The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public)

Wednesday 7th February 09:00h- 12:10h

Boardroom, Trust Headquarters

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday, 7 February 2024

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 7th February 2024, in the Boardroom, Trust HQ commencing at 09:00.

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

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

Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters Date 7 February 2024: 09:00h – 12:10h

Members attending

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Simon Page	Non Executive Director	(SP)
Mrs Jenny Belza	Non Executive Director	(JB)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Mathew Revell	Executive Medical Director	(MD)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mrs Sharon Latham	Head of Patient Experience	(SL)	[Item 1]
Mrs Claudette Jones	Senior Clinical Research Nurse /FTSU Guardian	(CJ)	[Item 11]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AR)	[Item 14&15]
Mrs Michelle Hubbard	Acting Executive Chief Operating Officer	(MH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Patient story	Presentation	SL
09:20	2	Apologies: Marie Peplow	Verbal	Chair
	3	Declarations of Interest	ROHTB (2/24) 001	Chair
	4	Minutes of Board Meeting held in Public on 6 December 2023: *for approval*	ROHTB (12/23) 019	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (12/23) 019 (a)	SGL
09:25	6	Questions from members of the public	Verbal	Chair
09:26	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (2/24) 002 ROHTB (2/24) 002 (a)	TP/JW
09:45	7.1	Update from Council of Governors	Verbal	SGL

09:50	8	Wellbeing update: *for assurance*	ROHTB (2/24) 027 ROHTB (2/24) 027 (a)	SM
09:55	9	Race Code Adoption: *for approval*	ROHTB (2/24) 003 ROHTB (2/24) 003 (a)	SM
10:10	10	Equality Delivery System (EDS) 2: *for approval*	ROHTB (2/24) 004 ROHTB (2/24) 004 (a)	SM
10:20	11	Freedom to Speak Up Update: *for assurance*	ROHTB (2/24) 005 ROHTB (2/24) 005 (a)	CJ
	GOVERNANCE AND COMPLIANCE			
10:35	12	Controlled Drugs Annual Report: *for approval*	ROHTB (2/24) 006 ROHTB (2/24) 006 (a)	NB
10:40	13	Infection Prevention & Control Annual Report: *for approval*	ROHTB (2/24) 007 ROHTB (2/24) 007 (a) ROHTB (2/24) 007 (b)	NB
10:50	14	Patient Safety Incident Response Framework (PSIRF) Update: *for assurance*	ROHTB (2/24) 008 ROHTB (2/24) 008 (a)	AR
11:00	15	Board Assurance Framework – Quarter 3 Update: *for approval*	ROHTB (2/24) 009 ROHTB (2/24) 009 (a) – (l)	AR
11:15	BREAK			
11:25	16	EPRR Position Statement: *for information*	ROHTB (2/24) 010 ROHTB (2/24) 010 (a)	SW
11:30	17	Position Statement and Gap Analysis against the NHS Workplace Health & Safety Standards: *for assurance*	ROHTB (2/24) 011 ROHTB (2/24) 011 (a)	SGL
11:40	18	Proposed changes to the Trust Constitution: *for approval*	ROHTB (2/24) 012	SGL
11:45	19	Assurance Report from the Non Executive Champion for Security: *for assurance*	ROHTB (2/24) 013 ROHTB (2/24) 013 (a)	LW
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
11:50	20	Upward reports from the Board Committees: • Finance & Performance Committee ○ Terms of Reference: for approval • Audit Committee • Staff Experience & OD Committee • Quality & Safety Committee	ROHTB (2/24) 014 ROHTB (2/24) 014 (a) ROHTB (2/24) 014 (b) ROHTB (2/24) 015 ROHTB (2/24) 016 ROHTB (2/24) 017	LW GH SJ IR
12:05	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
	21	Performance Reports: *for assurance* a) Finance & Performance b) Quality c) Workforce	ROHTB (2/24) 018 ROHTB (2/24) 019 ROHTB (2/24) 020	

12:10	CLOSE: Date of next meeting: Wednesday, 7 February 2024 @ 09:00

Notes

Quorum:

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

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

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

ATTENDANCE REGISTER – FY 2023/24 UPDATED TO SEPTEMBER 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	A						
Ian Reckless	A	✓	✓	✓	✓	✓	✓	✓			
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓			
Simone Jordan	✓	✓	✓	✓	A*	A	✓	✓			
Gianjeet Hunjan	A	✓	✓	✓	✓	✓	✓	✓			
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓			
Les Williams	✓	✓	✓	A	✓	✓	✓	✓			
Simon Page											
Jenny Belza											
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓			
Matthew Revell	✓	✓	✓	✓	A*	✓	✓	✓			
Nikki Brockie	✓	✓	✓	✓	✓	A	✓	✓			
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓			
Stephen Washbourne	✓	✓	✓	✓	✓	A	✓	✓			
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓	✓			
Simon Grainger-Lloyd	✓	A	✓	✓	✓	✓	✓	✓			

KEY:

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

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

TRUST BOARD DECLARATIONS OF INTEREST

Name	Interest	Voting Member
Tim Pile Chair	• Council Member, Aston University	Yes
Jo Williams Chief Executive	• Trustee, Versus Arthritis	Yes
Simon Grainger-Lloyd Director of Governance	• None declared	Yes
Steve Washbourne Chief Finance Officer	• Governor at University of Birmingham School • Independent Member of the Audit Committee at Aston University	Yes
Marie Peplow Chief Operating Officer	• None declared	Yes
Matthew Revell Medical Director	• Fellow of the Royal College of Surgeons • Member British Orthopaedic Association and British Hip Society • Founding Fellow of the Faculty of Medical Leadership and Management	Yes
Nikki Brockie Chief Nurse	• None declared	Yes
Sharon Malhi Chief People Officer	• Trustee, Victoria Academies Trust	Yes
Simone Jordan Non Executive Director & Vice Chair	• Managing Director, Simone Jordan & Associates Limited • Non Executive Director, George Eliot Hospital NHS Trust • LLR ICB Independent Non Executive Members (People & Remuneration) • Member of the Chartered Institute of Personnel and Development	Yes
Les Williams Non Executive Director	• None declared	Yes

Name	Interest	Voting Member
Gianjeet Hunjan Non Executive Director	• Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of CIPFA • Member of IHSCM • Member of HFMA	Yes
Ayodele Ajose Non Executive Director	• None declared	Yes
Ian Reckless Non Executive Director	• Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust • Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust) • Director, JTER Trading Limited (company involved in property services and antiques trading) • Fellow, Royal College of Physicians • Fellow, Faculty of Medical Leadership and Management • Member of Congregation, University of Oxford	Yes
Jenny Belza Non Executive Director	• New in post – Declaration to be completed	Yes
Simon Page Non Executive Director	• New in post – Declaration to be completed	Yes

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (PUBLIC) - DRAFT Version 0.1

Venue Boardroom, Headquarters Date 6 December 2023: 08:30h – 10:30h

Members attending:

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non-Executive Director	(GH)
Mr Les Williams	Non-Executive Director	(LW)
Dr Ian Reckless	Non-Executive Director	(IR)
Ms Ayodele Ajose	Non-Executive Director	(AA)
Mr Richard Phillips	Non-Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance:

Mrs Gayle Kwindini	Advanced Nurse Practitioner	(GK) [Item 1]
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)
Mrs Tammy Ferris	Corporate Services Manager	(TF) [Secretariat]

1. Patient story (GK)	presentation
The Board welcomed Gayle Kwindini (GK), Advanced Nurse Practitioner in Large Joints, who outlined the story of a patient who had been referred to the joint injection clinic and required an interpreter at their appointment. The patient was joined at her appointment by their son. During the consultation the son challenged the consent procedure that was being completed, however it was clear the patient had capacity but j did not understand English. The interpreter was listening to the conversation and asked GK to leave them to talk privately who explained the son was trying to make the decision for the patient. GK returned to the room and asked the son to leave the room as he was not needed to interpret for his parent. This was	

a challenging conversation to have and did raise safeguarding concerns for the patient, and the appropriate notification was completed. There were no further concerns, but two months later a further referral was made by the family member stating the patient did not know what was happening. GK reached out to the GP who made the referral and established that the consultation took place without the patient in the room. GK raised with the patient's usual GP, highlighting the concerns and whilst the GP did not have any safeguarding concerns agreed that the patient did have capacity and therefore their family member should not be making decisions for them.

GK explained how challenging the clinic is when the patient requires an interpreter, especially when the patient comes with a family member as it is important that the patient's voice is heard.

GK praised how the team stood their ground and recognised we have a very good safeguarding team.

TP thanked GK for sharing the story.

GH praised GK for challenging this. GH questioned whether we have all languages covered by interpreters. GK confirmed that we do and have more languages widely available on the phone, than face to face.

SJ appreciated the story that was shared and learned more about safeguarding through the story GK shared and thanked GK.

NB highlighted that whilst this was not a traditional Board story, the team wanted to share how challenging it is to make sure our patient voice is heard despite the pressures.

AA enquired when to the decision was taken to involve safeguarding and whether they informed of the outcome. GK explained that there is always follow up with the team.

TP questioned the communication that we send to our patients and whether it is clear that this service is available to them should they need it and whether the information is offered in the right language. GK confirmed in the referral letters that there are signposts to offer this. NB explained there is a task and finish group working on this to try and ensure the right letter goes to the right patient in the right language.

IR queried the financial cost of have interpreters in person. MP explained it is expensive, but we have chosen to go with this route to give the patient the best experience. JW explained our policy is we must not use staff to do this role due to potential conflicts. The cheaper model is the phone service.

TP enquired whether we had considered using an artificial intelligence system. A discussion took place with regards to whether we would want to rely on this. SJ suggested we should run a pilot. MP explained the current pilot on T Pro which using speech recognition might be something that could assist with this and is currently being used in physiotherapy.

RP highlighted the concern of misinterpretation and the risk of wrong advice using this method and assurances would be needed to ensure it is fit for purpose. The Board thanked GK for the care given to this patient.	
2. Apologies: (Chair)	verbal
All members were present at the meeting.	
3. Declarations of Interest (Chair)	ROHTB (12/23) 001
There were no new declarations to note or address.	
4. Minutes of board meeting held in public on 1 November 2023: *for approval* (Chair)	ROHTB (11/23) 027
The minutes of the meeting in public held on 1st November 2023 were approved subject to the following amendments: • Item 15, on page 8, should read mutual not mutal.	
5. Actions from previous meeting in Public: *for assurance* (SGL)	ROHTB (11/23) 027(a)
The Board was updated on all amber items on the action log: • ROHTBACT.216 - Net Zero update is on the agenda for this meeting. • ROHTBACT.221 - Leadership competency framework will be presented to SE&OD in January. GH queried whether the Freedom to Speak Up (FTSU) Guardian that required access to accommodation had been found. SGL confirmed that the Governance office is being reconfigured and there will be space for the FTSU Guardian to use when required.	
6. Questions from members of the public (Chair)	Verbal
No questions had been received from members of the public.	
7. Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	ROHTB (12/23) 002 ROHTB (12/23) 002 (a)
JW highlighted the key points from the Chief Executive Update that had been circulated to all Board members. • The Trust has received confirmation that it has retained its single oversight framework (SOF) rating of 2. The rating is testament to the sustained improvement across the Trust and reflects the collective contribution of all colleagues.	ROHTB (12/23) 000

• The Trust has retained a place in the Top 50 on Inclusive Companies, one of only three NHS trusts. West Midlands Fire Service achieved number 1 position and SM will be reaching out them to understand what best practice looks like. • Thanks were given to the ROH Charity team and all those involved in organising the annual Christmas Market; it was a great success. • After a rigorous recruitment process the Trust have successful recruited 3 x WTE Anaesthetic Consultants which means there is now only 0.8 WTE vacancy within the team. • Congratulations was given to the Radiology Team who won an international award award for Best NHS Trust for delivering Radiology Service and Dr Rajesh Botchu who won the Radiology Fellowship of the Year. • Professor David Sallah, Chair at Birmingham Community NHS Trust, was welcomed to the Trust on 22nd November. David was given a tour of the hospital and met a number of patients and colleagues. David has since formally thanked us for the day and commented how impressed he is with the quality and dedication of the team. Chair's Update • TP added that the feedback from David Sallah was exceptional, and as a Trust we should welcome others to come and see what is so unique about the ROH. • Following the AGM and Council of Governors, TP thanked the team for the organisation of the events and felt it was a successful afternoon where all presentations worked very well. • TP reported that the NED recruitment is progressing, and interviews are being held on Friday 8th December. • Further to JW's update TP highlighted it is an incredible achievement to be in the Top 50 of Inclusive Companies, and for Jo to be shortlisted as Chief Executive of the Year is an amazing achievement. The Trust are incredibly proud of JW – congratulations were offered.	
7.1 Update from Council of Governors (SGL)	Verbal
SGL updated the Board on the meeting that took place on 23rd November. This included newly appointed Governors. The governors were updated on the plans to implement the Patient Safety Incident Response Framework, Continuous Improvement, and the Quality Walkabouts. The Governors are keen to be more visible and the presentation from Emma Steele, Deputy Chief Nurse, explained how they could become involved.	

Training sessions will be arranged by SGL/TF to upskill and develop the Governors in their role. A template will be created based on the Executive 'Check and Chat' for them to be used.	
8. Update from CQC Engagement meeting: *for assurance* (SGL)	ROHTB (12/23) 003 ROHTB (12/23) 003 (a)
SGL provided an update on the quarterly meeting that took place with the Trust's CQC Engagement Manager on Tuesday 21st November. SGL and NB represented ROH at this meeting. The structure of the meeting is organised around a prescribed template that includes discussions around insights that the CQC has gained based on information available in the public or externally; key risks; complaints; performance against quality metrics; Freedom to Speak Up themes; and staff engagement. Recently, the meeting agenda has also included a focus on a core service which at this meeting considered an overview of the Imaging Service. It was suggested by the CQC that the examples of excellence and innovation that had been shared with them should be published to help other organisations how good performance and best practice is achieved. During the meeting, the detail of a small number of complaints that had been received by the CQC about ROH were discussed, with only one outstanding; the Trust agreed to keep the CQC abreast of the plans to resolve this. The CQC was keen to understand the compliments the Trust received and requested visibility of these in future meetings. The CQC provided an overview of the changes to the assessment framework from key lines of enquiry to key quality statements. This method will give more opportunities to providers to present a dossier of evidence to justify where services or areas are regarded as needing to be rated more highly. LW commented on the proposal to publish the excellent work in Imaging and questioned if this is something as a Trust we are going to do. MP explained the plan is to work the Imaging team and look at how we celebrate more widely the success. MP highlighted there is learning for us as we are proficient in developing clinical papers but not so experienced in sharing administration. LW queried what a 'Swarm' is in relation to IPC. NB explained it is a new way of moving into a PSIRF way of working by looking at clusters of IPC incidents rather than cases in isolation. JW explained that following the meeting with Inclusive Companies they also encouraged the Trust to publish our work and RL will be working with the Communications team to do this. NB added that it was a very positive meeting and as a Trust we have a very good working relationship with the CQC.	

TP enquired how do the complaints come to the Board. SGL explained they come through the quality reports. TP suggested it would be good for the Board to be aware of them. NB will bring to the February Board meeting an overview of the complaints. Action: NB to present at the February Board meeting an overview of concerns raised to the Care Quality Commission IR queried the metrics that are measured in Radiology and whether they included a stretch target. MP explained we deliver, and measure against, the national constitutional target and they are not easy targets to deliver each month. In some areas they are delivering to 4 weeks but for MRI it is very hard given the increase in referrals. TP suggested % by week to also be published. MP acknowledged and highlighted we do also publish our turnaround time which we do not have to. MP explained we publish what we think is relevant to the clinical pathway. GH questioned if we are likely to get the funding to replace our imaging system and, and if so, do we have this allocated for 2024/2025. SW explained that in the allocation from the system there is an area of capital allocation for diagnostics. It is up to the Trust how we prioritise what we think is the best to allocate against. SW explained we are in the process of 2024/25 planning. Part of this work is working with estates looking at a 3-year plan. MP added as part of the West Midlands Imaging Partnership we are looking at working collaboratively to fund this. TP highlighted we are investing in the area. JW explained there is forward look work taking place and the team is fully aware that we must consider funding for this.	
9. Wellbeing update: *for assurance* (SM)	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)
SM presented the Wellbeing and Cost of Living update and the following key points: • The Wellbeing Week took place last week and an update will be provided at the next Board meeting. • Hardship fund continues and interest from Inclusive Companies around this initiative. • Winter grant will go towards the pantry and the free porridge. Uptake numbers will be shared as part of the wider Wellbeing Week update at the next Board meeting. • Following the launch of the wellbeing plan, the HR Team is reviewing the priorities. This is being reviewed to determine what support such as mental health, MSK, etc we can offer. Visits to others, including Jaguar Land Rover (JLR), have also taken place to see what they offer.	ROHTB (12/23) 000

Action: SM to provide an update on the Health & Wellbeing week at the February Board meeting TP questioned the purpose of the visit to JLR, querying whether it was to understand their wellbeing offering. SM confirmed this is the case, and also highlighted MP and RL would visit from an operation and productivity point of view so best practice could be gathered. SM explained that the link with JLR also allowed us to explore a possible partnership that could be formed. AA wanted to thank Laura Tilley-Hood, Wellbeing Officer, for the work undertaken to produce the timetable for the Wellbeing Week. AA highlighted how valuable it was. AA also confirmed she had attended the Wellbeing Network. There is going to be a change to the name of the Wellbeing Guardian to the Health & Wellbeing Guardian. AA will provide a brief update at a future Board meeting. Action: AA to provide an update on the Health & Wellbeing Guardian role at a future Board meeting TP questioned how we prove that these interventions were working. SM explained the Trust are linking with the University of Canterbury and NHSE. A report will be produced in February that will be shared with the Board. TP highlighted it is important that we are able feel assured what we are doing is right and working. Action: SM to provide an update on the effectiveness of the Health & Wellbeing interventions at the February Board meeting JW asked for the comments shared with Inclusive Company to be shared with the Board at next meeting as this would help provide that assurance. ACTION: SM to circulate feedback from the Inclusive Company with Board Members for information at next Board meeting LW questioned whether the wellbeing grant is guaranteed income. SM explained that it is a winter funding that is ring fenced for this purpose from Birmingham Council. Most of our hardship fund is supported through the ROH charity.	
10. National Food Standards update: *for assurance* (NB)	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)
NB explained that in November 2022 NHS updated the national standards for food. As an organisation we are required to meet all four points. NB explained a gap analysis has been undertaken and highlighted the key actions the Trust needs to address. It was highlighted that as a Trust we have some challenges around creating a Food Safety Officer. The ability to achieve this is hard due to absence within the team. However, it remains a key action that is being worked on.	

Another risk that has been documented is the dietetic support and therefore work is currently underway to explore an independent model for the catering team to mitigate the risk. TP queried to where does progress with this work report. NB explained it comes to Quality & Safety in terms of patient food standards and for staff in Staff Experience & OD. TP requested that progress is monitored and fed back to Trust Board. NB explained it would report to both Quality & Safety Committee and Staff Experience & OD Committee and then upward to the Board through the usual assurance updates. TP asked how we compare to other Trusts and whether we benchmark ourselves. NB explained there is no issues that we are concerned about. JW explained we would look at other trusts and provide that assurance to the Board though. ACTION: NB to provide benchmark report on food standards and themes from patient and staff on a regular basis to relevant committees and report back to Trust Board SM raised the British Dietetic Society can help with these things. NB agreed to consider this suggestion. IR raised as a Board we need to understand what our patient/staff feel about what we provide. NB recognised this and will be considered in terms of how to build this into future reports. NB explained that the purpose of sharing this today was to ensure the Board was made aware of the paper and highlight what our focus as a Trust is. Now the themes have been identified they will be monitored and reported. GH queried how do we ensure that patients are catered for from all religious backgrounds. JW provided assurance that we do serve range of food, but accept the comments about not being able to read the menus, which creates a risk that people may not be sure what they are ordering. NB provided assurance by stating that in these situations staff would read the menu with the patients. MP highlighted that Steve Harnett, Head of Facilities, provided a benchmarking presentation at the last Model Hospital Club meeting, and this information is something that could be shared. SJ highlighted the common theme through today's meeting is we should routinely have in reports the benchmarking data as this will also support continuous improvement. ACTION: All Executive Directors to use benchmarking information as part of reports being prepared for the Trust Board and relevant committees	
11. Learning Disability and Improvement Standards: *for assurance* (NB)	ROHTB (12/23) 006 ROHTB (12/23) 006 (a) ROHTB (12/23) 006 (b)

	ROHTB (12/23) 006 (c)
NB provided an update on the annual benchmarking project with NHS England and NHS Improvement against the Learning Disability Improvement Standards. NB highlighted the areas which as a Trust we need to make improvements, which includes: • Lack of easy read material, particularly for our patients who wish to raise a complaint. • Monitoring of DNACPR orders applied to those with a learning disability, as Trust we do not have anything locally in place. NB provided assurance and stated work has already commenced to make reading material more appropriate and with the recruitment of the Resuscitation Officer they will work with the LD & Autism team to address the DNACPR. JW explained a meeting took place as a system where they met with National Director of Autism. We were able share the work what we have done as an elective hospital. JW asked whether the improvements would require be monitored through Quality & Safety Committee. NB explained the Learning Development strategy had gone previously to Quality & Safety and progress of this will be considered through this forum. LW raised the missing data in section 2, figure 26, from the *LD Benchmarking Summary* paper that was circulated to the Board.	
12. Net Zero update: *for assurance* (SW)	ROHTB (12/23) 007 ROHTB (12/23) 007 (a)
SW presented to the Board an update on the Trust's approach on achieving the challenging Net Zero targets of 2040 and 2045. In terms of ROH, 30% estates are pre-1948, and some parts go further back. The constructions methods are quite dated. This also means the hospital is predominately fuelled by gas fired boilers. 35 boilers are over 10 years old (mechanically good but less efficient). The cost of replacing this would require all our capital spend in one year. This also causes the same issue with mechanical ventilation in a number of areas, due to the age of the buildings they are over 10 years old. SW explained we are trying to invest where we can in an affordable way. The solar panels on block 36 have been updated; this generates savings for us in the long term.	ROHTB (12/23) 000

To achieve Net Zero it requires organisations to look at other ways to source heat and hot water. Some trusts are moving to heat pumps, but this comes at a cost to move from gas to electric. It would require a considerable upgrade to the electrical supply. There are also human factors and due to the nature and age of the buildings there will be heaters and fans plugged in throughout the year. SW explained that as a Trust we will be looking to develop the strategy to demonstrate how we will get to Net Zero. TP requested a timeline for plan. SW felt it would take some time to put together as we also need to create the long-term capital and estates strategy first, as all those things need to be prioritised. TP asked is there any support from the Board that could progress this. SW explained understanding the target and the expectations need to be addressed first. Needing to understand what we currently require is the first step. IR queried SALIX, and the need for us to match fund. SW confirmed that is correct. SW went on to explain it is spread over a period of time. SW explained it is within our gift, but the Board would need to make a decision with regards to the capital spend. IR raised that we should be looking to invest to protect the future. SW highlighted we have started to make progress on such things as LED lighting but there is more we can do. GH enquired how does this align with the NHSE sustainability plan. JW confirmed this document has been reviewed and will be shared. GH requested confirmation as to who is the NED lead for this; it was noted that there was not a specified NED for sustainability as the national guidance restricted the number of Non Executive champions to only five areas. RP highlighted that we would need to prioritise and focus on the hot spots across the estate. TP agreed, and suggested we need to take the strategy ensuring we demonstrate how we will prioritise this. Follow up discussion will need to take place. SJ queried whether the Board should be more aware of this work. The Board discussed how this used to be considered at Finance & Performance Committee. TP highlighted a wider Board discussion is required, but updates must continue through the Finance & Performance Committee and the Board would be informed through the upwards report.	
13. Guardian of Safe Working update *: for assurance*(JW)	ROHTB (12/23) 008 ROHTB (12/23) 008 (a)
JW highlighted that this should remain an independent item but Mr McKenzie is unable to attend the meeting today. It was recognised as the Guardian of Safe Working he undertakes a good job.	

IR highlighted there are a number of key themes you would expect to see in the report and one is an exception report. TP highlighted that is in the first sentences of the report rather than an actual report, so this has been provided. It was requested that Mr McKenzie comes to a Board meeting in person to inform the members. Action: Invite Mr Jamie McKenzie to attend the Board to present his independent view. SGL/TF	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
14. Finance & Performance Committee (LW)	ROHTB (12/23) 009
LW updated the Board following the F&P Committee held on 28th November. • Focus remains on delivering everything within our control. • There is a risk of not being able to deliver a break-even result. • FPC agreed plan for 2024/25 needs to be early. • Encouraging that no patients wish to be transferred to other providers through PIDMAS. • CIP is delivering a positive result.	
MATTERS TO BE TAKEN BY EXCEPTION ONLY	
15. Performance Reports: for assurance a) Finance & Performance b) Quality	ROHTB (12/23) 010 ROHTB (12/23) 011
Performance reports were taken as read and no queries raised.	
CLOSE: Date of next meeting: Wednesday, 7 February 2024 @09:00	

Next Meeting: 7 February 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 2 February 2024

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
(P)ROHTBACT. 001	Trust Board action points	Verbal	09-02-15	Prepare a paper outlining the new arrangements and reporting lines for the governance function	ACr/SGL	7-Oct-15	Paper developed and circulated to Board members	
(P)ROHTBACT. 002	Estates strategy	Enc 2	09-02-15	Through Stuart Lovack consider options around off site storage for medical records	JL	2-Dec-15	Verbal update at meeting	
(P)ROHTBACT. 001	Chief Executive's Update	Verbal	11-04-15	ACh to present an update on the use of agency staff at the next meeting	ACh	2-Dec-15	Included on the agenda of the December private Board meeting	
(P)ROHTBACT. 003	Monitor Guidance on improving productivity in elective care	Verbal	11-04-15	SGL to schedule discussion of the opportunities arising from the 'Monitor guidance on improving productivity in elective care' report into a future Board workshop	SGL	TBC	Aiming for Q1 2016/17	
(P)ROHTBACT.074	Paediatric transition update	Verbal	04-03-19	Provide an update on which residual elements of the paediatric service would remain after the transfer	JW	1-May-19	Included within the public paediatric transition paper considered at the May 2019 meeting	
(P)ROHTBACT.072	Chair & Chief Executive's update	Verbal	03-06-19	Present an update on partnership opportunities at the next meeting	PA	3-Apr-19	Added to the agenda of the April 2019 meeting	
(P)ROHTBACT.072	Final business case for the ePMA system: notes from the Committee	Enc 3	09-02-15	Present an update on the progress with the procurement of the ePMA system at the next meeting of the Transformation Committee	PA	22-Sep-15	Presented as part of Workstream 6 at the meeting held on 22 September 2015	
(P)ROHTBACT.073	Remuneration package for Physician Associates	Enc 7	09-02-15	Consider rebranding the allowance to represent an overseas living allowance	ACh	30-Sep-15	Re-branding considered, but discounted. Need to ensure rates for additional allowances reflect market conditions for each role type, rather than allowances that would apply to all staff.	
(P)ROHTBACT.074	Capital plan 2016/17 proposed adjustments as at Q2	ROHTB (10/16) 016(P) ROHTB (10/16) 016(a) (P)	10-05-16	Present the Root Cause Analysis for the theatres closure at the next meeting	GM	2-Nov-16	Discussed in detail by the Quality & Safety Committee during Quarter 3 of 2016/17.	
(P)ROHTBACT.075	Physician Associates	Verbal	07-06-16	Present an update on Physician Associates at the next Transformation Committee	AC	18-Oct-16	Discussion included as part of Workstream 1 update at Transformation Committee on 18 October 2016.	
(P)ROHTBACT.076	Financial and activity recovery plan	ROHTB (9/16) 014(P) ROHTB (9/16) 014 (a)(P)	09-07-16	Present an update on finance and activity recovery at the October meeting	PA	10-Oct-16	Included on the agenda of the October and November 2016 meetings	
(P)ROHTBACT.077	Contract 2016/17 risks and issues	ROHTB (9/16) 014 (a)(P)	04-06-16	Consider the practicality of closing the spinal deformity waiting list, taking legal advice where necessary	JL	1-Jun-16	Outlined in the paper concerning spinal deformity treatment on the agenda of the September 2016 meeting	
(P)ROHTBACT.078	Contract 2016/17 risks and issues	ROHTB (4/16) 021 (P) ROHTB (4/16) 021 (a) (P)	04-06-16	Provide an audit trail/chronology of what happened over time around the spinal service problem	JL	1-Jun-16	Subsumed by more recent discussions outlined in the spinal deformity paper included on the agenda of the September 2016 meeting	
(P)ROHTBACT.079	Activity recovery plan	HC1	09-02-15	PA to include reference costs within the Corporate Performance Report	PA	~~03/02/2016~~ ~~06 Apr 16~~ ~~Jun 16~~	Included in the Finance & Performance overview	
(P)ROHTBACT.080	E-rostering business case	ROHTB (4/16) 020 (P) ROHTB (4/16) 020 (a) (P)	04-06-16	Clarify the way in which the impact and quantity of time released for direct clinical care as a result of the implementation of e-rostering can be measured	AC	19-Jul-16	Remitted to Transformation Committee as part of Workstream 3 update	
(P)ROHTBACT.081	E-rostering business case	ROHTB (4/16) 020 (P) ROHTB (4/16) 020 (a) (P)	04-06-16	Develop a baseline comparison of rostering pre and post implementation of e-rostering	AC	19-Jul-16	Remitted to Transformation Committee as part of Workstream 3 update	
(P)ROHTBACT.082	Monitor Guidance on improving productivity in elective care	Verbal	11-04-15	SGL to schedule discussion of the 'Monitor guidance on improving productivity in elective care' report at the December private meeting	SGL	~~02 Dec 15~~ ~~06 Apr 16~~ ~~4 May 16~~	Subsumed into the work being considered by the Finance & Performance Committee around the Carter Review	
(P)ROHTBACT.083	Chief Executive's Update	Verbal	12-02-15	CQC - Real and specific examples of deteriorating children transferred out from the ROH needed to be examined and lessons learned. The two most recent cases to be reviewed at QSC.	GM	24-Feb-16	Subsumed into the CQC action plan	
(P)ROHTBACT.084	Activity recovery plan	HC1	12-02-15	The Director of Operations to review delivery plans and improve the current forecast position	JL	3-Feb-16	Subsumed into the work of the F & PC	
(P)ROHTBACT.085	Activity recovery plan	HC1	12-02-15	The Chief Executive and the Chairman to work together and agree a way forward to increase NED oversight of activity planning and would communicate this to the NEDs	JC/YB	3-Feb-16	The F&P Assurance Committee established for this purpose	
(P)ROHTBACT.086	Activity recovery plan	HC1	12-02-15	The Trust Board to follow up progress on the development of an improved model with detailed day by day plans for April at the next Trust Board meeting	Board	16-Feb-16	Discussed at the F&P Assurance Committee meeting in March	
(P)ROHTBACT.087	Chief Executive's Update	Verbal	12-02-15	A review of the Paediatric service to be carried out. The Chairman and Chief Executive to progress between Board meetings	YB/JC	21-22-Mar-16	RCPH invited inspection on 21/22 March 2016	
(P)ROHTBACT.088	Capital Plan including HDU proposals	Verbal	02-03-16	The Director of Finance to review the capital spend schemes to establish which could be supported by Charitable Funds	PA	6-Apr-16	Capital plan to be considered by the Board at the April meeting	
(P)ROHTBACT.089	Capital Plan including HDU proposals	Verbal	02-03-16	The Director of Finance to present a revised capital plan at the next meeting	PA	6-Apr-16	Capital plan to be considered by the Board at the April meeting	
(P)ROHTBACT.090	Chief Executive's Update	Verbal	12-02-15	The National Orthopaedic Alliance Vanguard - Copies of the presentation prepared by the Chief Executive to be circulated to the Trust Board	JC	3-Feb-16	Presentation circulated by JC	
(P)ROHTBACT.091	Chief Executive's Update	Verbal	12-02-15	CQC - The Chief Executive to circulate copies of the final letter to the CQC to Trust Board members	JC	3-Feb-16	Final letter to the CQC circulated by JC	
(P)ROHTBACT.092	Chief Executive's Update	Verbal	12-02-15	The Chairman, Chief Executive and Audit Committee chairman to look at the phasing of the development of a separate Paediatric unit and its effect on the adult use of HDU	YB/JC/ RA	1-Jun-16	Ongoing consideration as part of the refresh of the Trust's strategy	
(P)ROHTBACT.093	Chief Executive's Update	Verbal	12-02-15	Inquest - On receipt the Coronor's written report to be circulated to members of the Trust Board together with a report on lessons learned and when and how such learning would be implemented	GM	6-Apr-16	Detail included in Patient Safety & Quality report to Quality & Safety Committee	
(P)ROHTBACT.094	Chief Executive's Update	Verbal	12-02-15	A set of proposals on the creation of a Paediatric HDU to be brought to a future Board meeting	GM	1-Jun-16	Ongoing consideration as part of the refresh of the Trust's strategy and a consideration as part of the RCPCH report	
(P)ROHTBACT.095	Chief Executive's Update	Verbal	02-03-16	The Director of Workforce & OD to present the full staff profile at a future meeting	AC	4-May-16	Included in the Q4 workforce report	
(P)ROHTBACT.096	Contract 2016/17 risks and issues	ROHTB (4/16) 021 (P) ROHTB (4/16) 021 (a) (P)	04-06-16	Circulate the forward look and results	JL	21-Apr-16	Considered at the April meeting of the Finance & Performance Committee	
(P)ROHTBACT.097	Contract 2016/17 risks and issues	ROHTB (4/16) 021 (P) ROHTB (4/16) 021 (a) (P)	04-06-16	Write to commissioners in response to the current contract offer and associated issues to set out the Trust's concerns and proposed way forward	JL	30-Apr-16	Discussions held with commissioners. Verbal update needed at the meeting on status of the discussions with NHSE	
(P)ROHTBACT.098	Contract 2016/17 risks and issues	ROHTB (4/16) 021 (P) ROHTB (4/16) 021 (a) (P)	04-06-16					
(P)ROHTBACT.099	Minutes of the Private Board - 24 May 2016	ROHTB (5/16) 004 (P)	06-01-16	Notes of the private information session held on 4 May to be circulated	SGL	19-Jul-16	Circulated as requested	
(P)ROHTBACT.100	RCPCH report into care of Paediatric patients on HDU & Action Plan	ROHTB (6/16) 007(P) ROHTB (6/16) 007 (a) (P) ROHTB (6/16) 007 (b) (P)	06-01-16	A progress update with the RCPCH action plan to be shared at the July meeting	PB	19-Jul-16	Included on the July agenda as requested	
(P)ROHTBACT.101	People & OD Strategy	Presentation	07-06-16	Present a further update on the People & OD Strategy at the next meeting	AC	7-Sep-16	Included on the agenda of the September 2016 meeting.	
(P)ROHTBACT.102	Chief Executive's update & STP update	Verbal	10-05-16	Set the date for the special Board meeting to discuss the draft STP submission	SGL	12-Oct-16	Date set and meeting held on 12 October 2016	
(P)ROHTBACT.103	Financial and activity recovery plan update	ROHTB (12/16) 003 (P) ROHTB (12/16) 003 (a) (P) - ROHTB (12/16) 003 (f) (P)	12-07-16	Provide a further update on the delivery of the recovery plan at its next meeting and at the Finance & Performance Committee on 20 December 2016	PA	11-Jan-17	Included on the agenda of the Board meeting planned for 11 January and discussed at F & PC on 20 December 2016.	
(P)ROHTBACT.104	Staff survey	Verbal	04-05-17	Present an analysis of the staff survey at the next Board meeting with the plans for staff clinical engagement required to deliver the Board's priorities	PB	7-Jun-17	To be presented at the June Trust Board meeting	
(P)ROHTBACT.105	Trust strategy	Verbal	04-05-17	Organise a session to discuss a set of Options around the Trust's strategy	SGL	30-Apr-17	Organised for 25 April 2017	
(P)ROHTBACT.106	Recovery resources	Verbal	05-17-17	Present the resourcing requirements to deliver the recovery plan at a future meeting	JC	7-Jun-17	Included in papers issued for 7 June 2017 meeting	
(P)ROHTBACT.107	Integrated action plan	Verbal	05-17-17	Present the integrated action plan at the June meeting of Trust Board	GM	7-Jun-17	Included in papers issued for 7 June 2017 meeting	

(P)ROHTBACT.108	AOB	Verbal	05-17-17	Present the infection control peer review report and action plan at the June meeting	GM	7-Jun-17	Included in papers issued for 7 June 2017 meeting
(P)ROHTBACT.109	Quality & Safety Committee	Verbal	05-17-17	Invite the Associate Medical Director for Paediatrics to a future meeting of the Quality & Safety Committee to comment on the safety of the Paediatric services offered by the Trust	SGL	30-Jun-17	Has provided input into discussions around the WMQRS response on the agenda for the July Trust Board meeting
(P)ROHTBACT.110	Specialist Orthopaedics Partnership Memorandum of Understanding	ROHTB (6/17) 016 (P) ROHTB (6/17) 016 (a) (P)	06-07-17	Circulate possible dates for a joint meeting between the Non Executives of RJAH and the ROH	SGL	30-Jun-17	Agreed to revisit this later in the year; not an appropriate time for this work at present
(P)ROHTBACT.111	Specialist Orthopaedics Partnership Memorandum of Understanding	ROHTB (6/17) 016 (P) ROHTB (6/17) 016 (a) (P)	06-07-17	Advise the Robert Jones & Agnes Hunt NHS FT and the Royal National Orthopaedic NHS Trust that the ROH was willing to support the Memorandum of Understanding around joint working	PA	30-Jun-17	Verbal update to confirm that this discussion has been held - reported that this was the case at the July meeting
(P)ROHTBACT.112	Staff engagement strategy	ROHTB (9/16) 012(P) ROHTB (9/16) 012(a) (P)	09-07-16	Present the Staff Engagement strategy at the meeting of the Transformation Committee on 18 October 2016	AC PB	~~18/10/2016~~ ~~17/01/2017~~ ~~26/04/2017~~ 5/07/2017	Discussed at the meeting of the Major Projects & OD Committee in April where a rapid move to implementation of the staff engagement strategy was requested
(P)ROHTBACT.113	Outcome of West Midland Quality Review Service (WMQRS) review of Care of the Critically Ill Child and implications	ROHTB (7/17) 008 (P) ROHTB (7/17) 008 (a) (P) ROHTB (7/17) 008 (b) (P)	07-05-17	Seek advice on the Board's and Trust's liability should paediatric services continue in the short term, in the light of the risks highlighted by the WMQRS	SGL	2-Aug-17	Superseded by discussions with key external stakeholders and regulators where there is agreement that children should be treated in the short term using the existing model of Paediatric care
(P)ROHTBACT.114	Outcome of West Midland Quality Review Service (WMQRS) review of Care of the Critically Ill Child and implications	ROHTB (7/17) 008 (P) ROHTB (7/17) 008 (a) (P) ROHTB (7/17) 008 (b) (P)	07-05-17	Write to Specialist Commissioners to communicate the Board's decision to cease paediatric services on the ROH site by 31 December 2017	PA	2-Aug-17	Letter written provided within papers for the August meeting
(P)ROHTBACT.115	Trust strategic principles and vision	ROHTB (8/17) 002 (P) ROHTB (8/17) 002 (a) (P)	08-02-17	Reissue the five year vision in consultation with the Vice Chair	PA/PB	30-Sep-17	Included for discussion in meeting papers for the November 2017 meeting of the Trust Board.
(P)ROHTBACT.116	STP support to the Trust recovery and sustainability	Verbal	07-05-17	Chairman to arrange for a set of strategic principles to be presented at the next meeting	YB	2-Aug-17	Included on the agenda of the August meeting
(P)ROHTBACT.117	STP support to the Trust recovery and sustainability	Verbal	07-05-17	Chairman and Acting CEO to write to their counterparts at peer organisations to identify any thoughts on future strategic direction	YB/PA	31-Aug-17	Superseded by the work on the development of the Strategic Outline Case
(P)ROHTBACT.118	Five Year Vision	ROHTB (11/17) 002 (P) ROHTB (11/17) 002 (a) (P)	11-01-17	Refresh the five year vision to reflect the feedback from the Board	PA/PB	20-Dec-17	Refreshed and due for reissue to the Board in the new format.
(P)ROHTBACT.119	MAKO Business Case	Hard copy	09-06-17	Provide an update on the MAKO technology at the November Trust Board meeting	PA	1-Nov-17	Verbal update included on the agenda of the November 2017 Trust board meeting
(P)ROHTBACT.120	Paediatric Services Update	Hard copy paper	10-04-17	Seek written confirmation from Specialised Commissioners of the agreed risk sharing arrangement associated with the current paediatric care model and the extended transition arrangements	PA	1-Nov-17	To be discussed as part of the paediatric services update on the agenda of the November 2017 Trust Board meeting
(P)ROHTBACT.121	Action plans to address regulatory concerns and progress update on 18 weeks RTT recovery, including validation work	ROHTB (11/17) 004 (P) ROHTB (11/17) 004 (a) (P) ROHTB (11/17) 004 (b) (P) ROHTB (11/17) 004 (c) (P)	11-01-17	Circulate the spinal deformity trajectory	JWI	20-Dec-17	Included within papers for Finance & Performance Committee
(P)ROHTBACT.122	Scheduled Care Improvement Programme	ROHTB (9/17) 006 (P) ROHTB (9/17) 006 (a) (P)	09-06-17	Think through with the Executive Team how improvement skills could be introduced into the ROH	PA	4-Oct-17	Verbal update given at the October 2017 meeting
(P)ROHTBACT.123	Recovery Plan	Hard copy	09-06-17	Present the updated recovery plan to the Finance & Performance Committee in September 2017	PA	26-Sep-17	Presented as requested and updated version included on the agenda of the private Board session in October 2017
(P)ROHTBACT.124	Action plans to address regulatory concerns	ROHTB (8/17) 003 (P) ROHTB (8/17) 003 (a) (P) ROHTB (8/17) 003 (b) (P) ROHTB (8/17) 003 (c) (P) ROHTB (8/17) 003 (d) (P)	08-02-17	Provide an update on progress with the Scheduled Care Improvement Programme at the next meeting	JWI	6-Sep-17	Included on the agenda of the September 2017 meeting
(P)ROHTBACT.125	Financial position – Quarter 1	ROHTB (8/17) 005 (P) ROHTB (8/17) 005 (a) (P)	08-02-17	Present an update on financial recovery at the next meeting	PA	6-Sep-17	Recovery plan included on the agenda of the September 2017 meeting
(P)ROHTBACT.126	Trust Board action points	ROHTB (9/17) 015 (a) (P)	10-04-17	Present the revised five year vision at the next meeting	PA	1-Nov-17	Included within papers for the meeting of the Trust Board in November 2017
(P)ROHTBACT.127	Paediatric Services Update	Verbal	09-06-17	Pull together a timeline of the discussion and decision- making around the Paediatric surgery position	SGL	~~30/10/2017~~ 20/12/2017	Presented in hard copy at the December 2017 meeting
(P)ROHTBACT.128	Minutes of Private Board	ROHTB (1/18) 004 (P) ROHTB (2/18) 001 (P)	03-07-18	Amend Paul Athey's title in the private Board minutes	SGL	7-Mar-18	Amended as requested
(P)ROHTBACT.129	Five Year Vision	ROHTB (11/17) 002 (P) ROHTB (11/17) 002 (a) (P)	11-01-17	Develop the vision into a framework of targets that would be presented to the Board for monitoring progress on a quarterly basis	PB	4-Apr-18	Included on the agenda of the April 2018 meeting
(P)ROHTBACT.130	Chair & Chief Executive's update	Verbal	03-07-18	Present the paediatrics transition proposal at the next meeting	JWI	4-Apr-18	Included on the agenda of the April 2018 meeting
(P)ROHTBACT.131	Chair & Chief Executive's update	Verbal	04-04-18	Ensure that the Audit Committee is aware of the laptop information governance incident	SW	23-Apr-18	Included in the Annual Governance Statement (draft) that was considered by the Committee
(P)ROHTBACT.132	Chair & Chief Executive's update	Verbal	04-04-18	Ensure that a report is presented to the Finance & Performance Committee from the Information Governance Group to provide an update on progress with resolving the IG incident	SW	24-Jul-18	To be reported at the meeting after correspondence receive from the Information Commissioner
(P)ROHTBACT.133	Draft STP strategy	ROHTB (4/18) 012 (P)	04-04-18	Suggest that the Boards of STP providers be brought together for a discussion prior to launching the STP strategy at the next STP Board	YB	4-Jun-18	Covered as part of the STP update on private Board in June
(P)ROHTBACT.134	Chair & Chief Executive's update	Verbal	04-04-18	Present a recommendation as to whether the waiting list for paediatric spinal patients should be closed at the next meeting	Exec	2-May-18	Included as part of the Paediatric transition discussions at the May Board meeting; agreed not to close the list.
(P)ROHTBACT.135	Paediatric transition update	Verbal	06-06-18	Present a written update on paediatric transition for the next meeting	PA	4-Jul-18	Included on the agenda of the July 2018 meeting
(P)ROHTBACT.136	Any other business	Verbal	06-06-18	Circulate a list of dates for key events	SGL	4-Jul-18	Circulated as requested
(P)ROHTBACT.137	Musculoskeletal services update – commissioning intentions	ROHTB (11/18) 002 (P) ROHTB (11/18) 002 (a) (P)	11-07-18	Present a further update on the plans for therapies at the January 2019 Board meeting	JWI	9-Jan-19	Included as a verbal update on the agenda of the January 2019 meeting
(P)ROHTBACT.138	Final budget and financial plan	ROHTB (5/18) 002 (P) ROHTB (5/18) 002 (a) (P)	05-02-18	Arrange for an estates overview to be presented to the Trust Board at a future meeting	PB	5-Sep-18	Expedited to July meeting
(P)ROHTBACT.139	Governance Review	ROHTB (6/18) 004 (P) ROHTB (6/18) 004 (a) (P)	06-06-18	Develop an action plan in response to the Governance review	SGL	31-Aug-18	Included on public agenda as the Code of Practice
(P)ROHTBACT.140	Paediatric transition programme update	ROHTB (7/18) 001 (P) ROHTB (7/18) 001 (a) (P)	07-04-18	Include the paediatrics update on the public Board agenda in future	SGL	5-Sep-18	Included on the public agenda of the September 2018 meeting
(P)ROHTBACT.141	Board Assurance Framework	ROHTB (9/18) 001 (P) ROHTB (9/18) 001 (a) (P)	09-05-18	Add risks around cyber security and Brexit into the Board Assurance Framework	SGL	30-Sep-18	Added as requested
(P)ROHTBACT.142	Board Assurance Framework	ROHTB (9/18) 001 (P) ROHTB (9/18) 001 (a) (P)	09-05-18	Provide a briefing to the Board on the plans and communication with the Trust's suppliers around Brexit	SW	7-Nov-18	Included as an item on the agenda of the November Trust Board meeting
(P)ROHTBACT.143	Chair & Chief Executive's update	Verbal	11-07-18	Add an update on the Human Tissue Authority inspection to the agenda of the next Quality & Safety Committee meeting	SGL	28-Nov-18	Added as requested and item discussed in detail by the Committee. Reflected in the upward report taken at the January 2019 public session.
(P)ROHTBACT.144	Paediatric transition update	Verbal	11-07-18	Schedule a meeting of the Board for December 2018	SGL	18-Dec-18	Meeting held on 18 December 2018
(P)ROHTBACT.145	Paediatric transition update	Verbal	11-07-18	Produce a report outlining the decision making around the options for the paediatric transition work for consideration by the Board	JWI	18-Dec-18	Superseded by discussions at the December Trust Board meeting. A public paper is to be considered in January 2019.

(P)ROHTBACT.146							
(P)ROHTBACT.147							
(P)ROHTBACT.070	Litigation update	ROHTB (11/18) 004 (P) ROHTB (11/18) 004 (a) (P)	11-07-18	Give consideration to the means by which learning from claims is harnessed and disseminated to the Trust	SGL	~~27/02/2019~~ 27/03/2019	Built into wider governance plans, an update on which was presented to the Quality & Safety Committee in March 2019. Lessons learned will also fall within the remit of the Medico Legal Forum.
(P)ROHTBACT.071	Litigation update	ROHTB (11/18) 004 (P) ROHTB (11/18) 004 (a) (P)	11-07-18	Investigate the means by which the CNST premia may be forecast and reduced	SGL	27-Mar-19	ROH has had notification that the CNST premiums chargeable for 2019/20 have reduced by £300k, against an expectation of a further increase. Update presented to the Quality & Safety Committee in March 2019.
(P)ROHTBACT.073	Charitable Funds request – overseas nurse support	ROHTB (3/19) 004 (P)	03-06-19	Add 'overseas staff recruitment' as an item to the agenda of the next Staff Experience & OD Committee	SGL	3-Apr-19	Added to the agenda of the April 2019 meeting
(P)ROHTBACT.086	Board Development Plan	ROHTB (9/19) 003 (P) ROHTB (9/19) 003 (a) (P)	09-04-19	Complete a Board skills mapping exercise	SGL	~~31/12/2019~~ ~~31/03/2020~~ 31/12/2020	~~Board skills have been considered informally and it was identified that there was a gap in terms of legal expertise. New Associate NED recruited who is a barrister and lawyer. Formal skills map to be developed by the end of the calendar year.~~ Further work required to formalise a skills map - due to be completed as part of the Board succession work planned and new NED appraisal process. Discussions with incoming chair have identified skills gaps and expertise needed as the Board is refreshed. Summary of NED appraisals completed which shows the strengths and gaps in Board expertise.
(P)ROHTBACT.089	Cyber security	Presentation	10-02-19	Schedule a further update on cyber security for the Board	SGL	1-Apr-20	Annual review of compliance with the Data Security & Protection Toolkit planned. Audit Committee reviews the position on a quarterly basis.
(P)ROHTBACT.081	Paediatric transition update	Verbal	06-05-19	Arrange for a paper to be presented to the Board to evidence compliance with national paediatric care standards	GM	~~04/09/2019~~ 25/09/2019	Scheduled for presentation to the Board in September 2019. To be taken to Quality & Safety Committee for detailed scrutiny at the September meeting.
(P)ROHTBACT.091	Risk appetite	ROHTB (9/19) 003 (P) ROHTB (9/19) 003 (a) (P)	10-02-19	Schedule a further discussion on risk appetite for the Board	SGL	1-Oct-20	To be included in a future Board workshop later in 2020
(P)ROHTBACT.097	Update on incidents	ROHTB (11/19) 004 (P) ROHTB (11/19) 004 (a) (P)	11-06-19	Arrange for a presentation on Human Factors to be presented to the Trust Board	SGL	1-Apr-20	Obsolete action - to be closed. Will be arranged if or when needed.
(P)ROHTBACT.098	Estates heat map	ROHTB (11/19) 005 (P) ROHTB (11/19) 005 (a) (P)	11-06-19	Present an update on theatres digitisation to the Finance & Performance Committee	SW	23-Jun-20	Updates given on new technology as and when it is introduced as part of routine FPC meeting packs.
(P)ROHTBACT.079	Chair & Chief Executive's update	ROHTB (6/19) 001 (P) ROHTB (6/19) 001 (a) (P) ROHTB (6/19) 001 (d) (P)	06-05-19	Provide an update on Procurement to the Finance and Performance Committee	SW	30-Jul-19	Update provided as part of the July meeting and further update requested for September
(P)ROHTBACT.083	Orthopaedics across the STP	Verbal	07-03-19	Include a standing agenda item to allow a report back on orthopaedics across the STP	SGL	4-Sep-19	Included on the public agenda of the September 2019 meeting
(P)ROHTBACT.075	Chair & Chief Executive's update	Verbal	05-01-19	Arrange for an update on the pensions liability to be presented to the Trust Board at its next meeting	SGL	5-Jun-19	Included on the agenda of the June 2019 meeting
(P)ROHTBACT.077	UHB/ROH Alliance – Memorandum of Understanding	ROHTB (5/19) 002 (P) ROHTB (5/19) 002 (a) (P)	05-01-19	Amend the MoU to reflect comments made at the meeting and issue back to UHBNHSFT for views	SGL	31-May-19	Amended as requested and issued to UHB. No comments received to date
(P)ROHTBACT.078	Any Other Business	Verbal	05-01-19	Provide an update on the drugs administration anomalies at the next meeting	GM	5-Jun-19	Included under AOB on the agenda of the June 2019 meeting
(P)ROHTBACT.082							
(P)ROHTBACT.099	STP Five Year Plan & NHS Improvement trajectory	ROHTB (11/19) 013 (P) ROHTB (11/19) 013 (a) (P) ROHTB (11/19) 013 (c) (P)	11-06-19	Arrange for a presentation to be given to the Board by on GP engagement	MP	~~06/05/2020~~ 03/03/2021	To be rescheduled to new year to allow for further progress with marketing work.
(P)ROHTBACT.104	Paediatric services update	Verbal	03-04-20	Ensure that Paediatric services continues to be a standing item on the Board agenda	SGL	31-Dec-20	This item has been discussed at each meeting including NED briefing sessions to date.
(P)ROHTBACT.105	Trust's response to the Coronavirus pandemic and future operating model	ROHTB (05/20) 002 P ROHTB (05/20) 002 (a) P ROHTB (05/20) 002 (b) P Appendices A-H	05-06-20	Arrange for a Board session to consider the Trust's strategy and future operating model.	SGL	7-Oct-20	Board workshop scheduled for October 2020
(P)ROHTBACT.109	Report from the Freedom to Speak Up Guardian	Verbal	07-01-20	Ensure that the Staff Experience & OD Committee takes on the oversight of the work to develop an inclusive culture at the ROH	RP	31-Dec-20	Included as a regular item on the agendas of the Staff Experience & OD Committee
(P)ROHTBACT.104	Annual patient survey results	ROHTB (6/19) 002 (P) ROHTB (6/19) 002 (a) (P)	06-05-19	Present the inpatient survey results to the Quality & Safety Committee	GM	~~28/08/2019~~ 25/09/2019	To be presented after the results have been scrutinised by the Patient Experience & Engagement Group. Discussed at the October meeting after consideration by the Patient Engagement and Experience Group.
(P)ROHTBACT.105	Managed service contract	ROHTB (7/19) 003 (P) ROHTB (7/19) 003 (a) (P)	07-03-19	Arrange for the managed service arrangement to be reviewed by the Finance & Performance Committee in August	SW	~~15/08/2019~~ 24/09/2019	~~Contract not yet ready to present - defer to September meeting.~~ Contract approved under delegated authority by the Finance & Performance Committee at the October meeting.
(P)ROHTBACT.106	Chair & Chief Executive's update	ROHTB (7/19) 001 (P) ROHTB (7/19) 001 (a) (P) ROHTB (7/19) 001 (d) (P)	07-03-19	Arrange for a letter of thanks to be sent to the wards and departments for the inpatient survey results	JWI	4-Sep-19	Posters developed and issued to wards and departments at beginning of September
(P)ROHTBACT.107	Chair & Chief Executive's update	ROHTB (7/19) 001 (P) ROHTB (7/19) 001 (a) (P) ROHTB (7/19) 001 (d) (P)	07-03-19	Arrange for the Finance & Performance Committee to review the revised capital plan	SW	4-Sep-19	Presented to the Board at the September meeting
(P)ROHTBACT.108	Minutes of Private Board meeting held on 4 September 2019 and notes from the workshop on 2 October 2019	ROHTB (9/19) 011 (P) ROHTB (10/19) 003 (P)	11-06-19	Organise a meeting between the Chairs and Chief Executives of Birmingham Women's & Children's Hospital NHSFT and the ROH	JWI	28-Feb-20	Organised for 30 March 2020
(P)ROHTBACT.109	Chair & Chief Executive's update	ROHTB (11/19) 002 (P) ROHTB (11/19) 002 (a) (P) ROHTB (11/19) 002 (b) (P) ROHTB (11/19) 002 (c) (P)	11-06-19	Present a paper on the national position concerning ICS development and system change and present it at the next meeting	PB	5-Feb-20	There continue to be discussions at a national level concerning ICS development - update as part of Chief Executive's update in the February 2020 meeting. Close as direction still to be clarified within the system.
(P)ROHTBACT.110	Chair & Chief Executive's update	ROHTB (9/19) 001 (P) ROHTB (9/19) 001 (a) (P) - ROHTB (9/19) 001 (f) (P)	09-04-19	Present the plans for revised parking at the next meeting	PB	6-Nov-19	Included under the Estates Heat map discussion on the agenda of the November 2019 meeting
(P)ROHTBACT.111	Cyber security	Presentation	10-02-19	Consider resourcing for cyber security	SW	30-Nov-19	Discussed at Audit Committee in October and steer provided that additional investment was needed in cyber security. Plans being taken forward by Director of Finance.
(P)ROHTBACT.112	Cyber security	Presentation	10-02-19	Develop a formal disaster recovery process	PB	31-Dec-19	Disaster recovery arrangements/major incident arrangements have been tested in 2018 in preparation for a 'no deal' Brexit. Formal disaster recovery policy undergoing review for completion by the end of the calendar yea and disaster recovery/major incident even held on 3 February 2020.
(P)ROHTBACT.113	Risk appetite	ROHTB (9/19) 003 (P) ROHTB (9/19) 003 (a) (P)	10-02-19	Present the revised Board Assurance Framework to the Board in November	SGL	6-Nov-19	Included on the agenda of the November 2019 meeting
(P)ROHTBACT.114	Estates heatmap	Verbal	10-02-19	Present the revised Estates Heat Map to the Trust Board in November	PB	6-Nov-19	Included on the agenda of the November 2019 meeting
(P)ROHTBACT.115	Update on incidents	ROHTB (11/19) 004 (P) ROHTB (11/19) 004 (a) (P)	11-06-19	Present the external review of incidents at the November meeting of the Quality & Safety Committee	MR	27-Nov-19	Included on the agenda of the November Quality & Safety Committee
(P)ROHTBACT.116	Financial position and delivery of constitutional and contractual targets	Verbal	12-04-19	Provide a further update on the financial position and plans to mitigate the pensions tax issue at the January meeting of the Finance & Performance Committee	SW/JW	24-Jan-20	Included on the agenda of the January FPC

(P)ROHTBACT.117	Paediatric oncology update	ROHTB (11/19) 003 (P) ROHTB (11/19) 003 (a) (P	11-06-19	Ensure that the developments in terms of the paediatric oncology service are considered by the Quality & Safety Committee	KS	29-Jan-20	Included on the agenda of the January meeting of the Quality & Safety Committee to be reflected as part of the discussion at the Board in February	
(P)ROHTBACT.118	End of year forecast and recovery plan	Verbal	02-05-20	Arrange the financial and operational planning session for the Board meeting in March 2020	SGL	4-Mar-20	Arranged to follow the Board meeting in March	
(P)ROHTBACT.119	Paediatric services update	ROHTB (2/20) 004 (P) ROHTB (2/20) 004 (a) (P) - ROHTB (2/20) 004 (c) (P)	02-05-20	Write to RNOH to formally thank them for their support	JWI	29-Feb-20	Letter of thanks sent.	
(P)ROHTBACT.120								
(P)ROHTBACT.111	Any other business	Verbal	07-01-20	Invite Alison Gray to a forthcoming meeting of the Board	SGL	4-Nov-20	Invited to the November Board meeting to present the Charitable Funds strategy	
(P)ROHTBACT.076	Paediatric transition update	ROHTB (5/19) 001 (P) ROHTB (5/19) 001 (a) (P)	05-01-19	Provide an update on the hydrotherapy facilities at a future meeting	PM/MP	~~03/07/2019~~ 01/07/2020	~~Deferred to September November meeting to allow a comprehensive report on the estates and service to be developed.~~ Included within the estates heat map but further work needed to develop a strategic view on the service. Agreed to remit this to Finance & Performance Committee as part of the estates oversight.	
(P)ROHTBACT.101	Safe surgery external review update	Verbal	12-04-19	Arrange for an update on the actions arising from the external review of serious incidents to be presented to the Quality & Safety Committee	MR	~~26/02/2020~~ 25/03/2020	In agreement with the Chair of the Quality & Safety Committee deferred to the March 2020 meeting	
(P)ROHTBACT.103	Paediatric services update	ROHTB (2/20) 004 (P) ROHTB (2/20) 004 (a) (P) - ROHTB (2/20) 004 (c) (P)	02-05-20	Provide an overview from the transitional oversight meeting to the Quality & Safety Committee at the March meeting	MP	25-Mar-20	ACTION NOT YET DUE	
(P)ROHTBACT.106	Draft external well led assessment report	ROHTB (6/20) 003 (P) ROHTB (6/20) 003 (a) (P)	06-03-20	Challenge with Grant Thornton the narrative around the red/amber score in relation to KLoE5 in the well led assessment	SGL	1-Jul-20	Challenged and narrative revised to reflect that this related to the impact of the pensions tax liability issue on the financial position of the Trust	
(P)ROHTBACT.107	Chair & Chief Executive's update	ROHTB (07/20) 001 (P) ROHTB (07/20) 001 (a) (P) ROHTB (07/20) 001 (b) (P)	07-01-20	Ask the Communications Team to highlight key corporate messages that Non Executives could disseminate within their respective networks as and when necessary	SGL	2-Sep-20	Requested the Communications Team make contact with the Non Executives as and when necessary	
(P)ROHTBACT.108	Restoration and recovery update	ROHTB (07/20) 001 (c) (P)	07-01-20	Produce a forward activity plan for discussion at the next meeting of the Finance & Performance Committee	MP	28-Jul-20	Presented to the Finance and Performance Committee at its meeting on 28 September 2020.	
(P)ROHTBACT.110	Paediatric services update	Verbal	07-01-20	Share a written overview of the discussions around Paediatric Oncology with the Non Executives at their briefing session	MP	31-Jul-20	Discussed at the NED briefing session and by Quality & Safety Committee	
ROHTBACT.216	Net Zero progress update	ROHTB (9/23) 022 ROHTB (9/23) 022 (a)	09-06-23	Present the Green Board update to FPC and a summary of any barriers to the achievement of the intentions to the Board at a later date	SW	~~1/11/2023~~ 6/12/2023	Green Board update presented to FPC in September and further update to Board in ~~November~~ December. INCLUDED ON THE AGENDA OF THE DECEMBER BOARD MEETING.	
ROHTBACT.221	Wellbeing Plan	ROHTB (10/23) 005 ROHTB (10/23) 005 (a)	10-04-23	Present the revised leadership framework to Staff Experience & OD Committee in October 2023	SM	~~25/10/2023~~ 27/03/2024	Deferred to the ~~January~~ March 2024 meeting	
(P)ROHTBACT.138	Any Other Business	Verbal	06-01-22	Expedite the implementation of a Board portal	SGL	31-Oct-22	PROPOSE CLOSURE: Presentations for Board portals held on 24 January 2023	
ROHTBACT.222	Equality & Diversity Improvement Plan	ROHTB (10/23) 008 ROHTB (10/23) 008 (a)	10-04-23	Ensure the disciplinary process appears on the SE&OD and Trust Board agenda with regular update and progress reports	SM	~~07/02/2024~~ 27/03/2024	Deferred to the March 2024 meeting	
(P)ROHTBACT.114	Update from the Audit Committee	ROHTB (4/23) 004 (a)	02-03-21	Include a session on risk appetite within the Board workplan	SGL	7-Apr-21	Included within list of topics for inclusion in the Board work & development plans to be presented at the March meeting. STRATEGIC WORKPLAN FOR DECEMBER 2021	
(P)ROHTBACT.121	Perfecting Pathways Programme update	ROHTB (4/21) 023 (P) ROHTB (4/21) 023 (P) (a)	04-07-21	Present a summary of the projects delivered at the June 2021 meeting	PB	2-Jun-21	Reported to the Finance and Performance Committee at its meeting in May 2021.	
(P)ROHTBACT.117	Charity strategy & governance improvement	ROHTB (3/21) 013 (P) ROHTB (3/21) 013 (P) (a) ROHTB (3/21) 013 (P) (b) ROHTB (3/21) 013 (P) ©	03-03-21	Schedule a further update on the Charity into a future Board meeting	SGL	6-Oct-21	STRATEGIC WORKPLAN FOR DECEMBER 2021	
(P)ROHTBACT.115	Restoration and recovery update	Presentation	02-03-21	Develop a strategic board work & development plan	SGL	7-Apr-21	Included on the agenda for the April 2021 Board meeting	
(P)ROHTBACT.117								
(P)ROHTBACT.118	Chair and Chief Executive update	ROHTB (3/21) 014 (P) ROHTB (3/21) 014 (P) (a) ROHTB (3/21) 014 (P) (b) ROHTB (3/21) 014 (P) ©	03-03-21	Provide a further overview of the plan to support the system recovery and restoration work at the next meeting	MP	7-Apr-21	Included on the agenda for the April 2021 Board meeting	
(P)ROHTBACT.113	Paediatric oncology services update	ROHTB (11/20) 002 (P) ROHTB (11/20) 002 (a) (P) ROHTB (11/20) 002 (b) (P)	11-04-20	Provide an update on the paediatric oncology plans at the December Board informal session	MP	2-Dec-20	Provided as requested.	
(P)ROHTBACT.116	Any other business	Verbal	02-03-21	Provide an update on the plans for the bone tumour service at the next meeting	JWI	3-Mar-21	Included on the agenda of the March & April Board meeting	
(P)ROHTBACT.119	Items for the strategic Board work/ development plan	ROHTB (3/21) 016 (P)	03-03-21	Present the final strategic work and development plan at the next meeting	SGL	7-Apr-21	Included on the agenda for the April 2021 Board meeting	
(P)ROHTBACT.120	System plan update	ROHTB (4/21) 021 (P) ROHTB (4/21) 021 (P) (a)	04-07-21	Provide a letter back to Clinical Service Leads to address concerns raised around system working	TP	15-Apr-21	Letter written back to consultants	
(P)ROHTBACT.122	Deloitte proposal on shared services	ROHTB (7/21) 015 (P) ROHTB (7/21) 015 (P) (a) ROHTB (7/21) 015 (P) (b)	07-07-21	Suggest an area to test the shared services concept	Execs	31-Aug-21	Continue to monitor effectiveness of Procurement and transactional finance function for now	
(P)ROHTBACT.121	Modernising, Maintaining and Imagining the Future of the Trust Estate	Presentation	06-02-21	Share the estates development work at the Annual General Meeting in October 2021	PB	7-Oct-21	ACTION NOT YET DUE	
ROHTBACT.217	Stories for the Board	ROHTB (10/23) 001 ROHTB (10/23) 001 (a)	10-04-23	Liaise with NB with regard to how we bring together the learning from the stories on an annual basis	ES	3-Apr-24	Annual report on patient and staff stories to be presented in April 2024. ACTION NOT YET DUE	
ROHTBACT.184	Clinical strategy	ROHTB (11/20) 012 (P) ROHTB (11/20) 012 (a) (P)	11-04-20	Arrange for an update on the clinical strategy to be delivered to the Council of Governors	SGL	~~20/01/2021~~ 7/10/2021	Presented at the governors meeting on 7 October 2021	
ROHTBACT.185	Chair and Chief Executive update on any confidential matters	ROHTB (2/22) 015 (P) ROHTB (2/22) 015 (a) (P)	02-02-22	Organise for a date for a potential extraordinary Board meeting to be convened	SGL	16-Feb-22	Likely to use NED Briefing session on 16 February 2022	
ROHTBACT.186	H2 (Months 7 – 12) risk and issues	ROHTB (11/21) 016 (P) ROHTB (11/21) 016 (a) (P	11-02-21	Provide a view of the indicative additional cost for treating an extra 100 patients	SW	30-Nov-21	Discussed by the Finance & Performance Committee in November	
ROHTBACT.187	Any Other Business	Any Other Business	Verbal	Arrange for thanks to be given to the staff for their hard work and continuous improvement at a time of continued pressure for the ROH and the NHS	SGL	8-Nov-21	Included within the Corporate Affairs Team Brief slides for November 2021	
ROHTBACT.188	Chair and Chief Executive update on any confidential matters	ROHTB (11/21) 014 (P) ROHTB (11/21) 014 (a) (P) ROHTB (11/21) 014 (b) (P)	11-02-21	Develop an action plan to outline the way in which the allegations in from the CQC focus group would be addressed	SM/JW	2-Feb-22	Discussed in overview at the Staff Experience & OD Committee and to be incorporated into the overall Equality & Diversity action plan	
ROHTBACT.189	Birmingham Health Partners – 'Driving Efficiencies in Clinical	ROHTB (12/22) 018 (P) ROHTB (12/22) 018 (a) (P)	12-07-22	Organise for a quarterly update on Birmingham Health Partners – 'Driving Efficiencies in Clinical Trials' to be presented	PB MR	01/03/2023 5/04/2023	ACTION NOT YET DUE	
ROHTBACT.190	Osseointegration update	Presentation	12-07-22	Organise for a further update on Osseointegration to be presented at a future meeting	MP	6-Sep-23	ACTION NOT YET DUE	

