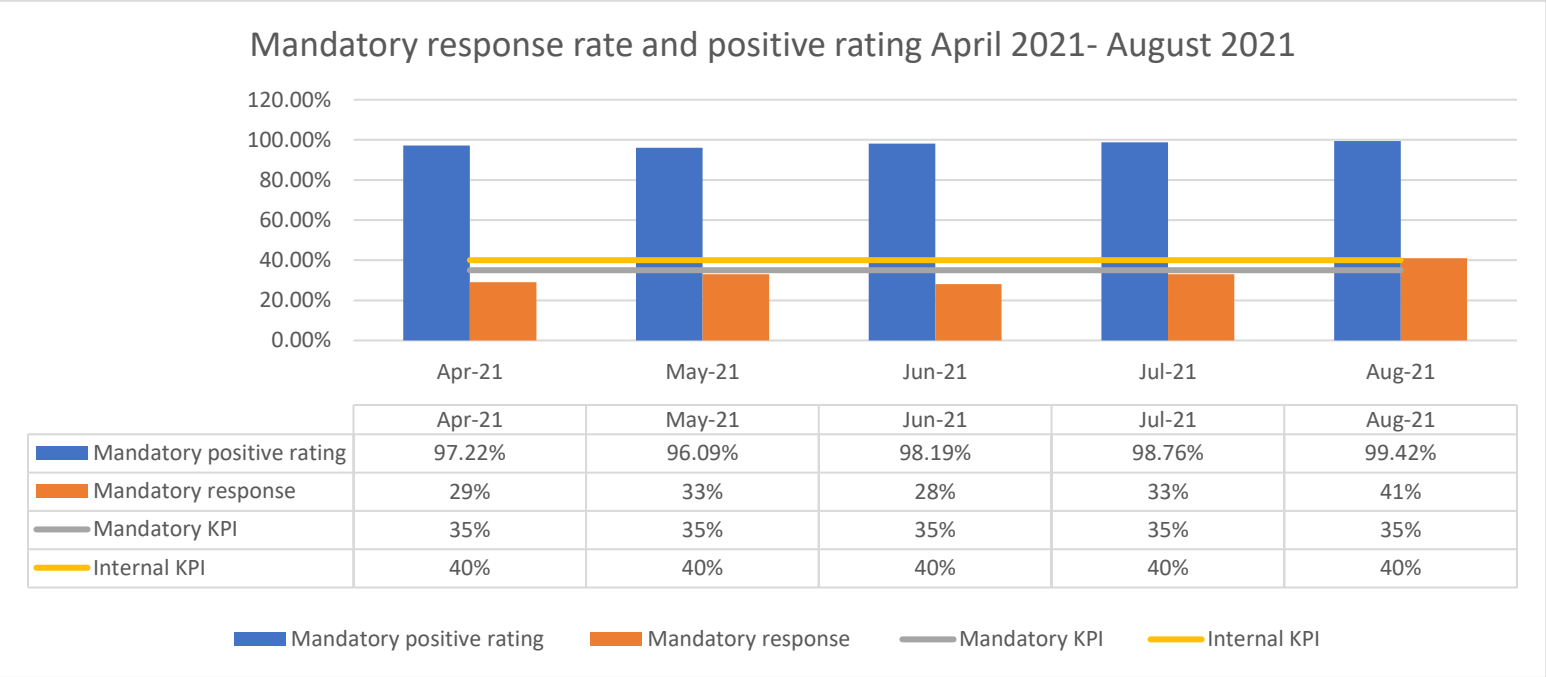
RISKS / ISSUES

The Trust Annual Complaints report did not go for approval at the September 2021 Trust Board as planned. It was agreed that the annual report for Complaints will go for approval on the October 2021 Quality and Safety Executive meeting with final approval at the Trust Board on the 2nd November 2021

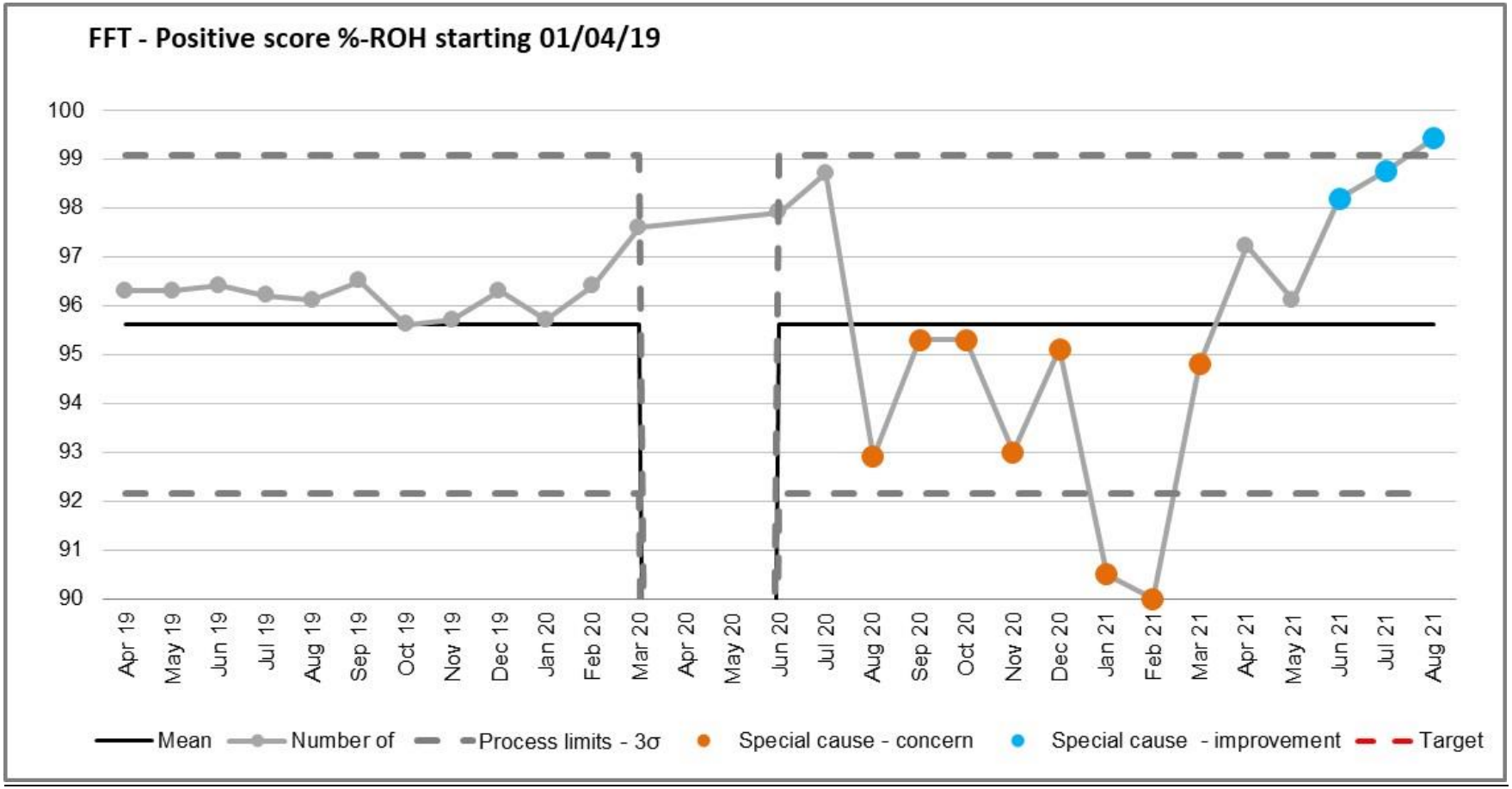
COMEBACK COMPLAINTS

None

9. Friends and Family Test Results (collected in the iwantgreatcare system). FFT Mandatory Reporting



	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Mandatory positive rating	97.22%	96.09%	98.19%	98.76%	99.42%
Mandatory response	29%	33%	28%	33%	41%
Mandatory KPI	35%	35%	35%	35%	35%
Internal KPI	40%	40%	40%	40%	40%


FFT - Positive score %-ROH starting 01/04/19
100
99
98
97
96
95
94
93
92
91
90
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Mean
Number of
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

INFORMATION
• Via the PALS team, area Managers are receiving any compliments or concerns from patients in a spreadsheet and scanned copies of forms that have staff names or are concerns that are immediate risk to the other patients. This allows the areas to share with their staff for learning and improvements.
ACTIONS FOR IMPROVEMENTS / LEARNING
• Although the Trust have hit mandatory response rate of 35% completion rate there were 4 inpatient areas that did not hit mandatory completion rate in August 2021. These 4 areas did show improved compliance so work will be undertaken to ensure they meet the KPI target • Meeting took place between Head of Patient Experience and Finance department in the QE to discuss possibility to use their texting services • The contract with I Want great care did not stop at the end of June 2021 due to late termination note, IWGC have agreed to give 20% off the original price. Head of Patient Experience have had a meeting with the new account manager form IWGC and still wait for them to complete their actions. For now, the ROH is not using IWGC as all internal processes work perfectly. • The Public Engagement team is in process of creating a template for compliments/ feedback or concerns so they can be displayed to the public within departments. • Trust collect patient feedback from non-mandatory areas within the hospital, capturing data on internal spreadsheet and sends any concerns, feedback or compliments back to the departmental managers.
RISKS / ISSUES
None

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 15 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

0 new claims against the Trust have been received in August 2021

On-going claims

There are currently 25 on-going claims against the Trust.

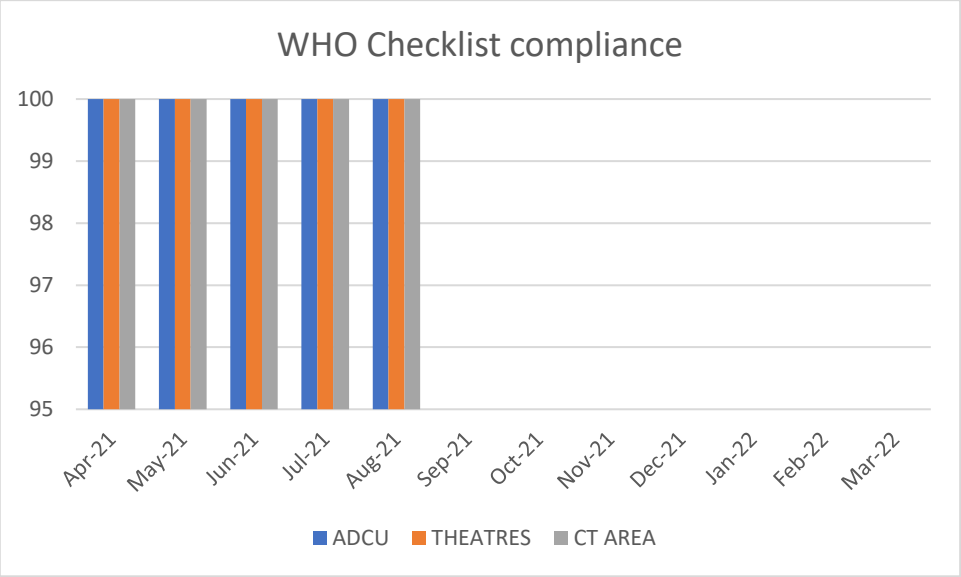
Pre-Application Disclosure

7 new requests for Pre-Application Disclosure of medical records were received in August 2021

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in August 2021

12. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 708

The total WHO compliance for Theatres in August 2021= 100%

CT area

Total cases = 65

The total WHO compliance for CT August 2021 = 100%

ADCU

The total WHO compliance for ADCU in August 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

The Visual Audit has yet to be undertaken so results are not available.

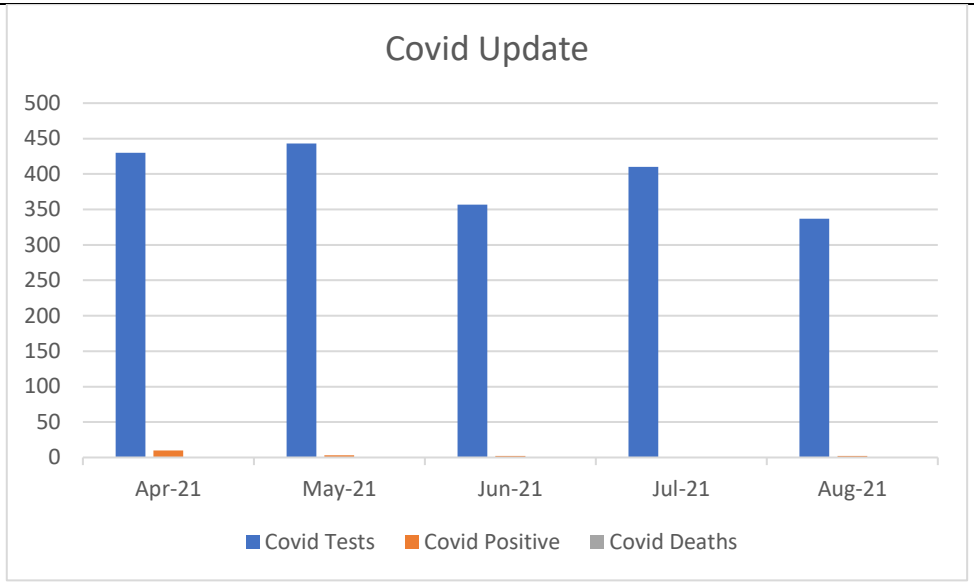
RISKS / ISSUES

None

13. Infection Prevention Control – Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly. All infections are reported and scrutinised at the IPCC committee.

INFORMATION

Infections Recorded in month and Year to Date (YTD)	August 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	1	3
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0



ACTIONS FOR IMPROVEMENTS / LEARNING

1 reported positive Clostridium Difficile. Sample reported on 4/8/21. Toxin report came back on 11/08/21.

Patient was transferred to the Queen Elizabeth on the 18/07/21 AMU then ward 302 the same day where he remained for the duration of his admission. 2 samples were sent from 302 on the 25/07/21. One inconclusive and 1 negative. Concerned with Infection control at Queen Elizabeth. No clostridium difficile on either AMU or 302 at the time of patient admission.

Patient then returned back to The Royal Orthopaedic Hospital on the 28/07/21.

RISKS / ISSUES

None

***Data Source – IPC team and Ulysses**

14. Safeguarding – Below details the Key perfomance indicators and metrics in relation to Safeguarding compliance within the Trust. The KPIS below are disucssed in detail at the Safeguarding Committee and are included within this report for awareness

	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Safeguarding Adult Notifications	37	36	49	22	36
Safeguarding Children and Young People Notifications	43	45	49	40	37
Mental Health Incidents	35	40	35	31	12
LD Adult	6	11	6	24	15
LD Children	73	61	65	68	68
Adult Level 2	98.09%	97.84%	97.49%	97.35	97.62
Adult Level 3	87.07%	86.88%	85.65%	84.45	86.03
Level 4	100%	100%	85.71%	80	80
Child Level 2	97.91%	97.66%	97.40%	97.08	97.18
Child Level 3	87.38%	87.41%	85.91%	84.67	86.07
Mental Capacity Act MCA	96.23%	96.65	96.45%	96.34	94.58
Deprivation of Liberty Safeguards DoLs	96.50%	96.75	96.72%	96.43	95.2
Prevent WRAP	82.92%	88.48%	87.50%	88.52%	88.37%
CE	0	1	0	0	0
FGM	0	0	0	0	1
DOLS	4	6	8	4	7
MCA	0	5	2	5	0
PIPOT cases	0	0	0	0	0
Domestic Abuse	3	5	6	3	6
PREVENT Notifications	0	0	0	0	0
WNB	15	8	16	11	16
Child in Care	2	1	1	3	2
Early Help	3	0	0	1	3
DHR- scoping Reviews	1	0	0	0	2
SARs- scoping review Or Rapid Reviews	0	0	0	0	0
Modern Slavery	0	0	1	0	1
Incidents	5	13	12	13	15
Open Cases	12	11	20	20	12
Closed Cases	69	65	78	42	24

15. CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

ALL CAS ALERTS (1 July 2021 - 30 July 2021)

ALERTS FROM PREVIOUS MONTHS

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
SDA/2021/010	Becton Dickinson blood specimen collection - supply disruption. Shortage of products from their Blood Specimen Collection Portfolio that is impacting across most main blood tube supplies. The supply position remains constrained and is forecasted to become even more constrained over the coming weeks. While it is anticipated that the position will improve from the middle of September, overall supply is likely to remain challenging for a significant period.	DHSC & NHS England and Improvement: Supply disruption alert	26-Aug-21	Issued for info to CAS team and J. Gardner. No response required. Action complete.	01 Sep 2021

	The tubes impacted by this shortage are: 1. 5mls Yellow top – SST 2 – clotted sample (e.g. U&E, LFTs etc) 2. Purple top – EDTA (e.g. FBC, HbA1c)				
NatPSA/2021/009/NHSPS	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures Exhalation valves on FFP3 respirators and the air exiting powered hoods (known as powered air purifying respirators – PAPRs), do not filter exhaled breath. This alert asks providers to revise procedures, purchasing processes, stock supply, checklists, and stock labelling around the use of these respirators to ensure they are not used during surgical and invasive procedures except in very specific circumstances set out in infection control guidance linked in the Alert.	National Patient Safety Alert - NHS England & NHS Improvement	25-Aug-21	7 Sep 2021: **Under review**	25 Nov 2021

NatPSA/2021/008/NHSPS	Elimination of bottles of liquefied phenol 80%. Following incidents where bottles of liquefied phenol 80% were either confused with other medication or caused burns when spilt, this alert asks providers to eliminate its use and to follow professional guidance to use safer alternatives. Phenol, a caustic compound used for its antimicrobial, anaesthetic, and antipruritic properties, is highly toxic and corrosive. Liquefied phenol 80% can cause burns, severe tissue injury and is rapidly and well absorbed causing systemic toxicity. It is most commonly used in podiatry and orthopaedic foot surgery for destroying the nail matrix.	National Patient Safety Alert - NHS England & NHS Improvement	25-Aug-21	6 Sep 21: Emailed to Pharmacy: **Under review**	25 Feb 22
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses. In the past 10-14 days there have been an unprecedented number of overdoses (with some deaths) in people who use drugs, primarily heroin, in some parts of the country (5 London boroughs, Hampshire, Essex, West Sussex, Dorset, Thames Valley).	National Patient Safety Alert - Public Health England	18-Aug-21	18 Aug 21: Email from J. Bloomfield: *'Extremely unlikely to affect us. Have briefed Pharmacy team and issued*	20 Aug 21

	This alert contains urgent actions for providers where staff may encounter people who use drugs and those providers that provide emergency care for opioid overdose.			*Comm's message'*. Action complete	
SDA/2021/009	Glipizide (Minodiab) 5mg tablets - Supply disruption. Glipizide 5mg tablets are out of stock until mid-October 2021.	DHSC & NHS England and Improvement: Supply disruption alert	02-Aug-21	6 Aug 21: Emailed to Pharmacy for info. Action complete	Response not Required

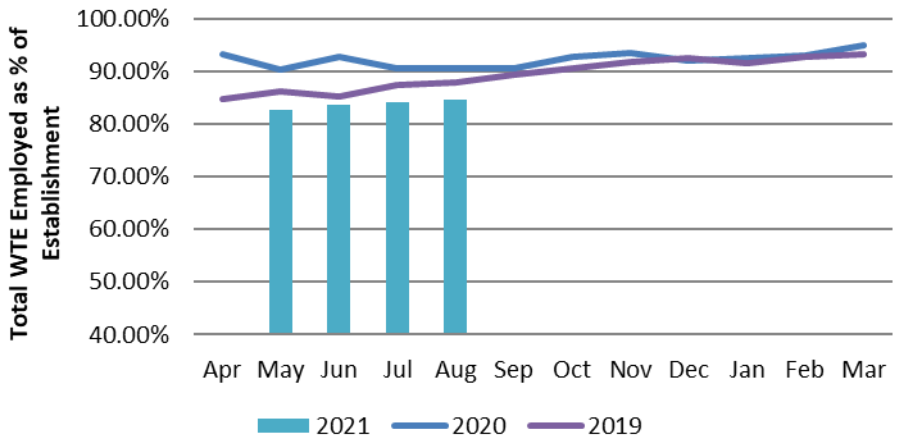
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Workforce

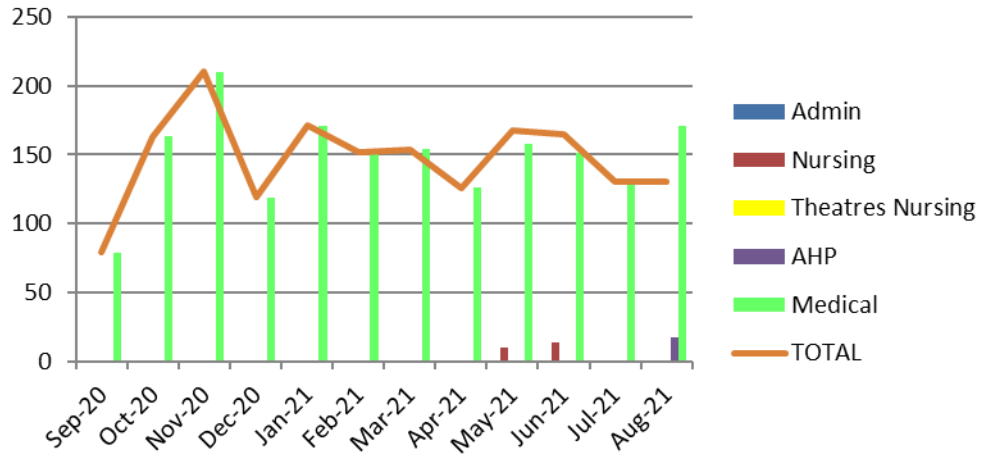
This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

Trust Workforce Metrics	Jun-21	Jul-21	Aug-21	This Month vs Last Month	Trend	KPI
Staff in Post - Headcount	1225	1233	1238	5	-	-
Staff in Post - Full Time Equivalent	1085.78	1093.82	1099.95	6.13	-	-
Staff Turnover (%) - Unadjusted	9.91%	10.27%	10.42%	0.15%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	7.11%	7.75%	8.23%	0.48%	⇧	<=11.5%
Total WTE Employed as % of Establishment	83.69%	84.23%	84.67%	0.44%	⇧	>=93%
Total WTE Employed as % of Establishment - Clinical	81.47%	82.03%	82.11%	0.08%	⇧	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	87.76%	88.25%	89.37%	1.11%	⇧	>=96%
% of Attendance	94.38%	94.49%	94.48%	0.00%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.31%	94.15%	94.13%	-0.02%	⇩	>=96.3%
% Staff received mandatory training last 12 months	82.45%	83.93%	84.11%	0.17%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	79.90%	79.05%	78.24%	-0.80%	⇩	>=95%
% of Sickness - Trust wide Long-term	3.93%	3.66%	2.94%	-0.72%	⇩	-
% of Sickness - Trust wide Short-term	1.69%	1.85%	2.57%	0.72%	⇧	-
Return To Work Completion %	65.89%	53.50%	51.66%	-1.85%	⇩	>=80%

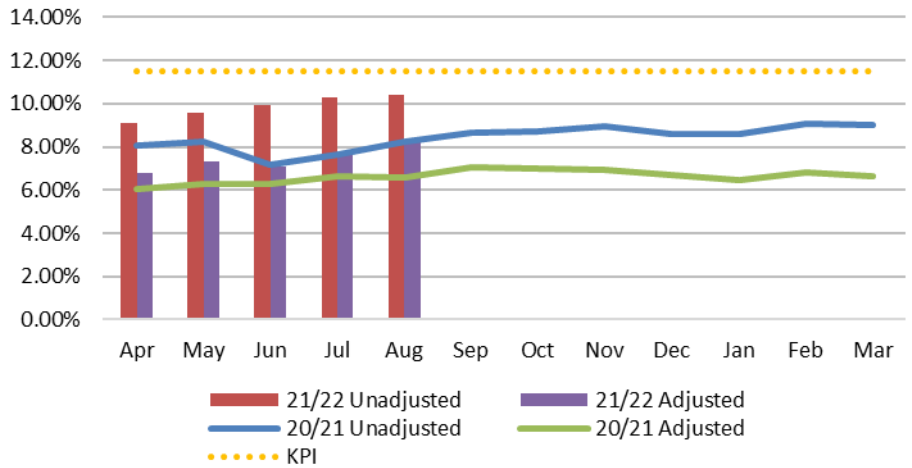
Staff In Post vs. Establishment



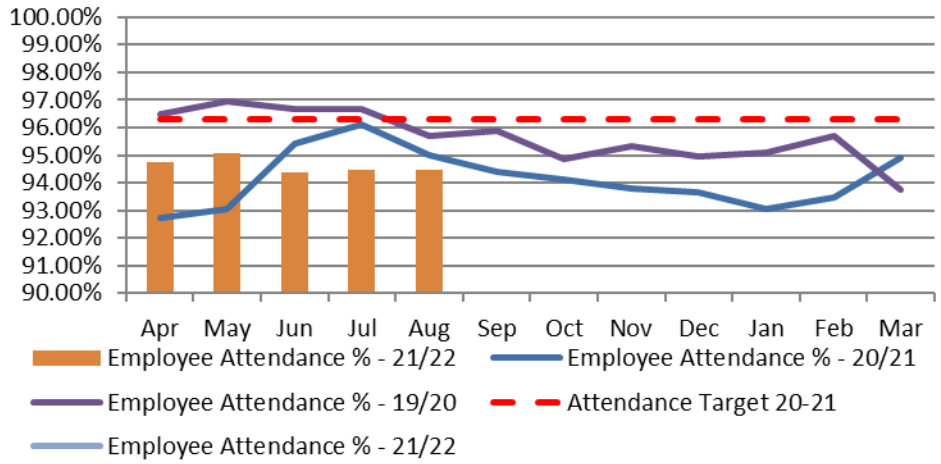
Agency Breaches



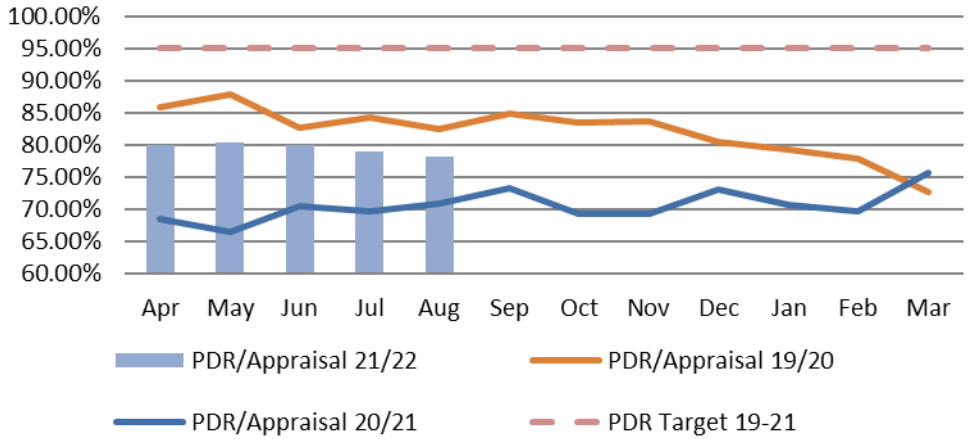
Staff Turnover



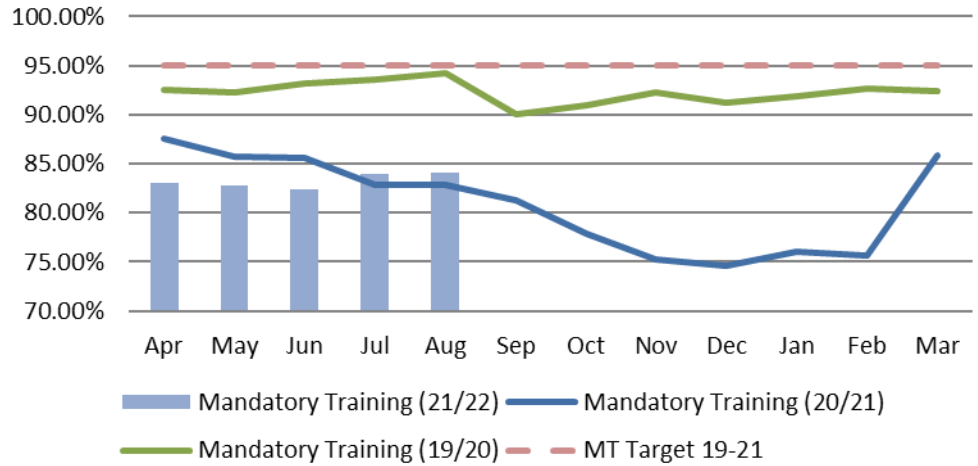
Employee Monthly Attendance %



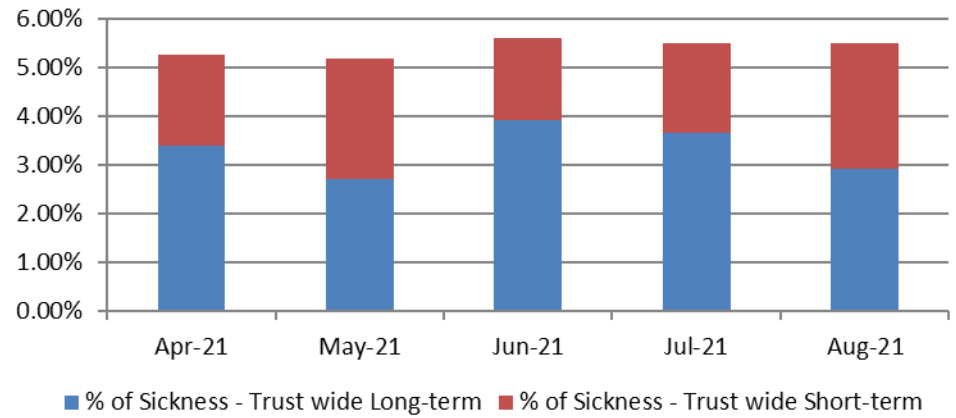
PDR/Appraisal



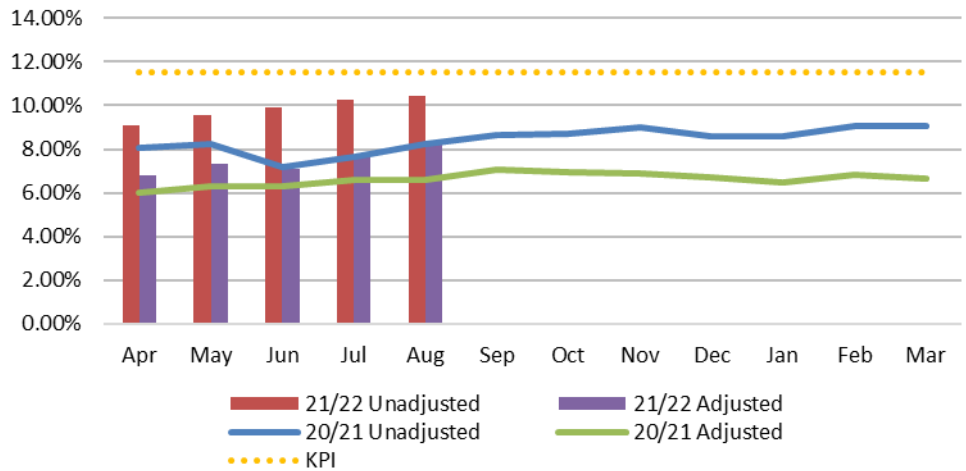
Mandatory Training



Sickness % - LT/ST (2021/22)



Staff Turnover



The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Trust Board Meeting in Public on Tuesday 2 November 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Tuesday 2 November 2021 commencing at **0900h**.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Woodbrooke Centre, 1046 Bristol Road, Birmingham **Date** 2 November 2021: 0900h – 1215h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Ayodele Ajose	Non Executive Director	(AA)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Chief Nurse	(GM)

In attendance

Mrs Sandra Crook	Facilities Officer	(SC)	[Item 1]
Mrs Alicia Stanton	Transformation Manager	(AS)	[Item 7]
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Housekeeping through COVID	Presentation	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 6 October 2021: *for approval*	ROHTB (10/21) 019	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (10/21) 019 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (11/21) 001 ROHTB (11/21) 001 (a) ROHTB (11/21) 001 (b)	TP/JW
		STRATEGY		
0945h	7	JointCare update: *for assurance*	Presentation	AS

PATIENT EXPERIENCE AND OUTCOMES				
1005h	8	COVID-19 update: *for assurance*	Verbal	GM
1015h	9	Annual complaints report: *for approval*	ROHTB (11/21) 003 ROHTB (11/21) 003 (a)	GM
1020h	10	National patient satisfaction survey: *for assurance*	ROHTB (11/21) 004 ROHTB (11/21) 004 (a)	GM
STAFF EXPERIENCE AND HEALTH & WELLBEING				
1030h	11	Guardian of Safe working hours update: *for assurance*	ROHTB (11/21) 005 ROHTB (11/21) 005 (a)	MR
GOVERNANCE AND COMPLIANCE				
1035h	12	Compliance with existing Guidance in regard to Mortuary and/or Body Stores: *for assurance*	ROHTB (11/21) 006	PB
MATTERS TO BE TAKEN BY EXCEPTION ONLY				
1040h	13	Upward assurance reports: • Finance & Performance Committee • Quality & Safety Committee • Staff Experience & OD Committee • Audit Committee	ROHTB (11/21) 007 ROHTB (11/21) 008 ROHTB (11/21) 009 ROHTB (11/21) 010	
1055h	14	Performance reports: *for assurance* • Finance & Performance • Quality & Safety • Workforce	ROHTB (11/21) 011 ROHTB (11/21) 012 ROHTB (11/21) 013	
BREAK				
CONFIDENTIAL SESSION				
1115h	15	Exclusion of the press and public	Verbal	Chair
	Date of next meeting: Wednesday, 1 December 2021 @ 0900h			

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 – UPDATED TO OCTOBER 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	7/10/21	3/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓					6/6
Kathryn Sallah	✓	✓	✓	✓	✓	✓					6/6
Richard Phillips	✓	✓	✓	✓	✓	✓					6/6
David Gourevitch	✓	✓	✓	✓	✓	✓					6/6
Simone Jordan	✓	✓	✓	✓	✓	✓					6/6
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓					6/6
Ayodele Ajose	✓	✓	✓	✓	✓	A					5/6
Les Williams	✓	✓	✓	A	✓	✓					5/6
Jo Williams	✓	✓	✓	✓	✓	✓					6/6
Matthew Revell	✓	✓	✓	✓	✓	✓					6/6
Garry Marsh	✓	✓	✓	✓	✓	✓					6/6
Phil Begg	✓	✓	✓	✓	A	✓					5/6
Marie Peplow	✓	✓	✓	✓	✓	✓					6/6
Stephen Washbourne	✓	✓	✓	✓	✓	✓					6/6
Sharon Malhi	✓	✓	✓	✓	✓	✓					6/6
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓					6/6

KEY:

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board - DRAFT Version 0.3

Venue Lecture Theatre, Knowledge Hub **Date** 7 October 2021: 0900h – 1300h

Members attending:

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Chief Nurse	(GM)

In attendance:

Ms Claire Hinwood	Clinical Nurse Specialist	(CH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RLl)	
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story: Transition to Adult Services	**Presentation**
The Board welcomed Claire Hinwood, Clinical Nurse Specialist for Transition Services. The Chief Nurse reported that there had recently been a Safeguarding champions day, where the role of Transition Services had been discussed. The reason for the presentation was to provide an understanding of the role of the transition nurse. It was reported that Claire had taken on the role of Lead Nurse for Transition Services when the inpatient children's services had moved to Birmingham Women's and Children's NHSFT (BWC). It was noted that much of the Transition Services work was done in collaboration	

with the Safeguarding team.

The Board was advised that the role of Transition Services was to oversee the movement of patient from children's services to adults. The long term plan suggests that children's services should span 0 – 25 years of age as there was a benefit of achieving better outcomes and continuity of care.

There were noted to be national standards around transition.

There was also a regional service to help young people achieve better outcomes and lifestyle. This was known as the 'Preparation for Adulthood' initiative. The 'Hello' documents were noted to focus on the young person as a whole not just health thereby allowing them the skills to move successful into adulthood.

It was reported that the CQC also suggested that there was much benefit in understanding the developmental phase of an individual and had built oversight of this into their Key Lines of Enquiry. Askills for health competency was being developed jointly with the CQC which included an evaluation framework. This would be published in the spring 2022.

The transition activity was noted to have dipped to some degree due to COVID. The 'Ready, Steady, Go…' electronic questionnaires were being used to help address this position.

The story of a patient was presented. It was noted that the story had been used at the Safeguarding Champions day. There had been much time dedicated to this case. A Youth Worker would be recruited to help with this work in future as part of the current year's Quality Priorities. It was suggested that there was a need to employ more young people as transition was an increasingly required service.

The Chief Nurse asked Claire where the Trust was in terms of its maturity around transition. He was advised that the Trust was doing well in comparison with others in the area but only 25% of the requirement was being achieved so there was more work to do.

Richard Phillips asked whether there was a difference in approach to physical and mental maturity. He was advised that a specific plan was put in place which was personalised and work was underway to amend the 'Ready, Steady, Go…' documents to ensure that they were suitable for individuals' communication needs.

Kathryn Sallah thanked Claire for the focus on transition and noted that communication needed to focus on learning disabilities too. She added that the future workforce plans around the employment of young people were exciting developments and it as suggested that these needed to take into account volunteers. Some younger HealthCare assistants may also be beneficial. It was noted that transitional safeguarding nurse skills were also valuable and there was

a national focus on this. The Director of Strategy & Delivery asked Claire if there was one improvement possible what this would be. Claire advised that this would be creating additional capacity for the team as demand for the service increased. The Chief Operating Officer noted that the role of the secretaries was important as part of the Transition Service and suggested that Claire joined the 'Admin Matters' forum to talk to the team about this. The Chief Executive thanked Claire for her care and dedication. It was noted that the patient story was emotional and that there was clearly a personal impact as a result of handling the case. The importance of the Youth Voice was underlined. This would be taken forward with the Burdett Trust and a youth worker would be appointed which was an important role.	
2 Apologies	**Verbal**
The Chairman thanked the Board for agreeing to meet in person, which it was noted was the first time in 616 days. Apologies were received from Ayodele Ajose.	
3 Declarations of Interest	**Verbal**
The register of interests was noted to be available on request from Company Secretary.	
4 Minutes of Board Meeting held in Public on 1 September 2021: *for approval*	**ROHTB (9/21) 024**
The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held.	
4.1 Actions from previous meetings in public: *for assurance*	**ROHTB (9/21) 024 (a)**
The Director of Strategy & Delivery advised that in terms of the action around the Junior Doctors' common room, there was not an official snagging list however the small issues raised when the Guardian of Safe Working Hours had joined the Board had been resolved now such as the introduction of a notice board and new power sockets.	
5 Questions from members of the public	**Verbal**
There were none.	
6 Chairman's and Chief Executive's update: *for information and assurance*	**ROHTB (10/21) 001** **ROHTB (10/21) 001 (a)**

The Chief Executive advised that the ROH continued to support the Birmingham and Solihull system particularly around restoration and recovery of elective services. A meeting around the form and function of the Provider Collaborative had been held. The Integrated Care System (ICS) Chief Executive interviews were planned for 12 October 2021. There were fortnightly meetings planned around recovery, with a strong focus on 104 week waits. The number of patients waiting for treatment at the ROH in excess of 52 weeks was noted to be reduced to 85. There had been some good work to present the Health Service Journal (HSJ) submission for the 'Trust of the Year' award to the judging panel. The submission had been based on the ability of the Trust to operate without 'fear, fanfare and favour' but on this occasion the Trust had wished to celebrated its achievements. An internal target of 70% was planned for the staff survey. The COVID booster roll out would start in November and 'flu vaccination had started. Black History Month was being celebrated. The Royal visit had been conducted well and there had been a positive vibe in the hospital. The cleaning team was thanked for their work and the catering team had also excelled. The Lord Mayor who had attended on the day would join the Multi Minority Ethnic Group (MMEG). Gianjeet Hunjan reported that the Non Executive staff walkabout had been positive and noted that there were some staff who had intended to join the ROH for a short time but had been in post for a significant number of years. The Chairman gave thanks to the Medical Director for his support for the recent visit to theatres. In terms of the royal visit, he noted that there was significant pride in the hospital and the visit had allowed the progress of the last few months to be shown. All members of the team had presented well and the Executive Team was congratulated.	

STRATEGY	
7 Musculo Skeletal Services (MSK) development: *for assurance*	**Presentation**
The Board was joined by Rebecca Lloyd, Deputy Director of Strategy who, jointly with the Chief Operating officer, delivered the presentation that had been shared with the ICS Board at its last meeting. The case for change was being developed. It was noted that a regular update on the development of MSK services was planned for the Trust Board and ICS Board. Richard Phillips noted that the work was excellent, particularly around leadership. The clinical collaboration was noted to be especially impressive and the work was gelling the clinicians from different organisations together. It was noted that the workshops had worked well despite the restrictions presented by COVID. Sandwell and West Birmingham Hospitals NHS Trust had also been invited given the planned boundary changes. Simone Jordan noted that the work to forecast demand based on population health and the link to workforce planning was sound. The enthusiasm for the work was particularly impressive. Alongside this, the surgical element of the work was being progressed with Stryker. The JointCare approach would be presented at the November 2021 meeting. Les Williams noted that the programme of work was comprehensive and asked about the extent of the engagement. He particularly questioned the reach into General Practice. He was advised that Dr Sunando Ghosh, Primary Care Lead for the ICS and two other GPs were part of the work but for the 'jobbing' GPs, three GPs had been nominated and engaged with the project. They were part of the public health promotion and inequalities work. There was noted to be more that could be done and to ensure that both Birmingham and Solihull were represented. There was also a forum for GPs which was being accessed and would be used to communicate the work. Kathryn Sallah noted that there was a need to think through the quality measures and outcomes throughout the pathway. David Gourevitch congratulated the team for the work. The Director of Finance noted that there was a link between access, need and inequalities as part of the work. It was suggested that access to the service may reflect affluence and there may be hidden need for orthopaedic services from those in deprived areas. He was advised that the population health needs assessment would help inform this and was key to the prioritisation and tailoring the offering. There was also input from those with lived experience which informed the work. There was noted to be a responsibility on Primary Care to	

ensure that the offering was fairly targeted. Commissioners and providers would also need to work jointly to ensure that there was equity of access. The Director of Strategy & Delivery noted that health, social care, housing and community needs all needed to be considered together to help strategically plan what was required. There was significant momentum behind the work. The Board thanked Rebecca for her attendance.	
PATIENT EXPERIENCE AND OUTCOMES	
8 COVID-19 update: *for assurance*	**Presentation**
The Chief Nurse noted that the national guidance around COVID had changed and provided an opportunity around swabbing and the impact on the red, amber and green pathways. Social distancing would also be impacted. There was a review of the guidance planned between the operational, medical and nursing teams and the outcome would be presented at the next Board meeting. There had been one inpatient that had tested positive for COVID and a review of the patient was being undertaken to identify the source given that this was hospital acquired. The patient remained stable and discharge was planned shortly. There was no transmission to any other patient.	
9 NHS England Infection Prevention and Control Board Assurance Framework: *for assurance*	**ROHTB (10/21) 002**
The NHS England Infection Prevention and Control Board Assurance Framework was presented and the Board was guided through the outstanding areas of risk. The risk around the FFP3 mask risk was discussed, these masks being used predominantly in theatres for treating those patients with a risk of transmitting COVID. Each member of staff needed an individual assessment to be able to wear a mask and the fit testing regime was not embedded in the Trust as there had not been a need previously. External assessors were needed for this purpose therefore and there was also a need to move to UK products, although there was a gap in meeting this at present. Some staff had been fit tested with the range of masks used and there were no clinical concerns, despite some disquiet early in the pandemic. There was a challenge with releasing staff for the fit testing which presented an operational issue. Staff could use hoods if they did not have access to the FFP3 mask. The Board was advised that there was currently no concern that staff were at risk based on the situation described. The quality of training data around this work was noted to be a challenge. The facility to upload training onto ESR was not in place at present and there was no understood date for addressing this. There was some local and centrally held data so this was being cleansed. Gianjeet Hunjan asked whether there were any financial penalties around this and there was noted to be no penalty at present.	

The ventilation risk was discussed and a review had been commissioned to review this. Audits around compliance with wearing Personal Protective Equipment (PPE) were now in place which addressed the previous amber risk. Adherence in non-clinical areas was a challenge at times given that there was a choice in some areas.	
STAFF EXPERIENCE AND HEALTH & WELLBEING	
10 Gender pay gap submission: *for assurance*	**Verbal**
The Acting Director of Workforce & OD reported that there was a need to submit the gender pay gap data on an annual basis. It was usual that this submission was made by the end of March, however this had been suspended for the 2020/21 year with the submission deferred to 5 October 2021, which had been made. There had been a slight worsened position in the gender pay gap from the previous submission due to the reduction in the female workforce. There was an obligation to include all staff and given the high number of male consultants at the hospital this impacted the position. A report would be presented back to Board showing the trends from 2017. A more robust action plan that addressed the gap was also planned. There had not been a national report developed for some time. The Board supported the work planned and the proposed report, which would be presented to Staff Experience & OD Committee at the next meeting. For clarity, it was reiterated that the position did not reflect any discrimination but the orthopaedic speciality, there were far more male staff than female surgeons nationally.	
ACTION: SM to present the gender pay gap action plan to the Staff Experience & OD Committee	
GOVERNANCE AND COMPLIANCE	
11 CQC Action Plan: *for assurance*	**ROHTB (10/21) 003** **ROHTB (10/21) 003 (a)**
The Chief Nurse reported that the CQC action plan had been considered through a number of forums prior to the Trust Board. It was noted that the full action plan was presented to provide some context around those actions that remained open. A number of actions had also been reopened based on the result of an audit undertaken recently. The issue over call bells raised in the report was to be reaudited.	

The environment in which dementia patients were treated was to be reviewed. There were now some good care enhancing interventions although the evidence to show that the environmental concerns had been addressed needed to be identified. It was noted that a pragmatic risk-based review needed to be agreed for this work given that there were few patients seen that would be affected by any changes made. In terms of movements at night, the data showed that there were occasions where patients were moved, although it was noted that this may relate to the accuracy and timing of the updates on the Patient Administration System (PAS). The breaking bad news training was discussed and it had been agreed that not everyone needed this but it would be tailored to those most relevant. More end of life care had been delivered and therefore this was included within the care certificate training now. David Gorevitch asked whether this also applied to consultants and it was noted that this was the case. In terms of IT, there was a reliance on the work in the ICS to fully address this action and therefore there was likely to be no quick fix. Risk assessments showing the mitigation were noted to be in place and were monitored. It was noted that this situation needed to be made clear to the CQC if required. Regarding the action around expanding JointCare into other specialities, it was noted that traction would be built though the Patient Experience and Engagement Group. This work would be led by those closer to the services. It was noted that there was a plan to reclose the reopened actions. It was noted that the situation reflected the enhanced scrutiny of the action plan, which the Board agreed was good assurance. The Chief Nurse reported that the Trust's longstanding relationship manager had moved on and a new manager would be appointed. Based on feedback from the recent engagement meetings it appeared that the Trust was classed as low risk for the CQC and therefore an onsite inspection was not imminent. Feedback from the focus group with Black, Asian and Minority Ethnic (BAME) colleagues was expected shorty and the process would close.	
12 2021 NHS Emergency Preparedness Resilience and Response (EPRR) Core Standards: *for assurance*	**ROHTB (10/21) 004** **ROHTB (10/21) 004 (a)**
The annual submission of compliance against the EPRR core standards was presented by the Director of Strategy & Delivery. There were reported to be three areas of non-compliance identified, including non-compliance with the Data Security and Protection Toolkit, the duty to maintain plans for mass casualty and the need for a chemical, biological and radiation and nuclear risk assessment. The plans were being developed side by side with UHB colleagues. It was noted that	

the ROH would be established as a step down facility in the event of a mass casualty situation. Les Williams noted that when the Cloud business case had been considered by the Finance & Performance Committee recently, it had highlighted that there was no disaster recovery for the Trust's IT systems yet the position statement seemed to suggest that this was in place. The Director of Strategy & Delivery advised that the standard as it was framed was met. The Director of Finance advised that a data recovery plan was in place but a strategy was not. In terms of the timescales for addressing the shortfalls identified, this was noted to be from the date of the review. It was suggested that this clarity was needed in the report.	
COMMITTEE UPDATES	
13 Finance and Performance: • **Upward assurance report** • **Terms of Reference**	**ROHTB (10/21) 005** **ROHTB (10/21) 005 (a)** **ROHTB (10/21) 005 (b)**
Richard Phillips advised that the Finance & Performance Committee was continuing to review the financial uncertainty and there was a plan to work through the activity implications. Based on the current funding arrangements the ROH was being incompletely reimbursed for the work it was handling. It was noted that a deep dive on the Cost Improvement Programme was planned. The Director of Finance reported that Trust was c.£1m in deficit even through the Elective Recovery Fund (ERF) threshold had been exceeded as this was planned at a system level. In terms of H2 (months 7 – 12), the position was not clear, although it was anticipated that the impact may not be as severe as that expected previously. Target Investment Fund had also been identified for the Midlands, which was to be split between recovery, capital/revenue and digital innovation. It was anticipated that the priority would be allocated to eliminating 104 week waits and improving ambulance turnarounds. The majority of schemes were noted to be of benefit to UHB. The delivery plan would be submitted. It was reported that 946 cases had been delivered in September and 1137 for October was planned. Kathryn Sallah commented that a written summary of the key points would be useful in future. The minor changes to the Terms of Reference were approved.	

14 Quality & Safety: • **Upward assurance report** • **Terms of Reference**	**ROHTB (10/21) 006** **ROHTB (10/21) 006 (a)** **ROHTB (10/21) 006 (b)**
Kathryn Sallah reported that there was a plan for the nursing workforce to be presented at a future meeting of the Committee and that this needed to be focussed on the context of agency and bank staff. It was suggested that this plan needed to be a consideration of each of the Committees from a different lens. The Board considered the Terms of Reference for the Quality & Safety Committee and it was suggested that it needed to be made clear that the Committee's responsibility for considering the Quality Account was to ensure it had received scrutiny prior to presentation to the Audit Committee. It was noted that the title Chief Nurse needed to replace the Director of Nursing & Clinical Governance. Subject to these amendments, the Trust Board approved the Terms of Reference.	
ACTION: SGL to amend the terms of reference for the Quality & Safety Committee in line with suggestions made	
15 Staff Experience & OD: • **Upward assurance report** • **Terms of Reference**	**ROHTB (10/21) 007** **ROHTB (10/21) 007 (a)** **ROHTB (10/21) 007 (b)**
Simone Jordan reported that the Staff Experience & OD Committee had considered the sickness absence position which was a concern. There were noted to be a significant number of initiatives and there was a need to evaluate the impact and outcomes of these, including the flexible working plan. The Chief Operating Officer was noted to be the Executive lead for this initiative. There was reported to have been a Non Executive staff walkabout and the feedback had been positive. The minor changes to the Terms of Reference were approved.	
16 Audit: • **Terms of Reference**	**ROHTB (10/21) 008** **ROHTB (10/21) 008 (a)**
The minor changes to the Terms of Reference were approved.	
17 Nominations and Remuneration (Executive Directors) • **Terms of Reference**	**ROHTB (10/21) 009** **ROHTB (10/21) 009 (a)**

The minor changes to the Terms of Reference were approved.	
David Gourevitch reported that in terms of Charitable Funds Committee there had been some good work generally around fundraising also there had been work with the Musculo Skeletal academy. The logo for the Charity would be amended. There had been a presentation around Research regarding the recent grant for Mr Snow. The grant needed to take into account the requirements of the Dubrowsky legacy.	
MATTERS TO BE TAKEN BY EXCEPTION ONLY	
18 Performance reports: *for assurance* • **Finance & Performance** • **Quality & Safety** • **Workforce**	**ROHTB (10/21) 010** **ROHTB (10/21) 011** **ROHTB (10/21) 012**
It was noted that the performance against the constitutional standards had been clarified in the reports.	
CONFIDENTIAL SESSION	
19 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
Date of next meeting: Tuesday, 2 November 2021 @ 0900h	

PUBLIC SESSION

Next Meeting: 7 October 2021, Woodbrooke Centre, Bournville

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 29.10.2021

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT.117	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Present the range of concerns raised by the Junior Doctors at a future meeting	JMc	03-Nov-21	Concerns outlined in Guardian of Safe Working Hours' report in November 2021	
ROHTBACT.119	Progress and next steps towards delivering a 'net zero' NHS	ROHTB (7/21) 005 ROHTB (7/21) 005 (a)	07/07/2021	Present the 'net zero' strategy at the January 2022 meeting	PB	12-Jan-22	ACTION NOT YET DUE	
ROHTBACT.120	Chairman's and Chief Executive's update	ROHTB (9/21) 001 ROHTB (9/21) 001 (a)	01/09/2021	Arrange for the Board to be update on the patient experience work at a future meeting	GM	01-Dec-21	ACTION NOT YET DUE	
ROHTBACT.121	Progress with delivery of the five year strategy	ROHTB (9/21) 002 ROHTB (9/21) 002 (a)	01/09/2021	Present the revised strategy during Quarter 4 2021/22	PB	31-Mar-21	ACTION NOT YET DUE	
ROHTBACT.123	IT & Digitisation plans update	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	01/09/2021	Arrange for a high level summary of the IT projects to be presented at a future meeting	SW	01-Dec-21	ACTION NOT YET DUE	
ROHTBACT.124	COVID-19 update	Presentation	01/09/2021	Arrange for the cleaning team to present their staff story to the Board or a Board Subcommittee	GM	24-Nov-21	Included on the agenda of the November 2021 meeting	
ROHTBACT.125	Gender pay gap update	Verbal	07/10/2021	Present the gender pay gap action plan to the Staff Experience & OD Committee	SM	24-Nov-21	ACTION NOT YET DUE	

ROHTBACT.118	Update from the Guardian of Safe Working Hours	ROHTB (7/21) 003 ROHTB (7/21) 003 (a)	07/07/2021	Resolve the snagging issues with the Junior Doctors common room	PB	30-Sep-21	Update provided at the October 2021 meeting - minor works now complete	
ROHTBACT.116	Musculo-skeletal (MSK) Transformation Programme update	Presentation	07/07/2021	Schedule in a further update on the MSK transformation work to the agenda of a future meeting	SGL	03-Nov-21	Included on the agenda of the October 2021 meeting.	
ROHTBACT.122	IT & Digitisation plans update	ROHTB (9/21) 004 ROHTB (9/21) 004 (a)	01/09/2021	Arrange for the Cloud business case to be presented to the Trust Board	SW	07-Oct-21	Included on the agenda of the October 2021 meeting.	
ROHTBACT.126	Quality & Safety: • Upward assurance report • Terms of Reference	ROHTB (10/21) 006 ROHTB (10/21) 006 (a) ROHTB (10/21) 006 (b)	07/10/2021	Amend the terms of reference for the Quality & Safety Committee in line with suggestions made	SGL	30-Oct-21	Amendments made as requested	

KEY:

	Verbal update at meeting
	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 that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**2 November 2021**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board is asked to note and discuss the contents of this report

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (11/21) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board (in Public) on 2nd November 2021

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 7th October 2021 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 We continue to support our partners across the BSol (Birmingham and Solihull) region with the Trust focusing on our role supporting the system restoration and recovery. System strategic calls continue three times per week. The Chief Operating Officers (COOs) across all providers also continue to meet twice a week to agree the operational changes required to address the system backlog for adults across BSol. We continue to support spinal patients who require surgery after attending at the Emergency Department (ED) of the Queen Elizabeth Hospital.

2.2 On 18 October 2021, NHS England/Improvement released the organisational-level classifications against the Single Oversight Framework (SOF), placing the ROH within Category 2 out of a possible 4 (Category 1 being organisations afforded maximum autonomy and Category 4 being 'Special Measures'). Appendix 1 provides the notification from NHSE/I's Director of Strategic Transformation for the West Midlands.

2.3 Our seasonal flu campaign has commenced with our performance currently at 54% against a national target of 85%. We plan to commence our COVID booster vaccination programme to run through 12th - 14th November 2021 on site at the ROH with colleagues able to access other sites if this is more convenient for them.

2.4 October was Black History Month (BHM) which is a national celebration which recognises the contributions of NHS staff from Black backgrounds. I would like to thank all colleagues who have either planned or attended the events throughout the month. Our Multi Minority Ethnic Group (MMEG) staff network has worked incredibly hard this year with multiple events to ensure we further develop our inclusive and diverse culture, ensuring that it is supportive and welcoming for all working at the ROH.

2.5 Last week we published our Autumn edition of 'ROH Life' which features many of the amazing stories, projects and highlights over the last few months. Thank you to the Communications Team for their continued enthusiasm and energy to make it a great read – I think it is the best issue they have produced so far.

2.6 On the 18th October we celebrated World Menopause Day and this year the theme was bone health and raising the awareness of osteoporosis. We started our Menopause Awareness two years ago with a commitment to normalise the conversations about the menopause and offer support to those who might be going through a life-changing experience. Over 70% of our

workforce is female and of that number, over 40% are in the normal peri/menopausal age range.

I was interviewed by ITV Central New team to record a piece about the menopause which was broadcast on World Menopause Day to share my experience and talk about how we're trying to support people at ROH.

I decided that if it would give someone the confidence to talk about it at the ROH then it would be a story worth sharing and I would be bring my authentic self to work, which is something we ask of our colleagues.

The ITV news team also interviewed a Healthcare Assistant in the Outpatients Department, Ava Pryce and Sandra Crook, Deputy Facilities Manager, to hear about the support we have given to staff, including the lightweight uniforms we have introduced. Ava and Sandra were both amazing and very open and it was lovely to hear them speak of their pride about being part of the ROH team. I have been extremely heartened by the number of colleagues who have stopped to talk to me about the interview or email their support, so thank you.

2.7 On Tuesday 19th October 2021 our 2020/2021 Annual Accounts were laid before Parliament which enables us now to present these at the Annual General Meeting which is being held on Thursday 25th November 2021. The event will be live streamed on Social Media as it was last year, to allow those that would normally attend in person to hear about the achievements of the last year.

2.8 On Wednesday 20th October I attended and officially opened the 2021 National Orthopaedics Alliance (NOA) National Conference held in Birmingham. It was an opportunity for NOA partners across the country to share achievements, address shared challenges and discuss what is in store for Orthopaedics in the coming year. It was great to have Andrew Bennett the National Clinical Director for Musculo Skeletal (MSK) services, opening the conference and to have patients in our workshops presenting and demonstrating the real value of lived experience ambassadors. Thank you to everyone who attend the day and it was great to see the ROH team presenting in various slots throughout the day with such enthusiasm and passion for Orthopaedics.

2.9 October was #SpeakUpMonth and Claudette Jones, our new Freedom to Speak Up Guardian, set up a stall outside Café Royale to ask staff to make a pledge around speaking up. A significant number of staff have made a pledge which have been promoted within the Trust and on social media.

3 BSol ICS (Integrated Care System) Update

3.1 The ICS Board meeting was held on Monday 11th October 2021 and part of the meeting was set aside for a workshop to discuss the vision for the ICS. It was agreed that we needed to ensure clear and consistent articulation was achieved, with an emphasis on where the ICS added value for people and communities. It was recognised that the measure of success for a compelling vision for our ICS is in how we bring this to life, ensuring hearts and minds are won over and that we are truly united by our shared vision. The next steps will be the collection of all views shared on the day and further engagement across a number of key forums with a range of stakeholders. The final proposal will be shared at the ICS Board meeting on 8 November 2021.

3.2 The recruitment process has concluded for the appointment of the BSol ICS Chief Executive with a number of colleagues at the ROH participating in the stakeholder focus groups. We await an update regarding the appointment.

4 NHS England/Improvement (NHSE/I) National updates

4.1 Fortnightly briefing calls remain in place with NHS Improvement with the focus being on the vaccination programme and restoration & recovery of elective activity across the Midlands and East region.

5 POLICY APPROVAL

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

- Safeguarding supervision

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

28 October 2021

Appendix 1 – Letter from NHSE/I re: Single Oversight Framework categorisation

Rebecca Farmer
Director of Strategic Transformation, West Midlands

23 Stephenson Street
Birmingham
West Midlands
B2 4BJ

T: 0300 123 2620
E: rebecca.farmer3@nhs.net
W: www.england.nhs.uk and www.improvement.nhs.uk

Joanne Williams
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust

Sent by email

18th October 2021

Dear Jo,

The Royal Orthopaedic Hospital NHS Foundation Trust: NHS system oversight framework segmentation

As you will be aware, NHS England and NHS Improvement (NHSEI) recently consulted on the new NHS System Oversight Framework (SOF) 2021/22, which introduced a new approach to provide focused assistance to organisations and systems.

Following feedback from local leaders and others, this new SOF is now being implemented. The final SOF can be found here.

Following consideration by the NHSEI Midlands Regional Support Group, it has been agreed that The Royal Orthopaedic Hospital NHS Foundation should be placed into SOF segment 2.

