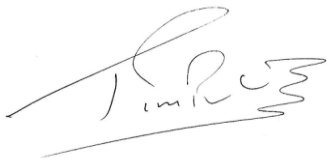
Notice of Trust Board Meeting in Public on Wednesday, 6 September 2023

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 6th September 2023, in the Boardroom, Trust HQ commencing at **09:00**.

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

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



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD (IN PUBLIC)

Venue Boardroom, Trust Headquarters **Date** 6 September 2023: 09:00h – 13:00h

Members attending

Mr Tim Pile	Chair	(TPi)
Mr Richard Phillips	Non Executive Director	(RPh)
Mrs Gianjeet Hunjan	Non Executive Director	(GHu)
Mr Les Williams	Non Executive Director	(LWi)
Ms Ayodele Ajose	Non Executive Director	(AAj)
Dr Ian Reckless	Non Executive Director	(IR)
Mrs Jo Williams	Chief Executive	(JWi)
Mrs Nikki Brockie	Executive Chief Nurse	(NBr)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SMa)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Dr Steven Beaumont	Interim Deputy Chief Nurse	(SB)	[Items 1 & 1.1]
Mrs Alison Newman	Personal Assistant & Revalidation Officer	(AN)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Patient Story	ROHTB (9/23) 001	SB
09:25	1.1	Schedule of patient stories 2023/24	ROHTB (9/23) 002 ROHTB (9/23) 002 (a)	SB
09:30	2	Apologies: Chris Fearns, Simone Jordan*, Matthew Revell*	Verbal	Chair
	3	Declarations of Interest. *Register available on request from the Director of Governance*	Verbal	Chair
	4	Minutes of Board Meeting held in Public on 5 July 2023: *for approval*	ROHTB (7/23) 017	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (7/23) 017 (a)	SGL
09:35	6	Questions from members of the public	Verbal	Chair
09:37	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (9/23) 003 ROHTB (9/23) 003 (a)	TP/JW
10:00	8	Speaking Up and Incident Management at the ROH: *for assurance*	ROHTB (9/23) 004 ROHTB (9/23) 004 (a) – (c)	SGL

10:15	9	Wellbeing strategy and Cost of Living update: *for assurance*	ROHTB (9/23) 005 ROHTB (9/23) 005 (a) – (c)	SM
10:30	9.1	Childcare offering	Verbal	JW
10:35	10	Turnover and retention plan update: *for assurance*	ROHTB (9/23) 006 ROHTB (9/23) 006 (a)	SM
10:45	11	Equality & Diversity action plan: *for assurance*	ROHTB (9/23) 007 ROHTB (9/23) 007 (a) ROHTB (9/23) 007 (b)	SM
11:00	**BREAK**			
11:10	12	Accreditation as an elective hub: *for assurance*	ROHTB (9/23) 008 ROHTB (9/23) 008 (a) – (f)	MP
11:20	13	Expanding elective capacity self-assessment: *for assurance*	ROHTB (9/23) 009 ROHTB (9/23) 009 (a) – (c)	MP
11:35	14	Patient Safety Incident Response Framework (PSIRF) update: *for information*	ROHTB (9/23) 010	SGL
11:45	15	NHSE Violence Prevention & Reduction standards – self-assessment and action plan: *for assurance*	ROHTB (9/23) 011 ROHTB (9/23) 011 (a)	SGL
	MATTERS FOR APPROVAL			
11:55	16	Annual reports for Safeguarding & Vulnerabilities: *for approval*	ROHTB (9/23) 012 ROHTB (9/23) 012 (a) ROHTB (9/23) 012 (b)	NB
12:05	17	Emergency Preparedness, Resilience & Response (EPRR) care standards self-assessment: *for approval*	ROHTB (9/23) 013 ROHTB (9/23) 013 (a)	SW
12:10	18	Revised Board Assurance Framework: *for approval*	ROHTB (9/23) 014 ROHTB (9/23) 014 (a) – (f)	SGL
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
12:20	19	Upward reports from the Board Committees: a) Quality & Safety Committee b) Finance & Performance Committee c) Staff Experience & OD Committee d) Audit Committee	ROHTB (9/23) 015 ROHTB (9/23) 016 ROHTB (9/23) 017 ROHTB (9/23) 018	Cttee Chairs

	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
12:35	20	National regulatory changes: Fit & Proper Persons Test and CQC Inspection Framework: *for information*	ROHTB (9/23) 019 ROHTB (9/23) 019 (a) – (c)	SGL
	21	Joint working forum with Robert Jones & Agnes Hunt NHSFT: *for information*	ROHTB (9/23) 020 ROHTB (9/23) 020 (a)	SGL
	22	Flu' and COVID vaccinations programme: *for assurance*	ROHTB (9/23) 021 ROHTB (9/23) 021 (a)	NB/SW
	23	Net zero progress update: *for assurance*	ROHTB (9/23) 022 ROHTB (9/23) 022 (a)	SW
	24	Learning from Deaths update: *for assurance*	ROHTB (9/23) 023 ROHTB (9/23) 023 (a)	NB
	25	Performance Reports: *for assurance* a) Finance & Performance b) Quality & Patient Safety c) Workforce Overview	ROHTB (9/23) 024 ROHTB (9/23) 025 ROHTB (9/23) 026	
	26	Exclusion of the press and public	Verbal	Chair
	CLOSE: Date of next meeting: Wednesday, 4 October 2023 @ 09:00 – 15:00			

Notes

Quorum:

i. No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

ii. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

iii. If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

* Apologies noted due to attending NHSE conference on behalf of the Trust

ATTENDANCE REGISTER – FY 2023/24 UPDATED TO JULY 2023

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

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

DRAFT PART ONE MINUTES - Trust Board Meeting in Public
5th July 2023, 09:00 – 12:35
Boardroom, Trust Headquarters

Members attending

Mr Tim Pile	Chair	(TPi)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJo)
Mr Richard Phillips	Non Executive Director	(RPh)
Mrs Gianjeet Hunjan	Non Executive Director	(GHu)
Ms Ayodele Ajose	Non Executive Director	(AAj)
Dr Ian Reckless	Non Executive Director	(IR)
Mrs Jo Williams	Chief Executive	(JWi)
Mr Matthew Revell	Executive Medical Director	(MRe)
Mrs Nikki Brockie	Executive Chief Nurse	(NBr)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SMa)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mrs Ali Sprason	Charity Manager	(ASp) [Item 9]
Ms Ruth Hughes	Charity Officer	(RHu) [Item 9]
Mr Amos Mallard	Deputy Director of Strategy & Head of Communications	(AMa) [Item 10]
Mr Rob Rowberry	Public Governor	(RRo)
Miss Jane Dominese	Corporate Services Manager	(JDo) [Secretariat]

Minutes		**Paper Reference**
1	**Welcome**	**Verbal**
1.1	The Chair opened the public meeting at 09:05 and welcomed all present. SWa was congratulated on his recent appointment to the substantive position of Executive Chief Finance Officer.	
2	**Apologies (Chair)**	**Verbal**
2	Apologies had been received from Chris Fearns and Les Williams and were accepted.	
3	**Declarations of Interest (Chair)**	**Verbal**
	There were no new interests declared. The Register was available, on request, from the Executive Director of Governance.	
4	**Minutes of Board Meeting held in Public 7th June 2023: (Chair)**	**ROHTB (6/23) 003**
4.1	The minutes of the minutes of the meeting in public held on 7th June 2023 **WERE APPROVED** as an accurate record of discussions held.	
5	**Actions From Previous Meetings in Public: (SGL)**	**ROHTB (6/23) 004**

5.1	The Board noted that a number of actions were proposed for closure. There were two amber actions, the first pertained to childcare arrangements which would be covered later on the agenda and the second, relating to risk management, would be included in the refreshed BAF which would be circulated in advance of the next meeting. The actions proposed for closure **WERE APPROVED**	
6	**Questions From Members of The Public (Chair)**	**Verbal**
6.1	No questions had been received and there were none raised by the Public Governor in attendance.	
7	**Chair's and Chief Executive's update (JWi/TPi)**	**ROHTB (7/23) 006**
7.1	JWi shared that the National NHS Workforce Plan would be launched by the Prime Minister and NHS England. A full review would be undertaken and presented at the SE & OD Committee.	
7.2	Five Colleagues would be attending a service at West Minster Abbey, to mark the 75 years of the National Health Service, on behalf of the Trust. Photographs of the event would be shared once available.	
7.3	Thanks was given to the ROH charity for supporting the 75th Anniversary of the NHS celebrations.	
7.4	A further Junior Doctors' strike had been announced. In addition, notification had been received of an upcoming Consultants' strike, from 13th to 18th July, with 'Christmas Day' cover arrangements being in place. MPe outlined the implications for the Trust and explained that there were potentially 118 cases at risk. UHB lists would be deferred. Patients whose surgery would need to be cancelled would be seen in the two weeks following the industrial action.	
7.5	JWi had recently signed the Armed Forces Covenant. The event had been well attended by staff.	
7.6	The Trust had received the sad news that a long serving member of Housekeeping staff had recently passed away. They had been nominated for a staff award; the family would be represented by the Housekeeping team leader at the awards ceremony.	
7.7	Feedback from the Elective Hub Accreditation panel had been excellent, and results of the visit were being awaited. Thanks was given to MPe for her leadership of the team effort. The learning from the visit, and the staff engagement, would be utilised for other inspections such as that of the CQC.	
7.8	The ROH had been shortlisted for four of the National Orthopaedic Alliance (NOA) Excellence in Orthopaedics Awards; of most note, the innovation in Orthopaedics MoD Osseointegration Surgery.	
7.9	TPi had attended the Volunteer Services Awards and expressed his, and the Board's, thanks to those that gave up their time to support the ROH's work.	
7.10	TPi had attended the Birmingham Health Partnership Board meeting on 8th June. The main purpose of the meeting had been to review the Strategy, a process that was being led by JWi on behalf of all partners. The Strategy had been welcomed and applauded as a major step forward for BHP.	
8	**Wellbeing update including childcare provision (SMa)**	**ROHTB (7/23) 007**
8.1	SMa gave an update on the progress made on the work being completed to deliver the wellbeing strategy and Childcare facilities.	

	The stop, start and continue feedback from staff slides were highlighted. Focus groups would be implemented to discuss requirements.	
8.2	A survey was being undertaken to determine staff childcare requirements. 86% of respondents were accessing childcare for two or more children, for between 20 and 30 hours per week, with an average monthly spend of £500. The majority of responders had indicated they would be interested in an offsite provision and only a small number had not expressed an interest in the subsidised childcare offer.	
8.3	In answer to a question, SMa shared that due to the workforce demographics, there was only a small number of maternity leave taken and planned.	
8.4	A Hardship Fund had been implemented. Seven applications had been received, of which, four had been considered by the awarding panel and had been supported. The Board was advised that it was likely the funds would exhaust quickly and it had been requested by the SE & OD Committee that if that were the case, further funds be allocated to the scheme.	
8.5	The Board expressed the wish for Wellbeing events to be made accessible to all staff.	
9	**Turnover and retention update: (SMa)**	**ROHTB (7/23) 008**
9.1	Due to staff turnover remaining high, it had been agreed for the item to remain on the agenda. Progress on the work being undertaken by the Workforce and OD team was illustrated, and assurance that the action plan had been streamlined was given. The Board expressed concern at the number of actions for the Interim Head of HR Operations and queried if the remaining staff would have the skill to extrapolate the data required. They were given assurance that the new, substantive, Head of HR Operations would be leading on elements of the plan. A draft report would be presented to the August SE & OD Committee giving clarity on staff's reasons for leaving. The Board were advised that every Hospital within BSol reported differently. It had been confirmed that a System Chief People Officer (CPO) would not be appointed. It was suggested that there were a large number of actions and that prioritisation of those that would make a substantial difference would be required.	
9.2	MPe praised the work that the Head of Business Intelligence and Data Quality had completed and added that it had made accessing data more effective.	
9.3	Following a rigorous interview process, a Deputy CPO had been appointed. They had a background in OD, Culture and HR Operations and would be joining the Trust on 2nd October.	
9.4	Following scrutiny of the survey results linked to recruitment and retention, it was agreed that there would be the requirement to determine which areas of the organisation would need specific support to retain staff. Consideration would be given to what had changed between 2021 and 2022, if there was an issue with line management or if there were other issues, to be determined.	
9.4.1	MPe shared that a deep dive into the reasons for administrative staff leavers had taken place and that 40% were moving into the private sector. Lower banded staff had been the highest responders.	

9.4.2	It was suggested that the graph relating to discussing flexible working with line managers there had been very little change over time and that an investment into change culture would be required.	
10	**Charity update (AS/RH)**	**ROHTB (7/23) 009**
10.1	The Board were joined by ASp and RHu who gave an update on the ROH charity's activity, Governance and Risks and proposed new Charity Structure. The new structure would be cost neutral and would be advertised the following week. It was hoped that current staff would apply for the roles. The Board was assured that all expenditure had to follow the Charity Commission's guidelines and reports on the spend were requested. ***AAj left the meeting at 10:01***	
10.2	A half day 'away day', in the Autumn, to discuss how the Charitable Funds Committee reported into the Board and proposed governance changes was suggested**. ACTION: SGL**	
10.3	The risk register would be updated that week to include risk management of internal processes.	
10.4	AAj was welcomed as the new Chair and she was thanked for the time she had taken with the team to better understand their roles and work.	
10.5	Discussions had taken place with corporate partners, for them to fundraise on behalf of the charity, with the aim of supporting large scale projects.	
10.6	Board's support was sought for engagement, recruitment, investment, networking, consolidation of funds and education.	
10.7	JWi thanked the team and commended them for being agile and for the large amount of work they had undertaken. They were also thanked for the Charity's contribution to that day's celebrations.	
10.8	Following the recent media scrutiny of the family of the Captain Tom's Charity, the question as to whether the Trust would be receiving funds from the charity was posed. The Board was assured that the Finance team would follow it up but that there had not been any concerns relating to the charity advertised.	
10.9	RRo offered his time to aid with fundraising.	
10.10	SGL welcomed the focus on Governance and emphasised the importance of the Charity Committee operating with the same rigour as the other committees. He would be working with AAj and the Charity team in the coming months to ensure it did.	
10.11	The link with the R&D team was commended and the Board was advised that the Trust's first PhD student had successfully completed their research that year.	
10.12	The opportunity for collaboration with large organisations as part of their employee wellbeing offer was noted.	
10.13	The team was thanked for their work and presentation, and ***they left the meeting at 10:20***.	

11	**Patient Pathway update (JWi)**	**ROHTB (7/23) 010**
11.1	***AMa joined the meeting at 10:20*** JWi opened that the work for the elective hub accreditation had helped to set the standards and that each element of the patient pathway had been prepared as a-stage-on-a-page.	
11.2	AMa gave a presentation that built on the recently approved Trust Strategy, detailing how the Trust would focus on individual elements of the orthopaedic patient pathway. Further work would be required, and the governance would need to be agreed and implemented.	
11.3	Feedback form patients was consistently positive; however, there was still room for improvement in appointments, GP engagement and parking.	
11.4	It was agreed that there wasn't a single patient pathway and that the idealised pathways had been illustrated.	
11.5	The Governance structure was highlighted, and duplication of remit of the Perfecting Patient Pathways and AQUILA boards were highlighted. ***AAj re-joined the meeting at 10:34***	
11.6	The next phase of the standards of care were illustrated and the Board were advised that it was a national agenda with work being undertaken across the system. An update would be brought to the Board in September. **ACTION: AMa**	
11.7	The Board was advised that Oncology patients would follow a slightly different pathway.	
11.8	A 'My Recovery' App would be available for patients' self-service for appointments and referral letters.	
11.9	**IT WAS NOTED** that car parking was problematic for patients.	
11.10	It was suggested that a patient experience video diary could be utilised to better gain an understanding of the full patient experience and allow a comparison between the Trust's aspiration and actual. Other hospitals that were successful in this area to be benchmarked against to determine their areas of focus. Clarity on the high-level steps to be taken was required in order to prioritise effectively.	
11.11	The GP Liaison Manager would be asked to present a progress report to the Board to include KPIs. **ACTION: MP**	
11.12	NBr offered her support in connecting with patients.	
11.13	**IT WAS AGREED** that it would be brought back to the Board once the patient's first experience and contact with the ROH had been developed. Clarity on where interventions would be made was also required.	
12	**Update on the ROH net zero strategy (SWa)**	**Verbal**
12.1	A paper would be brought to the September Board meeting. **ACTION SWa**	

13	**Annual complaints report (NBr)**	**ROHTB (7/23) 012**
13.1	The Board had received the yearly statutory report detailing the number and type of complaints received by the ROH and the actions taken to address them. There had been two formal complaints that had been referred to the Parliamentary and Health Service Ombudsman (PHSO) in the year 2022/23 and both had been closed without further action required by the Trust. The ROH had reported 5 reopened complaints in 2022/23.	
13.2	The Board was advised that the Head of Patient Experience had left the Trust and that a replacement had been recruited. They would likely start in role in September.	
13.3	IRe shared that the QSC Committee had reviewed the report and that it had been agreed that a distilled version, with focused priorities, would be provided moving forwards. The report would be published on the website following the Board meeting.	
13.4	The Chair enquired if the low number of complaints in some areas had been benchmarked. He was advised that they were measured against Model Hospital figures. The data would be added to the report prior to publishing. **ACTION NBr**	
13.5	The report had been previously provided in different languages and the Board were advised that the concise version of the report would be translated once the new Head of Patient Experience had started in post.	
13.6	The second pie chart on page 41 did not reflect the data in the table. The second sentence on page 50 to be amended.	
13.7	The report **WAS APPROVED** for publication subject to the amendments.	
14	**Gender pay gap (SMa)**	**ROHTB (7/23) 013**
14.1	The statutory report had been previously considered by the SE & OD Committee on 28th June 2023 and required publishing on the Trust's website.	
14.2	The Board was asked to note an amendment to the Coversheet and to note that there had been an increase in female medical colleagues and not female consultants. The decrease in pay gap was partly due to the changing demographics. Good progress had been made and it was hoped to link into the Women's Network.	
14.3	It was agreed that slide 10 be removed and gender pay gap only be included.	
14.4	The Board was advised that work was continuing based on feedback. Male colleagues were also being engaged to assist in helping to create female role models and recruiting females into orthopedics. Apprenticeships would give the opportunity to expand recruitment.	
14.5	The Chair asked for the Board to be briefed on the bonus structure at a future meeting. **ACTION SMa**	
14.6	IT **WAS AGREED** that the meeting would pause for 60 minutes to allow the Board to visit the activities that had been put in place to celebrate the 75th Anniversary of the NHS. ***The meeting paused at 11:14***	
14.7	***The Board reconvened and the meeting resumed at 12:07***	

	JWi was congratulated on the celebrations and commended for the good attendance.	
15	**Annual declarations and changes to the licence for NHS foundations trusts (SGL)**	**ROHTB (7/23) 014**
15.1	SGL explained that the Board of Directors was required to make a set of public declarations on an annual basis. The report represented the compliance and evidence to support the statements. It was proposed that the Trust was compliant with the terms of its license, the corporate governance statement and the requirement to train its governors. The Board were also asked to note the changes to the NHS Providers license from April 2023 and the proposal to continue making the declarations. The declarations **WERE APPROVED** and the Board also **APPROVED** the recommendation to continue making the annual declarations subject to capacity.	
16	**Revisions to the Code of Governance for NHS Foundation Trusts (SGL)**	**ROHTB (7/23) 015**
16.1	SGL presented a paper detailing the changes to the Code of Governance for the NHS, Governor duties, and the guidance on Good Governance and collaboration, that had come into effect on 1st April. Following consultation, there had been a slight amendment and the code now applied to all trusts and not just foundation Trusts. It was proposed that the Board receive an annual assessment detailing the Trust's position against the guidance. The report was **RECEIVED** and **NOTED**	
17	**Upward reports from the Board Committees:** **a) Quality & Safety Committee (IRe)** **b) Finance & Performance Committee (RPh)** **c) Staff Experience & OD Committee (SJo)** **d) Charitable Funds Committee (AAj)**	 **ROHTB (7/23) 016 (a)** **ROHTB (7/23) 016 (b)** **ROHTB (7/23) 016 (c)** **ROHTB (7/23) 016 (d)**
17.1	IRe highlighted that discussions on benchmarking data had taken place at the Q&S Committee. It was hoped to establish less generic metrics, that were more relevant to the Trust, as a specialist hospital. A detailed report had been received on an incident in Patient Pathways, whereby referrals had been delayed, from the point of receipt to referral to triage. A learning on a page was being produced. The Governance of Health & Safety was being reviewed and strengthened.	
17.2	RPh shared that the F&P committee had been pleased to note that GP referral levels were above those prior to Covid. Diagnostics and POAC figures had been good which, in turn had impacted positively on theatre utilisation. The Committee had asked for a presentation to Trust Board of the Limited Liability Partnerships (LLPs) for clinical services and an update on the GP engagement work. This would be scheduled for October.	

	Activity numbers had been impacted by industrial action. The cash targets however were not commensurate with the shortfall in activity. Activity and financial performance had been discussed.
17.2.1	SWa added that part of the variance related to a technical line. Depreciation had increased as had expenditure. Half related to pure non-pay and the remainder pertained to the GenMed line. Discussion with the finance team had taken place to determine the work required so as to proactively receive the information from GenMed rather that it having to be retroactively sought by the ROH.
17.2.2	SWa was asked if the Consultant industrial action would impact income and he responded that the number of Consultants taking part in the strike was not yet known. NHSE had advised that the financial position should not use the impact of elective recovery. Thus, the current financial figures did not include any provision for claw-back; however, assumptions would need to be made on what could be achieved.
17.3	SJo reported that the SE & OD Committee could provide the Board with substantial positive assurances however there were some considerable risks, some of which had been discussed earlier in the meeting. Retention and the impact of industrial action in particular. The Committee had noted the System's intention not to appoint a System CPO. They had also noted, with concern, that the mitigation for the decision had been to request individual organisations to release their CPOs to support the System agenda. Positive assurance had been provided by Prof Davis who had attended the Committee to present the staff story. He had outlined his career and the changes during his time at the ROH.
17.3.1	The Chair enquired if the absence of a System CPO was discussed at System Chief Executive Meetings and if other CEOs shared the same concerns; he was advised that it was not. It was suggested that the absence of the role be raised at BSol Chairs' meeting. **ACTION TPi to raise the matter at the next meeting**
17.3.2	JWi shared that a meeting for the Executive teams, of all of the Providers within the ICB, had been scheduled for Friday that week.
17.4	AAj highlighted some risks had been discussed at the Charitable Committee. It had been noted that the costs for the contactless payment units far outweighed the income generated through them. The team would be investigating alternatives and feedback would be given. A substantial donation had been received by way of a bequest. Sponsorship had increased significantly from the previous year. The impact of some of the research being undertaken, following the collaboration with R&D, would be fed back to the Board. The hardship funds applications had been discussed earlier in the meeting. Thanks was given to the Charity team for their time and openness in helping AAj, in her capacity of Chair of the Charity Committee, to understand their work, individual roles and the Trust's position.
17.4.1	The Chair shared that there had been previous detailed discussion on contactless payments. The Board had been previously advised that it would not be possible to exit the contract without a penalty. SWa advised that he would review the contract arrangements and proposal.

	It was suggested that a £3 minimum donation be implemented in the same way as other hospitals were already operating. The rounding-up of purchases made at Café Royale could also be considered and linked to charity contributions.	
18	**Performance Reports: *for assurance*** **a) Finance & Performance** **b) Quality & Patient Safety** **c) Workforce Overview**	**ROHTB (7/23) 017 (a)** **ROHTB (7/23) 017 (b)** **ROHTB (7/23) 017 (c)**
18.1	There were no comments on the reports and they were **NOTED**.	
19	**Exclusion of press and Public**	**Verbal**
19.1	The Chair thanked RRo for attending and closed the Meeting in Public. ***The meeting paused at 12:34 and RRo left the meeting.***	
19.2	The matters recorded at minutes 19 to 27 **WERE AGREED** to be treated as confidential and excluded from the minutes to be made available for public inspection. They were minuted in Part 2 of these minutes.	

Notes

Quorum:

i. No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

ii. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

iii. If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

ATTENDANCE REGISTER – FY 2023/24 UPDATED TO JULY 2023

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

KEY:

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

PUBLIC SESSION

Next Meeting: 4 October 2023, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 1 September 2023

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.183	Patient Pathway update	ROHTB (7/23) 010	05/07/2023	Present an update on the Outstanding Pathways work at a future meeting	AM	~~6/09/2023~~ 4/10/2023	Deferred to the October meeting to create more opportunity for refinement of the work and discussion	
ROHTBACT.203	Update on Safeguarding - the System approach	ROHTB (4/23) 004 ROHTB (4/23) 004 (a)	05/04/2023	Present an update on Safeguarding at a future meeting	NB	6/09/2023	Safeguarding annual report included on the agenda of the September 2023 meeting	
ROHTBACT.184	Patient Pathway update	ROHTB (7/23) 010	05/07/2023	Arrange for a further update on the GP liaison work to be presented to the Board	MP	01-Nov-23	ACTION NOT YET DUE	
ROHTBACT.186	Gender pay gap	ROHTB (7/23) 013	05/07/2023	Brief the Chair on the clinical excellence awards process	SM	30-Sep-23	ACTION NOT YET DUE	
ROHTBACT.229	Summary of patient stories	ROHTB (5/23) 010	03/05/2023	Provide an overview of the schedule of patient stories to the Board at a future meeting	NB	~~5/7/2023~~ 6/9/2023	Included in papers for the September 2023 meeting	
ROHTBACT.182	Board Assurance Framework	ROHTB (3/23) 008 ROHTB (3/23) 008 (a)	01/03/2023	Present the revised BAF to include risk appetites at a future meeting	SGL	~~5/7/2023~~ 6/9/2023	Included in papers for the September 2023 meeting	

ROHTBACT.185	Net zero strategy	Verbal	05/07/2023	Present a written update on net zero at the September meeting	SW	6/09/2023	Included in papers for the September 2023 meeting	
ROHTBACT.187	SE&ODC upward report	ROHTB (7/23) 016 ©	05/07/2023	Raise concerns around the proposal to not replace a system CPO at the next ICS Cahir's meeting	TP	31-Aug-23	Raised as suggested	

KEY:

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

ROHTB (9/23) 001

The Royal Orthopaedic Hospital
Trust Board Patient Story June 2023

Patient journey

- This patient was referred to the ROH for a MRI Scan.
- The patient had a history of a failed MRI Scan due to claustrophobia.
- The patient did not want sedation so an Open MRI was considered as an option.

Other Factors

- An Open MRI required additional funding.
- Prompt action needed to be taken to prevent a 78-week breach.
- The patient needed a specific MRI which the Heath Lodge had the required equipment; however, there was not a suitable appointment date.

Team Work

- There was excellent team work to ensure that the patient had the best experience. This included proactive communication with the patient.
- The patient was contacted to ask her to consider contacting her GP to have sedation prescribed.
- The option of completing the procedure on the new scanner which would be quicker.
- The patient consulted with her GP for sedation an appeared more relaxed about attending for her MRI.
- Arrangements were made for follow up in advance.
- A morning MRI appointment was made in line with the patient's preference – timings were changed to accommodate the patient's request.
- A bespoke patient pathway was developed taking previous experiences into account
- Patient was kept up to date to ensure that the patient felt safe and listened to.
- A member of staff stayed with the patient, including during the scan.

Success

- The MRI was completed.
- The patient was contacted on the 24th August to gain consent to share her story. The patient was so happy with her experience.

Summary:

A positive experience for one of our patients who was very nervous about the MRI procedure.

Positives

All these were excellent:

Really effective team work.

The patient was at the centre

Compassion

Patient felt safe and listened to

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Patient Story Schedule**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Executive Chief Nurse**
AUTHOR:	**Dr Steven Beaumont, Interim Deputy Chief Nurse**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

This report provides an overview of the plan to proactively arrange a set of patient stories to be presented to the Trust Board on alternate months.

REPORT RECOMMENDATION:

The Board is asked to note and accept the 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		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:

Supports the Trust's lessons learned framework and the Trust's ambition to foster a culture of openness and transparency.

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (9/23) 002 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

Patient Story Schedule

1 EXECUTIVE SUMMARY

1.1 Patient stories are an excellent way to ensure that lessons learned from patient experiences are shared. Stories can celebrate when we have had positive patient feedback as well as when we need to learn from when patients and families who have raised issues regarding their care. Such information supports quality improvement across the organisation.

1.2 Ideally, patients should attend the Trust Board meeting to tell their own story. However, if this is not possible the Head of Patient Experience will tell the story on behalf of the patient.

2 The Process

2.1 The Head of Patient Experience will identify suitable patient stories which have been identified from patient feedback.

2.2 Patients should be approached to ask if they are willing to share their story and attend a Trust Board meeting in person. Where attendance is not possible the patient's permission should be sought for the Head of Patient Experience to tell their story. The patient's consent is to be gained before the patient's story is told. Consent will be required from the patient to share their story.

3.0 The Plan

3.1 The following patient stories have been identified as suitable for sharing:

Themes of Story	Patient will attend meeting	Consent obtained	Board date
A good MRI experience	No	Verbal – 24.08.2023	Sep 2023
Multiple issues (awaiting patient to confirm detail)	No	TBC	Nov 2023
Appointment issues	No	TBC	Jan 2024

Dr Steven Beaumont PhD RN
Interim Deputy Chief Nurse
August 2023

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:	**6 September 2023**

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board (in Public) on 6th September 2023

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 July 2023 from the Chief Executive's position, this includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 I want to offer my sincere condolences to all the parents and families impacting by the Lucy Letby case, an appalling tragedy and it is hard to imagine the suffering and grief which they continue to endure. As the criminal process concludes, we anticipate that there will be a much-needed independent inquiry into the events at the Countess of Chester and this must lead to ensure that the NHS learns from this awful case.

We must not lose faith in our NHS; it provides life changing compassionate care each day for millions of people, but it must have effective robust systems in place to safeguard against these rare but terrible events for our patients and staff.

Whilst providing that care we have a responsibility to listen to the concerns of patients, families, and staff, follow whistleblowing procedures and ensure that the work of the Trust is underpinned by good governance.

As Chief Executive accountable to the Board, I have taken this opportunity to remind all colleagues of the Boards collective responsibility to ensure that everyone continues to feel safe to speak up in the ROH and to be confident that they we be heard, supported, and be provided with a response.

As a Board we continue to be committed to ensure that we collectively foster a shared healthy culture of openness and honesty so that everyone who works at the ROH feels valued and respected, knowing that their views are welcomed. This includes matters related to patient safety, the quality of care, and instances of bullying and harassment. To support this, we also ask our managers to feel comfortable having their decisions and authority challenged as speaking up should be embraced, staff will not be victimised for speaking up and it will be seen as an opportunity to learn and improve.

The NHS People promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words"- this remains at the heart of my role and our wider Trust Board.

We share the collective NHS commitment to do everything we can to prevent anything like this happening again and to help make the NHS a safer place for our staff and patients.

2.2 Following a two-day strike in August 2023, we have received notification from the British Medical Association (BMA) that hospital consultants in England have voted in favour of taking further strike action on the 19th and 20th September 2023. They have advised that it would be to provide "Christmas Day" cover meaning it would work to keep minimal emergency services open but not elective care.

2.3 I am delighted to share that the ROH Osseointegration Surgery has been shortlisted for two categories at the 2023 HSJ Awards: Acute Sector Innovation of the Year and Military and Civilian Health Partnership Award. The Royal Orthopaedic Hospital worked with the MoD to create a safe and effective patient pathway for osseointegration surgery. This enabled military personnel to have complex surgery, followed by an intensive recovery and rehabilitation programme. Congratulations to all the team and best of luck for November 2023 when the winners will be announced.

2.4 On the 13th July 2023, we received the fantastic news that following our Elective Hub accreditation site visit which took place on Friday 9th June 2023, that Trust has been accredited. The team who visited the hub were impressed with the professionalism and enthusiasm of the ROH team. We are keen to celebrate and take advantage of the benefits that the accreditation scheme offers. GIRFT's focus is on facilitating the development of surgical hubs with the aim of improving patient flow and utilisation and we are proud to be part of Cohort 1. Congratulations to the entire team: the accreditation panel were incredibly impressed with everything they heard and witnessed but what stood out for them was our kind, dedicated, friendly and compassionate staff.

2.5 On Monday 7th August 2023 we held our routine CQC engagement meeting with our relationship manager. It was a positive meeting covering all areas across the Trust and an overview of current performance.

2.6 On 27th July 2023, we held our long service awards, celebrating 20, 30 and 40 years' service in the NHS. It was a great event and one of the biggest ceremonies we have held celebrating with family members and colleagues from across the Trust. Thank you to each and every one of our long-serving employees who go above and beyond for our patients and their fellow staff members to make the Trust the successful, vibrant organisation it is and their continued commitment to the NHS.

2.7 We were delighted to find out that the Royal Orthopaedic Hospital has been awarded as an NJR Quality Data Provider for 2022/23. The 'NJR Quality Data Provider' scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets.

To gain Quality Data Provider (QDP) status for 2022/23, hospitals were required to meet the targets for best practice; increase engagement and awareness of the importance of quality data collection and embed the ethos that thorough and accurate data ultimately enables the NJR to develop improved patient outcomes.

2.8 On Monday 4 September 2023, we reopened our refreshed restaurant, Café Royal. The facility looks fantastic, and I hope that colleagues enjoy the new menu and new accommodation. I want to thank the Estate Team for delivering the scheme and the Catering team for managing what has been a challenging time continuing to provider meals on site whilst the building work was ongoing, thank you.

2.9 In June 2023 the Executive teams across ROH and RJAH both meet to discuss areas where we want to further strengthen our existing close working relationship. We have agreed on 6 key areas and over the next few months we will share the next steps for greater collaboration. A further update is provided later on the agenda.

2.10 On Thursday 17 August 2023, I was invited to join one of the art for health workshop which had been set up by our Pain Service. Three (3 hour) weekly sessions of clay art, stories and songs and acrylics art have been developed to support our patients struggling with chronic pain. The classes running weekly through June to September at Bournville Gardens have been developed with ROH Charity by Dr Lisa Tharakan (Anaesthetic and Pain Consultant) who approached the charity to support the pilot. The workshops are being evaluated and spending the afternoon with the patients and team was truly inspirational to see how patients could have some 'relief' from chronic pain, learning a new hobby, interacting with others, and having fun. It was a real privilege to attend the class and take part, although my pottery creations may need some further work it was evident to see the impact for our patients! I look forward to seeing the feedback and evaluation of the project to see how we can incorporate this into our Wellbeing support for our patients – a fantastic initiative thank you to all the team involved.

3. BSol ICS (Integrated Care System) Updates

3.1 The Birmingham and Solihull (BSol) Integrated Care Board (ICB) meets bimonthly, and next public meeting is being held on 11 September 2023.

3.2 The ICS has advised that it has been successfully selected by the Care Quality Commission (CQC) to take part in the ICS assessments pilots. They will also be piloting the approach with Dorset ICS. The aim is to understand how integrated care systems are working to tackle health inequalities and improve outcomes for people. This means looking at how services are working together within an integrated system, as well as how systems are performing overall. The Health and Care Act 2022 gives the CQC new regulatory powers that allow us to offer a meaningful and independent assessment of integrated care systems.

The reviews will take into consideration the core purpose of integrated care systems, as referenced in NHS England's design framework and the requirements of the legislation. They will focus on 3 themes:

1. Quality and safety
2. Integration
3. Leadership

The guidance is interim and is awaiting approval by the Secretary of State for Health and Social Care as required by the Health and Care Act 2022. Its aim is to help integrated care systems understand more about the CQC's approach during the pilot phase. The CQC will expand and update this interim guidance in collaboration with stakeholders as the model is developed over the coming months and it transitions to ongoing assessment. It will form the basis for the more detailed end-to-end guidance later in the year. Interim guidance on our approach to assessing integrated care systems - Care Quality Commission (cqc.org.uk)

3.3 The ICS is currently out to advert for the recruitment of a Chair, following the substantive appointment of Dame Yve Buckland at UHB NHSFT with a closing date of 4 September 2023.Interviews are planned for 20th (stakeholder session) and 21 (interview) September 2023.

4 NHS England/National updates

4.1 On the 2 August 2023, NHS England wrote to all trusts to confirm that it has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also considers the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles and focus on early intervention and prevention. A paper describing the changes and actions required is detailed in the September 2023 Trust Board pack.
NHS England » NHS England Fit and Proper Person Test Framework for board members

4.2 On the 4 August 2023, NHS England wrote to all Trust asking them to complete a self assessment against the key actions in the letter "Protecting and expanding elective capacity"
NHS England » Protecting and expanding elective capacity.

The letter sets out further detail on three key actions that all Trusts are required to deliver:

- Revisit plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that

RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

The Board self-certification process is to be signed off by trust chairs and Chief Executives by 30 September 2023 and is detailed in the Trust Board Pack for assurance and approval. The self-assessment return will be shared with the ICB and NHSE once approved.

4.3 We have been advised that there will be changes to cancer waiting times standards that have been agreed between NHS England and the Department of Health and Social Care (DHSC), and which will come into effect from 1 October 2023.

The changes include the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of those standards into three core measures for the NHS:

- The 28-day Faster Diagnosis Standard (75%)
- One headline 62-day referral to treatment standard (85%)
- One headline 31-day decision to treat to treatment standard (96%)

The standards will be updated and reported to the Finance and Performance Committee with continued oversight at the Cancer Board. NHS England » Diagnostic imaging reporting turnaround times

4.4 NHS Impact (Improving Patient Care Together) has been launched to support all NHS organisations, systems and providers at every level, including NHS England, to have the skills and techniques to deliver continuous improvement. NHS IMPACT is a single improvement approach to support organisations, systems and providers to shape their strategy underpinning this with continuous improvement, and to share best practice and learn from one another.

In the first instance, we have been asked to complete a self-assessment by all Acute and mental health trusts by 31st October 2023 in conjunction with the Integrated Care Board. There is also an acute provider self-assessment form which is required to be completed and shared with ICB by the end of August 2023. Both forms have been completed and we will share the feedback, next steps and our continue approach to continuous improvement with the Trust Board in November 2023. The self-assessment shows good progress across the Trust in all areas.

NHS England » NHS IMPACT self-assessment

4.5 A new set of standards for imaging reporting times have been produced to help providers hit the 62-day and faster diagnosis standard. The guidance includes a maximum timeframe within all imaging needs to be reported and next steps for implementation, reporting and monitoring. The guidance will be reviewed and aligned to the performance pack at Finance and Performance Committee where our reporting times are already reported as good practice with strong performance across the modalities.

4.6 At the beginning of August 2023, Jonathan Pearson has been appointed as the new Chair for Birmingham Health Partners.
https://www.linkedin.com/in/pearsonjonathan/
Jonathan is a management consultant with a strong background in health and life sciences, he lives locally and is keen to meet and understand all partners across BHP. Congratulations to Jonathan and thank you to Sir Bruce Keogh and colleagues across BHP for asking me to be part of the selection/interview process. Jonathan takes over officially for an initial term of two years from 1st October 2023.

4.5 The Department for Health and Social Care (DHSC) has published an interim case for change and strategic framework as part of the Major Conditions Strategy on 14 August 2023. The document sets out the evidence underpinning the strategy and provides an overview of initial plans for action over the next five years. The full strategy document is expected to be published in early 2024, following analysis of responses to DHSC's call for evidence, which closed on 12 July 2023, and further consultation with stakeholders. The strategy is relevant to England only.

NHS Providers have provided an overview of the case for change and strategic framework, the key areas of focus for the final strategy and our view. next-day-briefing-major-conditions-strategy-15-8-23-final.pdf (nhsproviders.org)

The strategy focuses on six major conditions: -

- Cancers
- Cardiovascular disease (CVD), including stroke and diabetes
- Musculoskeletal disorders (MSK) NHS Providers
- Mental ill health
- Dementia
- Chronic respiratory disease

It is positive to see MSK detailed in the strategy, and we will review this in line with our own MSK strategy to ensure that it is aligned and supports our Integrated Care Systems to further develop local approaches that best meet the needs of local populations.

4.6 We anticipate the release of the CQC Inpatient Survey for 2022 in September 2023 and once the embargoed results have been shared we will share this will colleagues across the Trust with evaluation and next steps reported to the Quality and Safety Committee in October 2023.

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:

- Policy for Use of Abloy CLIQ Digital Keys for Medicines on Wards and Departments

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

30 August 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Speaking Up and Incident Management at the ROH**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Trust Chair and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

The recent outcome of the Lucy Letby case has created significant reverberations across the NHS and high profile public attention that may call into question, by some, the oversight of care delivered in the many healthcare settings across the country.

Although the forthcoming statutory independent Inquiry into the Letby case will undoubtedly conclude with a report containing recommendations for organisations to implement or consider, it is regarded as appropriate given the gravity of the case, to provide the Board with some immediate assurance around two fundamental elements of governance at the ROH: the Speak Up framework and incident reporting and investigation. Both elements of the NHS governance framework are likely to be particularly scrutinised in the context of the situation reported at the Countess of Chester Hospital.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and ACCEPT the overview of the Speaking Up and incident management frameworks at the ROH, noting the assurances provided;
- AGREE to receive a further update providing further detail on the FTSU concerns raised at a future 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		

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:

- National Guardian's Officer Freedom to Speak up framework
- National Serious Incident Framework
- CQC Key Line of Enquiry (Well Led) *W3.5* Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

PREVIOUS CONSIDERATION:
FTSU update to the Board in February 2023.

FOR ASSURANCE

SPEAKING UP AND INCIDENT MANAGEMENT AT THE ROH

REPORT TO THE TRUST BOARD – 6 SEPTEMBER 2023

1.0 Introduction

1.1 The recent outcome of the Lucy Letby case has created significant reverberations across the NHS and high profile public attention that may call into question, by some, the oversight of care delivered in the many healthcare settings across the country.

1.2 An Independent Inquiry into the Lucy Letby case has now been agreed, the outcome of which will certainly result in a report which will contain a number of recommendations for healthcare organisations to consider and against which to self-assess. It is likely to be many months until the report is published, given the volume of evidence both verbal and documentary, which will need to be considered.

1.3 Pending publication of the formal report, this overview is designed to provide the Board with some immediate assurance, in a setting accessible to the public, around two aspects of the national governance framework that will undoubtedly receive scrutiny as part of the Letby Review: Speaking Up and Incident Investigation.

2.0 Speaking Up

2.1 The framework at the ROH to allow and encourage staff and patients to speak up about concerns comprises a number of routes described in Table 1:

Line Managers	This is regarded as the first and primary avenue for staff to use to raise a concern
Human Resources	In addition to the route through line managers, professional HR expertise may be accessed to support and facilitate fact finding and investigation of concerns that staff are experiencing
Staff Networks	The Trust has in place a number of staff networks aligned to support staff from common protected characteristics, encourage discussion and jointly handle any concerns that they may be experiencing. This is a fundamental aspect of the Trust's ambition to foster a truly inclusive culture
Theatre 'Stop Before You'…/ WHO check list process	This is a key element to patient safety in the environments where patients undergo procedures. It provides a platform for colleagues, regardless of role or seniority, to express any concerns that they may have with the planned treatment just prior to the point of delivery
CQC	Staff, patients and the public are able to register a concern or complaint with the Care Quality Commission if they feel that the other routes available to do this would not provide resolution. The

	CQC then in turn, can either decide to independently investigate the concern raised or seek assurance from the registered organisation that the matter will be considered and every effort made to resolve it
Freedom to Speak Up (FTSU)	A route for staff to use if they feel that their concern cannot be or has not been resolved successful using any of the other internal routes available. FTSU concerns can be raised anonymously, although staff are encouraged to disclose their details to ensure that they can be supported in the best and most informed way possible

Table 1: Routes for Speaking Up

While the Speaking Up framework in its wider sense, covers a wide range of portfolios and processes, in the letter received from the Chief Executive of the NHS, Amanda Pritchard, there was clear focus on the Trust's whistleblowing, including FTSU, arrangements. Amanda wrote: ' We… wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level'.

2.2 Freedom to Speak Up (FTSU) governance and oversight

2.2.1 Following the Francis Report in 2014, NHS organisations were required to appoint a local Freedom to Speak Up Guardian (FTSUG). The Trust's FTSUG is Claudette Jones, a nurse by background who also chairs the Equality and Diversity network. The role is independent, impartial, and confidential. Claudette provides visible leadership of the FTSU role, operating a series of walkabouts during the time that she dedicates to the role.

2.2.2 Governance and oversight of the FTSU Framework is led by the Executive Director of Governance, Simon Grainger-Lloyd and Non-Executive Director, Gianjeet Hunjan. The FTSUG is supported in her day-to-day work by a set of nine voluntary Freedom to Speak Up Champions, individuals from a range of disciplines and seniorities across the Trust (Appendix 1 details the FTSU individuals). While the champions are in place to signpost and offer support to those wishing to raise concerns, they do not take a role in reporting to the Board, handling cases or attending regional and national meetings; those responsibilities remain within the remit of the FTSUG.

2.2.3 The FTSUG and Champions have a monthly meeting with the Board-level leads to share the successes of their work and discuss any support that they may require.

2.2.4 According to the national mandate by the National Guardians Officer, the FTSUG reports to the Trust Board annually. The FTSUG also reports annually to the Quality & Safety Committee and will do so to the Staff Experience & OD Committee. Additional ways in which the services of the FTSU network are promoted at the ROH are:

- **100 days Induction** - All new staff are invited to an induction event where they can meet the Executive Team. The Executive Director of Governance discusses the

importance of FTSU and the link to staff working at the Trust feeling psychologically safe as part of their address to the new starters. New staff are also given a welcome bag including a 100-day booklet to provide guidance and support to help navigate the Trust, including FTSU information.

- **New starter events** – the FTSU attends events organised for new clinical staff to talk about the role of the FTSU network and how to raise a concern if needed.

- **Nursing Council** – FTSU Guardian is invited to the Nursing Council meetings to raise awareness of FTSU and work in partnership with the nursing leadership team.

- **Clinical Audit Day** – Clinical audit day is used as an opportunity to share knowledge and raise awareness of FTSU with the medical workforce.

- **Chief Executive 'Start of the Week'** – organisation-wide written communication from the Chief Executive issued each week often references and signposts staff to FTSU. The most recent communication is attached as Appendix B.

- **Posters** – FTSU posters have been distributed across the Trust, providing FTSU information and contact details. Posters are in the process of being updated to include all the picture of the new champions.

- **FTSU Boxes** – Three FTSU boxes are available across the Trust providing FTSU information and a secure facility for posting concerns. This will provide support for late and night staff and for staff who prefer to raise concerns anonymously.

- **FTSU Month** – In line the national model, Freedom to Speak Up month is celebrated each October, where promotional literature and gifts are offered to raise awareness of the FTSU network and processes.

2.2.5 In addition to face-to-face walkabouts and meetings, staff have at their disposal, a range of material aimed at educating and raising awareness of FTSU processes:

- **FTSU Intranet Page** – The FTSU Team and the Communication Team has updated the FTSU page with information to support the speak up agenda. This is easily accessible to staff. Guidance and support are provided to staff on how to access this information during weekly walkabouts.

- **Speaking Up Policy** – the 'Speaking Up' policy at the ROH follows the national model and is updated as advised by the National Guardian's Office.

- **E-Learning Modules** – Three E-Learning Modules are included in the Electronic Staff Record (ESR) – Core training-Speak Up: for all including volunteers, students, and those in training regardless of contract terms. This module explains the purpose of speaking up and how to speak up. Listen Up: Focus on how to listen and aimed at line managers and middle managers. Follow-Up: Aimed at all senior leaders, including executive board members and non-executives and Governors. This module provides

the guidance on how to support good speaking up culture and how speaking up can promote learning and improvement in the organisation.

- **Zero tolerance** – The FTSU Guardian is also the chair of the Equality & Diversity network and is working with ward mangers and Heads of Nursing to reinstate the Zero Tolerance poster across the organisation.

3.0 Effectiveness of the Freedom to Speak Up framework

3.1 It is clear that the promotion and education around FTSU is robust at the ROH. In terms of effectiveness, several reviews over the past few years have reviewed the framework and offered commentary on the FTSU approach as well as the culture of openness and support at the Trust.

3.1.1 ***CQC Inspection report 2019*** – 'Surgery': The service had an open culture where patients, their families and staff could raise concerns without fear. 'It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint'. Well Led (Trust Overall): Staff felt respected, supported and valued.

3.1.2 ***External well led assessment 2020*** - The Trust has developed many processes and opportunities for staff to raise concerns. An established Freedom To Speak Up (FTSU) Guardian is in place and we observed a proactive approach to raising awareness of this across the organisation. There are, however, improvements that could be made to enhance the opportunities to staff to raise concerns. Currently there are no FTSU Champions within the Trust, and the implementation of this model will assist with accessibility closer to grade and professional group for some staff.

The Board report from both the FTSU Guardian and the Guardian of Safe Working Hours are of good quality and provide the Board with useful analysis of key concerns raised, how these have been addressed, and the impact of the respective roles. The Freedom to Speak Up Guardian collects data for Board reporting and also for the National Guardian's office. Although data collated by gender is not a required reporting field, this could be useful to information for consideration. Following our interview with the Guardian this has now been implemented.

3.1.3 ***Elective Hub accreditation 2023*** - A magical environment where staff feel nurtured, safe and valued.

3.1.4 Two questions are included in the national staff survey that provide an indication as to the culture around speaking up in the organisation:

i) I feel safe to speak up about anything that concerns me in this organisation

ii) If I spoke up about something that concerned me, I am confident that my organisation would address my concern

The % of responses for those responding that they 'agree' or 'strongly agree' with those statements in the last staff survey is higher than the average trust response for

both questions. Notwithstanding this, there has been a dip in the ROH results from the position reported in 2021, therefore work is underway to understand the reasons behind this.

3.1.4 The FTSUG is required to make a submission to the National Guardian's Office on a quarterly basis reporting the number of concerns raised during the period. Statistics for the past two years are displayed below in Table 2.

Submission Date	Quarter	Number of Concerns
24/07/2023	Q1- 2023/2024	29
09/05/2023	Q4 - 2022/2023	42
03/02/2023	Q3 - 2022/2023	21
03/11/2022	Q2 - 2022/2023	13
25/08/2022	Q1 - 2022/2023	12
09/05/2022	Q4 - 2021/2022	39
31/01/2022	Q3 - 2021/2022	18
10/11/2021	Q2 - 2021/2022	13

Table 2: FTSU Concerns reported 2021 - 2023

3.1.5 Concerns are categorised according to a national model around the following themes:

- Patient Safety & Quality
- Bullying & Harassment
- Worker Safety or Well-being (the addition of well-being is a new addition)
- Element of other inappropriate attitudes or behaviours (this category is new)
- Disadvantageous and/or demeaning treatment

The majority of the concerns recently have fallen into the categories of Inappropriate attitudes or behaviours or worker wellbeing. A further breakdown and more detail will be provided to the Board at a future meeting.

3.1.6 In terms of the profile of staff reporting concerns, staff from across a wide range of areas of the Trust have reported concerns. It is widely recognised nationally that staff from an ethnic minority background are more likely not to speak up. The FTSUG has however, seen a good mix of staff from a range of protected characteristics speaking up within the Trust. The staff networks have been critical in supporting staff from multi -ethnicity groups to speak up.

3.1.7 The FTSU framework at the ROH is dynamic and evolving. It is apparent that the culture of the organisation supports staff wishing to speak up and every effort is made to ensure that action is taken where appropriate and that staff raising concerns are given the opportunity to comment on how satisfied they are with the way in which their concern has been handled. There is however more to do to improve the framework. The Letby case has prompted a swift review as to how the FTSU framework may be strengthened further with some early thoughts being:

- Developing case studies to share across the organisation to demonstrate the actions taken and changes made as a result of FTSU concerns being raised.
- Creating a greater overview at Executive level of the FTSU concerns and other concerns not raised through the FTSU route, being handled and formalising the response required when a FTSU concern is raised to a member of the Executive Team.
- Few FTSU concerns are currently received from medical staff in the Trust, therefore there are plans for further promotion of the FTSU process within these areas.
- In line with the Trust's lessons learned framework, further identifying lessons that can be learned and disseminated from FTSU concerns.
- Launching a FTSU survey to canvas from the organisation their views and a sense of satisfaction with the FTSU network.
- Improve the opportunities for learning and sharing best practice between partner organisations in the Integrated Care System.
- Strengthening the FTSU entries in the monthly Quality & Patient Safety report and Workforce overviews.
- Formalising the process to canvas satisfaction from those raining concerns around how they feel the matter has been handled and the end result.
- Creating a way to say thank you to those raising concerns.
- Creating visibility of benchmarking information around FTSU.
- Given that it has been some time since the last independent review of the Trust's Speak Up arrangements, it is proposed that a review is scheduled, either through the Trust's internal audit programme or via a peer review by another provider organisation.

4.0 Incident Investigation and Lessons Learned framework

4.1 Alongside the FTSU processes set out in this report, the Trust also has a robust incident management framework for the raising and investigation of staff incidents and incidents relating to potential patient harm. The processes for reporting and investigating incidents is defined in a well-embedded policy in the Trust, however, as will be evident from a report later on the agenda on the progress with the implementation of the Patient Safety Incident Response Framework (PSIRF), there are plans to amend this in line with the new approach.

4.2 The Trust has a positive, open, honest and well-established culture when it comes to incident reporting and furthermore, the divisional governance processes through which these incidents are investigated and escalated are well embedded. There are robust discussions at the Divisional Governance meetings where the initial level of harm associated with the incident reported is challenged and agreed. It is also through this route that any themes identified from incidents reported will be highlighted and where necessary agreement reached that a thematic review is conducted.

4.3 Depending on the level of harm, a Serious Notes Review, a 72-briefing or a full Root Cause Analysis will be instigated. For particularly wide reaching and serious incidents a 'Round Table' event will be held where discussions around the incident and the immediate learning and action is discussed by a multi-disciplinary team from nursing, medical, operational and governance teams.

4.4 The Trust adheres to the national Serious Incident Framework (SIF) (2015), which will be replaced when PSIRF is adopted.

4.5 An Executive Governance forum is in place, which sits on alternate weeks and is chaired by the Director of Governance and attended by the Heads of Nursing (divisional governance leads), the Deputy Medical Director and members of the governance team. The Medical Director, Chief Operating Officer and Chief Nurse also attend the meeting. The purpose of this forum is to allow the divisions to highlight any incidents reported that are of immediate concern and provide assurance around the actions taken in response. The forum also monitors that any Root Cause Analyses, Complaint responses and Learning from Death reviews are undertaken in a timely manner.

4.6 Patient safety and quality incidents are upwardly reported and escalated to the Quality & Safety Committee and also Trust Board for assurance via the Quality Report on a monthly basis. Further work is underway to refine the information provided in the Quality Report around incidents to better highlight any statistical deviations and provide better narrative around lessons learned. An annual risk management report will be developed which will summarise incidents reports over the period, highlight themes of note and identify the key lessons learned as a result of reports.

4.7 Included within the Quality Report is a section on FTSU concerns, which sets out the number of concerns raised over the month, with key themes identified and the actions and changes that have been implemented as a result of the concerns raised. The FTSUG and the Assistant Director of Governance & Risk are currently reviewing the FTSU section of the Quality Report with the view to refining it to provide more of a focus and awareness of the lessons learnt and the changes that occur as a result of FTSU concerns being raised.

5 Recommendation

5.1 The Trust Board is asked to:

- RECEIVE and ACCEPT the overview of the Speaking Up and incident management frameworks at the ROH, noting the assurances provided;
- AGREE to receive a further update providing further detail on the FTSU concerns raised at a future meeting.

Simon Grainger-Lloyd
Executive Director of Governance

31 August 2023

The Royal Orthopaedic Hospital
NHS Foundation Trust

FREEDOM TO SPEAK UP

FREEDOM TO SPEAK UP GUARDIAN

I endeavour to create a culture where you feel comfortable to speak up when you have worries or safety concern that prevents you from doing a good job, knowing you will be listened to and confident that you will receive feedback or see positive change as a result.

Claudette Jones
Senior Research Nurse

FREEDOM TO SPEAK UP CHAMPIONS

Our FTSU Champions are a new link for you to contact to provide you with guidance and signposting on how to raise issues or discuss concerns.

Petros Mikalef

Jane Bevan

Eileen Hendrick

Wilson Thomas

Asif Kabal

Uzo Ehiogu

Symeon Hopkins

Eunice Butler

James Jones

For further information please contact Claudette Jones, Freedom To Speak Up Guardian: 07970372476 or roh.guardain1@nhs.net or scan the QR. Champions may be contacted by email or telephone

Gianjeet Hunjan
FTSU Executive Lead

Simon Grainger-Lloyd FTSU Executive Lead

Freedom To Speak Up

Nurse Lucy Letby has been found guilty of murdering seven babies and trying to kill six other infants at the Countess of Chester Hospital between June 2015 and June 2016. I know all of you will join me in sharing our deepest condolences with all the parents and families impacting by this senseless tragedy.

Since hearing the outcome of this trial on Friday afternoon, like many of you it has left me shocked, appalled and deeply saddened. This case is shocking for obvious reasons. It's also particularly shocking for those of us who work in the NHS – those for whom whole careers are built on keeping people safe, offering compassionate care, and saving lives.

A much-needed independent inquiry will follow the criminal case and the Trust involved and wider NHS must learn from this tragedy to prevent it from ever happening again. But I think the question lots of our colleagues across the NHS will be asking themselves today is *'could something like that happen where I work?'*

We have excellent governance at ROH. We have a strong and dynamic safeguarding team, and a good patient experience team who share the patient voice. Our teams are well trained, and we have robust whistleblowing policies and incident systems, a Freedom to Speak Up (FTSU) Guardian and champions as well as a range of other staff groups that encourage dialogue. Most would say our culture is open and supportive.

However, culture is not static. It requires constant support to be healthy – just like a garden needs watering. We must ensure that people can speak up and are heard. And more importantly, that appropriate response and action is taken.

The Trust Board is committed to an open and supportive culture

As Chief Executive, accountable to the Trust Board I want to take this opportunity to remind all colleagues of the Board's collective responsibility in this regard. The Trust Board is responsible for ensuring that everyone feels safe to speak up and that ROH has an open and supportive culture. It is a responsibility we take very seriously. This includes matters related to patient safety, the quality of care, and bullying and harassment.

You will never be victimised for speaking up or whistleblowing. It will always be seen as an opportunity to learn and improve. If you ever feel you have not been heard, you can raise this with the FTSU Guardian or an FTSU Champion. View your Freedom to Speak Up Guardian and Champions here.

I promise you will always have my full support to speak up and be heard.

I speak for the whole Trust Board and Senior Leadership with I say that we are committed to maintaining a culture of candour and openness so that everyone that works at or receives treatment from the ROH feels heard and supported and safety is maintained.

Jo Williams

Chief Executive

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	Wellbeing Update
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Clare Mair, Head of OD and Inclusion Laura Tilley-Hood
DATE OF MEETING:	6 September 2023

EXECUTIVE SUMMARY:

This paper gives an update on the development of Wellbeing plan in line with the People Plan and ROH Trust Strategy. There is also a separate update report on Cost of Living and Wellbeing work.

1. The Wellbeing plan

The Wellbeing plan has been developed in draft version. The key actions to complete this work include:

- Final confirmation of key metrics in line with the People Plan
- Review and sign off from Chief People Officer
- Final consultation with key stakeholders including Executive Directors, Trust Wellbeing Implementation Group (TWIG) and People and OD Group

2. Cost of Living and Wellbeing support

Key programmes of work include:

- Part of the team to support the Hardship Fund which has been launched by ROC, the Trust charity
- New financial support sessions available through external partners
- Wellbeing work taking place at departmental level
- Wellbeing conversation training

Positive assurance

- The draft Wellbeing plan document incorporates key information from the NHS Health and Wellbeing Framework (copy attached) and also the Thrive at Work framework
- Colleagues from across the Trust have been consulted as part of the Wellbeing plan development
- Initial discussions have taken place with organisations to ensure the Trust can work with an external partner to evaluate future Wellbeing work at the Trust
- Colleagues are able to access the hardship fund with short turnaround times
- Discussions underway with clinical departments to create a space for colleagues to attend the Wellbeing Days.
- Positive feedback from colleagues on wellbeing interventions available

Current issues

- Ensuring the work on the final version of the Wellbeing plan can be completed by October 2023 without further delays
- Prioritising and funding future work to support colleagues in the current financial climate
- A space to host the Wellbeing Days in November.

Next steps

- Finalise Wellbeing Plan document

- Continue to obtain feedback from colleagues on what they would like at the Wellbeing Days and how we can support attendance within their departments.

REPORT RECOMMENDATION:

The committee is asked to review the two reports attached for assurance

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		Patient Experience	**X**
Clinical	x	Equality and Diversity	x	Workforce	X

Comments:

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

People Element of the ROH Strategy

PREVIOUS CONSIDERATION:

Staff Experience & OD Committee on 30 August 2023

Trust Board – September 2023

Wellbeing Plan Update

Progress to date

The Wellbeing plan has been developed with consultation and support from key colleagues including members of the Trust Wellbeing Implementation Group (TWIG) and People and OD Group. Ayodele Ajose, Wellbeing Guardian for the Trust has also provided a high level of support and advice for this work particularly around the future vision for Wellbeing work at the Trust.

This information has been translated into a draft Wellbeing Plan by Amos Mallard, Acting Deputy Director of Strategy, to fit in line with the ROH Trust Strategy and ROH People Plan.

External work used to inform the Wellbeing Plan

The Trust is currently working with Thrive at Work at the West Midlands Combined Authority (WMCA) to achieve the Silver level Accreditation (Bronze accreditation has already been achieved). This Thrive at Work framework has been reviewed to help identify key areas of focus for the Wellbeing plan moving forward including sickness levels and stress management.

The Engagement and Wellbeing officer continues to work with national and regional colleagues to understand key areas of focus for future Wellbeing work across the NHS.

Partnerships to support ongoing work

The work to define metrics, measure impact and outcomes will be supported by external partners.

Initial discussions have taken place with Adam Turner at the NHS National Wellbeing team who has undertaken work to look at the best practice approaches to measuring wellbeing across the NHS and wider. The discussion highlighted the key areas to be considered in the ROH Wellbeing plan, taking into account progress to date and potential barriers in the future.

Through these conversations with Adam Turner, the Trust has been asked to work with a national project involving external experts. This project would allow for ROH to work with external organisations to review and refine the ROH Wellbeing metrics, as an example, to support in the creation of national NHS wellbeing metrics. Currently University of Cambridge Hospitals Trust has also been asked to take part in this project work.

The Trust has also started initial discussions with University of Canterbury on options to work on a research project to evaluate Wellbeing at the Trust. The University is currently completing the evaluation report on behalf of the Trust for the 'Seeing Beyond the Stigma' exhibition. The University has a wealth of research experience in wellbeing evaluation work within the Sidney De Haan Research Centre for Arts and Health (SDHRC) and across the Faculty of Medicine, Health and Social Care.

Overview of priorities

The NHS Wellbeing Diagnostic Framework has previously been presented at the Staff Experience and OD committee and gives an overview of key areas of work required in a Trust Wellbeing approach within the NHS (see copy of dashboard pertaining to this tool attached). This framework has helped to identify gaps that will need to be addressed as a priority in future work. Key areas identified are under the following headings:

- Working together
- Data insights
- Design and Policy

The draft Wellbeing plan includes key priorities which have been defined around:

- Learning
- Improving
- Adapting
- Collaborating (and Leading)
- Planning

The team is now working with Amos Mallard to refine these priorities along with the critical success factors and key focus areas. This work will be completed by October 2023.

In addition, the initial discussions with Adam Turner have highlighted that the work for Wellbeing under these priorities must include:

- A robust financial system to support future work
- Working closely with partners particularly Occupational Health
- Health Surveillance work
- Board assurance led by support from the Wellbeing Guardian
- Clear HR metrics (already defined)

Next steps

Share document with key stakeholders – September 2023

Engagement with Executive Directors team to share and receive feedback on the final document – September 2023

Final Wellbeing Plan document presented at Trust Board – October 2023

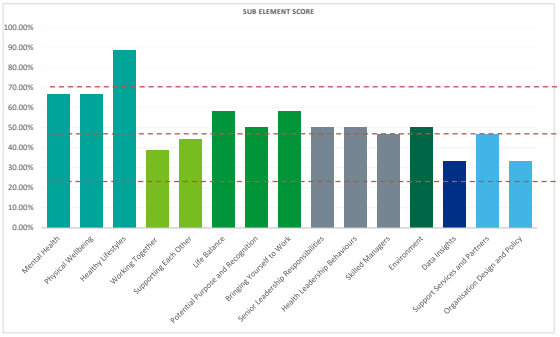
Develop and deliver communications plan to share Wellbeing Plan across the Trust in line with the launch of the People Plan – October 2023 onwards

Clare Mair – Head of OD and Inclusion

August 2023

Dashboard: NHS Health & Wellbeing Framework - ROHTB (9/23) 005 (b)

Version Control	Version 1d
Diagnostic completed by:	Laura Tilley-Hood, Engagement & Wellbeing Officer
SRO:	Sharon Malhi, Chief People Officer
Date completed:	Jan-23

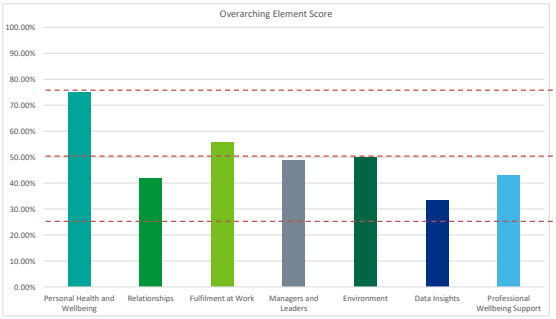


Predominantly 'area of excellence' scores - Area of best practice

Predominantly 'significant progress' scores - Multiple effective interventions in place

Predominantly' low level of progress' scores - Limited interventions in place

Predominantly not started scores - Limited to no interventions in place



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Trust Board – September 2023

Monthly Update on Wellbeing and Cost of Living

1. Wellbeing Update

Post Graduate Doctors (PGD) Induction – 21 Postgraduate Doctors and Fellows attended this event in August to find out about key Wellbeing information to support themselves and colleagues.

Clinical audit morning – Birmingham Art's Therapy visited the Theatres team in July for the clinical audit morning following feedback received from colleagues on preferred activities to support the team. A large number of colleagues took part in the Theatres break out area. The Wellbeing team has received some initial positive feedback about the event and will review further the impact of the event with a view to arranging another session.

Registered Nurses Induction – In June and July the team spoke to over 30 Nursing colleagues during their Induction.

Wellbeing Conversation Training –34 colleagues have attended the training sessions in June and July to upskill managers in the amended format. This has also given the opportunity for colleagues to share best practice on the ways in which wellbeing conversations are taking place at the Trust. Sessions resume in September, November and December.

Healthcare Workers Support Day – Members of the OD and Inclusion team attended the HCA away day to discuss about the importance of wellbeing and what support is available. Key activities included completing the stress bucket, pledged something they would do to support their wellbeing and were also asked for feedback for the upcoming Wellbeing Days. 22 colleagues were at this event which was co-ordinated by Healthcare Care Assistant (HCA) colleagues.

Wellbeing Days – The next session is planned for November. The team continue to engage with clinical colleagues to ensure everyone can get involved. For the next event the different stands will 'move' to different areas in the Trust during the days to give better access to clinical colleagues. The team are currently confirming a new location for the static days, due to the normal venue not being available.

West Midlands Combined Authority (WMCA) – Laura Tilley-Hood, Engagement and Wellbeing Officer was a guest speaker at an event to talk about implementing Thrive at Work at the ROH and what it means to the Trust. West Midlands Combined Authority have asked to visit the Trust with a particular interest in work around apprenticeships.

Rubery Swap Shop – The Trust continues to provide donations for Rubery Swap Shop with another bin full of clothes recently collected. The team also promotes this service to colleagues who may need some help with school uniform and PE kits.

Wellbeing Champions – Two new champions have been recruited in Theatres who will help to support the work being undertaken in that area.

Suicide Prevention Day – A stand will be run by Birmingham Mind, supported by HR, Wellbeing and Safeguarding. This links in with the work being undertaken by a project team to look at a Trust Suicide Prevention Guide.

Loop – The team are looking at sharing Inclusion and Wellbeing information to staff via Loop to help clinical colleagues receive updates in a more direct way. Wellbeing is working together with Communications, E-Rostering and HR to achieve this with a trial period planned.

2. Cost of Living

Royal Orthopaedic Charity initiative: The ROC Hardship Fund

The Workforce and OD team continue to work with colleagues to deliver the ROH Hardship Fund. The Hardship Fund panel, where all applications are discussed on a weekly basis is made up of representatives from:

- Finance
- Human Resources
- Wellbeing
- Charity (non-voting)

The panel works collaboratively, has a wide representation, and demonstrates our Trust values.

Patient and colleagues can access up to £100 by contacting the charity. For any requests upwards of that, a referral must be made, the maximum that can be requested is up to £500. Only one application can be made per year.

A key part of the hardship fund is to ensure the correct wellbeing support and signposting is given to individuals who applies for the funding. This is to ensure that immediate financial help is made available along with support, advice and signposting to help find longer term solutions for the individual. The Charities representative works closely with the individuals to ensure they have everything they need; and will link back to the Wellbeing Officer when needed.

Inclusive Companies

The Trust recently presented at an Inclusive Companies webinar 'Supporting staff through crisis' which included the work on the ROH Hardship fund. The presentation was well received, and Inclusive Companies have asked to visit the Trust and discuss this work in more detail.

There has been some great positive feedback from colleagues around the funding they have received. The Charities team have collected some of these, please see below.

HSBC Financial Support

The Trust have partnered with HSBC and have three different ways they will be supporting our colleagues at ROH.

1) **Always on** – this is a schedule of different daily webinars that provide colleagues with the knowledge and tools to look after their financial needs no matter who they bank with. This has been shared on the Weekly Wellbeing Email (this is also shared on Loop) and will also be distributed via posters.

Topics include:

- Making the most of your money
- Discover practical steps to optimise your everyday finances and gain financial confidence.
- My family Gain insights on childcare, family savings and how money can work harder for your family.
- Managing debt Get back on track financially and discover what debt support systems are available and many more.

2) Bitesize Webinars for ROH

The Bitesize sessions are 45-minute sessions, these will be delivered via MS Teams. They offer signposting and financial wellbeing support and a time for questions at the end. Space has been booked out in the Lecture Theatre for colleagues to attend. We are also hoping to run a bespoke session in Theatres at the Clinical audit meeting. Dates have been confirmed for October and November with different topics being covered. Clinical colleagues have their own sessions booked during Clinical Audit meeting in October.

3) 1:1 Financial Health Check

HSBC will be joining the Trust for Wellbeing Days to offer support. Colleagues can also book a free financial health check via a QR code or be emailing directly. This has been shared in the Wellbeing Weekly email and posters will also be distributed.

The HSBC Bitesize Webinars and 1-1 Financial Health Checks are free, confidential and open to all.

Other Cost of Living initiatives include:

£1 meals – 1018 sold in June.

ROH Pantry – the team have received a generous donation from a colleague which has kept it fully stocked.

Out of hours food – 60 frozen ready meals have been purchased.

Blue Bag Project – These bags are kept fully stocked across the Trust.

School Holidays – a guide was produced and taken round to all departments as well as being added to the Wellbeing Weekly email.

Laura Tilley-Hood

Engagement and Wellbeing Officer

September 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Recruitment and Retention Action Plan
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Terrie Hillier, HR Consultant Clare Mair, Head of OD & Inclusion Matt Dingle, Head of HR Operations
DATE OF MEETING:	6 September 2023

EXECUTIVE SUMMARY:

This report provides an update on the progress of the Recruitment and Retention action plan, including a RAG rating on progress against proposed deadlines.

REPORT RECOMMENDATION:

The Trust 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	x	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:

People element of the Trust strategy
Aligns to the workforce risks on the Corporate Risk Register and BAF

PREVIOUS CONSIDERATION:

Each Trust Board and Staff & OD Committee meeting. Last considered by SE&OD Committee on 30 August 2023.

Recruitment & Retention Action Plan

August 2023

Key Points

Executive Summary

This presentation gives an update on the work being undertaken on the Recruitment and Retention action plan to support the Integrated Workforce Plan.

Positive Assurances

- There has been positive progress made on sections of the action plan.

Key Risks

- Ensuring there is measurable change in positive recruitment and retention at the Trust
- Ensure work directly supports the Integrated Workforce Plan

Next Steps

- There is a need to ensure that this work impacts staff from top to bottom of the hierarchy and each action point should consider this as evaluation of effectiveness and sustainability.

A. Data Intelligence / Gathering

"You can't manage what you don't measure" (Peter Drucker)

Over the coming months, there will be an increased focus on establishing a focused and consistent reporting cycle across the Trust

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Data Intelligence / Gathering								
Design a consistent Retention & Recruitment Report using ESR data for assurance purposes	TH	A leaver survey for those who left in previous 12 months has been designed / sent out, but only 6 responses received so far.	Ongoing project	Ongoing			Due	
Provide new, informative data on turnover, including adjusted turnover.	MD / TH	This will form a part of the work to review the suite of monthly reports that get produced for various committees / meetings	Work on this remains ongoing	Ongoing			Due	
Continue staff feedback events on a regular basis - See engagement section	MD/CM/JS	See engagement section	Several feedback events are established	Ongoing			Due	
Improve the exit feedback process	MD/DM	This is part of the Leaver Workshop workstream	Team are designing this currently	Ongoing			Due	

B. Maximising Performance

The focus within this workstream is on the work already underway in determining revised methods of managing performance to enhance the employee experience.

Cont …

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Maximising Performance								
Overarching approach about managing the entire employee lifecycle	MD	Principles agreed at PODG & SE&OD	This is a large piece of work that may not be achieved by September as planned but we will continue progress	Ongoing			Due	
Reviewed and updated PDR/appraisal process and associated toolkit	CM	Principles agreed at PODG & SE&OD	Workshops with line managers / stakeholders to scope project	Ongoing			Oct 23	
Review all recruitment materials with a view to improving the attraction rate and clarifying the nature / location / benefits the ROH has to offer	MD	This will be an ongoing cycle of improvement	Some progress made around an 'come work with us' document and on course to deliver	Ongoing			Due	
Develop, launch and implement the ROH Wellbeing strategy as defined in the Maximising performance work to include engagement plan	LTH CM	Paper to be presented to June Trust Board	Confirm final strategy including comms plan				Due	
Develop a Talent and Succession Strategy and accompanying delivery plan to ensure there is a clear approach to understanding colleagues' potential, performance requirements and skills requirements for all future roles across the Trust.	SM CM	Working with ICS Talent and Succession group		Ongoing			Due	
Career development tool is well embedded	DR CF		Ongoing work	Ongoing			Due	
Enhance opportunities for apprenticeship programmes	DR CF		Ongoing work	Ongoing			Due	

Recruitment Improvement Plan / Retention Steering Group

1/2

This work focuses on existing workstreams

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Recruitment Improvement Plan / Retention Steering Group								
Full set of documents that outline processes relating to medical recruitment	MD/DM	We now have a set of SOP's for internal use	Need to finalise the policy	Ongoing			Due	
Candidate survey to evaluate the experience of candidates using TRAC	MD/DM	Plans in place but no action as yet.	Plans are in place around factoring in feedback to our processes but may be slightly over September before completion	Ongoing			Due	
Improved time to hire and the experience of staff at pre-employment stage	MD/DM	Interim Time to Hire plan is in place and monitored for sustainability	Improvements are starting to be realised. Too early to measure currently but will be measured in October.	Ongoing			Due	
Improve the processes of staff on bank contracts but would prefer substantive employment	MD/DM	Elieen Hendrick has worked on an approach with system colleagues. There is a draft concept created.	Review of draft concept needed	Ongoing			Due	
Review of recruitment practices from an inclusivity perspective	JS/DM	This is an activity that requires constant review and action to address	Plans to include one inclusive question around values to be added for all interviews. Further steps to be developed	Ongoing			Due	
Increase in staff disability declaration rates	DM / CM	There has recently been an increase in declaration rates, but an increase would help us to offer reasonable adjustments		Ongoing			Due	

C. Recruitment Improvement Plan / Retention Steering Group

2/2

This work focuses on existing workstreams

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Recruitment Improvement Plan / Retention Steering Group								
Close vacancy gap for HCSW's	MD/DM	Reporting currently takes place on a weekly basis	Continue progress	Ongoing			Due	
Streamlining of all recruitment practices including international nursing	MD/DM	We are working on ways to streamline all international recruitment	Action complete	Ongoing	Due			
Evaluate effectiveness of recruitment days/events	MD/DM	Reduced the number of events attended and focus on targeted events	Action complete	Ongoing	Due			
Benefits booklet to inform staff what discounts / offers and employment related benefits are available to them	DM/TM	This needs to cover both financial and non-financial benefits available to staff	A first draft is nearly complete	Ongoing			Due	
Promotion / education of retire / return options	DM/HR	Communications sent out in the organisation.	Next steps are to arrange education sessions	Ongoing			Due	
Line manager education around supporting staff with flexible working	MD/HR	New policy is approved and communication plans in place	Education sessions are being planned	Ongoing			Due	

D. Digitisation

Considered a high priority within the Trust to enable access to personal files to be allocated securely and efficiently on a cloud-based software solution. The preferred supplier also has the ability to produce electronic forms with built-in e-signatures. Pending approval for purchase.

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Digitisation								
Digitisation of personal files that are currently held in paper format	TH	The chosen option is to purchase a Document Management System to provide a cloud-based system for the storage of personal file	Business case currently under review. Due back to execs for a decision	Ongoing			Due	

E. Introduction of KPIs

Majority in relation to the recruitment processes, to ensure we are measuring efficacy of the TRAC system, and ensure a Return on Investment is identified.

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Introduction of KPIs								
Review and adjust KPI's to suit business need for various forums	TH/MD/CM	Feedback gained from survey	. Next steps are to evaluate and work up a proposal	Ongoing	Due			

F. System Working

There are a number of projects within the BSOL ICS that ROH is working on in relation to Retention, including the ICS Retention Steering Group

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
System Working								
Continue working alongside ICS colleagues within the Retention Group to address the high levels of turnover experienced within the locality. Improved retention and reduction in employee turnover	MD/CM	ROH to lead on Legacy Mentoring Workstream	System work is ongoing and we have been set a target of creating a model structure of legacy mentors by November 23	Ongoing				
Continue working with ICS Talent Development group to identify best practice and work with Talent diagnostic tool. To include work on career conversations and succession planning	CM	Group currently reviewing priority areas for ICS focus	Group currently reviewing priority areas for ICS focus	Ongoing				
Continue work with ICS colleagues on Inclusion and OD groups to identify best practice	CM SM	Joint working taking place e.g. EDS 22		Ongoing				
Continue work with ICS colleagues on staff engagement and Wellbeing groups to access best practice and ICS funded initiative available to ROH	LTH CM	ROH asked to showcase some of the work at the Trust	Continue networking opportunities with ICS and national colleagues	Ongoing				
Review the Job Evaluation Policy and Process and assess whether or not to join with other BSOL trusts to purchase a centralised JE service. Savings in time and effort needed to ensure an efficient JE service to the Trust	DM/SB	The revised Policy is in draft format, but no progress to date on a system decision regarding the centralised JE service proposed by CSU	Final decisions on system based JE process	Ongoing			Due	

G. Employee Engagement 1/2

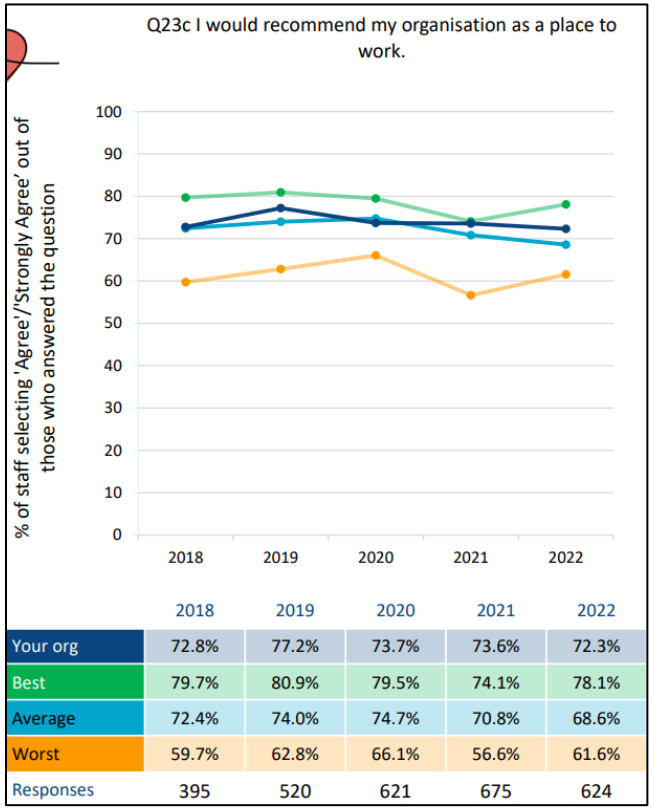
A significant number of these workstreams are already underway, but work will continue to develop and enhance employee engagement within ROH.

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Employee engagement								
Good levels of TED implementation to enable teams to discuss and feedback on positives and improvements	JS	Work started in key departments including Theatres	Execs to sponsor TED approach to be used in different departments	Ongoing			Due	
Good attendance and actions completed for monthly 'Be Involved' staff engagement sessions	JS LTH	Due to start in August 2023	Publish dates for workshops to ensure 6 weeks notice				Due	
Feedback from initial retention listening sessions shared with colleagues including actions completed	TH	Feedback requested by participants	Action is complete	Ongoing			Due	
Review and refresh values behaviours framework to be incorporated in all ROH work and enhance sense of belonging	CM JS SJ	Not started	This work will be part of the Maximising performance project work	Ongoing			Due	
Deliver training for managers to enable them to support team members through TED and Me as Manager	JS	Further schedule of workshops dates to be published	Confirm dates and ensure these are communicated to staff in various ways	Ongoing			Due	Ongoing

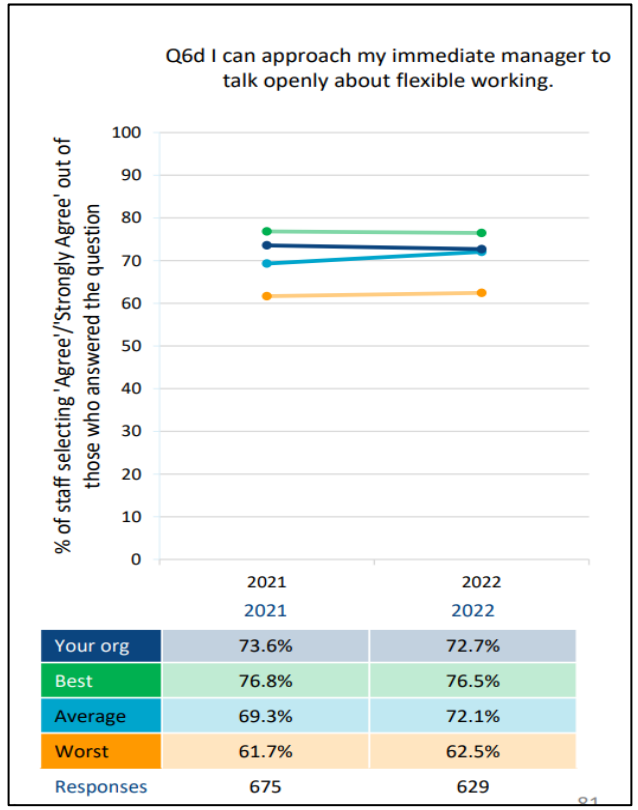
G. Employee Engagement 2/2

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jul-23	Aug-23	Sep-23	Progress RAG
Employee engagement								
Deliver a revised Staff Engagement Strategy	SM CM	Initial approach agreed by SE&OD committee		Ongoing				
Staff network meeting to discuss current topics and potential actions to improve engagement	JS Network chairs	Discussions and actions documented for each meeting	Quarterly meeting with all staff networks to be organised to enable conversations across different diverse groups	Ongoing			Due	
Awareness days organised by staff networks and other professional groups including Wellbeing Awareness Days	CM	Improved engagement opportunities now that face to face events are possible	Continue with awareness days using themes from staff feedback	Ongoing			Due	
Focus group for staff survey results to engage with staff an understand key priorities for action planning	JS LTH SM	Focus groups due to start in June and July	Information from focus groups to be collated as part of action planning	Ongoing			Due	
New programme of Schwartz Round dates to cover key areas of interest from staff members	CM AMcG	New schedule confirmed for next 12 months. Steering group formed to support delivery	Evaluate first session due to take place in June	Ongoing			Due	

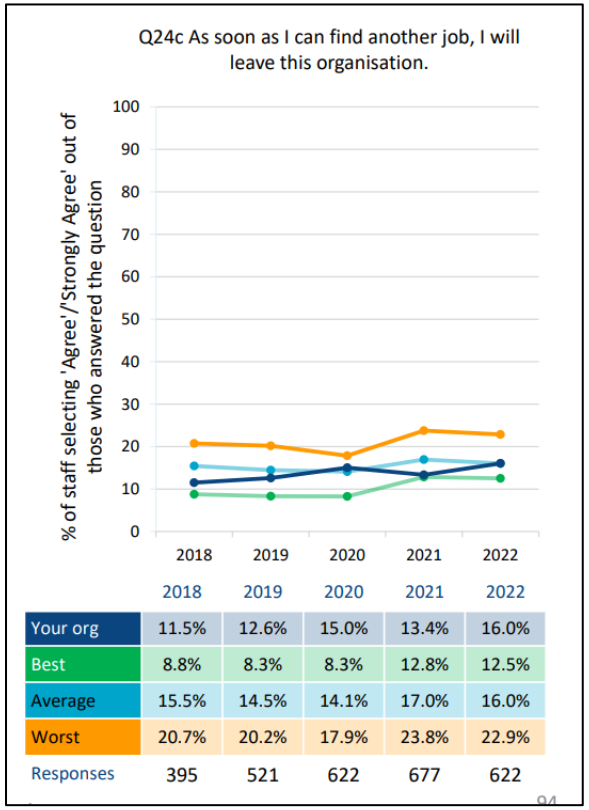
Key Staff survey results linked to recruitment and retention



	2018	2019	2020	2021	2022
Your org	72.8%	77.2%	73.7%	73.6%	72.3%
Best	79.7%	80.9%	79.5%	74.1%	78.1%
Average	72.4%	74.0%	74.7%	70.8%	68.6%
Worst	59.7%	62.8%	66.1%	56.6%	61.6%
Responses	395	520	621	675	624

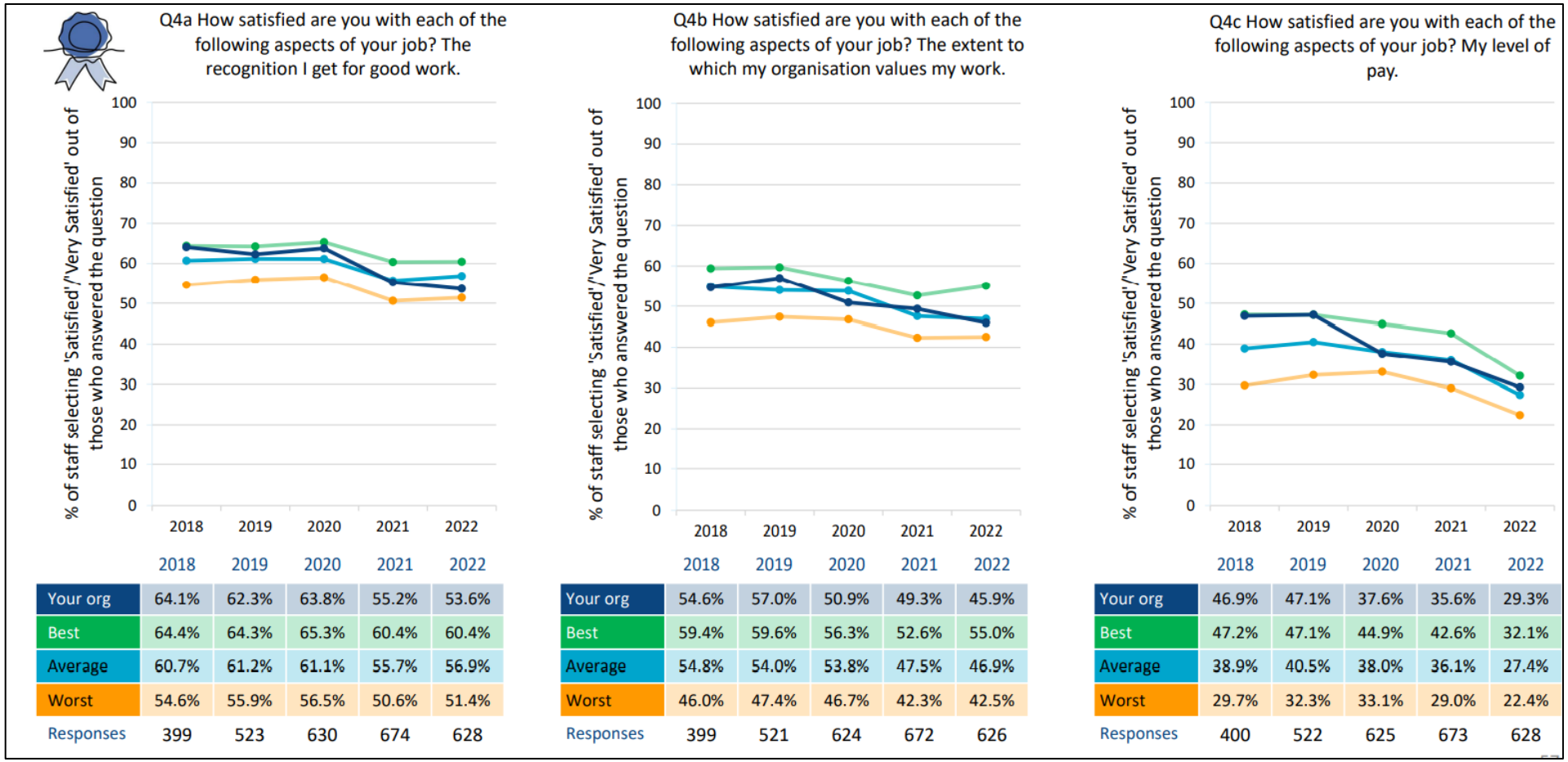


	2021	2022
Your org	73.6%	72.7%
Best	76.8%	76.5%
Average	69.3%	72.1%
Worst	61.7%	62.5%
Responses	675	629



	2018	2019	2020	2021	2022
Your org	11.5%	12.6%	15.0%	13.4%	16.0%
Best	8.8%	8.3%	8.3%	12.8%	12.5%
Average	15.5%	14.5%	14.1%	17.0%	16.0%
Worst	20.7%	20.2%	17.9%	23.8%	22.9%
Responses	395	521	622	677	622

Key Staff survey results linked to recruitment and retention



	2018	2019	2020	2021	2022
Your org	64.1%	62.3%	63.8%	55.2%	53.6%
Best	64.4%	64.3%	65.3%	60.4%	60.4%
Average	60.7%	61.2%	61.1%	55.7%	56.9%
Worst	54.6%	55.9%	56.5%	50.6%	51.4%
Responses	399	523	630	674	628

	2018	2019	2020	2021	2022
Your org	54.6%	57.0%	50.9%	49.3%	45.9%
Best	59.4%	59.6%	56.3%	52.6%	55.0%
Average	54.8%	54.0%	53.8%	47.5%	46.9%
Worst	46.0%	47.4%	46.7%	42.3%	42.5%
Responses	399	521	624	672	626

	2018	2019	2020	2021	2022
Your org	46.9%	47.1%	37.6%	35.6%	29.3%
Best	47.2%	47.1%	44.9%	42.6%	32.1%
Average	38.9%	40.5%	38.0%	36.1%	27.4%
Worst	29.7%	32.3%	33.1%	29.0%	22.4%
Responses	400	522	625	673	628

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	E&D Action plan update
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Clare Mair, Head of OD and Inclusion
DATE OF MEETING:	6 September 2023

EXECUTIVE SUMMARY:

This report gives an update on the work being undertaken as part of Inclusion action plan which is aligned to the ROH Inclusion strategy. This includes reporting in key progress made through completion of projects and metrics.

Initial information is also included on the NHS EDI Improvement plan that was launched in June 2023. A key impact area is highlighted to be delivered by senior leaders at the Trust.

Positive assurance

- Good progress has been made with the work on the Inclusion action plan
- Work is underway to renew the Inclusion Strategy (2021-2023) which will be aligned to the ROH Strategy and People plan
- Key metrics highlight progress:
  - The Trust continues to see an improvement in the disability declaration rate which has increased from 4% to 7.1% in the last 12 months. As at May 2023 the rate across all NHS Trusts and Foundation Trust was 3.7%. The WDES team have noted the significant progress made at the ROH to encourage staff to share their diversity data
  - There has also been an increase in staff members from an ethnic minority background across bands from 2 to 9 (agenda for change colleagues). It is particularly positive to see improvements at Band 6, 7 and 8a, in line with the WRES work

Current issues

- There are seven actions on the Inclusion action plan rated as Amber. These actions are due to be completed by deadline dates but there has been slower progress than expected

Next steps

Further progress on the Inclusion action plan to ensure completion of all action by December 2023

- Work to be undertaken to integrate the NHS EDI Improvement plan within the ROH Inclusion agenda
- Progress work on the Inclusion plan to replace the Inclusion strategy (2021 -2023)

REPORT RECOMMENDATION:

The Trust Board is asked to review the report for assurance

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	x	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**

The Royal Orthopaedic Hospital NHS Foundation Trust

Clinical	x	Equality and Diversity	x	Workforce	X
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
People Plan and ROH Trust Strategy					
PREVIOUS CONSIDERATION:					
None					

Trust Board – September 2023

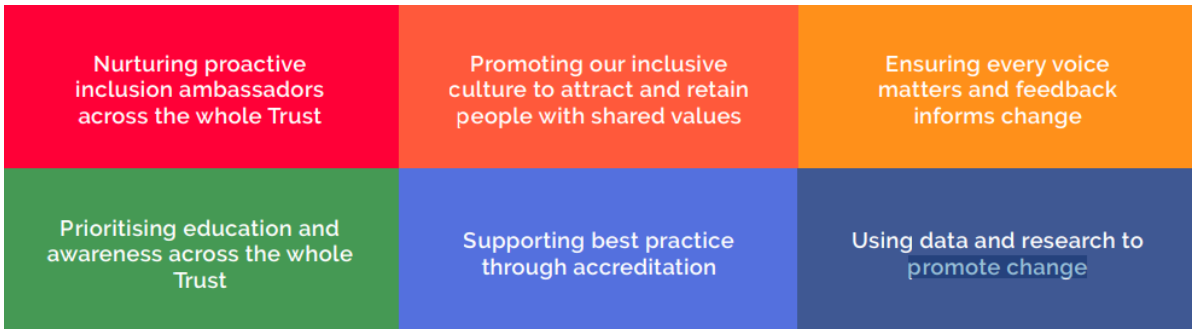
Equality and Diversity Action Plan update

1.0 Background

1.1 The Equality Diversity and Inclusion work (EDI) at the Trust is supported by the ROH Inclusion Strategy (2021 -2023) and action plan. This report gives an update on the Inclusion action plan along with some key areas of improvement achieved.