ROHTBACT.191	Any Other Business	Verbal	07-06-22	Provide an overview of the proposed changes to the Provider governance framework at a future meeting	SGL	7-Sep-22	Included on the agenda of the September public session	
ROHTBACT.192								
ROHTBACT.193	Any Other Business	Verbal	06-01-22	Arrange a strategic development session	SGL	7-Sep-22	Now set for 5 October 2022	
ROHTBACT.194	Private patient strategy update	Verbal	10-07-21	Present an update on the private patient work at the March 2022 meeting	RL	2-Mar-22	To be included in the Chief Executive's private report and also rescheduled for discussion at the April 2022 Board meeting	
ROHTBACT.195	Chair and Chief Executive update on any confidential matters	ROHTB (3/22) 013 (P) ROHTB (3/22) 013 (a) (P) ROHTB (3/22) 013 (b) (P) ROHTB (3/22) 013 (c) (P) ROHTB (3/22) 013 (d) (P)	03-02-22	Schedule a discussion around the private patient strategy for the next meeting	SGL	6-Apr-22	Included on the agenda of the April 2022 Board meeting	
ROHTBACT.196	Chair and Chief Executive update on any confidential matters	ROHTB (3/22) 013 (P) ROHTB (3/22) 013 (a) (P) ROHTB (3/22) 013 (b) (P) ROHTB (3/22) 013 (c) (P) ROHTB (3/22) 013 (d) (P)	03-02-22	Invite the team to present the hip and knee revision centre plans for the next meeting	SGL	6-Apr-22	Included on the agenda of the April 2022 Board meeting	
ROHTBACT.197	Update on annual plan	Verbal	03-02-22	Develop the bridge between 2019/20 to the current year	SW	6-Apr-22	Included in the annual planning update included on the agenda of the April 2022 meeting	
ROHTBACT.198	MSK system proposal	Verbal	04-06-22	Invite the strategy team to present to the Board at the next meeting	SGL	4-May-22	Included on the agenda of the May 2022 meeting	
ROHTBACT.199	Draft annual plan	ROHTB (4/22) 018 (P)	04-06-22	Present the finance and operations plan 2022/23 at the next meeting	SW	4-May-22	Included on the agenda of the May 2022 meeting	
ROHTBACT.200	Cloud migration update	ROHTB (4/22) 019 (P)	04-06-22	Invite the Head of IT Operations to the next meeting	SGL	4-May-22	Invited and attending the May 2022 meeting	
ROHTBACT.201								
ROHTBACT.202	Robotics surgery strategy	ROHTB (11/21) 021 ROHTB (11/21) 021 (a)	11-02-21	Organise for a presentation on the robotics strategy to be delivered in future to demonstrate how the technology worked and the plans for the future	MR	~~06/04/2022~~ ~~1/06/2022~~ 6/07/2022	PROPOSED FOR CLOSURE: In agreement with the Chair, deferred to June given the weight of the April agenda - not time critical. Now deferred to July due to availability of key surgeons. Included on the agenda of the July 2022 meeting	
ROHTBACT.203	Provider Collaborative update	ROHTB (5/22) 011 (P) ROHTB (5/22) 011 (a) (P)	05-04-22	Provide a further update on the development of a Provider Collaborative at the next meeting	TP	1-Jun-22	PROPOSED FOR CLOSURE: Included on the agenda of the June 2022 meeting	
ROHTBACT.204	Financial and operations plan 2022/23	ROHTB (5/22) 018 (P) ROHTB (5/22) 018 (a) (P)	05-04-22	Present the 2022/23 budgets for sign off at the next meeting	SW	1-Jun-22	PROPOSED FOR CLOSURE: Included on the agenda of the June 2022 meeting	
ROHTBACT.205	Birmingham and Solihull ICB update	Verbal	09-07-22	Approach the Director of Governance for the ICS to understand how the ROH is represented on the ICB Committees	SGL	30-Sep-22	Circulated membership of the ICB Committees	
ROHTBACT.206	Communications, marketing and promotion strategy	Presentation	06-01-22	Schedule reports to the Board on the Communications, Marketing and Branding strategy delivery	SGL	~~05/10/2022~~ ~~2/11/2022~~ 7/12/2022	Included on agenda for December Board meeting	
ROHTBACT.207	Business planning summary	Presentation	04-06-22	Ensure that a business planning summary document is produced and circulated to the Trust Board	PB/SW	~~31/05/2022~~ 30/09/2022	Now subsumed into the business planning documentation for 2023/24	
ROHTBACT.208	Chair and Chief Executive update on any confidential matters	ROHTB (10/22) 010 ROHTB (10/22) 010 (a) (P) ROHTB (10/22) 010 (b) (P) ROHTB (10/22) 010 (c) (P) ROHTB (10/22) 010 (d) (P)	10-05-22	Provide a briefing on Birmingham Health Partners at the next meeting	JWI	2-Nov-22	Included in public papers for the November Board meeting	
ROHTBACT.209								
ROHTBACT.210	Chair and Chief Executive update	ROHTB (11/22) 015 ROHTB (11/22) 015 (a) (P) - ROHTB (11/22) 015 (g) (P)	11-02-22	Ensure that the self-assessment against the National Oversight Framework be presented at the next meeting	SGL	7-Dec-22	Included on agenda for December Board meeting	
ROHTBACT.211	Any Other Business	Verbal	11-02-22	Provide a further update on EPR discussions at the next meeting	SW	7-Dec-22	Included on agenda for December Board meeting	
ROHTBACT.212								
ROHTBACT.213	Minutes of the previous meeting	ROHTB (12/22) 023 (P)	02-01-23	Amend the Board attendance list to include Dr Reckless	SGL	1-Mar-23	PROPOSE CLOSURE: Amended as required	
ROHTBACT.214								
ROHTBACT.215								
ROHTBACT.216								
ROHTBACT.229	Summary of patient stories	ROHTB (5/23) 010	05-03-23	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)	03-01-23	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	07-05-23	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 ©	07-05-23	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	
ROHTBACT.225	Retention & Recruitment update	ROHTB (11/23) 006 ROHTB (11/23) 006 (a)	11-01-23	Add update on visit to Jaguar Land Rover to a future agenda	TF	6-Mar-24	ACTION NOT YET DUE	
ROHTBACT.203	Update on Safeguarding - the System approach	ROHTB (4/23) 004 ROHTB (4/23) 004 (a)	04-05-23	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.186	Gender pay gap	ROHTB (7/23) 013	07-05-23	Brief the Chair on the clinical excellence awards process	SM	30-Sep-23	Included in CPO/Chair brief in September	
ROHTBACT.204	Schedule of patient stories	ROHTB (9/23) 002 ROHTB (9/23) 002 (a)	09-06-23	Present combined patient and staff story schedule at the next Trust Board	NB	4-Oct-23	Included in papers for the October 2023 meeting	
ROHTBACT.205	Board portal	Verbal	09-06-23	Include action around the Board portal on the public action log until implemented	SGL	04/10/2023 onwards	Verbal update included on the agenda of the October meeting	
ROHTBACT.206	Chair & Chief Executive's update	ROHTB (9/23) 003 ROHTB (9/23) 003(a)	09-06-23	Provide assurance on RAAC at the next meeting	SW	4-Oct-23	Included in papers for the October 2023 meeting	
ROHTBACT.207	Speaking Up and Incident Management at the ROH	ROHTB (9/23) 004 ROHTB (9/23) 004 (a)-(c)	09-06-23	FTSU poster to be amended for GH as Non-Executive Director	SGL	30-Sep-23	Poster now amended	
ROHTBACT.208	Speaking Up and Incident Management at the ROH	ROHTB (9/23) 004 ROHTB (9/23) 004 (a)-(c)	09-06-23	FTSU report to be presented at the Trust Board meeting in November to include themes, examples and benchmarking of concerns	SGL	1-Nov-23	Included in papers for the October 2023 meeting	
ROHTBACT.209	Wellbeing strategy and Cost of Living update	ROHTB (9/23) 005 ROHTB (9/23) 005 (a)-(c)	09-06-23	Present the wellbeing plan to the Board in October	SM	4-Oct-23	Included in papers for the October 2023 meeting	
ROHTBACT.211	Equality and Diversity Action Plan	ROHTB (9/23) 007 ROHTB (9/23) 007 (a) ROHTB (9/23) 007 (b)	09-06-23	Equality & Diversity Improvement Plan to be presented at the Trust Board meeting in October	SM	4-Oct-23	Included in papers for the October 2023 meeting	

ROHTBACT.212	Expanding elective capacity self-assessment	ROHTB (9/23) 009 ROHTB (9/23) 009 (a) – (c)	09-06-23	Consider further the self-assessment against the expanding elective capacity at the September meeting of the FPC	MR	26-Sep-23	Discussed and revised version included on the agenda of the October Trust Board meeting	
ROHTBACT.213	Emergency Preparedness, Resilience and Response (EPRR) care standards self-assessment	ROHTB (9/23) 013 ROHTB (9/23) 013 (a)	09-06-23	Circulate the spreadsheet which includes a 'RAG' rating to Trust Board members	SW	8-Sep-23	Circulated after the meeting as requested	
ROHTBACT.215	Board Committee updates	ROHTB (9/23) 015 ROHTB (9/23) 016 ROHTB (9/23) 017 ROHTB (9/23) 018	09-06-23	internal audit annual plan to be circulated for information with the papers for the next meeting	SGL	4-Oct-23	Included in papers for the October 2023 meeting	
ROHTBACT.227	Update from CQC Engagement meeting	ROHTB (12/23) 003 ROHTB (12/23) 003 (a)	12-06-23	Present at the February Board meeting an overview of concerns raised to the Care Quality Commission	NB	7-Feb-24	Included on the agenda of the private session of the February meeting	
ROHTBACT.183	Patient Pathway update	ROHTB (7/23) 010	07-05-23	Present an update on the Outstanding Pathways work at a future meeting	AM	~~6/09/2023~~ 4/10/2023	Discussed as part of the October private session	
ROHTBACT.184	Patient Pathway update	ROHTB (7/23) 010	07-05-23	Arrange for a further update on the GP liaison work to be presented to the Board	MP	1-Nov-23	To be referenced as part of the private patient work discussed on the agenda of the November Trust Board meeting	
ROHTBACT.210	Turnover and retention plan update	ROHTB (9/23) 006 ROHTB (9/23) 006 (a)	09-06-23	Staff turnover numbers to be reviewed at the Trust Board meeting in November	SM	1-Nov-23	Update included on the agenda of the November Public session	
ROHTBACT.214	Revised Board Assurance Framework	ROHTB (9/23) 014 ROHTB (9/23) 014 (a) – (f)	09-06-23	Present the revised BAF in November 2023	SGL	1-Nov-23	Update included on the agenda of the November Public session	
ROHTBACT.220	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	10-04-23	Lead on identifying administration resource for FTSU	SGL	1-Nov-23	To be provided by the Corporate Secretariat on an ad-hoc basis	
ROHTBACT.223			10-04-23					
ROHTBACT.224								
ROHTBACT.225								
ROHTBACT.226								
ROHTBACT.228	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12-06-23	Provide an update on the Health & Wellbeing week at the February Board meeting	SM	7-Feb-24	Included as part of the wellbeing report to be considerd at the February 2024 meeting	
ROHTBACT.229	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12-06-23	Provide an update on the Health & Wellbeing Guardian role at a future Board meeting	AA	6-Mar-24	ACTION NOT YET DUE	
ROHTBACT.223	Declarations of interest	ROHTB (11/23) 001	11-01-23	Amend the DoI to remove Tim Pile's directorship for Marshalls Plc	TF	6-Dec-23	Amended as requested	
ROHTBACT.224	Child care provision	ROHTB (11/23) 005 ROHTB (11/23) 005 (a) ROHTB (11/23) 005 (b)	11-01-23	Update the report based on discussions at today's meeting and those undertaken at Executive Team meeting	SM	6-Dec-23	Report updated and public record corrected	
ROHTBACT.230	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12-06-23	provide an update on the effectiveness of the Health & Wellbeing interventions at the February Board meeting	SM	7-Feb-24	Included as part of the wellbeing report to be considerd at the February 2024 meeting	
ROHTBACT.231	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12-06-23	circulate feedback from the Inclusive Company with Board Members for information ahead of the next Board meeting	SM	7-Feb-24	To be circulated	
ROHTBACT.232	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	12-06-23	Provide benchmark report on food standards and themes from patient and staff on a regular basis to relevant committees and report back to Trust Board	NB	5-Jun-24	ACTION NOT YET DUE	
ROHTBACT.233	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	12-06-23	Use benchmarking information as part of reports being prepared for the Trust Board and relevant committees	All Execs	3-Apr-24	To be built into the cover sheet of papers and new report templates	
ROHTBACT.234	Guardian of Safe Working update	ROHTB (12/23) 008 ROHTB (12/23) 008 (a)	12-06-23	Invite Mr Jamie McKenzie to attend the Board to present his independent view	TF	3-Apr-24	Invited and agreed to attend the April 2024 meeting	
ROHTBACT.218	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	10-04-23	Lead on finding a designated area for the FTSU Guardian	SGL	31-Dec-23	The FTSUG now has the opportunity use the governance offices for confidential conversations and dedicated administration has also now been identified	
ROHTBACT.219	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	10-04-23	Provide exact numbers relating to inappropriate attitude and behaviour concerns in the next update	CJ	7-Feb-24	Included in the latest update from the FTSUG	
ROHTBACT.226	Risk Appetite	ROHTB (11/23) 009 ROHTB (11/23) 009 (a)	11-01-23	Arrange for AR to attend future Board meeting to discuss the BAF risk appetite	TF	7-Feb-24	Included on the agenda of the February 2024 meeting	

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Chief Executive's update
SPONSOR (EXECUTIVE DIRECTOR):	Jo Williams, Chief Executive
AUTHOR:	Jo Williams, Chief Executive
DATE OF MEETING:	7 February 2024

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Board are 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

Report to the Trust Board (in Public) on 7 February 2024

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 6 December 2023 from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 On Thursday 1 February 2024 we opened for nominations for the Blue Heart Staff Awards which is being held in June 2024. At the end of the first day we had already received 75 nominations which is incredible.

2.2 Congratulations to the Oncology Team who hosted the Birmingham Orthopaedic Oncology Meeting (BOOM): The Consensus. The meeting was a two-day consensus meeting held at the Grand Hotel in Birmingham on 29th & 30th January 2024. The theme was centred around gaining global consensus on Chondrosarcoma and Infected Oncology Reconstructions. The team invited a global Scientific Committee from over 120 major units to shape the key controversies and research the evidence.

2.3 On 1st February 2024, the Trust hosted a visit from Versus Arthritis (VA) where we were able to start to map out a range of areas for collaboration which will aid our patients, pre and post operatively. We have already hosted a local event to support patients on site at Griffinbrook and we are excited to see how this can be widen out across the Birmingham & Solihull (BSol) System.

2.4 On 24 January 2024, Jonathan Pearson Chair of Birmingham Health Partners (BHP), revisited the Trust, and I would like to thank all the teams who welcomed Jonathan into their departments to showcase their services with such pride and enthusiasm.

2.5 Work is currently ongoing planning an event to celebrate the 80th anniversary of D-Day on 6 June 2024 where we plan to invite and celebrate with our veterans. Further information will be share over the coming weeks.

2.6 On 18 January we held our first Council of Governors (COG) meeting of 2024. As well as a general operational update it was great to share with the Committee an update about Jointcare, our joint replacement programme, and Ossoeintegration.

2.7 On 12 December 2023, the Executives undertook one of the regular 'Chat & Check' visits. Outpatients, Stores and HR were visited and the teams welcomed

the opportunity to share with the Executives their experience of working at the ROH.

2.8 I would like to give a warm welcome to our new Non-Executive Directors, joining us in February 2024, Simon Page and Jenny Belza. We look forward to welcoming you to the Trust and working with you over the coming months.

2.9 On Wednesday 17 January 2024, the Trust hosted a Sarcoma Research day which was well attended and showcased the range of services which the Trust provides. Thank you to all those who presented on the day and external partners who supported the event.

2.10 The new ways of working for the CQC (Care Quality Commission) means that Trust's will no longer be assigned an individual inspector but a whole team. The Midlands region has set a 'go-live' day of 6th February for the changeover to the new system.

I would like to thank our outgoing CQC Inspector Coral Peczek who has been incredibly supportive and helpful supporting and working alongside our teams.

2.11 I would like to thank the Imaging, Operational and Estates team for the continued support and work over the last few months manging the mobile MRI whilst repairs are conducted on site. I recognise that it has been extremely challenging, but patients have remained at the centre of everyone's thoughts and plans.

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 March 2024.

3.2 BSol is currently seeing an increase in the number of cases of measles. Measles is an infection that spreads very easily and can cause serious problems in some people. It is more than 'just a rash', it is a serious illness that can be unpleasant and lead to complications, especially in vulnerable, immunocompromised, or pregnant patients. Having the MMR (Measles, Mumps and Rubella) vaccine is the best way to prevent it. It is important that all staff and patients check with their local GP to see if you are up to date with this vaccine.

Measles is highly infectious to anyone who is not immune – being in the same room as someone with measles for more than 15 minutes is a significant amount of exposure. Measles starts with a two to four day 'prodromal' phase before the rash appears, with a stuffy nose, cough, conjunctivitis and a fever.

The rash generally starts behind the ears, spreads to the face, and then expands.

The national guidance if you think you or your child may have measles is as follows in the below circumstances:

- you've been in close contact with someone who has measles and you've not had measles before or you've not had two doses of the MMR vaccine
- you've been in close contact with someone who has measles and you're pregnant – measles can be serious in pregnancy
- you have a weakened immune system and think you have measles or have been in close contact with someone with measles

To avoid spreading measles, avoid close contact for at least four days from when the rash first appears. Do not share cutlery, cups, towels, clothes or bedding. Visit NHS England for more information about Measles and its symptoms: Measles - NHS (www.nhs.uk)

4 NHS England/National updates

4.1 NHSE has confirmed that the Trust has been successful as a People Promise pathfinder site. Established in April 2020, NHS England's People Directorate leads the programme and works to improve staff experience and the retention of our NHS people.

The programme works nationally as well as across all seven regions to support and help organisations and systems achieve real tangible improvements in staff retention. The People Promise exemplars are 23 organisations – a mix of acute, community and mental health providers. Pathfinders help to test assumptions about what can best empower the whole workforce to feel valued, safe, productive, and supported and therefore keep more of our valued staff in roles they love. The work will run in parallel with our existing work streams aimed at retaining, supporting and developing our workforce.

4.2 In January, we received a letter from the Environment Agency reminding us of our obligations as a healthcare provider over management of waste. The Agency is undertaking detailed healthcare waste audits at trusts to test compliance with the regulations. A copy of the letter is appended to this report. A position statement will be developed and presented to both the Quality & Safety Committee (from an IPC perspective) and Finance & Performance Committee (as part of the Green Board update) to provide assurance that the Trust is adhering to the guidance.

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:

- Special leave
- Asbestos management
- Research study management

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

1 February 2024

creating a better place
for people and wildlife

Environment Agency

FAO: The Chief Executive Officer

Our ref: NHS letter 0124
Your ref:
Date: January 2024

Dear Sir/Madam

Waste Management Duty of Care and your legal obligations

The Environment Agency wrote to all NHS Trust CEOs in December 2019 highlighting our concerns with the management of healthcare waste. We appreciate that this was overtaken by the COVID 19 pandemic when waste management became even more of a challenge for NHS waste managers. You may not have been aware, but we had to put in place additional contingency arrangements including facilitating the use of energy from waste facilities for emergency capacity.

As CEO of your Trust, it is your responsibility to ensure all of your waste from healthcare activities comply with waste management Duty of Care legal obligations. In particular, the duty to take measures to prevent another person contravening an environmental permit condition (as outlined in the Annex to this letter) with your waste.

You have an obligation to ensure that detailed audits of the waste produced at your sites are undertaken, to make sure your waste is properly segregated, classified and transferred to an appropriate waste management facility and that a copy of the waste audits are made available to your waste contractor prior to the waste being collected. Failure to get this right could lead to pollution of the environment or cause accidents and incidents that could harm people.

You will be aware that the NHS clinical waste strategy was published in March this year, as was the updated Health Technical Memorandum 0701: Safe and sustainable management of healthcare waste, which details the waste manager as a key role with specific responsibilities and accountabilities to ensure waste is managed effectively and appropriately.

Earlier this year we began undertaking detailed healthcare waste audits at some Trusts to review the healthcare waste management practices on sites. These audits are to satisfy ourselves that Trusts are compliant with their regulatory responsibilities or bring to their attention areas that require improvement. It is expected that this audit programme will continue into next year.

The purpose of this letter is to make sure that you are prepared for these audits and have dedicated, qualified waste managers in post who can deliver the segregation of waste required and comply with all your Duty of Care requirements.

To ensure this process goes smoothly please could you provide the contact details (name, job title, email address and phone number) of the person accountable for your waste management to our healthcare waste lead Jill Rooksby (wastetreatment@environment-agency.gov.uk).

If you require any further information, please contact: Jill Rooksby – Senior Advisor – Waste Transfer and Treatment, Waste Regulation (wastetreatment@environment-agency.gov.uk)

Yours faithfully,

Georgina Collins
Director Regulated Industry

Annex

Your legal obligation to prevent another person contravening an environmental permit condition

As waste producers, in order to comply with your Duty of Care, as defined in Section 34 of the Environmental Protection Act 1990 (http://www.legislation.gov.uk/ukpga/1990/43/section/34), NHS Trusts need to take all such measures that are applicable to them as a waste producer and as are reasonable in the circumstances, to prevent a contravention by another person of an environmental permit condition.

If your Trust is transferring its waste to a waste management company without having undertaken a comprehensive 'pre-acceptance audit', it will be failing its Duty of Care if it caused the waste management facility to breach its environmental permit.

Waste audits are an essential tool in assessing the quantity and composition of the waste produced, ensuring it is effectively separated and ultimately treated or disposed of at an appropriately permitted facility. Meeting these requirements will ensure a significant part of the Duty of Care (as defined in Section 34 of the Environmental Protection Act 1990) is complied with and ensures healthcare establishments take measures to prevent a contravention by another person of an environmental permit condition.

The Environment Agency seeks to work with those it regulates in order to secure compliance and reductions in the use of resources and production of waste. However, it is also our responsibility as a regulator to inform you that failure to comply with a duty imposed by Section 34 of the Environmental Protection Act 1990 is a criminal offence, which may lead to enforcement action being taken against the Trust, including prosecution.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	Wellbeing Update
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Laura Tilley-Hood, Wellbeing Officer
DATE OF MEETING:	7th February 2024

EXECUTIVE SUMMARY:

This report gives an update on Wellbeing work across the trust and the continued Cost of Living support.

Positive assurance

- Colleagues are able to access the hardship fund and there is a quick turnaround for them to receive the funds.
- Continuing to provide financial support for colleagues during the winter months, using support from the winter funding, Finance, Salary Finance, Barclays, HSBC, regional and national support.
- All colleagues had support during Wellbeing Week, packs were also given to night and weekend staff.

Current issues

Ensuring all managers attend the Wellbeing Conversation Training

Next steps

-Confirming the Wellbeing action plan to include priorities and next steps.

-Continue to work with colleagues around Cost of Living, sharing support via Weekly Wellbeing email, Managers Calls, posters and any other ways to signpost

-Next step following hardship fund review

REPORT RECOMMENDATION:

To review information

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

The receiving body is asked to receive, consider 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 & 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, ROH Inclusion strategy

PREVIOUS CONSIDERATION:

Cost of Living and Wellbeing update Trust Board – December 2023
Wellbeing update SE&OD committee – January 2023
People and OD Group January 2024
ROH Comms information

Trust Board – February 2024

Update on Cost of Living and Wellbeing

1. Cost of Living

Royal Orthopaedic Charity Initiative: The ROC Hardship Fund

As of 1st February, we have received a total of 69 hardship applications. Out of these, 57 have received approval, benefiting 40 staff members and 17 patients, resulting in a total grant allocation of £24,591.96.

On average, per application, patients receive £239.53 in financial support, while staff members are awarded an average of £463.00.

Examples of the types of requests we have received include assistance with essentials such as food, bills, and rent.

Next steps will be to provide a monthly breakdown of applications to allow trend analysis.

6-month Hardship Fund review meeting

The meeting was held with all Hardship Panellists and the ROC team.

- New questions to be added to the application form to make the process more robust and reduce the amount of additional information requested from applicants.
- Include definition of immediate financial hardship on application to make it clear to the people applying.
- Financial wellbeing support to be targeting in the two areas identified as patterns of colleagues applying for funds.
- To ensure applicants are aware that it is their responsibility to support their own financial wellbeing going forward, using the signposting and support offered when they apply for the Hardship Fund.

HSBC Financial Support

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

1) Always on - webinars on different financial subjects
2) 1:1 Financial Health Check - Colleagues can book a free financial health check via a QR code or by emailing directly. This has been shared in the Wellbeing Weekly email and posters have been distributed.

HSBC visited the Trust for Wellbeing Week to offer general support on a stand, they also ran a webinar and offered 1:1 support if needed. Fifteen colleagues visited the stand and spoke

about various topics, including general financial wellbeing and budgeting.

Other Cost of Living initiatives include:

Winter Grant – The Trust has secured further funding via the Winter Grant until March 2024 to support our COL work at the Trust. The funding secured is approximately £800 per month

Free Porridge – The Trust launched free porridge at the start of Wellbeing Week, we are continuing this throughout the winter months until the end of March, after gaining great feedback. We are averaging at 45 portions a day. Porridge Oats and milk has also been delivered to College Green.

ROH Pantry – continuing to keep the pantry restocked over the winter months, using the Winter Grant. This pantry was re stocked on 7th December. Another order will be made 2nd February. We have added a counter box, we ask colleagues to add a counter into the box if the ROH Pantry has helped them. Between 15th and 29th January, 28 counters were placed in the box.

Out of hours food – continue to re stock the freezer located in the Wellbeing Room with the Winter Grant, a new order will be placed on 2nd February.

Blue Bag Project – These bags are kept fully stocked across ROH using the Winter Grant. The Trust also have extra supplies in the ROH Pantry for colleagues to take home.

Toiletry Packs – more supplies were ordered and have been given out to students using the Winter Grant, we will order more on 2nd February.

Salary Finance – The Trust continues to share information on the support available

Stands at Wellbeing Week – The Finance team, HSBC and Barclays were available during Wellbeing Week to help with the Cost of Living.

2. Wellbeing Update

Wellbeing Week Overview 27th November – 1st December

Activity	How many colleagues attended	Information
Wellbeing Stand	43	All Wellbeing areas covered, what support is available and where to find it. How to look after our basic Wellbeing needs.
FTSU and E&D Stand	38	Talked about the services offered and how to contact the relevant people
Staff Mental Health Hub	25	Support and general advice on Mental Health and how to contact SMHH
Sleep Workshop	19	

		workshop to talk through the importance of sleep and give you hints and tips on how to get a better sleep.
HSBC Webinar	10	Managing Debt
Mindfulness Session	17	Guided Mindfulness Session
Managing low mood workshop	27	Tips on how to manage low mood and support available via the BSol Staff Mental Health Hub.
Hardship Fund and Charity Stand	15	The charity talked through the work they have done to support colleagues, how colleagues can get involved and information about the Hardship Fund. There was an increase in applications for the Hardship Fund following the stand and the Christmas Charity event.
Holistic Therapies	14	Hand, head and shoulder massages for colleagues.
Birmingham Mind Stand	24 colleagues and 2 patients	Rachel spoke about Stress at Work, Anxiety and Depression and gave their Helpline as an anonymous out of hours resource.
Managing Anxiety Workshop	19	Coping mechanisms on how to manage anxiety and further support from Staff Mental Health Hub
Aquarius (drugs, gambling and alcohol).	24	General conversations with colleagues. Some brief intervention conversations around alcohol. Provision of materials to HCA team for use with colleagues and as part of their frontline work. Several conversations about alcohol and drug education at pre-op assessments. Provided a range of conversational skills to enable effective communication.
MMEG walkabout	Ward 2 and 4 Imaging Outpatients POAC Theatres	Walkabout sharing info about MMEG and the networks. Marie and Falon visited clinical areas, they had some good conversations.
TBALD – Theatres	All colleagues	Reminded them of Wellbeing Week and what was on offer
Wellbeing Quiz	48	Winner in Pharmacy of the Starbucks hamper
Barclays	5	Talked about general finance but also specifically about savings
HSBC Stand	21	Talked through what HSBC can offer and where to access. Also passed on 1:1 information.
Training and Development	12	Continuous professional development – talked colleagues through opportunities
Finance	10	Conversations around hardship fund and the salary finance.
Tea Trollies	All areas	5 Tea Trollies throughout the week that visited all areas of the Trust

Wellbeing Days – Above is an overview of all the events that took place throughout the Wellbeing Week. All areas of the Trust were visited with the Tea Trollies. Packs made up of snacks, wellbeing booklet and Wellbeing support which were specifically for our colleagues that work nights/weekends, managers were asked to help distribute these. The Trust has also asked for feedback on the week on how it has helped individuals' wellbeing and the impact for individuals and team members, we are collating these results.

Wellbeing plan – work in progress
To review metrics for each of the wellbeing priorities to ensure there are clear actions which can measure impact.
To confirm key work programmes for the next 12 months taking into account the 4 key areas of focus in the wellbeing plan which are:

1. MSK – quicker referral, accessibility and support for colleagues and managers supporting colleagues with MSK
2. Stress and Mental Health – the HR and OD team are working together to look at sickness absence and target
3. Cost of Living – Winter Grant available until March 24. We are looking at how we support the COL initiatives beyond March 24.
4. Managers supporting Wellbeing – continuing to promote the Wellbeing Conversation Training for managers. Wellbeing Information Pack has been put into PDF for managers, they can then share this with their colleagues.

This work programme will be a transferred into a Wellbeing action plan, for work to be completed over the next 12 months. It will be monitored and reported via the People and OD group on a regular basis.

Additional wellbeing actions:

Wellbeing Conversation Training – Continuing to train managers and asking for feedback on sessions. 10 managers have been trained over the last two months with more sessions booked monthly.

Screen – Wellbeing Room – The screen has been fitted and information has been shared with the IT team to display. The screen will have tiles which colleagues can use to access different information such as Wellbeing Signposting, Mental Health Support and Mindfulness. The Trust is engaging will colleagues as to what they would like on there, we can also add different support in the future.

Menopause Training – Managers Session 7th February and General Awareness Session 27th February.

Health Kiosk – This was installed as part of Wellbeing Week; it was situated outside Café Royale. Colleagues could check their BMI by measuring their height and weight and could also check their blood pressure and body fat mass. There was also a survey on stress. There was help and support available at the end of the process. The Trust will be able to gain feedback from colleagues as the machine has a survey inbuilt into the questions.

International Nurses Event – wellbeing session delivered to around 35 international nurses.

Christmas Hampers – departments collected items using the reverse advent calendar within their teams. These were then delivered to the Knowledge Hub where a team put the hampers together. The Trust was able to make 25 hampers for the local community as well as three big boxes of toys.

Post Graduate Doctors – new support had been added to the PGD lounge and shared on the PGD meeting.

Laura Tilley-Hood

Engagement and Wellbeing Officer

February 2024

REPORT REF: ROHTB (2/24) 003

TRUST BOARD

DOCUMENT TITLE:	The RACE Equality Code Adoption
SPONSOR (EXECUTIVE DIRECTOR):	Jo Williams, CEO
AUTHOR:	Sharon Malhi, Chief People Officer
PRESENTED BY:	Sharon Malhi, Chief People Officer
DATE OF MEETING:	7 February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Introduction

The RACE Equality Code is designed to help organisations tackle boardroom race equality and make their leadership more representative of the communities they serve. It was launched as part of Black History Month 2020 by Dr Karl George MBE and a national steering group of experts in governance and racial inequalities.

It provides one set of standards and an accountability framework based on the latest laws, codes and best practice, and turns existing recommendations into real action that organisations across every sector can take. This is shown by its 4-key Principles: Reporting, Actions, Composition and Education. As the strategic voice, the board of directors (or equivalent) will have the opportunity to use the 4-key Principles of the Code as the core agenda for change. This includes taking responsibility for ensuring that the principles are implemented in a meaningful and considered manner and that the Board are regularly sighted on progress.

Organisations that use the RACE Equality Code to create real and lasting change are awarded the RACE Equality Code Mark. To receive the accreditation, organisations have to go through an in-depth assessment and develop an action plan to demonstrate that it encourages racial equality and the work that is being undertaken to further improve and support its diverse workforce. As part of the assessment process and before they are granted use of the mark, organisations must show that they meet the standards for each of the RACE principles and have an action plan to tackle areas of improvement. A RACE action plan will include measures for publicly reporting on progress, improving HR practices, increasing diversity at senior levels and educating staff on racial inequality.

What makes the Code unique is its 'apply and explain' approach to examining the main principles identified above. Organisations will then be guided through a series of 'Must' 'Should' and 'Could' elements. They will be shown what they MUST do; these requirements are essential. The things that they SHOULD do to meet good governance standards and if organisations do not meet these requirements they must explain why. Finally there are COULD items, which not all organisations will be able to apply, depending on their size, sector and structure.

The RACE Equality Code provides us with the opportunity to use a robust and comprehensive framework of measures and a methodology for transparent implementation of actions to which the organisation can demonstrate accountability.

Background

Ethnic Minority' Communities are 'majority' communities (over 70% in 3 Birmingham constituencies and 20% in Solihull) in many parts of BSol ICS (Birmingham and Solihull Integrated Care System) however there continues to be under representation at senior levels within health and social care.

Qualitative and Quantitative data from WRES, Staff Surveys and feedback through the Open Conversation which was held across the ICS in October 2023 indicates that further work is still required across the ICS to address issues around senior level representation.

The ICB have adopted the RACE Equality Code as a commitment to advancing Race Equality and ensuring that representation at senior levels of health and social care is reflective of the population of Birmingham and Solihull. The ICB have asked that all partner health organisations adopt the code to demonstrate a joint commitment to advancing race equality within BSOL and to combine efforts to reduce inequalities within the system.

CEOs across the system have agreed that the recommendation to adopt the Code will be shared across relevant Trust Boards given that adoption of the Code requires Board level buy in and commitment.

Several partner organisations within BSOL and the West Midlands have already adopted the Code (early adopters of the Code are included on page 32 of the attached appendix).

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• N/A	• N/A
NOT APPLICABLE	X

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board are asked to review the attached Race Equality Code and share views on the recommendation to adopt this Code at The Royal Orthopaedic Hospital NHS Foundation Trust.

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	x	Environmental/Net Zero		Communications & Media	x
Business and market share	x	Legal, Policy & Governance		Patient Experience	x

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

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

People Plan
Health Inequalities Plan
WRES Indicators

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

Birmingham and Solihull Integrated Care Strategy
Birmingham and Solihull DRAFT EDI Strategy
Reducing Health Inequalities Strategy

PREVIOUS CONSIDERATION:

Trust Board April 2022 (compliments the Board feedback sessions about Race Equality within the Trust; Inclusion Action Plan)
Staff Experience and OD Committee January 2024

The **RACE Equality** Code

DECEMBER **2021 | v2**

The **RACE Equality** Code

CONTENTS

INTRODUCTION

Now is the time to dismantle structural racism once and for all. The long-overdue need to tackle a woeful lack of racial diversity in the leadership of many of our organisations, is finally getting the attention it deserves.

We are living in a rapidly developing global business environment where technological advances, climate change, the current pandemic and civil activism, are the order of the day. Our global and national economies are underpinned by having successful and sustainable businesses, that are able to navigate this complex convergence of the new global realities that we face. Integrated, transparent reporting and constructive stakeholder engagement are critical components of ethical, informed and diverse leadership.

I would contend that the business of the future will not only embrace the skills of the millennial generation, (who will be in the majority over the next 10 years), and gender diversity, but the next bastion that needs to be tackled is Race and ultimately cognition.

Governance is "the system by which companies are directed and controlled..."as defined as far back as 1992 by Sir Adrian Cadbury. What is widely recognised across jurisdictions around the world and across the private, public and voluntary sector in the UK is, if you want a robust mechanism of transparency and accountability, then having a governance code which looks at best practice and a principle-based approach, creates that environment. In my opinion if we are to have an impact on the structural aspects of racism, we should adopt a similar strategy, and have a robust governance framework.

So, what are the systems that direct and control race equity and how can we develop a principle-based approach to tackling them?

We must find a framework that recognises that it is the governance of business ethics, business culture and attitudes to corporate social responsibility, that ultimately provide the results that we want. We want organisations to be responsible for outputs i.e. an increase in an organisation's performance and cohesive and inclusive culture. However, we are measuring a number of inputs, i.e. representation of Black people on the board, Black candidates interviewed, number of people who have attended anti–racism training and a reduction in micro-aggressions.

> *"separate inputs from outputs, and hold yourself accountable for progress in outputs, even if those outputs defy measurement"* - **Jim Collins**

The RACE Equality Code provides us with the opportunity to use a robust and comprehensive framework of measures and a methodology for transparent implementation of actions to which an organisation can demonstrate accountability.

Across the decades, many reports and reviews have tried to tackle race inequality and discrimination in the boardroom and the workforce.

They have all made valid recommendations and some progress has been achieved. The case for diversity and inclusion is now better established, but have charters, pledges or guidance notes succeeded in bringing about real and lasting change?

Racial tensions are being played out across the world. In 2020 we have seen the death of George Floyd, in America, and the increasing momentum of the Black Lives Matter movement, bring fresh focus and impetus of the need to address racism, discrimination and injustice once and for all.

One year on we are still tackling shocking and abhorrent racist behaviour. To take one recent example – Yorkshire Cricket Club – the club, the membership body and the governing body all seem to have failed miserably to protect an individual from systemic racism and then, when confronted, displayed a cognitive dissonance which led to another failure to address a toxic culture that has been allowed to thrive.

We must have robust procedures to put more Black people into leadership roles and make organisations accountable through what they publicly report. **That is the driving force behind this new Code.**

"Why, when these behaviours came to light, was there no examination of the governance structures that had allowed this to happen? Those same structures did nothing to address racism when it reared its ugly head."

Real change only happens when you are able to influence leadership - the board and executive management - and hold organisations to account. So, the focus of this new and very first RACE Equality Code is firmly on how we deal with race inequity in the boardrooms and senior leadership teams of the UK.

We must have robust procedures to put more Black and other ethnic people into leadership roles and make organisations accountable through what they publicly report. That is the driving force behind this new Code.Some of the wholly unacceptable statistics that emphasise the need for this focus include:

- Black workers with degrees earn 23.1% less on average than white workers.
- Just 6% of Black school leavers attended a Russell Group university, compared with 12% of mixed and Asian school leavers and 11% of white school leavers.
- In Britain, only 5.7% of Black people work as managers, directors and senior officials, compared with 10.7% of white people.
- Black people who leave school with A-levels typically get paid 14.3% less than their white peers.
- Unemployment rates were significantly higher for ethnic minorities at 12.9 per cent compared with 6.3 per cent for White people
- In Britain, significantly lower percentages of ethnic minorities (8.8 per cent) worked as managers, directors and senior officials, compared with White people (10.7 per cent)

The Parker Review was formed to consult on the ethnic diversity of company boards and published its first report in 2017. Since then, an 11 additional FTSE 100 companies now have a non-white director on their board, taking the total number of boards with diverse racial representation to just 37%. In the final quarter of 2020, almost 70% of FTSE 250 companies still have no diversity of race on their boards.

But we have now reached the tipping point where this unjust situation will no longer be tolerated. We are seeing some influential organisations move from 'calling' for change to 'insisting' on it. In October 2020, Legal & General, one of Britain's biggest investment companies, demanded that all FTSE 100 companies hire a non-white director by 2022. Legal & General owns up to 3% of every British blue-chip firm as part of its management of £1.2 trillion-worth of pension funds. It has written to all FTSE 100 members, as well as those in the US S&P 500 index, telling them it expects companies to have at least one Black, Asian, or other ethnic director by 1st January 2022. It says it will vote against the re-election of the Nomination Committee Chair, who are responsible for board appointments, in any companies that fail to meet the target.

The full and equal participation and progression of Black people in senior leadership roles would bring huge benefits, socially, culturally and financially. There is conclusive evidence that organisations with diverse boards and senior leadership teams are more successful. The potential benefit to the UK economy from full representation of race across the labour market, through improved participation and progression is estimated to be £24 billion per year, which represents 1.3% of GDP.

After studying as many reports, reviews and codes as I could get my hands on and more than 200 recommendations - I have developed a single Code providing one set of standards, applicable to any and every organisation irrespective of size or sector, and aimed at delivering real change.

Organisations can carry out a self-assessment against the Code requirements to find out what their targets should be and then put together an action plan to meet them. Finally, they must report regularly on their progress.

This is not in competition with other codes and it's not to say that other charters, pledges and recommendations have been wrong. This Code brings together all the best practice from across the years in one place and builds on it. It adopts a simple but robust 'apply and explain' approach, meaning that the Code can be integrated easily into any organisation's governance framework.

Karl George MBE

Race Report Statistics – Healing a Divided Britain

THE PRINCIPLES

THE **RACE CODE** PRINCIPLES

Words count for nothing without action. That is why the RACE Equality Code is not 'just another code'. This Code, and its accountability framework, is designed to provide organisations across all sectors and sizes, with the opportunity to address a very specific challenge. This is shown by its 4-key Principles: **Reporting, Actions, Composition and Education.**

As the strategic voice, the board of directors (or equivalent) will have the opportunity to use the 4-key Principles of the Code as the core agenda for change. This includes taking responsibility for ensuring that the principles are implemented in a meaningful and considered manner.

PRINCIPLE 1 – **REPORTING**

There must be a clear commitment to be transparent and to disclose all required information and updates on the progress of race initiatives across the organisation. Openness and transparency, for all stakeholders, must be valued and actively pursued in order to create the environment for change.

The fundamental role of high-quality and consistent reporting in the push for racial equity, cannot be understated. Initiatives and programmes aimed at creating greater racial equity need to be tracked and assessed, as do the extent to which the objectives are achieved on a consistent basis. Effective and diligent reporting, and the consistent tracking of initiatives and programmes over time, demonstrates that the organisation is whole-heartedly committed to racial equality.

The 'how', 'where' and 'when' of reporting on race initiatives and programmes is important. Different organisations may have different outputs, but the purpose must be the same. That purpose is to create an enabling environment for racial equity in each organisation and to advance the mission of racial justice. These will, in turn, serve to strengthen the organisation and render it more agile, more resilient, more transparent and fitter for its transformative purpose.

How: The way an organisation chooses to report the progress of its efforts is expected to be information-rich and not simply a presentation of data. Effective presentations are likely to include colourful or interactive charts, but whatever format is chosen, they must be easily accessible and readable. Reports are expected to be user-friendly and clear with full attention paid to their purpose. Reports should inform stakeholders with the ultimate aim of improving decision-making on matters of racial equity.

Where: Where the report will be displayed and made accessible is an important element of transparency. It is expected that reports will be clearly visible and accessible, available for analysis and to provide guidance to boards and other stakeholders. Reports showing the progress of race initiatives are expected to be on websites, in annual or quarterly reports, staff reports and other pertinent publications and documents. This is

consistent with the requirement of the UK Corporate Governance Code for FTSE 350 companies (Provision 23), and reiterated by The Parker Review Committee (The Parker Review, 2020). Whereas the UK Corporate Governance Code and the Parker Review related this to the broader remit of diversity and inclusion, this RACE Equality Code is advocating that the reporting relates specifically to Black and other ethnic inclusion.

When: The frequency of reporting on race initiatives may vary from one organisation to another and may be the product of internal or external factors. Whether the reports will be published monthly, quarterly or annually, the driving imperative will be the production of information and assessments, that can inform understanding of the progress that is being made in the drive for racial equity. Annual reports are where most stakeholders, including auditors and regulators, look to ascertain what is important to the organisation (Parker Review, 2017). The publishing of an annual report is a major undertaking by any organisation, regardless of its size.

What: The publishing of targets must also include those targets that have been missed. This will allow for better monitoring by auditors. This would also provide the organisation with a more meaningful guide to how it achieves the full inclusion of Black and other ethnic people and brings about racial equality.

Who: The target audience of the report must be identified, as this informs both the actual detail in the report and how this information is presented. The audience will include, amongst others; board members, staff, customers, regulatory authorities and the public.

PRINCIPLE 2 – **ACTION**

It is necessary for each organisation, that wants to achieve real change, to set clear objectives. It must have a list of the measurable actions and outcomes that contribute to, and enable a shift in, the organisation's approach to successfully delivering change. Without a set of targets and detailed plans for their achievement, change will not happen and it becomes harder to hold organisations accountable. Organisations should ensure that they are aware of what actions will have the most impact and these should be prioritised with the necessary resources for their achievement.

The continued absence of actions and targets will promote confusion, which in turn perpetuates discrimination, injustice and racial inequality. Actions are the steps by which the organisation will rise above these persistent afflictions and achieve the goals of justice and equity. Actions and actionable targets provide clarity at every level of the organisation and increase accountability from the boardroom to the proverbial cloakroom. The outlining of actions supports target-setting and also helps with the regular reporting, which we have already demonstrated is an essential element in the push for organisational change.

Since the earliest days of anti-racism campaigning in the UK, there has been much talk and, sadly, too little action. The rhetoric of equality often overshadows the need for action and change. This situation became the norm, forcing the recommendations that came from the Dame McGregor-Smith Review, which boldly declared, "The time for talking is over.

PRINCIPLE 2 – **ACTION**

Now is the time to act". Setting out the actions to be taken, removes the veneer of historical achievement that is often cited to deflect criticism and delay change. Nowhere is there greater proof of the maxim that 'talk is cheap' than in the continued need for racial justice and equity in the UK. Reports, reviews and recommendations are too many to mention, but action has been woefully short.

The RACE Equality Code endorses the recommendation of the Business in the Community's - Race at Work Charter principle of assigning an executive sponsor for race, to provide visible leadership. This recommendation is again reiterated by the organisation's 2020 publication. The NHS has also cited the need for sponsors in its bid to increase ethnic minority representation. The RACE Code argues that for meaningful actions to be taken, the responsibility must lie with someone at the highest level of decision-making ie the board. This action would show all stakeholders that the organisation is serious about making change and progress, and willing to be held accountable for its actions.

Now is the time for organisations to focus on clear, measurable, time bound actions that will support the objectives aimed at achieving racial equity.

PRINCIPLE 3 – **COMPOSITION**

This RACE Code places a premium on the composition component of the approach. In this, the emphasis is on establishing a series of indicators that will provide a measure of the organisation's progress, or lack of progress. Targets and objectives are great to have, but, without distinct and definitive data it is impossible to measure progress and so tackle inequality and inequity. Therefore, it is vital to identify the key indicators that will make a real impact over the long-term, creating tangible differences to the existing landscape around race diversity of the board and senior leadership team. The narrative around what is acceptable needs to change through dialogue, and this may lead to uncomfortable, but necessary decisions which the organisation is committed to having, hearing and making. From the McGregor-Smith Review, to the most recent Business in the Community report, the importance of data is championed. For this Code, composition goes to the very heart of what organisations need to do.

The founders of the Black British Business Award programme noted the important place that data holds in increasing transparency. The RACE Code concurs with this position, while insisting that organisations must be willing to confront the hard reality that data often shows as the organisation pushes for racial equity and equality. In order for this to take place it must be the right data. Organisations must put effort into not only the collection of the data, but also the type of data that is being asked of employees and stakeholders. This relates directly to what is being measured. From recruitment to pay levels (and hence ethnic pay gaps), the right questions must be asked in order to get to the data and information that will inform the discussions.

Employers continue to be urged to encourage their staff to participate in data-collecting exercises, including surveys and

focus group discussions. This also requires employers to create an environment in which employees will feel confident that this is a worthwhile exercise, and nothing does this better than for them to see results and improvement. Every effort must also be made to ensure that all the relevant data is complete and updated regularly. One example of an attempt to consistently improve and increase the range of indicators and data, is provided by the NHS Workforce Race Equality Standards, as it provides a picture of advances in the workforce equality agenda, using data gleaned from across the organisations.

The RACE Code recognises the urgency that exists and the opportunity to use data to have conversations about improving Black engagement and progress at every level within the organisation, but especially at board and senior leadership levels.

PRINCIPLE 4 – **EDUCATION**

The highest purpose of education is to create positive change and improvement. The pursuit of racial justice and equity requires education. Developing a robust education framework that presents the ethical and moral reasoning, behind a programme of training for every organisation, (using the RACE Code Principles) is an imperative. Perspectives need to be challenged. Prejudices, as well as systemic and institutional practices, must be acknowledged and abandoned.

The recommendations presented by Dame McGregor-Smith concluded that relevant training was essential for all managers in the workplace. Particular attention was paid to unconscious bias. This Code is advocating compulsory race training and deep dives into the prejudices, rationale, machinations and effects of race and cultural superiority notions. The dismantling of deep-seated ideas is not easily done. While this is ongoing, training around positive action by organisations must also be encouraged and instituted. The RACE Code sees much value in programmes of reverse networking aimed at empowering Black and other ethnic employees and workers. These actions can see high levels of engagement, increased productivity and retention, as well as community-wide empowerment via multiplier effects.

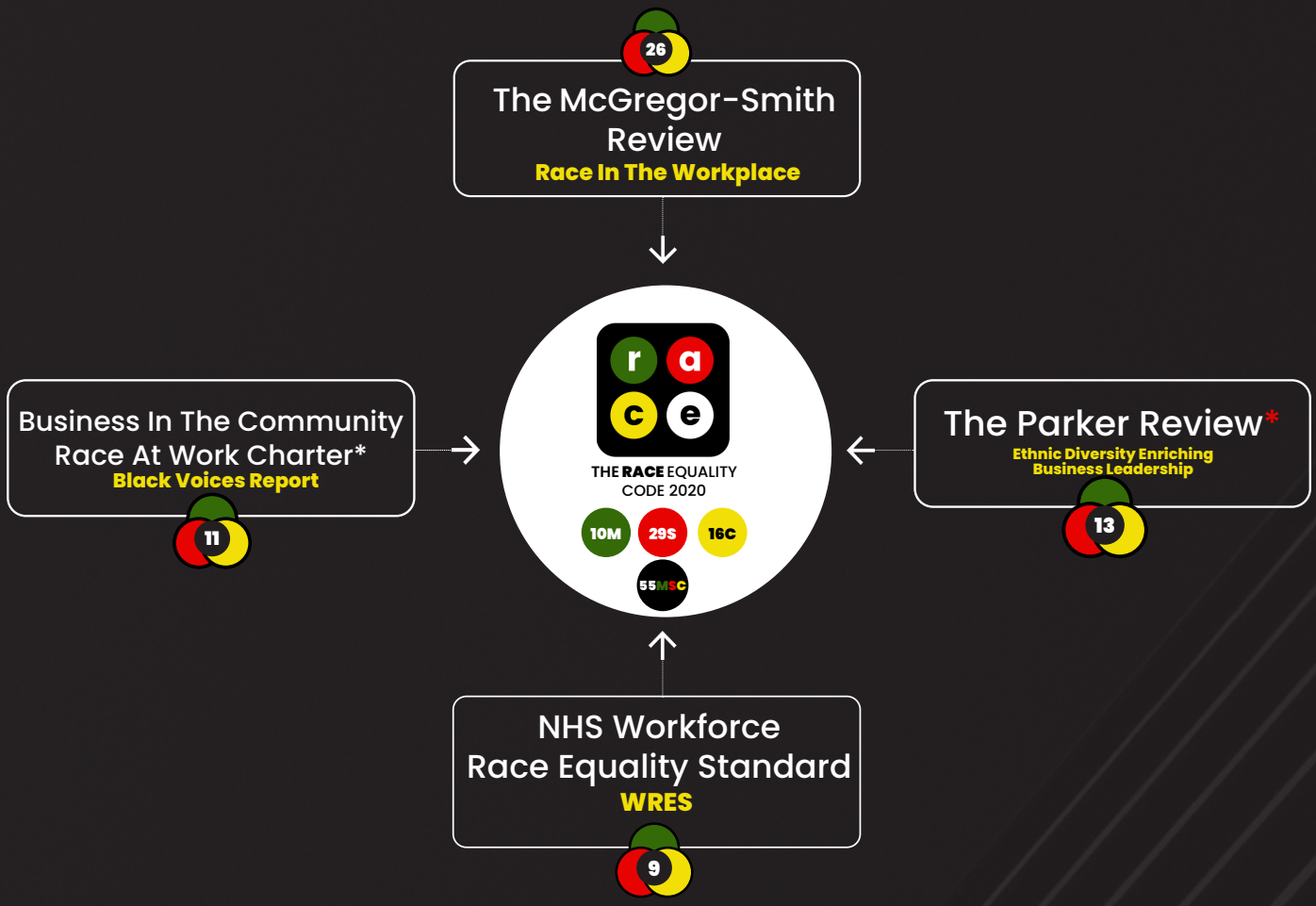
The value of group dynamics and relations is highly rated in the workplace. Group understanding must be leveraged to improve the effects on Black employees and workers. Learning opportunities must be created for meaningful inter-group interactions between Black employees and non-Black managers and executives. The principles of lifelong learning must be applied to race-related education for managers and executives for there to be meaningful change. From workshops, to lectures to intergroup sessions, regardless of the forms that these programmes of learning will take, the end result and key objectives must always be borne in mind and clearly relayed. This is about making the change; shifting away from the norm to a new level of engagement and substantial empowerment of not only Black staff but all stakeholders in the organisation.

Education has the greatest potential to effect the paradigm shift and break down the mental, cultural and institutional barriers to true racial equality and inequity.

PRINCIPLE 4 - **EDUCATION**

Changing attitudes through learning bears as much relevance to executives of an organisation as to pupils in a school setting. Because prejudice and bias are the product of culture and misguided perceptions developed over time, education must be ongoing and thorough for change to take place. It is now commonly accepted that correction to implicit bias takes time, requiring attention and understanding. It is clear that attention to racial equity and gaining understanding of the reason and need for it, in turn requires commitment, investment of resources and empathy. The potential gains in the drive for equality means that education is a pressing imperative that must be reflected by the seriousness and commitment paid by executives at the highest levels.

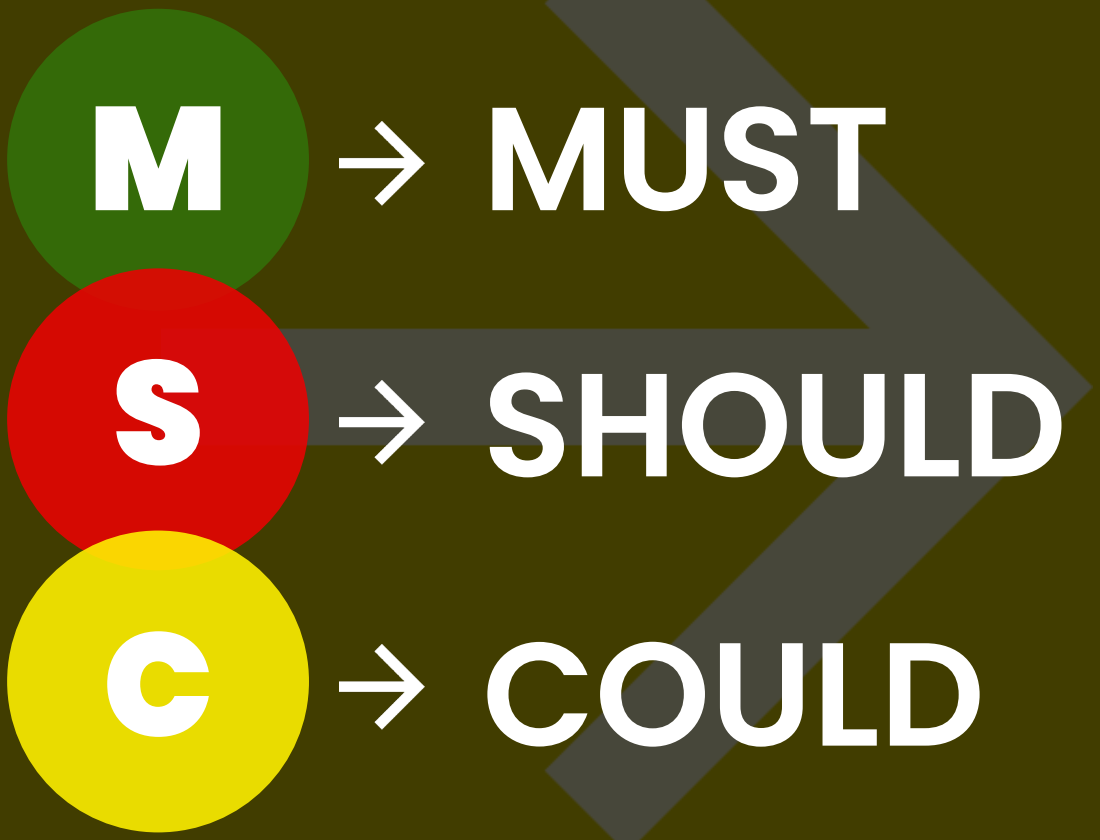
CONSOLIDATION



Black FE Leadership Group ✔
U.K Music - 10 Point Plan ✔
Commonwealth Games 2022 - 10 Point Plan ✔
Diversity In The Boardroom ✔
Rare - The Race Fairness Commitment ✔
The Diversity & Inclusion Charter ✔
Race Equality Matters ✔
CBI - Change The Race Ratio ✔
The FA Football Leadership Diversity Code ✔

*Includes latest updates

PROVISIONS



* "Senior Leadership Team" is used to refer to Directors and C-Suite Officers, "EDI" means Equality, Diversity, and Inclusion. Throughout the Code we refer to "underrepresented groups", meaning those groups which have a lower representation in the organisation and particularly in leadership and management roles, than the national or regional demographic.

* There are six occasions in this Code where we have a provision relating only to black employees this is for the purposes of benchmarking, targeting a specific data set for research and keeping to the integrity of the origin of the development of the Code.

→ REPORTING

A clear commitment to be transparent to all stakeholders through the disclosure of required, concise and current information on the progress and impact of race initiatives across the the organisation. Openness and transparency will be actively pursued and valued in order to create the right environment for change.

R1 Publish relevant data on diversity and specifically racial diversity in annual reporting.

- Description of Board's policy on overall diversity to be simple and compelling.
- Board race diversity.
- Senior Leadership Team race diversity.
- Measurable race diversity targets including Board and Senior Leadership Team composition recommendations.
- Steps being taken to improve race diversity within the organisation and the results of any initiatives taken.
- Breakdown of employees by race and pay band.

R2 Document and report the organisation's race strategy, which should:

- Highlight the approach to integrating race within the overall EDI strategy.
- Include the necessary resources (including a ringfenced budget).
- Include Board-level commitment to transformational change.

R3 Publish the organisation's commitments to tackling race inequity, including an anti-racism statement to promote zero tolerance of racism, harassment and bullying:

- Identify clear consequences for those that do not adhere.

R4 Publish details of the organisation's approach to achieving race equity within the Annual Report (or similar published document):

- Include how the organisation has integrated achieving race equity into the organisation's values, purpose and strategy.
- Report annually on progress in meeting targets.
- Clarify the role and remit of the nomination committee in relation to diversity and board appointments and its disclosure requirements.

R5 Present to the Board on annual basis:

- The process used in the recruitment of Board members and the Senior Leadership Team.
- The policy in relation to the ethnic diversity of Board members and the Senior Leadership Team.
- The outcome of the measurable objectives in relation implementing policy to diversity and the progress of these objectives.
- The statistical information about the ethnic diversity of the Board members to inform the Diversity in the Boardroom annual report.
- The work of the nomination committee in relation to board appointments.