What this means in practice is that the regional team will work with you to access flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via the regional improvement hubs.

We recognise and thank you for the efforts of you and your teams to provide the best

quality care to our patients, including meeting and recovering from the additional challenges COVID-19 has posed.

Please note that it is anticipated that the segmentation rating for all organisations will be published on the NHS England and NHS Improvement website later in the month. If you wish to discuss the above or any related issues in more detail, please contact katrina.boffey@nhs.net in the first instance.

Yours sincerely



Rebecca Farmer
Director of Strategic Transformation, West Midlands

Cc: Tim Pile

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Complaints and Patient Experience report 2020/2021**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Chief Nurse**
AUTHOR:	**Roko Skocic, Head of Patient Experience**
DATE OF MEETING:	**2 November 2021**

EXECUTIVE SUMMARY:

The Trust deals with complaints in accordance with its PALS and Complaints Policy and the NHS Complaints Regulations of 2009.

This report provides information with regards to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 1 April 2020 to 31 March 2021. It provides data in regard to the number of complaints received and identifies trends in relation to issues raised with the Trust.

The Trust treated a total of 72,220 patients during the 2020/21 year. The percentage of formal complaints was 0.08% (57), PALS concerns were 0.50% (363), PALS enquiries were 0.43% (311) and informal complaints were 0.004% (3).

In 2020/2021, ROH received 57 formal complaints. This is a 0.04% decrease in the formal complaints raised compared to the year before when considered as a percentage of activity handled. In 2020/2021, 0.08% service users have raised a formal complaint to the Trust compared to 2019/2020 when 0.12% of all patients raised a formal complaint.

The table below shows the total number of formal complaints received over a three-year period.

Formal Complaints	2018/2019	2019/2020	2020/2021
	128	138	57

REPORT RECOMMENDATION:

The Trust Board is asked to receive and approve the annual report and agree to its publication on tne Trust's internet page.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

Comments:
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
CQC compliance and compliance with NHS Complaints Regulations of 2009.
PREVIOUS CONSIDERATION:
Executive Team on 26 October 2021 and Quality & Safety Committee on 27 October 2021.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust



Annual Complaints and Patient Experience Report 2020/2021

The Royal Orthopaedic Hospital

Author: Roko Skocic, Head of Patient Experience
Executive Director: Garry Marsh, Chief Nurse and DIPC

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Preface from Garry Marsh, Chief Nurse



It has been a challenging period for the NHS. The pandemic has had a significant impact on service delivery, which in turn affects patient experience.

While we will continue to face challenges, we must continue to be a patient-centred organisation that listens. Ensuring the patient voice is at the heart of our services is an ongoing priority at The Royal Orthopaedic Hospital. We strive to deliver services which meet the needs of the people who use them.

Being patient-centred means involving people in meaningful ways. It means collaboration and co-production. It also means listening to and responding to feedback, both positive and negative.

Complaints create an opportunity to learn, to improve, to do better and reduce the risk of issues reoccurring. I am proud of how responsive we are to complaints and how we deal with them constructively. This report illustrates the nature of the complaints we receive and how they are handled.

Of course, we must continue to make progress. Both in the expedience of managing complaints and actions we take to mitigate them, as well as how we monitor complaints to understand emergent themes - allowing us to work proactively to address them.

In doing so, we will improve our services and continue to make them as patient-centred as possible.



Garry Marsh
Chief Nurse

1.0 Executive summary

The Royal Orthopaedic Hospital NHS Foundation Trust (the Trust) is committed to learning from complaints raised by our patients, their carers, their family and their friends. Furthermore, we are dedicated to continuously improving our services by listening to concerns, enquiries, feedback, comments and compliments.

Complaints made to the Trust are managed and dealt with in accordance with Managing of Complaints Policy and the NHS Complaints Regulations (2009). The fundamental objective is to resolve each complaint with the complainant through discussion, explanation or a written response to their satisfaction within the agreed timescale. Section 6.0. of this document outlines the statutory requirement that the Trust is measured against.

The Trust treated a total of 72,220 patients between 1 April 2020 to 31 March 2021. The percentage of formal complaints was 0.08% (57), Patient Advice & Liaison Service (PALS) concerns were 0.50% (363), PALS enquiries were 0.43% (311) and informal complaints were 0.004% (3).

In 2020/2021, the Trust was measured against two contractual complaint key performance indicators (KPIs) which were reported to the Trust Board and commissioners via the Quality Report as part of the monthly reporting cycle. In 2020/2021, the Trust acknowledged 100% of all complaint letters received within 3 working days. In addition, 98% of all formal complaints were responded to within the timescale agreed with the complainant (KPI target 80%, the contractual requirement). Compliance against these KPIs is outlined in section 6.0.

Under the Local Authority Social Service and National Health Service Complaints (England) Regulations (2009), the Trust must prepare an annual learning from complaints report each year. The report must specify the number of complaints received and number of complaints that the Trust decided were well-founded. It must also summarise the subject matter of complaints and any matters of general importance arising from those complaints. It must include the way in which the complaints have been managed and any actions that have been taken to improve services because of those complaints. This report will be publicly available on the Trust web site https://www.roh.nhs.uk/

However, as a result of vacancies in PALS and Complaints Team, as a part of the good practice, the Deputy Chief Nurse was unable to provide quarterly reports to the Quality and Safety Committee. Assurance was nevertheless provided via summaries included in the monthly Quality Report and at an Executive and Divisional level, by weekly / monthly reports that were shared and discussed at governance meetings.

In January 2021, in order to strengthen the Patient Experience Team a business case was presented by the Deputy Head of Patient Experience to the Executive Directors for approval. It was agreed that the team would have an uplift of two whole time equivalents (WTE) to support and move the patient experience agenda forward.

1.1. Definitions Within this Report

1.1.1. Type of Complaint

- **Formal Complaint**: Any expression of dissatisfaction, where the complainant wishes to have a fully investigated response in writing. These are likely to take longer than 5 working days to resolve, but may also include issues that are resolvable quickly, where the complainant expresses a wish for the complaint to be dealt with formally.

- **Informal Complaint:** A concern that is raised by the complainant where the issue can be resolved either immediately or to the complainant's satisfaction within 48 hours. It also applies to issues raised verbally through the Patient Advice and Liaison Service, or the Complaints Department where the complainant indicates he/she does not require a written response from the Trust or does not wish to proceed with a formal complaint, once resolved to their satisfaction. These are not formally reported via the complaints data to NHS England.

- **PALS Enquiry:** A general enquiry that does not raise any matters of concern, but the individual merely requires information. These are not formally reported to NHS England and are resolved within 2 working days.

- **PALS Concern:** An enquiry that requires contact with other members of staff to resolve and a response is required verbally or in writing to the individual providing answers to specified questions. These are not formally reported to NHS England and are resolved within 5 working days.

1.1.2. Formal Complaints Outcome Decision

- **Upheld:** If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld.
- **Partially upheld**: If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as partially upheld.
- **Not upheld:** Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld.

2.0. The PALS and Complaints Team

At the beginning of the 2020/2021 financial year, the team comprised 2.0 WTE, the Patient Relation Service Manager and Patient Experience Facilitator. During 2020/2021 the team experienced changes in staff turnover within the department and the team have had 1.0 WTE Deputy Head of Patient Experience and 0.5 WTE PALS Administrator for some time.

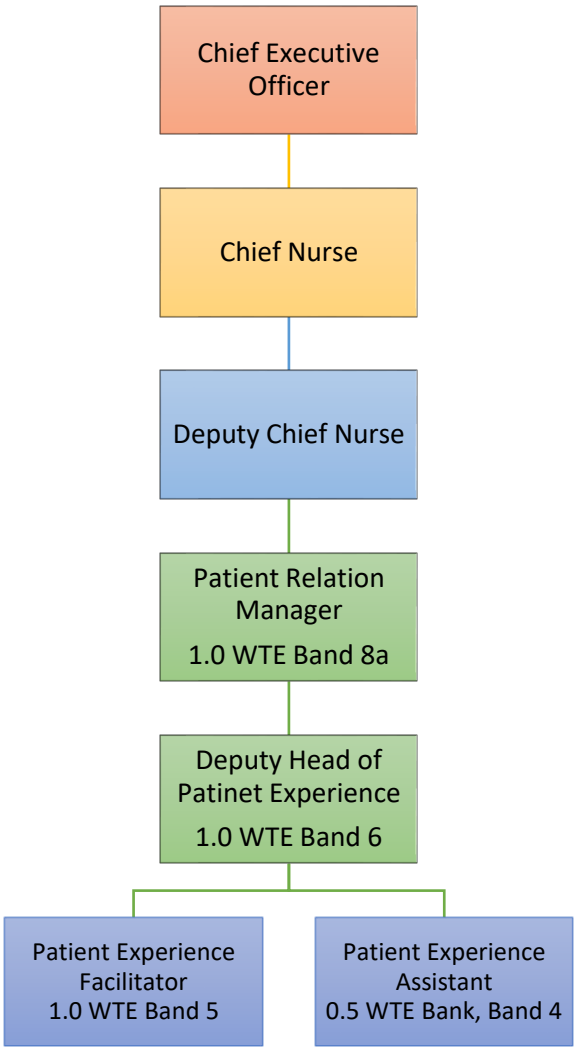


Figure 1: PALS and Complaints Team Structure during 2020/2021

- In 2020/2021 the team structure was as outlined above. The Deputy Head of Patient Experience post was appointed into in June 2020. The Patient Experience Facilitator post was vacant from June 2020 until December 2021 when a secondment started, which was due to conclude in May 2021, however the individual left the organisation before this time.
- As a result, the Department had only one WTE in post over this above timescale.
- The Trust reached a decision to restructure the team and recruit to a Head of Patient Experience (Band 7) with the role of Patient Relation Manager (Band 8a) being removed from the structure. The postholder started mid-March 2021.

- A business case was made by the Deputy Head of Patient Experience in January 2021 and approved by the Executive Directors in March 2021. The business case strengthens the PALS and Complaints team, adding two WTE posts.

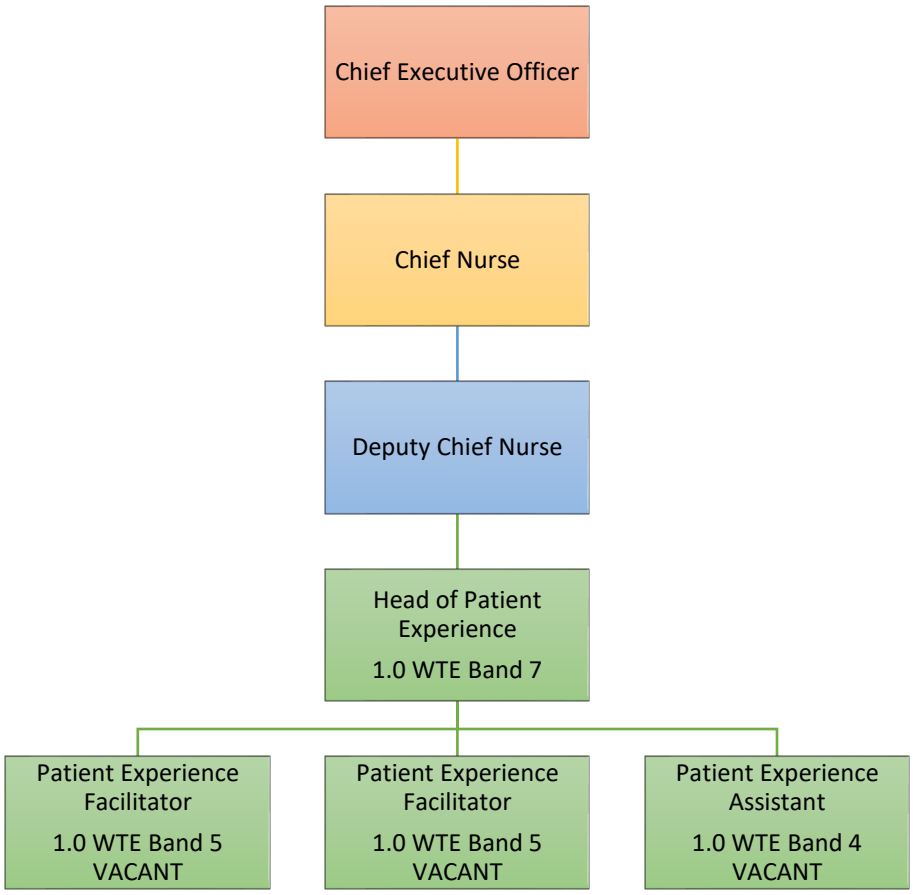


Figure 2: PALS and complaints team structure from March 2021

2.1. Roles and Responsibilities Within the Structural Team Tree

2.1.1. Chief Executive Officer (CEO)

- Named officer with responsibility for ensuring that the Trust complies with statutory obligations made under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. Ensuring that actions are taken depending on the outcome of complaints.
- The CEO or nominated deputy in his/her absence will read and review all complaint responses and provide a signed cover letter.

2.1.2. Chief Nurse

- Has overall responsibility, delegated from the CEO, for ensuring that effective systems and processes are in place to deal with patient and service users' feedback and to ensure that this is shared and acted upon in order to continually improve the quality of care.
- Presentation of an Annual Complaints Report to the Board of Directors.

2.1.3. Deputy Chief Nurse

- Is responsible for providing the Quality and Safety Committee with a quarterly report regarding complaints activity, the actions taken and an evaluation of the effectiveness of the action.
- Agreed actions to be taken when complaints are presented after the statutory 12-month period.
- Is responsible for ensuring detailed procedures are developed, agreed and implemented.
- Ensuring key performance indicators (KPIs) are monitored and reported to Divisions, Clinical Quality Group and Quality and Safety Committee.

2.1.4. Head of Patient Experience

- Day-to-day management and provision of a patient advice and support service in relation to feedback and complaints.
- Managing the procedures for handling and considering complaints and acts as a 'complaints manager' under The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009.
- Interpretation of NHS Complaints Procedure and developing and reviewing associated local policy and procedures.
- Execute his/her duties as described in the associated procedural documents.
- Providing quality assurance of complaint responses for complaints risk rated amber, yellow or green.
- Managing the administrative process for Parliamentary Health Service Ombudsman investigations.
- Providing training in relation to the management of Complaints and PALS.
- Monitoring concerns and complaints key performance indicators (KPIs) and analyses complaints information and provide data and information for Divisional Governance Board, Clinical Quality Group, Quality and Safety Committee and the annual complaints report to Trust Board
- Informing the Communications Manager of any potential media interest.
- Providing support to the Divisional leads as required.
- Development of an Annual Complaints Report for presentation to the Board of Directors by the Chief Nurse.
- Responsible for improving the Patient Advice and Liaison Service (PALS) and complaint services on a regular basis.

2.1.5. Patient Experience Team

- Is designated by the Trust to listen and respond appropriately and timely to feedback from patients and service users.
- Is responsible for maintaining accurate PALS records of contacts and outcomes that can be used for the identification of trends and for sharing learning across the Trust.
- Will report any issues of concern to the Head of Patient Experience
- Is responsible for providing written reports detailing PALS activity and outcomes to the Head of Patient Experience on a monthly basis in order to enable production of monthly quality report.

3.1. Governance Structure



Figure 3: PALS and Complaints Governance Structure for Reporting

3.1. Roles and Responsibilities within Governance Structure

3.1.1. Trust Board

- Receives assurance that robust systems are in place that enables feedback to be heard, actioned and lessons learned in order to provide the best possible care and experience to patients and service users.
- The Trust Board will receive information on the number of complaints and timeliness of response in the Integrated Performance Report.
- The Trust Board will receive and approve the Annual Complaints Report.

3.1.2. Quality and Safety Committee

- Will receive quarterly assurance reports about complaint numbers, timeliness of responses, themes and trends, risk grading of initial complaint, number upheld, partially upheld or not upheld.
- Number and percentage responded to in time agreed with complainant, complaint outcomes and learning identified, evidence of how learning has been shared across the Trust, number referred to Parliamentary Health Services Ombudsman (PHSO) and outcome, number and percentage of re-opened and criteria for re-opening, details of measure of complaint satisfaction sought via survey or proactive feedback process and summary of training undertaken in respect of learning from complaints. This report will also include details of concerns and compliments received by the Trust.

3.1.3. Clinical Quality Group

- Will receive monthly assurance reports about complaint and PALS numbers, timeliness of response, themes and trends, risk grading of initial complaint, number upheld, partially upheld or not upheld
- Number and percentage responded to in time agreed with complainant, complaint outcomes and learning identified, evidence of how learning has been shared across the Trust, number referred to Parliamentary and Health Service Ombudsman (PHSO) and outcome, number and percentage of re-opened and criteria for re-opening, details of measure of complaint satisfaction sought via

survey or proactive feedback process, summary of training undertaken in respect of learning from complaints. This report will also include details of concerns and compliments received by the Trust.

- Has overall responsibility for ensuring that complaint action plans are monitored and closed at Divisional level.
- Has responsibility for ensuring that learning from complaints is shared across the Trust.

3.1.4 Patient Experience and Engagement Group

- The purpose of this group is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement and experience within the Trust.
- The Patient Engagement and Experience Group is responsible for setting its own annual work plan in agreement with the Quality and Safety Committee and be accountable for delivering and evaluating its key tasks and responsibilities.
- Is responsible to ensure there is a clear Involvement, Experience and Volunteering Strategy in place with a work plan aligned to ensure implementation.
- Is responsible to oversee compliance with standards set by the Care Quality Commission and NHS.

3.1.4. Divisional Management Board

- Are responsible for ensuring that all complaints and patient feedback are investigated and responded to in line with the policy.
- Will monitor and oversee closure of complaint action plans and ensure that learning is widely shared across the Division.
- Will receive monthly reports with trends of PALS contacts (enquiries, comments or concerns) and Formal complaints covering the whole year from April to March, together with main trends from the month before.

3.1.5. Divisional Governance meeting

- Are responsible for ensuring that all complaints and patient feedback are investigated and responded to in line with the policy on a weekly basis.
- Will receive an open Formal complaints tracker, PALS contacts and PALS trends for that month.
- Will ensure that all complaint or concern actions are closed and track their process.

4.0 Data Collection and Analysis

All data from the PALS concerns, PALS enquiries, compliments and formal complaints are entered and collected via the Customer Service Module within Ulysses Safeguard System (USS). This has enabled more accurate and responsive trend and theme analysis across all Patient Experience data and allowed the team to work closely with the Divisional teams to improve the recording of actions and learning taken as a result of complaints.

The PALS and Complaints department produce reports on weekly, monthly and quarterly basis to ensure that Divisions are aware of any issues and themes within their departments.

4.1. Improvement to Ulysses Safeguard System in 2020/2021

- Department started to collect demographics data
- Reports are now being produced using Ulysses Safeguard System only
- New departments and categories have been implemented
- All actions have now been set on the Ulysses Safeguard System
- Staff and Patient lists are updated on a daily basis
- All contacts are recorded on the Ulysses Safeguard System
- Initial and final grading are now being used for every case

There is still room for improvement and the team will continue to work on developing the functionality of the USS.

5.0. Formal Complaints Process

Complaints are a rich source of patient feedback and this should be regarded as such by all staff members. From time to time, the experience of our service users is not as good as it should be and as a consequence there is an opportunity for us to learn from our mistakes.

In 2020/2021 the PALS and Complaints department changed the processes for formal complaints. The new process gives the Divisions full ownership and oversight of the formal complaints that are connected to their Division. The Triumvirate has full oversight of all complaints that are received by the Trust; identify the lead and providing divisionally sign off complaints before they go for Executive Director and Chief Executive Officer approval.



Figure 4. Formal complaints process hierarchy

5.1. Roles and Responsibilities within Formal Complaints Process

5.1.1. Patient Experience Facilitator

- Will receive complaint and act as a first point of contact to the complainant.
- Is responsible for reading and extracting the questions from the complaint, to allow timely investigation, responding and reading of the complainant
- Facilitates all processes for the formal complaint and makes sure that the complaint response is sent within the agreed timescale with the complainant

5.1.2. Triumvirate - Deputy Medical Director, Deputy Chief Operating Officer and Head of Nursing

- Are responsible for identifying a named individual to lead the complaint investigation.
- Are responsible for identifying a lead and completion of an immediate action plan.
- Are responsible for approving the draft response for a formal complaint before it goes to a Director.
- Quality assures all complaint responses and ensures all aspects of the complaint have been addressed and the response has been written in line with the guidance on writing response letters.
- Review and approve any changes within PALS and Complaints processes or system.

5.1.3. Investigation Lead - Matrons, Clinical Service Managers, Ward Managers, Deputy Directors and Managers

- Is responsible for ensuring that all staff within their team have read and understood the Trust Policy.
- That all identified staff have received relevant training and understand their responsibilities when responding to the specific needs/requests of patients and service users. Staff should aim to resolve issues locally wherever possible.
- Undertake local investigation into complaints as requested.
- Meet with complainants as required to enable local resolution of concerns/complaints.

5.1.4. Executive Director

- Is responsible for approval of the final complaint response before CEO approval.
- Executive Director will sign off all complaints within their portfolio.

5.1.5. Chief Executive Officer

- Is the named officer with responsibility for ensuring that the Trust complies with statutory obligations made under The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, and in particular ensuring that action is taken if necessary, in the light of the outcome of a complaint.
- The CEO or nominated deputy in his/her absence will read, review and approve all complaint responses and provide a signed cover letter.

5.2. Governance structure for approval of the Formal complaints

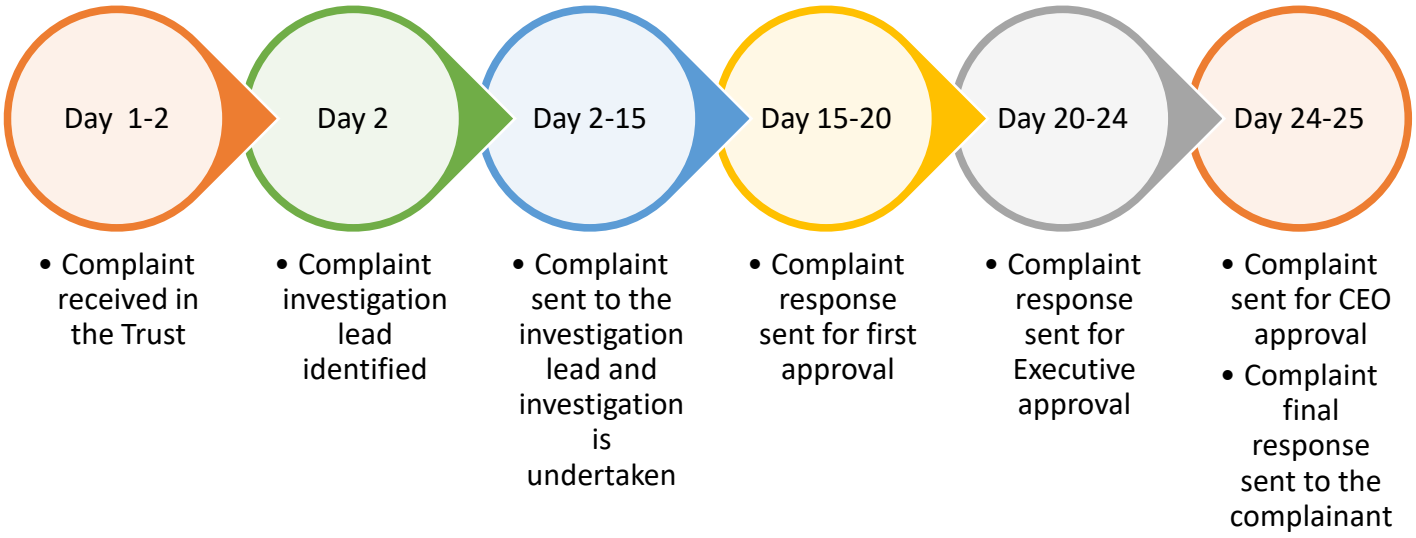


Figure 5. Formal Complaint Governance Process

5.2.1. Days 1 and 2 - Complaint Received in the Trust

- Complaints team will read the complaint letter and extract key elements.
- Complaints team phone the complainant to discuss key elements of the complaint and discuss complaint letter and extracted questions with complainant.
- Complaints team offer the complainant a telephone call and meeting with an investigation lead.
- Complaints team will email the Triumvirate requesting that they identify a lead for the complaint, provide the questions that the complainant would like answering and advise the method of response requested.

5.2.2. Day 2 - Complaint Lead Identified

- Triumvirate to complete an immediate action plan, initial risk rating and identifies lead for the complaint.
- Complaints department will forward the complaint to the investigation lead (the following will also be copied into the correspondence: the patient's Consultant, Clinical Service Manager and Clinical Service Lead who will contribute to the response if applicable) asking them to respond as per instructions.

5.2.3. Days 2 to 15 – Complaint Sent for Investigation

- Complaints lead to phone the complainant if instructed to do so, within 5 working days and notify Complaints team of the outcome of that conversation. Telephone response must be followed up with a written response, outlining the discussion with complainant.
- Complaint's lead has 15 working days to respond in the format of a letter.

5.2.4. Days 15 to 20 - Complaint Response Sent for First Approval

- Complaint version 1 draft response created and sent to Complaints team, together with final risk rating and final Action plan.
- Complaints team will proofread complaint version 1 response letter.
- Complaints team will notify Triumvirate that version 1 draft response has been created and it is ready for them to review, make comments/amendments or approve.
- Once a complaint draft response is approved by Triumvirate it will be sent for Director approval.

5.2.5. Days 20 to 24 Complaint Response Sent for Executive Directors Approval

- Complaints team will send a draft version of the response and final action plan to the Executive Director to review, make comments or approve.
- Executive Director approves draft response, and it is then sent for CEO approval.

5.2.6. Days 24 And 25 - Complaint is Sent for CEO Approval and to the Complainant

- CEO reviews draft response for the complaint and once it has been approved it becomes a final response.
- In the cover letter, the CEO will offer the complainant an opportunity to meet with key managers to discuss the outcome of the complaint.
- Final response letter and CEO cover letter is then scanned, and a copy saved on Ulysses.
- Complaint final letter sent to the patient and complaint closed.

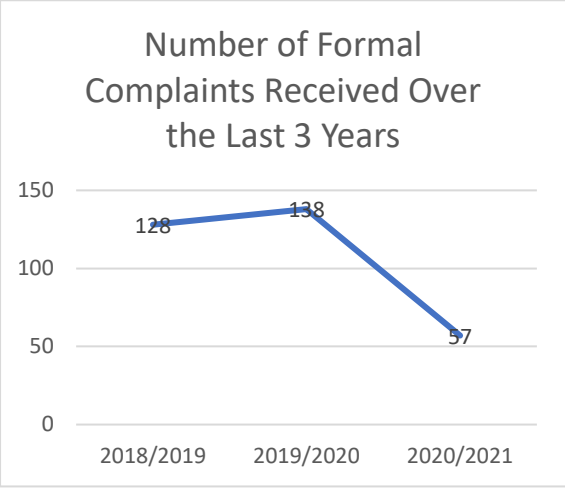
6.0. Complaints Received

This section is a statutory requirement for the Trust under the Local Authority Social Service and National Health Service Complaints (England) Regulations 2009.

From 1 April 2020 to 31 March 2021 (2020/2021), the Trust had a footfall of 72,220 patients throughout all services and received 59 formal complaints. Two complaints were withdrawn, leaving a total of 57 complaints which were investigated and formally responded to.

In comparison in the year 1 April 2019 to 31 March 2020 (2019/2020), the Trust had a footfall of 116,880 patients throughout all services and received 138 formal complaints.

In 2020/2021, 0.08% service users have raised a formal complaint to the Trust compared to 2019/2020 when 0.12% of all patients raised a formal complaint. The Trust saw a 0.04% decrease in the formal complaints raised compared to the year before.



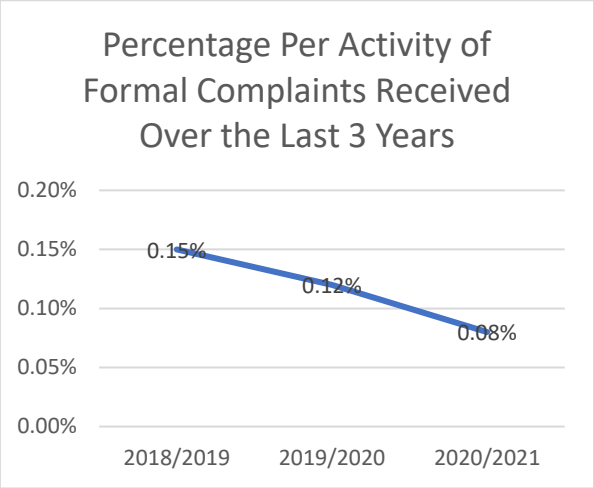


Figure 6 and 7. Number and Percentage of Formal Complaints Received Over the Last 3 Years

The data above shows that the Trust has had a decrease in the formal complaints received in the last 3 years. The Trust has had more contacts and cases open in the Patient Advice and Liaison Service (PALS) over last 3 years and it is believed that early prevention, intervention, and resolution has avoided our service users deciding to proceed to a formal complaint; this is outlined in the section 7.0. of this document.

In addition, 18 out of 57 complaints that were received in 2020/2021 were complaints in connection to the COVID-19 pandemic. In conclusion, if there was no impact of COVID-19 caused to services, 0.06% of our service users would complain which is a decrease of 0.06% in comparison to 2019/2020.

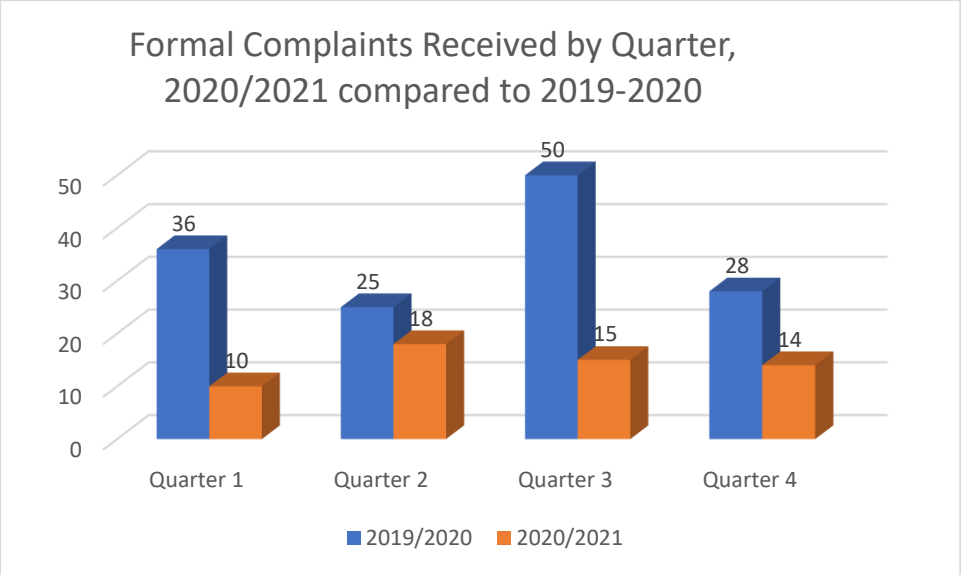


Figure 8 - Formal Complaints Received by Quarter

Figure 8 above details the number of complaints received by quarter in 2020/2021 with the previous year's data for comparison.

6.1. Themes of Formal Complaints 2020/2021

Listed below are the themes arising out of the formal complaints received during 2020/2021 compared to 2018/2019 and 2019/2020.

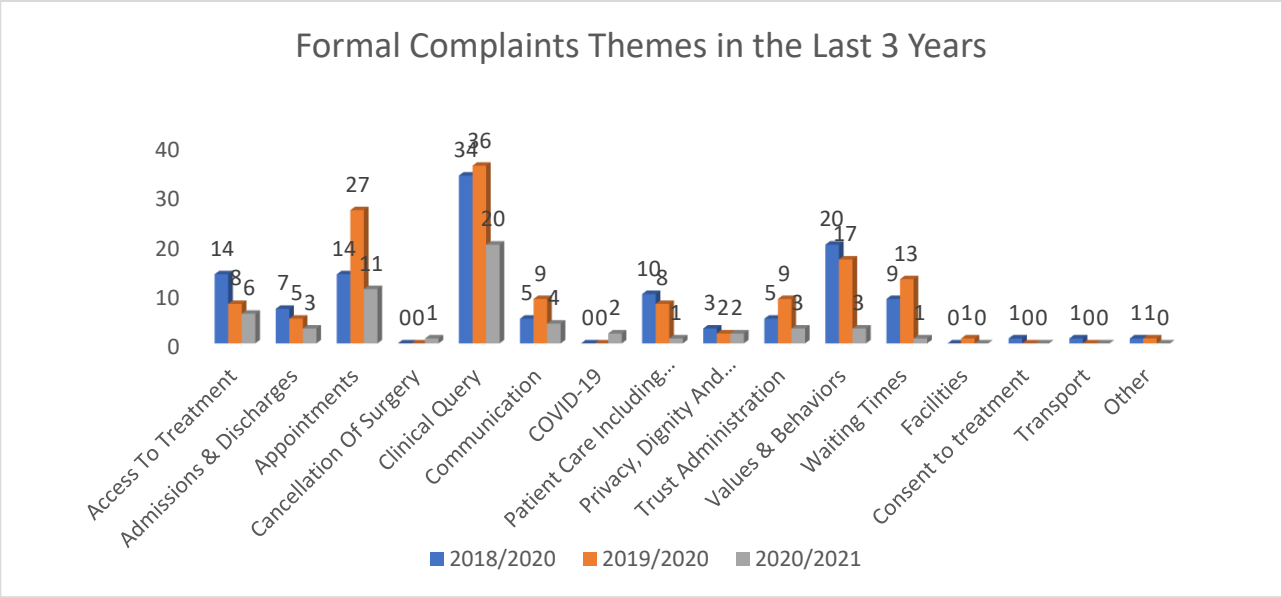
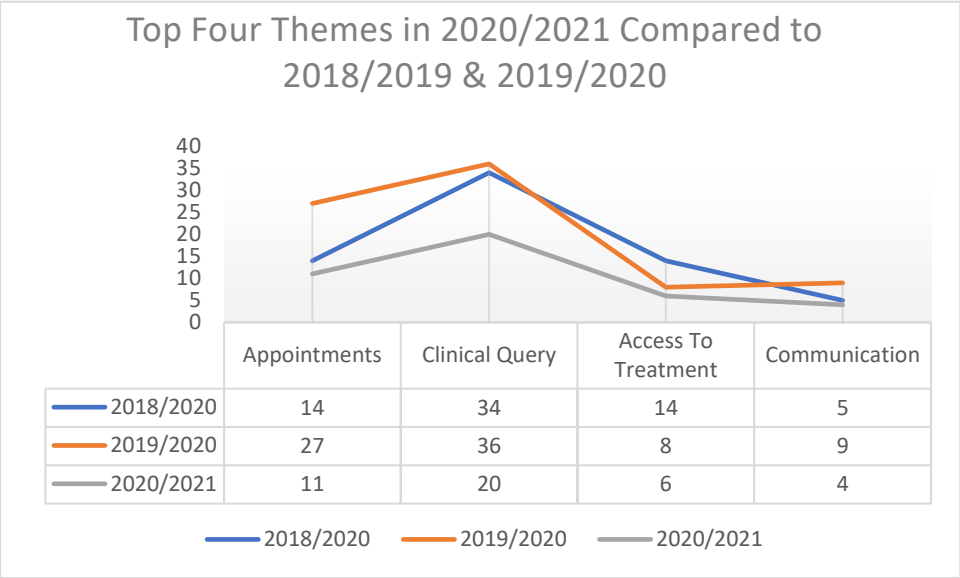


Figure 9. Formal Complaint's Themes Compared to the Last 3 Years

The top four themes of formal complaints received in 2020/2021 were:

- Clinical query; including clinical treatment, delay to be seen by doctor, delays with treatment and dispute over diagnosis.
- Appointments: including cancellation, delay, error, failure to provide follow up, letter not issued.
- Access to treatment; including access to physiotherapy services operation.
- Communication: including failure to communicate between departments and information given to patients.



	Appointments	Clinical Query	Access To Treatment	Communication
2018/2020	14	34	14	5
2019/2020	27	36	8	9
2020/2021	11	20	6	4

Figure 10. Top Four Themes in 2020/2021 Compared to 2018/2019 & 2019/2020

The top four themes in 2020/2021 were the same top themes in 2018/2019 and 2019/2020. Furthermore, as actions have been taken to improve our services this is reflected in the decreasing number of complaints outlined over the last three years.

6.2. Complaints per Division

The Trust has three Divisions that are supported by Corporate Department. Division 1 oversees the Ward areas, Main Outpatient department, Spinal Services, Large and Small Joints Services, Oncology Services and Patient access. Division 2 oversees Therapy Services, Theatres, Preoperative Assessment, Admission and Day Case Unit, Imaging and Pharmacy. Division 4 oversees Estates and Facilities.

The table below represents formal complaints received per Division in 2020/2021 compared to 2018/2019 and 2019/2020.

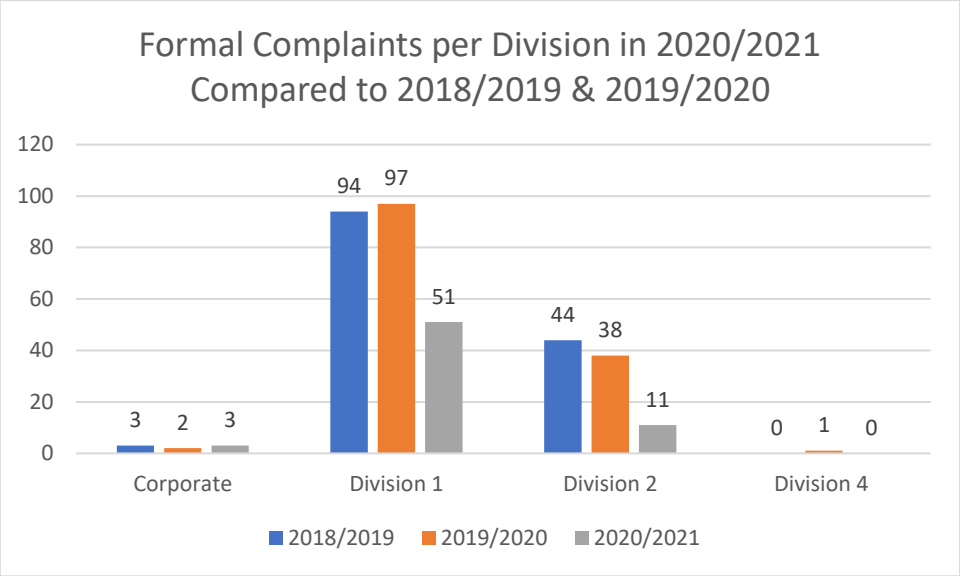


Figure 11. Formal Complaints per Division in 2020/2021 Compared to 2018/2019 &2019/2020

Division 1 received the majority of complaints at 78%, which is reflective of the size and nature of the Division.

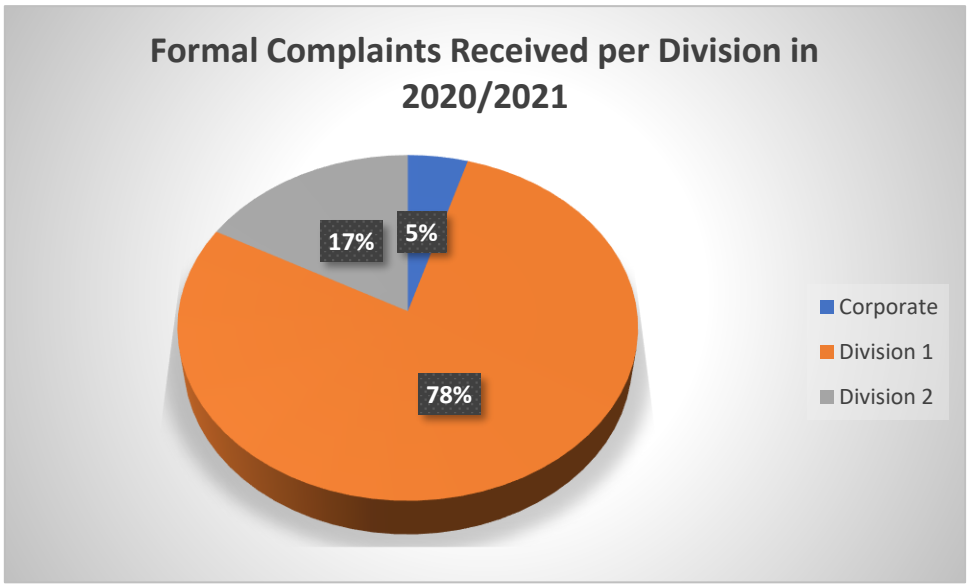


Figure 12. Formal Complaints Received per Division in 2020/2021

6.2.1. Division 1 and 2 Complaints by Area

The majority of complaints in 2020/2021 were in relation to Division 1 which has increased by 9% in the last 3 years. Division 2 saw a decrease of 14% in the same time period.

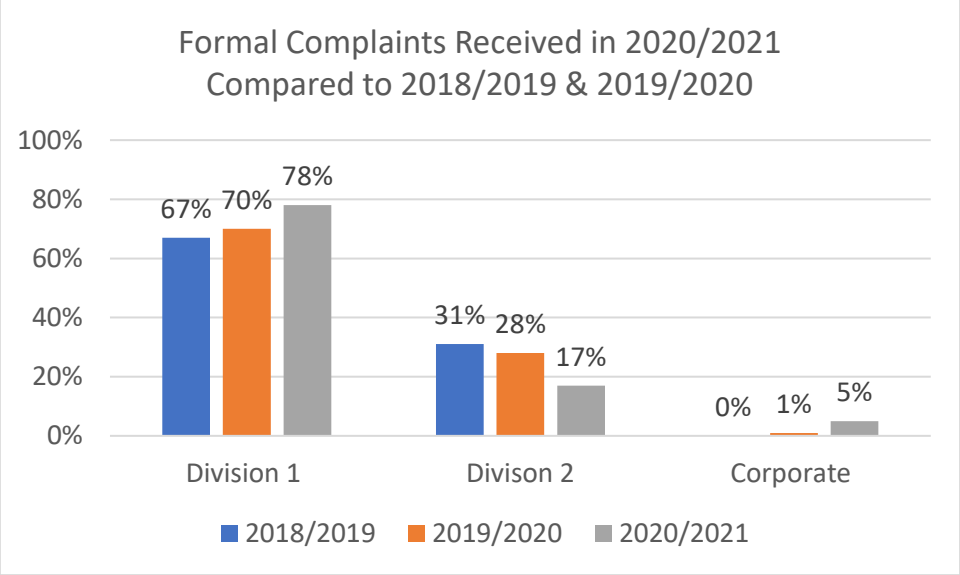


Figure 13. Formal Complaints Received in 2020/2021 Compared to 2018/2019 &2019/2020

The largest number of complaints received relates to concerns about large and small joint services. These related to all aspects of service, including cancellation of appointment, delay with the clinical treatment and administration processes that have all been changing rapidly as a result of the pandemic

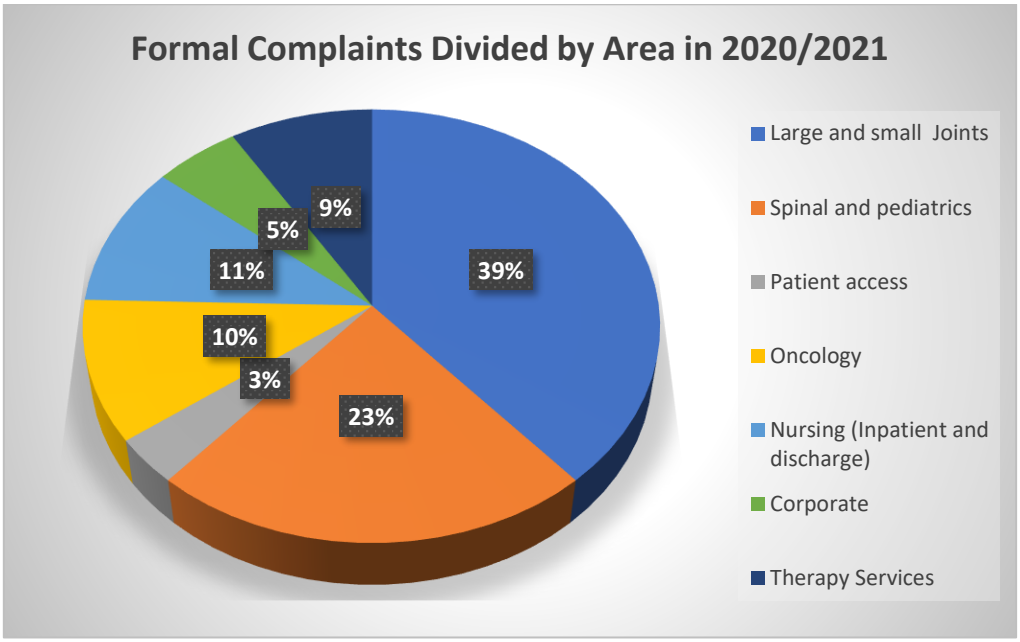


Figure 14. Formal Complaints Divided by Area in 2020/2021

6.2.2. Complaints by Ward

Complaints about aspects of Ward care or treatment has been mentioned in 11% of complaints this year, which is a significant decrease from the year before (17.5%). (This local key performance indicator was implemented in 2015/2016 as there was a marked increase in the number of complaints about ward care in the final quarter of that year (45%)). The data is scrutinised, together with other ward performance data in Clinical Quality Group meetings and forms part of the quality dashboard completed each month. These are also discussed with Senior Nurses and Ward Managers at their respective meetings. The Trust believes that this approach enables changes to be made earlier, thereby allowing significant improvement to be maintained. This also demonstrates that the Trust has strengthened learning from complaints.

The patient cohort was different during 2020/2021 due to the impact of the COVID-19 pandemic

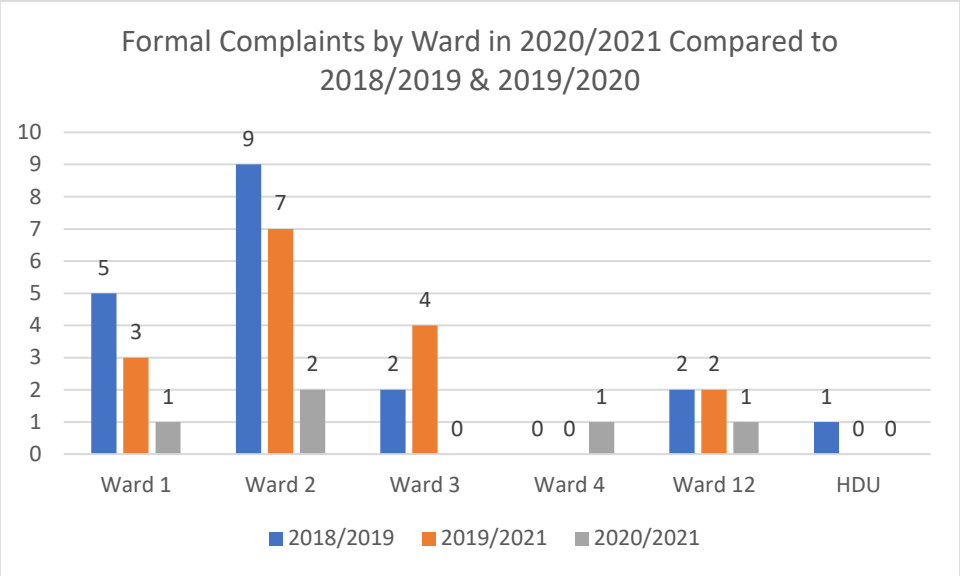


Figure 15. Formal Complaints by Ward in 2020/2021 Compared to 2018/2019 & 2019/2020

6.3. Acknowledgment of Complaints

The Local Authority Social Service and National Health Service Complaints (England) Regulations 2009 and the Trust PALS and Complaints Policy states that an acknowledgement should be made within three working days of receipt by any method.

The Trust's Policy states that all attempts should be made to contact the complainant by telephone within the first two days of receipt and this conversation informs the acknowledgement letter sent out by day three. If there is no telephone number available, or the complainant does not answer/return the calls, then the letter is sent within the same timescale.

In, 2020/2021 the Trust responded to 100% of complaint letters within the correct timescale, thereby meeting the standard. This was the first year in the last three years that the Trust achieved 100% against this target.

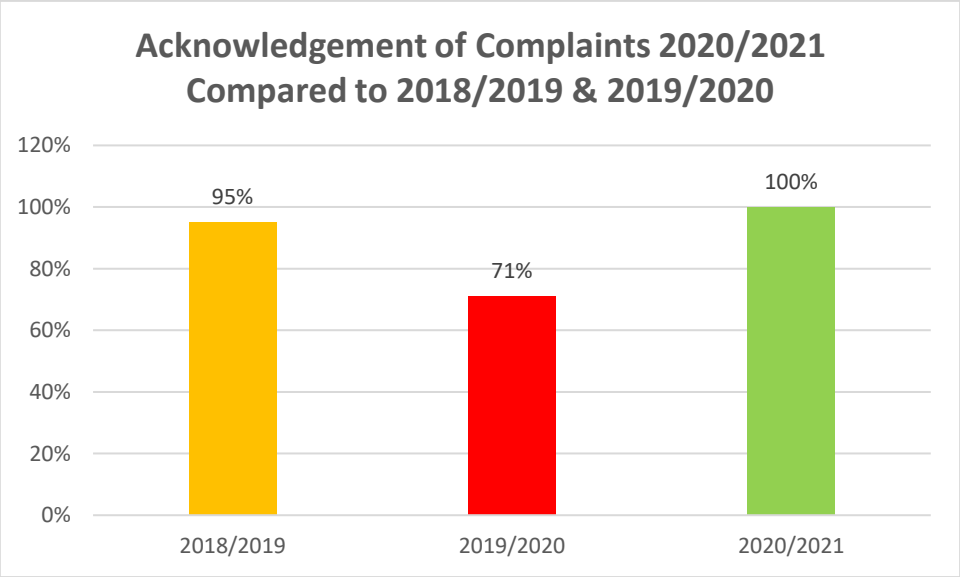


Figure 16. Acknowledgement of Complaints 2020/2021 Compared to 2018/2019 & 2019/2020

6.3.1. Responding to Complaints within the Agreed Timescale

The PALS and Complaints Policy states that the timescale for response should be agreed with the complainant. However, in the event of not being able to contact the complainant and speak to them directly, the Trust sets a provisional response date of 25 working days for routine/lower risk complaints and 40 working days for complex/higher risk complaints (dependent on discussion with the Deputy Director of Nursing, the Designated Complaint Investigator and the Complainant as to the complexity of work required).

In line with the Policy, it is permissible to discuss an extension with the complainant, particularly if there is significant delay with investigation, such as due to the unavailability of staff that are crucial in giving their statements or based on the complexity of case. If they agree with the extension, the complaint will be deemed to have been completed within agreed timescales. Any complaint timescale can only be extended once.

Annual compliance with the contractual reporting requirement of 80% for the year has been met at 98%. One formal complaint breached the agreed date with the complainant for one day and one complaint was extended for 5 working days with agreement from complainant, due to the member of staff not being available to give their statement.

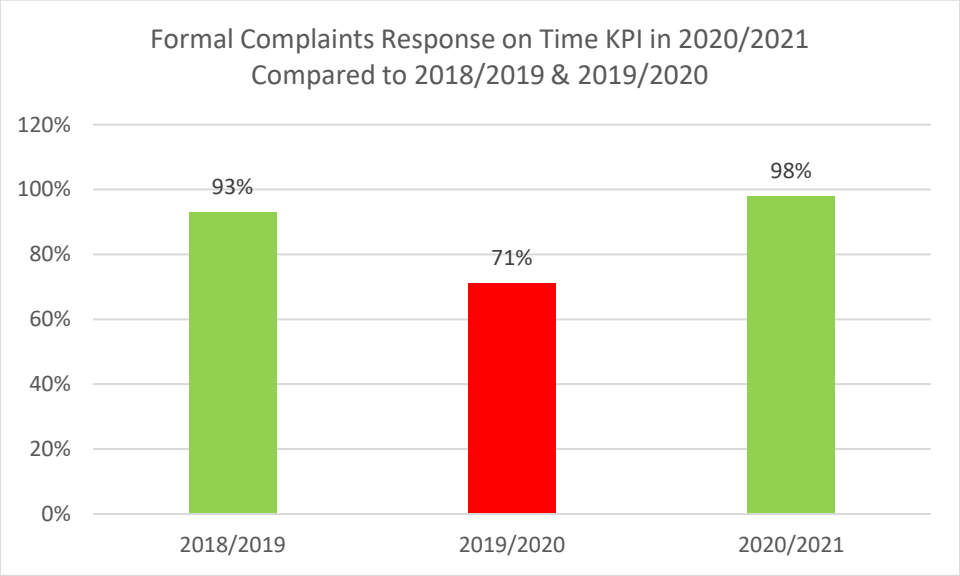


Figure 17. Formal Complaints Response on Time KPI in 2020/2021 Compared to 2018/2019 & 2019/2020

6.4. Risk Ratings of Formal Complaints in 2020/2021

The Trust has a robust system of tracking and monitoring complaints. Part of this tracking involves the logging of an initial risk rating. The Head of Patient Experience monitors these risk ratings, and the Triumvirate reviews all complaints, to ensure Duty of Candour requirements have been discussed and met where required.

	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk Yellow = MODERATE risk Amber = MEDIUM risk Red = HIGH risk

Figure 18. Trust Risk Rating Matrix

The results of this monitoring clearly show that most of the complaints that represent a lower risk to the Trust are handled via different processes within the Trust, such as PALS or informally, as the number of complaints assessed as green or low risk are few. A review of the formal complaints assessed in the lower risk categories shows that in each case, the complainant had expressed a preference for their concerns to be made formal. This is indicative that the Trust is handling complaints in accordance with the Department of Health Complaint Regulations 2012 – that the complainant is able to determine how their concerns are managed.

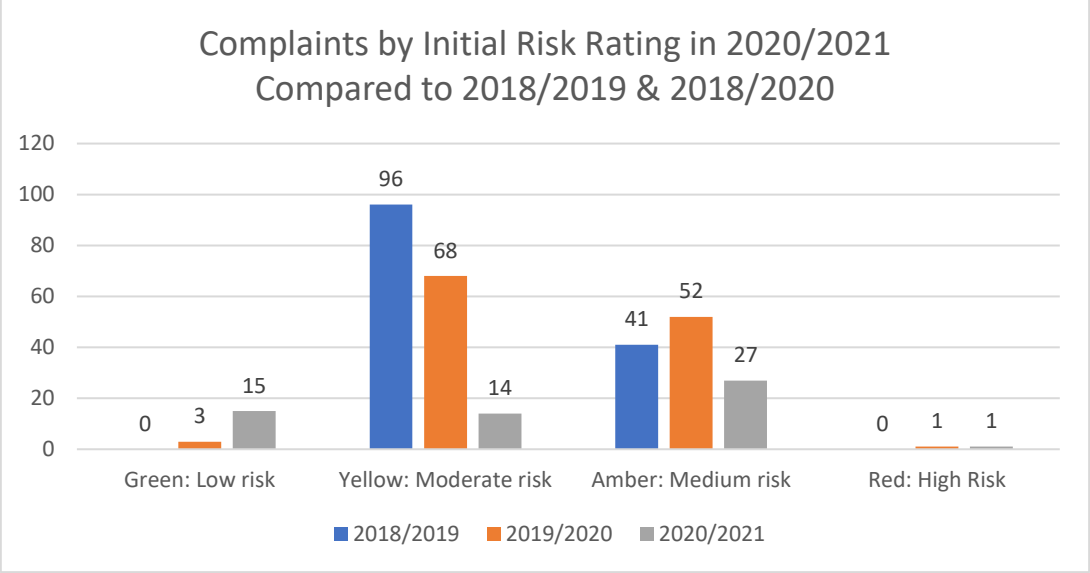


Figure 19. Number of Complaints by Initial Risk Rating in 2020/2021 Compared to 2018/2019 & 2018/2020

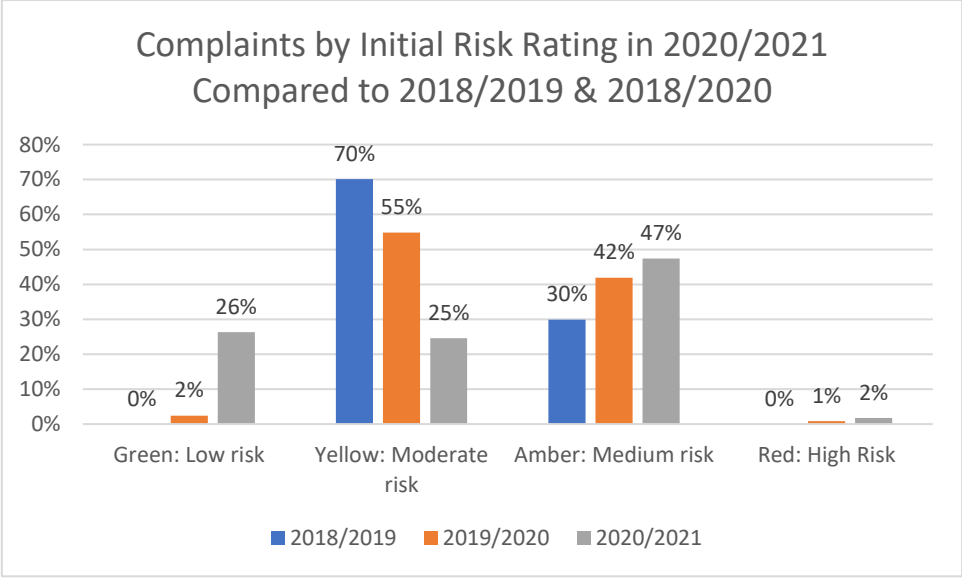


Figure 20. Percentage of Complaints by Initial Risk Rating in 2020/2021 Compared to 2018/2019 & 2018/2020

The percentage of initial risk rating for low-risk complaints went up to 26%, for Moderate risk went down to 45%, for Medium risk went up to 47% and for High Risk went up to 2% in the last 3 years.

It is believed that the reason for this is that during 2018/2019 and the first 3 quarters of 2019/2020, the Complaints department held the responsibility for initially risk rating formal complaints and as of the last quarter of 2019/2020 and the whole of 2020/2021 financial year, the Divisions took on the role of risk rating a formal complaint.

6.5. Complaints Referred to the Parliamentary Health Service Ombudsman (PHSO)

The Trust aims to resolve complaints by undertaking a thorough investigation, providing a comprehensive response, and offering all complainants the opportunity to discuss further concerns. Generally, the Trust is successful with this, but sometimes it is not always possible to achieve a resolution which satisfies the complainant.

Under the NHS Complaint Regulations, any complainant who remains dissatisfied with the response has the right to request an independent review of their case with the PHSO. Every response contains this information together with the contact details for the PHSO.

During 2020/2021, the PHSO did not request information for any complaints that have been raised in 2019/2020 nor 2020/2021.

6.7. Outcome of Complaints

The Trust upheld 30%, partly upheld 35% and did not uphold 35% of the complaints made in this year.

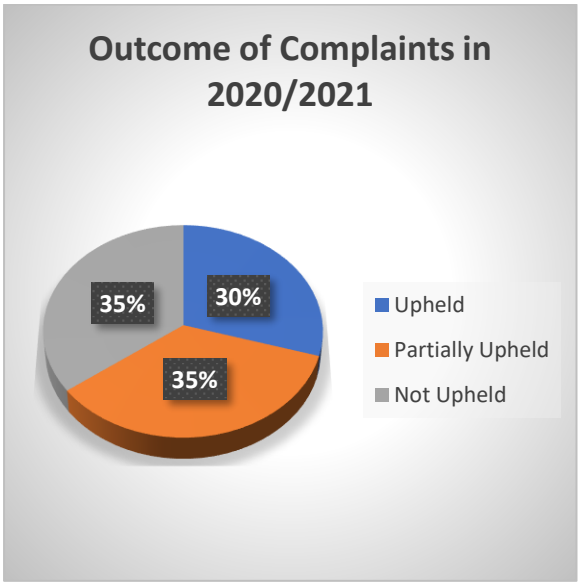


Figure 21. Outcome of Complaints 2020/2021

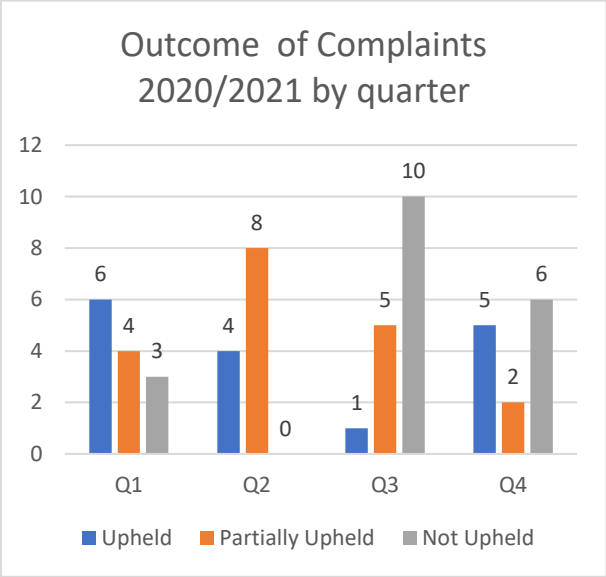


Figure 22. Outcome of Complaints 2020/2021 by Quarter

In 2020/2021, 35% off the complaints received were upheld which is lower than 2019/2020 (56%) and 2018/2019 (71%). Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint. The decisions about whether to uphold or not are taken from the results of the investigation and discussion with the Investigation Lead and Division if this is not explicitly clear in the report. The Trust believes that these figures show robust investigation and clearer expectations of good service provision across the Trust, which is being defined by the changes to the operational structure, the transformation agenda and the quality agenda priorities.