2.0 Inclusion action plan 2021 -2023

2.1 The work included in the action plan is focussed on key projects that will deliver continuous improvement in order to deliver the EDI agenda at the ROH. The actions are aligned to the Six High Impact areas in the Inclusion Strategy which are shown below.



2.2 The Inclusion action plan also identifies the projects that are being undertaken as part of the Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) improvement work. The individual action plans for WRES and WDES are currently being reviewed in line with required NHS reporting.

3.0 Progress to date

3.1 Since the start of the Inclusion action plan in 2021, key work has been completed in the following areas:

- Launch of the 'Seeing Beyond the Stigma Exhibition'
- Completion of two cohorts of the EPIC programme and delivery of masterclasses, to create a network of EPIC ambassadors.
- Introduction of the 10000 Black Intern project with two successful interns undertaking work experience at the Trust in 2022 and 2023
- Expansion of the staff networks with support from listening session events
- Development of the Freedom to Speak up programme

3.2 Good progress has been made which is highlighted in two key metrics below:

- The Trust continues to see an improvement in the disability declaration rate which has increased from 4% to 7.1% in the last 12 months. As at May 2023 the rate across all

NHS Trusts and Foundation Trust was 3.7%. The WDES team has noted the significant progress made at the ROH to encourage staff to share their diversity data

- There has also been an increase in staff members from an ethnic minority background across bands from 2 to 9 (agenda for change colleagues). It is particularly positive to see improvements at Band 6, 7 and 8a, in line with the WRES work

3.3 The Trust has also improved in the Inclusive Companies ranking to No 7 in the Top 50 rating. Feedback from the panel highlighted that it was clear to see the level of commitment shown to the EDI agenda by senior leaders and the progress made to support staff voice.

4.0 NHS Equality Diversity and Inclusion Improvement plan

4.1 This plan was launched in June 2023 as part of the ongoing commitment to support NHS patients and staff in an inclusive environment. The plan is aligned to the NHS People Promise and:

- sets out why equality, diversity and inclusion is a key foundation for creating a caring, efficient, productive and safe NHS
- explains the actions required to make the changes that NHS staff and patients expect and deserve, and who is accountable and responsible for their delivery
- describes how NHS England will support implementation
- provides a framework for integrated care boards to produce their own local plans

4.2 The work on this plan will be fully integrated into the future the EDI approach at the ROH. The plan is split into six high impact areas and the Board is asked to note that the first of these areas is:

'Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable'

4.3 Further updates will be provided to Trust Board as this work progresses.

5.0 Next steps

5.1 Working is currently underway to review the ROH Inclusion Strategy and action plan which are due to be renewed at the start of 2024. This work includes engagement from colleagues, particularly members of the staff network. Future work will be aligned to the ROH Trust strategy and the People Plan. Areas of focus will be underpinned by the NHS reporting requirements including WRES, WDES and the EDS frameworks.

Clare Mair – Head of OD and Inclusion

September 2023

ROH Inclusion action plan: 2021 - 2023

This plan gives an overview of the key areas of work in line with the ROH Trust's Inclusion Strategy and aligned to the six high impact areas.
Additional actions may be undertaken outside this plan (including the EDS23 framework) to meet the changing needs of the Trust. The actions will also be aligned to the NHS EDI Improvement plan. This activity will be reported to the People and OD Group, Staff Experience and OD committee and all staff networks.

Linked to	Outcome and Impact	Action	Planned Target date	RAG	Lead	Comments
	Impact area: Ambassadors					
WRES WDES	Embed an effective mentoring approach to offer staff from diverse backgrounds support particularly around career development. Number of colleagues who attend the mentoring and mentee programme Number of career opportunities confirmed for attendees Positive move in staff data including WRES and WDES indicators	Define overall Mentoring Framework which includes specific projects: • MMEG Mentoring Programme • Career mentoring programme • Disability Buddy Scheme • Reverse mentoring	December 2023		Jeeves Sundar	Project to be expanded following launch of MMEG programme Next phase is to expand MMEG programme to other groups – Career mentoring programme

	Impact area: Culture					
	Inclusive approach to attracting, recruiting, and retaining staff	Completion of Disability Confident Level 3 action plan	December 2023		Tammy Morris and Recruitment team	Work to be aligned with the EDI programme
		All managers trained in inclusive recruitment and onboarding approach	December 2023 - Ongoing		Recruitment team	To be incorporated into the Me as a Manager programme with specialist additional modules. This action will continue into 2024
		Completion of recruitment actions as part of the recruitment and retention programme	December 2023		Matt Dingle David Morris	Wider project also includes actions for OD and HR
		Update 100 days induction approach following evaluation	September 2023		David Richardson	Programme has been launched and first evaluation completed.
	Confirmed Project plan for Restorative Just Learning Culture (RJLC)programme to include Civility and Respect	RJLC project plan confirmed and ready to be delivered	December 2023		Clare Mair RJLC Project Team	Initial Project Team formed and Project Initiation document confirmed. Project plan currently being drafted

	Impact area: Staff voice					
WRES WDES	Networks are in place for staff to participate in to increase engagement and support on the ROH Inclusion journey Well established network for key diverse groups Increased participation of staff networks across all departments Good collaboration across the networks through Inclusion projects, with support for Executive Directors	Confirm structure and action plan for individual networks Develop future of staff networks through staff feedback	December 2023		Jeeves Sundar Network chairs Clare Mair	Current Networks • Equality & Diversity Network • Disability Network • Multi Minority Ethnic Group (MMEG) • BeMyself (WhatsApp group) • Menopause • Mankind • Women's network Work continues to ensure there is full management commitment to networks, encouraging and allowing their team time to attend Regular additional listening session 'Get involved' to be set up to capture any further areas of concern Staff networks continue to run awareness sessions across the Trust with ROH Inclusion calendar

	Further development of the Freedom to Speak Up Guardian (FTSU) approach All colleagues feel they have a voice and know the correct channels to ask for support in addition to their line manager	Review improvements made to the FTSU champions network and other communication work	December 2023		Claudette Jones	The FTSU champions network recruitment is now completed and a review will be undertaken to measure the impact of the changes made
WRES WDES	Improvement of declaration rates Increased number of staff sharing diverse information Opportunities and support communicated directly to diverse groups Increased participation through listening sessions and networks	To achieve a declaration rate of 7.5% for disability	December 2023 ongoing		Clare Mair Dave Morris Staff network	Good progress has been made over the last 12 months with an increase from 4% to 7.1%
	Impact area: Education					
	Further development of education programmes and tools to ensure staff at all levels have an awareness	To ensure a confirmed programme of sessions in line with colleague feedback	December 2023		Jeeves Sundar	Clear plan of development opportunities available for colleagues Plan will be ongoing into 2024

WRES WDES	and understanding of EDI topics Numbers of staff completing training Staff survey results linked to training Impact of training on individuals promoted	• Anti-Racist Workshop • Further development of EPIC programme • Regional and National • NHS development programmes • Integrate with Apprenticeship Programmes				
WRES WDES	Strengthen the importance of our staff network voice	Organise and run staff network conference	March 2024		Jeeves Sundar OD and Inclusion team Networks	Not started – Planning to begin in October 2023
	Impact area: Best practice					
	Ensure continued focus on accreditation through external best practice providers Improved on rating for Inclusive Companies Recognition of improvements at National level	• Complete Thrive at Work Silver Accreditation • Submit application for Inclusive Companies Top 50 • Submit nominations for industry awards • Continue work with other Trusts as part of Disability Confident Level 3	December 2023		Workforce and OD Team	• Application for Inclusive Companies Top 50 submitted August 2023

WDES WRES	Develop Evaluation tool through outcomes from Inclusive Companies application Benchmarking with staff survey results	• Partner with Inclusive companies to ensure that the work completed under the Inclusion Strategy and action plan will be evaluated in line with best practice	December 2023 – (January 2024)		OD and Inclusion Team Network chairs People and OD Group members	Ongoing work with Inclusive companies
	Ensure staff survey data is used to inform on priorities for the Inclusion agenda	• Full review of National staff survey data	December (February 2024)		Jeeves Sundar Clare Mair	Additional reporting now available through the IQVIA solar reporting system Work will continue into 2024
	Model hospital improvement tool integrated into ongoing inclusion agenda	• Regular review of model hospital system to align with inclusion actions	Ongoing			
	Develop ROH approach to the NHS EDI Improvement plan Ensure clear links with the NHS EDI Improvement plan and Inclusion strategy and action plan	• Confirm ROH EDI Improvement plan • Develop robust action plan	December 2023		Clare Mair Staff network chairs	Delay in starting this work

	Outcome	Action	Target date			Comments
	Impact area: Data and metrics					
WDES WRES	Embed an approach for staff and patients to access key inclusion data and information Key reports are accessible to patients, staff and visitors Inclusion work is made accessible to all, taking into account reason adjustments	• Establish a resource of information accessible for staff including intranet and ROH mobile app • Review and maintain intranet and internet site	November 2023		Workforce and OD Team Staff networks	• The intranet has been updated to provide information for staff, including the reporting listed in the section below. Work will continue to ensure the reports are informative and cover the correct data. • All reports are published on the ROH intranet. • Changes will be made now the new ROH website has been launched
WRES WDES	Developing further NHS compliance data and reporting Information can be used to review themes in different areas	Complete monitoring exercise to ensure NHS EDI data analysis and reporting is completed in a timely manner made visible for all staff and patients through reporting work in: • WRES • WDES	Ongoing		ESR Team OD and Inclusion team	• All reporting is completed in a timely manner • All networks share and discuss the reports to help inform on key actions • Data is shared with Executive Team and wider Board

	Reports show clear progress and future areas of focus	• Gender Pay Gap • EDS23 • Disparity Ratio • Access Information standards • WREI Strategy				• ESR now has improved functionality for data and reporting • Additional reporting available through SOLAR, IQVIA staff survey
WDES	Evaluation of WDES programme and interventions to review impact and effectiveness	Undertake full review of WDES "Seeing Beyond the Stigma" project	October 2023		Clare Mair University of Canterbury	University of Canterbury is completing the final write up for evaluation paper
	Embedded approach to Equality impact Assessments (EQIA) across all departments Robust approach to EQIA to be adopted across work at the Trust including policies, patient pathways and project plans	• Recommended documentation, guidance, monitoring, and training is embedded and understood within the Trust	Phase 1 – September 2023		Jeeves Sundar	Phase 1 of this project is completed. Further work will be needed to ensure approach is used with policies, patient pathways and other programmes to consider all nine protected characteristics. This project will be expanded to also include Health Inequalities.
	Enhanced communication channels to support all colleagues, managers, and patients Feedback from staff members to show improvement in communications	• Ensure there is a mix mode to inform and update staff and managers • Managers support with staff accessing opportunities • Ensure authentic messaging across Trust	December 2023		Comms Team Staff networks	Work completed to provide overview guide for development for all staff

Update: August 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Update on accreditation as an Elective Hub - for assurance**
SPONSOR (EXECUTIVE DIRECTOR):	**Marie Peplow, Executive Chief Operating Officer**
AUTHOR:	**Marie Peplow, Executive Chief Operating Officer**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

The paper gives an update on the Trust Elective Hub accreditation status:

- Confirming successful accreditation details
- Sharing Excellence in practice and opportunities for further improvement
- Detailing next steps

REPORT RECOMMENDATION:

The Board is asked to: note contents for assurance 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	x	Communications & Media	x
Business and Market Share	x	Legal and 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:

The accreditation process aligns to all key objectives within the Trust Strategy

PREVIOUS CONSIDERATION:

The Trust ambition to become an accredited elective hub was presented to Trust Board in May and was fully supported.

The Royal Orthopaedic Hospital NHS Foundation Trust

Elective Hub Accreditation update

REPORT TO TRUST BOARD - 6 SEPTEMBER 2023

1 Background

1.1 The Royal Orthopaedic Hospital (ROH) participated in the Getting it Right First time (GIRFT) accreditation process as part of the National Accreditation Programme Cohort one, having been nominated by the GIRFT Regional Director. Eight other Hubs participated in Cohort 1 which ran from March 2023 until July 2023. As previously reported at Trust Board, the team submitted extensive documentation and supporting evidence in preparation for an assessment visit on the 9th of June 2023.

1.2 The evidence was submitted successfully on the 26th of May and was reviewed by the national GIRFT team. No further requests for information were received by the Trust. The Trust subsequently welcomed the assessment team from GIRFT on the 9th June 2023 supported by the accreditation project team, Executive team and colleagues from across the BSol system. The visit also included contributions from a patient representative as the GIRFT team were taken through the ROH patient pathway. The team visited wards and the theatre complex speaking to staff and validating information included in the evidence submissions.

1.3 The initial staff feedback from the visit was that it had been a positive experience for all involved and the preparation of teams in readiness for the visit created a real sense of team working and energy around the organisation. Staff were really keen to share with pride the great care and excellence delivered at the ROH.

2 The outcome

2.1 The Trust received very positive feedback on the assessment day from the team. The national accreditation panel met on the 13th July to complete the assessment process. Following this meeting, the ROH were delighted to receive confirmation on the 8th August from Professor Tim Briggs Chair of GIRFT (National Director for Clinical Improvement and Elective Recovery, NHS England.) that the ROH had been successful in obtaining accreditation. (Letter of confirmation and full assessment documentation attached for your information in the appendices to this paper)

2.2 An excerpt from the confirmation of attainment letter reads as follows:

‘**A huge achievement and recognition of the clinical and operational excellence within your team and their engagement in the accreditation process.**

The team who visited your hub were impressed with the professionalism and enthusiasm of your staff and it was obvious that they were keen to take advantage of the benefits that the accreditation scheme offers. GIRFT's focus is on facilitating the development of surgical hubs with the aim of improving patient flow and utilisation and we are extremely grateful for your participation in Cohort 1 of the accreditation programme.'

3 Detail of assessment and recommendations

3.1 The report attached confirmed that of the 25 criteria, all were fully met, including those criteria deemed non-essential. This is a significant achievement for the team and the organisation as a whole.

3.2 The report outlined areas of excellence as follows:

- Excellent idea to photograph scratches or problems with wounds to send in following discharge rather than having to go to the hospital.
- Use of Omnicell's is efficient and effective.
- The use of a Trainer race chart on the wards following joint replacement is inspired and effective.
- The ROCS team is a remarkable service with passionate leadership.
- Weekly review of all cancellations is good practice.
- A magical environment where staff feel nurtured, safe and valued. Huge credit to the senior management team who have helped to create, facilitate, and support this environment.

3.3 Opportunities for improvement were also identified as follows:

- Opportunities for the ROH to offer further mutual aid.
- Could consider upskilling the nurses and having ANP to release anaesthetists.
- There is a further opportunity for reducing follow up appointments.
- Physio classes with patients take place excellent Mon to Fri. Continuing the physio classes over the weekend would be very useful.
- There is a problem with some imaging with some patients needing to have re imaging. Up to 50% which is costly and an inefficient use of resource if avoidable.
- Injections should be moved to procedure rooms as not all lists were optimally filled.
- Further work needs to be completed on rationalization of prostheses to just 2 per hip and 2 per knee.
- Frequent early finishes means that lists could have extra cases and may be the opportunity for adding in mutual aid.
- Frequent early finishes means that lists could have extra cases and may be the opportunity for adding in mutual aid.

Five of the opportunities noted were included in the Hub Optimisation action plan, however all opportunities will be explored by the accreditation team as best practice.

4. Next steps

4.1 Accreditation is reviewed at 3 months to consider any actions recommended by the accreditation panel. Accreditation lasts for three years, subject to maintaining standards and levels of performance as well as progress on areas for improvement, after which re-accreditation and a full assessment will take place.

4.2 Data submitted to the Model Health system will be reviewed on a monthly basis by the accreditation team to inform regular review meetings. It is clear that accreditation can be relinquished during the three-year period if standards are not continually met.

4.3 The Trust are required to submit a Hub Optimisation Plan (HOP) by the 31st August. This was prepared by the project team and reviewed by the SRO for the hub and was tabled at the weekly Executive meeting on the 15th August for review and endorsement from the wider Executive team. The HOP is enclosed in the pack as an appendix for your information and submitted to the national team on Friday 25th of August 2023.

4.4 The ROH team are keen to harness the opportunities the accreditation brings to support patient and staff morale and to enhance the ROH brand locally and nationally/ internationally. Therefore, we are working closely with the Communications team to maximise this opportunity in our marketing collateral.

4.5 On the 23rd of August a 'Thank you' event was held in the foyer in outpatients manned by the Operational teams. This event was hugely successful, and we believe over 300 staff and patients visited the stand to celebrate the achievement and learn more about the accreditation process.
Each attendee received a leaflet explaining the accreditation and on the reverse of a leaflet was a thank you certificate signed by our CEO, which was well received, along with free goodies and of course cake!
More events are planned in collaboration with the communications team with our system stakeholders and at the launch of our refreshed Trust strategy in Mid-September.

4.6 In addition to the above several of the team both clinical and non – clinical have been asked to take part in assessments all over the country in cohort 2 which is a great opportunity for us to support the programme and bring any learning back to the ROH. We are also delivering a national webinar on Monday the 4th of September with Colleagues at SWELOC to share our experiences of the programme and support other centres on their accreditation journey.

4.5 Last but not least I would like to thank team ROH for continuing to deliver excellence, which is endorsed nationally via this accreditation, for most of us this was a very special day and a milestone for the ROH and a career defining experience which was a privilege to be involved in.

5 Recommendations

5.1 The Board are asked to:

- RECEIVE AND NOTE the update on Elective Hub Accreditation
- SUPPORT the proposed next steps in Section 4

Author: Marie Peplow, Chief Operating Officer

30th August 2023

ROHTB (9/23) 008 (b)

Marie Peplow

SRO – ROH Birmingham

Marie.peplow@nhs.net

July 2023

Dear Marie

Elective Surgical Hub Accreditation

I am delighted to be able to offer my congratulations and advise you that ROH Birmingham has been recognised as an accredited hub following the site visit held on 9th June 2023.

This is a huge achievement and recognition of the clinical and operational excellence within your team and their engagement in the accreditation process.

The team who visited your hub were impressed with the professionalism and enthusiasm of your staff and it was obvious that they were keen to take advantage of the benefits that the accreditation scheme offers. GIRFT's focus is on facilitating the development of surgical hubs with the aim of improving patient flow and utilisation and we are extremely grateful for your participation in Cohort 1 of the accreditation programme.

Next Steps:

With this email you have also received the following documents:

- Two site reports
    - One relating to the detail of the compliance with criteria
    - One executive report
- Template for the Hub Optimisation Plan

A Communications briefing and pack containing sample press release, accreditation logo and social media cards with be sent to your comms lead on Monday 24th July.

You will have also received an invite to a call on Wednesday 26th July 9:00am-9:45am to hear more about the post-accreditation process.

Once again thank you for your contribution to this process and many congratulations to you and your team.

Best wishes

Professor Tim Briggs

Chair of GIRFT

National Director for Clinical Improvement and Elective Recovery, NHS England

Cc:

Site Contact – Michelle Hubbard

Regional Director – Dale Bywater

Recovery Leads – Ian Ellis/Fiona Gabbitas

ROHTB (9/23) 008 (c)

Accreditation Visit
The Royal Orthopaedic Hospital, Birmingham
National Accreditation Report July 2023

The visit was carried out on June 9th by the following team members:

- Tim Briggs - National Director for Clinical Quality and Effectiveness and Chair of GIRFT, NHS England
- Stuart Smith – Anaesthetist, Sheffield
- Vel Sakthivel – Surgeon, Grantham hub
- Deb Millington – Implementation Manager, Midlands (Nurse) GIRFT
- Rebecca Anderton - Implementation Manager, GIRFT
- Jane Rooney – Programme Lead, Accreditation, GIRFT

Executive Summary

This report brings together our findings and recommendations based on the evidence and data we collated during the Elective Hub accreditation process culminating in the site visit on June 9th 2023.

The Royal Orthopaedic Hospital (ROH) participated in the accreditation process as part of the National Accreditation Programme Cohort 1, having been nominated by the Regional Director. 8 other Hubs participated in Cohort 1 which ran from March 2023 until July 2023.

As part of the process, ROH was asked to submit evidence against national accreditation criteria which had been developed by a large cohort of experts, both clinical and non-clinical, and including several Royal Colleges.

On the day of the visit, it was a privilege to meet such a committed, talented and enthusiastic team. They shared examples and information on good practice and were open and transparent during interviews and focus sessions. It was delightful to meet the teams who are supporting the elective recovery process for this system and to better understand the pressures and daily challenges they face. The report both recognises areas of excellence and makes practical recommendations that will support and address some of these pressures.

The Accreditation Panel sat on July 13th and the outcome is that ROH Birmingham has been awarded accreditation.

Patient Pathway-Domain 1

Of the 13 criteria in this domain, all were fully met, including those criteria deemed essential.

Opportunities for improvement

- Opportunities for further mutual aid, particularly to include spinal surgery
- Could consider upskilling the nurses and having ANP to release anaesthetist and helps with career progression
- There is a further opportunity for reducing follow up appointments
- Joint school is planned to restart and will add further value to patients
- Physio classes with patients take place excellent Mon to Fri. Continuing the physio classes over the weekend would be very useful. Patients are working together and this will aid discharge. promote independence and has a positive effect psychologically as they are doing this together.

Examples of Excellence:

- Excellent idea to photograph scratches or problems with wounds to send in following discharge rather than having to go to the hospital
- Use of Omnicells is efficient and effective.
- The use of a Trainer race chart on the wards following joint replacement is inspired and effective
- The ROCS team is a remarkable service with passionate leadership

Staff and Training-Domain 2

Of the 8 criteria in this domain, all were fully met, including those criteria deemed essential.

Examples of Excellence:

- A magical environment where staff feel nurtured, safe and valued. Huge credit to the senior management team who have helped to create, facilitate and support this environment
- The inclusion of the dining room corridor design showing how each staff team impact the patient journey shows the value put on staff feeling included

Clinical Governance and Outcomes-Domain 3

Of the 4 criteria in this domain, all were fully met, including those criteria deemed essential.

Examples of excellence:

- Weekly view of all cancellations is good practice.

Utilisation and Productivity-Domain 4

Of the 3 criteria in this domain, all were fully met, including those criteria deemed essential.

Opportunities for Improvement:

- Frequent early finishes means that lists could have extra cases and may be the opportunity for adding in mutual aid

Facilities and Ring Fencing-Domain 5

Of the 7 criteria in this domain, all were fully met, including those criteria deemed essential.

Opportunities for Improvement:

- There is a problem with some imaging with some patients needing to have re imaging. Up to 50% which is costly and an inefficient use of resource if avoidable
- Injections should be moved to procedure rooms as not all lists were optimally filled
- Electronic x ray requesting is underway. Need to consider doing post op or on way back toward area. Similar to DC procedures. Have just had new x ray room installed which will help
- Further work needs to be completed on rationalization of prostheses to just 2 per hip and 2 per knee

Hub Optimisation Plan to be developed to address the following areas:

Domain	Action
1. Patient Pathway	There is a further opportunity for reducing follow up appointments.
1. Patient Pathway	Physio classes with patients take place Mon to Fri. Continuing the physio classes over the weekend would be very useful. Patients are working together and this will aid discharge, promote independence and has a positive effect psychologically as they are doing this together.
4. Utilisation and Productivity	Further engagement in mutual aid, particularly for spinal surgery, will fill lists and avoid early finishes
5. Facilities and Ringfencing	Injections should be moved to procedure rooms as not all lists were optimally filled.
5. Facilities and Ringfencing	Further work needs to be completed on rationalization of prostheses to just 2 per hip and 2 per knee.

The action plan using the template should be completed **by Thursday 31st August** and submitted to jane.rooney7@nhs.net for sign off by the accreditation panel.

Summary:

The Accreditation Panel sat on July 13th and the outcome is that ROH Birmingham has been awarded accreditation. Five actions are required and are identified above.

Accreditation is reviewed at 3 months to consider any actions recommended by the accreditation panel. Accreditation lasts for three years, subject to maintaining standards and levels of performance as well as progress towards the identified areas for improvement, after which re-accreditation will take place.

Any queries about this report should be directed in the first instance to your hub lead
Michelle Hubbard m.hubbard6@nhs.net

GETTING IT RIGHT FIRST TIME

The Royal Orthopaedic Hospital, Birmingham Accreditation Review

July 2023

Executive Summary

Date of visit: June 9th 2023

Visit team:

- Tim Briggs - National Director for Clinical Quality and Effectiveness and Chair of GIRFT, NHS England
- Stuart Smith – Anaesthetist, Sheffield
- Vel Sakthivel – Surgeon, Grantham hub
- Deb Millington – Implementation Manager, Midlands (Nurse) GIRFT
- Rebecca Anderton - Implementation Manager, GIRFT
- Jane Rooney – Programme Lead, Accreditation, GIRFT

High level findings:

Excellent compliance with criteria well demonstrated by timely submission of evidence.
Excellent senior level support for the facility
Excellent level of staff and patient satisfaction
Very Impressive site in all areas

Accreditation panel decision:

ROH Birmingham is awarded accreditation

Elective Hub Accreditation Criteria-Domain 1 Patient Pathway (page 1/3) ROH June 2023

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
1.Digitally enabled 'one stop' processes	1.a. Processes in place to support simple system-wide referral in and out of hub	Criteria met		Opportunities for further mutual aid, particularly to include spinal surgery
	1.b. Efficient processes for patient consent in place and this includes shared decision making	Criteria met		
	1.c. Efficient, streamlined pre-operative processes are in place	Criteria met	The assessment is valid for 4 months. MRSA valid 3 months and other tests validity can be considered as remaining still valid for up to 5 months. Good model.	Could consider upskilling the nurses and having ANP to release anaesthetist and helps with career progression

Elective Hub Accreditation Criteria-Domain 1 Patient Pathway (page 2/3)

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
2. Best practice pathways & protocols	2.a As many procedures as possible are being done as day cases'	Criteria met	Excellent use of day case and inpatient areas and recovery	
	2.b Good practice clinical pathways are embedded as standard alongside one stop administrative pathways	Criteria met		
	2.c Patients are safely transported to emergency care	Criteria met		
3. Patient Communication & Support	3.a Reasons & benefits of referral to hub and supporting information are explained clearly and comprehensively	Criteria met		

Elective Hub Accreditation Criteria-Domain 1 Patient Pathway (page 3/3)

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
4. Patient Selection & Optimisation	4.a The hub maximises suitability of patients and screens patients to ensure their safety	Criteria met		
	4.b. Patients are proactively prepared for surgery as much as possible	Criteria met		
5. Discharge support/rehab links	5.a. Effective discharge and safety netting of patients to avoid unnecessary delays and problems with discharge	Criteria met	Excellent idea to photograph scratches or problems with wounds to send in following discharge rather than having to go to the hospital Use of Omnicells is efficient and effective. TTO packs used in 96% of cases	There is a further opportunity for reducing follow up appointments
	5.b Patients are proactively supported to undertake rehab activities	Criteria met	Walking groups post-op are well attended. Good use of the MyRecovery app.	Joint school is planned to restart Physio classes with patients take place Mon to Fri. Continuing the physio classes over the weekend would be very useful. Patients are working together and this will aid discharge. promote independence and has a positive effect psychologically as they are doing this together.
6. Proactive User Engagement & Service Improvement	6.a Regular mechanism in place for collecting user feedback	Criteria met	Excellent 'Coffee Catch Up' model is in use with very positive outcomes	
	6.b. Patient, staff & data insights are used regularly to improve services	Criteria met	Team commented on the very happy staff throughout the site who were keen to show off their good work. The breaking down of hierarchy within the Trust has been very beneficial. Patients talked about staff going the extra mile and that was consistent across all areas. Very valuable to have a patient rep at the focus sessions	

Elective Hub Accreditation Criteria-Domain 2 Staff and Training

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
1. Dedicated & ring-fenced clinical and operational teams	1.a Robust clinical staffing model in place to address workforce issues	Criteria met		
	1.b System in place to enable staff to work effectively at hubs sites and to move efficiently between hubs	Criteria met		
	1.c Robust ring-fencing applied to hub staff	Criteria met		
2. Supported training of all staff	2.a There are regular, scheduled, training opportunities at the hub for doctors, including fellows	Criteria met		
	2.b Hub staff offered regular, relevant continued professional development (CPD) opportunities	Criteria met		
3. Strategy & approaches that promote staff well-being	3.a Staff have access to necessary basic facilities and services	Criteria met		
	3.b Staff feel safe in their work environment	Criteria met	Staff talk about a good safety culture and have undergone human factors training	
	3.c Staff feel valued and respected in their work environment	Criteria met	There is an Admin Matters group to ensure that non-clinical admin staff feel valued The patient pathway is being drawn along a corridor wall to illustrate how each team of staff interface with the patient journey (clinical and non-clinical)	

Elective Hub Accreditation Criteria-Domain 3 Clinical Governance and Outcomes

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
1. Dedicated hub management & quality governance in place	1.a Dedicated hub management & quality governance in place	Criteria met		
	1.b Clear and comprehensive policies and process are in place and embedded with regards to clinical risk management & learning from clinical incidence	Criteria met		
2. Achievement of good clinical outcomes	There is regular review and capture of a key data collection and data is within normal parameters or improving	Criteria met		
3. Collection, management and use of patient and operational information as BAU	Operational information is shared with relevant staff	Criteria met	Weekly view of all cancellations is good practice	

Elective Hub Accreditation Criteria-Domain 4 Utilisation and Productivity

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
1 Full utilisation of hub	Optimisation of utilisation through efficient use of operating theatres	Criteria met		Frequent early finishes means that lists could have extra cases and may be the opportunity for adding in mutual aid
2 System-wide referral process in place	Processes are in place guaranteeing a regular pipeline of suitable patients into the hub from across the wider system	Criteria met		
3. Productivity standards – cases per list; cancellations and DNA management	Clear responsibilities and processes to maximise hub productivity	Criteria met		

Elective Hub Accreditation Criteria-Domain 5 Facilities and Ring-Fencing

Headline criteria	Core elements of headline criteria	Criteria met	Comments	Recommendations
1. Activity is fully ring-fenced provision from acute care	The facility is protected to ensure that beds and theatres are available for elective procedures	Criteria met		
2 Diagnostic & other supporting facilities in place	Supporting services are utilised to optimise the productivity and effectiveness of the hub	Criteria met		There is a problem with some imaging with some patients needing to have re imaging. Up to 50% which is costly and a inefficient use of resource if avoidable
3 Optimised theatre layouts & flow	3a Theatre use is optimised by the implementation of clear policies	Criteria met		Injections should be moved to procedure rooms as not all lists were optimally filled
	3b Layout planning wherever possible supports efficient working in theatres	Criteria met		Electronic x ray requesting is underway. Need to consider doing post op or on way back toward area. Similar to DC procedures. Have just had new x ray room installed which will help
4. Equipment and facilities to maximise ca re outside theatre setting.	4a. There is appropriate provision for post operative care for patients and carers	Criteria met		Further work needs to be completed on rationalization of prostheses to just 2 per hip and 2 per knee
	4b Reasonable adjustments	Criteria met		
5. Patient Transport Solutions	Where appropriate hub patients can access efficient NHS transportation	Criteria met		

Hub Optimisation Plan – Areas to address

GETTING IT RIGHT FIRST TIME

ID	Name of Hub [please add] Areas to address	Action to be taken	Responsible Owner	Deadline for completion

Hub Optimisation Plan – Areas to address

ID	Name of Hub – Royal Orthopaedic Hospital NHS Foundation Trust Areas to address	Action to be taken	Responsible Owner	Deadline for completion
R1	There is a further opportunity for reducing follow up appointments.	• Obtain data on number of contacts to the wound care helpline over a 3 month period. • Liaise with ROCS regarding current process. • QI project re: 72 hour call being an opportunity to request images of any scratches to avoid patients coming in and being cancelled on the day.	Jennifer Pearson /Karen Hughes / Emma Steele	31.12.2023
	Additional work underway to reduce OP follow ups.	• Review OP follow up templates /pathways to ensure standardisation across specialties in line with GIRFT Best practice .	Nasir Uddin	31.12.2023

ID	Further Context
R1	GIRFT suggested that the use of photography for review of post op wounds could be an opportunity to reduce the number of follow ups patients receive. This idea can also be applied to Pre Op at the 72 hour call to avoid cancellations on the day.

Hub Optimisation Plan – Areas to address

ID	Name of Hub – Royal Orthopaedic Hospital NHS Foundation Trust Areas to address	Action to be taken	Responsible Owner	Deadline for completion
R2	Group physiotherapy classes with patients take place excellent during Mon to Fri. Continuing the physio classes over the weekend would be very useful. Patients are working together and this will aid discharge, promote independence and have a positive effect psychologically as they are doing this together. (Weekend therapy services are in place but currently delivered on an individualised patient basis over the weekend)	• Discuss with Inpatient physio lead Chris Aspland to agree the feasibility of w/end provision • Demand and capacity modelling to be undertaken to ascertain if resources required to deliver w/end classes Group or if current w/end resources can be repurposed .	Nicola Mason/ Marie Raftery	31.12.2023

Hub Optimisation Plan – Areas to address

ID	Name of Hub – Royal Orthopaedic Hospital NHS Foundation Trust Areas to address	Action to be taken	Responsible Owner	Deadline for completion
R3	Further engagement in mutual aid, particularly for spinal surgery, will fill lists and avoid early finishes	• Waiting list trajectories to be revised in line with system requirements and Trust requirements to support AQP framework . • Demand and capacity modelling to scope feasibility of further mutual aid. • Waiting list profiles at Robert Jones and ROH being reviewed to assess current need on both sites with an aim to equalising waiting times . • Registration of ROH on DMAS in line with national elective recovery updated requirements and enable visibility of ROH capacity.	Michelle Hubbard	31.12.2023

Hub Optimisation Plan – Areas to address

ID	Name of Hub – Royal Orthopaedic Hospital NHS Foundation Trust Areas to address	Action to be taken	Responsible Owner	Deadline for completion
R4	Injections should be moved to procedure rooms as not all lists were optimally filled.	• Review utilisation of injection suite to ensure capacity maximised. • Consider opportunity to provide more injections in an outpatient type setting by extending current working hours (if required). • Longer term business case for an ambulatory care unit to include an injection suite	Michelle Hubbard	31.1.2024

ID	Further Context
R4	Where possible injections are performed in an outpatients / injection suite setting. Injection procedures are also used as list fillers in main theatres due to the time available in theatres not lending itself to an additional jointas demonstrated in model health system data.

Hub Optimisation Plan – Areas to address

ID	Name of Hub – Royal Orthopaedic Hospital NHS Foundation Trust Areas to address	Action to be taken	Responsible Owner	Deadline for completion
R5	Further work needs to be completed on rationalisation of prostheses to just 2 per hip and 2 per knee	Understand current inventory for hips and knees prostheses. If more than 2 suppliers understand clinical rationale. Consider contractual status and implications. Engage with surgeons and Procurement to rationalise prostheses providers. (Confirm any contractual obligations)	Marie Raftery / Amanda Gaston	TBC once contractual status clarified (Contract review TBC by 1. 10.23)

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Expanding Elective Capacity Self-Assessment - for assurance**
SPONSOR (EXECUTIVE DIRECTOR):	**Marie Peplow, Executive Chief Operating Officer**
AUTHOR:	**Marie Peplow, Executive Chief Operating Officer**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

Following the letter circulated to all acute Trusts by NHS England on the 4th of August (Appendix 1) relating to expansion of elective capacity, this paper will update the Trust Board on actions required and progress to date at the Royal Orthopaedic Hospital.

The draft self-certificate that needs to be issued back to NHSE in relation to this is provided (Appendix 2).

The paper will encourage a discussion and challenge regarding the draft self-certification in preparation for discussion at system level and sign off by Chair and Chief Executive by 30th September 2023.

REPORT RECOMMENDATION:

The Board is asked to:

- Receive and note the update on the Expansion of Elective capacity NHS England request;
- Discuss and challenge as required the self-certification document;
- Support the intention for the Chair and Chief Executive to sign the assurance declaration and return it to NHS England, subject to further discussion at the September meeting of the Finance & Performance Committee

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	
Business and Market Share		Legal and 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:

The paper aligns to Trust strategic objectives in relation to improving access and quality of care whilst maximising productivity utilising digital enablers to meet national operational imperatives.

PREVIOUS CONSIDERATION:

Paper included in August Finance and Performance pack , however due to release of request on the 4th of August, extensive discussion has not been feasible

FOR ASSURANCE

ROHTB (9/23) 009 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

PROTECTING AND EXPANDING ELECTIVE CAPACITY
REPORT TO TRUST BOARD - 6 SEPTEMBER 2023

1 Background

1.1 On 4th August 2023 a communication was sent out to all NHS Acute Trusts by Sir James Mackey, National Director of Elective Recovery, NHS England and Professor Tim Briggs CBE, National Director of Clinical Improvement, Chair, Getting It Right First Time (GIRFT) Programme, NHS England. Circulation included Chairs, Chief Executives, Medical Directors and Chief Operating Officers. The letter is part of a series of recent guidance around elective and cancer recovery.

1.2 The letter can be found in the appendix to this paper. In summary it details the importance of ringfencing elective and cancer capacity, particularly though winter to maintain progress on the reduction of patient waiting times. The context outlines that even with significant operational challenges, including ongoing industrial action, nationally we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021; and now representing c0.1% of the total list; and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today. However, it is acknowledged in the letter there is still considerable work to be done in outpatients.

1.3 To facilitate outpatient transformation, collaborative work has been delivered by NHS England with the Royal Colleges , specialist societies to champion and enable outpatient recovery and transformation with a focus on two areas:

- **Review guidance on outpatient follow-ups**
- **Support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge and following clinically informed access policies**

The aim of the work is to free up capacity and increase productivity in this area. It is felt this can be achieved through: reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

The letter makes reference to a number of documents and tools developed to support this endeavour. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

2 Deliverables required to achieve compliance.

2.1 The letter sets out three key actions providers are being asked to undertake:

- Revisit plan on outpatient follow up reduction, to identify more opportunity for transformation
- Set an ambition that no patient in the 65-week 'cohort', patients who, if not treated by 31st March 2024, will have breached 65 weeks, will be waiting for a first outpatient appointment after 31st October 2023
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated, in line with December 2022 validation guidance, by 31st October 2023 and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

2.2 Trusts are asked to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients' transformation.

2.3 Each provider is asked to ensure that this work is discussed and challenged appropriately at Board, undertake a board self-certification process and have it signed off by Trust Chairs and Chief Executives by 30th September 2023**.**

3 The ROH response

3.1 A self-assessment against the requirements has been developed which will be discussed further at the meeting of the Finance & Performance Committee on 26 September 2023.

4. Recommendation

4.1 The Board is asked to:

- Receive and note the update on the Expansion of Elective capacity NHS England request
- Discuss and challenge as required the self-certification document
- Support the intention for the Chair and Chief Executive to sign the assurance declaration and return it to NHS England, subject to further discussion at the September meeting of the Finance & Performance Committee

Author: Marie Peplow, Chief Operating Officer
Date: 30th August 2023

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

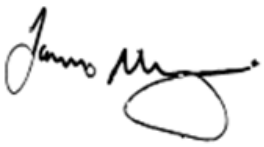
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Appendix B: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: The Royal Orthopaedic Hospital NHS Foundation Trust

The Chair and CEO are asked to confirm that the board:

Assurance area	Assured?

1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	**YES** **YES** **YES**

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	**YES**
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	**YES** **NOT APPLICABLE**
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	**YES** **YES** **YES** **YES**

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	**YES**
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	**Internally this will be monitored monthly via our Finance & Performance Committee and updates in our Trust Board.** **No external support required.**

Sign off

Trust lead (name, job title and email address):	Marie Peplow – Executive Chief Operating Officer (COO)
Signed off by chair and chief executive (names, job titles and date signed off):	Jo Williams Chief Executive (CEO) Tim Pile Chair

REPORT REF: ROHTB (9/23) 010

TRUST BOARD

DOCUMENT TITLE:	**Update on the Implementation of Patient Safety Incident Response Framework (PSIRF) – August 2023**
SPONSOR (EXECUTIVE DIRECTOR):	**Chief Nurse & Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
PRESENTED BY:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Overview of PSIRF

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

Implementation of PSIRF at ROH

We are required to apply this framework in the development and maintenance of a patient safety incident response policy and plan.

Our patient safety incident response policy should describe our overall approach to responding to and learning from patient safety incidents for improvement and identify the systems and processes in place to integrate the four key aims of PSIRF.

It should describe how those affected by a patient safety incident will be engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation.

The policy should also outline how patient safety incident response integrates with other activities such as clinical governance, HR and complaints management, and underline that the remits of different response types are distinct and must be kept so.

Both documents – our policy and plan – should align with and be integral to the Trust's wider approach to safety improvement and should be published on our website.

Going forward, our policy and plan should be updated regularly based on new learning, be adaptive to any changes in our risk and incident profile and reflective of ongoing improvements.

Progress with Implementation

There are 6 phases of PSIRF implementation as set out by the national PSIRF guidance. These are set out below:-

Phase 1: PSIRF Orientation
Phase 2: Diagnostic and Recovery
Phase 3: Governance and Quality Monitoring
Phase 4: Patient Safety Incident Response Planning
Phase 5: Curation and Agreement of the Policy and Plan
Phase 6: Transition

We are currently in Phase 5, which requires us to draft our formal PSRIF Plan and Policy.

Next Steps

We are currently in the process of drafting our PSIRF plan and policy before we then begin the consultation process.

The first stage of consultation will be to seek feedback from key internal stakeholders. The current plan is to have a draft of the plan and policy to share by early September 2023.

The second stage will involve us updating and amending the plan and policy following initial comments before submitting the policy to key internal committees and boards.

The current plan is to submit the drafts to the Quality and Safety Executive meeting scheduled for the end of September before then submitting to Clinical Quality Group followed by Trust Board in early October 2023. Due to the schedule of the meetings of the Quality & Safety Committee, the plan and policy will need to be shared for comment with members outside of a formal meeting.

Once comments and feedback have been incorporated we will then share the plan and policy with BSOL ICB.

Once these stages are complete we will be in a position to formally sign of the plan and policy internally and externally with BSOL ICB and set an official go live date.

Having set a go live date, a series of promotional events and workshops for the launch of PSIRF will be held to begin to embed the changes and begin to educate staff across the Trust on the new framework.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Implementation is on schedule • Good contact and engagement with BSol ICB has been maintained throughout the implementation phases with updates on progress provided at regular intervals • System based and co-ordinated approach to PSIRF implementation across BSol ICB with regular updates on progress provided to BSol ICB. Regular PSIRF events have been held by BSol ICB and have been attended by the Trust	• BSOL ICB want to co-ordinate a go live date with all trusts within the local system. Initial go live date was set for October 2023 but we are currently awaiting further information and updates from BSOL ICB on timescales for launch. Therefore current timescales seem likely to be delayed to allow time for consultation and sign off. There is no indication that this would be beyond the nationally mandated timescale of 'autumn 2023'. • BSol ICB want to take a system based approach to training on new PSIRF framework. However, we are still waiting for further details on the plans for roll out of this training, which means it will be difficult to provide detail of training within our draft plan and policy at this stage as we head into the period of consultation.

NOT APPLICABLE

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to note and accept the update as assurance.

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

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

Comments:

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

Contractual targets for quality and safety

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

System based and co-ordinated approach to PSIRF implementation across BSol ICB

PREVIOUS CONSIDERATION:

Trust Board - May 2023

REPORT REF: ROHTB (9/23) 011

TRUST BOARD

DOCUMENT TITLE:	**Violence prevention and reduction standard – position statement and gap analysis**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance and Sharon Malhi, Chief People Officer**
AUTHOR:	**Carl Measey, Health & Safety Adviser**
PRESENTED BY:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

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

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

A self-assessment against the standard has been completed and is attached as Appendix A.

The key areas of non-compliance are:

- No evidence of a violence prevention and reduction '*strategy*'.
- No evidence of organisational risks associated with violence have been assessed and shared with stakeholders in the Sustainability Transformation Partnership (STP) or Integrated Care System (ICS).
- No evidence of '*plans*' developed/updated to achieve violence prevention and reduction '*objectives*. No evidence of subsequent '*outcomes*' in the V&A policy.
- No evidence of a designated board-level director managing a violence prevention and reduction '*workstream*'.
- No evidence the senior management team provides accessible communications about violence prevention objectives and priorities.
- No evidence the risks of violence and their mitigations/controls communicated to all staff.
- No evidence of a '*diversity lens*' applied to objectives development.
- No evidence of violence prevention and reduction risk registers.
- No evidence of twice-yearly senior management review, the findings of which to be shared with the board.
- No evidence that violence prevention and reduction is being triangulated with WRES and WDES.

The Trust has a low level of violence and aggression incidents reported, i.e. five incidents were reported in 2022, three of which were due to medical factors e.g. post op delirium/dementia. Therefore a practical and proportionate approach to address the areas of non-compliance highlighted is proposed and where this is the case, this is reflected in the actions proposed.

The overall assessment against the compliance matrix attached as Appendix B is 'Partially Compliant'.

The assessment and action plan will be presented to the Staff Experience & OD Committee and Quality & Safety Committee prior to consideration by the Trust Board. This will be monitored through a twice-yearly update.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• The Trust is rated as 'Partially Compliant' with the standard reflecting that there are some good plans in place around policies, incident reporting, compliance with relevant legislation and definition of roles and responsibilities in connection with violence and aggression management.	• The self-assessment shows some areas requiring addressing including development of a reduction plan, sharing information with stakeholders and communications

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board is asked to:
RECEIVE and NOTE the self-assessment and the proposal to develop an action plan to address the areas of non-compliance.

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

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

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

Violence prevention and reduction standard 2020.

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

Requirement to share information around compliance with the standard with key stakeholders.

PREVIOUS CONSIDERATION:

Health & Safety Group in June 2023, Quality & Safety Committee on 23 August 2023 and Staff Experience & OD Committee on 30 August 2023.

Plan

1 The board (non-exec and exec members) endorses the violence prevention and reduction policy								
Ref	**Indicators**	**Compliant**	**Evidenced (how)**	**Gaps**	**Actioned Needed**	**Owner**	**Timescale**	**Status**
a)	• The organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.	NO	No evidence.	No evidence of a violence prevention and reduction 'strategy'.	'*strategy*' to be incorporated within V&A policy at date of next review - Nov 23.	S.G-L / C.M	Dec 23	
b)	• The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments.	YES	Trust has a violence and aggression policy (prevention and management). Date of next review Nov 2023.	n/a	n/a	n/a	n/a	n/a
c)	• The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.	YES	Key Stakeholders i.e. H&S Group, including trade union representation and clinical stakeholders consulted with. Evidenced in policy.	n/a	n/a	n/a	n/a	n/a

d)	• The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).	NO	No evidence	No evidence of risks associated with violence shared with STP/ICS.	Establish the need to share with STP/ICS	SG-L	Sep-23	
e)	• The senior management (the chief executive and the board) is accountable for the violence prevention and reduction strategy and policy, and this is clearly set out in both documents.	NO	Roles and responsibilities detailed in V&A policy. We have no specific '*strategy*'	No '*strategy*'	'*strategy*' to be amalgamated with V&A policy at date of next review.	S.G-L/ C.M	Dec 23	
f)	• Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and made available to all stakeholders.	PARTIAL	To date There has been no disparities/trends in terms of V&A incidents in relation to those with protected characteristics. Policy has undergone 'Equality and Impact Assessment' - but not a Full Equality Impact Assessment. No further action.	The need for a full equality impact assessment was considered but not deemed necessary (policy has a positive impact on **all** staff with protected characteristics). No further action.	Investigate if Ulysses can be altered to capture protected characteristics. If it can, ESR team to collate data once a year.	JS	Sep 23	

2 Clearly defined objectives and performance criteria

a)	• The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy.	YES	Objectives defined in policy. Performance and outcomes are measured utilizing data extracted from Ulysses and reported in H&S reports and during H&S Group meetings.	n/a	n/a	n/a	n/a	n/a
b)	• There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.	YES	All incidents of violence and aggression are identified via Ulysses incident reporting system and subsequently reported via regular H&S reports.	n/a	n/a	n/a	n/a	n/a
c)	• The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, i.e. via the organisation's auditors.	YES	Compliant with H&S legislation. Audited via external organisation - RSM.	n/a	n/a	n/a	n/a	n/a
d)	• Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.	YES	V&A policy has been subjected to EIA prior to publication.	n/a	In addition, HR to review each year to identify any disparities in experience for staff with protected characteristics. i.e. via staff surveys.	n/a	tbc	tbc

3 Violence prevention and reduction plans recorded, implemented, and maintained

a)	• Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy.	NO	No evidence, but on track.	No '*plans'* for achieving violence and reduction objectives.	'Plans' to be amalgamated In the V&A policy at date of next review – Nov 23.	S.G-L / C.M	Dec 23	
b)	• The plans are updated and maintained to consider improvements, lessons learnt and updated risk assessments, annually as a minimum schedule.	NO	No evidence, but on track.	No updated '*plans,*' nor '*maintained*'. To	To be amalgamated in the V&A policy (under 'strategy') at date of next review - Nov 23.	SG-L/ C.M	Dec 23	
c)	• Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.	YES	Local V&A risk assessments, as per Risk Management Policy.	n/a	n/a	S.G-L/ C.M	n/a	n/a
d)	• The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.	NO	On track. To be reviewed with Head of OD and Inclusion. To form part of V&A policy at date of next review – Nov 23.	No evidence of plans being reviewed by experts in EA 2010.	Violence and aggression policy to be reviewed by Inclusion Team at date of next review – Nov 23.	S.G-L/ C.M/JS	Dec 23	

Do

4 Board members approve resources

Ref	Indicators	Compliant	Evidenced (how)	Gaps	Actioned Needed	Owner	Timescale	Status
a)	• The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.	YES	Resources provided i.e: Security, CCTV, swipe card access control, conflict resolution trg etc	n/s	n/s	SGL/ C.M	n/a	n/a
b)	• A designated board-level (director) manages the violence prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).	PARTIAL	The Director of Finance is the Security Management Director	No evidence of 'workstream'.	Discuss with Steve Washbourne to clarify the programme of work	S.W/ C.M	Dec 23	

5 Regular workforce engagement

a)	• The senior management team regularly provides accessible communications on the violence prevention and reduction objectives and priorities.	NO	No evidence	No regular communication from senior management	Work to be undertaken with the Communications Team on the back of this self-assessment to design communications	S.G-L/ C.M	Sep-23	
b)	• Communications cover all staff groups and functions within the organisation.	NO	No evidence	No regular communication from senior management	Work to be undertaken with the Communications Team on the back of this self-	S.G-L/ C.M	Sep-23	

c)	• The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.	PARTIAL	V&A policy shared with stakeholders, including trade union reps during consultation phase.	No evidence of involvement / consultation from trade unions in the development of violence prevention and reduction 'objectives'.	Trade union reps to be consulted with when 'strategy' becomes amalgamated with V&A policy at date of next review - Nov 23	S.G-L/ C.M	Dec 23	
d)	• A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.	NO	No evidence	No 'objectives' No 'diversity lens' Public Sector Equality Duty? Not validated by subject matter expert in EA 2010.	E&D report to be completed annually.	JS/CMa	Dec 23	
6	**Clear roles, responsibilities, and training**							
a)	• The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.	YES	Violence and Aggression Policy (prevention and management)	n/a	n/a	n/a	n/a	n/a
b)	• A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.	YES	TNA promulgated in mandatory training policy - specifies who must undergo conflict resolution training and frequency (every 3 years, as mandated by Skills for Health).	n/a	n/a	n/a	n/a	n/a

7 Regular risk assessment

a)	• Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.	NO	No evidence	*'Workforce?* *'Workplace risk assessments'*?	Define evidence of local risk assessments	S.G-L / C.M	Sep-23	
b)	• Violence risks are co-ordinated across the organisation and are accessible and shared with senior management and all appropriate stakeholders.	PARTIAL	Targeted approach, based on type of incident, severity, and likelihood of re-occurrence. Incidents of V&A managed on a case-by-case basis.	No evidence of sharing risks with stakeholders	Need to define stakeholder and mechanisms for sharing risks	S.G-L/ C.M	Sep-23	
c)	• Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.	NO	No evidence.	No evidence of violence risks /controls communicated to staff via bulletin	Work to be undertaken with the Communications Team on the back of this self-assessment to design communications	S.G-L/ C.M	Sep-23	

Check

8	Process to assess violence prevention and reduction performance							
Ref	**Indicators**	**Compliant**	**Evidenced (how)**	**Gaps**	**Actioned Needed**	**Owner**	**Timescale**	**Status**
a)	• The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	NO	No evidence	No evidence of 6 monthly cyclical *review*	6 monthly cyclical review to be implemented	S.G-L C.M	Dec-23	
b)	• The senior management is directly accountable for ensuring that the system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.	YES	H&S reports H&S Group meetings Senior management overview	n/a	n/a	S.G-L / C.M	n/a	n/a
c)	• Staff members are actively encouraged to report all incidents, including near misses.	YES	Mandatory training presentations	n/a	n/a	n/a/	n/a	n/a

9 Data is traceable retrievable and accessible

a)	• Violence data is managed in accordance with the General Data Protection Regulations (GDPR)	YES	Fully compliant - data anonymised.	n/a	n/a	n/a	n/a	n/a
b)	• Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.	PARTIAL	Violence data is frequently analysed.	No evidence of violence prevention assessments/audit process.	n/a	n/a	n/a	n/a
c)	• Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability, and sexual orientation.	PARTIAL	Unable to demonstrate, however each incident is managed on a case-by-case basis.	No hard evidence of analysing violence data in relation to protected characteristics.	Violence data to be analysed on a rolling basis by Inclusion Team in partnership with ESR team.	JS	Dec-23	
d)	• The protection and storage of data about violence follows the organisation's information governance policies.	YES	IG governance polices adhered to in relation to violence data.	n/a	n/a	n/a	n/a	n/a
e)	• Data collected about violence assures that the processes are effective and identifies where lessons can be learnt and that the policy objectives are being achieved.	YES	Data clearly shown incidents are rare and infrequent. Managers give feedback on lessons learnt and future risk mitigation via Ulysses.	n/a	n/a	n/a	n/a	n/a

10	**Established audit and assurance process for violence prevention and reduction**							
a)	• A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.	PARTIAL	Witness statements Incident forms Emails H&S group meetings H&S Group reports	No documented process	Amend violence and aggression policy	S.G-L C.M	Sep-23	
b)	• The audit outcomes inform a regular senior management review held at least twice a year.	YES	H&S Group meetings	n/a	n/a	S.G-L C.M	n/a	n/a
11	**Process for corrective and preventative actions for violence prevention and reduction**							
a)	• All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders.	YES	All incidents logged via Ulysses, reviewed, and assessed. Corrective actions by managers undertaken in a timely fashion.	n/a	n/a	n/a	n/a	n/a
b)	• The violence prevention and reduction risk registers are updated accordingly.	PARTIAL	No requirement for V&A risk register due to frequency and severity of incidents to date.	n/a	n/a	S.G-L/ C.M	n/a	n/a

Act

12	Board reviews the violence prevention and reduction performance							
Ref	**Indicators**	**Compliant**	**Evidenced (how)**	**Gaps**	**Actioned Needed**	**Owner**	**Timescale**	**Status**
a)	• A senior management review is undertaken twice a year and **as required or requested** to evaluate and assess the violence prevention and reduction programme, **the findings of which are shared with the board.**	PARTIAL	H&S Group meetings H&S Group reports All part of a rolling program.	No evidence of formal twice-yearly review by senior management or sharing with Board	To be considered twice yearly by HSG and the Trust Board	S.G-L/ C.M	Dec-23	
b)	• Inputs to the process include: - local risk management system (data about violent incidents) - risk registers - audit and governance reports that include violence performance - lessons learned (STP and ICS level) - review of the violence prevention and reduction processes risk assessments (workplace and workforce) - triangulated with WRES and WDES - staff experiences (causation themes, impact on health and wellbeing, consequences, etc) - rates, absenteeism or retention rates)	PARTIAL	No previous concerns raised by members of the H&S Group, including trade union members with regards to frequency and severity of violent incidents. H&S reports document physical assaults (medical and non-medical). Other mechanisms we have to prevent/manage violence include CCTV, swipe card access control, 24-hour security presence, Lone working policy, Violence and aggression policy, access to lone working devices, suitable and sufficient lighting, Risk assessments for new and expectant mothers.	Evidence of triangulation with WRES/WDES information Evidence of staff experience (causation themes, impact on health and wellbeing, consequences etc) Evidence of HR intelligence (staff recruitment and leavers rates, absenteeism, and retention rates	Inclusion Team to discuss and identify a strategy to capture information and data.	CMa/JS	1 Aug 23	

	- Serious Incidents - NHS Staff Survey, local or pulse surveys - local HR intelligence (staff recruitment and leavers - key stakeholders. - trade union concerns raised through the health and safety committee - meetings with chief constable or designated representative, police and crime commissioners, etc.							
13	**Violence prevention and reduction policy updated with lessons learned**							
a)	• Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.	NO	No evidence	No evidence of twice-yearly senior management process review	To be considered twice yearly by HSG and the Trust Board	S.G-L/ C.M	Dec-23	

14 Informed decisions at senior management level

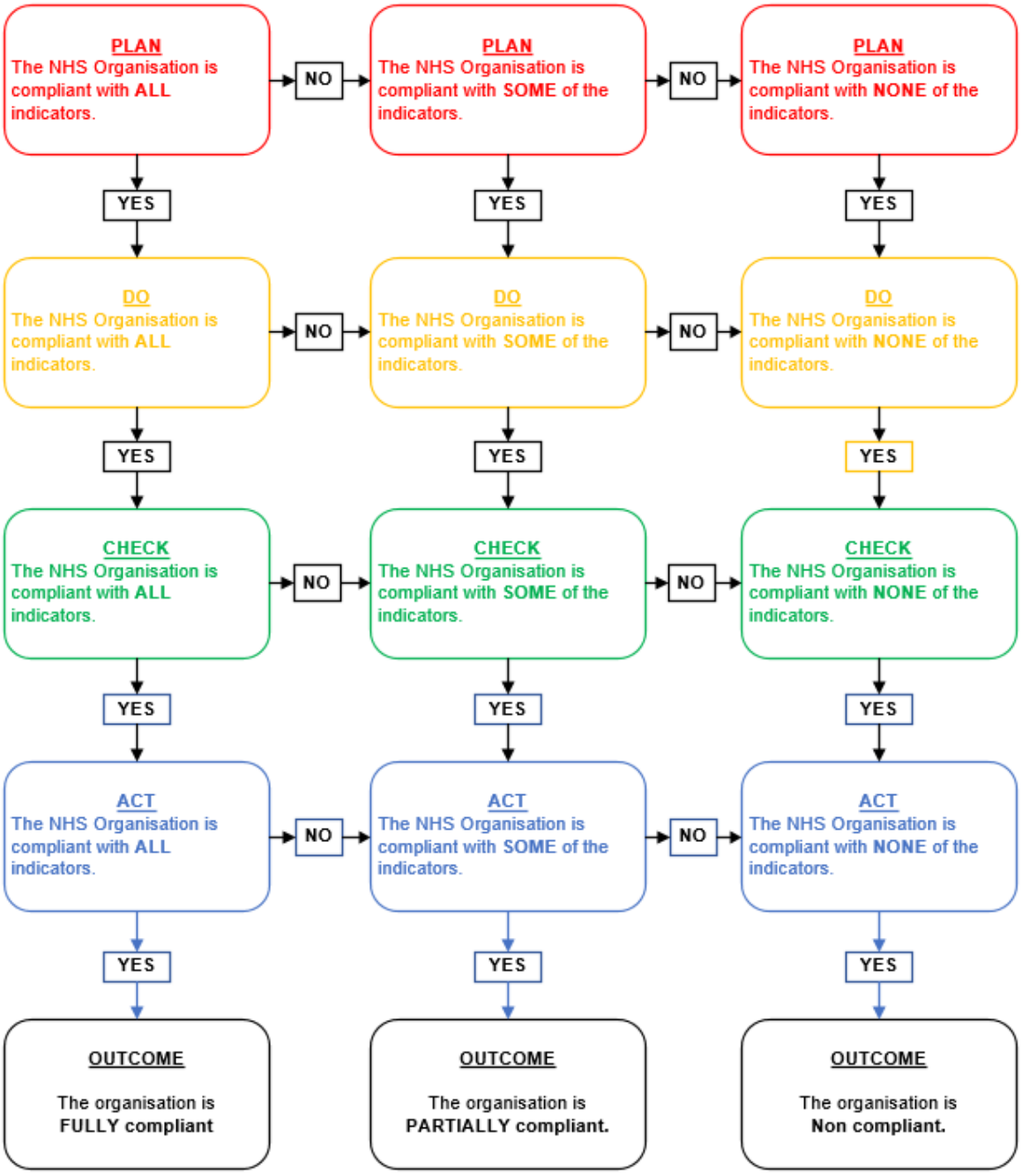
a)	• Senior management has enough information **from the violence prevention and reduction performance inputs** to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments.	YES	ROH is a small trust. Incidents managed on a case-by-case basis. Effectiveness of V&A policy regularly reviewed. Incidents published in H&S Group reports	n/a	n/a	S.G-L/ C.M	tbc	tbc
b)	• Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.	PARTIAL	Health and wellbeing strategy.	No evidence of alignment with STP/ICS strategy	Undertake research to establish how aligns with strategies of system partners	S.G-L/ C.M	Sep-23	
c)	• Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.	PARTIAL	Responses evidenced via managers feedback on Ulysses incident reports.	If investigations prolonged, difficult to evidence the recording of delays and if delays are communicated to staff, senior management, and relevant stakeholders.	Mitigated by rapid reporting by governance team and LSMS	S.G-L/ C.M	Sep-23	

KEY:

	Actions to achieve compliance on track to be delivered to time
	Minor delay with delivery of actions to achieve compliance
	Significant delay with delivery actions to achieve compliance
	Actions to achieve compliance completed
SGL	Simon Grainger-Lloyd, Director of Governance
CM	Carl Measey, Health & Safety Adviser
CMa	Clare Mair, Head of OD & Inclusion
JS	Jeeves Sundar, OD & Inclusion Manager

Compliance matrix

The matrix should be used to determine the overall level of compliance for the organisation, based on the criteria for the PDCA indicators.



REPORT REF: ROHTB (9/23) 012

TRUST BOARD

DOCUMENT TITLE:	**Safeguarding and Vulnerabilities Annual Reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Executive Chief Nurse**
AUTHOR:	**Rebecca Furnival Named Nurse for Adult Safeguarding/ Evelyn 'O'Kane Safeguarding Matron and Florence Dowling, Learning Disability & Autism Lead**
PRESENTED BY:	**Nikki Brockie Chief Nurse**
DATE OF MEETING:	**6 September 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Attached are the annual reports on Safeguarding and Vulnerabilities.

Safeguarding

This annual report highlights the work undertaken by The Royal Orthopaedic Hospital NHS Foundation Trust Safeguarding and Vulnerabilities Team which covers the period from 1st April 2022 until 31st March 2023. The report focuses on the Trusts commitment and responsibilities in maintaining the safety and protection of children, young people and adults at risk of abuse and neglect, whilst reducing health inequalities and poor patient experience for vulnerable groups within our communities. This report includes key achievements, future priorities and collaborative working and a review of the progress in the Mental Capacity Act (2005), Deprivation of Liberty Safeguarding/Liberty Protection Safeguards.

The Royal Orthopaedic Hospital has a statutory requirement to engage in any multi-agency Child Safeguarding Practice Review's (CSPRs), Safeguarding Adult Reviews (SAR's) or Domestic Homicide Review's (DHR's) where we have been involved in the care of the victim, perpetrator, or their family, if relevant.

<u>Safeguarding Adults Review (SAR)</u>
The Trust received one scoping request between 2022-2023
<u>Child Safeguarding Practice Review (CSPR)</u>
The Trust received fifteen scoping requests between 2022-2023
<u>Domestic Homicide Review (DHR)</u>
The Trust received six scoping requests between 2022-2023
All the above scoping requests were not known to the Trust of no involvements from our services.

The safeguarding team received at 945 internal safeguarding notifications between the period of 1st of April 2022 to 31st March 2023. Out of the 945 notifications received a total of 417 Adult safeguarding concerns and 528 safeguarding concerns for children.

Vulnerabilities

The Vulnerabilities Annual Report provides an opportunity to reflect on where we need to focus our

efforts in the year ahead and celebrate our achievements in 2022-2023.

The Vulnerabilities Team continues to grow encompassing Learning Disability and Autism, Transition to Adult Services, Mental Health and Dementia. The service aims to reduce health inequalities and improve health outcomes for these patient cohorts.

The Learning Disability and Autism service currently sits under the vulnerabilities arm of the Safeguarding Team and aims to respond effectively to the needs of people with Learning Disabilities (LD) and autistic (ASD) people. The service also aims to reduce health inequalities which this cohort of patients are too often exposed to by ensuring that reasonable adjustments are in place, quality assessments are carried out and appropriate interventions given. During the period April 2022 to March 2023 a total of 353 learning disability notifications were received for adult patients and a total of 708 notifications were received for paediatric patients.

Transition to Adult Services is a multifaceted process, which includes the event of transfer and encompasses the medical, psychosocial, and educational/vocational needs of young people with long-term conditions and/or disability and the needs of their parents/caregivers.
Total Number of Ready steady Go given out April 2022 – March 2023
Ready – 12, Steady – 181, Go – 302, Hello – 91

Dementia is a significant challenge and a key priority for the NHS with according to the Alzheimer's society 'Fix Dementia Care. However, only 0.41% of our patients have dementia however works is underway to ensure our provision meets the needs of our patient population.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Safeguarding • Quarterly safeguarding champions day training provided by the safeguarding team. • Safeguarding and Domestic Abuse Champions taking responsibility for their departments by sharing their knowledge and skills and supporting staff. • Safeguarding supervision embedded and regular attendance across outpatient settings and key departments. Regular safeguarding supervision is also delivered to professionals who hold caseloads such as Oncology Clinical Nurse Specialists and Advance Nurse Practitioners. • Internal quarterly safeguarding purple news shared Trust wide to provide staff with national and local training opportunities, safeguarding information and updates. • Positive feedback from external and internal professionals regarding the Safeguarding Children GAP analysis following the review and learning from local Child Safeguarding Practice Review (CSPR) Arthur Labinjo-Hughes and Star Hobson including recommendations by The	**Safeguarding** • A total of fifteen face to face level three training session was delivered by the safeguarding team. The average DNA rate is around 10%. • Safeguarding training figure remain low. Work is on-going to increase compliance. • Prevent training also remains low. **Vulnerabilities** • Learning disability notifications are still being submitted for learning difficulties or for cerebral palsy alone. Notifications are for those with a learning disability or autism only. • Relaunching patient forum to increase engagement has been a challenge. There have been numerous attempts but due to timing and patient involvement there has not been a successful date held yet. • Implementation of LPS remains unknown • Patient flagging and recording of needs remains a challenge. Currently the ROH has an internal system which relies on staff awareness and manual input

Child Safeguarding Practice Review Panels Annual Report (2020). • Internal lateral checks guidance for Children and Adults embedded Trust wide. • In August 2022 an internal Risk Assessment tool for children which is used for staff to enhance their critical thinking and analysis skills to reduce risks for children and young people. • Gillick Competency checklist to be used to empower young people in decision making. • Reviewed and amended the Increased and Therapeutic Observation of adult's policy which included the Internal enhanced observations care plans to support staff in decision making and evidence rational when depriving patients of their liberty. • Increase staff and public awareness of local and national safeguarding agenda and priorities across the Trust, using road shows and events. **Vulnerabilities** • Hospital passports are now being offered to the majority of patients with staff being encouraged to document whether a patient has declined one or if they have posted one out. • Mandatory learning disability training was available to staff between April 2022 and March 2023 via either e-learning through the e-learning for health portal. • Oliver McGowan Mandatory training has been launched, in the Trust. However, the Trust did previously provide training. • Learning Disability and Autism Strategy was published at the end of 2022. • Learning Disability Week 2022 took place between the 20th and 24th June. The focus set by learning disability charity MENCAP was on reconnection with friends and families following the Covid-19 pandemic. • The Trust takes part in the annual benchmarking project with NHS England and NHS Improvement against the Learning Disability Improvement Standards. With good uptake. Action is being develop. • Transition CNS worked with Manager of CYP Outpatients and Matron for CYP Outpatients to	which is open to human error. • Work continues with IT to set up a Transition Database. Difficulties have been noted with the current Transition spreadsheet for recording Ready, steady Go in that data appears to have gone missing. • Dementia plan is out of date; however work is underway.

write a business case for a Youth Worker for the Trust. Which is currently out to advert. • Youth Forum set up and has successful met several times in year. • Work is underway to initiate the Butterfly scheme in the Trust over the next year. • The annual audit of patient-led assessments of the care environment (PLACE) incorporates dementia friendly environments. The Trust scored higher that the national average within all fields. • 85.85% have completed the Dementia awareness Tier 1 training. HEE recommendation is 90%.	

NOT APPLICABLE

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Committee is asked to approve the publication of the annual reports.

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

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

Comments:

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

Section 11 of the Children Act (2004), The Care Act (2014), the Mental Capacity Act (2005, 2019), and the Prevention of Terrorism Act (2005).
NHS England and NHS Improvement Learning Disability Improvement Standards, LD & Autism strategy.

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

Birmingham Safeguarding Adults Board (BSAB)
Protect people from harm

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 23 August 2023.

Safeguarding Annual Report 2022-2023

Foreword

The Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements in 2022-2023. Despite the impact and challenges faced post Covid-19 we are assured that there has been no disruption to safeguarding provision and service provision across the Trust.

We continue to make good progress in relation to our 7 safeguarding priorities as set out in our Trust in 2021-2025. Our focus is always to work in partnership to make a difference the lives of our service users, to promote autonomy, inclusion, and ultimately better health outcomes. We work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse, or neglect. This city-wide approach is being embedded across all our services, whilst focusing on developing evidence-based approaches to safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm.

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

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

Our Mission: To provide outstanding safeguarding support and guidance to staff, patients, and visitors. To meet our national and local targets in delivering safeguarding training. To deliver safeguarding supervision to our staff allowing opportunities to reflect and use critical thinking when managing safeguarding concerns. To prevent harm and safeguard our patients, their families, communities and staff.

Our Vision: To be a safe and effective organisation where all children, young people, and adults who are at risk of harm, abuse or neglect are safeguarded by staff who feel empowered, valued, and supported. Working collaboratively with our patients and their families to ensure the best support and outcome is achieved.

Safeguarding Annual Report 2022-2023

1. Introduction

This annual report highlights the work undertaken by The Royal Orthopaedic Hospital NHS Foundation Trust Safeguarding and Vulnerabilities Team which covers the period from 1st April 2022 until 31st March 2023. The report focuses on the Trusts commitment and responsibilities in maintaining the safety and protection of children, young people and adults at risk of abuse and neglect, whilst reducing health inequalities and poor patient experience for vulnerable groups within our communities. This will include key achievements, future priorities and collaborative working and a review of the progress in the Mental Capacity Act (2005), Deprivation of Liberty Safeguarding/Liberty Protection Safeguards.

Safeguarding is a complex area of practice. The potential patient group is wide ranging from people able to self-care to those who are experiencing a short-term illness or a long-term disability. Abuse can happen in any context and takes many forms. Therefore, it is essential that the Trust continues to promote the importance of safeguarding for our patients and community.

The responsibility to safeguard adults, young people and children and promote their welfare is more comprehensive than protection. To be effective, this requires staff members to recognise their individual responsibility to safeguard and promote the welfare of vulnerable people at risk. This includes ensuring staff have access to appropriate training, advice, support and supervision in relation to Section 11 of the Children Act (2004), The Care Act (2014), the Mental Capacity Act (2005, 2019), and the Prevention of Terrorism Act (2005). These place a duty on key people and bodies, including NHS Trusts, to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children, young people and adults with care and support needs. “Working Together to Safeguard Children, 2018” sets out how organisations and individuals should work together to undertake their duties to safeguard and promote the welfare of children and young people in accordance with the Children Acts 1989 and 2004.

In addition to the requirements of the Care Act (2014) and the Children’s Act (2004), 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 robust governance.

The Accountability and Assurance Framework (NHS England 2019) sets out the safeguarding roles, duties and responsibilities for all NHS organisations and this report reflects the integrated safeguarding portfolio.

The Safeguarding Committee is an internal strategic meeting responsible for disseminating and monitoring information from Birmingham Safeguarding Adults Board (BSAB) and Birmingham Safeguarding Children’s Partnership (BSCP). In turn as a partner agency, the Trust provides challenge and scrutiny to both the BSAB and the BSCP via the Integrated Care Board subgroups/meetings as one of the statutory partners, as this is an essential part of working together to keep children, young people and adults at risk safe.

Domestic abuse, child and adult exploitation, neglect, changes to the Mental Capacity Act (2005) preparing for the implementation with Liberty Protection Safeguards (LPS) and reducing health inequalities have been priority work streams highlighted either by central government or by national or local publications. The safeguarding team have revised their training programmes to highlight these themes for frontline staff and these have also been included in quarterly safeguarding bulletins which are circulated across the organisation.

2. Local Partnership Arrangements

The Royal Orthopaedic Hospitals safeguarding team contribute to the local Safeguarding Partnership/Boards arrangements representing the Trust on a range of groups and committees. The team also provide assurance to Birmingham and Solihull Integrated Care Board (BSoL ICB) formally known as BSoL Clinical Commissioning Group (CCG) declaring compliance against NHS England Safeguarding Standards (Standard NHS Contract for All Services: Schedule C, Part 7.2).

Birmingham Safeguarding Adults Board (BSAB)

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

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

Ambition: Making safeguarding everybody's business.

Improve awareness of safeguarding across all citizens, communities and partner organisations

Ambition: Developing strategies that reduce the risk of abuse, as well as seeking assurance from partners.

Ambition: Ensuring that adults with care and support needs are being supported and encouraged to make their own decisions to stop harm and abuse in order to feel safe.

Ambition: Making sure safeguarding arrangements for adults with care and support needs work effectively and sharing learning to prevent harm and abuse

Birmingham Safeguarding Children's Partnership (BSCP)

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

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

Birmingham Children's Trust (BCT) set a strategic business plan between 2018-2023 and provides a yearly local update. The latest update was 2021-2022 (Year 4 update).

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

BCT will achieve this by:

- Compassion and with care
- Through positive relationships, building strengths.
- In collaboration with children, young people, families, and partners.
- By listening, involving, and including.
- In ways that are efficient and deliver value for money

Success will mean significant progress towards these outcomes:

- Health, happy, resilient children living in families.
- Families able to make positive changes.
- Children able to attend, learn and achieve at school.
- Young people ready for contributing to adult life.
- Children and young people safe from harm.

Birmingham and Solihull Integrated Care Board (BSoL ICB)

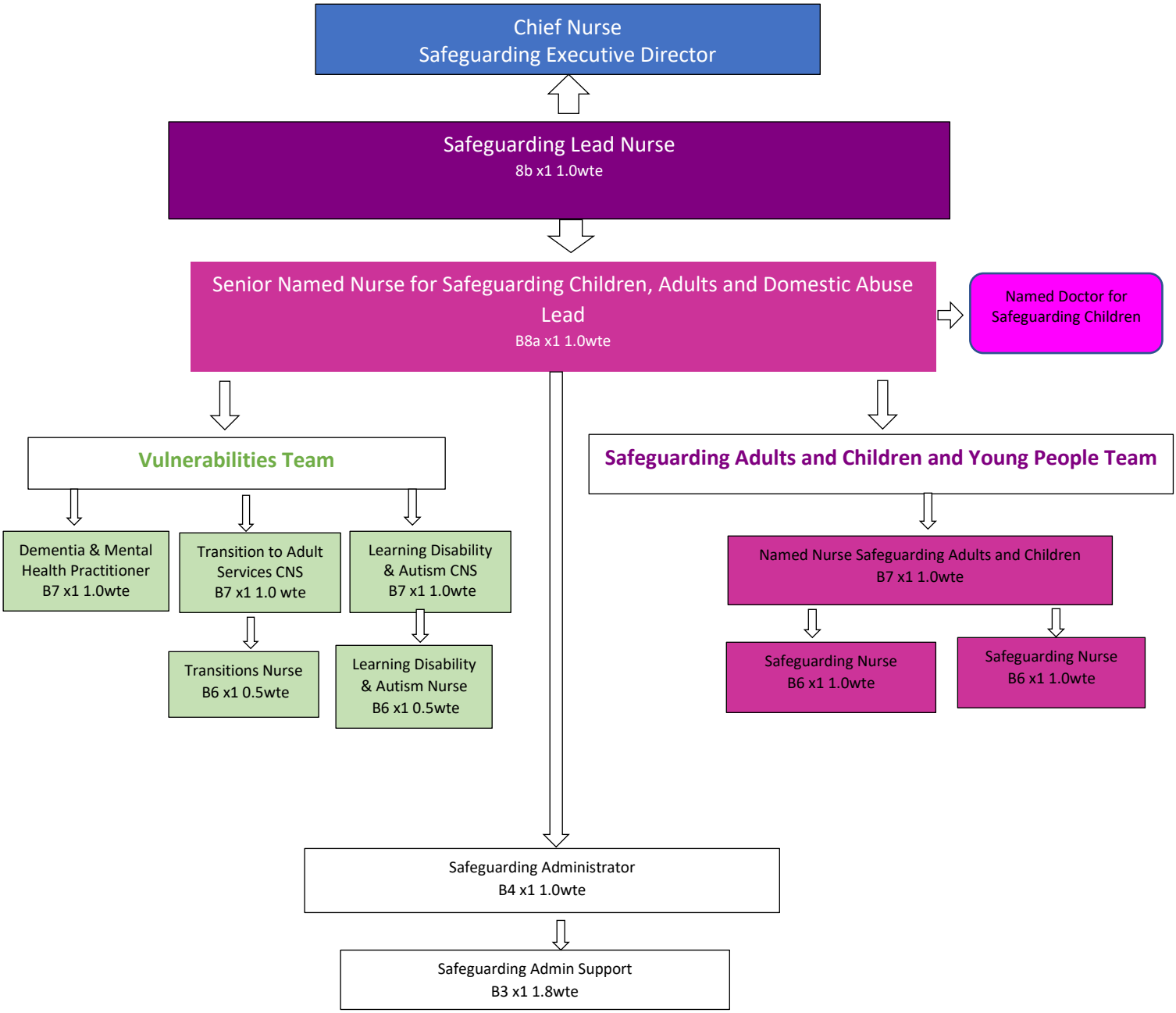
The Safeguarding Lead Nurse and Senior Named Nurse meet monthly with the BSoL Designate Nurse to provide assurance relating to the Trusts safeguarding activity including training compliance and person in position of trust internal cases.

BSoL Designate Nurses provide the Trusts Named Nurse and Safeguarding Nurse with quarterly safeguarding group supervision. The safeguarding supervision delivered by BSoL is aimed at band 6 and band 7 safeguarding nurses, practitioners or named professionals across Birmingham and Solihull.

The Trusts Named Doctor for Children receives monthly safeguarding supervision by the ICB Named Doctor. Over the last year the Trusts safeguarding team escalated three cases to BSoL Designate Safeguarding Nurses for support and guidance. The BSoL Safeguarding Team provide advice to professionals working within the safeguarding team via their duty line.

Designate Nurses and the ICB Designate Doctor attended the Trust bi-monthly safeguarding committee. All internal safeguarding policies, guidance or actions are shared with BSoL Designate Nurses and Doctor for review and feedback.

The Royal Orthopaedic Hospital Safeguarding and Vulnerabilities Team Structure



3. Safeguarding Governance and Partnership Working

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

The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. In 2022 the Safeguarding Lead Nurse presented a business case to the Trusts Executive Board which was approved for additional staff to be recruited for the safeguarding and vulnerabilities team due to the pressures and demand on the current workforce. The additional roles created were uplifting the previous Named Nurse for safeguarding adults and children to a Band 8a Senior Named Nurse for safeguarding adults and children and domestic abuse lead. This created a band 7 vacancy for a Named Nurse for children and adults which was successfully appointed in December 2022. An additional Band 6 Safeguarding Nurse vacancy advertised in March 2022. Safeguarding Support Administrator Band 3. The Learning Disability Nurse in the Vulnerabilities Team was uplifted to Band 7 following additional responsibilities added to the portfolio which includes supporting autistic patients, the new role is the Learning Disability and Autism Clinical Nurse Specialist. This created a band 6 vacancy for a Learning Disability Nurse which was successfully appointed in April 2023. The Dementia and Mental Health Practitioner was recruited in October 2022. The Transitions to adult services Clinical Nurse Specialist retired in March 2023. However, this role was successfully appointed to in February 2023 and a new vacancy created for a band 6 Transitions Nurse.

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

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

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

The Senior Named Nurse for children and adults is the Domestic abuse lead for the Trust. Provides the organisation with operational advice, support, and input. Is responsible for reviewing safeguarding training ensuring that the Trust is in line with the Intercollegiate Document (2018). The Senior Named Nurse reviews and implements all internal guidance and policies for safeguarding children and domestic abuse. Annual audits for safeguarding children, adults, and domestic abuse are completed, and duties disseminated across the team. The Senior Named Nurse is supported by the Named Nurse and Safeguarding Nurse, who provide advice, support, and training to all staff within the Trust about the management of safeguarding and vulnerability issues. The Senior Named Nurse attends Birmingham Safeguarding Children's Partnership and Birmingham Safeguarding Adults Board meetings and is a core member of the National Named Nurse meetings. The Senior Named Nurse reviews safeguarding supervision across the Trust ensuring that staff receive appropriate regular supervision dependant on their roles.

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

The Named Doctors also provide support to the safeguarding team and the Trust.

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

The Trust Safeguarding Committee is attended by a safeguarding representative from the Designated Nurse Team in the Birmingham and Solihull Integrated Care Board (BSOL ICB) and senior leaders of Trust departments whose role is to offer reporting, scrutiny, challenge, and cascade learning to their areas. The Safeguarding Team provide a monthly Safeguarding Quality Report which is reviewed at Safeguarding Committee. The quality report aims to provide a Trust-wide overview and assurance relating to the safeguarding of patients at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to (BSoL ICB) to provide assurance for contractual information requirements and for routine engagement visits.

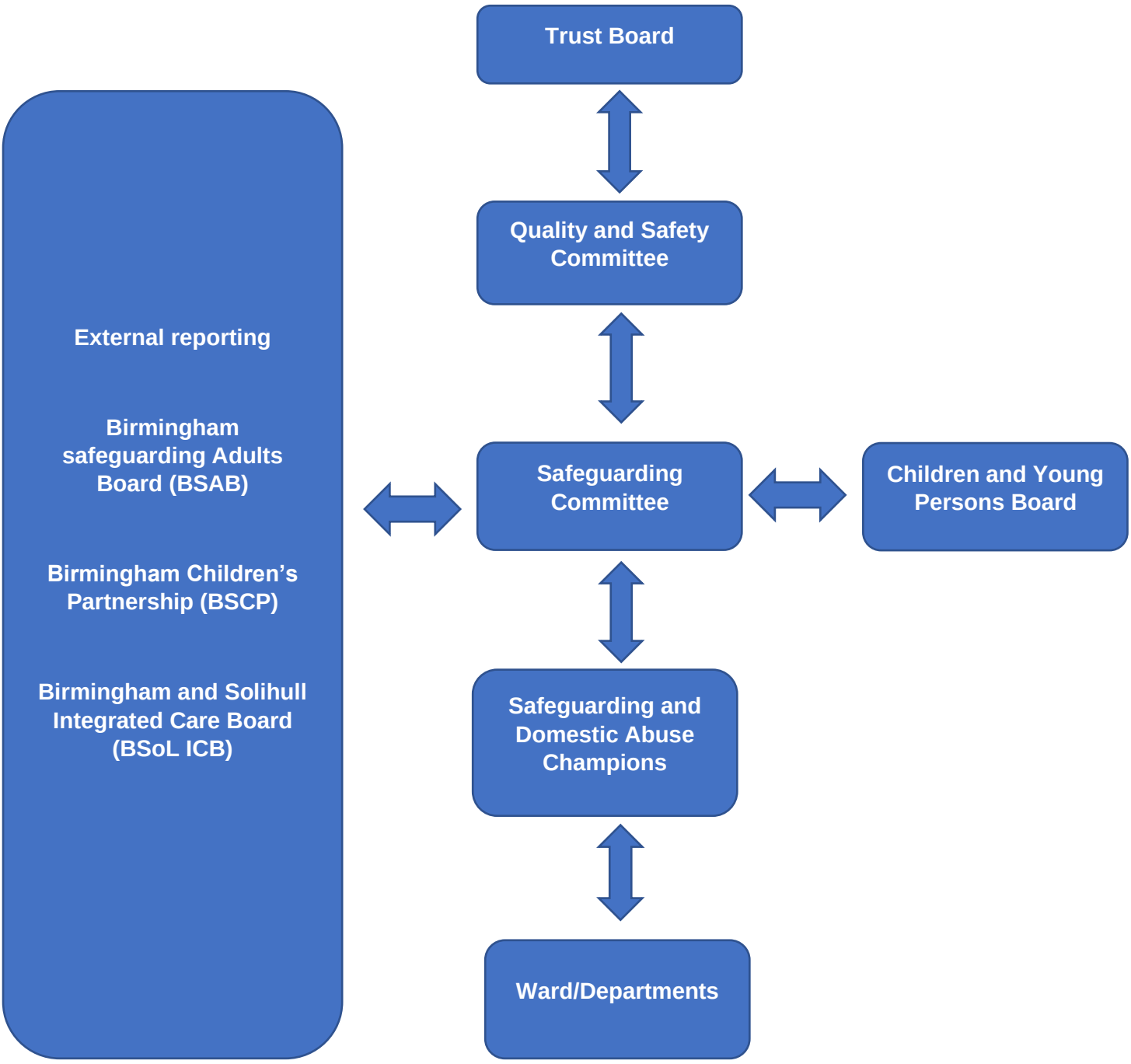
Safeguarding incidents in the Trust are monitored by the safeguarding team daily. Alerts for safeguarding incidents are generated via the Trusts electronic reporting system. The majority of incidents are managed at ward level by the Ward Manager however, some are more complex. The Safeguarding Lead Nurse is involved in providing safeguarding expertise when required. The incidents are analysed to detect trends and themes and to improve safeguarding within the Trust reporting to Quality and Safety Committee.

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

The Trusts intranet page provides staff with safeguarding policies, procedures, and guidance. The intranet is regularly reviewed and updated by the Senior Named Nurse and Safeguarding Lead and the Communications Team. The Trusts external website provides

the public with information in relation to safeguarding and signposts to other support services available in the community. The internal and external sites have been updated this year.

ROH organisational reporting structure



The Royal Orthopaedic Hospital Governance structure above reflects internal and external safeguarding reporting.

4. Key Achievements 2022-2023 Safeguarding Adults and Children

- Maintaining safe and effective safeguarding practices to reduce harm and or risk to patients and their families.
- Quarterly safeguarding champions day training provided by the safeguarding team. Each quarter safeguarding champions attend bespoke training sessions which include local and national key themes and external guest speakers within the safeguarding arena.
- Safeguarding and Domestic Abuse Champions taking responsibility for their departments by sharing their knowledge and skills and supporting staff.
- Safeguarding supervision embedded and regular attendance across outpatient settings and key departments. Regular safeguarding supervision is also delivered to professionals who hold caseloads such as Oncology Clinical Nurse Specialists and Advance Nurse Practitioners.
- Recruitment within the safeguarding and vulnerability team, following business case approval for investment in August 2022.
- Internal quarterly safeguarding purple news shared Trust wide to provide staff with national and local training opportunities, safeguarding information and updates.
- The safeguarding team have completed regular audits throughout the Trust to evidence good practice and highlight areas of improvement for adults and children.
- Positive feedback throughout the year received from staff who attend the mandatory safeguarding level 3 training for adults and children.
- Positive feedback from external and internal professionals regarding the Safeguarding Children GAP analysis following the review and learning from local Child Safeguarding Practice Review (CSPR) Arthur Labinjo-Hughes and Star Hobson including recommendations by The Child Safeguarding Practice Review Panels Annual Report (2020).
- Safeguarding Children's and Families policy reviewed with significant changes approved and receiving excellent feedback from the Trust Executive Board.
- Routine enquiry (direct domestic abuse) question launched and embedded across three departments admission day case unit, pre-operative assessment clinic and Physiotherapy department.
- Internal lateral checks guidance for Children and Adults embedded Trust wide.
- In August 2022 an internal Risk Assessment tool for children which is used for staff to enhance their critical thinking and analysis skills to reduce risks for children and young people.
- In April 2022 Internal safeguarding alerts guidance, to ensure staff are sharing concerns appropriately throughout the Trust.
- Gillick Competency checklist to be used to empower young people in decision making.
- In April 2022 Children and Young People and Adults suspected non-accidental injury internal guidance.
- In August 2022 internal Female Genital Mutilation reporting and safeguarding responsibilities guidance for adults and children.
- Reviewed and amended the Increased and Therapeutic Observation of adult's policy which included the Internal enhanced observations care plans to support staff in decision making and evidence rational when depriving patients of their liberty.
- Increase staff and public awareness of local and national safeguarding agenda and priorities across the Trust, using road shows and events.

- Development of the band 6 Safeguarding Nurse within the child safeguarding arena. The Safeguarding Nurse has completed a master's module for safeguarding at Birmingham City University and NSPCC safeguarding supervision course.

5. Safeguarding Strategy and Priorities

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

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

Our 7 Safeguarding priorities for 2021-2024	
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 demonstrate working in partnership
6	To have a safe and effective reporting workforce
7	To ensure a focus on transition from child to adult services

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

6. Safeguarding Training

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

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

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

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

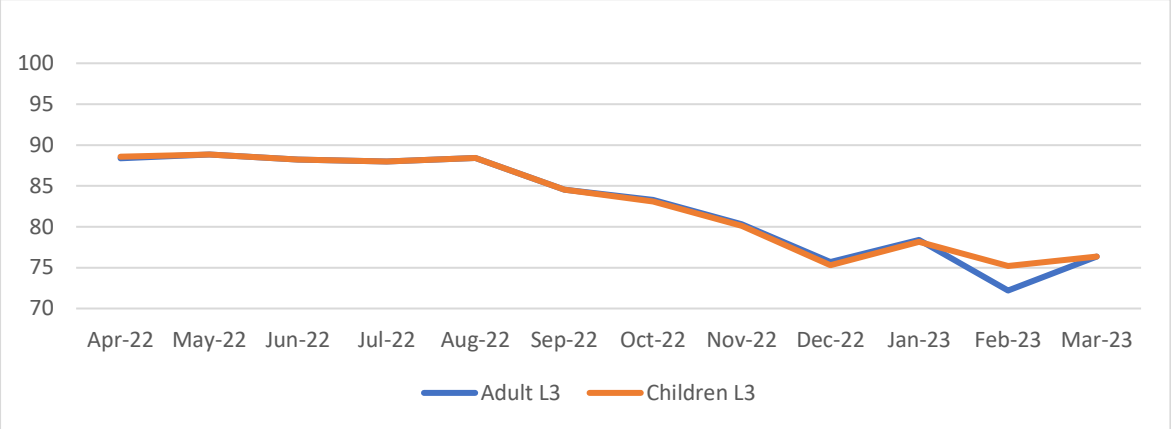
All staff including students and volunteers receive level one safeguarding basic awareness and PREVENT via the Trust Safeguarding booklet, this is available in electronic and hard copy version.

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

Training compliances are reported externally as a key performance indicator to the ICB as part of contractual arrangements and are requires as assurance against statutory

safeguarding requirements for the safeguarding boards/partnerships

The table below illustrates the compliance for safeguarding level three across the Royal Orthopaedic Hospital NHS Foundation Trust.



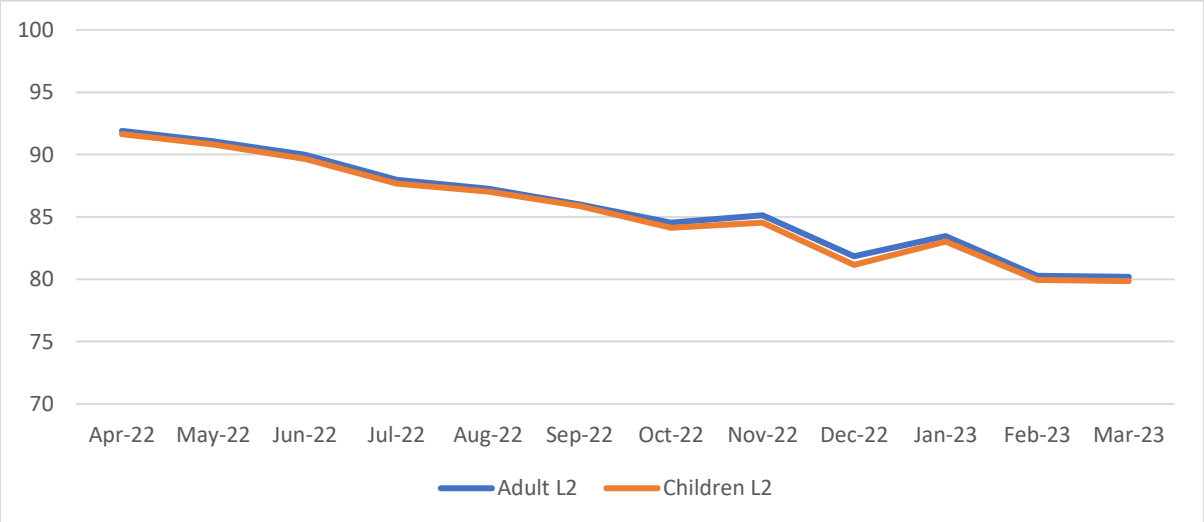
Level three training compliance

A total of fifteen face to face level three training session was delivered by the safeguarding team. The average DNA rate is around 10% this has been escalated divisionally by the Safeguarding Lead Nurse.