→ REPORTING CONTINUED

MUST SHOULD COULD

R6 Publish within the Chair and/or CEO statements in the Annual Report (or similar published document), specific comment on the steps being taken by the organisation to improve ethnic diversity.

- ➤ Such comments should make specific reference to the number of Black people in leadership where the data suggests there is a lack of representation.

→ ACTION

A list of the measurable actions and outcomes that contribute to, and enable a shift in the organisation's approach to be delivering positive and sustainable change in race equity and equality. Without a set of targets and detailed plans for their achievement, real change will not happen, and organisations will not be accountable.

A1 Take positive action to improve ethnicity reporting rates and collection of data, i.e.,

- ➤ Communicate the importance of reporting to the workforce through events, seminars and newsletters.
- ➤ Engage an executive sponsor who monitors reporting rates and ensures relevant data is being collected.
- ➤ Use HR data to drill down across different racial groups and intersectionality.

A2 Identify Board and executive level sponsors/champions for race and accountability in governance. These individuals should be responsible for:

- ➤ The monitoring of setting and overall delivery of a robust action plan including race diversity targets, on behalf of the Board.
- ➤ On meeting race diversity targets ensure the board has actively considered how to make diverse new starters (whether internally promoted or externally recruited) welcome and empowered to contribute
- ➤ The race objectives should connect to the overall mission and strategic objectives Ensuring there is accountability across governance structures.
- ➤ Ensuring appropriate mentoring and sponsorship is in place.
- ➤ Working with the relevant staff networks and resource groups.

A3 Ensure all elements of rewards and recognitions are fair and reflect racial diversity, i.e..,

- ➤ Leaders should have a clear and measurable diversity objective in their annual appraisal.
- ➤ Review employee life-cycle outcomes, checking recruitment, progression, appraisal, bonuses and achievement of high-profile jobs.
- ➤ Practise the fair distribution of high-visibility work and stretch assignments and holding managers accountable for how they allocate such work.
- ➤ Ensure there are transparent career pathways.

A4 Include diversity objectives and, in particular, race objectives, in the Board evaluation process, i.e..,

- ➤ Ensuring that evaluations are directly linked to performance, in the overall diversity and inclusion strategy.
- ➤ Measure progress against race and other EDI objectives.
- ➤ How successful have you been in ensuring the race objectives are embraced across the organisation.
- ➤ Use a board evaluation to assess the balance of skill, experience and knowledge on the board and to obtain information about its diversity composition.

→ ACTION CONTINUED

A5 Grow diverse talent through the support of employees and the talent pipeline, to reach the top of the organisation, ie.,

- ➤ Take action to support Black people with their career progression, specifically talent at middle and senior levels.
- ➤ Ensure Black people performing at a certain level, are as likely to be promoted as their non-Black counterparts, performing at the same level.

A6 Ensure formal interview processes are held for all roles by:

- ➤ Ensuring proportional representation on long and short recruitment/selection lists.
- ➤ Rejecting lists that do not reflect the local and/or stakeholder working age population.
- ➤ Conduct a review process to check the quality of decision making before finalising long and shirt lists where candidates from underrepresented groups have been disproportionately unsuccessful.
- ➤ Examine all components of recruitment from inception of post right through to progression examining best practise at every stage.

A7 Improve diversity in the talent pipeline, including:

- ➤ Implementing a robust talent management strategy to fill current senior vacancies and future leadership pipelines.
- ➤ Embedding mentoring and sponsorship schemes in the organisation.
- ➤ Ensuring all new entrants to the organisation receive a proper induction, which includes clear and transparent information on career pathways.
- ➤ Identifying ways to increase participation levels from underrepresented groups of students in key programmes.

A8 Measure the effectiveness of mechanisms to identify, develop and promote Black and other ethnic group employees, including:

- ➤ Focusing on creating a pipeline of Board-capable candidates.
- ➤ Reviewing and monitoring that the Senior Leadership Team appropriately reflects the diversity to the organisation.

A9 Review governing documents to ensure race is fundamentally and consistently embedded.

- ➤ Ensure accountabilities and responsibilities for race are documented in role descriptions for board and senior management.
- ➤ Ensure discourse on race inform Board and Committee discussions and decisions.
- ➤ Regularly review policies, processes and behaviours to make certain that race equity is embedded.

→ ACTION CONTINUED

A10 Have an accountability framework in place to ensure clear accountability for the performance criteria and targets that have been set for race equality, to include:

- Racial diversity objectives for Board members and Senior Leadership Team members.
- Performance criteria with targets monitored, including mandatory content and frequency of reporting to the Board.
- How Board and Senior Leadership Team actions, as a result of monitoring, are reported.

A11 Make clear that supporting equality in the workplace is the responsibility of all leaders and managers through:

- Integrating equality into performance reviews and remuneration.
- Including a clear race diversity objective in all leaders' annual objective setting/ appraisal (covering their responsibility to support fairness for all staff).
- Include race diversity as a key performance indicator for all leaders (to ensure that they take positive action seriously).

A12 Use relevant and appropriate imagery and language in recruitment campaigns, including adverts and job specifications to ensure applications from a wider set of individuals and ethnicities.

- Write adverts and job specifications in plain English and provide an accurate reflection of essential and desirable skills.

A13 Nomination Committee to be mindful of their EDI responsibilities when overseeing new Board appointments by:

- Requiring HR teams to identify and present qualified Black people and other ethnic groups, for consideration for Board appointments when vacancies occur.
- Ensure they are involved in the appointments process alongside the chair.
- Require search firms (as applicable) to identify and present qualified Black people and other ethnic groups, for consideration for Board appointments when vacancies occur.
- Ensure roles descriptions describe necessary skills, experience, knowledge and personal qualities for the role

→ ACTION CONTINUED

MUST SHOULD COULD

A14 Ensure that any executive search firm used by the organisation:

- ➤ Adheres to the relevant principles of Standard Voluntary Code of Conduct (SVCC) for Executive Search Firms.
- ➤ Applies the SVCC Code principles on a similar basis to the recruitment of Black and other diverse candidates.
- ➤ Is provided with a clear brief and targets.
- ➤ Is demonstrably proactive and has a track record in identifying and marketing talented Black candidates.
- ➤ Can demonstrate its effectiveness in improving diversity in appointments.
- ➤ Identify ways of attracting candidates from underrepresented groups and question them if the candidate list is not diverse.

A15 Ensure existing Board Directors mentor and/or sponsor Black employees within the organisation, to ensure their readiness to assume senior leadership positions internally.

A16 Ensure candidate pools are ethnically diverse by:

- ➤ Using a Market Map to identify roles with the most potential for ethnically diverse candidates.
- ➤ Targeting networks and connectors as part of the recruitment campaign.
- ➤ Reaching out to diverse recruitment channels and advertise widely.
- ➤ Regularly review diversity in the organisation's recruitment, development and retention strategy

A17 Involve underrepresented groups throughout the decision-making process in the workplace, including:

- ➤ Convening conversations and actively listening.
- ➤ Making plans on agreed actions.

A18 Ensure the panel in the interview process is ethnically diverse and,

- ➤ Ensure that the selection and interview process is undertaken by more than one person.
- ➤ Include individuals from underrepresented backgrounds to help eliminate bias.
- ➤ Ensure at least one person on the panel has undertaken recruitment and selection training.
- ➤ Consider including external independent experts on the selection panel.

→ ACTION CONTINUED

A19 Identify and develop a pool of Black and individuals from diverse backgrounds with potential or hold management positions as part of a cross-sector sponsorship/mentoring programme.

A20 Encourage and support candidates developing oversight, leadership and stewardship skills drawn from diverse backgrounds, to carry out activity that will enable them to compete on merit and provide them with development time to:

- Take on board roles internally (e.g. within subsidiaries) where appropriate, observe board meetings, as well as board and trustee roles with external organisations.
- Undertake training, leadership and development programmes that provide the necessary skills.

A21 Adopt the Race at Work Charter, or similar sector specific guide, and commit to the actions promoting race equality.

A22 Seek out opportunities to provide work experience to a more diverse group of individuals by,

- Looking for opportunities beyond the standard social demographic.
- Ceasing the practice of unpaid or unadvertised internships.

A23 Critically examine organisational entry requirements to ensure that the organisation focuses on potential achievement.

- Ensure that entry requirements do not place too much weight on which university or school the individual attended for their education.

A24 Use contracts and supply chains to promote diversity to ensure that contracts are awarded to bidders who show a real commitment to race diversity and inclusion.

→ COMPOSITION

A set of key indicators that create tangible differences in race diversity across all levels of the organisation. The narrative around what is acceptable will need to change through dialogue and data, and this will lead to challenging conversations leading to necessary decisions which the organisation is committed to making.

MUST SHOULD COULD

C1 Capture the relevant data required to report effectively on racial diversity, i.e.,

- Description of Board's policy on overall diversity.
- Board race diversity.
- Senior Leadership Team race diversity.
- Steps being taken to improve race diversity within the organisation and the results of any initiatives taken.
- Breakdown of employees by race and pay band.
- Any baseline data or gaps identified when considering data on progression, retention and other relevant statistics.

C2 Set clear race diversity objectives and relevant/appropriate targets, i.e.,

- Set general diversity and inclusion Key Performance Indicators.
- All senior leaders should have clear objectives in their annual appraisal, focusing on ethnic representation and progression.
- Measurable race diversity targets, including Board and Senior Leadership Team composition recommendations.
- Include race diversity as a Key Performance Indicator with stretching targets.
- Establish which areas of the business have barriers to progression or low levels of retention for Black and other ethnic employees.
- Collect HR data to drill down across different racial groups and intersectionality. Measure how achieving race objectives impacts internal rewards and recognition

C3 Set clear targets to increase race diversity on the Board and management teams, in particular:

- Having no less than one Black Board member and one Black member of the Senior Leadership Team within one year of adoption of the Code.
- Documenting and implementing a recruitment strategy to increase Black representation on the Board and management teams.
- Where the size of the organisation means this is not practical, then shadowing and co-opting or similar methods can be explored to demonstrate compliance.

C4 Use HR data to calculate proportional representation of race at all levels within the hierarchy of the organisation (including the Board and management teams), compared with the organisation as a whole.

- Use the data to inform the strategy and produce comprehensive management information.
  Use Census categories to capture HR data.

→ COMPOSITION CONTINUED

MUST SHOULD COULD

C5 Record the proportion of employees by race who have reported experiencing the following during their course of employment, in the preceding 12 months:

- ➤ Harassment, bullying or abuse from employees in the organisation.
- ➤ Harassment, bullying or abuse from individuals who work with the organisation, but are not employees of the organisation.
- ➤ Any form of discrimination.
- ➤ Formal disciplinary proceedings.

C6 Record the proportion of applicants by race shortlisted for recruitment across all posts within the organisation.

C7 Ensure all work experience opportunities promoted to underrepresented groups, are documented and measured.

C8 Record the proportion of employees by race attending non-mandatory race awareness and diversity training courses and take positive action to improve attendance by all staff.

C9 Record percentage of staff (diverse and White) believing that their organisation provides equal opportunities for career progression or promotion.

C10 Monitor ethnic representation at all stages of the recruitment process (including at application, shortlisting, interview and appointment).

C11 Identify areas in the business where there is underrepresentation and retention of Black and other ethnic groups of staff, compared with staff of white ethnicity.

→ EDUCATION

A robust organisational framework that develops the ethical, moral, social, and business reasoning for race diversity at all levels of the organisation. This will be underpinned by inclusive and embedded programmes of continuous professional development (using the Principles) through which perspectives and prejudices will need to be challenged, and systemic and institutional practices acknowledged.

MUST SHOULD COULD

E1 Explain the legal equality framework and the benefits of capturing data on ethnicity, to all employees appropriate to their role and responsibilities.

- Provide HR policies and training in respect of the Equality Act, the need for any D&I training to be fit for purpose and the seriousness of any sort of discrimination.
- Provide training to all leaders so that they are aware of the roles and responsibility in respect of race equality, to ensure this is taken seriously.
- Implement a detailed communications plan aimed at increasing disclosure rates.

E2 Build psychological safety in boards and throughout the organisation to create a positive culture and educational framework around race, i.e.,

- Hold focus groups/listening sessions, to better understand the issues.
- Clear directions and engagement should be provided from the leadership, to create a positive and belonging culture.
- Review inclusive leadership or similar training programmes to ensure that negative behaviour is challenged.
- To participate in Safe Space sessions and monitor outcomes.
- Bring race objectives to life with clear, compelling, communication and strategy.
- Promote and make accessible information on race issues and best practise in diversity

E3 Establish formal race diversity networks and consult with the networks as appropriate and encourage individuals to participate and use the networks to provide education opportunities.

- Where organisations are not big enough or sufficiently representative, they may join the networks of other organisations, or provide other forums.
- Ensure networks are supported by senior level employees and are included in the overall governance structure.

E4 Require all employees to undertake mandatory training which includes;

- Bullying and harassment, and how it relates to culture, race awareness and diversity.
- How to interpret and use data in regard to equality and inclusion.

→ EDUCATION CONTINUED

E5 Explain to all members of the board and management teams that it is a requirement of their role to promote and support race equality within the organisation:

- ➤ Train all leaders/managers on how to set and review race equality objectives and outcomes
- ➤ Train all leaders/manager on how to support board and management teams when responsibilities or targets to support race equality are not being met
- ➤ Regular awareness training on equality, diversity and inclusion to continuously build lived experience and cultural intelligence.

E6 Provide sponsor programmes to promote Black talent in the organisation:

- ➤ Education and support should be provided to the Board and management teams in the organisation, to allow such programmes to be structured and meaningful.

E7 Promote an open culture and safe working environment at the organisation, and

- ➤ Implement race equality and diversity policies and procedures, including but not limited to reporting and whistleblowing procedures.
- ➤ Such policies and procedures should be regularly reviewed and updated.
- ➤ Organisations should regularly review and update their policies, processes and behaviours to make certain that they demonstrate and support their commitment to race diversity.

E8 Ensure the management teams, executive boards and all those with a role in the recruitment process in the organisation, undertake comprehensive race awareness and diversity training:

- ➤ Provide additional training to the mandatory race awareness and diversity training.

E9 Educate applicants at induction as to career progression routes within the organisation:

- ➤ Information should include the proportion of employees by race at each level of the hierarchy in the organisation.

E10 Ensure access to sponsor and mentor programmes is available to all employees:

- ➤ The organisation should provide all necessary resources to ensure that the programmes are structured and meaningful and actively contributing to improving underrepresentation..

→ EDUCATION CONTINUED

MUST SHOULD COULD

E11 Establish opportunities for employees from underrepresented groups to mentor members of the Board and management teams (reverse mentoring):

- ➤ This reverse mentoring is intended to enable the Board and management teams to better understand their unique challenges as well as the positive impacts from diversity.
- ➤ Ensure reverse mentoring insights gained by this process are reflected in policy, resourcing, recruitment and talent management decisions with regard to improved progression of black staff

E12 Publish job history synopses for the Board and management teams, together with narrative as to how success has been achieved to educate employees on possible career paths at the organisation.

- ➤ As the purpose is to educate staff, such information does not need to be published outside of the organisation.

E13 Provide adequate and appropriate resources for staff to promote race equality within the organisation.

- ➤ Such resources may include a central portal or virtual learning environment containing the policies and procedures, training materials and forums to improve accessibility and ensure open communication at all levels within the hierarchy of the organisation.

E14 Organisations should regularly review their policies, processes, and behaviours to make certain that they demonstrate and support their commitment to race equality;

- ➤ Consult with employee representatives, trade unions and third party organisations (as applicable), to develop procedures and policies to ensure race equality.

HOW TO ADOPT THE CODE

FRAMEWORK

INTRODUCTION

The RACE Equality Code is a governance code. In order to demonstrate compliance with the Code there are a number of procedures that should be followed. The aim is to provide organisations of all sizes and maturity and across sectors with a robust framework for developing a Race Equality Action Plan and then to ensure accountability, it is to then present it to stakeholders of the organisation.

The Code has four principles which they are expected to apply and explain and 55 provisions which they are expected to comply or explain. Any actions that arise from carrying out the diagnostic should then be used to create an action plan.

APPLY AND EXPLAIN

This approach to governance finds it origins in the King IV Report on Corporate Governance for South Africa and assumes that organisations will already be in compliance with the principles and they should move beyond a "tick box" approach by them describing how their practices achieve compliance with the principles.

COMPLY OR EXPLAIN

This approach rejects the view that "one size fits all" and was first introduced after the recommendations of the Cadbury Report of 1992. This is a regulatory approach that allows for the organisation to explain publicly why they do not comply with a provision in the Code.

BENCHMARK 10

We are currently creating a national benchmarking exercise with early adopters of the Code. Please visit the website to be part of this initiative to compare compliance with the provisions.

→ **theracecode.org**

WHAT YOU NEED TO DO

1. Read and discuss the DRIVERS these are the key concepts around Race Equality and are found on the website www.theracecode.org with your Board and Senior Leadership Team. Also take some time to consider some of the key terminology by reviewing recommended books, articles and videos on the subject. The aim is to get some consensus around the key concepts that drive this Code.

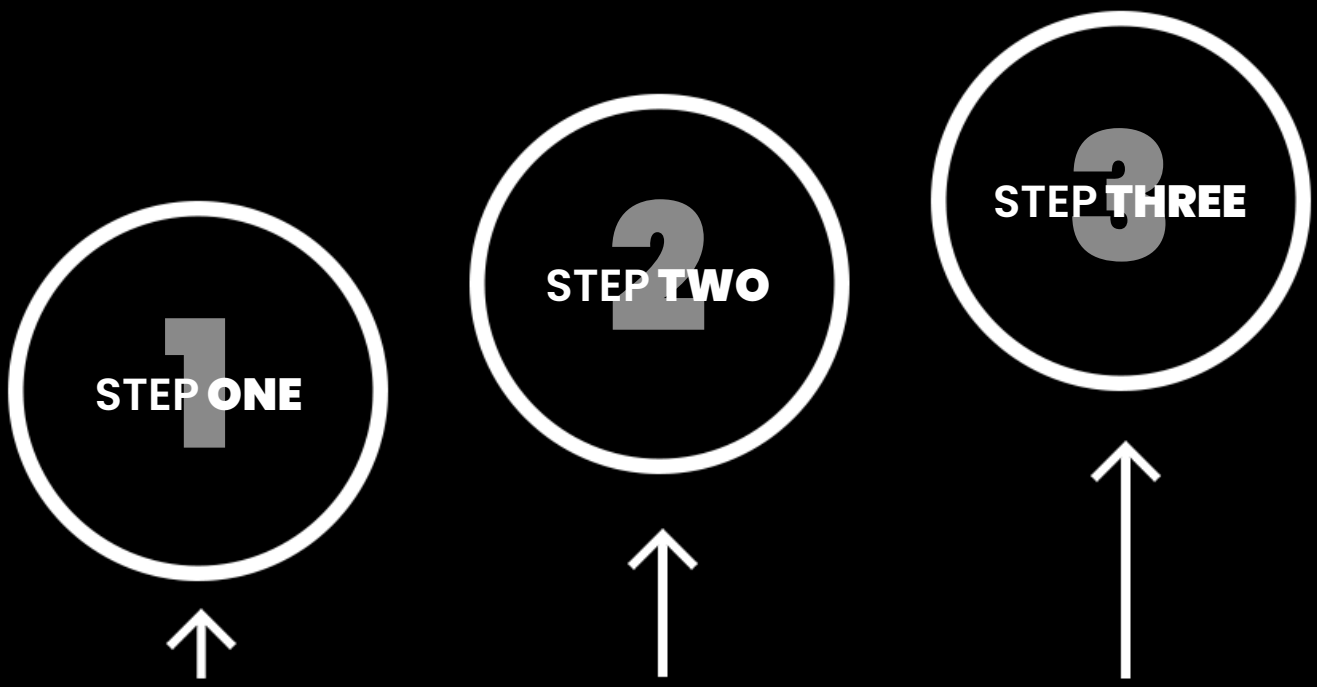
2. Create (or use an existing group if you have one), a small team or Committee, with representation from your Board and include the CEO plus an executive colleague with responsibility for Diversity and Inclusion. This Committee will take the necessary time to consider each of the 4 Principles of the RACE Code and the 55 provisions that have been identified.

3. APPLY AND EXPLAIN - Once the four principles have been discussed and the questions answered, the Committee should draft a robust statement (to be approved by the Board), as to how your organisation will apply these Principles. This statement should also identify any actions that arise as a result of your discussions.

4. THE MUST PROVISIONS - You can complete our diagnostic questionnaire to determine how close you are to full compliance of our 10 MUST actions. Once this is done, the steering group will record which actions you commit to doing in order to fully comply with the 10 MUSTS.

5. By completing the further 45 Should and Could provisions by recording whether you will comply or not, will lead to further actions.

To receive the Quality Mark and publicly evidence your commitment to Race Equality, contact http://theracecode.org Our specialist Race Consultants will explore and review your organisation's practises against the full framework.



EXAMINE

DIVERSITY
RESPONSIBILITY
INTEGRITY
VALUES
EQUITY
REALITY
SOCIETY

APPLY & EXPLAIN

REPORT
ACTION
COMPOSITION
EDUCATION

COMPLY OR EXPLAIN

MUST
SHOULD
COULD

HOW TO GAIN PUBLIC RECOGNITION

To receive the Quality Mark and publicly evidence your commitment to Race Equality, contact the theracecde.org and our team of specialist Race Consultants will explore and review your organisation's practices against the full framework and provide a comprehensive action plan.

An example of the RACE questions

Write comments to the extent that you agree with the following statements and provide as much evidence as you can to support your comments and how you will apply the RACE Code in relation to the 4-key Principles.

REPORTING - Are you happy with how your organisation reports on race, is information transparent and accessible by all stakeholders?

ACTIONS - Are you satisfied that the actions your organisation is taking are robust enough to make a real difference to race equality and that the board is accountable?

COMPOSITION – Has your organisation gathered the appropriate data? Are you satisfied with the targets that your organisation has decided upon, and that they are challenging enough? Has your organisation developed the relevant governance structure to ensure there is accountability?

EDUCATION - Are you confident that you have considered how your organisation will educate staff at all levels of the organisation and all the key stakeholders that work with your organisation around race equality, and that you have considered how to examine the culture, ensuring there is an inclusive and belonging environment?

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PROGRAMME TALENT PIPELINE

leadership2025.co.uk
raceequalitymatters.com
effectiveboardmember.co.uk
10000blackinterns.com
obv.org.uk
boardapprentice.com

EARLY ADOPTERS

As at 1/12/21

- Active Black Country
- Active Essex
- Birmingham City Council
- Birmingham & Solihull Women's Aid
- Birmingham Voluntary Service Council
- Black Country Healthcare NHS Foundation Trust
- Chartered Institute Housing
- Colmore Business District
- Coventry City Council
- Cure Leukaemia
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- East Midland Homes
- Greater Birmingham Chambers of Commerce
- MHS Homes
- Nehemiah Housing Association
- Open College Network West Midlands
- Sport Birmingham
- St Basils
- Taff Housing Association
- The Dudley Group NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- The Tavistock and Portman NHS Foundation Trust
- Together Active Staffordshire & Stoke-on-Trent
- Trident Group
- Walsall Healthcare NHS Trust
- West Midlands Combined Authority
- West Midlands Police & Crime Commissioner
- Wolverhampton City Credit Union
- Worldline

The **RACE Equality** Code

The **RACE Equality** Code

theracecode.org

karlgeorge.com

TRUST BOARD

DOCUMENT TITLE:	Equality Delivery System
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi – Chief People Officer
AUTHOR:	Clare Mair – Head of OD and Inclusion
DATE OF MEETING:	7th February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Background:
All NHS Trusts are required to complete the Equality Delivery System (EDS) reporting on an annual basis. The next submission date is 28th February 2024. This work is part of the National Equality Diversity and Inclusion (EDI) mandatory reporting and is in the NHS Standard Contract.

The reporting is broken down into three domains; Commissioned and provided services, Workforce Health and Wellbeing and Inclusive Leadership.

Changes to the format of this reporting now require ICS partners to work together on the first domain for commissioned and provided services. An ICS working group has been set up to complete work with focus on the areas shown below. This group is meeting on the 6 th February to collate information across Domain 1 and to moderate on peer responses for Domain 2 and Domain 3.

Area	Topic
1. End of Life Care	Cultural Competency,
2. PALS	Complaints - Protected Characteristics, Recording and Accessibility
3. Interpreting	Accessibility and Experience

Domain 2 - looks at workforce health and wellbeing and concentrates on the experience of staff members

Domain 3 - comprises of three outcomes that are a real test of commitment and inclusive leadership
Next steps

- ICS meeting to take place on 6 th February 2024 to compare and moderate information.
- Confirmation from ratings for each domain following ICS meeting
- Sign off for submission and publication on the ROH website

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
- The Trust is working with ICS EDI Partners to co -produce part of the EDS framework – Domain 1 - Staff side colleagues are supporting this work - Th work with internal stakeholder for this report is now completed however to note that content, actions and ratings may change	Delays in the ICS feedback session (scheduled now for February 6th) with EDI regional colleagues has impacted the completion of the final version of this report. However this work will still be completed by the national deadline of 28th February 2024

following the ICS feedback session on 6th February	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to RECEIVE and ACCEPT the report for 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		Equality and Diversity	x	Workforce	X
Inequalities	x	Integrated care	x	Continuous Improvement	X
Comments:					

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

People Plan

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

ICS EDI Strategy

PREVIOUS CONSIDERATION:

People and OD Group December 2023 and January 2024
Staff Experience and OD Committee November 2023 and January 2024
Consultation with subject matter experts across the Trust as outlined in the EDS document
Consultation with staff side and union reps December 2023
Consultation with staff network chairs and staff networks
Consultation with ICS EDS Working group

Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System 2023

The Royal Orthopaedic Hospital

Version 3 January 2024

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

Name of Organisation	The Royal Orthopaedic Hospital	Organisation Board Sponsor/Lead
		Sharon Malhi Chief People Officer
Name of Integrated Care System	BSol	

NHS Equality Delivery System (EDS)

EDS Lead	Clare Mair	At what level has this been completed?	
			*List organisations
EDS engagement date(s)	Staff Experience &OD sub board committee update, January 2024 People and OD Group (Organisational committee) November and December 2023 and January 2024 -Update Executive meeting February 2024 – Update Staff networks – December 2023 and January 2024 Feedback session with colleagues – January 2023 Update meeting (December 2023) and progress meeting (January 2024)with Staff side representative and UNISON representative Update at Trust Consultative Committee – January 2024 Progress updates from colleagues (see list at the end of this document)	Individual organisation	The Royal Orthopaedic Hospital Ongoing work with ICS EDI Leads for Domain 1

			Partnership* (two or more organisations)	Staff side representative UNISON
			Integrated Care System-wide*	EDI Leads, BSol
Date completed	February 2024		Month and year published	February 2024
Date authorised	February 2024		Revision date	

Completed actions from previous year (including additional actions from the ROH Inclusion Action plan)	
Action/activity	Related equality objectives
Mankind (Men's) network and the Women's network have been formed to supplement other staff networks within in the Trust. The creation of the networks has been supported by the OD and Inclusion team	Giving colleagues and patients a voice ongoing
Staff listening sessions have taken place through the previous twelve months to ensure staff can give key feedback on topics. Current areas of discussion include Cost of Living and Staff Retention	Giving colleagues and patients a voice ongoing
Awareness sessions run throughout the year including International Women's Day, Black History Month, Professional Nurse Advocate, Learning Disability awareness, Domestic abuse awareness and Birmingham Pride	Giving colleagues and patients a voice ongoing
The OD and Inclusion Team have developed a Network Chairs meeting to ensure support and collaboration across all the different channels to hear patient voice	Giving colleagues and patients a voice
Further Freedom to Speak up (FTSU) champions recruited to support staff and patients co-ordinated by the freedom to Speak up Guardian (FTSUG). A dedicated email and telephone line has also been set up	Giving colleagues and patients a voice
Youth Patient Forum continue to be run to hear the voice of patients	Giving colleagues and patients a voice
Launch of 'Many Cultures One' ROH photo exhibition	Giving colleagues and patients a voice

The Trust Charities team have run a number of projects to support patients stay at the Trust e.g. sensory room to support patients and their families	Creating an inclusive and healthy ROH culture
The first fully accessible adult toilet and changing facilities has been set up to support patients and their families	Creating an inclusive and healthy ROH culture
Disability Confident Level 3 – Leader achieved with the Trust now supporting other organisations.	Creating an inclusive and healthy ROH culture
Youth Mental Health First Aid programme and workshops are ongoing	Creating an inclusive and healthy ROH culture
An e learning package on Autism has been rolled out across the Trust with Support from the Learning Disabilities Nurse and the Education and Training Team	Creating an inclusive and healthy ROH culture
Additional physiotherapy locations have been set up in the community to enable patient access to services	Creating an inclusive and healthy ROH culture
Safeguarding training has been updated to support key groups including LGBTQ+ patients and colleagues. Safeguarding Adults at risk policy updated to reflect Care Act	Creating an inclusive and healthy ROH culture
Project Team worked on flexible working programme for the Trust	Creating an inclusive and healthy ROH culture
Inclusive Companies ranking the Trust at 26 out of their Top 50 rankings	Being recognised as a Top Inclusive Employer
Reports have been implemented to benchmark feedback from Learning Disability patients on comments and also compliments. The information is now reported to the Safeguarding committee	Tackling and removing any forms of discrimination
Successful career progression from colleagues who undertook the Mentoring programme launched for Multi Minority Ethnic Group (MMEG) colleagues as part of the WRES Action Plan.	Tackling and removing any forms of discrimination
Open Day recruitment events have been successful run to attract and reach candidates from a more diverse background	Tackling and removing any forms of discrimination
Work continues on revised approach to the ROH Equality and Health Inequalities Impact Assessments	Tackling and removing any forms of discrimination

Human Factors Development programme including a Trust conference has been designed and continues to be rolled out across the Trust	Ensuring our leaders, managers and colleagues role model in a compassionate and Inclusive Way
Completion of key development opportunities for staff including (1) Enabling a Productive and Inclusive Culture (EPIC) masterclasses open to colleagues across the Trust. (2) Me as a Manager awareness session to support managers in employee lifecycle (3) Mandatory inclusion training (4) Senior Leadership programme with Inclusion element included	Ensuring our leaders, managers and colleagues role model in a compassionate and Inclusive Way

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – organisations score out of 0 for each outcome	Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score out of 1 for each outcome	Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score out of 2 for each outcome	Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving

Excelling activity – organisations score out of 3 for each outcome	Those who score 33, adding all outcome scores in all domains, are rated Excelling

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
	1A: Patients (service users) have required levels of access to the service	Service 1 - End of Life Care This service supports patients and their carers through their palliative journey. In majority of cases, this would be for oncology patient. If the patient has a palliative diagnosis the pathway is started in conjunction with Macmillan nurses by consultants. Interpreters will be used to support if needed and any written information is translated by PALS if required. A service is available to translate information into any language – letter and patient information leaflets The Trust encourages family involvement and this is led by the patient needs. This includes extended visiting hours and access to appointments This programme is open to all patients who are on a palliative diagnosis. Patients may have started their palliative pathway before accessing the services at the ROH through GPs or referrals from other hospital. All patients come to hospital through GP referrals. In some cases, the referral is Hospital to Hospital. If a patient is not fit for surgery, then the procedure will not continue and different options will be discussed with the patient	2	NB LC

	Private patients are also eligible to palliative care given access through a referral from their GP or through their private medical insurance company Palliative care would also be applicable for emergency cases and complex cases that are Hospital to Hospital referrals Patients will be referred for Oncology services Service 2 - Complaints Patients, families and carers are able to access the PALS and Complaints Department at the time of their concern or within 12 months of the issue occurring. The department will ensure that the patient has all the information available to make an informed decision on how best to proceed and will also provide details on how to escalate their complaint should they be unhappy with the outcome. The department can be accessed by telephone, email, in writing or online via the website and Face to Face contact can be facilitated by arrangement. Information on how to contact the department and raise a concern, complaint or compliment is available on all wards and departments in written format in the 6 key languages of our patient demographic, the	2	NB SL EOK

	use of interpreting services is also available on request. This information can also be found on the PALS and Complaints page of the Trust website. Ward and department staff facilitate contact with PALS and Complaints if a concern is raised directly with them. The patient can raise a concern on their own behalf or can nominate a representative to do so. If the patient does not have capacity to act on their own behalf then their appointed advocate can do this for them in the patient's best interests Service 3 - Interpreting Further engagement with patient groups (including Youth voices) to obtain feedback on access to services and overall patient experience (EOK Update) Work has commenced by Dementia and Mental Health Lead on Dementia Group, patient experience and feedback Interpreters will be used to support if needed and any written information is translated by PALS if required. A service is available to translate information into any language – letter and patient information leaflets The Trust encourages family involvement and this is led by the patient needs. This includes extended visiting hours and access	2	NB SL

	to appointments		
1B: Individual patients (service users) health needs are met	Service 1 – End of Life Care Patient information to explain the palliative journey is available in different languages. These languages were decided following a review of key languages spoken by patients with support from the Patient Liaison (PALS) team. The patient information is provided in paper copies. Interpreters are also available to support patients and their families. Members of the Macmillan team are also available to speak directly to any patients during their palliative journey. Discharge destination would be home, hospice or other hospital to ensure they are in the correct care setting. Patients are part of the decision making for discharge destination along with their family. Access would be equal regardless of protected characteristic. Chaplaincy service is also available to support the transition with support from UHB. Patients are referred back to their GP, if appropriate.	1-2	NB LC

	Following surgery, where appropriate therapy sessions are booked to ensure continuing quality of life. These sessions can be face to face (inpatient) or online to suit the needs of the patients and their families. Online supports patients who may find it hard to travel back into the hospital for any reason. The options are discussed with patients to ensure therapy sessions are booked in. This would relate to Physiotherapy and OT combined. Interpreters are available for all clinic appointments (need pre-booking). All patients are encouraged to bring family member with them. Feedback for the service is received through Friends and Family Test (FFT) (PALS) or the national cancer patient experience survey (Nurse consultant, Oncology and CQC inpatient survey (Chief Nurse). Actions plans are in place to improve services moving forward. Palliative patients are offered a side room if appropriate and available. This is also considered to support visitors of patients If patients pass away on their palliative journey then there is a specific pathway for families with support from local funeral directors. This includes booklets and information (electronic and paper) that can be translated into different languages. The		

	funeral director also has a chapel of rest. Visitors are able to visit a deceased person at the Trust in the immediate hours (up to two hours before they are transferred to the funeral directors). The ward will organise for belongings to be returned to family members or next of kin Service 2 - PALS The PALS Team provide support to the patient to enable them to achieve the appropriate level of service and clinical care if the patient has not been able to resolve issues on their own behalf. The PALS Team can liaise with clinical services and service leads on behalf of the patient to assist the patient in receiving the appropriate information and intervention in a timely manner and resolve any concerns that they have and can sign post to additional support services for example Advocacy, Learning Disability and Autism Nurse support or interpreting services to ensure the patient journey is tailored to individual need and in the patient best interests Service 3 – Interpreting Interpreters are available for all clinic appointments (need pre-booking). All patients are encouraged to bring family member with them.	2 2	NB SL NB SL

1C: When patients (service users) use the service, they are free from harm	Service 1 – End of Life The Safeguarding team can support patients if they are alerted Staff are expected to notify the learning disability and autism team following contact with a patient who has a diagnosis of learning disability and/ or autism via learning disability and autism notification form. For complex cases, the team will then get in touch with the patient and their family/ carers to develop in depth plans to support them and ensure reasonable adjustments are in place. All staff receive training on learning disability and autism to ensure understanding of reasonable adjustments and how to apply these. Green paper is used in patient notes to record these, and hospital passports are offered to each patient. The learning disability and autism team work closely with all areas of the Trust to support with appointments, admission and discharge. There is set discharge criteria that must be confirmed before the patient is able to leave the hospital. This includes medical and therapy discharge goals. There is also a discharge check list which has been updated following patient feedback. The key elements includes an understanding of the	2	NB LC

	discharge medicines, and other equipment provided and how it is to be used and clear information on how to understand the first signs of infection The ROCS team may go out to visit patients on the first day after discharge (dependent on diagnosis and surgical input) to home or hostel only. This is to ensure patient and environment is safe, has no post discharge issues and understands next steps for recovery. They will also check all the medication to be taken. This service is available for patients who live within a 25 mile radius of the hospital Referral for outpatient physiotherapy is confirmed before discharge and this can be organised at the Trust, the nearest hospital to the patient's home or another hospital of their choice Follow up appointment – face to face and online appointments are available Feedback has led to a change in food menu options including gluten free, vegan and African Caribbean menus. Staff have also undergone training in understanding the different menu options as a result of feedback. Any incidents are discussed at divisional governance meeting and investigated as appropriate. Patients and relatives are		

	involved in the process. Any letters or governance letters can be translated by the PALS team. As mentioned in the previous section, survey results are used to form a service improvement plan and reported to Cancer Board Enable training of patients to self-inject to reduce the requirements of district nurses and enable independence of care for patients once at home. Work is undertaken to ensure information supplied to GPs post op is correct as part of quality audits & Doctors induction. These audits are focussed on patients with protected characteristics. This process has been reviewed and approved by Medical and Nursing teams. Service 2 – Complaints The PALS and Complaints Teamwork alongside all of the support services within the ROH including liaising with and completing referrals to the Safeguarding Team when required. The Learning Disability and Autism Nurse can be involved either in direct support of the patient through the complaints process or by assisting the team to ensure that they provide information and support in the most	2	NB LC

	appropriate format such as Easy Read documentation or utilising non complex speech. All patients are assured that raising a concern or complaint will not negatively impact on the provision of their care and that they will be supported and informed throughout the process. The PALS and Complaints Policy has been reviewed and presented for ratification to ensure that all actions are aligned with both local and national standards. All staff within the team are competent to Level 3 Safeguarding Children and Adults Training Service 3 – Interpreting Interpreters are available for all clinic appointments (need pre-booking). All patients are encouraged to bring family member with them.	2	NB LC

Domain 1 : Commissioned or provided services	1D: Patients (service users) report positive experiences of the service	Service 1 – End of Life care Friends and Family tests show positive feedback from patients with a current completion rate of 60% Incident reporting is well defined which includes a learning cycle to communicated and retrain any new information. Feedback for the service is received through FFT (PALS) or the national cancer patient experience survey (Nurse consultant, Oncology) and CQC inpatient survey (Chief Nurse). Actions plans are confirmed to improve services moving forward. PALS information is discussed at ward and department levels to highlight positive feedback and address where improvements can be made	2	NB LC AK
		Service 2 – PALS Patient Satisfaction Surveys are sent to all persons who have used the PALS and Complaints service and information is collated and presented quarterly at the Patient Experience and Engagement Group (PEEG) Patients desired outcomes are recorded and reviewed as part of the Complaints process. Friends and Family Tests (FFT) are coordinated by the PALS and Complaints Team and the results are shared with participating individual departments for inclusion in their reporting structure. Feedback received via	2	NB SL

		HealthWatch Birmingham is monitored and responded to on a monthly basis, this is then collated and reported on via the Patient Experience quarterly and annual reports presented at PEEG and Trust Board Ensure that the feedback from patient with protected characteristics (and also stakeholders) is reviewed and monitored to support a continued positive experience Transition to Adult Services -CNS working with PEE Lead to ensure that young voices feedback are noted Service 3 – Interpreting Interpreters are available for all clinic appointments (need pre-booking). All patients are encouraged to bring family member with them.	2	NB SL

Domain 1: Commissioned or provided services overall rating	2	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Wellbeing information which includes health information and mental health support is shared with staff in a number of ways including: - Information packs in each department - Wellbeing noticeboards across the Trust • Wellbeing information shared with all departments • Weekly Wellbeing email • Monthly Managers Calls • MHFA champions across the trust • Wellbeing Champions • Wellbeing Conversation Training • Library of support – Five Ways to Wellbeing Bi annual Wellbeing week highlights health issues and support available e.g. exercise bicycle to monitor heartbeat, Health Kiosk As part of the wellbeing events exercise classes are available for staff to attend e.g. yoga and Pilates and Zumba There are a number of Mental Health First aiders (MHFA) across the Trust from a diverse background who are able to support where appropriate	2	SM LTH NB EOK MP NM

	Staff have access to Therapies services treatment through self-referral to support MSK, weight and other health issues		NB FD
	The Learning Disability Nurse is able to advise and signpost individuals with a learning disability and/ or autism diagnosis and their line manager		
	Occupational Health services are available to support staff with health screening or health checks		SM & MD
	Staff have access to the NHS Regional Staff mental health Hub		SM LTH
	Staff have access to Citizen's Advice Birmingham, a direct line for help and support.		SM MD
	Staff have access to counselling for help and support.		SM LTH
	Staff have access to Relate counselling for help and support.		SM LTH
	Staff can join listening sessions and have access to support for Cost of Living issues including the impact on Mental Health conditions		
	Cost of living support, free out of hours meals, ROH Pantry (foodbank), Period Dignity, the Blue Bag Project, free sanitary		

	products and £1 meals in the Café. Staff networks are helping to support the sharing of information and give colleagues a voice: Mankind, Menopause, Equality and Diversity, MMEG, Able, Women's Network and LGBTQ+ Colleagues are able to raise key issues at the start of each Staff network meeting. This can be colleague from the community or as allies. Sickness data is shared at key meetings to understand links and agree support needed in different areas for staff members		SM JS SM Workforce and OD Team
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Staff survey results show that progress is being made in terms of supporting staff. The results are comparable to higher performing Trusts across the NHS For the Staff survey (2022) results, all staff percentages are: Free from abuse, harassment, bullying from staff 79.4% Free from physical violence from staff is 1.5% Comparing these scores for WRES and WDES are: WRES Free from abuse, harassment, bullying from staff is 72.2%	2	SM CM

	WDES Free from abuse, harassment, bullying from staff is 71.1% The results for NHS Staff Survey 2023 are not yet published but the information will be used once the national embargo is lifted in March 2024. Staff listening group and focus groups have continued to give colleagues the opportunity to share any feedback and issues. These sessions are open for all staff. The Trust is continuing to develop staff networks to support colleagues and give staff a voice. There has been increased participation from staff. Each network has a Chair and is supported by Executive Board members who attend the network meetings. In addition, each network has full support from the OD and Inclusion team including administrative support. Current networks include: -Equality & Diversity Network (E & D) -ABLE Disability Network -Multi Minority Ethnic Group (MMEG) -Be Myself LGBTQ+ network -Menopause Support Group -Women's Network -Mankind Men's network Network chairs meetings take place on a quarterly basis to share ideas, offer support		SM Workforce and OD Team SM JS

	and discuss how collective work links back to the Inclusion Strategy and Action plan Awareness projects to support diverse staff groups - e.g., Beyond the stigma, LGBTQ+ History Month, South Asian Heritage Month and Black History Month The Executive team actively support that no colleague should be a victim of harassment and bullying. The Chief Nurse has endorsed new posters around the Trust to showcase a zero approach to Harassment and Bullying of any kind. The MMEG network has showcased the ROH Many Cultures One ROH exhibition to show colleagues and patients that the Trust supports and employs colleagues from various cultural, ethnic backgrounds. The Trust is part of the Taskforce as a response to the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) report Continue the development of further staff networks through staff feedback • Building networks through the EPIC Masterclasses to allow staff to speaking up and supporting other staff members. • The Trust attends the ICS BAME network calls to discuss best practice regarding any form of harassment or		Executive Team MMEG Network SM NB CM SM JS

	bullying. • The Trust attends the LBGTQ+ ICS network with regional leaders in how we can support colleagues across the system from a LBGTQ+ community. The Trust has rolled out the Oliver McGowan Tier 1 Mandatory Training in Learning Disability and Autism. The e-learning went live in April 2023 for all staff, with the second sections of training still being developed The lead has undertaken training to facilitate the Oliver McGowan training Tier 2 Further develop work to enable staff with protected characteristics to be supported to report and refuse treatment to patients who verbally or physically abuse. Work to be linked to Link to the violence reduction framework and health and safety forum Work is being undertaken by the Chief Nurse on the Sexual Safety Charter standards with planned implementation in 2024 The Education and Training team and the learning disability and autism clinical nurse specialist attend regular stakeholder meetings. Whilst this training is predominantly focussed on patient interaction, it also highlights support required for any person with a learning disability or autistic person.		NB FD Education and Development department .

	Bespoke training is provided to departments to raise awareness of learning disability and autism and how to support colleagues Safeguarding (SG) training is undertaken to raise awareness on and to support colleagues • Roadshow and awareness events • SG Champions Day is held quarterly to support and help further educate staff • Full support from initiatives from Staff side and union support SG Champions Day are run quarterly to support and help further educate staff. The Royal Orthopaedic Hospital has a Domestic Abuse Lead for the Trust who is the Senior Named Safeguarding Nurse for Children and Adults which is recognised by the ICB. As per of the role she delivers annual training to the 52 clinical and non-clinical domestic abuse champions • There are two domestic abuse policies in place which supports staff, patients, visitors, and families which is reviewed and updated in accordance with local and national guidance yearly • The domestic abuse lead has designed an internal domestic abuse care pathway which supports staff and patients with assessing the risks of victims and their children.		NB EOK RF

	• Three areas within the ROH ask the routine enquiry (domestic abuse question) to all patients accessing our services (Physiotherapy, POAC and ADCU) • All staff who complete level 3 safeguarding training receive DASH risk checklist training and are provided with an internal “we are here to help” domestic abuse card which assist staff with internal and external domestic abuse procedures • The domestic abuse lead attends and contributes to regional domestic abuse meeting hosted by NHS England bi-monthly • The domestic abuse lead completes an annual domestic abuse audit which is shared with the safeguarding committee to provide assurance to the Trust. • All staff domestic abuse disclosures are managed by the domestic abuse lead and support is provided by the staff members line manager and HR • All departments within the Trust have access to the ROH domestic abuse signposting cards which provides contact details of domestic abuse services. The domestic abuse services are inclusive to the victims culture, sexuality and gender		

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Nine FTSU Champions from various background and qualifications has been recruited to help maximize effectiveness and visibility across the Trust. Their role facilitates patients and staff having a positive voice and helping to imbed an inclusive and healthy culture. They understand the values of the Trust and with guidance and support from the FTSU Guardian, deal with concerns in a compassionate manner. The Trust benchmark well against other Organisation FTSU Culture and this is shared with the Trust Board. The FTSU Team ensure that October FTSU Campaign is impactful across the Trust and used as a time of celebration, education and awareness and to embed a culture where staff are encourage to speak up about anything that prevents them from providing the highest standard of care and promote an environment that is fit for purpose for staff The FTSU Guardian is working to further develop the number of FTSU Team to ensure that speaking up is a part of everyday business. The FTSU Guardian is also working with managers and leaders withing the Trust to develop a system to triangulate information to be able to improve better support and outcome for staff members Self-referral Counselling service through the Trust Employee Assistance Programme (EAP) in addition to a local counselling	2	SGL & CJ SM Workforce & OD Team

	service. Access to the NHS mental hub Colleagues are encouraged to use the Birmingham & Solihull Waiting Room for health and wellbeing support. Other support includes: • ICS Staff Mental Health hub # • Bi annual Wellbeing weeks to share information with all staff across the Trust on ways to access support • Listening Sessions on key topics • Network of Mental Health First Aiders (MHFA) Staff attending Schwartz Round • Support from Workforce and OD team to help with signposting to the correct solutions • Network of Health and Wellbeing champions • Sessions run at departmental meetings to cover support available • Awareness sessions run at various events • Tea trolleys used as an additional way to promote support in all areas • Occupational Health support • Employee Assistance Programme support (EAP) There is also ongoing partnering with union representatives and staff side to keep them updated on key support available		SM Workforce and OD Staff side

Domain 2: Workforce health and well-being		Equality Impact Assessments are used for all Trust policies, projects and some patient pathways. An updated approach is due to rolled out in March 2024		SM JS
	2D: Staff recommend the organisation as a place to work and receive treatment	National survey results and Pulse results show positive scores from staff with scores listed below. For place to work the results are National Staff Survey (2022) 72.3% People Pulse survey results 2022/23(Q2) 81% (Q4) 80% For place for treatment the results are National Staff Survey (2022) 84.7% People Pulse survey results 2022/23 (Q2) 87% (Q4) 86% In addition, the scores for other themes are: We are compassionate and inclusive: National staff survey (2022) 7.5% We are safe and healthy: National staff survey (2022) 6.4% Colleagues Morale: National staff survey (2022) 6.1% Information from the National Staff Survey is used to inform of key priorities to support staff engagement Information from the Pulse Survey is used to inform of key priorities to support staff engagement	2/3	SM Workforce & OD Team

		Staff networks include on every agenda a 'check in' section to allow all participants to raise concerns or points of interest Focus Groups and listening sessions continue to be run to get feedback on ways to improve retention of staff The Trust has a ROH onboarding which includes a 100 day programme led by the Executive Directors, key departmental colleagues and line managers. This includes future learning opportunities and a 100 days Reunion Event. There is a feedback session to understand staff feedback and any learnings A project team has reviewed the Trust's flexible working approach at the Trust to incorporate Health and Wellbeing. Ongoing external company review – Inclusive Companies awarded ranking 26th in Top 50 Ongoing delivery of EPIC programme.		
Domain 2: Workforce health and well-being overall rating			2	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Equality & Diversity data is shared on a bi-annual basis to the staff responsible for service procurement, in order to support decisions making • Equality and Diversity data now available in an Integrated Performance Dashboard for those responsible for managing and procuring services. • Staff networks include Executive and senior leader sponsors • Executive and senior leaders support inclusion awareness sessions • Executive and Non-Executive Directors (NEDs) work with other organisations to network and raise awareness • All Leadership programmes include an element of Inclusive and Compassionate Leaders • Equality impact used on projects and patient pathways and policies (approach currently being updated) • Senior Leaders continue to attend upskilling sessions for colleagues • Each staff network is supported by an Executive sponsor	2	SGL SM CM

	• The Staff Experience and OD committee meeting is undertaken bi monthly to be give assurance on the Equality and Health Inequalities work. • The Chair of Trust Board and Executive Directors have equality objectives as part of the EDI Improvement Plan • Executive Directors and NEDs directly support with listening sessions on topics including Cost of living, and Menopause • Board placing a particular focus on Race Equality and steps to broaden this work are currently being scoped		
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• All polices and projects must include Equality Impact Assessments and these documents are reviewed at Board meetings • Equality and Health Inequalities information is regularly presented to Trust Board and other sub Board committees • Equality and Health Inequalities risks are included on the risk register and reviewed on a monthly basis. • Monthly updates on Equality, Diversity and Inclusion are given at Trust Board committee meetings with actions logged • Health inequality data is shared in senior operations meetings	2	SGL Governance Team SM NB

Domain 3: Inclusive leadership				
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Integrated Health and Equalities dashboard is reported to senior leaders on a quarterly basis • Key monthly focused report on specific questions around health and wellbeing linked to Health Inequalities • Model hospital is used to share information across the trust • Information on EDI metrics is shared regularly with Senior and Executive leaders at all Board meetings • Information on WRES, WDES Disparity ratio and other key reporting are presented and discussed with Board meetings to show progress and provide assurance • Feedback from work with external partner Inclusive Companies is regularly discussed with Board members	2	SGL Senior Managers SM CM
Domain 3: Inclusive leadership overall rating			2	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s):		Independent Evaluator(s)/Peer Reviewer(s):		

2	TBC – meeting delayed

EDS Organisation Rating (overall rating): TBC following Peer review meeting – February 2024 - 22
Organisation name(s): The Royal Orthopaedic Hospital
Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving Those who score 33, adding all outcome scores in all domains, are rated Excelling

EDS Action Plan				
EDS Lead			Year(s) active	
Clare Mair, Head of OD and Inclusion			7	
EDS Sponsor			Authorisation date	
Sharon Malhi, Chief People Officer			February 2024	
Domain	Outcome	Objective	Action	Completion date
	1A: Patients (service users) have required levels of access to the service	Increased patient engagement from diverse groups to access areas for improvement	• Further engagement with patient groups (including Youth Forum) to obtain feedback on access to services and overall patient experience	February 2025
		Support access for patients in line with Equality and Health Inequalities (CORE20PLUS5)	• Continue to work with regional colleagues to facilitate positive change in access for patient services as a result of the BLACHIR report	February 2025
	1B: Individual patients (service users) health needs are met	Ensure needs are met for higher risk patients in line with Trust's work on Health Inequalities and CORE 20 PLUS 50	• A new health and inequalities group has been developed to address workstreams to reduce health inequalities. For learning disabilities this includes a more streamlined pathway ensuring robust collection and sharing of data. This covers notification, planning and handover to GP including prompting of annual health check.	February 2025

Domain 1: Commissioned or provided services		Improved notification of and information about patients with learning disabilities when they attend the ROH.	• The mandatory training package on learning disabilities is regularly reviewed and updated. The updated package also covers autism in line with LeDeR Policy (2021, The NHS Long Term Plan (2019), and 'Right to be heard' (2019). Training sessions are running face to face once monthly. Mandatory e-learning sessions in autism and learning disabilities are also available.	
	1C: When patients (service users) use the service, they are free from harm	Ensure patients have the correct opportunities to feedback and to report incidents if necessary	• Review different options for patients to report any issues and viewing data for protected characteristics. Linked to work on Health Inequalities at Trust and with ICS colleagues	February 2025
	1D: Patients (service users) report positive experiences of the service	Ensure that the feedback from patient with protected characteristics (and also stakeholders) is reviewed and monitored to support a continued positive experience	Review of options to collect patient information and feedback by protected characteristics in line with Health Inequalities work	July 2024

Domain	Outcome	Objective	Action	Completion date
	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Enabling staff members to have access to health information and services to provide a healthy and supported workforce	Further work to expand the information provided to staff on health issues through Health and Wellbeing initiatives. Ensure interventions are targeted in line with Wellbeing Plan and NHS Health and Wellbeing framework Delivery annual Wellbeing priorities	February 2025 February 2025
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Working to reduce abuse, harassment bully and physical violence across protected characteristics	Ensure information from the staff survey data, sickness and absence data is used to identify positive action to reduce negative behaviours and improvements measured. Further work to enable staff with protected characteristics to be supported to report and refuse treatment to patients who verbally or physically abuse. Work to be linked to the violence reduction framework and health and safety forum	December 2024 February 2025

Domain 2: Workforce health and well-being	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Ensure staff have different options to access support	The FTSU Guardian is working to further develop the number of FTSU champions to ensure that speaking up is a part of everyday culture. The FTSU Guardian is also working with managers and leaders withing the Trust to develop a system to triangulate information to be able to improve better support and outcomes for staff with support across the Trust	December 2024
	2D: Staff recommend the organisation as a place to work and receive treatment	Improve the experience of staff members and aid retention	Clear actions plans identified with National staff survey results and other survey data	February 2025

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Board members and managers at all levels are well engaged with Equality and Health Inequalities work across the Trust	Develop work with the Board members on implementing the Leadership Framework for Health Inequalities Improvement. Objectives achieved by Executive Team members on High Impact EDI Improvement Action plan Run Race Code workshop for Trust Board members	February 2025 September 2024 December 2024
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Equality and health inequalities impact assessments are well embedded and understood across all the work at Trust	Develop work to ensure Equality and health inequalities are well reflected in the organisational strategy and business plans	February 2025
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Ensure effective monitoring of Equality and Health Inequalities for staff and patients	Report format established and presented to senior leaders to include all NHS metrics	February 2025

Work supported by colleagues including:	Example Evidence
Sharon Malhi (SM) Chief People Officer Rebecca Crowther, Deputy Chief People Officer Clare Mair (CM) Head of OD and Inclusion Laura Tilley Hood (LTH) Engagement and Wellbeing Officer Jeeves Sundar (JS) OD and Inclusion Manager Shelley Harker (SH) OD and Inclusion Administrator Rebecca Lloyd (RL) Director of Strategy Claire Felkin (CFe) Training & Development Manager Carl Measey (CMe) Health and Safety Manager Alex Gilder (AG) Deputy Director of Finance, Chair Able Evelyn O Kane (EOK) Matron, Safeguarding Rebecca Furnival, Senior Named Nurse for Safeguarding Children, Adults and Domestic Abuse Lead Florence Dowling (FD) Learning Disabilities and Autism Clinical Nurse Specialist Marjorie Nelson - Dementia and Mental Health Practitioner - Social Worker Laura Clinton, Matron, Wards Sharon Latham, Head of Patient Experience Claudette Jones (CJ) Freedom to Speak up Guardian, Chair of Staff Falon Paris Caines (FPC) Chair, Multi Minority Ethnic Group (MMEG) Gavin Newman Chair, Mankind network Colin Neal (CN) Staff side Neil Harwood (NU) Unison representative Executive Team Workforce and OD Team Staff networks	• Information from Matron, Wards • Information from PALS Team • National Staff Survey (NSS) result 2022 • People Pulse survey information for Quarters 1,2 in 2022/23 • Information for the WRES Indicators • Information from WDES indicators • Meeting and updates with colleagues across the Trust • Patient data • Information from external organisations including Thrive at Work and Inclusive companies

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Freedom to Speak Up annual report
SPONSOR (EXECUTIVE DIRECTOR):	Gianjeet Hunjan, Non Executive Lead for FTSU Simon Grainger-Lloyd, Director of Governance
AUTHOR:	Claudette Jones, Freedom to Speak Up Guardian Simon Grainger-Lloyd, Director of Governance
DATE OF MEETING:	7 February 2024

EXECUTIVE SUMMARY:

The attached presents a summary of the Freedom to Speak Up activity during 2023.

During the year, the Board has received two updates, one in September 2023 which provided assurance around the robustness of the Speaking Up framework in the Trust following the outcome of the Lucy Letby case.

The second update was received in October 2023 and provided additional detail and benchmarking information around the FTSU concerns raised in the Trust; a request that had been prompted by the earlier update.

The FTSU team have undertaken a considerable amount of activity over the year and has recruited a set of Champions to support the Guardian.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and APPROVE the annual update from the Freedom to Speak Up Guardian;
- NOTE the plans to further strengthen the framework in 2024

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
- 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 and update on Speaking Up framework to the Board in September 2023 and October 2023.

FREEDOM TO SPEAK UP ANNUAL REPORT

FREEDOM TO SPEAK TRUST BOARD ON 7 FEBRUARY 2024

1.0 Purpose of the Report

The purpose of this report is to provide the Board of Directors with an update of the activities of the Freedom to Speak Up (FTSU) Team at the ROH over the periods of February 2022 to February 2023.

1.1 Background of Freedom to speak up

The roles of the National Guardian Office (NGO) and the Freedom to Speak Up Guardian (FTSUG) were established in 2016 following the events at Mid-Staffordshire NHS FT which led to recommendations from the Francis Report. The NGO works to make freedom to speak up business as usual to improve cultural change within the NHS. Members of the NGO train, lead and support FTSUGs in England & Wales to challenge speaking up issues in the health care sector. The role of the FTSUGs is to help protect the safety of patients and the care they receive. They also help to improve workers experience by raising awareness, promote learning and improvement. They achieve this by tackling barriers and helping to foster a positive culture where, speaking up is a part of the organisation business as usual.

1.2 Roles and responsibilities of the FTSUG at The Royal Orthopaedic Hospital NHS FT

The FTSUG at the ROH works 22.5 hours in the Trust. The role is confidential, independent, and impartial. The Guardian is supported by the Executive Lead for Governance and a Non Executive who champions FTSG in line with national guidance. The FTSU also has regular meetings with the Medical Director and the senior nursing team and provides monthly information which is considered by the Board's Quality & Safety Committee.

1.3 The Guardians leads a team of FTSU Champions, who work voluntarily and are visible across the Trust. The champions' remit is to support and signpost workers to speak up about issues that prevents them from doing a good job; in line with NGO definition of the two roles, the champions signpost and do not handle cases. The FTSUG and Champions' visibility across the organisation provides reassurance as well as additional route for workers to raise concerns.

1.4 The number of champions has decreased from 9 to 8 due to the retirement of one individual. However, there are plans to increase the number of champions later in the year. The team is piloting regular team meeting on a 6-week basis and the frequency of this will be assessed. So far, the meetings that have taken place have proved constructive and allow sharing of experience and cases. Plans moving forward include the champions having regular meetings and a bespoke Professional Development Review meeting with the Guardian to strengthen and support the speak up agenda.

2.0 FTSU Cases Raised

Our records show that since 2021-2023 the number of cases reported to the FTSUG fluctuates. This does not appear to follow a pattern except a couple of occasions where activities were taking place across the Trust and workers were disrupted from their normal place of work. This was particularly the case during the aftermath of the COVID-19 pandemic.

Concerns raised per quarter 2021- 2023.

Q3 (2021-2022	Q4 (2021-2022	Q1 (2022-2023	Q2 (2022-2023	Q3 (2022-2023	Q4 (2022-2023	Q1 (2023-2023	Q2 (2023-2023

Nationally reported elements and data

Cases reported per quarter by theme

Quarter	cases	Inappropriate Attitude and behaviour	Element of bullying and harassment	Element of patient safety and quality	Element of workers safety and wellbeing	Element of detriment due to speaking up	Anonymous concerns
Q3 31/1/22	18	13	0	4	1	0	0
Q4 09/05/22	39	0	0	0	39	0	0
Q1 25/08/22	12	5	1	1	6	0	0
Q2 03/11/22	13	7	3	2	1	0	0
Q3 13/02/22	21	19	1	0	1	0	0
Q4 09/05/23	42	6	2	6	32	1	0
Q1 24/07/23	29	11	2	2	14	0	0
Q2 06/11/23	15		0	1	14	0	0

3.0 Freedom to Speaking Up categories and process.

As a reminder to the Board, the categories under which concerns are reported to the National Guardian's Office (NGO) remains the same as follows:

- Element of Inappropriate attitude and behaviour
- Element of Bullying and harassment
- Element of Patient safety and quality
- Element of Worker's safety and wellbeing
- Element of disadvantageous and/or demeaning treatment due to speaking up

3.1 Upcoming dates for data submissions

Q1 (2023-2024): Monday 10th July 2023- Monday 7th August 2023
Q2 (2023-2024): Monday 9th October 2023- Monday 6th November 2023
Q3 (2023-2024): Monday 8th January 2024 -Monday 5th February 2024
Q4 (2023-2024): Monday 8th April 2024 -Tuesday 7th May 2024

3.2 Example and Theme of concerns raised

As presented in the October 2023 report, the NGO recently introduced 'Inappropriate attitude and behaviour' as a new category for reporting and in 2022/23 almost a third of cases (30.0% or 7,621) were reported nationally against this category last year making it the most reported theme.

3.3 Although attitude and behaviour cases remain high at the Royal Orthopaedic Hospital (ROH), the most common theme has changed to workers safety and wellbeing. There have been no anonymous escalations this year, which remains a positive, however workers continue to discuss some concerns with the FTSUG that they have not given permission to be escalated.

3.4 Example of inappropriate attitude and behaviour include concerns around micro-aggressions, micromanagement, gossiping, aggressive communication - verbally, and via emails, rudeness and unprofessional behaviour that is not in line with the Trust values. Favoritism is also included within this category, for example the perception that white colleagues are given more time and opportunity to undertake training and balancing workload. Examples of 'Workers' safety and wellbeing' includes: experiencing stress due to poor treatment and not wanting to be at work, feeling anxious to have 1:1s with managers because of poor attitude and outcome, feeling excluded because of cliques within teams, cases closed without any feedback or outcomes causing staff to feel unsafe at work in some instances and not much trust in the system.