In 2018/2019 and the first three quarters of 2019/2021, the Complaints department was making decisions regarding the outcome of a complaint. In the last quarter of 2019/2020 and in the whole 2020/2021 the Division too responsibility for reaching decisions regarding complaint outcomes.

6.7.7. Reopened Complaints

The Trust offers meetings to the complainant in the verbal and written acknowledgement and in the response letter. Often complainants will wait for the first written response before arranging a meeting as they then have a clearer picture of what has happened with the concerns raised within their complaint.

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.

During a period of three years, it is evident that the Trust has received less reopened complaints. It is believed that this is due to the offer to meet with each complainant and a better quality of response letter.

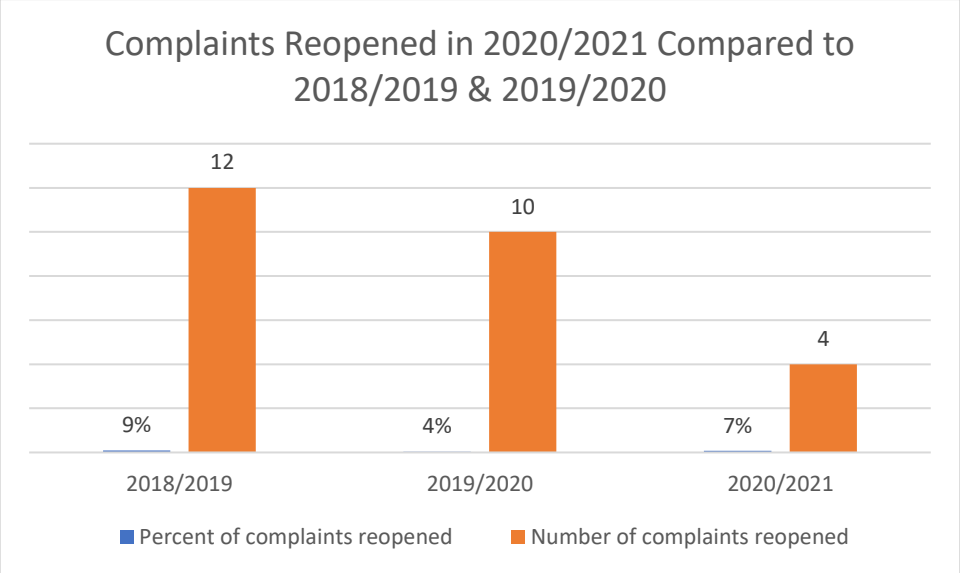


Figure 23. Reopened Complaints in 2020/2021 Compared to 2018/2019 & 2019/2020

6.7.8. Actions Taken

Individual action plans are created for any actions that are specific to an individual complaint. Where actions form part of a larger work plan, complainants are informed of this in their response. This ensures that complaint action plans remain targeted and relevant.

In 2020/2021, 65 individual action plans were created and almost all complaints had actions that were completed prior to the response being sent. The Trust had 46% more actions following a complaint. It is believed that this is because the Complaints team have new processes in place to record actions.

The Trust is now learning from complaints as opposed to responding to them without any follow up.

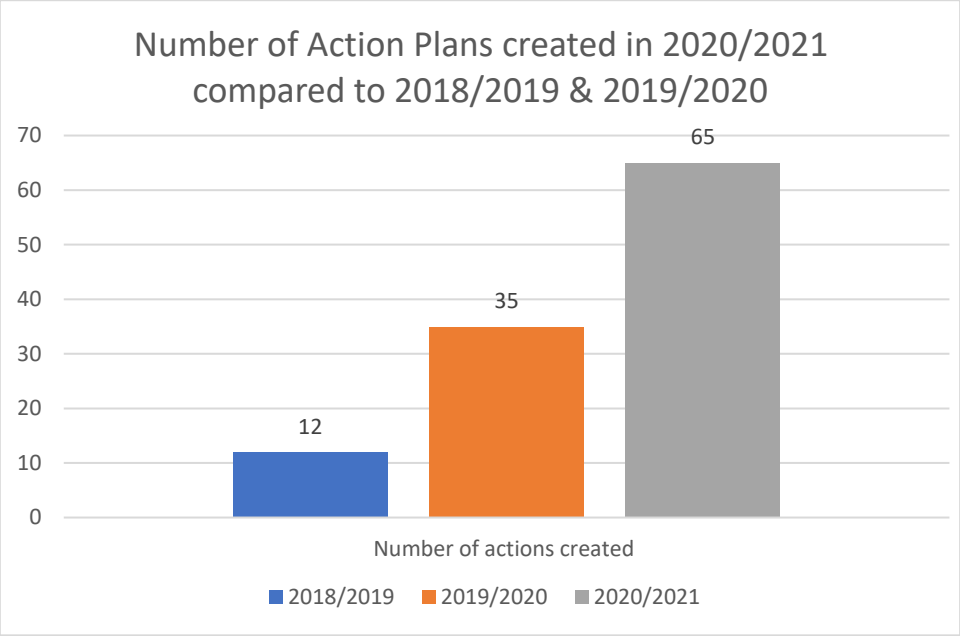


Figure 24. Number of Actions Created in 2020/2021 Compared to 2018/2019 and 2019/2020

7.0. Patient Advice and Liaison Service 2020/2021

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families, and their carers. The PALS department has handled 677 individual contacts in 2020/2021, which has reduced from 772 contacts last year. It is believed that this is due to the COVID-19 pandemic as there were months that PALS only received 10 calls. However, when the PALS contacts are compared against activity in 2020/2021 0.47% more patients have contacted PALS than in 2019/2020 and 1.1% in 2018/2019. Over the last three years, the number of formal complaints went down but the number of PALS contacts went up, which means that the PALS department are handling complaints at the PALS level and acts as a safety net.

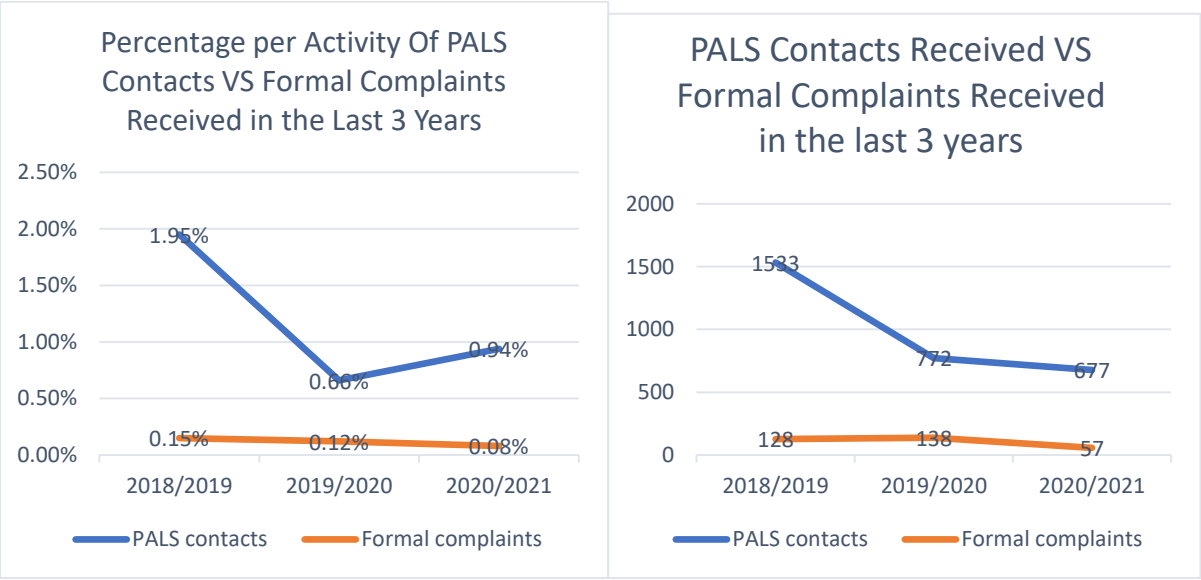


Figure 25 & 26. Percentage and Number per Activity of PALS contacts Compared to Complaints in the Last 3 Years

7.1. Contact Type

In 2020/2021 the Trust received 311 PALS contacts that were classed as a query, 363 Concerns and 3 informal complaints which is 122% more enquiries, 30% less concerns and 300% more informal complaints.

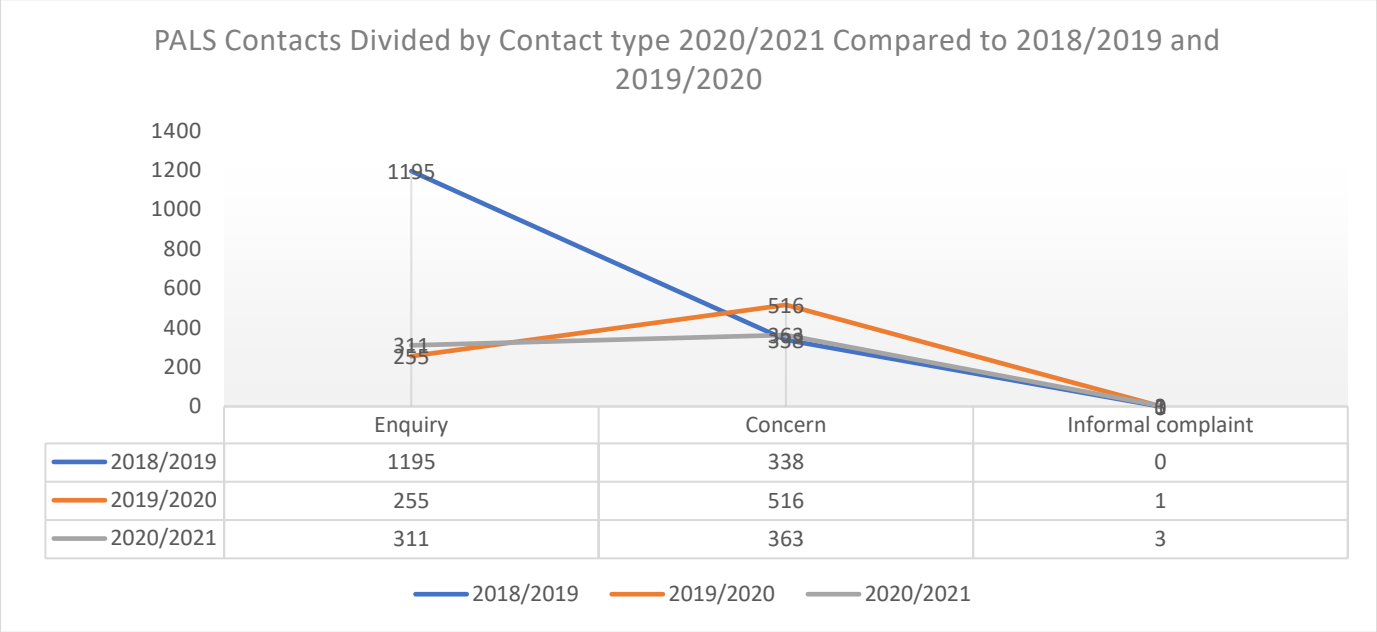


Figure 27. PALS Contacts Divided by Contact Type 2020/2021 Compared to 2018/2019 and 2019/2020

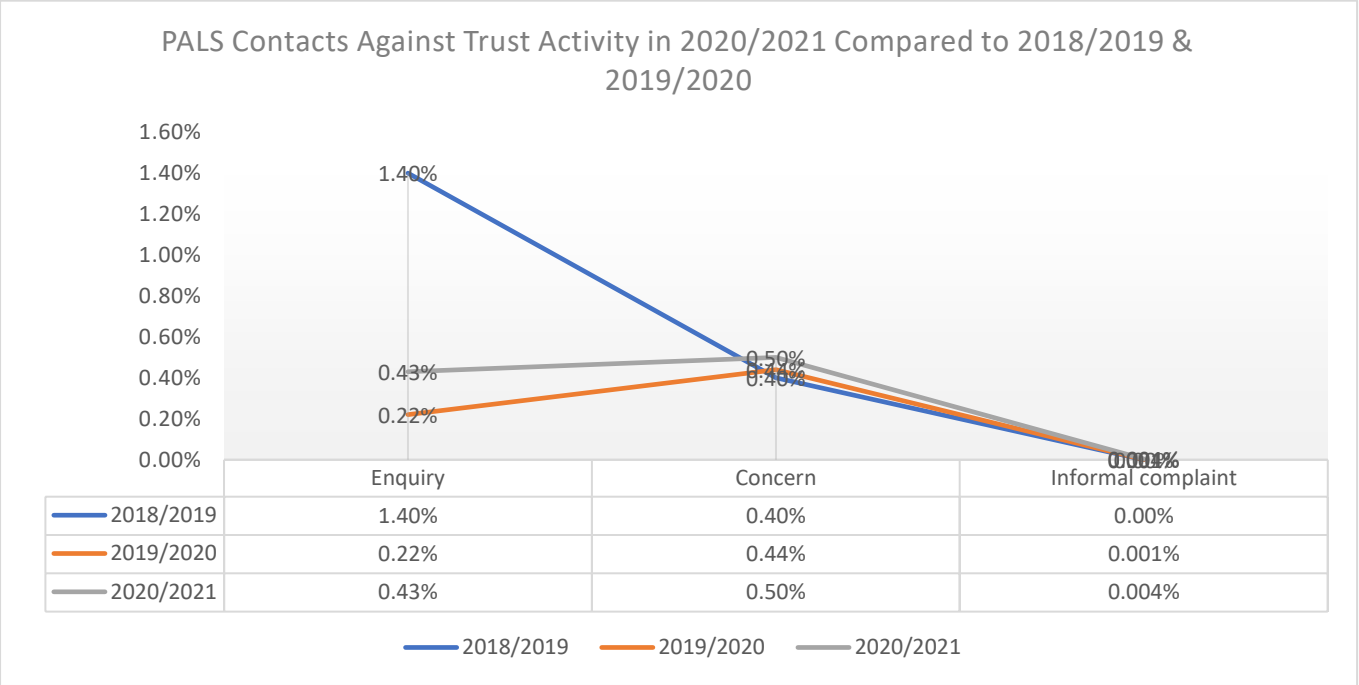
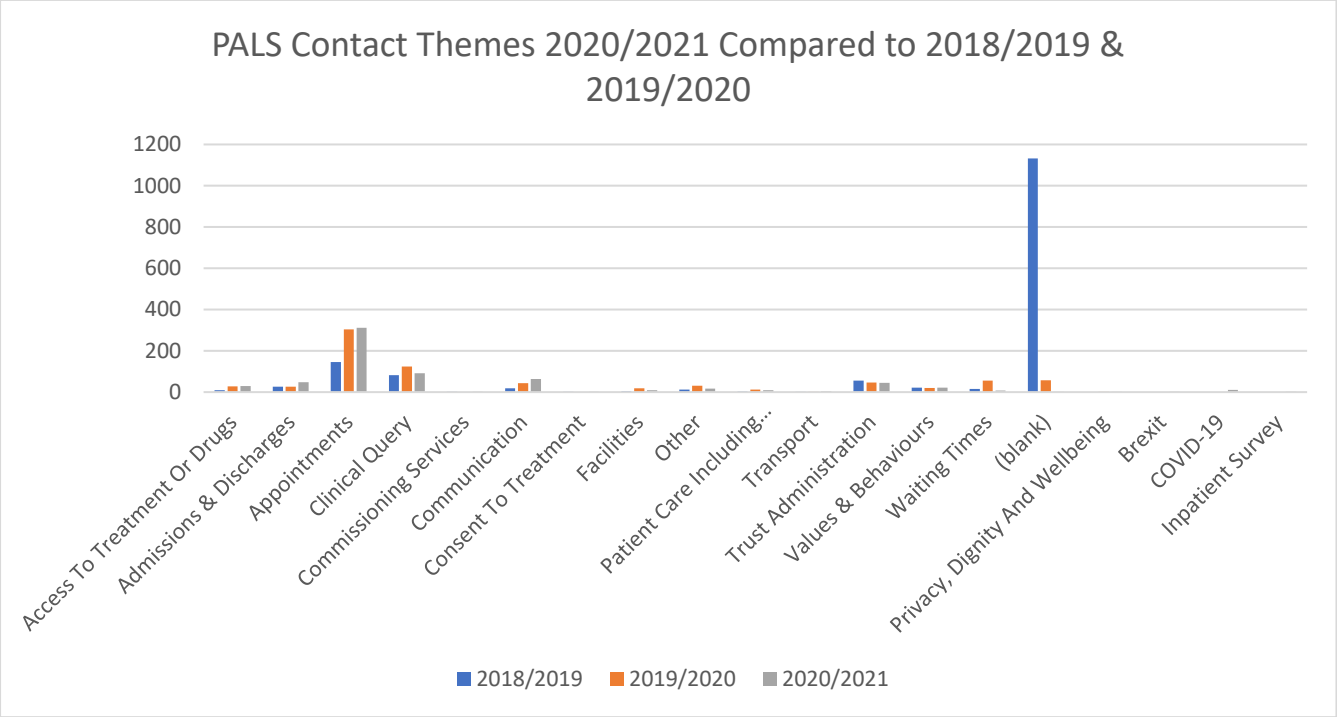


Figure 28. PALS contacts against Trust activity in 2020/2021 compared to 2018/2019 and 2019/2020

7.2. Themes of PALS Contacts

Listed below are the themes arising out of the PALS contacts received during 2020/2021 compared to 2018/2019 and 2019/2020.



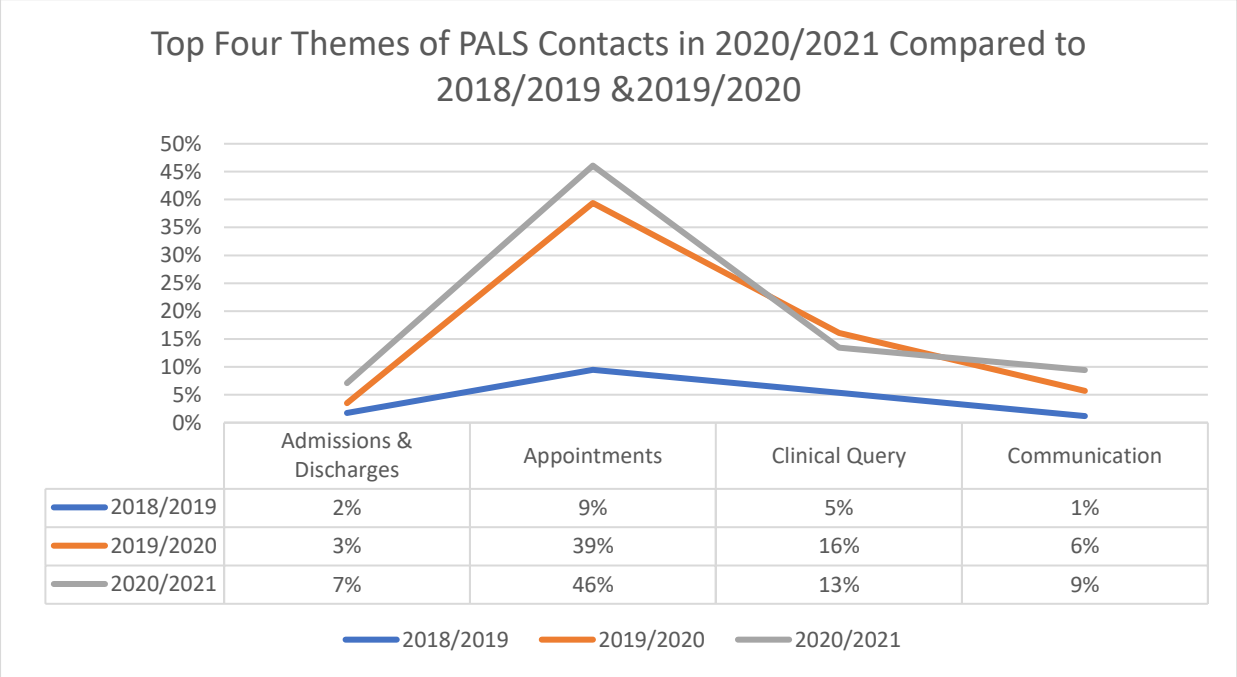
Theme/Financial year	2018/2019	2019/2020	2020/2021
Access to Treatment or Drugs	9	28	30
Admissions & Discharges	27	27	48
Appointments	145	304	312
Clinical Query	82	124	91
Commissioning Services	1		1
Communication	18	44	64
Consent to Treatment	1		1
Facilities	5	19	9
Other	13	31	17
Patient Care Including Nutrition/Hydration	3	13	9
Transport	2	2	4
Trust Administration	55	46	45
Values & Behaviours	22	20	21
Waiting Times	16	55	8
(blank)	1132	58	2
Privacy, Dignity and Wellbeing		1	2
Brexit			1
COVID-19			11
Inpatient Survey			1

Figure 29. PALS Contacts Themes 2020/2021 Compared to 2018/2019 & 2019/2020

The top four themes in PALS during 2020/2021 were (the 'blank' categorisation has virtually been eliminated meaning that the classification of complaints is much better now):

- Clinical Query; including clinical treatment, delay to be seen by a doctor, delays with the treatment, dispute over diagnosis.
- Appointments: including cancellation, delay, error, failure to provide follow up, letter not issued.
- Admission and Discharge; including arrangements, queries and cancellation on the day.
- Communication: including failure to communicate between departments and information to the patients.

The Trust received 5% more PALS contacts for Admission and Discharge in the last 3 years, 37% more PALS contacts for Appointments, 3% less for the Clinical query and 8% more for communication related issues.



	Admissions & Discharges	Appointments	Clinical Query	Communication
2018/2019	2%	9%	5%	1%
2019/2020	3%	39%	16%	6%
2020/2021	7%	46%	13%	9%

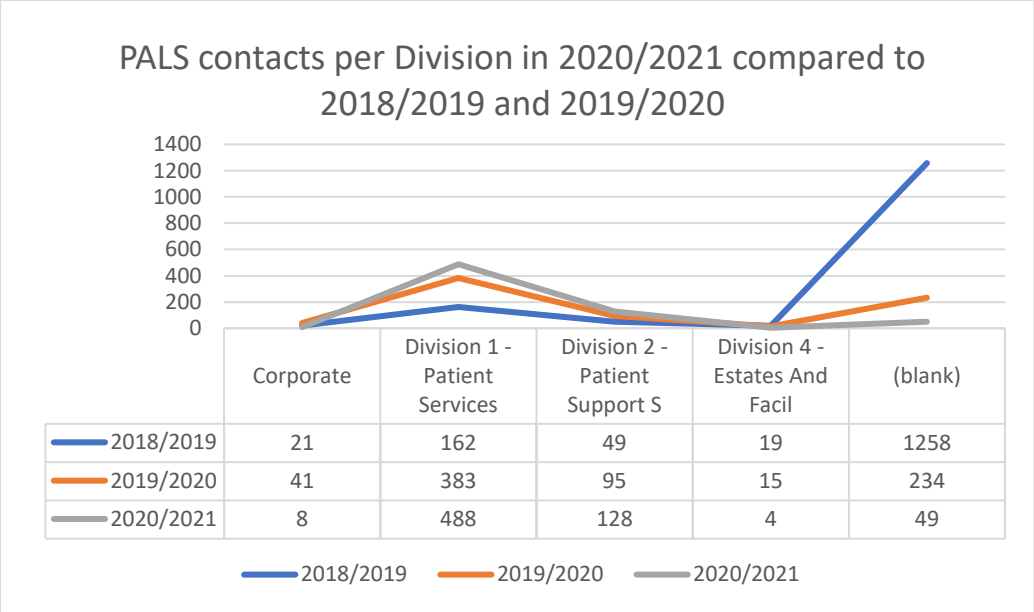
Figure 30. Top 4 Themes in 2020/2021 Compared to 2018/2019 and 2019/2020

During the 2020/2021 period, and COVID 19 pandemic, a large number of patients had to be cancelled or converted to virtual appointments. In order to reduce the risk of any adverse impact on the patients' clinical condition, as many as possible pre-booked appointments were converted to virtual appointments and specialties were asked to review patients on a rolling weekly forward look basis. The appointments team were then informed of patients who needed to be seen face to face, who would then contact them by phone. Because this was a new process which was labour intensive in the context of the already significant additional operational pressures created by the pandemic, some patients were not effectively identified and contacted by the specialties and appointments team. In addition to this, the clinic templates on the patient administration system were not set up to cohort virtual and face to face patients on separate codes. These codes have now been set up to ensure virtual and face to face appointments are booked to specific codes. Also,

partial booking has now been implemented with appointments only being booked 6 weeks ahead reducing the rescheduling of outpatient appointments by up to 80%.

7.3. PALS Contacts by Department

The table below represent PALS contacts received per Division in 2020/2021 compared to 2018/2019 and 2019/2020.



	Corporate	Division 1 - Patient Services	Division 2 - Patient Support S	Division 4 - Estates And Facil	(blank)
2018/2019	21	162	49	19	1258
2019/2020	41	383	95	15	234
2020/2021	8	488	128	4	49

Figure 31. PALS Contacts per Division in 2020/2021 Compared to 2018/2019 & 2019/2020

The majority of PALS contacts (72%) relate to Division 1, which is to be expected since Division 1 oversees the majority of services.

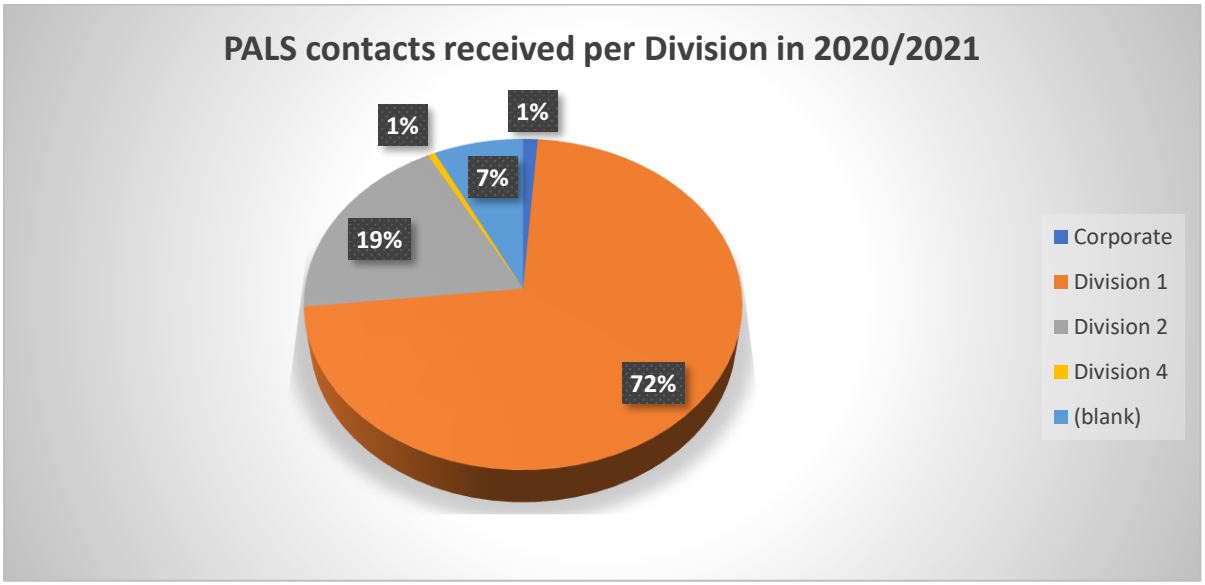


Figure 32. Formal Complaints Received per Division in 2020/2021

7.3.1. Division 1 and 2 PALS Contacts by Area

The majority of complaints in 2020/2021 were in relation to Division 1 which is an increase of 59% in the last 3 years. Please note that 2018/2019 had 82% of PALS contacts marked as blank. Division 2 had an increase of 16% in the same time period. In the last 3 years there was a decrease of 75% in blank Division field within Ulysses system where PALS are recorded.

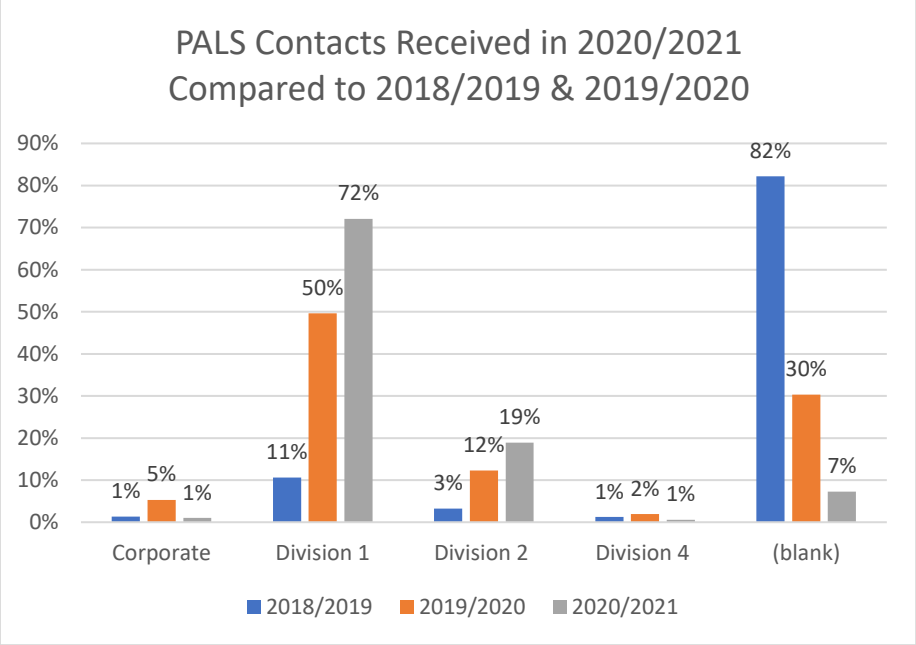


Figure 33. PALS Contacts Received in 2020/2021 Compared to 2018/2019 and 2019/2020

The largest number of PALS contacts received is related to concerns about Appointment services. These related to all aspects of service. It was expected to have this many PALS contacts regarding appointments due to the impact of the COVID- 19 pandemic and cancellation of non-urgent appointments following a risk assessment done by the consultant or clinician.

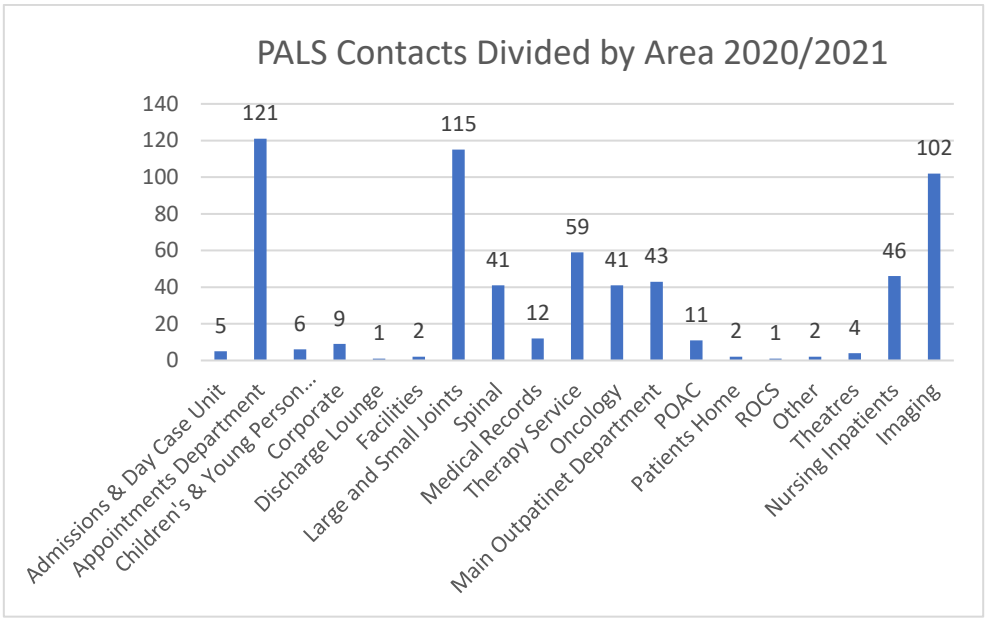


Figure 34. PALS Contacts Divided by Area in 2020/2021

7.4. Performance Against Key Performance Indicators

In line with the PALS and Complaints Policy, PALS Concerns must be responded to within 5 working days, PALS enquiries within 2 working days and Informal complaints up to 10 working days. Annual compliance with the contractual reporting requirement of 80% for the year has been met at 95%. The Trust met its internal KPIs for the first time in 3 years.

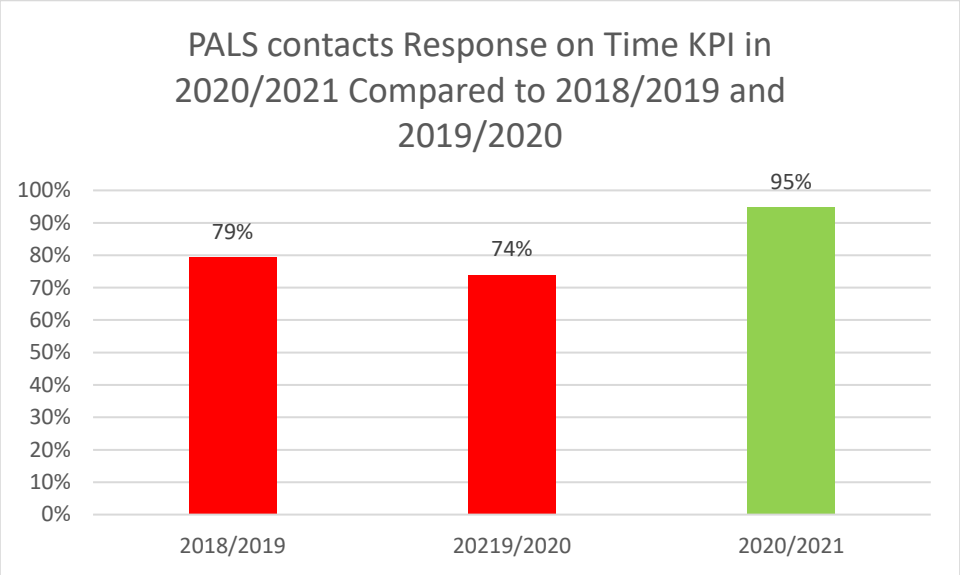


Figure 35. PALS contacts Response on Time KPI in 2020/2021 Compared to 2018/2019 and 2019/2020

8.0. Demographics of Formal Complaints and PALS contacts in 2020/2021

The main priority of the Trust is to provide the best care and services to the patients. To do that, the Trust first needs to understand who the community is that it serves. The information that the Trust collects regarding patients and complainants' demographics tells us a lot about their needs, allowing better care and a better patient experience to be provided.

Collecting sex, age and ethnicity data can help improve the quality of care for all patients because it helps to identify and address differences in care for specific populations and distinguishes which populations do not achieve optimal interventions.

The Trust started to collect demographics of complainants in 2020/2021, therefore there is not a comparison with 2018/2019 and 2019/2020.

8.1. Complainant Type

A Complainant type (Person type) that has complained tells us who had raised a complaint or PALS concerns with the Trust. It can be an adult patient, patient's member of family or friend, or it can be a paediatric patient. If a member of family or friend raises a complaint, concern or enquiry on behalf of the patient they will need to have a signed consent form from the complainant and verbal consent for PALS contact.

Using this data, the Trust can understand who has raised more complaints, concerns or enquiries. In 2020/2021, 85% of all PALS contacts and complaints were made by adult patients, 7% paediatric patients (16-25 years old) and 8% were made by the patient's member of family or friend.

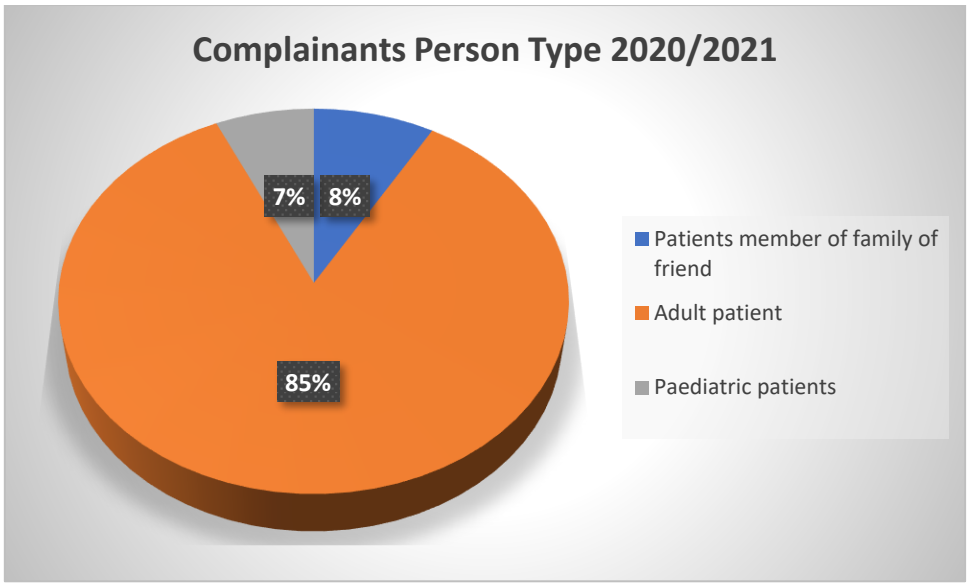


Figure 36. Complainants Person Type 2020/2021

8.2. Age

Figure 37 shows the number of complaints or PALS contacts received per age group in 2020/2021. Figure 38 shows the percentage of complaints or PALS contacts received by each age group against the activity of the patients within the same age groups.

The top three age groups with the most complaints in 2020/2021 were 56-60 years old (78 contacts), 51-55 years old (77 contacts) and 71-75 years old (76 contacts). The PALS and Complaints department did not have information concerning the age of 77 complainants; this may be due to the patient's member of family or friend contacting the PALS and Complaints Department rather than the patient themselves which made it more difficult for staff to collect this information.

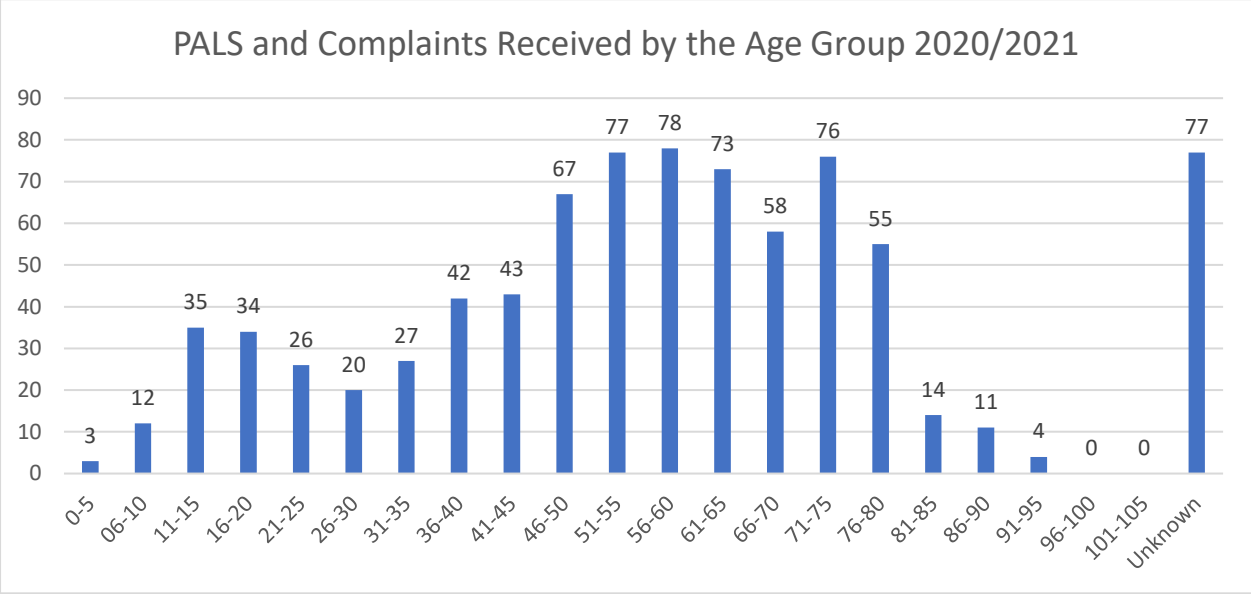


Figure 37. Complaints received by age group 2020/2021

The top three age groups with the most complaints in 2020/2021 against activity were 11-15 years old (2.81%) (these were presumably outpatients, given that the Trust does not treat inpatient paediatrics patients and those PALS contacts or complaints would have been made by the parents of the individuals) 46-50 years old (2.41%) and 6-10 years old (2.40 %)

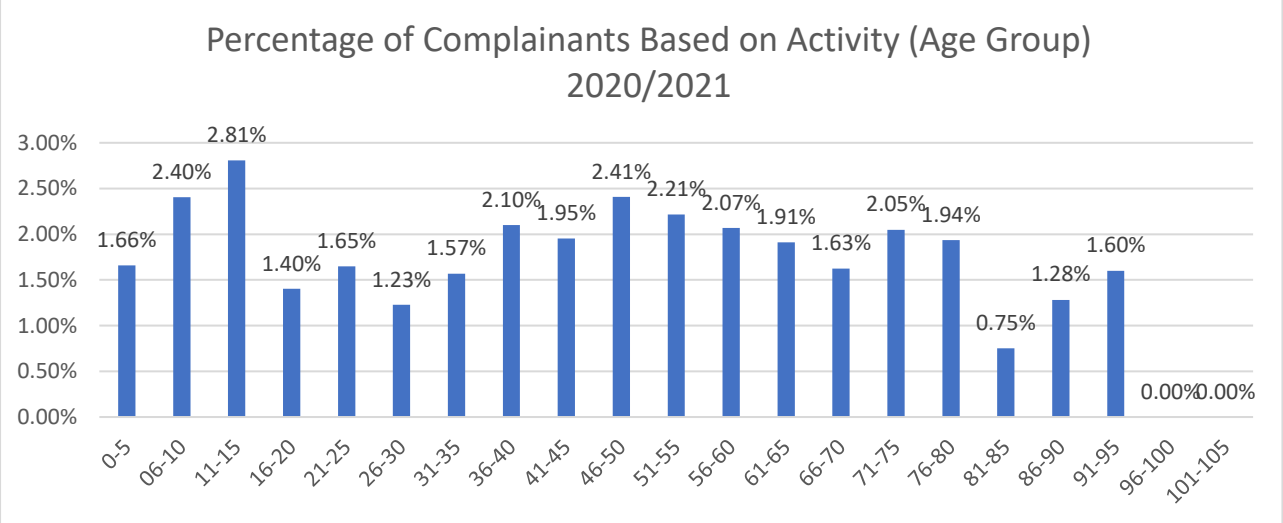


Figure 38. Percentage of Complainants Based on Activity (Age Group) 2020/2021

8.3 Ethnicity

Ethnic monitoring is an important issue for the Trust as it provides services to a diverse and multi-cultural community. The Trust collect this information so that it can better meet patients cultural, religious and language needs. It is important to collect ethnicity data to understand the needs of patients from different groups and provide better and more appropriate services and identifies patients at risk – some groups are more at risk of specific diseases or conditions. It is required in legislation that all NHS Trusts collect ethnicity data, as per the Race Relations (Amendment) Act 2000, which gives public authorities a duty to promote race equality. It is legislative requirement to monitor the ethnic group of all patients to identify who might be at a greater risk from conditions and to ensure that race discrimination is not taking place.

Collection of ethnicity data during the COVID 19 pandemic was challenging as self-check-in kiosks in outpatients could not be used and this is a source of a large amount of data. Collection of ethnicity data is a high priority for the Trust and reports are available which are monitored through the Data Quality Group chaired by the Chief Operating Officer.

Figure 28 shows the percentage of complaints or PALS contacts received per ethnic group in 2020/2021. Figure 29 shows the percentage of complaints or PALS contacts received by each ethnic group against the activity of the patients within the same ethnic groups.

The top three ethnic groups with the most complaints in 2020/2021 were British White (390 contacts), Indian-Asian or Asian British (18 contacts) and Other white - White and Black Caribbean-Black or Black British (10 contacts each). There were 351 contacts to the Complaints and PALS department where the complainant has not stated their ethnic group on the Patient Access System (PAS).

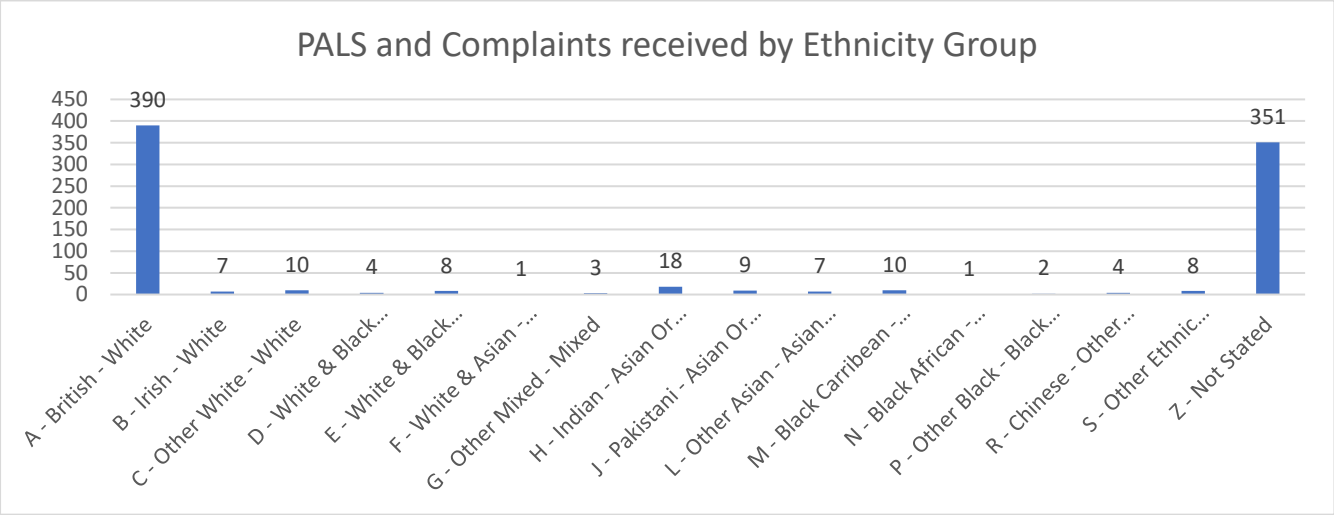


Figure 38. Complaints received by ethnicity group 2020/2021

Top three ethnic groups with most complaints in 2020/2021 against activity were White & Black African - Mixed (17.02%) Chinese - Other Ethnic (8.33%) and 6 - Other Mixed - Mixed (2.70%)

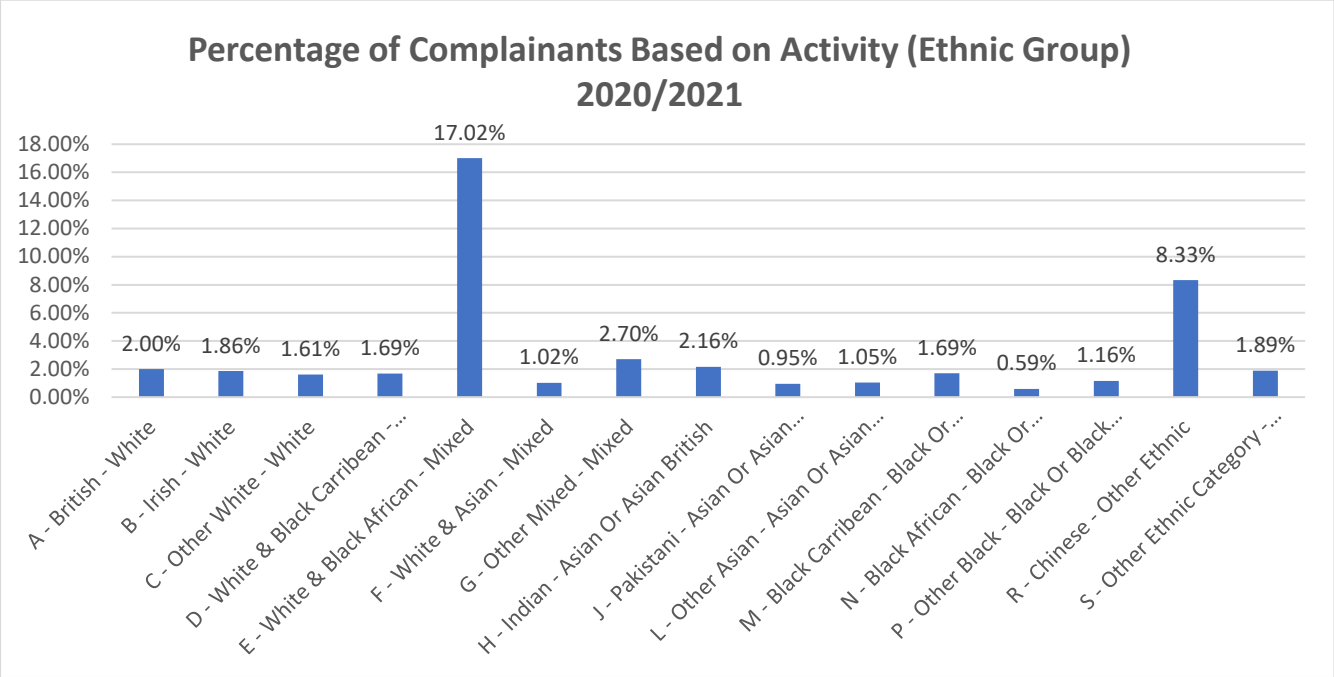


Figure 39. Percentage of Complainants Based on Activity (Ethnicity Group) 2020/2021

8.4. Sex

Figure 30 shows the percentage of complaints or PALS contacts received per sex group in 2020/2021. Figure 31 shows the percentage of complaints received by each sex group against the activity of the patients within the same sex groups.

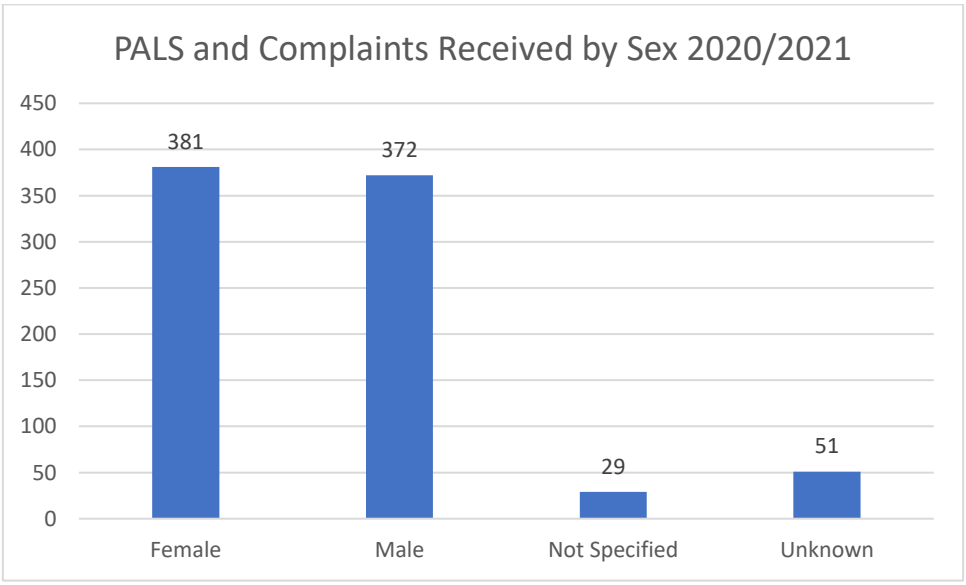


Figure 40. Complaints Received by Sex Group 2020/2021

In 2020/2021 most complaints were male (2.1% against activity); the sex group for 29 complainants were unspecified and for 51 complainants were unknown.

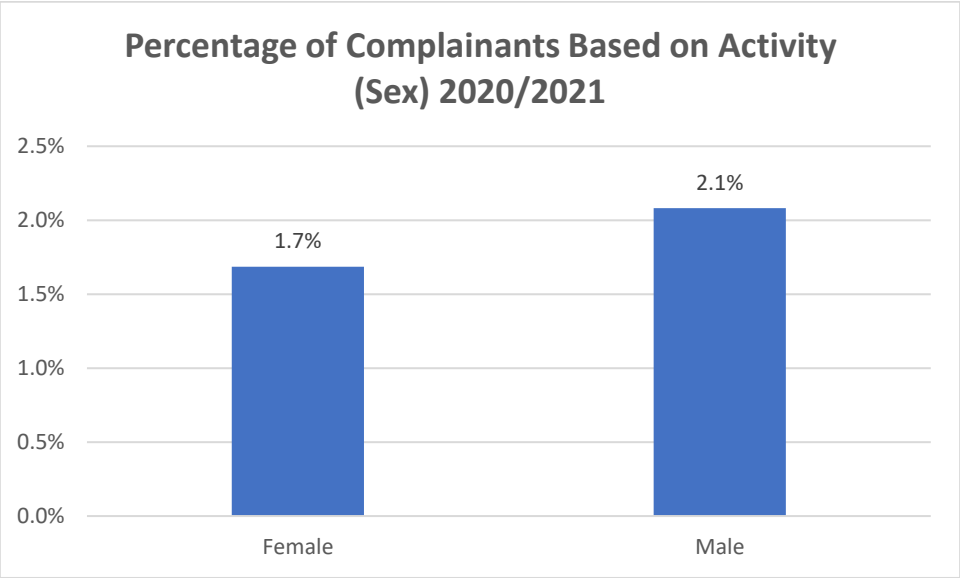


Figure 41. Percentage of Complainants Based on Activity (sex Group) 2020/2021

9.0. Friends and Family Test 2020/2021

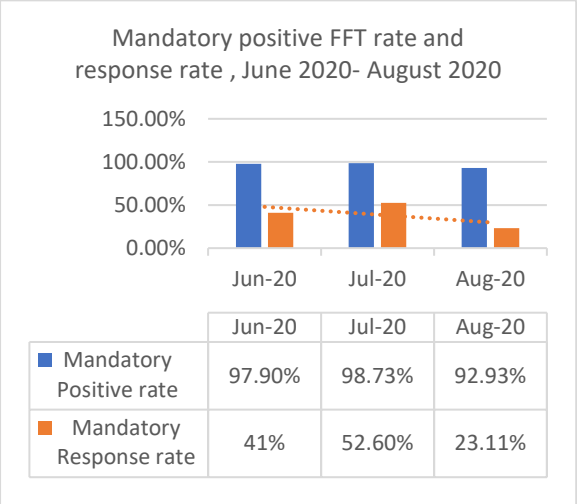
The NHS Friends and Family Test (FFT) was created to help service providers and Commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for the service users to provide views after receiving NHS care or treatment.

9.1. Friends and Family Test at the Trust

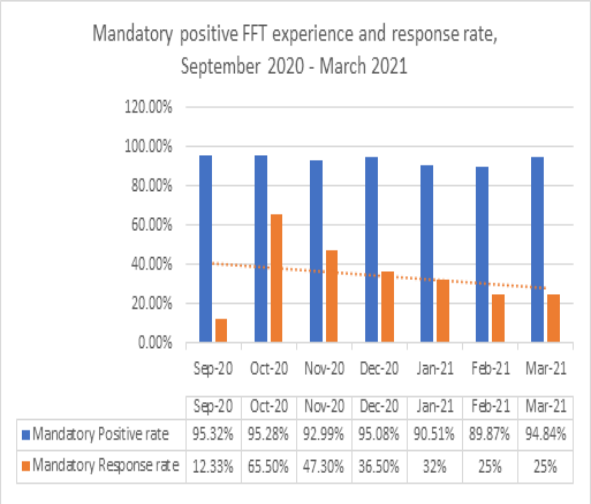
The Trust collects data for mandatory areas set by NHS England that includes all inpatient areas and non-mandatory areas which includes all outpatients' departments. The Trust reports FFT data for the mandatory areas on a monthly basis to NHS England.

- In September 2020, the focus of the FFT questions were changed by NHS England to focus on the patients experience at the Trust, rather than the previous focus on how highly service users would recommend the Trust. Therefore, figures 41 and 42 below have been separated to allow a more accurate comparison of the patient experience for mandatory areas of the Trust and figures 43 and 44 for non-mandatory areas.
- NHS England discontinued collection of the FFT during April and May 2020 due to the COVID-19 pandemic. The Trust restarted the reporting and collection of the FFT in June 2020.
- There appeared to be a disparity between data collection and results published. The issue has been flagged to the CQC and the Quality and Safety Executive meeting, with work underway to rectify issues. Since February 2021, the Trust has not reported on the non-mandatory areas while the data quality issues are resolved.
- The plan was put in place to scale down the collection to just the mandatory element to allow the position to be better understood.