Safeguarding level three training is audited quarterly. Staff who attended the training are required to complete a questionnaire which poses questions related to the training to ensure they have embedded their learning.

Staff complete feedback forms following the level three training sessions. The safeguarding team overall receive positive feedback regarding the level three training. The following examples of quotes below received during the period of 2022-20223

"The presenters evidenced a wealth of knowledge" "very interactive session, thank you" "really enjoyed the session, will be more aware of what to look out for in the future" "very engaging session, the presenter was great" "presenters were professional, very engaging and clearly spoken" "thank you for the educational and informative session. Delivered with enthusiasm and passion around such a difficult topic area" "would be prefer the session to be delivered over two days, a lot of content to digest" "great presenters who show passion about the subject" "I feel much more confident about asking safeguarding questions in clinic"



Level two training compliance is monitored by the Safeguarding Lead Nurse with the assistance of the Learning and Development Team. Safeguarding level two training is delivered face to face monthly or can be accessed via e-learning.

Safeguarding training compliance has continued to be a challenge post Covid-19. However, the Safeguarding Lead reviews all outstanding staff regularly and informs line managers of the Trusts requirements. The Safeguarding Lead and Chief Nurse encourage staff to attend training.

The Safeguarding Lead Nurse completed a review of the training needs analysis of all staff cohorts, this is reviewed and amended Quarterly. The level three training packages reviewed annually by the Senior Named Nurse for Adults and Children incorporating learning from local and national reviews and internal incidents and cover all risk factors for adults and children including contextual safeguarding child exploitation, modern day slavery, forced marriage, domestic abuse including stalking and honour-based violence (DASH) training, female genital mutilation. The Safeguarding Lead Nurse provides practice-based training in the use of the Mental Capacity act and the completion of the assessment.

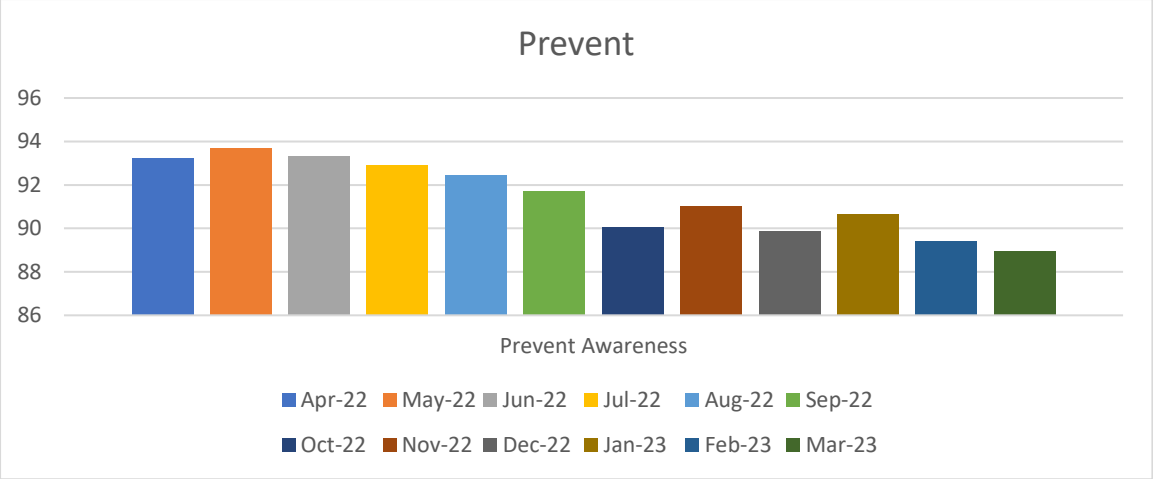
PREVENT

Prevent has been a statutory duty for NHS Trusts and Foundation Trusts since 2015 and compliance with the Prevent Duty is a contractual obligation for all NHS service providers. Prevent is part of the Government's counter-terrorism strategy CONTEST, which is led by the Home Office. The health sector has a non-enforcement approach to PREVENT and focuses on support for vulnerable individuals and healthcare organisations in helping to stop them becoming terrorists or supporting terrorism.

The Safeguarding Lead Nurse is our Trusts Prevent Lead who acts as the single point of contact and is responsible for implementing Prevent within our organisation. The Safeguarding Lead Nurse has had discussions with the Governments Prevent Lead and regional Prevent lead throughout the year to ensure the internal Prevent training is in line with national requirements and legislation and all information shared across the Trust is up to date. The Safeguarding Lead Nurse accesses the quarterly Prevent Digest.

Prevent training is delivered through e-learning and face to face. PREVENT WRAP training has been delivered face to face across the Trust this year. The basic awareness compliance nationally and locally is expected to be 95% and the WRAP training is 90%. The Prevent training figures below for the Royal Orthopaedic Hospital. The compliance is reported to the safeguarding committee.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Prevent Awareness	93.22	93.71	93.34	92.92	92.44	91.7	90.04	91.01	89.88	90.67	89.4	88.96
WRAP	83.98	84.71	85.36	83.84	82.51	82.86	80.15	81.80	81.06	80.86	78.55	80.20



7. Safeguarding Activity 2022-2023

The Royal Orthopaedic Hospital has a statutory requirement to engage in any multi-agency Child Safeguarding Practice Review's (CSPRs), Safeguarding Adult Reviews (SAR's) or Domestic Homicide Review's (DHR's) where we have been involved in the care of the victim, perpetrator, or their family, if relevant.

Safeguarding Adults Review (SAR)

The Trust received one scoping request between 2022-2023

Child Safeguarding Practice Review (CSPR)

The Trust received fifteen scoping requests between 2022-2023

Domestic Homicide Review (DHR)

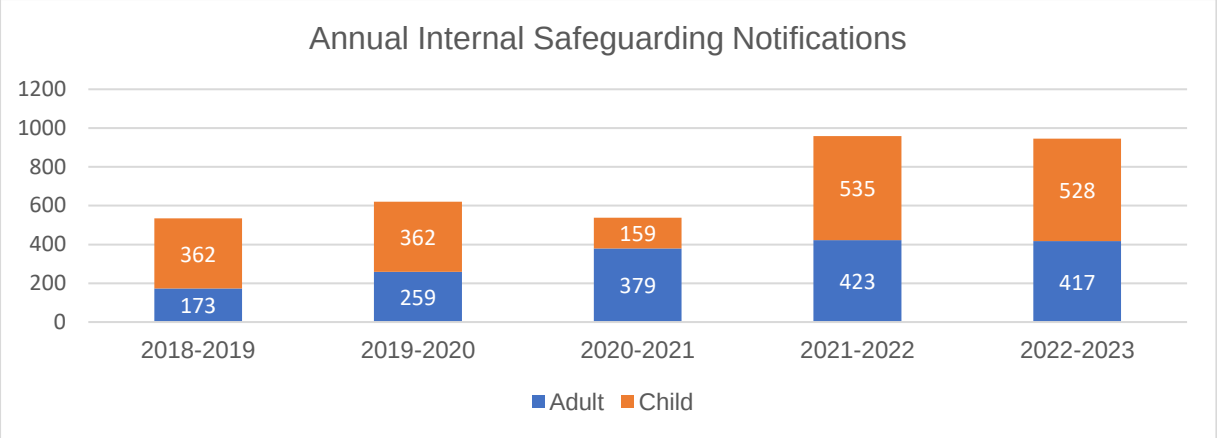
The Trust received six scoping requests between 2022-2023

All the above scoping requests were not known to the Trust of no involvements from our services.

The safeguarding team represent the Trust at safeguarding meetings, such as strategy discussions, child protection conferences, child in care meetings, core group meetings and child in need meetings. Compliance to the meetings is monitored by the Senior Named Nurse.

The safeguarding team received at 945 internal safeguarding notifications between the period of 1st of April 2022 to 31st March 2023. Out of the 945 notifications received a total of 417 Adult safeguarding concerns and 528 safeguarding concerns for children. The internal notifications are forwarded to the safeguarding team's central email and reviewed by the safeguarding team.

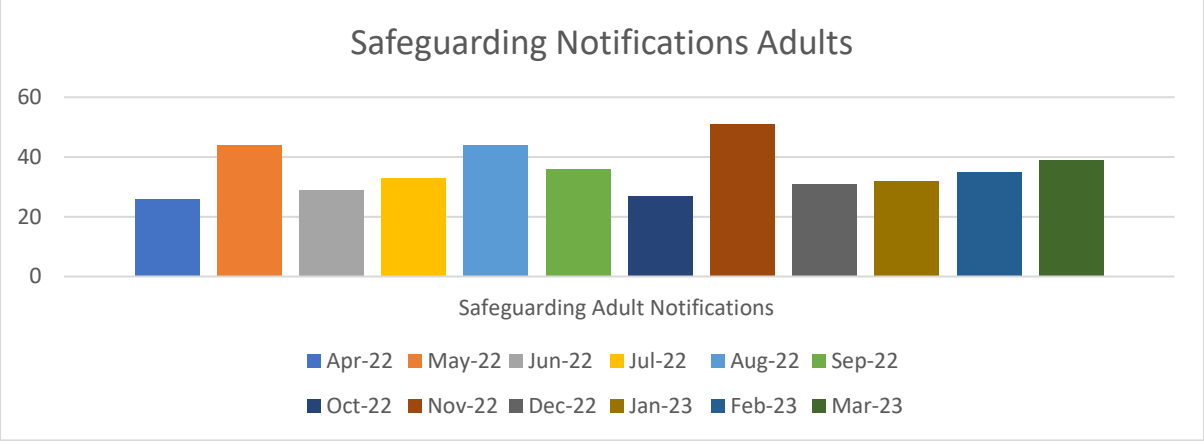
The internal notifications provide the safeguarding team with a list of concerns that staff have observed or that has been disclosed including what action has been taken. All high-risk safeguarding concerns that require support from external services such as social care or MARAC are also reported through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



8. Adult Safeguarding

The Royal Orthopaedic Trust has safeguarding arrangements in place as defined by the Care Act (2014). The protection of adults with care and support needs from abuse and or neglect is integral to all healthcare provision within the Trust. Staff ensure that making safeguarding personal is central when responding to safeguarding concerns and work together with local services to identify risks and take steps to protect people from harm.

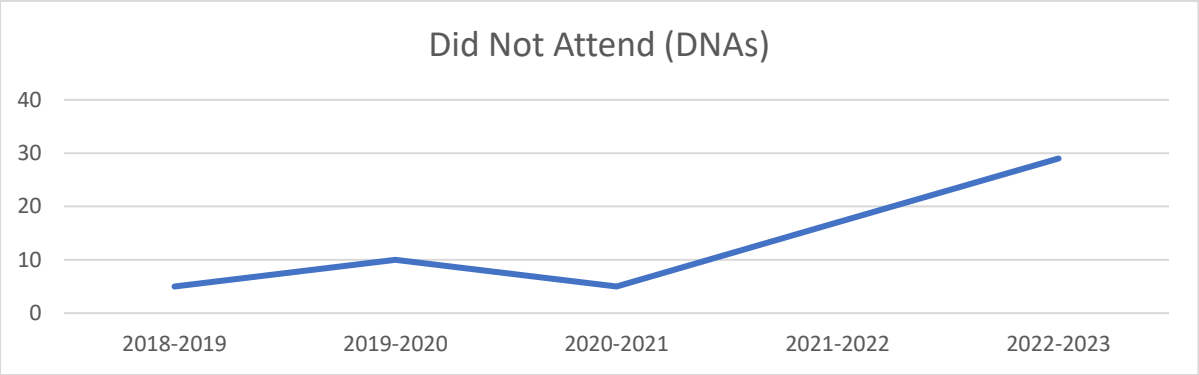
Locally Birmingham Safeguarding Adults Boards Annual Report 2021/2022 highlighted there was a 3.6% increase of concerns raised to social services. ROH have a 1.4% decrease in adult safeguarding notifications. However, this could be due to mental health no longer being reported directly to our safeguarding team since the Mental Health and Dementia Practitioner was appointed in 2022. The previous annual report 2021-2022 by ROH highlighted the largest category of referrals received was for mental health.



The largest single category for adult safeguarding notifications received in 2022-2023 is domestic abuse. The second highest referrals for adults safeguarding concerns are risks identified. Risks identified generally means that several concerns or risks have been identified.

Over the last year the safeguarding team worked with staff across the Trust on the importance of following the revised internal did not attend (DNA) guidance. Staff are required to inform the safeguarding team if a patient has DNA'd two consecutive appointments or rescheduled/cancelled. This encourages staff to critically analyse each DNA and perform lateral checks with key agencies such as social services and GP (primary care services) to

ensure there are no additional safeguarding concerns which could prevent patients accessing health appointments. The rise in safeguarding notifications under the category of DNA highlights a key achievement in spreading awareness with the risks associated with patients not accessing health appointments. Out of twenty-nine DNA received between 2022-2023 50% highlighted other risks or concerns not known to the Trust and three resulted in a section 42 enquiry.



Birmingham Safeguarding Adults Board (BSAB) reports that a 39% decrease in Section 42 enquiries. However, the Section 42 internal audit completed in 2022-2023 highlighted a 68% increase in referrals for Section 42 Enquiries between 2021-2022 and a 21% decrease between 2022-2023. A total of 19 referrals completed for section 42 enquiries in 2022-2023 78% of referrals made to adult social care Section 42 enquiries were initiated. Two referrals did not meet the threshold and adults signposted to third sector organisations and two referrals the adult declined support from social services following contact by a social worker for assessment. The ROH has imbedded the Think Family approach to safeguarding during 2022-2023 seven referrals to children's services were made following adult safeguarding concerns being disclosed or witnessed. Most of those referrals were due to children either witnessing or experiencing the impact of Domestic Abuse.

Mr G was transferred to the Royal Orthopaedic Hospital from another Trust outside of Birmingham as he required orthopaedic surgery. The previous Trust shared concerns with Nursing staff regarding Mr G's vulnerabilities including substance misuse concerns.

The safeguarding team spoke to Mr G alone and he disclosed that he is in debt to local drug dealers, his property has been vandalised and he has no friends and family in his area. Mr G is known to Social Services in his local authority due to his vulnerabilities and care and support needs. The safeguarding team liaised with social services to try and arrange alternative accommodation due to his mobility needs he would be unable to protect himself from harm. As Mr G was not a Birmingham resident multiple contacts were made between social services and the ICB to try and agree funding for a package of care and housing needs.

This delayed discharge; however, the safeguarding team highlighted the importance of reducing risks for Mr G before discharge. A professional meeting was arranged to discuss discharge plans which involved the head of nursing from the Royal Orthopaedic Hospital, the safeguarding team, Discharge Liaison Sister, social services, housing officer and care management team from ICB. Mr G requested to move to another area for his own safety. Although, this required co-ordination between three separate local authorities Mr G was successfully discharged to safe accommodation in his area of choice with a package of care and a referral to substance misuse services.

Vulnerable Adult with Care and Support Needs case 2023

In November 2022 the safeguarding team encouraged staff to take part in adult safeguarding week, which included online external training accessed through Ann Craft Trust which included Exploitation and County Lines, Self-Neglect, Safer Organisational Cultures, Elder Abuse and Domestic Abuse. The communications team shared online links to access the bite size training sessions. Staff who accessed the training provided positive feedback. As part of adult safeguarding week, the safeguarding team held a road show event focusing on difficult conversations relating to safeguarding, modern day slavery and self-neglect.

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is a form of child abuse and violence against women.

Female Genital Mutilation (FGM) is a routine question asked to patients who access the Trust. This is to ensure we provide them with a safe space to disclose any concerns they may have for their health and wellbeing and refer them to specialist services within Birmingham If required.

The Safeguarding Nurse completed internal FGM guidance for adults and children in 2022. This guidance highlights staff's responsibilities in reporting and supporting victims of FGM. Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' or potential risk of FGM in under eighteens to the Police. However, statistical information is gathered regarding women who have had FGM and present to the Trust. This information will be collated within the Safeguarding Team and then provided for the Informatics Team.

FGM awareness and staff responsibilities has been included in the level two and three safeguarding training.

External learning

The Trusts safeguarding team have continued to share learning across the trust throughout 2022-2023. The communications team provide support to the safeguarding team to share external training trust wide on the Trusts daily communication bulletins.

Following the BSAB Safeguarding Adult Review for "Stephen" published in 2021. The recommendations focused on key areas around capacity, self-neglect, multi-disciplinary risk assessments and a recognising the importance of responding to trauma and or neuropsychological impairment and homelessness.

The safeguarding team work with the Discharge Liaison sister for the Trust to identify vulnerable adults who may be experiencing homelessness and require accommodation or safe housing following discharge.

The safeguarding team plan to incorporate learning from Stephens SAR within the quarterly safeguarding champion day training in 2023.

BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

7-MINUTE BRIEFING – Learning from SAR on Stephen

Background:
This briefing summarises the key learning from a Review carried out by the BSAB. The review was in relation to a case where self-neglect was identified. The review was conducted involving the frontline staff that worked with Stephen.
Stephen was 65-year-old he was university educated and previously had a successful career. Stephen suffered trauma from the suicide of his sibling, and this led to him drinking and his mental health deteriorating. He later lost his job, his marriage came to an end, including less contact with his children. Some years on he lost his property and a large sum of money. This trauma is believed to have impacted on his drinking and mental health over time.
Stephen ended up in various accommodations, receiving criminal convictions including detention in prison.
Stephen was accommodated in Washington Court following release from prison in January 2018. Services were working towards providing appropriate long-term accommodation and support to meet his needs. He had had a history of alcohol abuse and rough sleeping. It would appear that Stephen slept on a public bench on the 4 July, where he was found collapsed the following morning. The Coroner recorded the death to be natural causes to be as a result of Hypertensive Heart Disease.

Key Learning in Identifying Self-Neglect:
- Where there are concerns relating to self-neglect, practitioners should carry out a multi-disciplinary identification of those needs, as well as identifying risk.
- Capacity assessments should be considered in relation to each of those identified needs.
- Practitioners should distinguish between ***'micro'*** **and** ***'macro'*** decisions in relation to self-neglect. This requires recognition that an adult may have capacity for decisions in relation to some element of their identified needs but may not have capacity in relation to the holistic impact of all the identified needs and vulnerabilities upon their wellbeing.
- Practitioners should be mindful of the impact of anxiety or depression upon self-motivation.
- Self-neglect can be a response to trauma and/or neuropsychological impairment.
- Where there are alcohol-related concerns combined with self-neglect, practitioners should identify the impact alcohol abuse has upon capacity.
- Multi-disciplinary meetings with an identified lead professional are always helpful in agreeing a support plan for self-neglect.
- A safeguarding referral should be considered where an adult who self-neglects refuses all support, remains at a high risk of harm and, as a result of their refusal, is unable to protect themselves from the risk of self-neglect.

Key Learning in relation to Mental Capacity:
- Practitioners should record all steps taken before a capacity assessment, to maximise an adult's ability to make that choice,
- practitioners should ensure they have identified the decision to be made, the choices, as well as the consequences of each choice, before starting to assess capacity.
- the civil burden of proof applies; they need simply to be 'reasonably satisfied' an adult has or does not have capacity (sometimes referred to as the '51% rule').
- The presumption of capacity should not be used as a reason not to assess capacity in relation to self-neglect.
- the function test precedes the two-stage impairment test to avoid discrimination.
- Capacity assessments should be recorded in sufficient detail to identify the nature of the decision and how the adult demonstrated understanding of those choices, as well as how they used or weighed the relevant information.
- Where executive function1 may be in doubt, practitioners should be aware that an adult may appear to be able to describe what they intend to do but be unable to carry those plans out in reality. Practitioners should therefore be alert to this possibility and look for these repeated 'disconnects' before reaching an assessment.

The Full Report and Recommendations are available on the BSAB Website

Senior Leadership Teams: should take from this SAR the learning that their professionals working with adults who self-neglect need be confident with early multi-disciplinary work to 'identify needs and display a clear understanding of mental capacity in relation to self-neglect. These are the pre-requisites for reducing the harmful impacts of self-neglect.

Conclusion of the Review:
The SAR has recognised that in 2021, Birmingham is better equipped to support homeless people like Stephen. It is to be hoped that funding is maintained so the improved provision can continue to have such a positive impact on the wellbeing of the homeless and on their transition to safe accommodation.
The recognition of need and multi-disciplinary approach to the homeless who self-neglect, appears to be in place and providing a more joined-up response to their needs. For the majority of the homeless who self-neglect, this is not a 'lifestyle choice' and it is not appropriate to see it in this light. Most are reacting to their changing social and environmental factors.
The challenge of supporting adults who self-neglect (including the homeless) requires both Homeless Pathways and Adult Self-Neglect Guidance to be mindful of the complexity of self-neglect in relation to adults with care and support needs (like Stephen) and those that may not have care and support needs but
are vulnerable, to ensure they do not develop care and support needs.

Key Learning in relation to Homelessness and Rough Sleeping:
- Where a homeless person presents with convictions or an antecedent history that could lead service providers to invoke an exclusion, professionals should ensure that they have clear, detailed information concerning those behaviours/convictions. Inclusive of any known history or risk assessment that suggests the risk has been effectively managed or reduced.
- Consider challenging refusals in relation to arson based upon alleged insurance requirements. A bespoke risk management plan for a tenant with an arson conviction would represent *'reasonable steps'*. Enquire if there are reasonable steps that could be taken to circumvent exclusion.
- Avoid 'over playing' the vulnerabilities.
- Ask if there are reasonable steps that could be taken to circumvent exclusion.
- Where a person is rough sleeping, or has been and is at risk of homelessness, a Homeless Application carried with it more duties upon the Local Authority than a Part 6 application and should be the default route into local housing.
- Where someone who is homeless is given temporary accommodation, for example hostel accommodation, the workers supporting the person should ensure that there is a homeless application with the Council that is still live for the individual.

Visit our website on www.bsab.org

9. Safeguarding Children

Safeguarding children, young people and families is the action the Trust take to promote the welfare of children and to protect them from harm. The Child's Voice underpins all safeguarding work and should be reflected in referrals and documentation throughout the Trust. The Trusts safeguarding duties are guided by core Child Protection Legislation and policy such as: The Children Act 1989, The Human Rights Act 1998, The United Nations Convention for the Rights of the Child (UNCRC) and Working Together to Safeguard Children (2018).

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

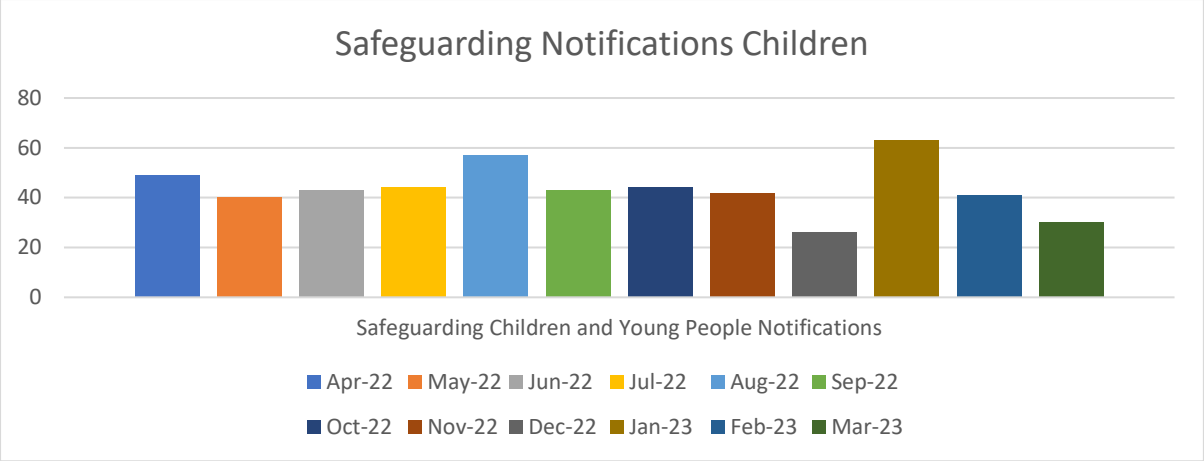
All children and young people under the age of eighteen are required to complete an internal first contact form with support of parents/caregivers if required. This form enables staff to identify any health concerns, vulnerabilities, and safeguarding concerns. This includes home educated, previously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

Over the last year the safeguarding team worked with staff to recognise the importance of the "child's voice". All staff are encouraged to see children alone when concerns are highlighted. The Children and Young Persons Outpatient Department and main Outpatients Department have a reflection room for staff to use to have "difficult conversations". This provides children and young people with a safe space to discuss their worries and provide support where needed.

Throughout the year the safeguarding team have received an increase in safeguarding notifications under the category of risks identified. This is generally following information being collated using the first contact form. This year the safeguarding team received 280 notifications under the category of risks identified. The internal lateral check guidance provides staff with a consistent approach for information sharing as per the HM Government Information Sharing Guidance (2018).

The safeguarding team received a total of 417 safeguarding notifications for children between 2022-2023. This is a 1.43% decrease compared to last year which is likely to be due to a reduction in clinics within the Children's and Young Persons Outpatient Department. Paediatric staff are encouraged to access external training during less busy periods. The Paediatric staff accessed early help training via Birmingham Safeguarding Childrens Partnership. Which has enabled staff to take a proactive approach to safeguarding children to address potential vulnerabilities that could cause hard such as poverty, missing in education, faltering weight and non-engagement with health services.

The safeguarding team received fifteen early help notifications in 2022-2023. This is over a 50% increase compared to last year which was 7.



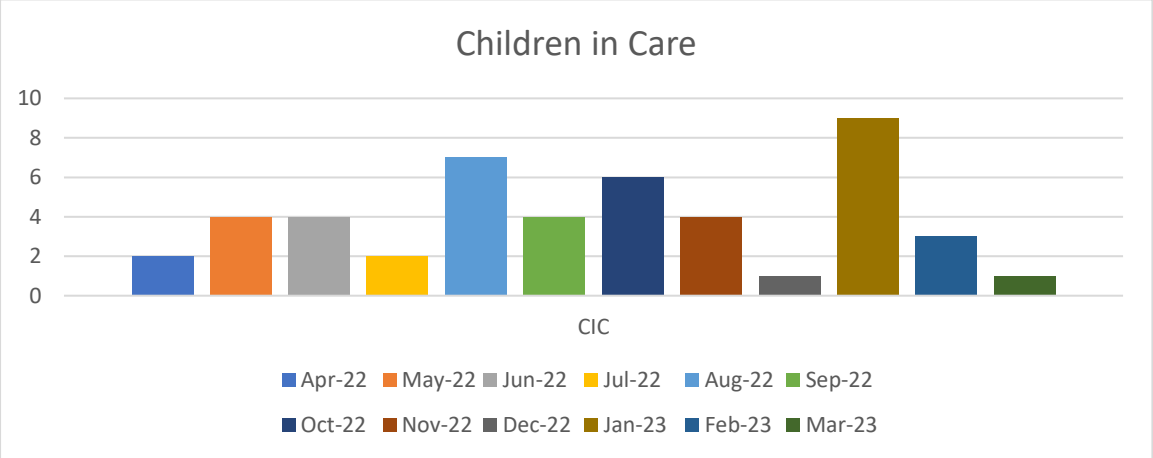
The was not brought (WNB) internal process has been embedded across the Trust. The Senior Named Nurse reviewed and amended the guidance in 2021. The was not brought process works in conjunction with the lateral check's guidance. Staff must complete a safeguarding notification if a child is not brought to two consecutive appointments, or two consecutive appointments have been cancelled or rescheduled. Recent Child Practice Reviews (CSPRs) have demonstrated the significant adverse effects on Children and Young People of not being brought to appointments, especially when transitioning between services.

The largest category for safeguarding children notifications is for risks identified.

This year the Senior Named Nurse focused on the importance of the safeguarding team contributing to child in care meetings and liaising with services that support children in care. The Senior Named Nurse attended external face to face training in Manchester that focused on children in care and reducing health inequalities that they may experience.

The safeguarding team have been encouraging staff to complete an internal notification for any children in care who access our services. Staff must contact the named social worker for the child and request for a member of the safeguarding team to be invited to the child in care meeting. This will enable the safeguarding team to gather a better insight into the child's lived experience and plan of care including any vulnerabilities or risks associated. This will continue over the next year as one of the ROH safeguarding children's priority

This year we received the following notifications for children in care



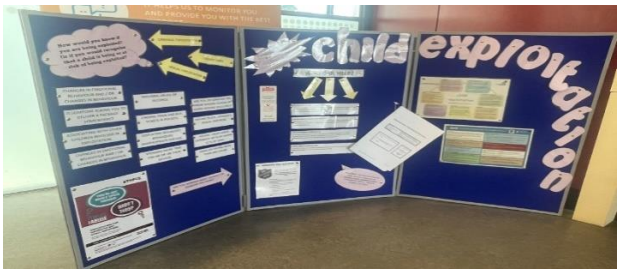
Birmingham Safeguarding Children's Partnership (BSCP) independent chairs accountability reports 2022-2023 highlighted progress with their upcoming Business Improvement Plan for 2023-2025 due to be released in April 2023. Four Key priorities to focus improving partnership intervention and strengthen collaborative working to safeguard children and young people in Birmingham.

Priority 1	Ensuring effective implementation of 'Working together to Build Strong Family Foundations' (Childhood Neglect Strategy 2022-2026)
Priority 2	Assuring a coordinated and coherent inter-agency response to children impacted by domestic abuse and violence in families
Priority 3	Developing a joint approach to understanding and responding to children who are, and who become, invisible to services
Priority 4	Enhancing anti-discriminatory practice, by improving partnership focus on the work we do, in the context of equity, equality, diversity and inclusion

The Senior Named Nurse incorporated all four above priorities into level three safeguarding training between 2022-2023. This includes recommendations following the Child Safeguarding Practice Reviews within the local area which focused on neglect and domestic abuse.

In 2023 the Senior Named Nurse and Named Nurse attended adultification training, which was provided by NHS England through, and organisation called Listen Up. The training focused on how adultification bias links to discrimination and how it can impact on protecting children from particular communities and safeguarding practices of staff. The level three safeguarding training discusses these notions when focusing on child exploitation and the importance of language and cultural competency within our safeguarding practices. The language matters booklet by the Children's Society has been shared with staff.

In March 2023 on Child Exploitation Awareness Day the Named Nurse authored a 7-minute briefing around child exploitation which was shared across the Trust and as part of the Exploitation Health Reduction Group ran by the ICB. The briefing incorporated external learning from CSPR "Child C" and the NHS Internal Concealment Guidance by BSOL ICB. A roadshow was based in the Children's and Young Persons Outpatient Department to spread further awareness to staff and the public.



In April 2022 the Senior Named Nurse developed an internal suspected non-accidental injury guidance for children and young people following learning from an incident with the Trust. As ROH does not have an inpatient paediatric ward or a paediatric consultant who can complete child protection medicals we rely on transporting children and young people to other Trusts or community paediatricians to support this. The internal guidance focuses on the importance of child's voice, information sharing between agencies, documentation, and

safeguarding responsibilities. The guidance is in line with the National Institute for Health and Care Excellence (NICE, 2017).

Local and national Child Safeguarding Practice Reviews are shared Trust wide. The safeguarding team disseminate learning and recommendations within training, supervision, bespoke events (champions day), road shows and Trust wide communications. The recent local CSPRs for Arthur Labinjo-Hughes and Hakeem both died because of sustained abuse and neglect by their caregivers, highlighted the importance of “unseen children”, “child’s voice” and a robust assessment of a child’s overall health and wellbeing. The safeguarding team have encouraged staff to access the CSPRs by sharing them Trust wide. The Senior Named Nurse presented Hakeems story at the internal Children’s and Young Peoples Board.

A GAP analysis was designed in April 2022 by the Senior Named Nurse which incorporates recommendations set out in The Child Safeguarding Practice Review Panels Annual Report (2020) and The Child Safeguarding Practice Review Panels report focusing on Child Protection in England (2022) following the national review into the tragic murders of Arthur Labinjo-Hughes and Star Hobson.

Star Hobson

Arthur Labinjo-Hughes

The Gap analysis has been reviewed bi-monthly by the Senior Named Nurse and action reported to the senior Executive team by the Chief Nurse.

Child TT attended children and young person’s outpatient department for a routine appointment with her grandparents. Staff used professional curiosity and asked further questions in relation to who child resides with parent or grandparents? It was discovered that Chill TT’s parent work abroad and Child TT has been residing with grandparents for over two years. No concerns voiced by child regarding their grandparents however, concerns raised regarding parental responsibility and is the Local Authority was aware of kinship placement.

The Senior Named Safeguarding Nurse spoke with grandparents and gained consent to share the information with the Local Authority who can provide support regarding kinship placements. The referral was completed, and the Kinship placement team reported they were not aware and would contact grandparents to offer support to the family.

. Kinship Placement- Safeguarding Children 2023

10. Domestic Abuse

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

The Trust has two domestic abuse policies which includes the internal domestic abuse care pathway. There is a Domestic Abuse Policy for patients, visitors and their families and a Staff Domestic Abuse Policy.

The Senior Named Nurse is the Domestic Abuse Lead for the Trust and is supported by the Safeguarding Lead who the Senior Named Nurse is accountable to provide assurance to. The Senior Named Nurse accesses regular external training in relation to Domestic Abuse and has built close working relationships with external professionals who work for domestic abuse services such as the BSoL ICB Interpersonal Violence Team, Womens Aid and ManKind, WAITS.

Domestic abuse is defined as any incident of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of their gender or sexuality. It can include, but is not limited to, the following:

- Coercive control
- Psychological and/or emotional abuse
- Physical or sexual abuse
- Financial or economic abuse
- Harassment and stalking
- Online or digital abuse

Around 160,000 adults report domestic abuse across the West Midlands region, each year. These statistics are only the tip of the iceberg as most domestic abuse incidents go unreported. Behind every statistic is a person and often a family which suffers.

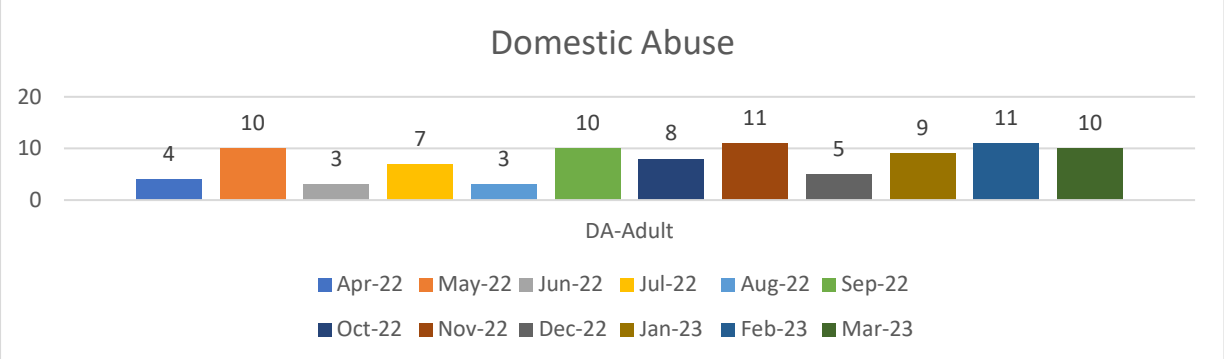
To protect and safeguard patients and staff it is acknowledged that there is a need to share information and work in partnership with other agencies with greater experience of domestic abuse in order to reduce the risk of harm to victims. The safeguarding team work closely with external partners such as Birmingham and Black Country Women's Aid, MARAC, BSoL ICB Interpersonal Violence Team and other third sector organisations.

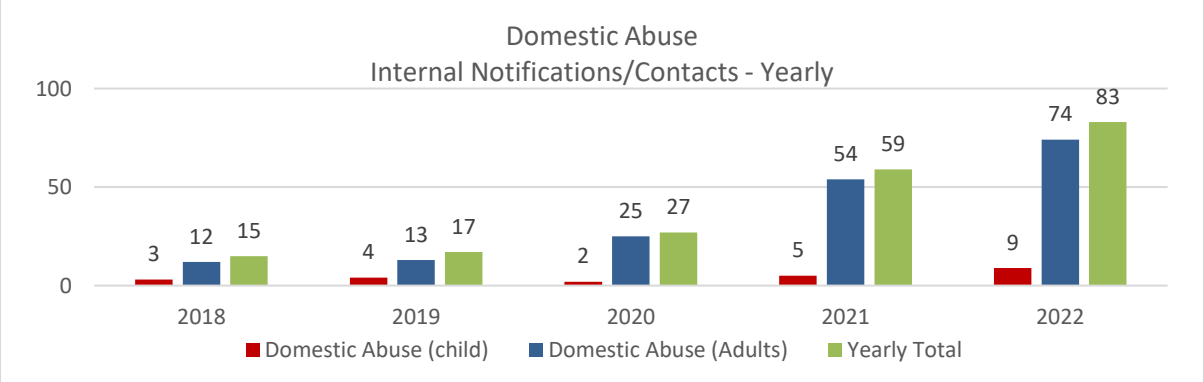
The Senior Named Nurse ensures that there is an effective staff domestic abuse policy that considers the impact of domestic abuse towards staff. This provides a nurturing and safer working environment for all staff, with the aim to encourage greater staff retention and importantly economic independence for those individuals living with or fleeing domestic abuse.

A survey by the Cavell Nurses' Trust (2019) reported that nurses, midwives, and healthcare assistants are three times more likely to have experienced domestic abuse in the last year than the average person in the UK and are twice as likely to be in financial hardship.

Throughout the year the safeguarding team have seen an 62% increase of staff domestic abuse disclosures. The Senior Named Safeguarding Nurse who directly oversees line managers and provides a safety plan to ensure staffs risks are reduced at work and within the community. The line managers adhere to the staff domestic abuse policy and support is provided by the Human Resources team. Support is also provided through Occupational Health and external agencies. Line managers are required to “think family” when responding to staff domestic abuse disclosures and ask direct questions regarding children, young people or vulnerable adults that may be witnessing or experiencing the impact of domestic abuse. The safeguarding team will complete referrals to social services if any of the above are at risk.

The safeguarding team received a total of 91 notification under the category of domestic abuse between 2022-2023. However, it is acknowledged that domestic abuse may have featured as a risk in other safeguarding notifications received in this year but was not the sole reason for safeguarding intervention.





The Trust has dedicated clinical and non-clinical domestic abuse champions who receive annual refresher training by the Senior Named Nurse. As of March 2023, the Trust had 52 Domestic Abuse Champions. All staff within the Trust receive domestic abuse awareness training which is incorporated within the level two mandatory safeguarding training. Staff who complete the level three safeguarding training will receive additional Domestic Abuse, Stalking and Harassment (DASH) training.

The safeguarding team have increased staff's confidence in asking the routine enquiry around domestic abuse. Staff now routinely asking for internal resources such as the "Ask Me" cards for signposting to external services and "we are never afraid to ask" routine enquiry cards.

The Trust is in line with national guidance working with external services to reduce the impact of domestic abuse for survivors and victims' using the DASH risk assessment tool as a prompt for external information sharing. All patients, family members and staff are referred to MARAC if deemed high risk or moderate risk using professional judgement. The safeguarding team complete all MARAC referrals and attend MARAC meetings.

The safeguarding team organised a roadshow in December 2022 as part of the 16 days of Action National Campaign for domestic abuse. The road show focused on key areas:

- The Domestic Abuse Act 2021
- Non-fatal strangulation
- Clare's Law
- Impact of Domestic Abuse for children
- Internal domestic abuse pathways and procedures

Mrs D is the wife of a Mr D a patient who was admitted to the Royal Orthopaedic Hospital. Mr D required inpatient stay at our Trust. The Nurses raised concerns to the safeguarding team during Mr D's inpatient stay regarding his aggressive behaviour towards his wife.

The Safeguarding Nurse spoke to Mrs D alone who initially did not disclose any concerns regarding Mr D's behaviour or when asked the direct domestic abuse question denied abuse. However, following multiple conversations with the safeguarding team over a duration of two days with Mrs D disclosed that she has no recourse to public funds, she has a spousal order in place, she relies on her husband for money, and he is very controlling and can be aggressive, she feels isolated from her friends and family. Although, she declined support from third sector organisations, staff worked well with Mrs D and signposted her to third sector domestic abuse services that can offer support to victims of domestic abuse who have no recourse to public funds. Mrs D was grateful for the support and agreed to contact the domestic abuse organisations

Domestic Abuse Case 2022

11. Safeguarding and Domestic Abuse Champions

Safeguarding Champions

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

Over the last year the safeguarding team have provided two champions days for the safeguarding champions across the Trust. Unfortunately, the safeguarding team cancelled the third champions day as due to national mourning for Her Majesty as the Trust has Royal associations. The two champions days between 2022 and 2023 focused on the following themes:

- Learning from Child Safeguarding Practice Reviews (CSPRs) which included Baby P, Victoria Climbie, Shia-anne Downer, Khyra Isahq, Daniel Pelka, Arthur Labinjo-Hughes
- ICON (infant crying how to cope) briefing
- Non-accidental injury process and guidance
- Right Help, Right Time threshold training
- Record Keeping and information sharing
- Hoarding and Self Neglect
- Domestic Abuse

All safeguarding champions are required to disseminate the information received on champions days across their departments and share learning.

Positive feedback is received from champions day training sessions. See below feedback from safeguarding champions during 2022-2023

“I have a better understanding of hoarding and documentation for safeguarding that I can share with my department”

“Presenters were great”

“Learning from why documentation is so important was really good”

Safeguarding champions are required to regularly review the safeguarding purple folders within their department to ensure all the guidance is up to date. They notify the safeguarding team if the purple folder need replacing or updating. Purple folders are located in ward or departmental areas. This folder has all internal safeguarding guidance and processes that can be also accessed via the Trust intranet. However, as staff in ward or departmental areas generally do not have access to their own computers it is important that staff have alternative ways to access safeguarding information, this would also include non-substantive staff such as bank staff.

In some departments or wards (Outpatients Department, Pre-operative Assessment Clinic, Admission Day Case Unit) their safeguarding champions have designed “grab and go” packs. These packs are put together using internal and external safeguarding guidance. Each pack is designed to support staff who receive a disclosure or witness concerns around a particular category of abuse.

Safeguarding champions are encouraged to take part in safeguarding audits within their own ward or departmental area. Annually the Safeguarding Lead Nurse reviews the audit schedule with the safeguarding team and plans what internal audits need to be completed in line with legislation and local/national or internal themes. This year the safeguarding champions were involved with dissemination the safeguarding supervision audit tool and collecting the information. The information is disseminated across departments and the Senior Named Nurse discusses annual audit plan with the safeguarding champions.

Domestic Abuse Champions

Domestic abuse champions are clinical and non-clinical staff. Domestic abuse champion training started in 2021 due to the launch of the internal Domestic Abuse policy and Staff Domestic Abuse Policy by the Senior Named Nurse. Following the launch of the policy and routine enquiry (domestic abuse direct questioning) in designated areas the safeguarding team received a significant increase of domestic abuse disclosures from patients and staff.

The Senior Named Nurse provides domestic abuse champions with external training opportunities shared through local safeguarding boards/partnerships. The Senior named nurse provides annual internal domestic abuse champions training day. Annual refresher training due to be completed in April 2023. The champions are required to evidence annual training attended which is reviewed by the Senior Named Nurse. Attendance is monitored by Safeguarding Administrators and Senior Named Nurse.

Domestic abuse champions are required to disseminate learning within their ward or departmental areas.

All champions are provided with a purple ribbon badge to wear on their work uniform which is recognised nationally as a symbol for domestic abuse. This should help staff and patients identify domestic abuse support available

12. Safeguarding Supervision

The safeguarding supervision policy was reviewed and amended by the Senior Named Nurse in November 2021 to meet the required standards of practice specified within national Safeguarding Children and Adults guidance and legislation including Working Together to Safeguard Children (2018) and The Care Act (2014). The aim is to ensure consistency of approach in the supervision of people who work to safeguard children and adults within the Trust.

The Safeguarding Lead, Senior Named Nurse, Named Nurse and Safeguarding Nurse are trained in delivering safeguarding supervision.

The Learning Disability and Autism Clinical Nurse Specialist and The Mental Health and Dementia Practitioner completed safeguarding supervision training through Birmingham Women's and Children's Hospital Safeguarding Team which was delivered by Richard Swann.

In 2022-2023 the Senior Named Nurse reviewed safeguarding supervision across the Trust and highlighted key areas and or specialities that should be accessing supervision. Safeguarding supervision is delivered to staff who work with adults and or children. The frequency of safeguarding group (ward or departmental) supervision is dependent on their roles and safeguarding activity within their areas.

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

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

In 2023-2024 the Safeguarding Named Nurse is planning to launch group safeguarding supervision within in-patient ward areas.

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

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

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

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

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

A safeguarding supervision audit is currently being completed by the Senior Named Nurse and Named Nurse which will be presented to the safeguarding committee in July 2023. This is a qualitative audit based on ten questions.

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

The Senior Named Nurse is currently locating an external safeguarding supervisor which is supported by the Safeguarding Lead Nurse. Currently the Senior Named Nurse receives weekly one-one meetings with the Safeguarding Lead which provides her with an opportunity to reflect and discuss safeguarding concerns.

The Safeguarding Lead receives one-one external safeguarding supervision.

The Named Doctor receives monthly safeguarding supervision by BSoL Designate Doctor.

The Senior Named Nurse provided bi-monthly supervision to the ICB Domestic Abuse and Serious Violence Nurse within Interpersonal Violence Team between 2022-2023.

In 2023 the Safeguarding Lead and Senior Named Nurse are in the process of locating restorative supervision for the safeguarding and vulnerabilities team to access. This has been approved by the Trusts board.

13. Audits

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

The annual audits completed this year

- Section 42 and 47 referrals audit- December 2022
- Training and Evaluation audit – Quarterly 2022
- Safeguarding Documentation Adults and Children audit – April 2022
- Modern Day Slavery and Human Trafficking Awareness audit – April 2022
- First Contact Form audit (Children and Young Persons Outpatient Department) – September 2022
- Virtual Clinic Audit - Children and Young Persons Outpatient Department -Quarterly 2022-2023
- Chaperone Audit – Children and Young Persons Outpatient Department and Main Outpatients Department
- Clinical Holding audit (Children)
- Mental Capacity and Deprivation of Liberty Safeguards- January 2023

Audit Findings 2022-2023

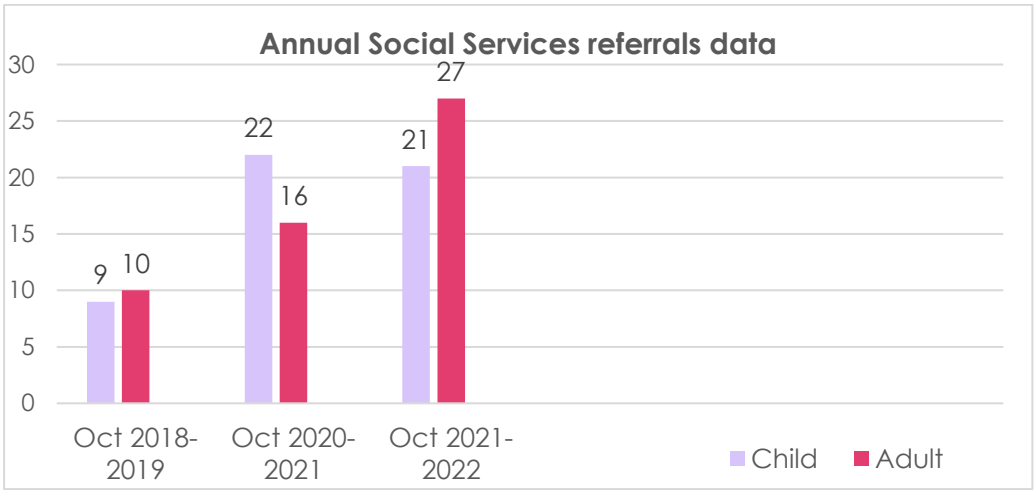
Evidenced below examples of an audit completed this year.

Section 42 and 47 enquiry audit was completed in December 2022. The audit analysed internal reporting, documentation and outcomes of safeguarding referrals submitted to social care between October 2021 and October 2022.

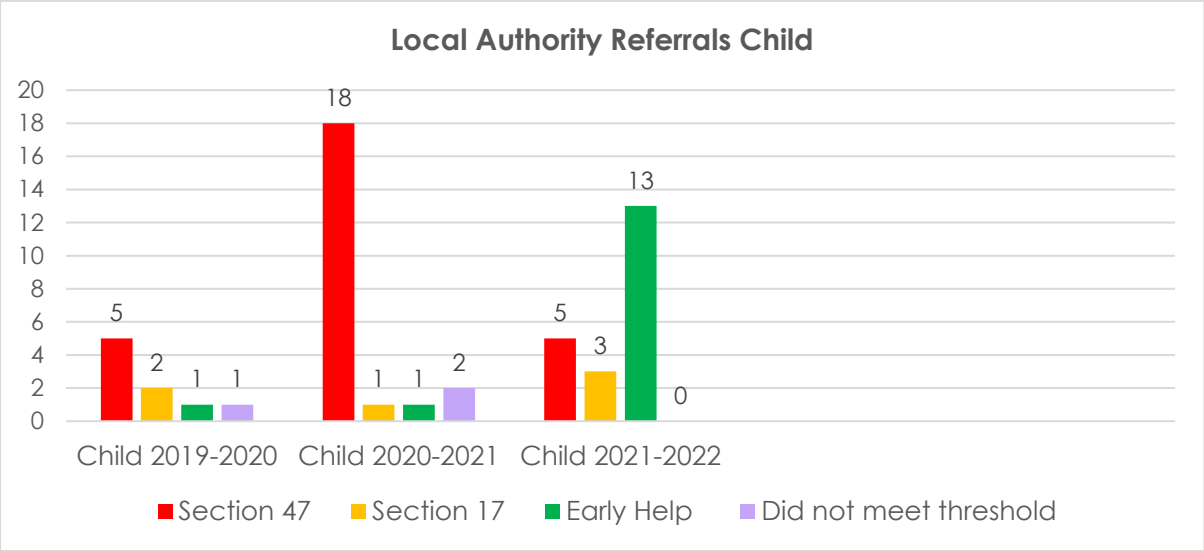
The audit provides

- an objective insight into the importance of recognising and responding to adults, children, and young people who may be at risk or experiencing harm.
- To ensure staff are responding appropriately to safeguarding concerns/risks as per local and national guidance (responsibility/accountability).
- To identify areas of improvement in care and practice (transparency)

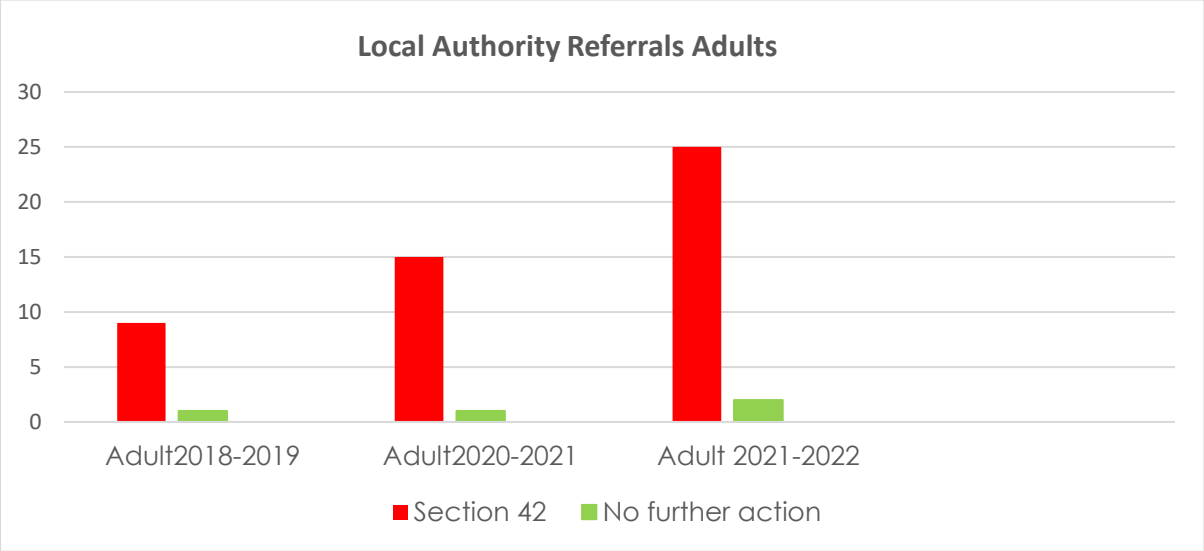
Between the period of October 2021 and October 2022 there was a 68% increase in adult social care referrals. This could be due to numerous factors; an increase in staff awareness regarding their responsibilities with recognising adults at risk, additional bespoke safeguarding group supervision, Safeguarding Champions, and the aftermath of the Covid-19 pandemic. However, referrals to Children's social care declined by 4% in 2021-2022. This could be due to an increase in Early Help referrals, recognising risks and concerns before children are harmed. The audit below shows the comparable data of social services referrals made by the Trust between 2019-2022



The audit data below provided assurance that referrals made to social services were proportionate to the needs and risks as they all met the right help, right time threshold for intervention. Nationally there has been a 1.1% decline for children who was made subject to child protection plans following a section 47 assessment in 2022 (Hm Government, 2022). The Senior Named Nurse has encouraged staff working with children and young people to offer early help for families that may require low level support such as: mental health, housing, poverty, educational needs. In 2021 -2022 there was a 92% increase in Early Help referrals completed.



Adult social care referrals data below evidence referrals completed for vulnerable adults with care and support needs were necessary and proportionate. The two referrals that did not meet the threshold, was due to one case being assigned to care management team and one case the adult changed their mind and declined social services input.



Section 42 and 47 documentation audit summary

The audit completed highlights good practice shown by ROH Safeguarding Team with decision making to refer vulnerable adults or children at risk to Social Services for intervention as:

- 97% of referrals where accepted and a Social Worker was allocated as per The Care Act (2014) and The Children's Act (2004).
- A 68% rise in social services referrals completed by ROH in 2021-2022. Staff taking responsibility in reporting concerns to the safeguarding team.

- A significant increase in referrals for vulnerable adults, which evidenced that safeguarding training, supervision, and the safeguarding purple paper (newsletter) has increased awareness and response throughout the Trust
- Most of the referrals clearly state concerns and risks which are based on fact not opinion
- The referrals evidenced the patient's wishes and feelings and child's voice.
- Increase in referrals outside of child designated areas demonstrating increased awareness of "Think Family"
- A significant rise in Early Help referrals completed in 2021-2022, staff being proactive in accessing early support for families before harm occurs
- Staff are recognising a wider variety of concerns
- An improvement in Birmingham adult and child social care sharing outcomes to ROH safeguarding team

Recommendations

Redesign/update of the electronic internal Safeguarding database (Access)-
This recommendation is outstanding since the previous audit. However, a business case was approved in 2022 for a new safeguarding database as this would assist with data collection for future audits and ICS. Safeguarding Team currently reporting all Local Authority referrals via an incident form to ensure accurate data collection in preparation for audits, reports and measurable outcomes. The new database should be completed by the end of 2023.

Local Authority referrals-
The recent data collated continues to evidence a "over reliance" on the safeguarding team to complete social services referrals staff reluctancy is based on staffing and time pressures. However, it is noted that staff have continued to report and respond appropriately to safeguarding concerns
Neglect training
Senior Named Nurse requested that a minimum of two staff from the following departments complete the Neglect graded care profile 2 training following recent child safeguarding practice reviews (CSPRs): CYPC, OPD, POAC, Physiotherapy, Orthotics and all members in the safeguarding team by December 2023.

The safeguarding team will continue to monitor trends and themes locally and nationally. This will assist the Safeguarding Lead Nurse in planning the annual audit schedule.

Planned Audits for 2023-2024

- Domestic Abuse Routine Enquiry Documentation audit
- Safeguarding Supervision audit
- Exploitation audit
- Safeguarding Documentation Adults and Children audit
- Neglect Awareness audit
- Mental Capacity and Deprivation of Liberty Safeguards
- Prevent Awareness audit
- Chaperone Audit – Children and Young Persons Outpatient Department and Main Outpatients Department
- Virtual Clinic Audit – Medical Directorate
- First Contact Form Audit

14. Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

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

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

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

Awareness throughout the Trust has been raised by the Safeguarding Lead Nurse and Safeguarding Team. The Level three safeguarding training incorporates MCA and DoLS face to face training and the level two safeguarding training provides basic awareness regarding MCA and DoLS including staff's responsibilities. The MCA and DoLS training incorporated within the level three safeguarding training is delivered by an external practitioner.

The Safeguarding Lead Nurse delivers monthly enhanced MCA and DoLS training to staff within the Trust. The training includes internal and external paperwork and professional responsibilities, care planning in patients' best interests and increased enhanced therapeutic observations.

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

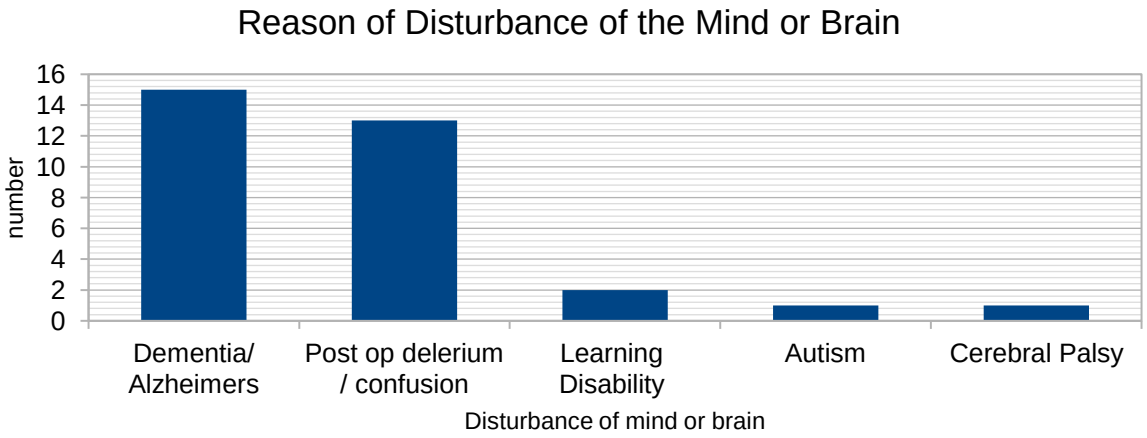
- In line with the Law Commission's to start at 16 years old
- There is no statutory definition of a deprivation of liberty beyond that in the Cheshire West and Surrey Supreme Court Judgment of March 2014 – the 'acid test'
- Deprivations of liberty have to be authorised in advance by the 'responsible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

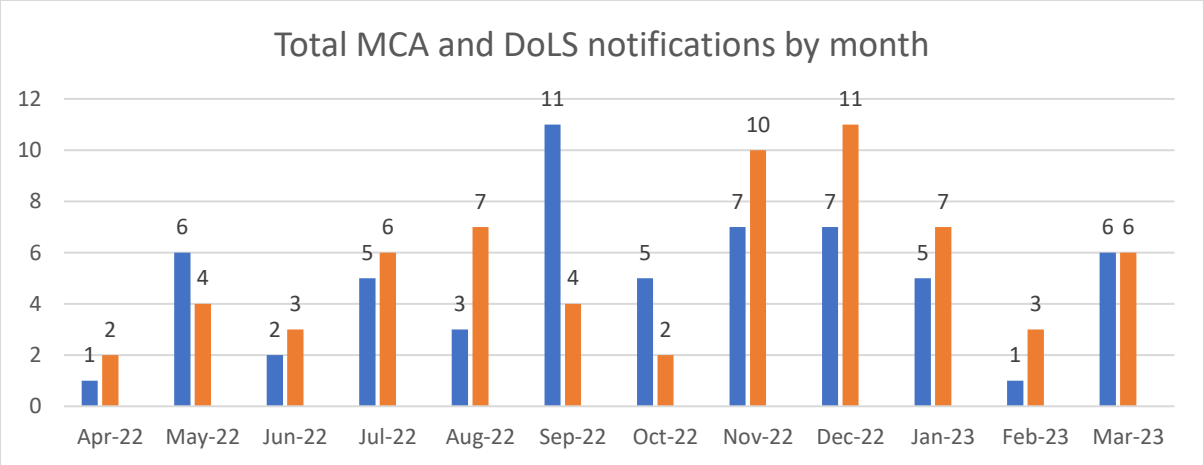
The implications for the Trust are that the local authority will no longer be the supervisory body for all applications, the hospital will become the responsible body and authorise their own LPS. This will now apply to individuals who are over 16 (previously 18) and deprivations may be transportable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

The Safeguarding Lead has been preparing the Trust for the launch of Liberty Protection Safeguards (LPS) throughout the year by sharing local and national updates and training. The Safeguarding Lead regularly attended the local LPS steering group led by the Designate Nurse from BSoL ICB for Adults. The Safeguarding Lead Nurse provide updates to Trust Safeguarding Meeting and upward reporting to Chief Nurse and Quality and Safety Committee for the Trust.

The Government's phrasing, 'beyond the life of this Parliament', means that no decision about whether or not to implement the LPS will now take place until after the next election, which is likely to occur in the second half of 2024 The Department of Health and Social Care (DHSC) announced in April 23.

In 2022-2023 the safeguarding team received a total of 59 DoLS authorisation form requests and 65 safeguarding notifications highlighting capacity concerns that may indicate that the patient may require further assessment on admission to the Trust.





The external MCA and DoLS trainer (Independent Practitioner) completed an annual MCA and DoLS audit for the Trust. The audit period was between October 2021 to September 2022. The audit was presented at the safeguarding committee in January 2023. The audit will also be reported to the Quality and Safety Committee and will be included in quality data feedback to Birmingham and Solihull Integrated Care System (BSoL ICS).

The recommendations from the previous audit were:

1. Need to evidence best interest decision on mental capacity assessment form.
2. Need to strengthen DoLS evidence of care and treatment
3. Enhance ward ownership of MCA and DoLS process and quality monitoring.
4. Need to evidence the means of the restrictions in DoLS.
5. Need to copy evidence of Lasting Power of Attorney where relatives state there is one in place.

This year's audit focused on the importance of the quality of the mental capacity assessment as LPS will focus particularly on this and will need to demonstrate that the patient lacks capacity, has a mental disorder and that any restrictions in place are to prevent harm and the care is appropriate and proportionate to the likelihood and seriousness of that harm.

Support staff may also provide a valuable role in aiding professionals, the following example of good practice was noted in the audit and shown below

Concerns were raised by a Medical Secretary regarding a patient's potential confusion and mental capacity. Patient X telephoned the Medical Secretary to cancel hospital admission and later telephoned again having forgotten the earlier call. The Secretary was concerned by the confusion which X demonstrated and alerted the Consultant who made contact with the X's General Practitioner (GP). The GP informed the Consultant of the patient's previous medical history of transient ischaemic attacks and mild cognitive disorder and was previously known to the local mental health trust. The GP subsequently arranged to review X. The admission was postponed at the request of the patient whilst further referrals were arranged by the GP.

The purpose of the audit:

To update the Safeguarding Committee on changes since the previous audit of March 2022, this includes

- recent mental capacity assessments and Deprivation of Liberty requests for authorisation
- quality of deprivation of liberty requests specific to future LPS requirements
- quality of mental capacity assessments specific to future LPS requirements
- strengths and areas where development and improvement may be needed as legislation changes and the Liberty Protection Safeguards are implemented.

Areas of Good Practice

- Good evidence of supporting patients in their decision making (section 2.1 of the Trust Mental Capacity assessment form)
- Compassionate end of life care documented
- High level of support by the Safeguarding Team
- High level of involvement of Learning Disability Specialist Nurse where appropriate
- Good communication links with Consultant Physician where appropriate
- Some high standard examples of the reason and means of deprivation of liberty
- Increased evidence of review of mental capacity
- Non-practitioner awareness of mental capacity and the need to escalate concerns

Areas of Improvement / Action Required

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

Recommendations

The recommendations were:

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

The Safeguarding Lead Nurse will continue to raise awareness over the next year and despite the delay in LPS preparation, training and strategies for these changes will proceed to ensure the Trust is ready to fulfil statutory obligations. This includes externally working with local and regional MCA and LPS Leads and internally with the Trust Learning and Development Training Department.

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

The Safeguarding Lead Nurse is the Named Senior Lead for allegations made against staff this role also includes ensuring all duties are fulfilled by the staff within the Trust. The Managing Allegations Against Staff Policy/ Person in Position of Trust (PiPoT) was reviewed and amended in October 2021.

All allegations of abuse or maltreatment of children/adults by a professional, staff member or volunteer are taken seriously and treated in accordance with the internal policy and the Trust Disciplinary Policy and Procedures. The Human Resources manager is responsible for supporting all individuals as per the Trust's Disciplinary Policy.

All employees working with children or vulnerable adults have a personal responsibility to report suspicions or allegations of abuse. This also applies when the suspicion is raised against a colleague or where staff/managers are informed by a colleague/member of the team that they:

• have become involved in a criminal investigation
• have been charged with a criminal offence
• have become involved in child protection proceedings where they are considered to have caused harm to a child or young person

The Children's Act 1989 and 2004 and the Care Act 2014, sets out statutory requirements for the Trust to have a clear process of managing allegations against people with children and adults who have care and support needs.

This year the Safeguarding Lead Nurse was involved in six PiPoT cases. Each case is managed on an individual basis and outcomes are dependent on the nature of the allegation and the staff members role for example access to vulnerable children and adults. A risk assessment is undertaken with the staff members line manager, Safeguarding Lead Nurse and Human Resources Manager.

If the allegation of abuse has been raised in respect of a child or young person, then the Safeguarding Lead will contact the Local Authority Designated Officer (LADO) by telephone to inform them of the allegation within one working day of the allegation being made known to them and before any investigation is commenced. This will be followed up with a written referral to LADO Referral Form as required.

16. Safer Recruitment and Disclosure Baring Service (DBS)

The Lampard Report, from the Savile Review published in 2015, raised 14 recommendations, several which are relevant to the Royal Orthopaedic Hospital NHS Foundation Trust. The Safeguarding Accountability and Assurance Framework (2019) states that providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working including arrangements of “Safe recruitment practices and arrangements or dealing with allegations against staff.”

In 2022 new internal safer recruitment training was launched by the Human Resources Department. The Trust ensured that all managers completed the online training.

The Disclosure and Barring Service is responsible for holding records of individuals who are considered to be unsuitable for working with vulnerable adults and/or children; these are known as the ‘Barred Lists’.

There is a legal duty to make a safeguarding referral to DBS if a person is dismissed or removed from their role due to harm to a child or a vulnerable adult. This is undertaken by the Lead investigator or the designated Safeguarding Lead Nurse supported by Human Resources department.

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

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

17. Safeguarding Policies and Risks

Risks

The Safeguarding Lead Nurse is responsible for managing and updating the risk register. The Safeguarding Lead Nurse reviews risks and meets with the Trusts Risk and Policy Officer who provides an upward report to the safeguarding committee bi-monthly for scrutiny and challenge from committee members. Each risk is measured against the risk matrix. The Safeguarding Lead Nurse divides particular risks to be overseen and amended by members of the safeguarding team as per their specialist areas of work.

This year there are currently fourteen risks between the safeguarding and vulnerabilities team:

- Mental Capacity Assessments
- IT Systems
- Mental Health Support for under 18s
- Mental Health Training

- Psychiatric Liaison Support
- Virtual Clinics Process
- Restrictive Interventions Procedures
- Implementation of LPS
- Autism Awareness
- Birmingham City Councils safeguarding referral portal
- Prevent Training compliance
- Prevent Training
- Safeguarding Internal database
- Safeguarding Team office accommodation

Safeguarding Policies

All internal safeguarding policies are reviewed and ammended as per local and national guidance and legislation. All policies reviewed are ammended are shared with the safeguarding committee members for feedback and scrutiny. If a policy has significant changes or is new the author will request further secrutiny and consultantion by the Trust Executative Board and Quality and Safety Committee.

The Risk and Policy Officer awaits approval of policies from the Chief Nurse before adding them to the Trusts intranet for staff to access. The safeguarding team request the support of the communications team to provide staff with an update Trust wide to inform them of the new policy available via the Trust Intranet.

The safeguarding team continue to spread awareness within safeuarding supervision and request feedback from frontline staff.

The safeguarding and vulnerabilities team have the responsibility to review and amend fifteen internal policies.

- Missing Patient Policy
- MCA and DoLS Policy
- Chaperone Policy (Adults)
- Transitional Care Policy for Young People with Long Term Conditions or Disability
- Mental Health Policy
- Learning Disability Policy
- Staff Domestic Abuse Policy
- Domestic Abuse Policy
- Restrictive Interventions Policy
- Prevent Policy
- Safeguarding Adults at Risk Policy
- Safeguarding Children, Young People and Families Policy
- Safeguarding Supervision Policy
- Managing Allegations Against Staff Policy
- Increased and Therapeutic Observations of Adults Policy

18. Safeguarding Priorities for Adults and Children 2023-2024

Acknowledging the work that has already taken place and seeks to strengthen our approach, the integrated safeguarding team have set priorities for 2023-2024 alongside the safeguarding Strategy 2020-2024 for the Trust these are:

To hear the voice of adults, young people, and children

- The safeguarding team will be raising awareness throughout the Trust of the importance of identifying indicators of Neglect. Recent CSPRs, SARs and The BSCPs priority highlights the need for professionals to work together to reduce the adverse effects that Neglect will have for on health, development, wellbeing and social integration. The safeguarding team will be developing internal Neglect guidance for children and adults, incorporating Neglect as a theme within safeguarding champions day and sharing external training opportunities to staff.

- The safeguarding team will be encouraging staff to ensure they clearly evidence the adults, child's, or young person's voice within safeguarding documentation. This will assist staff and the safeguarding team to accurately risk assess the impact the concerns are having on the person's life "lived experiences". The child's voice and making safeguarding personal regularly features as a recommendation following CSPRs, DHRs and SARs.

To make safeguarding a priority

Review of safeguarding supervision arrangements to all staff working with children, young people, and adults

Continue to spread awareness throughout the Trust for local, national and internal policies, guidance, training opportunities, roadshows and events.

Provide staff with face to face, telephone, and online support.

Reduce the risk of harm for patients, visitors and their family who access our services (increased team visibility)

To improve awareness and practice

The Safeguarding Lead Nurse and safeguarding team to raise awareness across the Trust on the importance of staff attending mandatory safeguarding training.

Regularly review internal mandatory training in line with local and national changes, priorities, and themes,

Ensure all information/guidance relating to safeguarding adults and children is up to date, reflects best practice and is easily accessible to staff across the Trust.

To implement any actions from the Independent Inquiry in Telford Child Sexual Exploitation when published later in 2023.

Embed learning from CSPRs, SARs and DHR.

To review annual safeguarding audits and identify gaps in practice and or knowledge.

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

The safeguarding team will continue to raise awareness and encourage staff to attend training in relation to MCA.

The Safeguarding Lead Nurse will provide regular LPS updates to both the Safeguarding Committee and Quality and Safety Board.

The Safeguarding Lead Nurse and Safeguarding Team will continue to support the Trust to meet its statutory obligations in respect of the implementation of the forthcoming Liberty Protection Safeguards (LPS).

To work in partnership

The Safeguarding team will continue to support the Local Safeguarding Adult and Children Partnerships/Boards, attending subgroups and participating in child and adult reviews.

The Safeguarding Lead and Senior Named Nurse to continue with regular one-one meetings with ICB Designate Nurses.

The safeguarding team will work closely with external partners to reduce the risk of harm for patients and staff. These would include the Local Authorities, Police, ICB, Education, Primary Care Services, third sector organisations.

The safeguarding team to work closely with Birmingham Women's and Children's Hospital (BWCH) safeguarding team to support staff and patients who work and attend across site.

Safeguarding Lead Nurse and Named Nurse to work with Trusts ward managers, senior managers, and executives to ensure they are aware of internal and external safeguarding duties by attending ward and departmental meetings, Trust team brief, supervision, Trust Board, children and young person's board, safeguarding committee and quality and safety board.

To have a safe and effective reporting workforce

The safeguarding team to continue to provide upward reporting to internal and external boards/partnerships to provide assurance in relation to safeguarding activity and standards of practice.

Safeguarding Lead and Senior Named Nurse to ensure their functions, and services that are contracted to other organisations/business, are discharged having regard to the need to safeguard and promote the welfare of children in line with Section 11(4).

Ensure key areas of safeguarding adults and children work are audited to gain assurance against key safeguarding documents and standards of practice.

Audit and monitoring of safeguarding practices, policies, training and compliance.

Support staff to identify, support and refer adults and children at risk of harm, and ensure concerns are reported appropriately.

The safeguarding team will continue to report risks associated with patients and staff and escalate matters of concerns to senior managements (transparency).

Support from IT in building a safe and effective Safeguarding and Vulnerabilities internal database to assist accurate reporting and internal and external auditing.

To raise awareness on the importance of record keeping and safeguarding decisions made including rationale within documentation.

Named Doctor for safeguarding children to raise safeguarding awareness across the medical division.

Safeguarding Lead Nurse and safeguarding team to regularly review risk register and update actions to reduce risks.

Safeguarding team to be provided with regular access to restorative supervision.

The safeguarding team to access internal and external training opportunities throughout the year which is relevant to their roles within the organisation.

To ensure a focus on transition from child to adult services

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

The safeguarding team to gain further insight into the complex risks young people face contextually and within familial environment.

The safeguarding team to adopt a fluid approach to safeguarding when supporting young people entering adulthood recognising their vulnerabilities which could result in unmet needs.

The safeguarding team to reduce the young person's experience of "cliff edge" in terms of support recognising the notable difference between thresholds and criteria when transitioning from children to adult services.

The safeguarding team to gain further insight into the risks posed to young people who are care leavers. The senior named nurse to work closely with ICB children in care team in 2023-2024 to ensure internal practices provide appropriate support for care leavers.

Safeguarding adult's priorities 2023-2024

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

Safeguarding Children priorities 2022-2023

- Focus on reducing the implications for children and young people experiencing neglect.
- To improve information sharing with parents and care givers when completing safeguarding duties.

- To reduce health inequalities for children in care who access our services. The safeguarding team to work alongside social services, foster parents, children in care nurses to ensure that the child in care has appropriate support in place to facilitate their needs.
- To improve mandatory training compliance across the Trust.

19. Conclusion

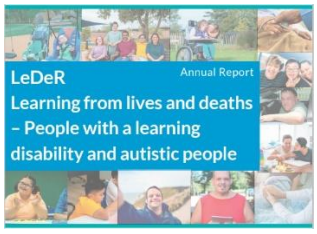
Safeguarding forms an integral part of the wider responsibilities for the Trust which meets the requirements of Section 11 of the Children Act (2004) and the Care Act (2014) for adults with care and support needs. Our safeguarding practices, policies, and guidance work in conjunction with local and national guidance and are regularly reviewed and audited.

This year the safeguarding and vulnerabilities team has expanded in September 2022 to meet demands and pressure on the services. The integrated team has continued to progress with the Trusts safeguarding agenda throughout 2022-2023 highlighted in the key achievements. The ‘Think Family’ approach is understood by staff to identify and respond to concerns/disclosures in line with legislative and professional responsibilities.

The Royal Orthopaedic Hospital NHS Trust continues to strive to ensure that the most vulnerable patients who are less able to protect themselves from harm, neglect or abuse are protected. To support this, we aim to have a workforce that recognises safeguarding is not only ‘Everyone’s Business’ but is our ‘Core Business ‘.

The Royal Orthopaedic Hospital NHS Foundation Trust

Vulnerabilities Annual Report 2022-2023



Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS Benchmarking Network
Learning Disability Improvement Standards

Dementia Friends
An Alzheimer's Society initiative

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Foreword

The Vulnerabilities Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements in 2022-2023. Despite the impact and challenges faced post Covid-19 we are assured that there has been no disruption to safeguarding provision and service provision across the Trust.

The Vulnerabilities Team continues to grow encompassing Learning Disability and Autism, Transition to Adult Services, Mental Health and Dementia. The service aims to reduce health inequalities and improve health outcomes for these patient cohorts.

The Learning Disability and Autism Team would like to thank the dedicated staff who work tirelessly to implement reasonable adjustments and support patients, the supportive partners across the Integrated Care System who inspire and challenge, and the Executive Team and the Trust Board who have championed and supported the publication of the Learning Disability and Autism Strategy 2022-2025.

The Transition to Adult services team have worked to embed transition for children and young people at The Royal Orthopaedic Hospital NHS Trust and would like to thank all staff who have help to accomplish this over the past year. The ROH Youth voices meetings are going from strength to strength and aim to provide the views of young people and give the trust ideas to improve services for young people at the Hospital. The trust has embraced the the transition to adult service over the past year creating a foundation to build upon, so we can develop it further with a gold standard service. We are looking forward to the future development of the the transition to adult's service in 2023-2024.

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1. Introduction

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They are socially determined by circumstances largely beyond an individual’s control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.

Being vulnerable is defined as in need of additional care, support, or protection. As health care professionals, having an awareness that this impact is not always visible and understanding how best to support individuals accessing services who may be vulnerable, will enable care to be provided that is accessible, appropriate, and effective.

The Vulnerabilities teams aim is to provide a service that is effective in reaching all vulnerable groups by ensuring that they eliminate any barriers across the healthcare settings within The Royal Orthopaedic Hospital such as stigma, accessibility, discrimination, attitudinal and information.

Transition between children's and adult's service across health and social care is often a disjointed and sometimes damaging process that can place huge stress on young people and their families. The Transitions to Adult Service is part of the Safeguarding Team which plans an effective transition from specialist paediatric services to adult health care and supports young people to understand how services will support them as adults.

The Learning Disability and Autism Service aims to respond to the additional needs of people with Learning Disabilities and Autism in a proactive way, supporting staff to implement reasonable adjustments and reduce health inequalities.

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). The Trust aims to protect the interests of people experiencing mental health concerns.

Dementia is a syndrome (a group of related symptoms) associated with ongoing decline of brain functioning. There are many different causes of dementia and many different types. The Trust is committed is making our hospital a Dementia friendly environment.

2. Learning Disabilities and Autism

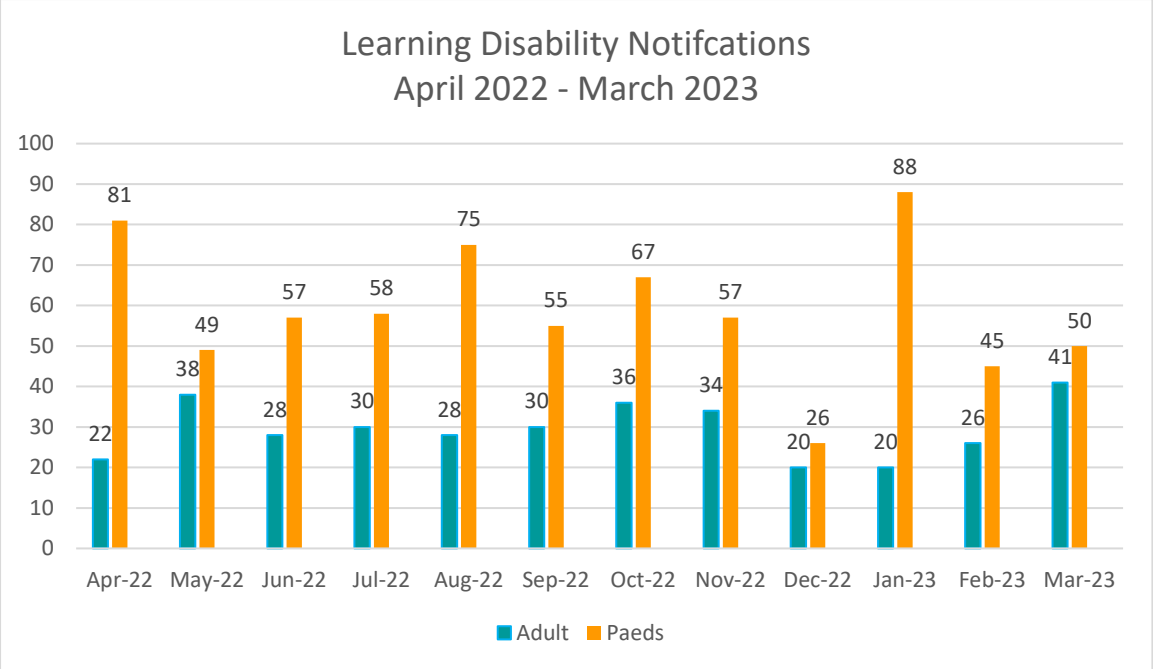
The Learning Disability and Autism service currently sits under the vulnerabilities arm of the Safeguarding Team and aims to respond effectively to the needs of people with Learning Disabilities (LD) and autistic (ASD) people. The service also aims to reduce health inequalities which this cohort of patients are too often exposed to by ensuring that reasonable adjustments are in place, quality assessments are carried out and appropriate interventions given.

The service aims to provide an outstanding quality of service and care for people with learning disabilities and autistic people when accessing the Royal Orthopaedic Hospital (ROH).

Activity between April 2022 and March 2023

Learning Disability Notification system

The LD and ASD service utilises an internal notification system whereby staff members are encouraged to submit a notification via the Trust's intranet page following contact with a patient who is diagnosed with learning disabilities or who is autistic.



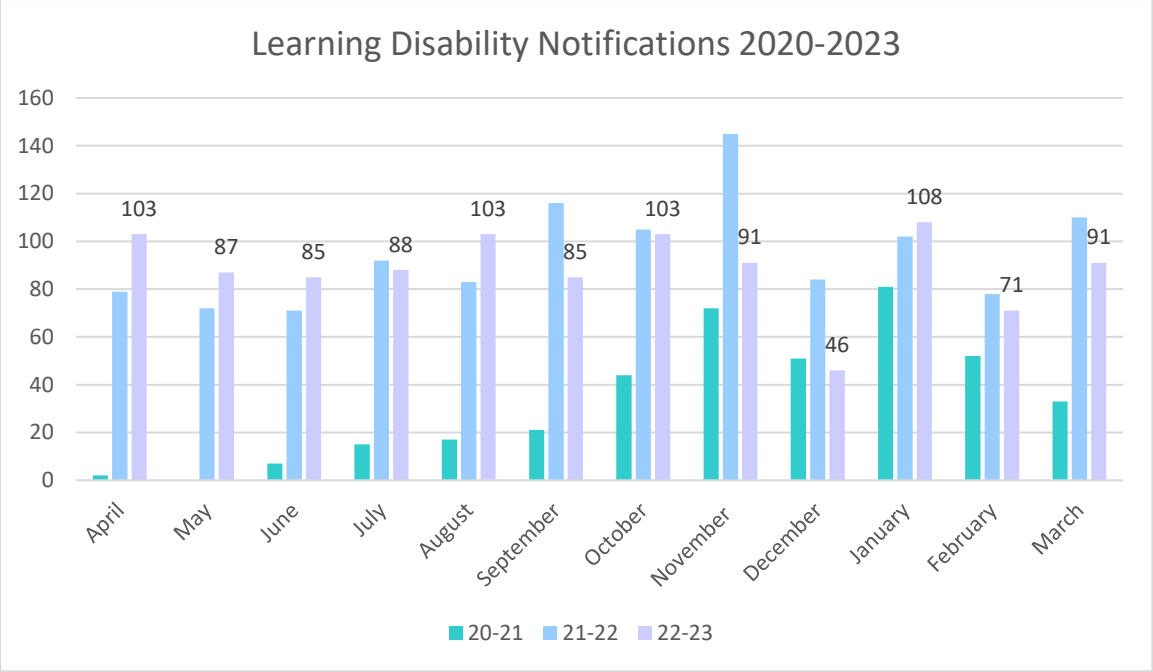
Data source – Internal learning disability reporting system recorded on excel spreadsheet

As shown in the above graph, during the period April 2022 to March 2023 a total of 353 learning disability notifications were received for adult patients.

A total of 708 notifications were received for paediatric patients.

These notifications were received from outpatient settings such as clinic appointments and therapy appointments (e.g. physiotherapy) and also inpatient wards on or during admission (patients aged 16 and over).

It must be acknowledged that although the current notification system is the only way to record contacts and data, it doesn't reflect the true workload and contact or referrals made within a monthly period. The data only capture the notifications which were made within that monthly period and does not reflect ongoing complex cases.



Data source – Internal learning disability reporting system recorded on excel spreadsheet

The graph above shows the number of notifications received per financial year for the past three years. From the graph it is clear to see there has been an increase of notifications submitted since 2020. Although there is some fluctuation between 21-22 and 22-23 rather than a steady increase as previously is shown, it is important to note the specific months and the circumstance of that time. For example, in December 2022 and February 2023 Royal College of Nursing strike action took place. This resulted in outpatient clinics being cancelled and staffing limited. It is also important to recognise that paediatric clinic activity has significantly reduced over the past six months due to consultant availability. Prior to this paediatric notifications made up the majority of notifications received per month.

Business Intelligence reporting

A request was submitted to the Business Intelligence (BI) team in May 2023 to request the date of how many patients with 'specific learning disability' or 'other difficulty/ disability' recorded on PAS under patient needs have attended outpatient appointments between April 2022 and March 2023.

Number of Appointments by Team (Outpatients)

Team	No of Appointments
Clinical Support & Diagnostics	212
Large Joints	142
Not Known	35
Oncology/Histopathology	42
Paediatrics	144
Small Joints	183
Spinal	645
Grand Total	**1403**

Data source – Business Intelligence

Narrative provided by the BI team clarified that the data is slightly skewed due to the type of need having to be removed from the figures as this causes several duplications if a patient had more than one need recorded on PAS. The number of patients also couldn't be split by appointments as the data can't be separated if a patient is under numerous services.

The data shows that the total number of outpatient appointments by team (not including therapy appointments) was 1403.

An additional request was submitted to the BI team in May 2023 to request the data relating to the number of patients who have been recorded as having a learning disability or autism diagnosis who have been an inpatient between April 2022 and March 2023.

The data collated from the BI team highlights the total number of inpatient episodes for patients record as having a learning disability or autism diagnosis as 470. The same data limitations apply as per the outpatient data.

Number of Episodes by Team (Inpatients)

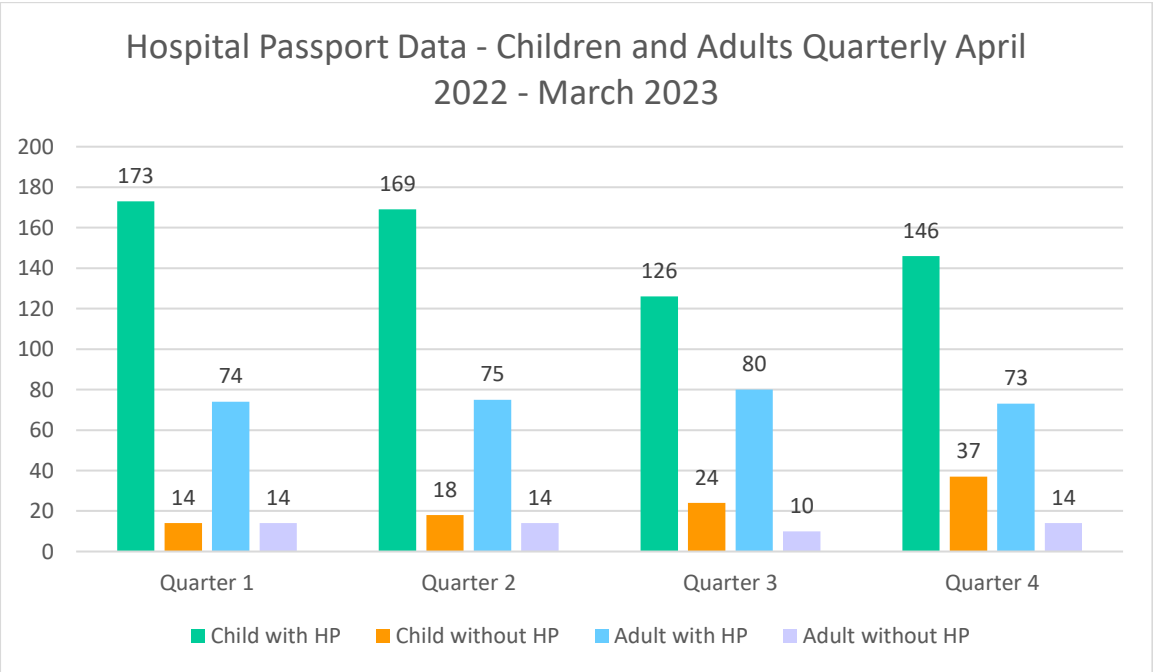
Team	Patient Need	No of Episodes
Clinical Support & Diagnostics	Specific Learning Disability	1
Large Joints	Other Difficulty / Disability	17
	Specific Learning Disability	26
Oncology/Histopathology	Other Difficulty / Disability	4
	Specific Learning Disability	8
Paediatrics	Other Difficulty / Disability	5
	Specific Learning Disability	18
Small Joints	Other Difficulty / Disability	61
	Specific Learning Disability	307
Spinal	Other Difficulty / Disability	19
	Specific Learning Disability	4
Total Number of Episodes		**470**

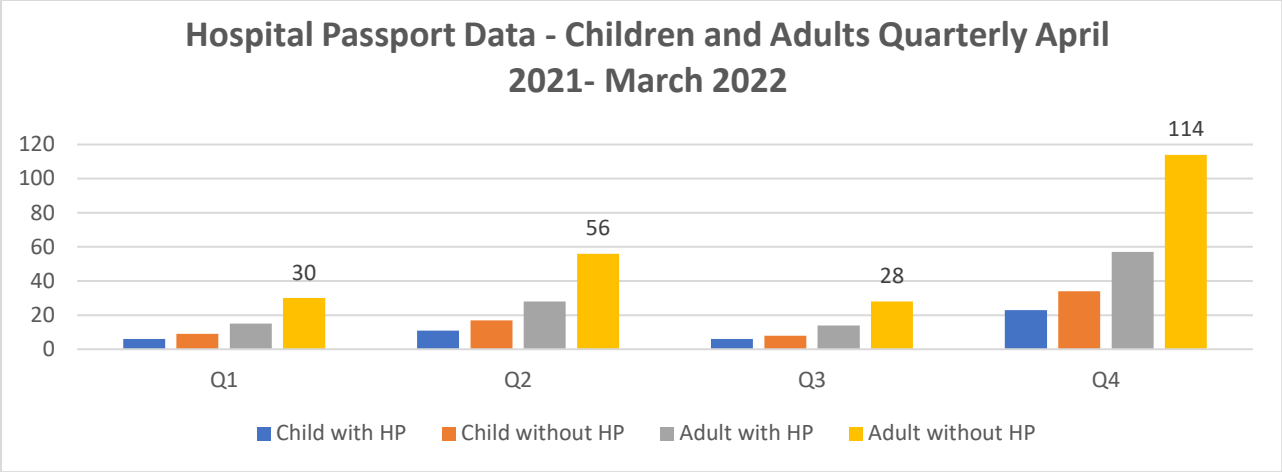
Data source – Business Intelligence

Combining the data together we can see that although the data may not be fully representative of the true number that attend the Royal Orthopaedic Hospital between April 2022 and March 2023, there was an approximate total of 1873 contacts over the outpatient and inpatient services.

Hospital Passport Compliance

Hospital passports are a national support tool containing invaluable information about a patient and how best to make reasonable adjustments, communicate, identify pain and provide support. It is usually filled in by the patient or their parent or carer. It is an evolving document which should be offered to all patients on contact with the ROH. The hospital passport is available as a hard copy in outpatient areas and on the internal intranet for staff to download and print.





To clearly illustrate the vast improvement of hospital passport compliance as recorded via the learning disability notification the quarterly data from April 2021 to March 2022 is shown.

Hospital passports are now being offered to the majority of patients with staff being encouraged to document whether a patient has declined one or if they have posted one out. Work still needs to be done on the use of passports to ensure that both patients and staff are using the document to their full potential. Reminders are provided within the bimonthly Safeguarding Committee.

Learning Disability Case Studies

Person-centred working
A 22-year-old male diagnosed with Lennox-Gastaut syndrome and severe learning disabilities was originally listed for a procedure, however by the time he was allocated a date the pre-op assessment had expired. It was difficult for the patient to attend the hospital so telephone assessment and ROCS team go out to the home for relevant tests was requested.

Adapted communication and feedback strategies
A young man with cerebral palsy, severe learning disabilities and limited communication skills attended young adult hip clinic. He had recently moved into a new care home and it was unclear how much pain, if any, his hip was causing him. Initially his carers were asked to compile a diary to record his sleeping pattern, eating habits, how often he was administered paracetamol and any observations when moving or changing. When the patient was reviewed face to face picture cards of 'yes' and 'no' were utilised. The patient was able to answer simple, direct questions. Following review of the information collected from the care home the consultant was able to reach the decision that the patient wasn't currently suffering from pain due to his hip, therefore surgery wasn't currently appropriate.

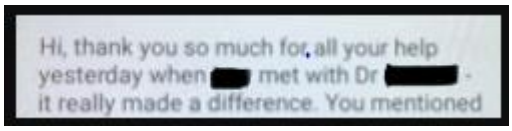
Individualised care and taking time to address concerns
A 32-year-old patient diagnosed with learning disabilities and autism had originally been listed for a right tibial rotational osteotomy in April 2022. Due to past trauma and anxieties she is very mistrusting of professionals and scared of having an anaesthetic. This was exacerbated by her father dying of covid. The night before the procedure she decided she couldn't go ahead. LD nurse liaised with the medical secretary and pre-op assessment unit and arranged an anaesthetic review for the anaesthetist to chat through any queries. The anaesthetist clearly explained the process of an anaesthetic and what happens. The patient was given the time and space to air her concerns and anxieties, and for them to be addressed appropriately which allowed her to become comfortable with the process.