3.5 In response to escalation of inappropriate attitude and behaviour, some of the outcomes includes:

1. Human Factor Training being recommended for staff to attend
2. in more serious cases staff have dismissed from the Trust

3.6 In terms of concerns raised under the category of workers safety and wellbeing, there were few issues raised that could be attributed directly to matters that could be seen to compromise workers safety and wellbeing. However, workers reported that some of the issues that they were experiencing were all contributing factors that could potentially affect patient safety and quality, for example:

> There are instances when it can take a long time to address some issues when raised through the management route; this is causing an impact on staff wellbeing which can have a consequential impact on the quality of care delivered to our patients;
> Poor outcomes and lack of support received after raising issues through the management route which is resulting in staff leaving the Trust and affecting staff retention which can potentially affect the quality of care delivered;
> Increased workload;
> Poor support from managers to be able to deliver quality care;
> Since September we have seen some increase in cases raised by managers on the challenges they experienced managing and supporting workers. It has been suggested that newly appointed managers might benefit from further support, such as a mentor and additional help might also be needed in implementation the new policies.
> Colleagues raised other concerns under the workers safety and wellbeing such as the difference in wages between bank and agency staff and the effect of this on dealing with the cost-of-living challenges. The learning from this was the contractual agreement was not the same which has since been addressed. Worker has recently raised concerns on band appropriate payment and felt that this might also affect cost of living challenges they are experiencing.

4.0 Raising Concern Route Process

4.1 The raising concern process and route in the Trust appeared to be being followed by staff. However, staff continue to seek support from the FTSU team when the usual route becomes arduous; workers feel that the way in which concerns are handled after an escalation sometimes affects their wellbeing causing time off from work due to stress related issues. They feel that they are listened to, but in some cases, they feel that "the problem is pushed under the carpet" and they appeared to be seen as troublemakers. They are also worried that if they pursue some cases, it might affect their career or work relationship.

5.0 Improvements and changes because of Freedom to Speak Up concerns being raised

5.1 The following provides some feedback on the changes that have been made or seen as a result of staff speaking up through the FTSU route:

- Workers have confirmed that they feel that they are being listened to and taken seriously by the Freedom to Speak Up team and are happy to approach the team.
- Workers have confirmed that they feel that speaking to the Guardian provides them with a safe and confidential space that helps to improve wellbeing.
- Action is seen to be being taken following escalation to the FTSUG, such as training being arranged to improve the culture, with the FTSU concerns being cited as one of the reasons it is being undertaken.
- Some workers who received support from the FTSUG are now undertaking training to become champions for other staff networks and are helping to develop networks that they feel will be beneficial to themselves and their colleagues, such as, Mankind and the Menopause groups.

5.2 It is important to note that some staff who seek support from the Guardian only need a safe space to talk about issues they are facing and someone to listen to them rather than having an expectation that there will be changes made. In some instances, staff come to seek guidance and signposting. Normally, in these cases they do not wish for the discussion to go any further but would like it to be documented. Although these concerns are not taken any further, it is very useful for the Trust because it influences FTSUG visibility and identifies areas where more focus may be needed. Most of the cases escalated to the Guardian have already been escalated by staff using the management route and they seek the support of the Guardian because of the length of time it was taking to see a resolution or be because of a poor outcome through other means.

6.0 Feedback

During the year, staff have reported that they feel supported by the FTSUG and are happy to raise concerns with them, however, they find it challenging to raise some concerns with the Guardian within their own working areas and would prefer going to the Guardian within a safe space. Feedback from the Guardian sometimes takes some time because of resolution timescale and chasing outcomes.

7.0 FTSU Resources Learning and Development

The FTSU eLearning is not mandatory but available on ESR (Speak up for all worker, Lister up for managers and follow up for Senior Leaders/board members) and workers are frequently reminded to complete these modules by the Guardian.

8.0 Freedom to Speak Up 2023

8.1 Every October the National Guardian Office celebrates Speak Up Month, a campaign to raise awareness of the FTSUG and the work the organisation is doing to create a culture where staff feel encouraged, confident and safe to speak up.

8.2 The NHS People Promise sets out a series of commitments, one of which is we each a have a voice that counts which states; “We all feel safe and confident to speak up. We take the time to really listen to understand the hopes and fears that lie behind the words.”

8.3 The ambition is to provide workers with a safe and confidential space to be able to speak up when they have a concern.

8.4 The theme for Speak Up Month 2023 was ‘Breaking Barriers’. The campaign was again impactful across the Trust. Below prove some highlights of the agenda activities that was organised and delivered by the FTSU team.

9.0 October 2023 campaign highlight

Week 1: The FTSU Team started off the month by visiting departments to hand out FTSU packs consisting of FTSU information and the programme for the month, as well as value cards providing the opportunity for everyone to get involved.
Throughout the month there was a particular focus for each week and staff was invited to Wear Green on Wednesdays to show their visibility and support for Speaking Up.
Week 2: Focused on ROH Trust values and being kind. Staff were encouraged to participate in sharing value cards with colleagues who have supported them to enjoy a good day at work. There was also a FTSU Stand outside Café Royale, attended and supported by Gianjeet Hunjan (non-executive lead for FTSU). It was very informative, interactive, and well supported by workers participating in quizzes, word search and giving their pledges.
Week 3: Focused on inclusion, working in collaboration with the staff networks across the Trust, promoting inclusion and breaking down barriers to ensure concerns are raised, people are listened to, and the relevant support and outcome is achieved. Staff were invited to join one of the network meetings to see how they can support each other in a positive way. The ABLE Network was visited by Gianjeet Hunjan, Non-Executive Director.
Week 4: Raising FTSU awareness across all areas and professionals – Managers and leaders were encouraged to discuss raising concerns in their team meeting to ensure everyone was aware of the process of raising concerns and speaking up. This was to strengthen the speaking up agenda and making sure it is business as usual for everyone. A laminated copy of escalating concerns was provided in the packs delivered to the departments earlier in the months. Managers were asked to discuss this with their team and ensure it is visible on notice boards within the staff areas.

On 31 October 2023 FTSU Month 'Grand Finale' culminated in the Theatre Department. The Theatre staff were very excited to host this awareness day as they find it difficult to leave their department on these occasions. Again, this was supported by attended and supported Gianjeet Hunjan. The staff were excited to meet Gianjeet and others member of the FTSU team. There were three FTSU stands during the month which facilitated listening events, provided support and guidance, signposting and education for all staff. This year some of the FTSU stands were visited by our Chair, Chief Executive, Heads of Nursing and Chief Nurse, consultants, Governance managers, anaesthetists and generally dedicated staff from across all disciplines and professions. The activities over the month were well received by the staff and they were featured on social media by the National Guardian Office.

10.0 Benchmarking Data

10.1 FTSU Benchmarking data extracted from the NHSE Model Health System late last year provides evidence of the Trust's commitment to the Freedom to Speak up agenda. In comparison to the other specialist trusts, scores place the ROH in the top quartile under the Raising Concern domain. ROH received the fourth highest score of all specialist providers. Scores are assessed on the results of the national staff survey that provide an indication as to the trusts' speak up culture . This data will be extracted and presented when next available for this year. All other collaborative work will also be presented when available.

11.0 Conclusion and recent feedback

11.1 Over the last year the FTSU Team continues to work hard to strengthen the Freedom to Speak Up agenda within the organisation. The Team continues to be visible across the Trust, raising awareness and facilitating activities to support the workforce.

11.2 Recent feedback

Several workers at the ROH have spoken about some of the challenges they experienced at work, such as the way in which they are spoken to and treated by colleagues at various levels which affect their wellbeing. They understand the escalation process but feel happy that there are additional resources such as the Freedom to Speak up route. One member of staff stated that "I find it easier speaking freely to the FTSUG because there is no conflict, it is confidential, and I do not feel like I am being judged". Other members of staff said it gives them time to think things through and provide a safe and confidential space. All the workers said they enjoy their jobs and are proud of the high standard of care the Trust provide to patients. They all acknowledge that staff wellbeing is a priority but think more training and awareness need to on kindness and civility.

Some workers said they were not happy about the closure of the café because of the inconvenience they experienced, but they are delighted about the new and redeveloped café especially the range of meals available on the menu. They are 'not sure' about the reusable lunch boxes but are getting used to them and happy to save 30 pence using them. They all expressed their thanks and appreciation for the staff discounted meals and look forward to their free breakfast porridge in the morning.

FOR ASSURANCE

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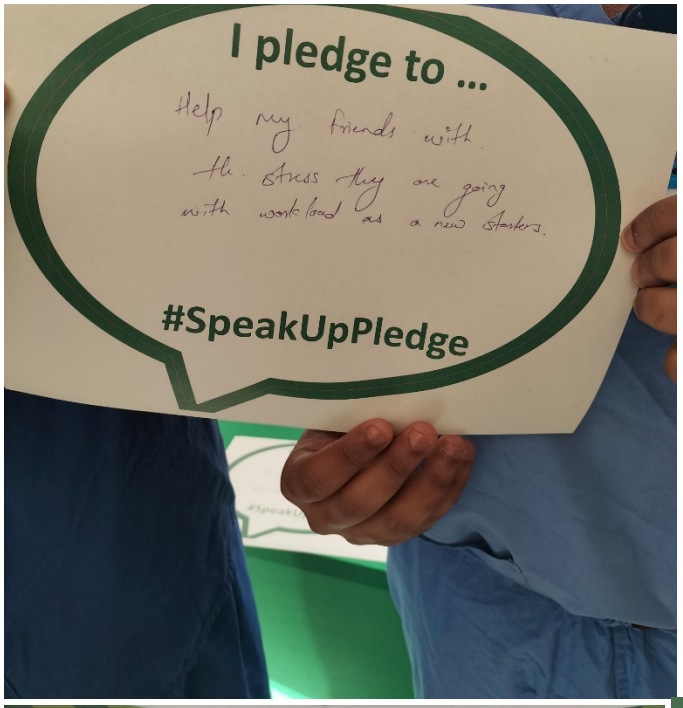
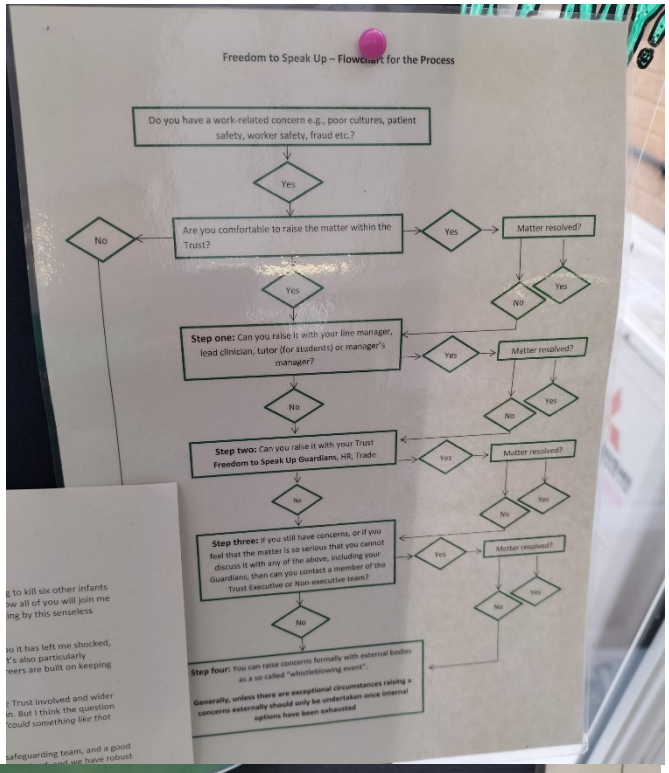
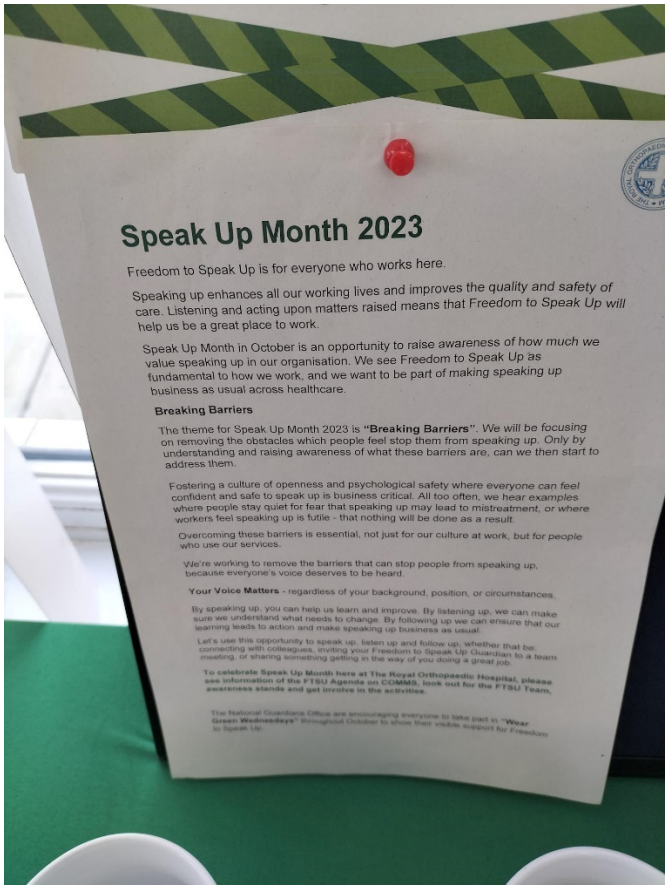
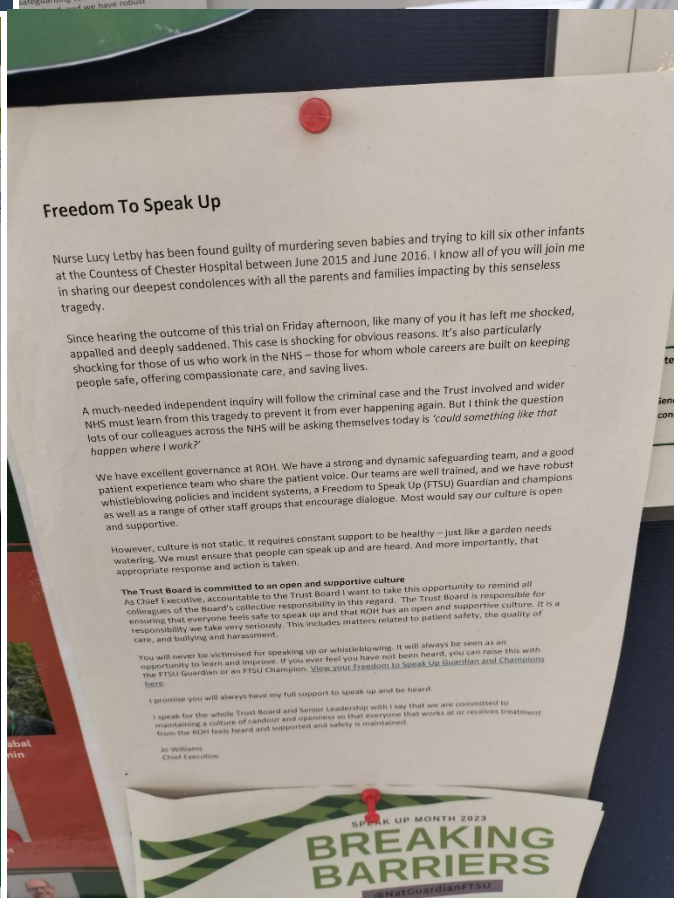
FTSU Month 2022 - 2023 photo highlights









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#SpeakUpPledge
I pledge to ...

FOR ASSURANCE

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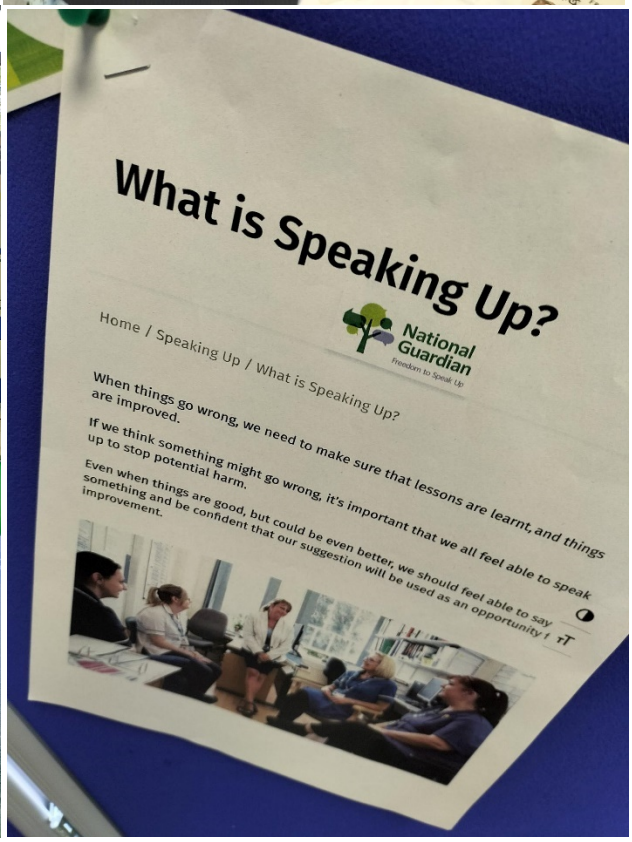

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REPORT REF: ROHTB (2/24) 006

TRUST BOARD

DOCUMENT TITLE:	Accountable Officer for Controlled Drugs - Annual report
SPONSOR (EXECUTIVE DIRECTOR):	Nicola Brockie, Chief Nurse
AUTHOR:	Sultana Begum Chief Pharmacist and Nicola Brockie CDAO
PRESENTED BY:	Nicola Brockie, Chief Nurse
DATE OF MEETING:	7 February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The purpose of this paper is to give assurance that the Controlled Drugs Accountable Officer at the Trust is fulfilling the role and provide assurance to the Quality and Safety Committee.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Number of reported CD incidents has reduced over past 2 years. • Move to electronic CD registers has been positive	• Pharmacy is reviewing SOP for CD collection to minimise CD diversion

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: accept and the approve the report

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

Financial		Environmental/Net Zero		Communications & Media	
Business and market share		Legal, Policy & Governance	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:

CQC CDAO

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

CD LIN,

Previous Considerations:

FY 22/23 Annual report

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Accountable Officer for Controlled Drugs Annual Report (Rolling Year)

Report to Quality & Safety Committee – Jan 2023 - Dec 2023

1. Purpose of this Paper

The purpose of this paper is to give assurance that the Controlled Drugs Accountable Officer at the Trust is fulfilling the role and provide that assurance to the Quality & Safety Committee. The paper is not designed to provide detailed analysis of Controlled Drugs at the Trust. This is provided to the Drugs & Therapeutic Committee via the Controlled Drugs Accountable Officer Assurance Group which reports exceptions to the Quality & Safety Committee.

2. Legislative Requirement for Controlled Drug Accountable Officer

Following the end of the Shipman enquiry in 2005, The Health Act 2006 outlined improvements in Controlled Drugs (CD) governance by introducing required designated bodies to appoint a Controlled Drugs Accountable Officer (CDAO). There have been a variety of legislative changes and introductions around CDs but the requirement to have a CDAO has not been amended. The latest legislation is The Controlled Drugs (Supervision of Management and Use) Regulations 2013 which came into force in England on 1 st April 2013.

The Royal Orthopaedic Hospital (ROH) as an NHS Foundation Trust fulfils the descriptor of "designated body" therefore has an appointed CDAO.

Within the Trust the CDAO is the Chief Nurse

The CDAO has attended a recognised CDAO two-day training course to discharge this role in November 2022. The Deputy Chief Nurse and Deputy Chief pharmacist have attended CDAO training in November 2023 for additional assurance.

Care Quality Commission (CQC) Regulation

It is also a statutory requirement that the CQC are aware of the name and role undertaking the role of CDAO, which is within the public domain of the CQC website.

The CQC website was updated with the named CDAO as Nicola Brockie (Chief Nurse).

4. Role of the CDAO

The CDAO role has a set of generic responsibilities summarised as:

- To ensure the safe and effective use and management of CD within their organisation;
- That adequate and up to date Standard Operating Procedures (SOPs) are in place;

- There are adequate destruction and disposal arrangements for CD; (Carl Measey is the designated authorised witness for stock CD destruction)
- Monitoring and auditing of the management and use of CD;
- Assessment & investigation of concerns with appropriate action taken;
- The establishment of arrangements for sharing information both externally and internally.

The CDAO at the Trust confirms these generic responsibilities are discharged within the Trust via close collaboration with the Chief Pharmacist and pharmacy team.

6. Controlled Drug Local Intelligence Networks (CDLIN).

Outside of the Trust, NHS England have a local area team CDAO to which the designated body CDAO accounts usually through the CDLIN. Outside of these meetings the CDAO at the Trust must notify the local area team CDAO of any issues which cause concern or actions being taken in relation to CD, in addition to any other responsible bodies such as the police.

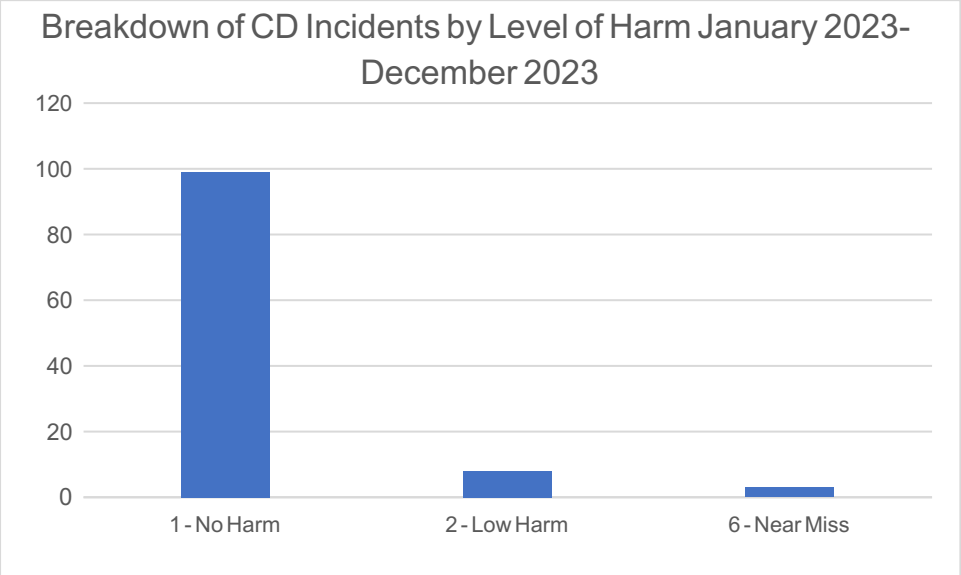
It is a statutory requirement of the Trust's CDAO that a quarterly report is provided to the CDLIN. In brief, Regulation 29 requires CDAO to give an occurrence report to the accountable officer for the local area team that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report). Attendance at the CDLIN is also required. The Chief Pharmacist may attend these meetings on behalf of the CDAO.

Table 1 - Number of Incidents reported to CD Lin over last 2 years

Jan 22-Dec 22	Jan 23-Dec 23
177	106

A more detailed analysis on the reported incidents is in section 8 (CD Incidents) below.

There has been a steady reduction in the number of incidents reported due to the move to electronic CD registers in ward areas. There is a consistent reporting rate of 25-35 per quarter which shows a positive reporting culture for CDs. Vast majority are no or low harm as shown in the bar chart below, however learning is shared and distributed from each incident theme via newsletters/ huddles. As theatres are still on paper registers, vast majority of incidents related to incomplete paper records in those areas.



7. Changes to management of low schedule-controlled drugs at ROH 2022

No further changes have been made since 2022 to schedules of drugs apart from switching to Sevredol for TTO's (Morphine Tablets) which are a schedule 2, thus require higher controls on storage compared to Liquid morphine which is a schedule 5 CD (See impact below).

Oxycodone liquid has been switched to capsules on wards to reduce liquid CD losses.

8. CD Incidents

All incidents with CD are logged on ULYSSES and the system sends an automatic notification to the CDAO at the Trust.

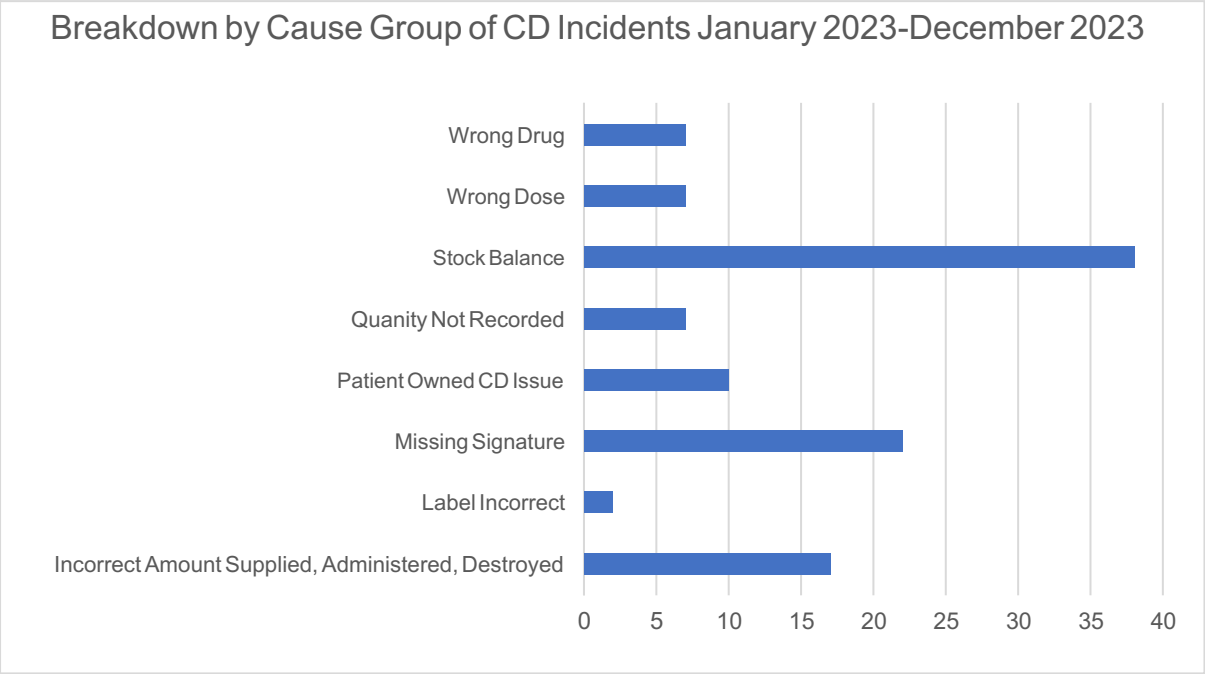
Each month an analysis of incidents is undertaken, and this is captured within a CDLIN quarterly upward report. This is used at the CDAO assurance group for scrutiny and also submitted on the required quarterly basis to the CDLIN.

All incidents are reviewed in detail at the Medicines Safety Group to ensure they are both closed and lessons are learnt within the Trust. Any trends or incidents of concern relating to CD are discussed in detail at the CDAO assurance meeting. Learning is also disseminated via the Medicines newsletter which pharmacy create bimonthly.

A spike in CD incidents are usually see when Pharmacy undertake Quarterly CD audits in all areas. There has been a steady reduction in incidents reported over the past 2 years. This is partly due to the Omnicell's and having less liquid CDS which account for majority of the unaccounted-for losses. Record keeping is an ongoing issue, particularly in theatres due to the nature of multiple practitioners being involved in the process of CD administration and reliance on paper records. Theatre Recover and HDU have Omnicell's with e-cd registers.

8.2 Incidents by cause

The key reasons for CD incident reports are consistent with previous years. Pharmacy generate incident reports from findings of the quarterly CD audits. This is above the regional requirement of providing action plans to each area. The largest number relate to loss of liquids which has been mitigated by using oxycodone capsules, these come under 'stock balance'. There are ongoing incidents relating to missing signatures in theatres due to stringent auditing requirements. There are action plans in place to address this in Theatres, reviewed by divisional leads. Incorrect administration of CDS has declined since installing the Omnicell's in ward areas. There were 3 incidents of unaccounted for losses for 2023 , one was 7 oxycodone capsules and 8 pregabalin capsules which could not be accounted for. Diversion was not suspected in either case. A box of dihydrocodeine was unaccounted for, this was not found after investigation.



CD Lin incidents for Jan -Dec 2023

All incidents of unaccounted loss are reported the West Midlands CD LIN as below:

Jan- April 2023 There were 39 incidents relating to CDs for Quarter 4 which is the average number per quarter. There were no low or moderate harm incidents. The vast majority of incidents related to liquid CD loss on wards and CD documentation errors in theatres.

- There was a notable loss of 19mls Oxycodone liquid on ward 12. Upon investigation this was unaccounted for and upon agreement with the HON. Chief Pharmacist and CDAO the Ward switched to Oxycodone capsules to prevent this happening again.
- Ward 3 had the largest number of CD incidents. One incident related to a patient receiving gabapentin instead of pregabalin which is a recurrent theme. Learning was shared vis the MSG

- Ward 3 also reported an unaccounted loss of 28 dihydrocodeine tablets which were requested from the Site co-ordinator and were left unattended by the discharging nurse. The incident has been declared to the CDLIN as it was not found. Further comms to be distributed via the medicine's links and MSG regarding safe custody of dihydrocodeine.
- Ward 3 went live with their Omnicell end of April 2023 when Cd incidents declined
- Ward 2 had an incident relating to Morphine capsules being administered against a prescription for tablets. Learning was shared with the pharmacy team and the ward.

April – June 2023 There were 7 incidents of unaccounted for loss of which 5 related to liquid losses.

- 1 incident was reported to CDLIN as an unaccounted loss of a schedule 2 drug. (Incident 43853) A patient in discharge lounge was given 7 oxycodone capsules 5mg which the family stated they did not find. 2 nurses had signed this out and it was never found. This was the first incident in DL.
- 1 incident related to a Alfentanil ampoule which was broken (44072) there have been at least 3 other incidents like this in previous 2 years. We have now switched manufacturer, but all occurred in different Theatres with different ODPs.
- There were 6 incidents related to Gabapentin and Pregabalin- mostly balance discrepancies. This is a recurring theme and is largely due to the frequency of administration. Ongoing awareness is raised via pharmacy to nursing teams and via the medicine's newsletter.
- 1 incident (43334) related to a patient receiving the wrong dose of midazolam in ADCU (50mg instead of 20mg). Guidelines were reviewed and doses clarified. Professional discussions and learning took place.
-

July-Sept 2023

- There were 2 dispensing errors that were picked up by the ward relating to incorrect CDs dispensed. One was regarding 29 capsules being dispensed for instead of 21 Pregabalin (45233). Pharmacy have reviewed processes to ensure that correct process for dispensing is followed particularly towards the end of the day when drugs are collected by wards.
- Vast majority of incidents related to documentation standards in paper registers in theatres. There is an ongoing action plan to address this.
- There were a small number of incidents relating to gabapentin and pregabalin, these were administered correctly but booked out wrong in the registers. All errors were rectified.
- There were no cases of suspected divergence / missing CDS not accounted for in this quarter.

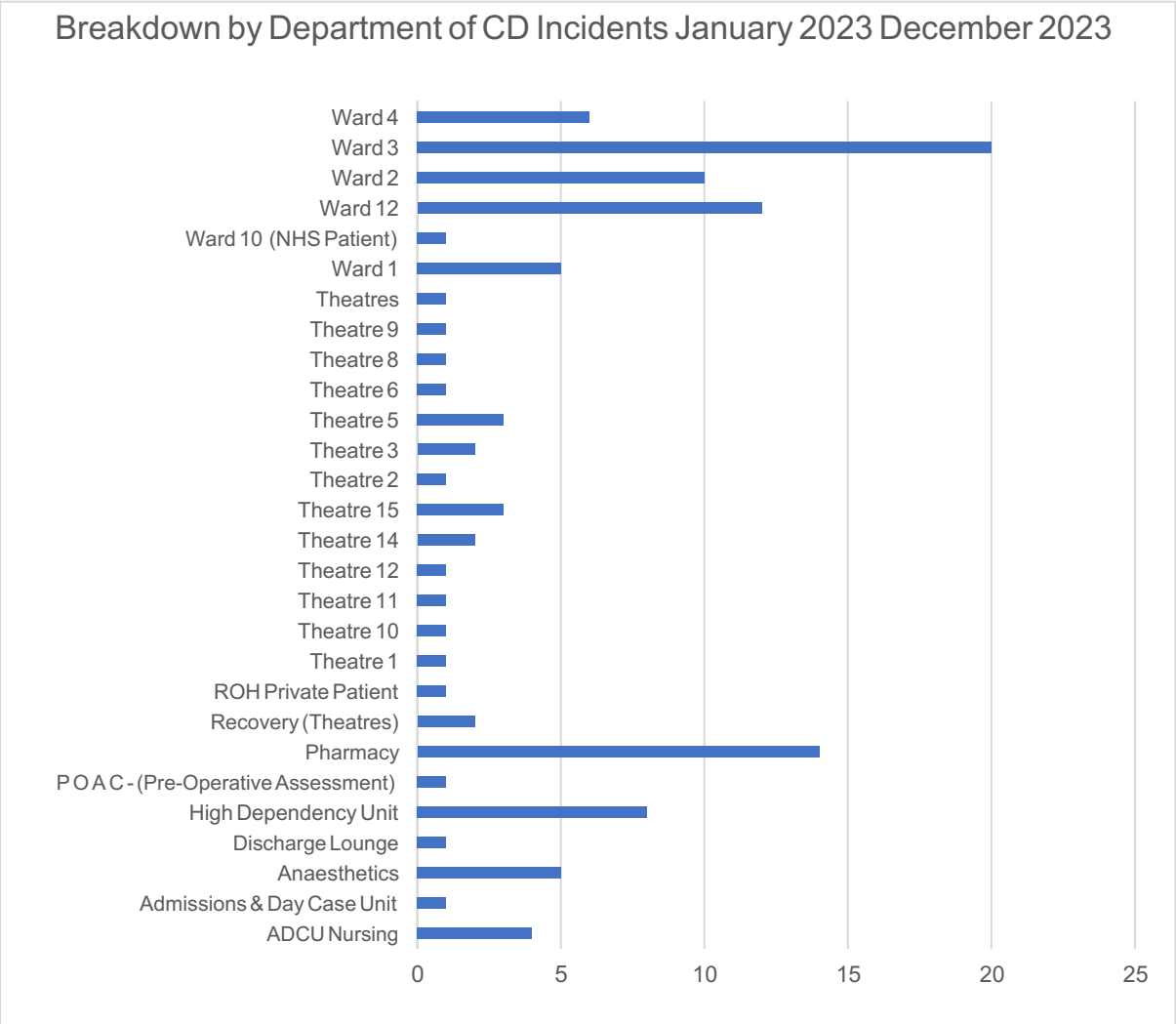
Oct-Dec 2023

- There were 3 incidents related to spillage of oral morphine liquid which were reported and identified correctly which provides positive assurance around accounted for losses

- Pharmacy reported an unaccounted-for loss of 8 Pregabalin capsules. This was thoroughly investigated and believed to have been disposed of accidentally.
- There were a couple of incidents which were related to Patients bringing in lower schedule CDS such as Pregabalin and Gabapentin which were not stored correctly, learning was shared with ADCU and wards to ensure correct transfer of patients own medicines and safe custody requirements.

8.3 Where the Incidents Occurred.

Most incidents relate to wards with high CD usage and theatres. These are largely down to Liquids and are reducing due to switching to Capsules instead of liquids for Oxycodone.



9. CQC self-assessment tool 2023

An annual self- assessment against CQC standards was undertaken by the Chief pharmacist in April 2023 and submitted to DTC for review. This includes reviewing SOPs, governance processes, prescriptions, ordering, transport and supply of CDs. Out of 74 standards only 2 were identified as requiring some improvement. This gave a compliance rate of 97.2%. The two areas for improvement were related to providing feedback to prescribers on their CD usage. It was decided this occurs daily on wards for prescriptions and will continue to be ad-hoc if anything is flagged on ADIOS or PICS reviews via audits. The second area was identified as evidencing SOPS had been read by clinical staff. Local records are held in some areas, however a digital governance system would help with this. This has been raised with the governance team and a new system is being looked at to improve this.

CQC annual report update 2023

A summary of key points raised in the annual CQC report are included below. The recommendations will form the action a plan for 2024 which is outlined at the end of the paper. This will be monitored by the CDAO group meeting.

1. Collection of CDs form pharmacy

Poor governance processes around the collection of CDs directly from pharmacies have been associated with an increased risk of diversion. This is when staff have delivered CDs to patients directly. ROCS have a specific SOP in place to ensure CDs are delivered.

At ROH Pharmacy staff never deliver CDs – CDs are not delivered to patients' homes.

2. Unless in exceptional circumstances, staff involved in the prescribing of controlled drugs for patients must have relevant information from the patients' medical records. Otherwise, they cannot prescribe.

At ROH Most controlled drugs within the trust are prescribed for inpatients and on discharge. Prescribers will have access to patient medical records via PICS. OPD prescribing remains very low and FP10 prescribing is monitored via the OOH Omnicell.

3. Transdermal patches

There continues to be patient harm because of inadequate risk assessments and monitoring. There is a paper form available to support nursing staff to manage transdermal patches appropriately. No incidents have been entered in the last 12 months regarding patches.

4. STOMP guidance

It is important that prescribing of controlled drugs such as benzodiazepines or Z-drugs for people with learning disability, autism or both is appropriate. Where possible, non-drug options are available.

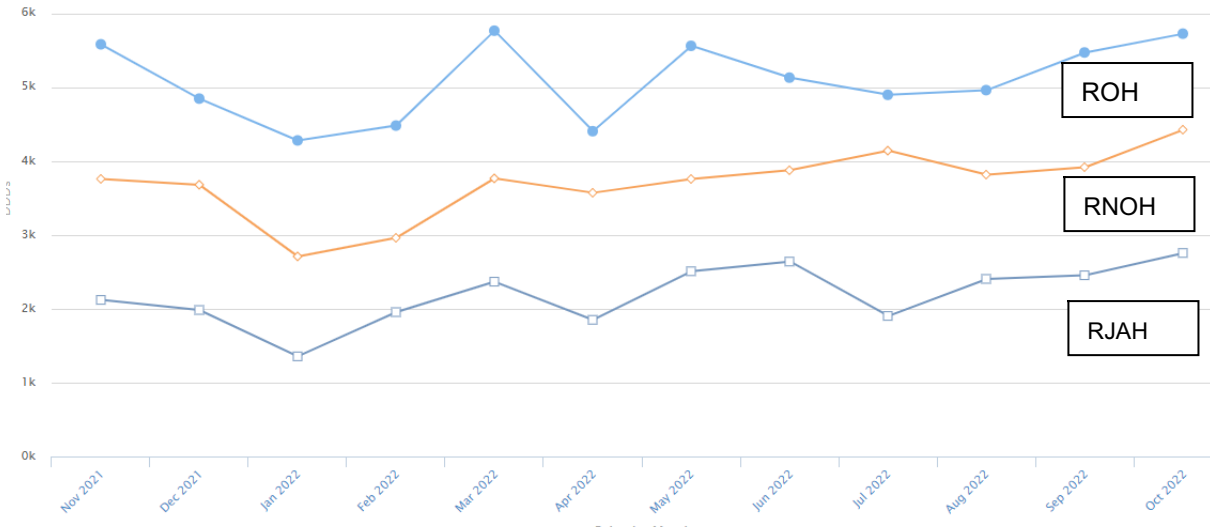
10. CD usage trend analysis – Adios

CD usage is monitored using Adios which is a benchmarking tool and issues alerts when there is an increase in usage compared to baseline activity. These are all investigated by pharmacy on a monthly basis and reported to the CDAO group.

Oramorph prescribing data was analysed to monitor consumption using benchmarking. Total opiate use was also analysed to ensure the Trust is issuing Opiates in line with other Orthopaedic centres.

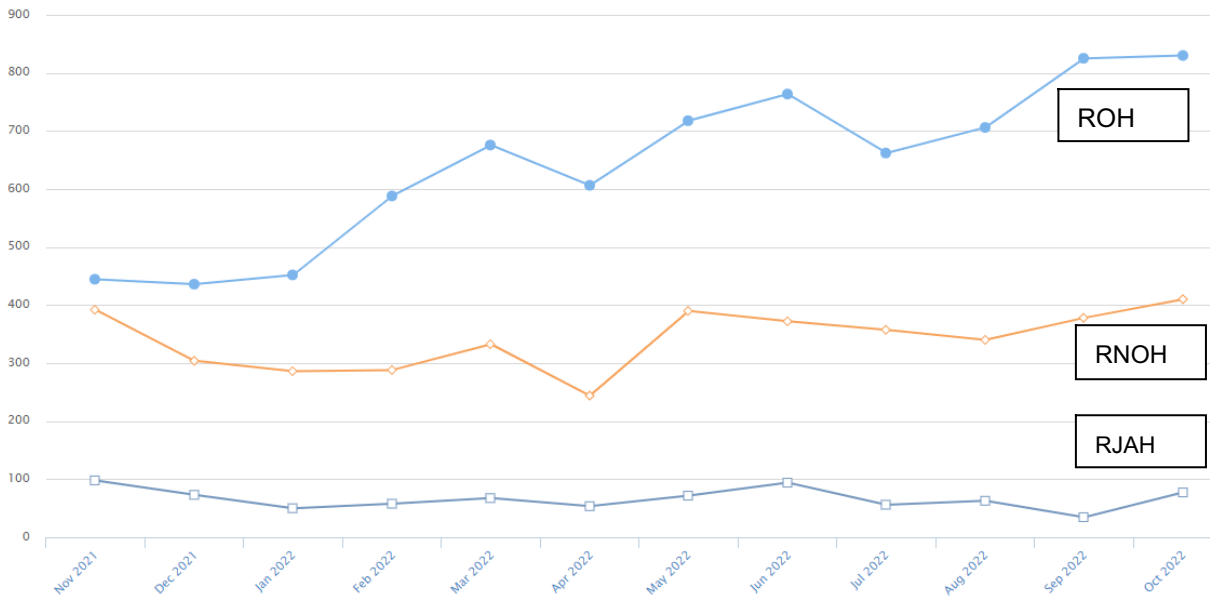
The following Graphs are taken from ADIOS and depicts the total opiate usage in the 3 specialist Orthopaedic Organisations. This is weighted by activity and bed days. ROH was the highest user of opiates out of the 3 Trusts in 2022 (graph 1). In January 2023 A decision was made at DTC to reduce the number of oral morphine doses provided on discharge to 7 morphine tablets instead of issuing 100mls of liquid oral morphine (20 doses). This led to a rapid decline in total opiate doses issued and brough us in line with our peers.

Total opioid consumption ROH vs Other specialist Orthopaedic Trusts in DDD 21- 2022



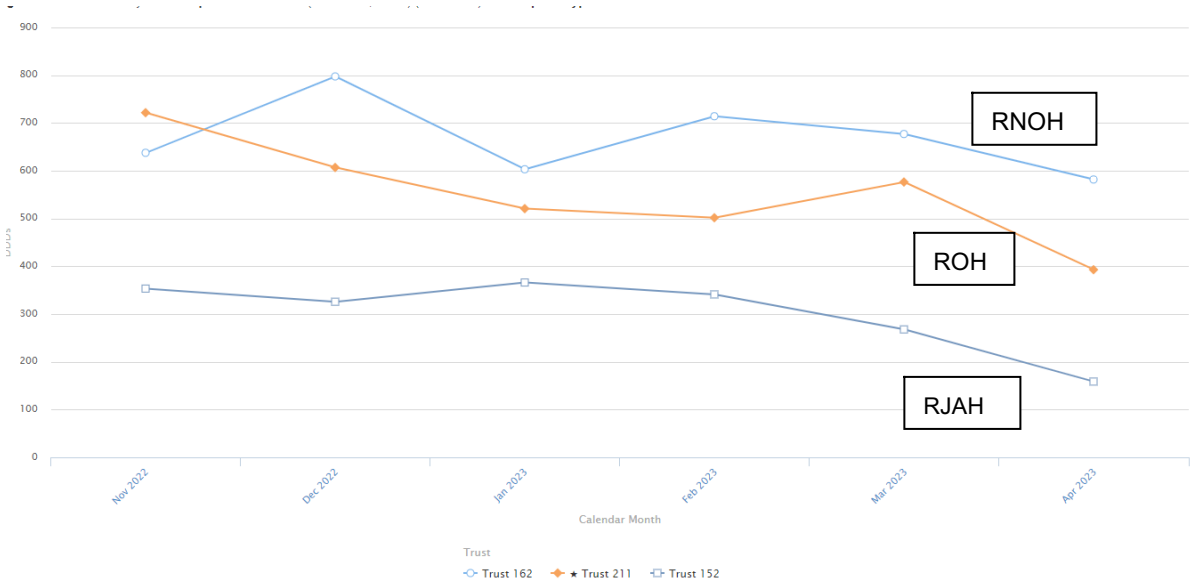
Morphine Sulphate liquid (Oramorph)

- In 12 months (Nov 2021 – Oct 2022) 2819 bottles of Oramorph (10mg/5ml) issued as TTO of which there were 103 returns (approx. 3.2%)

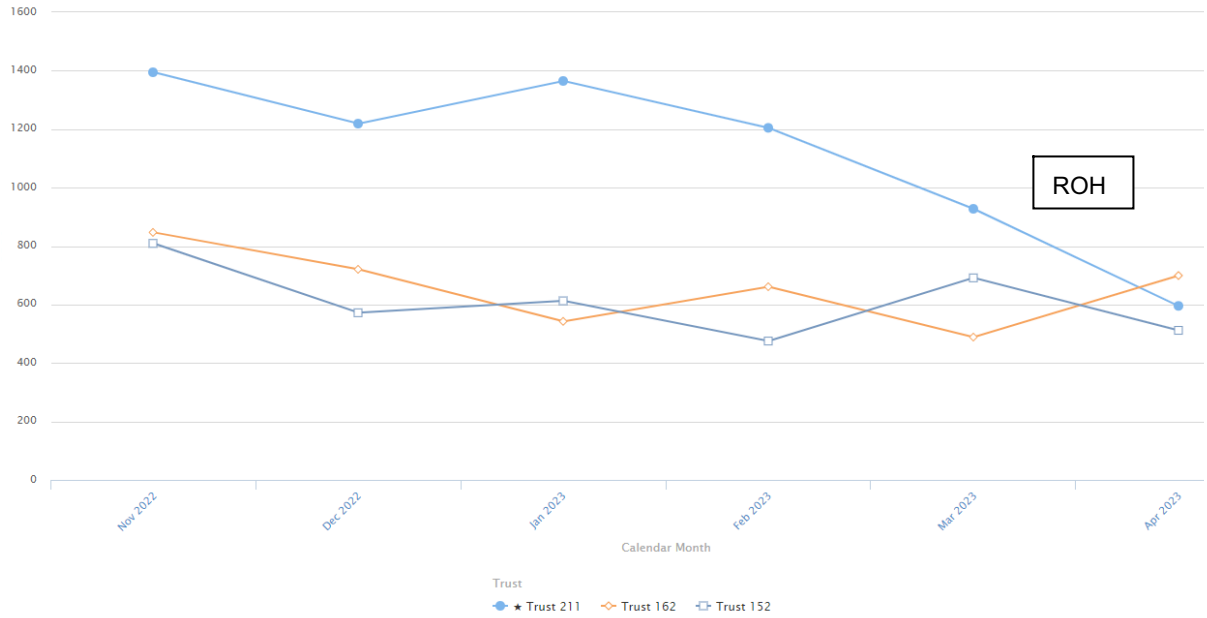


There is a significant opportunity to rationalise Opiate prescribing on discharge and ensure opiates are used appropriately in line with national programmes to reduce the prescribing of drugs that cause dependence. Pharmacy worked with clinicians on how to optimise the use of non- opiates and opiates without impacting effective pain management and patient experience. An action plan has been drawn up and discussed at DTC following an audit in TKR patients which suggests that Oramorph use needs to be rationalised both for inpatients day cases and on TTO's. Following an awareness campaign by pharmacy the opiate usage trend reversed and was in decline. Therefore, reducing unnecessary opiate prescriptions to patients on discharge and for day cases.

- Oxycodone – DDD's last 6 months (orange line)



- Morphine – DDD's last 6 months (top blue line)



Adios software is used to identify any trends in usage and will continue to be monitored. Further opioid reduction strategies will need to be implemented via ongoing education from an acute pain team, taking a multidisciplinary approach.

11. Standard Operating Procedures & Policies

The Trust has SOPs for CDs which are within date, and other details of the management of CDs are contained in the Medicines Management Policy which was updated to include all the Omnicell SOP changes in December 2023. Ongoing changes are made to the Pharmacy Omnicell SOPs to improve current processes and reporting of discrepancies on digital registers.

12. Destruction and Disposal Arrangements for CDs

The Trust has a process for the destruction of CDs, this is incorporated into the Medicines Management Policy. A T28 Certificate has been renewed in December 2023 and will last for a period of 3 years.

The regulatory requirement is that the person witnessing destruction is not involved in the destruction of CD in any way, therefore the witnessing of destruction is undertaken at the Trust by the Health & Safety Manager, who has received training and been DBS checked which also fulfils the requirement. The Trust is therefore compliant in its destruction of CD requirements.

13. Conclusion

The Accountable Officer confirms that the Trust fulfils legislation and CQC requirements by having a named CDAO who has received appropriate training who as part of their duties does not routinely become involved in CD.

The Accountable can provide assurance on the safe and effective management of controlled drugs at ROH by:

- Maintenance of professional knowledge of the CDAO by attendance at professional updates:
  - Attendance at the CDLIN and sharing through the CDLIN occurrence report issues around CD within the Trust.
  - A Governance framework which allows the Trust Board to be aware of the use and management of CD within the Trust by audits of management and usage of CD; The use of Adios has allowed benchmarking and interventions to be implemented to reduce opiate use such as the switch to Morphine tablets on discharge.
  - An incident reporting mechanism that allows the CDAO to be aware of all CD incidents and unaccounted for CDs within the Trust and evidence escalation to the Local Area Team CDAO.
  - Mechanisms for destruction and disposal of CD take place in pharmacy in a risk assessed environment.
  - A detailed audit programme exists within the Trust with frequent reviews of action plans for all clinical areas.
  - The roll out of automated CD cabinets and e-cd registers has improved documentation standards and security of CDS and reduced liquid discrepancies.
  - Candid reporting of diversion incidents suggests an open reporting culture with shared learning being disseminated via governance structures.
  - Continued engagement with pharmacy and various departments and escalation via MSG CDAO group to DTC to QSE.

Ongoing recommendations from CQC annual report 2024:

1. To audit controlled drug prescribing activity at least 6 monthly and feedback trends to CDAO group.
2. Pharmacy to review its standard operating policies (SOPs) for CD collection to ensure they are robust and help minimise CD diversion.
3. To audit the paper trail used by the ROCS team for delivery of CDs to patients to ensure process Is being followed.
4. Audit Fp10s and OPD CD prescribing at least 6 monthly and feedback trends to CDAO group.
5. Transdermal patch training to be incorporated into annual update for registered practitioners.

6. Request that the learning disability and autism team audit the trusts current practices regarding STOMP and report the finding to the CDAO and other relevant groups.
7. Pharmacy to develop a patient information leaflet on ‘safe storage of medicines (controlled drugs) in the home.
8. Consider switching from a liquid oral opioid to an orodispersible tablet. This may reduce the risk of unintentional overdosing and allow better control on the quantity of controlled drugs issued on discharge. These products would be schedule 2 and therefore, the trust would need to consider the implications of this.
9. An action plan needs to be developed by all relevant stakeholders to better understand local controlled drug prescribing practices and a process implemented to prevent excessive controlled drug prescribing on TTO’s.
10. A Pharmacist will be attending the forums for safeguarding and learning disabilities to review opportunities for using STOMP at ROH

Nicola Brockie CDAO and Chief Nurse

Sulthana Begum Chief Pharmacist

REPORT REF: ROHTB (2/24) 007

TRUST BOARD

DOCUMENT TITLE:	Infection Prevention & Control Annual Report FY 22/23
SPONSOR (EXECUTIVE DIRECTOR):	Nicola Brockie Chief Nurse / Director of Infection Prevention & Control
AUTHOR:	Victoria Clewer – Lead IPC Nurse
PRESENTED BY:	Victoria Clewer – Lead IPC Nurse
DATE OF MEETING:	7 February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This annual report provides an overview of the IPC performance from 1 April 22 to the 31 March 2023.

HACI reported in year:

- Clostridioides difficile infection (threshold 5 healthcare-associated cases) 8 cases reported.
- Klebsiella species bacteraemia – one case reported.
- COVID-19 - 37 patients that tested positive. With 5 outbreaks, 2 of which were in clinical areas and involved patients.

This report demonstrates how the Trust has systems in place for compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this there are two principles:

- to deliver continuous improvements of care.
- it meets the need of the patient.

Compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections is monitored against 10 criteria outlined in the report.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Zero cases of MRSA bacteraemia which is the same compared to the previous 10 years. • Strengthened system working ensured inclusion and representation of ROH at associated forums. • Carbapenem consumption has decreased compared to the previous financial year. • The Trust has achieved the CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+ with an overall compliance	• Clostridioides difficile infection (threshold 5 healthcare-associated cases) 8 cases reported. This was a national trend upwards. Work was carried out to improve awareness ands compliance with best practice. • Increase in Surgical Site Infection reported in year. o Hips - SSI rate was 0.6%. This is 0.3% above the national benchmark of 0.3%

of 45%.

- Regular medicines review with long term Bone Infection Service patients via telephone.

- Continued to deliver and improve the IPC training and education programme provided across the Trust.
- Organised and celebrated several key events in the IPC calendar across ROH, this included RCN Glove Awareness Day 2022, World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2022.

  - Knees - SSI rate was 0.4%. This is 0.2% above the national benchmark of 0.2%
  - Spinal - SSI rate was 1.2%. This is 0.3% above the national benchmark of 0.9%.
- Focused work carried out to address concerns – with Theatre Focus Group targeting specific areas of work.

NOT APPLICABLE

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: note and approve the report for publication on the Trust website.

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

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

Comments:

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

IPC BAF, IPC operating plan, AMS plan FY 21-22

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

Keeping people safe

PREVIOUS CONSIDERATION:

FY 21/22 Annual report.

Infection, Prevention and Control
Annual Report Summary 2022 / 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

Vision
Preventing harm from infection by delivering clean, safe care

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

The Royal Orthopaedic Hospital is committed to maintaining the highest standards of infection prevention and control (IPC). 2022 - 2023 has seen significant progress and this is reflected in the clinical outcomes of our patients. The IPC team continues to be committed to fostering and maintaining a safe and aware culture when professionals feel supported, and patients are safe.

Key Achievements of 2022/23

0 cases of MRSA bacteraemia (continuing our 10 year record of having 0 cases in the Trust.

Worked well with system collleagues, ensuring ROH was represented at important forums.

Carbapenem consumption has decreased compared to the previous financial year.

Achieved the CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+

Delivered comprehensive IPC training across the Trust and improved the training course.

Delivered an programme for pharmacy on antimicrobial stewardship and prescribing.

Contributed to IPC awareness culture by marking important campaigns with engagement events.

Delivered regular medicines review with long-term bone infection service patients via telephone.

The role of the IPC team

1. To have policies, procedures and guidelines for the prevention, management, and control of infection in place across ROH.
2. To communicate information relating to communicable disease to all relevant staff within ROH.
3. To ensure that training in the principles of infection prevention and control is accurate and appropriate to the relevant staff groups.
4. To work with clinicians to improve surveillance and to strengthen prevention and control of infection.
5. To provide appropriate infection control advice to key ROH committees, taking national guidance and policy into account.
6. To share information with relevant stakeholders within the NHS when transferring the care of patients to other healthcare settings.
7. To ensure high standards of infection control are maintained throughout ROH through a programme of audits and surveillance.

Our focus for the future

The focus for the IPC team and the Trust remains on improving and maintaining infection prevention and control practices, supporting patient care pathways and enhancing and improving clinical practice.

We must continue to evaluate and consider each step to ensure that patient safety remains at the forefront, while supporting the health and wellbeing of our team.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

Infection Prevention and Control

Annual Report 2022/2023

Infection Prevention and Control Annual Report 2022/23

Foreword by the Director of Infection Prevention and Control (DIPC)

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

I am proud to be able to present the Infection Prevention and Control annual report for 2022/2023.

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

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

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

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors, and volunteers across ROH, Clinical Commissioning Groups and the UK Health Security Agency (UKHSA) in relation to the prevention of HCAIs.

Nicola Brockie
Chief Nurse and Director of Infection Prevention and Control

Key Achievements of 2022/23

- The Trust reported zero cases of MRSA bacteraemia which is the same compared to the previous 10 years.
- Strengthened system working ensured inclusion and representation of ROH at associated forums.
- Continued to deliver and improve the IPC training and education programme provided across the Trust.
- Organised and celebrated several key events in the IPC calendar across ROH, this included RCN Glove Awareness Day 2022, World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2022.
- Carbapenem consumption has decreased compared to the previous financial year.
- The Trust has achieved the CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+ with an overall compliance of 45%.
- Educational programme for pharmacy team implemented including sessions on antimicrobial stewardship and prescribing.
- Regular medicines review with long term Bone Infection Service patients via telephone.

Key areas of Focus for 2023/24

Infection Prevention and Control is a top priority at The Royal Orthopaedic Hospital NHS Foundation Trust. Keeping our patients safe from harm is everyone's responsibility. The Infection Prevention & Control Team endeavour to support the delivery of continual improvement in order to deliver the best care for everyone and keep our patients at the heart of everything we do.

Our operational objectives for 2023/24 will focus on improving outcomes for our patients and provide a framework for our operational work plan, this includes:

- Embedding exemplary infection prevention and control practices by staff who are competent and confident in recognising and addressing infection prevention and control related risks and concerns.
- Providing a framework for appropriate antimicrobial usage, optimising treatment, and minimising the risk of healthcare associated infections.
- Providing a healthcare environment that is clean, safe and facilitates the prevention and control of infection.
- Working collaboratively with patients, patient advocates, Trust colleagues, system partners and commissioners as well as wider national organisations to improve the care we provide by being open, transparent, and inclusive.

Introduction

Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained. This report demonstrates how the Trust has systems in place for compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this there are two principles:

- to deliver continuous improvements of care.
- it meets the need of the patient.

Compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections is monitored against 10 criteria which we will look at in detail in the next section.

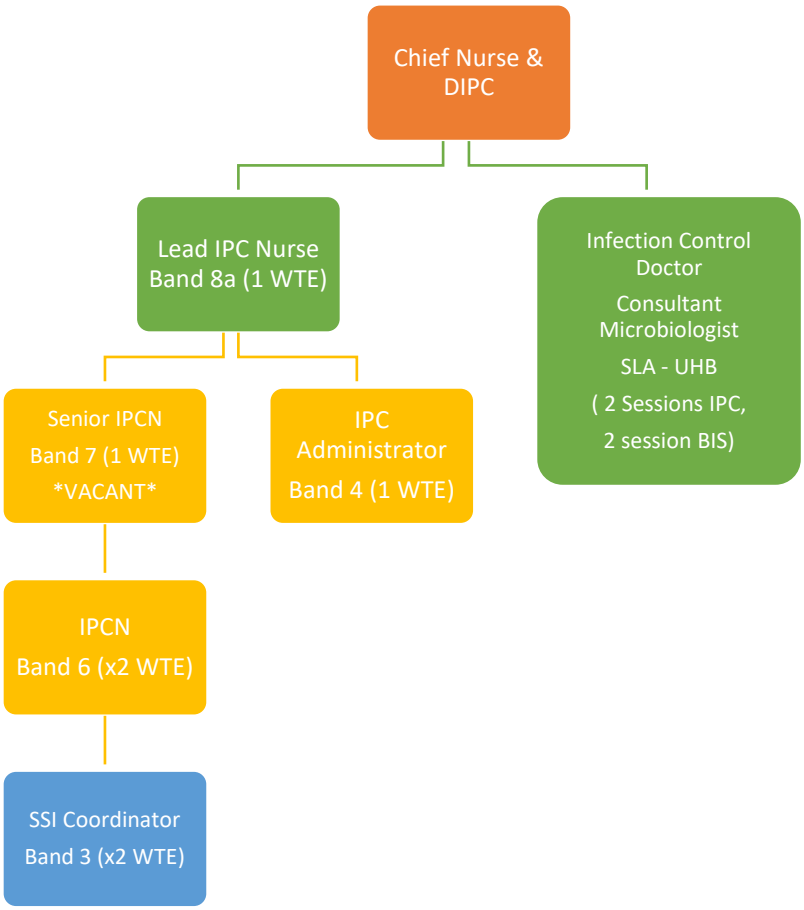
ROH IPC Vision

Preventing harm from infection by delivering clean, safe care.

ROH IPC Mission

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

Infection Prevention and Control Team Structure **(Criterion 1)**



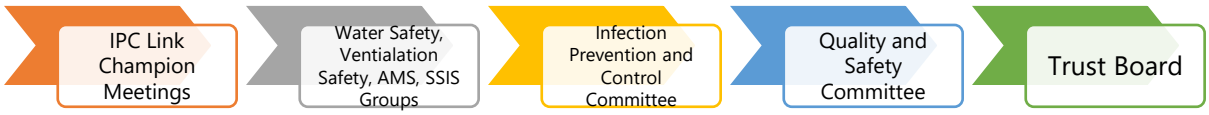
- Specialist IPC Team- Providing expert IPC advice and delviering IPC programme. Monday to Friday
- 24 hour access to Microbiologist advice - provided via SLA with UHB
- IPC doctor - SLA with UHB
- The IPC service is provided through a structured annual programme of work

During 2022/23 there were several changes of personnel and structure within the IPCT. The Bone Infection Service was funded to be a standalone service which combined with the formation of a new major revision service, to meet the ever-growing needs of the Trust which is external to the IPCT and managed separately.

External Reviews

No external reviews of IPC practice were undertaken during 2022/23.

Committee Structures and Governance



The Trust Infection Prevention and Control Committee (IPCC) is held bi-monthly and is chaired by the DIPC. A workplan is in place which details the cycle of reporting. Each clinical division and specialist service reports according to this to provide information by exception relating to IPC issues within their areas and assurance of mitigating actions taken to address these.

The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to reducing and preventing HCAIs. The Committee has a designated Non-Executive Director as a core member.

The Trust IPCC met bi-monthly between April 2022 to March 2023.

Assurances associated to Trust IPC matters is also provided by the DIPC, quarterly to the Quality and Safety Committee (QSC), which reports directly to Trust Board.

To keep IPC high on the agenda the IPCT regularly attend and champion IPC at many of the Trusts' forums and meetings.

To keep IPC high on the agenda the IPCT regularly attend and champion IPC at many of the Trusts' forums and meetings.

Collaborative Working

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

- Regional and national meetings with NHS England and Improvement (NHSE/I).
- Birmingham and Solihull (BSOL) system IPC Meetings.
- National personal protective equipment forums.

Infection Prevention Surveillance **(Criterion 1)**

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

- *Clostridioides difficile* infection (CDI)

- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* (*E coli*) bacteraemia
- *Klebsiella species* bacteraemia
- *Pseudomonas aeruginosa (P. aeruginosa)* bacteraemia
- Quarterly Mandatory Laboratory Return (QMLR)

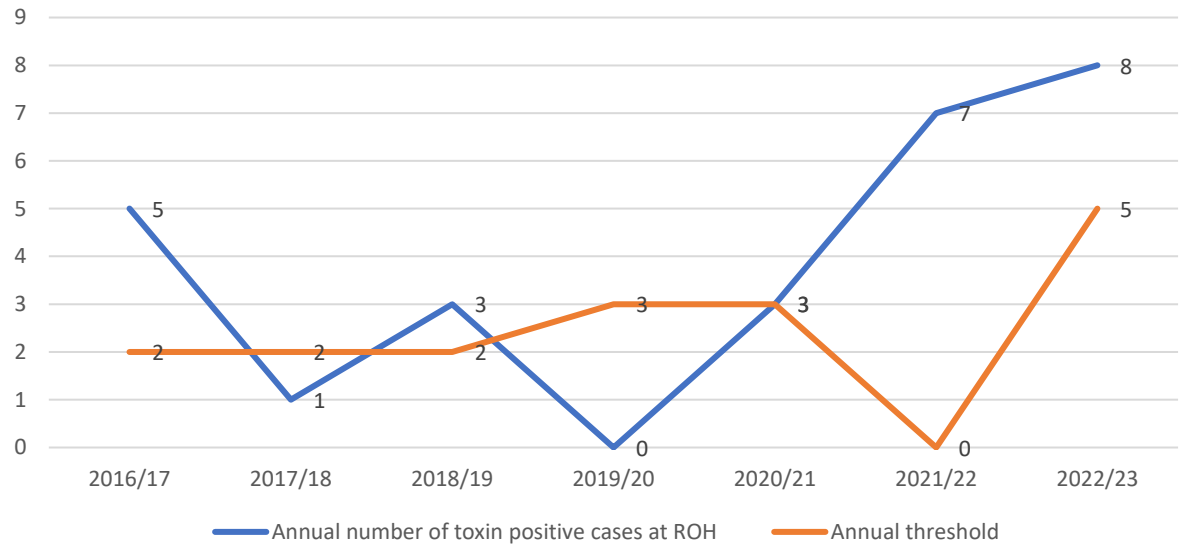
Performance is monitored by Birmingham and Solihull Integrated Care Board (formerly Clinical Commissioning Group - CCG).