9.1.1. FFT Mandatory Reporting



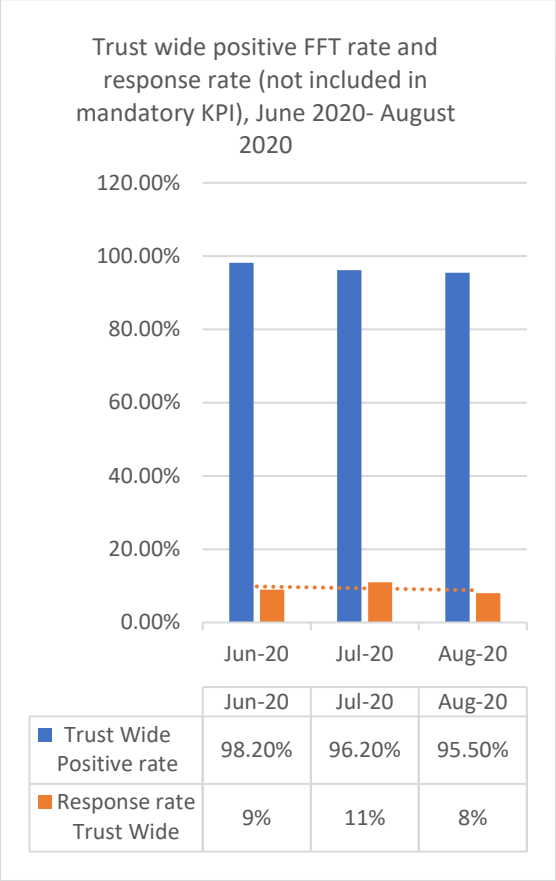
	Jun-20	Jul-20	Aug-20
Mandatory Positive rate	97.90%	98.73%	92.93%
Mandatory Response rate	41%	52.60%	23.11%



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Mandatory Positive rate	95.32%	95.28%	92.99%	95.08%	90.51%	89.87%	94.84%
Mandatory Response rate	12.33%	65.50%	47.30%	36.50%	32%	25%	25%

Figure 41. and 42. Mandatory Positive and Response FFT Rate and Mandatory Positive FFT Experience and Response Rate

9.1.2. FFT Non-Mandatory Reporting



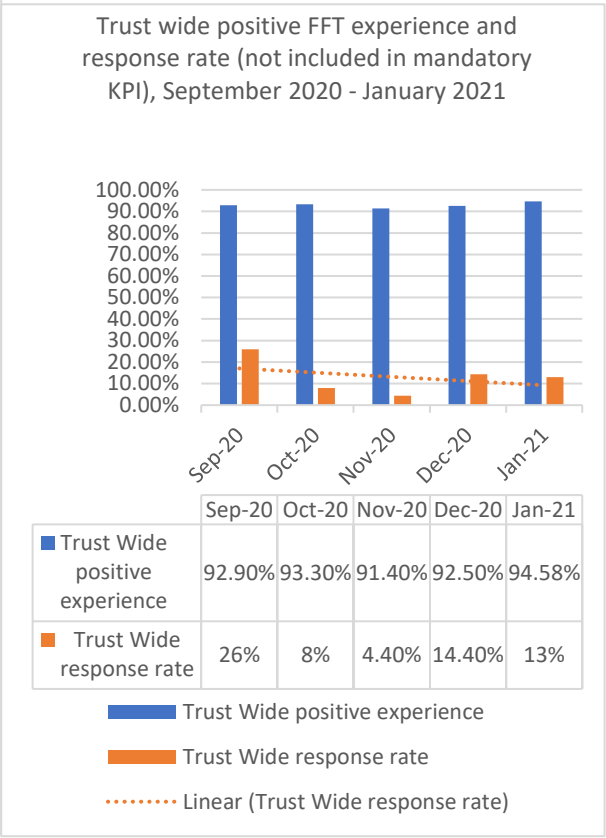


Figure 43. And 44. Non-Mandatory Positive and Response FFT Rate and Non-Mandatory Positive FFT Experience and Response Rate

9.1.3. FFT Statistical Process Control (SPC) Chart

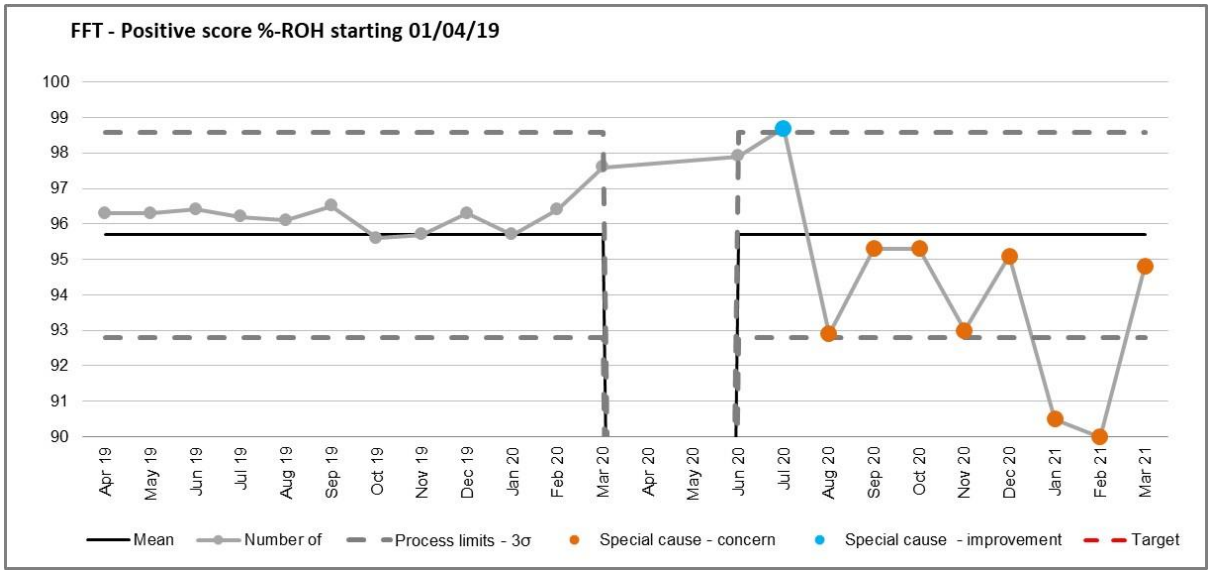


Figure 45. SPC chart of the FFT positive score

10.0. Listening and learning - JointCare Coffee Catch-Up

Since May 2019, as part of the award-winning Trusts JointCare pathway for hip and knee replacement surgery, all patients on the pathway are invited to attend a Coffee Catch-Ups. These events were organised to give patients the chance to provide detailed feedback on their whole patient experience, giving staff a valuable insight into what they do well, and perhaps even more importantly, what they could do better. With over 500 attendees, these events have been hugely important to the Trust's continuous improvement programmes. It was therefore a great disappointment when, as with all group events, Coffee Catch-Ups had to be cancelled in Spring 2020 due to the impact of COVID-19.

With it looking very unlikely that face to face meetings would be able to resume in the months ahead, when elective surgery restarted, the team decided to move the events onto a virtual platform. This enabled patients to still give feedback and let the team know how their recovery is going, at a time when patient experience is perhaps more important than ever, all from the comfort and safety of their own homes. The first virtual Coffee Catch-Up was held in November 2020. Any JointCare patients that had their surgery in July or August of that year were invited, and any patients unable to attend were encouraged to provide written feedback by email or letter.

During 2020/2021 the Trust sent invites to 1006 patients for the meetings held in November 2020, January 2021 and July 2021 and covered patients' experience during 2020/2021. Prior to the session, patients were asked to consider the following questions:

1) How well did we prepare you for surgery?
2) What went well?
3) What could have gone better?
4) How was your care after discharge (considering the services from the Royal Orthopaedic Community Service (ROCS), outpatient physiotherapy, clinic)?
5) What advice would you give to a friend/family member coming to us for a joint replacement?

Out of the 1006 patients that were invited and received a question, 78 attended a virtual meeting and a further 76 have provided the Trust with their feedback.

The feedback received was overwhelmingly positive, which provided a much-needed morale boost for the staff taking part. Comments included:

- 'These were exceptional times; the nurses and staff were absolutely fantastic with me'
- 'I felt very safe in the hospital even in the middle of the pandemic. The ROH reputation has already been earned and is still maintained'
- 'I feel that the operation has been a great success due entirely to skill, professionalism and care I received at the ROH. Many thanks to all of you'
- 'I am over the moon with my knee replacement and felt the entire team were amazing'
- 'I welcome the opportunity to thank the Royal Orthopaedic Hospital for giving me the chance to enjoy my life again.'

The feedback is circulated to all relevant teams and departments to ensure all staff involved in the pathway are reminded of the great care they are providing.

10.1. Patient Engagement During 2020/2021

The Trust has undertaken a number of patient engagement initiatives through the pandemic, which has helped shape the changes and service offerings, including:

- ✓ Feedback on new website via Healthwatch (April 2020)
- ✓ Discussions with Patient Engagement & Experience Group around virtual consultations (June 2020)
- ✓ Outpatients collected feedback from patients about their experience and potential improvements (July 2020)
- ✓ Public asked to share a note of thanks which were included in staff wellbeing bags (July 2020)
- ✓ Digital participation in public Board meetings, Council of Governors & AGM (September/October 2020)
- ✓ Patients asked for feedback on the design and delivery of new Modular Theatre building
- ✓ Patient feedback canvassed around planned patient entertainment system
- ✓ Feedback surveys on orthotics, podiatry and physiotherapy
- ✓ Feedback collected from Children & Young People on design of new Children and Young Person Centre in main Outpatient Department

11.0. ROH for Loved Ones

Due to the COVID-19 pandemic visiting our inpatient areas was restricted. The Patient Experience Team set up a dedicated inbox for the family members and friends to send letters to loved ones.

The Patient Experience Team have delivered over 300 letters during 2020/2021 to loved ones. This project has received positive feedback from our patients and their loved ones.

When delivering letters, the Patient Experience team give an opportunity for the patient to write back to the loved ones and this service has been used on a couple of occasions.

12.0. Working with Partners and Patients to Improve our Services

The Trust made connections with various external companies and NHS trusts during 2020/2021 through the Head of Patient Experience's network and research. The Trust will continue to work closely with Orthopaedic Specialist trusts and with Healthwatch Birmingham.

During 2020/2021, the Patients and Carers Forum was paused due to the impact of the COVID-19 pandemic as all meetings started to be held online. The Trust tried to hold meetings online, but it was unsuccessful, so the Trust adapted new ways to fulfil role of the forum. These new ways included sending feedback forms to the members, leaflets to review and using social media such as Facebook, Instagram and Twitter to ask members of public and patients to leave their comments and feedback.

13.0. Improvements made

The PALS and Complaints team has continued to work with the nursing and operational colleagues to identify more effective ways of working that benefit all and improve patient experience.

The priorities for the PALS and Complaints service during 2019/2020 were agreed and achieved as listed below:

Financial Year	Priority	Progress made	Status
2018/2019	The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.	**2019/2020** -Thematic reporting is now pulled directly and information for Departments. KO41a is still not available and will be rectified in the coming year **- Partially Achieved** **2020/2021** -The KO41 report is now pulled directly from the Ulysses system and all data is recorded on the Ulysses	**Achieved**
2018/2019 and 2019/2020	The KPI of 80% of complaints completed within the agreed timescale will be achieved.	**2019/2020** -The Trust did not hit Complaints nor PALS KPIs in this year **-Not Achieved** **2020/2021** -Trust hit KPIs for all months in 2020/2021 with only one complaint breaching agreed date with the complainant for one day	**Achieved**
2019/2020	Work will be undertaken with Divisional Leads to further in-bed ownership of complaint investigation and action planning	**2020/2021** - The Divisional Triumvirate have full ownership and oversight of all complaints, PALS contacts and actions made to the Trust	**Achieved**
2019/2020	Complaint investigation and report writing training will be available in house for staff that require it	**2020/2021** -The Trust now have clear process and standard operating procedures of the investigating and responding to the complaints - PALS and Complaints team is available to staff that require help with investigations or response writing	**Achieved**
2019/2020	The coding of compliments will be altered to the same system for complaints to allow for direct comparison of all Patient Experience data.	**2020/2021** -All compliments that are received within PALS and Complaints department are processed, saved on the Ulysses and shared with relevant departments/staff -The PALS and complaints department report on the compliments that are received by them but not on compliments received across the Trust	**Achieved**

Figure 46. Progress against 2018/2019 and 2019/2020 priorities for the Complaints Department

The PALS and Complaints department made improvements that were not included in the last year's priorities as it continues to improve services for our service users, the changes that were made are as follows:

- The Trust has invested into the PALS and Complaints Departmental Structure.
- The PALS and Complaints Department now record the demographics of the complainants so that the Trust can have a clearer picture of our complainants and to see if there are any minority groups the Trust need to focus on.
- The Trust has made connections with the other specialist Trusts and External Partners.
- The Trust Quality Priority for 2020/2021: 'Improving Experience for Patients', Carers and Service Users', as set out in the Quality Account, has been achieved.
- The PALS and Complaints department have a clear process of how to deal with a PALS contact or Complaint.
- The ROH "for Loved Ones" project has been launched.

14.0. Looking ahead to 2021/2022

The Trust will continue to improve the PALS and Complaints services and the Patient Experience in the 2021/2022. Improvements planned for the next financial year are as follows:

- The Patient Experience and Engagement Strategy 2019 to 2021 will be enhanced with a new strategy for the next 4 years and the associated action plan will be refreshed.
- The Trust will undertake a peer review of the Patient Experience and produce a responsive action plan.
- The Trust will roll out the Coffee Catch-Up patient engagement methodology to the Spinal Service.
- The Trust will engage with diverse groups of the community that the ROH serve, to understand their views and to improve their experience.
- The PALS and complaints team will further improve the Ulysses system to get more precise data for the directorates so that the operational team can focus on the specialities that receive most complaints and PALS contacts.
- A responsive action plan will be produced off the back of this annual report to look more closely into themes of the complaints and PALS contacts, demography of the complainants and departments.
- The Trust will work on the process of collecting compliments from the other departments so it can be tracked by the Ulysses system and disseminated accordingly.
- The Trust will recruit patients to be members of our Patient Engagement and Experience Group and will be included in all decisions made by the Group.
- New PALS and Complaints leaflets and posters will be created and translated in 6 common spoken languages with the community we serve.
- A new PALS and Complaints external internet page will be created which will include quarterly reports of the patient experience and a pop-up chat box on the Trust external internet page will be introduced.
- #Hellomynameis badges to be introduced within the Trust.
- The PALS and Complaints department will have a meeting room to meet with complainants and patients that wish to give us feedback.

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NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**NHS Adult Inpatient Survey 2020**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Chief Nurse**
AUTHOR:	**Roko Skocic, Head of Patient Experience**
DATE OF MEETING:	**2 November 2021**

EXECUTIVE SUMMARY:

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care. The NPSP is commissioned by the Care Quality Commission (CQC)

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos MORI. A total of 1250 ROH patients were invited to participate in the survey. Completed responses were received from 842 patients, an adjusted response rate of 68%

The questionnaire was amended significantly, with changes to both question wording and order. The 2020 results are therefore not comparable with previous years' data and trend data is not available. In future years, trend data will be incorporated into these reports.

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing.

The appendix presents only the key headlines from the report at this stage, given that the full analysis is still being reviewed by the Executive Team.

Following the Inpatient report, the Trust will create an action plan to improve our inpatient experience in 2022.

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the NHS Adult National Inpatient Survey 2020 and agree to devolve the ongoing monitoring of the action plan to the Quality & Safety Committee once the full report has been digested by the Executive Team.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Patient element of the Trust's strategy
PREVIOUS CONSIDERATION:
None.

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

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

1,250 invited to take part

842 completed

6% urgent/emergency admission

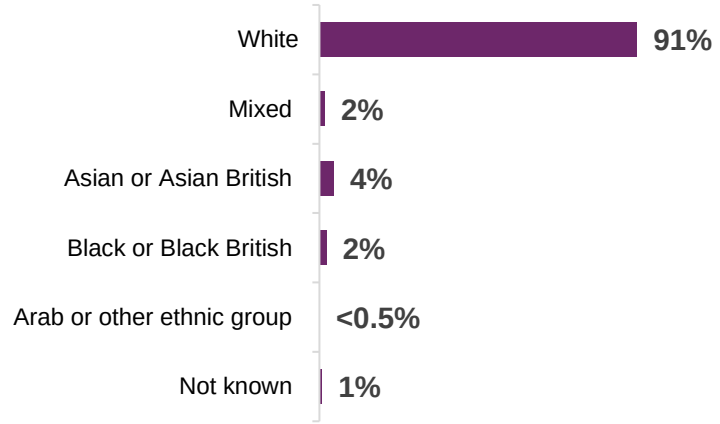
94% planned admission

68% response rate

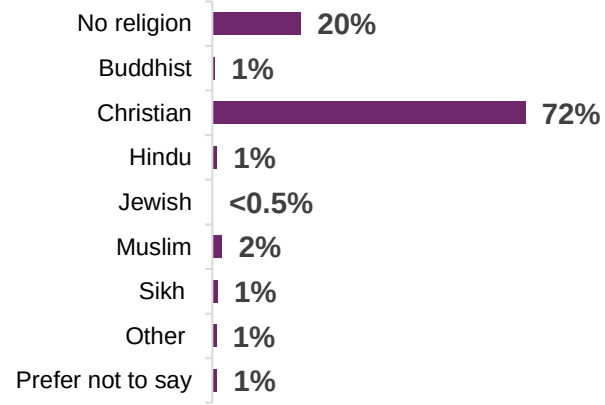
46% average response rate for all trusts

67% response rate for your trust last year

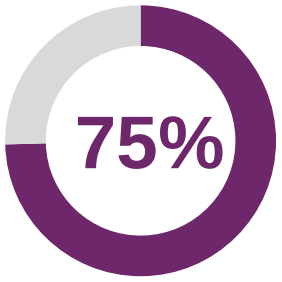
Ethnicity



Religion



Long-term conditions



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

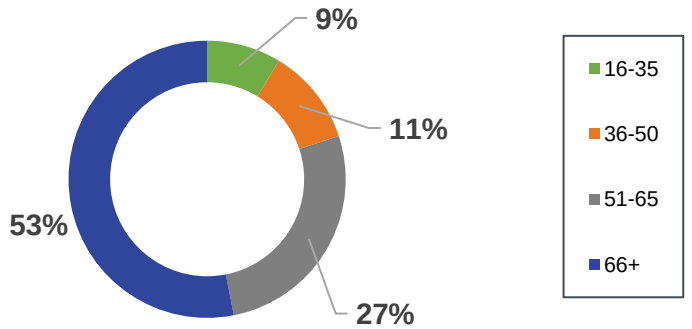
Sex

At birth were you registered as…



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

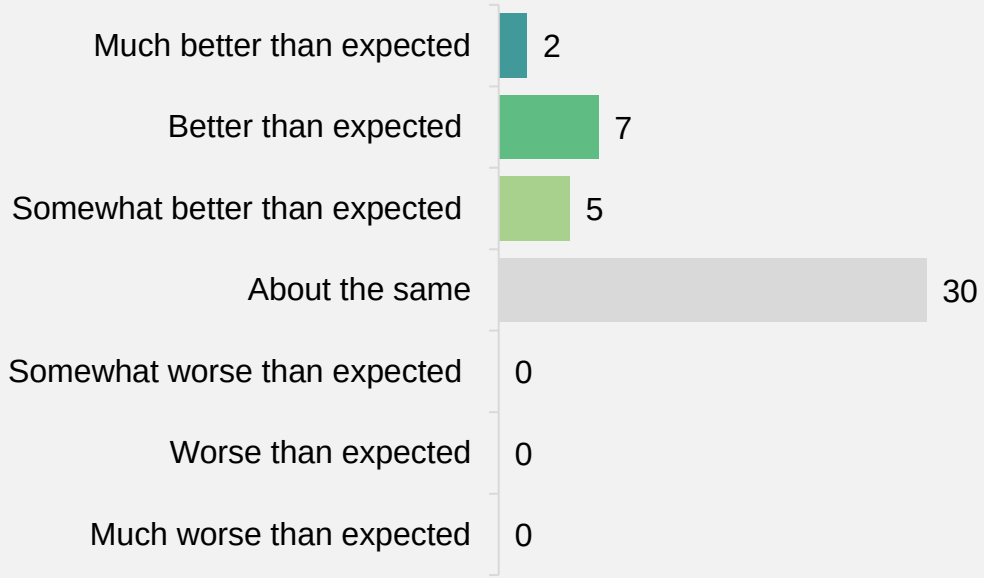
Age



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the survey development report.

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

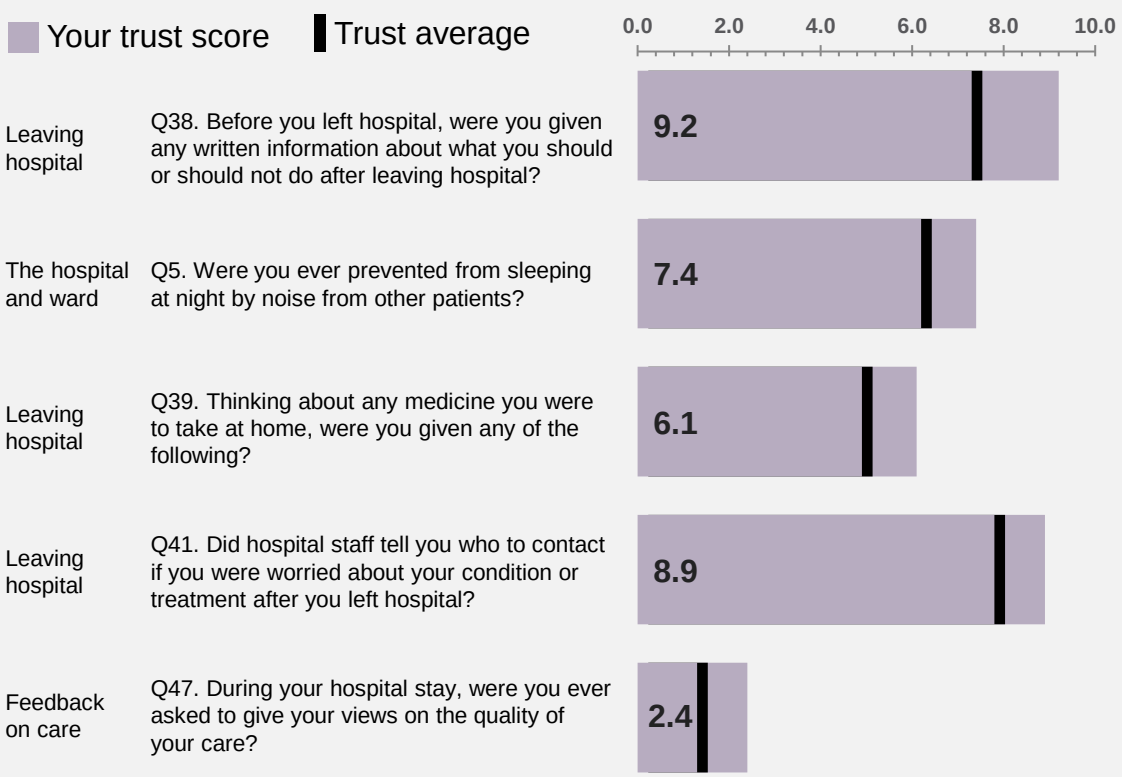
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Best and worst performance relative to the trust average

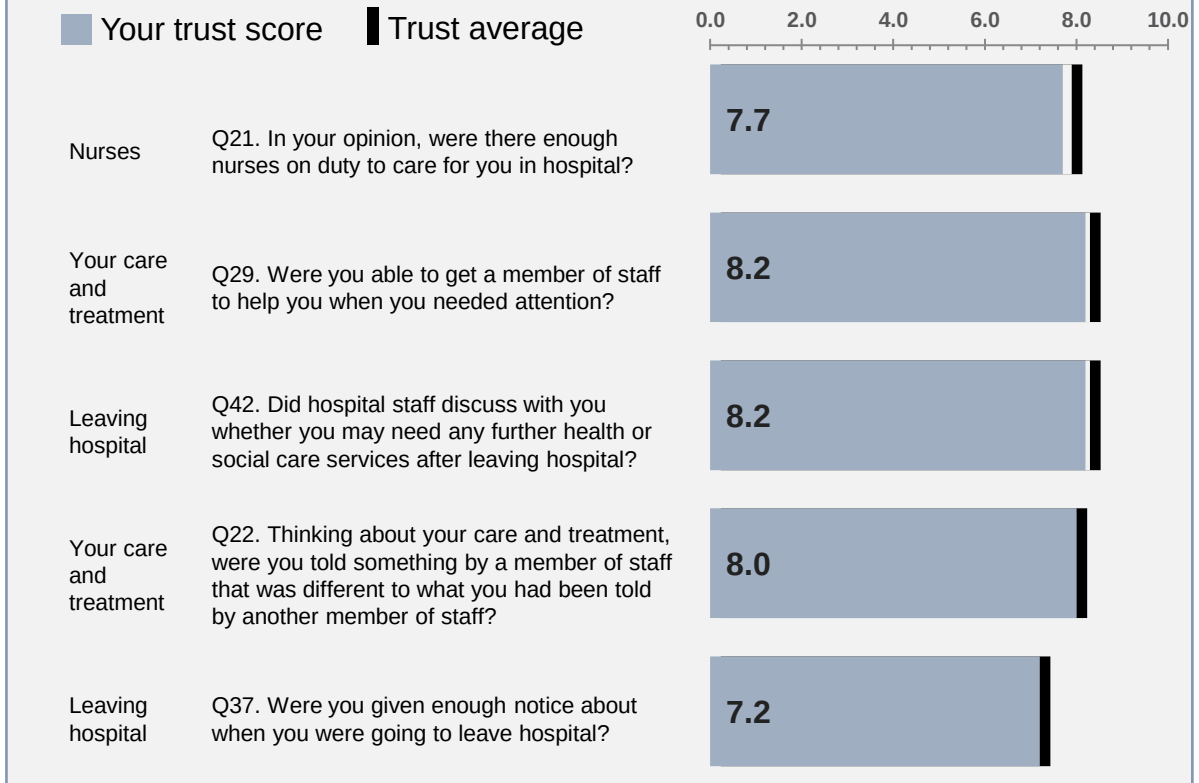
These five questions are calculated by comparing your trust's results to the trust average.

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with trust average)



Bottom five scores (compared with trust average)



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TRUST BOARD	
DOCUMENT TITLE:	**Update from the Guardian of Safe Working – Quarterly report for November 2021**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive Officer**
AUTHORS:	**Jamie McKenzie, Guardian for Safe Working** **Matthew Revell, Executive Medical Director** **Nas Uddin, Clinical Service Manager**
DATE OF MEETING:	**2 November 2021**

EXECUTIVE SUMMARY:

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

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

REPORT RECOMMENDATION:

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

- To provide continued support for the key individuals working to support junior doctors working conditions.
- Encourage further engagement with the junior doctors' forum

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the report	Discuss
X	**x**	

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

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

Comments:

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

Aligned to Trust Objectives

BAF Risk WF21 – Failure to attract and retain the skills and number of staff to secure financial sustainability

PREVIOUS CONSIDERATION:

Last considered by the Board in July 2021

The Royal Orthopaedic Hospital NHS Foundation Trust

FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – 2 November 2021

1.0 Situation

1.0.1 The Guardian for Safe Working is required to raise concerns about Safe Working for Junior Doctors by exception. Exception reports are the mechanism by which junior doctors record unscheduled episodes of work outside their normal working pattern. As of 25th October 2021, there have been no exception reports raised in the last quarter.

2.0 Background

2.1 Leadership Team

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

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

2.1.2 The current consultant staff post holders are:

Mr Matthew Newton-Ede	Clinical Tutor	All postgraduate medical and surgical trainees (ST1+) at the Royal Orthopaedic Hospital
Dr James Brunning	Tutor	Anaesthetics
Mr Angelos Politis	Clinical Lead for Mid-Level Care Providers	Locum Drs & Fellows
Mr Jamie McKenzie	Guardian for Safe Working	Safe working conditions of trainee doctors

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

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

2.1.5 All clinical supervisors and allocated educational supervisors are accredited as per the GMC and Academy of Medical Educators directive. Maintenance of accreditation is appraisee-led and recorded via the annual appraisal process. Consultants will be supported via a designated Educational Support Committee.

3.0 Junior Doctor Establishment

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

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

3.2 *GP Trainees*

3.2.1 There are a variable number of GP trainees at the ROH. GP trainees get three formal teaching sessions per week including release for their regional teaching. Additionally, they are supported to attend their awayday residential teaching. They are timetabled for weekly teaching clinics and operating lists, and cover is in place to maximise their educational exposure.

3.2.2 Remaining posts at Senior House Officer level are filled with locums or, more preferably, substantive mid-level care providers (MLCPs) where possible. At present, the strongest areas for MLCPs are pre-operative assessment, specialist ward cover, outpatients and theatres.

4.0 Junior Doctor Doctor's Forum

4.1 The junior doctor's forum meetings have not been well attended by the junior doctors but have provided a forum for the leadership team, including management, to discuss and plan

improvements. Encouraging juniors to attend is a priority and the leadership team is not relying on the belief that lack of engagement means lack of problems.

4.2 An issue with underpayment of anaesthetic trainees has been raised. This was likely due to a clerical error in HR and an internal review is underway to resolve it, supported by Dr Brunning and newly appointed HR staff.

5.0 About the Guardian for Safe Working Role

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

5.2 The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. It should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into junior doctor forums. Regular liaison with the director of medical education (DME), educational supervisors and the champion of flexible working is required.

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

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

5.5 The guardian is accountable to the board and should not hold any other role within the management structure of the employer. The line management arrangements for the guardian should be independent of the medical director and other medical managers to ensure appropriate independence. The reporting line should be to the appropriate executive director or equivalent, who will contribute to the annual appraisal of the guardian, in line with appraisal policy.

5.6 The post holder should have regular meetings with doctors in training, the champion of flexible training, the DME and any associate DMEs, educational, clinical and academic supervisors, the postgraduate dean, other senior staff within the HEE area office/deanery, the LNC, the junior doctors' forum, and both executive and non-executive Board members. In some locations the guardian may need to liaise with colleagues undertaking similar roles for other local organisations which employ fewer than 10 trainees.

5.7 The guardian has a page on the ROH external website with contact details and a description of the role. The role is explained at junior doctors' induction and leaflets are distributed with further details. The guardian attends the junior doctors' forum meetings and is easily accessible.

6.0 Recommendations and Ongoing Work

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

- To provide continued support for the key individuals working to support junior doctors working conditions, especially those involved directly in health and wellbeing.
- Encourage the junior doctors to further engage with the junior doctors' forum

Jamie McKenzie, Guardian for Safe Working
Matthew Revell, Executive Medical Director
Nas Uddin, Clinical Service Manager

25th October 2021

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Compliance with existing Guidance in regard to Mortuary and/or Body Stores**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Professor Phil Begg, Executive Director of Strategy & Delivery**
DATE OF MEETING:	**2nd November 2021**

EXECUTIVE SUMMARY:

On the 12th October 2021, NHS England/Improvement issued a request that NHS Trust Boards review their provision of mortuary or body store facilities in line with the current Human Tissue Authority (HTA) guidance.

For context, ROH has a very small mortuary/body store (Rose Cottage), which can accommodate 2 bodies at any time. Also it is important to note that the number of patients who, sadly, pass whilst at ROH in a standard year (i.e. not during the pandemic) is on average 4. This paper should be read with this context in mind.

In the letter from NHSE/I the Trust is requested to examine and respond by the 16th November to the HTA Guidance and in particular that the organisations are compliant with the following four areas with The Trust assurance response in italics below each of the four section:

1. Ensure all access points to the mortuary or body store are controlled by swipe card security access. Where this is not possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.

    a. *ROH mortuary has a traditional key lock which will now be accompanied with a SALTO swipe card access control. All access is recorded in a log book and the new swipe access will provide an electronic record also.*

2. There must be effective CCTV coverage in the mortuary area and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and the mental health support may be required to support staff to undertake this task.

    a. *The Trust has recently upgraded its CCTV system and the mortuary is covered by this system. The footage across the Trust is reviewed regularly by suitably qualified staff, including our Local Security Management Officer (LMSO) who has undergone specific training for the viewing of security camera footage.*

3. A documented risk assessment of the facility should be undertaken with regard to the operation, security and construction of the mortuary or body store area.

    a. *At the time of writing the report a risk assessment is underway, to include all areas requested in the compliance guidance. This will be completed in time for the submission date of Tuesday 16th November 2021.*

4. Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract. Employers are required to pay attention to the security features of a DBS certificate.

    a. *All Trust staff who have to access the mortuary/body store for any reason are fully DBS compliant, as part of their pre-employment with the Trust. Access to the mortuary is strictly limited to Porters transporting the deceased and/or clinical staff accompanying the Portering staff. No other member of staff should require access for any reason.*

REPORT RECOMMENDATION:

The Board is asked to receive this information for assurance that we comply with the HTA guidance and the four particular standards.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Full alignment to Trust objectives and performance metrics

PREVIOUS CONSIDERATION:

Trust Executive Team 19/10/2021

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 26 October 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• In-session theatre utilisation was noted to have reduced due to cancelled procedures as a result of a number of patients not being fit for surgery on the day of their treatment. There had also been sickness absence in theatres which had impacted. • The number of 30 minute clinic delays had increased and work was being undertaken to improve this position using virtual consultation when possible. • The level of virtual consultations as opposed to face-to-face appointments had reduced – this was driven by the consultant desire to see patients in clinic to more accurately to assess whether there had been any clinical deterioration as a result of waiting longer for treatment. A pilot of 'Attend Anywhere' was underway which would inform the future plans for virtual clinics and there was anticipation that as less complex patients were seen, then the number of virtual consultations would increase to nearer to the national target of 25%. • The diagnostic target had not been met during the month due to the exceptionally high number of referrals for Imaging interventions. It was anticipated that the position would be recovered by the end of November 2021 given the additional MRI facilities that had come on line. • Agency staffing costs were reported to be high covering sickness absence and additional activity. • Staff turnover rates had increased month on month, although this has been influenced by some degree by the change to the reporting arrangements on the Electronic Staff Record (ESR). • The system wide H2 (Months 7 -12) funding arrangements were noted to present a risk to the ROH in terms of the reimbursement model for the activity that the Trust was handling. The Trust would not be able to fully cover the cost of the additional activity being	• Produce a statement regarding the position of the Trust's disaster recovery arrangements for IT • Arrange for a presentation on the virtual clinical environment at a future meeting of the Quality & Safety Committee • The 'normalised' (position without the influence of COVID) activity plans to be developed and shared with the Committee • Delivery dates for the Cost Improvement Programme (CIP) schemes to be provided at the next meeting • There was continued planning to prepare for the H2 (Months 7 – 12) funding regime. • Model Hospital Club information to be shared at the next meeting.

handled as a result of the model expected. The Committee was of the view that it was in patients' interests to continue to drive down the waiting lists by treating patients as quickly as possible.	
POSITIVE ASSURANCES TO PROVIDE • The activity position was reported to be strong and there would be a further increase in the number of cases treated as the Trust moved through October, mainly as a result of being able to treat less complex patients as the waiting list by clinical prioritisation was worked through. • The Elective Recovery Fund trigger had been met, although there was limited benefit to the ROH as the allocation was made on a system basis. • Average length of stay remained settled and this performance would be split by procedure in future reports. • Pre-population of theatre lists and filling gaps in the theatre lists was working well, with the revised pre-operative isolation regime helping with this work. • Outpatient appointment levels had reached pre-COVID levels and 'In Touch' was being used better to capture demographic information of patients. • Referrals have now reached 91% of the pre-COVID levels, reflecting effective engagement with GPs. • Performance against the 18 weeks Referral to Treatment Time target had increased to 68.5% and there remained a low level of patients who had waited for treatment in excess of 52 weeks. There was an ambition to eliminate all cases of 52 weeks in all specialities other than spinal services by the end of the calendar year. • All cancer targets had been met with the exception of the 62-day target where there had been a shared breach as a result of delay to a patient's treatment as a result of them contracting COVID. • The Trust achieved a financial break-even position during the month, this being supported by an allocation of the Elective Recovery Fund. • Mandatory training rates had increased.	**DECISIONS MADE** • None specifically.

• International nurse recruitment plans would help support the ROH staffing position in coming months. • A balanced financial position for the Integrated Care System had been achieved in Month 6, although the full quantum of Elective Recovery Fund initially expected had not been recognised.	

Chair's comments on the effectiveness of the meeting: The meeting had run to time and had focussed on the items requiring most important discussion.

ROHTB (11/21) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 27 October 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remained a higher than usual number of infections reported and the reasons for these, which were mostly confined to one ward, were being reviewed. Each was robustly investigated and the position in the context of the systemwide infection rate would be considered. • The complaints Key Performance Indicator had been breached, although this related to a single complaint and reflected a change in the processes which had now been addressed. • The reduced number of virtual appointments was discussed which was noted to relate to the clinicians' desire to see patients face to face to more accurately assess any possible clinical deterioration as a result of waiting longer than usual for treatment, particularly if they were complex cases. • As part of the Safe Staffing report it was suggested that consideration needed to be given to the sustainability of reliance on agency staff to support the Trust. This had the impact on a number of aspects including finance; quality and staff experience. • There remained a gap in the establishment of Band 5 registered nurses, however work was underway to address this including international nurse recruitment.	• Outcome of the pilot of 'Attend Anywhere', the virtual clinics system, is to be presented at the next meeting. • An audit by the anaesthetics department around cancellations on the day to be presented in future. • An update on the Patient Safety Strategy & the work of the Patient Safety Specialists to be presented to the Trust Board. • Present the annual complaints report to the Trust Board. • Work was underway to assess how the inequalities work would be 'mainstreamed' into the existing governance structure of the Trust. • Update on Clinical Audit to be presented at the next meeting. • A note to be sent to the previous Chair of the Drugs and Therapeutics Committee to thank them for their work. • Work is underway to create an appealing and calming environment for patients similar to the scheme in the Children and Young People's outpatients' area. • Update on the Throne Project and bathroom refurbishment to be presented at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The future operation of the Admissions and Day Case Unit (ADCU) was being reviewed in the context of new Infection Prevention and Control guidance to understand whether there was a possibility of handling a higher number of patients through the facility. • The use of Advice & Guidance was being encouraged and Patient Initiated Follow Up (PIFU) would be used to reduce any unnecessary follow up appointments and thereby reduce the level of 'Did Not Attend' cases.	• Reporting on the Pathology and joint services to be escalated by exception from the Quality & Safety Executive in future.

• There was strong performance against a number of constitutional standards, with the position against the Referral to Treatment Time target improving, the number of patients waiting in excess of 52 weeks for treatment reducing and most cancer targets having been met. • An informative overview of the HealthAssure system was provided which showed good progress with embedding the system and supporting work such as the evaluation against the CQC Key Lines of Enquiry and populating the Trust's integrated dashboard. The use of the system would also streamline the information being presented to the Board committees. • An overview of the role of the Patient Safety Specialists was provided which detailed the areas of responsibility attached to this nationally mandated role. • The annual complaints report was presented which showed an improvement in the complaints processes and detailed some innovative ways in which the Trust had engaged with patients though the pandemic. There was noted to have been a decrease in the number of overall complaints received compared to previous years. • The update on the position against the Patient Reported Outcome Measures (PROMS) showed that there had been good improvement against a number of indicators. • A report offering positive assurance around the improvements to the clinical audit processes and system was presented. This included commentary and recommendations for further improvement from the Trust's Internal Audit function. • The Drugs and Therapeutics Committee was noted to be operating in a much improved way and a new Chair of the Committee had been appointed. • A new resuscitation officer had been appointed and was focussed on improving mandatory training rates in this area. • An upward report from the Safeguarding lead was presented which advised that processes in this areas were working well, although the volume of cases was increasing and were more complex. A national	

training package around the new Liberty Protection Safeguards is to be developed and will be shared with staff and the Trust Board. • The update from the Children's and Young People's Board presented good assurance that the risks associated with this work were being well reviewed. A Youth Worker would be recruited to support the transition services. • The upward report from the Patient Experience and Engagement Group presented a number of positive developments and improvements including the engagement of a number of external stakeholders in the forum, such as governors and Healthwatch; the reinvigoration of the PLACE assessments; the roll out of the patient experience web page; introduction of spinal patients' 'Coffee Catch up' meetings; the launch of patient information in a variety of languages; and the conclusion of the Patient Experience Network review. • There had been an increase in the overall mandatory training rates which reflected a progressive move to face to face sessions. • It was noted that there was some robust check and challenge sessions being held around the divisional risk registers to ensure that risks were being appropriately escalated to the Corporate Risk Register. The process was working well. • Performance against the Key Performance Indicators in the Pathology Service Level Agreement were noted to be improving and the service was running more efficiently given the recent consultant recruitment to support this.	

Chair's comments on the effectiveness of the meeting: The agenda contained a good balance of presentations and reports. It was noted that a stocktake of the effectiveness of the Committee would be arranged for the December 2021 meeting.

ROHTB (11/21) 009

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 27 October 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Turnover continued to rise however it was noted that there may be an influence as a result of changing the reporting process around this on ESR. • Staff survey completion was behind the Trust's trajectory and work was ongoing to create energy around this to ensure that the staff voice was heard as comprehensively as possible.	• A commitment was made to consider from where the bereavement service may be appropriately resourced and could gain clinical involvement. • Further work is planned to assess the effectiveness of the component bodies within the workforce governance structure. • Breakdown of staff turnover by role to be shared at the next meeting. • There was much work underway to achieve a reduction in the time to hire position, this being through the use of more robust systems and interventions by the workforce team. • Benchmarked WRES and WDES position to be brought back to a future meeting. • Update on Stonewall accreditation to be provided at the next meeting. • Update on the EPIC programme to be provided at the next meeting. • Further update on international recruitment to be provided at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a staff story from the individuals who had managed the bereavement process during COVID. The account was an honest reflection of the significant personal and professional impact of the situation where there had been a high level of mortality and little preparation or expertise to handle the interactions and processes required. • There was a plan to fill some key posts within the workforce structure over coming weeks, although there were challenges identifying appropriate resource to support the OD & Inclusion function. • The mandatory training rates had increased significantly as the Trust moved to more face-to-face interventions.	• None specifically.

• It was agreed that the sustainability of the wellbeing fora was a very positive highlight and covered a wide spectrum of issues such as menopause and men's health. • The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plan was considered. It was noted that the Multi Minority Ethnic Group (MMEG) and Disability Forum was taking an active role in helping to progress the actions. • An update on the effectiveness of the staff networks was provided. The Chair of the MMEG had received recognition within the Birmingham & Solihull system for the contribution to the recent conference around Black History Month. The networks continued to attract new members and the Executive sponsorship was working well. • The work to progress the international recruitment of nurses was presented by the Deputy Chief Nurse. The ROH was expected to benefit from the 50 nurses secured for University Hospitals Birmingham NHSFT and the ROH through this route by March 2022 the further 450 nurses in subsequent years.	

Chair's comments on the effectiveness of the meeting: The bereavement presentation was noted to have been particularly impactful. The meeting had run virtually to time despite a heavy and diverse agenda.

ROHTB (11/21) 010

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 15 October 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The external auditors highlighted a number of risks to the Trust's financial position for the coming year, including the impact of the H2 (Months 7 – 12) and 2022/23 funding arrangements. • The impact of the new accounting standards IRFS16 was discussed which would require the movement of the lease arrangements onto the Trust's balance sheet when introduced. • The instances of breaches and waivers of Standing Financial Instructions were reviewed. It was noted that there was further work to do to tighten up the processes to ensure that invoices were not received before a purchase order had been raised. The deterioration in the number of breaches was noted, although it was noted that this related to the higher level of financial transactions as opposed to a change in behaviours of staff.	• Contracts register and process for review to be presented at the next meeting. • Debrief and learning from the annual audit 2020/21 to be presented at the next meeting. • Circulate a statement around the Trust's IT disaster recovery arrangements. • A consolidated view of the outstanding recommendations to be presented at the next meeting. • Present clinical audit review to the Quality & Safety Committee. • Prepare a briefing around the impact of the new national guidance on the audit process. • Prepare a consolidated report on losses and special payments every six months rather than quarterly. • Breaches and waivers of SFIs to be presented by department in future. • The annual process to redeclare interests was noted to be underway.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was noted to be good progress with addressing outstanding audit recommendations and actions. It was suggested that there could be a role for the Board committees in assessing progress with audit recommendations pertinent to their remit. • Internal audit was of the view that the transparency around the breaches and waivers of SFIs was positive. • The Committee reviewed the current Board Assurance Framework noting that the process to refresh it was dynamic and working well. • An update on the Risk Improvement Plan was provided which highlighted some good progress with actions around identifying risk leads across the Trust and embedding some discussions around risk into existing fora.	• Executive Directors should attend the Audit Committee meetings by rotation to present an overview of progress with the audit recommendations. • The Committee approved the external audit fees of £89,616 to include the limited assurance report on the Quality Account. If there was no need to audit the Quality Account then the fee would be reduced.

• It was noted that there was anticipated to be better compliance with the Data Security and Protection Toolkit given the planned move of the IT infrastructure to the Cloud platform.	

Chair's comments on the effectiveness of the meeting: The Committee agreed that the meeting had been effective and discussions sufficient despite the detailed agenda. There had been a good level of challenge and insightful discussion.

Finance and Performance Report

September 2021

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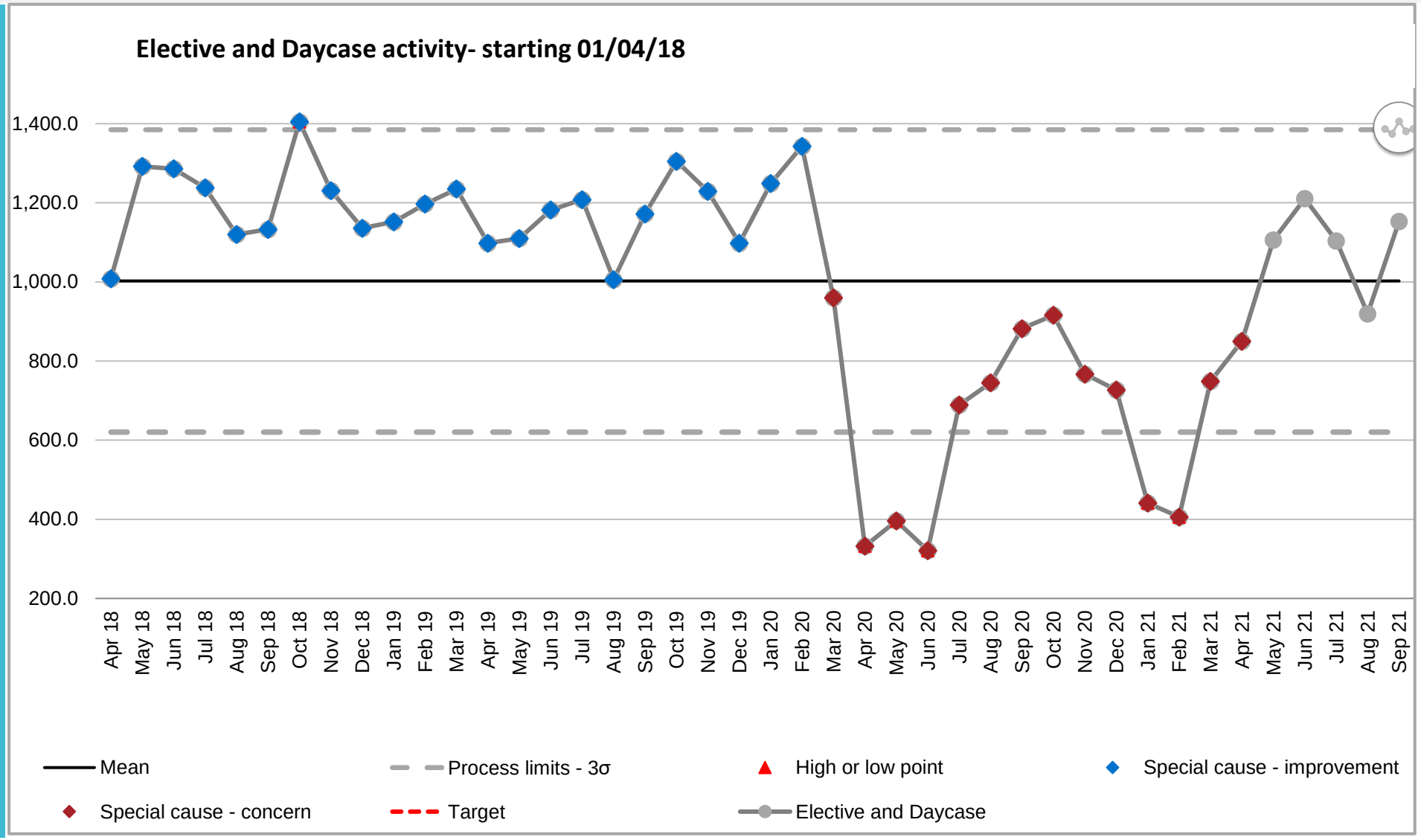
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Introduction

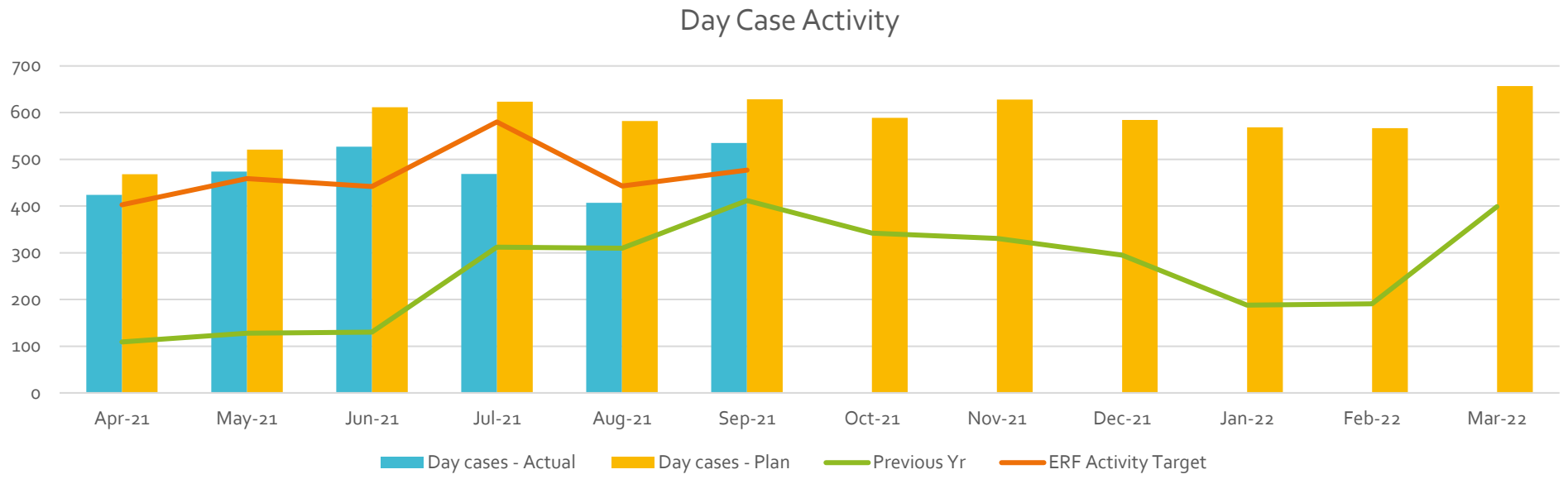
The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

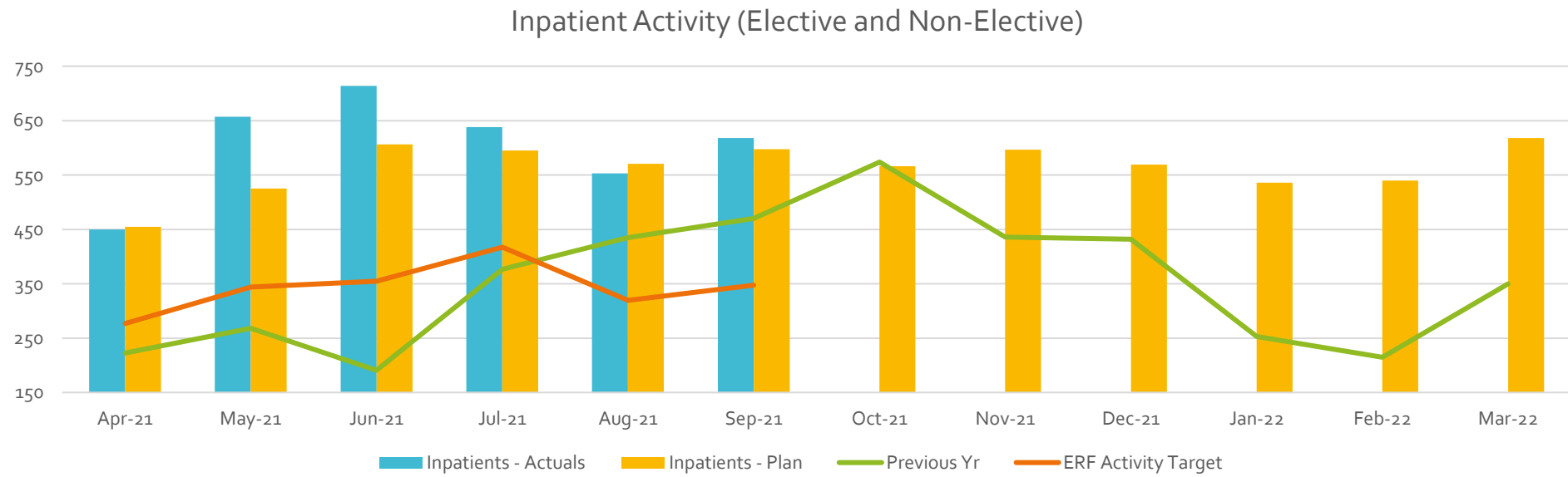
A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues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

1. Activity Summary

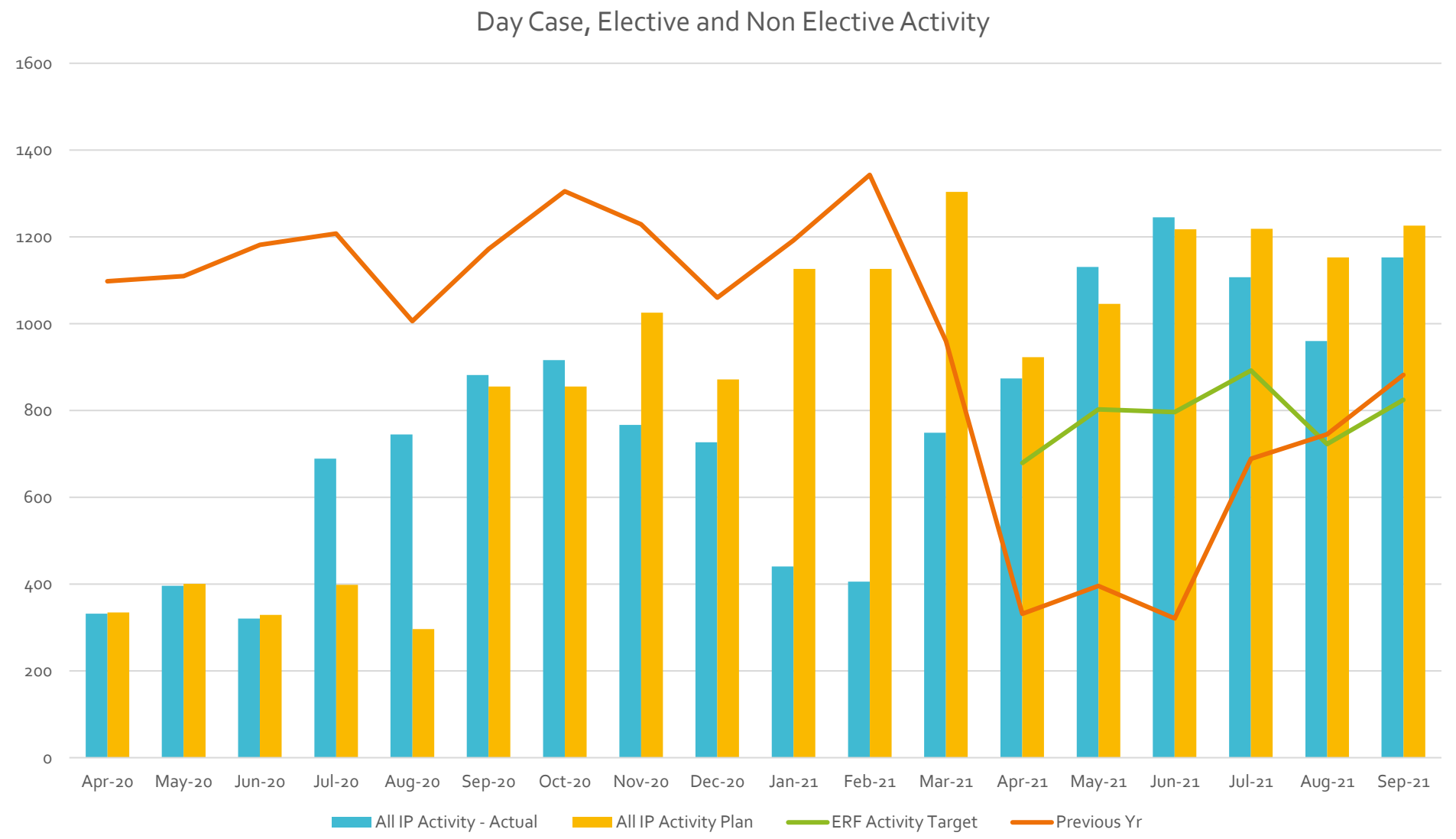


1. Activity Summary





1. Activity Summary



1. Activity Summary

SUMMARY

September Plan 1226 – Actual 1139

Day Case Plan 629 – Actual 528
IP Elective Plan 597 – Actual 582

September activity plan was underachieved by 87 cases (-7%). Under utilisation of theatre capacity and short notice cancellations have impacted on our ability to deliver the plan.

Initial draft of H2 activity plans has been submitted.

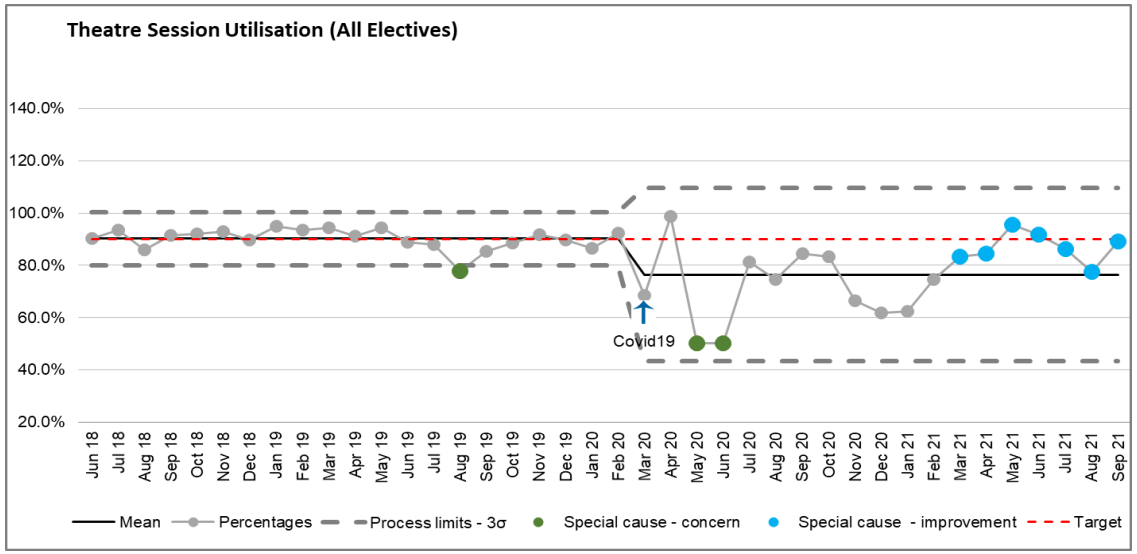
AREAS FOR IMPROVEMENT

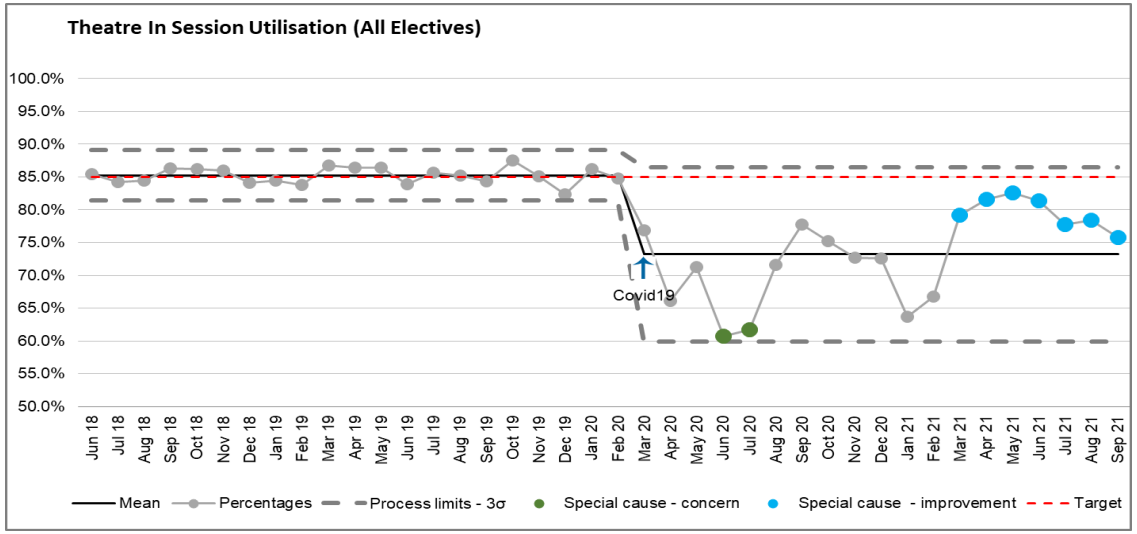
Pre-populating of theatre lists at least 4 weeks in advance with contingency patients now being actively sort from September 2021 should enable us to mitigate the short notice cancellations and ensure theatre capacity is maximised.

Continue with weekend theatre lists and proactive recycling of in week sessions.

RISKS / ISSUES

2. Theatre Utilisation





Elective Session Utilisation (September-21)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	449	406	20	90.42%
UHB	134	113	11	84.33%
Totals	583	519	31	89.02%

Elective In Session Utilisation (September-21)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1791	1375	415	76.80%
UHB	503	364	139	72.32%
Totals	2294	1739	555	75.82%

2. Theatre Utilisation

SUMMARY

Overall theatre utilisation was 89.02% compared to 77.61% the previous month. Total in session utilisation was 75.82%

ROH list utilisation improved as a result of consultants returning from annual leave which impacted in August, and UHB also improved slightly, however there is still a need for UHB Consultants to support trauma lists across UHB theatres sites when the need arises which results in an inability to recycle as usually very short notice given (24/48 hrs)

In session utilisation remained a challenge which is mostly due to cancellations of patients due to either being unfit or testing positive / isolating due to covid. A full breakdown of cancellation reason can be seen on the next slide, however a snap shot audit is being carried out by Anaesthetic Consultant colleagues in POAC to review those procedures cancelled on the day / deferred to identify any key clinical themes which can be addressed. Clinical audit to be presented to theatre lookback meeting at the end of October.