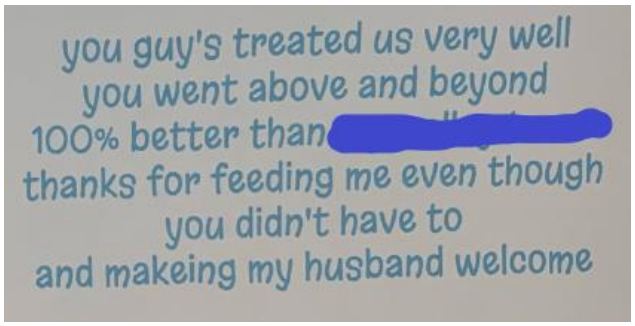
Reasonable adjustments and sharing of information to provide effective care
A 54-year-old woman with learning disabilities was transferred to the ROH from an out of area hospital. The LD nurse worked closely with this patient around her behaviour and worked with the ward to understand the communication behind these. Contact was made with her local learning disability team who knew her well to gather more in-depth information about support needs. The ward were reminded to check basic things such as that hearing aid had batteries or her glasses were clean. Other adjustments included changing the type of needle used to check her blood sugars and prescribing a different brand of medication as it wasn't the usual shape that the patient was used to.

Proactive planning and adjustment of practice
51-year-old female who was diagnosed with severe learning disabilities, cerebral palsy, and epilepsy was supported in clinic to ensure the patient's voice was heard throughout consenting. The LD nurse supported the patient and carers through the pre-operative planning process and worked closely to create a comprehensive plan and provide reassurance. The carers were apprehensive of the patient coming into hospital as she had previously had negative experiences in another Trust's. Concerns were discussed and how potential issues could be avoided, with all this being documented within the patient's plan. The carers knew this patient extremely well so had completed a thorough hospital passport. Once this was shared with pre-operative assessment staff care could be adapted to best suit the individual. For example, she couldn't have blood taken from her arm however would tolerate it from her foot. All requirements for admission will be shared with the ward area so they can be prepared with the right equipment and the right support will be in place from the start.

Reasonable adjustments and proactive planning
A 14-year-old patient with LD and safeguarding concerns was extremely anxious to attend an appointment. Photographs of the areas that he will go through were sent to his teacher for her to go through with him and a video call took place between the patient, his teacher and the learning disability nurse to discuss any outstanding concerns or queries the patient had. The patient was very grateful and felt he had all the answers he needed. The outcome was shared with his mother and social worker to ensure that all were aware of the plan for the appointment and the child's expectations could be managed.

Feedback





I just wanted to express my thanks over the way you looked after during his recent stays in hospital. It was much appreciated.

Also please pass on my thanks to the staff on Ward 4 and HDU who looked after so well. He was treated with such kindness and dignity.

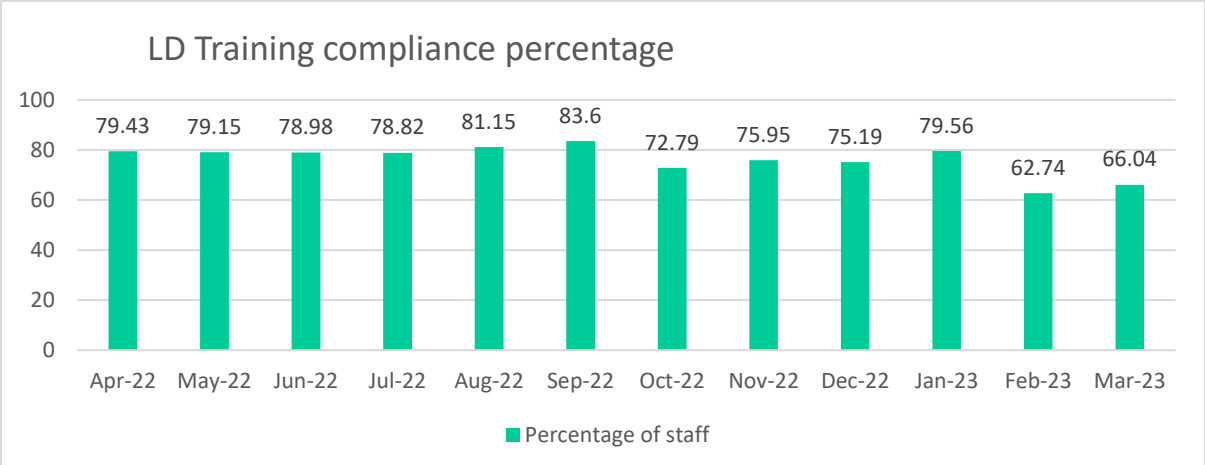
We are so pleased that his two operations seem to be successful and hopefully will improve his quality of life.

Thank you once again

Best wishes

Training

Mandatory learning disability training was available to staff between April 2022 and March 2023 via either e-learning through the e-learning for health portal (e-lfh) or via a face-to-face session delivered monthly on the core mandatory training day.



From September 2022 autism was also added onto the mandatory training competencies. This was covered in the face-to-face sessions provided by the learning disability team or by a standalone e-learning package delivered by e-lfh.

Autism mandatory training was added following the collation of autism under the learning disability service, and with the view to implement both autism and learning disabilities as mandatory training following the publication of the Health and Social Care Act 2022. This legislation placed mandatory learning disability and autism awareness training for all health

and social care into law. Prior to the Oliver McGowan Mandatory training being launched, the learning disability team along with the learning and development team took steps to ensure autism awareness was covered by Trust training.

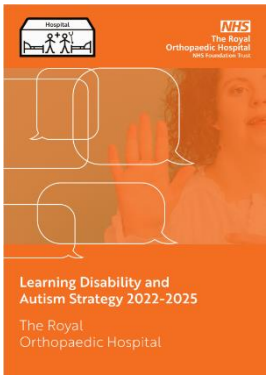
To reflect these changes in content and ensure information delivered was relevant and up to date the training package was regularly reviewed.

As shown in the graph, historically compliance has been low within the learning disability mandatory training.

The aim of all training packages is that staff have an increased awareness and confidence when working with people with learning disabilities and autistic people. As there is so much enthusiasm behind the rollout of the Oliver McGowan training along with regular input and sharing of information by the communications team it is hoped that this will improve staff compliance

The Learning Disability and Autism Strategy

Following an extended period of development, approval and design the Learning Disability and Autism Strategy was published at the end of 2022.



The strategy has been published in 3 forms: a full document, a summary document, and an easy read document.

The strategy is comprised of 4 main goals. These consist of we will provide outstanding care, we will always listen, we will have the right skills to help and we will build positive partnerships.

The full strategy document goes into further detail as to how these goals will be achieved.

A separate action plan has been compiled to go alongside the strategy outlining how the goals and actions will be achieved.

Learning Disability Week 2022

Learning Disability Week 2022 took place between the 20th and 24th June. The focus set by learning disability charity MENCAP was on reconnection with friends and families following the Covid-19 pandemic. The week also highlights the importance of reducing stigma, ending discrimination, education and raising awareness around learning disabilities.

The learning disability CNS held a stand outside Café Royale so people walking through the hospital could have a look at what is offered by the ROH and make a pledge of how they would support someone with learning disabilities. A suggestion box was also present, with people asked to make a suggestion of changes that they would like to see within the service.

A plethora of useful information was collated with suggestions going forward to inform the learning disability strategy and implemented changes within the service.

Benchmarking against the Learning Disability Improvement Standards

The Trust takes part in the annual benchmarking project with NHS England and NHS Improvement against the Learning Disability Improvement Standards. The LD nurse submitted the required data return in March 2023 which covered the time period 1st April 2021 to 31st March 2022.

The project is made up of three streams of data collection:

1) Organisational level data collection – this consists of several questions that require both qualitative and quantitative responses from appropriate service leads
2) Patient level data collection – this consists of an easy read survey. 100 hard copies were sent to the trust with approximately 80 of these being posted out to patients who had a learning disability notification submitted during the time period. The remaining copies of surveys were handed out at patient appointments.
3) Staff survey – this is an anonymous survey collecting staff experience and opinion. The survey link and QR code was shared trust wide with support from the communications team.

A total of 50 staff surveys were collected for the previous year's project which was 100% of the allocated number. For the 2023 submission the number was increased to 100, however only 52 were completed.

There was an increase of patient feedback for the 2023 submission with 32 patients responding to the survey compared to 14 in 2022.

An official report is published annually which includes data from all contributing Trusts. An action plan is then created from these results to ensure the ROH is implementing the standards in line with the NHS Long Term Plan. This action plan is monitored and updated accordingly with reports feeding into the bimonthly Safeguarding Committee.

Learning Disability Audit 2022

The learning disability and autism audit took place in June 2022 focussing on documentation and patient notes.

Recommendations from the audit included that there needed to be improvement around the recording of adjustments and support needs, staff to gain confidence removing reliance on the learning disability nurse and staff to evidence use of patient voice.

Actions from the audit included information folders to be developed and update of information available on the ROH Hub, internal digital system to liaise with the NHS England/ ICB project managers around the digital flag and bespoke work to be done with ward and departmental managers about taking ownership of patient adjustments and support plans.

Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)

- Learning Disability CNS continued to sit on the local LeDeR review oversight panel (Birmingham and Solihull) as vice chair
- Changes from publication of the LeDeR Policy 2021 were implemented into the Trust's learning from lives and deaths policy
- Updates on themes arising from Review Oversight Panel meetings shared within the bimonthly quality report

Areas of success

- Successful business case and job matching exercise to enable the 'learning disability nurse' to becoming the 'learning disability and autism clinic nurse specialist' (CNS) and creating a new post of 'learning disability liaison nurse' (recruitment successful with new staff member commencing April 2023)
- Publication and launch of the Learning Disability and Autism Strategy
- Collaborative working cross services, with the Birmingham Women's and Children's Trust learning disability team
- Regular review of the learning disability notification to ensure it is relevant and capturing meaningful information
- Increased staff and patient engagement for the annual benchmarking project against the Learning Disability Improvement Standards
- Implementation of forward look planning for the NPP Botox clinic to ensure staff are prepared and can proactively plan for clinics
- Close working with the ICB
- The learning disability and autism CNS completed supervision training
- Bespoke training sessions put together for Care Certificate, Support 4 Healthcare Workers, student nurses as well as for specific ward and departmental areas
- Collaboration across the multi-disciplinary team to ensure that policies, strategies and standard operating procedures reflected the needs of those with a learning disability and autistic people
- Involvement with the Oliver McGowan Mandatory training launch
- Learning disability and autism was a quality priority for the trust for 2022-23
- Learning disability and autism CNS continues to sit on internal committees and meetings such as Safeguarding Committee, Children's Board, staff networks, Patient Experience and Engagement Group and the Accessible Information Standards group

Risks

A total of three risks were closed by the learning disability team:

- Risk identifying that trust IT infrastructure not able to identify patients via a system wide electronic flagging system was closed and collate with a generic risk regarding trust IT infrastructure and the lack of communication between systems
- Risk highlighting staff awareness and understanding of learning disabilities due to training closed and reopened to combine with autism and implementation of training
- Risk highlighting the potential for a patient to have poor care, or a poor experience was closed due to the learning disability team being able to clear illustrate what has been done to mitigate this risk with any local concerns being highlighted and dealt with through audit and supervision

Risks remaining open:

- The risk that staff may not have awareness and understanding of learning disabilities and autism, how to effectively identify and apply reasonable adjustments to reduce health inequalities and improve outcomes. This is currently being address by the learning disability CNS undertaking a postgraduate degree in autism and the implementation of the rollout of the Oliver McGowan Mandatory Training in Learning Disabilities and Autism. The current risk score is a 6 with the target being a 5.
- Risk regarding a robust and appropriate reporting and database system for the safeguarding and vulnerabilities team

- Risk regarding IT system alerts and flagging

Challenges

- Work stills needs to be done to raise the profile of hospital passports to ensure staff are referring to them at appointments and on admission
- Work done with department areas around hospital passports, encouraging the use of them and ensuring they are offering passports and documenting if refusal
- Learning disability notifications are still being submitted for learning difficulties or for cerebral palsy alone. Notifications are for those with a learning disability or autism only
- Implementation of the Oliver McGowan Mandatory Training
- Relaunching patient forum to increase engagement has been a challenge. There have been numerous attempts but due to timing and patient involvement there has not been a successful date held yet
- Implementation of LPS remains unknown
- Patient flagging and recording of needs remains a challenge. Currently the ROH has an internal system which relies on staff awareness and manual input which is open to human error. There is also currently no robust system to record contact and actions taken.
  The NHS Long Term Plan 2019 introduced the nationwide development of a reasonable adjustments flag to enable all patients with a learning disability or an autistic patient to automatically be flagged up on all hospital systems. Unfortunately, due to the lack of collaboration between different systems the digital flag project remains ongoing.
- Referral letters continue to not contain patient diagnosis of learning disability or autism

Areas of focus for 2023/24

- The learning disability team will continue to work with the Accessible Information Standard group to ensure that adjustments are made in communication and that patient preferences are recorded. Work to be done around patient letters and communication to be available in an easy read format
- Learning disability and autism CNS to complete PgCert in Inclusion: Autism Adults at the University of Birmingham
- Successfully launch the learning disability and autism forum to ensure patient voice is captured and used to influence services
- The development of the new learning disability and autism strategy within the ICB for implementation across the ICS
- Implementation of the aims laid out in the learning disability and autism strategy along with the Learning Disability Improvement Standards
- To improve mandatory training compliance across the Trust

3. Transition to Adult Services

Transition to Adult Services is a multifaceted process, which includes the event of transfer and encompasses the medical, psychosocial, and educational/vocational needs of young people with long-term conditions and/or disability and the needs of their parents/caregivers.

Transition has been highlighted as an integral component of care for all young people especially those with long-term conditions and/or disability. Transitional care is underpinned by the core principles of adolescent medicine and development of young person friendly health care services.

The Transition Service forms part of the Vulnerabilities Branch of the Safeguarding Team. To Ensure a Focus on Transition from Child to Adult Services is Priority 7 of the Trust Key Priorities (Safeguarding 5-year Strategy 2021-2025) approved by the Trust Board in August 2021.

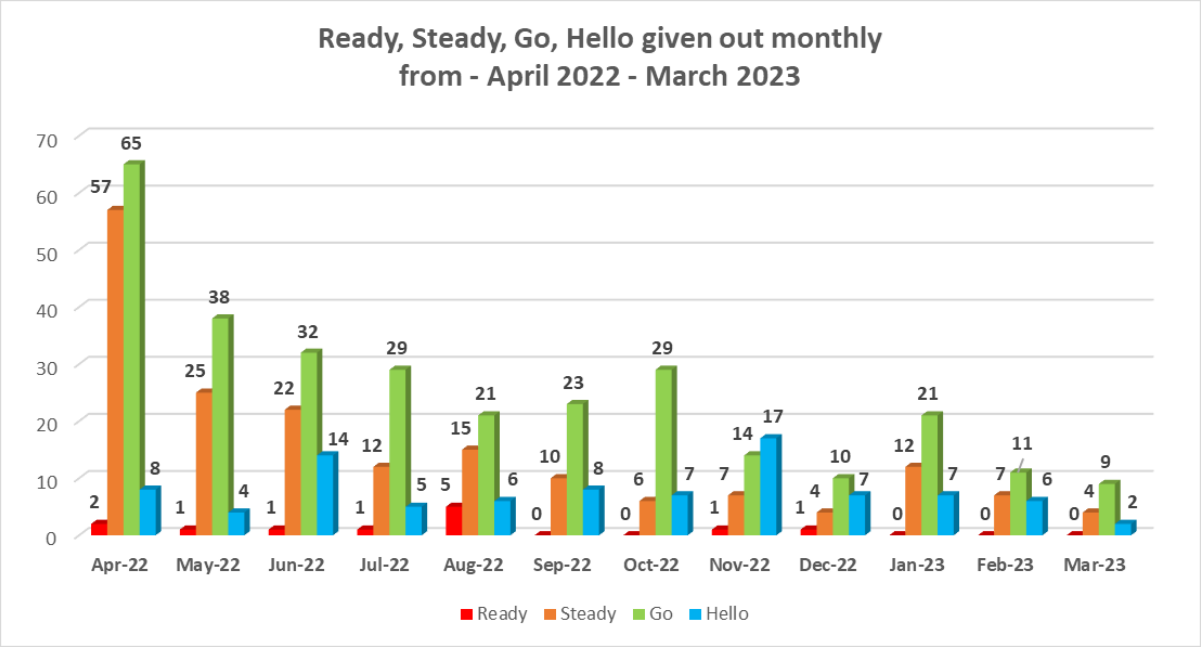
The Transition Clinical Nurse Specialist (CNS) presents a detailed quarterly report to upwardly feedback to the Trusts Children and Young People's Board, chaired by the Chief Nurse and Executive Lead for Transition and participates in the bi- monthly Safeguarding Quality Report presented to the Safeguarding Committee.

Transition Programme

The Ready, Steady, Go, Hello documents are an NHS recognised document created by Southampton Children's Hospital which the Trust use to support children and young people to prepare them for adulthood. For those patients that we anticipate will be moving into adult services within the Trust we ask the child /young person and their parent to complete the relevant document at specific ages:

- Ready from age 12 years
- Steady from age 14 years
- Go age 15 years and prior to their 16th birthday.
- Hello, is used by Adult Services staff for patients being received into that service.

The table below shows the amount of Ready, Steady, Go, Hello documents that have been given/sent out from April 2022 to March 2023.



Data collected from Transition excel spreadsheet

Total Number of Ready steady Go given out April 2022 – March 2023

Ready - 12

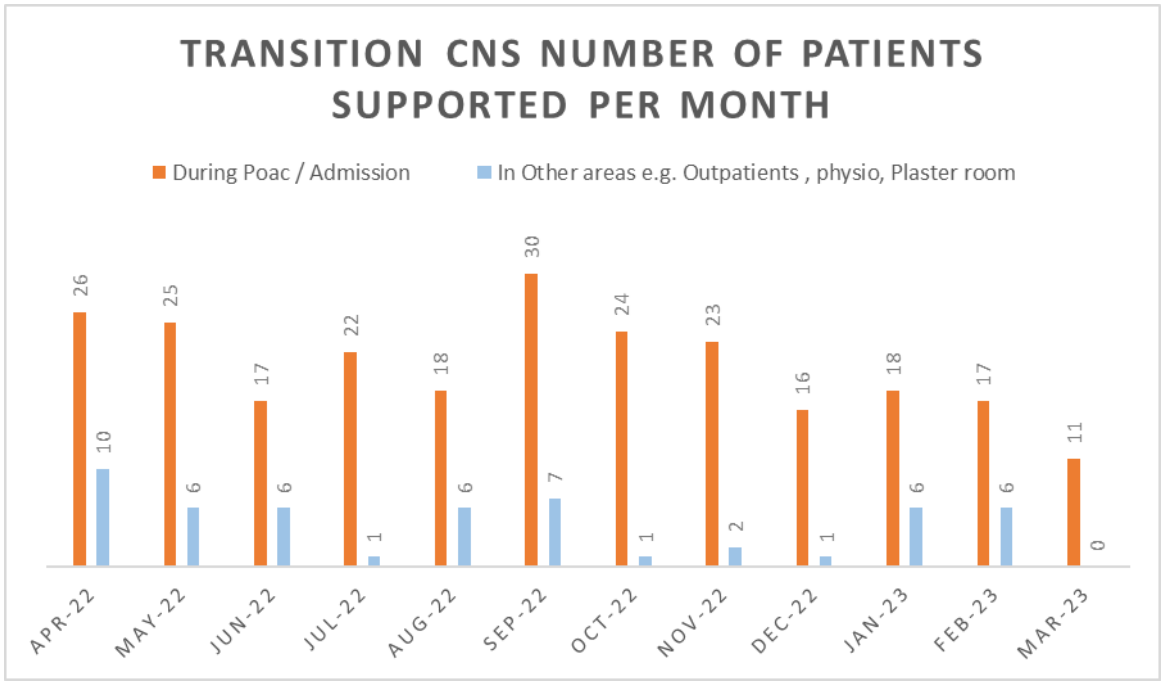
Steady - 181

Go - 302

Hello - 91

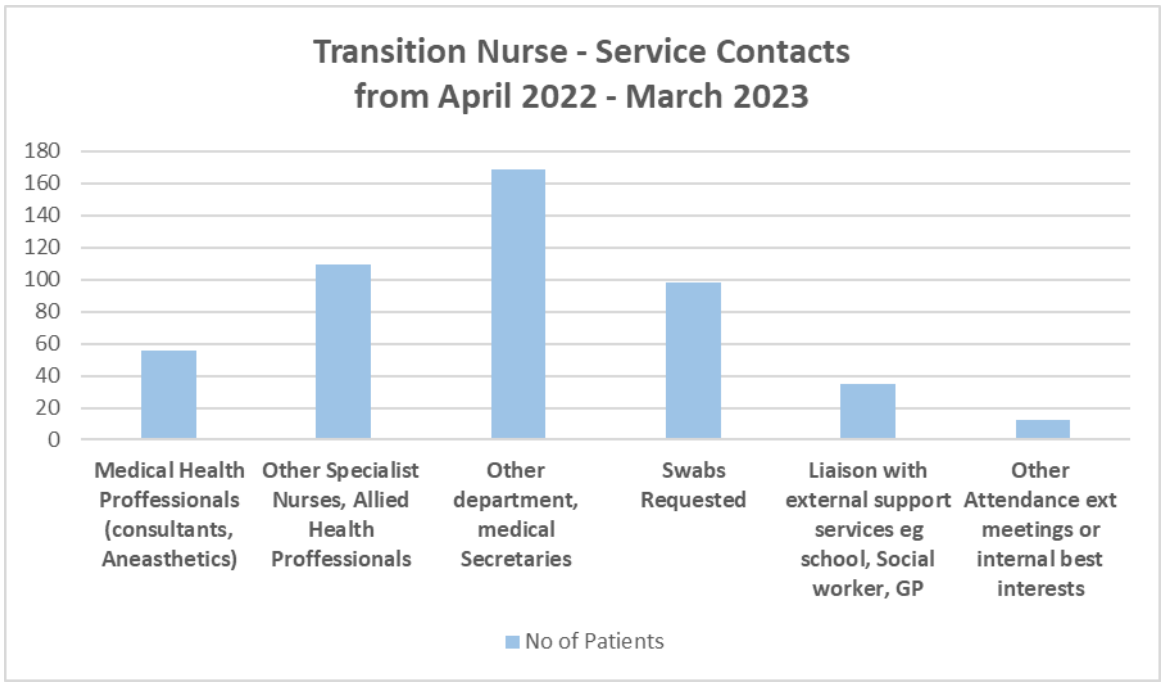
Part of the Transition CNS role is to provide support to young adult patients aged 16 – 19 years old who have moved into adult services and are being admitted for surgery. The Transition CNS makes contact either face to face in Outpatients or Pre- assessment, or else by telephone and email prior to the young person's admission and discusses support required and possible reasonable adjustments to implement. The CNS will then make contact with the young person on admission.

The chart below highlights the number of young adult patients supported by Transition CNS in pre assessment, ADCU and on the wards during the admission process and within other departments e.g. Outpatients, physio, plaster room.



Data Source : internal excel spreadsheet - CNS

The chart below records contacts the Transition Service have made with other medical professionals and departments both internal and external while offering support to young adults.



Data Source: Internal Transition Quality report

Case Studies.
The following case studies are about young adult patients that the Transition CNS has supported at various points of their journey.

Case A July 2022- Promoting Independence

Transition CNS has been supporting an 18-year-old young adult patient over a period of several months during admission, in outpatients and in plaster room for wound care. Patient had complex surgery to both legs, ankles, and feet.

Patient has spina bifida and is wheelchair dependent and has cognitive delay and processing difficulties. Patient's next of kin was his sister whose husband was being treated for cancer.

Patient required an extended inpatient stay due to difficulties in him being able to access upstairs and limited room downstairs. Patient was in below knee plasters with long leg cylinders and was required to be NWB for 8 weeks following surgery.

During the inpatient stay CNS strove to find entertainment for the young adult as he did not have anyone staying with him and was bored. CNS liaised with patients' school who sent an assistant to visit him before the school holidays.

During conversations CNS and Learning Disabilities Nurse had with the patient, he expressed feelings that he wanted to become more independent. He did not like school very much and was keen to leave and would like to get employment of some sort as he felt "like he was on a lead, and it was not an extending one". He realised he was limited due to difficulties with his disabilities. He wanted in the future to be able to be more independent and have his own house/flat. He expressed concerns that he had limited money and was not sure if he was receiving the benefits he was entitled to.

CNS talked to patient about making a referral to Preparation for Adulthood (PFA) as they would be able to support him with these concerns, however patient declined this option at this point.

Patient had a disability social worker and after discussion with patient, CNS made contact with the social worker and shared patient's concerns and frustrations. Social worker felt that a referral to PFA was the best approach and agreed to visit patient at home once discharged to offer further support.

During one of the numerous appointments that patient attended, Transition CNS and LD nurse discussed with patient the possibility of voluntary work as an option, as patient had talked about needing experience to get a job but how difficult it was to get that experience. A typical problem for young people in these current times.

LD Nurse organised for patient to meet the volunteer lead and discuss options available. Consequently, patient is now going to join the volunteer Team in the hospital.

Transition CNS continues to support young person.

This case highlights the importance of Transition support to our young adult patients.

Case B - August 2022- Information Sharing

CNS was contacted by CYP (Children and Young People) outpatients' staff regarding a steady questionnaire completed by a 14-year-old patient during her appointment.

On the steady questionnaire under the Managing Your Emotions section there is a question “I am happy with Life” and the patient had written “No” as a response.

CNS contacted the parent of the patient and chatted to her about this response. Patient was diagnosed with epilepsy and was struggling with coming to terms with this disease and the impact it was having on her life. She also had dyslexia. Patient was having seizures and absences numerous times per hour and non-epileptic seizures. Patient felt different to her friends, and they were not supportive of her difficulties and made fun of her. Patient had received support in the past from Foreword Thinking Birmingham, which she had found beneficial at the time. She had also had a family support worker to help with the epilepsy in the past. Her mother felt she would benefit from some group therapy with peers of a similar age who also had epilepsy.

With parents’ consent CNS contacted the Epilepsy Specialist Nurse at Birmingham Women’s and Children’s Hospital and shared the steady document and the information that the parent had provided regarding her concerns. Patient will soon be starting Transition planning from BWCH with regards to her epilepsy.

The Epilepsy Nurse agreed to contact the family and provide support.

CNS contacted parent to provide an update and the parent was happy and grateful for the support and felt like she might be able to get answers to some of her questions.

This case highlights the support that can be offered or signposting that can occur following the completion of the Transition documentation.

Case C- September 2022- Promoting Independence.
Transition CNS has been supporting an 18-year-old young adult patient over a period of several months in outpatients. Patient is awaiting complex shoulder surgery but has epilepsy and surgery cannot be contemplated until patients’ epilepsy is better controlled as if a fit occurred post-surgery, it might undo the fixture gained in surgery. Patient had concerns around finances, employment and social interaction and CNS supported patient by signposting to appropriate support services.

CNS supported patient at Outpatients appointment where patient disclosed to consultant that his mother was having problems with obtaining his epilepsy medication and there were periods when he was not taking them due to not having any. Consultant expressed to patient the importance of taking this medication.

CNS contacted the Practice Nurse at GP practice and requested for them to support and educate the patient in taking responsibility for his own medication and promoting independence to do this as part of the transition process.

CNS has been sharing information and liaising with the Epilepsy Specialist Nurse from hospital where patient’s epilepsy is managed.

This case highlights the importance of Transition support to our young adult patients.

Transition Database
Work continues with IT to set up a Transition Database. Difficulties have been noted with the current Transition spreadsheet for recording Ready, steady Go in that data appears to have gone missing. This was looked at by admin and Missing data has been recovered.

Transition Poster
CNS with support from admin and coms has designed a Transition poster to go up in the CYP waiting area highlighting about Transition and the support available to young adults and their families. This is currently under review a\and will be looked at by the new CNS in the transition role. Some parts of the poster need updating.

Transition documentation/pathway for complex patients. CNS had meeting with Transition Nurses from Birmingham Community Healthcare Trust. They have been involved in designing the WHAT (Wellbeing and Health at Transition) booklet. They have started sending this into young adults in the Special Schools within Birmingham at Year 10 (age 14 – 15 years) and year 14 for parents to complete. It is then loaded onto RIO and the Parents complete the hard copy. It is anticipated parents would be encouraged to take this with them to hospital appointments and share the information. It is like a super Learning Disabilities passport and covers all areas related to the child. There is an area for orthotics and Hospital input which would be appropriate to our care.
Research has identified that this group of young people with complex needs and their carers get tired of continually repeating the same information to different people and WHAT should help with this.
CNS acknowledges that this would be beneficial to this specific group of patients within the Trust and IT are in ongoing discussions with Birmingham Children's Community Trust regarding staff being able to access this information. Due to the delay, this has been added to the CYP risk register. The Transition Team responsible for the document presented about the WHAT document at Transition Champions Day in January 2023. Transition CNS is meeting with the Transition Lead at Birmingham Community Healthcare to discuss the sharing of this document in June 2023 to discuss this further.

CNS is currently securing copies of recently revised Transition leaflet produced by Together for short lives: Transition to Adult Services – Parents Guide. These can be shared with the parents/ guardians of young adults with complex disabilities who are unable to complete Ready, steady, Go documents.

National Transition Improvement Process.

The first step of a mapping session, with key stakeholders was completed on 14/01/2022 to map the current Transition process and pathways for our young adults so we can identify gaps. Two further sessions with key stakeholders were completed in June 2022 to map Phase 2 of the process, which was to undertake a piece of work to establish a more detailed pathway for each of the boxes on the right-hand side of the "Future State" diagram. A Document showing the pathway into the Trust for all 16-year-olds either as a new patient or those moving into adult services from CYP Outpatients has been developed.
Further in-depth pathways need to be looked at and the benchmarks for Transition completed. The benchmarks for transition have been developed in collaboration with young people, parents and health professionals and offers a 'practice guide' to support transitional care. Benchmarks provide a systematic approach to the assessment of practice.
The benchmarks for transition consist of eight main factors and each of these factors contains a number of indicators of best practice.

The Burdett National Transition Network

The Burdett National Transition Network have been involved in supporting and co-producing several national pieces of work, many in collaboration with NHSE&I. These include a National Framework for Transition and the Core Capabilities for all healthcare staff to ensure high quality care of young people, including supporting them as they transition from children into adults' services.
There has been a continued delay in these documents. The National Framework is the key principles around transition and a minimum standard. The core capabilities are the knowledge and skills that staff need to care for young people and deliver transition.
Transition CNS has provided provisional information to the Mandatory Training delivery group around the anticipated mandatory training related to the Transition core capabilities.

The Capabilities Framework aims to identify and describe the knowledge, skills, behaviour, and attitudes that healthcare staff need to apply to deliver high quality, compassionate, personalised care to young people. It will provide a single, consistent, comprehensive, and explicit framework on which to base review and development of all relevant staff across clinical services. The Framework will define standards for transition education and training and will be applicable to all healthcare employers.

Capability	Capability Heading
1	Young people's development
2	Communicating with young people
3	Preparing for adulthood
4	The role of parents carers and significant others
5	Challenges for and influences on young people
6	Providing accessible high quality developmentally appropriate healthcare for young people and engaging them in their care
7	Confidentiality
8	Consent
9	Safeguarding
10	Multi-disciplinary working in partnership and collaboration across organisational boundaries
11	Involving young people in improving and developing services
12	Hospice and palliative care support
13	Complex needs transition
14	Leadership and transformation in transition

Tier 1 The knowledge, skills, attitudes and behaviours for all staff working with young people aged 11 to 25 years in healthcare settings

Tier 2 Knowledge, skills and attitudes and behaviours of all staff who work directly with young people aged 11 to 25 years who are in, or require, healthcare transition from children's into adult services. This includes support for young people to be settled and engaged within adult services.

Tier 3 Enhancing the knowledge, skills, attitudes and behaviours of all healthcare staff who are responsible for the leadership, transformation and monitoring of transition services.

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Other work in conjunction with the Framework will include:

Community Currencies
The Community currencies, which is the funding streams for Transition, have now been put together and they have produced seven example patients, so personas that will be going into pilot stages this year and they are looking at a final rollout in 2024 into 2025. So that is when the transition funding will come in for all services.

Guidance Training
There is some guidance training coming out for adult continuing healthcare teams and children's continuing healthcare teams around transition, including when to start, the ages to start and what might be included. This is currently being put together and should be released soon.

CQC briefing paper
The National Transition Team have had contact with the CQC and the briefing paper for the adult services will be written soon. It is anticipated to have adult inspection on the care of young people and Transition towards the end of this year.
Work being undertaken nationally regarding Transition also include:

- **NIHR Med Tech transition** – Mind the Gap this is based on work undertaken by Janet McDonagh 5 years ago and is looking at evaluating patient experience and moving to a digital service evaluation tool that will be nationally available.
- **Video project** – Sheffield is currently looking at videos and podcasts nationally around Transition to improve information sharing with patients and parents.
- "**Me First" Transition Module.** This was initially developed by Common Room and Great Ormond Street Hospital and focuses on Fundamentals communication training as well as Transition communication. They have just completed the pilot stage and next steps is to rollout across England.

The Burdett National Transition Network announced in February 2023 that the Network in its current form will end in May 2023 due to lack of funding support for the Regional Nurse Advisors from NHSE. The Midlands is currently the only Region that has secured local funding for continuation of the Regional Nurse Advisor.

Transition CNS has regular meetings with The Burdett National Transition Network Regional Nurse Advisor for the Midlands every six weeks. The Nurse Advisor attended a meeting in the Trust in March 2023 to meet The Chief Nurse and Safeguarding Matron to discuss the impact of the imminent Transition Framework for the Trust.

National Transition Study Days
CNS attended Sheffield Transition Conference on 17th May and the 6th National Transition conference on 15th June 2022. Both were virtual conferences and provided a varied programme with useful resources especially around the importance of Youth workers and Youth Forums.

Ready Steady Go Study Day - 4th November 2022
Transition CNS attended the Virtual Ready Steady Go and Hello Conference Delivering Patient Empowerment, shared decision making, and Transition organized by the Team in Southampton.
The day focused on delivering high quality, sustainable healthcare for patients and families from childhood, through transition and into adult services. Topics included the psychosocial impact of living with a long-term condition and strategies to address this. Examples of good practice and resources were shared.

Children's and Young people's Quality Objective.
Transition CNS worked with Manager of CYP Outpatients and Matron for CYP Outpatients to write a business case for a Youth Worker for the Trust. Revision of the Business case for a Youth worker has been completed by CYP Matron and Head of Nursing. This has now been through approval process at required meetings and the post has been agreed. Funding is currently being sought.

The Youth Forum is part of the Trust Quality Objectives, not only to gain the voice of Young People in the Trust but also to increase local Young People's employment opportunities in the Trust.
CNS presented the Youth Forum Proposal to PEEG (Patient Experience and Engagement Group) meeting on 12th May 2022 and the Forum was agreed.
CNS arranged a meeting with the Lead of the National Youth Forum who shared information around the best ways of setting up a Youth Forum.
A meeting has also been had with staff from Derby and Burton who run the Youth Forum there and which has been established for 6 years. This is a forum that is comparable to the one we need to set up and ideas were shared around recruiting young people, incentives to encourage attendance, the target audience, ways of promotion as well as potential projects, activities, and issues to consider. Discussion was also had with Sandwell Hospital who have a regularly active Youth Forum and it is hoped shared activities might be an option in the future.

The audience targeted for the Youth forum includes not only patients but the wider community. CNS has focussed on information going out to reach not just patients but schools, colleges, Universities, local groups, staff within the Trust, volunteers, and children of staff who are aged between 13 – 25 years old. This is customary practice in youth forums.

Information about the forum has been spread on social media across our main channels and community pages multiple times including: B31 voices (their main social page and their dedicated events page along with information on their website), Selly Oak Community, Harborne Community, Weoley Community, Northfield Community Partnership, Northfield Families and Early Help in Selly Oak.

Communications also shared information about the youth forum on the hub and in weekly updates for staff to be aware of this and to share in their networks/on their social media channels too. Posters and flyers have been put up and given out in CYP Outpatients, Main Outpatients, Pre- assessment, and Therapies. Information is included on the young adult patient information leaflet given out and emailed by CNS.

Following recommendations from the National Youth forum an Eventbrite page was set up with a QR code for young people to access and managed by the Communications Department. The page for the first meeting had 123 views.

The First Youth forum

The first youth forum Scoping meeting was held on 27th September from 5-7pm in the Knowledge Hub. On the evening we had 2 young adults attend, both patients in the Trust, who both had a parent with them and a Neighbourhood Action Coordinator from Birmingham City Council.
The evening started with introductions and an ice breaker quiz "all about bones" which encouraged a relaxed but competitive atmosphere between the two teams.
This was followed by a presentation by Transition CNS around why the Trust want a youth Forum and what we can offer the young adults who participate. A good discussion was had, and the young people came up with some excellent ideas and suggestions around engagement which we will work on for the next forum.
A break was had with pizza and cake which was received well by all present and this was followed by an activity around writing some ground rules and Terms of reference (TOR) for the forum.
The Young adults did not appreciate "the long waffly sentences" and so formulated some rules that they valued in an easier format.
These have since been formatted into a document and were discussed at CYP Board on 14/10/22.

The gift at the end of the evening of a knowledge Hub stationary pack went down well with all the visitors.
Despite there only being a small number of attendees, their engagement and involvement was immense and both young adults said they had enjoyed the evening and would come again

The Second Youth Forum meeting held on 31st January 2023 was successful with 9 young people plus 3 parents attending. A presentation by the Learning and development team around employment opportunities for young people and apprenticeships within the Trust was received well and the young people found the personal experience talk by a young person around her change in career and progression within the Trust unbelievably valuable.
Three young adults spoke about their experience in volunteering in the Trust and discussed around how young people can get beneficial experience from volunteering appropriate to their interests.
Plans are underway for the next meeting on 9th May 2023

James Brindley School
CNS has met with the Centre Leader for Hospitals and Short-Term Provision, DSL from James Brindley School to review the support offered and the referral process for young adult inpatients from an education aspect following the resumption of services post Covid 19.
James Brindley have set up a self-referral process for young people aged 16 – 19 years with a QR code (see attachment). Two laptops have also been provided by the school and is available for young adults to use to access remote tuition from a James Brindley Teacher whilst in hospital. This is currently stored with Transition CNS.
The DSL presented at the Transition Champions study day.

NCEPOD – Transition from child to adult healthcare services study
The Trust participated in the NCEPOD study. The aim of the study is to explore the barriers and facilitators in the process of the Transition of young people with complex chronic conditions from child to adult health services study.
Process to date:

- Transition CNS, with the support of informatics, initially submitted data for 740 patients who met the criteria of the study.

- A random selection of 15 patients was then made by NCEPOD and further information provided.
- CNS submitted information regarding Transition services within the Trust on an online questionnaire as requested by NCEPOD after discussion with Matron and Transition Executive.
- Selection of 5 patients from the 15 was made by NCEPOD and Consultants responsible for these patients were requested to complete an online questionnaire.
- A further selection of patients was identified as matched cases, these are patients under more than one specialty in our Trust or under a different Trust primarily but also our patient. Consultants again were required to complete online questionnaires.
- Results of the study are anticipated later in 2023

Transition Awareness Day

CNS held a Transition awareness day on September 23rd to increase awareness of the support for young adults in the Trust, as well as impart information around the current National Transition work including the imminent Framework and core capabilities.
A stand was held outside Café Royale which was received well and visited by staff, patients, and parents/carers. Visitors to the stand were asked to make a pledge or suggestion around Transition and were given a Transition pen and ready, steady Go lollipop in recompense.
Key themes included communication with young people, development of a young adult ward, and increasing awareness around Transition.
Unfortunately, the planned Transition video to be run on that day on the Trust intranet was not completed due to difficulties engaging young people to take part. The CNS is proposing that this becomes an area of focus for the youth Forum in the future.

Transition Awareness stand 2022

Feedback from Transition Awareness Day

At the Transition awareness day on 23rd September attendees to the stand were asked to offer suggestions or pledges around transition.

My Transition Suggestions / My Transition Pledge

- *Young Adult ward and allow Teenagers to have surgery here at ROH*
- *More support for young individuals*
- *More Equipment & Room Availability*
- *More easier processes to support the young individuals*
- *More up to date with Technology maybe a QR code can be developed for ease for Teenagers with mobile phones*
- *A young adult ward would be beneficial to patients & their parents. This would make their Transition to Adulthood much smoother*
- *More Training For staff*
- *To Engage in training updates following the competencies*
- *To continue to collaborate with transition CNS on complex patients*
- *We in plaster room pledge to respect the wishes of the young transition patients*
- *To not be afraid to speak to a younger patient – asking them how are they or how are they feeling?*

- *The ROH really needs a ward for Transition patients to offer the amazing service the department provides*
- *I would suggest that we should have a dedicated young adult ward*
- *To increase the service support & the transition throughout the hospital from OPD to Inpatients*
- *I pledge to support all young patients as the transition process is a vital part of our service*
- *Continue to support colleagues with Transition paperwork*
- *To support young people on the ward when they come in for surgery & to make their stay as comfortable as possible*
- *Offer reasonable adjustments*

Transition Champions Meeting

CNS has continued to hold Transition Champions meetings the last being on 16th June 2022. Attendance in the last year has fluctuated due to difficulty with staffing levels, sickness and Covid restrictions.

Transitions Champions Study Day

The Transition Champions and Safeguarding Champions Study Day was moved from September 2022 to January 11th, 2023, due to unavoidable circumstances. CNS had planned a varied programme with topics related to young adults. External speakers presented on subjects including Consent, Capacity & The liberty Protection safeguards', Education support for young people with medical needs, Children in Care, NHSE National Transition update and a young person spoke of her personals experience of having an eating disorder and going away to university.

Twenty champions attended the event and the feedback received was positive. Staff enjoyed the day and found the information received valuable. Evaluation was incredibly positive. Thanks to the colleagues who generously gave their time to present.

Succession Planning-

Interviews were held on 9th November 2023 to find a successor for the retiring current Transition CNS.

A young adult Interview panel was set up to question the candidates as well as the formal interview process. Four young adults were involved in the panel. Unfortunately, one was unwell on the day and could not attend, but she provided questions which the other 3 panel members asked on her behalf. The young adults were supported in preparing and posing their questions by the Manager and a staff nurse from CYP Outpatients.

The three young adults fed back that they had enjoyed the experience and they were provided with a certificate and some gifts in thanks. It is hoped they will be able to use the experience to help them with their own application and interview processes for college and University in the future.

The Safeguarding business case secured approval for a Band 6 part time Transition Nurse. Interviews for this post took place in March 2023. The successful candidate is awaiting clearance from recruitment.

Training and education

Transition CNS continues to teach on the care certificate training for healthcare assistants in the Trust.

In February 2023 CNS attended the Work experience week run by the Education and Training department and delivered a presentation around the Youth Forum to the group of 14 young people present. The presentation included information around why the Trust want a Youth Forum and benefits to the young people from participating.

In January 2023 Transition CNS was asked to present to the Staff Engagement and OD Board around 40 years of Nursing and her journey at ROH (Royal Orthopaedic Hospital). The presentation encompassed the highs and lows of working as a nurse for 40 years and focused on a passion for orthopaedics. Feedback received was incredibly positive.

Patient Story

Transition CNS has been supporting an 18-year-old young adult with Complex medical conditions and Learning disabilities for the last 18 months.
The patient returned to Outpatients for follow up and was told that further surgery was required. This triggered great apprehensions in the young adult due to experience. The patient was obviously apprehensive about her further planned admission in view of the problems they had encountered previously. The parent of the young adult shared with CNS the difficulties they had faced during their admission in the form of a letter.
They made it clear they did not want to make a formal complaint but wanted lessons to be learned from their difficult experience.
CNS requested responses from the departments involved and then formulated them into a patient story.
This patient story was presented at Ward Managers Meeting and at Champions Day to share the patients experience, the importance of the voice of our young adult patients and every contact counts.
CNS has fed this information back to the young adult and her parent.

International Adolescent Health Week

International Adolescent Health Week 2023 runs from 19th – 25th March 2023

The Official Theme of IAHW 2023 is With and For Adolescents: Building a Healthier and More Inclusive Future.

The Official Colour of IAHW is Lime green, which represents health, happiness, and the high energy and passion of adolescents.

The Transition Service joined with CYP Outpatients and Safeguarding to stage an information stand outside Café Royale focussing on 3 areas pertinent to young people:

- Mental Health support
- Healthy Eating
- Internet Safety

Resources and signposting were available as well as a quiz around the 3 topics with a healthy eating prize.

Donations were received from Morrison's Longbridge to assist with goodies for the day and The Communications team provided ROH water bottles as the SIP till Send incentive was reinforced.

75 people engaged with the Team and attempted the quiz on the day, which proved to be a thought-provoking exercise.

Future Proposed Actions/Target work

For the Transition to Adult Services going forward:

- Implementation of the Transition Framework and core capabilities and associated documents. Training requirements will be attached to this.
- Production of effective documentation for young adult patients with complex needs/learning disabilities. Access to RIO and WHAT document.
- Development of Transition database which includes transition notification system.
- Ensure Band 6 Transition Nurse in post.
- Relaunch of Transition email: transition.toadultservices@nhs.net
- Produce a Standard Operating Procedure (SOP) with Vulnerabilities to establish clear referral guidelines.
- Undertake Transition benchmarking against "You're Welcome criteria" and National Transition benchmarks.
- Undertake a two-part Audit on staff engagement and the use of the ready Steady Go Documentation in transition age patients.

It is important to remember in terms of service provision that The NHS Long Term Plan states that "the NHS will move to a 0-25 years' service by 2028 and towards service models for Young people that offer person- centred age-appropriate care for mental and physical needs, rather than an arbitrary transition to adult services based on age not need." Transition CNS has initiated discussions with Chief Nurse around the potential for a young adult ward.

4. Mental Health

We all have mental health which is equal to our physical health, however, not everyone has a mental illness. Mental Health and Mental illness are not the same thing. Mental Health refers to our emotional and psychological wellbeing, influenced by our life experiences which can impact the way we think, feel and behave. Mental illness involves a wide range of disorders often caused by biological factors and chemicals in the brain. A mental illness is a recognisable condition that is diagnosed by a trained professional and treated. Mental health and mental illness are two separate things and should be treated as such. To give an example, a patient has attended the Royal Orthopaedic hospital for an appointment and they express that their mood is low due to pain. This could lead to feelings of poor mental health but it does not mean they are suffering from a mental illness. Equally, a patient attends the hospital and has a diagnosis of schizophrenia but it is managed effectively. That patient has a mental illness but good mental health. Good mental health and resilience are fundamental to our physical health.

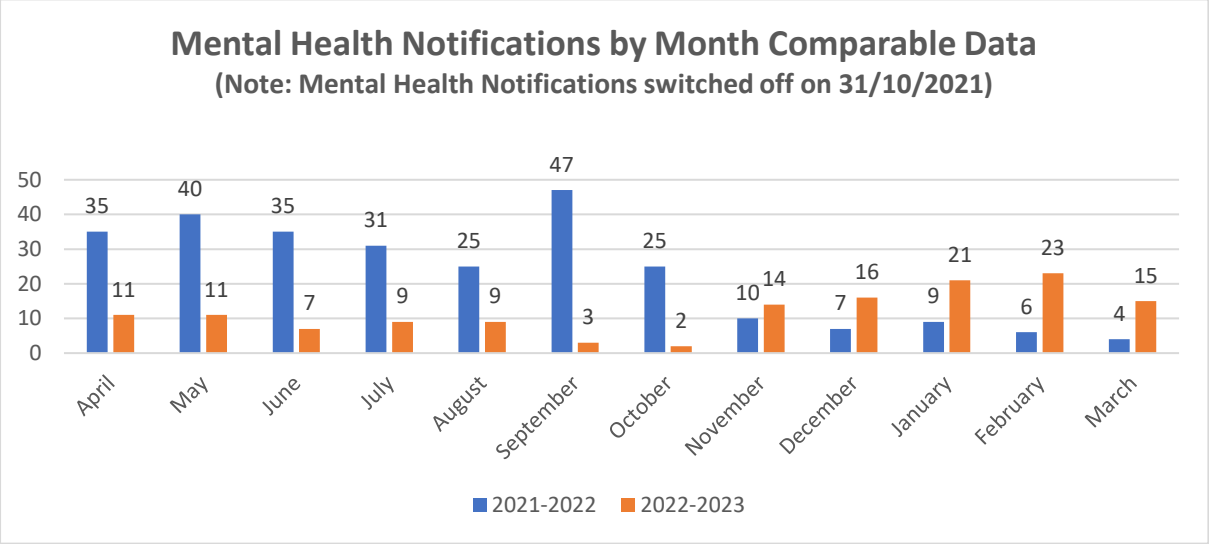
As a Trust the Royal Orthopaedic hospital does not treat or diagnose Mental Health conditions but it does have an obligation to maintain patient safety. In a Mental Health Crisis, the staff here need to be able to provide immediate support and consider referral to specialist mental health services.

Since the appointment of the Dementia and Mental Health Practitioner, (see table 1) which represents comparable data for the total number of mental health notifications received by the Dementia and Mental Health Practitioner. This year there has been a total of 151 compared with 274 the previous year.

The previous figure of 274 was representative of the number of patients being seen in the Trust during COVID-19. COVID had a significant impact on the number of notifications coming through which is now no longer the case.

The decision was made to switch off the internal notification system for Mental Health in October 2021 following a review of the current Mental Health process and pathway. The Executive Team approved this in September 2021. Of the 151-notifications received in 2022 -2023, two were under the age of 18. Further demographic data is presented in tables 2,3 and 4.

Table 1 Total number of notifications received



Data source Trust Internal Database

Table 2 Represents the demographic data

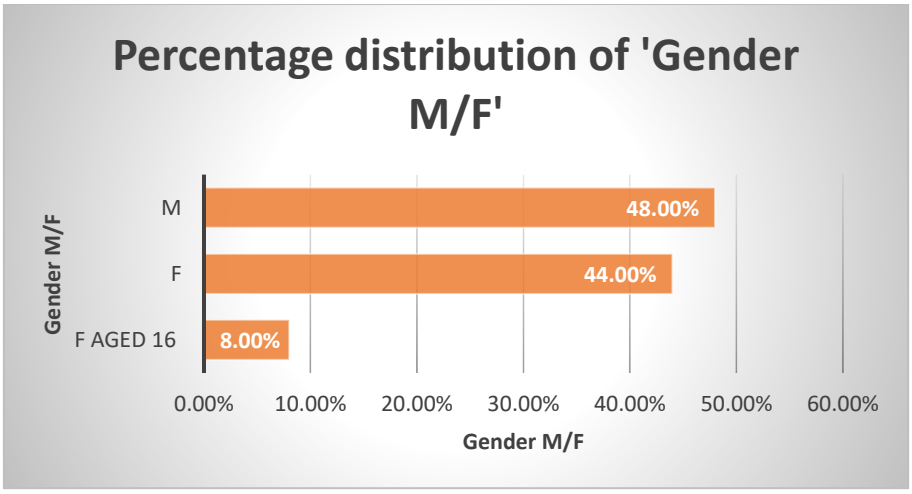


Table 3 Represents the department with the highest number of MH notifications

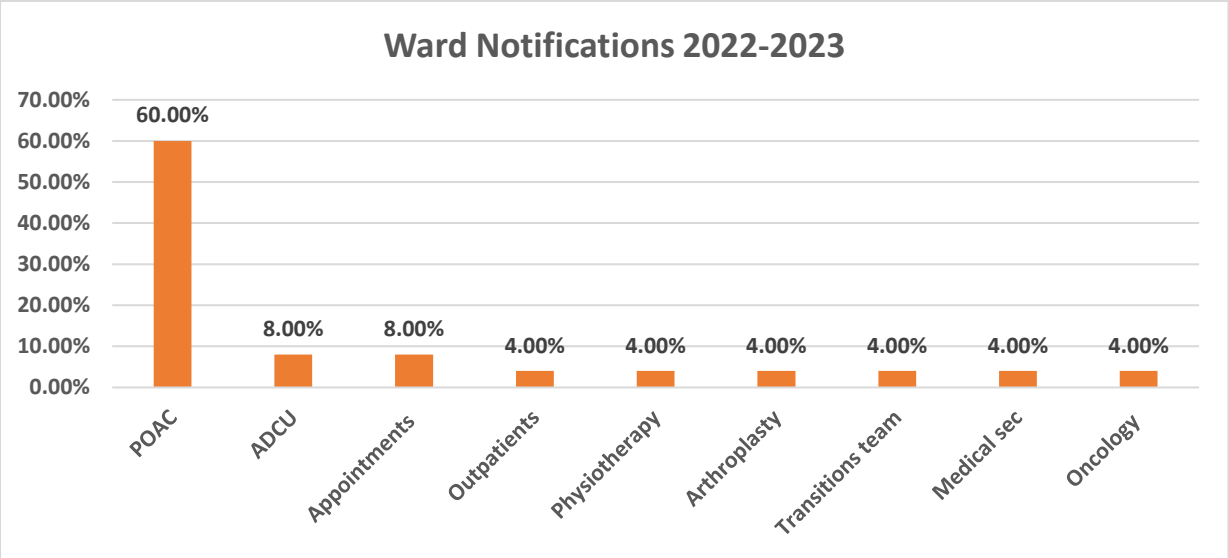
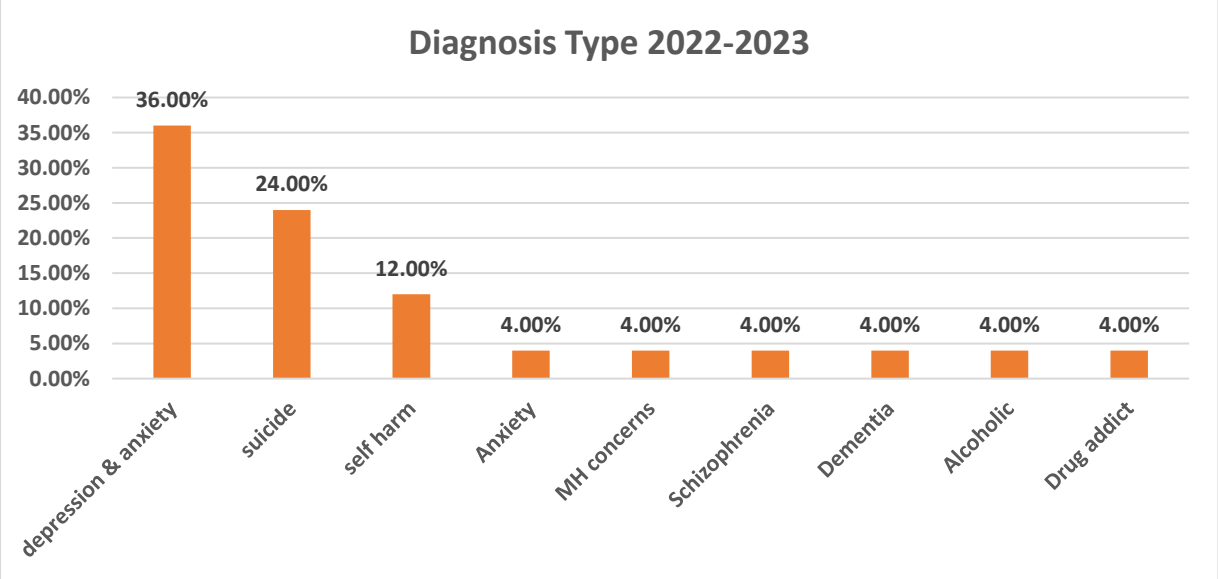


Table 4 Represents the type of mental health concerns being reported.



Psychiatric Liaison Support, Service Level Agreement (SLA)

The Dementia and Mental Health Practitioner is of the view that patients in the acute hospital should have the same level of access to the opinion of a consultant psychiatrist as they would have from a consultant specialising in physical health problems. However, the Royal Orthopaedic Hospital no longer has a Service Level Agreement (SLA) with Birmingham and Solihull Mental Health Foundation Trust (BSHMHFT), as this ended on 31st March 2022.

Input provided by the Dementia and Mental Health Practitioner has been communicated to staff to assist them to signpost patients to support organisations. Staff should be aware of how to inform the following professional services: -

- GPs
- Crisis Team
- Community Mental Health Teams (CMHT)

Staff can now report their concerns to the Dementia and Mental Health Practitioner to assess patients if there are concerns around a patient's mental health. This has reduced the number of safeguarding referrals being made to the safeguarding team.

Access to Birmingham and Solihull Mental Health Trust

- The process for referring urgent requests for a mental health assessment/mental health Act assessment should now be made to the Single Point of Access service (SPoA) operated by BSMHT. (As confirmed by Anna Williams Clinical Lead for Liaison Psychiatry services 7/12/22).
- SPoA urgent response time is within 24 hours not the 4 hours as provided to A&E.

Mental Health Current provision within ROH

- The Dementia /Mental Health specialist practitioner was appointed on 3rd October 2022.
- The Dementia and Mental Health Practitioner provides short term (time limited) mental health support, assessment and sign posting for individual patients as appropriate.
- The Dementia and Mental Health Practitioner has liaised with the full range of primary and secondary mental health services in respect of individual patients as appropriate.
- The Dementia and Mental Health Practitioner has provided mental health supervision regarding individual patients within the acute hospital as necessary.
- The Dementia and Mental Health Practitioner has provided effective, holistic, and person-centred care within the acute hospital (as illustrated in case studies).
- The Dementia and Mental Health Practitioner provides expert mental health advice, information, support, supervision and sign posting for acute hospital staff.
- Will liaise with the SPoA duty worker if a patient transfer is necessary via ambulance to the nearest Accident and Emergency for a psychiatric liaison review.
- Once a referral has been made to the Dementia and Mental Health Practitioner and input is required, then the outcome will be conveyed to staff.
- Staff have been informed of the importance of sharing and communicating information about the care of patients with the relevant professional services involved.
- Staff have been informed that gaining patient consent where possible is important.
- Staff should raise mental health concerns with departmental line managers or nurse in charge, also clinical site manager (CSM) in the absence of the Dementia and Mental health practitioner.
- The Dementia and Mental Health Practitioner will follow up and review all referrals that have required involvement from the vulnerabilities team at the time of referral.
- Staff contact the Dementia and Mental Health Practitioner for advice and/ or support.
- Staff to follow current MH guidance approved May 2023 by the Safeguarding committee.

Mental Health Case Studies-

Case A

Patient was called to complete Joint Initial paperwork over the phone however he was very angry. Patient described himself as a 'violently angry man', who suffers with PTSD post army career. He also has lots of other past medical history, some disclosed as mental health others he wasn't happy to disclose. Patient reports he attends appointments with his psychiatrist who keeps his anger 'in check'. Patient stated he would punch the consultant in his face if he were made to have this surgery. Patient verbally aggressive on the phone reports he was seen by a consultant 6 years ago who listed him for BHR surgery, however he has recently been seen by a different consultant who has now listed for THR surgery. Patient cannot fathom the rational for this change and is extremely frustrated/angry. Dementia and Mental health practitioner contacted for advice. The dementia and mental health practitioner contacted the patient. He presented as experiencing a mental health crisis. A telephone call was made to the GP who arranged a face-to-face appointment with the patient on the same day. The GP arranged for the patient to have several follow up appointments over the coming weeks to address his severe social anxiety with the support of a CPN at the surgery. An ROH staff nurse during supervision with the Dementia and mental health practitioner mentioned that she had a good relationship with the patient. The staff nurse agreed to call the patient and complete the paperwork. This allowed for the formal consent process to be completed. It was agreed that he would be seen by a different consultant who knew him well. The patient received support for his longstanding mental health difficulties, the consultant was safeguarded and the patient received his treatment. (Jan 2023)

Case B

Call received from physio, patient disclosed a suicidal plan. The patient's operation had to be cancelled for 7 days she was in chronic pain and became mentally distress by the decision. Patient stated that when she returned home, she would end her life. Dementia and mental health practitioner was contacted for advice. Following an assessment, the patient disclosed that she was concerned about her 5 cats. Prior to coming to the ROH she had spent 3 days in a different hospital and had been wearing the same clothes throughout. It was established that she was known to the Community mental health team for previous attempts to end her life. The team had discharged her indicating a historical risk that she would carry out her plan to end her life. The patient had a diagnosis of emotionally unstable personality disorder. To alleviate anxieties the dementia and mental health practitioner arranged for a neighbour to look after the cats and a friend to bring in some clean clothes. The patient maintained that she would end her life due to her chronic pain she made the decision to self-discharge. The CMHT stated that they would not be able to see her as they were not an emergency service. Her GP rejected the request to see her stating she should be transported to A&E. The patient presented as fully capacitated it was agreed that when she left the hospital the police would be contacted to carry out a safe and well check. The dementia and mental health practitioner spent time talking through the concerns with the patient. As the patient had full capacity she would not agree to be transferred to A&E. It was agreed that she would be reviewed by physio and the consultant prior to leaving. The consultant took note of the Dementia and mental health practitioner's recordings. Given the concerns regarding the patient's mental distress and previous history of suicidal attempts her surgery was brought forward to be within 24- 48 hours rather than 7 days. Upon discharge

that patient contacted her GP for ongoing support regarding her mental health. (March 2023)

Case C
Patient in POAC with clear plan to end her life supported by mental health first aider. The MHFA was able to support the patient to maintain her safety moving forward. Patient requested the involvement of the Dementia and mental health practitioner. Patient was experiencing on going suicidal thoughts following the death of her child. Dementia and mental health practitioner supported patient over a several weeks to access bereavement counselling alongside mental health support via her GP surgery. (Feb 2023)

Case D
Gentleman attending ROH for an outpatient's appointment he is currently psychiatric inpatient concerns were raised regarding his mental state and the need for a care plan and staff seeing him in pairs. Dementia and mental health practitioner contacted for advice. Dementia and mental health practitioner established that this person was a detained patient under the mental health Act. Outpatients advised that the patient would be attending his appointment with an escort eliminating the need to be seen in pairs. A care plan was not required as this was an outpatient's appointment and the psychiatric hospital would have completed their own risk assessment prior to the patient attending ROH. (Feb 2023)

Case E
Telephone call from the ward patient stated that she just wanted to die referral made to Dementia and mental health practitioner to review patient. Patient seen by dementia and mental health practitioner. Patient recanted her statement and expressed that she had a history of depression and felt lonely. Her family lived out of area and were unable to visit. Patient presented as low in mood the dementia and mental health practitioner arranged for ROH volunteer to visit patient to provide company/stimulation. (Jan 2023).

Case F
I am writing to inform you that today, I have seen a patient who has had a history of mental health issues (depression) and has had suicidal intent in July 2022.
Patient denied any suicidal ideation at present. However, last year in July, he told staff at ROH he is going to end his life as he was frustrated when he couldn't get help from any staff in regard to his back pain. Staff at ROH immediately helped him to be seen by one of the Drs and sign posted to mental health team. Patient said he is now on their list waiting for therapy. Following conversation with the patient, I have documented what he said to me and asked him if he needs any more support from us (ROH). Patient stated he is fine and he will wait for therapist to contact him. I informed him to contact his GP if he experiences same in the future and patient agreed. I have given patient informative leaflets i.e 'find an NHS psychologic.' and 'where to get help for self-harm'. I am going to notify his GP as well. (Dec 2022)

Case G Incident reported by SG Nurse on review of patient notes, SHO completed Section 5.2 at weekend – completed by SHO following assessment that deemed patent to lack capacity. No MCA completed in notes. No further immediate assessment with regards to Mental health not escalated or handed over to SHO on shift, no incident form completed - consultant not aware. Patient reviewed by medical team and consultant. Learning in terms of assessment and review and

information sharing. Patient also had a SG log due to disclosure of historical abuse from family member.

Case H Relates to a patient who attended OPD and was listed for a procedure, she was issued with the Integrated care Pathway booklet which she was asked to complete. Upon completion the nurse identified that she had ticked that she suffers with depression, anxiety, self-harm, suicide and an eating disorder. The nurse discussed this with the patient and ascertained that she was under the care of a mental health team and has a support worker. On questioning the patient stated that she was well supported and the nurse's assessment found her not to be at any risk currently. This was recorded in the patients records. A few weeks later a letter came into the Trust from the patient stating that she was concerned that this disclosure would now be recorded on her medical records and that she this declaration without context may cause alarm. Her letter went on to say that she does not have psychosis and is not a risk to others. I contacted the patient and discussed the letter and reassured her that this was not the case and that the OPD nurse had clearly documented the context. This highlights the stigma that remains around Mental Health and patients fear of being labelled.

Case I Patient contacted PALS in month and disclosed that she 'felt like ending it' and that she 'saw no life ahead of her'. PALS had put in a notification for this. On receipt of the notification, I spoke with the PALS staff member and raised my concerns that she has not explored these statements further or escalated her concerns immediately following the call. She is new to the team and therefore I coached her through the appropriate questioning when patient makes a statement like this and the required action if they are concerned for the patient's safety. She then re contacted the patient and spoke to her, she ascertained that the patient was safe and not at any immediate risk, the patient had since contacted her GP for support but was very grateful for the call back to check on her. (March 2022)

Case J Patient admitted for surgery known diagnosis of Emotionally Unstable Personally Disorder (EUPD). Self-harmed on the ward. Immediately placed on a DoLs despite having full capacity. Patient placed on one-to-one care with no review. Dementia and Mental Health practitioner became involved 1-1 removed, patient placed in open bay DoLs removed. Patient proceeded to walk unaided and fell had to be transferred to A&E arrangements made for patient to be reviewed by psyche liaison. Discharged home with original care package. (Dec 2022)

The above cases studies are examples of patients with a mental health concern who presented with a high risk of suicide or potential harm to others. They were assessed by staff and the immediate problem was managed first, then the patient was referred on to specialist services for ongoing support if needed.

In summary the current level of mental health support within the Royal Orthopaedic hospital consists of the Dementia and Mental Health Practitioner offering listening support, advice, information and signposting to patients as referred by staff.

Achievements to date

- Has benchmarked Royal Orthopaedic Hospital against other acute trusts to identify the strengths and weaknesses of the current structure of mental health support.

- Updated the previous Mental health Act policy.
- Produced a referral guidance with flow chart (accessed via the intranet).
- Scoping mental health awareness risk assessment training for staff.
- Meeting regularly with the Engagement and Wellbeing officer re staff well-being.
- Provided supervision sessions to support staff when working with patients who present with mental health issues.
- As part of the PLACE assessment, I arranged for a person living with dementia and their carer to carry out a walkabout the results of which contributed to the action plan.
- I jointly chair the Dementia and Falls group bimonthly meetings.
- I have participated in the Care Certificate training re Mental Health awareness.
- I continue to maintain my Approved Mental Health Professional (AMHP) status and participate in Birmingham City Council AMHP rota.
- Sent out Dementia Plan contribution questionnaires
- Sent out Carers survey questionnaires.
- Attended virtual Dementia Care Conference 25/4/23
- Attend monthly meetings with the Dementia Voices Group

Mental Health Provision prior to the appointment of Dementia and Mental Health Practitioner.

Mental Health First Aid (MHFA)

Mental Health First Aider (MHFA) Training

Mental Health First Aid (MHFA) Training which commenced in Oct 21. MHFA training was initially targeted at departmental senior staff, bleep holders and clinical site coordinators. No training has been undertaken since COVID. An audit of staff using their mental health first aid skills is currently being undertaken and those staff will be targeted for MHFA refresher training, this will require funding for training to be completed.

List of current MHFA 2022 -2023 was updated and posters were updated.
Communication team have sent out information reminding staff to use MHFA within areas.

The Safeguarding Lead Nurse is currently reviewing the number of staff required to complete MHFA refresher course. Refresher training is required for those staff who were trained more than 3 years ago to enable the Mental Health First Aiders to update their skills. It is a way to demonstrate that the Royal Orthopaedic is committed to treating mental health and physical health equally. Staff trained in MHFA need to maintain their skills and competence to mitigate over reliance on the Safeguarding team to deal with Mental Health concerns. Communications have been sent out to managers that mental health concerns of patients are not safeguarding issues.

Youth Mental Health First Aider

Childrens service ward manager and childrens senior physiotherapist have completed their Youth MHFA training.They have successfully delivered x3 two-day courses to date. We can confirm that 43 staff members have attended and completed their course to date and two further dates are booked for 18/19th July 23rd & 26/27th October 2023. The most recent Youth MHFA training was delivered by March 2023 with an external trainer. The July and October dates will be delivered with the same external trainer.

Current Risks to patients experiencing a mental health crisis

- No Service level agreement in place between Royal Orthopaedic Hospital and Birmingham and Solihull Mental Health Trust.
- Staff are insufficiently trained to support patients experiencing a mental health crisis.

1. Physical illness is associated with an increased suicide risk. Many people who live with long-term conditions - including physical illness, disability, and chronic pain will, at some time, experience periods of depression. MHFA training cannot be relied upon to sufficiently meet the needs of patients experiencing a mental health crisis.

- Staff burnout

Where we need to be within the next 12 -24 months

- A Mental Health plan to support the mental wellbeing of patients struggling with a mental health crisis.
- In order for staff to provide person centred care for patients experiencing a mental health crisis, they need to receive appropriate training to:
    a) Define mental health and mental illness
    b) Recognise the most common mental health conditions ie signs and symptoms' that impact on mental health.
    c) How to respond to a mental health crisis
    d) Identify the support interventions which would be the most effective in promoting mental wellbeing.
    e) Funding will be required and training organisations have been identified.

5. Dementia

Dementia is a term used to encompass a group of illnesses that cause progressive damage to the brain resulting in its function being impaired. People with dementia may have problems with:

a) Understanding
b) Memory
c) Changes in their behaviour and mood
d) Communication
e) Day-to-day activities such as cooking and personal care
f) Falls
g) Managing their own health

Dementia is a significant challenge and a key priority for the NHS with according to the Alzheimer's society 'Fix Dementia Care – Hospitals' an estimated 25% of acute beds being occupied by people with dementia at times.

Within the Royal Orthopaedic Hospital 2022 -2033 0.41% of patients.

The aim of the Royal Orthopaedic Hospital 2016 -2019 Dementia Strategy was to provide the best possible, patient centred care to people living with dementia and to support and work with their families and carers. The aims and objectives are shown below:

1. To develop a skilled aware, effective, caring and compassionate workforce who were unafraid to stand up and tackle stigma.
2. To become a dementia friendly organisation working to improve our environments and services to ensure no avoidable harm is caused to patients with dementia.
3. To work in partnership with carers and families.
4. To provide person centred care through ensuring staff are provided with skills and information to understand individual needs and to support patients and carers accordingly.

Current Position

All clinical and non-clinical staff are expected to have a good understanding of the issues faced by patients with dementia. This awareness has been helped with the Trust's dementia training film "Barbara's Story". Currently, 85.85% have completed the Dementia awareness Tier 1 training. HEE recommendation is 90%. The ESR system is not recording the correct figures. The Royal Orthopaedic Hospital need to ensure the correct data is collated.

The annual audit of patient-led assessments of the care environment (PLACE) incorporates dementia friendly environments. The assessments are undertaken across NHS trusts, voluntary, independent, and private healthcare providers. They use information gleaned directly from patient assessors to report how well a site/organisation is performing in terms of national standards and against other similar sites/organisations.

The Trust scored higher that the national average within all fields. However, the Trust fell below the 2019 score within the category of "Organisational Food".

To improve care and outcomes for individuals with dementia, a 'person centred' approach is essential. Person centred dementia care is emphasised in the National Dementia Strategy and National Institute for Health and Care Excellence (NICE) Dementia Quality Standards. It is often difficult for patients with dementia to communicate their preferences, choices and needs to hospital employees. Therefore, person-centred care can only be provided following detailed discussions with individuals who are well acquainted with the person living with dementia.

Where do we want to be in 12 months

The Royal Orthopaedic hospital requires a new Dementia Plan. The Dementia and Mental Health Practitioner plans to consult to with key stakeholders, including Trust staff, people living with dementia, carers and professionals who provide care and support for people with dementia in the community. Based on that consultation, aims and objectives will be identified for the new plan.

What is currently being worked on

- Updating the Trust's dementia training package.
- Carried out an audit of dementia care within The Royal Orthopaedic hospital
- Communications have relaunched the "This is me" document. This will help health and social care professionals better understand who the person really is, which can help them deliver care that is tailored to the person's needs. It can therefore help to reduce distress for people with dementia and their carers. It can also help to overcome problems with communication and prevent more serious conditions such as malnutrition and dehydration.
- The Dementia and Mental Practitioner is now signed up to engage with the Dementia Voices group
- The Dementia and Mental Health Practitioner is updating the current care plan for patients with dementia.
- The Dementia and Mental Health Practitioner plans:

To initiate the Butterfly scheme within the Royal Orthopaedic Hospital - The Butterfly Scheme is the foundation of good dementia care and is now in use in over 200 hospitals throughout the UK. It is a national initiative to improve patient safety and well-being in hospitals and helps staff to recognise when a patient has dementia. Staff are also trained in the best way to communicate with patients with dementia and delirium. (Funding will be required).

- To roll out Dementia Tier 2 training over the next 12 - 24 months
  Supporting people living with dementia in a hospital environment can be incredibly rewarding, but also bewildering at times. For example:
  Why does a person living with dementia suddenly become angry when staff are trying to help?
  How do staff respond to people who are asking for their mother (who has been dead for many years)?
  How do early attachment experiences affect a person's experience of dementia?
  Training will support staff to have to a deeper understanding of what happens both physiologically and psychologically when a person develops dementia. It will support staff to explore how changes in the brain affect comprehension and behaviour and how small changes to approach can make a big difference to a patient's stay.
- Once Tier 2 has been rolled out the Royal Orthopaedic staff will have a wealth of new insights and practical tools to better support patients with dementia, underpinned by research-based best practice and mapped to the Dementia Training Standards Framework. Training organisation has been identified and **funding will be required**.

- Dementia and Mental Health Practitioner is currently auditing the care of dementia patients within the Royal Orthopaedic Hospital.

The Trust is working towards being a Dementia Friendly Hospital and to achieve this we need to implement variety of initiatives to help us deliver the best possible care for our patients with dementia and to support their families and carers.

5. Conclusion

The Vulnerabilities Team continues to grow and provide an invaluable service to the Trust. Working collaboratively both internally and externally the service follows local and national policy and guidance with the aim of reducing health inequalities across this cohort of patients.

The Learning Disability and Autism team has seen great work achieved through 2022-2023. The Royal Orthopaedic Hospital NHS Foundation Trust has championed the needs of patients with learning disabilities and autistic patients through ensuring it was a quality priority for this period. This continues through the implementation of the Learning Disability and Autism Strategy, which will be ongoing throughout the next year. Through greater understanding of learning disabilities and autism health inequalities can be reduced and health outcomes be improved.

The Transition to Adult Services Team has developed over the past year and continues to support the needs of young people and young adults with long term health needs moving from paediatric Servies to adult services within the Royal Orthopaedic Hospital NHS Trust. We are hoping to future proof the service by aligning with the NICE (NG43) guidelines for transition to adult services to produce a gold standard service for children and young adults moving through the trust to reduce health inequalities for children and young adults. We continue to use the Ready, Steady Go, Hello program to give young people the knowledge and confidence to manage their condition, empowering them with the skills and knowledge they need moving into adult services.

Dementia and Mental Health has been growing in importance on the health agenda. Standards have already been set by NHS Implementation plans, Liaison Psychiatry and NICE guidelines etc. The Royal Orthopaedic Hospital has employed a Dementia and Mental Health Practitioner. There are recommendations within this report as to the future direction the Royal Orthopaedic Hospital needs to take in terms of training for staff. Moving forward a Mental health Policy and Dementia Plan will be developed to support the staff delivering care.

ROHTB (9/23) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2023 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Stephen Washbourne, Executive Chief Finance Officer**
AUTHOR:	**Stuart Lovack, Deputy Director of Delivery**
DATE OF MEETING:	**6 September 2023**

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 2023 NHS Core Standards profile.

The review process has identified 10 areas of partial compliance against the 2023 EPRR Core Standards and 2 area of partial compliance against the EPRR Training Deep Dive.

The 10 areas of partial compliance against the 2023 EPRR core standards are:

- Governance – EPRR Board Reports
- Training & Exercising – Responder Training
- Warning & Informing – Incident Communication Plan
- Warning & Informing – Media Plan
- Business Continuity – Data Protection & Security Toolkit
- Business Continuity – BCMS Monitoring & Evaluation
- Hazmat/CBRN – Hazmat/CBRN Planning Arrangements
- Hazmat/CBRN – Equipment - Preventative Programme of Maintenance
- Hazmat/CBRN – Hazmat/CBRN Training Resource
- Hazmat/CBRN – Staff Training Recognition & Decontamination

In relation to the 'ERPP Training Deep Dive' the areas of partial compliance are:

- EPRR Training - Monitoring
- EPRR Training – Continuous Improvement Process

The Trust through the self-assessment process has graded itself as 'Partial Compliant'.

An 'action plan' forms part of the EPRR Core Standards spreadsheet for the areas identified as partial compliant.

The overall timescale identified for completion of these areas (where achievable) is twelve 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 2023 NHS Core Standards, noting the actions being taken to address the areas where EPRR 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 name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	The organisation has appointed an Accountable Emergency Officer (AEO - Steve Washbourne) 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 will be further supported by an Emergency Planning/Sustainability Officer (Bernie Sheridan). The Trust has a Non-Executive Director (Richard Phillips) identified to suppot this role.
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. 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.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has an EPRR Strategy which has been reveiwed/agreed, a Memorandum of Understanding for Mutual Aid dated 2014 was agreed with neighbouring local Trusts. The Trust is part of NHS Birmingham and Solihull and a meber of Health Emergency Preparedness Officers Group (HEPOG). Work plans are focussing on Business Continuity Management, current documentation is in the process of being reviewed and updated. An Emergency Planning budget has been established for the organisation. Emergency Planning support has been identified and agreed. Organisation is committed to supporting EPRR process and has plans in place.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	The 2021 Core Standards were reported publicly at the Trust Board on Wednesday 6th October 2021. The 2022 Core Standards were discussed at Executive Level. The 2023 Core Standards will be reported publicly to the Trust Board in 4th October 2023 following this year's self-assessment completion and validation.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning aspects are embedded into the Trust. An annual work plan has been developed and is monitored, work plan covers annual exercising , communication cascade, business continuity and risk management. The Trust is a member of HEPOG. An ICC desk has been established at the Trust to cover the additional reporting requirements needed during the COVID-19 Pandemic and continues to operate Monday to Friday.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource 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 are embedded into the Trust, Strategic Command Training developed to a over 28 staff members. The Trust has succesfully recruited to the role of Emergency Planning Officer. An annual work plan has been developed and monitored. Additional resources allocated to respond to the COVID-19 pandemic continues to be commissioned. The Trust have an established and agreed budget for Emergency Planning.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Continuous improvement forms part of our Emergency Planning policies/philosophies. Training programmes are offered/cascaded to our staff in the form of refresher Decision Logging, The Context & Personal Awareness of EPRR, The Role of the ICT & BCT Staff, Tabletop Exercise walk through, Strategic Briefing & Refresher Updates. Stragetic Commander Training was delivered to 28 staff on 8th june 2023. National and regional exercise reports are revewed, any lessons learnt which are transferable are implemented. The Trust has an EPRR Strategy document, a statement has been added for lessons learnt regarding timelines, tracking and monitoring.
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 all relevant risk registers including community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Risk Register has been developed for the Trust, risks are reviewed on a regular basis. The Trust has a risk management process in place, all risks are recorded on the Ulysses System. High level risks are escalated to the BAF. If risks need to be escalated to the LHRP then this will be done through the various groups/forums which are in existence. Processes are in place for dealing with adverse weather.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	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. Risk reigster is reviewed regualarly by the EPO and any issues escalated to the EPRR Group meeting. There is an escalation process in our risk management policies/procedures. The risk profile for each department has been embedded
Domain 3 - Duty to maintain Plans																	
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust have a policy on the 'Development, Approval and Management of Trust-wide Policies'. All policies go through a full review process. The Trust is a member of the Health Emergency Preparedness Officers Group. The Trust works in partnership with other Emergency Planning Leads and is part of the regional EPRR Network. There are processes in place to keep our internal stakeholders up-to-date.
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents 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 & Major Incidents'. The Trust has an up-to-date Incident Response Plan. The plan is tested during exercise in accordance with CCA guidance. The footnote indicates Incident Response Plans latest version. Terminology and contact section updated in October 2022.

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11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Department registered with the UK Health Security Agency Met Office, regular weather notifications received. The temperatures across the site are monitored by the Building Management System, thermometers are present locally in key areas. Adverse Weather Plan developed and circulated. The Trust's 'Heatwave Plan' has been incorporated in an 'Adverse Weather Plan'. The 'Heatwave Plan for England' is available on the Emergency Planning Portal on the Trust's Intranet site. Heatwave checklists are available and guidance on medications likely to provoke or increase the severity of heatstroke. Met office reports received during hot weather period and cascaded to key stakeholders. The Trust's 'Inclement and adverse weatther policy & procedures' and 'Cold Weather Plan for England' are available on the Emergency Planning Portal on the Trust's Intranet site. Met office reports received during cold weather period are cascaded to key stakeholders.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust have a number of policies which cover infectious dieases management, these can be found in the Trust's Clinical Hub. They include a major outbreak policy, a standard infection control precautions policy and an isolation policy which details the precautions required for many organisms. The Trust has as up-to-date VHF policy and policies for commonly seen organisms such as MRSA, C.difficile, MDROs, influenza etc. COVID-19 is now 'business as usual' and incorporated into the relevant polices such as the Isolation Policy. The IPC Team regularly meet with system and regional partners to monitor regional and national rates of HCAI and new and emerging pathogens.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	COVID-19 is now 'business as usual' and incorporated into the relevant polices such as the Isolation Policy. The IPC Team regularly meet with system and regional partners to monitor regional and national rates of HCAI and new and emerging pathogens. IPC Plans in place.
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust during the COVID-19 outbreak have worked with our neighbouring hospital to provide step down orthoapedic care for trauma pateints. The ROH have partnered with our neighbouring Trust and provided access to our theatres and supported the transfer of clinical staff between sites. We are not a receiving hospital; the Trust are aware of NHS England's Guidance for the requesting and receipt of countermeasures.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust is a member of NHS Birmingham & Solihull Health Emergency Preparedness Officers Group. The Trust has fostered good relationships with other local Trusts and EPRR locality Leads. We are a Specialist Elective Orthopaedic Trust and have the ability to flex clinical services to meet the demands of 'Mass Casualty', as detailed in the National Guidance for the treatment of Orthopaedic patients. Narrative has been added to the IRP indicating 20% of our bed capacity equates to circa 24 beds. During the Covid-19 pandemic outbreak we have worked with neighbouring Trusts and changed our model excepting 'step-down' trauma cases for UHB, our theatres have also been staffed/used by UHB colleagues.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has an up-to-date Hospital Evacuation and Shelter Plan in place. The plan has been reviewed and now incorporates the Trust's lockdown procedure. Off-site transportation services to be tested at a future exercise.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Y	Y	Y			Y					Y	Y	The Trust has an established 'Lockdown' procedure in place which is detailed in a standard operating procedure. A minimum of two porters are on site all at times. A security officer is on site 24/7. Lockdown procedure has been embedded into the Hospital Evacuation and Shelter Plan.
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	The Trust has a Private Patient policy, we have identifed an area whin the hospital to cater for VIP's. The Trust has a VIP Action Card incorporated in the Trust's Incident Response Plan.
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Y	Y	Y			Y					Y		We are a specialist orthopaedic hospital and understand our role within a multi-agency response. We do not have mortuary or post mortum facilities on site, we have a two place body storage facility. The Trust have arrangements in place with our neighbouring Trust UHB who will provide additional mortuary support as required. We are in the same Coromer's District and have inter-Trust arrangements in place to support UHB in step down care.
Domain 4 - Command and control																	
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. 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	Processes are described in the Trust's Emergency Preparedness Resilience and Recovery Strategy document. Escalation process is detailed in the 'Bleep Holder Pack'. EPRR and Executive Director's On-call arrangements are in place 24/7. Strategic command training delivered to Senior Managers.

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21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Strategic commander training was delivered through an external facilitator on 8th June 2023. The training session was delivered to approx. 30 members of staff which included Directors, senior staff and key individuals. Additional training to be scheduled as necessary throughout the year. EPO's and Chief Nurse has attended the National Training session on Priniciples of Health Command.
Domain 5 - Training and exercising																	
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training programmes are cascaded to our staff in the form of Decision Logging, The Context & Personal Awareness of EPRR, The Role of the ICT & BCT Staff, Tabletop Exercise walk through, Strategic Briefing & Refresher Update. Bleep Holder trainining is scheduled and delivered throughout the year. Additional training to be scheduled as necessary throughout the year.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Six monthly Incident Response Communication Cascade exercise delivered on 11th September 2022 and 24th July 2023. Cyber security walk through test exercise undertaken between 1st June to 15th June 2022. Tabletop Cyber exercise undertaken on 7th December 2022. Strategic command exercise training delivered on 8th June 2023 to strategic commanders. Live exercise to take place on 2nd September 2023.
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business continuity training delivered to staff. Strategic command training delivered to staff. Principles of Health Command Training completed by EPO's and Chief Nurse.
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust accesses external facilitorators to delivery EPRR training. The Trust trains key individuals in 'Bleep Holder On-call' and 'Incident Control Room Activation and Operation'. Training records are held centrally. Business Continuity Training delivered to key staff throuhgout the organisation.
Domain 6 - Response																	
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust accesses external facilitorators to delivery EPRR training. The Trust trains key individuals in 'Bleep Holder On-call' and 'Incident Control Room Activation and Operation'. Training records are held centrally.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Documentation available on the Trust's Intranet site, on sharepoint and in hardcopy format.
28	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	The Trust has systems and processes in place to deal with business continuity incidents. The Trust has a 'Clinical Site Co-ordinator' on site 24/7 and a well established escalation and on-call procedure. An Executive Director is on-call 24/7. Business continuity plans have been reveiewed in each department.
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Key response staff are aware of the need to keep comprehensive records during an incident, the 'Bleep Holder On-call Training' and 'Incident Control Room Activation and Operation Training' covers this element. The Trust has a small team of loggists who have been trained and are available upon request. The loggists are in process of completing refresher training.
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust receives an operational Sitrep report, three times a day. The Trust through the ICC desk monitors incoming emails. The Trust has an established system in place to receive, complete, authorise and submit situation reports.
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Y												We are not a receiving hospital however the guidance is available and can be found on the Trust's Intranet site under Emergency Hub/Emergency Planning Documents.

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32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y													Not applicable.
Domain 7 - Warning and informing																	
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Head of Communication and his team are aware of their role during a critical or major incident. Access to a communications officer is available 24/7 through email link or telephone. Communications and Marketing Plan in place and in date.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has an active Media Policy. The Incident Response Plan incorporates an action card for the 'Communications Manager'. EPO to work with Trust's Communication Department to develop a crisis management communication plan.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, 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 'Incident Response Plan'. The Trust maintains active channels of communication with local groups/organisations. The Trust's Communication Department liaises with its key stakeholders.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	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. EPO to work with Trust's Communication Department to review plans.
Domain 8 - Cooperation																	
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	Y	Y	Y			Y	Y		Y			Y	AEO attends Local Health Resilience Partnership meetings.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	Y	Y	Y			Y	Y		Y			Y	The AEO or EPO attends and has delegated authority at the Birmingham and Solihull Health Emergency Preparedness Officers Group meetings. The Trust is willing to attend any further emergency planning related meetings.
39	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. In line with current NHS guidance, 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	A Memorandum of Understanding for the mobilisation of NHS resources in the event of a significant Health Protection incident has been in operation since 1st April 2014. The Trust has supported other local Trusts during the COVID-19 pandemic and continues to work with it's neighbouring Trust UHB. The AEO or CEO or Executive Director Lead/On-call will have the authority to request/sign-off for mutual aid.
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y	Y			Y	Not applicable.
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					Not applicable.
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.								Y		Y				Not applicable.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Memorandum of Understanding document has been signed by local Trusts in 2014. Open protocol arrangements with Emergency Planning organisations are in place. NHS Local Resilience Partnership Representation Agreement and Information Sharing Document in place.
Domain 9 - Business Continuity																	
44	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) that aligns to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity Recovery Plan is active and up-to-date. The plan includes a commitment to the principles of a Business Continuity Management System.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
45	Business Continuity	Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity Recovery Plan incorporates scope, objectives and details a risk management approach. The information is disseminated throughout the organisation.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity Recovery Plan incorporates scope, objectives and details a risk management approach. The information is disseminated throughout the organisation.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has 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 organisation has an electronic repository (Shared Folder) for Business Impact Assessments, departments are asked to update their BIA's on an annual basis. Check and challenge is currently underway, together with Business Continuity testing.
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust's tabletop and live exercises cover business continuity. The most recent exercise being a cyber security walkthrough test exercise undertaken on 7th December 2022. Cyber secuirty testing is a feature within the Trust.
49	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 Trust is approaching the standard, we have an improvement plan which has been approved by NHS Digital.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Emergency Preparedness, Resilience and Response Group monitors our Business Continuity Management Systems. The TOR's for the group include Business Continuity plans as a key objective. The group reports upwardly to the Health & Safety Group which reports through to the Quality Safety Committee and through to the Trust Board. An annual EPRR report is due.
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Business Continuity process is audited and outcomes are recorded. Check and challenge is currently underway with departments to ensure their BIA plans are up-to-date. Check and challenge process has been completed with all Wards and Departments which is our audit process.
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Business Continuity systems are reveiwed Bi-annually, lessons learnt are incorporated into further planning to foster a system of continuous improvement. All department have been re-assessed in 2023.
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust gains assurance through the Procurement Hub who have processes in place to ensure key suppliers to have Business Continuity systems in place. It is written within procurement specifications/documentation that Business Continuity Planning is essential to ensure continuity of services. National and regional framework agreements are in place. Check and challenge processes are in place for critical suppliers.
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon			Y											Not applicable.
Domain 10 - CBRN																	

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Y	Y	Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan which details key contact numbers, procedures and how to deal with potentially contaminated persons. The document also contains action cards.
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Y		Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan in place and the 'Planning for the management fo self presenting patients in healthcare settings' NHSE guidance document is available on our Trust intranet site.
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Y		Y			Y					Y		The Trust is not a receiving hospital however, it has a CBRN Plan in place and the 'Planning for the management fo self presenting patients in healthcare settings' NHSE guidance document is available on our Trust intranet site.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Y		Y			Y							As a Specialist Trust we do not have an Emergency Department however we have appropirate 'Personal Protective Equipment' (PPE) to ensure safe delivery of care to potentially contaminated persons. We have CBRN Plan and the Public Health England documentation 'Chemical, biological, radiological and nuclear incidents: clinical management and health protection' available in our emergency planning documentation. The CBRN Plan is based on the guidance from the 'Planning for the management of self-presenting patients in healthcare settings'. FFP3 Fit Testing Programme in place.
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y													Not applicable.
60	Hazmat/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. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed 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	Y	Y		Y			Y							As a Specialist Trust we do not have an Emergency Department however we have appropirate 'Personal Protective Equipment' (PPE) to ensure safe delivery of care to potentially contaminated persons. We have CBRN Plan and the Public Health England documentation 'Chemical, biological, radiological and nuclear incidents: clinical management and health protection' available in our emergency planning documentation. The CBRN Plan is based on the guidance from the 'Planning for the management of self-presenting patients in healthcare settings'.

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61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Y		Y			Y					Y		The Trust is not a receiving hospital however, it has a CBRN Plan in place.
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y													Not applicable.
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Y		Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan in place and plans to deliver CBRN training to key staff.
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Y		Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan in place. The Trust have a FFP3 fit test programme in place.
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Y		Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan in place. The Trust have a FFP3 fit test programme in place.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Y		Y			Y							The Trust is not a receiving hospital however, it has a CBRN Plan in place. To be incorporated into future EPRR testing and exercising.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.			Y											Not applicalbe.
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.			Y											Not applicalble.

REPORT REF: ROHTB (9/23) 014

TRUST BOARD

DOCUMENT TITLE:	**Revised Board Assurance Framework (BAF) Report – August 2023**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
PRESENTED BY:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This reported is intended to summarise the proposed changes to the way in which the Trust's Board Assurance Framework (BAF) is structured and presented.

The purpose of a Board Assurance Framework

Assurance goes to the heart of the work of any NHS board of directors. The provision of healthcare involves risk and being assured is a major factor in successfully controlling risk. Assurance is the bedrock of evidence that gives confidence that risk is being controlled effectively, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed.

The simplest purpose of the BAF is to bring together in one place all of the relevant information on the risks to the board's strategic objectives. It provides an effective methodology for boards to help them use their BAF productively so that they have real confidence that they are providing thorough oversight of strategic risk.

The BAF is also of vital regulatory importance. The well led framework of both NHSE and the CQC requires the boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include a board assurance framework being in place, which is assessed by the board, reflecting risks to the initiatives in the strategic plan.

The requirement to have a BAF forms part of the relevant governance codes and frameworks and is applicable to all providers of health and social care services in England whether the entity is private, public sector, not-for-profit or charitable.

There is some ambiguity and differences of opinion around whether a BAF should be used, quite literally, as a wider mechanism for managing a Trust's assurances to the Board; or whether the BAF should be used as the key document used to record and report on an Trust's risks, controls and actions that drive towards its achievement of its strategic aims and objectives.

Guidance from NHS Providers suggests that the correct approach for Trust boards should be to align their BAF to their strategy and/or strategic objectives.

The Revised ROH Board Assurance Framework

New Strategic Risks

The drafting and publication of the Trust's new strategy for 2023/2028 provided the ideal opportunity to review and reflect upon the current iteration of the Trust's BAF.

Upon review of the 'current' BAF it was apparent that the risks populating it were more akin to high level current operational risks that were not sufficiently clearly, nor adequately, aligned to the specific strategic objectives of the Trust.

In essence, the risks were of clear strategic relevance and significance in terms of their impact but were not framed or worded in a way that reflected the actual risk to delivery and implementation of each of the specific objectives set out in the Trust Strategy. There were no overarching high level risks that directly correlated with the actual aims and objectives of the strategy and the risk to its delivery.

Based on the review and based on the new Trust Strategy it is proposed that the Trust adopts a BAF that carries 6 overarching, high level risks that correlate and align directly to each of the 6 new strategic objectives (Our Care, Our Expertise, Our People, Our Community, Our Services and Our Collaboration).

In the enclosed revised BAF you will see that there is a newly proposed risk that summarises the risk to achievement of each specific objective, with the potential causes and consequences set out within the narrative of each risk.

Risk Appetite Statements

You will also see that the BAF includes a provisionally drafted a risk appetite statement for each of the 6 newly proposed strategic risks. Having risk appetite statements for each of the strategic risks is a key means of enabling the board to measure its tolerance of the strategic risks and is an important tool in terms of the Boards ability to measure the adequacy and success of the controls and mitigations put in place to reduce the risk of non-delivery of the strategic objectives.