National reduction objectives have been set for five of the six HCAI included in mandatory surveillance and due to the impact of the COVID-19 pandemic on hospital admissions the baseline period used to set these objectives was the calendar year 2019. MSSA is the only HCAI without a national objective.

Clostridioides difficile **Infection (CDI)**

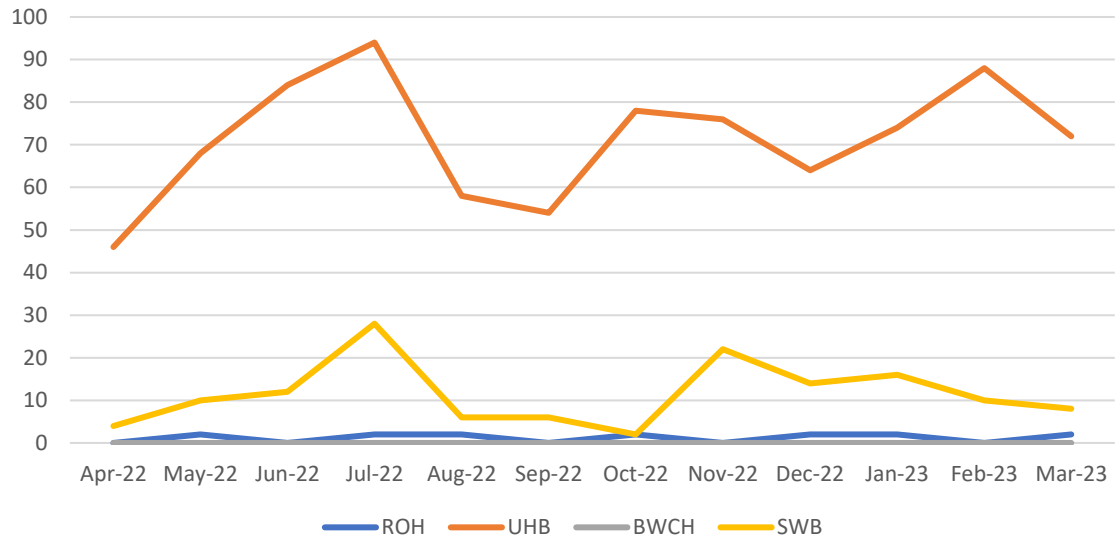
All toxin positive cases of CDI are reportable to UKHSA via the HCAI data capture system (DCS), and since April 2020, all healthcare associated (HOHA and COHA) cases count towards the ROH threshold.

Total number of toxin positive CDI reported by ROH annually



As can be seen in the table below, ROH contributes relatively few cases of *Clostridioides difficile* (*C. difficile*) to the overall BSOL system totals.

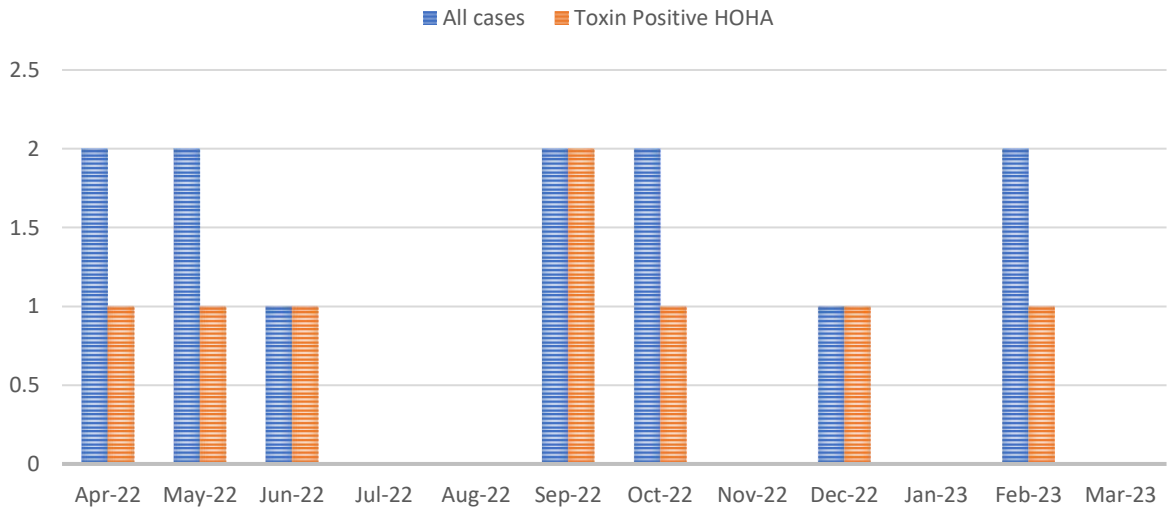
CDI cases reported by Trusts within BSOL system 2022/23*



*Data obtained from https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure

Trusts are required under NHS standard contract to minimise rates of *Clostridioides difficile* so that they are no higher than the threshold level set by NHS England. The ROH CDI 'threshold' for 2022/23 was set at 5 healthcare-associated cases. For 2022/23 ROH reported 8 healthcare associated cases of CDI.

CDI cases reported by ROH between April 2022 and March 2023

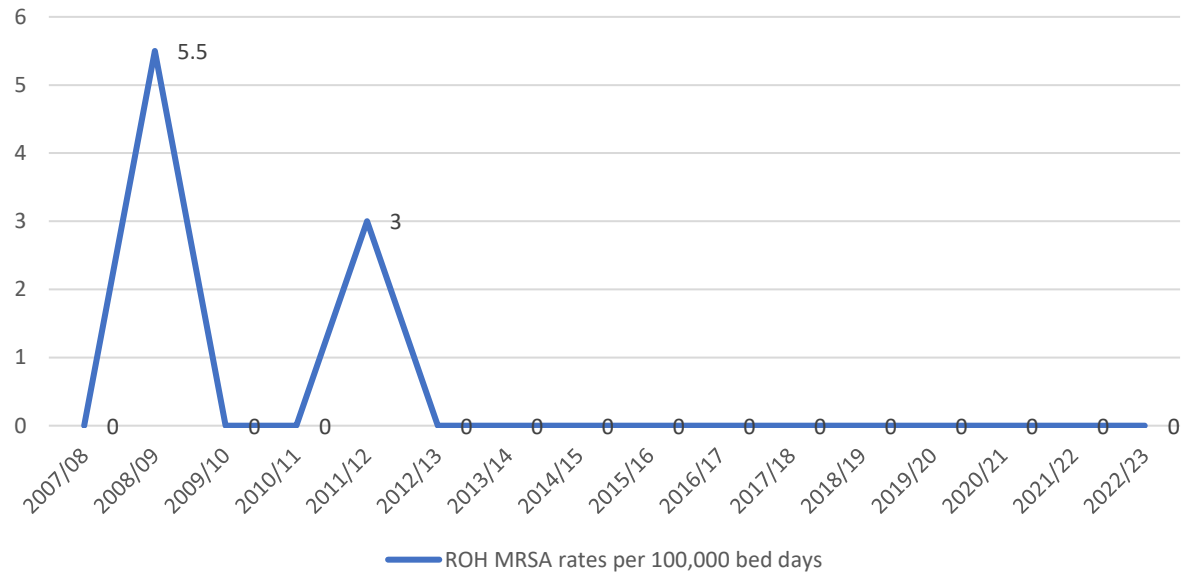


Up to and including 2022/23, NHS organisations have continued to be required to demonstrate year on year reductions in *Clostridiodies difficile* Infection (CDI) cases. However, as published national data shows, the rate of improvement for CDI has slowed over recent years.

MRSA Bacteraemia

During 2022/23 ROH reported zero cases of MRSA bacteraemia which is the same compared to the previous 10 years.

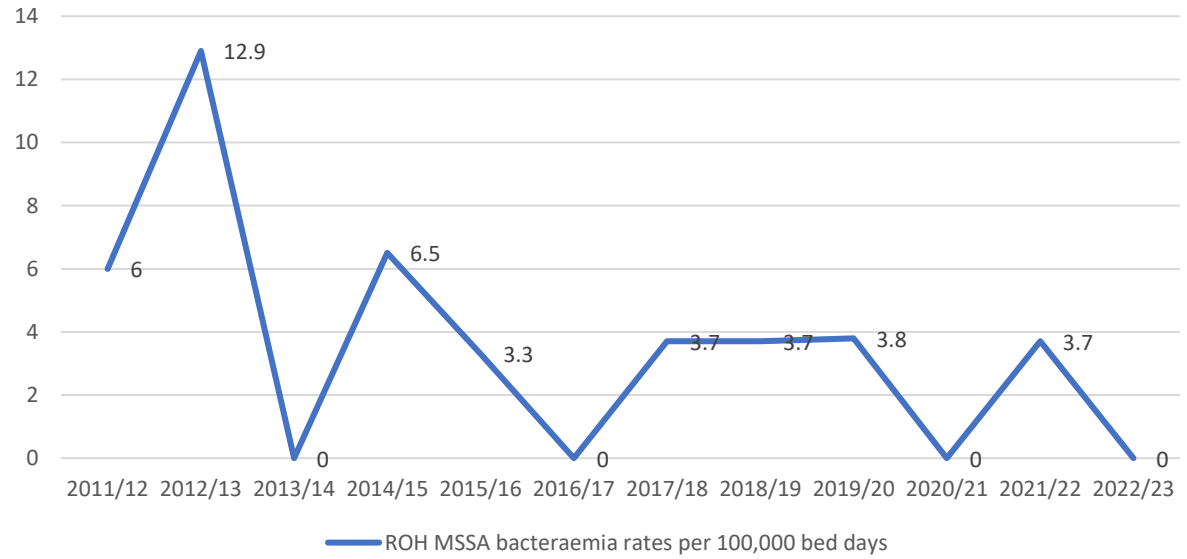
Methicillin resistant *Staphylococcus aureus* blood stream infections ROH rate per 100,000 bed days



MSSA Bacteraemia

ROH reported 0 MSSA bacteraemia during 2022/23. This is a decrease in cases from 2021/22 in which 1 case was reported.

MSSA bacteraemia rates per 100,00 ROH bed days



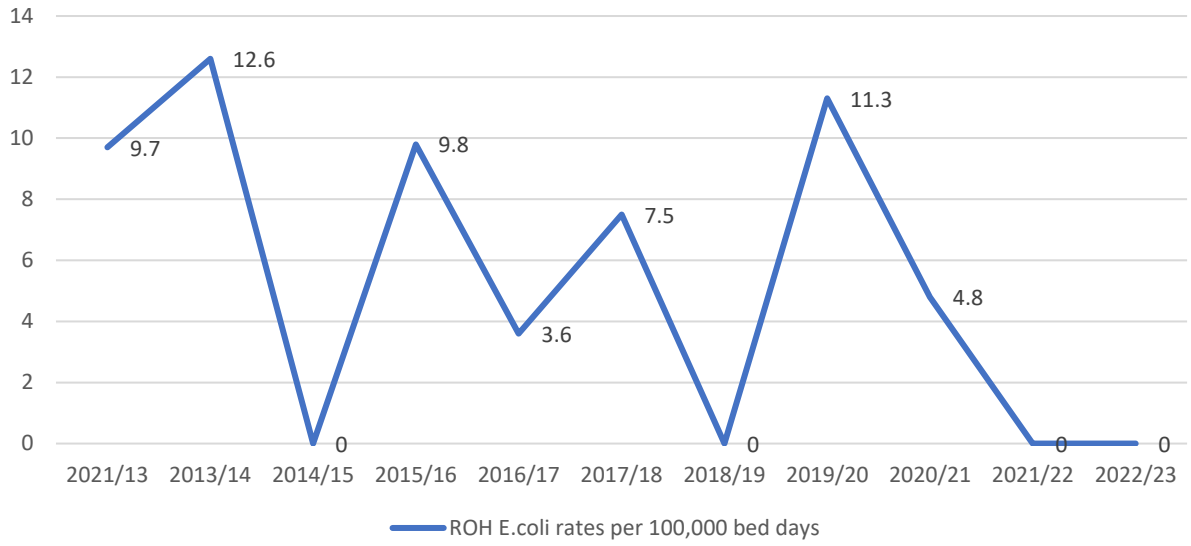
Gram-negative Organism Bacteraemia

Gram-negative bacteria such as *Escherichia coli*, *Klebsiella spp.* and *Pseudomonas aeruginosa* are the leading causes of healthcare associated bacteraemia.

***Escherichia coli* (*E. coli*) Bacteraemia**

ROH reported 0 *E. coli* bacteraemia during 2022/23. This is the same as the number of cases reported during the previous year.

ROH annual *E. coli* bacteraemia rates per 100,000 bed days

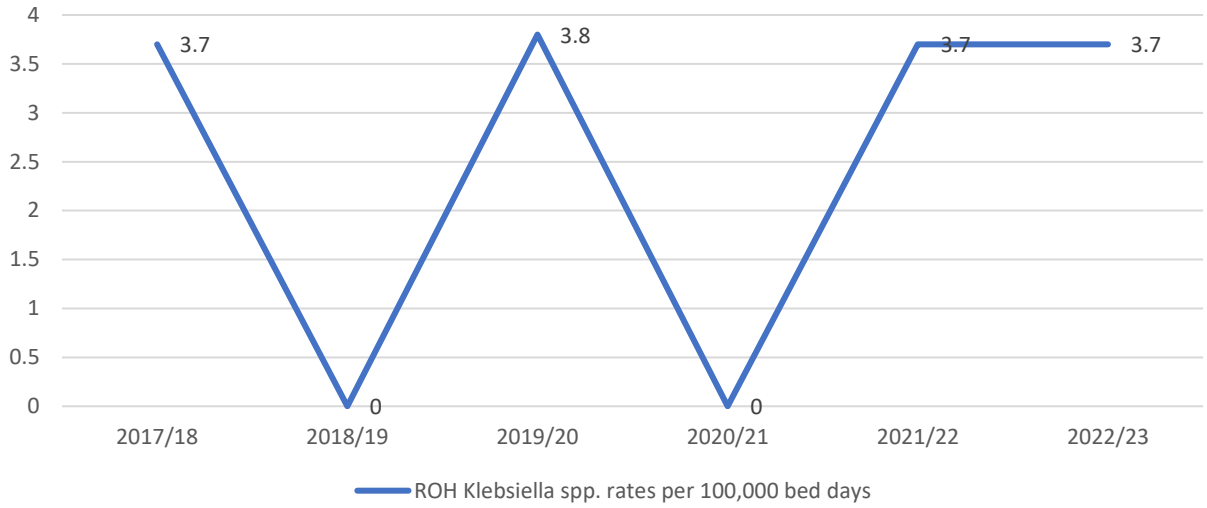


***Klebsiella spp.* Bacteraemia**

ROH reported 1 *Klebsiella spp.* bacteraemia during 2022/23. This is the same as the number of cases reported during the previous year.

The case was subject to a PIR which found no clear source of infection. The patient had multiple risk factors and invasive devices which may have contributed to the development of the bacteraemia.

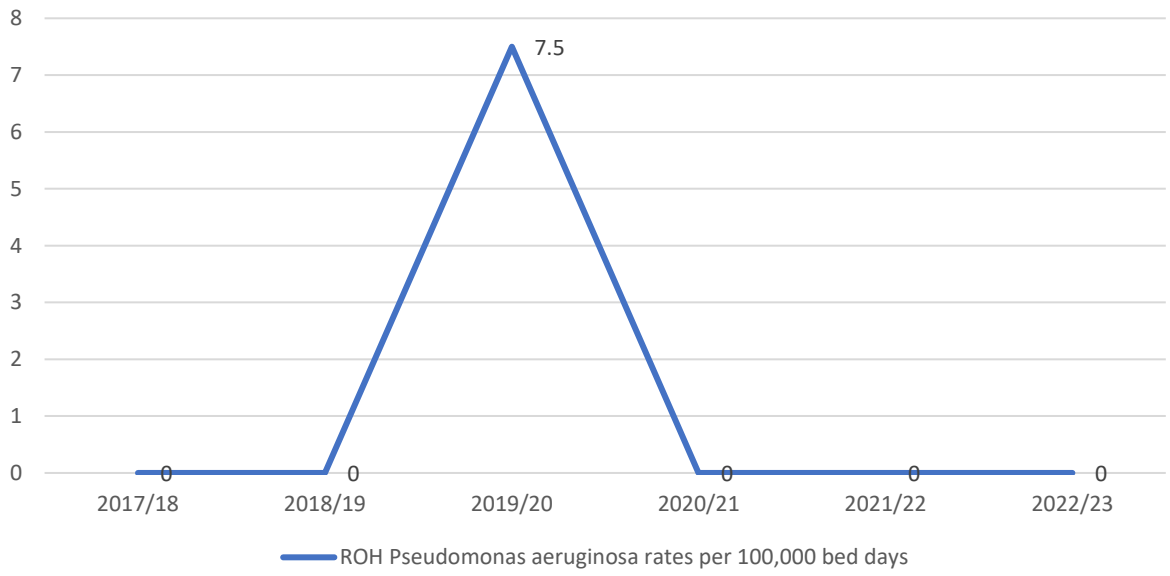
ROH annual *Klebsiella* bacteraemia rates per 100,000 bed days



***Pseudomonas aeruginosa* Bacteraemia**

ROH reported 0 *P. aeruginosa* bacteraemia during 2022/23. This is the same as the number of cases reported during the previous year.

ROH annual *P. aeruginosa* bacteraemia rates per 100,000 bed days



Carbapenemase producing *enterobateriaceae* (CPE)

During 2022/23, ROH CPE screening guidance was updated to reflect changes to the national CPE screening guidance as described in Framework of actions to contain Carbapenemase-producing *Enterobacterales* (UKHSA, 2022).

ROH reported 2 cases of CPE during 2022/23. Both cases were identified pre-admission, because of enhanced screening implemented as described above.

Reporting of quarterly totals of rectal swabs and faecal specimens taken for CPE screening was added to the mandatory quarterly laboratory returns (QMLR) section of the HCAI DCS in October 2019, and reporting became mandatory in October 2020.

Number of samples sent to be tested for CPE during 2022

Year/Quarter	Jan to March	April to June	July to Sep	Oct to Dec
2021	25	56	31	38
2022	58	300	300	348

Norovirus

During 2022/23, ROH reported 0 Norovirus cases and 0 Norovirus associated outbreaks. This is the same as the number of cases reported the previous year.

Influenza

During 2022/23, ROH reported 1 case of Influenza, identified on admission to the Trust and 0 influenza outbreaks.

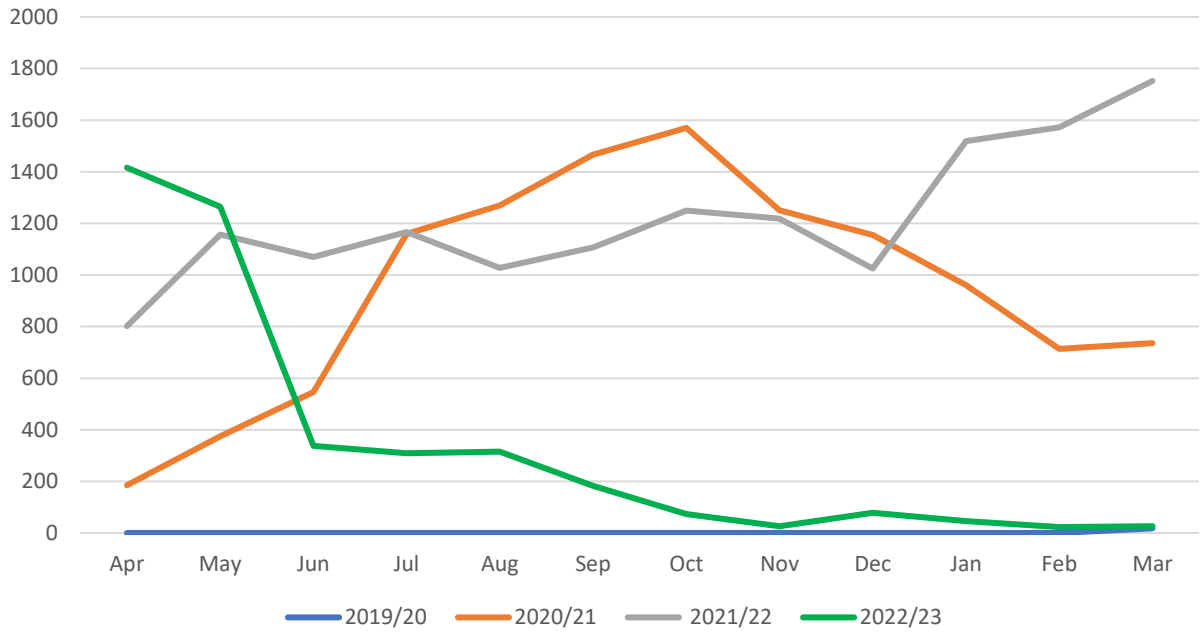
COVID-19

Between April 2022 to March 2023 the Trust cared for 37 patients that tested positive for COVID-19.

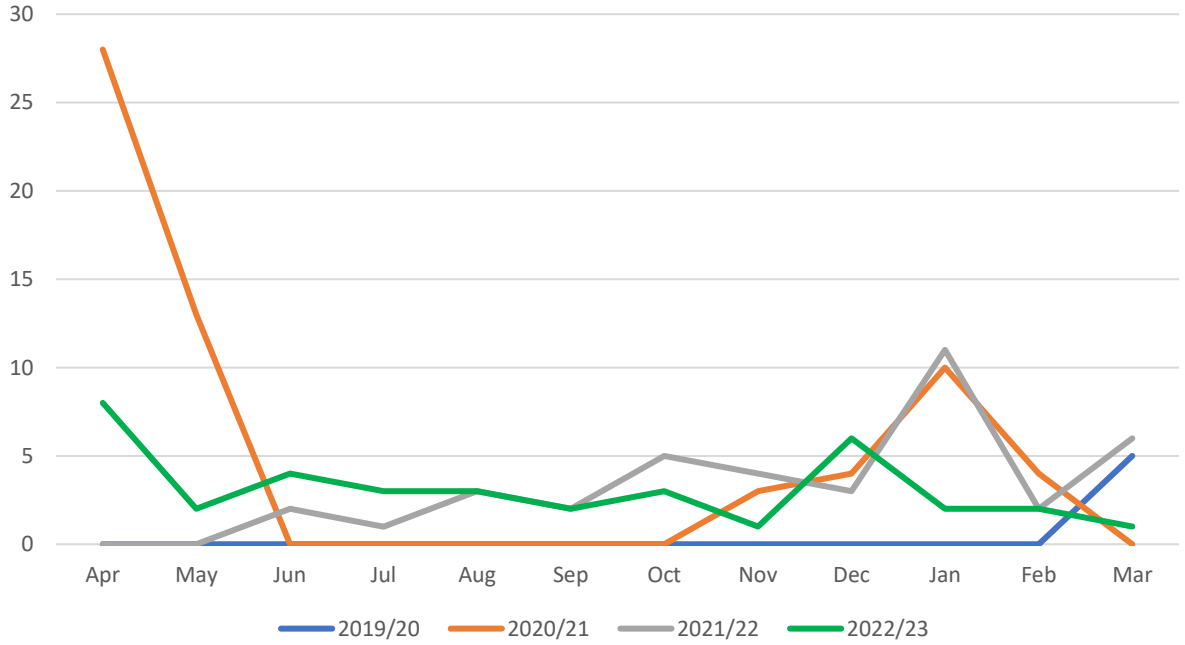
Days from admission to positive result – healthcare onset	2019/20	2020/21	2021/22	2022/23
0-2 days (unlikely)	2	11	25	22
3-7 days (indeterminate)	0	28	7	6
8-14 days (Probable)	1	15	2	3
>15 days (Definite)	2	7	5	6
Totals	**5**	**61**	**39**	**37**

The graph below details the number of COVID-19 tests performed, positive cases and deaths reported between April 2022 and March 2023. To note, there were no staff deaths linked to COVID-19 in the Trust.

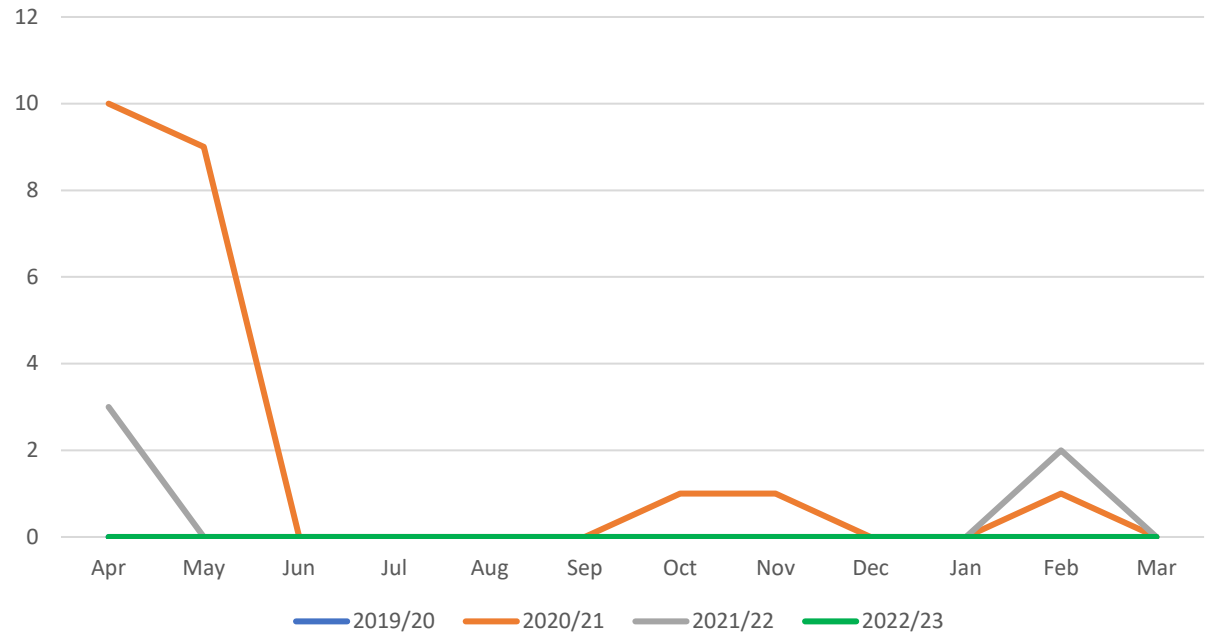
Total number of COVID-19 PCR swabs sent by ROH between March 2020 and March 2023



Total number of positive COVID-19 cases identified at ROH **on or during admission** between March 2020 and March 2023



Total number of COVID-19 related deaths at ROH between March 2020 and March 2023



All COVID-19 related deaths were investigated following the ROH learning from deaths process.

During 2022/23, ROH reported 5 COVID-19 outbreaks, 2 of which were in clinical areas and involved patients.

All COVID-19 outbreaks are investigated fully with the involvement of NHSE, UKHSA and the CCG IPCT. For all outbreaks, the outbreak management control group is formed (chaired by the DIPC) and meet daily to review the situation and manage cases as well as oversee the implementation of mitigations and actions to prevent further transmission.

The IPCT report all COVID-19 related outbreaks via the online COVID-19 reporting system and update them with changes until the outbreak is declared closed.

IPC Audit Programme **(Criterion 1)**

Each year the ROH IPCT review the audit programme to ensure it meets the needs of the organisation and demonstrates compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

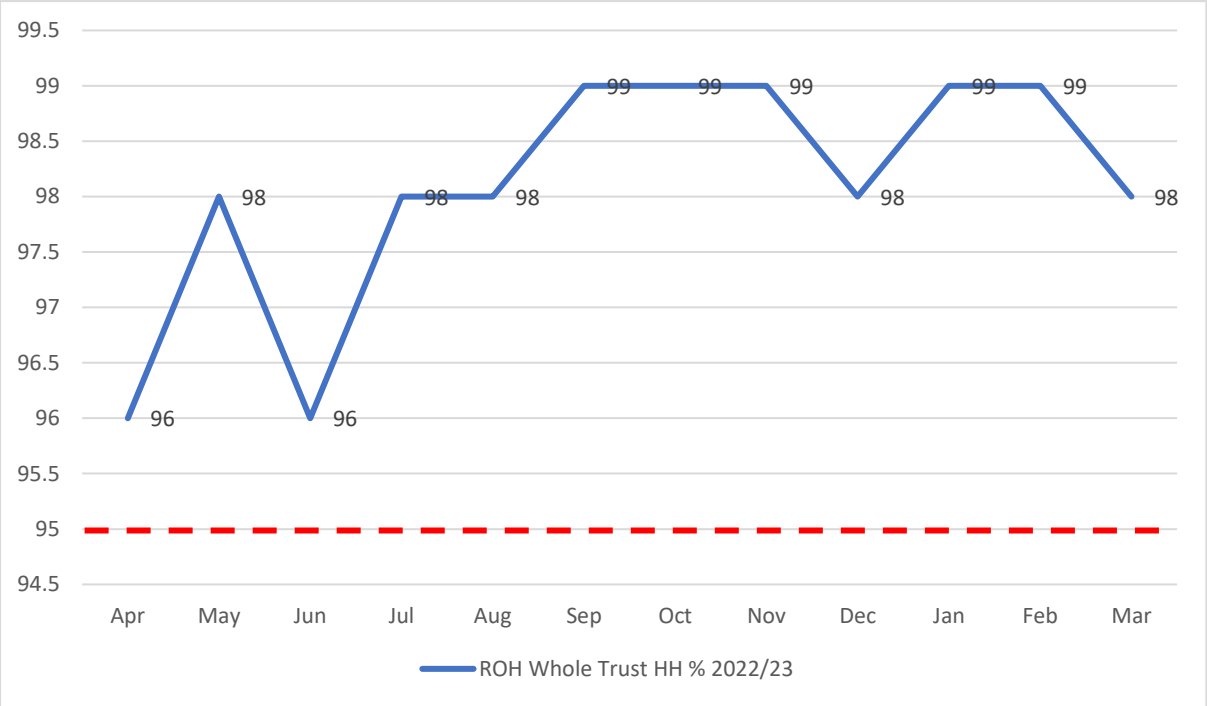
Hand Hygiene Audits (inc. bare below the elbows)

Hand hygiene audits are undertaken monthly by all clinical areas. Data is manually entered onto the quality dashboard by each area.

The hand hygiene compliance target for ROH has historically been >95%.

From the audits undertaken during 2022/23, moment 1 - before patient contact is the most frequently missed opportunity to perform hand hygiene.

ROH Trust Hand Hygiene Compliance April 2022 to March 2023



IPC Quality Assurance Audit (inc. use of isolation, TBPs, equipment cleanliness etc.)

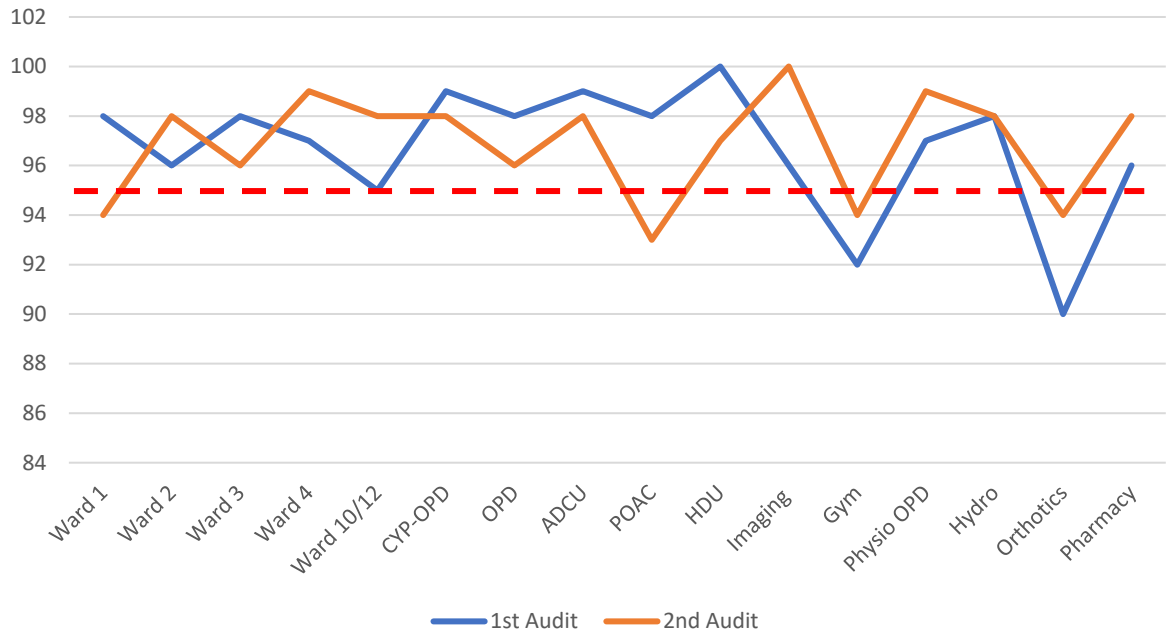
These are spot checks that are undertaken by the IPCT in response to increased concerns relating to practice within a specific area e.g., in response to a suspected outbreak.

These audits can be undertaken by anyone (IPCT, Ward/Dept. manager, Matron) to monitor the IPC practice in a specific area.

IPC audit (environment & practice)

All clinical areas are audited by the IPCT in conjunction with facilities and estates every 6 months. This is a formal structured review based on an audit tool developed by the Infection Prevention Society (IPS).

IPC audit (6 monthly) undertaken during 2022/23



All audits that fail (<95%) have improvement recommendations made and are re-audited until compliance achieved, however re-audit figures are not included in the chart above.

Commode Audit

Commode audits are undertaken monthly in all areas that have commodes by the IPCT. The audit is pass or fail. Most failures are related to the absence of cleaning assurance tape, which is required to be applied at the end of the cleaning process, prior to storage. An audit failure due to lack of assurance of cleaning is just as significant as an audit that fails due to being visibly soiled. Microorganisms cannot be seen by eye and without any definitive evidence of cleaning taking place, we must assume that the equipment is dirty.

High Impact Interventions

The HIIs are an evidence-based approach that relate to key clinical procedures or care processes. When these HIIs are performed appropriately they can reduce the risk of infection. They were developed to provide a practical way of highlighting the critical elements of a procedure or care process, the key actions required and a means of demonstrating assurance.

Overall compliance with the HII bundles across the Trust remains high which indicates good standards of care being delivered. To ensure improvements and provide ongoing assurance of these standards being maintained, further work is taking place to ensure documentation of care provided is accurately documented each time a device is accessed or reviewed.

Safe Management of the Healthcare Environment **(Criterion 2)**

Facilities – Cleanliness

Cleaning and environmental decontamination services provided at ROH are undertaken by an in-house team within the Facilities department. These services are provided by a dedicated team of environmental cleaners and an enhanced cleaning team.

Environmental cleaners provide cover in all patient areas from 06:00 to 22:00hrs Monday to Friday and 08:30 to 19:00hrs Saturday & Sunday. The enhanced cleaning team undertake all enhanced cleaning and terminal cleaning requests which includes UV-C & Bioquell between the hours 08:30hrs to 05:30hrs (split over two long shifts) Monday to Sunday.

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

National Cleaning Standards

During May 2021 NHS England published the 'National Standards of Healthcare Cleanliness 2021'. Since the publication of the standards, facilities have welcomed the opportunity to measure performance in a uniform way, and to benchmark Trust cleaning services against other healthcare environments. Our star ratings are derived from the original audit score at the time of audit. Scores can only be updated following the next full re-audit. The monthly star ratings are displayed within all patient facing locations displays. This system enables easier administration and allows monitoring to take place.

Patient-Led Assessments of the Care Environment (PLACE)

Good environments matter. A clean environment is the foundation for lower infection rates, while good food promotes recovery and improves the patient experience. High standards of privacy promote patient dignity, and good maintenance and décor support a safe and comfortable environment. But good environments don't just happen. Without the efforts of all staff, the benefits of cleanliness, good food, privacy, and proper maintenance may be lost.

Patient-led assessments of the care environment (PLACE) assist organisations to understand how well they are meeting the needs of their patients and identify where improvements can be made. Assessments were performed over a one-day period on the 11th of November 2022 with Trust volunteers and lead personal, and uses information gleaned directly from patient assessors to report how well our trust has performed – in terms of national standards and against other similar trusts. Assessments were undertaken on our wards, clinics, out-patient departments, and public areas.

PLACE Audit Scores 2022/23

Discipline	National Average	ROH 2022/23	Comment
Cleanliness	98.01	99.49	Above national average
Food	90.23	96.15	Above national average
Organisational Food	90.23	91.67	Above national average
Ward Food	90.23	97.62	Above national average
Privacy, Dignity	84.08	91.62	Above national average
Condition/Appearance	95.79	96.71	Above national average
Dementia	80.60	86.81	Above national average
Disability	82.49	88.96	Above national average

A summary report along with an agreed action plan has been written, outlining key areas in where improvements can be made. These actions are monitored through the care quality and patient experience and engagement groups, which meet bi -monthly.

Ventilation

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

Water Safety

The Water Safety Group (WSG) continues to meet bi-monthly and reports upwardly to the IPCC. The group is chaired by the Deputy Director of Delivery (Estates). As per requirements set out in HTM 04-01: Safe water in healthcare premises, it is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan (WSP).

Safe Management of Healthcare Equipment (Criterion 2)

Decontamination

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

As set out in HTM 01-01, which offers best practice guidance on the whole decontamination cycle including the management and decontamination of surgical instruments used in acute care, ROH have an appointed Sterile Services Manager (SSM) who takes responsibility for coordinating activity between the theatre, decontamination, and supply/purchase teams. They

ensure that the inventory of surgical instruments is proactively reviewed and managed in accordance with national and local guidance, clinical requirements, and industry best practice.

The SSM reports to the Trust's Decontamination lead. This position is held by the DIPC. The SSM provides an upward report on decontamination at IPCC.

Antimicrobial Stewardship (Criterion 3)

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

The action of the AMSG continues to be hampered by the lack of attendance of the medical and nursing representatives. This means that the group meetings are often non-quorate. Actions by the group can therefore be difficult to implement.

ROH Antibiotic Consumption (2022/23)

Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Antimicrobial Pharmacist. Several audits have been completed during 2022/23 to assess appropriateness of antimicrobial usage within the Trust. The pharmacy team continue to undertake interventions relating to inappropriate antibiotic usage with prescribing teams to maintain good antimicrobial stewardship. Total antibiotic usage is monitored quarterly and ROH continues to maintain usage below the England average.

All antibiotics

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

Year	2018	2019/20	2020/21	2021/22	2022/23
Total Antimicrobial consumption (DDD)	42008	48607	39194	50179	54783
Target Total DDD		41587.9	41587.9	41587.9	41587.9
Antimicrobial consumption Per 1000 admission	3239	3719	5518	3947	4125
Target DDD/ 1000		3206	3206	3206	3093

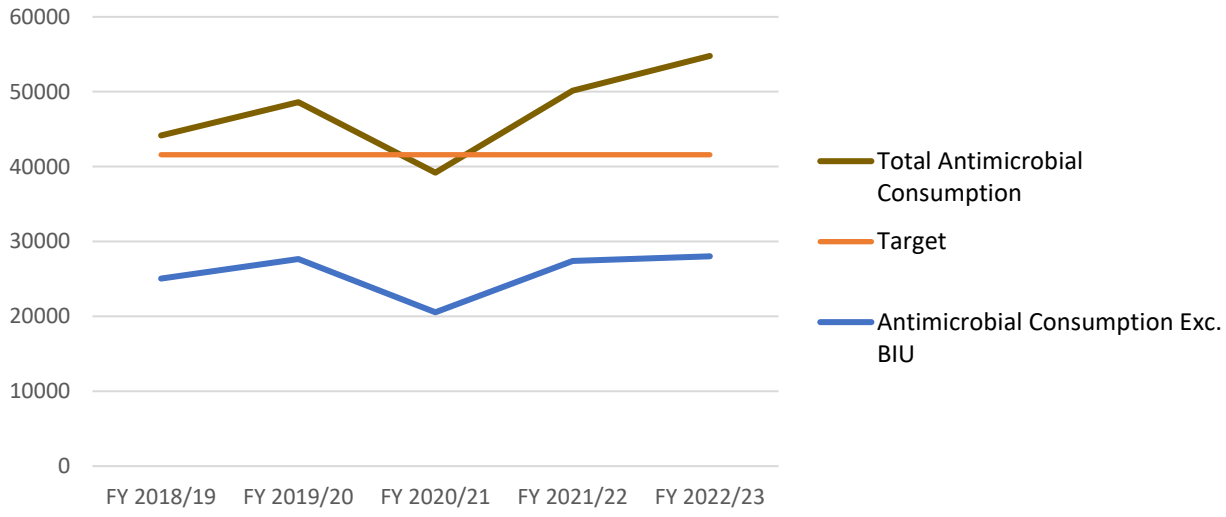
Total Antibiotic consumption data in DDDs and DDD per 1000 admissions compared to the 2018 reference year (Jan to Dec) for all antibiotics excluding those prescribed by the BIS:

Year	2019/20	2020/21	2021/22	2022/23
Total Antimicrobial consumption (DDD) (Excluding BIU)	27647	20549	27408	28024
Target Total DDD	41587.9	41587.9	41587.9	41587.9
Antimicrobial consumption Per 1000 admission (Excluding BIU)	2115	2894	2159	2110
Target DDD/ 1000	3206	3206	3206	3093

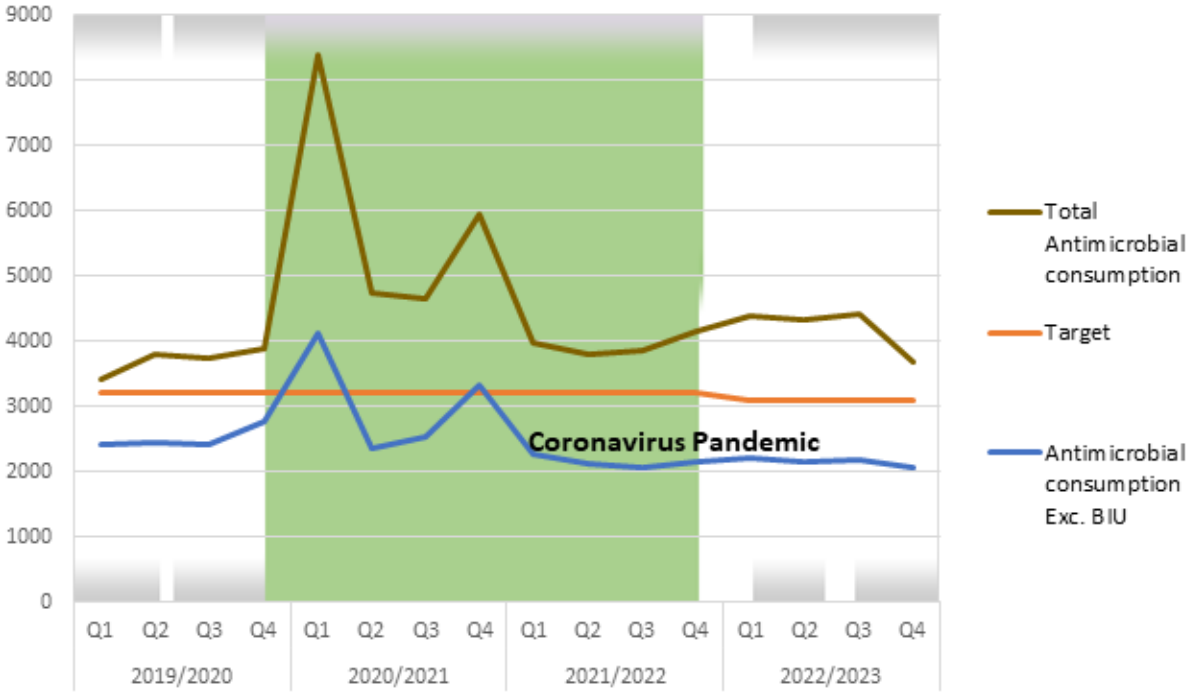
Total antimicrobial consumption (DDD) 2019/20 to 2021/22

The tables above provide a breakdown of the overall antimicrobial consumption for each financial year since 2018. The data shows that the overall consumption has increased in 2022/23 compared to the previous year. However, if we exclude the antibiotics used for the Bone Infection Service, we are below the NHSE targets.

Total antimicrobial consumption (DDD) 2019/20 to 2022/23:



Quarterly antimicrobial consumption – 2019/20 to 2022/23 (DDD/1000 patients):



Carbapenem Usage

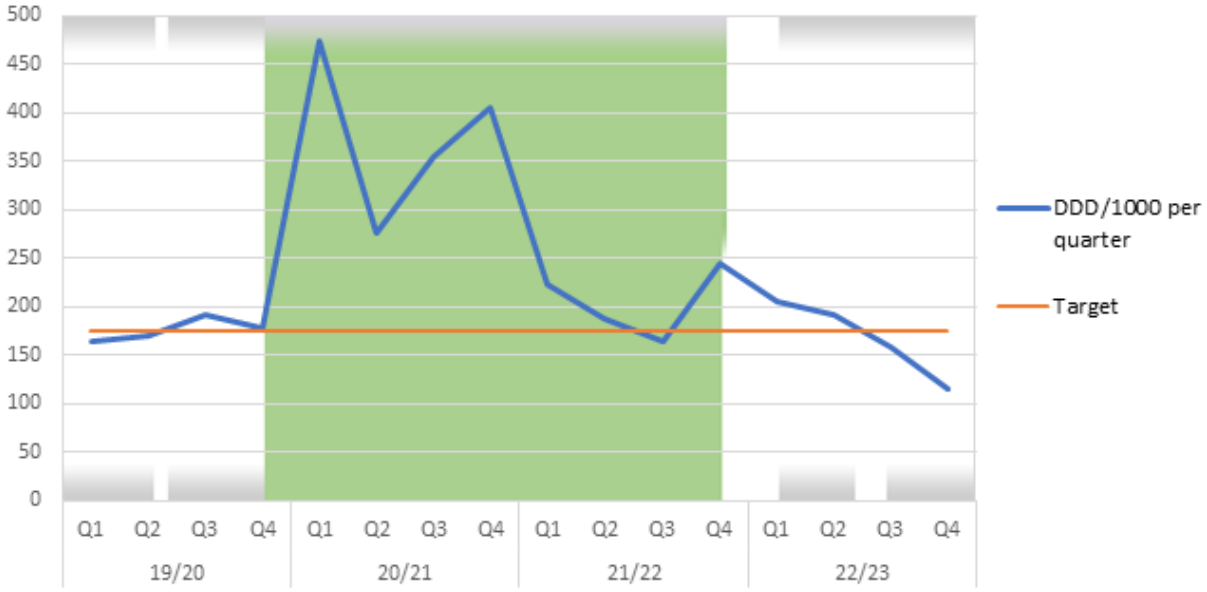
Total Carbapenem consumption data in DDDs and DDD per 1000 admissions compared to the 2018 reference year:

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

Quarterly carbapenem consumption data and DDD per 1000 admissions compared to the 2018 reference year:

Carbapenem consumption	Q1	Q2	Q3	Q4
	2019/2020			
DDD / Per 1000 admission	163.157	170.236	191.359	178.389
	2020/2021			
DDD / Per 1000 admission	473.237	275.382	354.923	404.597
	2021/2022			
DDD / Per 1000 admission	222.647	186.623	164	244
	2022/2023			
DDD / Per 1000 admission	206	191	159	114

Quarterly carbapenem consumption for 2019/20 to 2022/23 (DDD/1000 patients):



The graph above shows quarterly carbapenem usage has decreased this quarter and is below the target set by NHSE.

Yearly usage of antimicrobials within the WHO "access" category of the AWaRe list financial years 2019/20 – 2022/23:

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

The 'AWaRe' Classification of antibiotics was developed in 2017 by the WHO 'Expert Committee on Selection and Use of Essential Medicines' as a tool to support antibiotic stewardship efforts at local, national, and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, considering the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use. The 2021 update of the 'AWaRe' classification includes an additional 78 antibiotics not previously classified, bringing the total to 258.

The percentage of antibiotics used at the ROH that fall within the 'access' group category has remained steady between 43-52% for the past 3 financial years. There was a decrease in

proportion of 'access' antibiotics in 2020/21, but this can be attributed to the pandemic and a different cohort of patient to which ROH is usually accustomed.

It is important to note antibiotics routinely used for BIS patients are mostly found within either the 'reserve' or 'watch' categories; therefore, as activity remains high for BIS patients then this impacts on the percentage consumption of 'access' antibiotics. Excluding BIS antibiotics, the Trust comfortably achieves the reduction targets as evidenced below.

Yearly usage of antimicrobials within the WHO "Access" category of the AWaRe list (DDD per 1000 patients) – excluding those prescribed by the BIS – NB: 1% excluding Meropenem:

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

The Trust's overall usage of antibiotics is currently lower than the target set by NHS England in the 2019 CQUIN once antibiotics prescribed by the BIS are excluded.

The use of carbapenems has declined even further since the previous quarter and is below the target set by NHS England in the 2019 CQUIN.

Access antibiotics has increased from 52% (2021/22) to 57% (2022/23) and there has been a reduction in the Watch category of antibiotics. The majority of 'Watch' and 'Reserve' antibiotics are prescribed for patients under the Bone Infection Service, so if this data is excluded, the percentage of Access antibiotics increase to 73% which is a significant percentage of our consumption.

Communications **(Criterion 4)**

Central to the success of any IPC programme is an effective and dedicated communications plan. Collaborative working between the IPCT, and ROH communications and strategy team helps bring about improvements in care through the appropriate and successful instigation of IPC initiatives, as well as timely and targeted public and patient information to improve safety and awareness of IPC issues and topics. The Trust's dedicated communication team have been instrumental in assisting with the execution of the IPC programme throughout 2022/23 and is no different to the excellent support and collaborative working they provide year in year out.

Examples of collaboration during 2022/23:

- Planned and delivered IPC roadshows based on IPC 'focus of the month' and key dates within the IPC calendar such as World Hand Hygiene Day and World Antimicrobial Awareness Week.
- Utilised social media to support communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating key messages to the wider health economy.
- Supported the annual flu vaccination and COVID-19 vaccination campaigns.

Screening and Reporting of Infections **(Criterion 5)**

Robust screening and testing procedures are in place to identify those most at risk of developing an infection. As an elective orthopaedic hospital, all patients (except for the small number of spinal emergency patients) who attend pre-operative assessments clinics will be tested for MRSA as well as any other infection as deemed necessary based on assessment (this may include CPE screening).

Surgical Site Infection Surveillance (SSIS)

Infections of the surgical site account for approximately 16% of all HCAI, are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care.

During 2022, the substantive experienced band 5 SSIS Nurse left the Trust. This left a relatively new and inexperienced band 3 SSI coordinator to undertake the surveillance programme, who themselves required long-term absence during quarter 4 of 2022. This resulted in ROH withdrawing from the UKHSA SSI surveillance programme for quarter 4. After successful recruitment, training and return of the team, ROH began participating in the surveillance programme again from quarter 1 of 2023.

SSI Data for 2022/23

The data presented below is a combination of mandatory surveillance data for SSI identified following total hip and knee replacement surgery and voluntary surveillance data for SSI identified following spinal surgery. In addition to this the SSI team undertake in-house surveillance which looks at several other areas of interest including oncology cases. This enables the team to gain an informed understanding of SSI across all specialities and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.

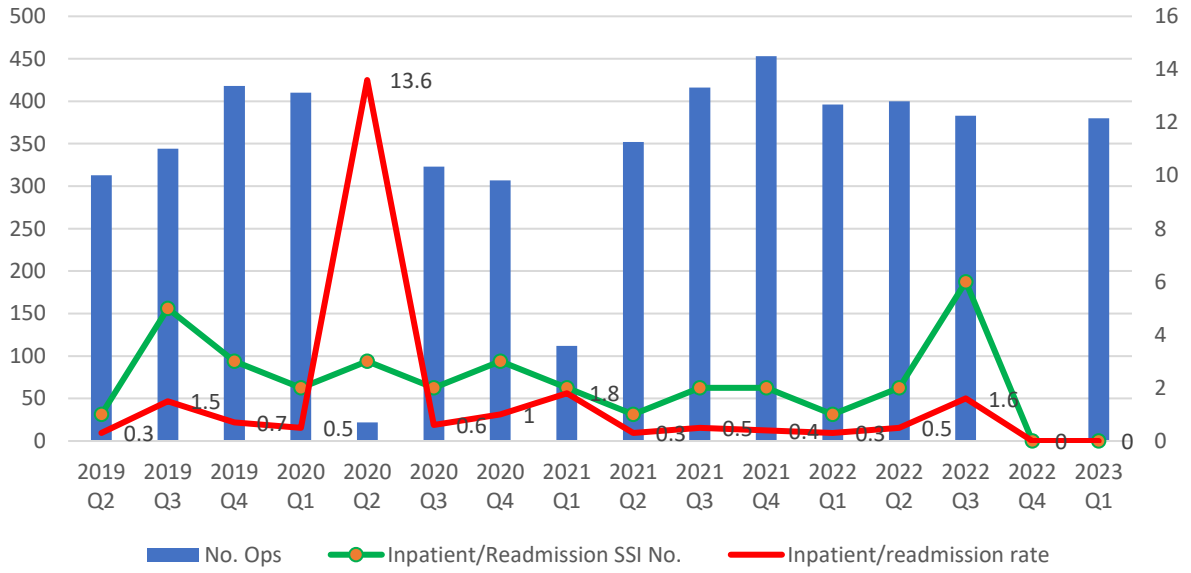
Note: All data on SSI is submitted to UKHSA, however benchmark data (gained from other trusts submitting their rates) only consists of inpatient/readmission figures.

Hips – 2022/23

The national benchmark for hips is based on inpatient/readmission SSIs for the previous 5 years. For April 2022 to March 2023 the ROH inpatient/readmission SSI rate was 0.6%. This is 0.3% above the national benchmark of 0.3%.

ROH withdrew from the SSI surveillance programme for quarter 4 2022 (October to December) due to vacancies within the SSI team.

Trend in Rate of SSI – Arthroplasty – Hip Replacement



HIPS		April 2022 to March 2023
Operations	**Total № of procedures**	1559
	№ of successful patients contacted for post discharge surveillance	1550
	% of post discharge surveillance completed	54.9%
SSI	**№ of inpatient/readmission SSI**	9
	% Infected	0.6%
	№ of post discharge confirmed SSI	2
	% Infected	0.1%
	№ of patient reported SSI	7
	% Infected	0.4%
	All SSI	18
	% Infected	1.2%

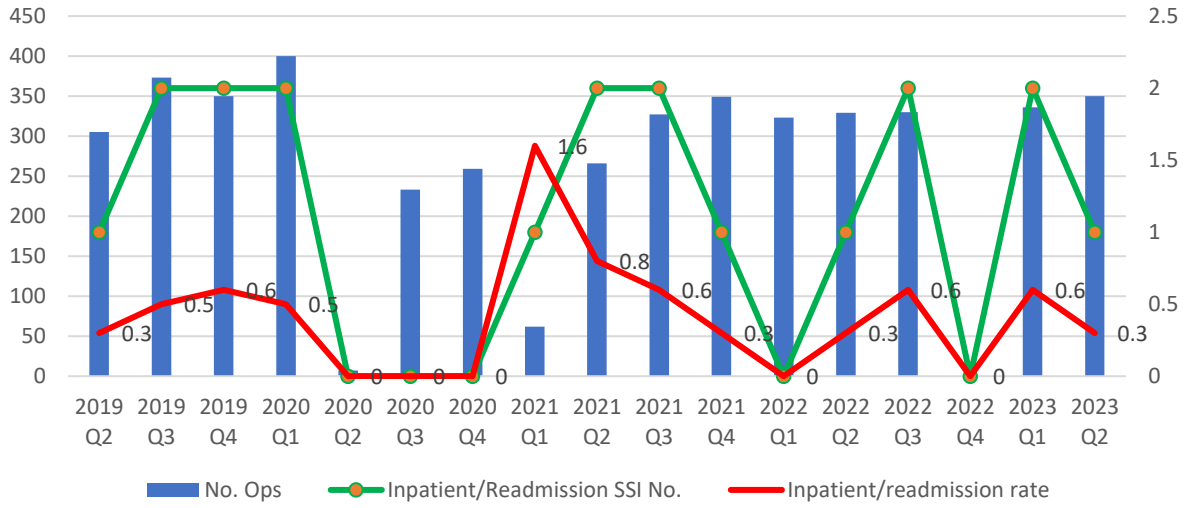
The graph and table above provide a breakdown of the trends in the rates of SSIs for hips from January 2019 to March 2023. The graph reflects the inpatient & readmission SSIs which include organ/space and deep infections. There has been a steady increase and decrease in the rates of infections during this timeframe. The peak during April to June 2020 was due to the very low number of operations performed because of cancelled elective work due to the COVID-

19 pandemic. Rates reported by ROH have been slightly above the national benchmark for most quarters. However, overall, when looking at the total number of infections reported over this time frame, the number of inpatient/readmission infections out of the number of operations that were performed is low.

Knees – 2022/23

The national benchmark for knees is based on inpatient/readmission SSIs for the previous 5 years. For April 2022 to March 2023 the ROH inpatient/readmission SSI rate was 0.4%. This is 0.2% above the national benchmark of 0.2%.

Trend in Rate of SSI - Arthroplasty – Knee Replacement



KNEES		April 2022 to March 2023
Operations	**Total № of procedures**	1318
	№ of successful patients contacted for post discharge surveillance	1316
	% of post discharge surveillance completed	53.0%
SSI	**№ of inpatient/readmission SSI**	5
	% Infected	0.4%
	№ of post discharge confirmed SSI	1
	% Infected	0.1%
	№ of patient reported SSI	13
	% Infected	1.0%
	All SSI	19
	% Infected	1.4%

The graph and table above provide a breakdown of the trends in rates of SSIs for knee surgeries from April 2019 to March 2023. The graph reflects the inpatient & readmission SSIs which include organ/space and deep infections. There have been areas of increase and

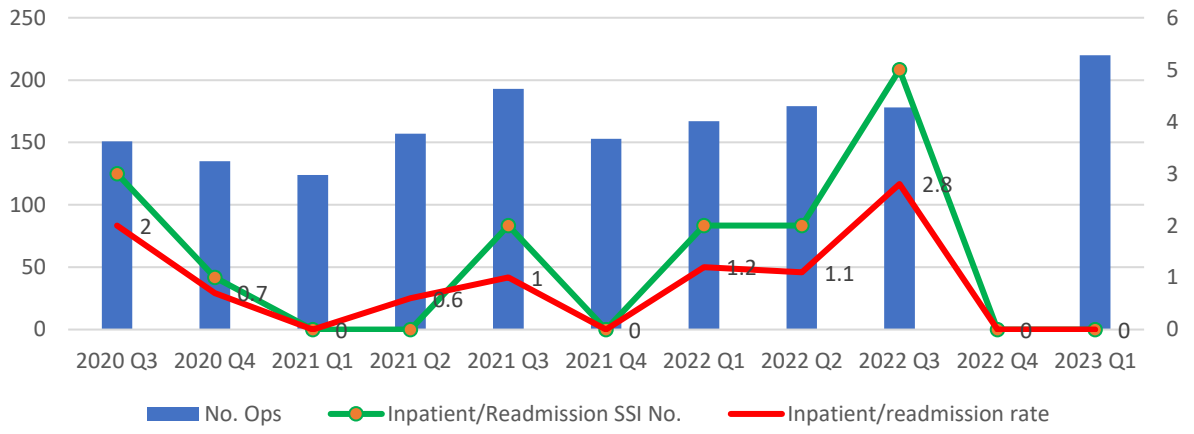
decrease in the rates of infections during this timeframe. The peak during January to March 2021 was due to the very low number of operations performed because of the COVID-19 pandemic. The rates reported by ROH have been slightly above and below the benchmark for some quarters. However, overall, when looking at the total number of infections reported over this time frame, the number of inpatient/readmission infections out of the number of operations that were performed is low.

Spines - 2022/23

Spinal surgery was included as part of the ROH surveillance programme from July 2020 onwards.

The national benchmark for spines is based on inpatient/readmission SSIs for the previous 5 years. For April 2022 to March 2023 the ROH inpatient/readmission SSI rate was 1.2%. This is 0.3% above the national benchmark of 0.9%.

Trend in Rate of SSI – Spinal Surgery



SPINES		Trust Total (Last 4 periods)
Operations	**Total № of procedures**	744
	№ of successful patients contacted for post discharge surveillance	734
	% of post discharge surveillance completed	42.6%
SSI	**№ of inpatient/readmission SSI**	9
	% Infected	1.2%
	№ of post discharge confirmed SSI	0
	% Infected	0.0%
	№ of patient reported SSI	5
	% Infected	0.7%
	All SSI	14
	% Infected	1.9%

We began participating in spinal surveillance from July 2020. The graph and table above provide a breakdown of the trends in rates of SSIs for spines from July 2020 to March 2023. The graph reflects the inpatient & readmission SSIs which include organ/space and deep infections. There have been areas of increase and decrease in the rates of infections during this timeframe. The rates reported have been below national benchmarking for each quarter except for July – September 2020, July – September 2021 and January to March 2022.

Training and Education **(Criterion 6)**

At ROH infection prevention is everyone's responsibility and is included in all job descriptions. All staff, clinical and non-clinical receive training and education in optimum infection prevention practices via formal and information teaching session including mandatory training, and ad-hoc department-based teaching sessions.

The IPC team deliver training sessions year-round according to a training needs analysis which aids the population of a training and education calendar which is reviewed before each financial year. This includes sessions tailored towards, nurses, junior doctors, students, administrators, contractors etc. The team have also provided bespoke training sessions within ward and department areas, so staff do not have to leave their working environment to attend sessions.

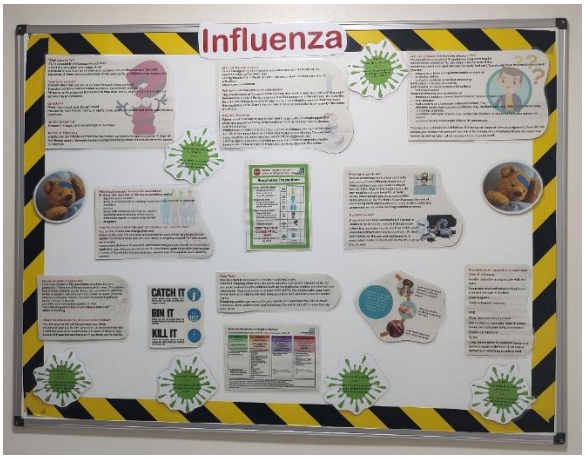
Examples of engagement and training undertaken by the IPCT during 2022/23:

- Facilitated quarterly meetings for IPC link champions (from each ward and department).
- Continued to utilise educational 'grab packs' for hand hygiene, Influenza, MRSA, PPE, and CPE across ROH to support staff with effective application of theory into practice within their areas of work.
- Delivered bespoke infection prevention training, in line with HBN 00-09, for all preferred contractors coming into ROH.
- Facilitated the national antibiotic awareness and hand hygiene days across ROH.

IPC monthly focus

Before each new financial year, the IPCT undertake an away day where a review of the previous year's performance is undertaken, and ideas are shared to help formulate the IPC programme for the following year. Included in this is the creation of new 'IPC monthly focus'. This provides an opportunity to plan a programme of audit activity and quality improvement work specifically focussed on a key issue. The themed focus allows the team to provide support on a range of infection prevention issues throughout the year. Details of the audits and training provided throughout the months is shared within the IPC summary report at the IPCC.