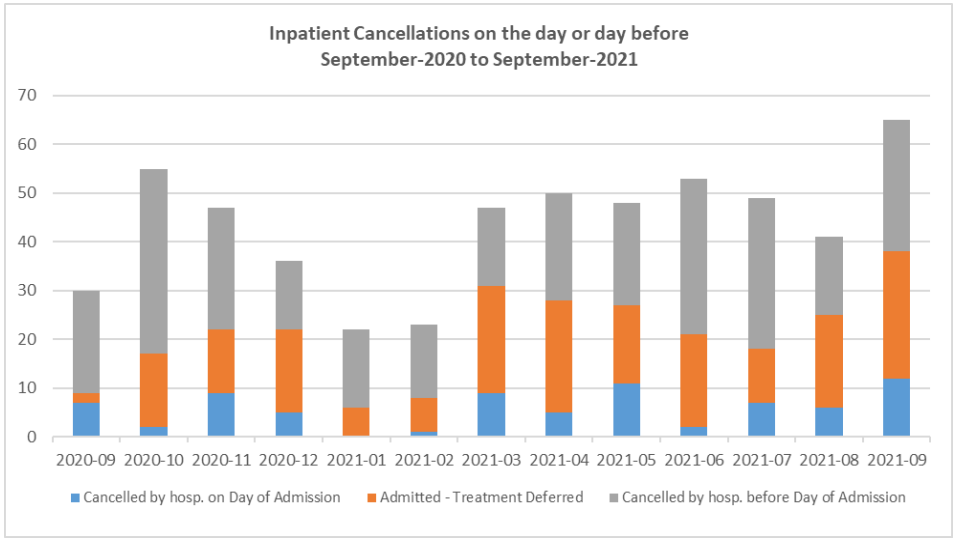
AREAS FOR IMPROVEMENT

Pre-populating of theatre lists at least 4 weeks in advance with contingency patients now being actively sort from September 2021.

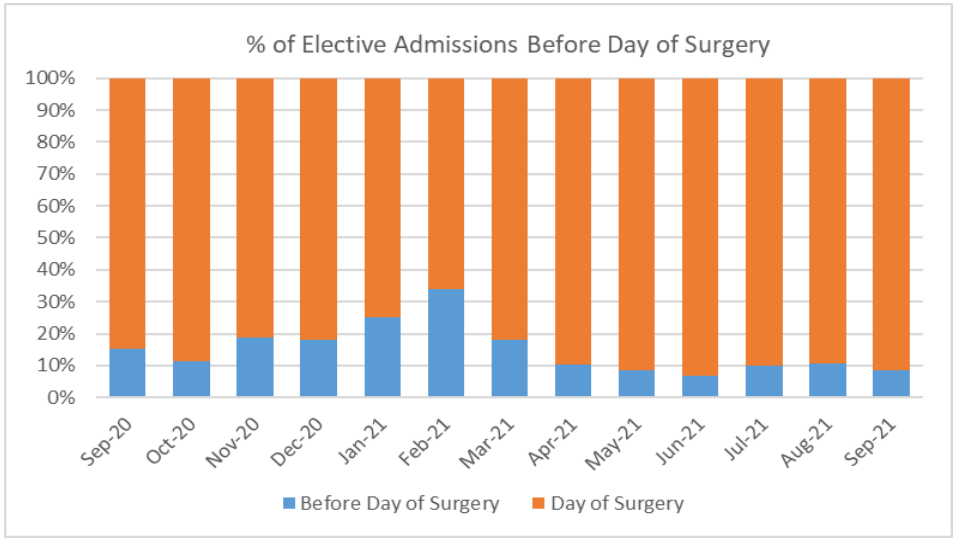
RISKS / ISSUES

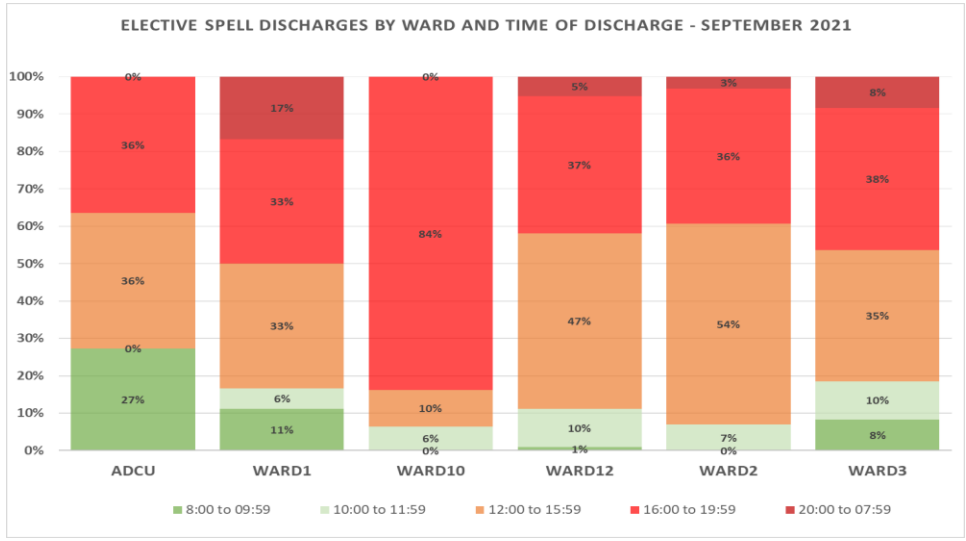
The in sessions utilisation of system lists will need to be improved in order to maximise resources and the ROH team are working closely with operational colleagues at UHB to ensure planning of lists is in place to improve efficiency overall

2. Theatre Utilisation/ Hospital Led Cancellations



Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2020-09	7	2	21	30	0
2020-10	2	15	38	55	0
2020-11	9	13	25	47	1
2020-12	5	17	14	36	0
2021-01		6	16	22	0
2021-02	1	7	15	23	0
2021-03	9	22	16	47	0
2021-04	5	23	22	50	0
2021-05	11	16	21	48	0
2021-06	2	19	32	53	0
2021-07	7	11	31	49	0
2021-08	6	19	16	41	0
2021-09	11	28	28	67	0
Total	75	198	295	568	1





2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed does not include those who were either emergency or urgent cases as these are more difficult to avoid due to the very short notice of being booked.

There were 11 patients cancelled on the day pre admission admission in September with reasons detailed as follows;

3 x Pt choice/ compliance
2 x not fit / more tests required
4 x covid +
1 x no transport booked via nursing home
1 x lack of theatre time due to emergency over run

There were 28 patients admitted but where treatment was deferred, with reasons broken down as follows:

15 x Medically unfit / Clinical change in condition, e.g, chest infections
3 x Covid + / broke isolation rules/compliance
5 x Procedure no longer required, patient choice
2 x surgeon availability
1 x equipment issues
2 x admin errors

There were 28 patients cancelled by the hospital prior to date of admission.

5 x surgeon availability due to Covid restrictions
1 x patient admitted to another hospital
1 x replaced by more urgent/emergency case
7 x change in TCI date e.g, – due to staffing issues – all deferred to next day surgery
10 x Medical deferrals due to complexity in co-morbidities found in POAC/ Patient conditions eg chest infections
4 x patient broke isolation / covid +

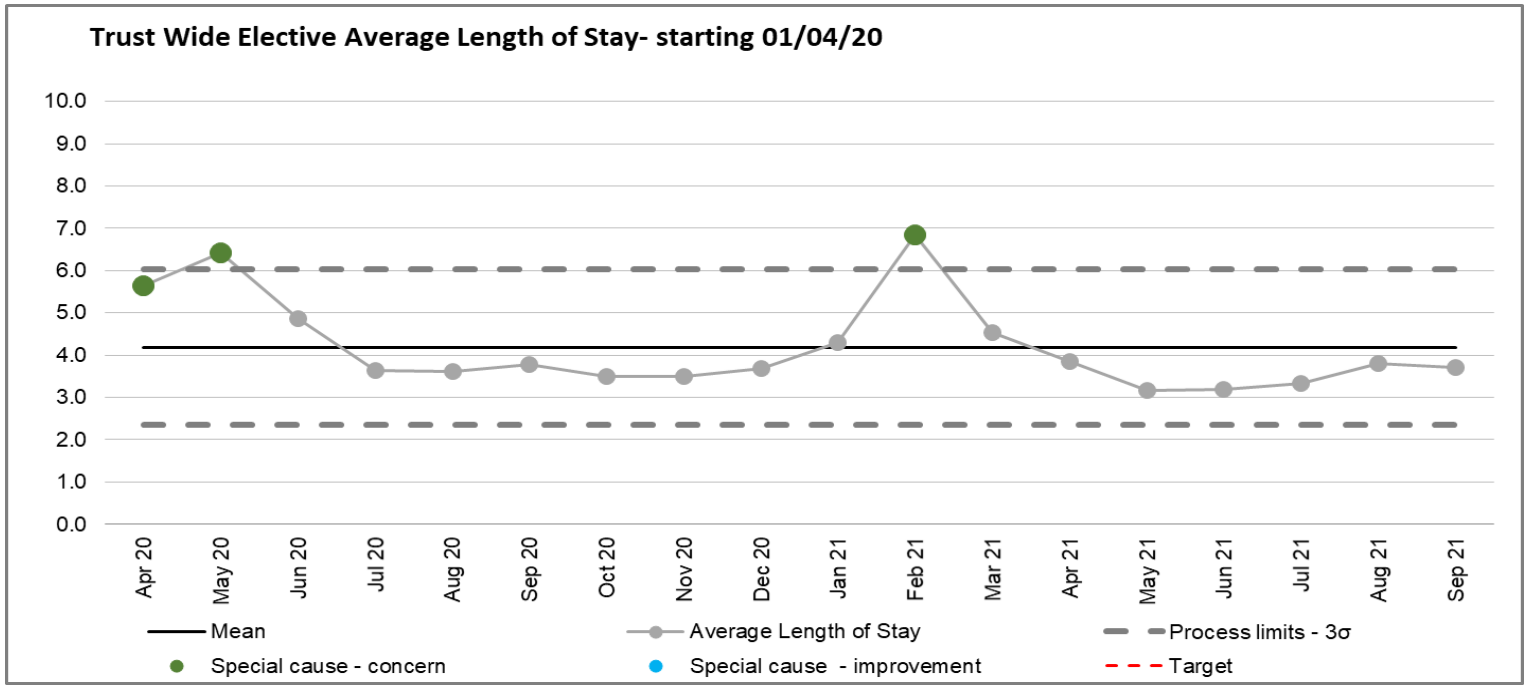
AREAS FOR IMPROVEMENT

6/4/2 scheduling meetings and 'theatre look back' meetings are in place which will also focus on cancellations from the previous week. This will identify themes and actions to minimise the number of avoidable cancellations as possible. An audit is also being carried out by Anaesthetic Consultant colleagues in POAC to review those procedures cancelled on the day / deferred to identify themes.

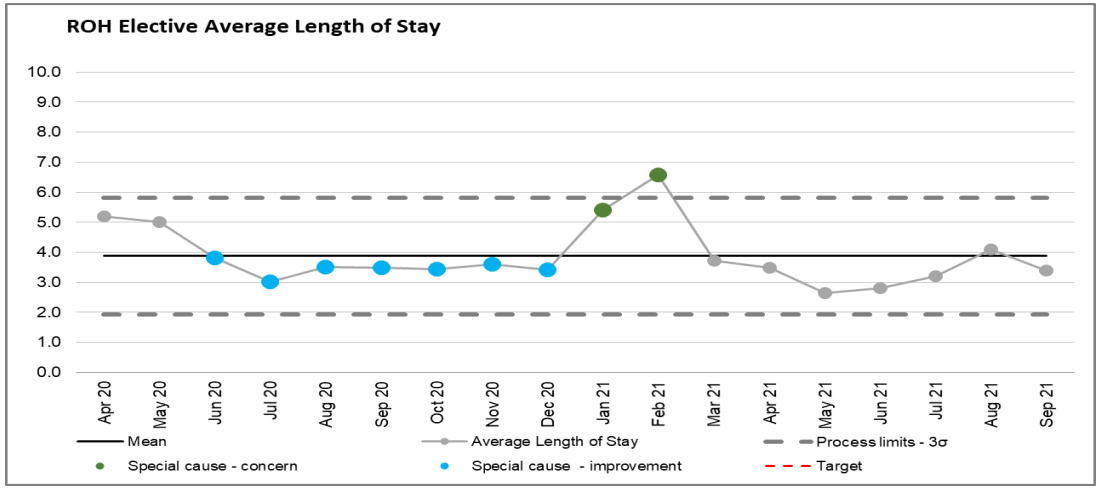
RISKS / ISSUES

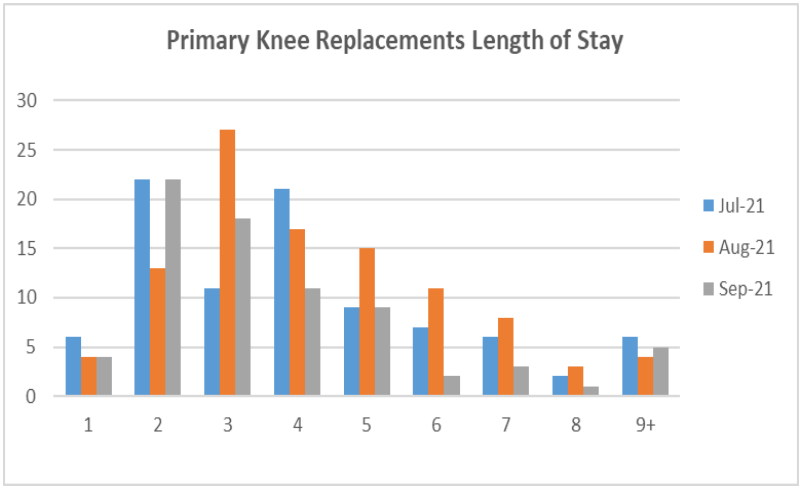
Impact of the reduction in the number of theatres running and the prioritising of patients as per NHSI/RCS in order to support the system in delivering the most urgent patients procedures has resulted in patient deferrals which will require monitoring as services are recovered through the harm review process.

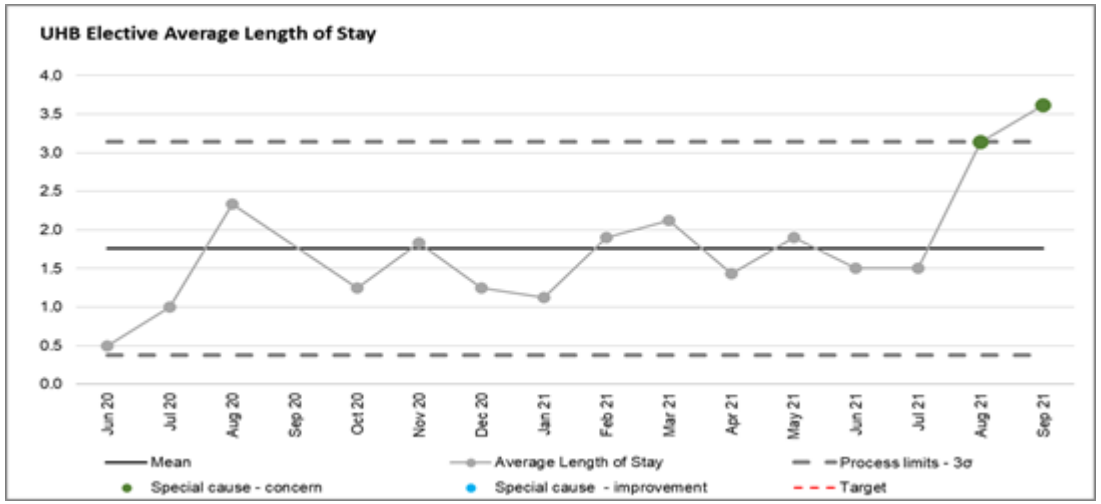
3. Length of Stay

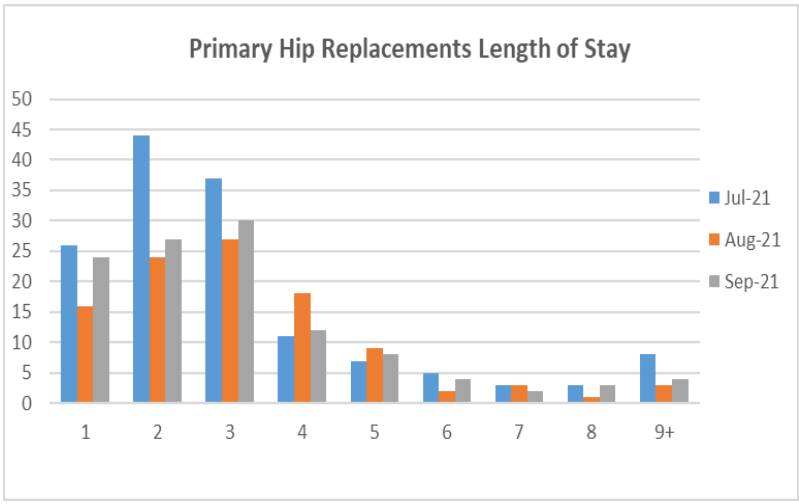


3. Length of Stay









3. Length of Stay

SUMMARY

The average length LOS for ROH patients from *all* specialities is 3.70 (3.83 August).
The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is 3.43 (4.05 August)
The average length of stay for UHB patients at ROH is 3.61 (3.08 August)

September length of stay data produced for UHB and ROH, has been reviewed and the following observations made:

- **21 UHB patients with LOS greater than 3 days. 7 with a length of stay greater than 5 days and 3 with a stay greater than 7 days. (excludes Rehab)**. Those patients with stays greater than 7 days were due to complexity of surgery, clinically justified reasons or specific discharge needs e.g. Rehabilitation.

- **43 ROH patients (arthroplasty and oncology arthroplasty), 31 - arthroplasty only had a LOS greater than 3 days.17 with a length of stay greater than 5 days (arthroplasty and Oncology arthroplasty), 9–arthroplasty only had a LOS greater than 5 days and 13 (arthroplasty and oncology) , 5 arthroplasty only patients with a length of stay greater than 7 days**

- In summary 3 UHB patients had a LOS greater than 7 days and 5 ROH arthroplasty patients

- PICs information reviewed continues to demonstrate that ROH oncology arthroplasty surgeons are undertaking surgery more complex than a primary joint replacement that may be on the joint care programme. These patients due to the nature of the surgery have a longer length of stay.

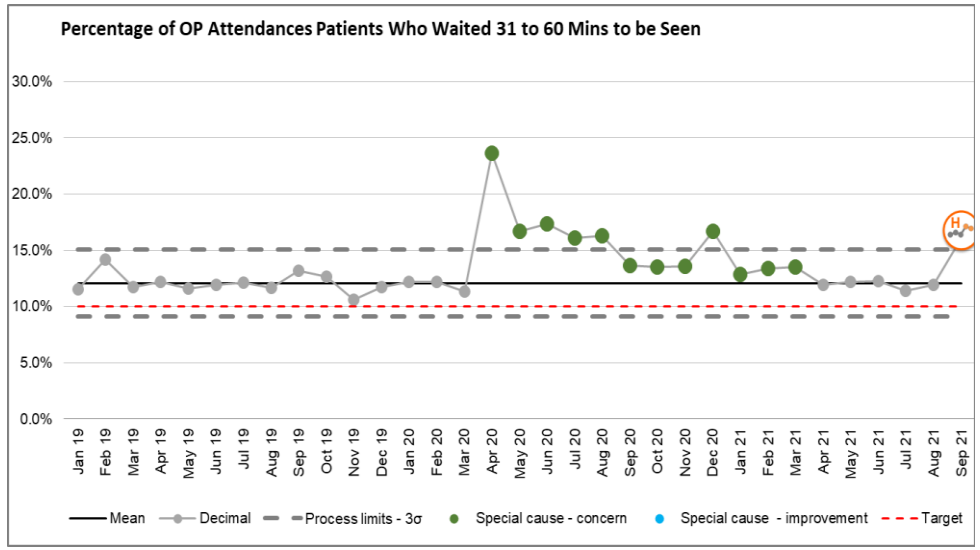
AREAS FOR IMPROVEMENT

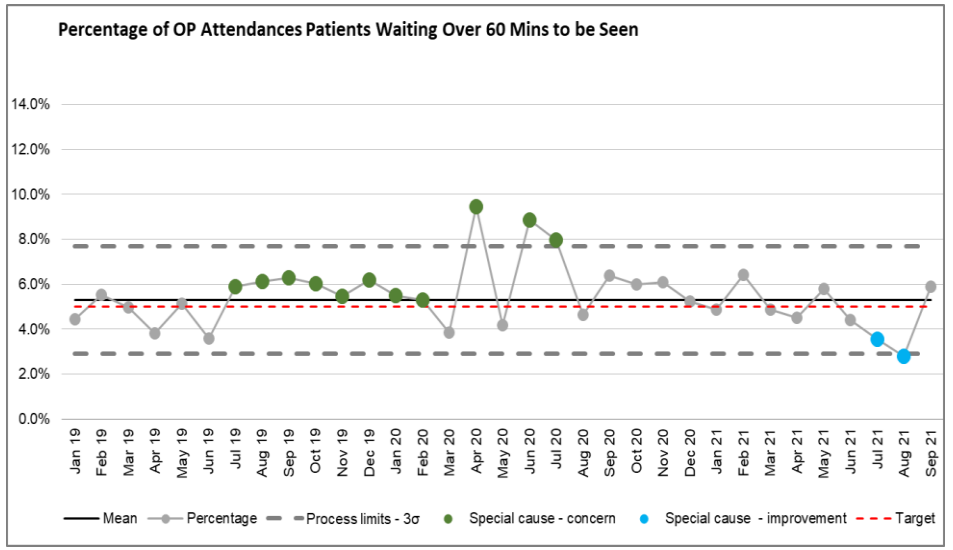
For October UHB data will be sub speciality filtered to allow a comprehensive comparable data review.
A review of TTOS is currently underway to analyse the impact of medicines allocation on timely discharge

-

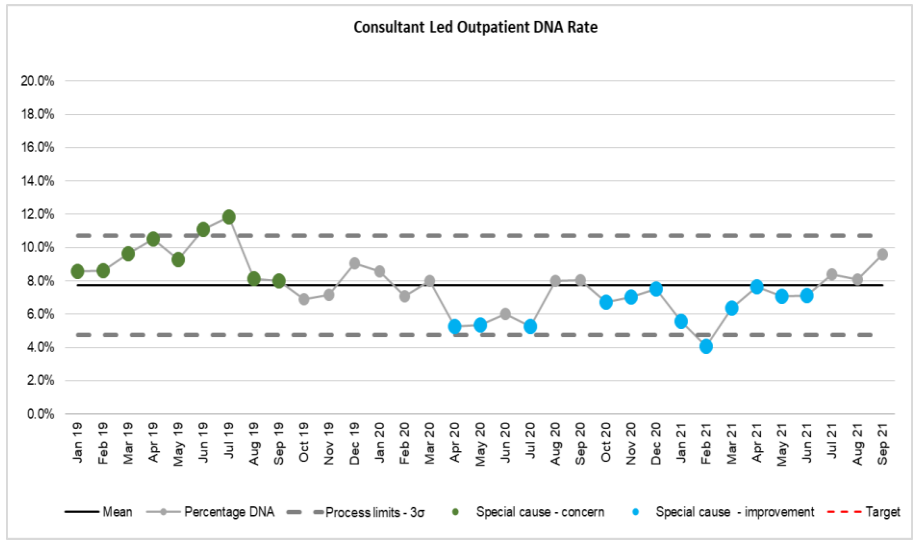
The Discharge Lounge continues to be used by the ROCS/IPC and Tissue Viability Teams, as activity increases, this facility needs to be in place .
Scoping options for where these teams will move to a new permanent location with support from the estates team.

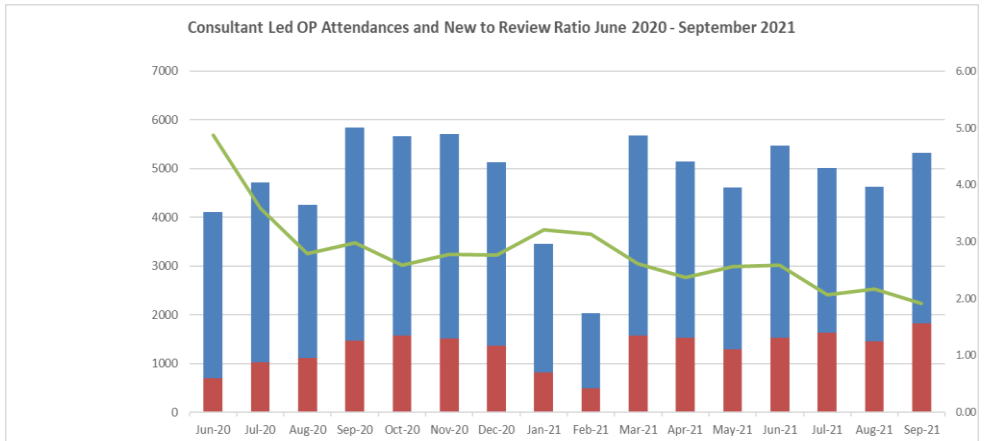
4. Outpatient efficiency



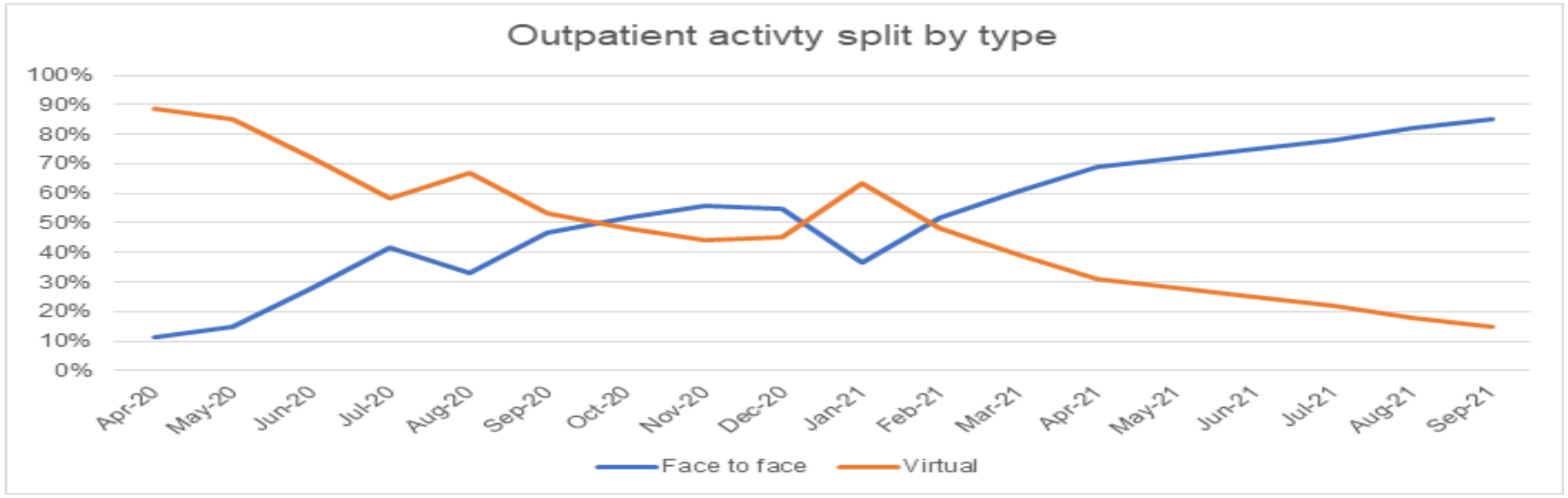


4. Outpatient efficiency





	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
All Follow Up Attendances	3409	3685	3128	4374	4084	4201	3767	2639	1539	4109	3619	3321	3945	3380	3167	3496
All First Attendances	699	1025	1122	1464	1576	1509	1363	822	492	1575	1526	1294	1525	1639	1458	1826
New To Review Ratio	4.88	3.60	2.79	2.99	2.59	2.78	2.76	3.21	3.13	2.61	2.37	2.57	2.59	2.06	2.17	1.91



4. Outpatient efficiency

SUMMARY

30 minute delays - **12.3%** (August **11.9%)** Below Target **10%**
60 minute delays – **3.6%(** August **2.8%**.) Meeting Target **5%**

An analysis of 30 minute delays has shown an increase attributed to the change in clinic templates in some areas back to pre covid booking levels. In some specialities this has resulted in delays due to complexity of the patients now presenting. Following a clinical review clinic times have now been adjusted to allow more time for these consultations. As other specialties are rolled out to pre covid templates clinical oversight is now in place.
A new electronic form is being piloted to manage the patient flow from outpatients to imaging and acts as a communication tool for the clinical team to send down patients from the pods and manage the waiting list of patients to be sent down to imaging as walk ins.

An escalation process is in place for delays in outpatients over 15 minutes which are now escalated to the Operational and Nursing Team and the Outpatient Huddle continues to take place daily and is having a positive impact on processes and the flow within the department as well as improving communication between the nursing and operational teams.

There were 4,532 face to face and 793 virtual appointments carried out in September (15% virtual). This is attributed to patients needing to be seen face to face post Covid . The CSM for Outpatients and Patient Access is working with the Clinical Service Leads to define virtual appointment pathways and encourage greater uptake by the clinical teams and has presented at the September Clinical Service leads meeting to promote engagement.

InTouch has now been upgraded to the new version which has improved functionality to support a better patient experience.

AREAS FOR IMPROVEMENT

The DNA rate for September is 9.7% which is an increase from 8.3% in August. Trust target is 8%. –
A detailed audit of the DNA rates has been undertaken and a sample of 50 patients have been contacted, the audit has demonstrated:

- patients forgot to reschedule their appointment due to being on holiday or busy schedules however they did confirm they had recived have a letter and a text reminder
- Change of address and letter not received. The reception staff have been reminded to check patient details when they do check them in to ensure any changes or amendments are captured
- Patients rescheduled and their previous appointment had not been cancelled by admin team – the rescheduling process and retraining is being rolled out to all staff
- Small number of patients received no notification of appointment by letter or text, this is being investigated with Synertec.

RISKS / ISSUES

A business case for the use of Griffins Brook Medical Centre has been approved and will provide additional outpatient capacity for Clinical Support Services and is due to commence in Q4.

5. Referral to Treatment

Referral to Treatment Snapshot as at 30th September 2021 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2021

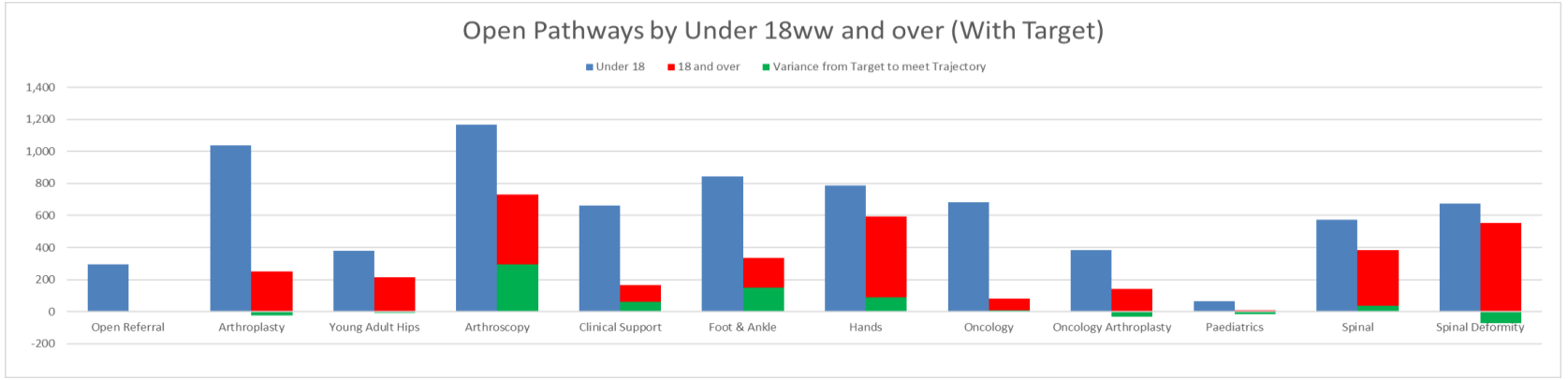
	Est Over 18 Clock Stops Required	
To achieve	71.45%	512
To achieve	74.76%	1051
To achieve	78.07%	1543

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**3,504**	256	542	161	479	294	414	316	368	116	26	247	285
7-13	**2,788**	34	352	133	475	271	294	306	230	185	32	224	252
14-17	**1,264**	4	144	84	213	99	137	165	84	85	7	104	138
18-26	**1,802**	0	161	104	376	125	223	270	59	83	7	140	254
27-39	**990**	0	74	68	218	34	67	178	14	30	1	130	176
40-47	**478**	0	15	37	109	4	34	102	4	22	0	76	75
48-51	**103**	0	1	4	18	4	6	22	2	3	0	14	29
52 weeks and over	**92**	0	1	0	11	1	7	21	1	4	0	25	21
Total	**11,021**	294	1,290	591	1,899	832	1,182	1,380	762	528	73	960	1,230

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,556**	294	1,038	378	1,167	664	845	787	682	386	65	575	675
18 and over	**3,465**	0	252	213	732	168	337	593	80	142	8	385	555
Current Month End RTT %	**68.56%**	**100.00%**	**80.47%**	**63.96%**	**61.45%**	**79.81%**	**71.49%**	**57.03%**	**89.50%**	**73.11%**	**89.04%**	**59.90%**	**54.88%**

30/09/2021 Trajectory RTT %	71.45%	100.00%	78.93%	63.09%	72.80%	86.15%	81.98%	60.99%	90.44%	69.01%	74.31%	62.37%	51.85%
Target for RTT Trajectory	3,020	0	277	221	436	107	186	503	72	173	22	347	627
Variance from Target to meet Trajectory	445	0	-25	-8	296	61	151	90	8	-31	-14	38	-72



5. Referral to Treatment

Referral to Treatment Snapshot as at 30th September 2021 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2021

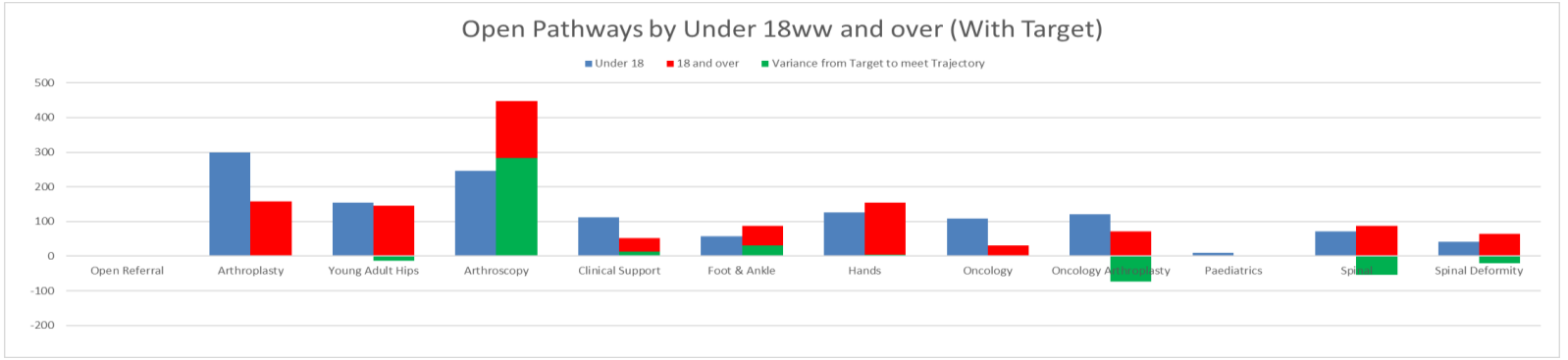
Est Over 18 Clock Stops Required		
To achieve	56.60%	307
To achieve	74.76%	973
To achieve	78.07%	1061

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**550**	0	112	53	78	52	21	61	59	53	5	37	19
7-13	**479**	0	111	62	94	27	21	50	38	43	1	20	12
14-17	**319**	0	77	40	74	33	16	16	11	24	3	14	11
18-26	**609**	0	97	66	209	37	45	49	19	37	1	26	23
27-39	**389**	0	52	48	137	15	17	54	7	16	1	20	22
40-47	**217**	0	8	29	79	0	17	35	2	15	0	19	13
48-51	**47**	0	1	2	14	0	4	11	1	3	0	8	3
52 weeks and over	**39**	0	0	0	9	0	4	6	1	1	0	15	3
Total	**2,649**	0	458	300	694	164	145	282	138	192	11	159	106

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,348**	0	300	155	246	112	58	127	108	120	9	71	42
18 and over	**1,301**	0	158	145	448	52	87	155	30	72	2	88	64
Current Month End RTT %	50.89%	n/a	65.50%	51.67%	35.45%	68.29%	40.00%	45.04%	78.26%	62.50%	81.82%	44.65%	39.62%

30/09/2021 Trajectory RTT %	56.60%	100.00%	65.40%	49.48%	59.99%	74.38%	51.13%	45.73%	80.15%	45.12%	78.57%	33.42%	33.00%
Target for RTT Trajectory	1,034	0	159	158	164	39	55	151	27	146	2	141	85
Variance from Target to meet Trajectory	267	0	-1	-13	284	13	32	4	3	-74	0	-53	-21



5. Referral to Treatment

Referral to Treatment Snapshot as 30th September 2021 (Non Admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2021

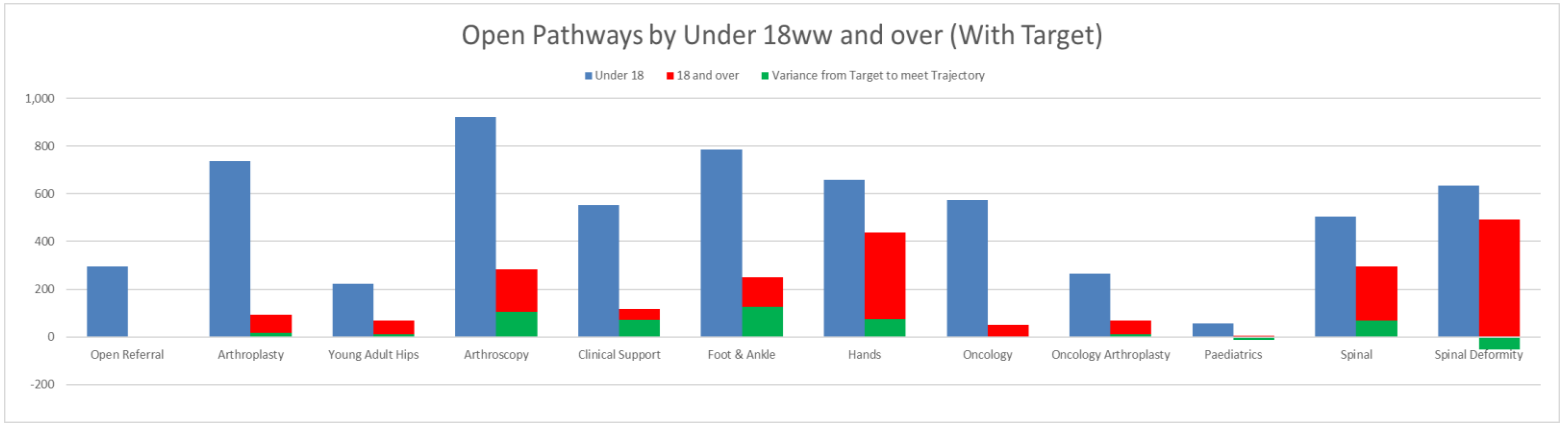
Est Over 18 Clock Stops Required		
To achieve	77.42%	407
To achieve	74.76%	78
To achieve	78.07%	483

Select Pathway Type: Non Admitted

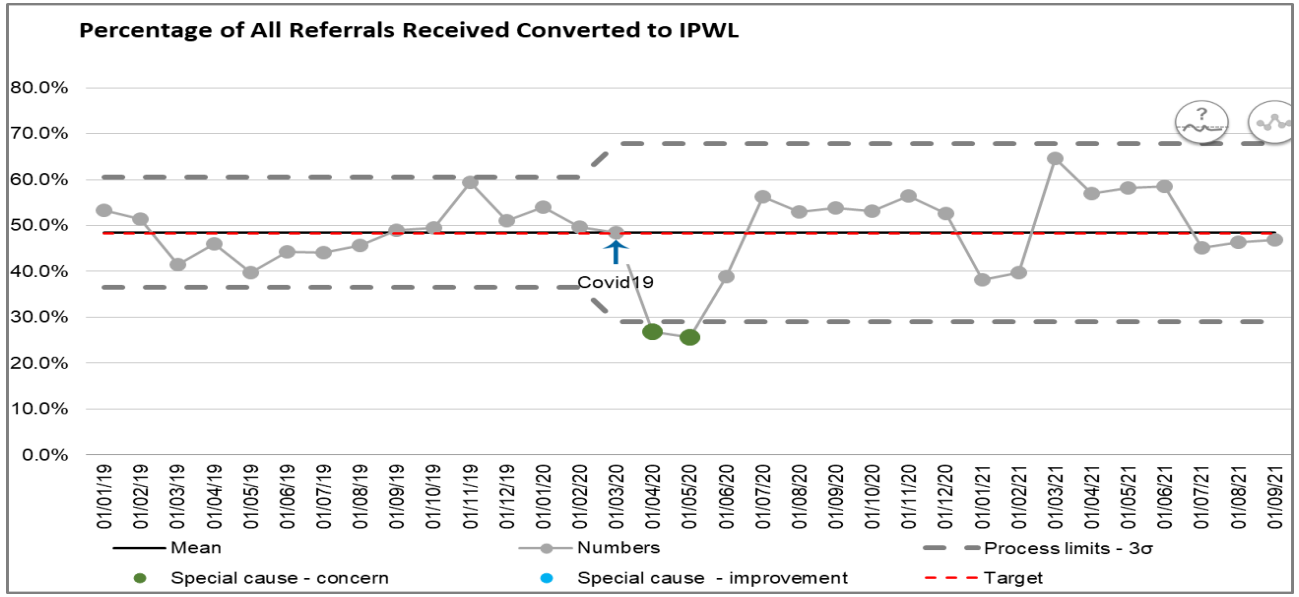
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,954**	256	430	108	401	242	393	255	309	63	21	210	266
7-13	**2,309**	34	241	71	381	244	273	256	192	142	31	204	240
14-17	**945**	4	67	44	139	66	121	149	73	61	4	90	127
18-26	**1,193**	0	64	38	167	88	178	221	40	46	6	114	231
27-39	**601**	0	22	20	81	19	50	124	7	14	0	110	154
40-47	**261**	0	7	8	30	4	17	67	2	7	0	57	62
48-51	**56**	0	0	2	4	4	2	11	1	0	0	6	26
52 weeks and over	**53**	0	1	0	2	1	3	15	0	3	0	10	18
Total	**8,372**	294	832	291	1,205	668	1,037	1,098	624	336	62	801	1,124

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,208**	294	738	223	921	552	787	660	574	266	56	504	633
18 and over	**2,164**	0	94	68	284	116	250	438	50	70	6	297	491
Current Month End RTT %	**74.15%**	100.00%	**88.70%**	**76.63%**	**76.43%**	**82.63%**	**75.89%**	**60.11%**	**91.99%**	**79.17%**	**90.32%**	**62.92%**	**56.32%**

30/09/2021 Trajectory RTT %	77.42%	100.00%	90.70%	79.50%	83.73%	92.53%	86.27%	64.50%	92.43%	82.05%	73.88%	68.73%	53.84%
Target for RTT Trajectory	1,810	0	76	58	179	45	125	363	47	58	20	229	543
Variance from Target to meet Trajectory	354	0	18	10	105	71	125	75	3	12	-14	68	-52

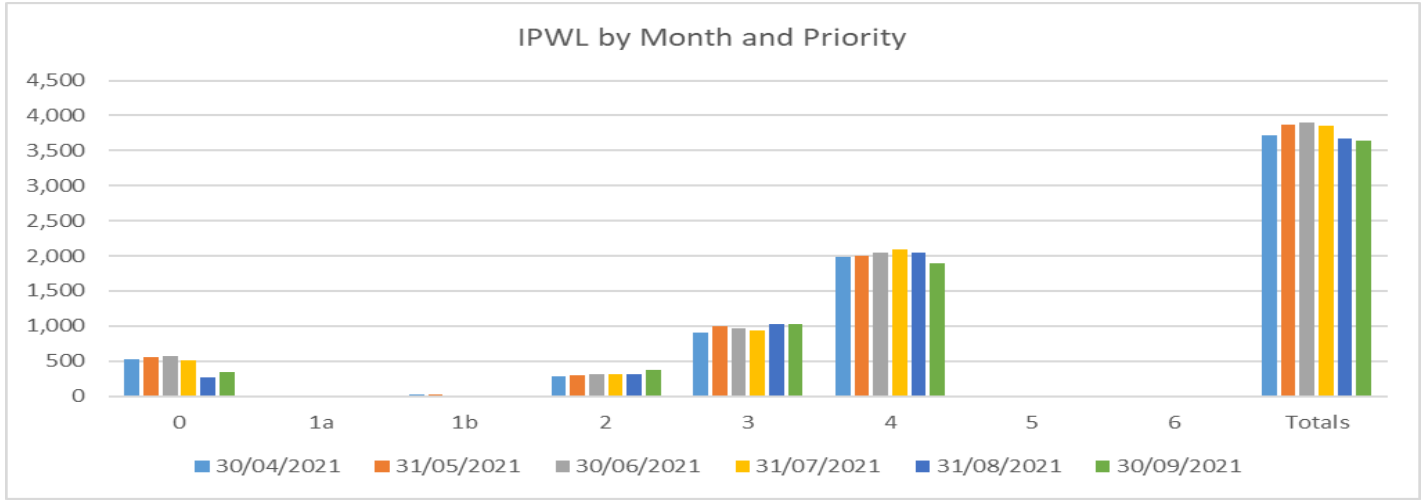


5. Referral to Treatment

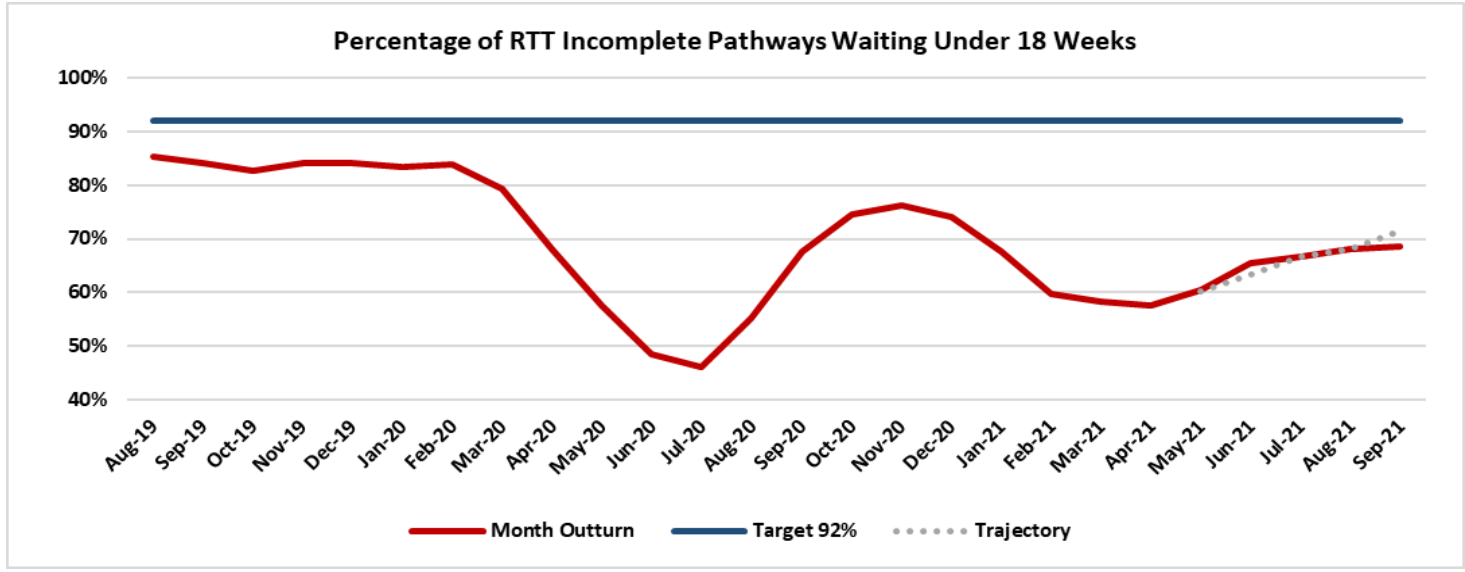


Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Number of Referrals	996	1154	1212	1576	1521	2031	2019	1796	1700	1560	1431	1954	2344	2292	2584	2428	2273	2453
Number of IPWL Additions	268	295	470	887	806	1095	1074	1014	893	596	569	1264	1336	1334	1511	1096	1054	1149
Percentage of All Referrals Received Converted to IPWL	**26.91%**	**25.56%**	**38.78%**	**56.28%**	**52.99%**	**53.91%**	**53.19%**	**56.46%**	**52.53%**	**38.21%**	**39.76%**	**64.69%**	**57.00%**	**58.20%**	**58.48%**	**45.14%**	**46.37%**	**46.84%**

5. Referral to Treatment



5. Referral to Treatment



ALL Pathways	RTT Trajectory as at:																	
	31/07/2021	31/08/2021	30/09/2021	31/10/2021	30/11/2021	31/12/2021	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	31/11/2022	31/12/2022
Under 18 Weeks	6,747	6,861	7,420	7,832	8,143	8,423	8,749	9,033	9,282	9,375	9,448	9,523	9,578	9,605	9,625	9,629	9,639	9,648
18 Weeks and Over	3,367	3,227	2,966	2,644	2,288	1,967	1,774	1,533	1,318	1,147	1,057	964	902	859	821	798	778	768
Total ALL Pathways	10,114	10,087	10,386	10,476	10,431	10,391	10,523	10,567	10,601	10,522	10,505	10,487	10,479	10,463	10,446	10,427	10,417	10,416
ALL RTT %	66.71%	68.01%	71.45%	74.76%	78.07%	81.07%	83.14%	85.49%	87.56%	89.10%	89.94%	90.81%	91.40%	91.79%	92.14%	92.35%	92.53%	92.63%
Month % Movement	3.30%	1.30%	3.43%	3.31%	3.31%	3.00%	2.08%	2.35%	2.07%	1.54%	0.84%	0.87%	0.59%	0.40%	0.35%	0.20%	0.18%	0.10%

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for September is **68.56%** against the National compliance target of 92% and is just below the agreed trajectory . This is an increase compared to August 21 reporting at **68.02%** and is reflective of the increase in elective procedures in month. There are 92 patients over 52 weeks, an increase from **85** in August - **39** admitted and **53** non-admitted with plans or actions in place to progress these pathways or patients.

All patients over 52 weeks have or will be reviewed through the harm review process. No harm has been concluded on all patients to date. 581 patients are waiting over 40-51 weeks. All patients in this category are being contacted and regularly reviewed by their clinical teams on a monthly basis.

At PTL meetings P1 ,P2 and P3 patients are reviewed weekly to ensure they are booked for surgery in the appropriate timeframe for their set priority in line with the national guidance for clinical prioritisation of patients awaiting surgery, **2649** patients are on the admitted waiting list **(P2 – 325 patients, P3 – 917 patients, P4 – 1279 patients, P5 – 2 patients, P6 – 0 patients**.

Referrals continue to move towards Pre-Covid levels with 2,453 (91%) referrals received in September 2021, the average monthly referrals received Pre-Covid (2,704)

IPWL as at 30/09/2021 is 10.6% higher than the Last Pre-Covid Position (3,297 as at 28/02/2020)

We are continuing to working closely with the CCG and GP's to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure we keep in regular contact and update the CCG and GP's on the current position and mutual aid support being provided.
An ERS working group is in place to actively monitor referrals and provide updated regular communications to the GP's.

AREAS FOR IMPROVEMENT

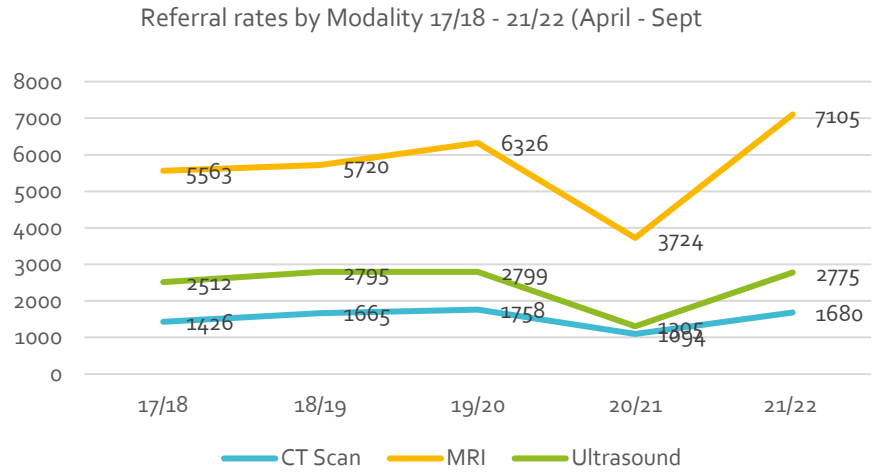
Weekly PTL meetings and RTT Trajectory and Activity monitoring meetings are in place to monitor compliance and to ensure we are actively progressing patients through their pathways.

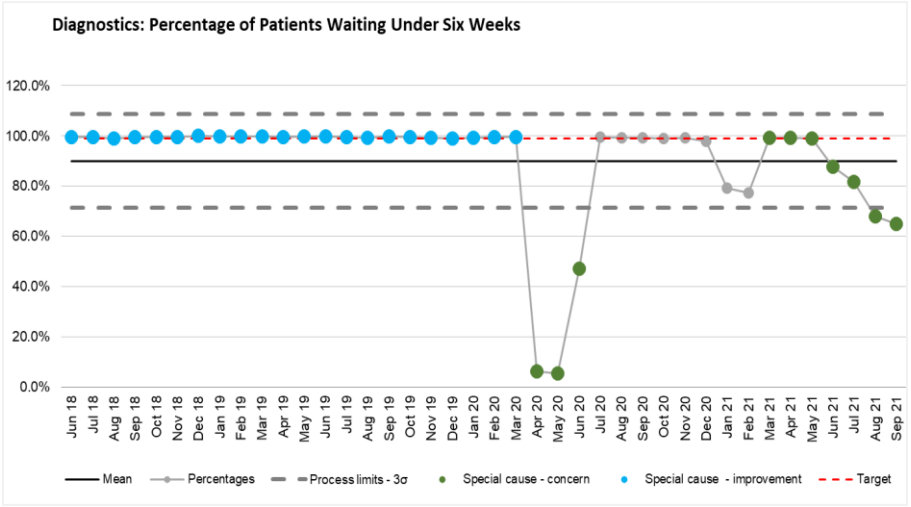
RISKS / ISSUES

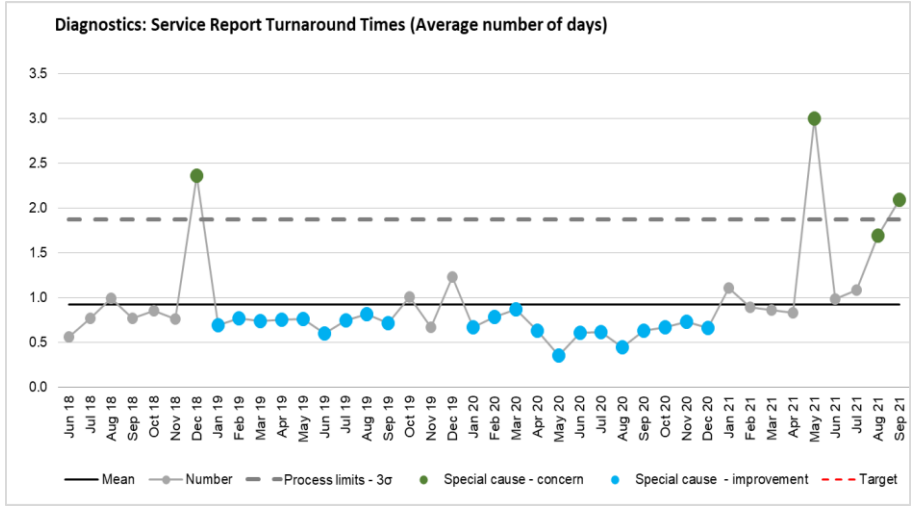
6. Diagnostic Performance

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

	Pending Patients still waiting at month end							Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Sep-20	611	129	131	871	6	865	99.3%	704	179	303	1186
Oct-20	868	127	186	1181	11	1170	99.1%	761	235	332	1328
Nov-20	877	82	127	1086	7	1079	99.4%	866	238	379	1483
Dec-20	941	139	200	1280	25	1255	98.0%	787	206	319	1312
Jan-21	815	110	196	1121	232	889	79.3%	759	214	182	1155
Feb-21	533	37	127	697	159	538	77.2%	583	205	234	1022
Mar-21	645	61	174	880	6	874	99.3%	804	197	284	1285
Apr-21	776	68	182	1026	8	1018	99.2%	770	233	298	1301
May-21	956	93	353	1402	14	1388	99.0%	599	166	299	1064
Jun-21	1268	64	287	1619	201	1418	87.6%	807	248	391	1446
Jul-21	1390	53	317	1760	324	1436	81.6%	911	212	318	1441
Aug-21	1492	54	376	1922	613	1309	68.1%	768	186	277	1231
Sep-21	1656	82	504	2242	786	1456	64.9%	1001	171	298	1470







6. Diagnostic Performance

SUMMARY

Imaging did not meet the diagnostic target in September reporting 64.94%. Reporting times are good despite leave during August and September.

The department continued to see significant increases in referrals in September with MRI at 128% and Ultrasound at 107% when compared to the same period in 19/20. CT remains within target.

The 2nd MRI scanner experienced a fault which resulted in 2 ½ days of reduced capacity at the end of September and beginning of October, it has since been rectified with no further issues reported. Additional mobile MRI van capacity will be available from mid October until the end of November which will have a positive impact on the recovery of the MRI target.
A review of Consultant Radiologist job plans has realised additional capacity and the commencement of additional lists on Saturdays has also begun, these combined measures has increased capacity by an extra 20 hrs. per week

AREAS FOR IMPROVEMENT

To continue to ensure all capacity is fully utilised.

RISKS / ISSUES

The impact of social distancing and new processes to meet IPC recommendations is currently being scoped and the working day increased to provide appropriate capacity going forward.
Increasing levels of referrals risk delivering the diagnostic target for MRI and Ultrasound for October but is being monitored closely by the team to mitigate where possible.

7. Cancer Performance

		August 2021 (Complete)				July 2021 (Complete)			
Target Name	National Standard	%	In target	Breach	Total	%	In target	Breach	Total
2ww	93%	98%	46.00	1.00	47.00	95%	61.00	3.00	64.00
31 day first treatment	96%	100%	6.00	0.00	6.00	100%	15.00	0.00	15.00
31 day subsequent (surgery)	94%	100%	5.00	0.00	5.00	100%	5.00	0.00	5.00
62 day (traditional)	85%	67%	1.00	0.50	1.50	30%	1.50	3.50	5.00
62 day (Cons Upgrade)	n/a	63%	2.50	1.50	4.00	69%	5.50	2.50	8.00
28 day FDS REPORTED	75%	87%	58	9	67	89%	81	10	91

7. Cancer Performance

SUMMARY

Performance against 2 week wait, 31 day first and subsequent surgery and 28 day FDS performance continued in a positive trajectory in August. As predicted, there continued to be a drop in performance in August for the 62 day traditional target due to low numbers having been allocated to the ROH. September figures are not finalised to date as further treatments will be added to Somerset.

Contributing factors for August performance include:
0.5 shared breach – patient COVID positive causing a delay in diagnosis. Diagnosis made on day 70 and subsequent delays are attributable to surgical capacity at UHB.

31 patients have been referred from RJAH as part of the SLA of which 22 have had surgery

AREAS FOR IMPROVEMENT

RMS pathways and implementation continues – system issues have delayed the 6th September start date, however this gives further opportunity to test the new pathway. A new date is to be confirmed for early November
Pathology database transition work ongoing – Jon Stevenson is Consultant lead
NJR form designed for Metastatic Bone Disease

RISKS / ISSUES

Ultrasound capacity is challenged due to the increase in 2ww referrals however the Teams have identified a solution that provides a increase in available slots for Oncology and this will be monitored over the coming weeks.

8. Overall Financial Performance

SUMMARY

The Trust delivered a break even position year to date against a break even plan.

Income year to date is overperforming against plan by £2,469k. This is an increase on last month of £1,891k.

ERF income recognised to date is £3,267k against a year to date plan of £1,900k.

Pay and non pay expenditure overspent year to date by £2.469k. There was an increase in month of £671k compared to August expenditure.