Having risk appetite statements for each key strategic risk is considered to be best practice in term of risk management and governance and was a recommendation from our last risk management audit.

Risk Mapping

In addition to the newly proposed 6 strategic risks and the corresponding risk appetite statements we have also undertaken a process of mapping all of the current high level operational risks that currently populate our Corporate Risk Register and our 'current' BAF, as these are the day to day operational risks and issues that, through on-going control, mitigation and forward looking action plans, really strike to the heart of the Trust's ability to reduce the risks to delivery of the new Trust Strategy.

The alignment of these risks is a means of assurance that both strategic and high-level risks are being controlled and mitigated or will enable gaps to be identified and addressed.

The Trust Board is asked to consider and discuss the proposed changes described above and as set out in the enclosed report. Feedback and comment would be gratefully received.

Next Steps

Subject to approval, further work is needed to revise, amend and improve the mapping of the high-level operational risks that are aligned to the risks to delivery of the Trust Strategy.

Work is planned to ensure all relevant risks are captured; that the risks are well articulated; that the mitigations and future actions are clear and up to date; and that the sources of assurance for the controls is comprehensive. There is also work alongside this to check and challenge the current entries on the Corporate Risk Register to ensure that they truly represent the most serious operational risks to the Trust.

The presentation of the aligned risks, so they provide a sufficient level of assurance and detail, will also be refined and improved over the coming weeks and months.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Alignment of BAF to strategic objectives is in line with true purpose of BAF and follows relevant risk management guidance and best practice. • Proposed new strategic risks have risk appetite statements	• Mapping of current high-level risks to new strategic risks is a work in progress

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: consider, discuss and approve the proposed changes to the Board Assurance Framework.

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

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

Comments:

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

Links directly to the strategic priorities set out in the new Trust Strategy

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

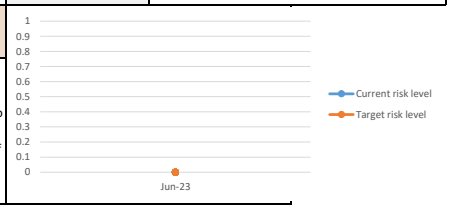
Duty to collaborate and many risks align to the wider System risks

PREVIOUS CONSIDERATION:

One to one meetings have been held with each of the Trust Executives to inform the creation and framing of the new BAF.

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of being rated as 'outstanding' by the CQC by 2028 if we are not able to :-maintain current standards of service and patient care; are not able to continue to provide the current levels of assurance; if we are not able to build upon those baselines standards by optimising pathways to ensure they are seamless and patient centred; enabling patient-led booking via implementation of innovative ditigal technologies; and if we do not have enough staff and resources and/or the physical environment needed to deliver the highest quality of care, which could have the consequence of being deterimental to patient safety, the quality of service we provide and ultimately our reputation as a Trust.					**Strategic objective:**	**CARE - By 2028, we will be rated as 'outstanding overall' by our regulators, the Care Quality Commission. This will indicate that we are achieving the highest levels of care and quality.**

Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	4	4	4		
Initial Date of Assessment	Aug-23	**Likelihood**	3	3	1		
Last reviewed	N/A	**Risk Rating**	12	12	4	The Trust has a low/no tolerance to risks that havde the potential to negatively impact the quality of care we provide and the safety of our patients	
Last changed	N/A						

Alligned Risks	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**
Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	Patients are screened prior to admission: Emergencies undergo a "Boarding Card" process. This is mature and embedded. Elective cases start a consent process at the time of listing and through the Pre-operative clinic any further concerns or issues around co-morbid conditions or potential organ support post-operatively are developed and discussed. Staff are aware of the isolated site and of the need to ensure that patients who may encounter a ceiling on care are treated elsewhere or consented appropriately. Deteriorating ward patients are identified and managed by a coordinated rota of clinical, nursing and rapid response team staff. The Trust has a Level 2 critical care facility with excellent outcomes audited through the national network. It is possible to provide ventilation support on site for required periods if necessary. Through a combination of ICS partnerships, custom and practice and partner SLAs, staff are able to call assistance to the ROH site if appropriate or transfer patients out of the Trust to partner organisations where necessary. There is a clear escalation policy. Cases where escalation in care are reviewed through incident reporting and in clinical morbidity and mortality meetings as well as a data driven review at AQILA regularly on its workplan	Gaps in control and cases where there may have been a risk of an "invisible" or "implied" ceiling of care are discussed openly at the combined clinical morbidity and mortality meeting. There are cases also where after fully informed consent a patient may choose to agree a ceiling of care in order to access the safety benefits of receiving complex orthopaedic care in a centre where the experience and equipment are available to do so. The Trust has less control if a patient does require the expertise of our staff but at another site. Clinicians will normally refer onward or request access through honorary contracts and if necessary take experienced staff with them. Access to other sites facilities is monitored through strategic oversight groups for key partners and escalated if challenged. Service delivery issues on other sites can challenge patient flow and experience.Emergency transfers in, unplanned admissions to HDU, rapid response team activity and transfers out are all audited through the service units, divisions and AQILA on its workplan. The Trust is a net importer of urgent / emergency cases at a ratio of about 10:1. Unplanned HDU admissions and transfers out of the hospital must have incident forms and therefore can be tracked and reviewed through governance. All of these processes are subject to continuous improvement, both in the data to support them and in the quality of the upward reports. The Anaesthetic unit is in discussions with UHB partners about rotating staff and strengthening outflow pathways to UHB critical care. They also have links to the regional critical care network		Positive

Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts, however the Trust has bilateral oversight arrangements in place with partners it works with closeModerate harm or above triggers formal governance mechanisms, clinicians and clinical service units are empowered to manage no and low harm locally and have access to system overrides if patients require prioritisation. Clinicians have a tracker which is continuously improving. Audits have demonstrated high compliance with use and process / data quality issues which are being addressed. Patients transferred from outside the Trust must be assessed at the time of their first appointment by the clinician providing care so that harm / risk of harm and clinical priority from there are anchored.ly to mitigate this.	Outpatient tracker not yet in place. Ambiguity over clinical responsibility for management of co-morbid conditions with primary care during wait, particularly outpatient wait.	Divisional Governance, Divisional Management Board, Quality Report, Quality & Safety Committee	Positive
Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. The Trust takes care in assessing the capacity avialable for transferring patient cohorts and makes efforts to mitigate clinical risks associated through bilateral relationships with transferring providers. Ref also CE2 Prioritiation rules are well established and understood. To date clinical compliance has been good when audited.	There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts. External authorities may require mutual aid to be provided regardless of the Trust's own position as a part of managing and sharing risk on a regional or national scale, meaning that the Trust may have very limited control. Improvement and refinement of clinical prioritsation tracking and process. Care / forecasting and modelling before cohort transfer.		
1089 - risk relating to failure to meet national 52 week waiting time targets	All 14 theatres are operational and scoping three session days and weekend working. Continued monitoring of PTL to ensure delivery of P2/3 procedures in line with RCS guidance and speciality level/harm review process instigated where appropriate. Weekly delivery of performance against trajectory at system oversight and assurance group.	As part of the Trust strategy a business case is in development to deliver fully equipped 4 theatre day case unit with options to expand or replace theatre capacity	Regular operational and quality reports to:- Divisional Management Board, Divisional Performance Board, Ops Management Board, Sub-Board Committees, Exec Team, Trust Board, Joint Governance SOG boards, ICB Contracting and	Positive
656 - risk relating to delayed or missing imaging referals due to reliance on a paper based referral system posing a risk to patient safety, diagnostic standards, cancer target performance and overall compliance with national RTT targets	Electonic soluton via Order Comms system now implemented	N/A	Implementaion to be monitoried and reviewed before consideration of closure of this risk	Positive
1423 - risk relating to lack of strategic workforce planning		Development of an integrated workforce plan as part of new Trust strategy	Staff & OD Committee	
1783 - risk relating to high levels of employee turnover		Development of an integrated wirkforce plan as part of new Trust strategy	Staff & OD Committee	
1918 - Risk relating to patients no longer having access to specialist speech and language assessment and support	UHB have agreed if urgent they will provide review and advice, although this may be virtual. ROH will be invoiced on a case by case basis. Ensures ROH in-patients have access to specialist service if urgent need identified. Dysphagia protocol available to staff. Provides advice and guidance on managing patients with swallowing difficulty.	Locum SLT identified, previously worked at ROH, who will be able to work a Thursday at ROH. They have joined an on framework agency and are just completing required mandatory training. This will not provide any sickness or annual leave cover and they are unable to work more than 1 day a week. This will however ensure patients are assessed and seen. Assured by Chief Nurse that this is being discussed at system level as current plan does not offer any resilience.		
Risk relating to patients not having their dietary needs assessed and met as a result of lack of suitabilty skilled and trained staff employed by the Trust	0.4WTE Locum dietitian employed by UHB who will provide patient reviews 1 day per week and remote advice/review 1 day week. Ensures some access to specialist dietetic advice for ROH patients.	Deputy Finance manager and Head of Nursing met with Birmingham Community lead nurse. Proposal to support ROH has not yet been signed off by operational leads there so cannot progress at the moment. Awaiting update. Locum dietician remains in post.		

Risk 27 - risk relating to Inability to control the use of unfunded temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	Recurrent use of agency staff is now limited to specialist areas such as Paediatrics, HDU and theatres, all of which are areas influences by national shortages. Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. A rota co-ordinator is in place and focuses on weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce	Development of an integrated workforce plan as part of new Trust strategy		
Risk 770 - risk relating to aged theatre plant	Theatre Maitenance Plan - 1st phase of Theatre maintenance was successfully completed in April 2022 (Theatres 5, 6 and 7 and Ward 2). Second phase was successfully completed in August 2022 (Theatres 9 and 10 and Ward 1). Further work scheduled for April 2023 (Theatres 11 and 12), August 2023 (Theatres 3 and 8 and Ward 4) and November 2023 (Theatres 1, 2 and 4 and Ward 10/12). Emergency maintenance has been completed on Theatres 14 and 15 and Ward 3 in January 2023, other works to continue as planned.	Day Case Unit, which would free up capacity to replace aged theatre plant		
791 - risk relating to number of Trust policies overdue for review	The pathway for policy approval remains robust as per the Policy on policies. This policy continues to provide clarity on mechanisms for approval, both for new and/or substantially revised policies and for policies needing minor amendment. Oversight is provided by the Corporate Governance Manager who reports to the Director of Corporate Affairs & Company Secretary. The Executive Team considers a routine policy status report, which is broken down by individual directorate to allow easier assessment of the status of policies in the various areas.		Regulary Policy Compliance Report submitted to Exec Team and Clinical Quality Group	
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	Staff Heath and Wellbeing programme. HRM team working with managers to practically manage absences. Further embedding of staff requirement to take leave for rest and recuperation. Human Resources and OD teams working on action plan to address high level of health related absences. BSOL looking to getting recurrent funding to keep making recurrent offer to staff.	Development of an integrated workforce plan as part of new Trust strategy		
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	Offer by Smith and Nephew to support an analyst within the Informatics department to support Clinical Informatics Transfer of legacy 20 year outcome data from an old Macintosh system – this information has clinical and potentially financial value in establishing funding streams to secure the future outcomes work Work with Amplitude clinical outcomes database provider to provide clinicians with improved access to their individual outcomes data and the Trust with clinical outcomes data that will provide assurance around clinical practice across the Trust			

Risk 1181 - risk realting to lack of abilty for IT systems to flag safeguarding alerts	Staff are requested to email leads in the areas with separate IT data base systems i.e. Oncology ONKOS, X-Ray CRIS and PACS and Therapies - TiRIA as these systems do not pull alerts from PAS Lorenzo system. The email address for leads in all areas have been included in every purple folder to ensure staff can communicate alerts required to the correct areas. Flow chart made to explain to staff how to add information under patient needs tab on PAS/ Lorenzo.	IT are now working with Safeguarding and Learning Disability Teams to develop a database to mitigate risk on Safeguarding Risk Register. PICS has been identified as 6 versions behind, with the most up to date version addressing key parts of this risk. UHB to explore how to deliver this update.	the risk and action plan as well as any issues/incidents relating to this are monitoried at the Safeguarding Committee	
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	Outpatients under 16 years seen in a specific CYPOPD setting. Managed by Registered Children's Nurses. Policies and procedures specific to under 16s in place. Transition process commenced. 16-18 year old's nursed in adult wards. Policies and procedures for 16 + in place. Including safeguarding. Transition nurse in post and involved in care pathway of complex cases. On call anaesthetic registrar and consultant surgeons on 24/7 call. SLA between BWCH and ROH established. Children Matron in post one day a week	ICS working allow for advice and guidance from BWCH for under 16s.	Incidents monitored via Children's Board	
Risk No 1919 - Risk relating to potential patient harm due to possible failure of current blood glucose meters which could result in insufficient monitoring devices within the Trust	Asset register of current devices available and monitored. All areas who require blood glucose monitors currently have at least one device	Procurement of new meters		
Risk 1467 - Risk relating to non-compliance with blood transfusion standards as a result of no Transfusion Practitioner dedicated to ROH.	Blood training deliverede as part of mandatory training day by the Interim Head of Nursing. Priorities areas identified with UHB leads and named individuals responsible (whilst no TP in post) identified which has provided assurance to UHB (traceability and SHOT - interim Head of Nursing/Blood Fridges - Theatres Human Tissue Lead. UHB are assured they have a named contact who they can liaise with regarding any concerns or issues. Policies in place, monitored by UHB.	Head of Nursing is having discussions with TP service to explore a development post with UHB oversight and Head of Nursing continuing to support.		

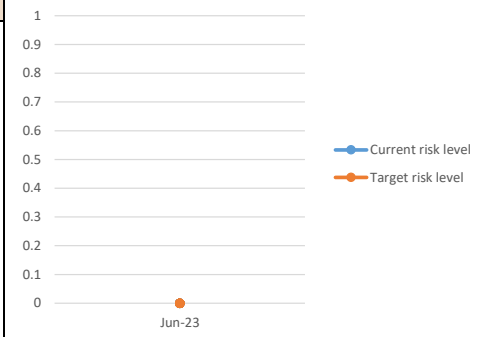
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the All managers being encouraged to plan leave and carry over pro-actively Wellbeing day has been provided to staff	Annual Leave uptake remains on trajectory. Revised annual leave policy to incorporate buying and selling annual leave now been consulted on and is to be presented to Execs for ratification before roll out		
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	Production and authorisation of rotas 6/52 week ahead. Confirm and Challenge meeting are in place to ensure Rotas are produced and worked effectively. Feedback to the Trust 6-4-2 process on any gaps in the nursing workforce to allow amendments to the Trust activity plans where appropriate Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm ROH International recruitment plan in place, target 40 nurses by December 2023, targetting Theatres which hold the largestvacancy risk at present.	Planning international nurse recruitment to complete by December 2023 which a total of 40 nurses in country and trained. Over the summer open days will take place. There is work ongoing to explore transformational roles such as top ups to degree nurse apprentices and TNAs recruitment is underway for next cohort to start in September 2023, business case approved.		
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	Paediatric wait times have now reduced to 15 weeks which is an improved position from January 2023 wait times of an excess wait times of 25 weeks. Adult physio wait time is currently sitting at 31 weeks, the wait times, reflect the physio wait time nationally with incrased demand against capacity shortage. Actions and mitigation in place: - Invite to patient to use GetUBetter app sent to all eligible patients waiting self managmentment too prior to appointment. - Demand and capacity to be finalised to ensure service has sufficent resource to supoort the demand - Plan recruitment campaign linked to new department - 6.5 WTE appointed - Introduction of Dr Doctor opportunites to help help to reduce DNAs and late notice cancellations Paper with position statemnet , trajectories for improvement will be presented at April FPC and monitored monthly at divisional level, included in FPC pack going forward from April 2023.		Monitored at F&P Committee and any potential harm is channled through divisional governance processes.	

Risk 1887 - Risk that air conditioning unit will fail causing the temperature within the Theatre specimen room to raise beyond a safe level. This will affect quality and safety of all Blood and Human Tissue products stored within the specimen room; rendering them unusable and wasted.	Estates have contacted the external engineering company and will liaise a time to carry out works. Temperature is within normal limits after a temporary repair put in place. Resilience flowchart created in order to plan for if this should happen again. Identification flowchart created for staff to follow in the event of a facility failure. This has allowed the trust to provide limited solutions until a more permanent solution can be found or financed in order to meet current regulations. Current processes in place to identify a concern early. In the event of a complete failure and raise in temperature requiring immediate removal of blood/blood products we could utilise blood cool boxes to maintain cold chain compliance in the short term.	Confirmed by QE Transfusion leads fridges loaned for blood storgae purposes are unsuitable. Meeting with estates confirmed that current back up Labcold fridge can be removed from the specimen room and re located in new recovery . After mapping this can be used whilst works in place. Actions plans, risk assessment for QE quality leads completed (both attached to risk) and regular MDT meetings in place to ensure all required actions are taken to enable required works to take place whilst ensuring required regularory/legal MHRA/UKAS requirements are still met.	Blood Safety Group and HTA Group	
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	Twice weekly PTL meeting tracking all malignancy possible patients. Patients monitored and tracked until outcome known Escalation process in place for all potential cancer target breaches Turnaround times reported into monthly cancer board meeting Incident report delayed patients and cancer breaches	Joint contract meetings are recommencing and improvement plan to be agreed. Discussion with DCOO and CSL around scoping other histology services. SLA requires review - with clear plan for patients outside of SLA, and clear ownership of SLA	Monitored via Cancer board	
Risk 1895 - Risk of regulatory non compliance as a result of the Trust being unable to recruit a resuscitation officer. With this post vacant the trust is at risk of not remaining up to date with legislation/ guidance and changes in practice	The trust is using the expertise of an outside company to deliver training. The company are also supporting with updates and supporting a refresh of policies. Extenal company provide ILS training and currently hold the ILS lience in order to deliver training. The staff within the company are all clinical current and are ALS instructors. Training provision remain in line with UK resus council guidance and is reviewed by the company. A Resus officer is supporting the RRT lead to review and update the policy. A band 6 resus nurse is currently on secondment ensuring compliance with audit and ensure stock etc is readily available.	Post is back out to advert	Monitored via Resus Committee and Clinical Quality Group	
Risk 1938 & MD4 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	The Trust has a Medical Devices Advisory Group (MDAG) for new implants with good links to the Modern Interventions Panel (MIP) for new techniques. The MIP has clinical, transformation, operational and financial input as well as the facility to co-opt the Director and Head of Research for advice. There are clear criteria for how technologies are assigned depending on the level of evidence to support them. The Trust has used the IDEAL model successfully to weigh the level of scientific evidence. Those new technologies assigned to research have national research ethics and approval frameworks and methodologies which cover much of the risk management aspects around the evaluation. Sponsors for those new technologies assigned to service evaluation must demonstrate financial viability, operational application, training and preceptorship, patient information and recall arrangements. The lead must register an audit indicating when the follow up data will come back into the organisation. Clinicians are trained in consent and supported in Shared Decision Making by an active group with a clinical lead.	Evaluation of technology: Limited evidence about the technique. Sources of bias. Roll out: Finite ability to control and monitor cases and clinicians. Unit level and individual level responsibilities are covered however in normal GMC defined good clinical practice. Refinement of MIG process and approval. Learning when things go wrong. Consistent messaging to clinicians at approval stages.	Reporting through governance to quality and safety committee	

Risk MD2 - There is a risk of a shortfall of ward doctors due to the Deanery do not send the agreed number of GP trainees to rotate into the Trust. This may lead to gaps in the ward cover rota, clinical risk, reduced contact with the GP community or financial cost.	Post event mitigation: locum cover, exploration of expanding non-medical support – eg 24 hour rapid response, mid level provider numbers. Proactive clinical leadership from clinical lead for locums, clinical tutor in relationship management with th deanery, appointment of new Director of Medical education. Excellence in rostering and employee relationships through rota coordinator and learning hub administrative staff.	This is an intermittent issue as much as a risk – the trust encountered the situation in 2022. Discussion with the deanery around how the ROH is labelled on trainee choices and agreed quota numbers being re-explored. There is already an agreed rotation numbers which the deanery has not met and the Trust feeds back on. Structurally the Trust is exploring how others mid level providers may mitigate or remove any service dependence on this group. In the shorter term the Trust intends to Grow the Rapid response capability and cover Explore any opportunity that presents to cover wards wtih medical staff from other sources		
Risk 1089 - There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines. This will impact on an ability to meet the national Healthcare Information and Management Systems Society required level 5 be met, and we will fail to achieve Digital Capable Framework Compliance. This would put at risk the financial sustainability by restricting our ability to transform processes and deliver efficiencies.	Continue upgrade and expansion of functionality of current stand alone electronic systems, this would include, but not limited to; - PICS - ROCS Portal - Theatreman upgrade to AQUA - PAS replacement - Silo'd PAS systems - Tiara, OnKos. Data quality group focus on ensuring adequate controls are in place to deliver optimum data quality from existing systems. Perfecting pathways Board monitoring transformation of existing processes across service improvement group programmes of work and digital transformation. Cost Improvement Board (CIP) monitoring performance of CIP schemes to deliver maximum productivity and efficiency gains.	Development work underway with Safeguarding database. Digital pre-op with the implementation of Synopsis. Electronic outcomes pilot using VitalHub (InTouch) system (podiatry and hands) by end of May 2023. PAS - using a legacy PAS, which both has inflated costs and limited functionality. Replacement necessary and regional discussions about to commence		
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	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. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target. Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard. Will be picked up as part of 2023/24 financial planning process that has just started.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update.	

CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	International nurse recruitment at 26/40. Retention nursing action plan being developed and key work stream due to start to support retention. Open days taking place. Production of rotas 6/52 in advance. Feedback to Trust 642 process on any gaps in nursing workforce to allow amendments to the Trust activity plans where appropriate. Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations Ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm	Retention work Open Days Exploring and presenting business cases for TNA in Theatres		
Risk CL2 - There is a risk that the lack of suitable technology to automate the assessment of the Trust's delivery of care against the CQC key lines of enquiry that areas of poor compliance may not be visible.	Manual workarounds in place IT working on system updates	Issues have been raised in IM+T Board. Trust upgrade awaited		
Risk CL6 - There is a risk that poor mechanisms for staff engagement will limit the Trust's ability to demonstrate the linkage between the work of staff in all disciplines to the delivery of excellent patient care.				
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.				

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of being kitemarked as a Major Revision Centre and Surgical Elective Hub and will publish 30% more research publications. This could be caused by not having the neccesary capital and/or resource to enable growth, expantion and innovation and our ability to develop and train the next generation of NHS clinicians, nurses and leaders, especially in light of the current economic climiate in which the Trust, and the NHS more generally, is operating within. With the consequence being that we are not able to obtain and/or retain kitemarks and other accreditations, thus potentially diminishing our reputation, our ability to recruit and retain staff and students and our ability to address health inequalities in our regional patient demographic					**Strategic objective:**	**OUR EXPERTISE - Innovate, improve, research and teach - By 2028, we will be kitemarked as a Major Revision Centre and Surgical Elective Hub and will publish 30% more research publications. This will indicate our expertise**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	3	3	3		
Initial Date of Assessment	Aug-23	**Likelihood**	3	3	2		
Last reviewed	N/A	**Risk Rating**	9	9	6	The Trust has a higher level of tolerance to risks that involve innovation and service improvement which would enable us to grow and expand our expertise and our reputation as a specialist provider of orthopaedic care. It is accepted that in order to grow, expand, innovate and push the boundaries etc. the Trust needs to be bold and brave and at the forefront of change. However this has to be balanced carefully, especially in relation to clinical innovation, with a no/low tolerance of risk to patient harm.	
Last changed	N/A						

Alligned Risks	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	Offer by Smith and Nephew to support an analyst within the Informatics department to support Clinical Informatics Transfer of legacy 20 year outcome data from an old Macintosh system – this information has clinical and potentially financial value in establishing funding streams to secure the future outcomes work Work with Amplitude clinical outcomes database provider to provide clinicians with improved access to their individual outcomes data and the Trust with clinical outcomes data that will provide assurance around clinical practice across the Trust			

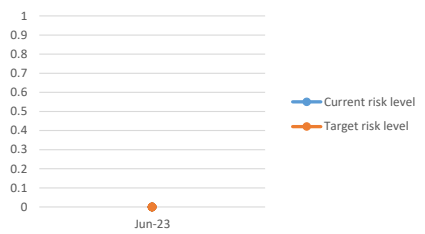
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the	Annual Leave uptake remains on trajectory. Revised annual leave policy to incorporate buying and selling annual leave now been consulted on and is to be presented to Execs for ratification before roll out		
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	Production and authorisation of rotas 6/52 week ahead. Confirm and Challenge meeting are in place to ensure Rotas are produced and worked effectively. Feedback to the Trust 6-4-2 process on any gaps in the nursing workforce to allow amendments to the Trust activity plans where appropriate Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm ROH International recruitment plan in place, target 40 nurses by	Planning international nurse recruitment to complete by December 2023 which a total of 40 nurses in country and trained. Over the summer open days will take place. There is work ongoing to explore transformational roles such as top ups to degree nurse apprentices and TNAs recruitment is underway for next cohort to start in September 2023, business case approved.		
Risk 1938 & MD4 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	The Trust has a Medical Devices Advisory Group (MDAG) for new implants with good links to the Modern Interventions Panel (MIP) for new techniques. The MIP has clinical, transformation, operational and financial input as well as the facility to co-opt the Director and Head of Research for advice. There are clear criteria for how technologies are assigned depending on the level of evidence to support them. The Trust has used the IDEAL model successfully to weigh the level of scientific evidence. Those new technologies assigned to research have national research ethics and approval frameworks and methodologies which cover much of the risk management aspects around the evaluation. Sponsors for those new technologies assigned to service evaluation must demonstrate financial viability, operational application, training and preceptorship, patient information and recall arrangements. The lead must register an audit indicating when the follow up data will come back into the organisation. Clinicians are trained in consent and supported in Shared Decision Making by an active group with a clinical lead.	Evaluation of technology: Limited evidence about the technique. Sources of bias. Roll out: Finite ability to control and monitor cases and clinicians. Unit level and individual level responsibilities are covered however in normal GMC defined good clinical practice. Refinement of MIG process and approval. Learning when things go wrong. Consistent messaging to clinicians at approval stages.	Reporting through governance to quality and safety committee	

Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts, however the Trust has bilateral oversight arrangements in place with partners it works with closeModerate harm or above triggers formal governance mechanisms, clinicians and clinical service units are empowered to manage no and low harm locally and have access to system overrides if patients require prioritisation. Clinicians have a tracker which is continuously improving. Audits have demonstrated high compliance with use and process / data quality issues which are being addressed. Patients transferred from outside the Trust must be assessed at the time of their first appointment by the clinician providing care so that harm / risk of harm and clinical priority from there are anchored.ly to mitigate this.	Outpatient tracker not yet in place. Ambiguity over clinical responsibility for management of co-morbid conditions with primary care during wait, particularly outpatient wait.	Divisional Governance, Divisional Management Board, Quality Report, Quality & Safety Committee	Positive
Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. The Trust takes care in assessing the capacity avialable for transferring patient cohorts and makes efforts to mitigate clinical risks associated through bilateral relationships with transferring providers. Ref also CE2 Prioritiation rules are well established and understood. To date clinical compliance has been good when audited.	There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts. External authorities may require mutual aid to be provided regardless of the Trust's own position as a part of managing and sharing risk on a regional or national scale, meaning that the Trust may have very limited control. Improvement and refinement of clinical prioritsation tracking and process. Care / forecasting and modelling before cohort transfer.		

Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	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. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target. Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard. Will be picked up as part of 2023/24 financial planning process that has just started.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update.	
CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	International nurse recruitment at 26/40. Retention nursing action plan being developed and key work stream due to start to support retention. Open days taking place. Production of rotas 6/52 in advance. Feedback to Trust 642 process on any gaps in nursing workforce to allow amendments to the Trust activity plans where appropriate. Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations Ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm	Retention work Open Days Exploring and presenting business cases for TNA in Theatres		
Risk CL4 - There is a risk that as a result of insufficient research funding the ability of the Trust to incease it's research profile and portfolio will be limited.				

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of being rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey. This has the potential to be caused by difficulties in recruiting and retaining staff at both a trust/local level and is also impacted upon by the difficulties the NHS is experiencing with recruitment and retention at a national level, which could have the potential to impact on the culture within the Trust and also potentially impact considerably on our abilty to deliver large aspects of the Trust's Strategy, for example our ability to provide outstanding care, our ability to continue to provide our current level of service, our abilty to expand and innovate, our inability to addres health inequalities within our region and our ability to collaborate and contribute to wider system work.					**Strategic objective:**	**OUR PEOPLE - Rated as among the best NHS hospitals to work for by our team - By 2028, we will rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey. This will indicate that we are supporting our most valuable asset; people**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	5	5	5		
Initial Date of Assessment	Aug-23	**Likelihood**	4	4	2	The Trust has a low tolerance for risks relating to our people and the recruitment and retention of staff, as being able to attract and retain staff is absolutely essential to not only our abilty to achieve our stategic objectives but also to our continued day to day delivery of services and care.	
Last reviewed	N/A	**Risk Rating**	20	20	10		
Last changed	N/A						



Alligned Risks	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**
1423 - risk relating to lack of strategic workforce planning		Development of an integrated workforce plan as part of new Trust strategy		
1783 - risk relating to high levels of employee turnover		Development of an integrated wirkforce plan as part of new Trust strategy		

Risk 27 - risk relating to Inability to control the use of unfunded temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	Recurrent use of agency staff is now limited to specialist areas such as Paediatrics, HDU and theatres, all of which are areas influences by national shortages. Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. A rota co-ordinator is in place and focuses on weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce	Development of an integrated workforce plan as part of new Trust strategy		
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	Staff Heath and Wellbeing programme. HRM team working with managers to practically manage absences. Further embedding of staff requirement to take leave for rest and recuperation. Human Resources and OD teams working on action plan to address high level of health related absences. BSOL looking to getting recurrent funding to keep making recurrent offer to staff.	Development of an integrated workforce plan as part of new Trust strategy		
Risk 1083 - risk relating to inabilty to defend Employment Tribunal claims due to gaps in process and record keeping in regards to employee records	Managers being provided with guidance on the importance of retaining employee records through Me as a Manager programme and regular meetings with Employee Relations Team.	options appraisal considered at Execs for system based solution. Further work required to obtain further quotes and then consideration to be given to formal procurement exercise.		
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the	Annual Leave uptake remains on trajectory. Revised annual leave policy to incorporate buying and selling annual leave now been consulted on and is to be presented to Execs for ratification before roll out		

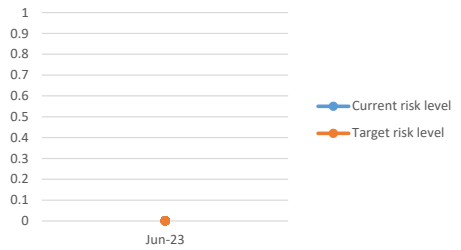
Risk HR11 - Risk relating to diversity of workforce in regards to recruitment and retention of BME staff	A review of the experiences of recently appointed BAME colleagues is taking place to identify whether there are any elements of unconscious bias taking place within the recruitment process WRES data (2020) indicates that since 2019 there has been: · an increase in BAME clinical colleagues at Band 6, change from 37 -47 staff members which equates to 27% · -Increase in BME clinical colleagues at Band 7, change 5 -11 staff members which equates to 120% · A Reduction in the likelihood of appointment from shortlisting for white candidate from 1.7 to 1.36 which shows positive impact for BME applicants · An increase in the % of Non Executive Board members from 0% - 11% Multi Minority Ethic Group has been established Chair for Multi Minority Ethnicity Group (MMEG) being recruited Inclusion Strategy and action plan to be finalised WRES action plan to be finalised Staff survey feedback from BAME colleagues to be incorporated into organisational action plan and inclusion action plan Model Employer recommendations to be reviewed and action plan to be developed accordingly 6 High Impact Inclusive Actions being developed and will roll out upon appointment of resourcing manager.	Initial review of WRES data suggests that further work is required to address disparity in shortlisting. Action plan being developed to bring through relevant governance routes.		
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	Production and authorisation of rotas 6/52 week ahead. Confirm and Challenge meeting are in place to ensure Rotas are produced and worked effectively. Feedback to the Trust 6-4-2 process on any gaps in the nursing workforce to allow amendments to the Trust activity plans where appropriate Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm ROH International recruitment plan in place, target 40 nurses by December 2023, targetting Theatres which hold the largestvacancy risk at present.	Planning international nurse recruitment to complete by December 2023 which a total of 40 nurses in country and trained. Over the summer open days will take place. There is work ongoing to explore transformational roles such as top ups to degree nurse apprentices and TNAs recruitment is underway for next cohort to start in September 2023, business case approved.		
Risk 1777 - risk relating to damage to employee engagement, staff retention and financial hardship to individuals as a result of Payroll errors	Error log has been set up for all payroll errors. Quality of service has been raised at UHB. Ensuring that payroll forms are completed properly.	Although error rate has reduced there is still some ongoing service issues such as delayed contract monitoring information being received in a timely manner arising due to reduced capacity from the payroll service provider - UHB. Procurement exercise for payroll being carried out with Birmingham Womens and Childrens NHS Hospital Trust.		

Risk 1886 - risk that continued industrial action will have a negative impact on attraction, recruitment and retention of staff.				
Risk MD2 - There is a risk of a shortfall of ward doctors due to the Deanery do not send the agreed number of GP trainees to rotate into the Trust. This may lead to gaps in the ward cover rota, clinical risk, reduced contact with the GP community or financial cost.	Post event mitigation: locum cover, exploration of expanding non-medical support – eg 24 hour rapid response, mid level provider numbers. Proactive clinical leadership from clinical lead for locums, clinical tutor in relationship management with th deanery, appointment of new Director of Medical education. Excellence in rostering and employee relationships through rota coordinator and learning hub administrative staff.	This is an intermittent issue as much as a risk – the trust encountered the situation in 2022. Discussion with the deanery around how the ROH is labelled on trainee choices and agreed quota numbers being re-explored. There is already an agreed rotation numbers which the deanery has not met and the Trust feeds back on. Structurally the Trust is exploring how others mid level providers may mitigate or remove any service dependence on this group. In the shorter term the Trust intends to Grow the Rapid response capability and cover Explore any opportunity that presents to cover wards wtih medical staff from other sources		
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	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. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target. Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard. Will be picked up as part of 2023/24 financial planning process that has just started.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update.	

CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	International nurse recruitment at 26/40. Retention nursing action plan being developed and key work stream due to start to support retention. Open days taking place. Production of rotas 6/52 in advance. Feedback to Trust 642 process on any gaps in nursing workforce to allow amendments to the Trust activity plans where appropriate. Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations Ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm	Retention work Open Days Exploring and presenting business cases for TNA in Theatres		
Risk CL5 - There is a risk that failure to deliver the ambitions set out in the ROH, System and National People Plan will compromise the ability of the Trust to provide the best experience for staf				
Risk CL6 - There is a risk that poor mechanisms for staff engagement will limit the Trust's ability to demonstrate the linkage between the work of staff in all disciplines to the delivery of excellent patient care.				

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of reducing health inequality by improving access for people in the most deprived 20% of our communities. This could potentially be caused by a lack of quality data to help identify this cohort of patients; a lack of a framework for the necessary outreach and engagement work; and a lack of resource to fund the work required to achieve this objective, especially in the current financial situation the Trust and the wider NHS are operating within and an inabilty to work collaboratviely within the BSOL ICB to ensure there is a jointed up system based arrpoach to talking regional health inequalities, the consequences of which would be no change or improvement in obtaining access or earlier access to health care for those wihtin our community who would benefit from earliewr access to health services, which in turn would help reduce the long term burden and cost to the NHS if treated earlier.					**Strategic objective:**	**OUR COMMUNITY - Work with our community to reduce health inequality and support prevention - By 2028, we will be reducing health inequality by improving access for people in the most deprived 20% of our communities. This will indicate that we are reducing health inequality**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	4	4	4		
Initial Date of Assessment	Aug-23	**Likelihood**	3	3	2	The Trust has a higher tolerance for risk in regards to tackling regional health inequalities. Earlier access to treatment for this cohort of patients is important in terms of reducing health inequalities within the region and thus in turn also helping reduce the long term cost and burden on the NHS. However, it is key to balance this with the reality of the current ecomnomic situation we as a Trust and the wider NHS are operating in and the pressure to prioritise the need to mainatian current levels and standards of service with the same/or less levels of resource and income.	
Last reviewed	N/A	**Risk Rating**	12	12	8		
Last changed	N/A						



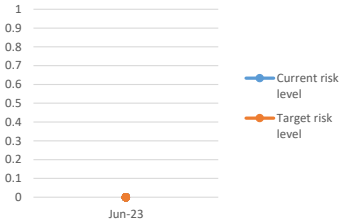
Alligned Risks	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**

Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the All managers being encouraged to plan leave and carry over pro-actively Wellbeing day has been provided to staff	Annual Leave uptake remains on trajectory. Revised annual leave policy to incorporate buying and selling annual leave now been consulted on and is to be presented to Execs for ratification before roll out		
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	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. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target. Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard. Will be picked up as part of 2023/24 financial planning process that has just started.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update.	

CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	International nurse recruitment at 26/40. Retention nursing action plan being developed and key work stream due to start to support retention. Open days taking place. Production of rotas 6/52 in advance. Feedback to Trust 642 process on any gaps in nursing workforce to allow amendments to the Trust activity plans where appropriate. Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations Ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm	Retention work Open Days Exploring and presenting business cases for TNA in Theatres		
Risk CL7 - There is a risk that as a result of limited resource to undertake engagement activities with Primary Care, there is reduced ability to access hard to reach communities.	Insufficient capacity to treat cohorts of patients from the most deprived communities due to the continuing operational pressures associated with mutual aid.			

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of increased the number of people we treat by 20% within our current resources (this figure will be adjusted as resources increase), which could potentially be caused by:- breakdown of aged theatre plant/estates; increased costs associated with staffing and retention levels; mutual aid and collaborative work within the BSOL system to ease waiting list pressure; increased demand for services via health inequality work plans; the risk of breaches of our cyber security defences; further financial controls imposed by BSOL ICB due to current system financial position, which could have the consequence of an increase in patient safety incidents as well as financial and reputational loss and poor compliance with national targets.					**Strategic objective:**	**OUR SERVICES - Efficient, effective and sustainable- By 2028, we will have increased the number of people we treat by 20% within our current resources (this figure will be adjusted as resources increase) . This will indicate excellent productivity and support more people to access treatment.**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	5	5	5		
Initial Date of Assessment	Aug-23	**Likelihood**	3	3	1	The Trust has a low tolerance for this risk due to the potential negative impact on our activity levels, the quality of our patient care and the financial implications for the Trust both as a standalone legal entity and as part of the wider BSOL ICB system	
Last reviewed	N/A	**Risk Rating**	15	15	5		
Last changed	N/A						



Alligned Risks (risks taken from current BAF and CRR)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**

Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	Patients are screened prior to admission: Emergencies undergo a "Boarding Card" process. This is mature and embedded. Elective cases start a consent process at the time of listing and through the Pre-operative clinic any further concerns or issues around co-morbid conditions or potential organ support post-operatively are developed and discussed. Staff are aware of the isolated site and of the need to ensure that patients who may encounter a ceiling on care are treated elsewhere or consented appropriately. Deteriorating ward patients are identified and managed by a coordinated rota of clinical, nursing and rapid response team staff. The Trust has a Level 2 critical care facility with excellent outcomes audited through the national network. It is possible to provide ventilation support on site for required periods if necessary. Through a combination of ICS partnerships, custom and practice and partner SLAs, staff are able to call assistance to the ROH site if appropriate or transfer patients out of the Trust to partner organisations where necessary. There is a clear escalation policy. Cases where escalation in care are reviewed through incident reporting and in clinical morbidity and mortality meetings as well as a data driven review at AQILA regularly on its workplan	Gaps in control and cases where there may have been a risk of an "invisible" or "implied" ceiling of care are discussed openly at the combined clinical morbidity and mortality meeting. There are cases also where after fully informed consent a patient may choose to agree a ceiling of care in order to access the safety benefits of receiving complex orthopaedic care in a centre where the experience and equipment are available to do so. The Trust has less control if a patient does require the expertise of our staff but at another site. Clinicians will normally refer onward or request access through honorary contracts and if necessary take experienced staff with them. Access to other sites facilities is monitored through strategic oversight groups for key partners and escalated if challenged. Service delivery issues on other sites can challenge patient flow and experience.Emergency transfers in, unplanned admissions to HDU, rapid response team activity and transfers out are all audited through the service units, divisions and AQILA on its workplan. The Trust is a net importer of urgent / emergency cases at a ratio of about 10:1. Unplanned HDU admissions and transfers out of the hospital must have incident forms and therefore can be tracked and reviewed through governance. All of these processes are subject to continuous improvement, both in the data to support them and in the quality of the upward reports. The Anaesthetic unit is in discussions with UHB partners about rotating staff and strengthening outflow pathways to UHB critical care. They also have links to the regional critical care network		Positive
1298 - cyber security risk	Process implemented to patch corporate windows servers monthly	Apple MACS are still a work in progress. Digital and BI Teams working on moving these into other systems and developing other systems. Cyber Security Training has been rolled out and we have 1220 people trained. Still have a range of unsupported systems. We are ongoing the review of best available options to move this forward Currently have a Cyber Security Contractor to help assist with the strategic direction for ROH. Currently works 5 days a week but looking to see what we can do for the future around this role and if a pernament role could be put in place		Positive
1423 - risk relating to lack of strategic workforce planning		Development of an integrated workforce plan as part of new Trust strategy		
1783 - risk relating to high levels of employee turnover		Development of an integrated wirkforce plan as part of new Trust strategy		

Risk 27 - risk relating to Inability to control the use of unfunded temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	Recurrent use of agency staff is now limited to specialist areas such as Paediatrics, HDU and theatres, all of which are areas influences by national shortages. Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. A rota co-ordinator is in place and focuses on weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce	Development of an integrated workforce plan as part of new Trust strategy		
Risk 770 - risk relating to aged theatre plant	Theatre Maitenance Plan - 1st phase of Theatre maintenance was successfully completed in April 2022 (Theatres 5, 6 and 7 and Ward 2). Second phase was successfully completed in August 2022 (Theatres 9 and 10 and Ward 1). Further work scheduled for April 2023 (Theatres 11 and 12), August 2023 (Theatres 3 and 8 and Ward 4) and November 2023 (Theatres 1, 2 and 4 and Ward 10/12). Emergency maintenance has been completed on Theatres 14 and 15 and Ward 3 in January 2023, other works to continue as planned.	Day Case Unit, which would free up capacity to replace aged theatre plant		
791 - risk relating to number of Trust policies overdue for review	The pathway for policy approval remains robust as per the Policy on policies. This policy continues to provide clarity on mechanisms for approval, both for new and/or substantially revised policies and for policies needing minor amendment. Oversight is provided by the Corporate Governance Manager who reports to the Director of Corporate Affairs & Company Secretary. The Executive Team considers a routine policy status report, which is broken down by individual directorate to allow easier assessment of the status of policies in the various areas.		Regulary Policy Compliance Report submitted to Exec Team and Clinical Quality Group	
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	Staff Heath and Wellbeing programme. HRM team working with managers to practically manage absences. Further embedding of staff requirement to take leave for rest and recuperation. Human Resources and OD teams working on action plan to address high level of health related absences. BSOL looking to getting recurrent funding to keep making recurrent offer to staff.	Development of an integrated workforce plan as part of new Trust strategy		

Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	Offer by Smith and Nephew to support an analyst within the Informatics department to support Clinical Informatics Transfer of legacy 20 year outcome data from an old Macintosh system – this information has clinical and potentially financial value in establishing funding streams to secure the future outcomes work Work with Amplitude clinical outcomes database provider to provide clinicians with improved access to their individual outcomes data and the Trust with clinical outcomes data that will provide assurance around clinical practice across the Trust			
Risk 1181 - risk realting to lack of abilty for IT systems to flag safeguarding alerts	Staff are requested to email leads in the areas with separate IT data base systems i.e. Oncology ONKOS, X-Ray CRIS and PACS and Therapies - TiRIA as these systems do not pull alerts from PAS Lorenzo system. The email address for leads in all areas have been included in every purple folder to ensure staff can communicate alerts required to the correct areas.	IT are now working with Safeguarding and Learning Disability Teams to develop a database to mitigate risk on Safeguarding Risk Register. PICS has been identified as 6 versions behind, with the most up to date version addressing key parts of this risk. UHB to explore how to deliver this update.	the risk and action plan as well as any issues/incidents relating to this are monitoried at the Safeguarding Committee	
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	Outpatients under 16 years seen in a specific CYPOPD setting. Managed by Registered Children's Nurses. Policies and procedures specific to under 16s in place. Transition process commenced. 16-18 year old's nursed in adult wards. Policies and procedures for 16 + in place. Including safeguarding. Transition nurse in post and involved in care pathway of complex cases. On call anaesthetic registrar and consultant surgeons on 24/7 call. SLA between BWCH and ROH established. Children Matron in post one day a week	ICS working to allow for advice and guidance from BWCH for under 16s.	Incidents monitored via Children's Board	
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the All managers being encouraged to plan leave and carry over pro-actively Wellbeing day has been provided to staff	Annual Leave uptake remains on trajectory. Revised annual leave policy to incorporate buying and selling annual leave now been consulted on and is to be presented to Execs for ratification before roll out		

Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	Production and authorisation of rotas 6/52 week ahead. Confirm and Challenge meeting are in place to ensure Rotas are produced and worked effectively. Feedback to the Trust 6-4-2 process on any gaps in the nursing workforce to allow amendments to the Trust activity plans where appropriate Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm ROH International recruitment plan in place, target 40 nurses by December 2023, targetting Theatres which hold the largestvacancy risk at present.	Planning international nurse recruitment to complete by December 2023 which a total of 40 nurses in country and trained. Over the summer open days will take place. There is work ongoing to explore transformational roles such as top ups to degree nurse apprentices and TNAs recruitment is underway for next cohort to start in September 2023, business case approved.		
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	Paediatric wait times have now reduced to 15 weeks which is an improved position from January 2023 wait times of an excess wait times of 25 weeks. Adult physio wait time is currently sitting at 31 weeks, the wait times, reflect the physio wait time nationally with incrased demand against capacity shortage. Actions and mitigation in place: - Invite to patient to use GetUBetter app sent to all eligible patients waiting self managmentment too prior to appointment. - Demand and capacity to be finalised to ensure service has sufficent resource to supoort the demand - Plan recruitment campaign linked to new department - 6.5 WTE appointed - Introduction of Dr Doctor opportunites to help help to reduce DNAs and late notice cancellations Paper with position statemnet , trajectories for improvement will be presented at April FPC and monitored monthly at divisional level, included in FPC pack going forward from April 2023.		Monitored at F&P Committee and any potential harm is channled through divisional governance processes.	

Risk 1887 - Risk that air conditioning unit will fail causing the temperature within the Theatre specimen room to raise beyond a safe level. This will affect quality and safety of all Blood and Human Tissue products stored within the specimen room; rendering them unusable and wasted.	Estates have contacted the external engineering company and will liaise a time to carry out works. Temperature is within normal limits after a temporary repair put in place. Resilience flowchart created in order to plan for if this should happen again. Identification flowchart created for staff to follow in the event of a facility failure. This has allowed the trust to provide limited solutions until a more permanent solution can be found or financed in order to meet current regulations. Current processes in place to identify a concern early. In the event of a complete failure and raise in temperature requiring immediate removal of blood/blood products we could utilise blood cool boxes to maintain cold chain compliance in the short term.	Confirmed by QE Transfusion leads fridges loaned for blood storgae purposes are unsuitable. Meeting with estates confirmed that current back up Labcold fridge can be removed from the specimen room and re located in new recovery . After mapping this can be used whilst works in place. Actions plans, risk assessment for QE quality leads completed (both attached to risk) and regular MDT meetings in place to ensure all required actions are taken to enable required works to take place whilst ensuring required regularory/legal MHRA/UKAS requirements are still met.	Blood Safety Group and HTA Group	
Risk 1888 - Risk that continued industrial action will have a negative impact on attraction, recruitment and retention of staff				
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	Twice weekly PTL meeting tracking all malignancy possible patients. Patients monitored and tracked until outcome known Escalation process in place for all potential cancer target breaches Turnaround times reported into monthly cancer board meeting Incident report delayed patients and cancer breaches	Joint contract meetings are recommencing and improvement plan to be agreed. Discussion with DCOO and CSL around scoping other histology services. SLA requires review - with clear plan for patients outside of SLA, and clear ownership of SLA	Monitored via Cancer board	
Risk 1895 - Risk of regulatory non compliance as a result of the Trust being unable to recruit a resuscitation officer. With this post vacant the trust is at risk of not remaining up to date with legislation/ guidance and changes in practice	The trust is using the expertise of an outside company to deliver training. The company are also supporting with updates and supporting a refresh of policies. Extenal company provide ILS training and currently hold the ILS lience in order to deliver training. The staff within the company are all clinical current and are ALS instructors. Training provision remain in line with UK resus council guidance and is reviewed by the company. A Resus officer is supporting the RRT lead to review and update the policy. A band 6 resus nurse is currently on secondment ensuring compliance with audit and ensure stock etc is readily available.	Post is back out to advert	Monitored via Resus Committee and Clinical Quality Group	

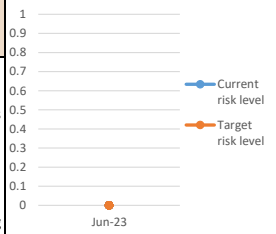
Risk 1938 & MD4 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	The Trust has a Medical Devices Advisory Group (MDAG) for new implants with good links to the Modern Interventions Panel (MIP) for new techniques. The MIP has clinical, transformation, operational and financial input as well as the facility to co-opt the Director and Head of Research for advice. There are clear criteria for how technologies are assigned depending on the level of evidence to support them. The Trust has used the IDEAL model successfully to weigh the level of scientific evidence. Those new technologies assigned to research have national research ethics and approval frameworks and methodologies which cover much of the risk management aspects around the evaluation. Sponsors for those new technologies assigned to service evaluation must demonstrate financial viability, operational application, training and preceptorship, patient information and recall arrangements. The lead must register an audit indicating when the follow up data will come back into the organisation. Clinicians are trained in consent and supported in Shared Decision Making by an active group with a clinical lead.	Evaluation of technology: Limited evidence about the technique. Sources of bias. Roll out: Finite ability to control and monitor cases and clinicians. Unit level and individual level responsibilities are covered however in normal GMC defined good clinical practice. Refinement of MIG process and approval. Learning when things go wrong. Consistent messaging to clinicians at approval stages.	Reporting through governance to quality and safety committee	
Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts, however the Trust has bilateral oversight arrangements in place with partners it works with closeModerate harm or above triggers formal governance mechanisms, clinicians and clinical service units are empowered to manage no and low harm locally and have access to system overrides if patients require prioritisation. Clinicians have a tracker which is continuously improving. Audits have demonstrated high compliance with use and process / data quality issues which are being addressed. Patients transferred from outside the Trust must be assessed at the time of their first appointment by the clinician providing care so that harm / risk of harm and clinical priority from there are anchored.ly to mitigate this.	Outpatient tracker not yet in place. Ambiguity over clinical responsibility for management of co-morbid conditions with primary care during wait, particularly outpatient wait.	Divisional Governance, Divisional Management Board, Quality Report, Quality & Safety Committee	Positive
Risk MD2 - There is a risk of a shortfall of ward doctors due to the Deanery do not send the agreed number of GP trainees to rotate into the Trust. This may lead to gaps in the ward cover rota, clinical risk, reduced contact with the GP community or financial cost.	Post event mitigation: locum cover, exploration of expanding non-medical support – eg 24 hour rapid response, mid level provider numbers. Proactive clinical leadership from clinical lead for locums, clinical tutor in relationship management with th deanery, appointment of new Director of Medical education. Excellence in rostering and employee relationships through rota coordinator and learning hub administrative staff.	This is an intermittent issue as much as a risk – the trust encountered the situation in 2022. Discussion with the deanery around how the ROH is labelled on trainee choices and agreed quota numbers being re-explored. There is already an agreed rotation numbers which the deanery has not met and the Trust feeds back on. Structurally the Trust is exploring how others mid level providers may mitigate or remove any service dependence on this group. In the shorter term the Trust intends to Grow the Rapid response capability and cover Explore any opportunity that presents to cover wards wtih medical staff from other sources		

Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. The Trust takes care in assessing the capacity avialable for transferring patient cohorts and makes efforts to mitigate clinical risks associated through bilateral relationships with transferring providers. Ref also CE2 Prioritiation rules are well established and understood. To date clinical compliance has been good when audited.	There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts. External authorities may require mutual aid to be provided regardless of the Trust's own position as a part of managing and sharing risk on a regional or national scale, meaning that the Trust may have very limited control. Improvement and refinement of clinical prioritsation tracking and process. Care / forecasting and modelling before cohort transfer.		
Risk 1089 - There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines. This will impact on an ability to meet the national Healthcare Information and Management Systems Society required level 5 be met, and we will fail to achieve Digital Capable Framework Compliance. This would put at risk the financial sustainability by restricting our ability to	Continue upgrade and expansion of functionality of current stand alone electronic systems, this would include, but not limited to; - PICS - ROCS Portal - Theatreman upgrade to AQUA - PAS replacement - Silo'd PAS systems - Tiara, OnKos. Data quality group focus on ensuring adequate controls are in place to deliver optimum data quality from existing systems. Perfecting pathways Board monitoring transformation of existing processes across service improvement group programmes of work and digital transformation.	Development work underway with Safeguarding database. Digital pre-op with the implementation of Synopsis. Electronic outcomes pilot using VitalHub (InTouch) system (podiatry and hands) by end of May 2023. PAS - using a legacy PAS, which both has inflated costs and limited functionality. Replacement necessary and regional discussions about to commence		
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	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. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target. Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard. Will be picked up as part of 2023/24 financial planning process that has just started.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update.	

Risk CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	International nurse recruitment at 26/40. Retention nursing action plan being developed and key work stream due to start to support retention. Open days taking place. Production of rotas 6/52 in advance. Feedback to Trust 642 process on any gaps in nursing workforce to allow amendments to the Trust activity plans where appropriate. Ensure all temporary staffing needs are allocated to the nurse bank at the point rotas are approved to ensure timely filling of shifts. Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations Ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm	Retention work Open Days Exploring and presenting business cases for TNA in Theatres		
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.				

Board Assurance Framework (BAF): August 2023

Principal risk (what could prevent us achieving the strategic priority)	There is a risk that the Trust will fail to meet its objective of delivering a standardised pathway for elective orthopaedics in Birmingham and Solihull and this could be caused by not having the neccesary capital and/or resource to enable growth, expansion and innovation in terms of our ability to Establish the Trust as a Major Revision Centre (MRC) and also the logitical and/or policitcal and operational difficulties of trying to embed new apthways and processes across the system, which could have a financial impact as well as a reputational impact in terms of our allignment, position and standing within BSOL ICB.					**Strategic objective:**	**OUR COLLABORATION - Collaborate to support improvement, locally, regionally and nationally - In the next five years, we will help to deliver a standardised pathway for elective orthopaedics in Birmingham and Solihull. This will indicate that our system is transforming for the benefit of patients.**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk appetite Statement**	
		Consequence	4	4	4		
Initial Date of Assessment	Aug-23	**Likelihood**	3	3	2	The Trust has a higher tolerance for risk in regards to our ability to engineer improvement to system wide pathways and services and our abilty to influence and have a strong voice within the BSOL ICB system	
Last reviewed	N/A	**Risk Rating**	12	12	8		
Last changed	N/A						



Alligned Risks	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Risk Control Assurance rating**
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	Relevant managers are now receiving a monthly report showing the take up of annual leave within their teams so that they have the ability to manage this more pro-actively HR Managers are reviewing annual leave take up with managers as part of regular 121s HR&OD are monitoring uptake of annual leave across the trust and have rolled over statutory leave untaken to the All managers being encouraged to plan leave and carry over pro-actively Wellbeing day has been provided to staff			

Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	Patients are screened prior to admission: Emergencies undergo a "Boarding Card" process. This is mature and embedded. Elective cases start a consent process at the time of listing and through the Pre-operative clinic any further concerns or issues around co-morbid conditions or potential organ support post-operatively are developed and discussed. Staff are aware of the isolated site and of the need to ensure that patients who may encounter a ceiling on care are treated elsewhere or consented appropriately. Deteriorating ward patients are identified and managed by a coordinated rota of clinical, nursing and rapid response team staff. The Trust has a Level 2 critical care facility with excellent outcomes audited through the national network. It is possible to provide ventilation support on site for required periods if necessary. Through a combination of ICS partnerships, custom and practice and partner SLAs, staff are able to call assistance to the ROH site if appropriate or transfer patients out of the Trust to partner organisations where necessary. There is a clear escalation policy. Cases where escalation in care are reviewed through incident reporting and in clinical morbidity and mortality meetings as well as a data driven review at AQILA regularly on its workplan	Gaps in control and cases where there may have been a risk of an "invisible" or "implied" ceiling of care are discussed openly at the combined clinical morbidity and mortality meeting. There are cases also where after fully informed consent a patient may choose to agree a ceiling of care in order to access the safety benefits of receiving complex orthopaedic care in a centre where the experience and equipment are available to do so. The Trust has less control if a patient does require the expertise of our staff but at another site. Clinicians will normally refer onward or request access through honorary contracts and if necessary take experienced staff with them. Access to other sites facilities is monitored through strategic oversight groups for key partners and escalated if challenged. Service delivery issues on other sites can challenge patient flow and experience.Emergency transfers in, unplanned admissions to HDU, rapid response team activity and transfers out are all audited through the service units, divisions and AQILA on its workplan. The Trust is a net importer of urgent / emergency cases at a ratio of about 10:1. Unplanned HDU admissions and transfers out of the hospital must have incident forms and therefore can be tracked and reviewed through governance. All of these processes are subject to continuous improvement, both in the data to support them and in the quality of the upward reports. The Anaesthetic unit is in discussions with UHB partners about rotating staff and strengthening outflow pathways to UHB critical care. They also have links to the regional critical care network		Positive
Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts, however the Trust has bilateral oversight arrangements in place with partners it works with closeModerate harm or above triggers formal governance mechanisms, clinicians and clinical service units are empowered to manage no and low harm locally and have access to system overrides if patients require prioritisation. Clinicians have a tracker which is continuously improving. Audits have demonstrated high compliance with use and process / data quality issues which are being addressed. Patients transferred from outside the Trust must be assessed at the time of their first appointment by the clinician providing care so that harm / risk of harm and clinical priority from there are anchored.ly to mitigate this.	Outpatient tracker not yet in place. Ambiguity over clinical responsibility for management of co-morbid conditions with primary care during wait, particularly outpatient wait.	Divisional Governance, Divisional Management Board, Quality Report, Quality & Safety Committee	Positive

Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	The Trust has a working clinical prioritisation policy and mechanism for clinicians to escalate harm or risk of harm within the Trust. The Trust takes care in assessing the capacity avialable for transferring patient cohorts and makes efforts to mitigate clinical risks associated through bilateral relationships with transferring providers. Ref also CE2 Prioritiation rules are well established and understood. To date clinical compliance has been good when audited.	There is limited scope for influencing the quality and currency of clinical prioritisation and harm from other Trusts. External authorities may require mutual aid to be provided regardless of the Trust's own position as a part of managing and sharing risk on a regional or national scale, meaning that the Trust may have very limited control. Improvement and refinement of clinical prioritsation tracking and process. Care / forecasting and modelling before cohort transfer.		
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Risk CL7 - There is a risk that as a result of limited resource to undertake engagement activities with Primary Care, there is reduced ability to access hard to reach communities.	Insufficient capacity to treat cohorts of patients from the most deprived communities due to the continuing operational pressures associated with mutual aid.			
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.				
CL9 - There is a risk that the funding regime for orthopaedic work does not provide sufficient flexiliby to be able to create and deliver a model of standardised care for orthopaedics.				

PAPER REFERENCE: ROHTB (9/23) 015

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 23 August 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The clinical extract of the Corporate Risk Register was discussed which had been refreshed and reflected new risks associated with deficiencies in the performance against the histopathology Service Level Agreement; the continued vacancy in the Resuscitation Officer role; and the potential patient harm arising from using new and novel techniques and devices. The mitigations for these were described and considered adequate. • The detail of a case where a patient had experienced a post-operative stroke was discussed. The outcome of the investigation and lessons learned from the case had been shared with the patient's family. • The Committee was updated on the decision to pause the endoscopic spinal surgery service temporarily, following a small number of incidents concerning nerve damage. An initial review had been undertaken and a 'round table' would be held to further review and discuss the cases before the service resumed.	• It was agreed that although there was significant assurance provided by the Vulnerabilities and the Safeguarding annual reports, future versions could be more concise and focus both on the matters needing to be published due to regulatory requirements and the key pieces of improvement work completed during the year. The format could also be reviewed and tailored to relevant audiences. • Update on new complaints process and policy to be presented at the next meeting. • In the light of the recent Lucy Letby case, it was noted that an update would be provided to the Trust Board on the ways in which staff could speak up. This included the Freedom to Speak Up route. Assurances would also be provided around the incident investigation framework and the confidence in the processes to identify trends. It was noted that whistleblowing and the Freedom to Speak Up functions were important safety nets but that relationships and communication at service and team level were absolutely core to the delivery of high quality care. • Action plan to address the improvements identified from the self-assessment against the NHSE Violence Prevention & Reduction standards to be developed and shared at the next meeting. • Present an update on joint services and pathways to the Trust Board at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The investigation into the appointment incidents was reported to be ongoing, however reassurance was provided that no harm to patients had been identified to date. • Good progress was reported with the delivery of the annual quality priorities year to date. • Following an elevated number of Surgical Site Infections (SSIs), previously reported it was noted that investigations had been	• Approved the onward transmission of the Safeguarding & Vulnerabilities reports to the Trust Board for approval to publish.

undertaken into the potential causes and a number of mitigating actions had been undertaken. The latest analysis showed that infection rates associated with hip and knee replacements and spinal procedures were largely as expected. It was agreed that given the elective nature of the treatment at the ROH, SSI rates should be regarded as a key quality metric. It was also agreed that reporting into the surveillance frameworks should be regarded as mandatory and therefore contingency for this be arranged. Finally, it was noted that there should be a common understanding of the reasons behind the spike in SSI infections in 2020, this being associated with the different profile of patients treated during the service reconfiguration required during the pandemic and a lower level of elective cases treated, thereby impacting the denominator. • The quarterly Learning from Deaths update did not highlight any adverse findings or significant points of learning from the mortality cases reviewed by the Trust. • The Safeguarding and Vulnerabilities annual reports were reviewed and agreed to demonstrate good practice at the ROH. • A self-assessment against the national Violence Prevention & Reduction standards was considered which highlighted overall good compliance, although some improvements were identified. • The plan to roll out the annual 'flu vaccination programme was described, with an ambition to achieve 90% take up for front line staff. There was an in-depth discussion on this. There was some delay with provision of the vaccine, therefore the programme would commence from October 2023. Board members were invited to support the campaign. • An overview of the joint clinical pathways in which the ROH was involved was considered. Some work was reported to be underway to review the Service Level Agreements and the oversight meetings for the services. It was agreed that further information concerning the strategic direction of joint services would be useful to understand and whether	

there were any services that were subject to vulnerability, from shortages in medical staffing for instance. • Continued delivery of the Committee effectiveness plan was noted.	

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting with a good focus on the key risks. The emphasis of reporting by exception was welcomed. There was a discussion around whether the Committee should meet face to face and it was agreed that a model whereby some meetings were face to face and others virtually would suit most attendees, and support committee effectiveness.

PAPER REFERENCE: ROHTB (9/23) 016

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 25 July 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Performance against the national Referral to Treatment Time (RTT) standard was below the required 92%, at 56.07% largely as a result of accepting additional cohorts of mutual aid patients. There was continuing work to ensure that no patients wait over 40 weeks for treatment and this was of significant focus at present. • In terms of length of stay, it was noted that the numbers of patients being treated with high complexity and co-morbidities had increased, which in turn impacted the time patients stayed in the hospital after surgery. • The impact of the mutual aid arrangement on the financial position of the ROH was discussed. • At a System level, it was noted that there had been a significant deficit incurred year to date. • The overspend at the ROH was noted to be driven by bank and agency costs, much of this being associated with the need to cover Industrial Action. • It was reported that national guidance required that all Systems produced a financial plan with an underlying balanced financial position by 2024/25.The challenges with achieving this were discussed. • 'Grip and Control' measures were discussed which are designed to address any potential unnecessary overspend. For the ROH, control of temporary staffing costs was key. The implementation of the measures was being reported up to the Integrated Care Board.	• Further update on FOI and SAR compliance at the next meeting. • Length of stay information to be presented to distinguish between complex and routine patients. • An update to the Trust Board on the national financial planning guidance is required. • The action plan to address the recommendations arising from the Committee self-assessment to be considered at the September Committee meeting. • An update on Limited Liability Partnerships (LLPs) to be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Positive assurance was provided that the substandard performance against the Freedom of Information and Subject Access legislation was being addressed and good improvements had been seen. There are plans to ensure that the new governance team structure builds in resilience to handling these requests to required timescales.	• None specifically

• It was noted that there was work underway to move some medical records offsite to alleviate the pressures in the area. • Actual activity delivered in month was 1339 vs 1203 System Plan (Variance +136) • The Year To Date activity position of Actual vs System plan was 102.4% (Variance +83) • An over achievement in June inpatient activity has resulted in being ahead of the System plan for Quarter 1 overall. • There continued to be good delivery of the Cost Improvement Programme. • The Committee was provided with an update on the plans for the Elective Recovery Fund and targets would be allocated per provider. • The overview of the outcome of the Committee self-assessment was discussed which was largely positive.	

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting with a good focus on the key risks associated with Industrial Action and the national financial planning regime.

PAPER REFERENCE: ROHTB (9/23) 017

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 30 August 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Workforce risks on the Corporate Risk Register were considered. The score for the risk around payroll errors was noted to have been elevated to reflect some issues arising with changes made through Health Roster. A new risk had been added around the impact of industrial Action on attraction, retention and recruitment of staff. • The Return to Work interview rate was noted to have dipped, although it was expected that this was due to managers not reporting that they had been completed on ESR, rather than the interviews not being undertaken. Appraisal rates were similarly below expectations and the Committee asked that urgent attention be focussed on this underperformance. • Attendance at the staff networks was noted to be poor at present and discussions were planned with the Executive sponsors for each to help improve membership. • Resuscitation training figures were below required levels, although there had been a significant improvement from the previous month. • An overview of the Trust's use of temporary staffing was presented which showed a concerning level of expenditure on bank and agency staff, with the Trust being an outlier compared to other System partners. The number of vacancies was noted to be a significant reason behind the need to use temporary staffing. An oversight body had been set up to monitor the situation and would report to the Finance & Performance Committee and Staff Experience & OD Committee.	• It was noted that given the recent Lucy Letby case, enhanced communications had been issued around routes to speak up and a summary would be considered by the Trust Board at its next meeting. • The workforce planning report would be presented to the Trust Board in October but engagement with the Staff Experience & OD Committee around the key messages and actions would be undertaken prior to this. • Provide benchmarking information on violence and aggression incidents at a future meeting. • Provide an update on the use of bank and agency staff at each meeting, including the trajectory to reduce it to <4%. A specific request was made to provide detail on the use of temporary staffing in the IT area.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee welcomed a Senior Physiotherapist who described her experience of working at the Trust and in particular the movement of the Outpatients Physiotherapy service to the College Green facility. She described how working in the new facility had created a positive morale	• None.

for the team and how they worked well together. There was significant success with managing the waiting lists for physiotherapy appointments. There were some good ideas suggested for research and innovation proposed by the physiotherapy team. • New members of the Workforce team would join shortly. • A positive summary of the experience of the delegate from the 100,000 Black Internship programme was considered. It appeared that expectations of the individual had been exceeded. • There was reported to have been good engagement with the team producing the workforce planning report. • The disability declaration rate was noted to have improved. • The Committee thanked Victoria Scott, former chair of the LGBTQ+ 'Be Myself' network, for her work to strengthen the forum. She had now left the Trust and was wished well. • An update on the key actions developed in response to the nursing staff survey results was presented, which were around improving the staff voice; working as a team; and engagement. It was noted that the introduction of the Professional Nurse Advocate role was a positive move. • Work to improve the experience of volunteers at the ROH was reported to be underway and the patient experience team had visited elsewhere to understand best practice. • A self-assessment against the national Violence Prevention & Reduction Standards was presented which offered partial assurance. Further work was planned around communication, capturing diversity of those experiencing violence and aggression and sharing information with the System. • The nurse retention action plan was provided in overview which highlighted a number of positive measures to ensure that nursing staff felt supported and wished to remain working at the ROH. Accreditation of the preceptorship programme was a particular welcome measure. There was also a programme to convert HealthCare Assistants into Registered Nurses underway.	

• The Committee considered an action plan arising from the Committee self-assessment, with the main actions around better use of paperwork & templates; reconsidering the appropriateness of attendance; and suggesting that the staff story be heard at Board on the months that the Committee did not meet. • Thanks were offered to the estates and catering team for the work to refurbish the Café Royale.	
Chair's comments on the effectiveness of the meeting: It was noted that the meeting was not quorate – agreement on the accuracy of the minutes of the previous meeting and the action plan from the Committee self-assessment would be gained from others outside of the meeting and reflected in the minutes to be considered next time.	

PAPER REFERENCE: ROHTB (9/23) 018

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM THE AUDIT COMMITTEE

Date Group or Board met: 21 July 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The report on Health Inequalities provided 'Partial Assurance', although it recognised that there were some good areas of work already underway. The strategy for health inequalities needed to be developed using data to drive discussions and decisions.	• Report to be produced on contract management and to be considered at the next Audit Committee • Circulate the report on the plans for retendering for Counterfraud service • Ensure that the register of interests for Directors is included in Board papers for the next Board meeting and that the full register of interests is published on the internet • Invite the Chief Nurse to the next meeting to discuss the plan for Health Inequalities • Update on risk improvement to be presented at the October meeting • Discuss changes to the internal audit plan with the Executive Team with a view to signing off the final plan by 31 July 2023 • It was agreed that Les Williams and the Local Counterfraud Specialist would meet to discuss security • It was agreed that a report on the Data Security and Protection Toolkit would be considered at the next meeting which would also focus on compliance for the Mandatory Training in Information Governance and Cyber Security.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The report on the BAF and risk management was reported to provide 'Significant Assurance', with minor improvements required in connection with sourcing a new system for the management of risk • The final Head of Internal Audit for 2022/23 was reported to be positive and reflected a sound system of internal control at the ROH • Some changes to the proposed internal audit plan for 2023/24 were discussed and it was agreed that these would be fed back to the Executive Team	• In future the draft internal audit plan needs to be considered at the January Audit Committee meeting with final approval sought in April

• The annual report and accounts had been submitted to NHSE to the required timetable • Thanks were offered to the ROH staff for the positive year end position and the improvement from the previous year • The external audit for 2022/23 was noted to have been good and the Value for Money review did not highlight any matters of significant concern • The Counterfraud functional standard return had been submitted which provided a green rating • There had been a positive reduction in the numbers of losses and special payments made	

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting with a good balance of discussions. The issue of late papers was highlighted to be concerning however, a matter which would be addressed by the Director of Governance.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Changes to National Regulatory Guidance**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Trust Chair and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

Two significant changes to the national regulatory regime are due to take effect from autumn 2023, the first concerning the requirements around the application of the Fit and Proper Test and secondly, the CQC inspection framework. The latter remains a work in development, with no firm date set for switching to the new approach.

This briefing is designed to make the Board aware of the forthcoming changes and any steps being made at the ROH to accommodate them.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and ACCEPT the update on the planned changes to the national regulatory frameworks
- NOTE the work planned to prepare for their adoption and implementation

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		Equality and Diversity	x	Workforce	x

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

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

Requirement to adhere to the legal obligations under the terms of the Health and Social Care Act 2022.

PREVIOUS CONSIDERATION:

None.

FOR INFORMATION

National Regulatory Changes

BRIEFING TO THE TRUST BOARD – 6 SEPTEMBER 2023

1.0 Introduction

1.1 Two significant changes to the national regulatory regime are due to take effect from autumn 2023, the first concerning the requirements around the application of the Fit and Proper Test and secondly, the CQC inspection framework. The latter remains a work in development, with no firm date set for switching to the new approach.

1.2 This briefing is designed to make the Board aware of the forthcoming changes and any steps being made at the ROH to accommodate them.

2.0 Fit and Proper Persons Test

2.1 On 2 August 2023, NHS England advised that it had published the revised Fit and Proper Person Test ("FPPT") Framework. This was in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. A summary of the recommendations from the Kark review are included in Appendix 1.

2.2 The key principles of the revised framework are:

- It has been designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member.
- It has been designed to be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.
- Ensuring high standards of leadership in the NHS is crucial and the framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.
- The FPPT applies to executive and non-executive directors of integrated care boards, NHS trusts and foundation trusts, NHS England and Care Quality Commission – interim as well as permanent appointments.
- CQC Regulation 5: 'to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role' remains unchanged and the framework is designed to support it.
- Accountability for the implementation of the new framework rests with the Chair of the organisation.
- A further review of the framework will be undertaken in c. 18 months when consideration will be given to expanding the scope of the FPPT to roles beyond Board members.

2.3 Adoption of the new framework is due from 30 September 2023 and requires additional pre-employment checks and completion of new proforma to demonstrate compliance with the framework. The attached appendices include the new proforma for completion.

2.4 New data points are being added to ESR to record the testing of relevant information about board members' qualifications and career history.

2.5 From 30 September 2023, organisations should use the new board member reference template for references for all new board appointments and by 31 March 2024 the annual FPPT submission must be completed and submitted for and on behalf of the Chair to the NHS Regional Director.

2.6 From 30 September 2023, organisations should complete and retain locally the new board member reference for any board member who leaves their position for whatever reason, and record whether or not a reference has been requested.

2.7 The changes to the FPPT do not have any implications on the role and duties of governors. The Council of Governors will still be expected to receive an annual update on the Board FPPT declaration made however.

2.8 The Director of Governance attended a webinar hosted by NHS England on 30 August 2023 where the key elements of the changes to the FPPT were outlined. Clarity was requested by those on the webinar around some technical matters such as:

- Guidance on social media checks for those due to be appointed
- Impact on DBS checks conducted
- Disclosure of settlement agreements
- GDPR implications

A Frequently Asked Questions (FAQ) will be developed to offer clarity and guidance around these matters which will be circulated after the follow up webinar in September 2023.

3.0 Care Quality Commission inspection framework

3.1 In July 2022, the CQC announced that it would be changing its assessment framework. Whilst the details of the changes are yet to be fully developed or communicated it is clear that the changes will involve a departure from the current 'Key Lines of Enquiry' (KLOE) methodology.

3.2 In terms of what we do know about the new assessment framework, it is clear that the CQC is not departing from the current rating system (Special Measures, Requires Improvement, Good and Outstanding). We also know that it intends to continue to use the five key questions (i.e., is the service safe, effective, caring, responsive and well-led) as a core part of the assessment framework.

3.3 In terms of the actual changes and differences with the new assessment framework we do know that the CQC will be moving to a system of assessment based on 'Quality

Statements'. There will be 36 quality statements (or 'We' statements), focusing on specific topic areas under each of the five key questions and will set clear expectations of providers based on people's experiences and the standards of care they expect. The statements will be the commitments that we, as a provider, should live up to and will show how we will plan and deliver high quality care. The statements are listed in Appendix 6.

3.4 Furthermore, we also know that the CQC is introducing six new evidence categories to organise and help quantify the information that is to be submitted as part of an assessment. These categories of evidence set out the types of evidence that will be used to understand the quality of care being provided and the performance against each quality statement. The categories are as follows:

1. People's experience of health and care services
2. Feedback from staff and leaders
3. Feedback from partners
4. Observation
5. Process
6. Outcomes

3.5 A further briefing on the new assessment framework will follow when further details and guidance is available.

4 Next steps

4.1 Having reviewed the guidance, there are no immediate concerns around whether the Trust would meet its obligations under the new FPPT framework or CQC inspection framework.

4.2 The current Non Executive recruitment campaign will need to accommodate the new FPPT requirements given that it will conclude after 30 September 2023.

4.3 As clarified on the recent webinar, there is no need to apply the new requirements in retrospect, so the pre-employment checks and FPPT self-declarations remain fit for purpose. The new self-attestation will be issued to all Board members towards the beginning of 2024 however to ensure that the annual FPPT declaration can be made for and on behalf of the Chair by 31 March 2024.

4.4 Work continues at the ROH to prepare for the next CQC inspection. This includes:

- Quality Assurance walkabouts to clinical areas
- Undertaking an assessment against the current Key Lines of Enquiry for the Well Led domain
- Preparation of an engagement and communications plan to let the organisation what to expect from an inspection and how to prepare
- Identification and collection of evidence that may be regarded as 'Outstanding'
- Implementation of a new CQC assessment module as part of the new risk management technology due to be implemented later in 2023/early 2024

6 Recommendation

6.1 The Trust Board is asked to:

- RECEIVE and ACCEPT the update on the planned changes to the national regulatory frameworks

- NOTE the work planned to prepare for their adoption and implementation

Simon Grainger-Lloyd
Executive Director of Governance
31 August 2023

Appendix 1: Recommendations from the Kark Review (2019)

The table below summarises the recommendations in the Kark Review (2019), and the response from the Secretary of State (SofS) for Health and Social Care.

	Recommendations	SofS response
1	All directors should meet specified standards of competence to sit on the board of any health-providing organisation. Where necessary, training should be available.	Accepted
2	That a central database of directors should be created to hold relevant information about qualifications and history.	Accepted
3	A mandatory reference requirement for each director should be introduced.	Accepted
4	The FPPT should be extended to all commissioners and other appropriate arm's length bodies.	Accepted
5	The power to disbar for serious misconduct.	Not accepted
6	Remove the words 'privy to' from regulation.	Accepted
7	Examine how FPPT works in social care.	Not accepted

Appendix 2: The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)

B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**	Yes □	No □

• **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 3: New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to [complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter self-attestation

[NAME OF NHS ORGANISATION]

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	

For chair to complete

Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 4: Letter of confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[**LEAD EMPLOYING ORGANISATION**[1] **LETTERHEAD**]

[**DATE**]

Dear [**CHAIR NAME**[2]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/24**] as at [**date of conclusion of annual**[3] **FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**], I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

---

[1] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.

[2] This is the name of the chair of the other organisation that the joint board appointment is made with.

[3] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing

[LEAD EMPLOYING ORGANISATION[1] LETTER HEAD]

Date……

Dear [**CHAIR NAME**[2]]

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/2024**] as at [**date of conclusion of annual[3] FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**] I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the FPPT and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely

……(Signature)

……....(Chair of lead employer organisation)

Date……

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion

……(Signature)

……....(Chair of non-lead employer organisation)

Date……

---

[1] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation

[2] This is the name of the Chair of the other organisation that the joint board appointment is made with

[3] It should be noted that whilst there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

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

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: FPPT reviews / inspections

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

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:		
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:				
Date signed:				

For the regional director to complete:	
Name:	
Signature:	
Date:	

APPENDIX 6 – CQC QUALITY STATEMENTS

SAFE

- We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices
- We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
- We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately
- We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them
- We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care
- We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs
- We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly
- We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen

EFFECTIVE

- We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them
- We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards
- We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
- We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
- We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves
- We tell people about their rights around consent and respect these when we deliver person-centred care and treatment

CARING

- We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect
- We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics
- We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing
- We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress
- We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care

RESPONSIVE

- We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs
- We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
- We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs
- We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result
- We make sure that everyone can access the care, support and treatment they need when they need it
- We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this
- We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life

WELL LED

- We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
- We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty
- We foster a positive culture where people feel that they can speak up and that their voice will be heard
- We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us

- We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate
- We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement
- We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research
- We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Collaboration with Peer Provider Organisations**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

Although the formal framework for collaboration between orthopaedic providers across the country is through the National Orthopaedic Alliance, additional conversations have been instigated between the three main specialist orthopaedic organisations around a more informal approach to sharing best practice and joint working.

This paper sets out some of the areas to date that have been agreed as useful to discuss further between the specialist providers.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and ACCEPT the update on the joint working with peer specialist orthopaedic providers

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		Equality and Diversity	x	Workforce	x

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

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

Duty to collborate

PREVIOUS CONSIDERATION:

None.

FOR INFORMATION

COLLABORATION WITH PEER PROVIDERS

BRIEFING TO THE TRUST BOARD – 6 SEPTEMBER 2023

1.0 Introduction

1.1 Although the formal framework for collaboration between orthopaedic providers across the country is through the National Orthopaedic Alliance, additional conversations have been instigated between the three main specialist orthopaedic organisations around a more informal approach to sharing best practice and joint working.

1.2 This paper sets out some of the areas to date that have been agreed as useful to discuss further between the specialist providers.

2.0 Robert Jones & Agnes Hunt NHS Foundation Trust

2.1 The first of the joint meetings between the Executive Teams of Robert Jones & Agnes Hunt NHSFT was held on 27 June 2023. The teams welcomed the opportunity to meet and provide ideas for areas which may benefit in some further exploration for joint working or sharing best practice.

2.2 The key areas agreed as priorities for further discussion were:

- Model Hospital
- Non medical roles
- Training & Education and medical staffing
- Productivity
- Implementation of the Patient Safety Incident Response Framework
- Peer review

2.3 In recognition of the significant operational pressures both at a national and local level for both organisations at present, limited progress has been made with advancing the discussions and work around the priorities above. A summary to date is however provided below.

Model Hospital - RJAH are regular attenders at the Model Hospital Club meetings and are making really useful contributions and offering some best practice in relation to a number of specialities. The meetings were paused for some time but are now rescheduled so it is anticipated that there will be further valuable discussions around areas where there is common ground. This is a valuable source of benchmarking information that the Board is always keen to see.

Non Medical roles – some early discussions have been held between the Chief Nurses of the two organisations around some new non-medical roles and how these can add value to the workforce and be used to drive attraction, recruitment and retention into the organisations. The possibility of rotations or secondments between the two organisations is also being explored.

Training & Education and medical staffing – discussions to date have centred on the possibility of sharing skills and expertise in terms of medical staffing. This is an element of the workforce team that has historically posed a challenge for the ROH, so there is clear benefit in some joint expertise and resource in this area. An additional opportunity being explored is around joint spinal and orthopaedic training courses, where there is clear synergy between the work of the two organisations.

Productivity – a joint session was planned for 23 August which had to be cancelled, however this is now rearranged for 30 October 2023. This will focus on three areas of high impact where there would be benefit in joint working. Initial thoughts are around Length of Stay; theatre utilisation and Outpatients services.

Patient Safety Incident Response Framework (PSIRF) – the implementation of the PSIRF is a fundamental change to the way incidents are reported, investigated and lessons learned. Despite the wealth of national guidance, each organisation is likely to be assessing the implications of adopting this and tailoring their approach to best fit. As such, there is benefit in sharing the approaches being developed between the two organisations and early discussions have been held ready for the nationally mandated deadline of implementation of autumn 2023.

Peer review – discussions are planned around the areas where there is benefit in peer review. Initial thoughts include review of the Trust's preparedness for a CQC inspection or a well led review. In the light of the recent Lucy Letby case, it would also be worth considering a peer review around the Trust's speaking up framework.

3.0 Royal National Orthopaedic Trust

3.1 Discussions aligned to the approach with Robert Jones and Agnes Hunt NHFT will be developed and progressed over coming months.

4 Recommendation

6.1 The Trust Board is asked to:

- RECEIVE and ACCEPT the update on the joint working with peer specialist orthopaedic providers

Simon Grainger-Lloyd
Director of Governance
31 August 2023.

REPORT REF: ROHTB (9/23) 021

TRUST BOARD

DOCUMENT TITLE:	**Influenza Vaccinations for Frontline Healthcare Workers**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse and Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Vicky Clewer, IPC lead**
PRESENTED BY:	**Nikki Brockie, Chief Nurse**
DATE OF MEETING:	**6 September 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This paper is to provide assurance and oversight of the *Influenza Vaccinations for Frontline Healthcare Workers* campaign for FY 23/24.

The campaign was extremely successful last year with 68% all frontline healthcare workers receiving flu vaccination. However, the Trust failed to achieve the CQUIN by 12%.

The Board will also be verbally updated with the new national guidance and timetable for COVID-19 vaccinations in the light of the new variant.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
Action plan is attached and is on target for the campaign to start with Board in September 23.	Early indications suggest the vaccination maybe delayed until October this will impact on the planned roll out programme.

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Committee is asked to: accept and note the update.

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

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

Comments:

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

National flu immunisation programme 2023 to 2024

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

CQUIN for FY 23/24

PREVIOUS CONSIDERATION:

FY 22.23 report and outcome presented to Board in May 23.

This report has also been considered by the Quality & Safety Committee on 23 August 2023.

The Royal Orthopaedic Hospital NHS Foundation Trust

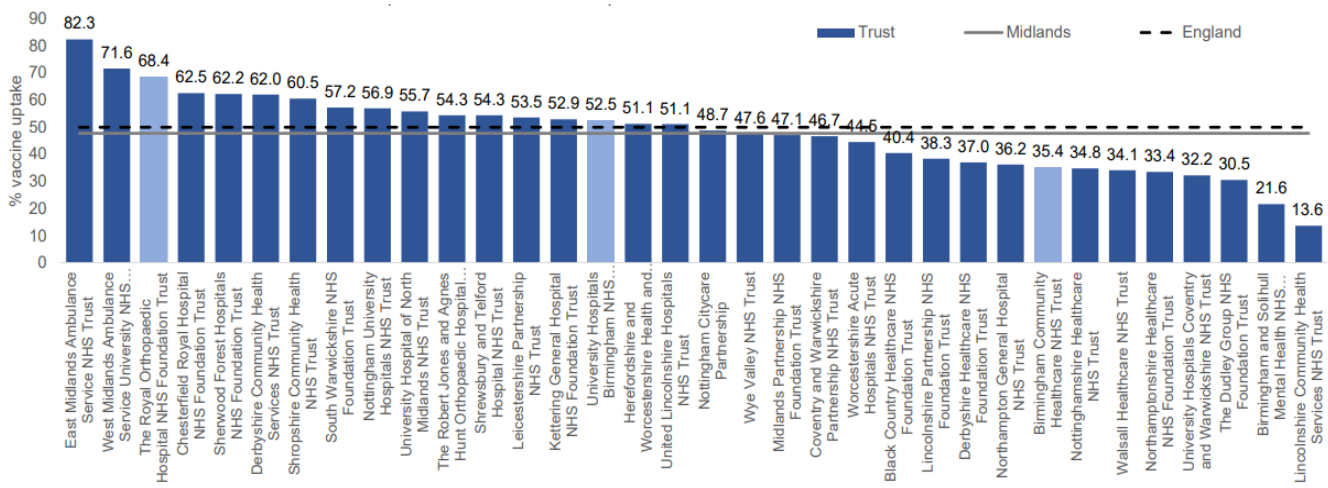
Influenza Vaccinations for Frontline Healthcare Workers

2022/23 Summary and 2023/24 Delivery Plan

1. 2023/24 Successes

1.1. ROH vaccinated 68.4% (600) of all eligible frontline healthcare workers with patient contact (877), falling short of the 70% target by 1.6% (14).

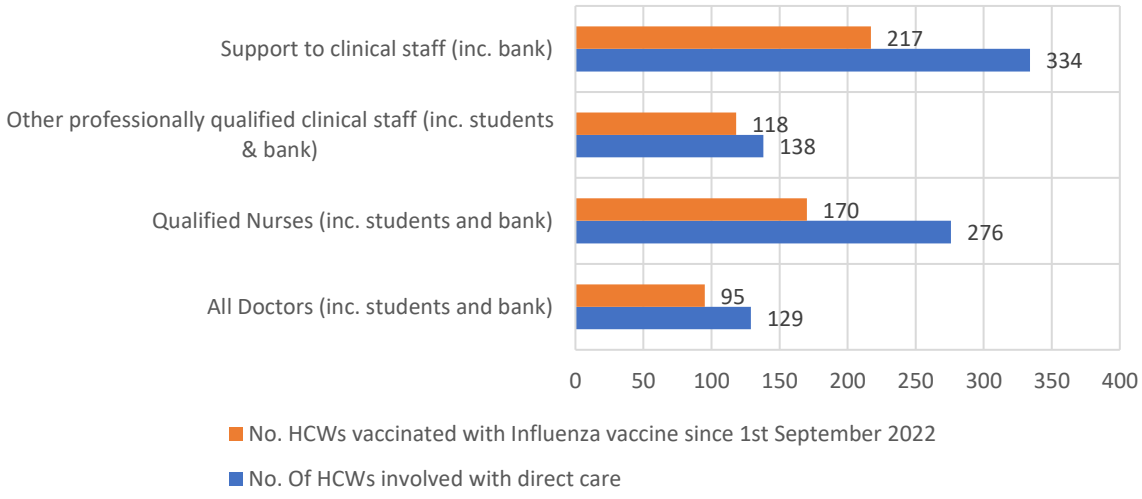
1.2. Of the four Trusts within the Birmingham and Solihull region, ROH reported the highest uptake, exceeding both regional and national averages.

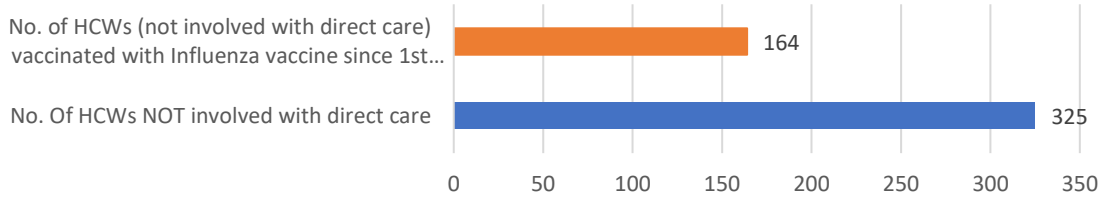


Note: The chart above only contains information on 34 out of 43 Trusts in the Midlands, who reported uptake in the ImmForm Healthcare Worker Flu and Covid-19 vaccine uptake 2022/23, February 2023.

Data source: UKHSA_Seasonal_influenza_vaccine_uptake_Frontline__HCW_February-2023.ods (live.com)

ROH Vaccination Programme 2022/23





2. 2022/23 challenges, and lessons learned

2.1. There were many lessons learned from the 2022/23 campaign. It was the first campaign led by the IPC Lead Nurse who had no prior experience of delivering or leading on this at the ROH. Planning and delivery of the vaccination campaign was turned around in a short space of time but was very labour intensive, identifying and training vaccinators, coordinating vaccinations, collecting/submitting data and promoting vaccinations.

2.2. Enthusiasm for the 2022/23 campaign was not as profound as seen in the previous years. It is likely this is due to vaccine fatigue, especially as the campaign was run alongside the autumn COVID-19 boosters.

2.3. Sourcing peer vaccinators was a challenge. In total there were eleven trained vaccinators. Vaccination uptake may have been increased if there was support from clinical teams to identify 'peer vaccinators' within their areas.

2.4. Encouraging support for the campaign is an absolutely necessity and buy in from senior members of the Trust will help to cement this. Planning the campaign as early as possible will help to ensure measures and processes are in place before the campaign begins. Also, key stakeholders to help influence and deliver the campaign have been identified and engaged with early on to support a better delivered campaign for 2023/24.

3. 2023/24 CQUIN

3.1. The 2023/24 CQUIN01 will run for quarters 3 and 4 only, from 1st September 2023 to 29th February 2024.

3.2. The CQUIN lead is Victoria Clewer, Lead Infection Prevention and Control Nurse and the Executive Lead is Nicola Brockie, Chief Nurse and Director of Infection Prevention and Control. The Board Champion is Steve Washbourne, Executive Director of Finance & Performance.

2.3. The aim is to achieve 80% uptake of flu vaccinations by frontline staff with patient contact. The minimum uptake required to achieve the CQUIN is 75%. Payment is made based on the whole period (September 2023 to February 2024).

2.4. Achievement of the CQUIN will be calculated from the specified numerator and denominator. The numerator is the number of staff who receive their flu vaccination. The denominator is made up of the total number of frontline healthcare workers in the Trust between 1st September 2023 and 29th February 2024 who are eligible to receive the vaccine.

2.5. In line with the widened definition of frontline healthcare workers used during the 2021/22 flu season, eligible staff includes non-clinical staff who have contact with patients.

2.6. Exclusions – the following staff/groups are to be excluded from the denominator:

- Staff working in an office area with no patient contact.
- Staff out of the Trust for the whole of the flu vaccination period (e.g., maternity leave, long term sickness).
- Staff vaccinated at the Trust but leave the Trust during the vaccination period (leavers).

2.7. The Trust are required to submit data monthly (between 1st September 2023 and 29th February 2024) to UKHSA via ImmForm. Data will be made publicly available approximately six weeks after each quarter.

4. Improvement Priorities

4.1. The Royal Orthopaedic Hospital Foundation Trust (ROHFT) is committed to offering 100% of employees the influenza vaccination during 2023-24. This goes beyond the requirement to vaccinate frontline healthcare workers who have patient contact.

4.2. The Influenza vaccination Management Group has been set up and meet monthly since June 2023 to plan and organise the 2023/24 campaign.

4.3. A self-assessment against the UKHSA best practice checklist has been completed (see Appendix A). The checklist has been developed based on the four key components of developing an effective influenza vaccination programme (Committed leadership, Communications, Accessibility, and Incentives). There is a requirement to share the completed checklist in public board papers at the start of the influenza season which will be undertaken by the Executive Lead.

4.4. <u>Committed Leadership</u>

4.4.1. All Board members will be offered the influenza vaccination during the first week of the 2023/24 campaign.

4.4.2. The 2023/24 Influenza Campaign Management Group (ICMG) is formed by representatives including:

- Executive lead (ICMG Chair)
- Board Champion
- CQUIN lead
- Infection Prevention and Control
- Divisions (1,2 and Corporate)
- Pharmacy
- Communications
- HR
- ESR
- Information Governance
- Digital Transformation
- Staff Side

4.4.3. A full progress update will be provided to the Executive Team every fortnight throughout the campaign by the CQUIN Executive lead.