Examples of monthly focus themes:



IPC Link Champions

All areas (clinical and non-clinical) at the ROH are encouraged to have in place a designated IPC link champion. This role can be undertaken by anyone with a keen interest in IPC and are willing to champion IPC within their area of practice/work. IPC link champions are supported by the IPCT and attend quarterly meetings in addition to study days to support them in their role. They provide advice, support, education, and training to operational staff as well as monitoring compliance with the IPC agenda. One of the most important roles of the IPC link champions is to perform hand hygiene training and assessments within their areas utilising the UV glow boxes.

IPCT Development **(Criterion 1 & 6)**

During 2022/23, the team took part in the following development opportunities:

- Away day to review previous year's performance and plan for the year ahead.

- Several Infection Prevention Society study days attended focusing on key topics that benefit service provision at ROH.
- SSI team undertook annual SSI surveillance training refresher provided by UKHSA.

The lead IPC Nurse progressed from the Deputy Education Officer to the full Education Officer position of the West Midlands Branch of the Infection Prevention Society. This role provides networking and development opportunities for the ROH IPCT and helps to better facilitate system and national working.

Isolation Facilities (Criterion 7)

Most NHS hospital wards have a mixture of open bays, with multiple beds, and single or double side rooms. Except for some recent new builds, the beds in open bays still predominate.

ROH have a total of 127 inpatient beds. Of these there are:

- 56 single occupancy rooms with en-suite.
- 3 single occupancy rooms without en-suite.

The IPCT work closely with the clinical site team and clinical areas to review the single room usage to ensure it is most efficiently utilised. A local isolation risk assessment tool continues to be utilised to help bed mangers to safely allocate beds based on clinical need, factoring in infection status and risk of transmission.

Access to Laboratory Support (Criterion 8)

ROH do not have access to an onsite laboratory. Laboratory services are provided by UHB which has purpose-built laboratory's onsite at both The Queen Elizabeth Hospital and Heartlands Hospital where ROH samples are processed. The UHB microbiology laboratory has full (UKAS) accreditation ISO Standard 15189. ROH has electronic access to microbiology results to facilitate prompt identification and response.

IPC Policies (Criterion 9)

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

During 2022/23 the IPCT reviewed/updated the following polices:

- Decontamination Policy
- Hand Hygiene Policy

- Isolation Policy
- CJD/TSE Policy
- Permit to Work Policy

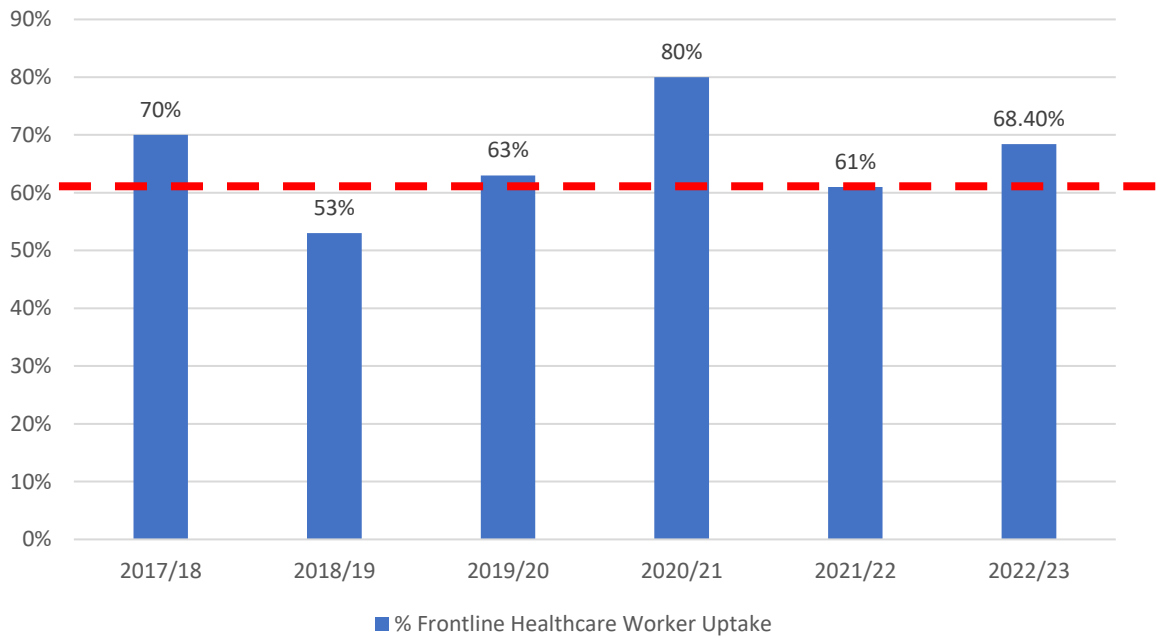
Occupational Health **(Criterion 10)**

Occupational Health services are provided via an SLA by UHB. Occupational Health (OH) staff from UHB provide one session (1 day) per week to support the OH requirements of ROH staff. The OH team carry out preplacement health assessment and immunisation needs, skin health surveillance (from referral) and management of inoculation injuries.

A report from the Occupational health service is provided to the IPCC every quarter.

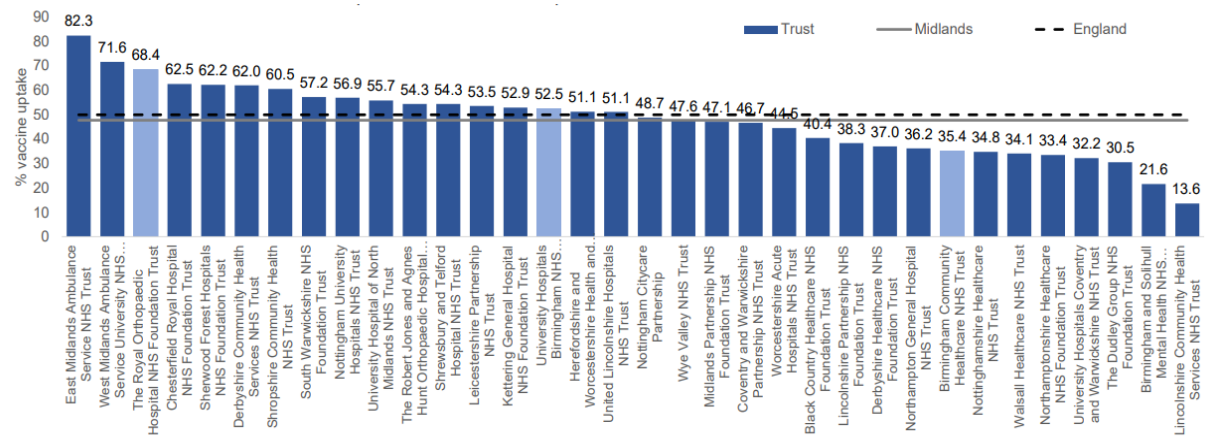
The seasonal influenza staff vaccination campaign is well established at ROH. The 2022/23 campaign officially commenced on 1st October 2022 with a wealth of information available to staff on the Trust intranet, information boards across the site and locally based influenza champions. The uptake for 2022/2023 was 68.4%. This was higher than the uptake reported for 2021/22, this was believed to be a result of vaccine hesitancy due to the ongoing COVID-19 pandemic and booster vaccination programmes running concurrently. The graph below shows the final uptake percentage for vaccination of frontline healthcare workers for the last 5 years.

Annual ROH frontline healthcare worker influenza vaccine uptake percentage



Red dotted line shows the minimum CQUIN threshold = 70% of all frontline healthcare workers who have patient contact.

Trusts in the West Midlands that submitted frontline healthcare worker vaccination data via Immform 2022/23



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)

Conclusion

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

2022/23 has seen the IPCT continue to lead the Trusts core IPC programme to reduce HCAIs, whilst battling ongoing recruitment and full team establishment setbacks. The IPCT have met the challenge well and collaborative working, with divisional colleagues, has continued to ensure IPC practices are supported and maintained across all clinical services.

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

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

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UKHSA (2022) Framework of actions to contain carbapenemase-producing Enterobacterales Actions to contain carbapenemase-producing Enterobacterales (publishing.service.gov.uk)

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NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

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DOCUMENT TITLE:	Patient Safety Incident Response Framework – Update on Implementation – January 2024
SPONSOR (EXECUTIVE DIRECTOR):	Executive Director of Governance and Executive Chief Nurse
AUTHOR:	Rebecca Hipwood, Patient Safety Lead and Adam Roberts, Assistant Director of Governance & Risk
DATE OF MEETING:	7 February 2024

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.

Summary of Transition to implementation of PSIRF

PSIRF Policy and Plan

The approach currently set out in Trust's PSIRF Plan in regard to the management of Infection related patient safety incidents is due to change.

The changes will be in line with the proposed IPC PSIRF plan that has been agreed across the midlands region following consultation with the NHSE Midlands regional Assistant Director of Infection Prevention and Control (IPC), local ICB IPC leads, and local Trust ICP leads.

The final version of the Trust's IPC PSIRF Plan is due to be presented at the Trust's internal IPC Committee. An amended and updated version of the Trust's PSIRF Plan will then be submitted to a future Q&S Committee meeting for comment before final approval.

Timescale for Completion – February 2024.

Engagement

Thorough engagement with ops and nursing staff has been undertaken. PSIRF project leads have attended a large number and wide variety of meetings (for example Divisional Governance, Divisional Management Board, Ops Management Board, AQILA, Ward Managers Meetings) as well as holding meetings with teams and manager individually.

The Medical Director has supported with the engagement of clinicians. It is acknowledged that further work is needed to continue and enhance the engagement with clinical teams, and in particular with the Clinical Service Leads.

There has also been engagement with HR staff in relation to how PSIRF aligns to HR performance management processes and how it supports the Human Factors and Just Culture agenda.

Initial meetings to discuss how PSIRF can be linked in with the current wider work being carried out by the Strategy and Transformation team around Continuous Improvement have also taken place.

Duty of Candour (DoC)

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

Timescale - Revised DoC template letters and an amended flow chart will be disseminated for consultation in February 2024 with approval by March 2024 at the latest.

VTE & Tissue Viability Investigation Templates

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

Speciality teams will be consulted on the proposed new templates and the intention is to trial use of new templates to gauge effectiveness.

Timescale – trial to commence immediately and approval and use by no later than March 2024.

Divisional Governance Meetings

With engagement and education of divisional stakeholders complete both divisions have adopted new PSIRF practices and have begun to utilise the new patient safety incident investigation methodologies (AAR reviews in particular).

The 'new' principles of PSIRF were also recently applied successfully to an incident relating to post-operative deterioration that led to a patient having to undergo a partial digit amputation following hand surgery. An AAR style initial review of the incident was undertaken that quickly identified the contributory factors and the learning and professional feedback that was necessary to try to prevent similar harm happening again. The incident was subject to good discussion at both the division 2 divisional governance meeting and a recent Executive Governance Meeting, where it was agreed no further investigation was

required. This was an appropriate, PSIRF compliant, systems based and proportionate response to the learning. The incident also allowed the opportunity for an adapted LOOP feedback document to be used to summarise the learning. The LOOP document will also be shared internally and with the patient as part of the DoC process.

A copy of the LOOP feedback template is attached as an appendix.

Quality Report

The Assistant Director of Governance is currently working on a revised version of the Quality Report to reflect the changes brought about due to the implementation of PSIRF.

The intention is to provide a cleaner, simpler, more visual, high-level, dashboard-based approach to oversight of patient safety incidents that align to the patient safety incident priorities that form the backbone of the Trust's PSIRF Plan. This will be supplemented with a focus on the learning identified from patient safety investigations and details of wider quality and continuous improvement work that is on-going across the Trust that align to the patient safety incident priorities within the PSIRF Plan.

Timescale – involvement of Chief Nurse, Medical Director and Director of Governance in development of draft revised version, which is then proposed to go to next Q&S Executive for further comment and input before being presented at the next Q&S Committee for further comment and approval.

Quality Improvement Work

Work remains ongoing to align and join up our governance process with the wider quality and continuous improvement work that is being carried out across the Trust. The appointment of a Quality Improvement Nurse within the Patient Safety team has provided specialist knowledge to support and drive forward this work, with a key aspect being the utilisation of the AMat system to record and monitor all quality and continuous improvement work. The Governance team will also create links into some of the key corporate groups where there are also Quality Improvement initiatives being monitored and discussed.

Timescale – Ongoing

Review of PSIRF Implementation

A first review of the implementation of PSIRF is due to occur in April 2024, with a report setting out the findings to follow in May 2024 (6 months from 'go live').

REPORT RECOMMENDATION:
The Trust Board is asked to receive this update for assurance.

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

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

PSIRF is a national framework for the management of patient safety incidents with the intent to better identify and embed learning and improvement across the Trust, therefore it aligns to the Trust's strategic objectives, its BAF and the standard of service provided
PREVIOUS CONSIDERATION:
PSIRF Update presented in November 2023. This report was discussed by Quality & Safety Committee on 31 January 2024.

Learning On One Page (LOOP)

Division:

Ulysses ID:

Date:
Area:
Author:

The Royal Orthopaedic Hospital NHS Foundation Trust

A brief description of the incident

[Description / Executive Summary from RCA report, Complaint, or litigation]

Actions taken

- *[Include immediate and subsequent actions taken]* Discussed timely re

Good practice

[Note any practices or processes found to have been used that promoted and supported safe and effective care being delivered]

What didn't go so well?

[Note any gaps or weaknesses in care delivery processes that were contributory factors in the incident]

Next steps

[What are the further actions now to be taken in order to learn from the incident and ensure the risk of recurrence is reduced or eliminated?]

Any key themes?

[What were the main areas of care delivery or processes that were relevant in this case?]

An overview to keep, copy and share

Final approval from:

REPORT REF: ROHTB (2/24) 009

TRUST BOARD

DOCUMENT TITLE:	Revised Board Assurance Framework (BAF) Report – January 2024
SPONSOR (EXECUTIVE DIRECTOR):	Simon Grainger-Lloyd, Executive Director of Governance
AUTHOR:	Adam Roberts, Assistant Director of Governance & Risk
PRESENTED BY:	Adam Roberts, Assistant Director of Governance & Risk
DATE OF MEETING:	February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report is intended to summarise the latest proposed changes to the way in which the Trust's Board Assurance Framework (BAF) is structured and presented.

It also proposes a new risk assurance rating scheme and process for review and management of BAF going forward.

The Revised ROH Board Assurance Framework

New Strategic Risks

Based on the previous review and based on the new Trust Strategy, the Board has adopted a new BAF that contains 6 overarching, high level strategic 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 previous report a revised layout for 1 of the 6 new strategic risks was presented for approval. This report now contains all 6 new strategic risks, presented in the new format and layout.

As previously stated, this work builds upon the refinements made in the BAF presented to Trust Board in October and November 2023 and incorporates comment and feedback from those meetings and also from our internal auditor, KPMG.

In line with feedback received when the earlier versions were received, each risk has been designated an executive lead and also stipulates the sub-board committees at which the respective risks will be monitored and discussed. In the same way that the relevant extracts of the Corporate Risk Register are discussed, then so will the respective extracts of the BAF going forward.

Risk Appetite Statements & Risk Assurance Rating

Following on from the Risk Appetite Presentation at the November Trust Board meeting the 6 new strategic risks all contain a risk appetite statement.

In order to build upon the risk appetite session and put into practice the principles of risk appetite and risk tolerance, it is further proposed that going forward the Board adopts a risk assurance rating scheme. The risk assurance rating is the evaluation and grading measure given by the Board to the level of assurance it receives on the progress made towards controlling the risks to achievement of each of the 6 strategic objectives.

The proposed risk assurance rating scheme is as follows:-

Assurance Rating	Description
Significant Assurance	Limited scope for improving existing controls. Actions are on target for completion
Reasonable Assurance	Minor scope for improvement in existing controls. Majority of actions and/or key actions remain on target for completion
Limited Assurance	Substantial scope for improvement in existing controls. Actions not on target for completion. Low to medium risk of not achieving strategic objective
Very Limited Assurance	Substantial risk of failure to achieve strategic objective

Board Management of BAF

The controls and proposed actions for each of the 6 strategic risks are aligned to the workplan that was created to add detail to and supplement the wider Trust Strategy.

Going forward, the performance towards the completion of the plans and key projects within the strategy workplan is to be regularly monitored via the relevant sub-board committees and upwardly reported to Trust Board.

These upward reports can then be utilised by the Board to assist with the review of the 6 strategic risks, and in particular with the assessment of risk appetite and risk tolerance that then culminates in the assignment of a risk assurance rating for each of the 6 strategic risks.

It is recommended that the respective sub-board committees' upward report should include a summary of progress towards the strategy workplan and highlight risks and/or issues to the completion of plans and key projects. The upward report should further include a suggested risk assurance rating of the current controls and ongoing actions that are essential to the management of the risks to achieving our strategic objectives. This proposal from the subcommittee around the assurance rating is one which the Board is then invited to consider and approve.

Next Steps

It is recommended that the following actions are taking in order to continue toward more effective management of the BAF:-

Review of 6 strategic risks

Strategic risks as currently presented to be reviewed by respective Executive Director risk leads and should include:-

a) Review of the risk summary
b) Review of current risk score
c) Review of risk appetite statement
d) Review of current controls
e) Review of proposed actions
f) Propose an initial risk assurance rating

The outcome of these reviews can then be presented for discussion at Sub-Board Committees in March 2024 and Trust Board in April 2024.

Review of high level, corporate risks that align to strategic risks and the strategy workplan

As a key principle of project management each of the plans and key actions contained within the strategy workplan should have a risk register associated to them. Furthermore, any plans and projects approved as part of the current round of business planning for the 2024/25 financial year should also have a risk register associated with them.

Therefore, it is proposed that the risks contained in the risk registers for above plans and projects can then be aligned to the relevant strategic risks and therefore help in achieving a review and cleanse of the risks that align to the strategic objectives.

The governance team has already made progress with work to ensure that the risks identified as part of the work on the strategy work plans and business plans are used to populate risk registers and are then escalated and aligned as necessary.

The governance department has also held risk summits with the HR team to begin the work to align their risks to the proposed people plan and also hold regular risk summits with the chief nurse to review clinical risks.

The governance team will also begin to undergo a review of the risks currently on the Trust's Corporate Risk Register, which will further help with a cleanse of the CRR and thus enable us to better align the CRR risks to the 6 strategic risks.

It is proposed that an update on the progress of the above recommendations be presented at April Trust Board Meeting.

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 • Action plans are aligned to the wider Trust Strategy and workplan • Revised BAF incorporates comments and feedback from KPMG external audit lead	• Mapping of workplan risks, business plan risks and current high-level risks to new strategic risks is a work in progress and is a considerable piece of work to undertake

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board is asked to: consider and discuss the proposed changes to the Board Assurance Framework and support the approach to monitoring and assurance described.

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

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

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

Direct alignment to Trust Board Assurance Framework

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

PREVIOUS CONSIDERATION:

Previously considered at November 2023 Trust Board and Executive Team on 6 February 2024

Board Assurance Framework (BAF): SR1 - OUR CARE - January 2024

Risk Reference: SR1 - Our Care	Strategic Risk: There is a risk that the Trust will fail to meet its objective of being rated as 'outstanding' by the CQC by 2028.	**Causes**	As a result of the Trust:- Not being able to maintain current standards of service and patient care; Not being able to optimise pathways to ensure they are seamless and patient centred; Not being enabling patient-led booking via implementation of innovative digital technologies; Not having enough staff and resources Not having a suitable physical estate or environment	**Consequence**	With the consequence of detriment to:- Patient safety, The quality of service we provide; and Our reputation and rating as a Trust.	**Priorities**	Workforce Estates Digital Transformation Operational performance	**Strategic objective:**	**CARE - By 2028, we will be rated as 'outstanding overall' by our regulators, the Care Quality Commission. This will indicate that we are achieving the highest levels of care and quality.**
Lead Committees	Quality & Safety Committee, SE & OD Committee, Finance & Performance Committee & Trust	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3lX4c)
Executive Lead:	Chief Nurse & Chief Operations Officer	**Likelihood**	3		1			**April 2024**	
Initial Date of Assessment	January 2024	**Risk Rating**	12		4	TBC		**July 2024**	
Risk appetite Statement	The Trust has a low/no tolerance to risks that have the potential to negatively impact the quality of care we provide and the safety of our patients							**October 2024**	
								January 2025	

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
Good oversight of current clinical and operational performance at sub-board committees	Delivery of our Patient Safety Plan
Maintenance schedule	Delivery of our Patient Experience Plan
Quality & Safety walkabouts	Implementation of PSIRF
GIRFT accreditation	Implementation of actions in our Good to Outstanding Plan
People Plan	
Nursing Plan	
Estates Plan	
Clinical Plan	
Digital Plan	

Corporate Risk Register Risks aligned to BAF Risk SR1 - Our Care

Aligned Clinical Risks	Target Score	Current Score
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.	5 (1Lx5C)	10 (2Lx5C)
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.	10 (2Lx5C)	15 (5Lx3C)
1918 - Risk relating to patients no longer having access to specialist speech and language assessment and support	4 (1Lx4C)	16 (4Lx4C)
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.	4 (1Lx4C)	8 (2Lx4C)
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	4 (1Lx4C)	12 (3Lx4C)
Risk 1467 - Risk relating to non-compliance with blood transfusion standards as a result of no Transfusion Practitioner dedicated to ROH.	5 (1Lx5C)	10 (2Lx5C)
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)

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.	10 (2Lx5C)	15 (3Lx5C)

Aligned Operational Risks	Target Score	Current Score
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.	8 (2Lx4C)	12 (3Lx4C)
1089 - risk relating to failure to meet national 52 week waiting time targets	9 3Lx3C)	20 5Lx4C)
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	3 (1Lx3C)	16 (4Lx4C)
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	8 (2Lx4C)	16 (4Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 1423 - risk relating to lack of strategic workforce planning	6 (3Lx2C)	16 (4Lx4C)
Risk 1780 - risk relating to high levels of employee turnover	4 (2Lx2C)	16 (4Lx4C)

Risk 1917 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	4 (1Lx4C)	12 (3Lx4C)
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.	4 (1Lx4C)	12 (3Lx4C)
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	6 (2Lx3C)	12 (4Lx3C)
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	6 (2Lx3C)	9 3Lx3C)
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	6 (2Lx3C)	9 3Lx3C)
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	6 (2Lx3C)	9 3Lx3C)
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.	4 (1Lx4C)	12 (4Lx3C)
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.	4 (1Lx4C)	12 (3Lx4C)
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.	tbc	tbc

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	5 (1Lx5C)	12 (3Lx4C)
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.	4 (1Lx4C)	12 (3Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1Lx3C)	12 (4Lx3C)
Risk 1181 - risk relating to lack of abilty for IT systems to flag safeguarding alerts	6 (2Lx3C)	12 (4Lx3C)
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.	9 3Lx3C)	20 5Lx4C)
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.	3 (1Lx3C)	12 (4Lx3C)

Aligned Governance Risks	Target Score	Current Score
791 - risk relating to number of Trust policies overdue for review	6 (2Lx3C)	12 (4Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [3]

Digital [4]
Operational: [4]
Clinical [8]
Workforce: [11]
Finance [1]
Governance [1]

Board Assurance Framework (BAF): SR2 - OUR EXPERTISE - JANUARY 2024

Risk Reference: SR2 - Our Expertise	Strategic Risk: OUR EXPERTISE - 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.	**Causes**	As a result of the Trust:- Not having the neccesary capital and/or resource to enable growth, expansion 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.	**Consequence**	With the consequence of detriment of:- not being 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.	**Priorities**	Workforce, Estates, Digital Transformation, Operational performance	**Strategic objective:**	**OUR EXPERTISE - Innovate, improve, research and teach - By 2028, we will be kitemarked as a Major Revision Centre and Surgical Elective Hub and will publish 30% more research publications. This will indicate our expertise**
Lead Committees	SE & OD Committee, Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	3		3			**January 2024**	9 (3Lx3C)
Executive Lead:	Medical Director	**Likelihood**	3		2			**April 2024**	
Initial Date of Assessment	Jan-24	**Risk Rating**	9		6	TBC		**July 2024**	
Risk appetite Statement	The Trust has a higher level of tolerance to risks that involve innovation and service improvement which would enable us to grow and expand our expertise and our reputation as a specialist provider of orthopaedic care. 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.							**October 2024**	
								January 2025	

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
Estates Plan	Develop MSK Academy
People Plan	Provider Alliance Development
Digital Plan	MSK Transformation Programme
Nursing Plan	Expansion of Day Case Service
Clinical Plan	Re-introduction of JointCare pathway
Knowledge Plan	Become a Major Revision Centre
	Establish an Osseointegration service
	Become a centre for robotic assisted surgery

Corporate Risk Register Risks aligned to BAF Risk SR2 - Our Expertise

Aligned Clinical Risks	Target Score	Current Score
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1LX3C)	12 (4LX3C)
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	6 (2LX3C)	6 (2LX3C)
Risk 1938 - 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.	10 (2LX5C)	15 (3LX5C)
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.	8 (2LX4C)	20 (5LX4C)

Aligned Operational Risks	Target Score	Current Score
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	8 (2LX4C)	20 (5LX4C)

Aligned Workforce Risks	Target Score	Current Score
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	6 (2LX3C)	9 (3LX3C)
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.	4 (1LX4C)	12 (3LX4C)

Aligned Finance Risks	Target Score	Current Score
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.	TBC	TBC
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years	12 (3LX4C)	16 (4LX4C)

Aligned risk
Estates: [0]

Digital [0]
Operational: [1]
Clinical [4]
Workforce: [2]
Finance [2]
Governance [0]

Board Assurance Framework (BAF): SR3 - OUR PEOPLE - JANUARY 2024

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

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
People Plan	

Corporate Risk Register Risks aligned to BAF Risk SR3 - Our People

Aligned Clinical Risks	Target Score	Current Score
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.	TBC	TBC

Aligned Workforce Risks	Target Score	Current Score
1423 - risk relating to lack of strategic workforce planning	6 (2LX3C)	12 (3LX4C)
1783 - risk relating to high levels of employee turnover	4 (2Lx2C)	9 (3Lx3L)
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.	4 (1Lx4C)	12 3Lx4C)
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	6 (2Lx3C)	12 (4Lx3C)
Risk 1803 - risk relating to inabilty to defend Employment Tribunal claims due to gaps in process and record keeping in regards to employee records	4 (2Lx2C)	9 (3Lx3C)
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	6 (2LX3C)	9 (3Lx3C)
Risk HR11 - Risk relating to diversity of workforce in regards to recruitment and retention of BME staff	6 (2LX3C)	9 (3Lx3C)
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	6 (2LX3C)	6 (2LX3C)
Risk 1777 - risk relating to damage to employee engagement, staff retention and financial hardship to individuals as a result of Payroll errors	1 (1Lx1C)	8 (4Lx2C)
Risk 1886 - risk that continued industrial action will have a negative impact on attraction, recruitment and retention of staff.	6 (3Lx2C)	12 (4Lx3C)
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 staff	TBC	TBC
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.	4 (1Lx4C)	12 (3Lx4C)
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.	4 (1Lx4C)	12 (4Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [0]
Digital [0]
Operational: [0]
Clinical [1]
Workforce: [13]
Finance [1]
Governance [0]

Board Assurance Framework (BAF): SR4 - OUR COMMUNITY - January 2024

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

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
People Plan	Expand community health offering
Estates Plan	Reduce health inequalities
Digital Plan	

Corporate Risk Register Risks aligned to BAF Risk SR4 - Our Community

Aligned Clinical Risks	Target Score	Current Score
Risk CL1 - 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.	4 (1Lx4C)	12 (3Lx4C)
Risk CL7 - limited resource to undertake engagement activities with Primary Care, there is reduced ability to access hard to reach communities.	4 (1Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 1809 - potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 (3Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [0]
Digital: [0]
Operational: [0]
Clinical: [2]
Workforce: [1]
Finance: [1]
Governance: [0]

Board Assurance Framework (BAF): SR5 - OUR SERVICES - January 2024

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

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
People Plan	Future of Care: Outstanding Pathways
Digital Plan	Expansion of community health offering
Estates Plan	Reduce health inequalities
Nursing Plan	Expansion of day case service
Clinical Plan	

Corporate Risk Register Risks aligned to BAF Risk SR5 - Our Services

Aligned Clinical Risks	Target Score	Current Score
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.	5 (1Lx5C)	10 (2Lx5C)
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.	4 (1Lx4C)	12 (3Lx4C)
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1Lx3C)	12 (4Lx3C)
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.	4 (1Lx4C)	8 (2Lx4C)
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	6 (2Lx3C)	6 (2Lx3C)
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	6 (2Lx3C)	9 (3Lx3C)
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.	10 (2Lx5C)	15 (3Lx5C)
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.	4 (1Lx4C)	12 (4Lx3C)
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.	6 (2Lx3C)	15 (3Lx5C)
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	4 (1Lx4C)	12 (3Lx4C)

Aligned Operational Risks	Target Score	Current Score

Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)
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	8 (2Lx4C)	16 (4Lx4C)
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.	8 (2Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
1423 - risk relating to lack of strategic workforce planning	6 (3Lx2C)	12 (3Lx4C)
1783 - risk relating to high levels of employee turnover	4 (2Lx2C)	9 (3Lx3C)
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	6 (2Lx3C)	12 (4Lx3C)
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	6 (2Lx3C)	9 (3Lx3C)
Risk 1886 - risk that continued industrial action will have a negative impact on attraction, recruitment and retention of staff.	6 (3Lx2C)	12 (4Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	12 (4Lx3C)	5 (1Lx5C)
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.	12 (3Lx4C)	4 (1Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
1298 - cyber security risk	16 (4Lx4C)	8 (2Lx4C)
Risk 1181 - risk realting to lack of abilty for IT systems to flag safeguarding alerts	12 (4Lx3C)	6 (2Lx3C)
Risk 1902 - 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.	8 (2Lx4C)	20 (5Lx4C)

Aligned Governance Risks	Target Score	Current Score
791 - risk relating to number of Trust policies overdue for review	9 (3Lx3C)	3 (1Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [2]
Digital [3]
Operational: [3]
Clinical [11]
Workforce: [5]
Finance [1]
Governance [1]

Board Assurance Framework (BAF): SR6 - OUR COLLABORATION - JANUARY 2024

Risk Reference: SR6 - Our Collaboration	Strategic Risk: There is a risk that the Trust will fail to meet its objective of delivering a standardised pathway for elective orthopaedics in Birmingham and Solihull	**Causes**	As a result of the Trust:- 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 logistical and/or policitcal and operational difficulties of trying to embed new pathways and processes across the system	**Consequence**	With the consequence of detriment to:-financial impact as well as a reputational impact in terms of our allignment, position and standing within BSOL ICB	**Priorities**	Workforce Operational performance	**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 Committees	Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3L x 4C)
Executive Lead:	Chief Operating Officer	**Likelihood**	3		2			**April 2024**	
Initial Date of Assessment	January 2024	**Risk Rating**	12		8	TBC		**July 2024**	
Risk appetite Statement	The Trust has a higher tolerance for risk in regards to our ability to engineer improvement to system wide pathways and services and our abilty to influence and have a strong voice within the BSOL ICB system							**October 2024**	
								January 2025	

SUMMARY OF KEY CONTROLS AND MITIGATIONS (full details of key controls and performance metrics are set out within respective plans)	ACTIONS PLANNED
People Plan	MSK Transformation Plan
Estates Plan	Provider alliance development
	Become a major revision centre
	Private income generation

Corporate Risk Register Risks aligned to BAF Risk SR6 - Our Collaboration

Aligned Clinical Risks	Target Score	Current Score
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.	5 (1Lx5C)	10 (2Lx5C)
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.	6 (2Lx3C)	15 (5Lx3C)

Aligned Operational Risks	Target Score	Current Score
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.	8 (2Lx4C)	12 (3Lx4C)
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.	4 (1Lx4C)	12 (3Lx4C)
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.	4 (1Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
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	6 (2Lx3C)	9 (3Lx3C)
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.	4 (1Lx4C)	12 (3Lx4C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)
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.	4 (1Lx4C)	12 (3Lx4C)

Aligned risk
Estates: [0]

Digital [0]
Operational: [3]
Clinical [2]
Workforce: [2]
Finance [2]
Governance [0]

TRUST BOARD

DOCUMENT TITLE:	Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2023 NHS Core Standards profile
SPONSOR (EXECUTIVE DIRECTOR):	Mr Stephen Washbourne, Executive Director of Finance, IT & Estates
AUTHOR:	Mr Stuart Lovack, Deputy Director of Delivery
DATE OF MEETING:	7 February 2024

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 Trust's original self-assessment process identified areas of partial compliance however following a period of 'Check & Challenge' the ICB/Regional Team review our self-assessment and we have since identified/agreed on 32 areas of partial compliance against the 2023 EPRR Core Standards and 7 area of partial compliance against the EPRR Training Deep Dive.

The 32 areas of partial compliance against the 2023 EPRR core standards are:

- Governance – EPRR Board Reports
- Governance – Continuous Improvement
- Duty to maintain plans – Collaborative Planning
- Duty to maintain plans – Infectious Diseases
- Duty to maintain plans - New and Emerging Pandemics
- Duty to maintain plans – Counter Measures
- Duty to maintain plans – Mass Casualty
- Duty to maintain plans – Excess Fatalities
- Command & Control – Trained On-call Staff
- Training & Exercising – EPRR Exercising & Testing Programme
- Training & Exercising – Responder Training
- Response – Management of Business Continuity Incidents
- Response – Situation Reports
- Response – Access to 'Clinical Guidelines for Major Incidents & Mass Casualty Events'
- Warning & Informing – Warning & Informing
- Warning & Informing – Incident Communication Plan
- Warning & Informing – Media Strategy
- Co-operation – Information Sharing
- Business Continuity – Business Continuity Management Systems (BCMS) scope & objectives
- Business Continuity – Training & Exercising
- Business Continuity – Data Protection & Security Toolkit

- Business Continuity – BCMS Monitoring & Evaluation
- Business Continuity – BC Audits
- Business Continuity – BCMS Continuous Improvement Process
- Business Continuity – Assurance of Commissioned Providers / suppliers BCP's
- Hazmat/CBRN – Hazmat/CBRN Risk Assessments
- Hazmat/CBRN – Hazmat/CBRN Planning Arrangements
- Hazmat/CBRN – Equipment & Supplies
- Hazmat/CBRN – Equipment - Preventative Programme of Maintenance
- Hazmat/CBRN – Hazmat/CBRN Training Resource
- Hazmat/CBRN – Staff Training Recognition & Decontamination
- Hazmat/CBRN - Exercising

In relation to the 'ERPP Training Deep Dive' the areas of partial compliance are:

- EPRR Training – EPRR TNA
- EPRR Training – Minimum Occupational Standards
- EPRR Training – ERPP Staff Training
- EPRR Training – Senior Leadership Training
- EPRR Training – Training Data
- EPRR Training - Monitoring
- EPRR Training – Continuous Improvement Process

Through the EPRR Core Standards process the Local Health Resilience Partnership (LHRP) which includes Birmingham & Solihull ICB and Black Country ICB has been graded as 'non-compliant' with an overall rating of 57% compliance. The Trust forms part of this overall rating. The full analysis is provided to members as part of the private Board pack.

Due to the specialist Orthopaedic nature of the Trust, there will be areas listed above where the Trust will be challenged in achieving full compliance, these will be discussed with the ICB/Regional Team throughout 2024.

The areas of partial compliance listed above form part of the Trust's 'action plan', addressing these issues will move the Trust towards better compliance with the EPRR Core Standards.

The overall timescale identified for completion of these areas (where achievable) is twelve months; a project lead has been identified.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which has been re-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	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
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.		Fully compliant				
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.		Fully compliant				
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.		Partially compliant	2023 EPRR Core Standards to be reported publicly through Trust Board.	AEO & EPO	3 months	
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.		Fully compliant				
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.		Fully compliant				
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. Feedback tracker sheet and continuous improvement process to be reviewed.		Partially compliant	Continuous improvement process to be reveiwed.	EPO's	12 months	
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.		Fully compliant				
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 in their Business Contunity Plans.		Fully compliant				
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. Stakeholder engagement process to be reveiwed.		Partially compliant	Stakeholder engagement process to be reviewed.	EPO	12 months	
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.		Fully compliant				
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.		Fully compliant				
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. Review the Trust's role in an infectious disease outbreak.		Partially compliant	Review the Trust's role in an infectious disease outbreak.	EPO and IPC	12 months	
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. Review the Trust's role in a Pandemic outbreak.		Partially compliant	Review the Trust role in a Pandemic outbreak.	EPO and IPC	12 months	
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	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 orthopaedic 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. Review the Trust's role in supporting countermeasure deployment.		Partially compliant	Review the Trust's role in countermeasure deployment.	EPO	12 months	
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. Review the Trust's role in a mass casualty deployment.		Partially compliant	Review the Trust's role in a mass casualty deployment.	EPO	12 months	
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.		Fully compliant				
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 at all times. A security officer is on site 24/7. Lockdown procedure has been embedded into the Hospital Evacuation and Shelter Plan.		Fully compliant				
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 wthin the hospital to cater for VIP's. The Trust has a VIP Action Card incorporated in the Trust's Incident Response Plan.		Fully compliant				
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. Review the Trust's role in excess deaths and mass fatalities.		Partially compliant	Review the Trust's role in excess deaths and mass fatalities.	EPO	12 months	
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.		Fully compliant				
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. Review Training Needs Analysis for key members of the Trust.		Partially compliant	Review TNA's for key members of the Trust.	EPO	12 months	
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.		Fully compliant				
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. Review training schedule.		Partially compliant	Review training schedule.	EPO	12 months	
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.		Partially compliant	On-call Directors to undertake Principles of Health Command Training	EPO's	12 months	
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.		Fully compliant				
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.		Fully compliant				
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.		Fully compliant				
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. Review business continuity arrangements.		Partially compliant	Review business continuity arrangements.	EPO	12 months	
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.		Fully compliant				
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. Review Situation Reports to ensure they are consistent with ICB/NHSE processes.		Partially compliant	Review Situation Reports to ensure they are consistent with ICB/NHSE processes.	EPO	12 months	
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. Review Trust's role in relation to clinical interventions in Mass Casualty events.		Partially compliant	Review Trust's role in relation to clinical interventions in Mass Casualty events.	EPO	12 months	
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. Review Trust's communication planning in relation to Warning and Informing.		Partially compliant	Review Trust's communication planning in relatino to Warning and Informing.	and Communication Team	12 months	
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.		Partially compliant	Crisis Management Communication Plan to be developed.	EPO and Communication Team	12 months	
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 liasies with its key stakeholders.		Fully compliant				
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.		Partially compliant	Communication Plans to be reviewed.	EPO's	12 months	
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.		Fully compliant				
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.		Fully compliant				
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	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.		Fully compliant				
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. Review information sharing protocols.		Partially compliant	Review Information Sharing Protocols.	EPO	12 months	
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.		Fully compliant				
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. Review the Trust's Business Continuity Management Systems.		Partially compliant	Review the Trust's Business Continuity Management Systems.	EPO	12 months	
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.		Fully compliant				
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.		Fully compliant				
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. Review the Trust's testing and exercising schedule.		Partially compliant	Review the Trust's Testing and Exercising Schedule.	EPO	12 months	
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.		Partially compliant	Improvement plan agreed.	Head of IT	12 months	
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.		Partially compliant	Annual EPRR report to be upwardly reported.	EPO	6 months	
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. Review external auditing process.		Partially compliant	Review external auditing process.	EPO	12 months	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	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. Describe the BCMS continuous improvement process in Trust documentation.		Partially compliant	Describe the BCMS continuous improvement process in Trust documnetation.	EPO	12 months	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	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. Review the assurance process for commissioned providers/suppliers in relation to BC plans.		Partially compliant	Review the assurance process for commissioned providers/suppliers in relatino to BC plans.	EPO	12 months	
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																							
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.		Fully compliant				
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. Develop risk assessment for CBRN presenters.		Partially compliant	Develop risk assessment for CBRN presenters.	EPO	12 months	
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.		Fully compliant				
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.		Partially compliant	Difficult to achieve as we do not have an ED or decontamination facilities.			
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'. Review equpiment provision to ensure safe decontamination of CBRN presenters.		Partially compliant	Review equipment provision for the safe decontamination of CBRN presenters.	EPO	12 months	
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.		Partially compliant	Unachievable as we do not have an ED or decontamination facilities.			
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.		Partially compliant	Unachievable as we do not have an ED or decontamination facilities.			
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.		Partially compliant	Unachievable as we do not have an ED or decontamination facilities.			
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.		Fully compliant				
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. Review the Initial Operation Response.		Partially compliant	Review the Initial Operational Response.	EPO	12 months	
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.						
69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).			Y											Not applicable.						
70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.			Y											Not applicable.						
71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.			Y											Not applicable.						
72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.			Y											Not applicable.						
73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.			Y											Not applicable.						

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART Domain: Capability										
H1	HART	HART tactical capabilities	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through periods of significant local or regional demand pressure.	Y	Not applicable.					
H2	HART	National Capability Matrices for HART	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.	Y	Not applicable.					
H3	HART	Compliance with National Standard Operating Procedures	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)	Y	Not applicable.					
Domain: Human Resources										
H4	HART	Staff competence	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies.	Y	Not applicable.					
H5	HART	Protected training hours	I Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H5 Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.	Y	Not applicable.					
H6	HART	Training records	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets.	Y	Not applicable.					
H7	HART	Registration as Paramedics	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.	Y	Not applicable.					
H8	HART	Six operational HART staff on duty	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Y	Not applicable.					
H9	HART	Completion of Physical Competency Assessment	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.	Y	Not applicable.					
H10	HART	Mandatory six month completion of Physical Competency Assessment	All operational HART staff must undertake an ongoing Physical Competency Assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. The Trust must then implement appropriate support for individuals on a restriction of practice.	Y	Not applicable.					
H11	HART	Returned to duty Physical Competency Assessment	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.	Y	Not applicable.					
Domain: Administration										
H12	HART	Effective deployment policy	Organisations must maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y	Not applicable.					
H13	HART	Identification appropriate incidents / patients	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.	Y	Not applicable.					
H14	HART	Notification of changes to capability delivery	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y	Not applicable.					
H15	HART	Recording resource levels	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y	Not applicable.					
H16	HART	Record of compliance with response time standards	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y	Not applicable.					
H17	HART	Local risk assessments	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	Not applicable.					
H18	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Not applicable.					
H19	HART	Safety reporting	Organisations must have a robust and timely written process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 24 hours of the risk being identified.	Y	Not applicable.					
H20	HART	Receipt and confirmation of safety notifications	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	Y	Not applicable.					
H21	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y	Not applicable.					
Domain: Response time standards										
H22	HART	Initial deployment requirement	Four HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y	Not applicable.					
H23	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.	Y	Not applicable.					

H24	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on_x0002_scene at strategic sites of interest within 45 minutes. These sites were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their LRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y	Not applicable.					
H25	HART	HART Mutual aid	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region	Y	Not applicable.					
Domain: Logistics										
H26	HART	Capital depreciation and revenue replacement schemes	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).	Y	Not applicable.					
H27	HART	Interoperable equipment	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.	Y	Not applicable.					
H28	HART	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.	Y	Not applicable.					
H29	HART	Fleet compliance with national specification	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.	Y	Not applicable.					
H30	HART	Equipment maintenance	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).	Y	Not applicable.					
H31	HART	Equipment asset register	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Not applicable.					
H32	HART	Capital estate provision	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y	Not applicable.					
SORT Domain: Capability										
S1	SORT	Maintenance of national specified MTFA capability	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.	Y	Not applicable.					
S2	SORT	Compliance with safe system of work	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	Y	Not applicable.					
S3	SORT	Interoperability	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.	Y	Not applicable.					
S4	SORT	Access to specialist scientific advice	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).	Y	Not applicable.					
Domain: Human Resources										
S5	SORT	SORT establishment	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on_x0002_duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non_x0002_compliant.	Y	Not applicable.					
S6	SORT	Completion of a Physical Competency Assessment	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.	Y	Not applicable.					
S7	SORT	Staff competency	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Y	Not applicable.					
S8	SORT	Training records	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.	Y	Not applicable.					
S9	SORT	Provision of clinical training	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.	Y	Not applicable.					
S10	SORT	Staff training requirements	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	Y	Not applicable.					
S11	SORT	Arrangements to manage staff exposure and contamination	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.	Y	Not applicable.					
S12	SORT	CBRN Lead trainer	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.	Y	Not applicable.					
S13	SORT	FFP3 access	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).	Y	Not applicable.					
S14	SORT	IOR training for operational staff	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).	Y	Not applicable.					
Domain: Administration										
S15	SORT	Effective deployment policy	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).	Y	Not applicable.					

S16	SORT	Identification appropriate incidents / patients	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).	Y	Not applicable.					
S17	SORT	Change Management Process	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.	Y	Not applicable.					
S18	SORT	Record of compliance with response time standards	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators on request.	Y	Not applicable.					
S19	SORT	Notification of changes to capability delivery	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y	Not applicable.					
S20	SORT	Recording resource levels	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y	Not applicable.					
S21	SORT	Local risk assessments	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	Not applicable.					
S22	SORT	Lessons identified reporting	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.	Y	Not applicable.					
S23	SORT	Safety reporting	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.	Y	Not applicable.					
S24	SORT	Receipt and confirmation of safety notifications	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.	Y	Not applicable.					
S25	CBRN	HAZMAT / CBRN plan	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.	Y	Not applicable.					
S26	SORT	SORT Audit and inspections	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.	Y	Not applicable.					
S27	SORT	SORT capability funding	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.	Y	Not applicable.					
Domain: Response time standards										
S28	SORT	SORT Readiness to deploy	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.	Y	Not applicable.					
S29	SORT	SORT response time	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y	Not applicable.					
S30	SORT	SORT Mutual Aid	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.	Y	Not applicable.					
Domain: Logistics										
S31	SORT	PPE availability	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).	Y	Not applicable.					
S32	SORT	Equipment procurement via national buying frameworks	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.	Y	Not applicable.					
S33	SORT	Equipment maintenance	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.	Y	Not applicable.					
S34	SORT	SORT asset register	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national Equipment Data Sheets. The register must include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Not applicable.					
S35	SORT	PRPS - minimum number of suits	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y	Not applicable.					
S36	SORT	Individual / role responsible for SORT assets	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.	Y	Not applicable.					
S37	SORT	CBRN countermeasures	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).	Y	Not applicable.					
S38	SORT	Water supply for clinical decontamintion	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.	Y	Not applicable.					
S39	SORT	Equipment Vehicles	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available split over the organisations geographical area based on a local Trust assessment of risk.	Y	Not applicable.					
S40	SORT	Equipment vehicle readiness	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene.	Y	Not applicable.					
S41	SORT	Vehicle Tracking	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident.	Y	Not applicable.					
Mass Casualty Capability Domain: Capability Alignment Standards										
M1	MassCas	Mass casualty response arrangements	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.	Y	Not applicable.					

M2	MassCas	Arrangements to work with NACC	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.	Y	Not applicable.					
M3	MassCas	EOC arrangements	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared.	Y	Not applicable.					
M4	MassCas	Casualty management arrangements	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y	Not applicable.					
M5	MassCas	Casualty Clearing Station arrangements	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation.	Y	Not applicable.					
M6	MassCas	Management of non-NHS resource	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y	Not applicable.					
M7	MassCas	Mass Cas Audits and Inspections	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England.	Y	Not applicable.					
Domain: Mass Casualty Equipment										
M8	MassCas	MCV accommodation	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability.	Y	Not applicable.					
M9	MassCas	Maintenance and insurance	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty Officer informed.	Y	Not applicable.					
M10	MassCas	Mobilisation arrangements	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) assets maintain a 30-minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non_x0002_operational.	Y	Not applicable.					
M11	MassCas	Mass oxygen delivery system	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance).	Y	Not applicable.					
M12	MassCas	Drug and pharmaceutical stock management	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.	Y	Not applicable.					
M13	MassCas	Fleet compliance with national specification	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.	Y	Not applicable.					
M14	MassCas	Compliance with safe system of work	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.	Y	Not applicable.					
Command and control (C2) Domain: Generic Standards										
C1	C2	Consistency with NHS England EPRR Framework	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England.	Y	Not applicable.					
C2	C2	Consistency with Standards for NHS Ambulance Service Command and Control.	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the National Command and Control Guidance published by NARU.	Y	Not applicable.					
C3	C2	NARU notification process	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS ambulance strategic commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y	Not applicable.					
C4	C2	AEO governance and responsibility	The Accountable Emergency Officer in each NHS Ambulance Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y	Not applicable.					
Domain: Resource										
C5	C2	Command role availability	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.	Y	Not applicable.					
C6	C2	Support role availability	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.	Y	Not applicable.					
C7	C2	Recruitment and selection criteria	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	Not applicable.					
C8	C2	Contractual responsibilities of command functions	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.	Y	Not applicable.					
C9	C2	Access to PPE	The NHS Ambulance Trust must ensure that each commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.	Y	Not applicable.					
C10	C2	Suitable communication systems	The NHS Ambulance Trust must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y	Not applicable.					
Domain: Decision making										
C11	C2	Risk management	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles.	Y	Not applicable.					
C12	C2	Use of JESIP JDM	NHS ambulance commanders at all levels must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y	Not applicable.					
C13	C2	Command decisions	NHS ambulance command decisions at all three levels must be made within the context of the legal and professional obligations set out in the National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work provisions.	Y	Not applicable.					
Domain: Record keeping										
C14	C2	Retaining records	All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y	Not applicable.					
C15	C2	Decision logging	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs.	Y	Not applicable.					
C16	C2	Access to loggist	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one operational commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for additional logs to be kept by non_x0002_trained loggists should the need arise.	Y	Not applicable.					
Domain: Learning Lessons										
C17	C2	Lessons identified	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP.	Y	Not applicable.					
Domain: Competence										
C18	C2	Strategic commander competence - National Occupational Standards	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.	Y	Not applicable.					
C19	C2	Strategic commander competence - nationally recognised course	Personnel that discharge the strategic commander function must have successfully completed a nationally recognised strategic commander course (nationally recognised by NHS England / NARU). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y	Not applicable.					

C20	C2	Tactical commander competence - National Occupational Standards	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.	Y	Not applicable.					
C21	C2	Tactical commander competence - nationally recognised course	Personnel that discharge the tactical commander function must have successfully completed a nationally recognised tactical commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y	Not applicable.					
C22	C2	Operational commander competence - National Occupational Standards	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their command.	Y	Not applicable.					
C23	C2	Operational commander competence - nationally recognised course	Personnel that discharge the operational commander function must have successfully completed a nationally recognised operational commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y	Not applicable.					
C24	C2	Commanders - maintenance of CPD	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the minimum requirements for the role.	Y	Not applicable.					
C25	C2	Commanders - exercise attendance	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a ‘player’ at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.	Y	Not applicable.					
C26	C2	Training and CDP - suspension of non-compliant commanders	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y	Not applicable.					
C27	C2	Assessment of commander competence and CDP evidence	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake ‘dip sampling’ of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.	Y	Not applicable.					
C28	C2	NILO / Tactical Advisor - training	Personnel that discharge a NILO or Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y	Not applicable.					
C29	C2	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO or tactical advisor function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to_x0002_date competence in the NILO or tactical advisor discipline.	Y	Not applicable.					
C30	C2	Loggist - training	Personnel that discharge the loggist function must have completed a loggist training course which covers the elements and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.	Y	Not applicable.					
C31	C2	Loggist - CPD	Personnel that discharge the loggist function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	Not applicable.					
C32	C2	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).	Y	Not applicable.					
C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a ‘player’ at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise	Y	Not applicable.					
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (strategic, tactical and operational) and the NILO and tactical advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in compliance with these principles	Y	Not applicable.					
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors (or equivalent) must be aware of the ambulance service’s operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)	Y	Not applicable.					
C36	C2	Responders awareness of NARU major incident action cards	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust’s major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.	Y	Not applicable.					
JESIP Specific Core Standards										
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency emergency response within NHS Ambulance Trusts.	Y	Not applicable.					
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y	Not applicable.					
J3	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine	Y	Not applicable.					
J4	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that commanders and command support staff have access to the latest JESIP products, tools and guidance.	Y	Not applicable.					

J5	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene.	Y	Not applicable.					
J6	JESIP	Awareness of JESIP - control room staff	NHS ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets.	Y	Not applicable.					
J7	JESIP	Training records - staff requiring training	NHS ambulance service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y	Not applicable.					
J8	JESIP	Command function - interoperability command course	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Y	Not applicable.					
J9	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e_x0002_learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y	Not applicable.					
J10	JESIP	Commanders - interoperability command course	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y	Not applicable.					
J11	JESIP	Participation in multiagency exercise	At least every three years, all NHS ambulance commanders (at strategic, tactical and operational levels) must participate as a player in a joint exercise with at least Police and Fire Service command players where JESIP principles are applied.	Y	Not applicable.					
J12	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y	Not applicable.					
J13	JESIP	Training records - 90% operational and control room staff are familiar with JESIP	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.	Y	Not applicable.					

Over arching changes:	Domain 10 - CBRN renamed to Domain 10 - HazMat/CBRN Domain 10 standards reordered amd renumbered

Previous standard detail					New standard detail			
Ref	Domain	Standard	Detail	2023 Changes	Ref	Domain	Standard name	Standard Detail
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.	No change	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.
2	Governance	EPRR Policy	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.	No change	2	Governance	EPRR Policy	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.
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	No change	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
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.	No change	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.
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.	No change	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.
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.	No change	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.
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.	No change	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.
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	No change	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
Domain 3 - Duty to maintain plans								
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Standard detail has been updated to emphasise the importance of joint working and collaborative planning with emergency services and health partners following lesson identified through JOL working group.	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.
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.	No change	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.
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.	No change	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.
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	No change	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
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.	No change	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.
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	No change	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
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.	No change	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.
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.	No change	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.
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.	No change	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.
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'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	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'; Very Important Persons (VIPs), high profile patients and visitors to the site.
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.	No change	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.
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.	No change	20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
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	No change	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
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.	No change	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.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with 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)	No change	23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with 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)
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	No change	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
25	Training and exercising	Staff Awareness and 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.	No change	25	Training and exercising	Staff Awareness and 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.
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.	No change	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.
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.	No change	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.
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).	No change	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).
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	No change	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
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.	No change	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.
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.	No change	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.
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)	No change	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)
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.	No change	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	No change	34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
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.	No change	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.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	No change	36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
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.	No change	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.
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.	No change	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.
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.	No change	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.
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.	No change	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.
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.	No change	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.
42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	No change	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.	No change	43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								
44	Business Continuity	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.	No change	44	Business Continuity	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.
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.	No change	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.
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).	No change	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).
47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change	47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
48	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	No change	48	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
49	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.	No change	49	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.
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.	No change	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.
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.	No change	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.
52	Business Continuity	BCMS continuous improvement process	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.	No change	52	Business Continuity	BCMS continuous improvement process	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.
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 work with their own.	No change	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 work with their own.
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	No change	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
Domain 10 - HazMat/CBRN								
				New Standard	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
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Amended wording of standard so not specific to telephony advice.	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
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Standard detail amended to include specific elements of Hazmat/CBRN plan	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
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Standard detail amended and supporting information developed with evidence of risk assessments.	56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Standard detail amended to incroporate wet, dry, interim and improvised decontamination where necessary and availibilty of staff.	59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be deployed within 30 mins 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)
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Standard detail amended to reflect need to ensure equipment is in line with organisational Hazmat/CBRN risk assessments	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
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Standards merged.	65		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
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.					
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Standards merged.	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 Where applicable, the PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - 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
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment					
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Standard detail amended to reflect need to ensure the organisation has processes in place to manage waste, including but not limited to PPE.	62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Hazmat/CBRN Training standards have been consolidated from four into two standards	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
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.					
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		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 of 'Remove, Remove, Remove' and isolation when necessary. (This includes (but is not limited to) acute, community,
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.					
				New standard	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
				New Core Standards applicable to NHS ambulance services and developed by NARU in consultation with all NHS Ambulance Services in England to standardise the approach and support offer to acute Trusts	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
					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.
					69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).
					70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.
					71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.
					72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.
					73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.

Ref	Domain	Standard	Deep Dive question	Further information	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 Boards	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - EPRR Training																							
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Roles and responsibilites defined in the EPRR Strategy document. Training Needs Analysis developed for strategic and tactical command roles. Review specific training needs for key Trust staff.		Review specific training needs for key Trust staff.	EPO	12 months	
DD2	EPRR Training	Minimum Occupational Standards	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Strategic and tactical command roles are aligned to NOS minimum requirements, TNA and CPD requirements plan developed. Review specific training needs for key Trust staff.		Review specific training needs for key Trust staff.	EPO	12 months	
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Officer's and Head of Communications included in TNA. Review specific training needs for key Trust staff.		Review specific training needs for key Trust staff.	EPO	12 months	
DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Accountable Emergency Officer included in the TNA. Review specific training needs for AEO.		Review specific training needs for AEO.	EPO	12 months	
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training co-ordinated through the EPO's for all Strategic and Tactical Commanders, all have access to the Prinicples of Health Command Training.					
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	TNA developed for strategic and tactical commanders, central repository for all emergency planning training. Review training records process.		Review training records process.	EPO's	12 months	
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR report to be produced and taken through governance structure, report to include EPRR training compliance.		Annual EPRR report to be upwardly reported.	EPO's	6 months	
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Strategic command trainnig is delivered by an external provider aligned to the JESIP joint doctrine.					
DD9	EPRR Training	Continuous Improvement process	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Continuous improvement process to be defined for EPRR training.		Continuous improvement process to be reviewed.	EPO's	12 months	
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training evaluation feedback sheet used for internal training modules.					

REPORT REF: ROHTB (2/24) 011

TRUST BOARD

DOCUMENT TITLE:	NHS workplace health and safety standards – position statement and gap analysis
SPONSOR (EXECUTIVE DIRECTOR):	Simon Grainger-Lloyd, Director of Governance
AUTHOR:	Carl Measey, Health & Safety Adviser
PRESENTED BY:	Carl Measey, Health & Safety Adviser
DATE OF MEETING:	7 February 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

These NHS workplace health and safety standards, updated for 2023, provide the basis of effective health and safety management to support staff.

There is strong evidence linking patient safety, patient experiences and the quality of care with the safety, health and wellbeing of the workforce. Developed by the NHS Staff Council's Health, Safety and Wellbeing Group, these standards pull together legal requirements and guidance to help organisations comply with goal-setting legislation.

They provide practical pointers and signposting for meeting appropriate standards in key areas of workforce health and safety.

The standards:

- describe the principles which provide the basis of effective health and safety management
- set out the issues which need to be addressed
- provide links to the relevant guidance
- can be used for developing improvement programmes, self-audit or self-assessment.

A detailed self-assessment against these standards has been undertaken to provide a view of the ROH's compliance against health and safety legislation and best practice. The full self-assessment is available to Board members should any member wish to receive the detail.

Overall, compliance is very positive with few gaps or non-compliance identified.

Key areas of partial or non-compliance include:

- Strengthening reporting of health and safety matters at Board level, including introduction of an annual report
- Clarifying health & safety responsibilities in job descriptions of those responsible for oversight
- Trustwide communications around health & safety to be improved and details of health & safety group to be included on the inter/intranet
- Streamlining attendance at Health & Safety Group meetings and ensuring there is appropriate representation
- Undertaking of formal qualification in Health & Safety by the Director of Governance

- Improvements in performance against the Occupational Health Service Level Agreement
- Introduction of a Work Equipment Policy and policy for managing contractors
- Refresh of the policy referencing indoor temperature management

An action plan has been developed in response to this self-assessment and is considered at each meeting of the Health & Safety Group; this is attached as Appendix A.

The next meeting of the Health & safety Group is on 8 February 2024.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• The Trust is rated as fully compliant with 224 out of 257 standards (4 of which were not applicable to the Trust) – 87%.	• The self-assessment shows some areas requiring addressing through 26 areas of partial compliance and 3 areas of non-compliance.
NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to:

- RECEIVE and NOTE the outcome of the self-assessment and the development of an action plan to address the areas of partial and 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:

NHS Workplace Health & Safety Standards
Health and Safety at Work etc Act 1974
Management of Health and Safety at Work Regulations 1999

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 on 26 October 2023.

Status of Health and Safety Policies/Arrangements
(NHS Workplace Health and Safety Standards)

The 'Workplace Health and Safety Standards' has been devised by the Department of Health and the Health and Safety Executive. It is aimed at all healthcare providers. It identifies many of the significant typical risks affecting providers. The standards should be used as a guide when considering the need for written policies, procedures and arrangements, thereby ensuring the health, safety and welfare of employees and anyone else affected by our undertakings.

Standard	Policy/Arrangements Required	Status
1. Health and Safety Policies	'The organisation has a': • Health and Safety Policy (due to be reviewed May 24 after new Work Equipment Policy and Contractors Policy ratified. • Risk Assessment Policy.	Completed
2. Incident Reporting	'Organisation has an incident reporting procedure which sets out the requirements of accident and incident reporting under RIDDOR'. Will incorporate into H&S Policy at date of review (May 24) - see comment under 'Status'	On track (May 24). Trust did have an Incident Reporting Policy. Policy outlined RIDDOR reporting requirements. *Has this policy been recently replaced?*
3. Occy Health Service	'The organisation provides access to a comprehensive OH service'.	Completed
4. Slips, Trips and Falls	'The organisation has a slips, trips and falls policy and associated procedures'	Completed

Standard	Policy/Arrangements Required	Status
5. MSK Disorders / Manual handling	'The organisation has a current manual handling policy and associated procedures'	Completed
6. Electric profiling beds	'Generic assessments of wards/units is undertaken by a competent person to consider whether EPBs are required'. H&S Adviser: EPB's in situ for several years. Not aware of any historical risk assessments undertaken to assess suitability prior to original procurement. This standard would only potentially become relevant in the event of a new build/new service, or adoption of new design/model of beds.	Completed
7. V&A/ Challenging behaviour	'The organisation has current polices and procedures to manage the risks from challenging behaviour'.	Completed
8. Lone working	'The organisation has a lone working policy'.	Completed
9. Stress	'The organisation has a work-related stress policy and procedures'.	Completed
10. Bullying and harassment	'The organisation has policies and procedures in place for managing incidents of bullying and harassment'.	Completed

Standard	Policy/Arrangements Required	Status
11. Hazardous substances	'The organisation has current policies and procedures for the control of chemical and biological hazards. 'The organisation has an effective fit testing programme to ensure tight fitting respirators selected are suitable for the wearer. This should include': • clear responsibility within organisation for fit testing programme oversight, monitoring and review. • sufficient resources provided to carry out fit testing. • competency of those providing fit testing. • fit testing record keeping compliant with requirements of INDG479. • effective RPE storage arrangements.	Completed
12. Management of Sharps	'The organisation to have suitable sharps management policies and procedures in place'.	Completed
13. Work Equipment	'The organisation has a Medical Devices Policy covering selection, procurement, trial, training, use, maintenance and procedure for final disposal'. H&S Adviser: For equipment falling outside the definition of 'medical device' a Work Equipment Policy is also required. New policy drafted - to be discussed at H&S Group on 9 May 24.	On track. New Work Equipment Policy scheduled for discussion with H&S Group on 9 May 24.
14. Legionella	'The organisation has policies and procedures in place for managing the risk from legionella'.	Completed

Standard	Policy/Arrangements Required	Status
15. Temperature	'The organisation has policies and procedures in place for managing reasonable temperatures in indoor workplaces'. 'The temperature in the workplace should provide reasonable comfort without the need for special clothing'. 'The temperature in workplaces should normally be at least 16 degrees Celsius - or 13 degrees Celsius if much of the work indoors involves severe physical effort'. H&S Adviser: No temperature policy, however, temperature on wards 1/2/3/4/12 monitored via the BMS system. Temperatures are maintained throughout the Trust, so far as is reasonably practicable, at a minimum of 16 degrees in all other areas. Risk assessments completed for high-risk environments i.e. main kitchen.	Completed
16. Workplace transport	'The organisation has policies and procedures in place for managing the risks from workplace transport, ensuring safe site, safe vehicle, safe driver'.	Completed

Standard	Policy/Arrangements Required	Status
17. Electricity	'The organisation has suitable safe working practices for electrical systems and equipment. The following may be relevant depending on level of risk': • task specific risk assessments • written safe systems of work which may include 'Permit to Work' procedures. • authorisation of personnel to perform certain safety related tasks. H&S Adviser: Permits to work system in situ. Electrical safety policy in situ. Authorised Persons and competent persons in situ. Adherence to Electricity at Work Regs.	Completed

Standard	Policy/Arrangements Required	Status
18. Noise and Vibration	'The organisation has policies and procedures in place for managing the risk from noise and vibration at work'. Suitable and sufficient risk assessments for noise and vibration at work are undertaken. These should: • identify where there may be a risk from noise and who is likely to be affected. • reliably estimate exposures and compare these with the action and limit values. • identify actions to comply with the law. H&S Adviser: No Noise or Vibration policies, however robust procedures in place- <u>Vibration</u>: Contractor 'Environment Essentials' undertake regular vibration assessments on powered hand tools used by Estates staff and floor buffing machines used by Facilities staff. This undertaking complies with the Control of Vibration at Work Regs 2005 and Management of Health and Safety at Work Regs. <u>Noise</u>: Areas have been identified which are likely to exceed upper exposure action levels (85Db) - i.e. plant rooms. These areas have controlled access and mandatory blue and white signage is displayed - 'hearing protection must be worn'. Hearing protection provided free of charge.	Completed

Standard	Policy/Arrangements Required	Status
19. Contractors and subcontractors	'The organisation has policies and procedures in place for managing contractors'. H&S Adviser: New policy drafted. To be discussed at H&S Group on 8 Feb prior to final ratification.	On track. New Contractors Policy scheduled for discussion with H&S Group on 8 Feb 24.
20. Radiation	The organisation has policies and procedures in place for managing the risks from radiation. The organisation has access to appropriately qualified experts on radiation safety. The organisation has appointed RPS and LPS and satisfied itself that it has: • appointed an appropriate number of competent staff with the authority to supervise the work. • Provided appropriate information and instruction, including what to do in an emergency and where to seek more information.	Completed
21. First-aid	The organisation has policies and procedures in place for first aid arrangements. The organisation has carried out an assessment of first aid needs. This involves consideration of workforce hazards and risks, the size of the organisation and other relevant factors, to determine what first aid equipment, facilities and personnel should be provided.	Completed

Standard	Policy/Arrangements Required	Status
22. Working Time Directive (Including night workers)	'All employees have been made aware of their rights under the Working Time Regulations, including': • maximum working weeks and agreement to exclude the maximum. • patterns of work. • rest breaks, daily and weekly rest. • entitlement to annual leave. • young workers.	Completed
23. New and Expectant mothers	The organisation has policies and procedures in place for managing the risks to new and expectant mothers. Risk assessments are carried out to assess the risks to new or expectant mothers. Suitable facilities are provided for new and expectant mothers to rest.	Completed

Standard	Policy/Arrangements Required	Status
24. Pandemic and worker Health and Safety	The organisation has carried out, and recorded, suitable and sufficient risk assessments of work environments and work activities that could expose workers to pandemic infections.	For discussion. Workers in all environments are at risk of pandemic infection.
	From the risk assessments carried out, the organisation has identified who can be harmed and how, from potential exposure to pandemic infections, including individuals who may be more at risk of contracting and becoming unwell with the pandemic.	For discussion. As before, Trust will act in accordance with guidance from NHS England.
	The organisation has identified and implemented adequate measures to reduce potential exposure to pandemic infection, so far is reasonably practicable, in line with the hierarchy of controls identified in the principles of prevention and principles of good practice.	As before, Trust will act in accordance with guidance from NHS England.
	A process is in place to ensure risk assessments are reviewed regularly and that an immediate review takes place if the risk assessment is no longer valid, or if there have been significant changes to guidelines, outbreaks, or deaths of workers.	As per Covid-19, risk assessments will be reviewed.