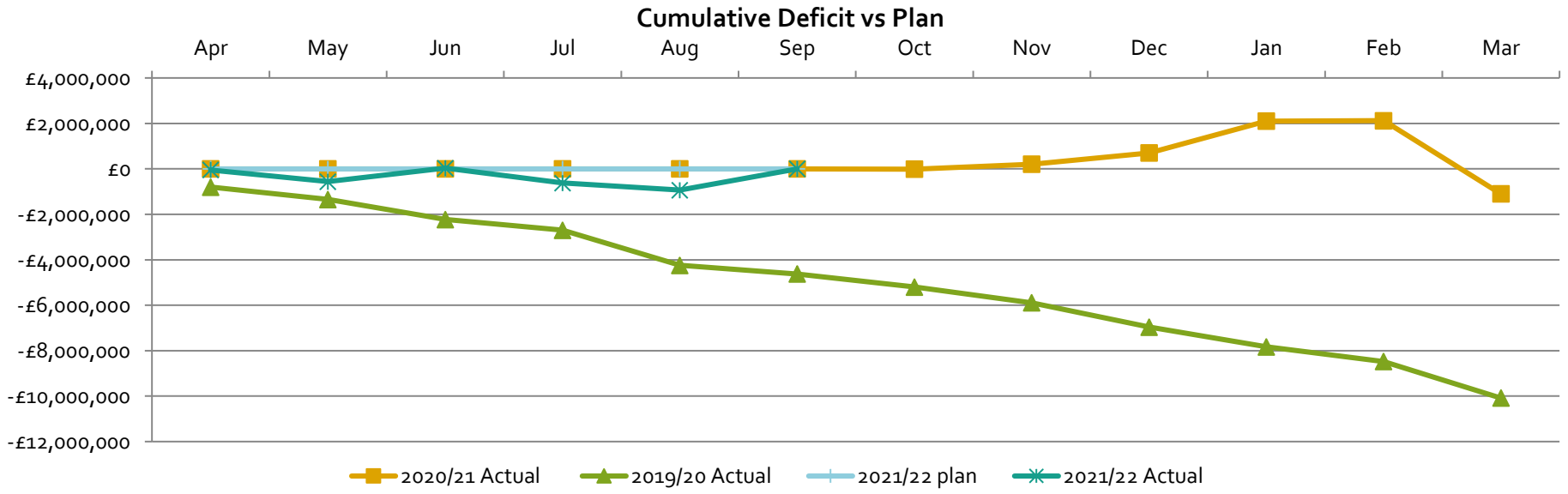
Capital expenditure to date is slightly overspent by £25k with £1,428k spent against a plan of £1,403k. Forecast overspend of £46k with £3,198k against a plan of £3,152k, which is in line with the capital limits set for the organisation.

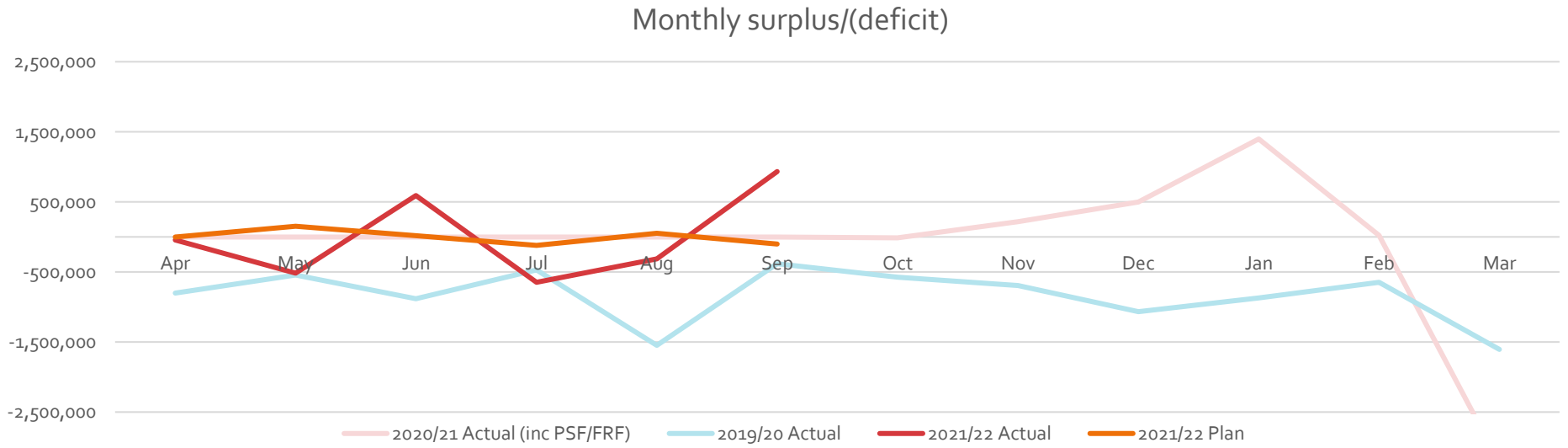
	£'000s			
	Income	Pay	Non Pay	Total
Year to date Variance	2,469	(1,367)	(1,102)	0
Year to date plan	52,321	(29,127)	(23,194)	0
Year to date actual	54,790	(30.494)	(24,296)	0
Actual compared to previous month	▲	▲	▲	▲
Forecast Variance				

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	50,338	52,311	1,973
Other Operating Income (Excluding top up)	1,983	2,479	496
Total Income	52,321	54,790	2,470
Employee Expenses (inc. Agency)	(29,127)	(30,494)	(1,367)
Other operating expenses	(22,816)	(23,635)	(819)
Operating Surplus	378	661	283
Net Finance Costs	(412)	(408)	4
Net surplus/(deficit)	(33)	253	287
Remove donated asset I&E impact	34	(253)	(287)
Adjusted financial performance	0	0	0
Non recurrent funding			
Underlying surplus/(deficit)			

8. Overall Financial Performance





9.Income

SUMMARY

Income year to date is overperforming against plan by £2,469k. This is an increase in income on last month of £1,891k. This is largely as a result of £1,362k of Elective Recovery Fund (ERF) income recognised in month and £3,267k year to date, against a year to date plan of £1,900k.

In addition Income has been accrued for in month relating to the funding of the back dated pay award for all Agenda for Change staff, this totalled £715k.

ROH performance would have generated £3,995k in ERF income if the system target had been achieved. The system are currently underperforming against the ERF target.

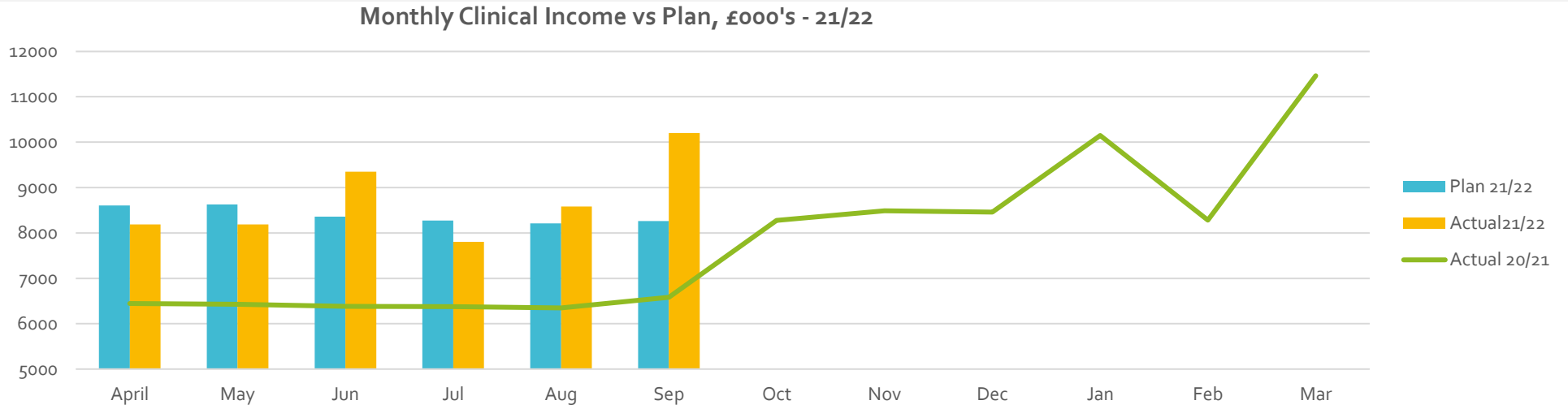
AREAS FOR IMPROVEMENT

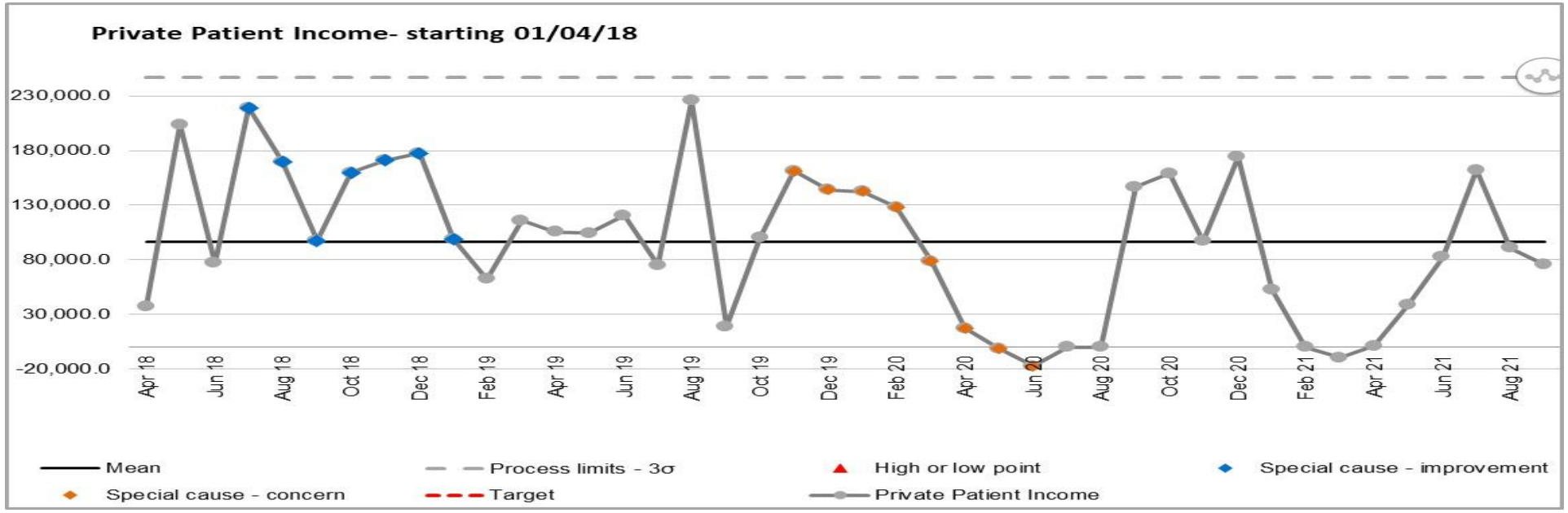
Other income whilst above plan are still below 2019/20 levels. This includes; car parking, catering and accommodation.

RISKS / ISSUES

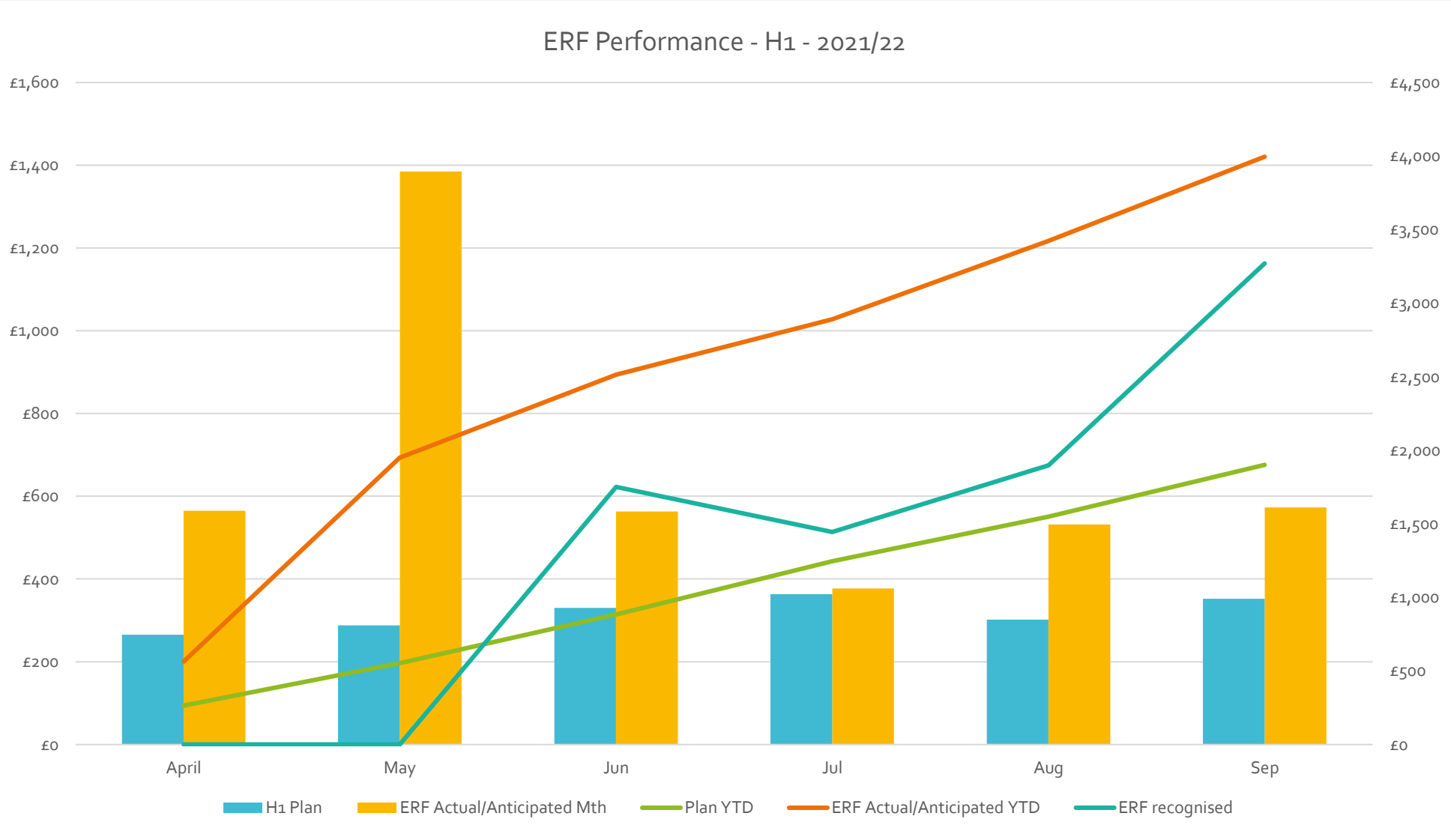
Elective Recovery Fund (ERF) income estimated to be achieved in H2 is yet to be finalised as a system. The ERF target is now based on a percentage position of Referral to Treatment (RTT) target.

9. Income


Monthly Clinical Income vs Plan, £000's - 21/22
12000
11000
10000
9000
8000
7000
6000
5000
April
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan 21/22
Actual21/22
Actual 20/21


Private Patient Income- starting 01/04/18
230,000.0
180,000.0
130,000.0
80,000.0
30,000.0
-20,000.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

9. Income


ERF Performance - H1 - 2021/22
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
April
May
Jun
Jul
Aug
Sep
H1 Plan
ERF Actual/Anticipated Mth
Plan YTD
ERF Actual/Anticipated YTD
ERF recognised

9. Expenditure

SUMMARY

Pay and non pay expenditure overspent year to date by £2,469k, which has been driven by increased activity against original plan.

The Agenda for Change pay award back dated to April 2021 has been recognise din month at £715k with the same level of income recognised to neutralise this expenditure.

The Trust are expecting to receive H2 allocations imminently, and will update the F&P Committee on the key impacts. Once the allocations have been made available, budgets will be able to be allocated for H2.

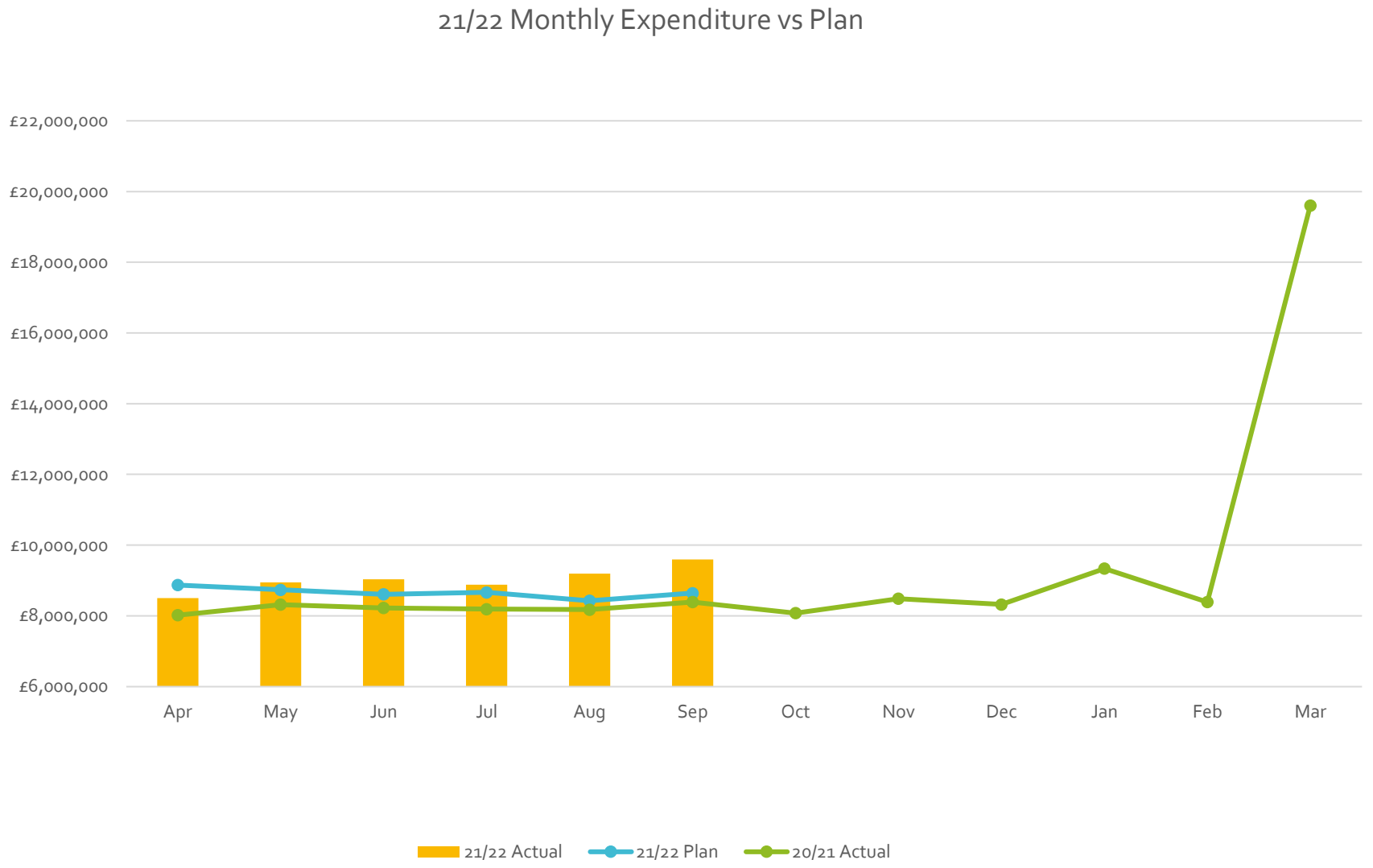
AREAS FOR IMPROVEMENT

Agency spend is slightly above plan year to date by £137k. Agency costs as a percentage of total staff costs has remained almost static compared to last month at 6.1%. This is an increase from 4.6% in 2020/21, and is above planned levels of 5.9%.

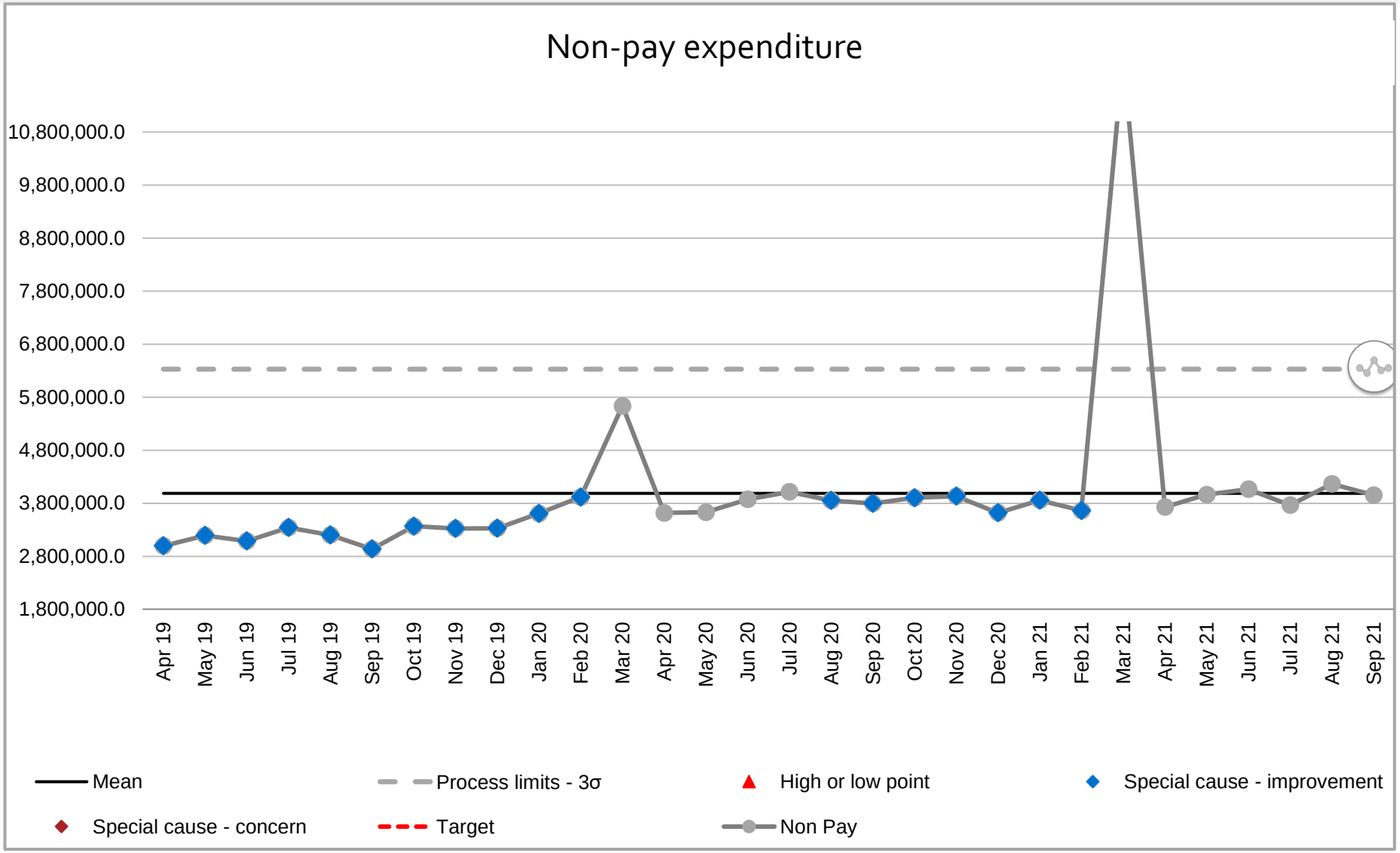
RISKS / ISSUES

As described above, the H2 financial plan not yet been agreed as the funding envelope has not yet been allocated to the ICS, although this is expected to occur imminently.

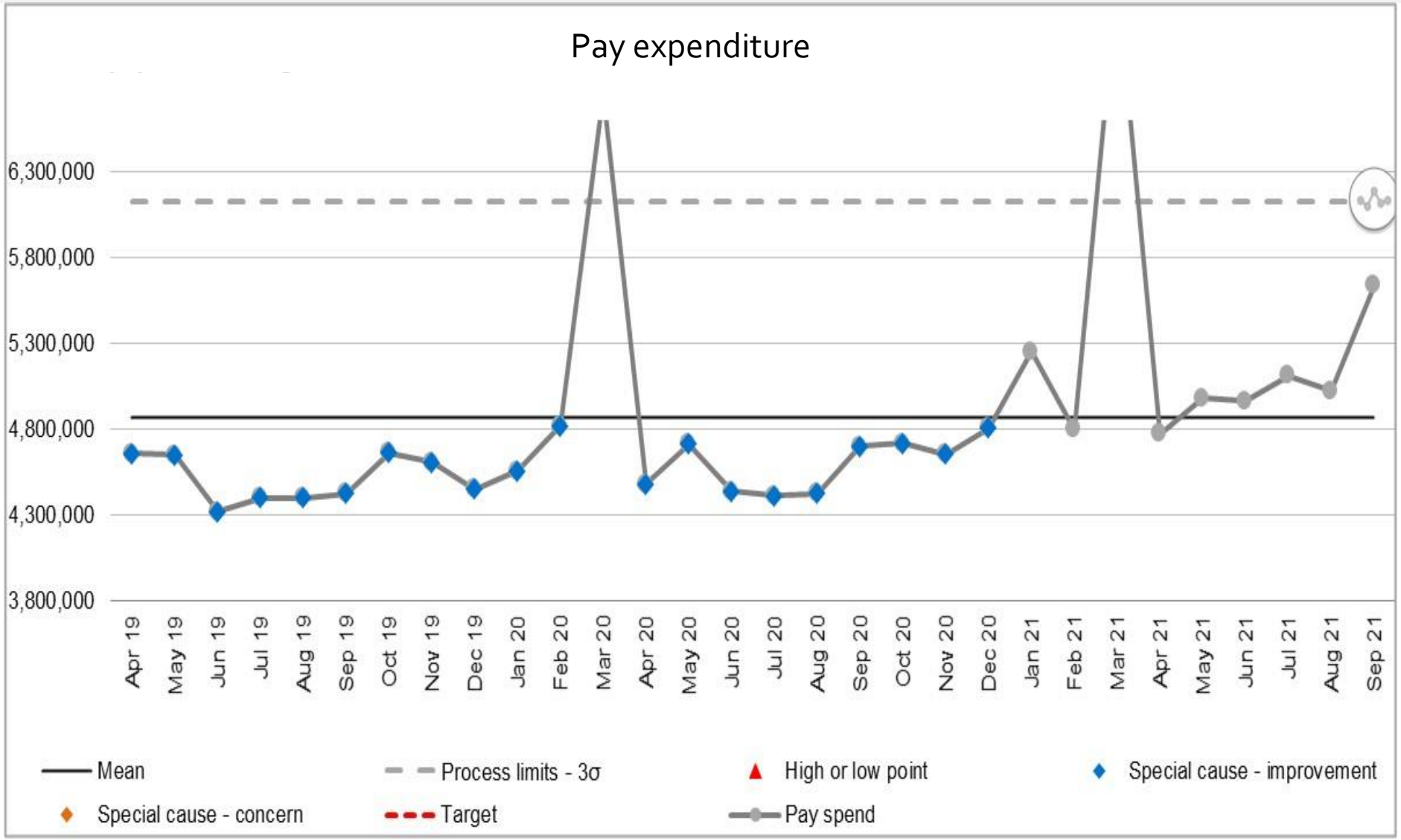
9. Expenditure



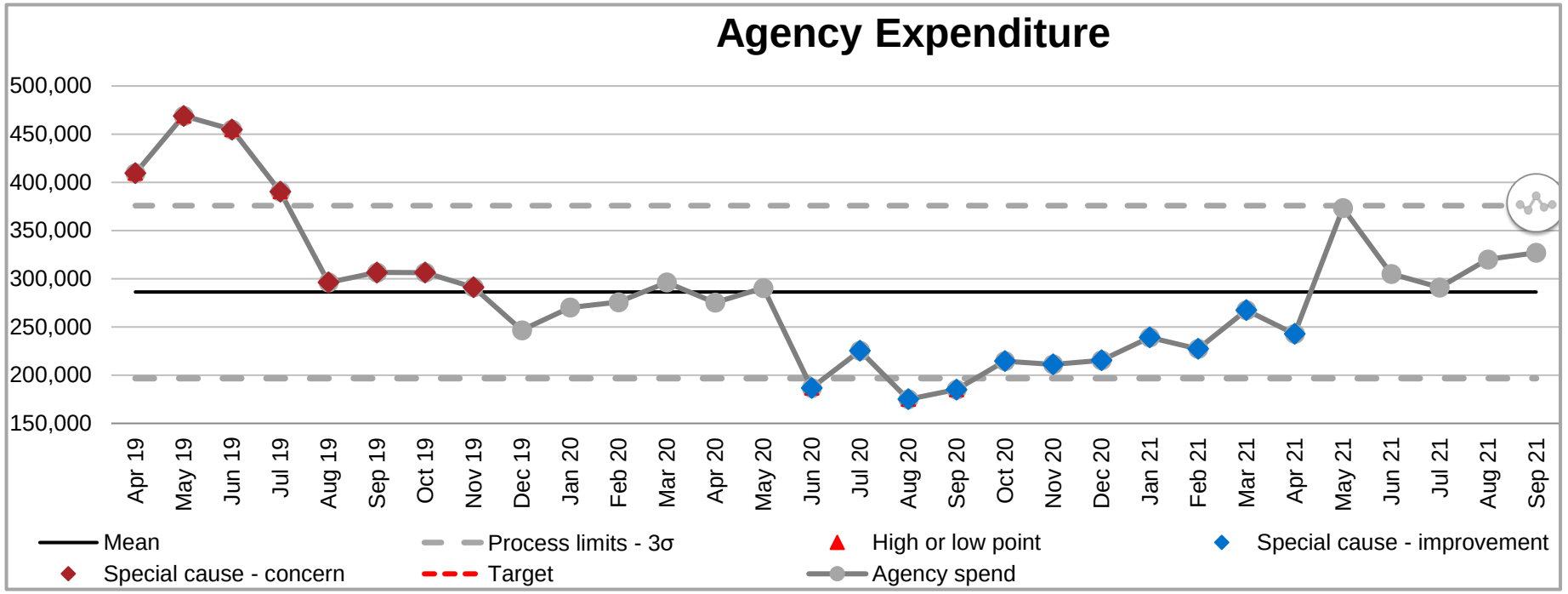
9. Non Pay Expenditure



9. Pay Expenditure

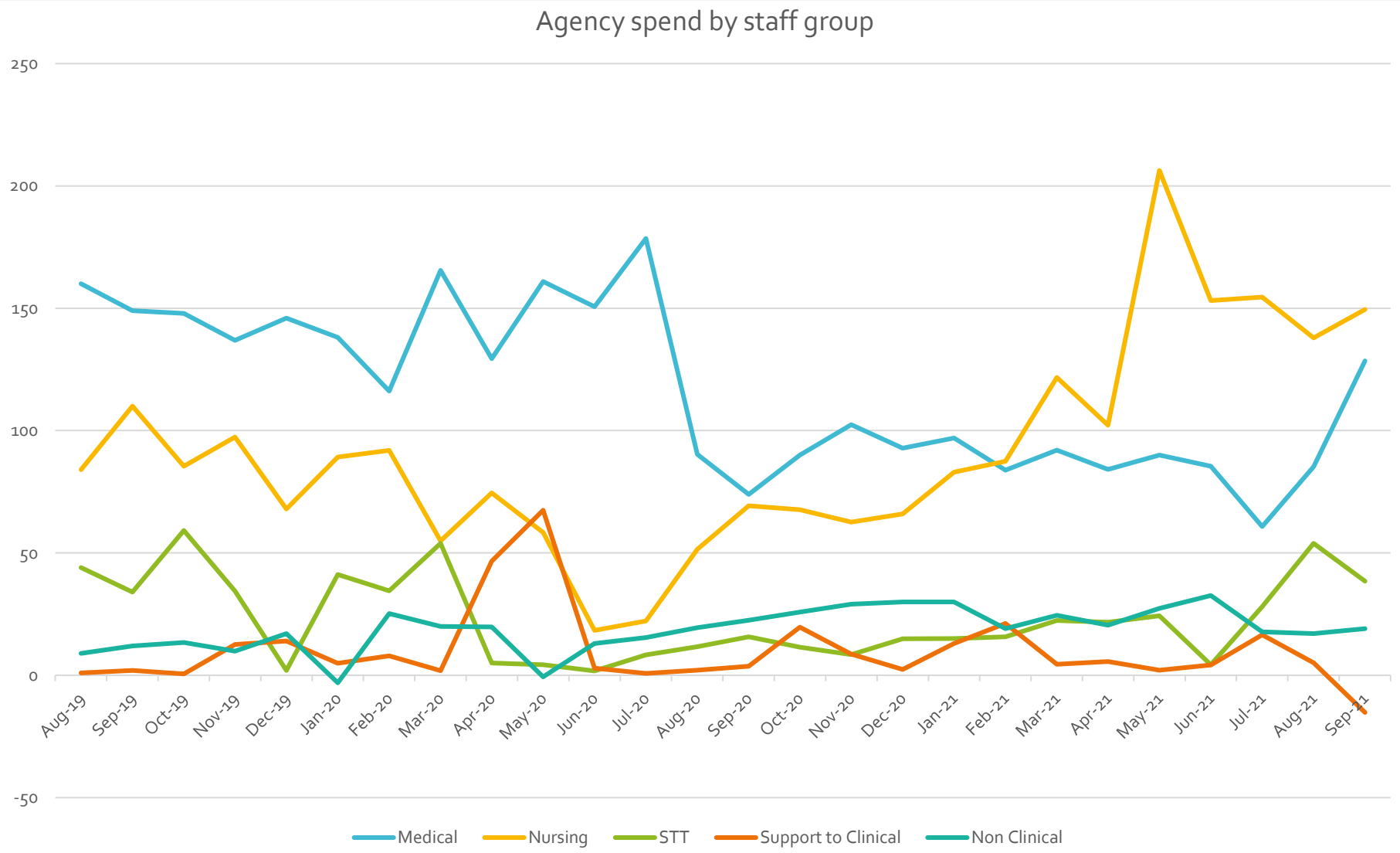


11. Agency Expenditure



	Year to date Spend (£'000s)			
	Agency	Bank	Substantive	Total
Medical staff	534	331	7,490	8,355
Clinical Staff (exc medical staff)	1,088	1,208	11,362	13,658
Non clinical staff	237	718	7,422	8377
Total	1,859	2,256	26,274	30,389

11. Agency expenditure



12. Cost Improvement Programme Summary

SUMMARY

Efficiencies totalling £657k have been recognised year to date with £2,748k expected to be delivered in total during 2021/22. The most significant scheme delivering savings to date is non pay procurement savings. The planning assumptions for H1 expected CIP of 2.15%, £1,236k to be delivered. H2 it is expected to be 3%.

CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£132	£77	-55	£77
Non Pay	£1,076	£555	-521	£2256
Income	£118	£25	-93	£195
Total	**£1,326**	**£657**	**-£669**	**£2,830**

Scheme	Confidence level of delivery	Year to Date (£'000s)		
		Plan	**Actual**	**Forecast**
VAT recovery on Consumables and Prosthesis	High	£696	£0	£1,391
Procurement - Birmingham Hospital Alliance Collaborative	Med	£229	£489	£738
Private patient service expansion	High	£60	£25	£145
Diagnostics and Therapies - Synertec	High	£68	£0	£135
Microsoft 365 Licence review	High		£53	£96
Spinal Implant Rationalisation & Modernisation	Med	£45	£0	£90
Substantive Medical recruitment - reduce agency spend and DE saving	Med	£132	£77	£77
Enhanced Voice Recognition - Digital Dictation	Med	£30	£0	£60
DNA Rate Reduction - OP	Med	£25	£0	£50
Managed Patient Communications via Synertec	High	£0	£14	£28
Interpreting via telephone	Med	£9	£0	£18
Employee benefits scheme - VIVUP scheme	Med		£2	£2

13. Statement of Financial Position

SUMMARY

The cash balance has increased in comparison to the year end, largely due to an expected credit note being received from a supplier, in addition to timing differences at the month end on payables.

	2020/21 M12	2021/22 M6	Movement
	(£'000)		
Intangible Assets	1,255	1,164	-91
Tangible Assets	45,798	46,039	241
Total Non Current Assets	**47,053**	**47,203**	150
Inventories	1,800	1,811	11
Trade and other current assets	8,492	9,241	749
Cash	5,703	7,801	2,098
Total Current Assets	**15,995**	**18,852**	2,857
Trade and other payables	(11,396)	(13,693)	-2,297
Borrowings	(877)	(555)	322
Provisions	(2,758)	(3,448)	-690
Other Liabilities	(344)	(496)	-152
Total Current Liabilities	**(15,375)**	**(18,192)**	-2,817
Borrowings	(1,009)	(946)	63
Provisions	(1,029)	(1,029)	0
Total Non Current Liabilities	**(2,038)**	**(1,975)**	63
Total Net Assets Employed	**45,635**	**45,888**	253
Total Taxpayers' and Others' Equity	**45,635**	**45,888**	253

14. Workforce

SUMMARY

In September, over 90% of staff had completed their mandatory training within the last 12 months which is the highest this has been since March 2020. Staff have been completing their mandatory training through e-Learning over the last year, with new starters supported to complete their mandatory training prior to starting.

Turnover (both Unadjusted and Adjusted) has been increasing over the last few months and at the moment, turnover unadjusted stands at 11.27% which is the highest it has been since 2018.

The percentage of staff attendance in the month has remained constant with previous months and the percentage of staff who had an appraisal in the last 12 months dropped slightly.

There were 196 agency breaches in September, a rise of 8 compared to 188 in August. The entirety of this was medical usage.

AREAS FOR IMPROVEMENT

Turnover figures should be monitored over the next few months to understand the impact of the new process for turnover reporting, in combination with returning to a pre-pandemic time.

Manager Dashboard on Electronic Staff Record to be finalised shortly to support with data quality issues when reporting on workforce metrics and allow managers to view their own workforce data.

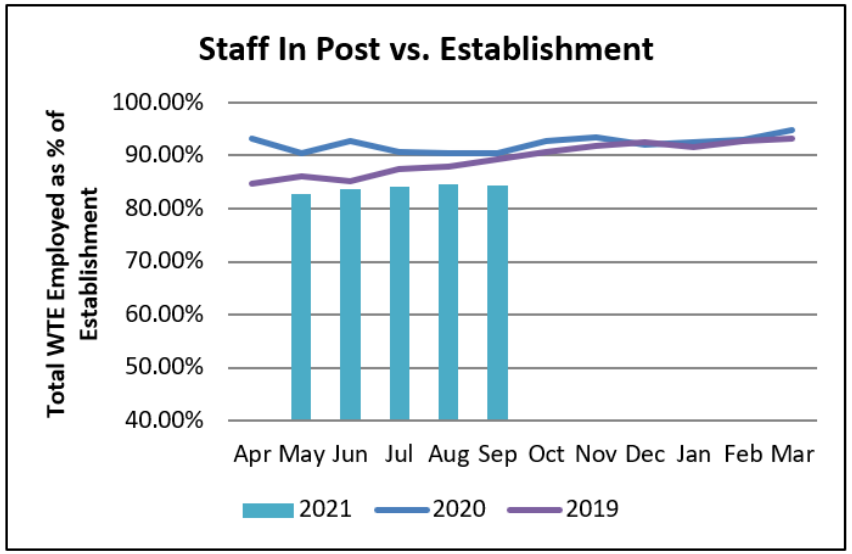
RISKS / ISSUES

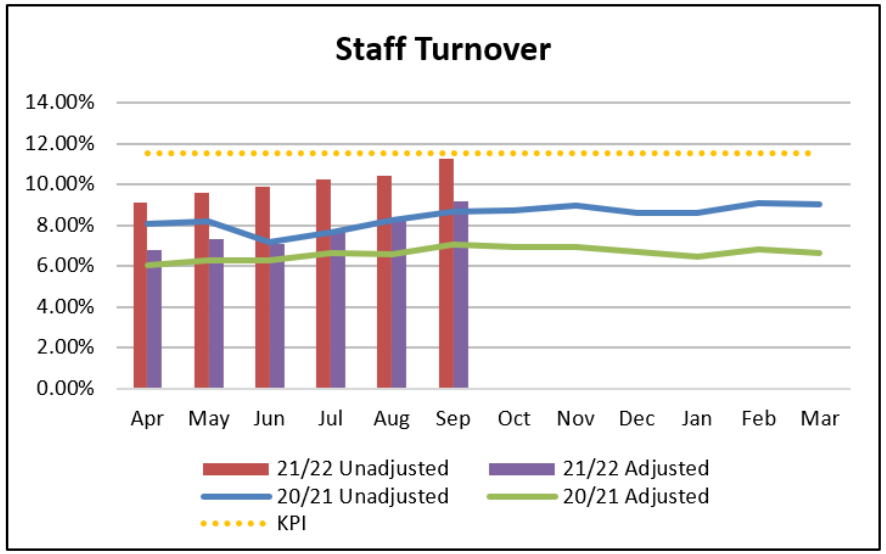
A new process was implemented in April 2021 to support with more accurate reporting of staff turnover. Since this launch the figures have slowly increased.

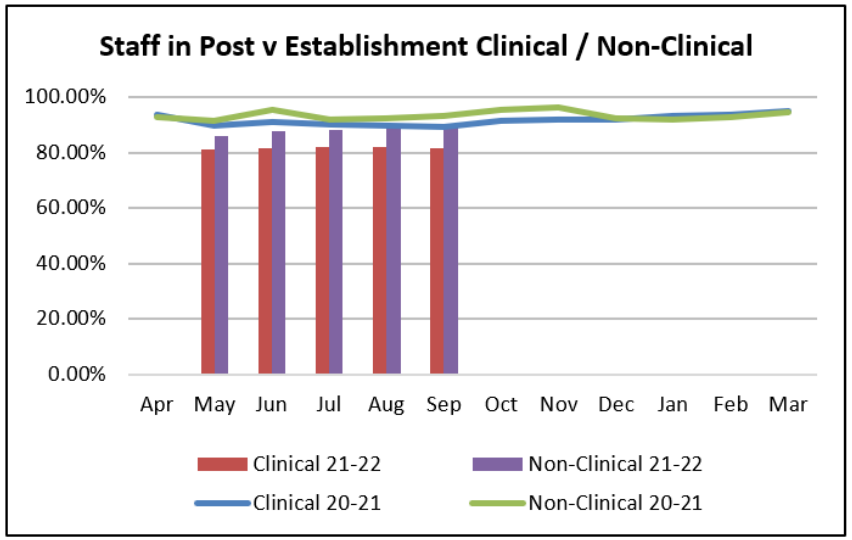
Turnover pre-COVID was just above 10%, so this may not be an unusual trend for the Trust, and also reflect how more staff where retained through the peaks of the COVID pandemic.

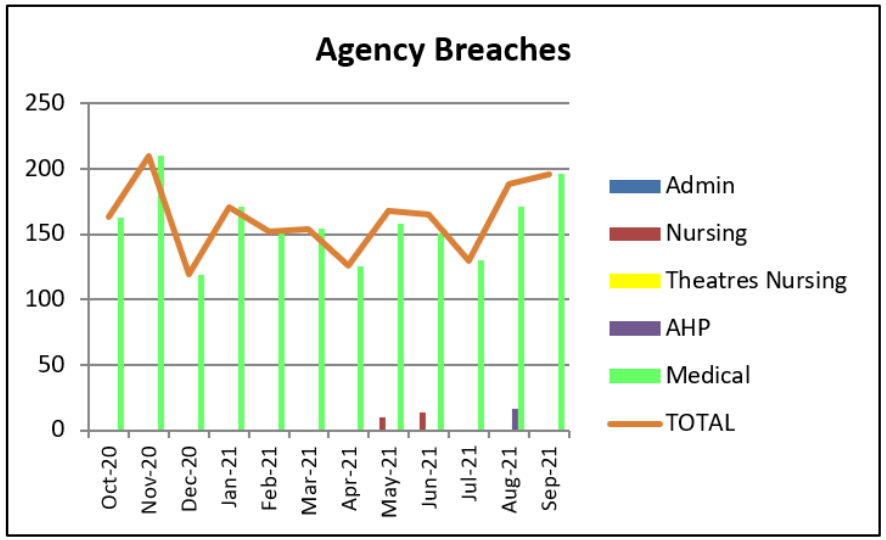
We anticipate that over the next few months, attendance will decrease as we come into the winter months. Staff are being encouraged to have their flu vaccinations which should hopefully help with minimising the impact of this.

14. Workforce

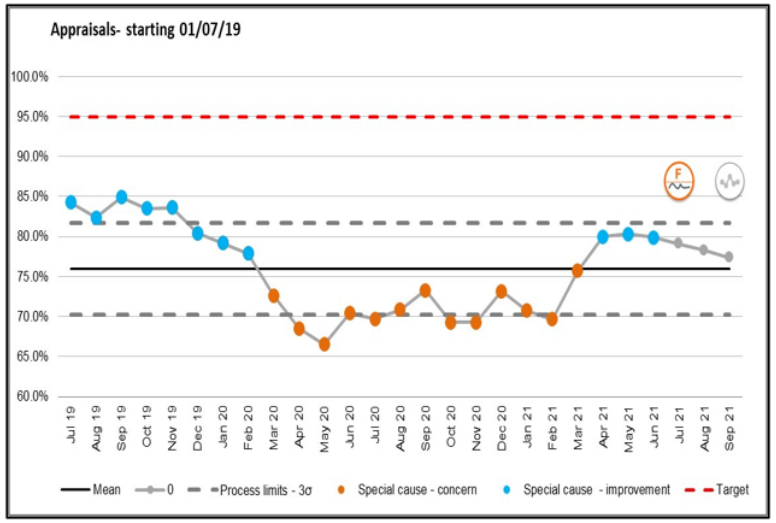


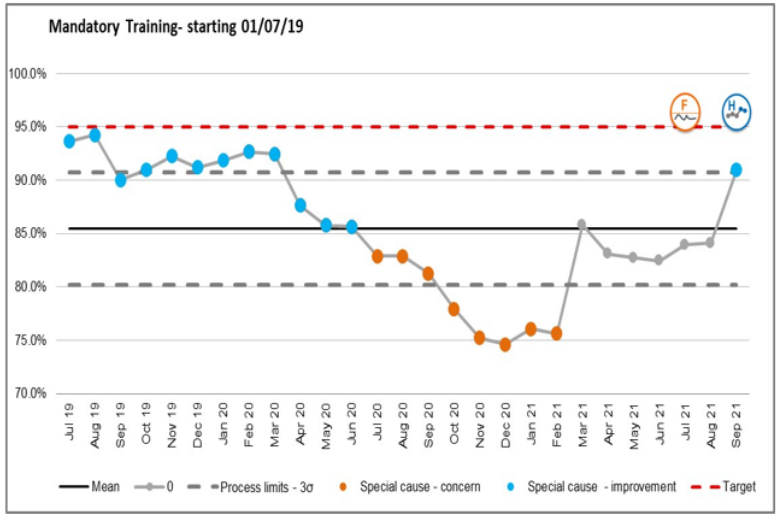


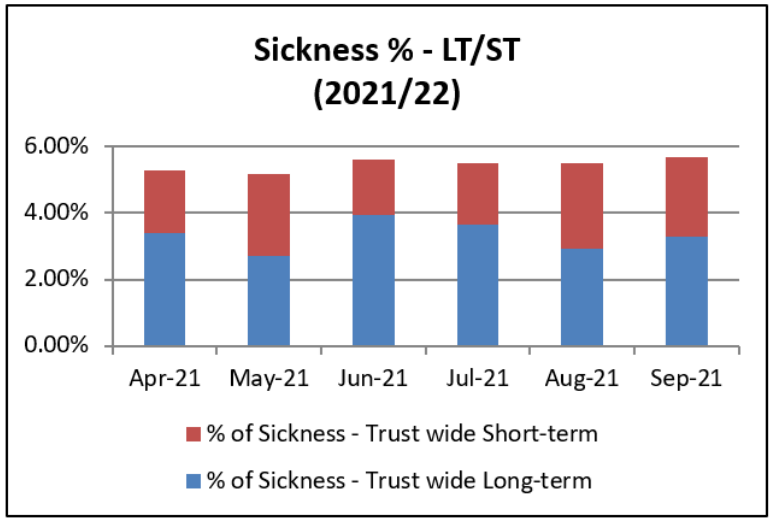


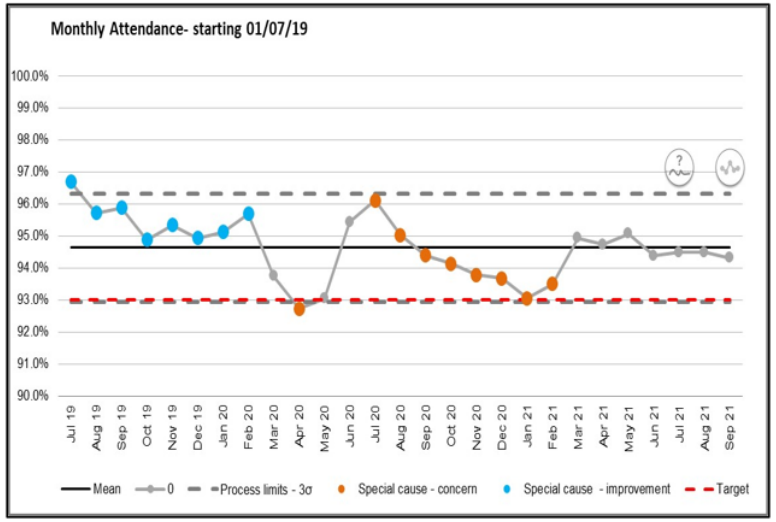


14. Workforce









14. Workforce

Trust Workforce Metrics	Aug-21	Sep-21	This Month vs Last Month	Trend	KPI
Staff in Post - Headcount	1238	1238	0	-	-
Staff in Post - Full Time Equivalent	1099.95	1097.26	-2.68	-	-
Staff Turnover (%) - Unadjusted	10.42%	11.27%	0.86%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	8.23%	9.20%	0.97%	⇧	<=11.5%
Total WTE Employed as % of Establishment	84.67%	84.47%	-0.19%	⇩	>=93%
Total WTE Employed as % of Establishment - Clinical	82.11%	81.72%	-0.40%	⇩	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.37%	89.53%	0.17%	⇧	>=96%
% of Attendance	94.48%	94.31%	-0.17%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.13%	94.09%	-0.04%	⇩	>=96.3%
% Staff received mandatory training last 12 months	84.11%	90.94%	6.84%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	78.24%	77.33%	-0.91%	⇩	>=95%
% of Sickness - Trust wide Long-term	2.94%	3.31%	0.37%	⇧	-
% of Sickness - Trust wide Short-term	2.57%	2.37%	-0.20%	⇩	-
Return To Work Completion %	51.66%	54.67%	3.01%	⇧	>=80%

ROHTB (10/21) 012 **QUALITY REPORT OCTOBER 2021**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
3 Moderate Harms Reported **3 Formal complaints received and acknowledged in September 2021** **Complaint KPI.** The Trust did not meet its KPI for completion of formal complaints in September 2021 (67%). 1 x complaint missed deadline. **2 reportable infections recorded**. **CAS alert update not available within the quality report due to absence in the team.**	**Compliance with mandatory 24-hour re-assessment** Re audit of the VTE 24-hour re-assessment process to be undertaken December 2021.
POSITIVE ASSURANCES TO PROVIDE • No patient deaths reported in September 2021. • No Serious Incidents reported in September 2021. • One Serious Incident closed by the CCG -– Never Event – Retained equipment in bone post surgery/ equipment failure. Learning included within the report and has been reported to Trust Board in October 2021. • No VTE incidents reported. • 5 inpatient falls reported with a low 1.3 falls per 1000 patient bed days. • No Category 2 or 3 Pressure ulcers reported in September 2021. • No reopened complaints in September 2021. • WHO checklist 100%. • Prevent training compliance rates have improved (89.84%) (90% KPI).	**DECISIONS MADE** **Friends and Family Test completion external KPI** NHS England have removed their mandatory completion rate FFT KPI. The Trust will continue to have an internal KPI target of 40% completion rate for the FFT in the inpatient areas.

Quality Report - October 2021 (September 2021 Data) – Front Cover and Dashboard

	April 2021	May 2021	June 2021	July 2021	August 2021	Sept 2021	2021/2022	2020/2021 YTD
Incidents	391	345	376	317	308	387(↑)		
Serious Incidents	1	0	0	0	1	0(↓)	2	10(Total)
Internal RCA investigations	5	1	3	4	3	0(↓)		
VTEs (Avoidable)	0	0	0	0	0	0(↓)	0	1(Avoidable)
Falls	6	8	8	7	10	5(↓)	44	76(Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0	0	1	1	0(↓)	2	10(Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0(Avoidable)
Complaints	3	4	7	4	3	3	24	57(Total)
PALS	47	62	68	90	61	39(↓)		
Compliments	5	5	5	7	3	0(↓)		
FFT Score %	97	96	98	98	99	99		
FFT Response %	29	33	28	33	41	36(↓)		
Duty of Candour	10	12	16	20	15	12(↓)		
Litigation	0	0	1	0	0	0		
Coroners	0	0	0	0	0	0		
WHO %	100	100	100	100	100	100		
Infections	0	1	1	0	1	2 (↑)	5	3 (Total)

(↑) (↓)(↔) Symbolise the trend from the previous month.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

October 2021 (September 2021 Data)

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

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1	Introduction
2	Incidents and Mortality
3	Serious Incidents
4	Internal RCA investigations
5	VTEs
6	Falls
7	Pressure Ulcers
8	Patient Experience
9	Friends & Families Test and Iwantgreatcare
10	Duty of Candour
11	Litigation and Coroners Inquests
12	WHO Surgical Safety Checklist
13	Infection Prevention Control + Covid update
14	Safeguarding
15	CAS Alerts

1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

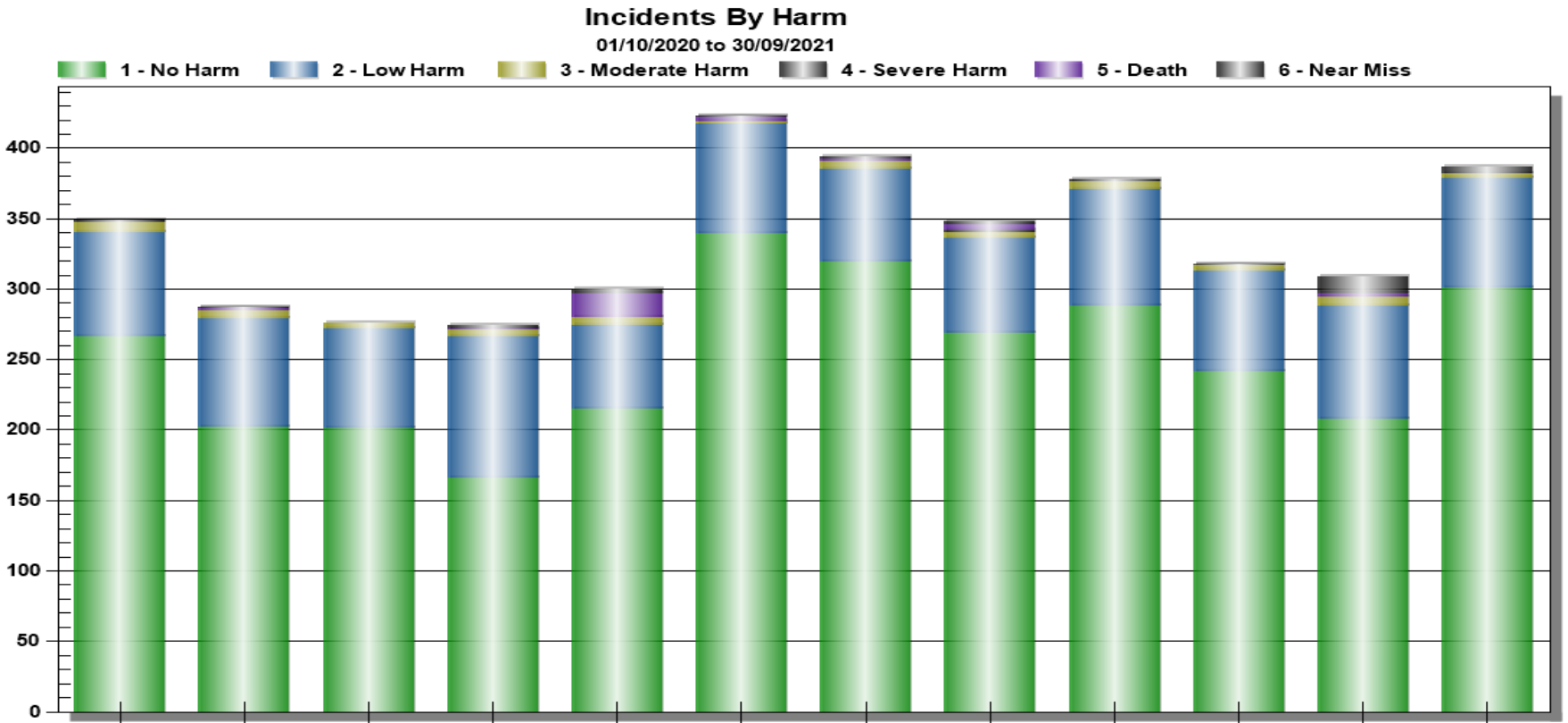
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report, please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: **0121 685 4000 (ext. 55216)**

2. **Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.**

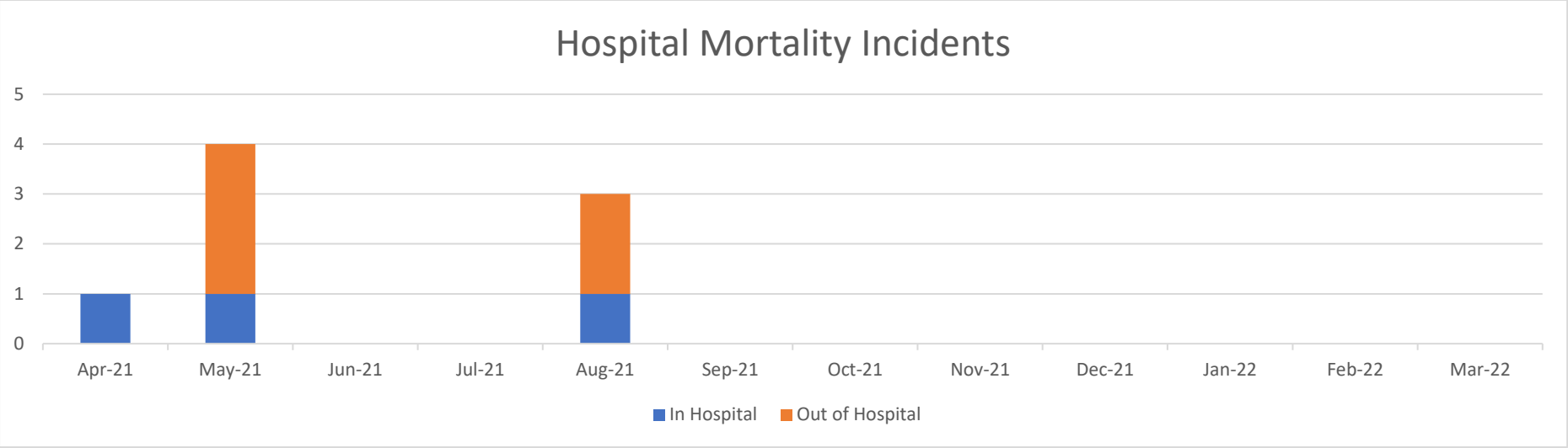


Month and Year	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
1 - No Harm	266	202	201	166	215	339	319	269	288	241	208	301
2 - Low Harm	74	77	71	100	59	78	66	67	83	72	80	78
3 - Moderate Harm	7	6	4	5	6	2	6	4	5	4	6	3
4 - Severe Harm	0	0	0	0	0	0	0	2	0	0	0	0
5 - Death	0	1	0	1	17	3	1	4	0	0	3	0
6 - Near Miss	2	1	0	2	3	1	2	2	2	1	12	5

Data source – Ulysses

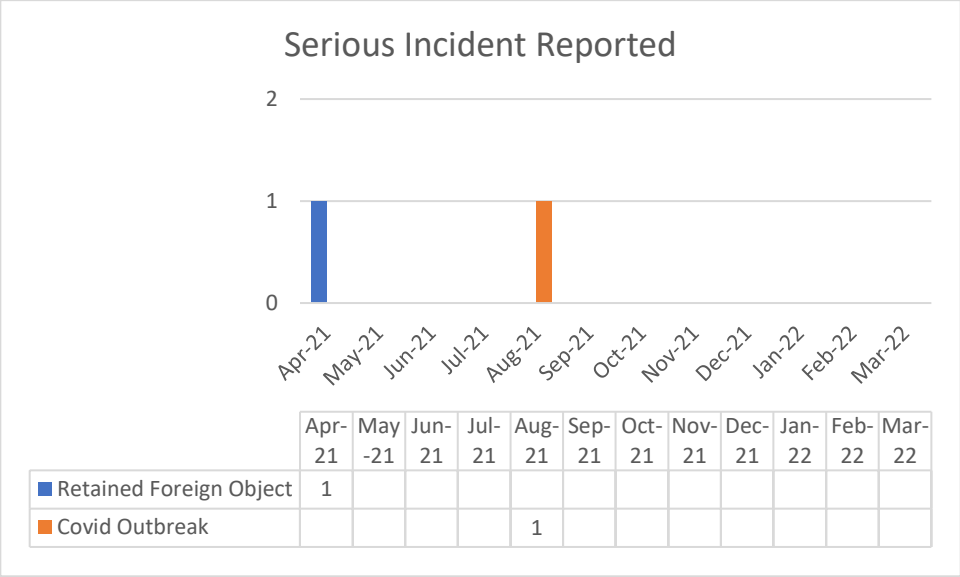
INFORMATION
ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
None

In hospital Mortality Incidents reported – All incidents reported will been reviewed as part of the learning from deaths process.