4.5. Communications Plan

4.5.1. The Trust Communications team will lead the development of the 2023/24 Influenza Campaign Communication Plan (see appendix C).

4.6. Flexible accessibility

4.6.1. There are plans to train and develop as many 'peer' vaccinators as possible – which is the preferred method as set out in national guidance. This will include:

- Matrons and ward/dept. managers to lead vaccinations for their areas.
- A team of flu vaccinators available to staff vaccination clinics for bookings.
- Hubs will be set up in high footfall areas such as outside Café Royale, entrances etc. during the initial vaccination period.
- A rota for 'roving vaccinators' will be created to support clinical vaccinators to undertake vaccinations in their areas.
- Dedicated 'department specific' vaccination sessions will be provided for areas such as theatres, College Green, ROH community hub acknowledging the group of staff who may struggle to leave their department to obtain their vaccination elsewhere.

4.7. Incentives

4.7.1. Incentives for the 2023/24 vaccination programme are yet to be finalised. Previous campaign incentives have included:

- £5 Café Royale lunch voucher.
- 'I've had my flu jab' cards.
- 'I've had my flu jab' stickers.
- Drink voucher.

4.8. Vaccination window

4.8.1. Vaccinations will be available from Monday 4th September 2023 until 29th February 2024.

4.8.2. The Trust aim to vaccinate as many staff as possible in the first two months of the campaign working hard to ensure staff have access to the vaccine at a time that suits them.

4.9. Outstanding actions/risks

4.9.1. Ongoing actions are to be monitored weekly by the influenza vaccination management group. See Appendix B for the current action plan.

Nikki Brockie
Executive Chief Nurse

16 August 2023

Appendix A - The Royal Orthopaedic Hospital Influenza Vaccination Best Practice Management Checklist

For public assurance via Trust Board. Last updated: 26/07/2023

Status Key

R	Red – No Progress
A	Amber – On Track
G	Green - Complete

5.

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients)	
A2	Trust has ordered and provided a quadrivalent (QIV) influenza vaccine for healthcare workers.	
A3	Board receives an evaluation of the influenza programme 2022 to 2023, including data, successes, challenges, and lessons learnt	
A4	Agree on a board champion for influenza campaign	
A5	All board members receive influenza vaccination and publicise this	
A6	Influenza team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Influenza team to meet regularly from June 2023	
B	**Communications plan**	
B1	Rationale for the influenza vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Influenza vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters, and social media	
B6	Weekly feedback on percentage uptake for directorates, teams, and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least two in each clinical area to be identified, trained, released to vaccinate, and empowered	
C2	Schedule for easy access drop-in clinics agreed	
C3	Schedule for 24-hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

R	Red – No Progress
A	Amber – On Track
G	Green - Complete

Appendix B - The Royal Orthopaedic Hospital Influenza Vaccination Action Plan

Formatted to incorporate the NICE assessment tool NG103.

Priority Area	Action	Lead	Progress update	Status
Multicomponent approach	To gather data on the 2022/23 campaign and provide overview to Trust board.	VC	Report created. To be taken to Trust board in September by NB/SW.	
	Influenza Campaign Management Group to be created.	VC	ICMG has been formed. Meetings are currently set to run once a month from June. Frequency will need to increase to fortnightly to ensure monitoring of actions prior to the start of the programme at the start of September 2023.	
	Work collaboratively with BSOL ICS flu vaccination delivery group.	VC	VC and SW attend these meetings on behalf of the ROH.	
	PGD to be signed by Medical Director and vaccinators who have completed training.	MR	Awaiting release of campaign resources.	
	Staff uptake survey and preference for timing to be sent out.	VC	Await sharing of survey questions and format from regional flu group for use at ROH.	
Raising awareness	Education, information & advice to be provided through. • Information leaflets • Trust Intranet • CEO weekly message • Team Brief • Information boards • Mandatory training • Induction training	YB	Communications plan being created. Plans in place for the 2023/24 campaign. Full update to be provided when ICS flu communications plan released.	

	Slide to be created to be included in all team briefs from July 2023.	NB	NB to discuss with Jo Williams if able to have a flu slide in team brief in July and August.	
	CEO to incorporate announcement of the vaccine programme into their weekly updates.	NB	NB to discuss with Jo Williams.	
Offering vaccination	To identify peer vaccinators within clinical areas.	KH/JP	HoN to identify staff to undertake peer vaccination training and deliver vaccines in clinical areas.	
	To identify bank staff to support vaccination campaign and 'bookable' vaccination slots – to identify times, days etc.	RH	RH to discuss with Eileen Hendrick to identify staff to cover vaccination hub sessions – all hours/days.	
	To identify the training requirement for peer vaccinators and facilitate access to training.	VC	Awaiting update of e-learning for health influenza vaccination training package for the 2023/24 campaign. VC to share training requirements with all who come forward to be a peer vaccinator and to monitor training records/competency documents.	
	To identify what vaccine(s) will be used for the 2023/24 campaign, order enough stock, and identify how they are to be administered.	GB	GB to identify how the vaccines will be administered, any storage requirements, and order vaccines/consumables.	
	Identify number of anaphylaxis packs that will be required.	GB	To be decided once vaccination locations agreed.	
	To organise and make available consumables for vaccination. • Small plasters • Sharps bin • Cool bags • Gauze	VC	Consumables required to be identified once vaccination locations agreed. VC to liaise with Stores to source consumables not already ordered via foundry with the vaccines.	
	Vaccination clinics to be scheduled and advertised via the Trust Intranet.	RH	To be discussed when number of vaccinators known.	

	Vaccinator rota to be created and monitored to provide access to vaccination.	RH	To be discussed when number of vaccinators known.	
	'Department specific' sessions to be staffed for off-site and 'difficult to leave' departments such as College Green, ROH community hub and theatres.	RH	To be discussed when number of vaccinators known.	
	Locations for 'pop-up' vaccination areas to be identified.	RH	Suggested at ICMG held on 26/07/23 by SW – Rathbone Hall (old physio gym) can be used as a vaccination hub. Scoping to be undertaken o identify equipment required such as chairs, tables, screens etc. Also, security to be considered.	
Audit, monitoring & feedback	Create a digital solution to consenting for vaccination (inc. opt out and vaccines delivered elsewhere) and data collection for mandatory reporting.	VC	Discussions held with Gavin Newman – plans in place to create a digital consent form and database for external reporting.	
	To identify list of eligible staff to include in reporting (denominator for CQUIN data).	VC	VC to discuss requirements with David Morris and to identify denominator – as well as a way of updating this regularly.	
	To identify who will be responsible for entering data onto ImmForm, how often this is required etc.	VC	VC will undertake the monthly Immform submissions from September 2023.	
Increasing uptake in health & social care staff	Trust Board to lead by example - be the first to be vaccinated.	NB	Plan in place to vaccine Trust Board 5th September if the vaccines are delivered and there are no delays.	
	To agree incentives and to identify who will be responsible for arranging this.	NB	NB and SW to discuss. Trust Board to agree incentives for the 2023/24 campaign. YB arranging 'I've had my flu jab' cards and stickers.	

Appendix C – Healthcare Worker Influenza Vaccination Campaign 2023/24 – Communication Plan

To be devised.

ROHTB (9/23) 022

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Net Zero Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Executive Chief Finance Officer**
AUTHOR:	**Stuart Lovack, Deputy Director of Delivery**
DATE OF MEETING:	**6 September 2023**

EXECUTIVE SUMMARY:

The NHS has set out an ambitious plan for the NHS family with each organisation contributing to its core aim; to be the world's first net zero National Health Service.

Within this aim are two key strategic targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

In 2021 the Trust Board approved its Net Zero Strategy taking into account its approach to environmental, carbon reduction and ecological sustainability factors.

The ROH Green Board was established with 10 defined workstreams. This paper provides the Board with an update on progress within each of these workstreams

REPORT RECOMMENDATION:

The Trust Board is asked to note the progress described.

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		Legal & Policy	**x**	Patient Experience	**xx**
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:

Net zero imperative set nationally by NHSE

PREVIOUS CONSIDERATION:

Annual consideration by the Trust Board

The Royal Orthopaedic Hospital NHS Trust

Net Zero Strategy (Update)

2022- 2032

September 2023

Introduction

The NHS has set out an ambitious plan for the NHS family with each organisation contributing to its core aim; to be the world's first net zero National Health Service.

Within this aim are two key strategic targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

Approach

In 2021 the Trust Board approved its Net Zero Strategy taking into account its approach to environmental, carbon reduction and ecological sustainability factors.

The ROH Green Board was established with 10 defined workstreams, each with an Executive Sponsor and a working group designed around the themes of:

- Workforce and System Working
- Sustainable Models of Care
- Digital Transformation
- Travel and Transportation
- Estates and Facilities
- Medicines and Anaesthetics
- Supply Chain and Procurement
- Food and Nutrition
- Adaptations
- Communications and Media

Workforce and System Working

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Engage with the Carbon Literacy Project to increase staff awareness and education around the impact of carbon emissions.	% of staff who have received Carbon literacy training. % staff reporting that they have made a change to support sustainability as a result of the training.	SM	DR/CL	End of Q2 22- ongoing	Dependent on engagement with the sustainability agenda leading up to launch of training and feedback from induction sessions.		Not started
1.02	Encourage staff to sign up to the Greener NHS Community linked to the Sustainability strategy.	% of staff signed up to the initiative. Communicating successful projects/ideas across the Trust and wider. Establish a 'Greener ROH' staff network/community of practice.	SM/SW	CM/JS/BS	By end of Q1 22 - ongoing By end of Q2 2023 – ongoing	Staff need to feel able to make changes which will make a difference.	Discussions to take place at existing staff networks to see how work can be incorporated as well as reviewing options to start a greener network group.	BAU
1.03	Link sustainability to the Trust Health and Wellbeing agenda and incentivise sustainability actions to increase staff engagement.	% uptake of carbon friendly wellbeing initiatives i.e. walking to work week, linking with local partners (Living Streets) Portfolio of wellbeing initiatives offer from the Trust.	SM	CM/LTH		Managers to champion initiatives. Secure future funding for initiatives. (Living Streets)	Regular Wellbeing updates to Trust Board members and managers meetings. Follow up with Living Streets.	BAU
1.04	Further embed an agile/flexible working culture across the Trust.	% of total staff with flexible working arrangements (WFH). Increase in positive responses to flexible working questions within the annual staff.	SM	AH	Ongoing	Staff turnover/reductions in workforce availability/large vacancy gaps may result in less flexible working requests being considered/approved.		In progress
1.05	Ensure that sustainability and the responsibilities of staff in terms of moving towards net zero are included within recruitment literature for all staff.	Statement within recruitment literature which highlights the Trusts commitment to sustainability/net zero.	SM	DM/TH	End of Q3 2023	Improvements in attraction rates in the age groups of those most likely to be interested in the green agenda.	The ROH use TRAC for all recruitment processes, therefore ensure any statements are included within the introductory documentation in recruitment campaigns.	In progress

Workforce and System Working

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Ensure that sustainability and the responsibilities of staff in terms of moving towards net zero are included within Trust Induction and Mandatory training for all staff.	Trust and local inductions to include information on sustainability/net zero.	SM	DR/CF	End of Q1 2022		Relevant session to be confirmed.	In progress
1.07	Ensure that sustainability and the responsibilities of staff in terms of moving towards net zero are included within job descriptions for all staff.	Generic statement/s to be agreed and included in all Job description templates.	SM	JC/HR Recruitment	By end of Q1 2022 - ongoing	Ensure that environmentally friendly ways of working are considered by all of the workforce and job applicants.	This has already been included in the AFC Job Description template.	BAU
1.08	Ensure all leaders are aware of their responsibilities with regards to sustainability and include in individual objectives and one to one conversations.	Spot checks of individual objectives.	SM	OD Team	Ongoing	Dependent on all Trust leaders understanding their responsibilities in relation to sustainability. Dependent on all staff having individual appraisals/objective setting.		In progress
1.09	Ensure all leaders are aware of their responsibilities with regards to sustainability and include in team annual plans.	Annual planning template to include standard section to prompt teams to consider sustainability. Included as topic in Management and Leadership programme.	SM	Trust leaders, Business planning teams, Facilitators.	End of Q4 2021 - Ongoing	Dependent on all team annual plans being completed. Duration and frequency of development programme.	Included in documentation for annual planning.	BAU
1.10	Implement an electronic document management system for the storage and access to employee personal files.	Purchase and implementation of software. Implementation of guidance on storage/content of personal files. Destruction schedule for leaver files.	SM/JW	TH	End of Q3 2023	Granting of authority to go ahead with the procurement of a DMS/off-site storage for leaver files.	Three providers have been contacted and given the specifications. Commercials have been obtained pending authority to purchase.	In progress

Sustainable Models of Care

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Reduce number of patients travelling onto site. Increase number of virtual consultations.	Increasing number of virtual appointments. Reduced traffic to site.	MP	MP	Ongoing	Dependent on uptake of virtual consultations.	Ongoing	In progress
1.02	Reduce number of patients travelling onto site and reduced number of unnecessary consultations with increased uptake of PIFU.	Reduced traffic to site.	MP	MP	Ongoing	Dependent on uptake of patients on a PIFU pathway.	Ongoing	In progress
1.03	Reduce number of patients travelling onto site and reduced number of unnecessary consultations with increased uptake of advice and guidance.	Reduced traffic to site, reduction in inappropriate referrals.	MP	MP	Ongoing	Dependent on number of A&G requests vs direct referrals.	Ongoing	In progress
1.04	Reduce printing and letter sending through use of online letters and texts.	Increase in number of patients using the apps, decrease in the number of printed sets of information.	MP	MP	Ongoing	Dependent on patient's acceptance of using an apps, risk to increased uptake with patients who are unable to access via smart phone/ phone/another IT equipment.	Ongoing	In progress
1.05	Reduce number of patients travelling to joint care catch ups by moving the meetings online.	Reduced traffic to site.	MP	MP	Ongoing	Risk to increased uptake with patients who are unable to access via smart phone/phone/ another IT equipment.	Ongoing	In progress

Sustainable Models of Care

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Reduce printing of paper booklets through utilising my recovery app.	Increase in number of patients using the app, decrease in the number of printed sets of information.	MP	MP	Ongoing	Dependent on patient's acceptance of using an app. Risk to increased uptake with patients who are unable to access via smart phone/ phone/another IT equipment.	Ongoing	In progress
1.07	Reduce paper in OPD through the Intouch Upgrade.	Reduced sets of papers and forms being printed.	MP	MP	Ongoing		Ongoing	In progress
1.08	Reduce plastic waste though exploring alternatives to kit wrappers in theatres.	Reduction in plastic waste, reduction in kits being re-sterilised due to breakages in wrapping.	MP	MR	Ongoing		Ongoing	In progress

Digital Transformation

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Digital Care Pathway Redesign - Clinical Portal.	% of paper patient-based notes not being required for clinic. ▪% of Patient information available electronically.	SW	GN	Ongoing	Reliance on UHB resource.	Configuration underway.	In progress
1.02	Cloud Migration – Replacing. Hardware removal of Data Centre.	Total amount of ROH estate migrated to cloud. Total Power and cooling costs saved.	SW	MM	Ongoing			In progress
1.03	EPMA Phase 3	Total paper-based process replaced.	AT	GN	Ongoing	Reliance on UHB resource.	Delivery planning underway.	In progress
1.04	Order Comms	% electronic ordering completed.	AT	GN	Ongoing	Reliance on UHB resource.		In progress
1.05	RPA (FX) replace paper processes	Total paper processes replaced with electronic/web-based solution.	SW	GN	Ongoing			In progress

Digital Transformation

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Digitise Medical Records	% of full electronic patient records ingested to Clinical Portal.	SW	GN/MP	Ongoing	ICS based initiative dependant on funding.		In progress
1.07	Electronic Referral Management (Replacement of paper-based referrals.	% of Referrals managed via RMS.	MP	MB/TC	Ongoing	Adoption in all departments.	Underway	In progress
1.08	Reduced Printer estate	% reduction in printing. Total amount of printers reduced.	SW	MM	Ongoing	Risk – Increased printing volumes.		In progress
1.09	Digital Care Pathway Redesign – Digitise Pre-Op.	Total reduction in patient costs and distance travelled. % of completed pre-assessments electronically.	MP	KO/GN	Ongoing	Board approval of Project Charter.	Project Charter due to go Execs Jan 2022.	In progress
1.10	Video Consultations	Total amount of consultations conducted virtually. (Phone, Video)	MP	MP/GN	Ongoing	Integration to Clinical Portal an interdependency.	1400 consultations conducted so far.	In progress
1.11	Electronic correspondence to Patients/ GP's.	Total amount of correspondence sent digitally to patients. Total amount of correspondence sent digitally to GP Surgeries.	MP	MP/GN	Ongoing	Operational onboarding of outstanding departments. Linking up additional services to GP surgeries requires UHB resource.	200,000 documents sent to GP'S. 65,000 digital appt letters opened so far.	

Travel and Transportation

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Reduce Air pollution to improve health in the Greater Birmingham area.	No Idling Zones, reduce patient/ visitor travel, reduce use of non-emergency patient transport, reduce deliveries to site.	SW	SWL	Q4 2024	Engage with West Midlands Travel, employees, ICS, Procurement.	Virtual clinics in progress at ROH, ICB established, net zero included in ICB metrics, centralised booking system for non-emergency patient transport.	In progress
1.02	Green Car Parking Policy	Flexible/Hybrid Working annual staff travel survey, car sharing platform, review staff car parking spaces, ULEV/ZEV Car Lease Scheme introduced for staff, reduction in non-essential staff parking applications	SW	SWL	Q2 2023	Government Policy on NHS Car Parking, some financial commitment, staff engagement.	Flexible/hybrid working available, car sharing available, EV charging points available for staff and visitors, ULEV/ZEV car lease scheme available, off-site car park spaces reviewed.	BAU
1.03	Increase staff cycling to work	Establish cycling club, provide additional secure cycle storage, dedicated changing/shower facilities, regular Dr Bike sessions, use of Loan Bike scheme.	SW	SWL/BS	Q2 2024	Availability of cycle commuting routes, increase staff fitness, increase changing and shower provision on site, Loan Bike scheme established.	Additional cycle storage under review, achieved Bronze Accreditation for Green Travel Plan.	BAU
1.04	Increase staff using public transport	Promotion of flexible discounted NHS staff Swift Ticket Scheme, work with Birmingham and Solihull ICS and transport providers to offer better options for staff.	SW	SWL/BS	Q3 2023	Commercial offerings may change.	Discounted NHS travel tickets promoted throughout Trust. Discussions underway through ICS Green Board, achieved Bronze accreditation.	BAU
1.05	Increase staff walking to work	Promote benefits of walking to work, review car parking policy and increase no car parking application zone.	SW	ALL		Lack of staff interest, policy not applied.	Working with Living Streets to promote benefits of walking, lunchtime walks available to all staff.	BAU

Travel and Transportation

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Promote Sustainable Travel Modes	Offer discounted travel to patients and their carers, changing/showering facilities available on site, reduced demand for car parking	SW	SWL/BS	Q4 2024	National Express West Midlands (NXWM) offering discounts, change in Government Policy on hospital car parking.	Discussions continue with NXWM, promote ways to travel through theROH Website, increased number of EV chargers on ROH site, ZEV for Specimen vehicles procured.	In progress
1.07	Reduce Business Travel	Use of teleconferencing, Executive sign-off for any non-essential business travel.	SW	SWL	Q2 2023	All staff have access to IT and staff engaged.	MS TEAMS established and in use.	BAU
1.08	Collate payroll data for business mileage	To provide a baseline, to identify essential journeys.	SW	SWL	Q2 2024	Lack of payroll data to provide baseline or monitor.	Payroll to collect data.	BAU
1.09	Reduce number of site deliveries	Increase storage space on site, work with suppliers to reduce number of journeys made to ROH site.	SW	SWL/BS	Q2 2024	Lack of available space, financial commitment to increase storage capacity, likely changes to Central Procurementand BSOL ICS contracts.	Link to Estates Development Strategy, link to Procurement Strategy.	BAU
1.10	Reduce use of Non-Emergency Patient Transport	Virtual clinics	NB	SH	Q2 2023	WMAS have established plan and targets.	Centralised non-emergency patient transport system established in BSOL.	BAU

Estates

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Utility metering - automatic reading	Being able to view live utility consumptions for half hourly data.	SW	DC	Q2 2024	Meters will enable us to view and understand its carbon performance and relate it to activity and consumption targets.	Meters approved by IPAG.	In progress
1.02	Building Management System (BMS) – Consultant to advise on best practice set up and operation to minimize carbon footprint.	Consultant based report.	SW	DC	Q2 2024	May need moremonitoring and sensors installed, more sub-metering required.	Modifications and optimizing the BMS will require local automatic submetering to ascertain the real value of BMS system recommissioning.	In progress
1.03	Boilers replacement programme – old mid1980s installations.	Consultant to report on replacement options to renew. Is it worth replacing with gas? Do we replace with an electric only solution, if so, what?	SW	DC	Q4 2024	Other M & E costs will be associated with boiler replacement. Should an alternative method of heat be used as cost could be significant. QS and/or Consultant to advise Trust.	The Trust engaged a Building Services Specialist to review its boilers, Trust applied for PSDS funding to progress the scheme however was unsuccessful in its application.	In progress
1.04	Combined Heat and Power	Viability re CHPinstallation – Consultant to investigate and provide report.	SW	DC	Q2 2024	Assess gas supply size onto site. Location requirements. Consider impact on Estates Strategy works, consider electrical shutdowns.	CHP – it is assumed that this will be a non-starter due to the pressure and drive to move away from natural gas. That is unless the Trust receives any external advice to the contrary.	Closed
1.05	Photovoltaic generation	Consultant to report upon viability of further PV generation on site.	SW	DC	Q2 2024	Cost, space, planning.	Photovoltaic system installed on block 37 roof, investigate feasibility of further expansion.	In progress

Estates

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Solar Thermal	Consultant to report upon viability of further solar thermal installations at the Trust.	SW	DC	Q4 2023	Cost, space, planning	Solar Thermal – roof space limited with installation of PV system.	BAU
1.07	Lighting & small power installations	Consultant to review clinical and non-clinical lighting and power use, report upon any reductions from models or investments implemented.	SW	DC	2024	Cost	Engage consultant to conduct a room-to-room survey to tabulate what is fluorescent lighting and form a replacement plan/ project.	In progress
1.08	Building thermal performance	Consultant to assess buildings internally and externally for thermal performance.	SW	DC	Q2 2024	Viability, cost, planning	Building thermal assessment to be undertaken.	Not started
1.09	Estates helpdesk	Staff awareness of Helpdesk calls that relate to carbon reduction and efficiency.	SW	DC	Q2 2023		Estates Helpdesk – this conversation has occurred.	BAU

Facilities

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Clinical waste Strategy targets	Implement 20:20:60 waste targets.	NB	SH/KJ	Q2 2024		Waste is segregated into three core waste streams as outlined in HTM 07:01. Split broadly constitute 20% destined for high temperature incineration, 20% destined for alternative treatment and 60% destined for low temperature domestic incineration. No NHS waste to be sent to landfill.	In progress
1.02	Reduce general (food contaminated) waste	Providing Trust staff with reusable food containers as part of a loyalty scheme.	NB	SH/KJ	Q4 2023		Sample containers to have ROH branding.	In progress
1.03	Metal recycling	Recycle surgical implants.	NB	SH/KJ	Q2 2024		Metal recycling scheme available from clinical waste provider. Alternative is OrthoMetals who process implants from crematoriums. Netherlands and Cheshire based. Cost of processing outweighs any recovered costs. Rebate on metal not feasible.	In progress
1.04	Food Waste	Sent for anaerobic digestion.	NB	SH/KJ	Q1 2023		Food waste collections in place, food waste summary report available.	BAU
1.05	Single source recycling – paper.	Combined with confidential waste.	NB	SH/KJ	Q1 2023		Confidential waste collections in place.	BAU

Facilities

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Single source recycling	DMR incorrectly segregated.	NB	SH/KJ	Q2 2024		Single source for cardboard and paper in place. Single stream for plastic and metal. Use a reverse vending machine or have central recycling points in place.	In progress
1.07	Reusable sharps containers	Replacing single use containers.	NB	SH/KJ	Q4 2023		Audits completed. Install of Bio Systems scheduled for 27th April.	In progress
1.08	Furniture reuse- internal	Reduce going to landfill.	NB	SH/KJ	Q2 2024		Introduce a “market place” for unwanted furniture/ equipment within the Trust.	In progress
1.09	Furniture reuse	Reduce going to landfill.	NB	SH/KJ	Q2 2024		Collected by the charity CT Transport. Auction the furniture to provide transport for elderly, vulnerable and SEN children to appointments or school.	In progress
1.10	Walking Aids Recycle/Re-use	To be agreed.	NB	SH/KJ	Q2 2024	To be agreed	Procurement leads (CH/LC) to discuss with Head of Therapies & CA.	In progress

Medicines and Anaesthetics

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Waste – recycle blister strips	Implement TerraCycle blister strip recycling boxes.	NB	SB	Q2 2023	Cost, time	2 boxes ordered for trial in Pharmacy and Ward 4. Abandoned due to license required to de-blister meds.	Closed
1.02	Reduce the use of plastic bags	Phase out the use of plastic Pharmacy bags and use recyclable paper bags.	NB	SB	Q2 2024	Cost pressure	Trial has commenced on Ward 4 – November 2022	In progress
1.03	Desflurane/Sevoflurane	Reduction in the use of Desflurane and increase in the use of Sevoflurane.	NB	SB	Q2 2024	Clinical need	Desflurane not used Sevoflurane is gas of choice.	Complete
1.04	Medical gases	Reduce use of Nitrous Oxide and Entonox.	NB	SB	Q2 2024	Clinical need	Nitrous Oxide capped off in theatres – only small cylinders in use.	In progress
1.05	Inhaler recycling	How inhalers are returned and disposed	NB	SB	Q3 2023	Cost pressure	Volumes are too low to initiate this scheme. Abandoned.	Closed

Medicines and Anaesthetics

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Sevoflurane recapture system	Implement devices to recapture Sevoflurane from atmosphere.	NB	SB/MR	Q2 2024	Resource to implement and buy-in from anaesthetic team.	Need to scope companies that do this- have an agreed trial of new generic Sevoflurane first March 2023.	Not started
1.07	Reduce Pharmacy deliveries	Reduce Pharmacy deliveries from twice a day to once a day for all suppliers. (unless an urgent item is required)	NB	SB/JB	Q4 2024	Stock may run out between deliveries however we have a robust system in place to ensure we have a sufficient stock holding; urgent orders are sent if required on the day.	Implemented.	Complete

Supply Chain and Procurement

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	IT Asset Recycling and Disposal (UHB and ROH led procurement).	25% or less of asset components to landfill, 75%+ target of reuse of materials/assets, 98% target for recycling/recovery of assets.	SW	MM	Q4 2023	Subject to successful award of tender.	Final review of specification currently being completed by ROH leads. Aim to publish tender next month (May). Project has been delayed by implementation of new PC Lease Management Service contract at UHB necessitating changes to the original specification.	In progress
1.02	Reduction of plastic and clinical waste by moving to a paper-based wipe.	Reduction in the use of plastic, reduction in carbon footprint, reduction in waste, reduced cost.	SW	CEPG	Q2 2024	Project planned, supplier having issues with CE marking. Infection control approval, training for staff required.	CE marking under review.	In progress
1.03	Standardise the use of medicine pots from plastic to paper once.	Reduction in the use of plastic, reduction in carbon footprint, reduction in waste, reduced cost.	SW	CPEG	2022			Complete
1.04	Reduction of plastic and clinical waste by moving to a smaller pad.	Reduction in the use of resources, reduction in clinical waste, reduction in recycling waste, reduced cost.	SW	CEPG	2022/2024	Staff training and awareness.		Complete
1.05	Gloves off campaign.	Reduction in use of plastic, reduction in clinical waste, which is not recyclable.	SW	CEPG	2024	Staff training and awareness.	Start date to be agreed.	In progress

Supply Chain and Procurement

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.06	Scrub brushes - Reduction of plastic and clinical waste by removing from use as suggested by WHO and AFPP guidelines.	Reduction in use of plastic, reduction in waste which is not recyclable, reduction in use of resources, reduce cost	SW	CEPG	Q1 2024	Staff education due to change of practise.	Awaiting a decision	In progress
1.07	Introduction of new neonatal nasal cannula which uses less plastic.	Reduction in use of plastic, reduction of clinical waste which is not recyclable, reduce cost	SW	CEPG	Q2 2023		Complete	BAU

Food and Nutrition

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Promote smart technology and emerging technologies in ourfuture developments.	Integrated intodevelopment strategy.	PB	SWL/JD	2022-2024	I - Keep up to datewith emerging technologies R – Lack of capitalfunding	LED lighting installed in Wards 1, 2 and 3.	BAU
1.02	Take a 'Whole LifeCycle Approach' to sustainability and reductions in environmental impact.	Integrated into development cycle.	PB	SWL/JD	2022-2024	R – Lack of capital funding	Whole life cycle approach considered on all new schemes.	BAU
1.03	Develop local sustainability standards/guidelinesfor major capital developments.	Production of sustainability standards for capital schemes.	PB	SWL/JD	2022		To be progressed.	Not started
1.04	Endeavour to meetthe 'Passivhaus Standard' and 'BREEAM Outstanding' status.	Integrated intofuture capital developments.	PB	SWL/JD	2022/2024	R – Lack of capitalfunding.	Considered on all new schemes at design stage, will require additional capital resource.	In progress
1.05	Strive for 'Net Zeroin Operation'.	Monitor annualmetrics against baseline data.	PB	ALL	2024		Net zero part of ICB agenda Energy data monitored/supplied by LASER.	In progress

Adaptations

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.01	Promote smart technology and emerging technologies in ourfuture developments.	Integrated intodevelopment strategy.	SW	SWL/JD	Q2 2023	I - Keep up to date with emerging technologies R – Lack of capital funding	LED lighting installed in Wards 1, 2, 3 and 12.	BAU
1.02	Take a 'Whole LifeCycle Approach' to sustainability and reductions in environmental impact.	Integrated into development cycle.	SW	SWL/JD	Q2 2023	R – Lack of capitalfunding	Whole life cycle approach considered on all new schemes.	BAU
1.03	Develop local sustainability standards/guidelines for major capital developments.	Production of sustainability standards for capital schemes.	SW	SWL/JD/BS	Q2 2024		To be progressed.	Not started
1.04	Endeavour to meetthe 'Passivhaus Standard' and 'BREEAM Outstanding' status.	Integrated intofuture capital developments.	SW	SWL/JD	Q2 2023	R – Lack of capitalfunding.	Considered on all new schemes at design stage, will require additional capital resource.	In progress
1.05	Strive for 'Net Zero in Operation'.	Monitor annualmetrics against baseline data.	SW	ALL	Q2 2023		Net zero part of ICB agenda Energy data monitored/supplied by LASER.	In progress
1.06	Assess and monitor the energy performance of the building throughout its life.	Install and monitormeter readings.	SW	SWL/DC		I - Keep up to date with emerging technologies R – Lack of capital funding	Energy metering part of Estates workstream.	In progress

Adaptations

Ref	Objective	How/Measurement	Senior/ Exec Lead	Operational Lead	Timescale	Interdependencies/Risks	Progress Update	Status
1.07	Invest in greener alternative energy solutions such as a 'Solar Farm'.	Development of a 'Solar Farm'.	SW	SWL/JD/DC	Q2 2023	R – Lack of capitalfunding	A 'solar farm' is complete on Blocks 37 & 76. Explore further opportunities.	BAU
1.08	Improve the thermal capacity of the retained estate and reduce energy leakage.	Agree development strategy and invest in the retained estate.	SW	SWL/DC	Q2 2024		To be progressed.	Not started
1.09	Always consider the use of 'Free Heating' and 'Free Cooling'.	Incorporate insustainability guidelines documentation.	SW	SWL/DC	Q2 2023	R – Lack of capitalfunding.	Free cooling trial being undertaken in Estates.	In progress
1.10	Develop our 'Agile Working' strategies and link this to service adaptation & improvement.	Development of HR Strategies & Documentation.	SW	ALL	Q2 2023		Flexible/hybrid working is part of our HR policies.	BAU
1.11	Agree a 10 year estates development strategy which incorporates the ROH Green Plan.	Board approved Development and Capital Investment Strategy.	SW	SWL	Q4 2023		Proposed estates development strategy produced, currently being discussed at Executive and TB level.	In progress
1.12	Maintain and maximise our 'Green Space' to enhance everybody's health and wellbeing.	Annual review and development of our greenspace.	SW	SWL	Q2 2023		Additional trees plants. Site maintained to a high standard.	BAU
1.13	Develop outdoor Health &Wellbeing facilities.	Improved outdoor facilities.	SW	SWL	Q3 2024		To be progressed.	In progress
1.14	Further enhance the local ecology.	Annual review of local ecology.	SW	SWL	Q2 2023		Additional bird boxes, bat boxes, orchard created.	BAU

Next Steps

- Continue to promote the Trust's Net Zero Strategy
- Monitor progress of workstreams and identified schemes
- Maintain ROH Green Board governance structure
- Identify capital investment for invest to save schemes
- Look for external 'Net Zero' funding opportunities

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

REPORT REF: ROHTB (9/23) 023 & 023 (a)

TRUST BOARD

DOCUMENT TITLE:	Learning from Deaths and Mortality Review
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Revell, Executive Medical Director
AUTHOR:	John Va Faye – Associate Medical Director Adam Roberts – Assistant Director of Governance & Risk
PRESENTED BY:	Matthew Revell, Executive Medical Director
DATE OF MEETING:	6 September 2023

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Trust Board schedules a Learning from Deaths (LFD) report quarterly on its workplan.

Governance update:
With the recent changes in staffing and leadership within the governance team, the trust is reviewing its approach to organizational learning, including the Learning from Deaths (LFD) process. The new team members are reviewing existing processes and assessing ways to maintain and enhance their effectiveness in alignment with current best practice. The outcome of this review will be an improved policy, incorporating any improvements identified by the team. By doing so, the hospital will strengthen its existing commitment to learn from deaths, ensuring that insights are captured, analysed, and disseminated throughout the organisation.

Policy update:
Deaths from people with learning difficulties has been discussed at a recent regional LFD meeting (attended by the AMD). Patients with learning difficulties had already been specifically incorporated in ROH LFD policy as a result of championing by the learning difficulties team. The policy has been reviewed within the last quarter and as stated above, is under active review with a new governance team.

Medical Examiner:
The Trust continues to explore options to restore / enhance medical examiner input following the withdrawal of the service from University Hospitals Birmingham in 2022. This has had previous consideration at Q&S. The Trust is in discussion with more than one provider and there is a high level of confidence that we will be able to enhance ME support later in the calendar year.

Qualitative Analysis: Key Learning from this reporting interval:
Key learning points from the last review which have been discussed at trust wide audit now include:

- Anticoagulant bridging therapy, particularly related to new oral anticoagulants (NOACs).
- Thoroughness of procedure consent, to include discussions patient to death as result of complications from surgery.
- Review of patient medicines preoperatively particularly those agents which have a contributory side effect pertinent to cardiac conditions.

- Resuscitation equipment and training on the wards.
- Considerations for viewing the patient and their wellbeing as a whole versus only a focused management of a particular ailment.

Quantitative Analysis:
Analysis of the Crude In-Hospital Death Rate, calculated as the number of in-hospital deaths during the period divided by the number of discharges between April 2019 and May 2023, data suggests steady state / stable rate of deaths. Benchmarking our Trust's mortality rates at AQILA, using HES/HED data against specialist orthopaedic provider peers to Mar 2023 shows rates in line with other providers and comparable comorbidity per patient. Our analysis supports equitable, quality care provision by our teams regardless of background. The Trust continues to emphasise the importance of careful case selection for admission. Presently, weekend admissions do not appear influence the 30-day mortality risk.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Mortality rate remains low overall and within historical control limits • LFD team can demonstrate the care of their reviews and leading on learning across existing governance structures • Deaths from people with learning difficulties are now discussed and incorporated into the trust's LFD policy, although the trust has not as yet experienced such a death. • The Trust has identified key learning points and actions arising have clear owners • No major evident care deficiencies or issues with decision making were revealed from the analysis of deaths in the last quarter. • The change in the governance team will impact on LFD process should be positively.	No new risks to escalate for this reporting interval Improvement work identified: • Continued monitoring of the IT feed on deaths in light of issues reported earlier in the year • Care with weekend operating case selection • Policy review around bridging anticoagulant therapy and the use of oral anticoagulants • Care with consent of high risk patients – including complications and site resources

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board is asked to:

Check and challenge the information in this report. Note and accept the sources of assurance and the work in progress to optimise the informatics feed as a result of external changes in the mortality information we receive.

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

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

Comments:

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

Best Care
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
Keeping patients safe and offering the right care, at the right time, in the right setting.
PREVIOUS CONSIDERATION:
Quality and Safety Committee on 23 August 2023

Introduction

The learning from deaths process has been described in previous papers to Quality and Safety Committee. The standard national model is that the LFD process supplements normal governance processes around deaths and examines a sample of cases, not otherwise escalated. From these learning is drawn and cases can be diverted back into governance if concerns arise. The ROH LFD process similarly supplements normal governance processes and in addition monitors all deaths within 30 days of discharge from hospital. The process is administered by the governance team who manage the tracker and the dashboard on the Trust website. It is clinically overseen by the AMD(Corporate). The AMD(Corporate) attends the regional Learning from Deaths forum regularly.

The Trust monitors mortality rates overall from an informatics standpoint at AQILA on the workplan.

Qualitative Review: Learning from Deaths

Four cases with notable learning from the last quarter are outlined below:

Case 1

[Previously considered in the last quarter's report]
A high-risk patient with aortic stenosis underwent a total hip replacement and subsequently died from a cerebro-vascular accident (stroke). The LFD process rated care as very good on the ROH site and the death as unavoidable. The case was presented at hospital wide audit and a new action was identified for the VTE group, pharmacy and Pre-Operative Clinic to further develop the policy for bridging anticoagulation, oral anticoagulants and high-risk patients (task in hand). Consent in high-risk patients was also discussed and clinician-patient conversations about incidents of death was reiterated to the consultant and clinical body. By enhancing the anticoagulation bridging policy, the hospital aims to provide clear guidance to healthcare professionals, reduce variability in practice, and enhance the quality and safety of care for patients requiring anticoagulation bridging therapy.

Case 2

A patient with above average clinical risk and comorbidities (American Society of Anaesthesiologists – ASA - score 3) underwent a total knee replacement on an additional capacity Saturday list. Surgical and peri-operative care did not give rise to concerns. The patient deteriorated post operatively during the week and died. Although the death was deemed unavoidable the issue of weekend operating on higher-risk patient has been raised and discussed at hospital wide audit. Clinicians agreed to take even more care in selecting patients for weekend operating lists. Historically, higher risk elective patients have been generally avoided at weekends. Post pandemic prioritisation and long waits have put pressure on this principle but at the same time the Trust is growing its infrastructure towards 6 day operating, in line with GIRFT HVLC discussions.

Case 3

A spinal oncology patient, who was referred to the coroner, highlighted the exceptional care and treatment provided by the trust. The investigation found that the patient's condition presented complex challenges. The patient had tumour related cord compression but had also developed a grade 1 sacral sore. A surgical decompression had been successful, and it was the sacral sore that unfortunately deteriorated after discharge to another healthcare setting. The deterioration was primarily attributed to the patient's inability to be moved due to intractable cancer pain and a residual neurological deficit, despite timely surgical intervention at ROH. As a result, the sacral sore worsened, leading to the development of sepsis and ultimately contributing to the patient's death in another institution. Such scenarios, where patients with oncological conditions require extensive care and management, pose significant challenges for both staff and patients. Positive learning is that the management of intractable cancer pain and the prevention of complications such as pressure ulcers require a multidisciplinary approach and the allocation of substantial resources which the trust provides. The Trust acknowledges the difficulties associated with these cases and remains committed to continually improving care for patients with complex oncology needs.

Case 4

A patient who had undergone a total knee replacement patient who was found unresponsive two days after surgery, having progressed very well post-operatively. Despite resuscitation efforts, the patient could not be revived. This was a high-risk patient with multiple risk factors, including a high cardiac hazard index, high body mass index, diabetes, cardiovascular issues, and a history of smoking and taking three different antidepressant medications. The antidepressants shared a common side-effect involving sudden cardiac arrest and death due to ventricular tachycardia resulting from QT interval elongation and a sinister electrocardiographic (ECG) feature called Torsades de pointes. A review of the patient's pre-operative ECG confirmed there had not been evidence of any of these changes. A structured judgment review estimated a 5/6 outcome, indicating a slight possibility of preventable death associated with this feature, although still unavoidable. The patient’s outcome was not thought to have been affected by having surgery on an isolated site, however the level of co-morbidity prompted a discussion about the upper boundary of the co-morbid profile for patients given access to surgery at ROH. Our hospital's relatively low patient death rate and the small cardiopathic patient population here made it difficult to compare with other centres to determine a hazard ratio.

Discussions at the hospital's multidisciplinary team (MDT) meetings and with members of the POAC and AMD suggested a proposal of a mechanism for enhanced review of borderline patients pre-operatively. The AMD corporate and divisional teams will take this forward; the meeting may take the form of a case conference or a regular small panel from POAC.

Quantitative Review

The 12 month rolling average 30 day mortality (HES data) June 2022 to May 2023 shows 22 cases, compared with 28 cases July 21-June 22. (Fig 1). There was 1 death in hospital during that period. Table 1.

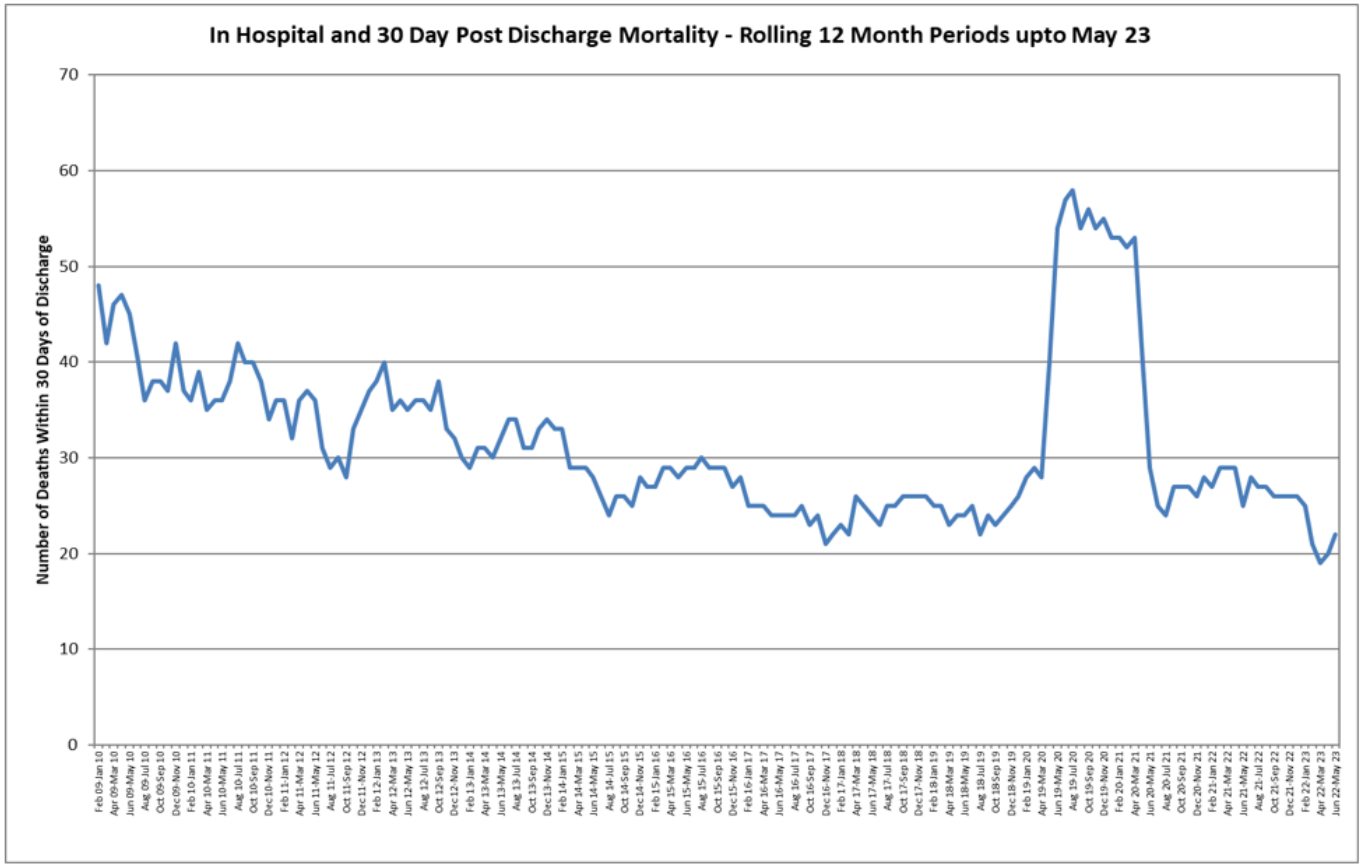


Fig 1- graph showing downward trend and overall slight drop in mortality Feb 2010- May 2023 (notwithstanding the interval increase in deaths during covid 19 pandemic)

30 Day Mortality by Month June 22 – May 23

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Deaths In Hospital										1		
1-7 Days from discharge		1	2	1		2			1			
8-30 Days from discharge	3	3		1	2		2	1	1	1		
Total	**3**	**4**	**2**	**2**	**2**	**2**	**2**	**1**	**2**	**2**	**0**	**0**

Table 1 - 30 day mortality month-by-month to May 2023, with peak in July 2022

Causes of death are summarised in Table 2 (appendix). Some benchmarking data for in-hospital deaths and co-morbid scores against other stand-alone orthopaedic Trusts are shown graphically in Figs 2 and 3 in the appendix also.

Conclusion

Mortality remains within historical control limits.

The learning from deaths team continue to review all deaths within 30 days of discharge and to facilitate and support learning through the governance and clinical audit meetings.

Figure 2 Learning from Deaths Dashboard

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

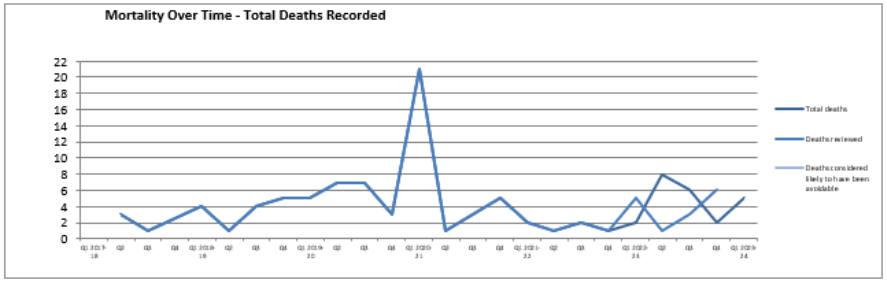
Department of Health

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	2	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	2	0	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	18	0	15	0	0

Time Series: Start da 2017-18 Q1 End date 2023-24 Q1



Total Deaths Reviewed by RCP Methodology Score

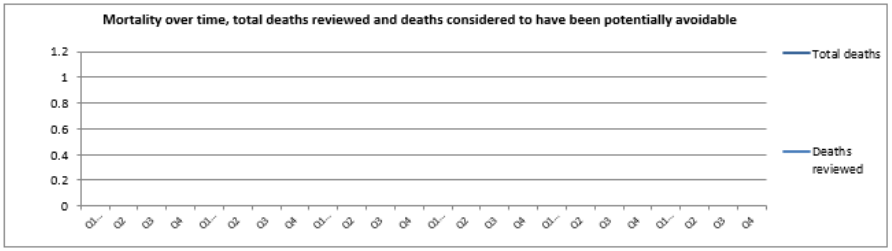
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month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

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

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

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

Time Series: Start da 2017-18 Q1 End date 2022-23 Q4



Appendix

Cause of Death (ICD10 Diagnosis Code – June 22 – May 23

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

Mortality Outcome	CCS Code	Cause of Death Description	Total
DEATHS IN HOSPITAL	203 - Osteoarthritis	Chronic ischaemic heart disease, unspecified	1
1-7 DAYS	203 - Osteoarthritis	Joint disorder, unspecified	2
	21 - Cancer of bone and connective tissue	Other and unspecified intestinal obstruction	1
	238 - Complications of surgical procedures or medical care	Acute peritonitis	1
	42 - Secondary malignancies	Not Recorded	1
	95 - Other nervous system disorders	Malignant neoplasm: Bronchus or lung, unspecified	1
		Striatonigral degeneration	1
8-30 DAYS	203 - Osteoarthritis	Acute myocardial infarction, unspecified	1
		Bronchopneumonia, unspecified	1
	209 - Other acquired deformities	Not Recorded	1
	21 - Cancer of bone and connective tissue	Malignant neoplasm: Connective and soft tissue, unspecified	1
	238 - Complications of surgical procedures or medical care	Bronchopneumonia, unspecified	1
	42 - Secondary malignancies	Not Recorded	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Diffuse large B-cell lymphoma	1
		Malignant neoplasm, primary site unknown, so stated	1
		Malignant neoplasm: Colon, unspecified	1
		Malignant neoplasm: Connective and soft tissue, unspecified	1
		Malignant neoplasm: Oesophagus, unspecified	1
	205 - Spondylosis; intervertebral disc disorders; other back problems	Atherosclerotic heart disease	1
		Not Recorded	1
		Other specified inflammatory liver diseases	1
Grand Total			22

Table 2- Cause of Death as per ONS data CCS code (June 22- May 23) with malignant disease as a leading cause and/or contribution to death.

Comparison of Mortality Data between Royal Orthopaedic Hospital, Royal National Orthopaedic Hospital and Robert Jones and Agnes Hunt Orthopaedic Hospital

July 20 – May 23

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

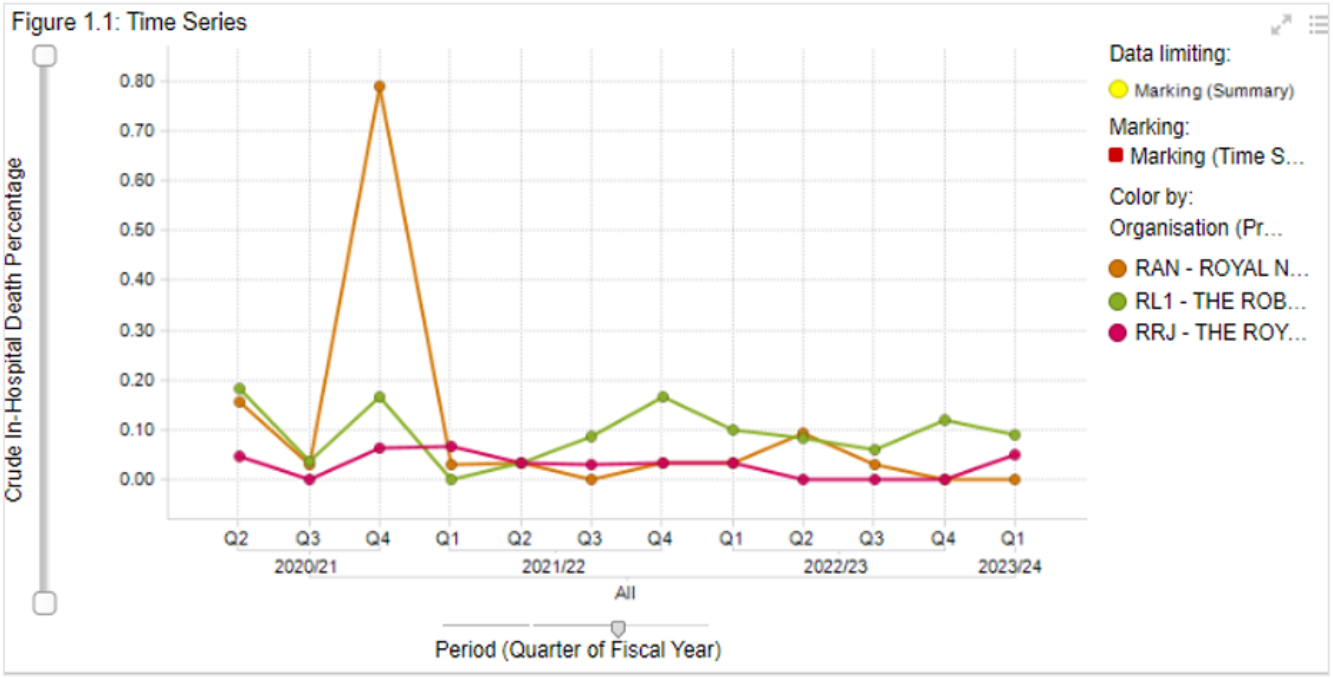


Fig 2 - Quarterly in-hospital deaths compared with other stand-alone orthopaedic trusts.

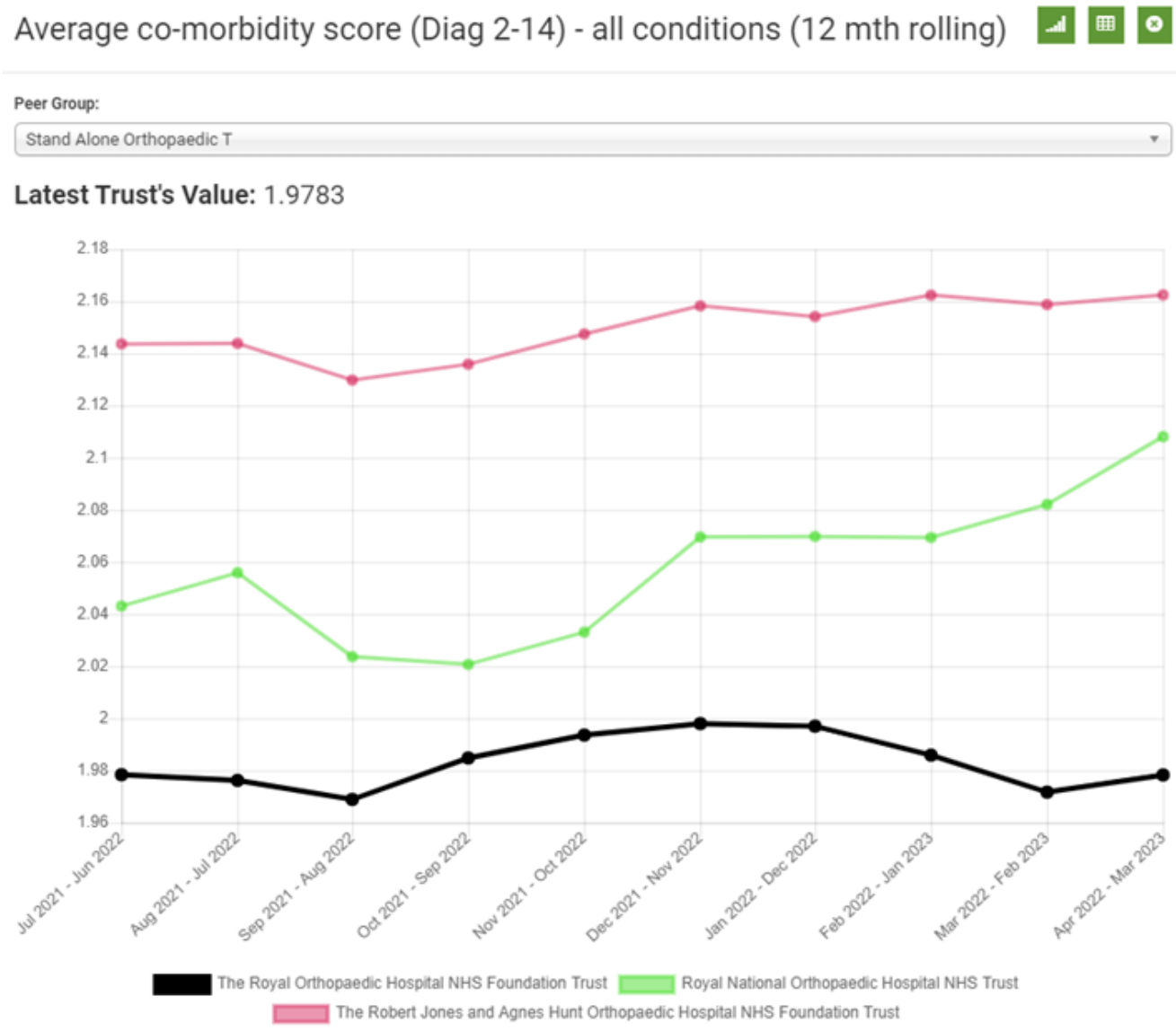


Fig 3- 12 month rolling average comorbidity score to March 2023 compared with other specialist orthopaedic Trusts

Finance and Performance Report

Month 04

Introduction

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

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

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

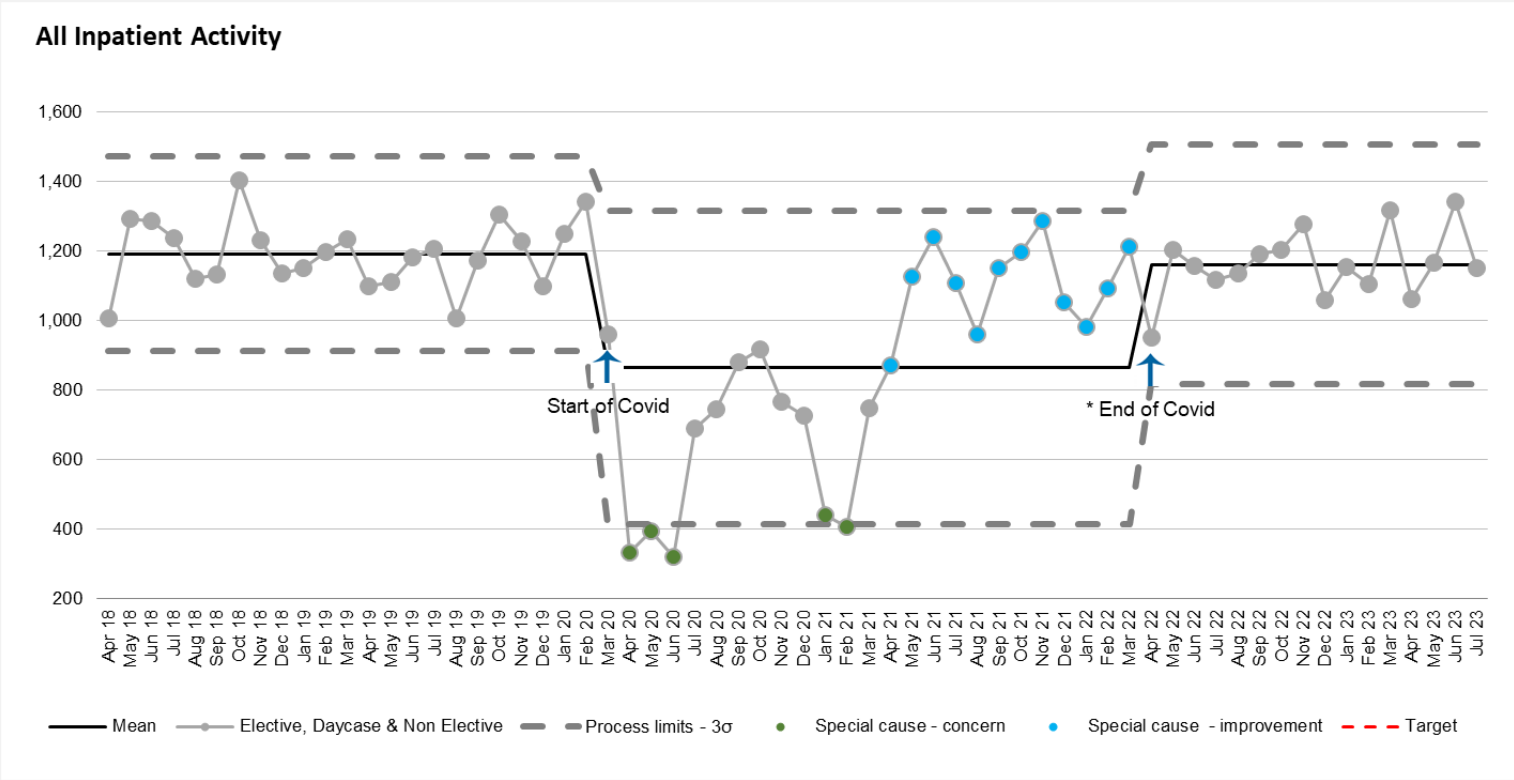
Operational Performance Summary

	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (In Session)	83.28%	80.90%	85%		
Cancer - 2 week wait (May – Apr)	98.8%	100%	93%		
Cancer - 31 day first treatment	94.1%	90%	96%		
Cancer - 31 day subsequent (surgery)	100%	90%	94%		
Cancer - 62 day (traditional)	61.5%	43%	85%		
Cancer - 62 day (Cons upgrade)	81.8%	71%	n/a		
28 day FDS	80.4%	79%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	8,156	6,079 Cumulative	7,712 Cumulative		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.55	3.20	n/a		
LOS - elective primary hip	3.50	3.20	2.7		
LOS - elective primary knee	2.90	3.20	2.7		
BADS Day Case rate (Note: due to time lag in month is Apr'23)	76%	78%	85%		

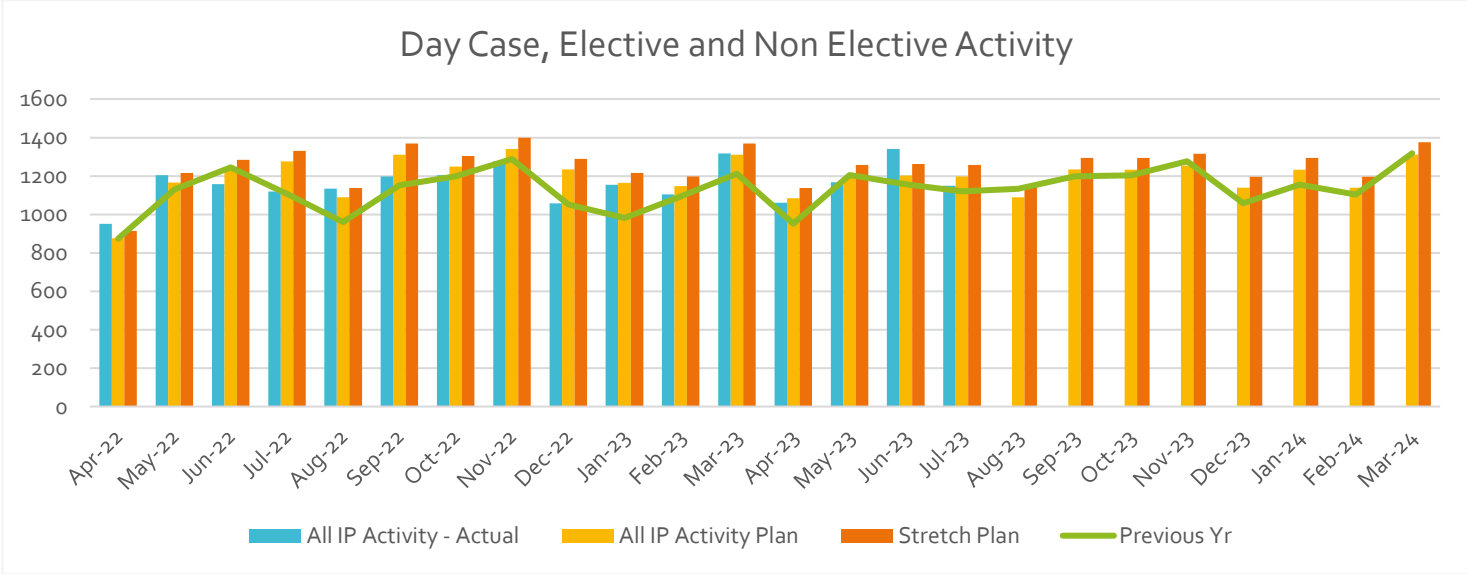
Operational Performance Summary

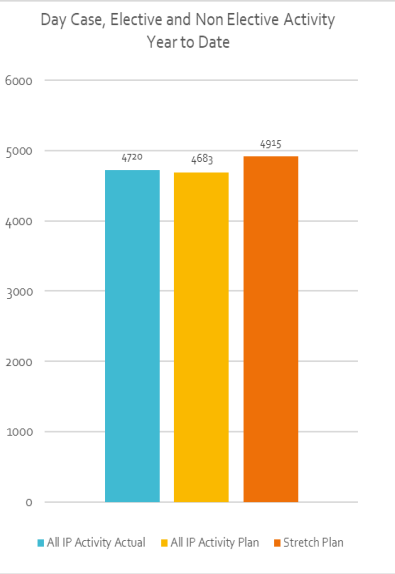
Performance to end July 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.61%	56.07%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	13	19	0		
52 week waits (52 – 64 Weeks)	309	266	0		
All activity YTD (compared to plan)	4,720	3,570	4,683		
Outpatient activity YTD (compared to plan)	21,487 100.1% Cumulative	16,376 102.9% Cumulative	21,455 YTD Target		
Outpatient Did Not Attend (YTD)	8.3%	7.88%	8%		
PIFU (trajectory to 5% target)	439 8.2%	465 7.9%	193 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	11.3%	10.6%	19%		
FUP attendances(compared to 19/20 baseline)	89.4%	92.9%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	104.8%	105.9%	N/A		
Diagnostics volume YTD (compared to plan)	7,624 Cumulative	5,982 Cumulative	6,207 YTD Target		
Diagnostics 6 week target	99.8%	99.4%	99%		

1. Activity Summary



1. Activity Summary



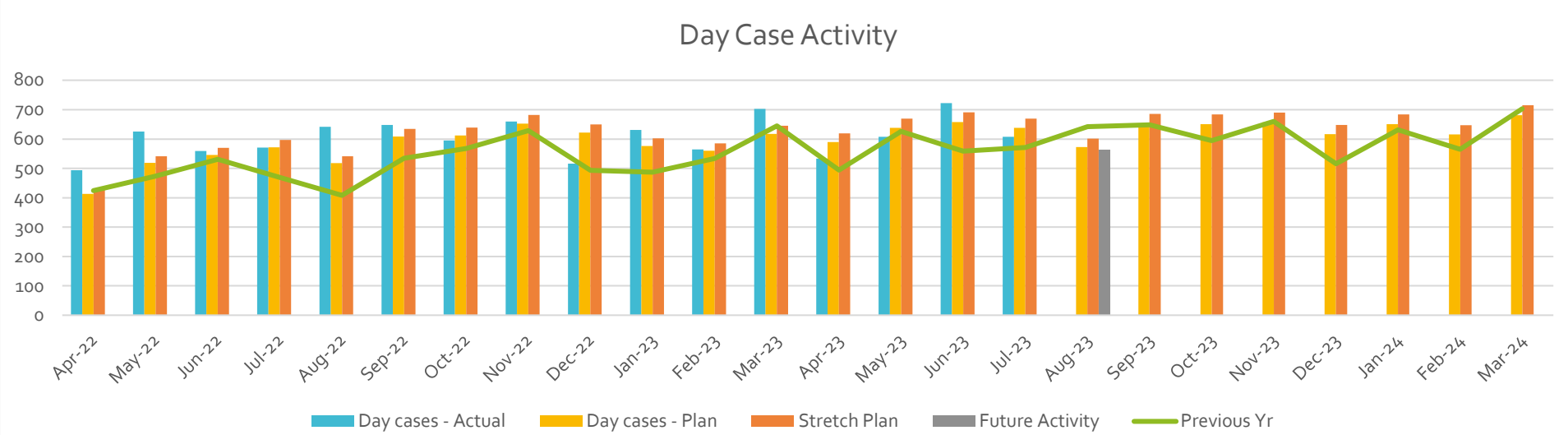


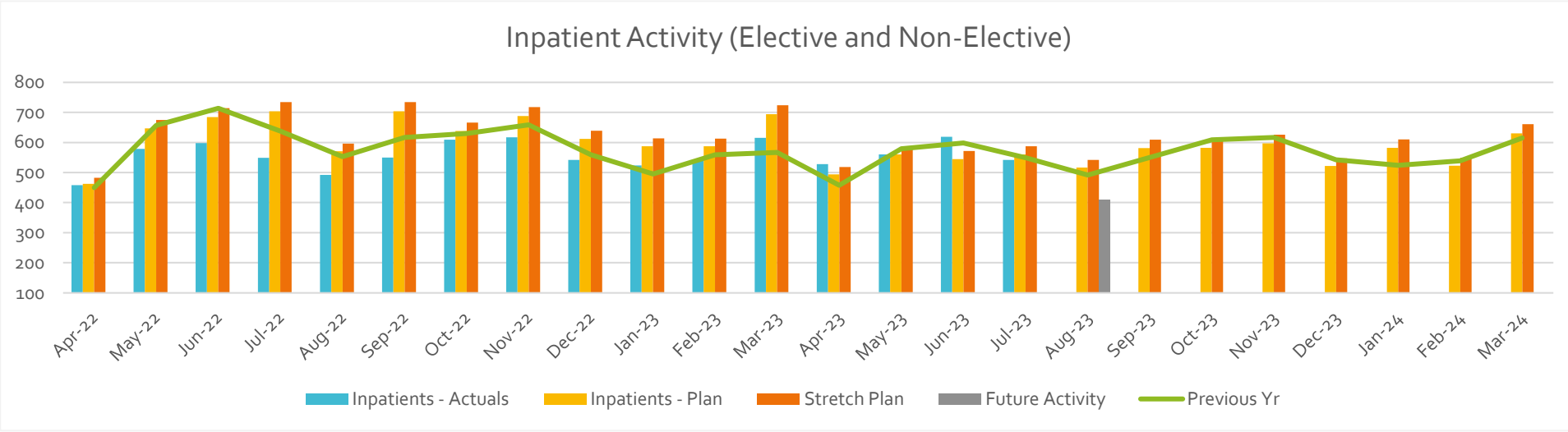
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	2110	2138	101%	28
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	2524	2471	98%	-53
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	49	111	227%	62
	All Activity	**1084**	**1198**	**1203**	**1198**	**1090**	**1234**	**1233**	**1254**	**1139**	**1233**	**1139**	**1311**	**4683**	**4720**	**100.8%**	**37**
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	2216	2138	97%	-77
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	2650	2471	93%	-179
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	49	111	227%	62
	All Activity	**1138**	**1257**	**1263**	**1257**	**1144**	**1295**	**1294**	**1316**	**1195**	**1294**	**1195**	**1376**	**4915**	**4720**	**96%**	**-195**

July 2023

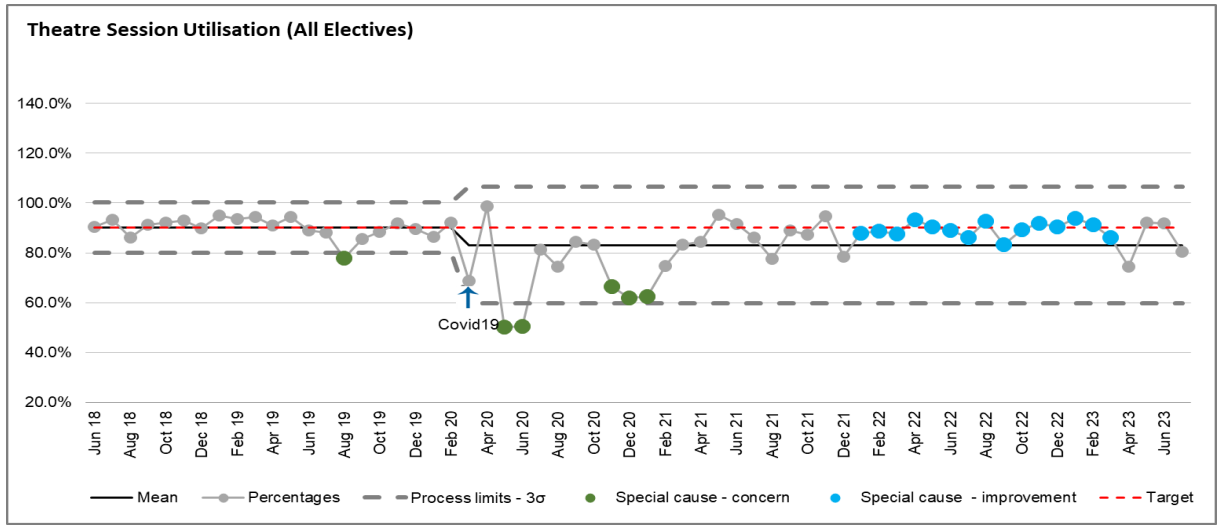
Actual in month 1150 vs 1198 System Plan (Variance -48)
YTD position against Actual vs System plan is 100.8% (Variance +37)
Current forecast for August is on track to meet the system plan (Variance +16)

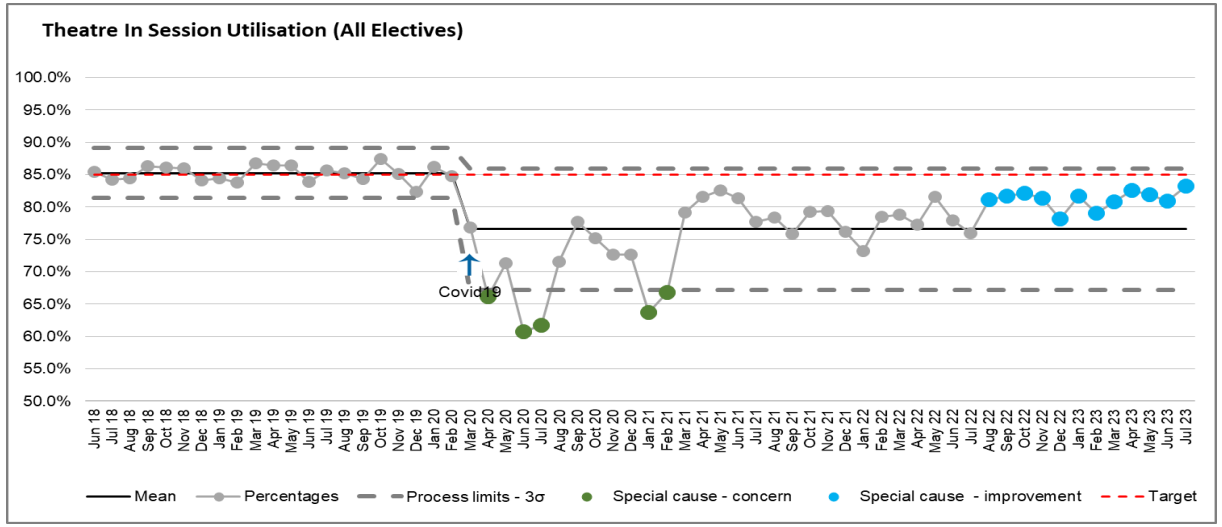
1. Activity Summary





2. Theatre Utilisation

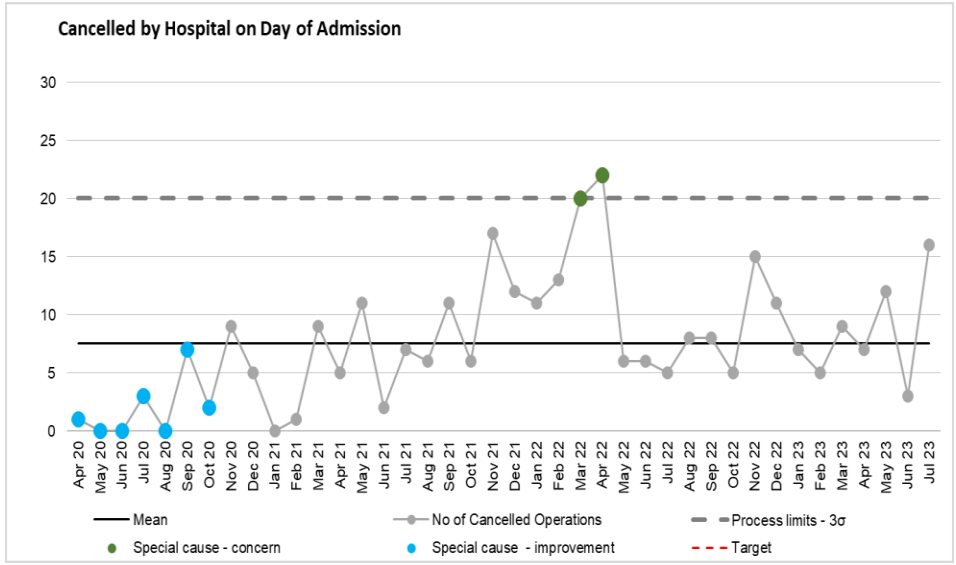


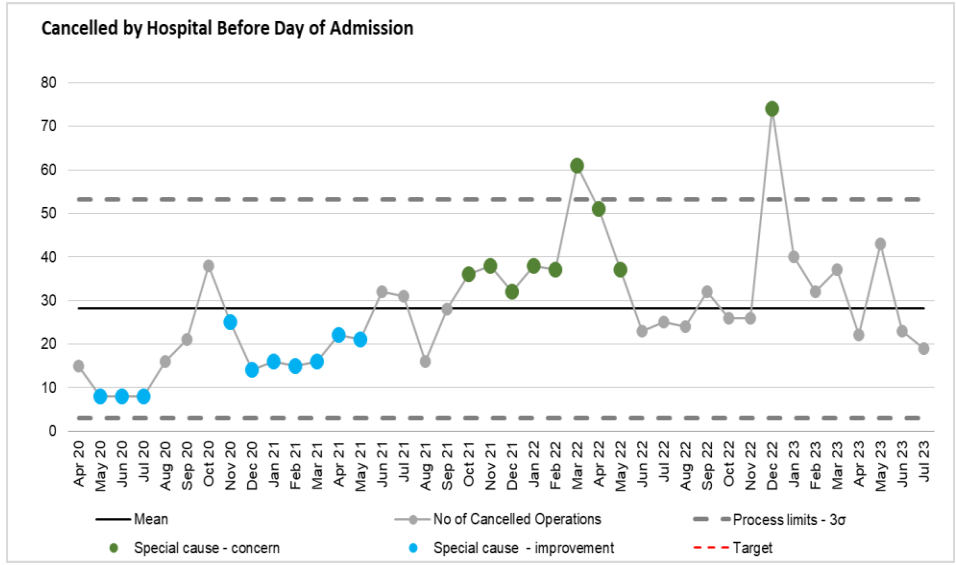


Elective Session Utilisation (July 2023)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	445	358	87	80.45%
UHB	69	55	14	79.71%
Totals	514	413	101	**80.35%**

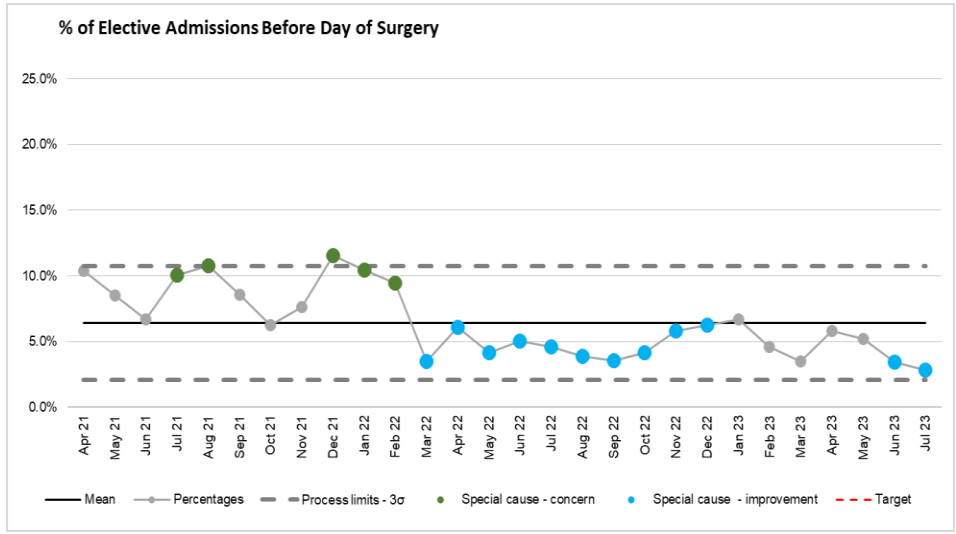
Elective In Session Utilisation (July 2023)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1593	1334	259	83.72%
UHB	253	203	49	80.51%
Totals	1846	1537	309	**83.28%**

2. Theatre Utilisation/ Hospital Led Cancellations





Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Jul-22	5	28	25	58	0
Aug-22	9	28	23	60	0
Sep-22	8	29	32	69	0
Oct-22	5	35	26	66	0
Nov-22	15	18	26	59	0
Dec-22	11	24	74	109	0
Jan-23	7	25	40	72	0
Feb-23	7	29	33	69	0
Mar-23	9	31	37	77	0
Apr-23	7	24	22	53	0
May-23	12	16	43	71	0
Jun-23	3	27	23	53	0
Jul-23	16	20	19	55	0
Total	**114**	**334**	**423**	**871**	**0**



2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for July was **80.35%** which was below the Trust target of **85%,**

The in-session utilisation of the ROH lists improved in month at **83.72%** and the utilisation of UHB lists was **80.51%** resulting in an overall **t**otal in-session utilisation of **83.28**%.

List utilisation reduced in July when compared to June. The main driver was the impact of the consultant industrial action which took place on the 20th and 21st July and resulted in only emergency theatres being provided. The impact was that all elective theatres were cancelled over the two days. If the industrial action had not taken place, then list utilisation has been estimated as 88%. It is not possible to ascertain what the in-session utilisation would have been.

AREAS FOR IMPROVEMENT

The proposed deep dive into early finishes supported by the clinical teams and by the BI dashboard has been delayed due to change in personnel, this has now been incorporated into the Trust's GIRFT Hub Optimisation Plan. Reviewing opportunities to utilise mutual aid patients prepped for surgery to avoid early finishes and also, auditing themes regarding cancellations on the day. Themes have been picked up on the UHB lists that have been shared with the team and requested an action plan to improve.

In parallel, Division 1 are focussing on the outpatient booking to maximise available slots that will contribute to an increased conversion from outpatient to electives generating a larger pool of patients to fill lists at short notice. This compliments the ongoing outpatient transformation work.

RISKS / ISSUES

LLP arrangements have now been agreed with Arthroplasty to support additional activity outside of job planned sessions supporting current vacancy gaps. Close monitoring of tray and consumable usage has commenced, and a gap analysis of requirements is being undertaken to ensure sufficient trays and consumables are available to support the additional activity at weekends. There is no B Braun decontamination service on Sundays, this will be re-negotiated, as a part of the new system contract negotiations.

The team expects the uptake of standby patients to improve in September 23. KPsI are being agreed with the clinical teams and will be reported from Q3.

2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases. These cases are more difficult to avoid due to the very short notice booking:

16 patients were cancelled on the day with reasons detailed as follows:
11 x Surgeon/Anaesthetist absence due to sickness or emergency leave
3 x Lack of theatre time
1 x Medically unfit / Clinical change in condition
1 x Lack of equipment due to company representative not providing in the required timeframe.

19 patients admitted and had treatment deferred, with the reasons detailed as follows:
8 x Medically unfit / Clinical change in condition / Covid / Flu related
3 x patient choice
2 x procedure abandoned/no longer required – patient unwell in theatre / patients condition improved
2 x Surgeon/Anaesthetist absence due to sickness or emergency leave
2 x patients hadn't stopped meds
1 x further assessment required
1 x procedure done elsewhere – needed cardiology input and transfer to UHB for procedure.

19 patients cancelled by the hospital the day before the date of admission
10 x Medically unfit / Covid/Flu related
1 x Staff availability
1 x lack of equipment
5 x patient choice
2 x Industrial action

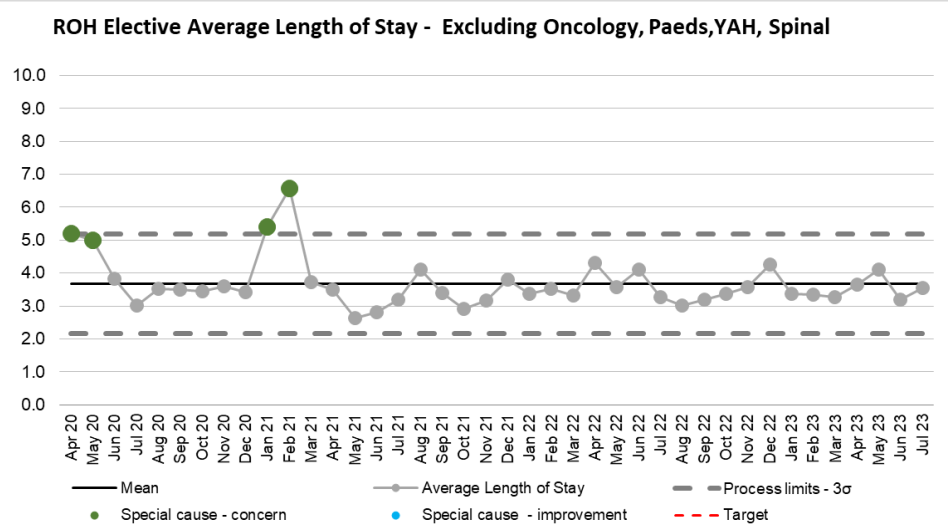
AREAS FOR IMPROVEMENT

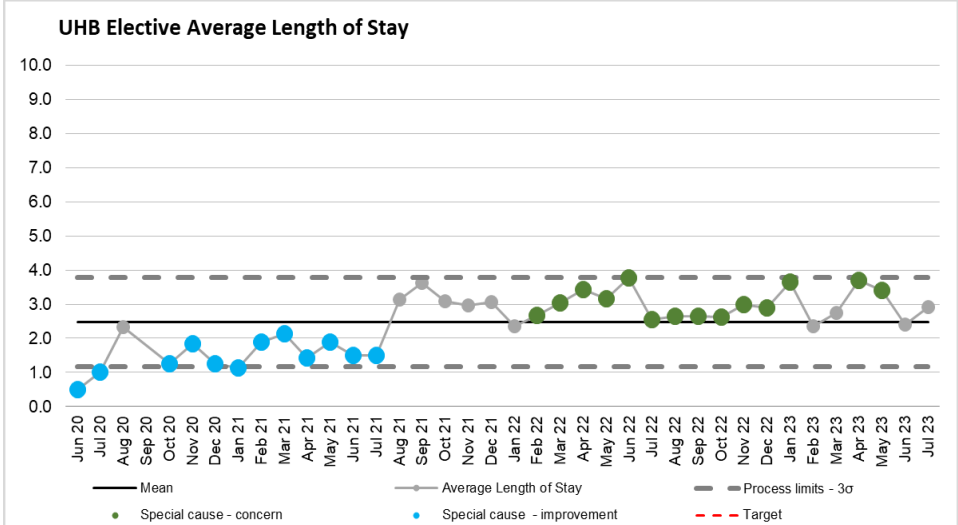
Deep dive to investigate why patients cancelled due to them no longer requiring surgery or patients changing their mind about surgery to take place, The deep dive will focus on any learning / process changes required to prevent / reduce the risk of this continuing. Work to commence in September and report in October.

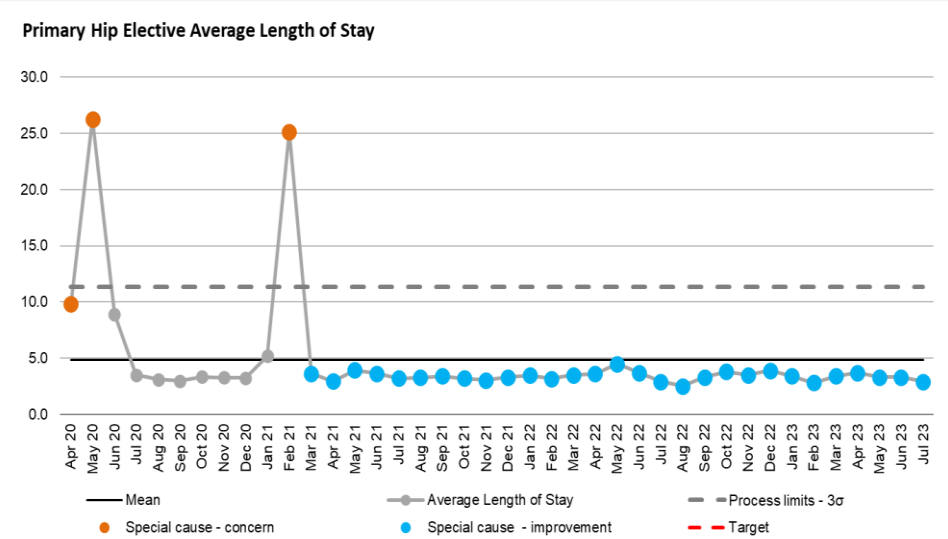
RISKS / ISSUES

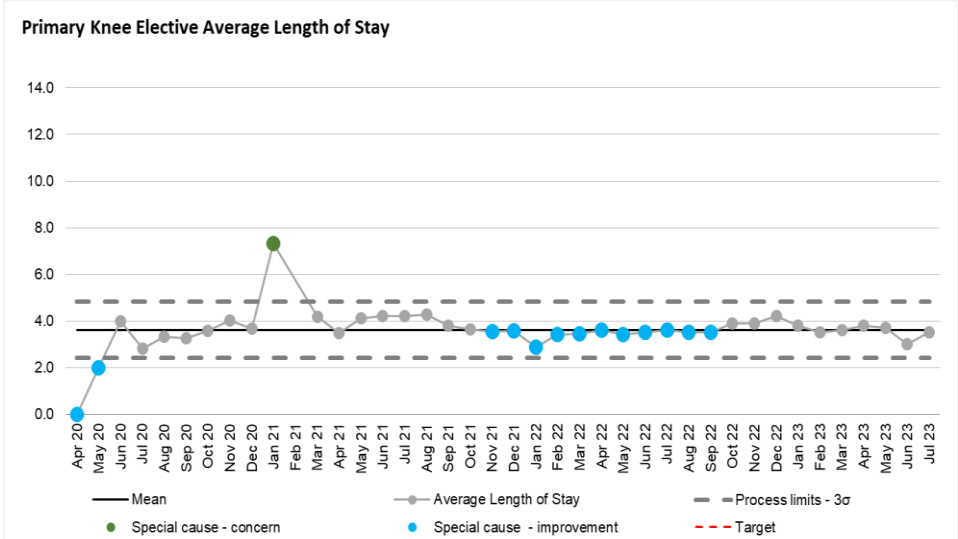
Risks continue to centre around vacancies in respect of on-going recruitment and, also the length of time to get staff in post. This is an area of specific focus for the newly appointed HR Manager whois working with the clinical Operational teams at ways that processes can be streamlined.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips is at 2.9 days (3.2 days June 23) and primary Knees 3.5 days (3.2 June 23).

June 2023 length of stay data produced for ROH, has been reviewed and the following observations made:

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is **3.55 days** (3.20 June).

ROH patients-179 arthroplasty/Oncology arthroplasty

- 65 (68 June) ROH patients, arthroplasty and oncology arthroplasty, with a LOS greater than 3 days. 32 (39 June) with a length of stay greater than 5 days, 18 (28 June) with a length of stay greater than 7 days.

UHB patients-12 arthroplasty.

- 5 (3 June) UHB arthroplasty patients with LOS greater than 3 days. 4 (1 June) with a length of stay greater than 5 days and 1 (1 June) with a stay greater than 7 days.

In summary 18 ROH arthroplasty and 1 UHB arthroplasty patient had a length of stay greater than 7 days.
Oncology Arthroplasty data included procedures such as long and complex Endoprosthetic Replacements and amputations .
All ROH patients reviewed on PICS had a greater LOS due to clinical (not medically fit) or social needs.

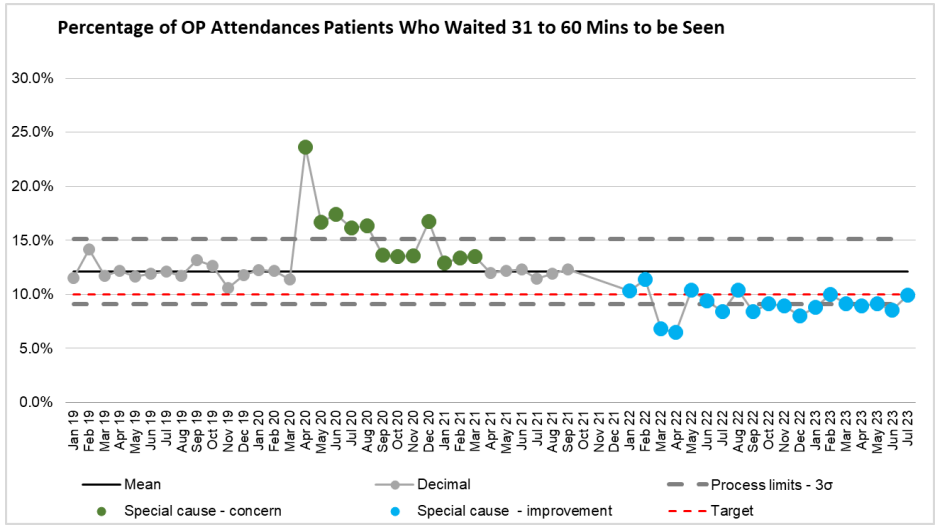
AREAS FOR IMPROVEMENT

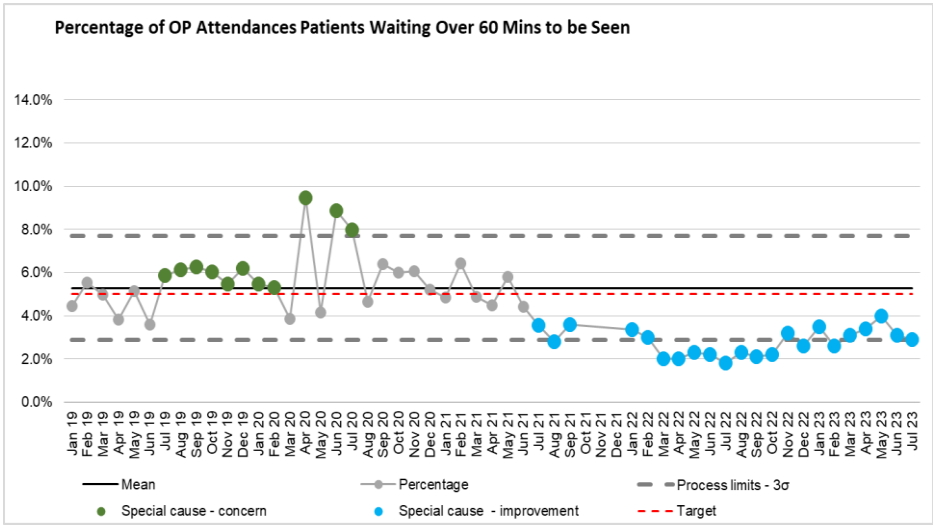
Following a recent Model Hospital Club presentation by spinal services, service improvement board is reviewing opportunities to increase day case options for spinal. The Deputy COO, AMD and Head of Nursing – Division 1 have reviewed May data and are ensuring processes for escalation are being followed for patients staying longer than the average LoS. ROH is ahead of comparable peers such as RJAH and RNOH on most Orthopaedic Model Hospital metrics. The aspiration for overall Average LOS for primary arthroplasty patients is 2 days. This is in place for Uni-knees and planning is being undertaken for TKR and shoulder cases. Further benchmarking will be undertaken and conversations with peers that are achieving 2 days for hip and knee primaries. The revised slide to split out medically complex from routine patients will be shared at next month's committee.