	Where the risk assessment has identified that PPE is required this will be provided by the employer free of charge, in sufficient quantities and will be suitable for use. Where required, as a result of the risk assessment, users of tight-fitting respiratory protection, such as FFP2 and FFP3 facemasks will be face fit tested by a person competent to do so. Information and training in the safe use of PPE, including the need for wearers to fit check tight fitting respiratory protection, is provided. Where individuals fail fit testing, suitable alternative respiratory protection such as a powered filtered hood, should be provided.	Completed. PPE is provided free of charge and in sufficient quantities. Face fit testing will be undertaken. Where required FFP3 facemasks and training will be provided. Powered filtered hoods will be made available.
	Suitable and sufficient rest facilities will be readily available and accessible to allow employees to have uninterrupted breaks away from their work area.	Completed
	An adequate supply of drinking water will be provided at readily accessible places to ensure hydration is maintained.	Completed

	Workplace ventilation is sufficient to mitigate risk of exposure to airborne viruses and mechanical systems are maintained in line with manufacturer's guidelines. Where assessed as insufficient, measures are put in place to reduce the risk to workers.	In terms of mechanical ventilation Estates dept adhering to HTM's currently in use – until such time amended to address ill health risks from pandemics.
	Other foreseeable risks of working in a pandemic are assessed and reduced so far as is reasonably practicable including: • Heat stress • Work related dermatitis • Work related stress • Work related violence	Completed Arrangements, policies and procedures in situ.
	Cases of occupational disease resulting from workplace exposure to pandemic infections are reported to the regulator in line with the RIDDOR regulations.	Completed
	Mechanisms are in place to ensure union health and safety representatives and occupational health are consulted on risk assessments and measures in place to reduce the risk of harm to staff.	Completed

	On track or in progress
	Delayed completion
	Completed

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	Changes to the Trust's Constitution
SPONSOR (EXECUTIVE DIRECTOR):	Tim Pile, Trust Chair
AUTHOR:	Simon Grainger-Lloyd, Director of Governance
DATE OF MEETING:	7 February 2024

EXECUTIVE SUMMARY:

The last changes to the Trust's Constitution were approved in August 2022. This principally, increased the number of public governors from the Rest of England & Wales constituency from 4 to 5, to reflect that the ambition and vision of the Trust has evolved to create a more national presence and service delivery model than just within the Birmingham & Solihull region but also to create parity with the 'Birmingham & Solihull' constituency.

Some further changes are now proposed for consideration:

1) Regarding provision 23.2.2 to increase the Non Executive cadre of the Board from seven to eight, plus the Chair. This is designed to create a greater level of independent (non-management) representation on the Board and this model is common in many other organisations. It is also designed to support effective succession planning and provide a greater range of experience to support the organisation's challenges in future years.
2) Regarding Annex 4 to create an additional appointed governor place into which Aston University will be offered the opportunity to provide a representative. This reflects the strengthened relationship with Aston University and the increased number of medical students from this establishment that the ROH now hosts each year.

To effect these changes, the Constitution requires approval by a third of each of the Council of Governors and the voting cadre of the Trust Board. The Council of Governors approved these changes at its meeting held on 18 January 2024.

REPORT RECOMMENDATION:

The Trust Board is asked to approve the proposed amendments the Trust's Constitution which will take immediate effect.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

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

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Process follows the requirements set out in the Trust's Constitution.
PREVIOUS CONSIDERATION:
Council of Governors on 18 January 2024.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Assurance Report from the Non Executive Champion for Security
SPONSOR (EXECUTIVE DIRECTOR):	Les Williams, Non Executive Director
AUTHOR:	Les Williams, Non Executive Director
DATE OF MEETING:	7 February 2024

EXECUTIVE SUMMARY:

National guidance was received in 2022 which rationalised the number of Non Executive champion roles to five: Freedom to Speak Up; Security Management; Wellbeing; Doctors' Disciplinary; Maternity Safety (not relevant to ROH).

When the new guidance was presented to the Board, it was agreed that the assigned Non Executive champions would provide an assurance report to the Board by rotation.

Attached is the first of these reports, this being from the Non Executive Champion for Security, Les Williams.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and NOTE the update and assurance within the report.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

Financial		Environmental		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:

- NHS E guidance on Non Executive championships

PREVIOUS CONSIDERATION:

Report to Trust Board in June 2022.

ASSURANCE REPORT FROM THE NON EXECUTIVE CHAMPION FOR SECURITY MANAGEMENT

Definitions and scope of responsibility	'Security Management' in the NHS covers: ■ Physical security of estates and assets ■ Counterfraud identification and prevention ■ Prevention and reduction of violence and aggression towards staff and patients Scope of Non Executive champion based on national guidance is: ■ Familiarity with the responsibilities of the Trust identified in national guidance, including relationship with national bodies ■ Understanding the roles and activity of Local Security Management Specialist ■ Understanding the roles and activity of Executive Directors with responsibility for Security Management ■ Assurance reporting to Council of Governors, in addition to Trust Board
Operational and Executive Leads with responsibility for Security Management	■ Health & Safety Adviser, Carl Measey who also undertakes role of Local Security Management Specialist (LSMS) ■ Alex Gilder, Deputy Director of Finance is the operational lead for Counterfraud ■ Chief Finance Officer, Steve Washbourne, as lead Director for Security Management and for Counterfraud service, delivered by external consultancy (RSM currently); ■ Director of Governance, Simon Grainger-Lloyd, as lead director for health and safety; ■ Chief People Officer, Sharon Malhi, as joint lead, with the Director of Governance, for prevention and reduction of violence and aggression towards staff and patients
Activity this period (January 2023 – January 2024)	■ Gained familiarity with national guidance ■ Discussions with lead directors, managers and staff as appropriate ■ Discussions with RSM ■ Quarterly meetings set up with H&S Advisor/LSMS ■ Monthly discussions with CFO (to include F&P Committee preparation)

	■ Discussions held with Director of Governance and CPO as required ■ Responsibilities of Board sub-committees in respect of Security Management clarified as: • Physical security of estates and assets - Quality and Safety Committee, Staff Experience and Organisation Development Committee • Counterfraud identification and prevention - Audit Committee • Prevention and reduction of violence and aggression towards staff and patients - Quality and Safety Committee, Staff Experience and Organisation Development Committee
Status of relevant strategies and policies	*Physical security of estates and assets* : • Covered within Health and Safety Policy - discussed at Health and Safety Group which meets quarterly and considers a comprehensive report that includes both H&S and Security matters • Health and Safety Policy is currently being reviewed and will be presented to the May 2024 meeting of the Health & Safety Group and subsequently to Quality & Safety Committee and Trust Board as part of the Health & Safety annual report *Counterfraud*: • Presentation by RSM to at least two Audit Committee meetings each year (Executive Summary, Fraud Risks, Progress Against Annual Work Plan, Management Actions, Reactive Work, Emerging Risks and Alerts Issued, NHS Counter Fraud Authority Action Plan) • Conflict of Interests policy has been reviewed by Local Counterfraud Specialist and is due for review in 2025 *Prevention of Violence and Aggression* : • Report on standards, self-assessment and action plan discussed and agreed at September Board and is monitored through Health & Safety Group
Matters of escalation/key points of assurance to the Board	■ No overall concerns to raise

	■ Assurance that robust policies and effective and proportionate arrangements are in place, with regular policy reviews built into the annual workplan of relevant committees
Actions planned for next period	■ Ongoing identification of shortfalls in compliance with national guidance and requirements ■ Retendering of Counterfraud Service currently under way, to be concluded on 4th March 2024, with successful tender coming into operation on 1st April 2024 ■ Scheduling of policy reviews ■ Proposed that the role of committees to be executed as follows: • Quality and Safety to oversee Health and Safety Policy, with update to Staff Experience and Organisational Development for information and assurance • Staff Experience and Organisational Development to oversee Prevention of Violence and Aggression standards, with update to Quality and Safety for information and assurance • LSMS to attend Audit Committee to update on role and areas of concern ■ Identification of risks to inform BAF and Corporate Risk Register

Les Williams
January 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 30 January 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that there had been deterioration in performance against the national Referral to Treatment Time (RTT) target from 53.47% to 50.60%, which reflected some variation between specialities that impacted on the overall position. • Theatre in-session utilisation reduced due to the impact of Industrial Action and annual leave. • There continues to be delays associated with the histology service. This position, although it has not compromised the Trust's ability to meet national cancer targets, has been escalated to the Strategic Oversight Group and University Hospitals Birmingham NHSFT (UHB). The delays are due to shortfalls in capacity to provide the service and annual leave. • It was noted that the level of virtual consultations has reduced and work is underway to improve clinical engagement with the technology to improve this. • The financial outturn for Month 9 was highlighted to be below expectations with a deficit being reported rather than a breakeven position. • The end of year cash provision was noted to be tight, however discussions with the Integrated Care Board were underway to understand how this could be mitigated. • There was reported to be an adverse variance in both pay and non-pay expenditure. Bank staffing costs were high in December and were also elevated for agency staff. • There was noted to have been an increase in sickness absence, a significant amount being associated with mental health issues. • National operational planning guidance remains awaited.	• Update from Information Governance Group to be considered at the February 2024 meeting. • Committee's workplan to be considered at the February 2024 meeting. • Update on the ROH's adoption of the 'Sussex' model for physiotherapy treatment to be provided at the next meeting. • The outstanding bad debt was reported to have been escalated to the Integrated Care Board and relevant organisations. • 'Predictable Terms' national guidance was reported to have been issued, with requires the Trust to consider its flexible working practices and most notably bank staff engagements.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Funding has now been agreed for the 'People's Promise' manager. • It was noted that the Committee's terms of reference had been expanded to include oversight of the Digital, Data and Technology functions, which was welcomed by the Committee. • The Trust continues to report zero 104 and 78 week waits for treatment. • 116 cases above the System plan for treating elective cases had been delivered for the month, despite the impact of industrial action. • The level of 'Did Not Attend' cases reduced by 0.3%, reflecting the success of the Dr. Doctor technology. • Length of Stay was reported to have reduced to 2.8 days for primary hip and knee procedures. • Delivery of the private patient plan was reported to be above expectations. • The Trust has continued to accept mutual aid patients requiring spinal surgery, some of which are outside of the Birmingham and Solihull footprint. The Trust is proactively offering mutual aid for primary joints where it is identified that there would be a benefit in treating patients at the ROH rather than elsewhere. • Although the number of patients cancelled for surgery by the Trust remains higher than desired, there has been a decrease. Key reasons for cancelled operations have been patients not being fit for surgery or patients reprioritised to accommodate emergency procedures. The development of a 'standby' list of patients will help fill gaps caused by cancellations in future. • There was reported to be an improvement against the Better Payment Practice Code. • Agency spend, although higher than expected in December, remains on a downward trajectory overall. Non-clinical spend was noted to have reduced to minimal levels. • There remains good progress with the delivery of the Cost Improvement Programme.	• The Committee approved their revised terms of reference and agreed that they should go forward for the Board's formal endorsement.

Chair's comments on the effectiveness of the meeting: The Committee ran to a shorter agenda, meaning some regular or scheduled items were deferred to the February 2024 meeting. Thanks were given to Richard Phillips for his time served as a Non Executive Director and his stint as Chair of the Finance & Performance Committee.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Finance & Performance Committee terms of reference
SPONSOR:	Les Williams, Finance & Performance Committee chair
AUTHOR:	Simon Grainger-Lloyd, Executive Director of Governance
DATE OF MEETING:	7 February 2024

EXECUTIVE SUMMARY:

The attached present some proposed changes to the terms of reference for the Finance & Performance Committee, these being:

- To reflect the Committee's role in reviewing the operational performance as well as financial performance.
- To reflect that the updated portfolio of the committee to include the Trust's Digital, Data and Technology Plan.
- To update the membership following the retirement of the Executive Director of Strategy & Delivery
- To update the secretariat support to the Finance & Performance Committee.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the revised terms of reference

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Provides oversight and assurance to the Board on financial performance and operational performance against key national & local targets.

PREVIOUS CONSIDERATION:

Finance & Performance Committee on 30 January 2024.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee will operate independently of the Trust's Audit and such other Committees that the Board creates, but will work to avoid duplicating discussion of issues.

3 PURPOSE

3.1 The Committee, within the framework of the Trust's strategy and annual corporate and financial plans, shall undertake detailed oversight and scrutiny of the Trust's financial and operational~~activity~~ performance, including contractual performance and performance against key national performance targets to provide assurance to the Board on its financial stewardship, the robustness of its financial forecasts and on its regulatory returns.

3.2 The Committee shall also take responsibility on behalf of the Board, for oversight of the Trust's ~~project management and~~ Information Governance frameworks and the progress with the achievement of the Trust's environmental sustainability targets. ~~.~~

3.2 The Committee shall have oversight of the development and delivery of the Trust's ~~e~~Estates Plan ~~strategy.~~, and Digital, Data and Technology Plan, including implementation of an Electronic Patient Record (EPR).

4 MEMBERSHIP

4.1 The Committee will comprise of three Non-Executive Directors, the Chief Executive, the Executive Chief Finance Officer ~~Director of Finance~~, the Executive Chief Operating Officer, Executive Chief People Officer, Executive Chief Nurse and the Executive Director of Governance ~~& Performance, the Executive Director of Strategy & Delivery and the Chief Operating Officer~~.

4.2 A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.3 The Chair of the Committee will be ~~the~~ a Non Executive Director and if the Chair is absent from the meeting then another Non-Executive Director shall preside.

5 ATTENDANCE

5.1 Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the ~~C~~chair of the Committee.

5.2 Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.3 The ~~Director of Corporate Affairs & Company Secretary~~ Executive PA to the Executive Chief Finance Officer shall be secretary to the Committee and the Corporate Services Manager will provide administrative support and advice. The duties of the Corporate Services Manager ~~Director of Corporate Affairs & Company Secretary~~ in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Organise ~~T~~taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly, with the exception of August and December.

7 DUTIES

The Committee shall, on behalf of the Board, monitor and where appropriate review in greater detail the information within the Finance & Performance Overview and on any other information which it requires on finance and activity, financial forecasts and regulatory returns in order to:

7.1 Assess progress on the Trust's financial position and commissioned activity to provide assurance to the Board.

7.2 Monitor progress with performance against key national performance metrics, such as Referral to Treatment Time, ~~and~~ cancer waiting time targets and diagnostics performance.

7.3 Keep the Board informed on the robustness of plans and proposals which focus on improvement or recovery to address material deviation from the long term delivery plan or areas where poor performance against national or local targets are identified.

7.4 Assess the level of any key financial and performance risks to the Trust and to assess that the mitigating actions to manage these risks are sufficient to inform the Board appropriately.

7.5 Benchmark Trust performance through trend analysis and comparative data in order to highlight any specific concerns to the Board.

7.6 Scrutinise in greater detail the proposed annual budgets for revenue and capital and to recommend their adoption by the Board.

7.7 Monitor the development and delivery of the Cost Improvement Programme and recommend to the Board any concerns or opportunities for improved efficiencies or cost savings.

7.8 Look at detailed forecasts on the Trust's short and medium term financial position and financial plans to feed into the Board's implementation of its Strategy.

7.9 Review ~~—~~the Integrated Care System's financial and operational position, discussing contribution that the Trust may make to any improvement plans set.

7.10 Ensure the Board is drawing upon suitable sources of information which are timely, reliable and comprehensive in relation to finance and performance.

7.11 Oversee the submission of returns to NHS England~~Improvement~~ after these have been discussed and agreed at the Board taking into account the Board timetable and any other responsibilities.

7.12 To seek assurance on any additional matter referred to the Committee from the Board

7.13 Keep oversight of key financial and operational risks on behalf of the Board, seeking assurance on adequacy of mitigating actions where needed.

7.14 ~~Review the framework for the management of Trustwide projects and programmes and receive detailed reports on the benefits realisation from initiatives according to the timetable of delivery and implementation.~~ Receive regular progress reports from the Service Improvement Board relating to the Trust's work on continuous improvement and innovation (including benefits realisation).

7.15 Receive upward assurance reports from the Operational Management Board (OMB), the Green Board and the ~~–~~Information Governance Group, seeking assurance on behalf of the Board that there is compliance with connected legislation and regulatory requirements.

7.16 Review progress with the development and delivery of the Trust's ~~e~~Estates Plan ~~strategy.~~, and Digital, Data and Technology Plan (including the delivery of an Electronic Patient Record (EPR).

8 REPORTING

8.1 The minutes of all meetings of the Committee shall be recorded and submitted, together with recommendations where appropriate, to the Board at its private session. A summary of the key matters discussed, including any action commissioned will be presented by the Chair of the Committee in public.

8.2 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate Trust Board meeting for information.

8.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8.4 The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

9 REVIEW

9.1 The terms of reference of the Committee shall be reviewed by the Board annually.

Date of adoption: ~~October 2021~~ January 2024

Date of review: ~~October 2022~~ January 2025

PAPER REFERENCE: ROHTB (2/24) 015

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE AUDIT COMMITTEE

Date Group or Board met: 19 January 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remain a number of instances of breaches to or waivers of SFIs, which the Committee noted was disappointing and encouraged further work to make it clear that where appropriate, these were unacceptable. It was noted that in a number of cases however, the instances reflected an extension to current contracts which using the new contracting management solution, would be addressed more robustly in future. • There remain a number of key contracts with other NHS organisations that remain unsigned. Although this does not impact on service delivery, for reasons of good governance, the Committee agreed that these needed to be formalised as soon as possible and urged the Chief Finance Officer to escalate using appropriate routes at this stage. • The Committee was concerned at the elevated number of overpayments made to staff through payroll. It was highlighted that in most circumstances these were detected quickly and mechanisms are in place to recover the overpayments. Greater education for managers was agreed to be needed around the work required to ensure overpayments are not made in error.	• Work continues to develop the Atamis database to ensure that all contracts are logged and actioned robustly. A dashboard of contracts held on Atamis will be provided at the April 2024 meeting. • Update on open audit actions to be presented to the Executive Team. • Draft internal audit plan for 2024/25 to be presented to the Executive Team for final thoughts before sign off at the April meeting of the Audit Committee. • It was highlighted that a core audit for internal audit in the next three years is to be compliance against the new Fit and Proper Persons Test. • It was agreed that an update to the Committee on progress with the recommendations arising from the Workforce Planning audit should be presented at the next meeting. • Work was reported to be underway to finalise the contract for counterfraud services. This would be completed in February 2024.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was advised that preparation for the new national Procurement regulations (Provider Selector Regime) was complete and the procurement processes used by the ROH were compliant with these. • The Committee received a comprehensive update on the work to understand and improve health inequalities, which provided good assurance that recommendations from the last internal audit were being addressed. • Although still below the required level against the Better Payment Practice Code, the Committee was pleased to see good progress being made.	• The Committee approved its revised workplan. • The Committee agreed on an approach for contracting with internal and external audit functions.

• Good progress was being made to address open internal audit recommendations. • It was highlighted that there had been good attendance at the fraud webinars. • Good progress was noted to being made to refresh and redesign the Board Assurance Framework and realign it to the new Trust strategy. • It was highlighted that the initial comments arising from the Audit Committee and auditor effectiveness exercise were positive and demonstrated that the Committee and audit functions were operating well and delivering good value.	
Chair's comments on the effectiveness of the meeting: It was agreed that, despite some technical issues, the agenda included enough space for discussion to seek assurance from colleagues on key pieces of work and the attendance of the Chief Nurse had been very useful.	

PAPER REFERENCE: ROHTB (2/24) 015

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 31 January 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• All workforce risks were in the process of being refreshed to realign them to the Board Assurance Framework. In summary the top risks were: sickness absence due to stress & anxiety; storage of employment documentation; staff burnout due to reluctance to take annual leave; and payroll errors. The mitigations for each were outlined. • The Committee received an update on the position regarding the use of temporary staffing and the approach being taken to monitor and reduce this. A number of additional controls were noted to have been introduced including extra levels of authorisation to use agency staff and work to fill vacancies substantively. • Compliance with fire safety training was noted to be below expectations and there was some feedback that for some other modules, there was difficulty in releasing staff to attend face to face courses. Plans were outlined which would improve the position. • It was noted that the new guidance around predicable work patterns may impact, to some degree, the Trust's use of bank staff flexibly. • It was reported that the nursing & Allied Health Professional (AHP) Continuous Professional Development (CPD) funding had been allocated, however there was a risk to individual provider organisations from next year as allocations would be made at System level.	• An update on the outcome of the National Staff Survey to be presented at the next meeting to include the weighted data and the engagement plan for colleagues across the Trust. • Training sessions were reported to be underway for sickness absence management and flexible working. • From a wellbeing point of view, there was an initiative underway to encourage staff to consider stop doing or doing in a different way, activities that added pressure to workloads yet offered little value. • The Learning Management System (LMS) specification was reported to have been developed and procurement processes were underway. • Update on progress with the actions from the KPMG internal audit into Mandatory Training information to be presented at the March 2024 meeting.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• A positive staff story was received from two clinical pharmacy leads who described how they had welcomed the flexible approach to work following a return from maternity leave and also during the COVID pandemic. The staff were very positive about the leadership in the Pharmacy department and to the changes to the team & environment over the past few years. • The Committee was advised that there were candid conversations being held with the Birmingham & Solihull (BSol) Integrated Care System	• The Committee supported the adoption of the national Race Code and would recommend the same to the Trust Board. It was suggested that a gap analysis against the Code be considered by the Board in future, using an external party to test and challenge the Trust's compliance. The Multi Minority Ethnicity Group (MMEG) would be engaged with this work.

around the outcome of the 'Open Conversations' exercise, where staff across the System had been asked to describe their experience of working in the BSol footprint. • Work was reported to be underway to support female medical staff and this would be extended to those working at the ROH from University Hospitals Birmingham NHSFT (UHB). It was reported that Jo Thomas had been appointed as the new Associate Medical Director for Division 1. • The staff turnover position was noted to have improved. • Recruitment activity was noted to have recovered after a dip in December and time to hire was reduced to 63 days. • There was reported to be an improvement in the number of staff attending staff network meetings. • Spending the apprenticeship levy was reported to be progressing well and the Trust hosted 31 apprentices against a target of 29. Recruiting managers were encouraged to use apprentices where possible as part of their plans. • The Committee received the final Internal Audit report from KPMG concerning mandatory training information. The report highlighted several areas of good practice and offered a high level of assurance overall. • The Committee considered an update against the Equality & Delivery System (2) requirements which highlighted a good level of compliance with a plan to address any gaps identified.	
Chair's comments on the effectiveness of the meeting: The Committee meeting was completed ahead of the scheduled finish time and all were thanked for the good quality reports presented and the positive level of assurance offered. It was noted that the agenda focussed on 'Grip & Control' and compliance, rather than engagement and wellbeing although this work had continued and would be reported more fully at the next meeting.	

PAPER REFERENCE: ROHTB (2/24) 017

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 31 January 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The extract of the Corporate Risk Register that detailed clinical risks was considered, which included concerns over the robustness of the provision of Speech & Language and Dietetics services. Solutions were currently in place using support from partner organisations in the Birmingham & Solihull footprint or temporary workforce arrangements. It was noted that discussions related to the need for more permanent arrangements through Service Level Agreements were underway as part of the Provider Collaborative conversations and through the System Strategic Oversight Group. • Other risks included the difficulties experienced by the microbiologist in accessing patient prescribing information or patient records through the Prescribing Information & Communications System (PICS) and challenges with creating electronic flags on patient records for Safeguarding alerts. Manual processes were used as mitigation for these risks at present. • It was noted that there had been nine formal complaints received in Quarter 2. • Patients mobilising against clinical advice remains a risk and work is underway with the clinical teams, particularly as part of the admissions process, to ensure that patients are aware of expectations following surgery.	• Update on the WHO checklist process to be presented at the next meeting. It was suggested that a visible overview of the process needed to be displayed in theatres. • Include additional information in the next version of the Quality Report around the outcome of investigations into moderate harm incidents and near misses. The information is to include lessons learned. • It was noted that work was underway to redesign the Quality Report to ensure it was aligned with the intentions of PSIRF. • Update on feedback from 'Coffee Catch Up' sessions to be presented at the next meeting. • Consider how enquiries or concerns that would usually be handled by PALS may be recognised as part of the overall patient experience activity. • Benchmarking information for peer organisations around CNST premia to be obtained if possible. • Present the implementation plan for PSIRF at the next meeting, highlighting the timescale for significant changes in processes across the Trust. • Consider investigating the reason for the higher level of Opioid usage at the ROH compared to peer orthopaedic providers. • Further work is underway to inform the decision to resume the endoscopic spinal surgery service and an update & recommendation would be presented at the next meeting. • Work is underway to gather intelligence around staff immunisation against measles given the risk around current prevalence in the community.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• It was reported after a period of being vacant, a Resuscitation Officer had been recruited and would take up post in February 2024. • Good progress was reported against all Quality Priorities, with all forecast to be achieved by the year end.	• The Committee approved revisions to two terms of reference: Infection Prevention & Control Group and Health & Safety Group. • The Committee approved a proposal to recommended by Internal Audit, to amend its workplan to ensure that there is an update on clinical audit at

• It was noted that the level of PALS contacts and complaints received by the ROH was significantly less than that of peer orthopaedic organisations and work was underway to understand the reasons for this. • As part of the claims & litigation process, it was noted that the majority of cases closed during the last period had been financially settled below the worst case scenario. The Committee particularly welcomed the further reduction in the CNST premia which continued the trend seen over the past seven years. Reasons for this related to better internal processes for handling cases and early admission of liability where appropriate. • Progress with the implementation of the Patient Safety Incident Response Framework (PSIRF) was outlined. It was noted that there remains further work to do to fully implement the requirements of the framework and thereby reduce the burden of heavy investigations where this is not needed. • The processes, including the escalation mechanisms, should a death occur at the hospital, were described. • The Committee considered the Annual Report from the Accountable Officer for Controlled Drugs. It was highlighted that there had been a reduction in the number of CD incidents and the move to an electronic register for CDs had been a positive development. • The Committee considered the Annual Report on Infection Prevention & Control. The report outlined robust processes for the management of the IPC framework.	each meeting.
Chair's comments on the effectiveness of the meeting: The Committee meeting finished ahead of the scheduled time. It was agreed that there had been an appropriate focus on key risks and assurances to offer the Board.	

Finance and Performance Report

Month 09

Introduction

The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues that are being highlighted.

Icons reading guide

Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

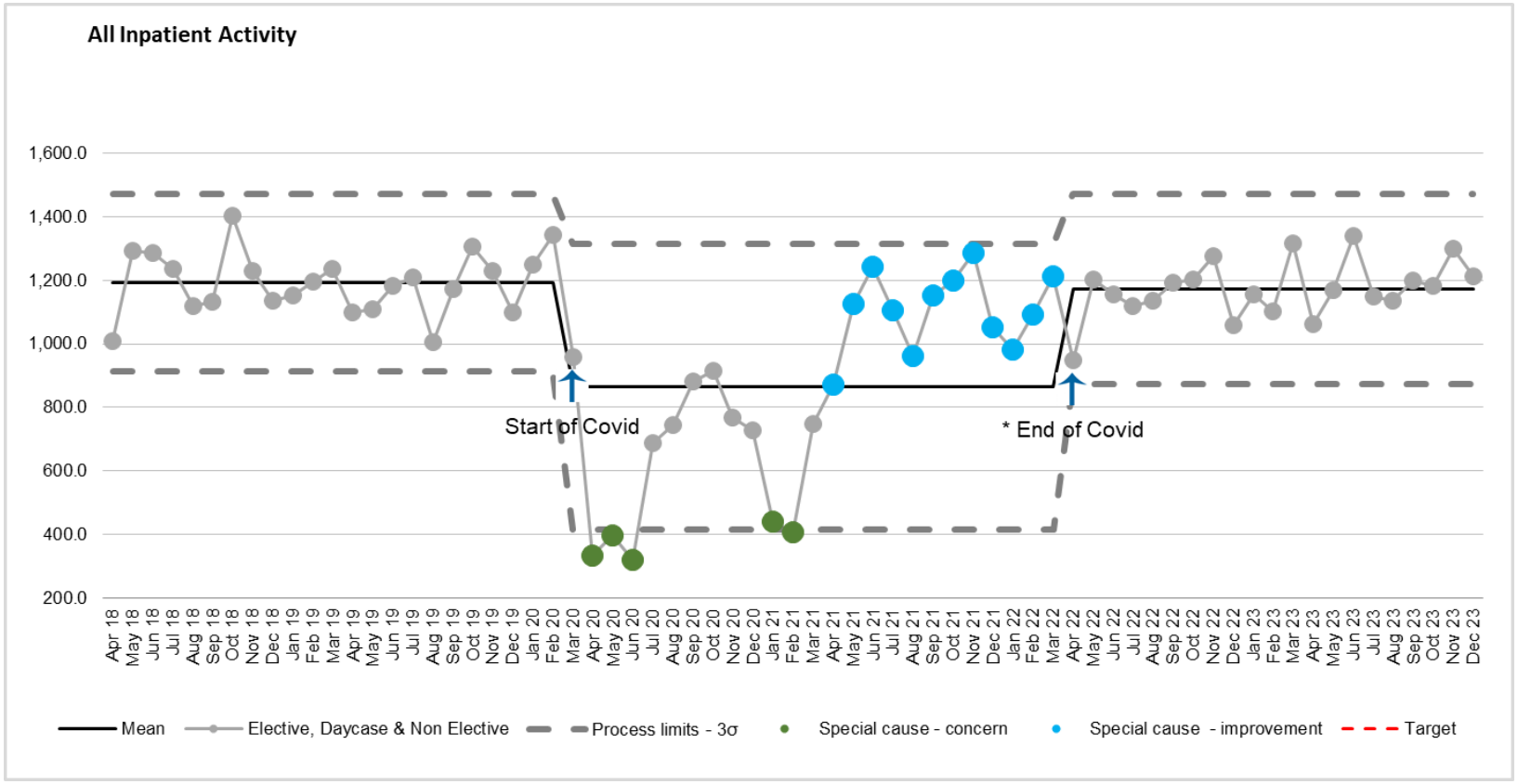
Operational Performance Summary

Performance to end December 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	50.60%	53.47%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	87	77	0	L	F
52 week waits (52 – 64 Weeks)	474	502	0	H	F
All elective activity YTD (compared to plan)	10,749	9,533	10,633		P
Outpatient activity YTD (compared to plan)	49,332 100.3% Cumulative	44,839 102.1% Cumulative	49,201 YTD Target		P
Outpatient Did Not Attend (YTD)	7.8%	8.1%	8%		P
PIFU (trajectory to 5% target)	392 9.1%	490 9.5%	184 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	8.4%	11.8%	19%		F
FUP attendances(compared to 19/20)	90.6%	91.3%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	110.1%	109.0%	120%		F
Diagnostics volume YTD (compared to plan)	18,571 Cumulative	16,428 Cumulative	14,080 YTD Target		P
Diagnostics 6 week target	99.7%	99.9%	99%		P

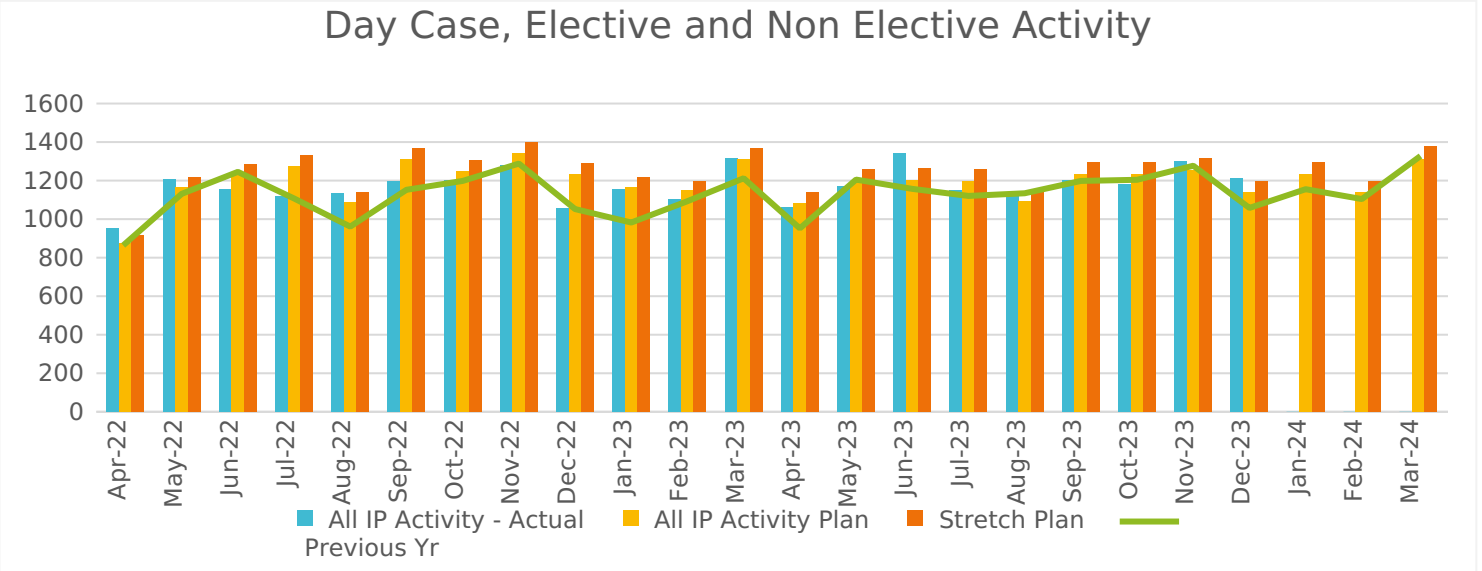
Operational Performance Summary

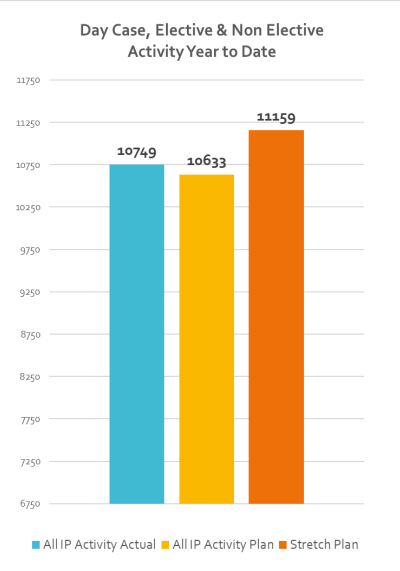
Performance to end December 23	In month	Previous month	Target	Variation	Assurance
Theatre in-session utilisation (Uncapped)	83.07%	85.35%	85%		
Cancer – 31-day first treatment	100%	100%	96%		
Cancer – 62-day (traditional)	85.7%	85%	85%		
28-day FDS	100%	75%	75%		
Patients over 104 days (62-day standard)	0	1	0		No Target
POAC activity volume (YTD)	18,978 Cumulative	17,060 Cumulative	17,282 Cumulative		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.57	3.55	n/a		No Target
LOS - elective primary hip	2.80	3.50	2.7		
LOS - elective primary knee	2.80	3.50	2.7		
BADS Day case rate (Note: due to time lag in month is Sep'23)	77.0%	76.4%	85%		

1. Activity Summary



1. Activity Summary



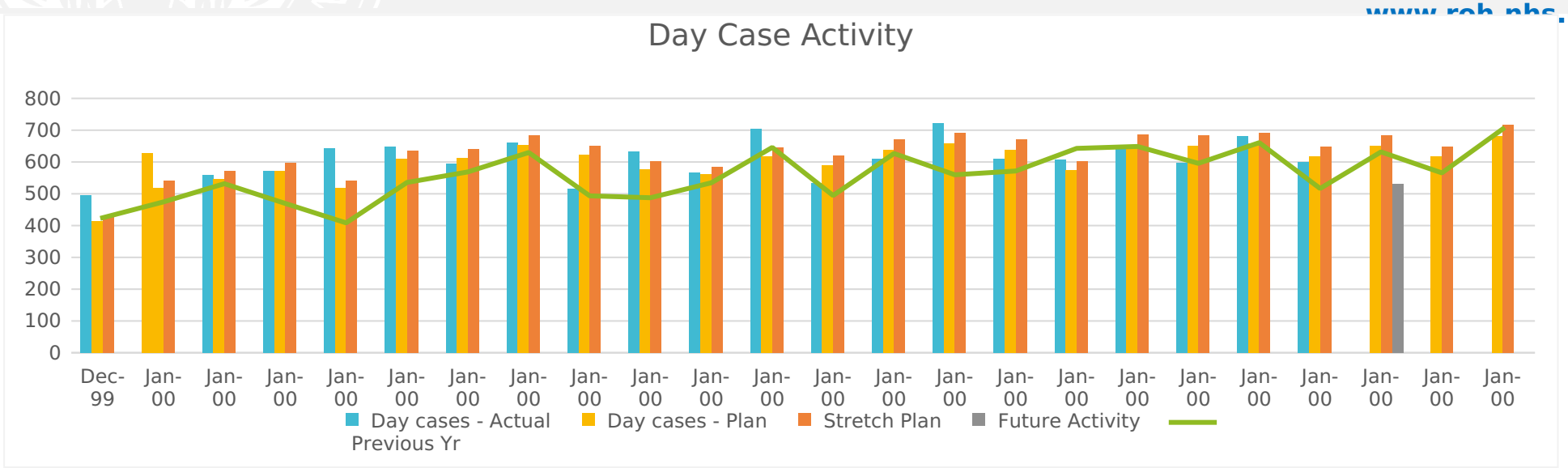


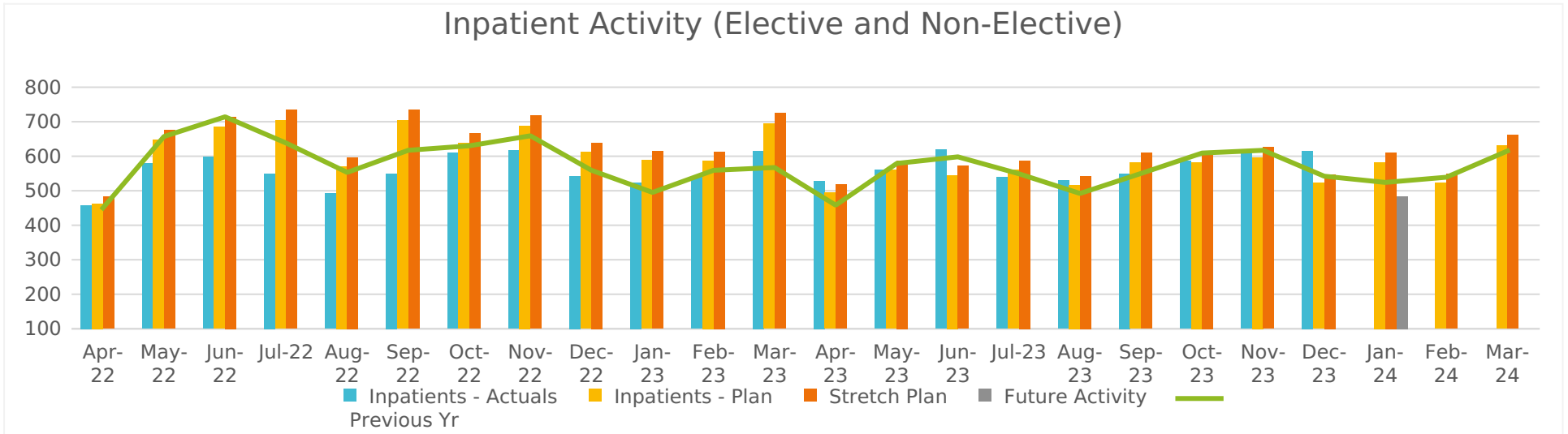
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	4846	4929	102%	83
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	5675	5605	99%	-70
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	112	215	192%	103
	All Activity	1084	1198	1203	1198	1090	1234	1233	1254	1139	1233	1139	1311	10633	10749	101.1%	116
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	5088	4929	97%	-159
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	5959	5605	94%	-354
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	112	215	192%	103
	All Activity	1138	1257	1263	1257	1144	1295	1294	1316	1195	1294	1195	1376	11159	10749	96%	-410

December 2023

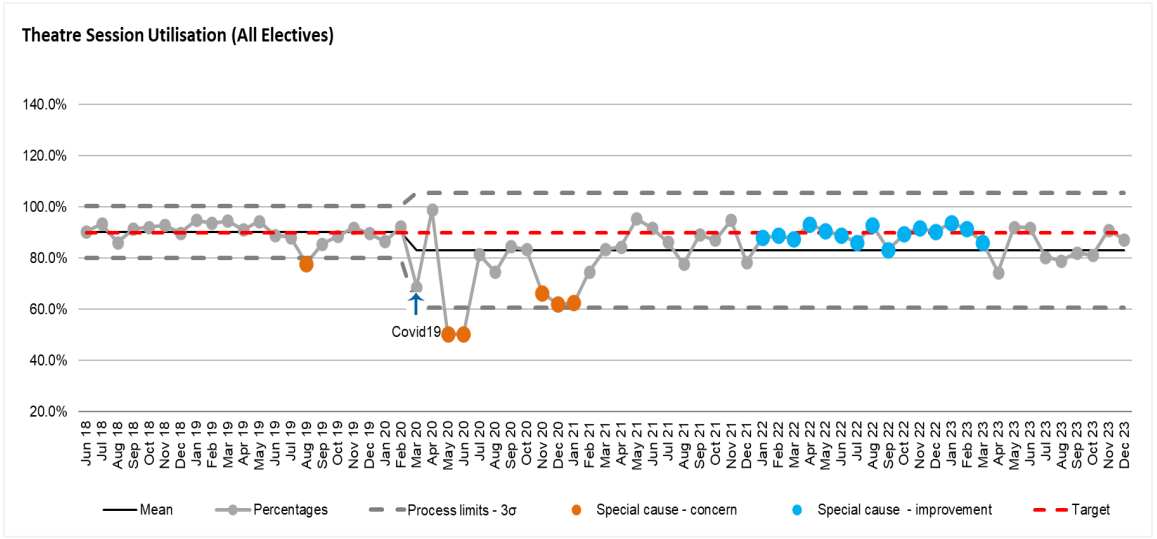
Actual in month 1214 vs 1139 System Plan (Variance + 75)
YTD position against Actual vs System plan is 101.1% (Variance +116)

1. Activity Summary

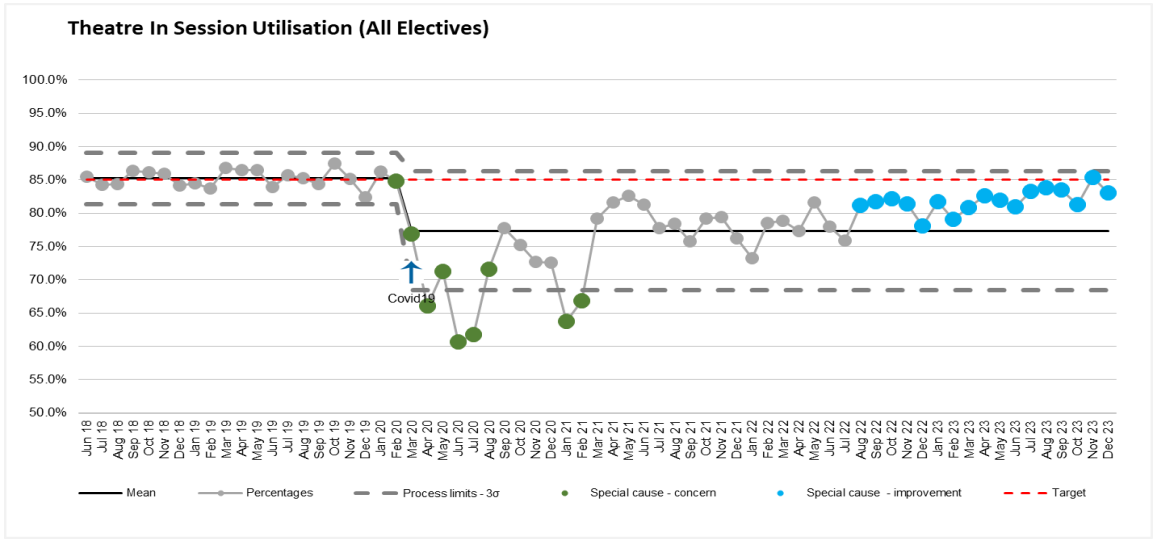




2. Theatre Utilisation



Elective Session Utilisation (December 2023)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	418	366	52	87.56%
UHB	67	57	10	85.07%
Totals	485	423	62	87.22%



Elective In Session Utilisation (December 2023)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1612	1336	275	82.91%
UHB	253	213	40	84.11%
Totals	1865	1549	316	83.07%

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for December was 87.22% which was above the Trust target of 85%.

There were 3 days of industrial action during December, if this had not taken place then utilisation would have been 89.43%

The overall in-session utilisation for November 23 was 83.07%.

AREAS FOR IMPROVEMENT

The Theatre triumvirate will be meeting with each specialty triumvirate to understand opportunities to improve and how theatres can support with this. These meetings are scheduled from January 2024.

To support UHB in respect of improving theatre utilisation, an initiative is being scoped out as to whether UHB elective patients who have had their pre-operative assessment carried out at UHB can be operated on at the ROH, without the need to carry out a pre-operative assessment at the ROH. This will require access to and transfer of clinical information and once received that information will be checked by clinical colleagues in POAC. The clinical and nursing lead for POAC are supportive of this initiative.

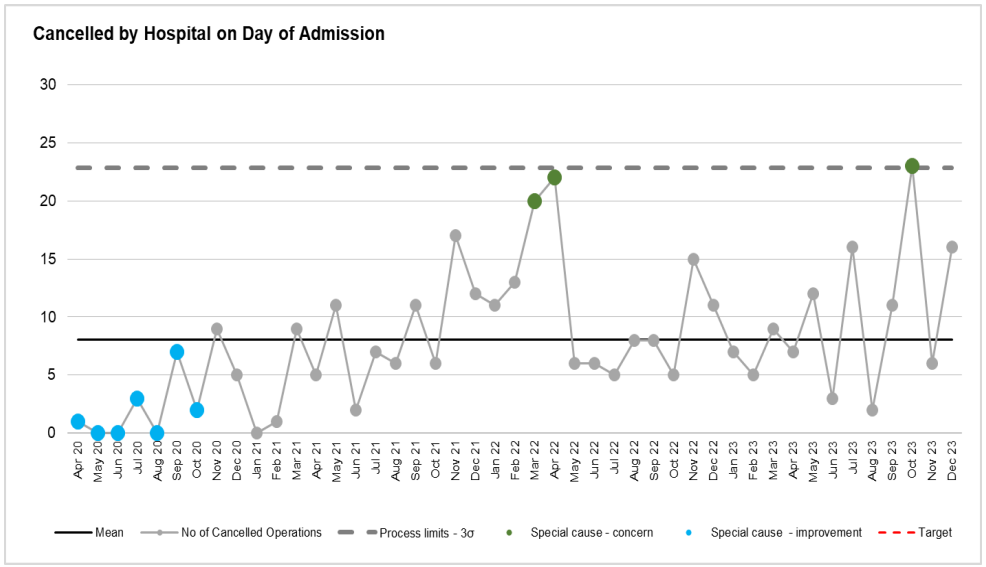
Activity is monitored daily by the Div 1 Associate Director of Operations to maximise existing capacity.

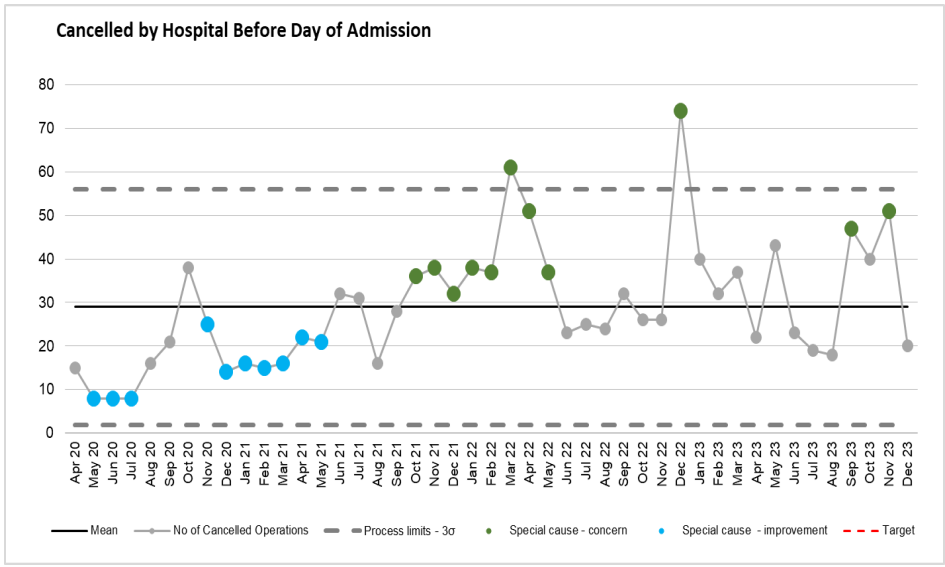
RISKS / ISSUES

There is currently no B Braun decontamination service on a Sunday, this will be added to the service specification for the new BSOL system led contract.to support 6 day working as business as usual from April 2024.

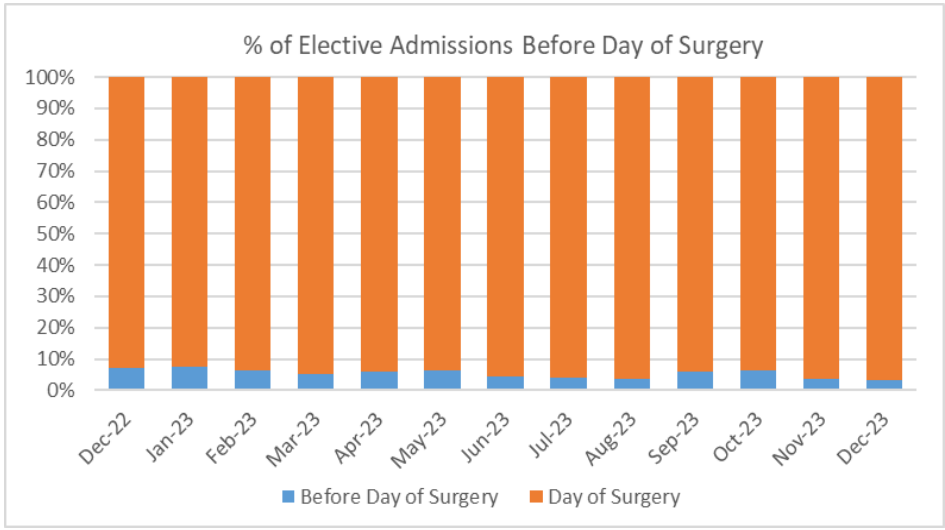
Activity for UHB continues to be behind plan, utilisation improved in the lists that went ahead. A rectification plan has been requested from UHB to improve fill rate of lists and to ensure utilisation exceeds 85%. This has been raised at System level due to the risk to delivery of the system financial plan. Acting Executive COO is meeting with the Group Deputy COO for UHB and the Hospital Ops Director for QE on Monday to discuss opportunities to improve fill rates and backfilling dropped sessions.

2. Theatre Utilisation/ Hospital Led Cancellations





Year - Month	Cancelled by Hosp. o Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
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
Aug-23	2	27	18	47	0
Sep-23	11	22	48	81	0
Oct-23	23	26	40	89	0
Nov-23	6	36	51	93	0
Dec-23	16	12	20	48	0
Total	134	360	500	994	0



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases.
These cases are more difficult to avoid due to very short notice bookings:

16 patients were cancelled on the day with reasons detailed as follows:
7 x lack of theatre / nursing staff due to sickness
3 x Clinician unavailable/unwell
3 x Lack of theatre time – complex cases ran over allocated time
2 x Equipment issues – holes in drapes
1 x Replaced by emergency cases – emergency case took priority

12 patients admitted and had treatment deferred, with the reasons detailed as follows:
12 x Medically unfit / Clinical change in condition / Patient Medication Issue / Loose tooth / Loose brace

20 patients cancelled by the hospital the day before the date of admission
7 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds
5 x Change in TCI date -
5 x Lack of theatre staffing – weekend PP lists swapped from a Sat to a Sunday
2 x Replaced by more urgent case
1 x consent process not completed

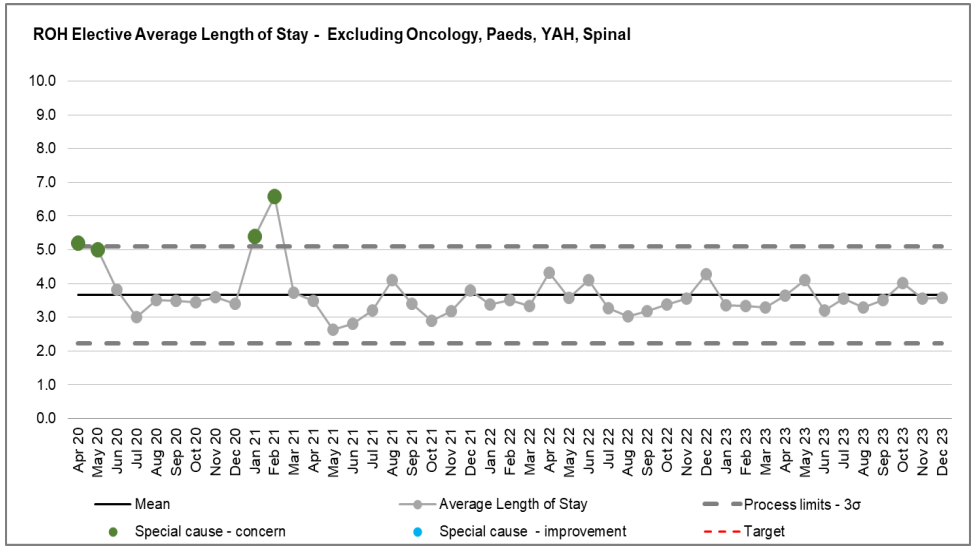
AREAS FOR IMPROVEMENT

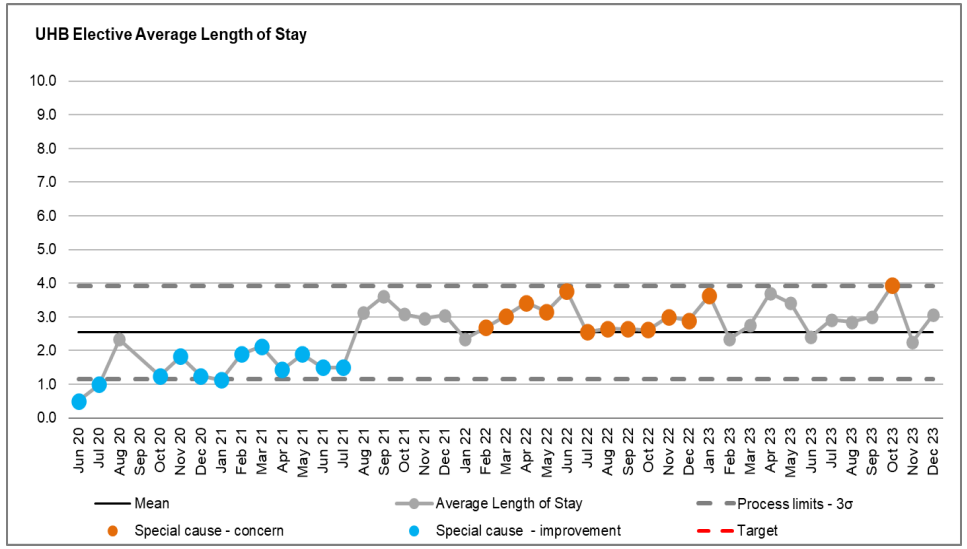
A review of the medical processes within POAC is to be undertaken supported by the Associate Medical Director Div 2 and a newly appointed Consultant Physician/Geriatrician to identify areas of improvement within the patient's pathway. Review to be undertaken in the new year.

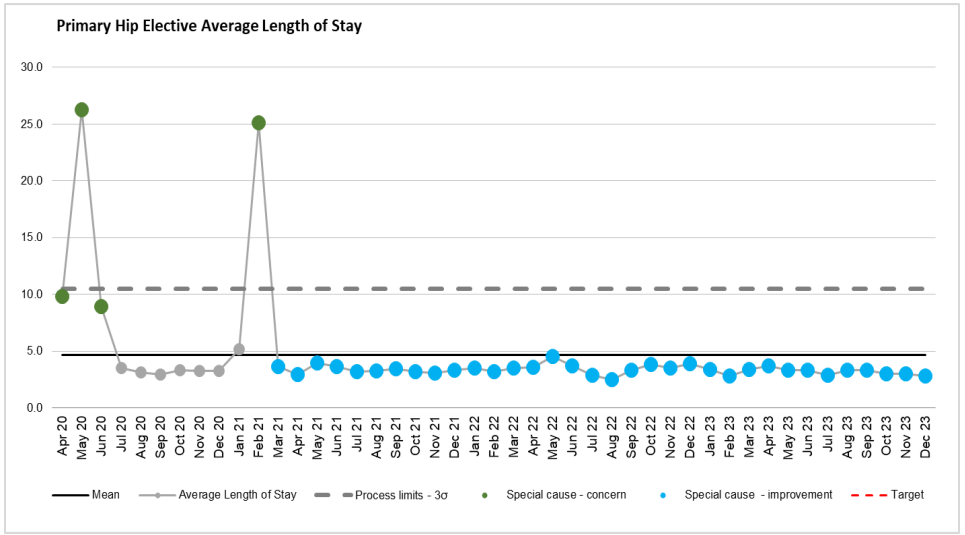
RISKS / ISSUES

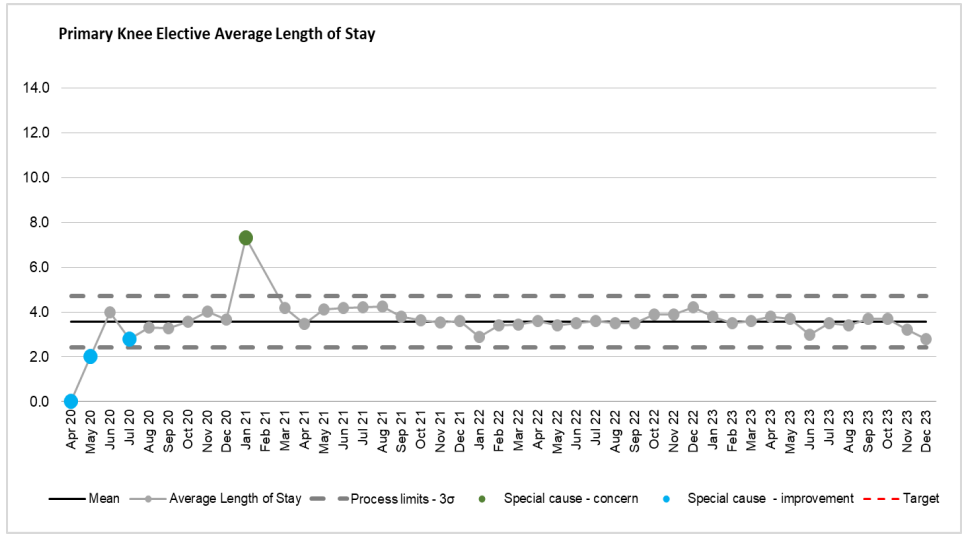
Increasing number of patients being assessed as medically unfit and the risk of this increasing further due to covid and usual winter medical conditions. Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips remains at 2.8 days (3.0 days November 23) and primary Knees has reduced to 2.8 days (3.2 November 23).

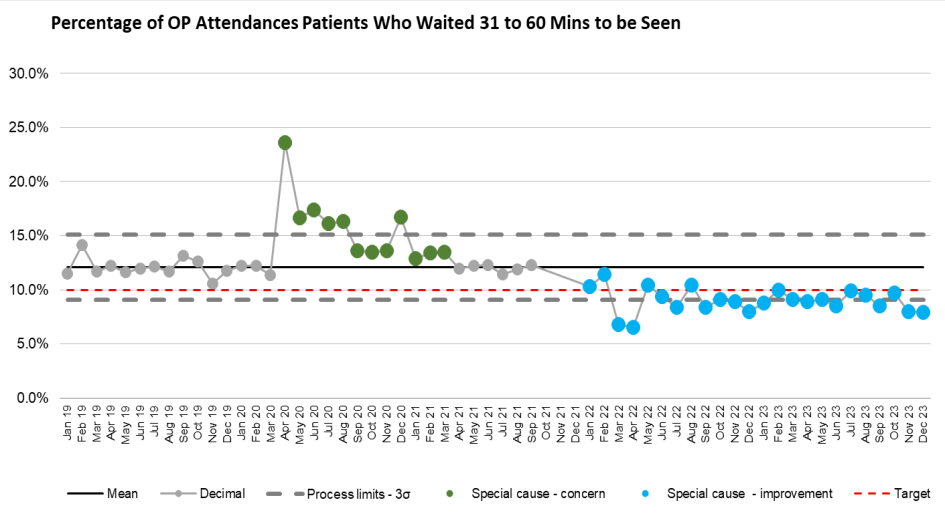
The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal has reduced to 3.57 days (3.55 November).