INFORMATION
No deaths were reported in September 2021.
ACTIONS FOR IMPROVEMENTS / LEARNING
None
RISKS / ISSUES
None

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



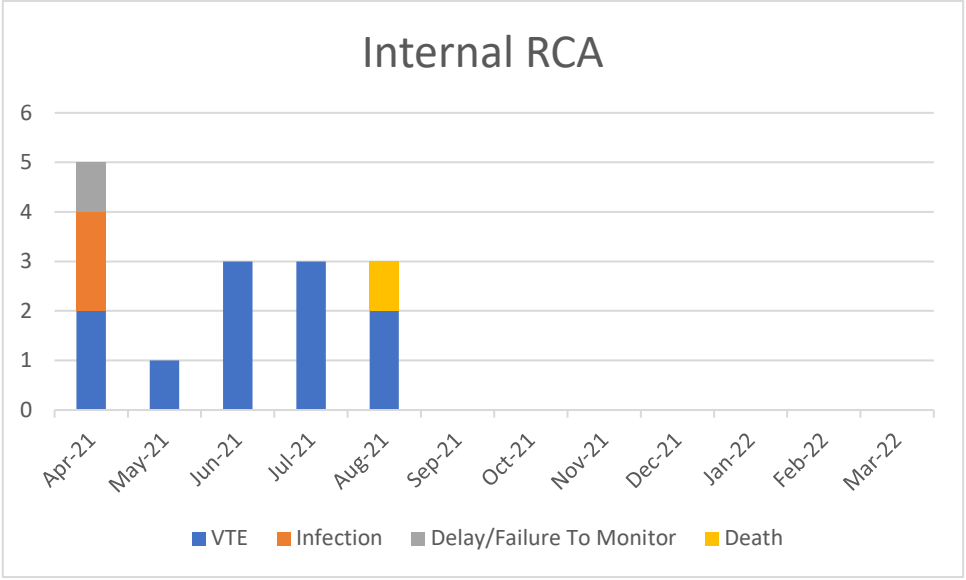
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Retained Foreign Object	1											
Covid Outbreak					1							

Year Totals	
20/21	11
21/22	2

Data Source – STEIS

INFORMATION
No Serious Incident was reported in September 2021. An avoidable VTE has been recorded as a Serious Incident in October 2021 and will be reported in the next quality report.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident closed by the CCG – Never Event – Retained equipment in bone post surgery/ equipment failure. Learning included within the report and has been reported to Trust Board in October 2021.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



Data Source – Internal RCA tracker

INFORMATION

There were 0 internal RCAs reported in September 2021

ACTIONS FOR IMPROVEMENTS / LEARNING

One RCA was closed in September 2021

Lessons Learned

Communication regarding the patient's mobility status was inconsistent in this case which needs addressing moving forwards
Training on falls is only provided for nursing on clinical update days and not for medical staff or physiotherapists once in post so this also requires resolution
Bin sizes in the bathrooms are different on different wards so facilities and infection control should review to determine if the size could be standardised across all wards

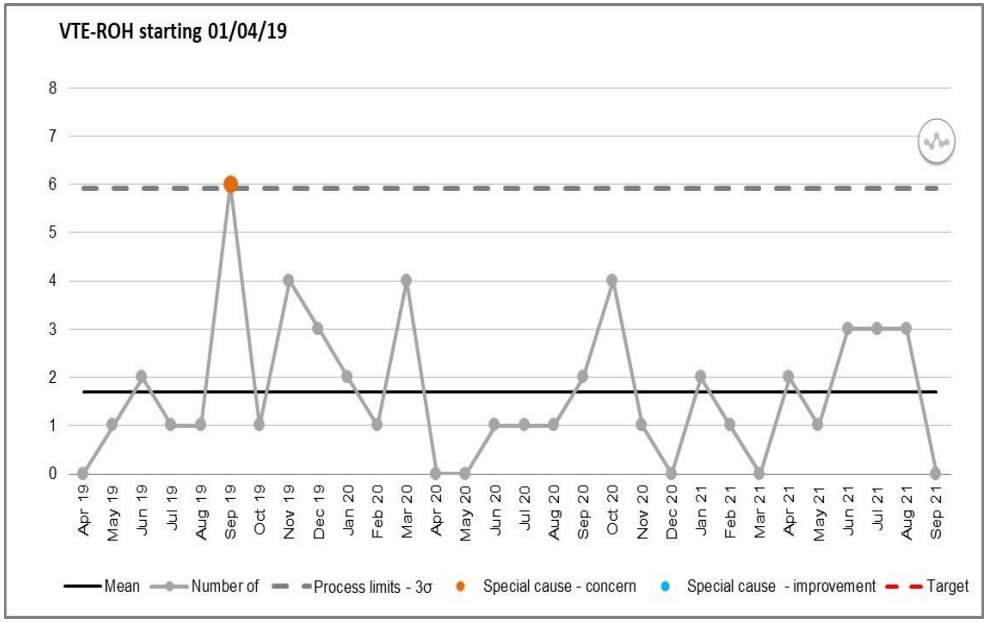
Although not relevant to this investigation, incidental findings indicate that in addition to the allergen advice provided on the intranet and in ward nutrition folders, the catering department have a recipe folder for all meal options offered to patients which could be used on the wards and provided to patients with food intolerances. They could then choose meals that were appropriate for their need rather than relying on ward staff calling the kitchens to check ingredients at every meal time.

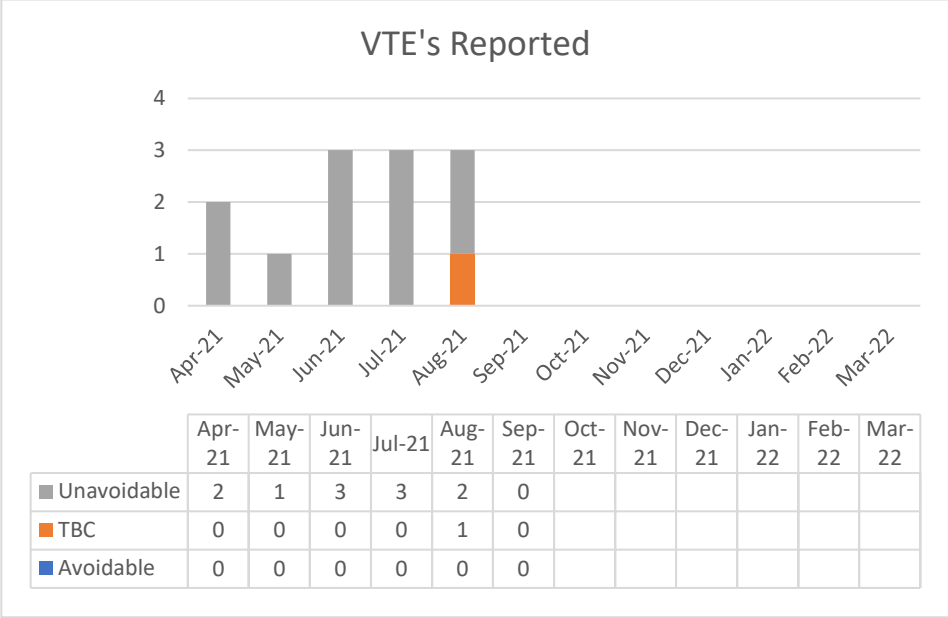
Recommendations

1. Ward managers to discuss the falls policy at the next department meeting to ensure all staff are aware to review the falls care plan at any change in condition or as a minimum every seven days as per falls policy and to accurately complete the post falls care plan
2. Medical teams to discuss the falls policy at the next department meeting to ensure all medical staff are aware of accurate completion of the post falls medical review form
3. Medical teams to include training on falls at doctor's induction
4. Physiotherapy leads to include training and update on falls at bi monthly team training sessions
5. Lead physiotherapists to discuss appropriateness of using Tiara as a stand-alone system rather than documenting in the medical notes and add to corporate risk register
6. All department leads to discuss the Clinical Record Keeping Policy, including the Trusts Documentation Standards at the next department meetings
7. Housekeeping and infection control to review the waste bins provided in bathrooms to determine if the size could be standardised across all wards
8. Catering to provide a recipe folder for the wards so they can check ingredients in meals for patients with food intolerances rather than food allergies
9. Catering to ensure all patient menus, breakfast, lunch and supper have the key to dietary codes included
10. Ward managers to ensure all food allergy information is available in the ward nutrition folders

RISKS / ISSUES
None

5. **A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism). Charts below show the number of VTE's (SPC chart) and whether or not they are unavoidable or avoidable (excel chart)**





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Unavoidable	2	1	3	3	2	0						
TBC	0	0	0	0	1	0						
Avoidable	0	0	0	0	0	0						

Avoidable Year Totals		Total including unavoidable
20/21	1	13
21/22	0	12

Data Source – Ulysses and VTE leads

INFORMATION

0 ROH associated VTEs incidents were reported in September 2021. An avoidable VTE (TBC in graph) has been recorded as a Serious Incident in October 2021 and will be reported in the next quality report.

24-hour reassessment: need for re-assessment-current PICS report methodology to be reviewed – please see narrative below

24hr review	464
missed 24hr review	329
total	793
24hr %	58.5%

On admission assessment

total possible	897
total assessed	886
%	98.77%

ACTIONS FOR IMPROVEMENTS / LEARNING

Compliance with mandatory 24-hour re-assessment

Actions are underway to:

Review wording of standard. NICE ng89 2018; states Reassess all medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes opposed to specifically 24 hours. The wording has been agreed and the policy is currently being updated.

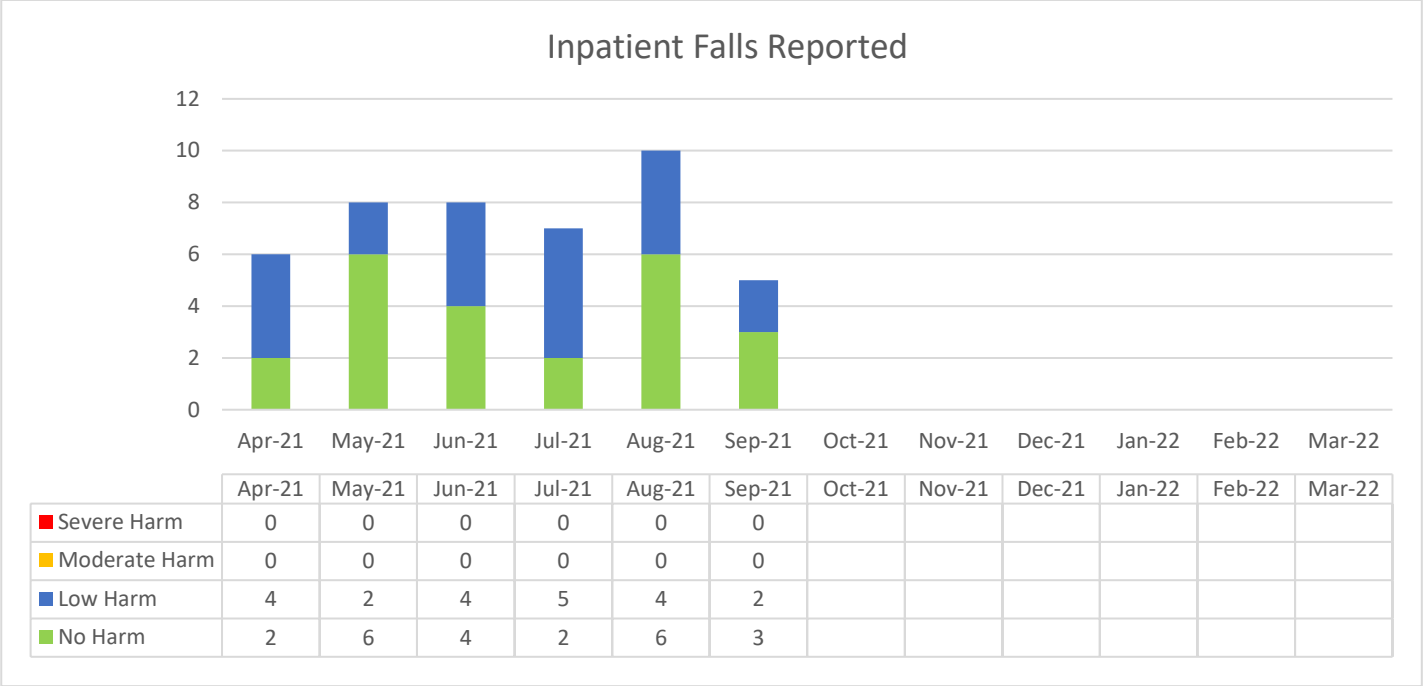
PICS alert gives option to acknowledge (by ticking accept responsibility for having completed) or Ignore (not done now so will keep alerting) need for re-assessment- current PICS report methodology to be reviewed to ensure this is reflected in the data collection (not currently). A meeting has been held to discuss the requirements and methodology. Informatics are currently reviewing the new process

Re-audit has been planned in December 2021.

RISKS / ISSUES

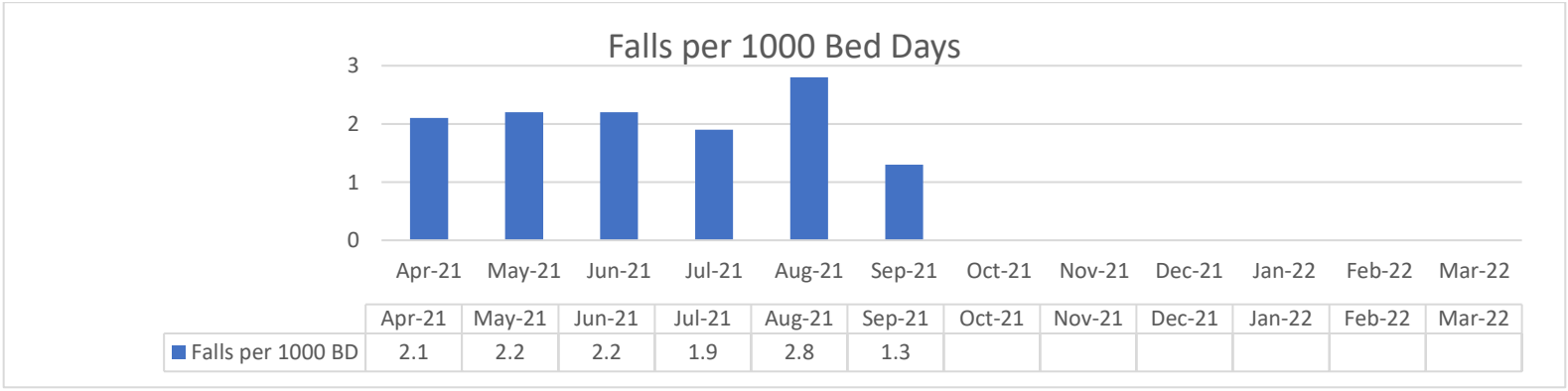
Risk 43: re 24 hour re-assessment to remain on the risk register until above recommendations complete. This month's compliance was 58.5%

6. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each fall's incident.**

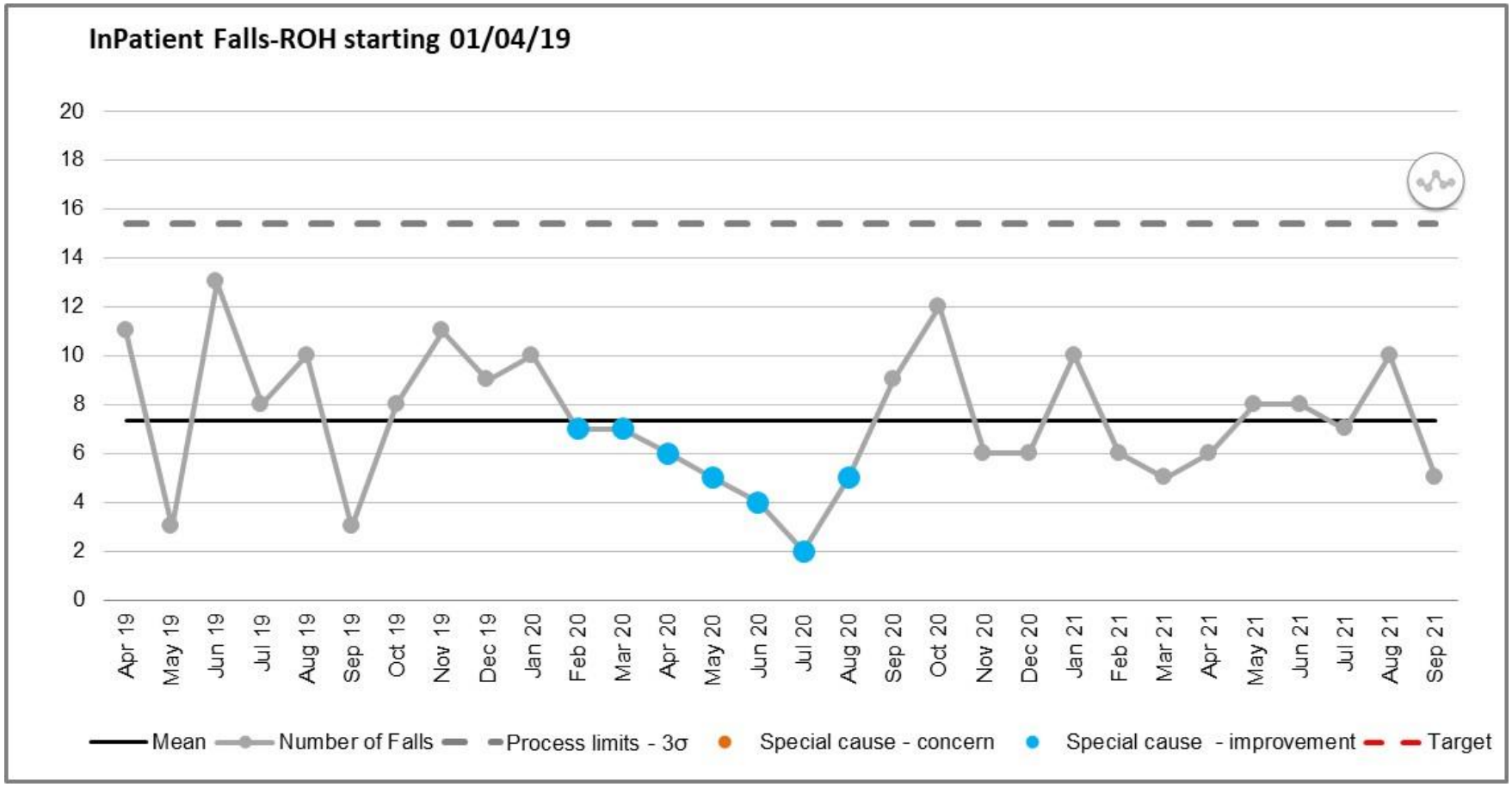


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Severe Harm	0	0	0	0	0	0						
Moderate Harm	0	0	0	0	0	0						
Low Harm	4	2	4	5	4	2						
No Harm	2	6	4	2	6	3						

Year Totals	
20/21	76
21/22	44



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Falls per 1000 BD	2.1	2.2	2.2	1.9	2.8	1.3						



Data Source – Ulysses and Falls Group

INFORMATION

There were 8 incidents reported across the Trust in September 2021 relating to Falls:

5 x In-Patient Falls Incidents

1 x Out-Patient Falls Incident

1 x Staff Incident

1 x ROCS Incident

The number of in-patient falls remains low and has dropped further this month. There is no evidence of any pattern or trends to falls this month

ACTIONS FOR IMPROVEMENTS / LEARNING

Positive Assurance

- The number of in-patient falls remains low and has dropped slightly more this month.

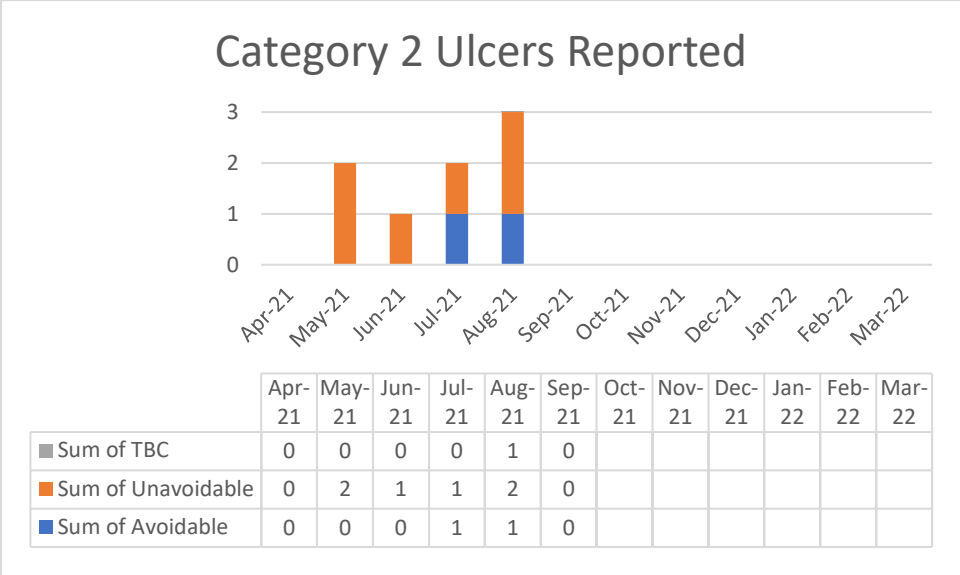
Actions

- To review patient engagement & input to falls/dementia group.
- To look at rolling out screening patients for delirium across all wards, so that those patients that may potentially mobilise against advice can be more readily identified and placed in a bed where closer supervision can be provided.
- Review of bed rails policy & slips, trips & falls policy underway.

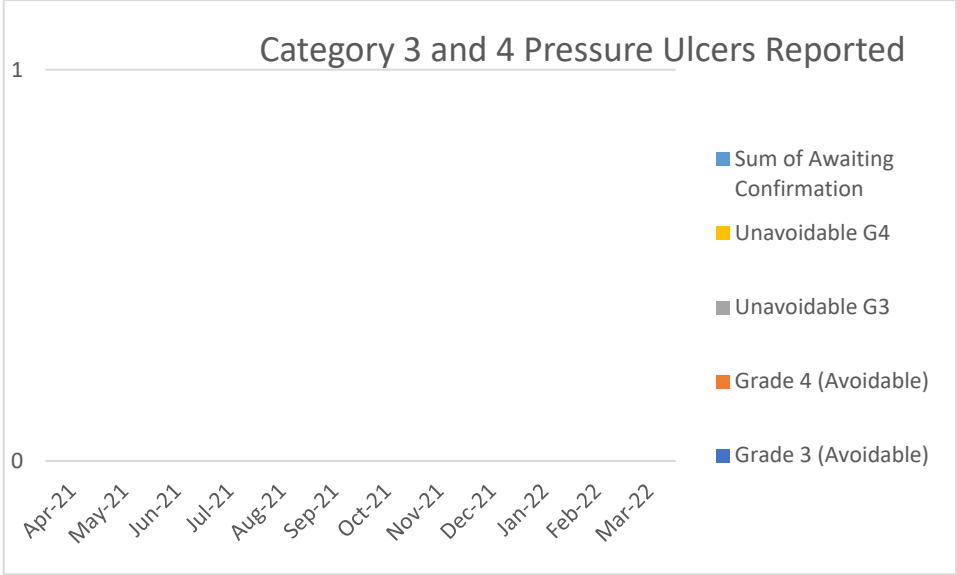
RISKS / ISSUES

Meeting on 28/9/21 non-quorate due to sickness, next meeting rescheduled for 23/11/21. The meeting last sat in July 2021.

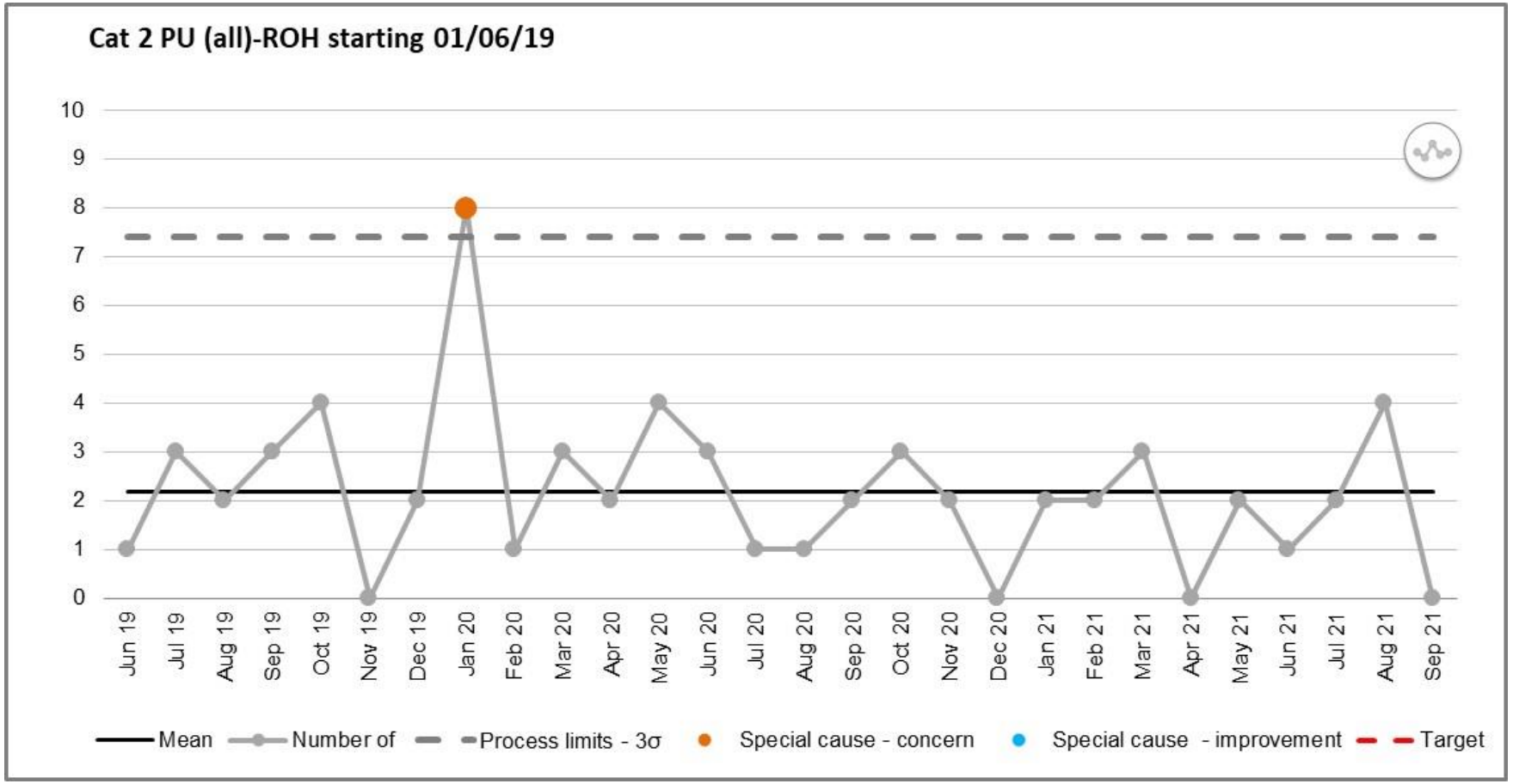
7. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Sum of TBC	0	0	0	0	1	0						
Sum of Unavoidable	0	2	1	1	2	0						
Sum of Avoidable	0	0	0	1	1	0						



Number of PU reported total		
Year Total	Cat 2	Cat 3
20/21	25	1
21/22	9	0



Data Source – Ulysses and TV team

INFORMATION

September 2021 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	0
Category – 2 (Device)	0
Category – 1	x 4 – None deteriorated
Suspected Deep Tissue Injury	PU ROH Ungradable DTI (at least a category 3) - 1
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence – 2 MASD ROH Intertriginous dermatitis – 0 MASD admitted with Incontinence x 4 MASD admitted with Intertriginous dermatitis x 2

Patients admitted with PU's	Cat 1- Nil Cat 2- Nil Cat 3- Nil Cat 4- Nil

Avoidable only Pressure Ulcer CCG Contracts KPI

2021/2022 – Contract to be confirmed.

2021/2022	
Avoidable Grade 2 pressure Ulcers	2
Avoidable Grade 3 pressure Ulcers	0
Avoidable Grade 4 pressure Ulcers	0

2020/2021	
Avoidable Grade 2 pressure Ulcers limit of 12	10
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

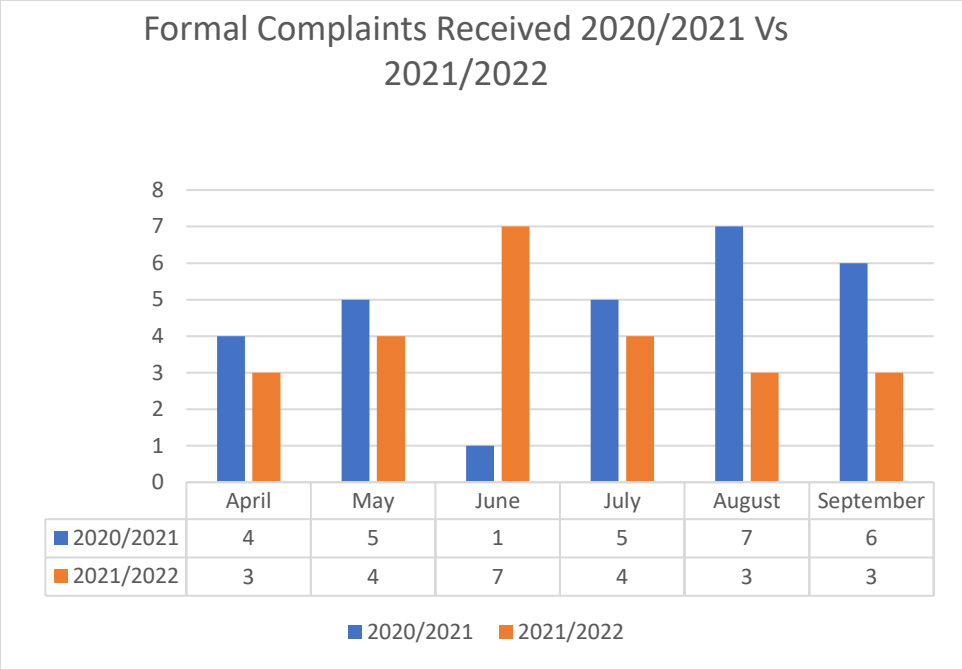
ACTIONS FOR IMPROVEMENTS / LEARNING

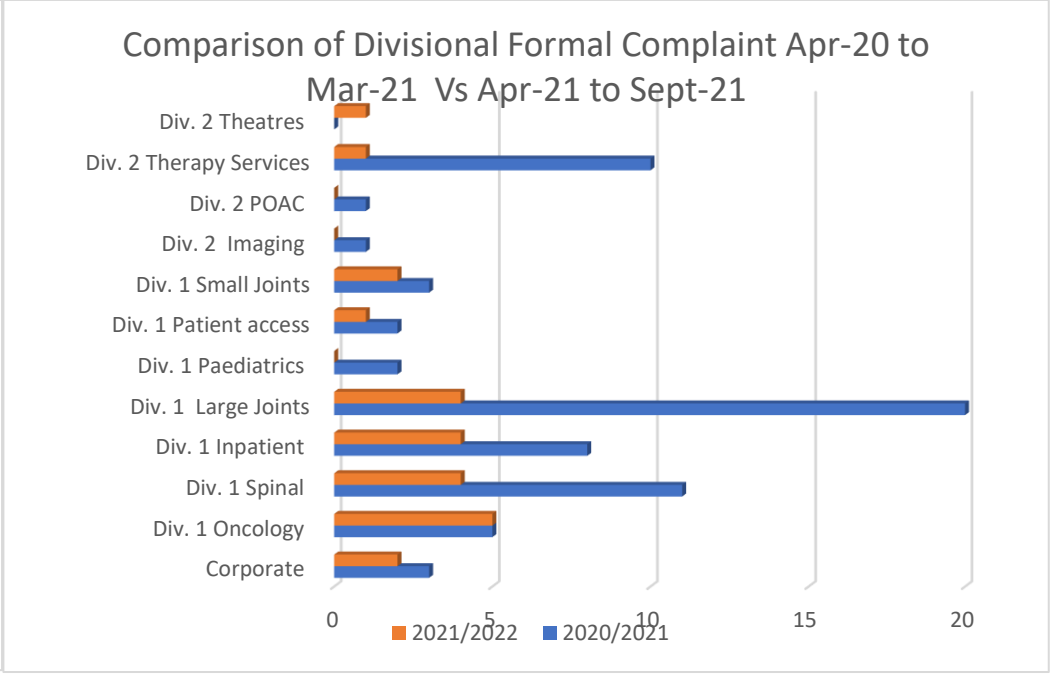
Tissue Viability Competency document being reviewed as part of Outstanding Care Every Time programme.

RISKS / ISSUES

None

8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Data Source – Patient Experience team

Complaint Year Totals	
20/21	57
21/22	24

INFORMATION

Complaints

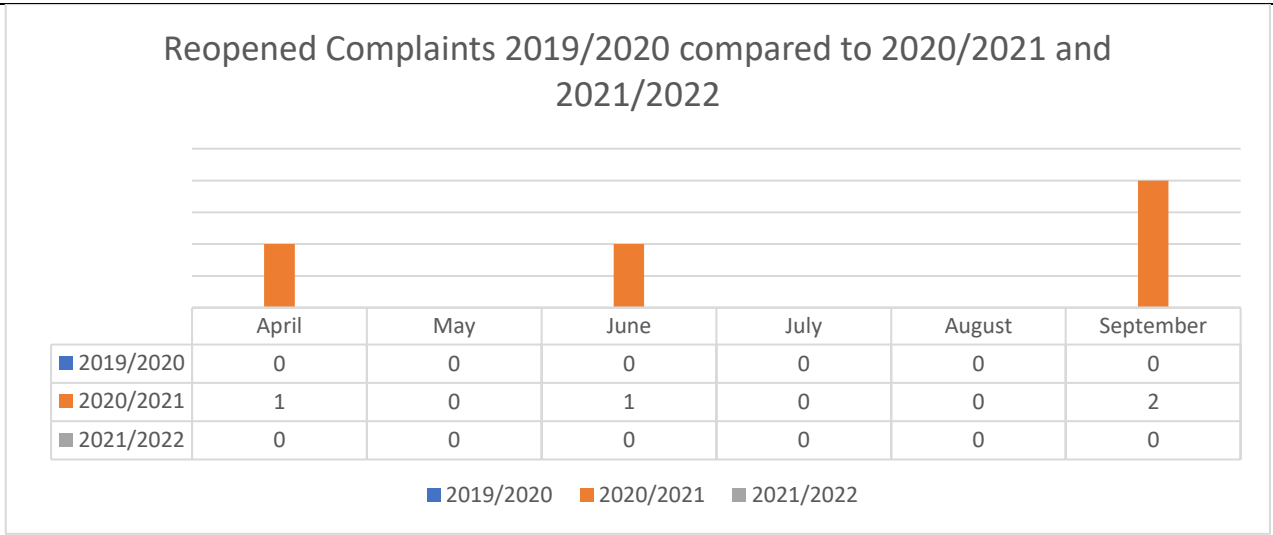
- There were 3 formal complaints received and acknowledged in September 2021 and all 3 are in relation to Division 1.
- Categories and subcategories of formal complaints received in September 2021;

Category type/Category	Number
Clinical Query	**1**
Dispute Over Diagnosis/Treatment	1
Values & Behaviours	**2**
Attitude Of Staff - Medical	1
Attitude Of Staff - Other	1

- In September 2021 – 2 Formal Complaints were closed within the agreed date with patient and 1 complaint has breached agreed date for the response with complainant for 1 day . This gives a 67% completion on time rate and does not meet the KPI for the month. This is first time in the last 17 months that a complaint has breached its agreed date with a patient. The average response for formal complaints was 25 days.
- At the time of producing this report there are 4 open complaints.

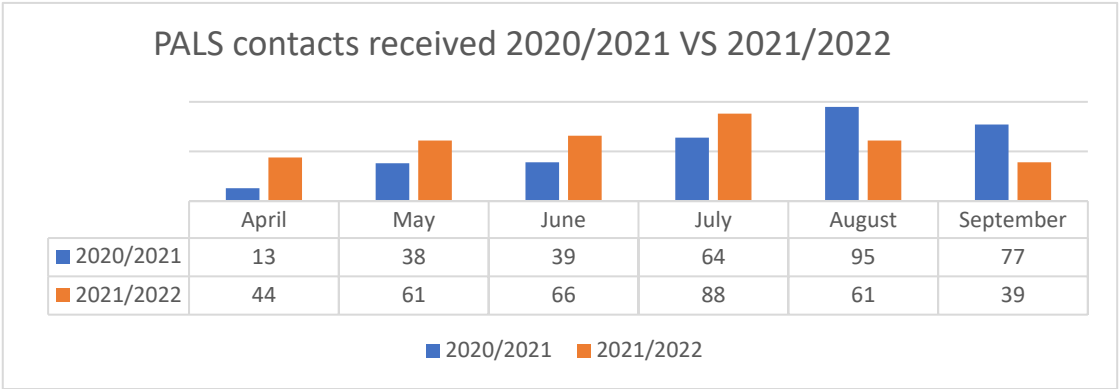
Reopened Complaints

- In September 2021, the Trust did not reopen any complaint on the request of the complainant



Patient Advice and Liaison service - PALS

- In September 2021 the PALS department handled 39 contacts of which 33 were classified as concerns, and 5 as enquiries and 1 as informal complaint. This is a decrease in contacts compared to the same time last year.



- The main themes in the PALS data relate to Appointments, Clinical queries and Communication.
- The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. In September 2021, 100% of enquires and 100% of concerns were handled within the agreed timescales with patient and we did not breach any KPI's in the month.

Top 3 PALS Categories and top 2 PALS Subcategories

PALS Contacts	Count
Appointments	**9**
Appointment Cancelled	4
Appointment Rescheduled	3
Clinical Query	**8**
Dispute Over Diagnosis/Treatment	2
Inadequate Pain Management	2
Communication	**13**
Communication/Info To Patients	1
Method/Style Of Communication	3

Patient experience KPI from April 2021

Complaints KPI were not hit in September due to delay in the Public Engagement Department with one complaint and there was a learning for staff. Complaints KPI in September was 67%, however the KPI was hit for the last 17 months and this financial year average is 95% and overall KPI is hit. PALS KPI's were hit for all months with an KPI average of 99% for PALS concerns and 98% for PALS enquiries

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
Apr-21	100	99.69	100
May-21	100	100	100
Jun-21	100	100	100
Jul-21	100	94	89
Aug-21	100	100	99.8
Sept-21	67	100	100

Compliments

There were 0 compliments recorded on Ulysses in September 2021

ACTIONS FOR IMPROVEMENTS / LEARNING

- The team have a vacant patient experience assistant (Band 4). This is awaiting recruitment now the ATR has been completed.
- The Public Engagement Department have designed new PALS posters that have been translated to the 5 most common languages spoken by our patients. The Posters include a contact for patient to text the Public Engagement team with their preferred language and the time/date for a PALS call back. This will encourage more patents to provide feedback, raise concerns or complaints.
- The Public Engagement department is looking into the collection of compliments as the number of reported is low to the department.
- A new external internet page is under construction for the Public Engagement Department and its focus will be on the PALS, Complaints and Patient Experience
- Head of Patient Experience will arrange Ulysses system administration training for team members to ensure the system is used to its full potential.
- Gap analysis of the CQC Regulation 16.1 (Receiving and acting on complaints) is currently being undertaken by the Head of Patient Experience and will be presented on the next Patient Experience and Engagement Group
- The PALS department handled 55% more contacts this year (449) in comparison to the same time last year (249); this is due to the COVID-19 pandemic which started last year in April, which resulted in less activity and PALS team did not log general enquiries in 20/21

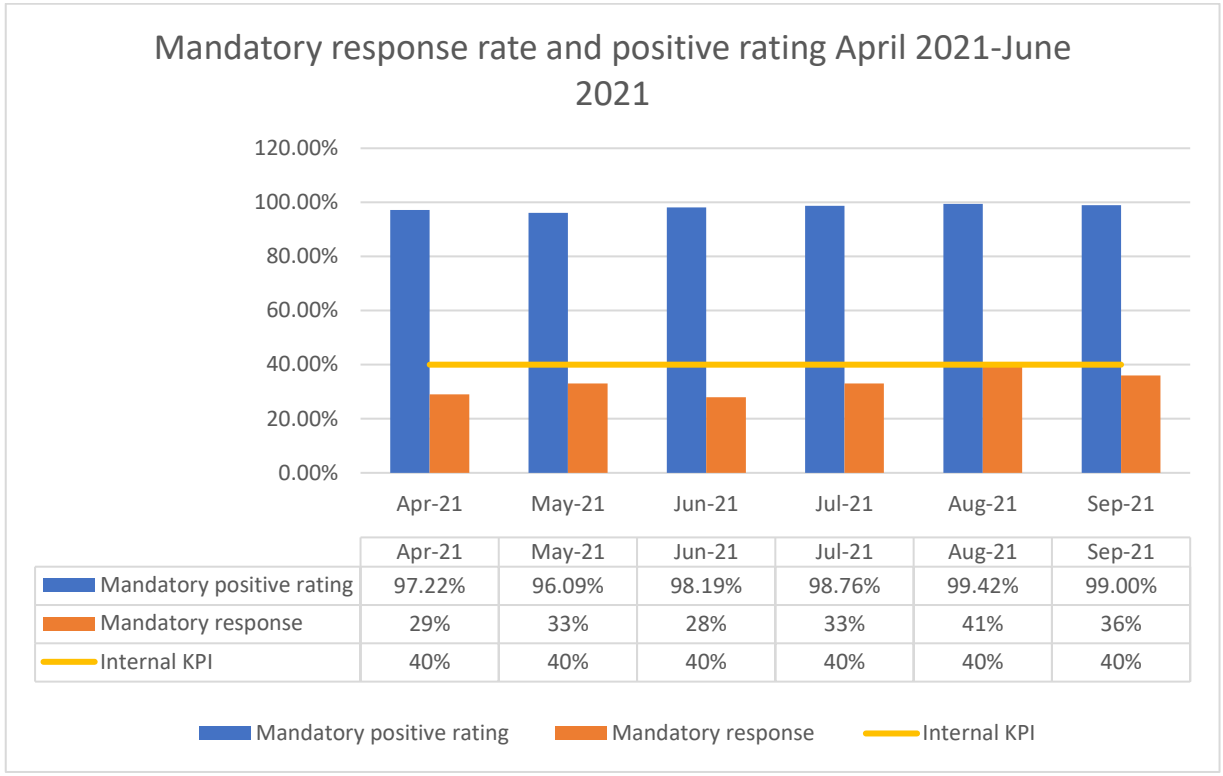
RISKS / ISSUES

- The Trust did not meet its KPI for completion of formal complaints in September 2021 due to the new staff within Public Engagement, the team have had an additional training and support. 1 complaint breached

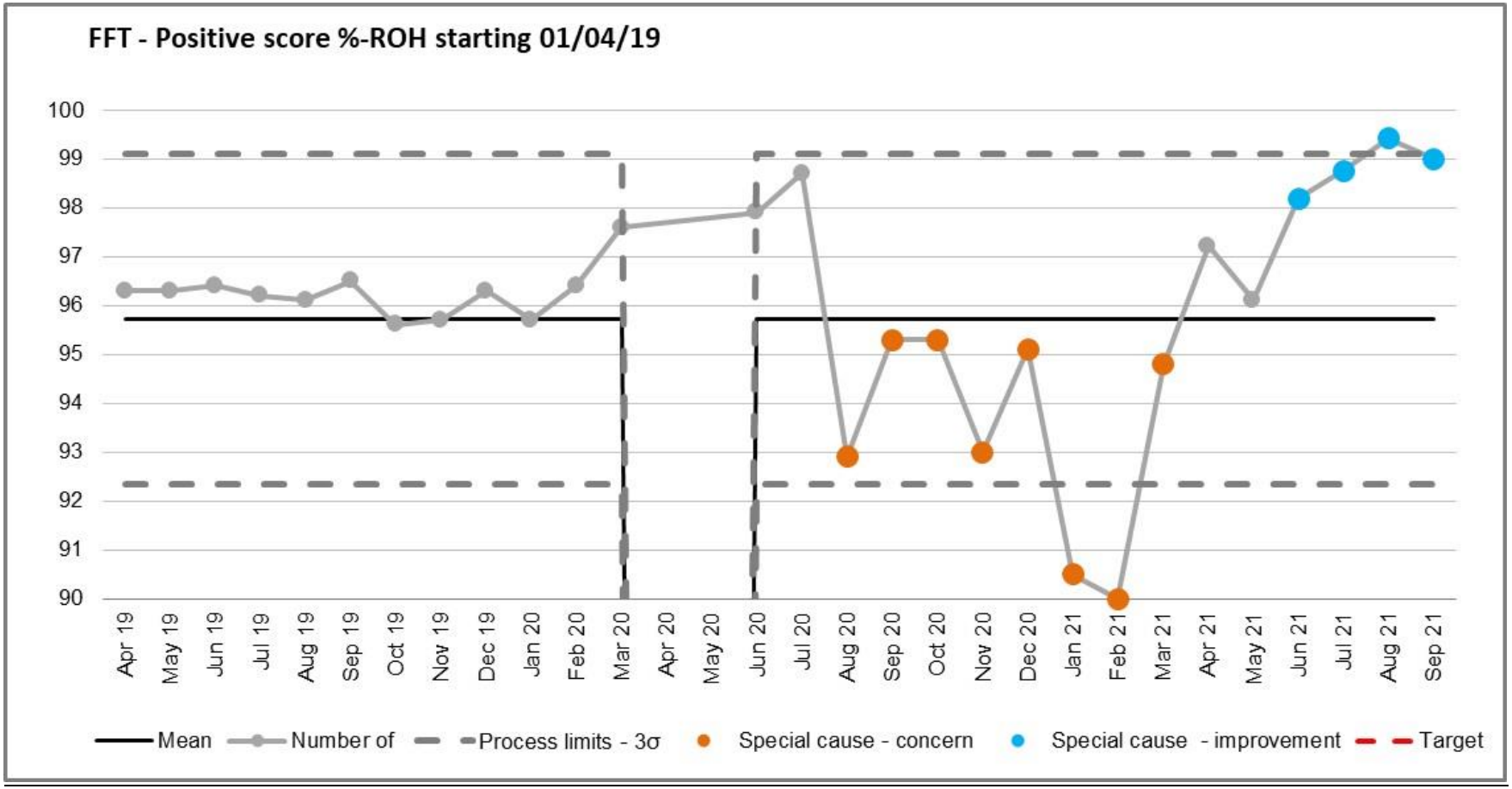
COMEBACK COMPLAINTS

None

9. Friends and Family Test Results (collected in the iwantgreatcare system). FFT Mandatory Reporting



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Mandatory positive rating	97.22%	96.09%	98.19%	98.76%	99.42%	99.00%
Mandatory response	29%	33%	28%	33%	41%	36%
Internal KPI	40%	40%	40%	40%	40%	40%


FFT - Positive score %-ROH starting 01/04/19
100
99
98
97
96
95
94
93
92
91
90
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Mean
Number of
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

INFORMATION
New process in place with the PALS team. Ward and Departmental Managers are receiving any compliments or concerns from patients in a spreadsheet and scanned copies of forms that have staff names or are concerns that are immediate risk to the other patients. This allows the areas to share with their staff for learning and improvements.
ACTIONS FOR IMPROVEMENTS / LEARNING
• An in-depth report for the Quarter 1 and quarter 2 has been produced for the FFT response rates and results by the Head of Patient Experience, this report will be presented on the DMB and PEEG. Ward managers will produce a responsive action plan to improve the FFT response rates in their areas. • The NHS England have removed their mandatory completion rate KPI with the following statement: "Response rates in the three settings for which we have previously published response rates (general and acute inpatient, A&E and the second maternity touch point), this is no longer possible because there is no limit on how often a patient or service user can give feedback. Therefore, we will no longer calculate or publish a 'response rate'. Providers will, however, continue to submit the same data items, and we will continue to publish an indicator which will put the number of responses collected in the context of the size of the service provided, which will help to give commissioners and regulators a sense of how effectively the FFT is being implemented by each provider. This is consistent with other settings. • • The Trust will continue to have an internal KPI target of 40% completion rate for the FFT in the inpatient areas
RISKS / ISSUES
None

10. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 15 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. **Litigation and Coroners**

New claims

3 new claims against the Trust have been received in September 2021. These were reported in a detailed report to the Quality and Safety Committee in September 2021

On-going claims

There are currently 29 on-going claims against the Trust.

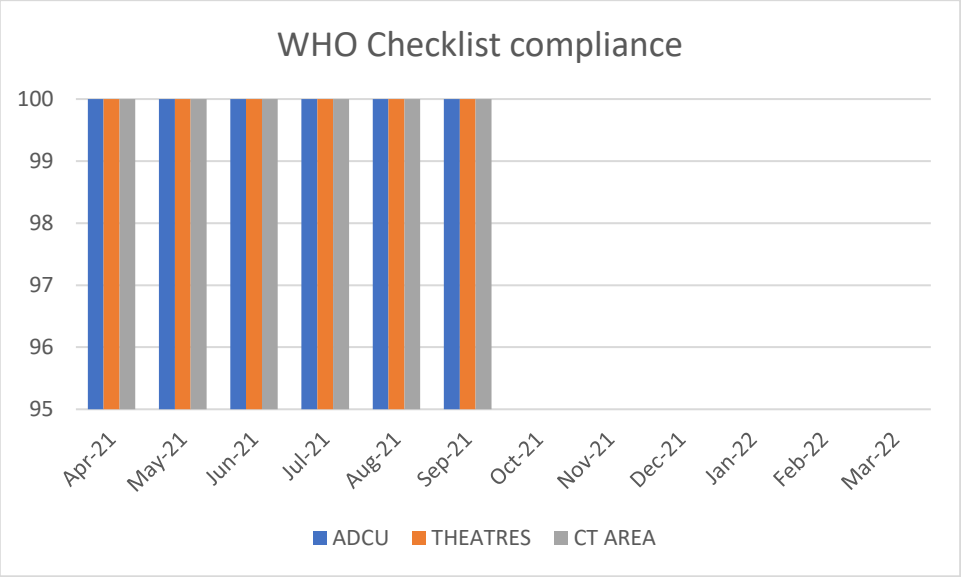
Pre-Application Disclosure

2 new requests for Pre-Application Disclosure of medical records were received in September 2021

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in September 2021

12. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete listed patients will have their case notes retrieved, and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined;

- Form evident in notes
- Sign in Section
- Timeout section
- Sign out section

Theatres

Total cases = 799

The total WHO compliance for Theatres in September 2021= 100%

CT area

Total cases = 90

The total WHO compliance for CT September 2021 = 100%

ADCU

The total WHO compliance for ADCU in September 2021 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

The Visual Audit has yet to be undertaken so results are not available.

RISKS / ISSUES

None

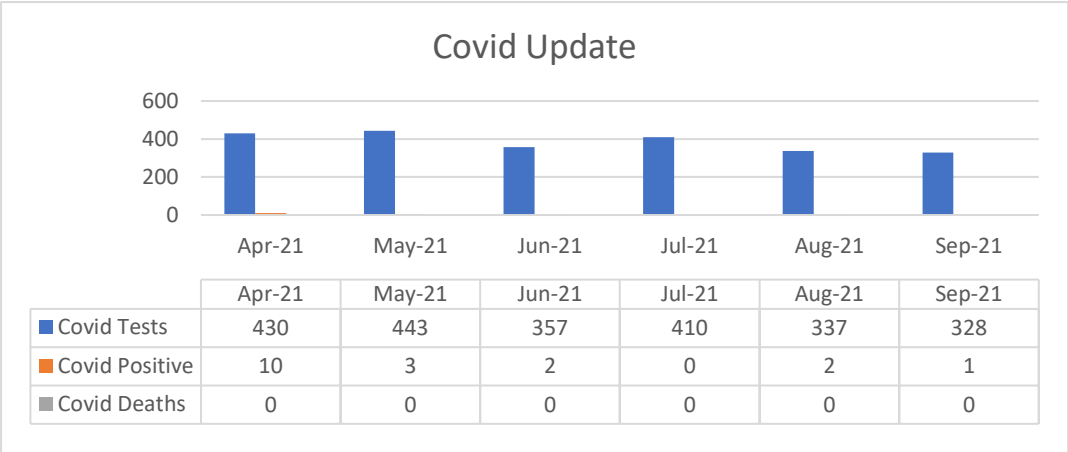
13. Infection Prevention Control – Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly. All infections are reported and scrutinised at the IPCC committee.

INFORMATION

The graph below details the reportable infections reported in month and year to date.

Infections Recorded in month and Year to Date (YTD)	September 2021 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	1	3
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	1	0
Pseudomonas aeruginosa BSI cases	0	0

The graph below details the number of tests, positives and deaths for Covid-19.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Covid Tests	430	443	357	410	337	328
Covid Positive	10	3	2	0	2	1
Covid Deaths	0	0	0	0	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 3 infections reported in September 2021. 2 of which were reportable as recorded in the graph above.

RISKS / ISSUES

None

***Data Source – IPC team and Ulysses**

14. Safeguarding – Below details the Key perfomance indicators and metrics in relation to Safeguarding compliance within the Trust. The KPIS below are disucssed in detail at the Safeguarding Committee and are included within this report for awareness

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Safeguarding Adult Notifications	40	37	36	49	22	36	37
Safeguarding Children and Young People Notifications	29	43	45	49	40	37	47
Mental Health Incidents	20	35	40	35	31	25	47
LD Adult	10	6	11	6	24	15	37
LD Children	75	73	61	65	68	68	79
Adult Level 2	98.45%	98.09%	97.84%	97.49%	97.35	97.62	97.16
Adult Level 3	86.04%	87.07%	86.88%	85.65%	84.45	86.03	86.15
Level 4	100%	100%	100%	85.71%	80	80	80
Child Level 2	98.27%	97.91%	97.66%	97.40%	97.08	97.18	96.72
Child Level 3	86.56%	87.38%	87.41%	85.91%	84.67	86.07	86.2
Mental Capacity Act MCA	95.65%	96.23%	96.65	96.45%	96.34	94.58	94.17
Deprivation of Liberty Safeguards DoLs	95.91%	96.50%	96.75	96.72%	96.43	95.2	94.52
Prevent WRAP	84.14%	82.92%	88.48%	87.50%	88.52%	88.37%	89.84%
CE	0	0	1	0	0	0	0
FGM	2	0	0	0	0	1	1
DOLS	6	4	6	8	4	7	3
MCA	0	0	5	2	5	0	3
PIPOT cases	1	0	0	0	0	0	0

Domestic Abuse	3	3	5	6	3	6	6
PREVENT Notifications	0	0	0	0	0	0	1
WNB	11	15	8	16	11	16	19
Child in Care	1	2	1	1	3	2	3
Early Help	4	3	0	0	1	3	0
DHR- scoping Reviews	0	1	0	0	0	2	2
SARs- scoping review **Or Rapid Reviews**	0	0	0	0	0	0	0
Modern Slavery	0	0	0	1	0	1	0
Incidents	6	5	13	12	13	15	18
Open Cases	11	12	11	20	20	12	23
Closed Cases	58	69	65	78	42	24	62

15. CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

ALL CAS ALERTS

ALERTS FROM PREVIOUS MONTHS

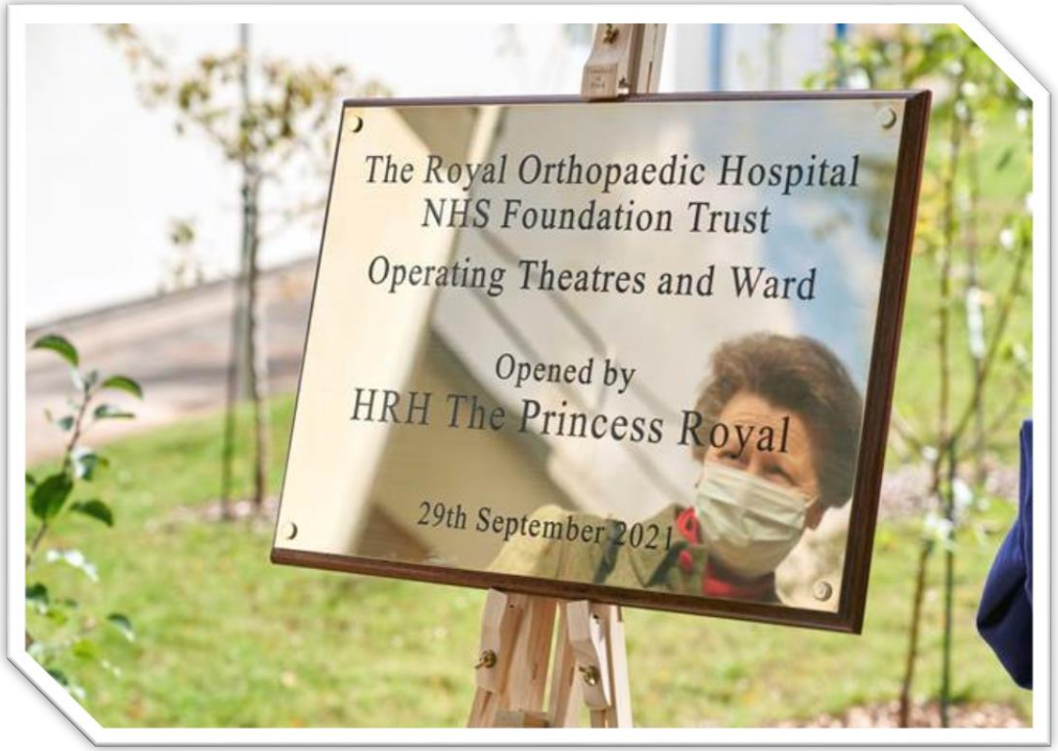
Report not available this month due to leave. The process was reviewed and approved by the Quality and Safety Executives to prevent this single point of failure but this does not seem to be embedded. This will be escalated to the Accountable Director for review.

The Royal Orthopaedic Hospital NHS Foundation Trust

Workforce Performance Report Month End Sep 2021

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Please be aware that the information included in this report relies upon the timely update of information into ESR and Healthroster, this report is based on data as at the 7th working day in October, please note the figures are likely to change if information is input into the systems after the cut-off date.