RISKS/ISSUES

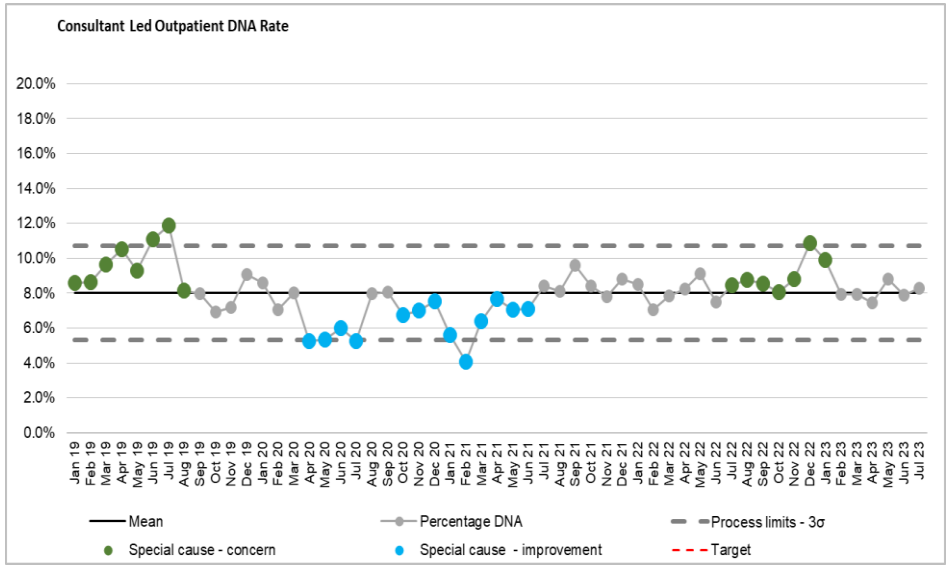
Major Revision Centre/BIS work. A service framework is in development, in association, with the clinical teams and the national programme.
Pre-existing social care and medical needs of primary arthroplasty patients need to be considered when aspiring for 2-day LOS.

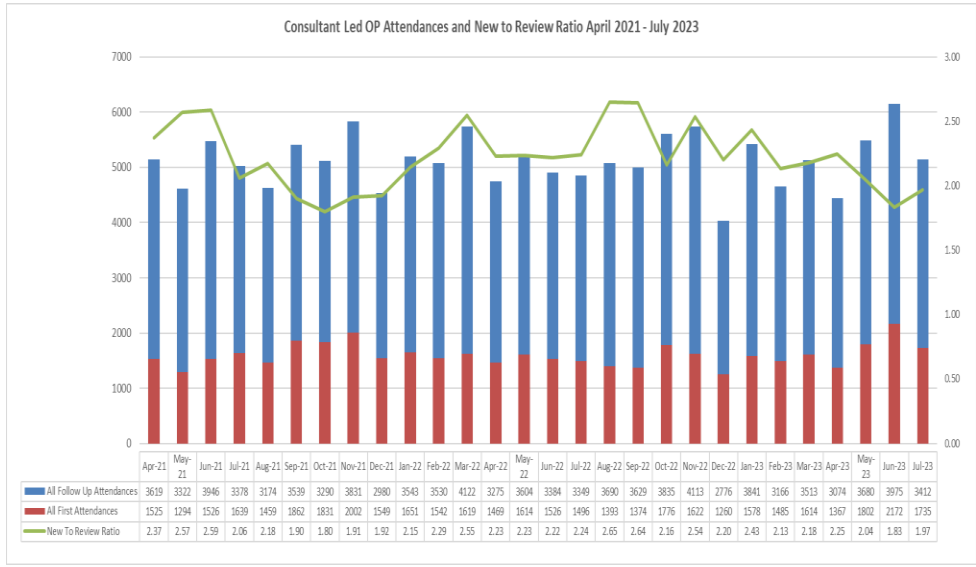
4. Outpatient efficiency



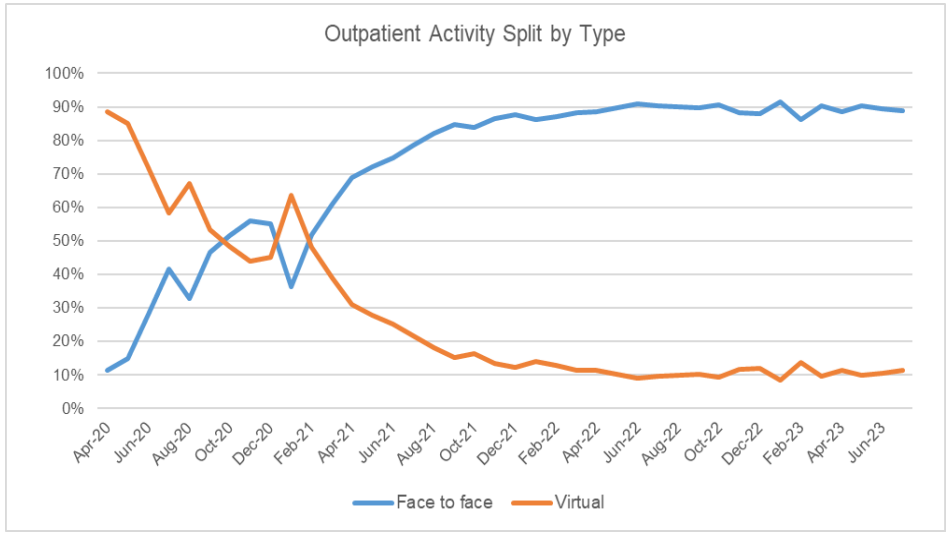


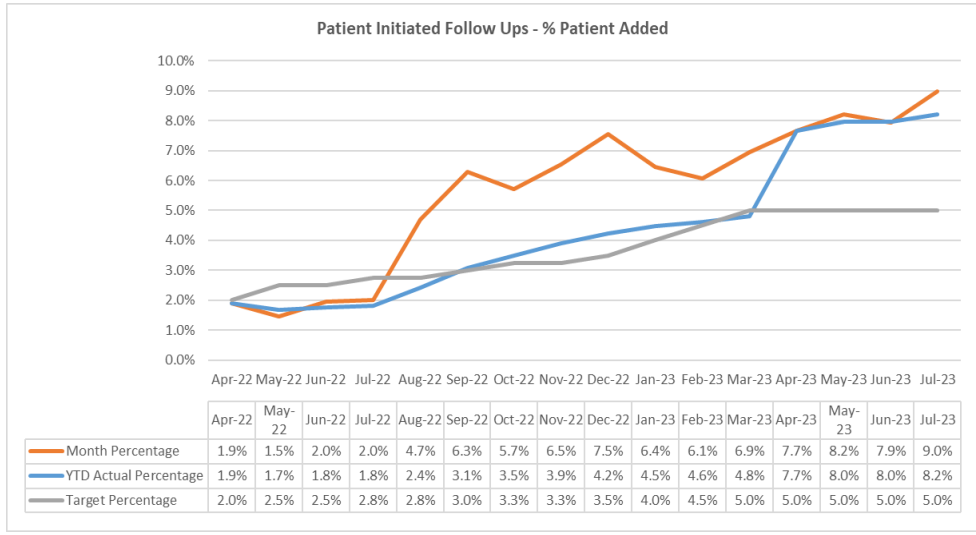
4. Outpatient efficiency





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
All Follow Up Attendances	3619	3322	3946	3378	3174	3539	3290	3831	2980	3543	3530	4122	3275	3604	3384	3349	3690	3629	3835	4113	2776	3841	3166	3513	3074	3680	3975	3412
All First Attendances	1525	1294	1526	1639	1459	1862	1831	2002	1549	1651	1542	1619	1469	1614	1526	1496	1393	1374	1776	1622	1260	1578	1485	1614	1367	1802	2172	1735
New To Review Ratio	2.37	2.57	2.59	2.06	2.18	1.90	1.80	1.91	1.92	2.15	2.29	2.55	2.23	2.23	2.22	2.24	2.65	2.64	2.16	2.54	2.20	2.43	2.13	2.18	2.25	2.04	1.83	1.97





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Month Percentage	1.9%	1.5%	2.0%	2.0%	4.7%	6.3%	5.7%	6.5%	7.5%	6.4%	6.1%	6.9%	7.7%	8.2%	7.9%	9.0%
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%

4. Outpatient efficiency

SUMMARY

There were 4,534 face to face and 577 virtual appointments carried out in July 23 (**11.29% virtual**).

This month **9.0%** of outpatient attendances moved to the PIFU waiting list. The overall YTD position is **8.2%.** In total there are 4,603 patients on a PIFU waiting list. The PIFU waiting list is being validated to confirm that patients wish to remain on the list. In future, this will be automated through the use of Dr Doctor.

AREAS OF IMPROVEMENT

Appointments
Daily KPIs are now being monitored by the Division, for referral processes to ensure RMS is embedded and the referal and appointment process is optimised . To improve clinic utilisation, the Trust intends to use the Dr Doctor Quick Question function to validate waiting lists. This will ensure that all patients have been communicated to and validated. This will increase utilisation and reduce the level of DNAs in clinic.

During August 2023 and September 23, a focus will be held on validating patients down to 12 weeks in line with NHS England's request to maintain an accurate and validated waiting list. Ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023. Reinforcing and applying RTT rules in line with the RTT national rules suite and local access policies.

The teams are also focussing on clinic slot utilisation and review reports regularly to ensure that any data quality issues are resolved to provide an accurate utilisation status.

Clinic Delays:
30-minute delays **– within trust target at 9.9% (Target 10%)**
60-minute delays – **within trust target at 2.9% (Target 5%)**

The DNA rate for July has increased from June and is currently **8.29**%. The aspirational Operational target for 23/24 is 6%. A reduction of DNAs is confirmed as one of the key Divisional quality improvement schemes for 2023/24 with a plan to extend the use of the Dr Doctor system to radiology, therapies and spinal teams. Audits which are planned to be set up via the patient experience team using text messaging and web-based questionnaires have been delayed. The Clinical Service Manager supporting transformation of outpatients will be moving this forward. The audit will aim to ascertain the reasons behind patient DNAs and patient not brought outcomes.

In addition, a pilot will commence of consultants calling patients who DNA and converting the appointment to a virtual consultation to avoid losing the slot and reappointing to a patient that may no longer wish to be seen. GIRFT outpatient principles for reducing follow ups are being reviewed and an action plan will be developed.

RISKS / ISSUES

- Outpatient Incident reports continue to be actively managed and investigated, ensuring feedback has been provided to the reporters.

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for July was **55.61%** against the National Constitutional Target of 92%. This represents a 0.46% decrease compared to the June reported position of **56.07%** that includes patients transferred from other providers**.**

There were **322** patients waiting over 52 weeks in July, an increase from the trust wide position in June which was **285** patients.

The Team continue to work in partnership with UHB,RJAH,UHNM and SATH to support with orthopaedic recovery.

During July 23, ROH received 2,760 referrals (102.07%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid. The team continues to work closely with the system and GPs to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure that the team stay connected and update the ICB and GPs on the current position.

AREAS FOR IMPROVEMENT

The newly appointed Associate Director of Operations – Operational lead for system integration is leading on agreeing terms of engagement with new organisations requesting support. This is to ensure that the process remains streamlined and concise. All BSOL patients are formally transferred onto the ROH PTL. PTL meetings are in place with RJAH and UHB. The Deputy COO has overall oversight of BSOL orthopaedic patients waiting.

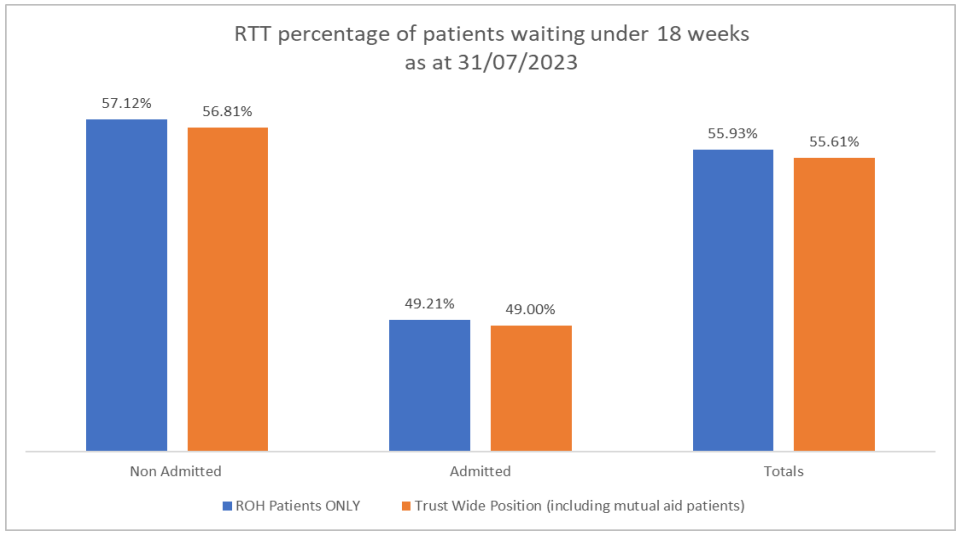
RISKS / ISSUES

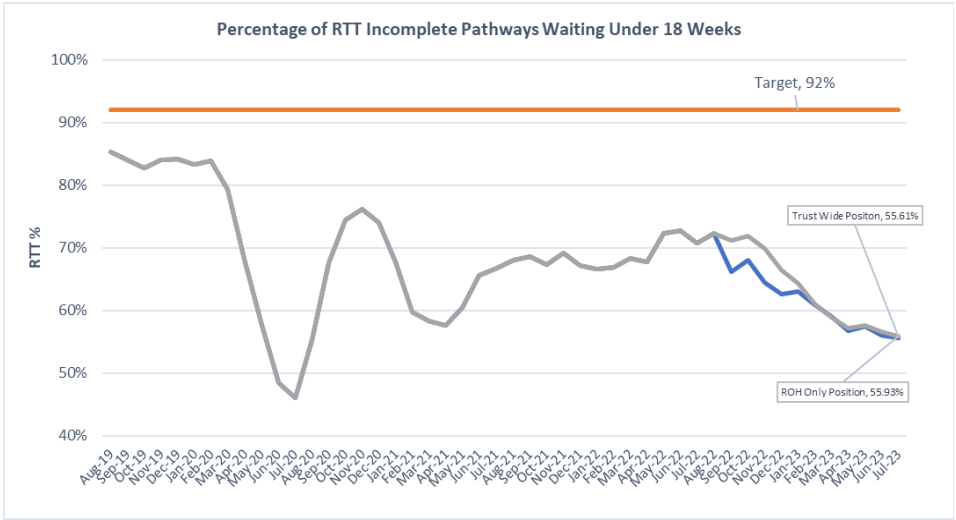
Due to the continued success of the ROH's management of long waiters from other providers, further requests have been received from NHSE, GIRFT and the system for help with long waiting patients across England. These requests will need to be considered and monitored closely to ensure ROH continues to meet its own trajectory.. Industrial action continues to be a risk for 65 weeks delivery, and this is being monitored closely by the Operational/performance teams and the Deputy COO.

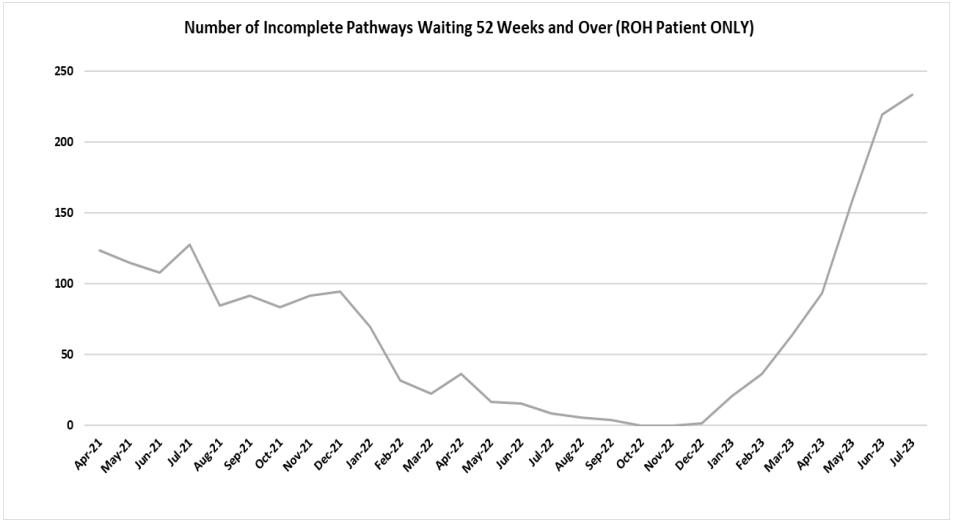
5. Referral to Treatment

	ROH Patients ONLY			Trust Wide Position (including mutual aid patients)		
Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
0-6	3,606	569	4,175	3,616	582	4,198
7-13	2,786	419	3,205	2,795	431	3,226
14-17	1,349	203	1,552	1,352	206	1,558
18-26	2,530	396	2,926	2,538	401	2,939
27-39	2,206	480	2,686	2,216	481	2,697
40-47	744	192	936	754	193	947
48-51	190	67	257	193	72	265
52 weeks and over	140	94	234	200	122	322
Total	13,551	2,420	15,971	13,664	2,488	16,152

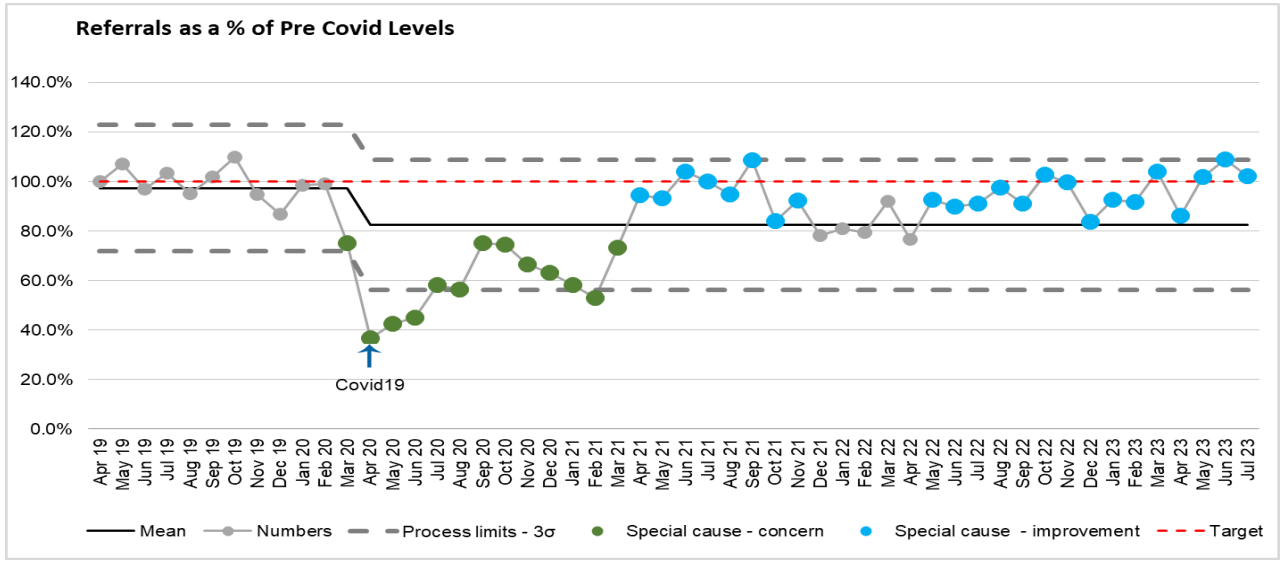
Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
Under 18	7,741	1,191	8,932	7,763	1,219	8,982
18 and over	5,810	1,229	7,039	5,901	1,269	7,170
Month End RTT %	**57.12%**	**49.21%**	**55.93%**	**56.81%**	**49.00%**	**55.61%**







5. Referral to Treatment



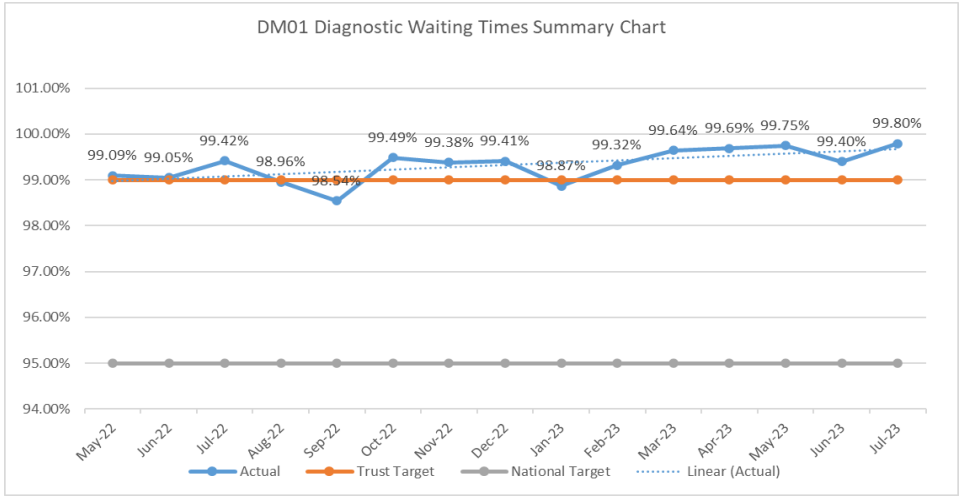
Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of Referrals	2706	2895	2626	2801	2574	2752	2976	2561	2351	2667	2683	2030	996	1154	1213	1578	1522	2034	2019	1803	1704	1574	1437	1983
Referrals as a % of Pre Covid Levels	100.07%	107.06%	97.12%	103.59%	95.19%	101.78%	110.06%	94.71%	86.95%	98.63%	99.22%	75.07%	36.83%	42.68%	44.86%	58.36%	56.29%	75.22%	74.67%	66.68%	63.02%	58.21%	53.14%	73.34%

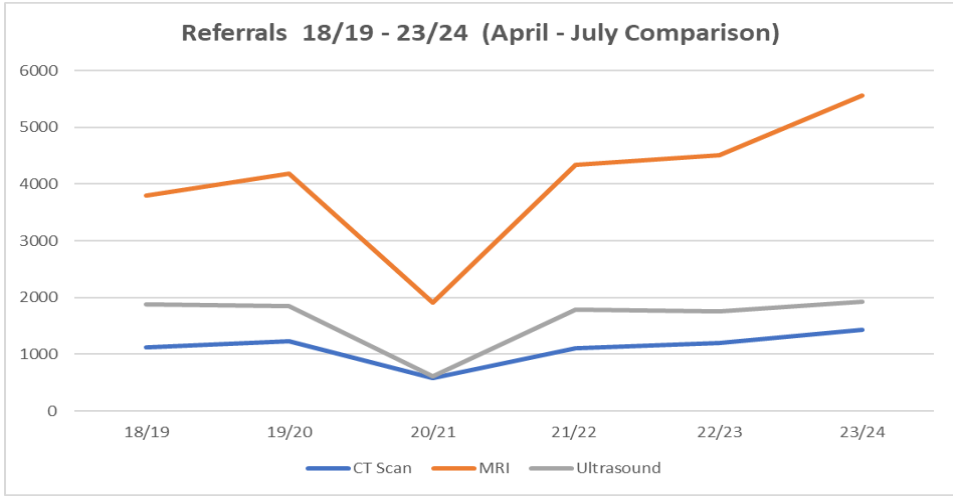
Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of Referrals	2557	2521	2815	2704	2567	2941	2273	2495	2113	2193	2148	2492	2076	2508	2431	2461	2639	2467	2777	2696	2267	2510	2480	2812
Referrals as a % of Pre Covid Levels	94.56%	93.23%	104.11%	100.00%	94.93%	108.76%	84.06%	92.27%	78.14%	81.10%	79.44%	92.16%	76.78%	92.75%	89.90%	91.01%	97.60%	91.24%	102.70%	99.70%	83.84%	92.83%	91.72%	103.99%

Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2331	2752	2946	2760																				
Referrals as a % of Pre Covid Levels	86.21%	101.78%	108.95%	102.07%																				

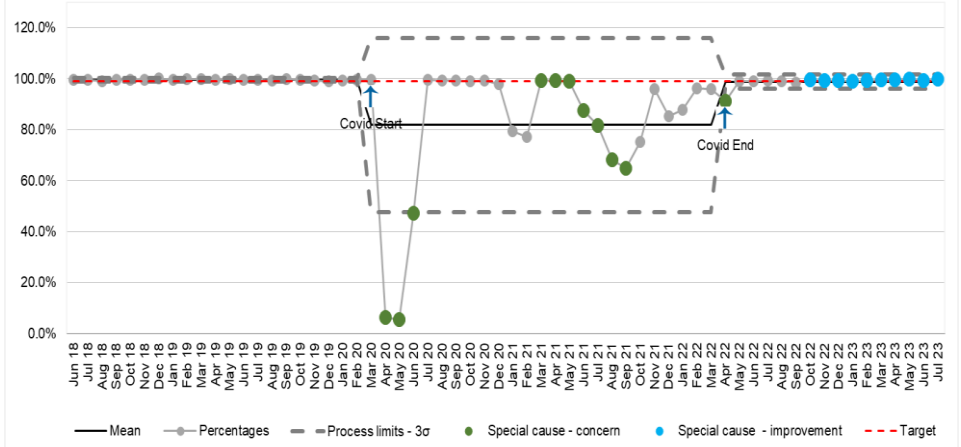
6. Diagnostic Performance

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

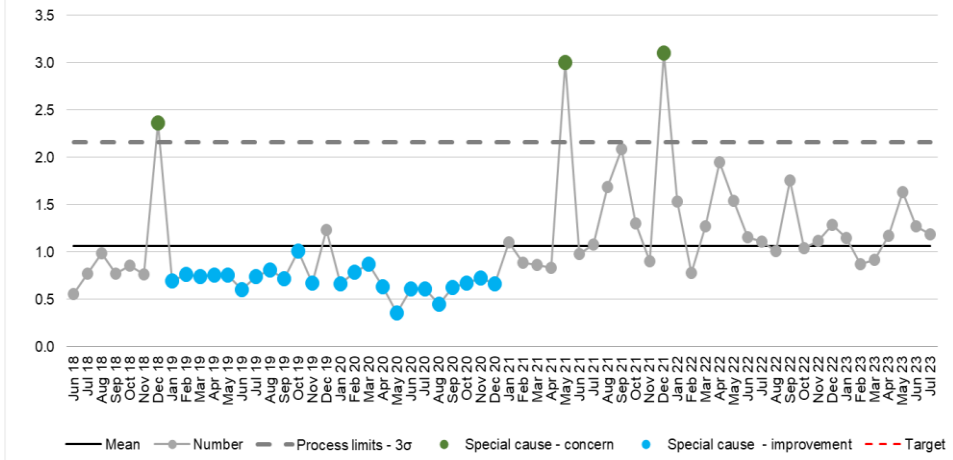




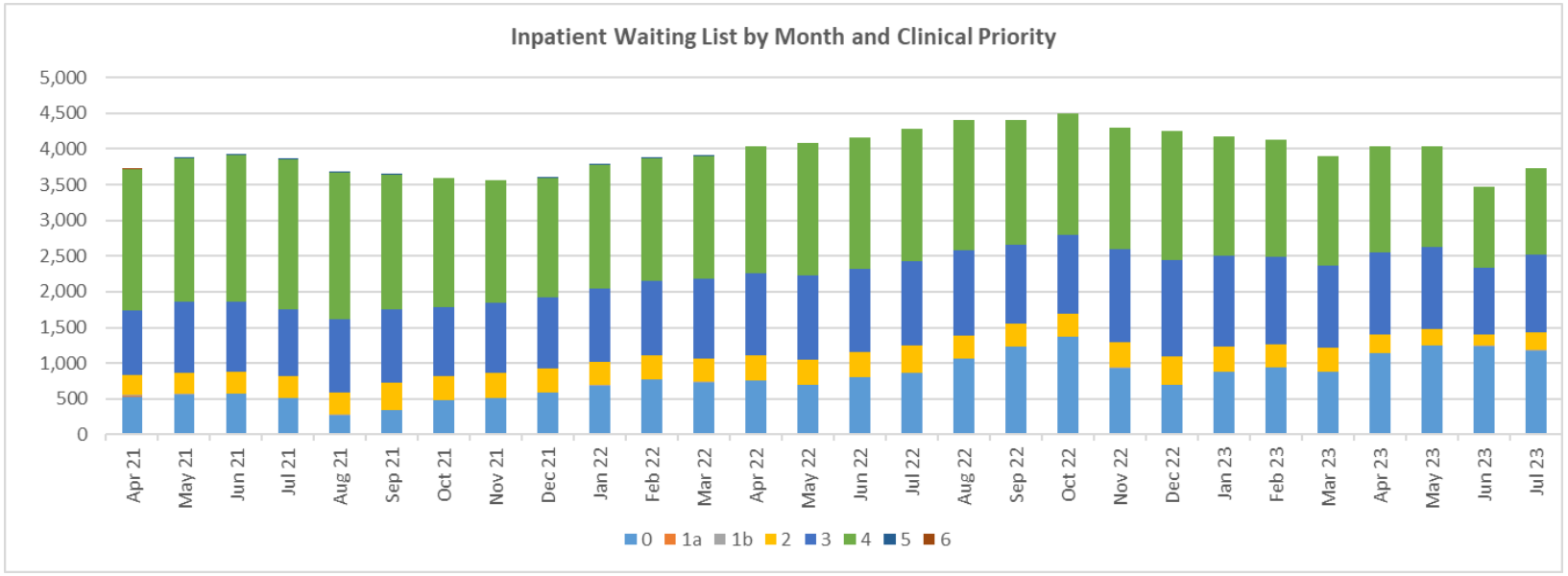
Diagnostics: Percentage of Patients Waiting Under Six Weeks



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



5. Referral to Treatment



	Number of IP waiting as at	% of IP waiting as at
Priority	31/07/23	31/07/23
0	1175	31.5%
1a		0.0%
1b	5	0.1%
2	245	6.6%
3	1096	29.4%
4	1208	32.4%
5		0.0%
6		0.0%
Total	3729	100.0%

All specialities review and update admitted patients without a priority status. Regular review meetings are held to ensure that all patients are given a priority score. This data is reviewed monthly at the CSLs meeting in conjunction with the Medical Director.

Ongoing work to ensure the P score is being recorded in the right place to feed the PTL to pull through to the BI report. Reviewing whether this can be made a mandatory field and automated.

Figures show total inpatient waiting list including planned patients and patients with a TCI date.

Private Patients

SUMMARY

There were 55 inpatients treated privately in July 23
There were 100 private patient consultations in outpatients in July 23

The service has exceeded its inpatient activity plan in July by 31 patients.
The service has exceeded its income target in July by £91k

The service did not meet its income target in Q1, however the financial position has improved in July and YTD income is above plan .

	M1	M2	M3	M4	YTD
Income Plan	306	306	306	306	1224
Activity Plan	9	24	35	24	92
Income actual	353	229	254	397	1233
Activity actual	47	37	41	55	180

* The above figures are based on activity and income through the service which may not have been invoiced yet. Finance figures are based on what has been invoiced

AREAS FOR IMPROVEMENT

Although activity has exceeded plan since April, the income has not matched this. Work has been undertaken to phase the income with a more realistic activity plan, Based on the average income per patient and the number of patients who have come through the service this year. The table below details the new activity and income plan from August 23 which would support an overall in year income of £3.6m and 549 inpatients.

	M5	M6	M7	M8	M9	M10	M11	M12
Income Plan (000)	255	253	325	361	209	289	346	361
Activity Plan	37	35	45	50	29	40	48	50

The service is seeking to increase its spinal theatre capacity to support future planned scoliosis cases, and this would support increased income due to the higher fees attached to these cases (circa £30k per case).

RISKS / ISSUES

Due to the resignation of the Clinical Service Support Manager, there is a risk that specialist knowledge around private practice / invoicing / quotation / insurance relationship management will become less robust. The role is currently being advertised with a view to recruit by the end of the year. In the meantime, the current post holder will return on ad hoc bank arrangements to support the team.

The Trust contract with Aviva and Vitality has reached the end of its 3 year term and is being extended by a further year as agreed within the contract terms.

6. Diagnostic Performance

SUMMARY

The Imaging service achieved the 99% DM01 target in July 2023 closing the month at 99.80%. Order comms (electronic requesting) via PICS went live on 26/7/23 and has been well received. Mobile CRIS is being implemented to support electronic referrals which will provide real time data for patients' imaging events.

The National 23/24 operational target remains at 95% which ROH are achieving; however, we have retained reporting against the traditional 6-week diagnostic target locally as our aspirational target within our constitution.

AREAS FOR IMPROVEMENT

To continue to ensure all capacity is fully utilised and minimise DNA's with the rollout of Dr Doctor.

Utilisation of diagnostics capacity will be maximised with the introduction of Dr Doctor within the imaging service that will also help reduce DNAs. Dr Doctor will be an added form of digital patient engagement to support patient communication and appointment management. The initiative will allow patients to receive text messages to inform them of their appointments to allow patients to access the patient portal remotely.

Speech recognition is being discussed with CRIS (Radiology Information System) to pilot in Imaging.

RISKS / ISSUES

Delay to MRI 3T scanner upgrade due to a new Faraday cage being required which will extend the project from approx. 6 weeks to 22 weeks; service will be re-provided by using a mobile van, this work is now due to start mid-October 2023 with completion early January 2024.

Due to an admin vacancy being difficult to fill, typing turnaround has exceeded the 2 week KPI. Mitigation is in place through the use of outsourcing whilst the current vacancy is being filled. This is being monitored closely by the Associate Director of Operations. Oncology work is being prioritised along with all MRI 7 CT scan reporting.

7. Cancer Performance

Metric	Patients	Compliant	Breach	Total Accountable	%	Target
2WW	86	85	1	86	98.8%	93%
31 day 1st	17	16	1	17	94.1%	96%
31 day sub	9	9	0	9	100.0%	94%
62 days	8	4	2.5	6.5	61.5%	85%
62 day upgrade	13	9	2	11	81.8%	90%
28 day FDS	92	74	18	92	80.4%	75%
104 days treated at ROH	0	0	0	0		0

Performance

June 2023 saw the highest number of referrals since August 2021. There were 50 more 2ww referrals, and 170 more 'total' referrals than this time last year.
Total inpatient admissions was also the highest since August 2021.

The root cause of the cancer performance breaches were:

31-day 1 x breach due to the time taken for a custom-made implant to be designed and delivered. This patient also breached the 62-day upgrade standard.

62-day standard – late tertiary complex referral to UHB rejected back to ROH, then sent to Bristol. 1x (half) breach , further delay with histology results. Histology delays have been escalated to UHB via Trust contract monitoring process and is also raised at a system level via the weekly SOG.

62-day upgrade – 2 patients breached the 62-day upgrade. Both required custom implants, both patients were aware that the implants would delay their pathway.
Discussions ongoing with supplier to expedite implants if feasible.

The 31-day subsequent, 2 week wait, and the 28 day faster diagnostic standards were all compliant with national standards.

Risks /actions ongoing

ROH are actively participating and engaging with the weekly System Oversight Group for cancer recovery and receive positive feedback against overall performance standards.

8. Cancer Target Changes

In August 2023 NHS England formally announced plans to change the existing Cancer Targets – by streamlining the existing 10 standards into 3. The new standards are expected to be formally launched in October 2023.

- The '2 week wait' standard becomes redundant. Initially 2 week wait clinics at ROH will continue as it links in with our existing daily MDT, MRI and USG Biopsy pathways – which will continue to be key for the 28-day FDS standard. The ROH will continue with its in-house aim of 10 days from receipt of referral to initial consultation.

- The 28-day Faster Diagnosis Standard (FDS) - remains with no change.
  - Patients should have cancer ruled out or receive their diagnosis within 28 days of urgent referral.
  - 75% of patients should meet this standard.

- The 62-day referral to treatment standard
  - People with cancer should start their treatment within 62 days of an urgent referral going forward this will include screening and upgrade patients, as a combined target.
  - 85% of people should meet this standard.

- The 31-day decision to treat to treatment standard
  - People with cancer should start their treatment within 31 days of the 'decision to treat' their cancer. This target now also includes subsequent treatments for cancer.
  - 96% of people should meet this standard.

Expected impact on ROH

- 28 Day FDS – the current mean average compliance is 81%, therefore, no impact.

- 62 standard - our current compliance with the 62-day standard is variable – often determined by the number of accountable patients rather than the number of breached patients. The overall waiting list is small making it difficult to achieve by offsetting breaches with compliant patients. Combining the 'standard' and 'upgrade' targets should improve our average compliance (in comparison to the current 62-day standard).

8. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £588k against a planned deficit of £65k, generating a £523k adverse variance, resulting in a year to date deficit of £1,986k against a surplus plan of £71k, generating an adverse variance of £2,088k.

Income year to date is £34k below plan.

Pay expenditure is overspent by £410k. Non pay expenditure is overspent against plan with an adverse variance of £1,738k.

Agency spend remains a concern and spend is 8.7% pay bill year to date.

The key drivers for the non pay overspend is indicating above inflationary pressures across clinical supplies, utilities and other supplies.

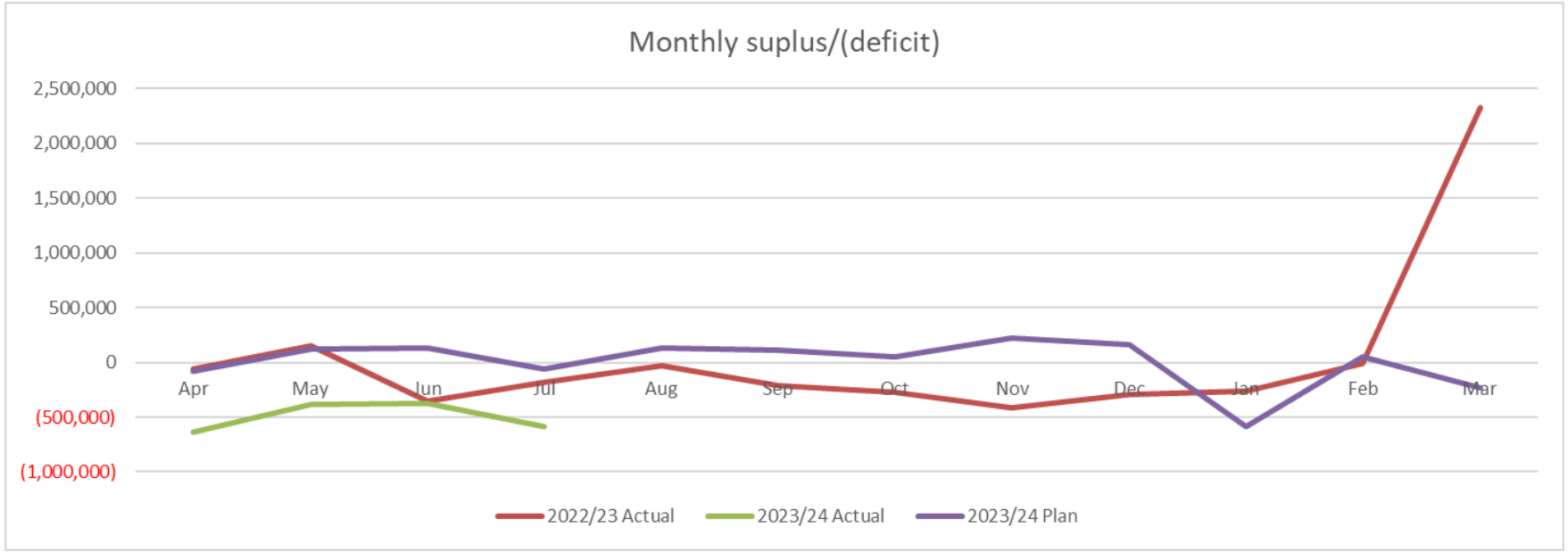
Forecast remains as breakeven against plan.

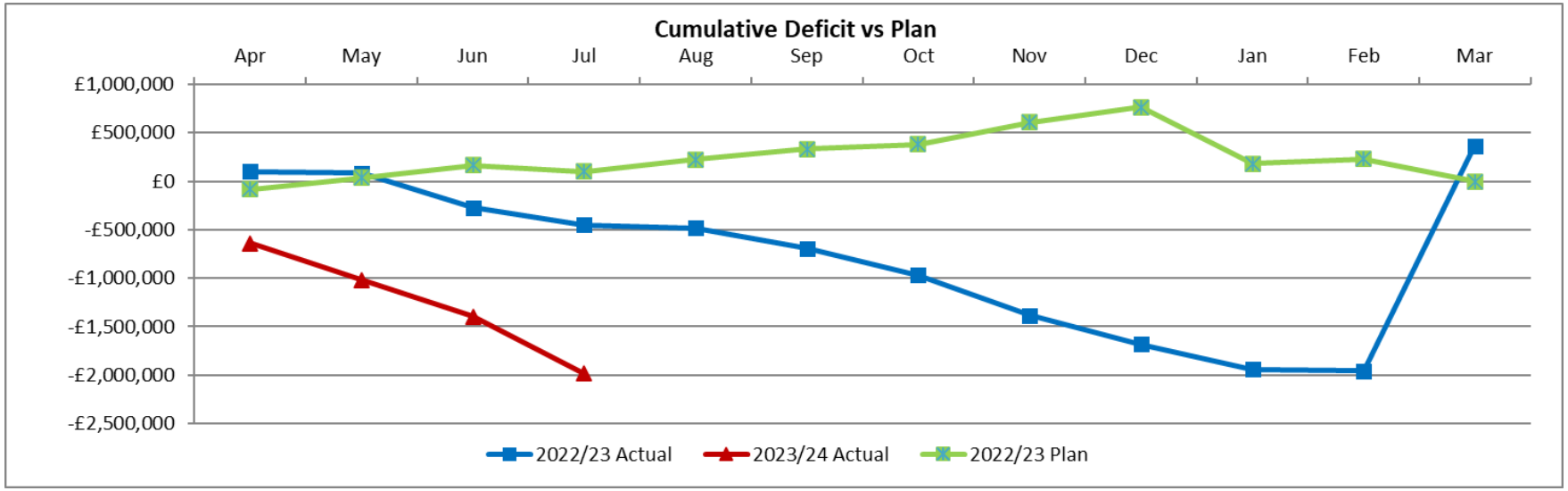
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(34)	(410)	(1,738)	94	(2,088)
Year to date plan	42,246	(24,454)	(17,237)	484	71
Year to date actual	42,212	(24,864)	(18,975)	(359)	(1,986)
Variance compared previous month	↑ 246	↑ (176)	↓ (624)	↑ 30	↓ (524)
Forecast Variance	0	0	0	0	0

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	40,558	40,694	136
Other Operating Income (Excluding top up)	1,688	1,518	(170)
Employee Expenses (inc. Agency)	(24,454)	(24,864)	(410)
Other operating expenses	(17,237)	(18,975)	(1,738)
Operating Surplus	555	(1,627)	(2,182)
Net Finance Costs	(484)	(390)	94
Net surplus/(deficit)	71	(2,017)	(2,088)
Remove donated asset I&E impact	28	31	3
Adjusted financial performance	99	(1,986)	(2,085)

8. Overall Financial Performance





9. Income

SUMMARY

Income achieved during Month 1 to 4 is performing slightly below plan by £34k.

The elective recovery fund (ERF) communications from NHS England has requested no adjustment is applied for ERF clawback in Months 1 - 4. A revised ERF baseline has been released by NHS England to adjusted for the strike action that occurred during April with strike action in other months still under consideration. The national target has been reduced by 2% for the year, from 107% to 105, and work is underway to validate the revised baseline.

Private patient income has recovered during July with a year to date over performing against plan by £79k.

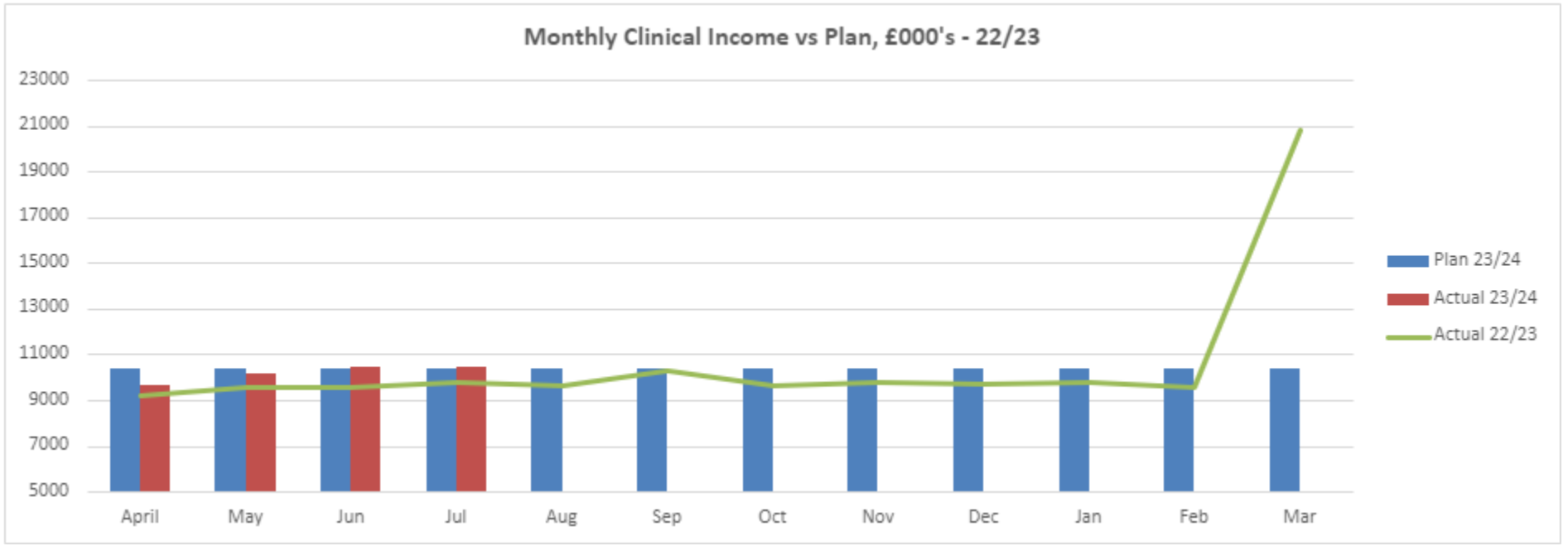
AREAS FOR IMPROVEMENT

RISKS / ISSUES

Elective recovery target delivery during the year remains a risk.

Non recurrent funding has been included within plans for 2023/24, generating an underlying financial risk for 2024/25 and beyond.

9. Income

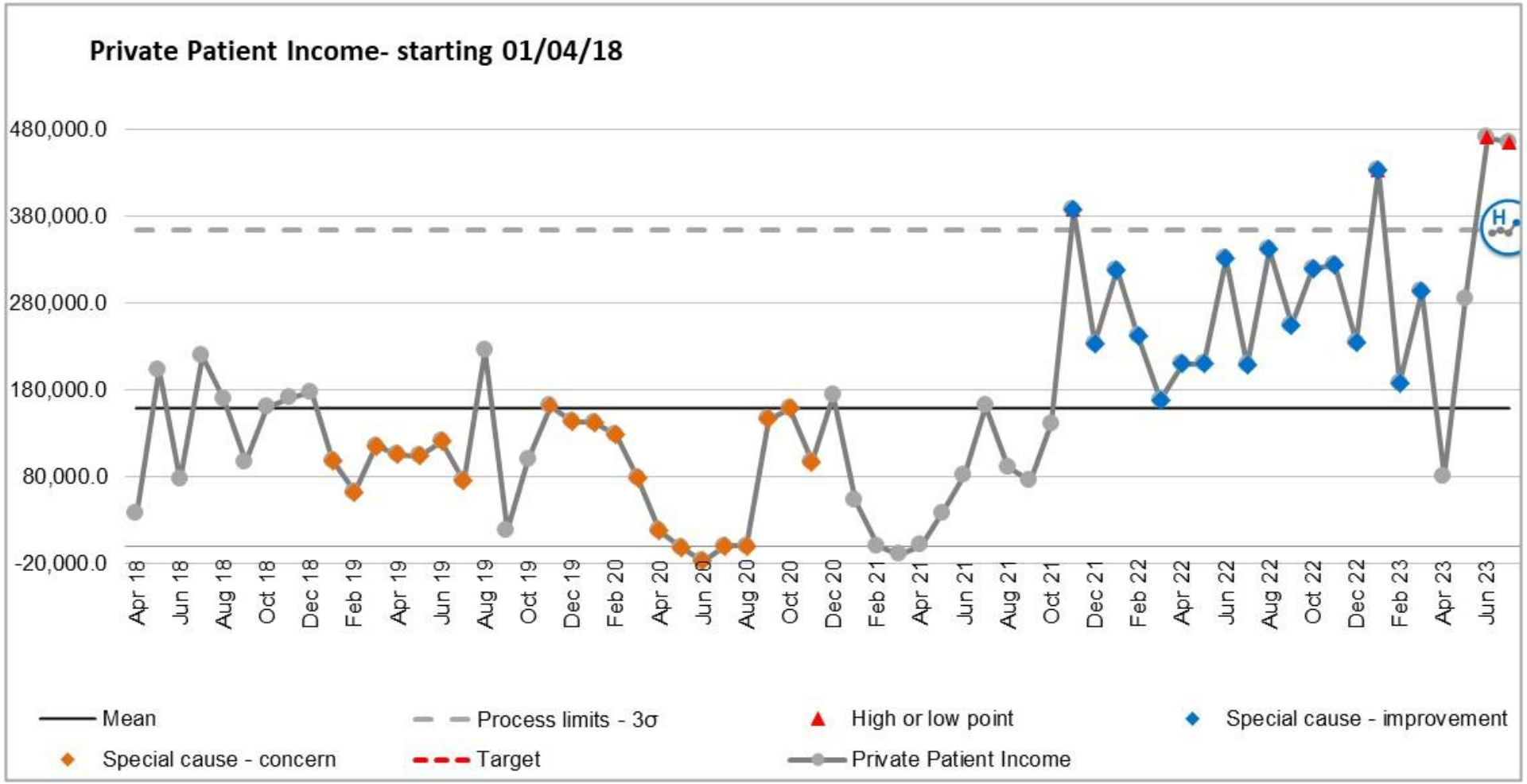


Elective recovery fund (ERF) value weighted activity (VWA) performance

Elective Rec	1	2	3	Year to Date
DC	£689,352.76	£885,962.10	£804,151.07	£2,379,465.93
EL	£2,594,708.90	£3,171,437.51	£2,884,501.17	£8,650,647.58
OPFASPCL	£274,164.50	£341,788.25	£595,476.05	£1,211,428.80
OPFASPCLNFTF	£8,964.22	£7,681.03	£11,495.00	£28,140.25
	£3,567,190.38	**£4,406,868.89**	**£4,295,623.29**	**£12,269,682.56**
ERF Plan	**£4,251,755**	**£4,315,265**	**£4,379,837**	£12,946,857
Variance	**-£684,565**	**£91,604**	**-£84,214**	**-£677,175**

Please note this ERF Value weighted activity (VWA) performance is subject to change as agreements to revise the target to reflect industrial action in April..

9. Income


Private Patient Income- starting 01/04/18
480,000.0
380,000.0
280,000.0
180,000.0
80,000.0
-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
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Oct 21
Dec 21
Feb 22
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Apr 23
Jun 23
H
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

9. Expenditure

SUMMARY

Pay remains in balance in month and year to date after the pay award impact (Month 2) is removed (offset by corresponding income variance). Non pay expenditure is overspent against plan by £1,738k.

Although Agency spend remains below plan year to date, it is above price cap with 8.7% overall pay spent on agency year to date against an agency cap of 3.6%. This is an increase for the third month this year. Key drivers for high agency spend remain continued high sickness, high turnover rate and high vacancy levels.

Non pay spend has also remained high in month generating an adverse variance of £1,738k. Key drivers for this include continued high consumable spend in theatres, a significant increase in drug costs in month 4 (£130k year to date) and above inflationary pressures particularly with regards to estates spend. There is also higher than expected use of LLPs, particularly spinal.
A supplementary paper has been included which identifies additional control measures the Trust should consider

AREAS FOR IMPROVEMENT

Agency spend is above agency cap with 8.7% of our pay bill against a cap of 3.6%.

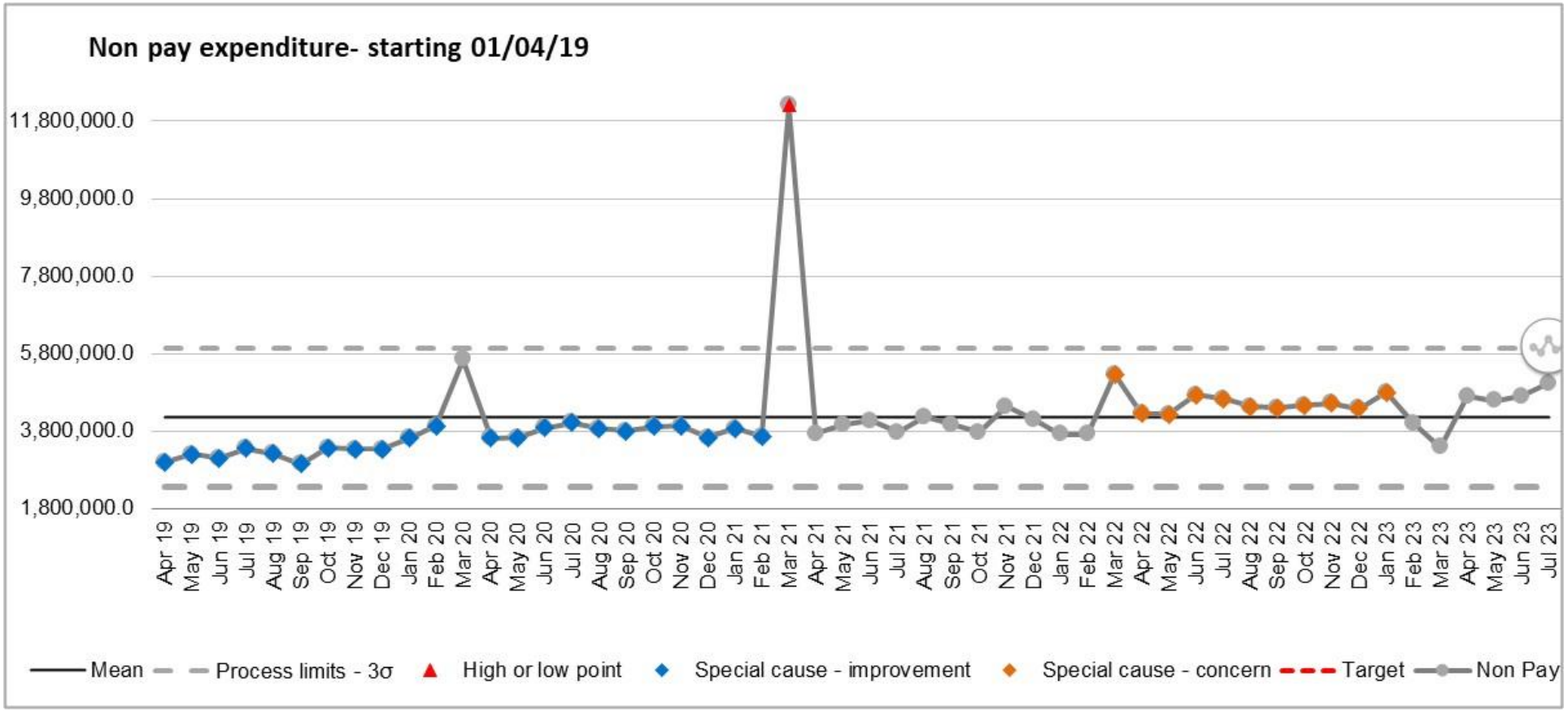
Theatre consumable spend reducing to planned levels.

RISKS / ISSUES

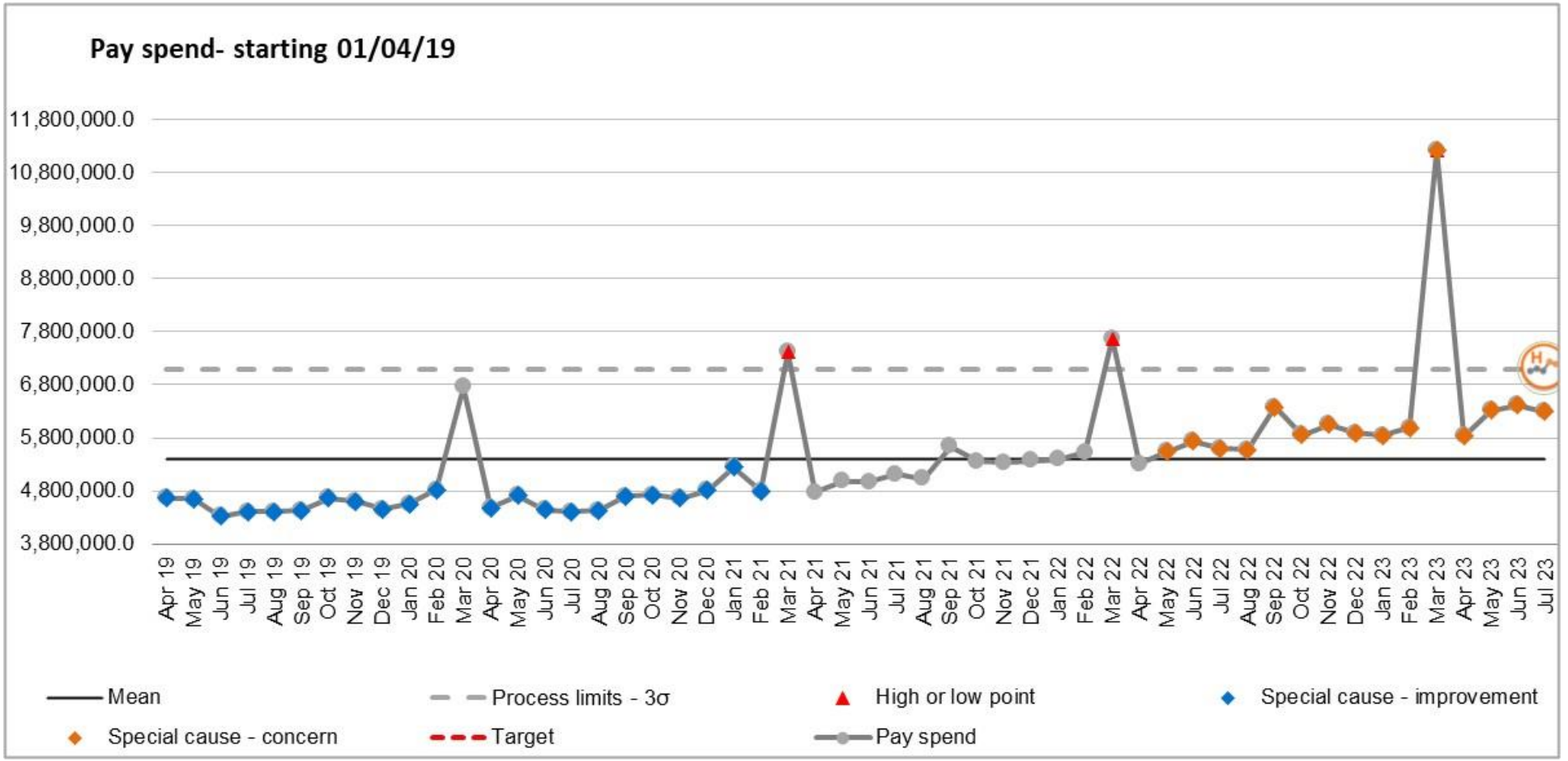
Agency spend remains high causing a cost pressure during the year.

9. Expenditure

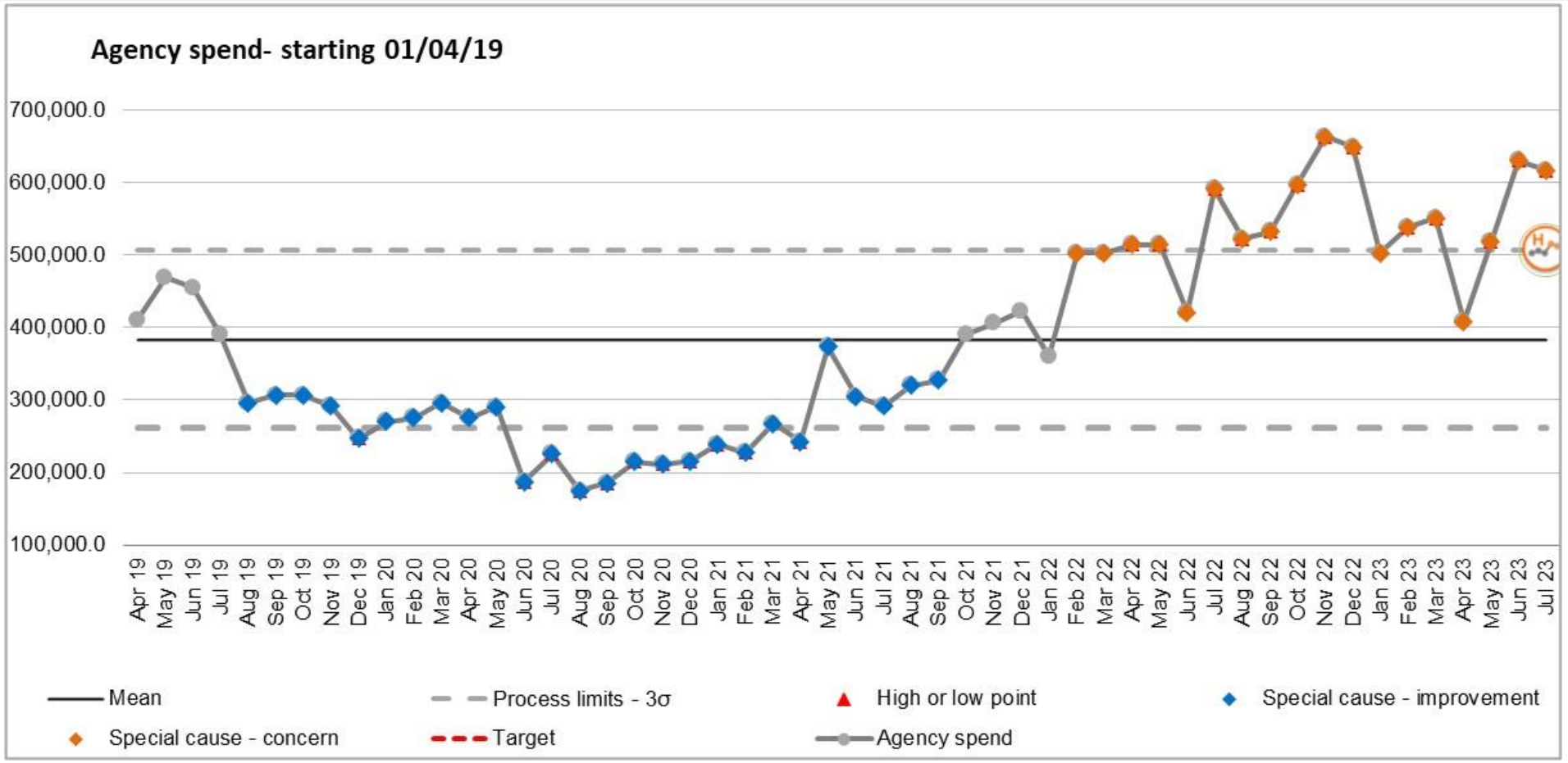
9. Non Pay Expenditure



9. Pay Expenditure



11. Agency Expenditure

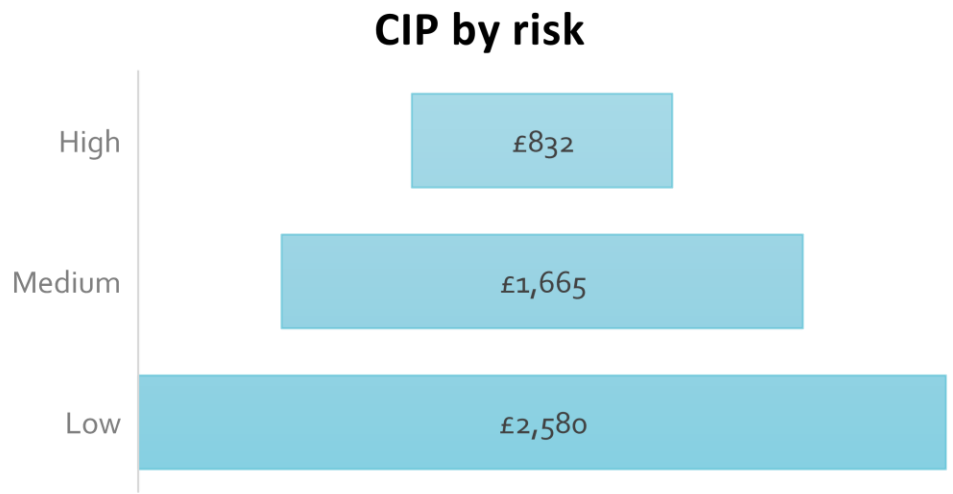


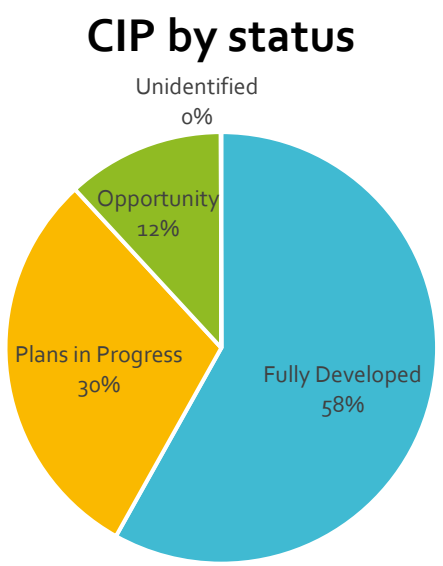
12. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £1,371k have been delivered, against a plan of £1,378k, delivering a small variance of £7k. CIP schemes have been identified totalling £5 million, with over 100 schemes identified at varying stages of the planning process.

£000s				
CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£86	0	(86)	£679
Non pay	£1,126	£1,332	£206	£3,897
Income	£167	£39	(£128)	£500
Grand Total	**£1,378**	**£1,371**	**£7**	**£5,076**





13. Statement of Financial Position

SUMMARY

There have been limited balance sheet movements since year end, with the main movement being a reduction in cash, due to a combination of the deficit year to date against plan, and the ongoing investment in the Trust's estate.

	2022/23 M12	2023/24 M3	Movement
		(£'000)	
Intangible Assets	1,339	1,238	(101)
Tangible Assets	69,123	68,157	(966)
Total Non Current Assets	**70,462**	**69,395**	**(1,067)**
Inventories	19	20	1
Trade and other current assets	12,839	12,558	(281)
Cash	7,591	4,608	(2,983)
Total Current Assets	**20,449**	**17,186**	**(3,263)**
Trade and other payables	(20,229)	(17,196)	3,033
Borrowings	(18,339)	(17,285)	1,054
Provisions	(1,329)	(1,328)	1
Other Liabilities	(273)	(2,612)	(2,339)
Total Liabilities	**(40,170)**	**(38,421)**	**1,749**
Total Net Assets Employed	**50,741**	**48,159**	**(2,582)**
Total Taxpayers' and Others' Equity	**50,741**	**48,159**	**(2,582)**

14. System

SUMMARY

It has been a challenging start across the ICB, with a significant deterioration across the system in Month 4. The year to date position is largely due to a mix of continuing industrial action, and the significant level of CIP that needs to be delivered on a monthly basis

Organisation	Surplus / (Deficit) - Adjusted Financial Position								Prior Month		Movement	
	Plan	Actual	Variance		Plan	Forecast	Variance		Actual	Variance	Actual	Variance
	YTD	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	Year Ending	YTD	YTD	YTD	YTD
	£000	£000	£000	%	£000	£000	£000	%	£000	£000	£000	£000
Birmingham And Solihull ICB	5,917	3,816	(2,101)	(0.2%)	-	(58)	(58)	(0.0%)	4,910	(1,012)	(1,093)	(1,088)
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(442)	(442)	(0.2%)	-	-	-	(0.0%)	(287)	(287)	(155)	(155)
Birmingham Community Healthcare NHS Foundation Trust	176	(1,038)	(1,214)	(1.0%)	-	-	-	0.0%	(837)	(969)	(201)	(245)
Birmingham Women'S And Children'S NHS Foundation Trust	-	(1,609)	(1,609)	(0.7%)	-	0	0	0.0%	(989)	(989)	(619)	(619)
The Royal Orthopaedic Hospital NHS Foundation Trust	99	(1,986)	(2,085)	(4.9%)	(0)	0	0	0.0%	(1,398)	(1,562)	(588)	(523)
University Hospitals Birmingham NHS Foundation Trust	(10,100)	(28,887)	(18,787)	(2.6%)	-	-	-	0.0%	(19,836)	(9,936)	(9,051)	(8,851)
ICS Total	(3,908)	(30,146)	(26,238)	(2.5%)	(0)	(57)	(57)	(0.0%)	(18,438)	(14,756)	(11,707)	(11,481)

15. Workforce

Trust Workforce Metrics	Jun-23	Jul-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1320	1318	-2	-	-
Staff In Post - Full Time Equivalent	1165.82	1167.84	2.02	-	-
Staf Turnover % - Unadjusted	17.68%	16.99%	-0.69%	↓	<=11.5%
Staf Turnover % - Adjusted	12.57%	12.12%	-0.45%	↓	<=11.5%
Total WTE Employed as % of Establishment	84.50%	84.81%	0.31%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.61%	82.42%	0.81%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.89%	89.20%	-0.69%	↓	>=96%
% Of Attendance	94.90%	94.17%	-0.73%	↓	>=96.3%
% Of 12 mth MAA Attendance	94.12%	94.24%	0.12%	↑	>=96.3%
% Staff received mandatory training last 12 months	89.26%	90.34%	1.08%	↑	>=93%
% Staff received formal PDR/appraisal last 12 months	61.95%	64.69%	2.74%	↑	>=95%
% of Sickness - Trust wide Long-term	2.47%	3.44%	0.97%	↑	-
% of Sickness - Trust wide Short-term	2.63%	2.39%	-0.24%	↓	-
Return To Work Completion %	57.33%	55.21%	-2.12%	↓	>=80%

15. Workforce

Summary / Highlights

In July, 90.34% of staff had completed their mandatory training within the last 12 months which is a slight increase on June. 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. Classroom sessions have now started back up.

Turnover (both Unadjusted and Adjusted) have been increasing over the last months this trend has changed. Turnover unadjusted stands at 16.99% which is an decrease from June which was 17.68%.

The percentage of staff attendance in the month has decreased to 94.17%.
The Establishment of WTE is still below target and has increased to 84.8% from 84.5% in June.
Clinical staff are currently 82.4% established in terms of WTE.
Non-Clinical staff are currently 89.20% established in terms of WTE.

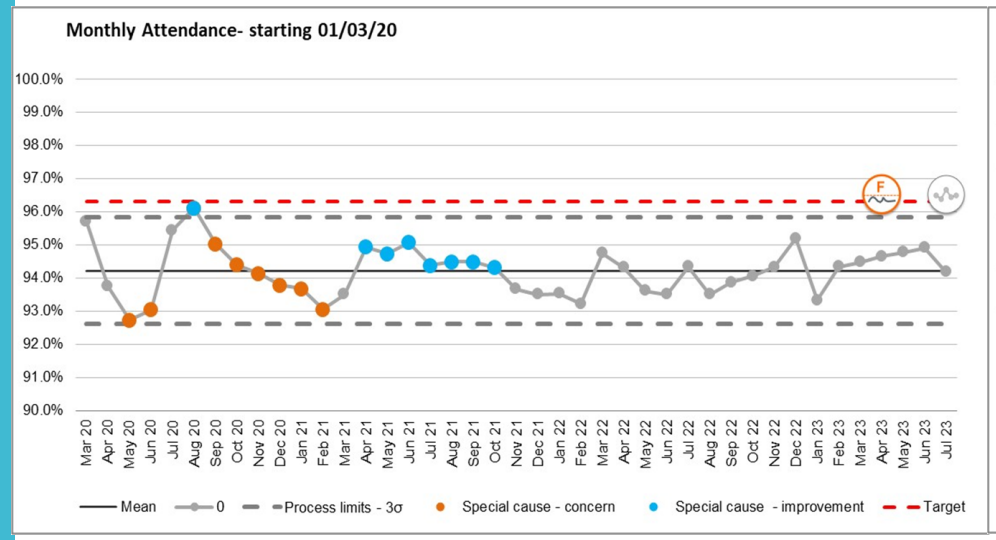
Risks / Issues

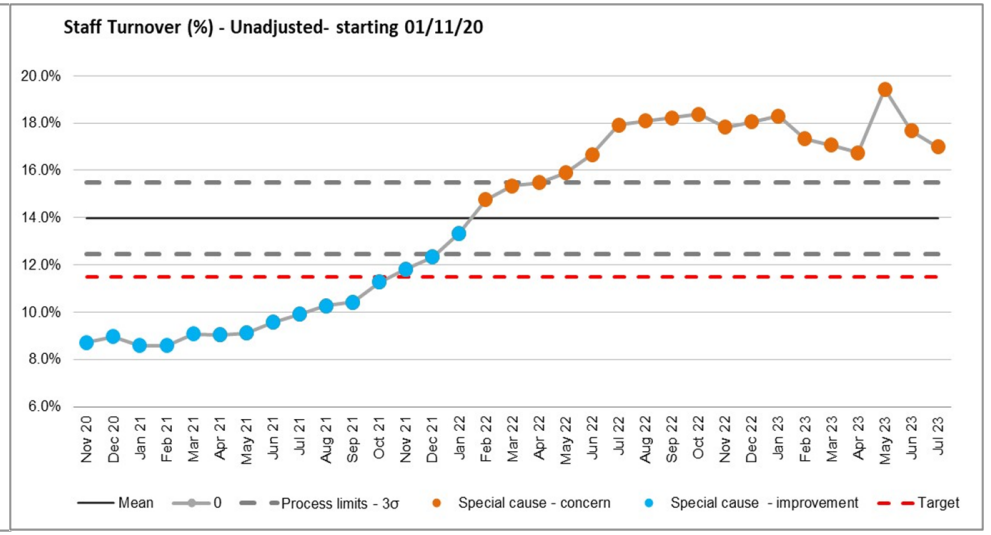
Cost of living seems to be affecting the NHS as a whole, the Trust is doing it's upmost to alleviate the impact. Other Trusts seem to be able to offer higher bands, this has seen some employees move on.
Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
Return To Work meetings if these aren't carried out there is a potential for further sickness and opportunities to support employees will be missed.
We anticipate that over the next few months, attendance may drop as we come to the summer months. Staff are being encouraged to have their Annual Leave which should hopefully help with minimising the impact of this.

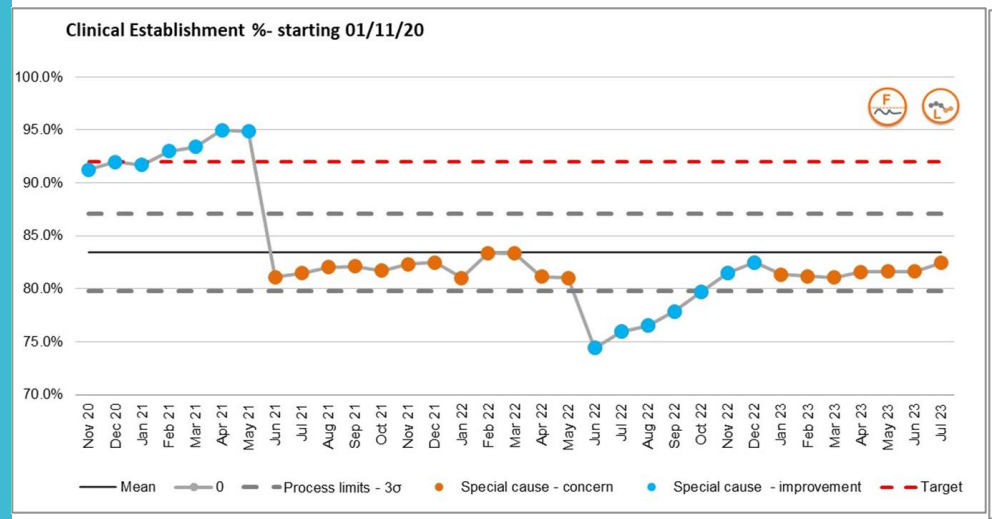
Actions

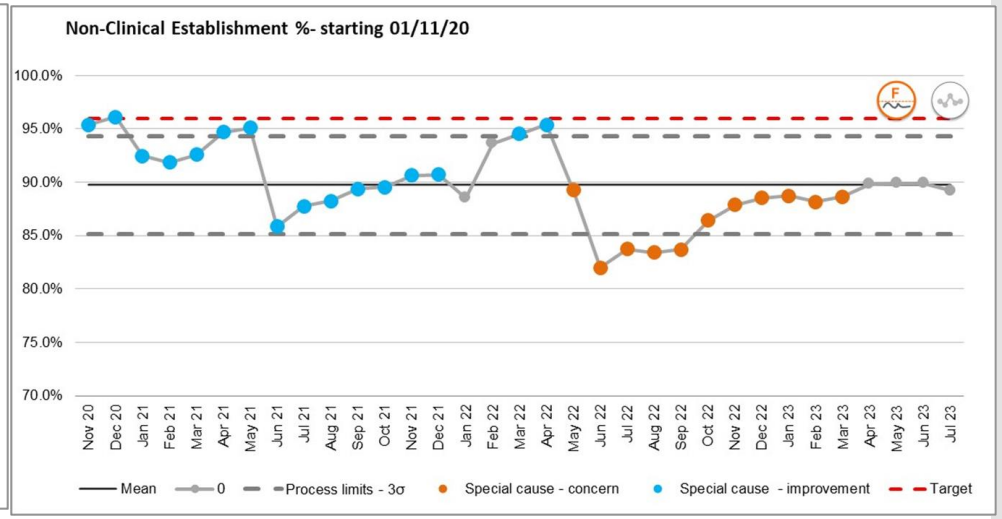
Recruitment activity has increased to help get the Establishment back up to where we need to be.
HR to review the Staff Turnover and investigate the reasons and dig deeper into them, Terrie Hillier provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.
Absence is also being monitored in HR, and a deep dive into sickness is also being provided.

15. Workforce

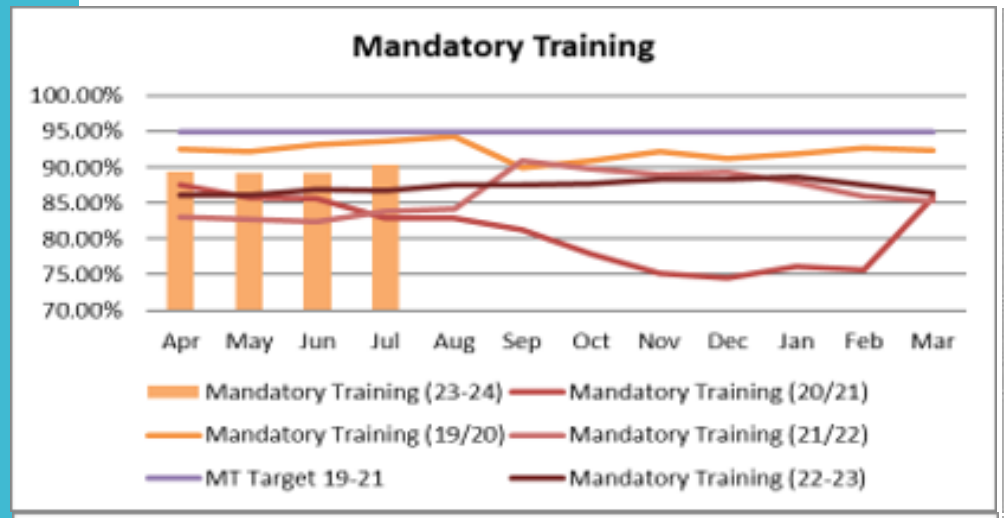


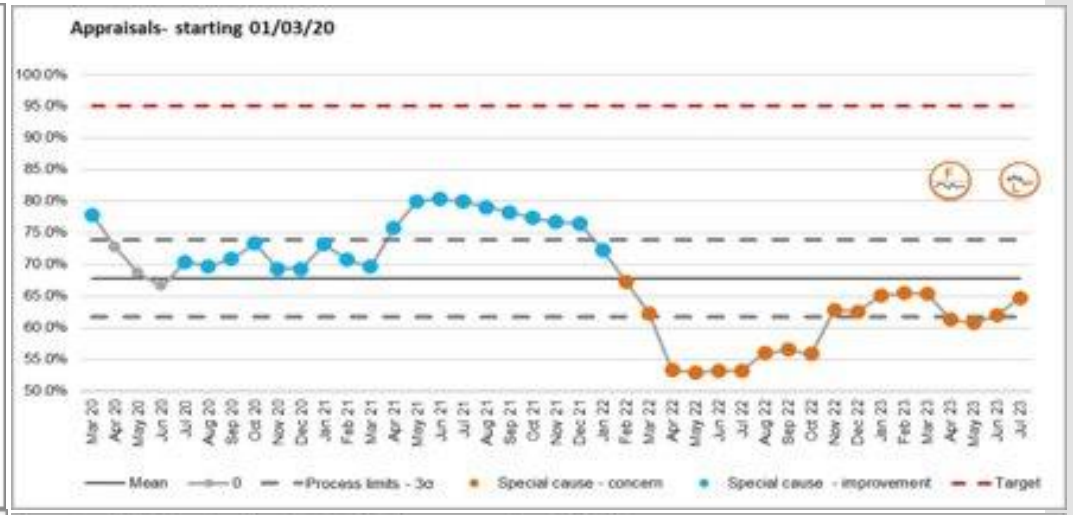


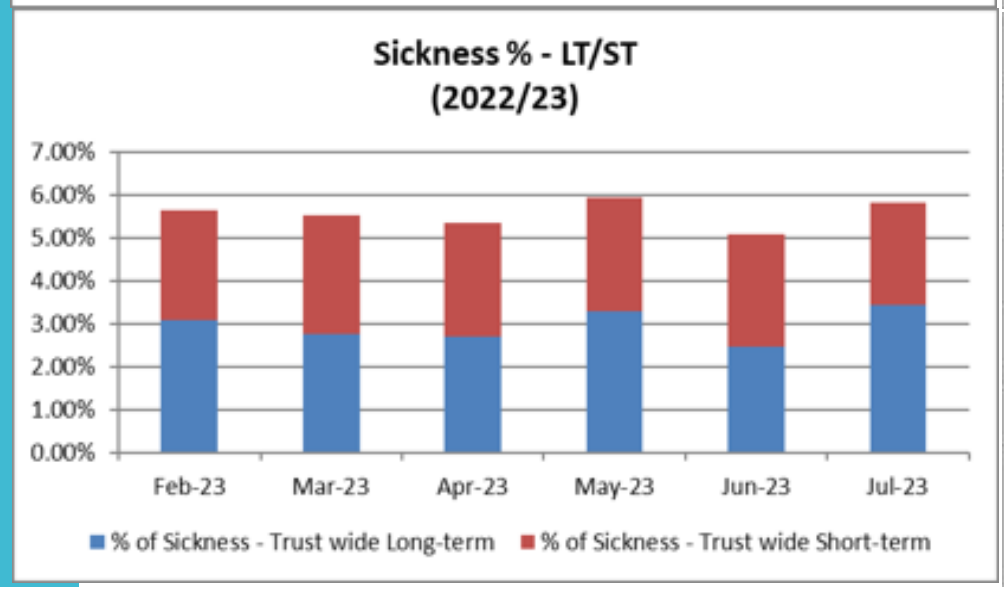


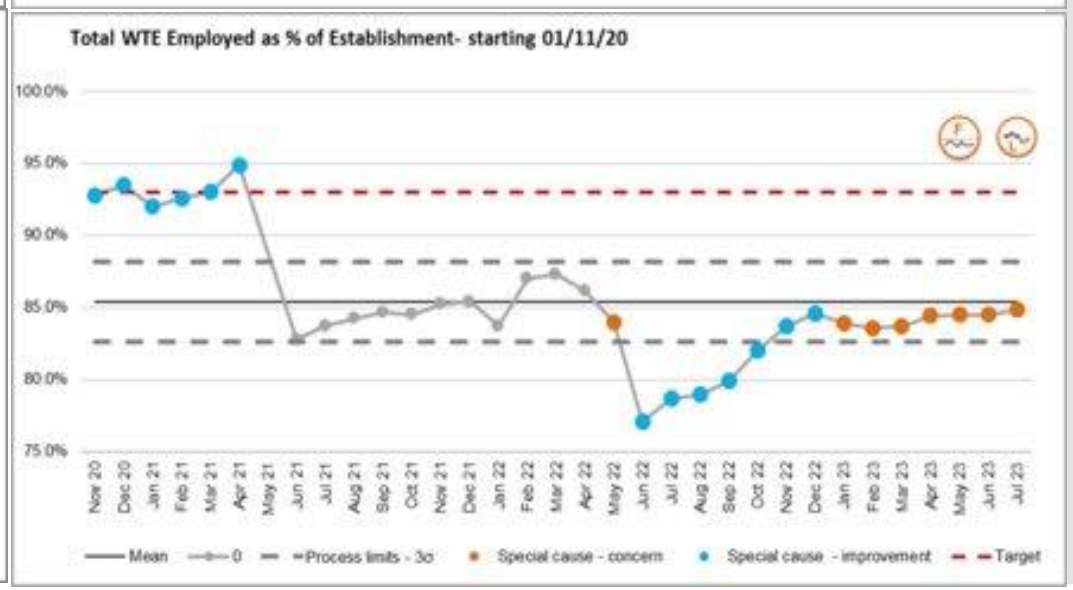


15. Workforce









The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

August 2023 (July 2023 Data)

EXECUTIVE DIRECTOR:	Simon Grainger Lloyd	Director of Governance
	Nikki Brockie	Chief Nurse
	Marie Peplow	Chief Operating Officer
AUTHOR:	Adam Roberts	Assistant Director of Governance & Risk

Quality Report – August 2023 (July 2023 Data) – Summary Dashboard

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	2022/2023	2023/24
Incidents	387	304	289	280	296	308	329	310 (↓)	283 (↓)	292 (↑)	374 (↑)	269(↓)	378 (↑)	341 (↓)	323 (↓)		
Serious Incidents	0	1	2	0	1	0	0	1	0 (↓)	2 (↑)	0 (↓)	1(↑)	1	0 (↓)	0	8	2
Inpatient Deaths	0	0	0	0	0	0	0	0	0	0	0	0	1 (↑)	0 (↓)	1 (↑)	1	2
VTEs (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	10	4	3	5	3	10	5	9 (↑)	3 (↓)	7 (↑)	5 (↓)	12(↑)	9 (↓)	7 (↓)	7	79	28
Pressure Ulcers: Cat 2 (Avoidable)	3	0	0	0	0	0	2 (↑)	0	0	0	0 (0	0	0	0	0	5	0
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	1	0	1	0 (0	0	0	0	0	2	0
Infections	1	2	0	0	1	1	1	1	0	1 (↑)	0 (↓)	0 (↓)	0	1 (↑)	1	9	2
Complaints	5	4	1	2	6	4	4	3	2	4 (↑)	1 (↓)	3(↑)	2 (↓)	2	5 (↑)	45	12
Litigation	0	0	1	2	0	0	3	0	0	2 (↑)	2	0(↓)	0	0	3 (↑)	9	3
Coroners	0	0	0	0	0	0	0	0	0	0	0	0(↓)	1 (↑)	0 (↓)	1 (↑)	0	2

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 Integrated Care System and the CQC for routine engagement and assurance meetings.

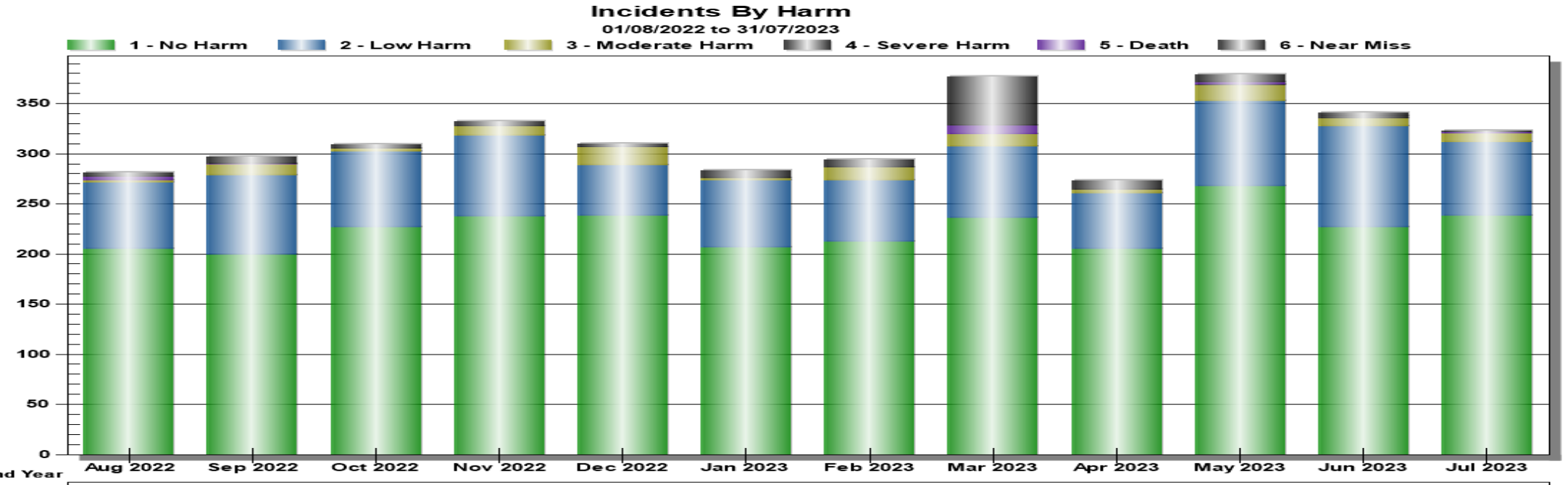
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
1 - No Harm	205	199	226	237	238	206	212	236	205	267	226	238
2 - Low Harm	66	79	76	81	50	67	61	71	55	85	101	73
3 - Moderate Harm	2	11	3	9	18	2	13	12	4	16	8	9
4 - Severe Harm	0	0	0	0	0	0	0	0	0	1	2	0
5 - Death	4	1	0	0	0	0	0	9	0	2	0	1
6 - Near Miss	4	7	4	5	4	8	8	49	9	8	4	2

In the month of July 2023, there were a total of 323 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows;

238 – No Harm

73 - Low Harm

9 - Moderate Harms

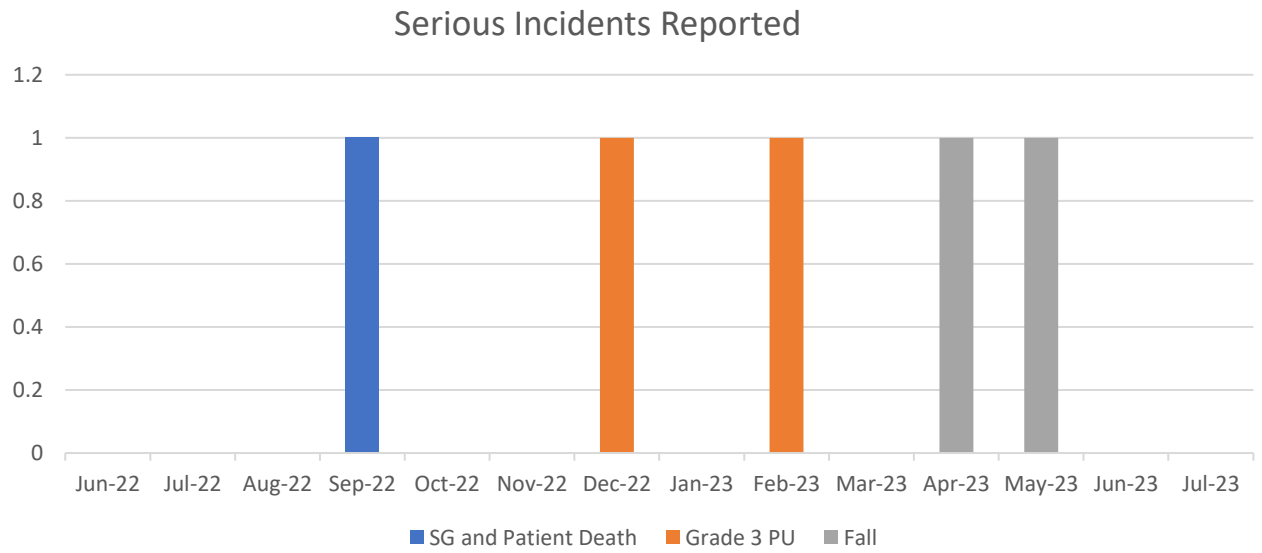
0 - Severe Harm

2 - Near Miss

1 – Death *NOTE: To be removed from this bar chart from September 2023*

3. Serious Incidents – are incidents that are declared on STEiS to the BSOL ICB 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.