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

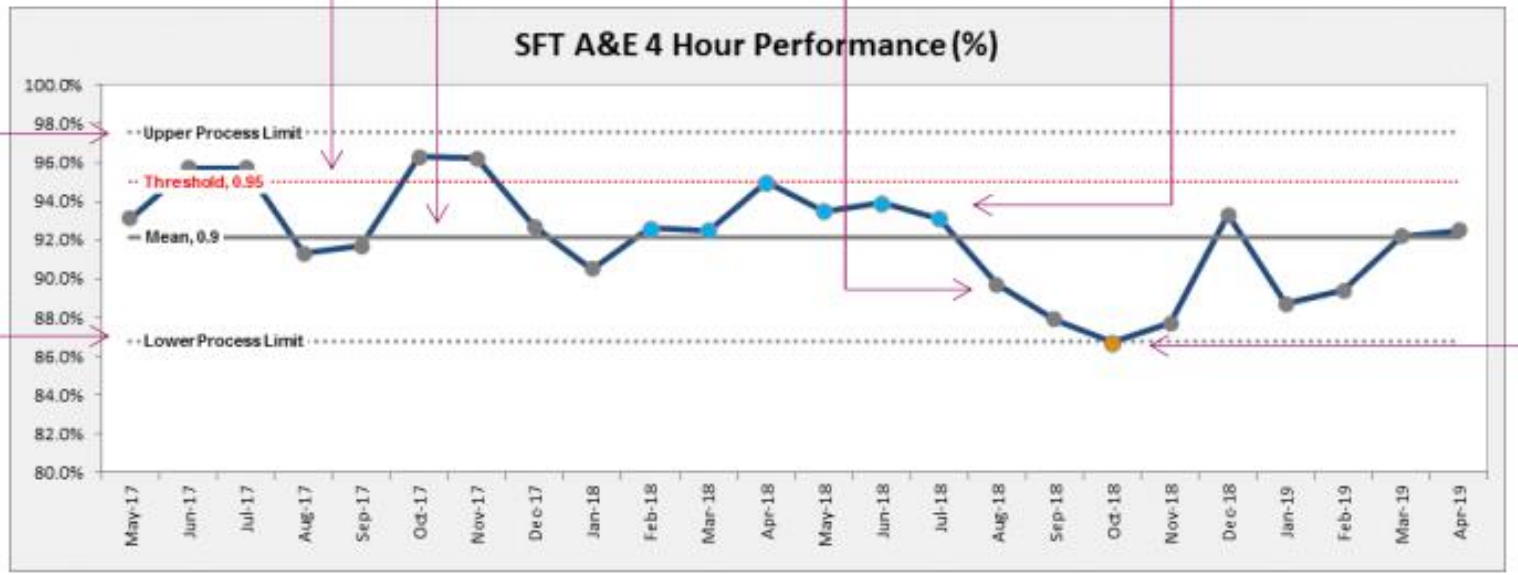
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

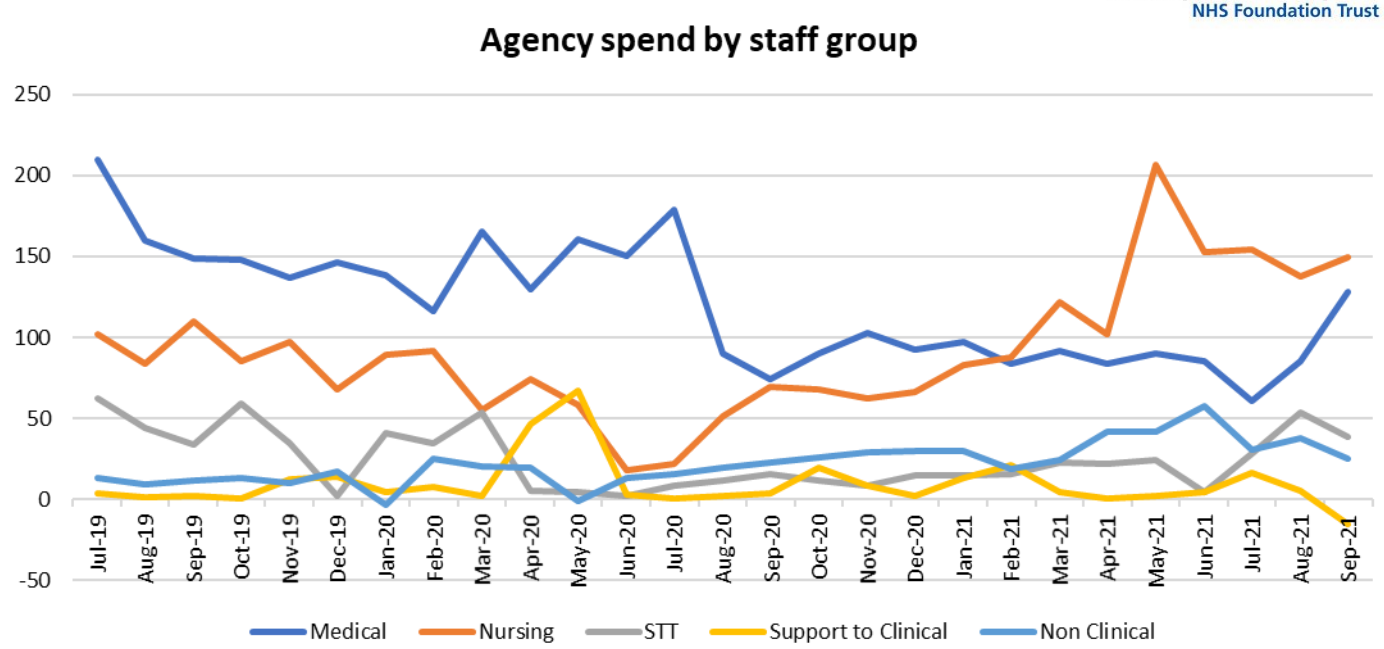
Workforce Monthly Snapshot Overview

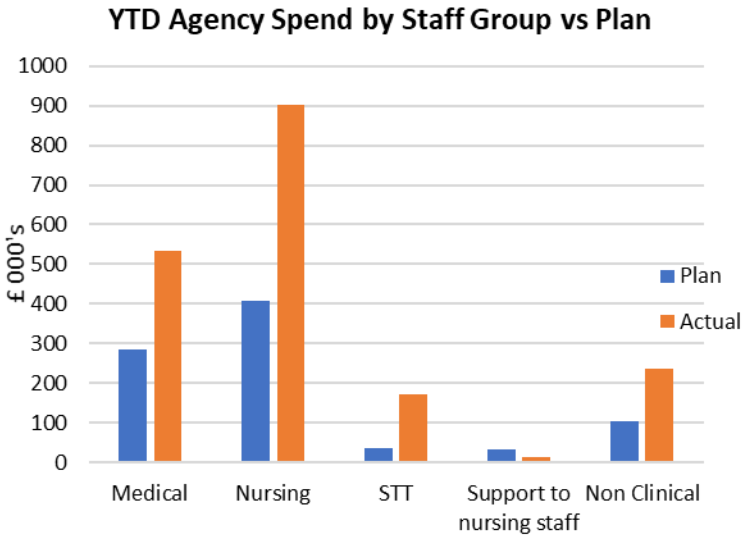
NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

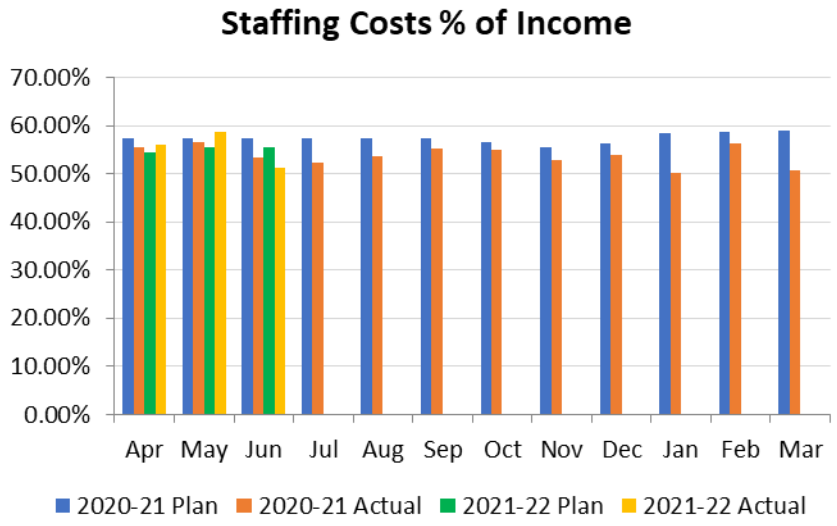
Trust Workforce Metrics	Aug-21	Sep-21	This Month vs Last Month	Trend	KPI
Staff in Post - Headcount	1238	1238	0	-	-
Staff in Post - Full Time Equivalent	1099.95	1097.264	-2.69	-	-
Staff Turnover (%) - Unadjusted	10.42%	11.27%	0.86%	⇧	<=11.5%
Staff Turnover (%) - Adjusted	8.23%	9.20%	0.97%	⇧	<=11.5%
Total WTE Employed as % of Establishment	84.67%	84.47%	-0.19%	⇩	>=93%
Total WTE Employed as % of Establishment - Clinical	82.11%	81.72%	-0.40%	⇩	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.37%	89.53%	0.17%	⇧	>=96%
% of Attendance	94.48%	94.31%	-0.17%	⇩	>=96.3%
% of 12 mth MAA Attendance	94.13%	94.09%	-0.04%	⇩	>=96.3%
% Staff received mandatory training last 12 months	84.11%	90.94%	6.84%	⇧	>=95%
% Staff received formal PDR/appraisal last 12 months	78.24%	77.33%	-0.91%	⇩	>=95%
% of Sickness - Trust wide Long-term	2.94%	3.31%	0.37%	⇧	-
% of Sickness - Trust wide Short-term	2.57%	2.37%	-0.20%	⇩	-
Return To Work Completion %	51.66%	54.67%	3.01%	⇧	>=80%

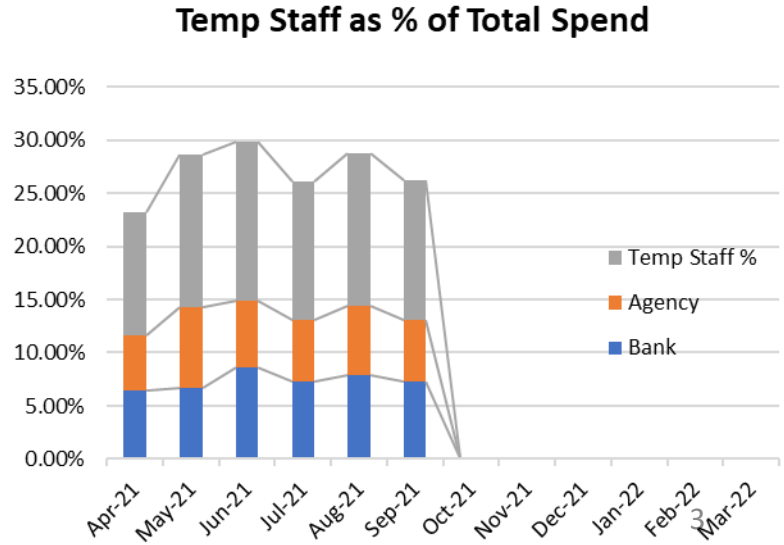
Workforce Composition & Cost

Sep-21		
Pay Cost Analysis		
	£'000's	Variance
Planned Income YTD	52321	
Actual Income YTD	54797	104.73%
Planned Pay Staffing Costs (YTD)	29127	
Actual Pay Staffing Costs (YTD)	30493	105%
Planned Substantive Pay Costs (YTD)	25318	
Actual Substantive Pay Costs (YTD)	26274	104%
Planned Bank Pay Costs (YTD)	1987	
Actual Bank Pay Costs (YTD)	2256	114%
Planned Agency Pay Costs (YTD)	1722	
Actual Pay Costs (YTD) Agency Staff	1859	108%
Planned Agency Pay Costs as % of total Pay costs (YTD)		5.91%
Actual Agency Pay Costs as % of total Pay costs (YTD)		6.10%









***All Data From Oct 20 – Sep 21**

Workforce Establishment

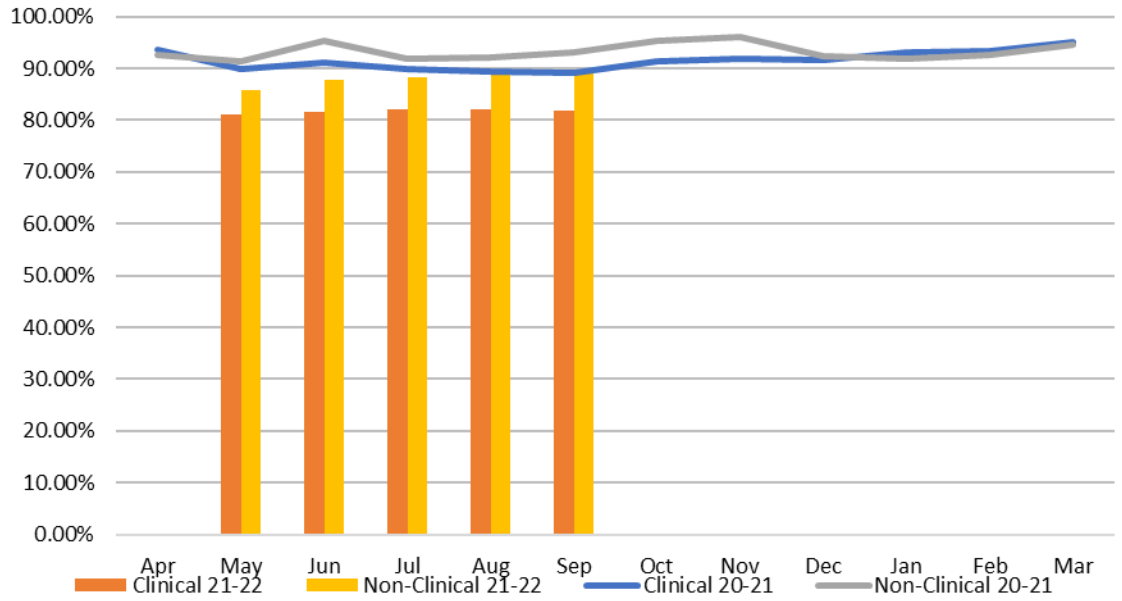
The Royal Orthopaedic Hospital NHS Foundation Trust

Summary

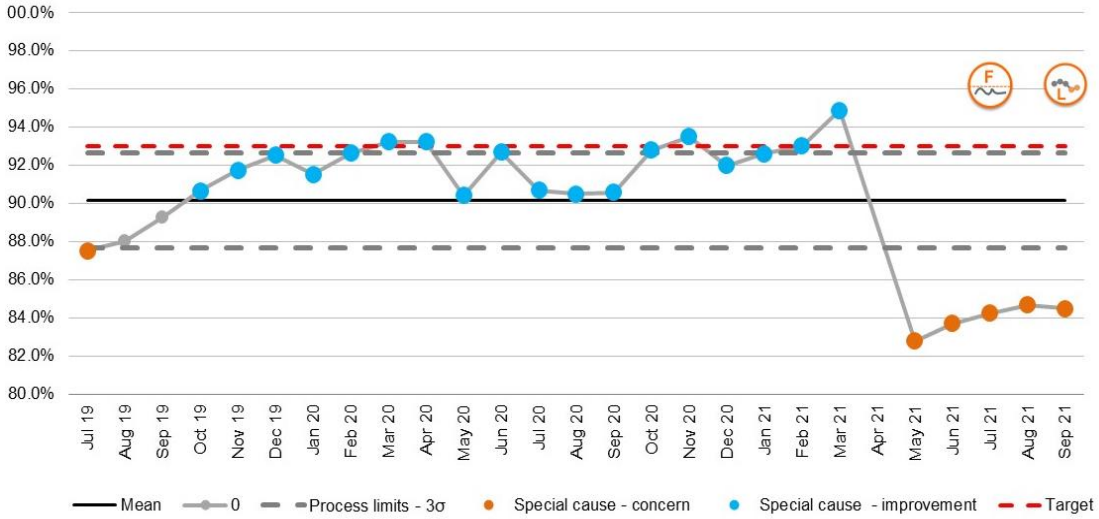
At the end of September, the number of staff on payroll stood at 1238 (WTE 1097.262) which is a decrease of **2.69 WTE** from August.

The Total WTE Employed as a % of the Establishment this month was **84.47%** which rests below the Trust Target 93%. Following the start point budgets for the financial year being reset in April, the establishment has been steadily increasing over the last few months.

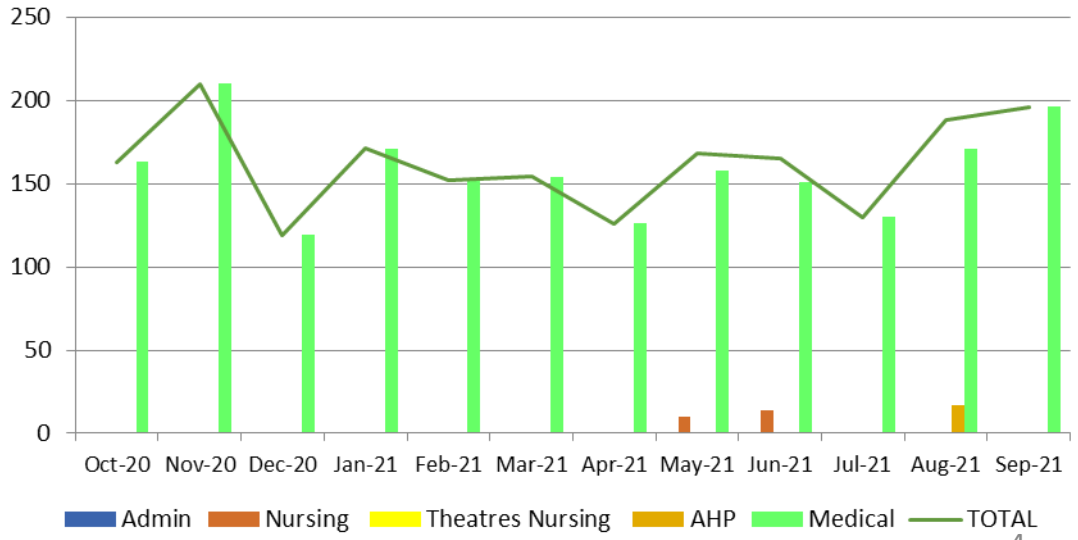
Staff in Post v Establishment Clinical / Non-Clinical



Total WTE Employee as a % of Establishment



Agency Breaches



Workforce Turnover

The Royal Orthopaedic Hospital NHS Foundation Trust

Summary

Unadjusted turnover (all leavers excluding rotational doctors) for this month was **11.27%** which rests just below the Trust target of 11.5%. The Corporate Division continues to have the highest turnover of all divisions this month at **19.80%** in September 2021 and **18.69%** in August 2021. Division 2 turnover has increased to over 10% this month at **11.06%** which should be monitored as this is close to becoming of concern against the Trust targets.

For unadjusted turnover by staff group, over the last 12 months, turnover was the highest in the Administrative & Clerical staff group, closely followed by Allied Health Professionals which are both in the red category against the Trust target.

Risk / Issues

A revised process implemented at the end of April 2021 has supported with more accurate reporting of the turnover of staff within the Trust. Previously for any substantive staff that left the Trust and wanted to remain on the bank, they were marked at retained staff and the system wasn't fully acknowledging the termination of the substantive post. The new process includes completing ending all assignments in addition to the substantive post and re-creating staff records for any staff which wish to remain on the back. We anticipate that over the next few months, that turnover may continue to rise in line with this.

Actions

Analysis should be undertaken of exit questionnaires / interviews to understand and establish any themes contributing to higher turnover in the Administrative & Clerical, and Allied Health Professional's which should then help to understand the higher turnover in the Corporate Division & Division 2 – Patient Support respectively.

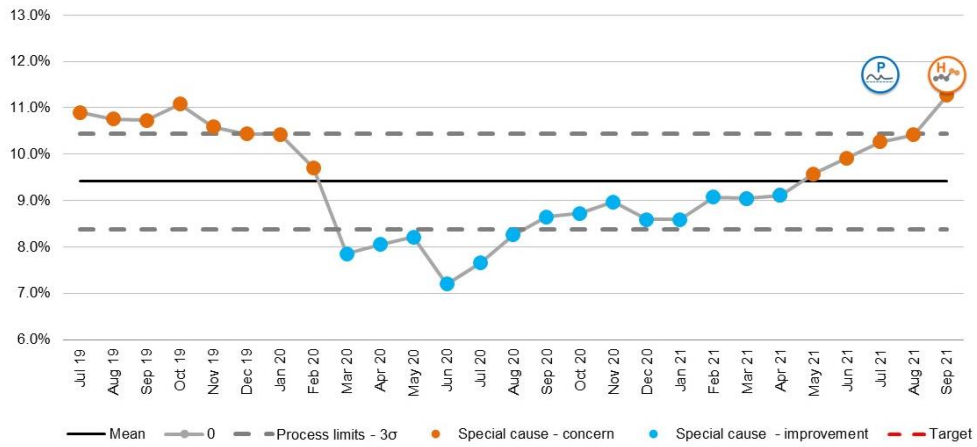
Analysis will be undertaken in the future to understand our substantive leavers to bank retention rate once more data is available on this.

Staff Group	FTE
Add Prof Scientific and Technic	11.26%
Additional Clinical Services	12.04%
Administrative and Clerical	13.96%
Allied Health Professionals	13.37%
Estates and Ancillary	6.02%
Medical and Dental	5.20%
Nursing and Midwifery Registered	11.12%

***Data From Oct 20 – Sep 21**

	TOP 3 LEAVING REASONS (Oct 20 -Sep 21)	
	ESR Data	Exit Questionnaire
1	Voluntary Resignation - Other/Not Known	Employee morale
2	Voluntary Resignation - Promotion	Lack of recognition
3	Voluntary Resignation - Relocation	Unrealistic workload

Staff Turnover Unadjusted (%)



Leaving Reasons

Summary

Over the last 12 months, the main reasons for staff leaving (according to ESR data) were other not known, promotion and relocation which is similar to previous months. From the exit questionnaires, over the last 3 months, the most common leaving reason was employee morale, followed by lack of recognition and unrealistic workload which has crept up over the last 6 months.

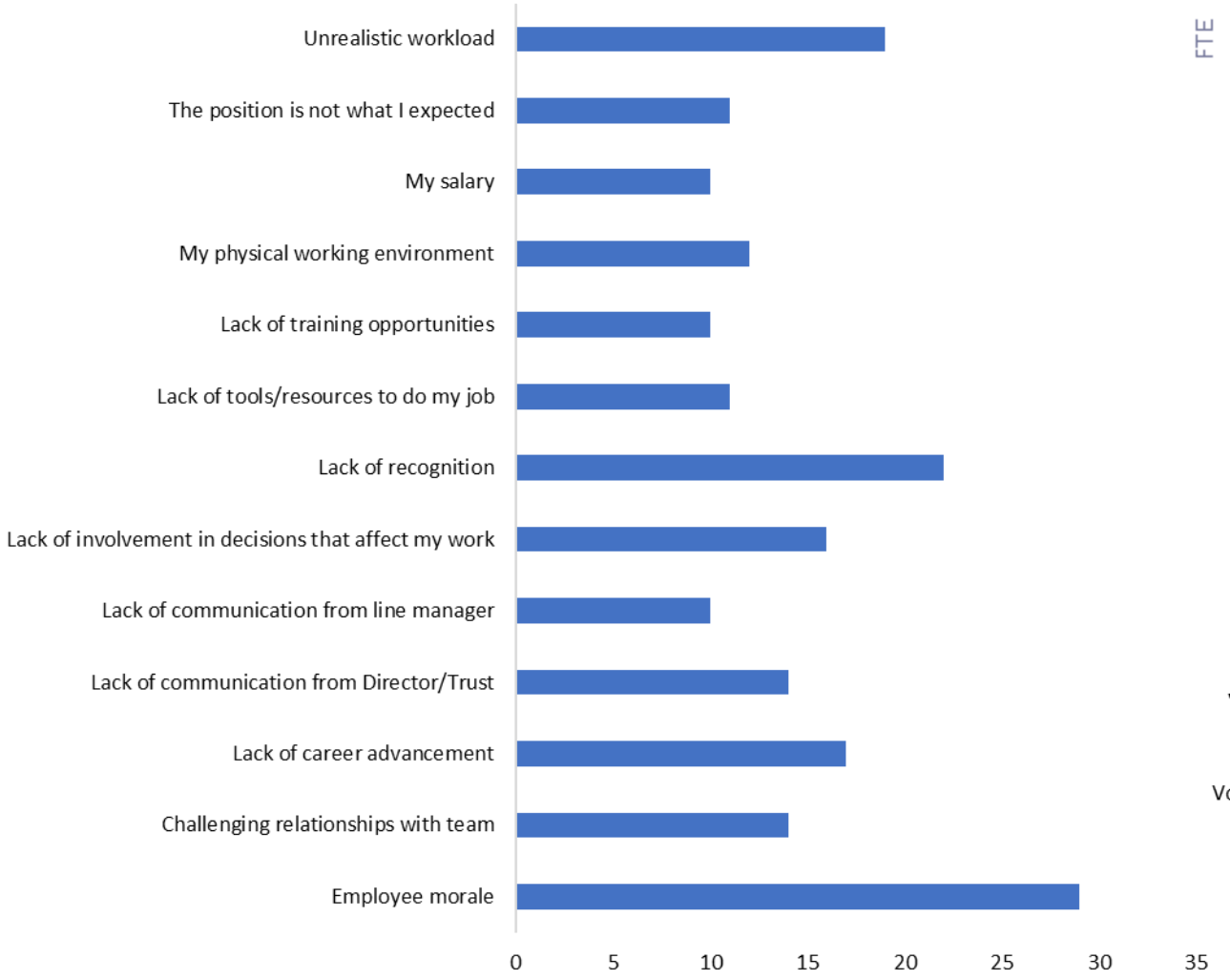
66.17% of leavers over the last 12 months were with the Trust for less than 5 years

Actions

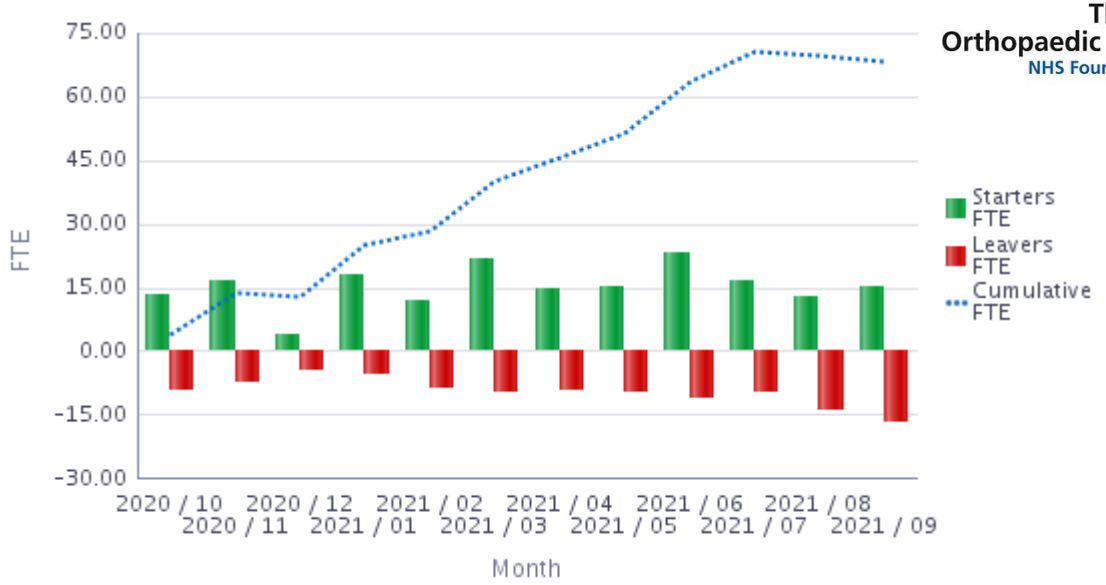
HR will continue to encourage managers to select more specific leaving reasons when doing terminations through ESR where possible.

Workforce Turnover - Starters and Leavers Data

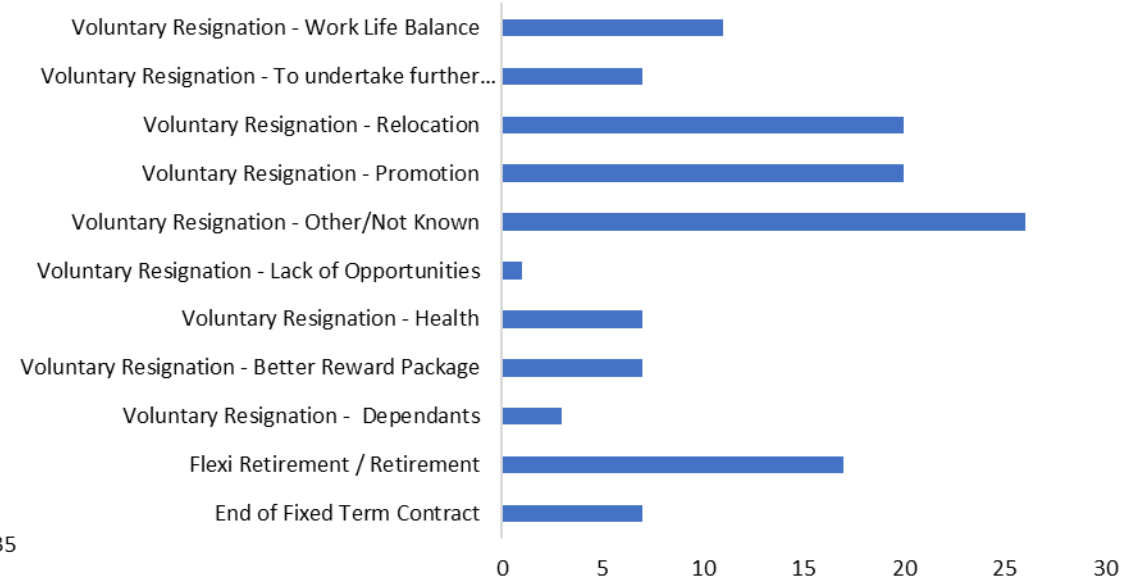
Top 10 Reasons For Leaving (All Staff) Exit Questionnaire Data



*Data From Oct 20 – Sep 21



Reasons For Leaving (ESR Data)



*Data From Oct 20 – Sep 21

Workforce Attendance & Sickness Absence

Summary

Attendance & Sickness Absence

Attendance for this month was **94.31%** (sickness absence % = 5.69%) and Attendance for the rolling past 12 months was **94.09%.** This currently sit below the Trust target of 96.3% and has remained fairly consistent over the past few months.

Over the last 12 months, sickness absence has cost the Trust approximately **£1,983,963.96**

The top reasons for sickness absence included cold cough or flu like symptoms (including COVID-19), gastrointestinal problems and musculoskeletal problems.

At the end of September 2021, there were 36 staff on long term sickness, where 5 of the these staff members have been absent for longer than 6 months.

COVID Related Absence

This month COVID-related sickness made up **0.25%** of all sickness absence within the Trust. Compared to this time last year, the figures are slightly lower which suggests positive impact of measures to reduce the spread of infection e.g. vaccinations.

Furthermore, over the last 12 months, COVID related sickness absence has cost the Trust approximately £286,961.70. COVID-related absence data is reported daily to NHS England and weekly to the BSOL STP.

Return To Work Discussion Meetings Following Sickness Absence

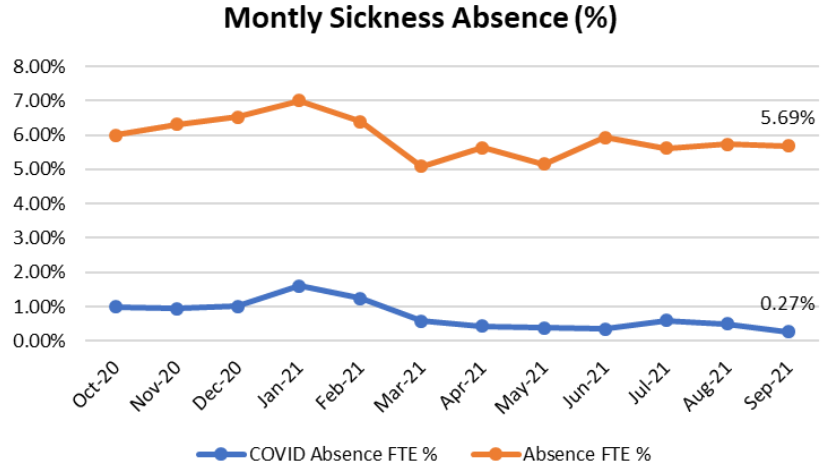
Trustwide Return To Work (RTW) interviews decreased increased to **54.67%** in September, compared to **51.66%** in August. This still remains below the Trust Target of 80%.

Risks / Issues

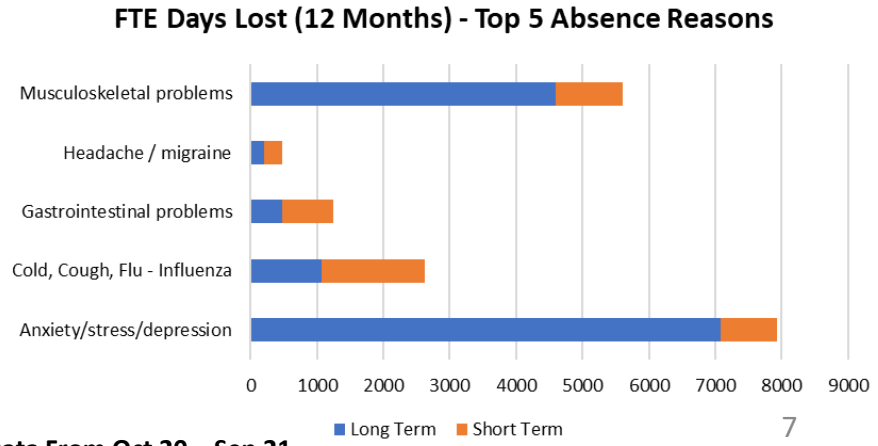
There is a risk that Return to Work meetings following sickness absence are not happening in a timely manner / being recorded on the system accurately

Actions

HR are continuing to support managers with ensuring that absence meetings are taking place in a timely manner and staff are being supported throughout their absence.



Top Absence Reasons In Last 12 Months by FTE Days Lost	Amount of Episodes	FTE Days Lost	Estimated Cost of Absence
Anxiety/stress/depression	202	7930.30	£696,911.37
Cold, Cough, Flu - Influenza	311	2620.18	£260,627.31
Gastrointestinal problems	306	1250.43	£119,226.94
Headache / migraine	137	472.61	£45,697.88
Musculoskeletal problems	271	5605.07	£429,205.06

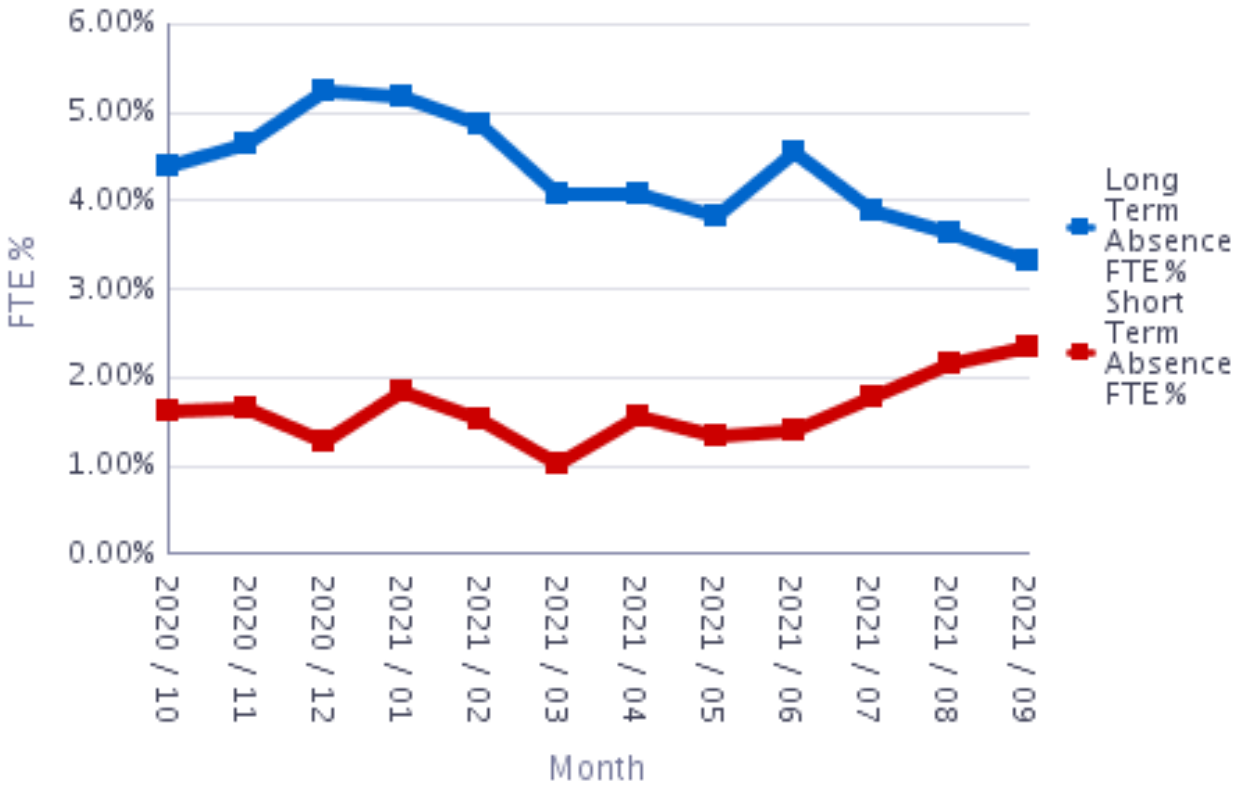


*Data From Oct 20 – Sep 21

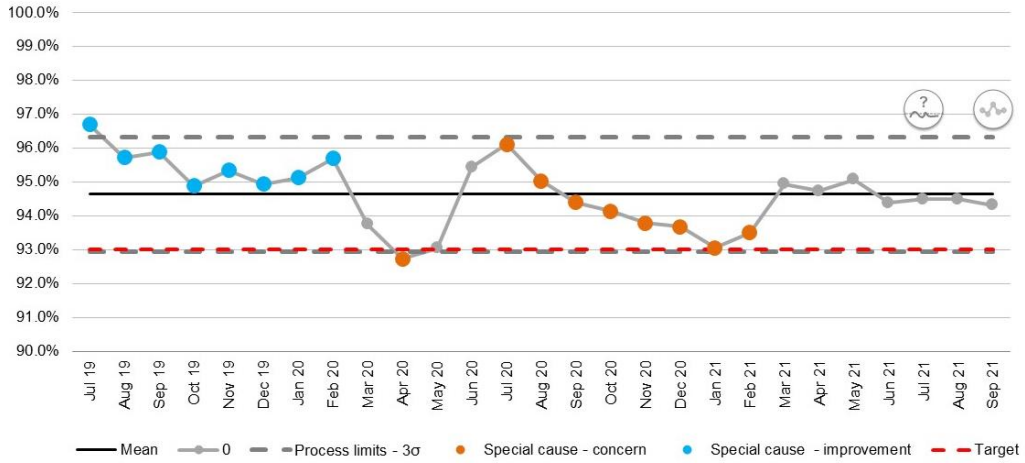
Workforce Attendance & Sickness Absence

The Royal Orthopaedic Hospital NHS Foundation Trust

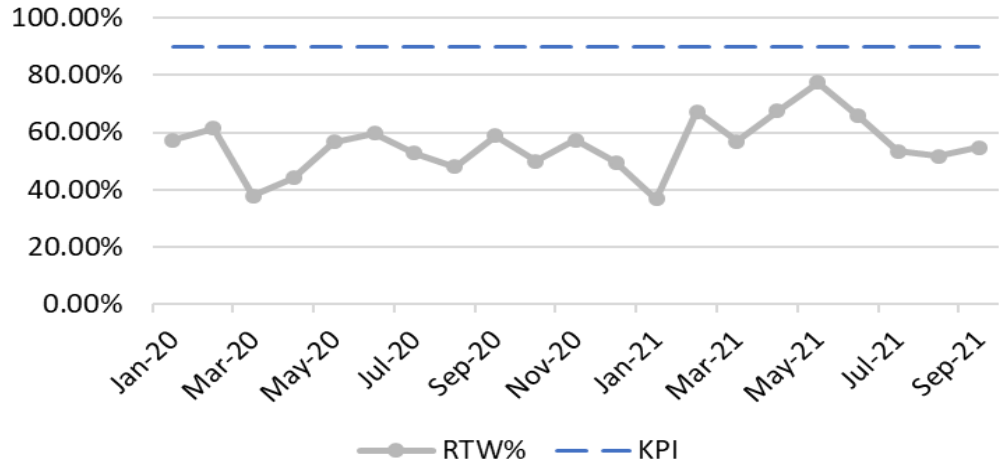
Long Term / Short Term Absence FTE (%)



Monthly Staff Absence FTE (%)



Monthly Return To Work %



***Data From Oct 20 – Sep 21**

Formal Capability / Disciplinary Processes

The Royal Orthopaedic Hospital NHS Foundation Trust

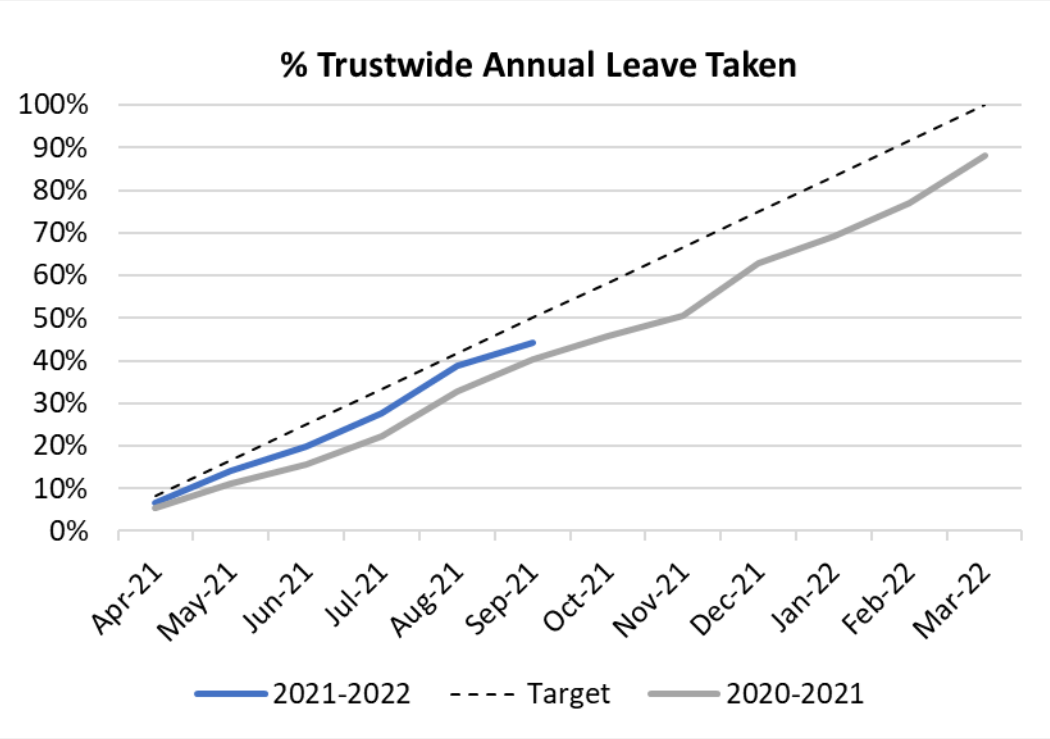
Summary and Actions

At the end of September, there were no formal capability cases and no formal conduct cases. Since June, two formal conduct case were closed.

Actions

Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being kept informed of any informal processes to ensure we can anticipate potential future formal cases and appropriate action/measures that needs to be considered.

Workforce Wellbeing



Annual Leave

At the end of Q2 (Sep 21) for the financial year, AfC staff have taken **44.11%** of their annual leave entitlement. At this point in the year, staff are expected to have taken at least 50% of their annual leave entitlement, to support staff in having regular rest breaks

% Annual Leave Taken as at 30th September 2021

Division	% Annual Leave Taken
303 Corporate Directorate	39.49%
303 Covid-19 Division	34.74%
303 Division 1 - Patient Services	44.95%
303 Division 2 - Patient Support	44.97%
303 Division 4 - Estates and Facilities	46.05%
Trust Total	**44.11%**

Staff Group	% Annual Leave Taken
Add Prof Scientific and Technic	42.32%
Additional Clinical Services	45.48%
Administrative and Clerical	43.17%
Allied Health Professionals	40.98%
Estates and Ancillary	45.45%
Registered Nursing	44.54%

Wellbeing Day

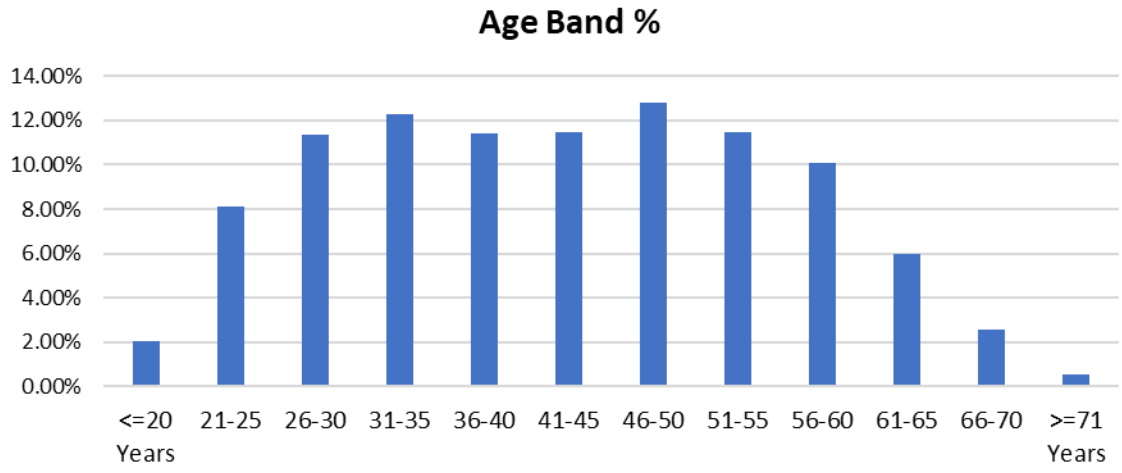
At the end of September, **32%** of eligible staff have taken their wellbeing day. There are a further **7%** of staff so far who have this booked in the coming financial year. Staff are continually being encouraged to their wellbeing days in line with regular annual leave

Workforce Demographics

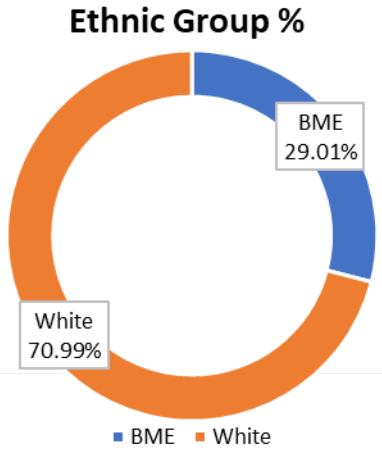
Summary

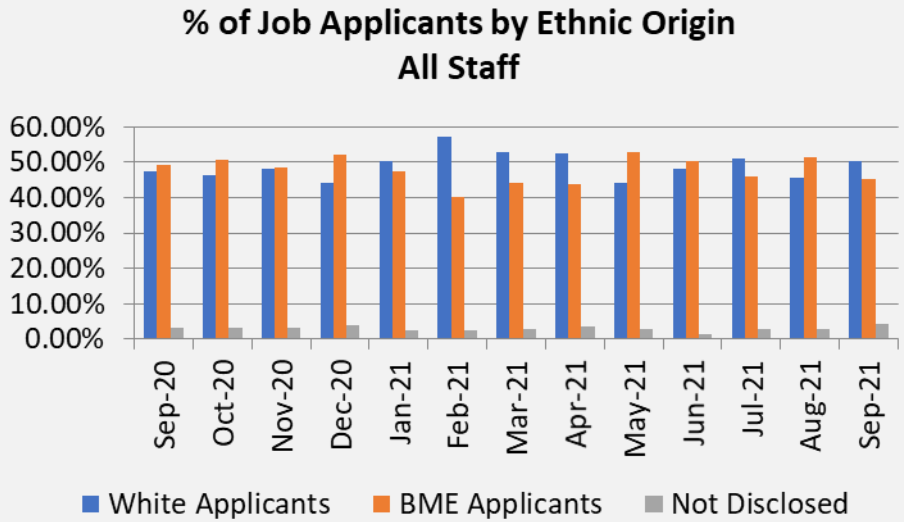
The Trust (including bank staff) is made up of 70.93% female and 29.06% male staff

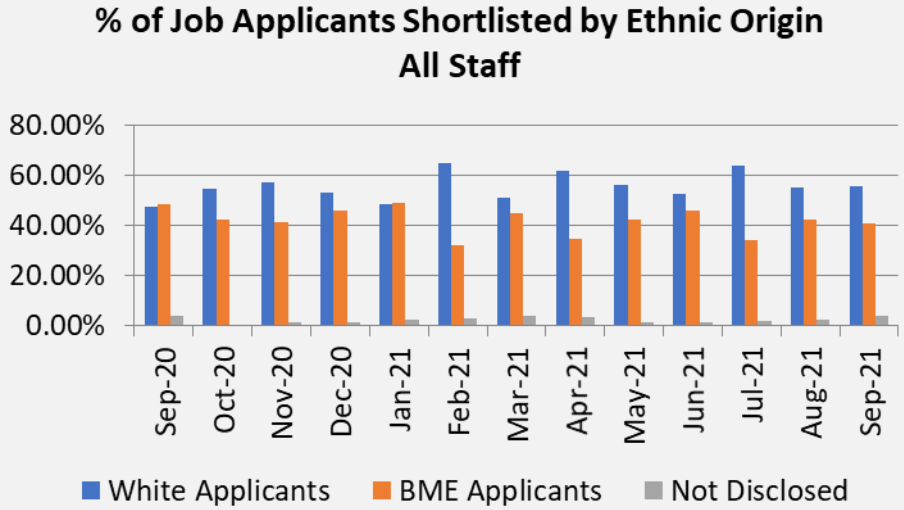
Our current status of staff with a disability is 3.6% with **15.8%** of staff still to declare their disability status. Staff are being encouraged to update their equality and diversity details through Electronic Staff Record



NHS
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2021	2020	2019	2018	2017	2016	National Benchmark
1.64	1.36	1.70	1.64	1.45	1.99	1.60

WRES Indicator 2 – Relative Likelihood of BME Appointment From Shortlisted Candidates

Over the last few months, the percentage of staff not disclosing their ethnic background has slowly increased to 4.40% of all applicants

Applications from BME staff made up 45.24% of all applications made in September

40.75% of shortlisted candidate were from a BME background, with 3.8% undisclosed

Workforce – Experience and Engagement

The Royal Orthopaedic Hospital NHS Foundation Trust

Quarterly NHS Staff survey (previously Friends and Family Test (FFT))
A new staff survey format has been launched by NHS England. Most recent Information confirms that the Trust will be required to start the survey at ROH in January 2022.

The **National NHS survey (NSS)** launched on October 1st 2021. Each Executive Director is leading on supporting staff in completing the survey in order to share their feedback. The campaign is being led by the OD and Inclusion team with support from Communication Team, Knowledge Hub library and the staff survey champions.

Inclusion Work
Data for the Workforce Disability Equality standard (WDES) and Workforce Race Equality standard (WDES) standards has been submitted to NHS England. Action plans for each standard have been formulated in collaboration with the staff networks at the Trust and linked to the ROH Inclusion plan

The Multi Minority Ethnic Group (MMEG) has planned and is running the ROH Black History Month in October 2021

The photography and video exhibition has now been launched as a physical display outside Outpatients and online. There was good representation from across the Trust at the launch and positive feedback from staff members, regional and national partners. The next phase of the project will be to develop awareness session and also a Buddy scheme in line with the mentoring work continuing across the Trust.

The BeMyself LGBTQ+ team worked with regional teams to co-ordination an NHS float at Birmingham Pride in September 2021.

Network meeting have taken place in September and October for Equality and Diversity, Disability Network, Menopause support group and Multi Minority Ethnic Group (MMEG). Key focus for the networks is planning for events in the future to engage staff across all departments. Election for the Disability network chair is now underway

Workforce – Experience and Engagement

The Royal Orthopaedic Hospital NHS Foundation Trust

Health and Wellbeing

The work around **Health and Wellbeing** is now focussed on supporting staff through the recovery phase for Covid-19. Information is currently available through information packs on the intranet and in departments, one to one meetings and manager calls. Key work to support staff includes:

- Thrive at work – continue with Bronze Accreditation. West Midlands Combined Authority have confirmed that the Trust will receive this accreditation by January 2022
- Health and Wellbeing Room is now completed and all staff can access the space
- The finance for the BSol bid have been confirmed which total approximately £27000. This money will be used for an outdoor wellbeing space at ROH
- New Menopause Support Posters to be distributed and a successful Menopause awareness event was run on October 18th (as well as the ITV news piece)
- Revised Heath and Wellbeing Conversations within a 1:1 format currently being developed
- Health and Wellbeing Champions working with national and regional colleagues and supporting staff survey work
- TWIG (Trust Wellbeing and Implementation Group Meeting) – worked needed to review members of group
- A successful Health and Wellbeing Week on 13th-17th September – a full evaluation is underway

Future Events

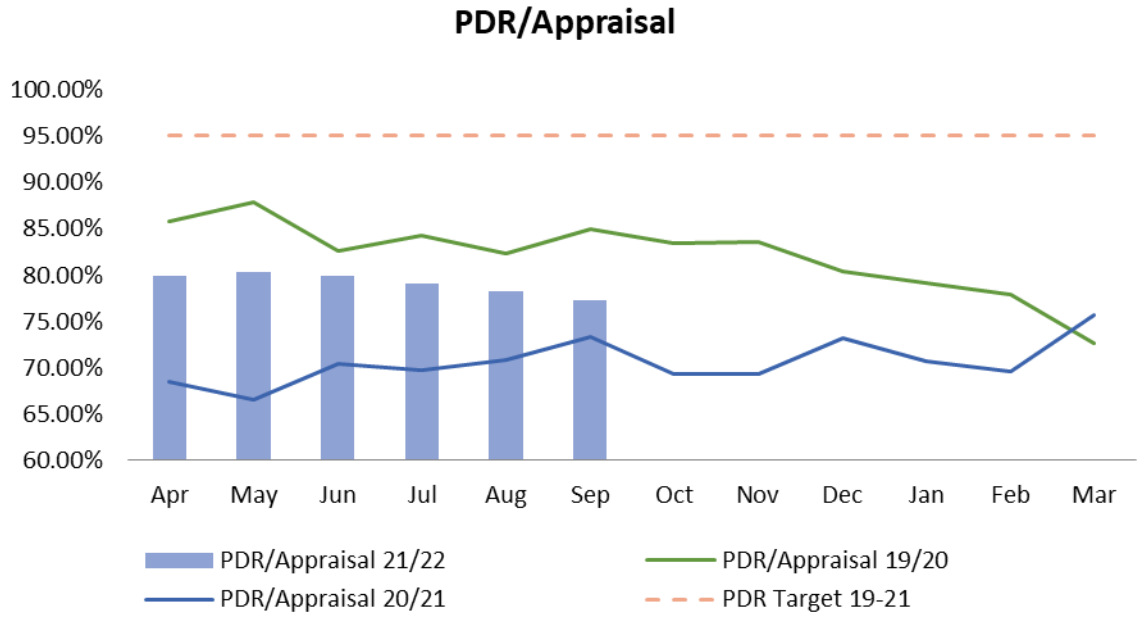
Wellbeing at Christmas

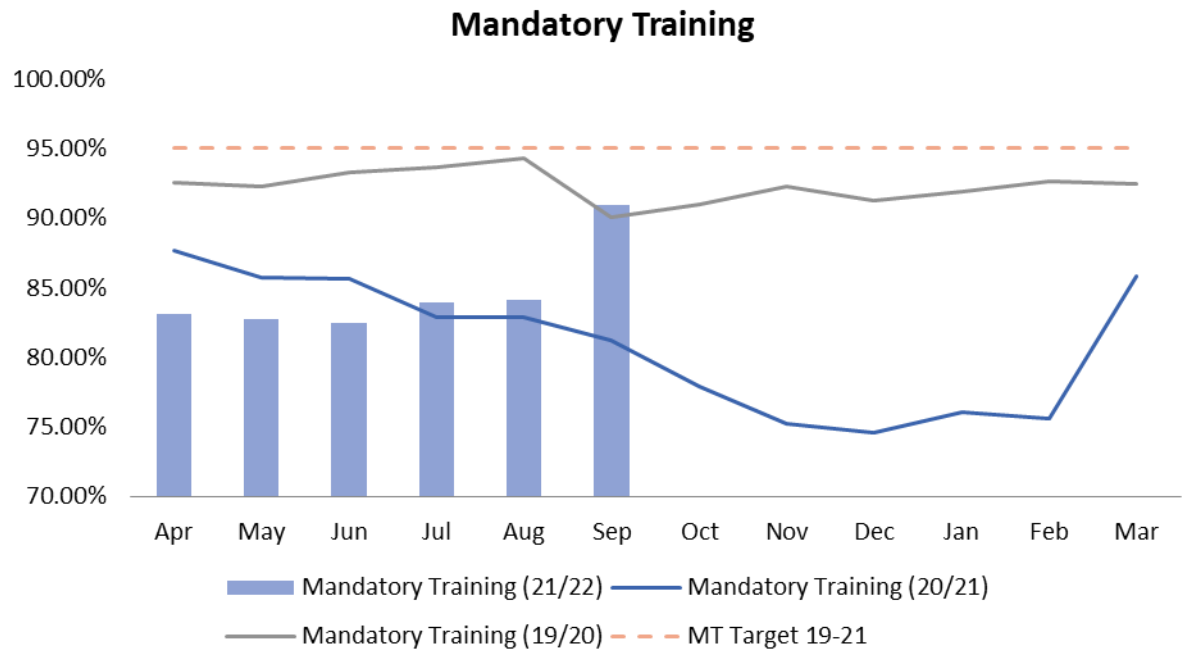
Men's Health awareness in November

Support has been offered to a number of department across the Trust to facilitate **team building** and a high performance team culture with sessions which have taken place in September and October with some key actions confirmed for improvement

We recognise that some staff may not be able to participate in all activities where there are work pressures and fatigue across staff groups, but we continue to ensure all staff are make aware of support available and events upcoming within the Trust

Training and Development





Appraisals

Appraisals completions decreased by 0.91% to **77.33%** in September and retains it's red status against the Trust target of **95%**

The ESR & HR Teams are continuing to liaise directly with teams where there is continual non-compliance and also support managers with ensuring the information is accurately recorded on ESR in a timely manner.

Mandatory Training

Mandatory training increased by 6.84**%** to **90.94%** in September, moving to the orange status against the Trust's target of **95%.** This is the first time since March 2020 that staff have been more than 90% compliant in this.

Staff are still actively being encouraged to complete their mandatory training via e-Learning. New starters are also being supported with completing their mandatory training prior to starting.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday 1 December 2021

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 December 2021 commencing at **0900h**.

Unfortunately, due to the implications of the ongoing Coronavirus pandemic and the need to adhere to social distancing guidelines set by the government, the public or press are not invited to join the meeting. The agenda and papers for the public part of the meeting are available on the website however.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.



Tim Pile

Chairman

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

Venue Woodbrooke Centre, 1046 Bristol Road, Birmingham **Date** 1 December 2021: 0900h – 1130h

Members attending

Mr Tim Pile	Chairman	(TP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Kathryn Sallah	Non Executive Director & Senior Independent Director	(KS)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Leslie Williams	Non Executive Director	(LW)
Mrs Ayodele Ajose	Non Executive Director	(AA)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Chief Nurse	(GM)

In attendance

Ms Rebecca Furnival	Safeguarding Nurse	(RF)	[Item 1]
Mr Ashleigh Tullett	Head of Clinical Governance	(AT)	[Item 8]
Mrs Sharon Malhi	Acting Associate Director of Workforce & OD	(SM)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
0900h	1	Patient story: Domestic absuse	Presentation	GM
	1.1	Future patient stories	Verbal	GM
0920h	2	Apologies	Verbal	Chair
0922h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 6 October 2021: *for approval*	ROHTB (11/21) 022	Chair
	4.1	Actions from previous meetings in public: *for assurance*	ROHTB (11/21) 022 (a)	SGL
0925h	5	Questions from members of the public	Verbal	Chair
0927h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (12/21) 001 ROHTB (12/21) 001 (a)	TP/JW
0945h	7	COVID-19 update: *for assurance*	Verbal	GM
0950h	8	National Patient Safety strategy: *for assurance*	ROHTB (12/21) 002	AT

1005h	9	Board Assurance Framework: *for assurance*	ROHTB (12/21) 003 ROHTB (12/21) 003 (a)	ALL
		MATTERS TO BE TAKEN BY EXCEPTION ONLY		
1015h	10	Upward assurance reports: • Finance & Performance Committee • Quality & Safety Committee • Staff Experience & OD Committee	To follow ROHTB (12/21) 004 ROHTB (12/21) 005	
1025h	11	Performance reports: *for assurance* • Finance & Performance • Quality & Safety	ROHTB (12/21) 006 ROHTB (12/21) 007	
		BREAK		
		CONFIDENTIAL SESSION		
1045h	12	Exclusion of the press and public	Verbal	Chair
	Date of next meeting: Wednesday, 2 February 2021 @ 0900h			

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 – UPDATED TO NOVEMBER 2021

MEMBER	ATTENDANCE										TOTAL
	7/5/2021	5/5/2021	2/6/2021	7/7/2021	1/9/2021	7/10/21	2/11/2021	12/1/2022	2/2/2022	2/3/2022	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓				7/7
Kathryn Sallah	✓	✓	✓	✓	✓	✓	A				6/7
Richard Phillips	✓	✓	✓	✓	✓	✓	✓				7/7
David Gourevitch	✓	✓	✓	✓	✓	✓	✓				7/7
Simone Jordan	✓	✓	✓	✓	✓	✓	A				6/7
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	✓				7/7
Ayodele Ajose	✓	✓	✓	✓	✓	A	✓				6/7
Les Williams	✓	✓	✓	A	✓	✓	✓				6/7
Jo Williams	✓	✓	✓	✓	✓	✓	✓				7/7
Matthew Revell	✓	✓	✓	✓	✓	✓	✓				7/7
Garry Marsh	✓	✓	✓	✓	✓	✓	✓				7/7
Phil Begg	✓	✓	✓	✓	A	✓	✓				6/7
Marie Peplow	✓	✓	✓	✓	✓	✓	✓				7/7
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓				7/7
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓				7/7
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓				7/7

KEY:

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