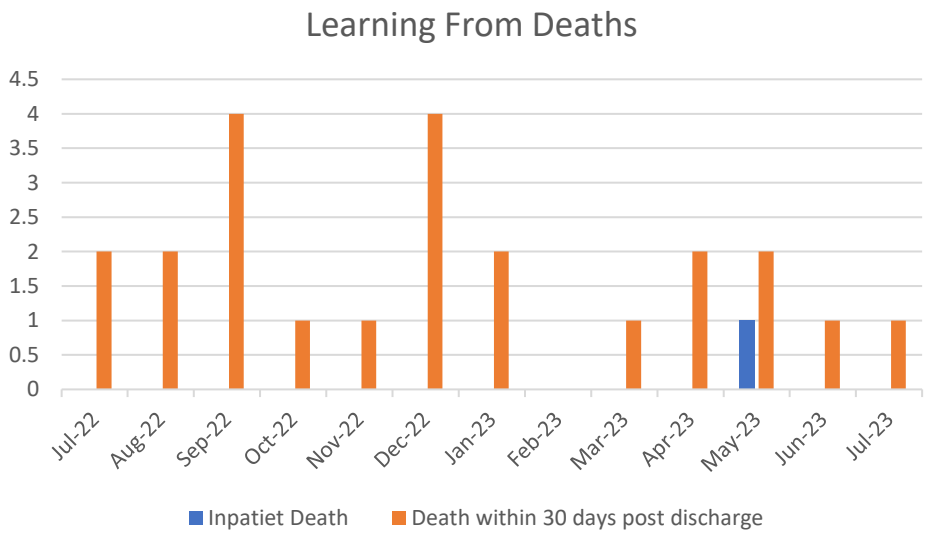
There were no Serious Incidents reported in July 2023



4. Patient Deaths – All inpatient deaths and deaths within 30 days of discharge will be incident reported and will be reviewed as part of the learning from deaths process.

1 x death within 30 days of discharge was reported in July 2023.

The incident report for the death relates to the Coroner's Inquest summarised in section 13 of this report



5. Potential Moderate Harm & Severe Harm Incidents

There were **9** potential Moderate Harm incidents reported in July 2023

All incidents have been tabled at Divisional Governance Meetings and are currently being investigated via divisional governance processes

Summary of Potential Moderate Harm Incidents

- 1 x HDU Incident – Emergency Transfer Out related incident
- 1 x Ward 4 – E.Coli Infection related incident
- 2 x Ward 1 – Surgical Site Infection (SSI) related incident
- 1 x Ward 3 – SSI related incident
- 1 x Ward 2 – Fall related incident
- 1 x Theatres – medication error related incident
- 1 x Theatres – deterioration of patient/cardiac arrest related incident
- 1 x Spinal Incident – Deterioration of patient related incident

6. Near Miss Incidents

There were two Near Miss incidents reported in July 2023

All incidents have been tabled at Divisional Governance Meetings and are currently under investigation

Summary of Incidents

1 x Blood Safety Incident
1 x Theatres/GenMed Incident

7. Learning from Serious Incidents (SI), Never Events (NE) and RCAs

Internal RCAs

There were 3 RCAs closed in July 2023

1. **3 x VTE incidents**

Summary

2 x VTEs deemed unavoidable
1 x No VTE identified upon investigation

Combined learning from all 3 RCAs summarised as follows:-

- To ensure detailed documentation is made stating whether AES have been re-measured and put back on after they had been taken off due to them being tight and digging into legs.
- Governance Team to be reminded that on notification of death within 30 days of admission to ROH or VTE within 90 days of discharge an incident form should be completed and all deaths to remain on Learning from Deaths Tracker until reviewed at Divisional Governance meetings and all Governance processes have been completed.
- To ensure accurate record keeping is completed in relation to recording that both surgical stockings and sequential compression devices are recorded as being in situ when necessary.

8. Venous thromboembolism (VTE) Incidents

There were 3 VTE incidents reported in July 2023

All 3 have undergone investigation to determine avoidably as per Trust policy and standard practice.

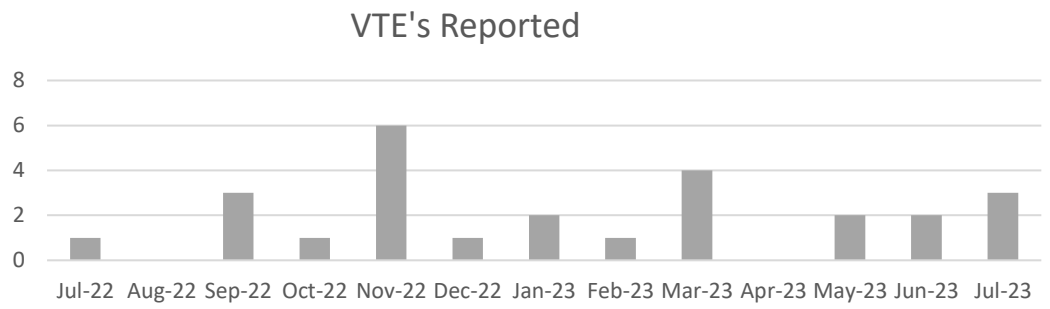
2 x VTEs were deemed unavoidable (one of them was the subject of the death and coroners inquest summarised in section 13 of this report)

1 x No VTE present upon investigation

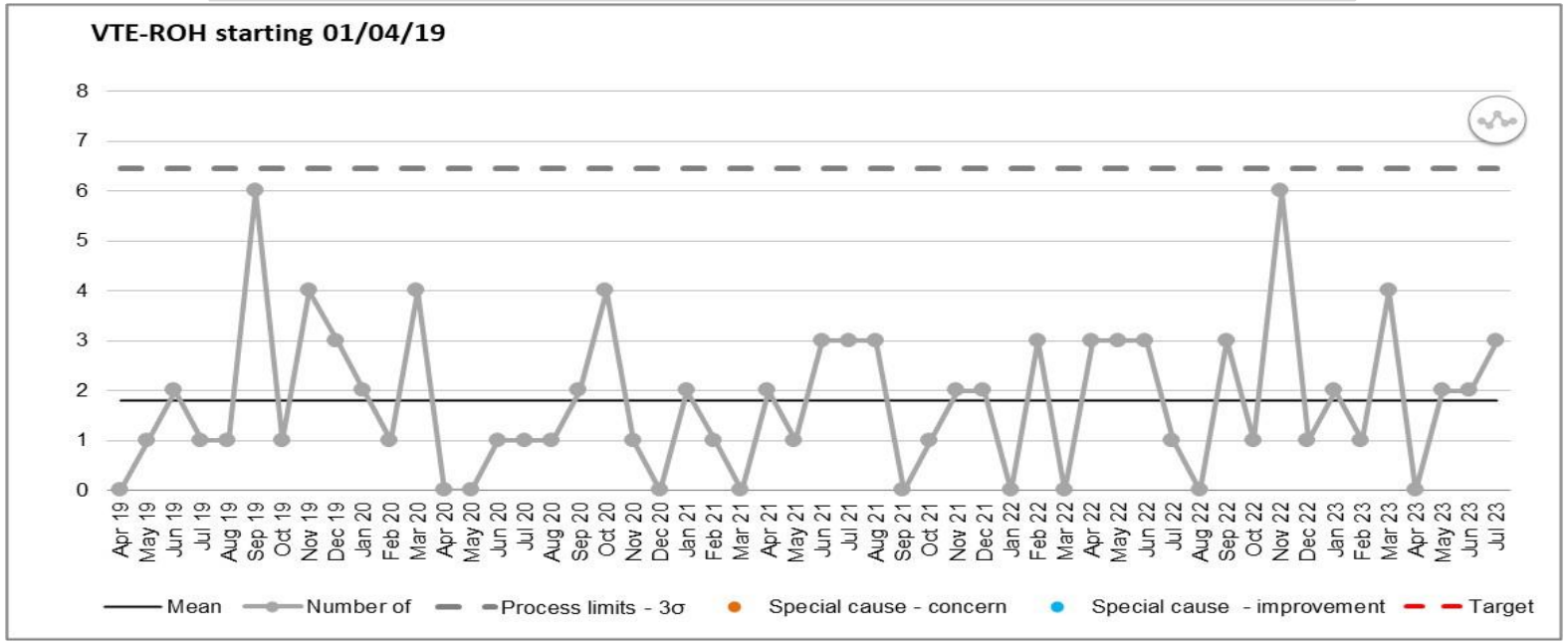
See section 7 for summary of learning from these VTE investigations

<u>VTE On Admission Assessment Compliance</u>

Pre-validation figure for July 2023 = **97.39%**



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Unavoidable	1	0	3	1	6	1	2	1	4	0	2	2	3
TBC	0	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0



9. Falls

7 falls incidents reported in July 2023 – reduction on last month

No Harm = 5
Low Harm = 1
Moderate Harm = 1

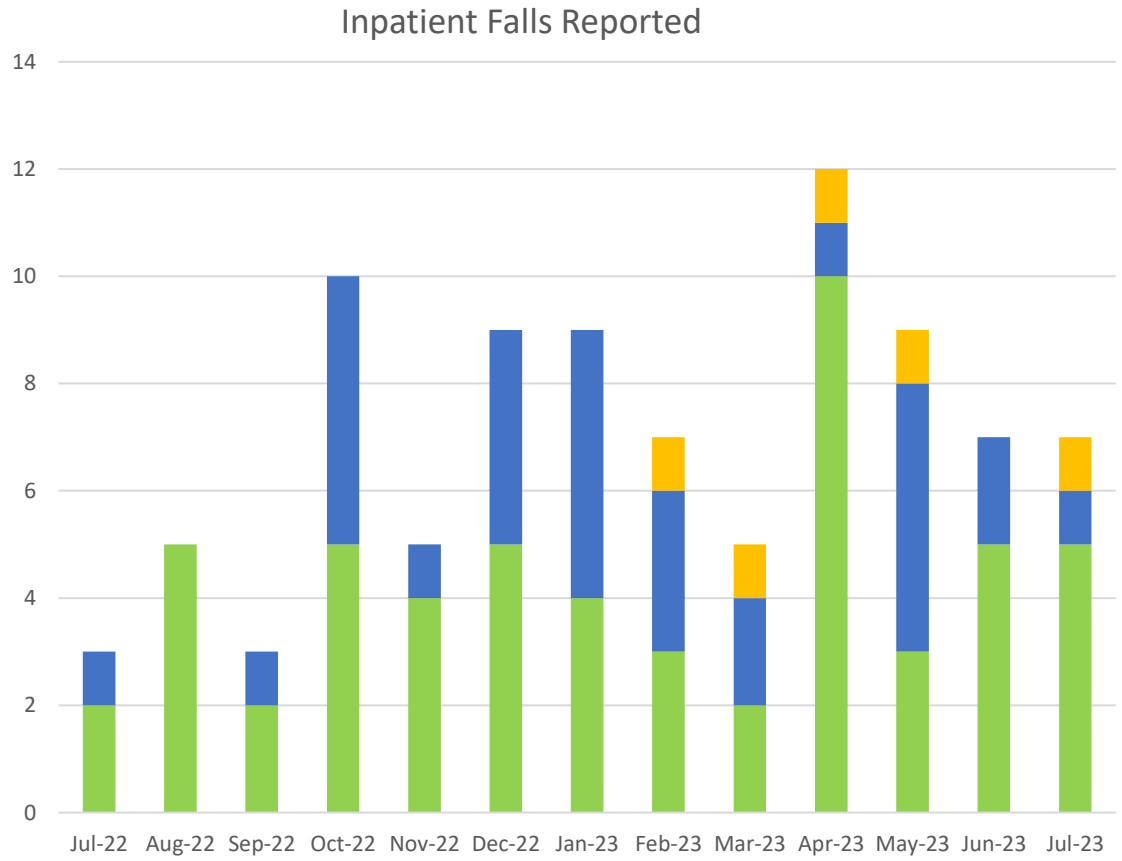
Potential Moderate Harm highlighted previously in section 5 of this report and is currently undergoing investigation

Trends

6 of the 7 were unwitnessed falls
4 of the 7 were bathroom related
3 of the 7 were bed related

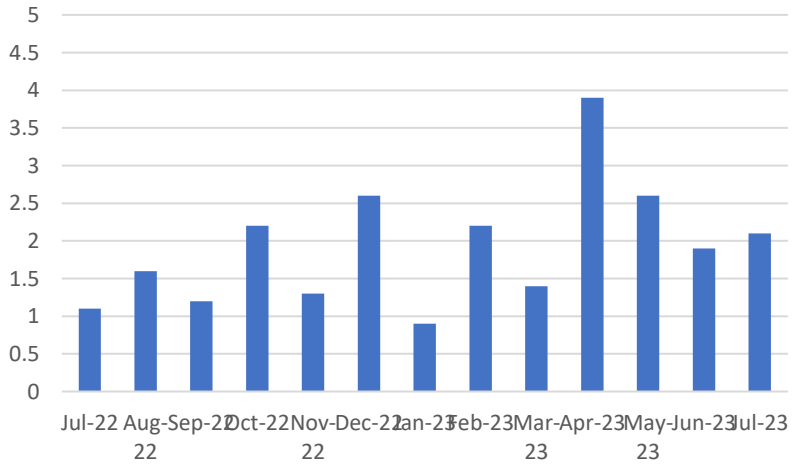
Quality Improvement Work Underway

- Bathroom audit carried. Equipment is being streamlined to ensure consistency and to reduce clutter in the space.
- Increased awareness of 'call don't fall' campaign is underway, the sign appears in bedspaces and bathroom, planned to go on Patient Information System.
- Patient survey highlighted patients don't want to ask for help as they're concerned nurses a busy. Team aware re-enforcing the message with patient and carers.
- Safety huddles are in place and used to identify patient at risk to the whole ward team.
- Falls board have been redesign to update learning and will be replaced.
- Induction for new doctors being updated to included clearer responsibilities in relation to falls management

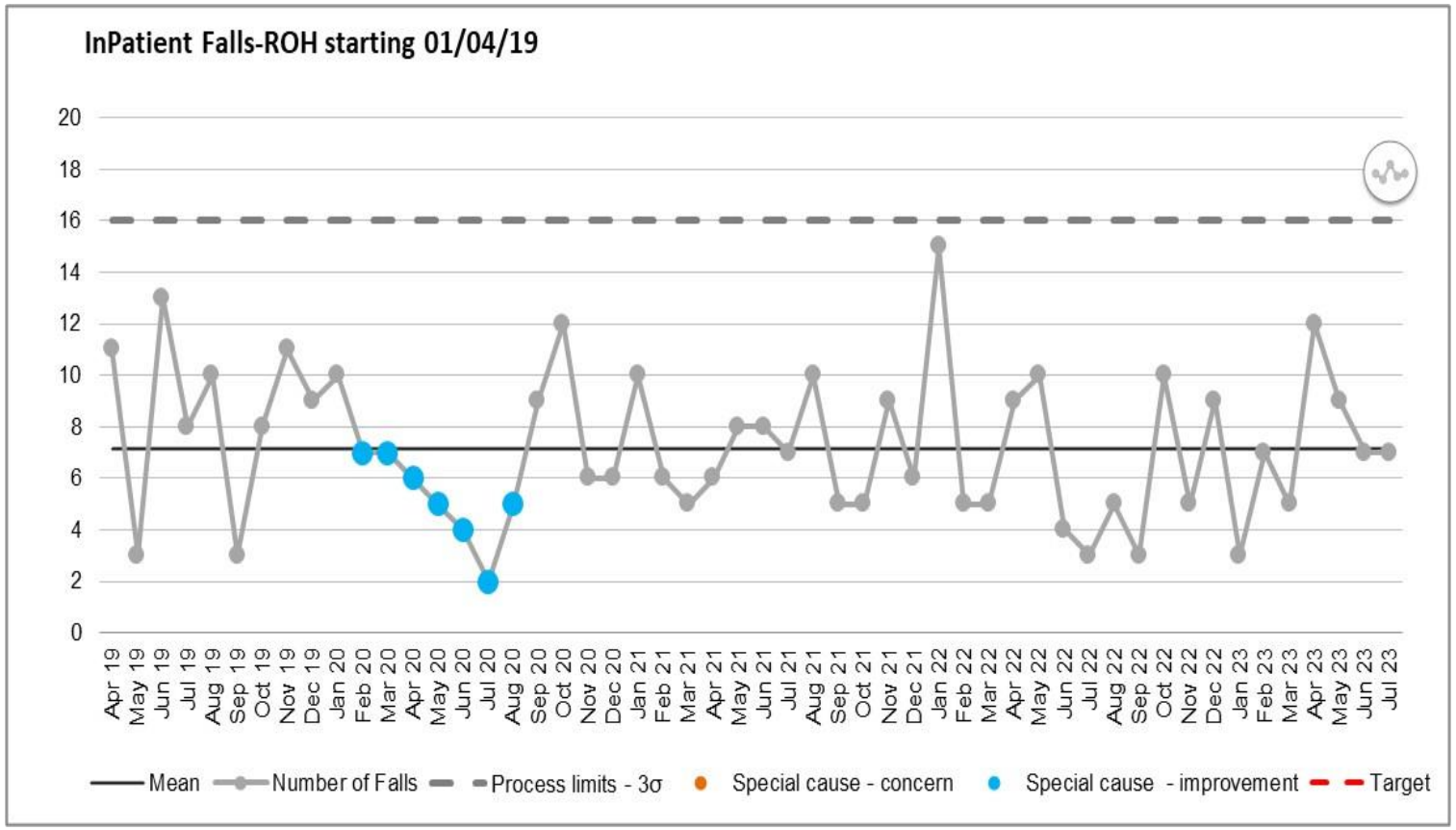


	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	1	1	1	1	0	1
Low Harm	1	0	1	5	1	4	5	3	2	1	5	2	1
No Harm	2	5	2	5	4	5	4	3	2	10	3	5	5

Falls per 1000 Bed Days



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Falls per 1000 BD	1.1	1.6	1.2	2.2	1.3	2.6	0.9	2.2	1.4	3.9	2.6	1.9	2.1



10. Pressure Ulcers

No Category 3 or 4 PU reported in July 2023

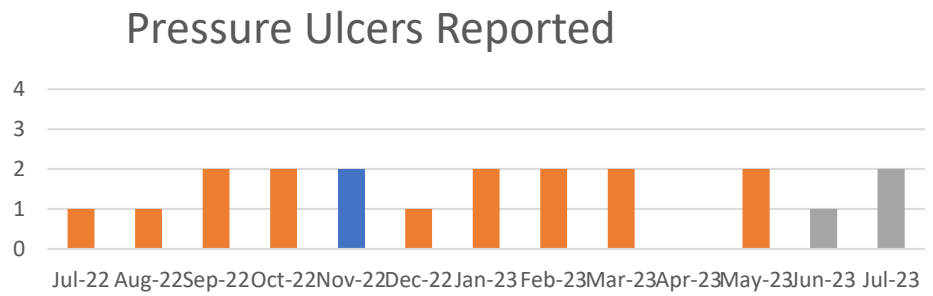
2 x Category 2 ROH acquired PU incident reported in July 2023 – both are currently under investigation

Quality Improvement work underway

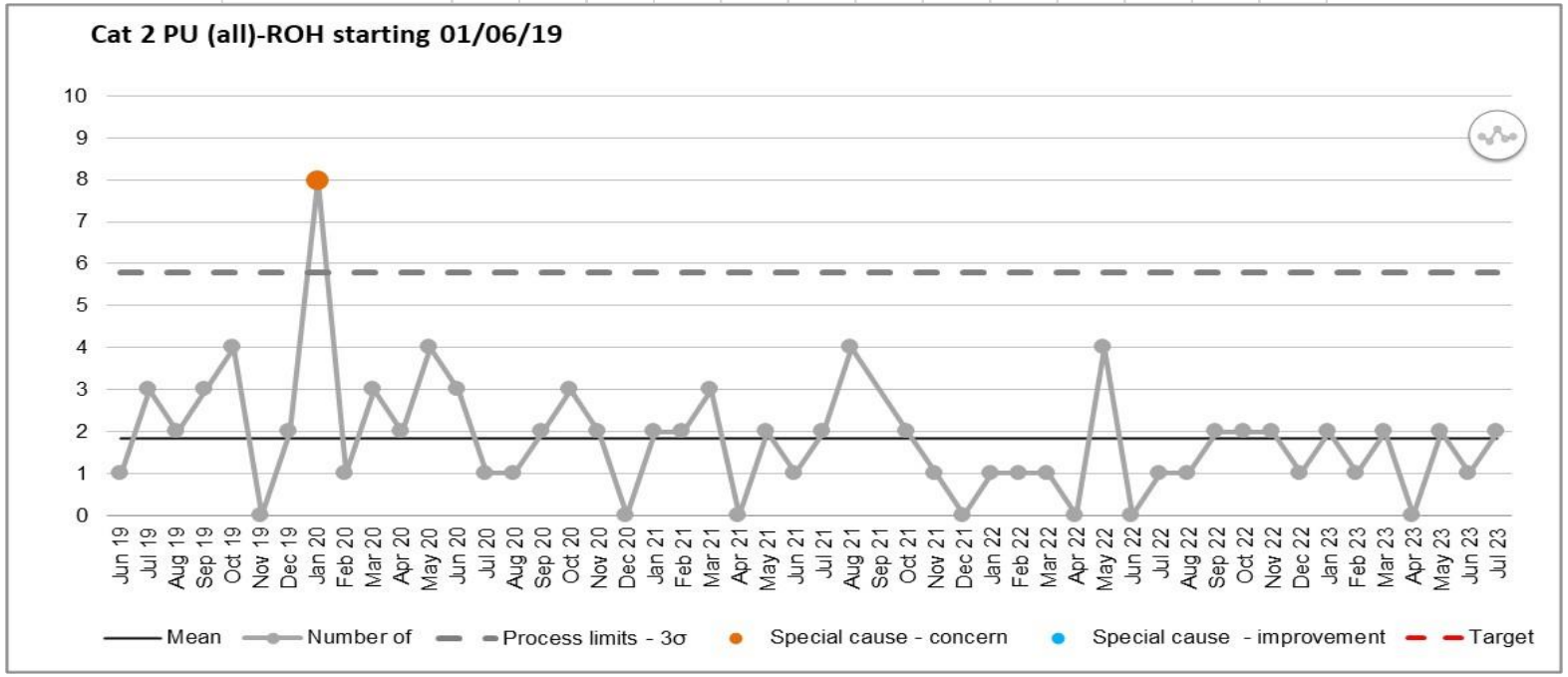
- Newsletter developed and published focusing on all skin issues (shared with all clinical staff).
- 'What's under the dressing?' Campaign is being rolled out, to remind staff to review and check skin under dressing.
- PDSA cycle approach has been introduced to skin damage reduction (not just pressure damage). Focusing on raising awareness and outcome will be monitored.

Risks/Issues

- **Skin tears**- A thematic review is underway following an increase in skin tears noted in Division 2 governance. Focusing on theatres, specifically drapes removal. Interventions in place to reduce risk and training being rolled out.
- **Aqua cell dressing skin damage** – 9 patient affected reported by ROCS team, reported to MHRA and company (Some indication of other issues). Training issues addressed, communication and change in practice, however issues continued. Consultants have now agreed to trial Mepilex Border Post-op dressing.



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Sum of TBC	0	0	0	0	0	0	0	0	0	0	0	1	2
Sum of Unavoidable	1	1	2	2	0	1	2	2	2	0	2	0	0
Sum of Avoidable	0	0	0	0	2	0	0	0	0	0	0	0	0

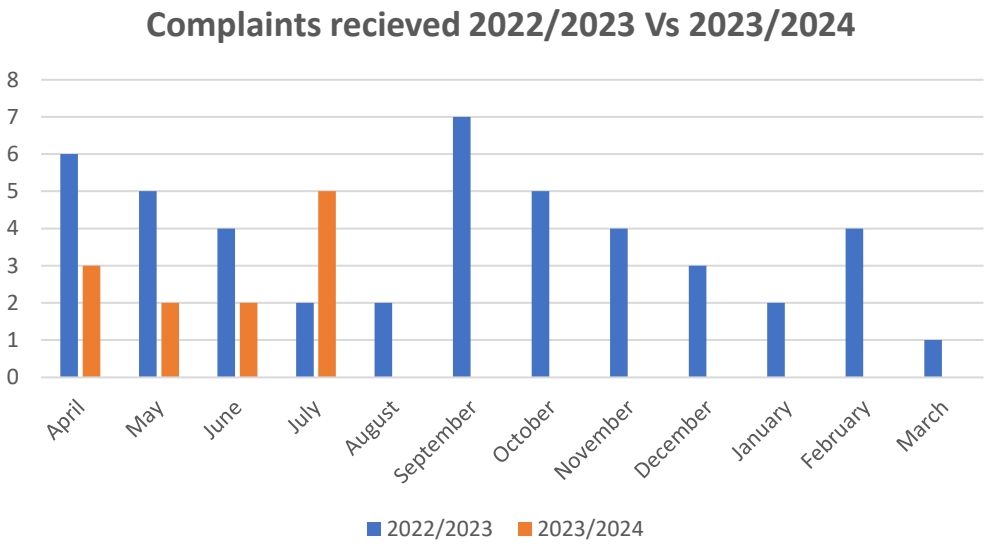


11. Infection Prevention Control

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.

Infections Recorded in month and Year to Date (YTD)	July 2023	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)	1	1
E.coli BSI	0	1
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

12. Complaints



The above table shows that so far this year, we have received less formal complaints compared to 2022/2023.

Complaint Year Totals	
April 2022- March 2023	45
April 2023 - August 2023	14

Complaints KPIs

KPI	Complaints %
April 2023	100%
May 2023	67%
June 2023	75%
July 2023	100%

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

The KPI was met for complaints in July 2023. The PALS KPI was not met due to 5 PALS cases breaching out of 40 cases received for July 2023.

Actions from Complaints

In July 2023 5 actions were identified on complaints received
Immediate action plans were completed for 1 of the complaints received and 2 actions were identified during the investigation created by the lead.
LOOP's were not completed for any complaints for the month of July

Complaint Information

The Trust received **5** complaints in July 2023
Below are the summaries for complaints received

1. Poor Follow up care
2. Lack of Communication / processes
3. Patient needs not met
4. Lack of care provided
5. Failure to provide satisfactory care

2 Complaints are for Division 2 (POAC and Imaging) and 3 are for Division 1 which were all Spinal.
In July 2023, the complaints team **closed 1** formal complaints. **This complaint breached** the agreed timeframe with the patient, however this was communicated with them.
At the time of producing this report (11th August 2023) we **currently have 8 open** formal complaints. 6 are for Division 1 and 2 for Division 2

Complaint Resolution Meetings

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 four 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

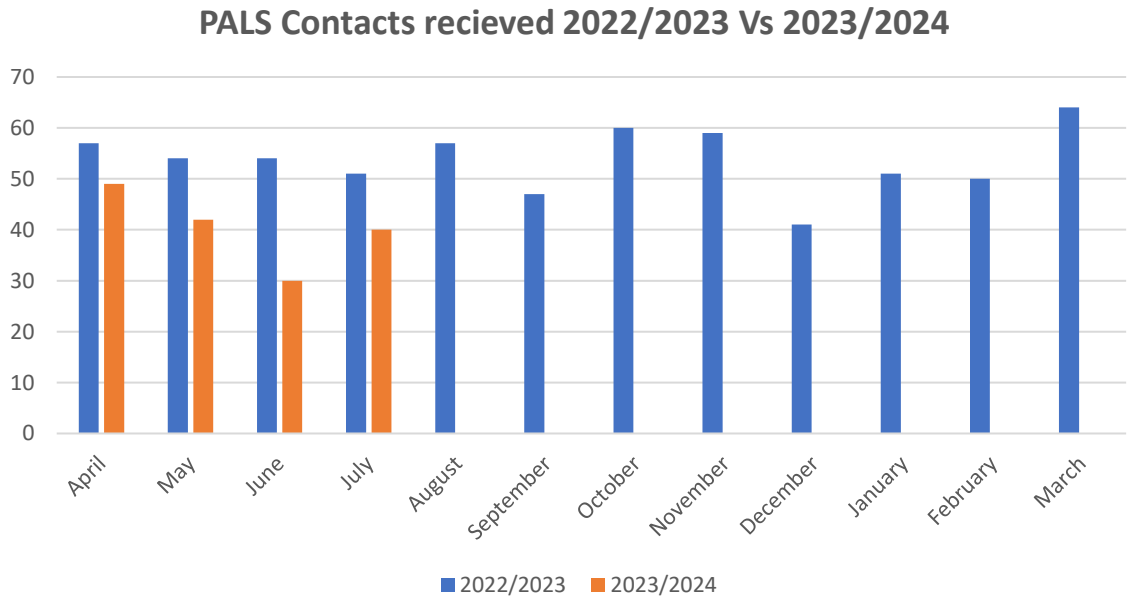
In July2023 the Trust received **1 reopened complaints**. (still awaiting written consent from complainant)

In July 2023 the Trust received **1 meeting requests** (meeting arranged for 24.08.2023)

RISK AND ISSUES WITHIN PATIENT EXPERIENCE

1 complaint breached in July 2023.
3 members of staff in Patient Experience Department are on secondment
Currently no Head of Patient Experience in post (due to start in September 2023)
Person who is being complained about, is being identified as complaint lead by Triumvirate.
All complaints opened in July for Division 1 were Spinal

Patient Advice and Liaison Service – PALS



The above graph shows that so far this year, we have received less PALS contacts compared to last year

PALS KPI's

KPI	PALS Contacts %
April 2023	85%
May 2023	93%
June 2023	90%
July 2023	88%

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

Themes

The main themes in the PALS data related to:

- **Appointments** (Appointment request, Appointment not satisfactory)
- **Referral** (Referral not actioned, Update on Waiting List)
- **Communication** (Communication Info To Patients)

Risks and Issues

5 PALS Cases breached in July 2023.
The departments who breached their PALS cases were Spinal Services and Therapy Services

13. Litigation and Coroners

New claims

Three new claims against the Trust were received in July 2023. NHS Resolution has been notified of all 3 claims and initial liability investigations have commenced.

Details of the cases will be provided in the next version of the report following initial scoping and discussion with the medical teams.

Pre-Application Disclosure

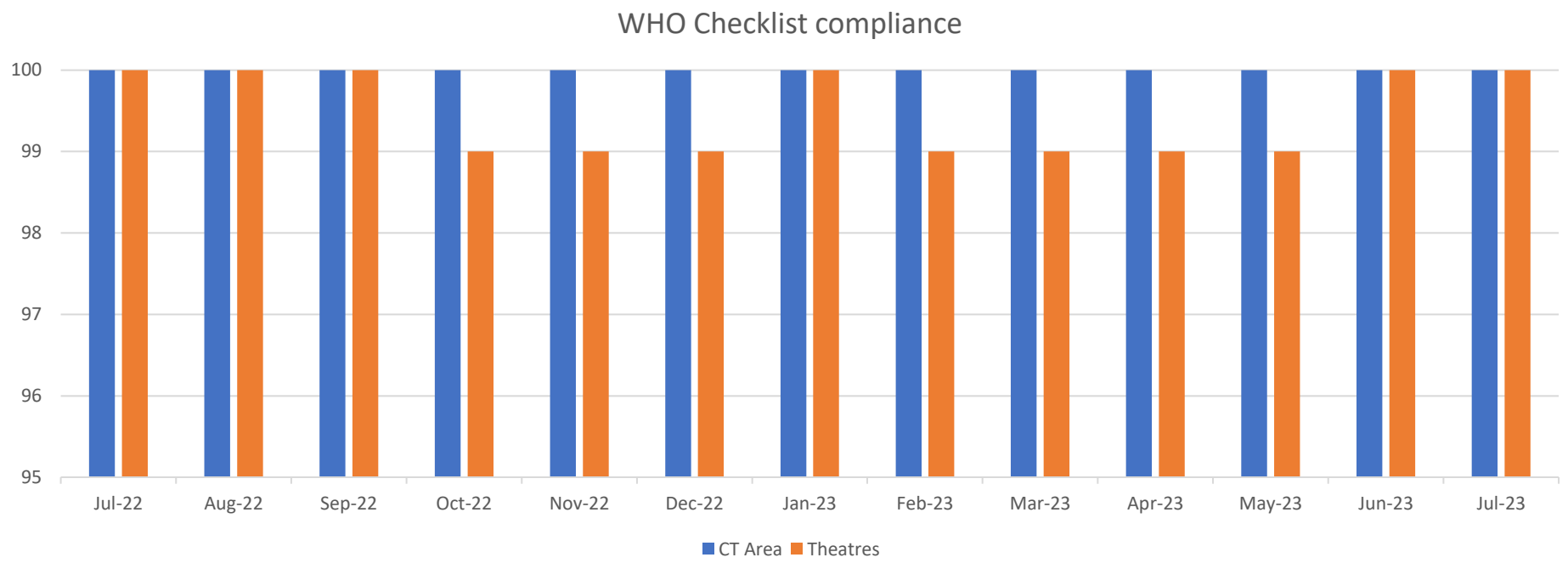
2 new requests for Pre-Application Disclosure of medical records were received in July 2023

Coroner's Inquests

1 Inquest in which the Trust was an 'interested person' was held in July 2023.

14. 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.



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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.

Reference	Alert Title	Originated By	Issue date by MHRA	Deadline	Response
NatPSA/2023/009/OHID	Potent synthetic opioids implicated in heroin overdoses and deaths. In the past 8 weeks there has been an elevated number of overdoses (with some deaths) in people who use drugs, primarily heroin, in many parts of the country (reports are geographically widespread, with most regions affected but only a few cities or towns in each region). Testing in some of these cases has found nitazenes, a group of potent synthetic opioids. Nitazenes have been identified previously in this country, but their use has been more common in the USA. Their potency and toxicity are uncertain but perhaps similar to, or more than fentanyl, which is about 100x morphine.	National Patient Safety Alert - Office for Health Improvement and Disparities	26-Jul-23	4 Aug 23	4 Aug 2023: Email from Pharmacy: 'Alert partially applicable to the trust'. 'We keep Naxoline in all clinical areas, plus advice is on PICS for doses. All relevant persons notified. Alert can be closed'. Actions completed. Alert closed.
NatPSA/203/008/DHSC	Shortage of GLP-1 receptor agonists. There are very limited, intermittent supplies of all glucagon-like peptide-1 receptor agonists (GLP-1 RAs). Supplies are not expected to stabilise to meet full market demand until at least mid-2024. The supply issues have been caused by an increase in demand for these products for licensed and off-label indications. The off-label use of these agents for the management of obesity is strongly discouraged. Existing stock must be conserved for use in patients with diabetes. These shortages have serious clinical implications in the management of patients with type 2 diabetes.	National Patient Safety Alert - DHSC	18-Jul-23	18 Oct 23	26 Jul 23: Email from Pharmacy: 'We don't routinely stock these items. We don't initiate patients on these items. Only usually supply them if the patient was unable to bring in their own supply, however we would attempt to get their own supply brought in before ordering it in here. We currently have no patients in the trust on these items. MDSO: 'Based on the information provided, alert can be closed'. Not relevant. Alert closed.

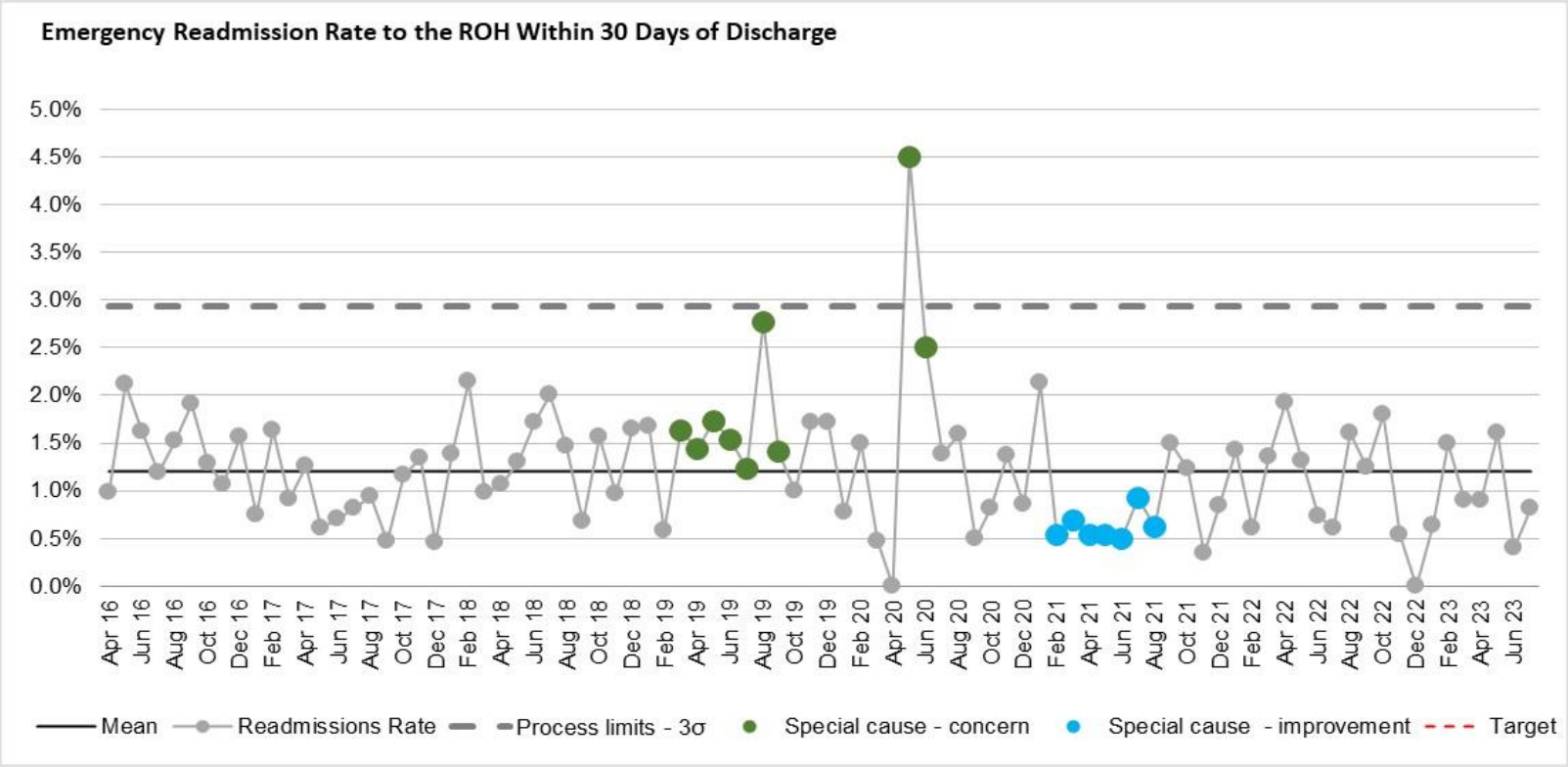
16. Safeguarding

KPI	Jun-22	Jul-22	Aug-22	Sept 2022	Oct-22	Nov-22	Dec-22	Jan-22	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Safeguarding Adult Notifications	29	33	44	36	27	51	31	31	35	17	43	21	44	43
Safeguarding Children Notifications	43	44	57	43	44	42	26	26	76	23	37	29	55	51
Adult Level 2 – 85%	89.98%	87.99%	87.26%	86.01%	84.53%	85.14%	81.83%	81.83%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)
Adult Level 3 – 85%	88.71%	87.97%	88.41%	86.52%	83.30%	80.31%	75.68%	75.68%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)
Level 4 – 90%	75%	75%	75%	66.67%	66.67%	75.00%	75.00%	75.00%	60% (↓)	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)
Child Level 2 – 85%	89.65%	87.66%	87.02%	85.87%	84.12%	84.54%	81.16%	81.16%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)
Child Level 3 – 85%	88.21%	87.97%	88.41%	84.52%	83.10%	80.12%	75.29%	75.29%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)
Mental Capacity Act MCA – 85%	88.97%	87.58%	88.84%	85.78%	84.48%	84.97%	81.67%	81.67%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)
Deprivation of Liberty Safeguards DoLs	88.97%	87.58%	86.84%	85.87%	84.48%	85.05%	81.58%	81.58%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)
Prevent Awareness – 95%	93.34%	98.92%	92.44%	91.70%	90.04%	91.01%	89.88%	89.88%	89.40%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)
WRAP (prevent level 3) – 90%	85.36%	83.84%	82.51	82.86%	80.15%	81.80%	81.06%	81.06%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)
FGM	1	0	1	0	3	1	1	1	2	1	3	0	1	0
DOLS	2	5	3	11	5	7	6	6	4	0	7	0	6	4
MCA	3	6	7	4	7	4	4	4	0	1	3	4	1	4
PIPOT cases	0	0	2	1	1	0	0	0	1	0	0	0	0	1
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Actions underway to recover position:

- Safeguarding team are providing two additional super session over and above normal programme, with capacity for up to 100 staff during July and August.
- Training dates until April 2024 have been uploaded onto ESR and the Trusts Intranet. The Communications Team have sent a Trust wide bulletin including all the safeguarding training available and to signpost staff how to access training.
- Executive and Divisional leads have been written to by the Executive for Safeguarding seeking support to recovery and compliance at training.
- All non-medical clinical staff seeking to access additional training outside of mandatory training will have to provide evidence 100% mandatory compliance prior to approval

17. Patients Readmitted to a Hospital Within 30 Days of Being Discharged



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
No of Readmissions	7	6	9	3	0	3	7	5	4	7	2	4
Denominator	435	484	556	556	486	468	468	546	465	494	554	494
% Readmissions	1.6%	1.2%	1.6%	0.5%	0.0%	0.6%	1.5%	0.9%	0.9%	1.4%	0.4%	0.8%

18. Freedom to Speak Up Update

Concerns Raised

There were 2 concerns raised in July 2023; these were in relation to the following theme:-

- Disparity in pay between bank and agency staff

Employee safety and wellbeing

N/A

Learning and Improvement Work Underway

Remains the same, with a focus on:-

- Implementation of TED Tool across the organisation to improve team engagement and development
- Improvement of culture and inclusivity within the organisation, staff feel more empowered to speak up without fear of negative consequences with the support of the Freedom to Speak up Team
- Working with the HR department to support, empower and educate managers on how to use Trust policy to help make informed decisions
- Feedback received from workers regarding improvements within their local areas following speaking up
- Roll out of FTSU 'Green Boxes', where staff can register concerns/issues confidentially
- FTSU team to consider branding
- Collaborative working with FTSU Guardian, Matron and Head of Nursing to ensure action taken to support staff and embed learning

Operational Performance

July 2023

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Operational Performance Summary

Performance to end July 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.61%	56.07%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	13	19	0	L	F
52 week waits (52 – 64 Weeks)	309	266	0	H	F
All activity YTD (compared to plan)	4,720	3,570	4,683		P
Outpatient activity YTD (compared to plan)	21,487 100.1% Cumulative	16,376 102.9% Cumulative	21,455 YTD Target		P
Outpatient Did Not Attend (YTD)	8.3%	7.88%	8%		F
PIFU (trajectory to 5% target)	439 8.2%	465 7.9%	193 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	11.3%	10.6%	19%		F
FUP attendances(compared to 19/20)	89.4%	92.9%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	104.8%	105.9%	N/A		F
Diagnostics volume YTD (compared to plan)	7,624 Cumulative	5,982 Cumulative	6,207 YTD Target		P
Diagnostics 6 week target	99.8%	99.4%	99%		P

Operational Performance Summary

	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (In Session)	83.28%	80.90%	85%		
Cancer - 2 week wait (May – Apr)	98.8%	100%	93%		
Cancer - 31 day first treatment	94.1%	90%	96%		
Cancer - 31 day subsequent (surgery)	100%	90%	94%		
Cancer - 62 day (traditional)	61.5%	43%	85%		
Cancer - 62 day (Cons upgrade)	81.8%	71%	n/a		No Target
28 day FDS	80.4%	79%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	8,156	6,079 Cumulative	7,712 Cumulative		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.55	3.20	n/a		No Target
LOS - elective primary hip	3.90	3.20	2.7		
LOS - elective primary knee	2.90	3.20	2.7		
BADS Day Case rate (Note: due to time lag in month is Apr'23)	76%	78%	85%		

Monthly Workforce & OD Report

July 2023

Key Points

Executive Summary

- Overall 84.8% of WTE employed against the Establishment
- Staff Turnover remains high at 16.99% but decreasing
- PDR/Appraisals are still well below what we should be doing as a Trust currently at 64.69%
- Return To Work meetings are still not being recorded fully currently 55.21%

Positive Assurances

- The HR Team will be focussing more on training of line managers in the coming months with an aim towards increasing managerial confidence and competence in key areas
- Flexible retirement options have been communicated in the Trust and further methods of educating staff around retirement options and flexible working are in the pipeline.
- Improvements in the recruitment teams time to hire will help to improve our overall establishment.

Key Risks

- PDR/Appraisals are essential for staff development and performance. Underutilisation could lead to lower staff engagement and may impact retention.
- National reports indicate that more people are leaving roles than ever in seek of promotional opportunities and flexible working. This is a trend that appears to be impacting ROH, as these are our two highest leaving reasons behind retirement.

Next Steps

- Training and education will be higher on the agenda for the HR Team with some key areas of focus for the team.
- The new appraisal policy is currently being developed.
- HR to review the Staff Turnover and look into the reasons and dig deeper into them, Terrie Hillier provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.
- Absence will remain monitored by the HR Team who will provide advice and guidance to managers in supporting their staff.

CONTENTS

Introduction

This report shows the Workforce and OD information for the months of July 2023 compared with the previous month(s).

This information is at the point of when the reports are taken in ESRBI and relies on the updates from managers and members of staff to keep the data up to date.

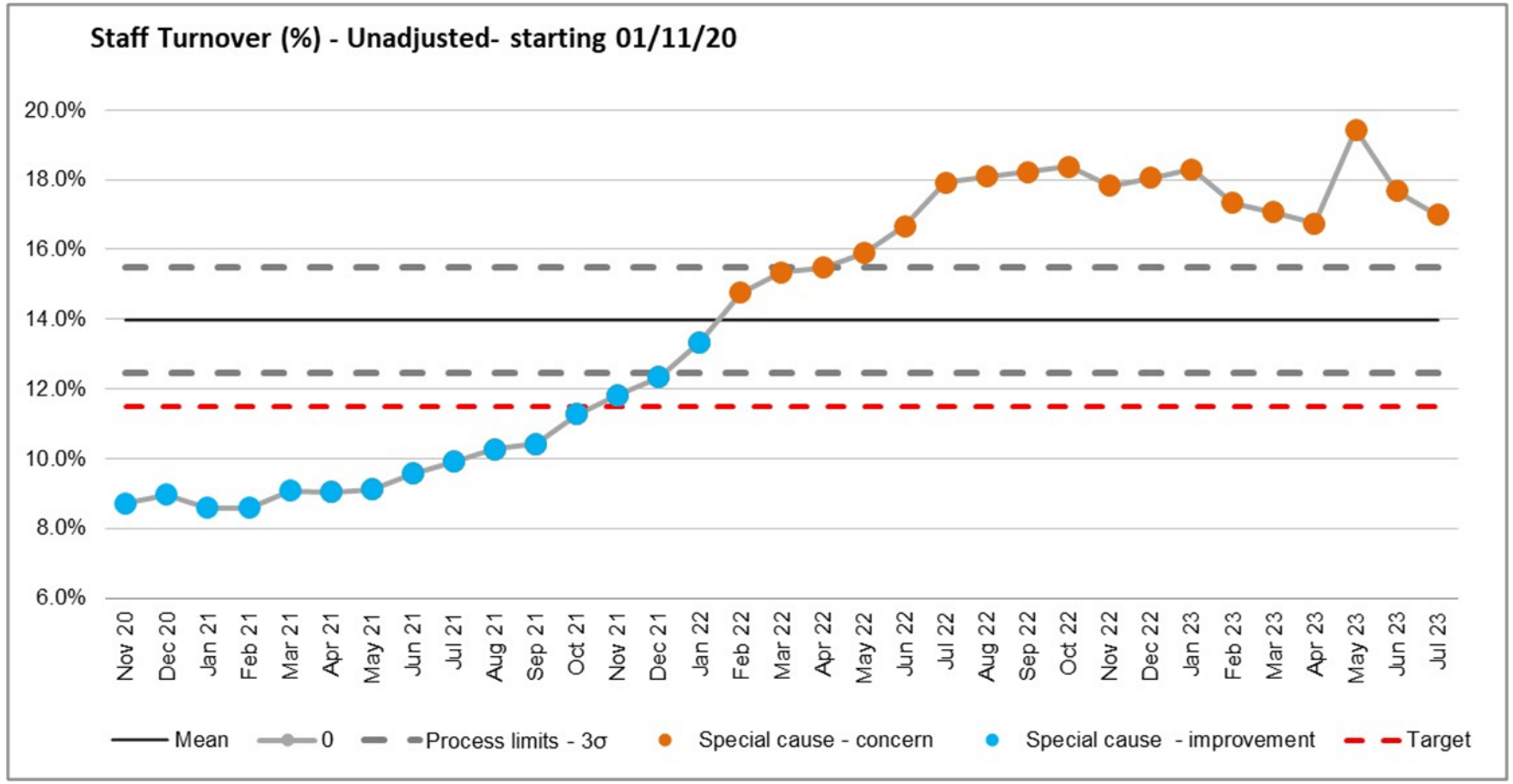
1. Workforce Overview

Trust Workforce Metrics	Jun-23	Jul-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1320	1318	-2	-	-
Staff In Post - Full Time Equivalent	1165.82	1167.84	2.02	-	-
Staf Turnover % - Unadjusted	17.68%	16.99%	-0.69%	↓	<=11.5%
Staf Turnover % - Adjusted	12.57%	12.12%	-0.45%	↓	<=11.5%
Total WTE Employed as % of Establishment	84.50%	84.81%	0.31%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.61%	82.42%	0.81%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.89%	89.20%	-0.69%	↓	>=96%
% Of Attendance	94.90%	94.17%	-0.73%	↓	>=96.3%
% Of 12 mth MAA Attendance	94.12%	94.24%	0.12%	↑	>=96.3%
% Staff received mandatory training last 12 months	89.26%	90.34%	1.08%	↑	>=93%
% Staff received formal PDR/appraisal last 12 months	61.95%	64.69%	2.74%	↑	>=95%
% of Sickness - Trust wide Long-term	2.47%	3.44%	0.97%	↑	-
% of Sickness - Trust wide Short-term	2.63%	2.39%	-0.24%	↓	-
Return To Work Completion %	57.33%	55.21%	-2.12%	↓	>=80%

2. Turnover & Retention

Unadjusted turnover for this month was 16.99% which is well above the Trust target of 11.5%.
For unadjusted turnover by staff group, over the last 12 months, turnover was the highest in the Add Prof Scientific and Tech, followed by Nursing & Midwifery which are all in the red category against the Trust target.

Work continues to look into the Recruitment & Retention of staff within the Trust. HR continue to work with Managers to review reasons why employees are leaving.

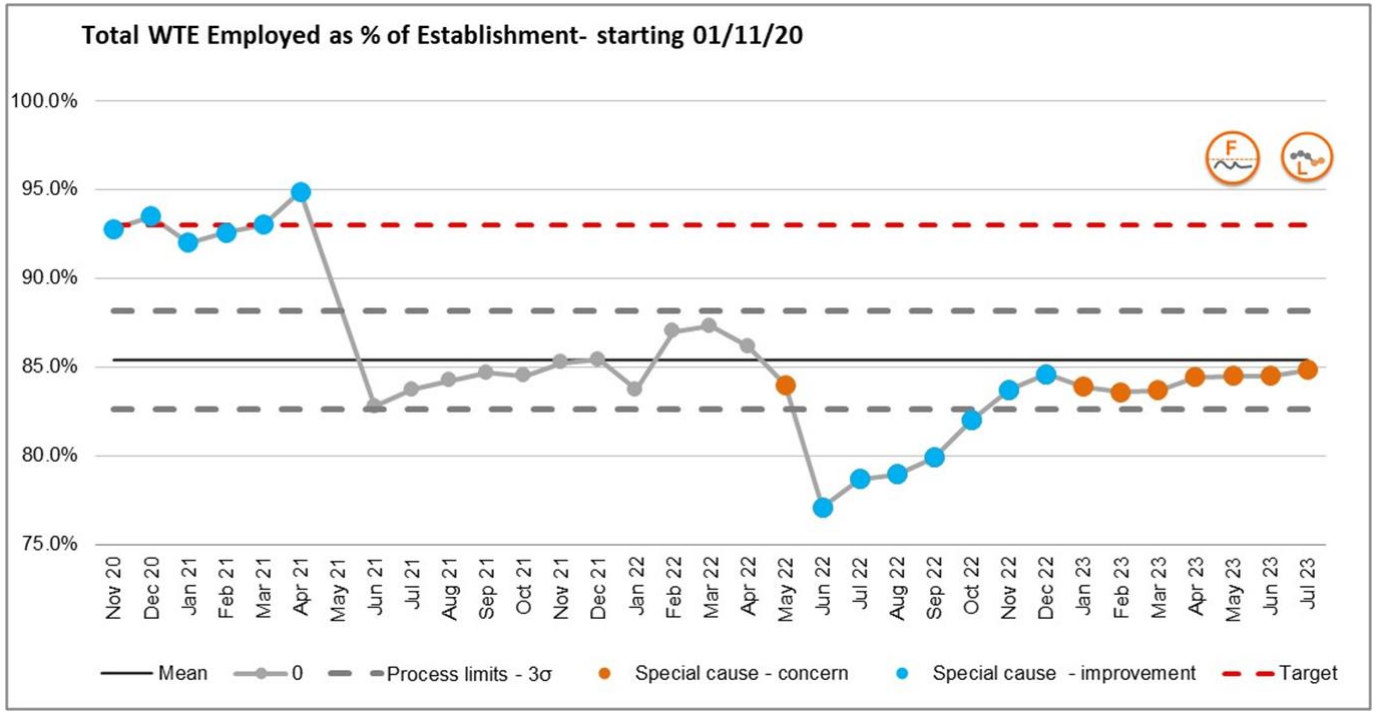


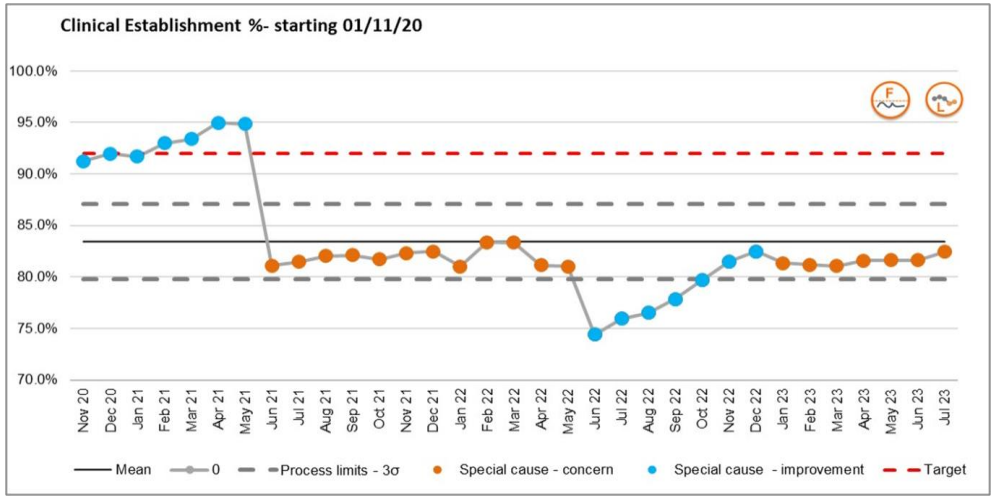
Staff Group	FTE
Add Prof Scientific and Technic	21.23%
Nursing and Midwifery Registered	15.69%
Allied Health Professionals	15.06%
Administrative and Clerical	13.83%
Additional Clinical Services	11.84%
Estates and Ancillary	9.47%

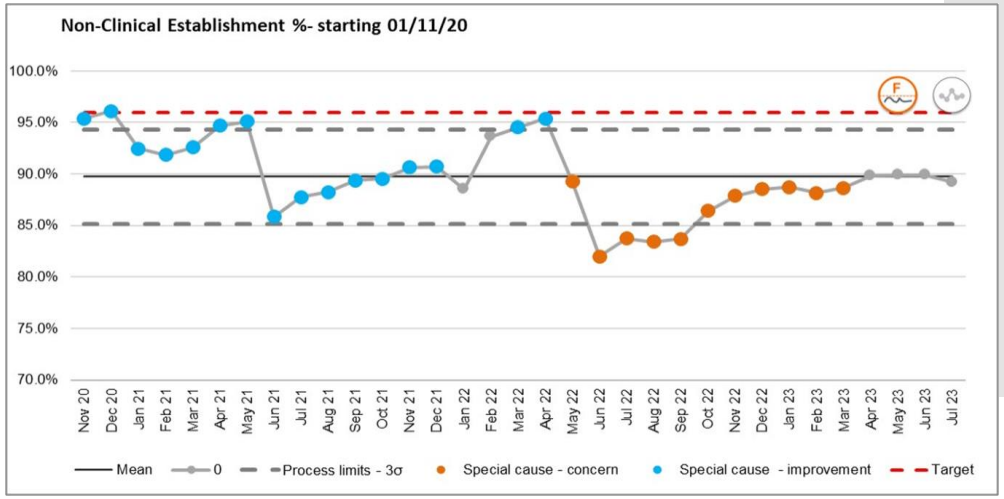
Org L4	FTE
303 Corporate Directorate	19.87%
303 Division 1 - Patient Services	19.74%
303 Division 2 - Patient Support	15.76%
303 Division 4 - Estates and Facilities	8.47%

3. Establishment

At the end of July, the number of staff on payroll stood at 1318 (WTE 1167.84) which is a decrease of 2.02 WTE from June.
The Total WTE Employed as a % of the Establishment this month was 84.8% which rests well below the Trust Target 93%.





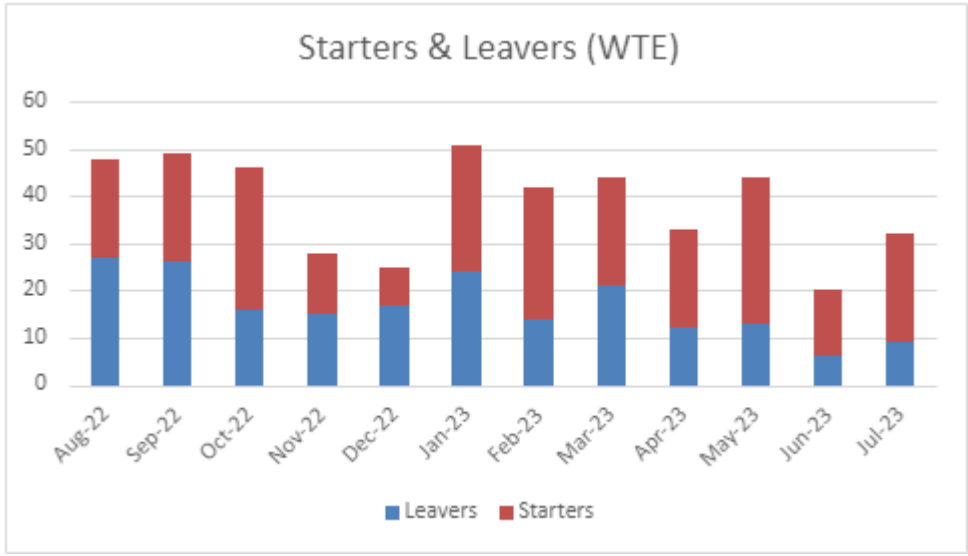


4. Starters & Leavers

Over the last 2 months, the main reasons for staff leaving (according to ESR data) were Retirement, promotion and work-life balance.

Managers will be provided training around flexible working in the coming months, which will aim to increase managerial knowledge around the benefits and the process of offering flexible working.

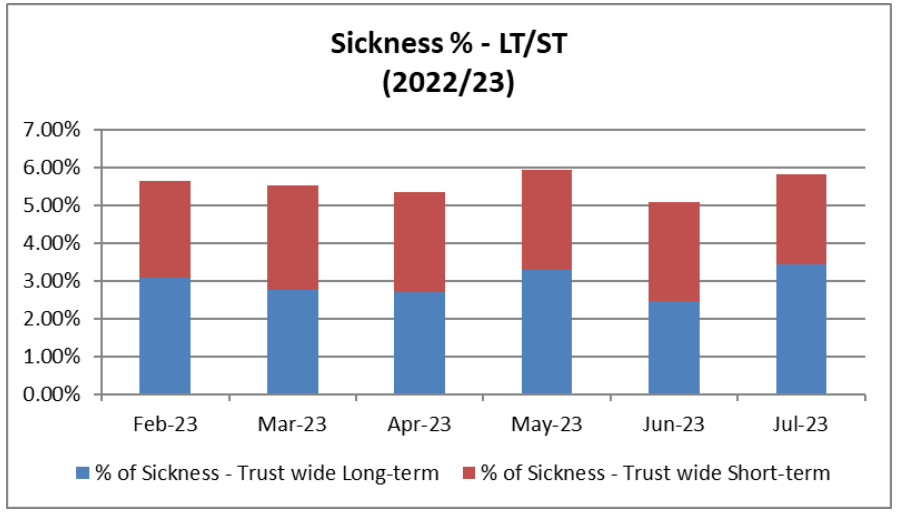
New flexible retirement options have been communicated in the Trust to help maintain staff who are looking to take their pension.

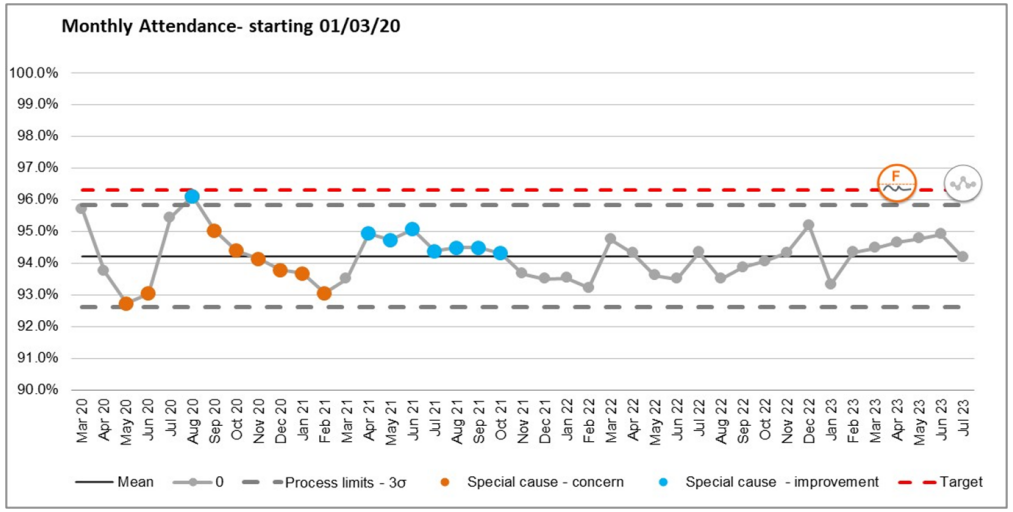


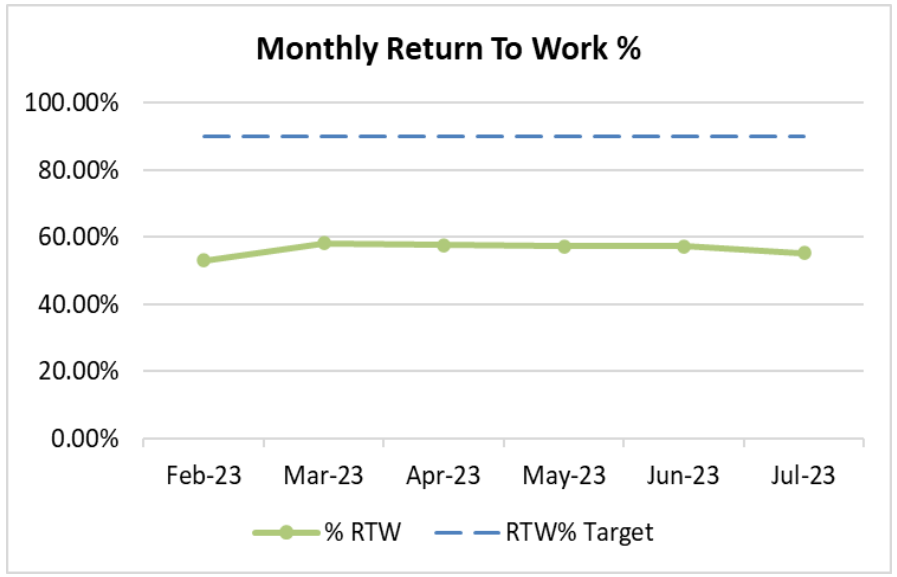
5. Attendance & Sickness

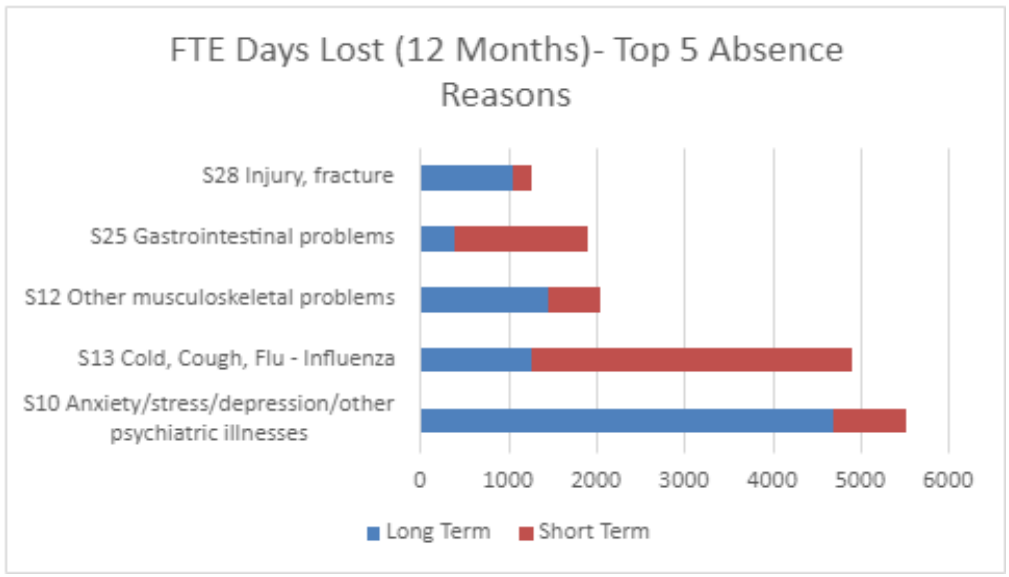
Return To Work Discussion Meetings Following Sickness Absence

Trust wide Return To Work (RTW) interviews decreased to 55.21% in July, compared to 57.33% in June. This still remains below the Trust Target of 80%.





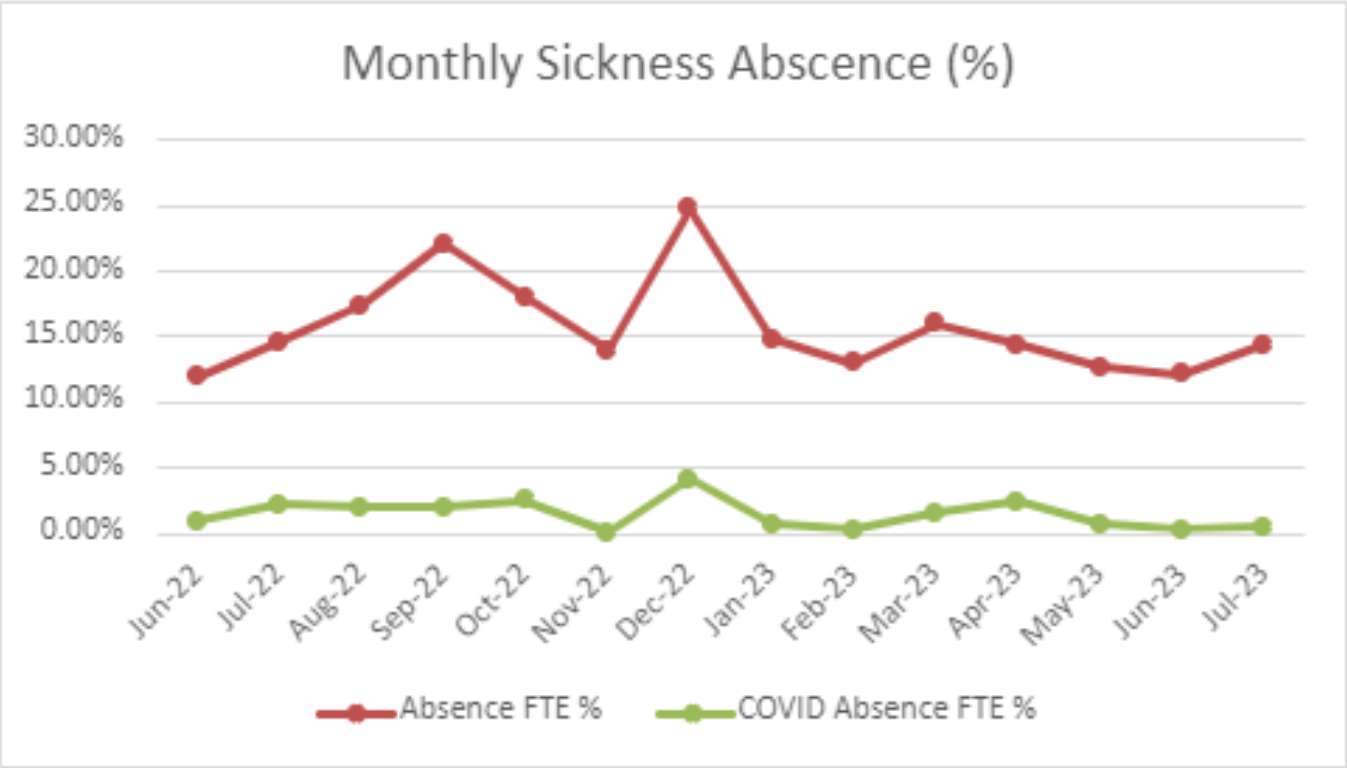




5. Attendance & Sickness

Attendance for this month was 94.17% (sickness absence % = 5.83%) and Attendance for the rolling past 12 months was 94.24%. This currently sits below the Trust target of 96.3% and has remained fairly consistent over the past few months.

The top reasons for sickness absence included Anxiety/stress, cold cough or flu like symptoms (including COVID-19), gastrointestinal problems and musculoskeletal problems. This month sees Anxiety take over at the top.



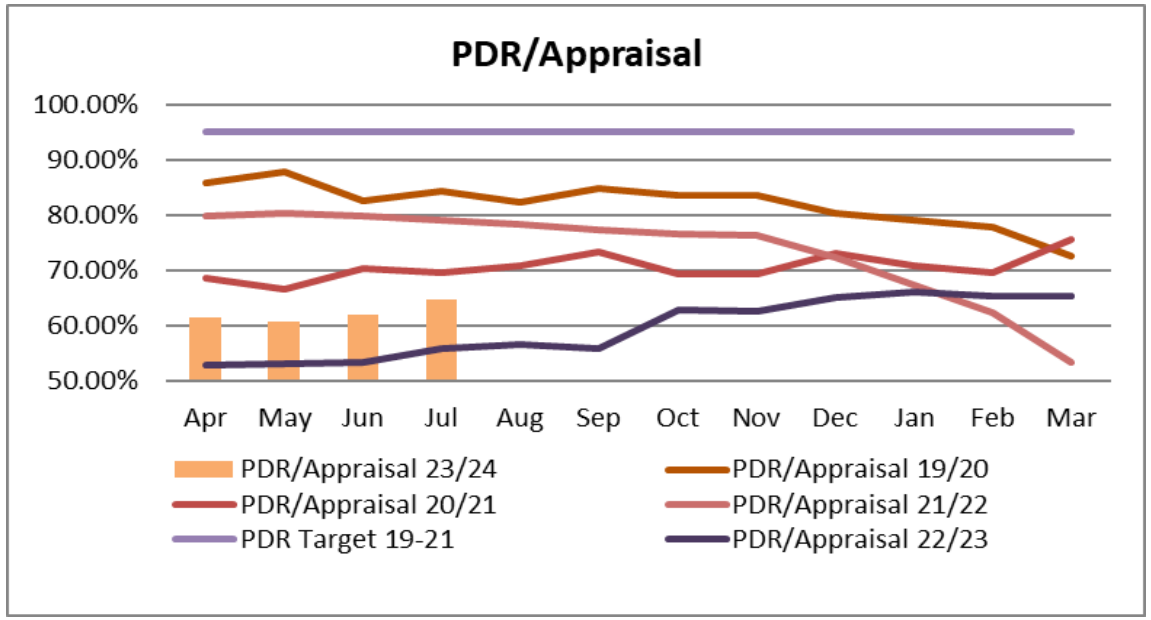
This chart shows that 14% of the WTE were off with sickness which started in July 2023 (not inc Long Term Sickness) and of that sickness 0.48% is attributed to Covid, this against the WTE figure of 1167.84

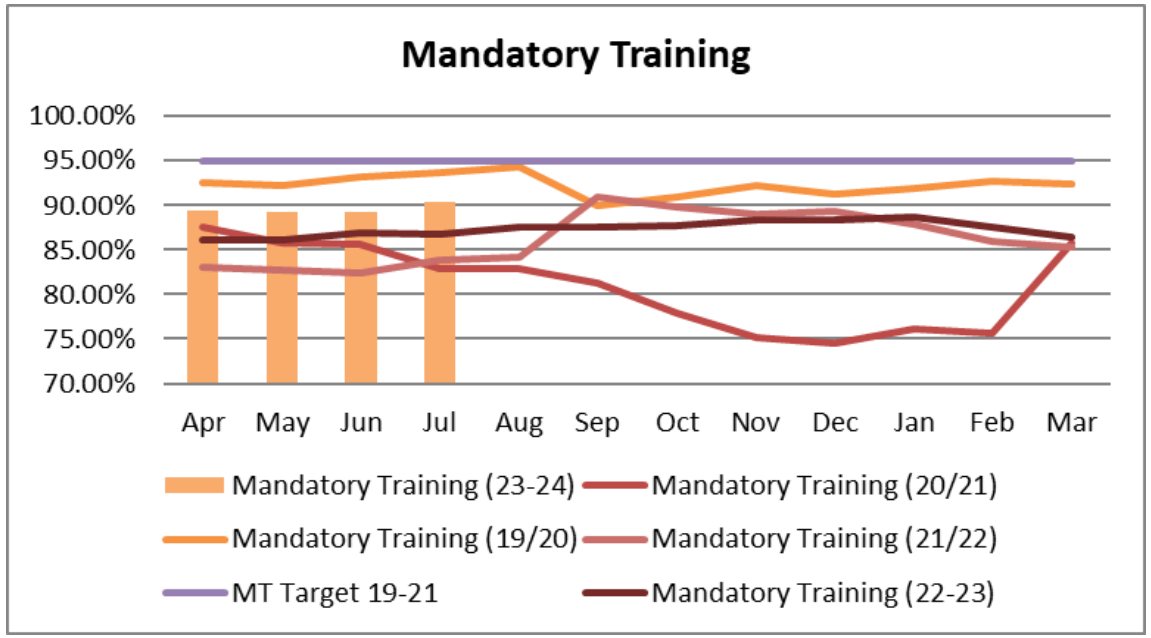
Top Absence Reasons In the Last 12 Months by FTE Days Lost	Count of Episodes	FTE Days Lost	Estimated Cost Of Absence
Anxiety/stress/depression	193	5527.82729	£519,240.20
Cold, Cough, Flu - Influenza	815	4909.74414	£481,607.05
Musculoskeletal problems	152	2059.40583	£211,215.96
Gastrointestinal problems	501	1910.27581	£178,231.91
Chest & respiratory problems	99	1135.89451	£123,305.21

6. Training & Education

Appraisals completions increased by 2.74% to 64.69% in July and retains it's red status against the Trust target of 95%

Mandatory training increased by 1.08% to 90.34% in July, staying in the amber status against the Trust's target of 95%. This has stayed steady since January 2022 that staff have been more than 85% compliant in this.





Monthly OD and Staff Engagement Report

August 2023

CONTENTS

Key Points

Executive Summary

- Work continues to ensure staff are well engaged and have the opportunity to share ideas through staff voice
- There is updated information on staff engagement at OD and Inclusion interventions

Positive Assurances

- The Disability Declaration rate has again seen an increase to 7.12% above the national NHS average
- Annual leave for staff at 33.38% is slightly higher than expected. This is slightly less than the previous year but still on target.
- There was positive engagement at the recent Wellbeing conversation training sessions
- Work to engage staff through focus groups continues to be well supported

Key Risks

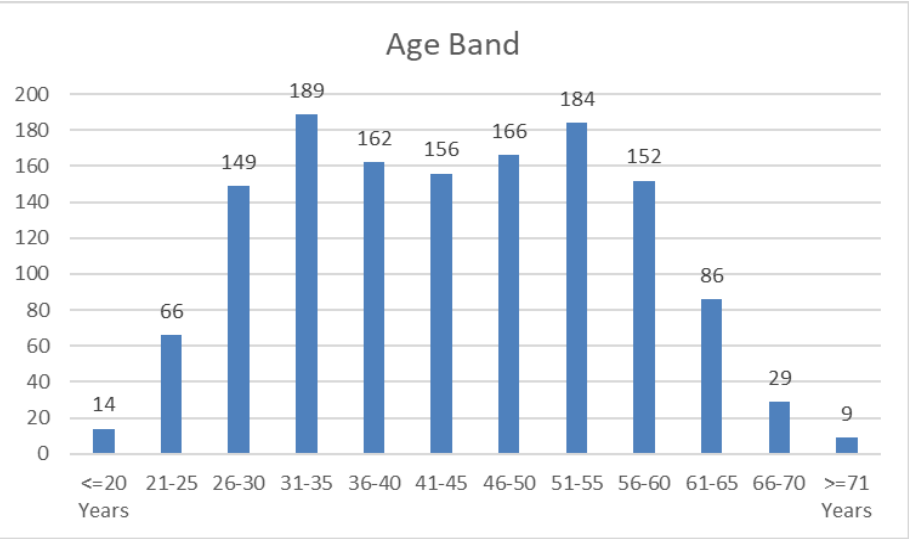
- Cost of living seems to be affecting the NHS as a whole, the Trust is doing it's upmost to alleviate the impact.
- Staff with no PDR/Appraisal will have no way of being appraised, agree personal goals or have the opportunity to speak to managers about personal wellbeing
- Ensuring there continues to be engagement with staff to support them in joining staff networks. Network Chairs are working together to look at different options to enable staff to attend meetings

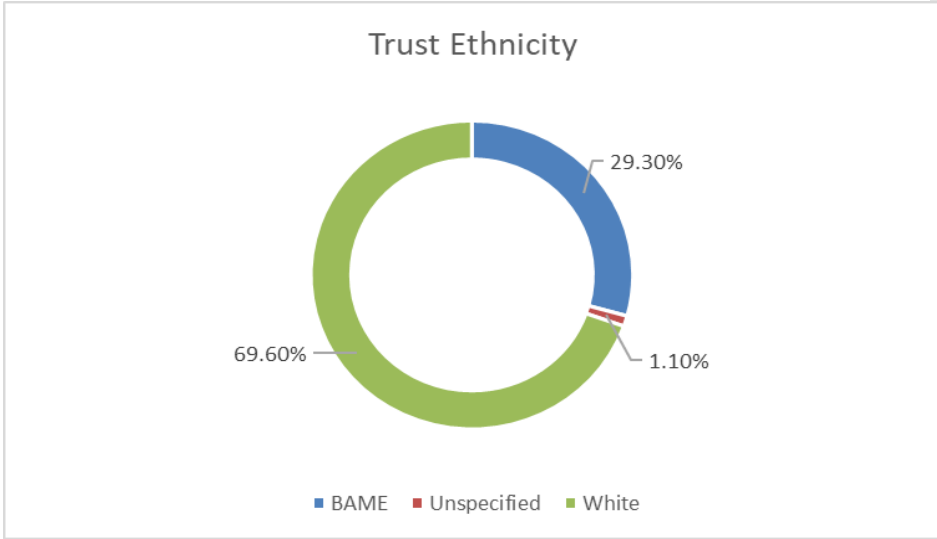
Next Steps

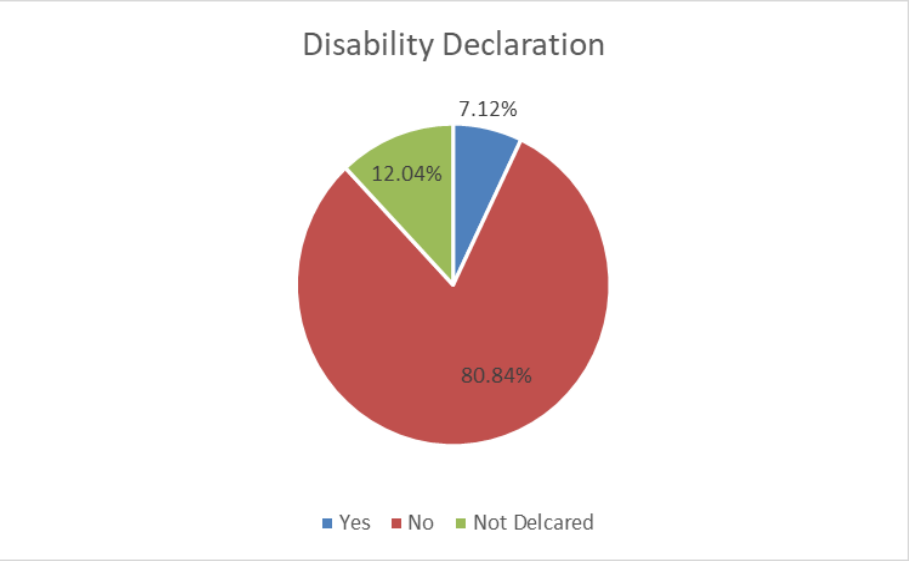
- Further development of the metrics for OD, Inclusion and Wellbeing to support the People Plan strategy
- Planning for the National Staff survey programme 2024/2024

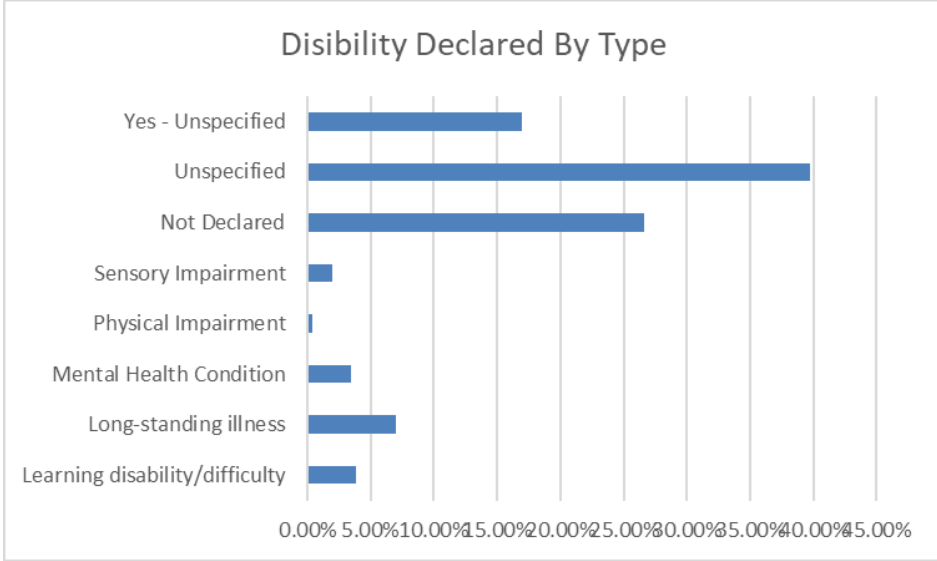
1. Workforce Demographics

The Trust is made up of 70.78% female and 29.22% male staff
Our current status of staff with a disability is 7.12% with 12.04% of staff still to declare their disability status, this has decreased slightly due to a new members of staff joining with declaring. Staff are being encouraged to update their equality and diversity details through Electronic Staff Record.



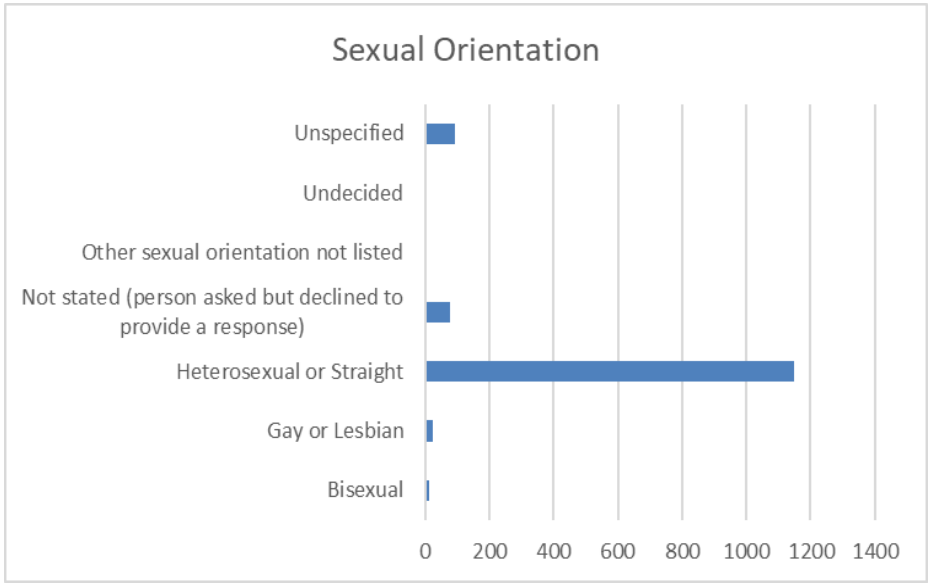


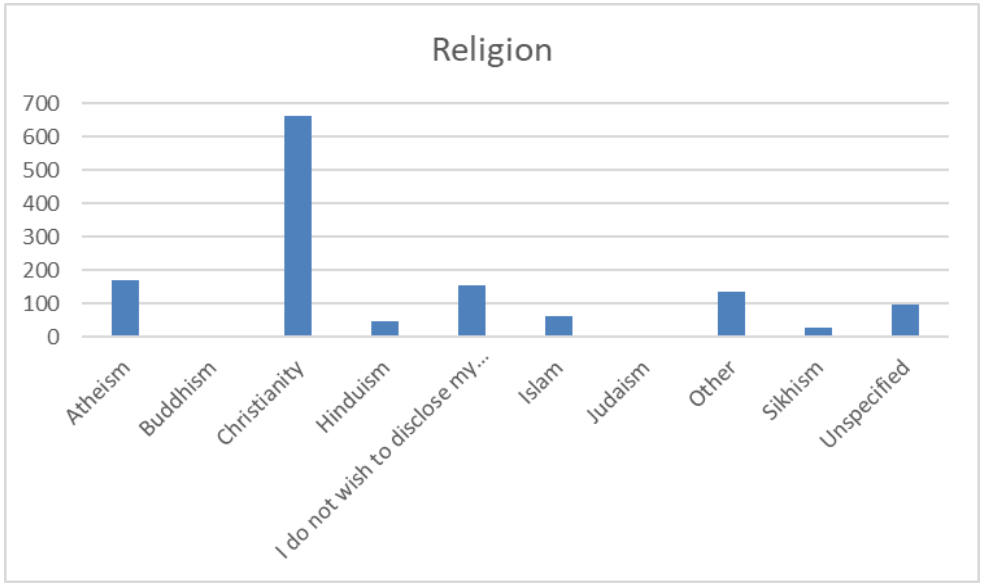


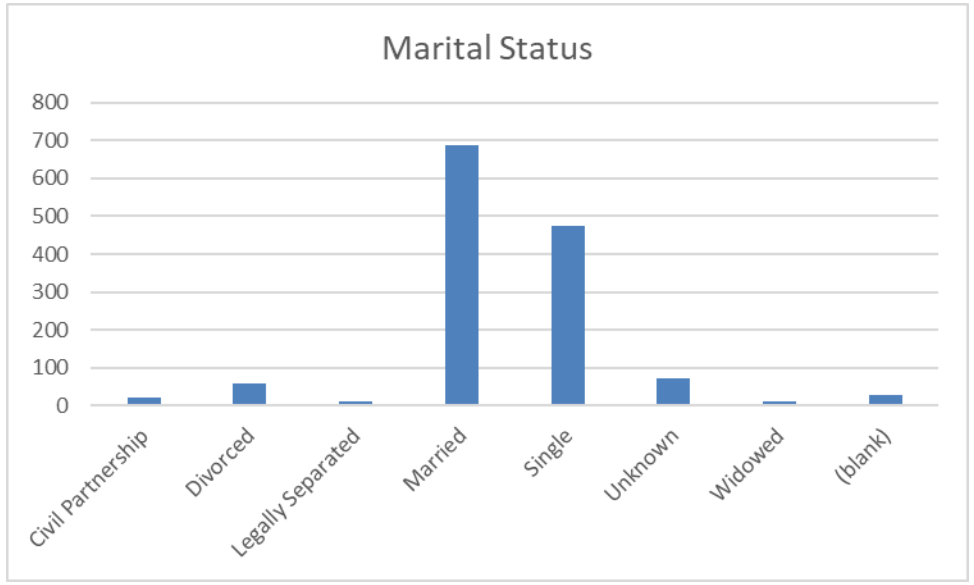


2. Workforce Demographics cont.

Currently in the Trust we have 34 staff members on Maternity or Adoption Leave



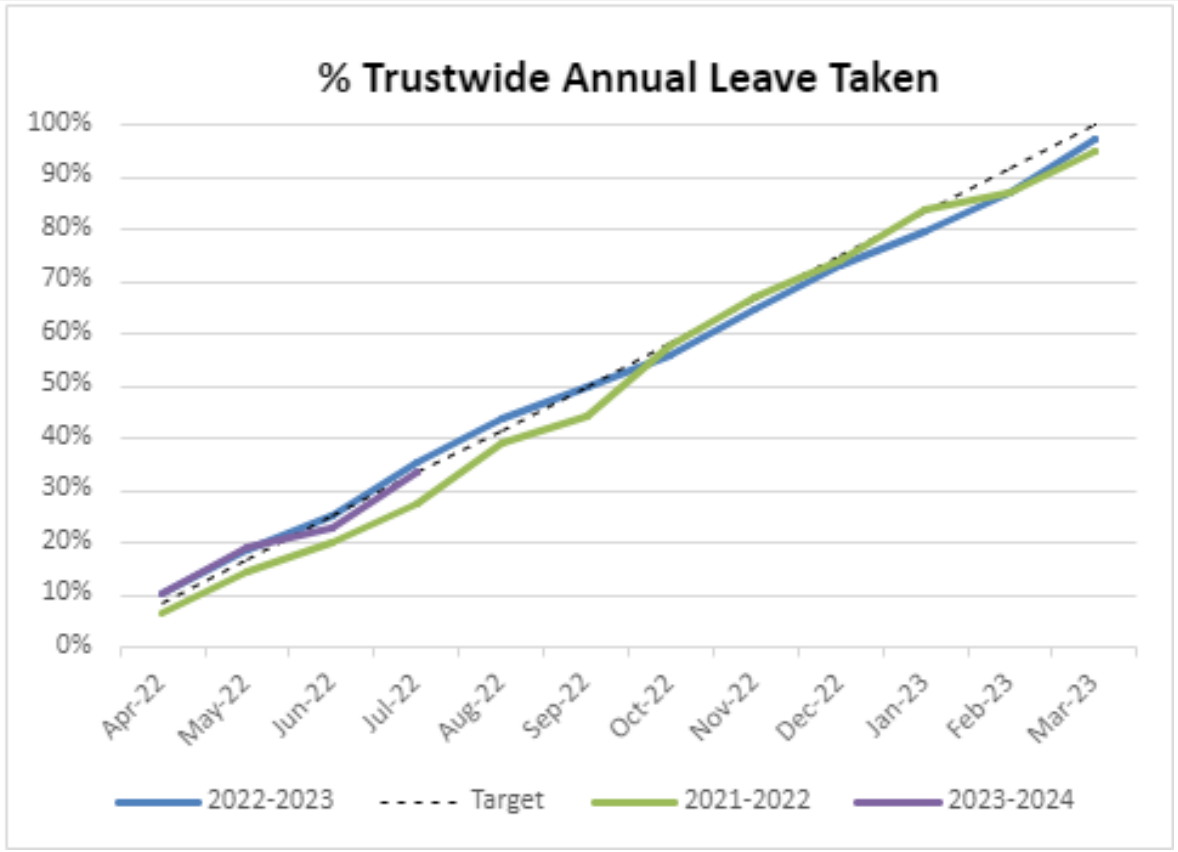




3. Workforce Wellbeing – Annual Leave

Annual Leave

At the Start of Q1 (July 23) for the financial year, AfC staff have taken 33.38% of their annual leave entitlement. At this point in the year, staff are expected to have taken at least 33% of their annual leave entitlement, to support staff in having regular rest breaks. This is slightly less than the previous year but still on target.



Division	% Annual Leave Taken
303 Corporate Directorate	34.65%
303 Division 1 - Patient Services	33.70%
303 Division 2 - Patient Support	31.89%
303 Division 4 - Estates and Facilities	36.01%
Trust Total	**33.38%**

Staff Group	% Annual Leave Taken
Add Prof Scientific and Technic	25.80%
Additional Clinical Services	33.31%
Administrative and Clerical	35.95%
Allied Health Professionals	33.39%
Estates and Ancillary	35.71%
Nursing and Midwifery Registered	32.78%

4 Workforce Experience and Engagement

Disability Declaration rate

DDR 2022					DDR 2023				
Jan	Mar	June	Sept	Dec	Feb	March	May	July	August
4.0	5.2	5.3	4.3	5.7	6.3	6.2	6.9	7.0	7.1

Support metrics

Initiative	April	May	June		July	
Number of members of staff network meetings – (All members of all staff networks – from June)	189	150	310		305	
Number of attendees at staff network meetings	23	37	6		33	
Number of hits on Staff Networks intranet site - (**Viewers** – how many individual staff members have viewed site/ **Views** – number of people visiting site more than once from July)	104	78	524		40 Viewers	58 Views
Number of hits on Health & wellbeing intranet site/ Wellbeing new link (**Viewers** – how many individual staff members have viewed site/ **Views** – number of people visiting site more than once from July)	137	105	405	110	59 Viewers 602 Viewers	149 Views 483 Views
Workshop attendance OD	121	100	16		158	
Workshop attendance Health & wellbeing	0	0	9		52	
Entrance swipe to Wellbeing room / Dome (from July)	216	144	208		Not available	