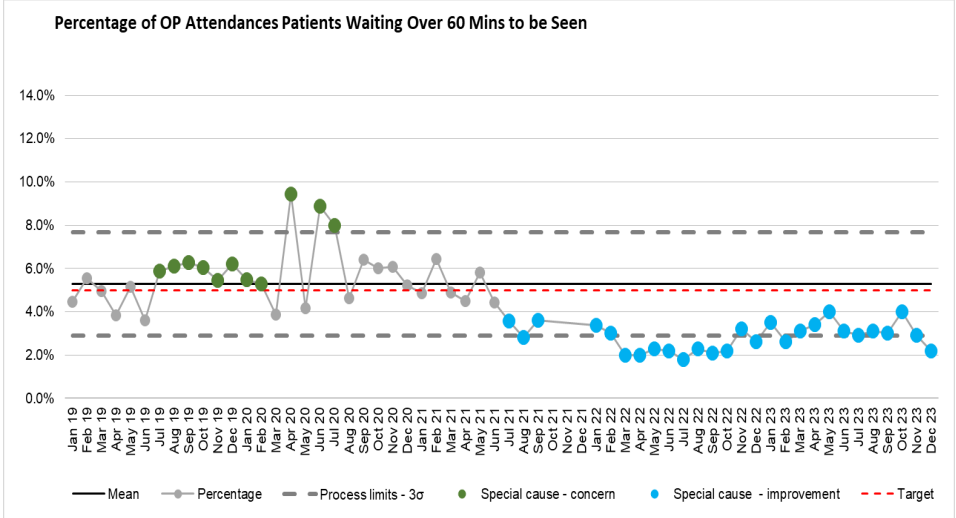
A review of the ROH primary arthroplasty and oncology arthroplasty patients, identifies a further reduction in the number of patients with LOS >/= to 8 days. 2 patients stayed >/= to 8 days compared to 4 in November 23. Both were arthroplasty and had an ASA score of 2. Review of records identifies that 1 had extended length of stay as not medically fit for discharge prior, 1 not physio fit and required package of care in place prior to discharge.

AREAS FOR IMPROVEMENT / ACTION PLAN

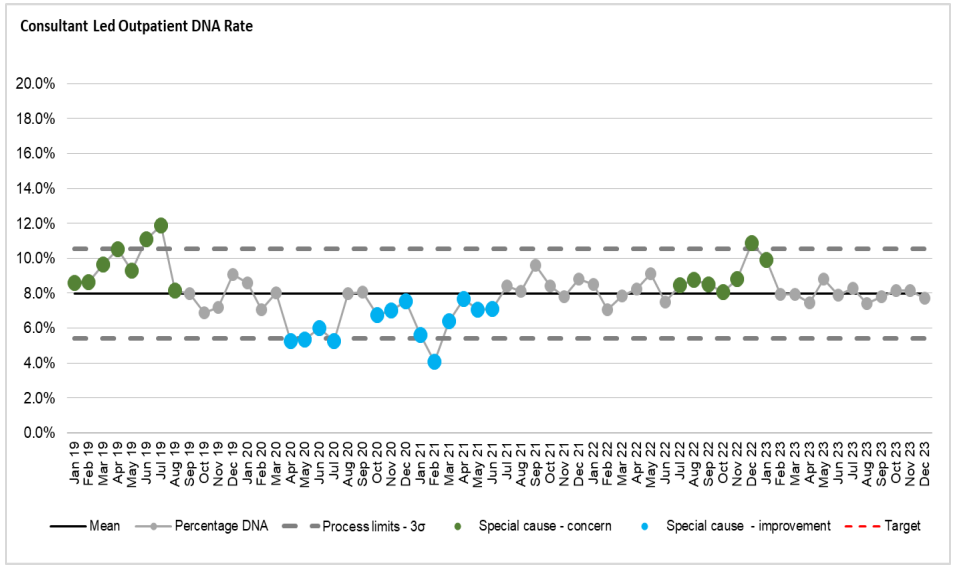
- Review and develop documented process/pathway for default to day case primary hip/knee procedure and how information is captured.
- MDT discussion involving medical, nursing and therapy colleagues to identify barriers to day case procedures and reducing length of stay for primary hips and knees.
- Consultant Physician and Discharge Liaison nurse ward rounds have recommenced which will assist in identifying any potential delays.
- Undertaking a review of themes regarding why patients convert from day case to overnight.
- Consolidate the learning from GIRFT visits of other sites.
- Head of Nursing Div 1 and Deputy COO to attend Day Case meeting to progress actions to reduce length of stay.
- Deputy COO met with a colleague at UHB on 29.11.23 to review UHB proposal on a Virtual Arthroplasty Ward. The offer was support of remote monitoring electronic system to manage patients virtually. The service sounded very similar to ROCS. The project lead at UHB has left, so ascertaining the correct contact to liaise with our ROCS lead.

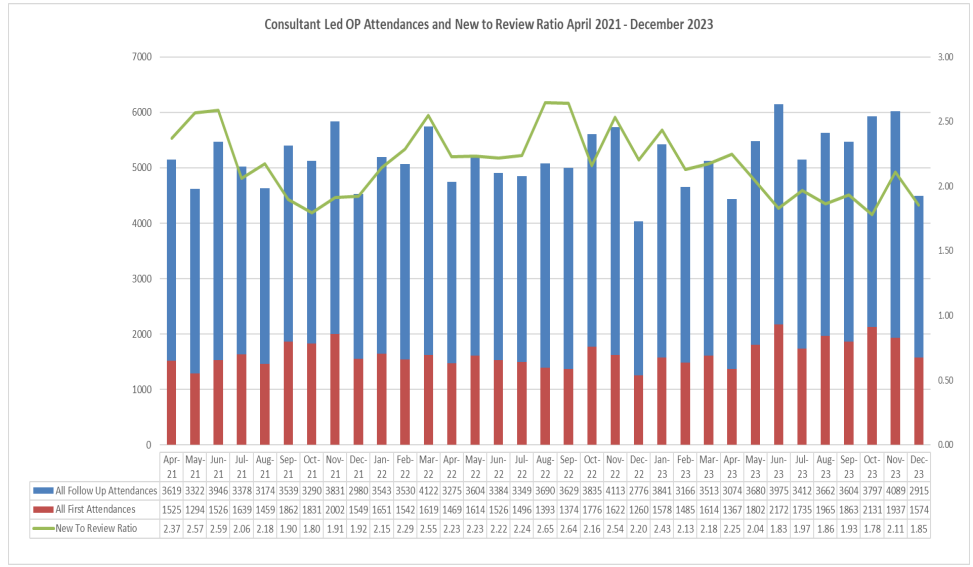
4. Outpatient efficiency



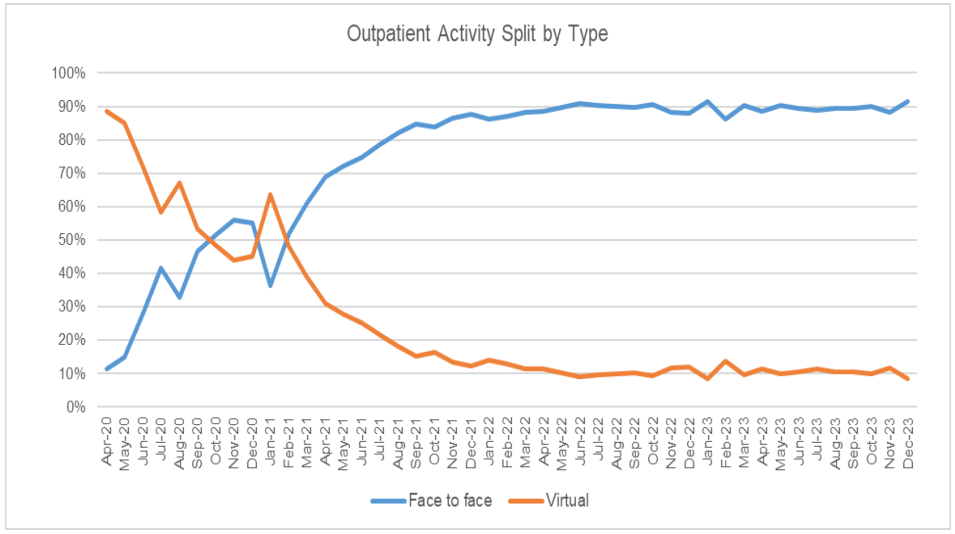


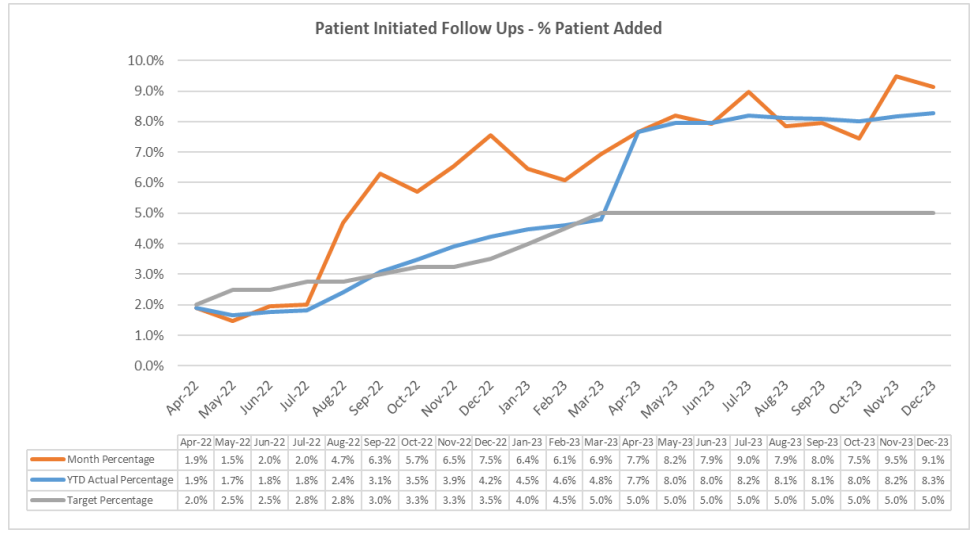
4. Outpatient efficiency





	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	Aug-23	Sep-23	Oct-23	Nov-23	Dec-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	3662	3604	3797	4089	2915
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	1965	1863	2131	1937	1574
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	1.86	1.93	1.78	2.11	1.85





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
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%	7.9%	8.0%	7.5%	9.5%	9.1%
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%	8.0%	8.2%	8.3%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

4. Outpatient efficiency

SUMMARY

November 2023 performance is as follows:
Overall Outpatient activity was -1% variance against the Trust trajectory for November 2023 delivering 6,001 (New and Review) episodes. However, our delivery of outpatient episodes was +60 against October 2023 and +210 (4%) against the System trajectory for November 2023.

- 4,115 face to face and 378 virtual appointments
- 8.41% virtual in total.
- 9.1% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 8.3%.
- 7.7% DNA rate – lower than Trust target of 8% DNA rate

- Clinic Waiting Times
- 30-minute delays – within trust target at 7.9% (Target 10%)
- 60-minute delays – within trust target at 2.2% (Target 5%)

AREAS OF IMPROVEMENT

DNAs
The Trust has an aspirational 6% target that will be facilitated utilising Dr Doctor text messaging for appointments and reminders being extended to other areas. Rollout of Dr Doctor to Oncology and Imaging has had a positive impact on missed appointments during 2023/24. Therapies and clinics which are not active are being targeted in Q4.

DNA audit of 207 patients has provided useful insight into why patients do not attend. A sub-group to the Outpatient Transformation Programme is being led by the Outpatients CSM to focus on the outcomes from the audit and improve communication with our patients. This is being done with patient experience to ensure that we maintain the patient voice at the front of this piece of work.

The team had acknowledgment of a successful bid in December 2023 to further support Dr Doctor developments to improve DNA reduction. This will include the DNA module in Dr Doctor, direct messaging with patients and two staff to support Dr Doctor system management.

Appointments
Daily Outpatient KPIs have now been agreed and are monitored by the Division 1 triumvirate with escalation to the Deputy COO, as required.
The Division are having a specific focus on referral processes and pathways to ensure KPI's are met, and patients are booked in a timely manner.

Outpatient Review Waiting List
January 2024 will focus on ensuring that patients on a follow up pathway receive a trust communication using Dr Doctor text messaging to validate that patients still require their review consultation. This will help reduce the DNA rate and ensure a targeted approach to ensuring that all patients on a review waiting list are appointed accordingly.

ROH is represented clinically and operationally at the ICB Outpatient Transformation Group and Task & Finish groups.

4. Outpatient Transformation

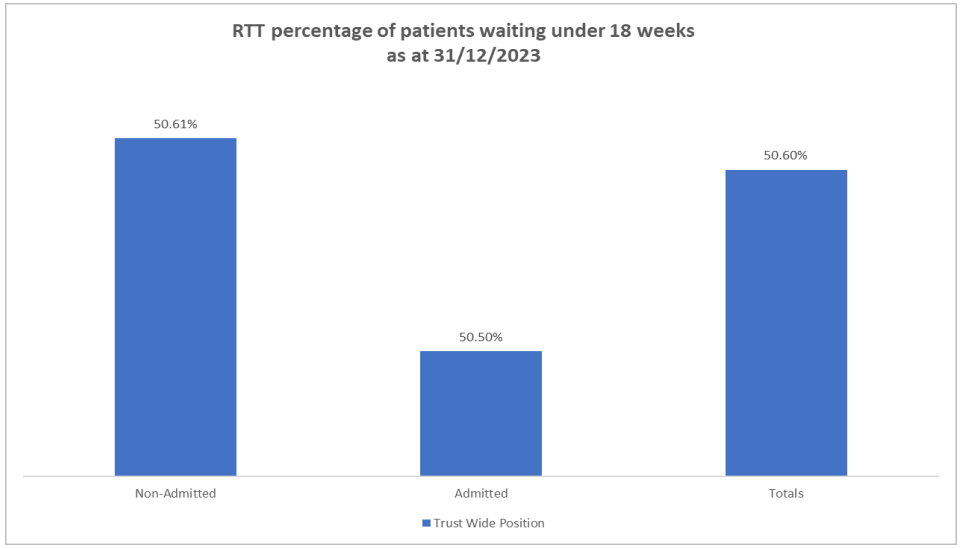
Specialty Priority Updates / Highlights				
PIFU	**Reduction in DNAs**	**Reduction in Follow Ups**	**Clinical Pathways (e.g. Specialist Advice)**	**Productivity & Efficiency**
PIFU relaunch is underway with progress as follows: - Second PIFU working group to be held January 2024. - Communication strategy TBC for end of January 2024 for patients and staff. - Sharing learning on PIFU with UHB. - Utilising NHS Futures site for pathway ideas and following GIRFT principles.	DNA audit has been completed with 200 patients contacted to obtain feedback. First DNA Group scheduled for 12th January 2024. Work has commenced for TIARA (Therapy System) to go live for Dr Doctor text messaging.. Patient portal and options for patient led booking to be confirmed. Successful bid for funding to support Dr Doctor DNA package and Dr Doctor direct messaging.	The MSK team are confirming what focus they wish to have for online interactive forms. Conversation planned with Oncology in February to discuss outpatient transformation. Validation of OPFU being planned via Quick Question. Supported by other workstreams.	Clinical Pathways landing page in ICB is in development. First scoping meeting held with Young Adult Hips in January 2024 as the pilot site. Advice & refer is under review in parallel with referral mapping exercise with Appointments.	Appointments team have carried out a review of activity over the last 4 years and identified areas which have lower throughput post covid. Stakeholders are being identified for the P&E working subgroup to the Outpatient Transformation Programme.

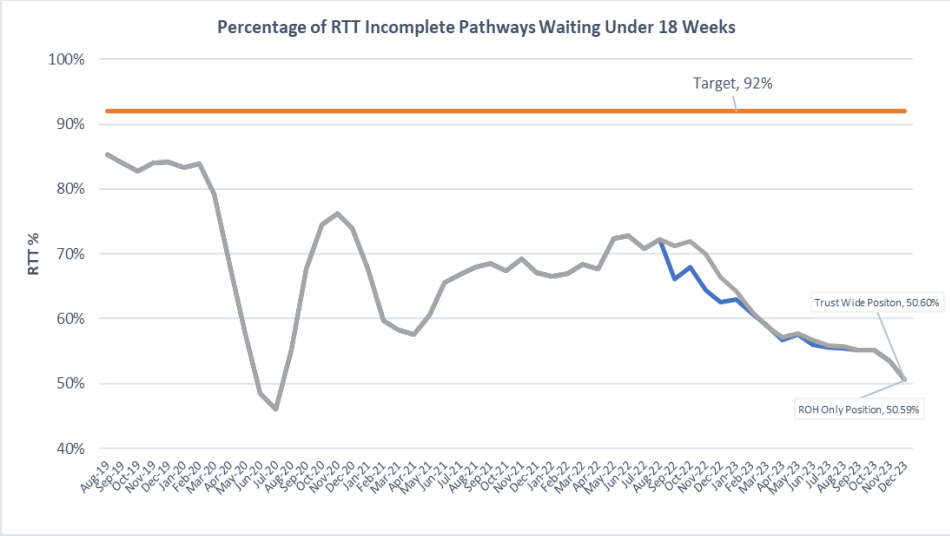
replacement). Lessons learnt taking place and feedback sessions are being organised for specialty teams. Gateway criteria to commence to stages 2 and 3 to be agreed.
- Clinical portal testing commences end of January 2024.

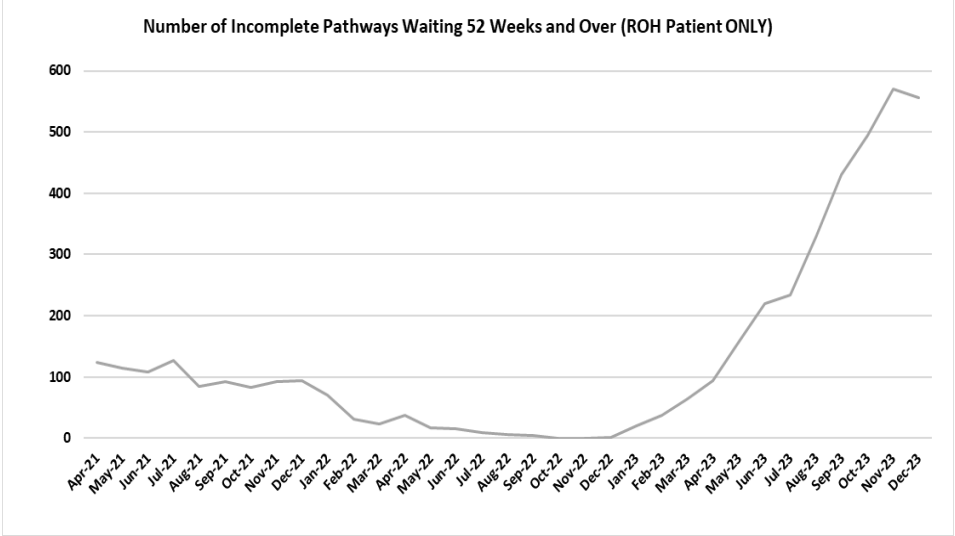
5. Referral to Treatment

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,760	505	3,265
7-13	2,842	491	3,333
14-17	1,300	207	1,507
18-26	2,734	433	3,167
27-39	2,384	404	2,788
40-47	928	162	1,090
48-51	250	58	308
52 weeks and over	439	122	561
Total	13,637	2,382	16,019

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,902	1,203	8,105
18 and over	6,735	1,179	7,914
Month End RTT %	50.61%	50.50%	50.60%



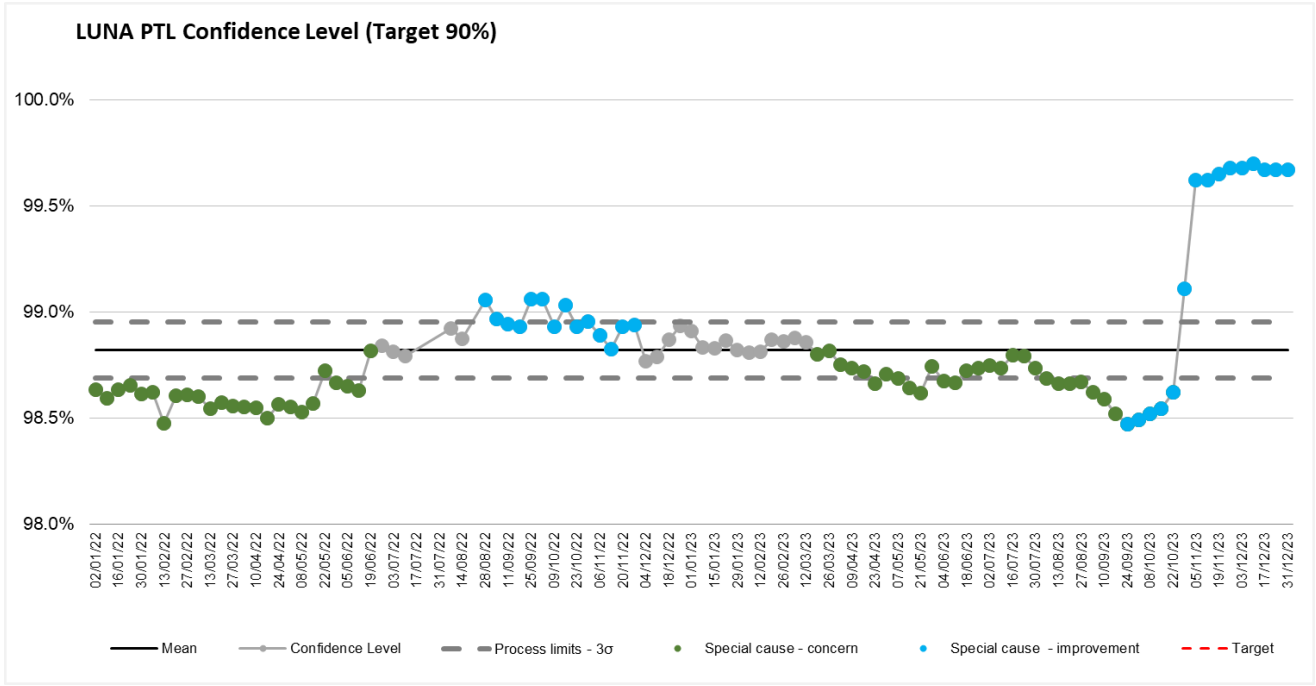




5. Referral to Treatment

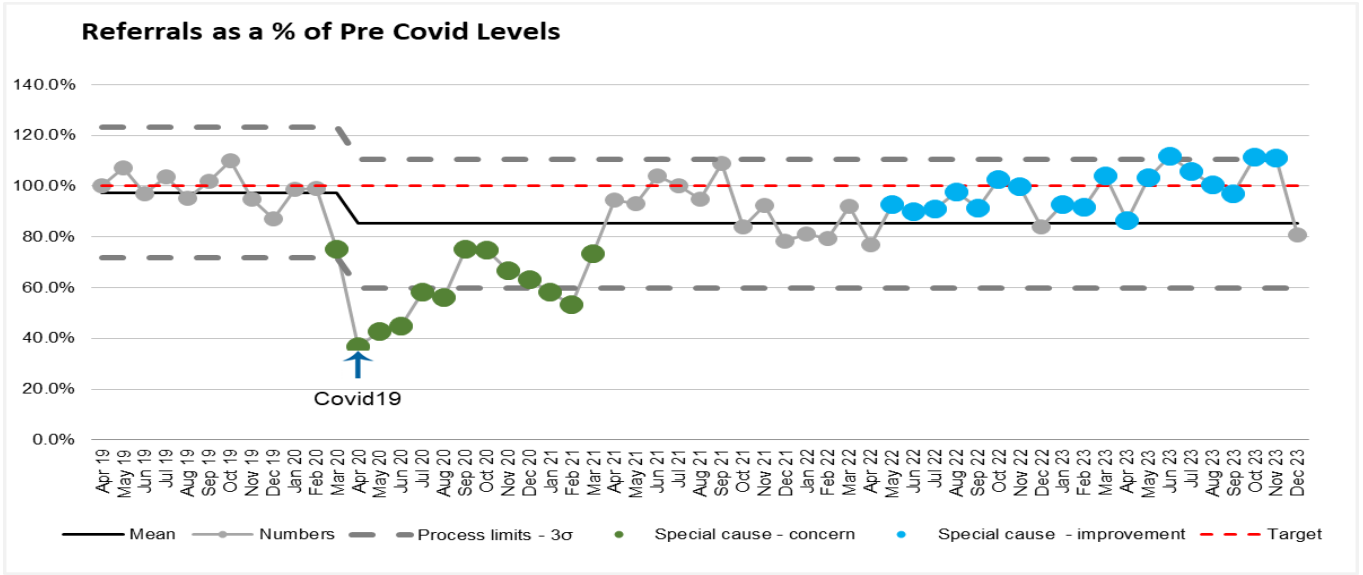
Luna Data

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



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

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	2339	2792	3025	2862	2716	2623	3015	2999	2184															
Referrals as a % of Pre Covid Levels	86.50%	103.25%	111.87%	105.84%	100.44%	97.00%	111.50%	110.91%	80.77%															

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for December was 50.59% against the National Constitutional Target of 92%. This represents a 2.88% decrease compared to the November reported position of 53.47% that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

There were 561 patients waiting over 52 weeks in December, an increase from the trust wide position in November which was 579 patients.

The Team continue to work in partnership with regional providers to support orthopaedic recovery. Long waiters added to the PTL have been prioritised leading to the number of shorter waits growing impacting on the overall RTT position, as well as the reduction in capacity due to industrial action. Extra clinics were provided in November and December to continue to support the reduction of our waiting lists and to support the national delivery of zero 65-week waiters by March 2024.

During December 23, ROH received 2,184 referrals (80.77%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

RTT training has commenced by the Validation manager to support the trust data quality and education around national referral rules.

Weekly meetings chaired by the DCOO to focus on our longest waiting patients and achieving the 0 x 65 weeks target for Orthopaedics by 31.12.23 and Spinal by 28.02.24. A review has commenced of Arthroscopy patients that are complex and allocated to 1 specialist clinician. Where clinically appropriate, patients are being re-allocated to an alternative clinic to reduce the waiting times.

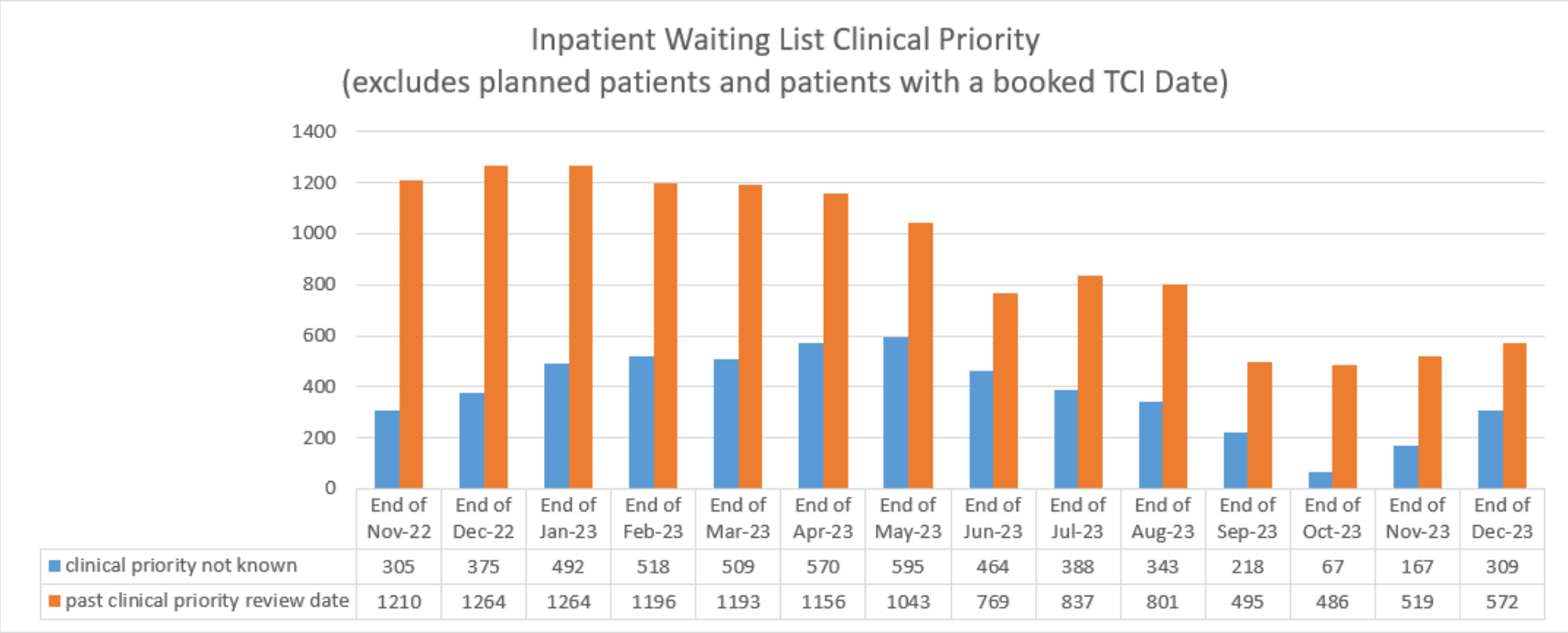
The Validation team are providing extra support to spinal services to help manage patients through the pathway and all patients down to 12 weeks have been sent a text message to determine whether they wish to remain on the waiting list in line with national guidance.

RISKS / ISSUES

The system requested 0 x 65 weeks by 31.12.23, and this was achieved for most services. It was agreed that Spinal and Arthroscopy (specialist surgeon patients) will achieve by 31.03.24 in line with the national requirement. The teams are focussing on maintaining under 65 weeks for all other services and working towards delivery of 0 x 52 weeks. Exceptions will be patients choosing to wait.

5. Referral to Treatment

Overdue Clinical Priority:

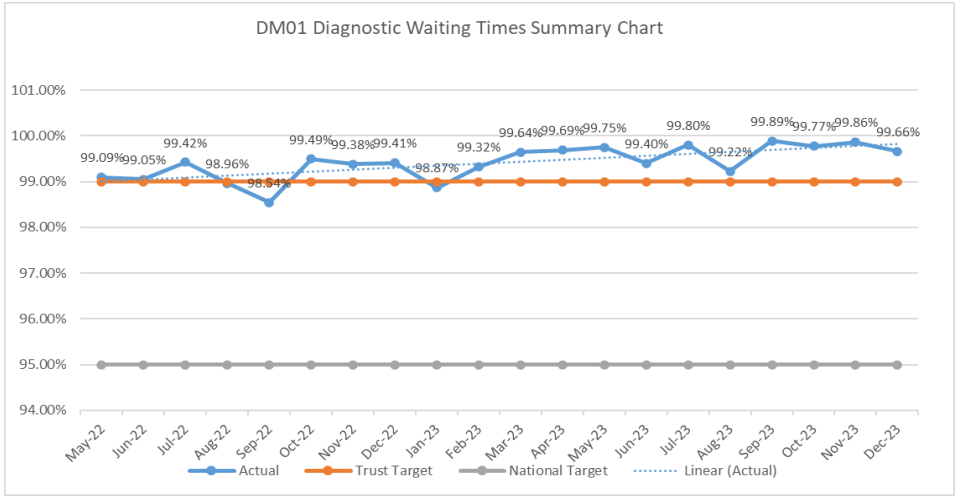


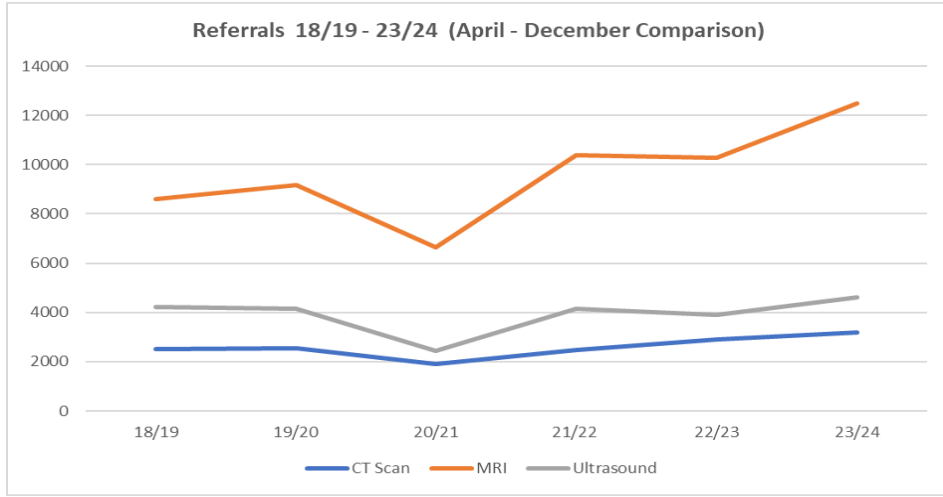
	End of Nov-22	End of Dec-22	End of Jan-23	End of Feb-23	End of Mar-23	End of Apr-23	End of May-23	End of Jun-23	End of Jul-23	End of Aug-23	End of Sep-23	End of Oct-23	End of Nov-23	End of Dec-23
clinical priority not known	305	375	492	518	509	570	595	464	388	343	218	67	167	309
past clinical priority review date	1210	1264	1264	1196	1193	1156	1043	769	837	801	495	486	519	572

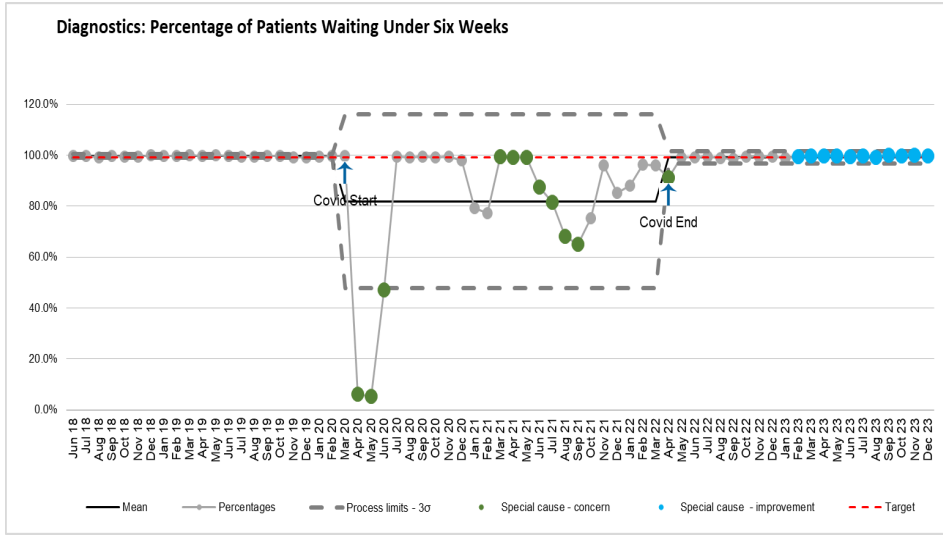
There has been an increase in the clinical priority not known within December 23. UHB patients often don't have the priority score included and this is being picked up at the UHB/ROH operational group. The Associate Director of Operations Div 1 has also requested a deep dive into the areas. The outcome and rectification plan will be provided at the next meeting.

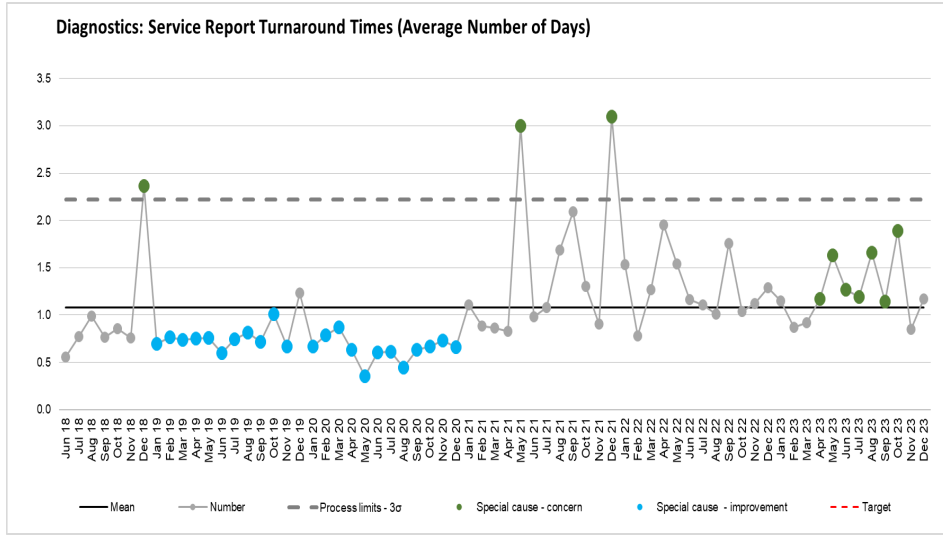
6. Diagnostic Performance

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









7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in December 2023 closing the month at 99.66%. Order comms (electronic requesting) via PICS went live on 26/7/23 and has been well received. Mobile CRIS has been implemented to support electronic referrals.

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 DNAs with the use of Dr Doctor sending text messages at 1 week and 48 hours prior to appointments; improvements in MRI DNAs have already been seen.

Speech recognition implementation is being discussed with the CRIS (Radiology Information System) team with a plan to commence a pilot in Imaging in January 2024.

RISKS / ISSUES

Following a spontaneous quench of an MRI scanner on 28/12/23, further issues have since occurred that resulted in the scanner being out of action for a minimum of 4 weeks (possibly longer). The other MRI scanner was out of action due to upgrade. The MRI service continued with a mobile / static MRI scanner with Oncology work and urgent patients being prioritised. Mutual aid was offered by UHB in the event an urgent MRI scan was needed for an inpatient. Fortunately, this was not needed.

The loss of activity caused due to the quench will have an impact on our diagnostic DM01 target for January 24 that is currently being quantified.

Referral rates are increasing for all modalities and the reduction in DNA rates is helping to mitigate this risk.

8. Cancer Performance

Summary Performance Figures – November 2023 (January 2024 Submission)

		November 23 (New Standards)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	23	0	23
62 day RTT to treatment	85%	85.7%	9	1.5	10.5
28 day FDS REPORTED	75%	78.8%	67	18	85
Patients over 104 days (62 day standard)	0				

		November 23 (old Standards)			
Target Name	National Standard	%	In target	Breach	Total
2 WW	93%	97.5%	79.0	2.0	81.0
31 First	96%	100%	11.0	0.0	11.0
31 day subsequent	94%	100%	120	0.0	120
62 day Standard	85%	25%	0.5	1.5	2.0
62 day (Cons Upgrade)	n/a	100.00%	8.5	0.0	8.5
28 day FDS REPORTED	75%	78.8%	67.0	18.0	85
Patients over 104 days (62 day standard)	0				

Performance

The trust was compliant against all three cancer standards for November 2023. The 62-day target was achieved with a compliance rate of 85.7%.
We had a total of 2 patients breaching the 62-day standard target. We were compliant with the 28 days FDS standard achieving 78.8% against a target of 75% and 100% compliance against the 31-day metric.

The root cause of the delays for the 62-day breaches were;

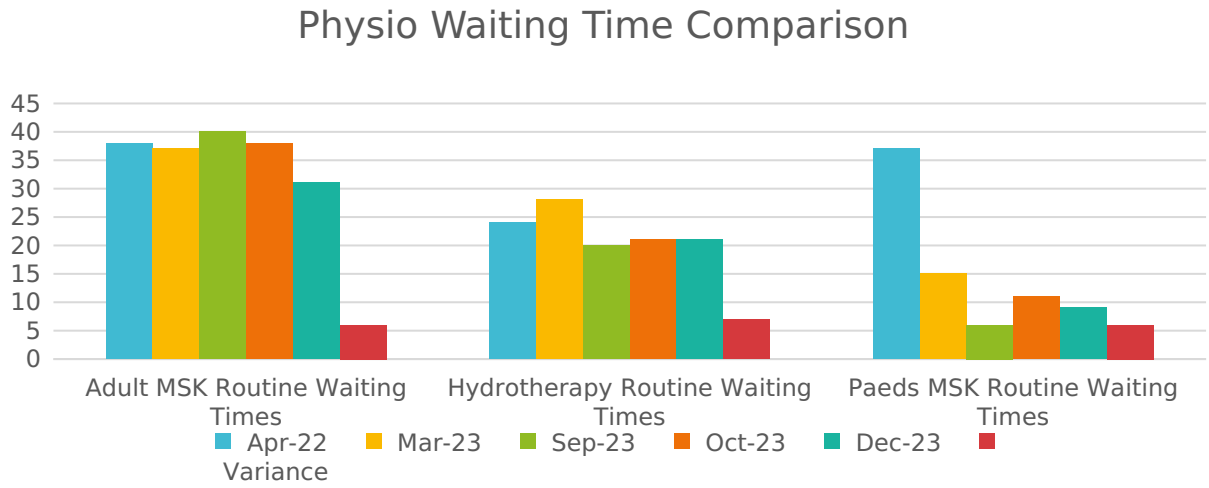
- 1 x 0.5 breach – Tertiary referral received into the ROH day 39. Patient required full diagnostic work up upon receipt of referral, Soft tissue biopsy took 14 days for formal reporting then required PET scan unable to achieve 24-day target as required full diagnostic work up then joint orthoplastic surgery. Patient treated on day 91.
- 1 x breach, 2ww referral into ROH diagnosed on day 69. Patient was originally planned for Tru-Cut biopsy in clinic however procedure was cancelled in clinic as lesion not amenable to Tru-Cut biopsy. US guided biopsy then arranged, and pathology took 14 days due to additional test. Lymphoma was confirmed patient sent out day 69 and local team started chemotherapy within 24 days therefore full breach allocated to ROH.

Risks /actions ongoing

ROH continues to monitor performance twice weekly at the cancer PTL meetings, actively participating and engaging with the weekly System Oversight Group for cancer recovery and receives positive feedback against overall performance standards. Ongoing concerns regarding diagnostic capacity and histological reporting resulting in delays in patient pathways which are under current analysis/review. Pathology delays have been raised at the System Oversight Group, as an area of concern. Histology delays are escalated to UHB DOP for an expedited resolution.

9. MSK Waits

Physio Wait Comparison April 22 vs March and Dec (as at 17th)



Summary

Paediatric Physio waits continue to be maintained below 12 weeks.
Hydrotherapy waits remain at 21 weeks.
Adult physio waiting times have reduced from 44 weeks in June/July to 31 weeks as of 17th December 23 with a trajectory to continue reducing waits.
Back Pain waiting times reduced from 39 weeks to 35 weeks.

Risks /actions ongoing

- A comprehensive action plan has been produced to address the long waits associated with Adult MSK Routine appointments.
- Discussions ongoing with system partners in respect of the transfer of patients.
- 2 further members of staff due to commence in Q4.

10. Private Patients

SUMMARY

There were 39 inpatients treated privately in December and there were 101 private outpatient consultations.
The service has exceeded its inpatient activity plan by 28 patients and YTD by 157. There is no outpatient target, however, the service has booked 965 outpatient attendances YTD.
The service overachieved against its income target in December by £99k and is over its YTD position by £184k.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
Income Plan £000	306	306	306	306	255	253	325	361	209	2627
Activity Plan	9	24	35	24	37	28	29	36	11	233
Income to be collected £000	353	229	254	397	255	314	347	354	308	2811
Activity actual	47	37	41	55	38	39	46	48	39	390

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

To support additional income and activity generation to support the Trust position to year end and to assure the committee that key actions from the strategic plan are being delivered, the following actions are being undertaken:

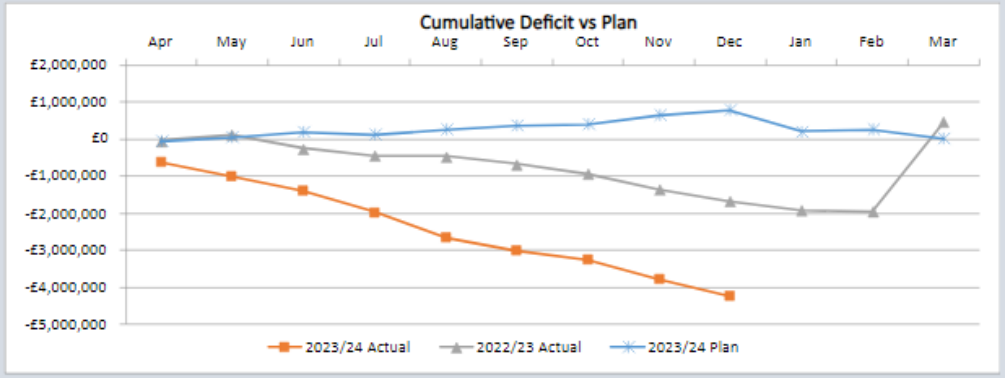
A) Renegotiation with insurance companies to agree tariff pricing for the new financial year
B) Implementation of additional in week theatre capacity (as agreed by the Board).
C) Finalisation of foot and ankle bespoke package pricing
D) Completion of the patient experience report
E) Expansion of the administration team portfolio to include imaging invoicing
F) Business case being developed in conjunction with finance identifying the need for dedicated finance roles to support the management of invoices.

8. Finance on a Page

Month 9

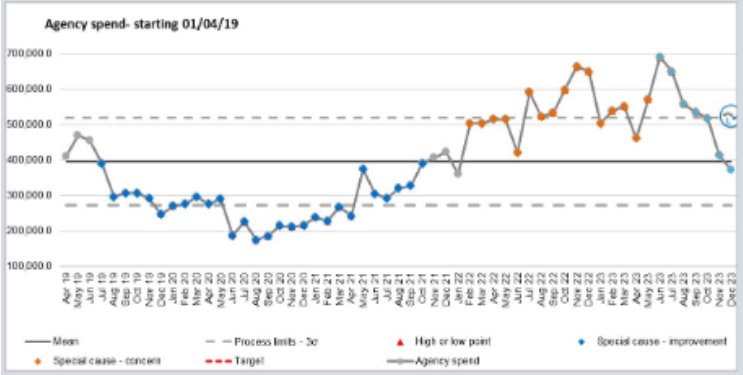
FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay	-£6,235	-£6,560	-£325	-£56,041	-£57,004	-£963	-£74,746	-£74,940	-£194
Non Pay	-£4,114	-£5,170	-£1,056	-£38,115	-£42,943	-£4,828	-£51,756	-£52,306	-£550
Income from patient care activities	£10,199	£10,976	£777	£92,214	£91,988	-£226	£122,811	£122,136	-£675
Other income	£422	£403	-£19	£3,798	£4,643	£845	£5,064	£5,785	£721
Non operating costs	-£121	-£126	-£5	-£1,089	-£940	£149	-£1,455	-£1,248	£207
Remove capital donations	£7	£6	-£1	£63	£63	£0	£82	£94	£12
TOTAL	£158	-£478	-£636	£767	-£4,257	-£5,023	£0	-£479	-£479



Agency as a % of paybill 8.4%

Recurrent efficiency % of forecast 100%



Efficiencies	YTD	Forecast
Plan	£3,670	£5,076
Actual	£3,807	£5,076
Variance	£137	£0

Capital	YTD	Forecast
Plan	£2,589	£3,909
Actual	£2,146	£3,614
IFRS 16	£0	£574
Variance	-£443	-£279

Better Payment practice code	YTD	% movement previous month
Non-NHS		
By number	88.9%	0.0%
By Value	90.3%	-0.2%
NHS		
By number	47.3%	1.6%
By number	10.2%	3.5%
Total		
By number	88.0%	0.1%
By Value	80.4%	0.7%

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £478k against a planned surplus of £158k, generating a £636k adverse variance, resulting in a year to date deficit of £4,257k against a surplus plan of £767k, generating an adverse variance of £5,023k.

Income year to date is £619k ahead of plan.

Pay expenditure is overspent by £963k. Non pay expenditure is overspent against plan with an adverse variance of £4,834k.

Agency spend remains a concern – although a reduction in agency spend in month has improved the percentage of pay bill to 5.7% in month and 8.4% year to date.

The key drivers for the non pay overspend is indicating above inflationary pressures across clinical supplies, utilities and other supplies.

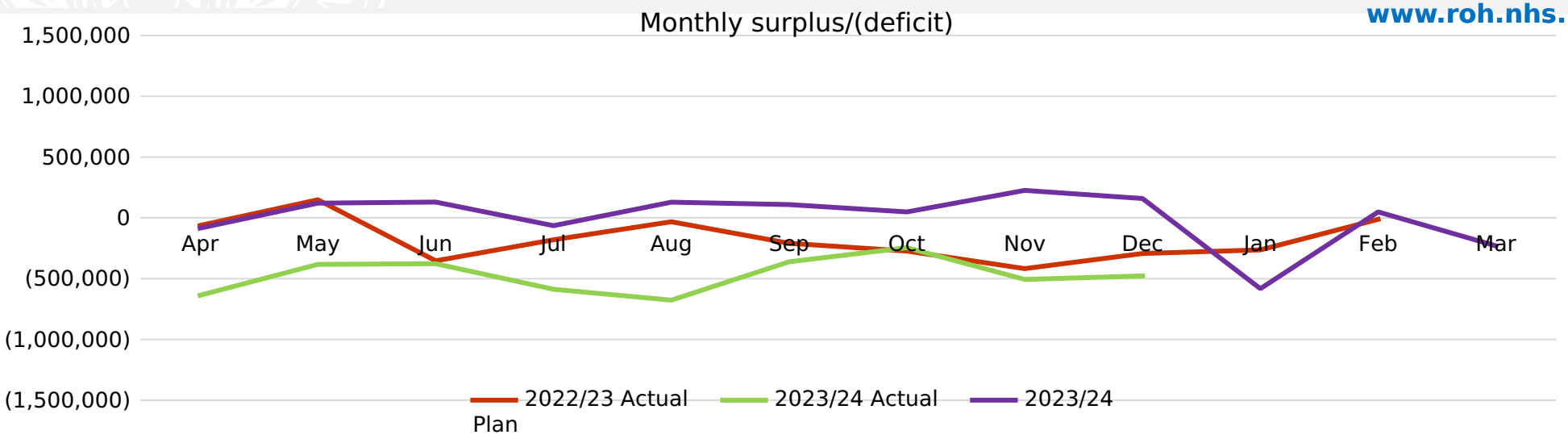
Forecast has been adjusted to account for the impact of industrial action in December and January with a forecast deficit expected of £479k.

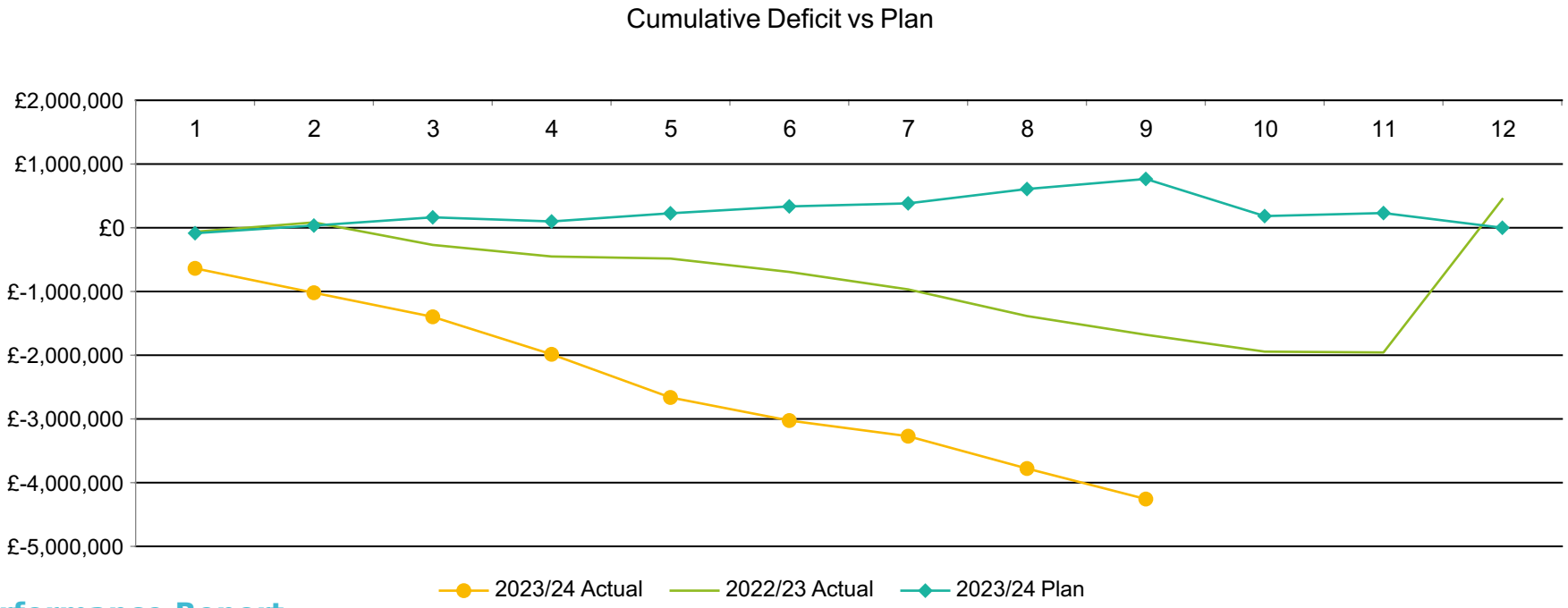
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	619	(963)	(4,834)	149	(5,023)
Year to date plan	96,012	(56,041)	(38,178)	(1,026)	767
Year to date actual	96,631	(57,004)	(43,012)	(871)	(4,257)
Variance compared previous month	758	(325)	(1,064)	(10)	(636)
Forecast Variance	139	(194)	(644)	220	(479)

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	92,214	91,970	(244)
Other Operating Income (Excluding top up)	3,798	4,661	863
Employee Expenses (inc. Agency)	(56,041)	(57,004)	(963)
Other operating expenses	(38,178)	(43,012)	(4,834)
Operating Surplus	1,793	(3,386)	(5,178)
Net Finance Costs	(1,089)	(940)	149
Net surplus/(deficit)	704	(4,326)	(5,029)
Remove donated asset I&E impact	63	69	6
Adjusted financial performance	767	(4,257)	(5,023)

9. Overall Financial Performance

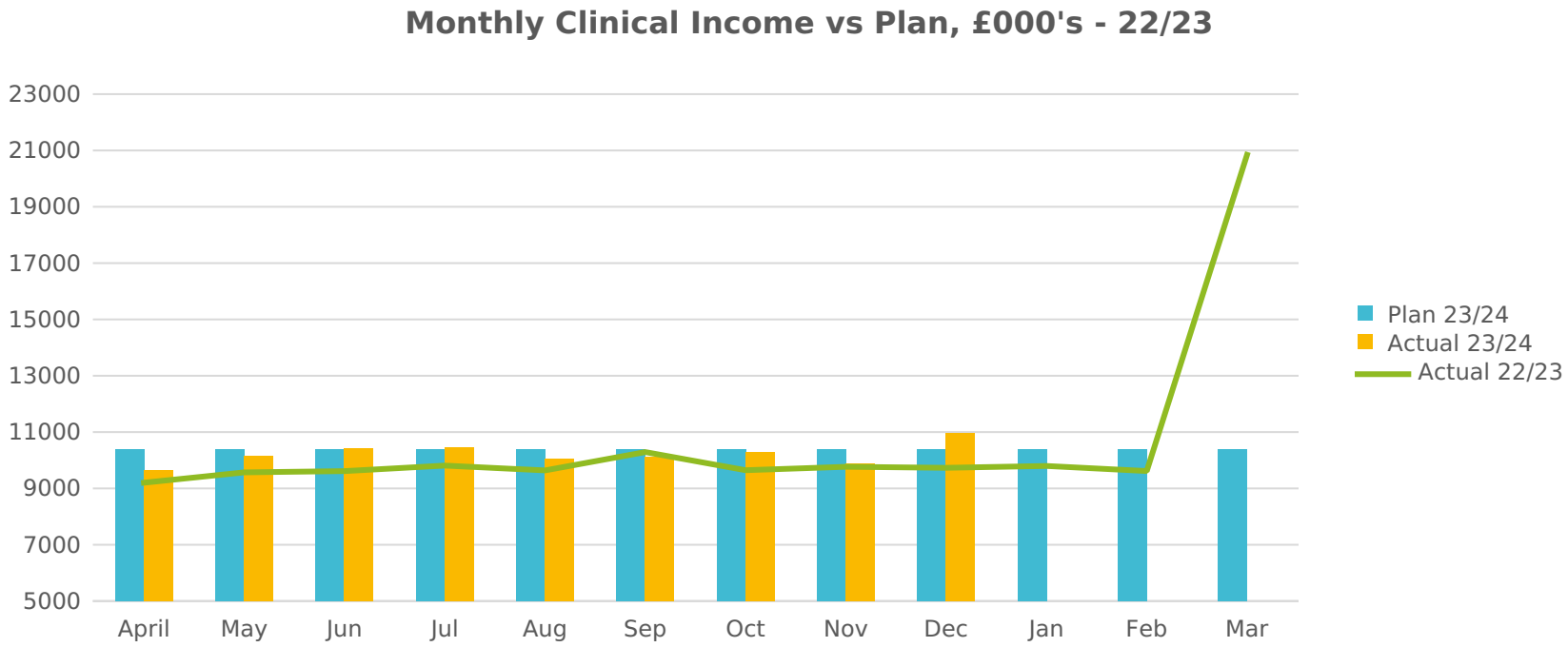




Financial Recovery Plan

	Base Case	Delivery Risk	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Month 5 YTD Deficit	(2,664)								
Month 6-12 at Month 5 run rate	(3,730)		(533)	(533)	(533)	(533)	(533)	(533)	(533)
Bad debt release - associate	2,400								2,400
Pay award reserve release	500		71	71	71	71	71	71	71
Gen Med adjustment	460		66	66	66	66	66	66	66
Bespoke device income recovery	600		43	43	43	43	43	43	343
Grip and Control - agency	1,050		150	150	150	150	150	150	150
Grip and control - non pay	148			25	25	25	25	25	25
Grip and Control - income	125				25	25	25	25	25
Grip Control- Other	116				23	23	23	23	23
Non Recurrent Annual leave accrual release	150								150
Productivity - Theatres	840				168	168	168	168	168
Job planned sessions owed repaid	116				23	23	23	23	23
2023/24 Revised FOT	111		(203)	(178)	61	61	61	61	2,911
2023/24 Cumulative YTD			(2,867)	(3,045)	(2,984)	(2,923)	(2,862)	(2,801)	110
Actual performance			(326)	(246)	(507)	(478)			
Variance			-123	-68	-568	-539			

10. Income



ERF target has been updated further nationally by 2% reduction to reflect industrial action. ROH ERF has seen only a 0.875% reduction on BSOL ICB due to a cap applied on commissioner target reductions. Year to date performance is a slight underperformance against revised target of £3,439, with the largest variance against specialised commissioning. Forecast trajectory based on activity plan is an expected overperformance against target which has been included within the recovery plan.

	YTD 23/24 Target	YTD 23/24 Actuals	over/(under) performance	% Performance
Elective Recovery Fund	£39,515,231	£39,332,311	(£182,921)	-0.5%

10. Income

SUMMARY

Income year to date is £619k ahead of plan. £592k of the overperformance related to education and training income and £361k to support IFRS16 transition.

Elective recovery performance is showing an underperformance year to date by £182k.

Private patient income is performing well against plan with a year to date overperformance of £143k.

AREAS FOR IMPROVEMENT

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

RISKS / ISSUES

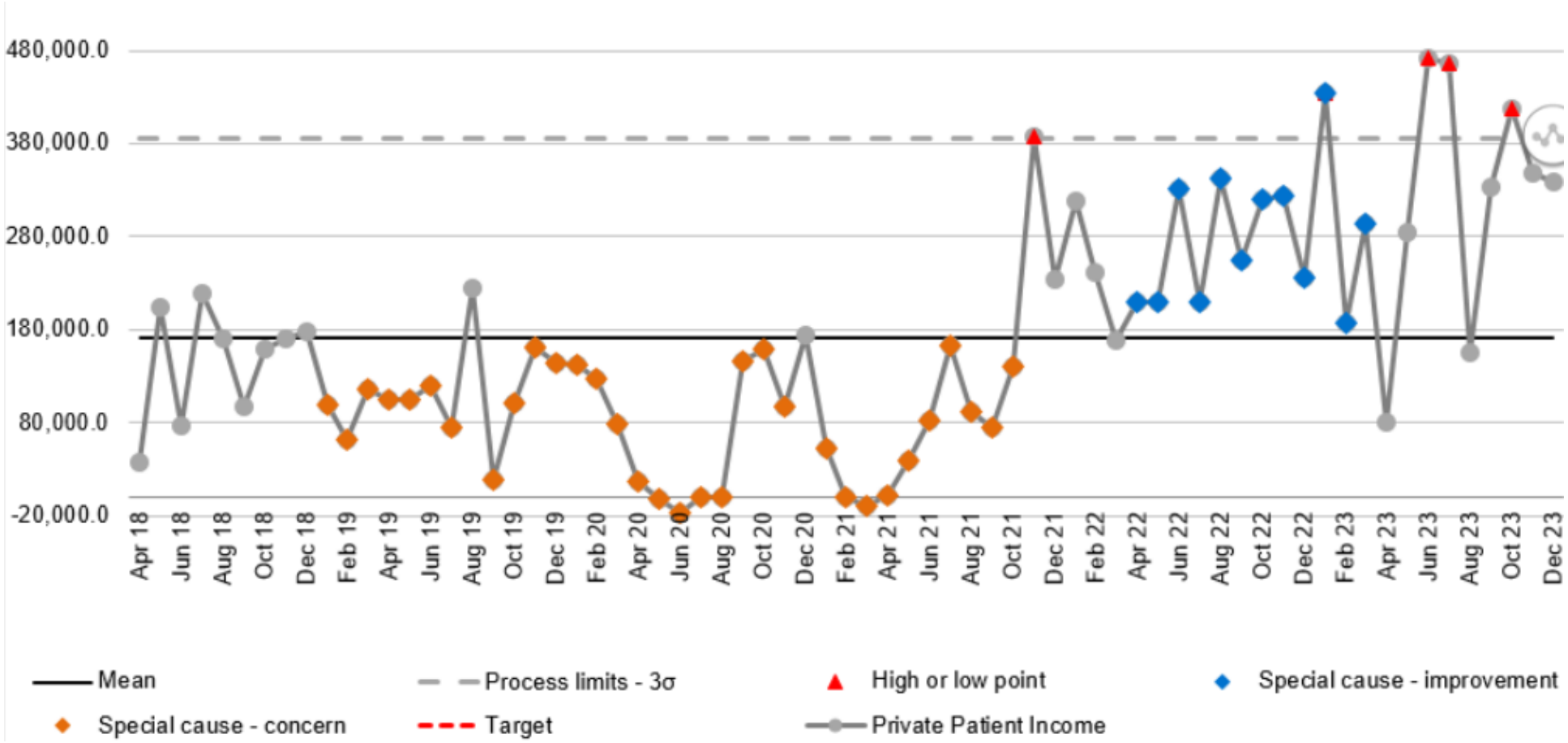
Elective recovery target delivery during the year remains a risk.

Discrepancies between NHS England published ERF performance for Months 1 –5 compared with our internal dataset continue to be worked through.

Non recurrent funding has been included within plans for 2023/24, generating an underlying financial risk for 2024/25 and beyond.

10. Income

Private patient income



11. Expenditure

SUMMARY

Pay expenditure is overspent by £963k. Non pay expenditure is overspent against plan with an adverse variance of £4,834k.

Agency spend has reduced in month with a significant reduction seen in non clinical agency spend. This has delivered an improvement to the percentage of pay bill to 5.7% in month and 8.4% year to date.

Non pay spend has also remained high in month, with key drivers for this including higher than expected use of LLPs to provide surgeon sessions, continued high consumable spend in theatres, and above inflationary pressures particularly with regards to estates spend

AREAS FOR IMPROVEMENT

Agency spend is above agency cap as a % of pay bill against a cap of 3.7%.

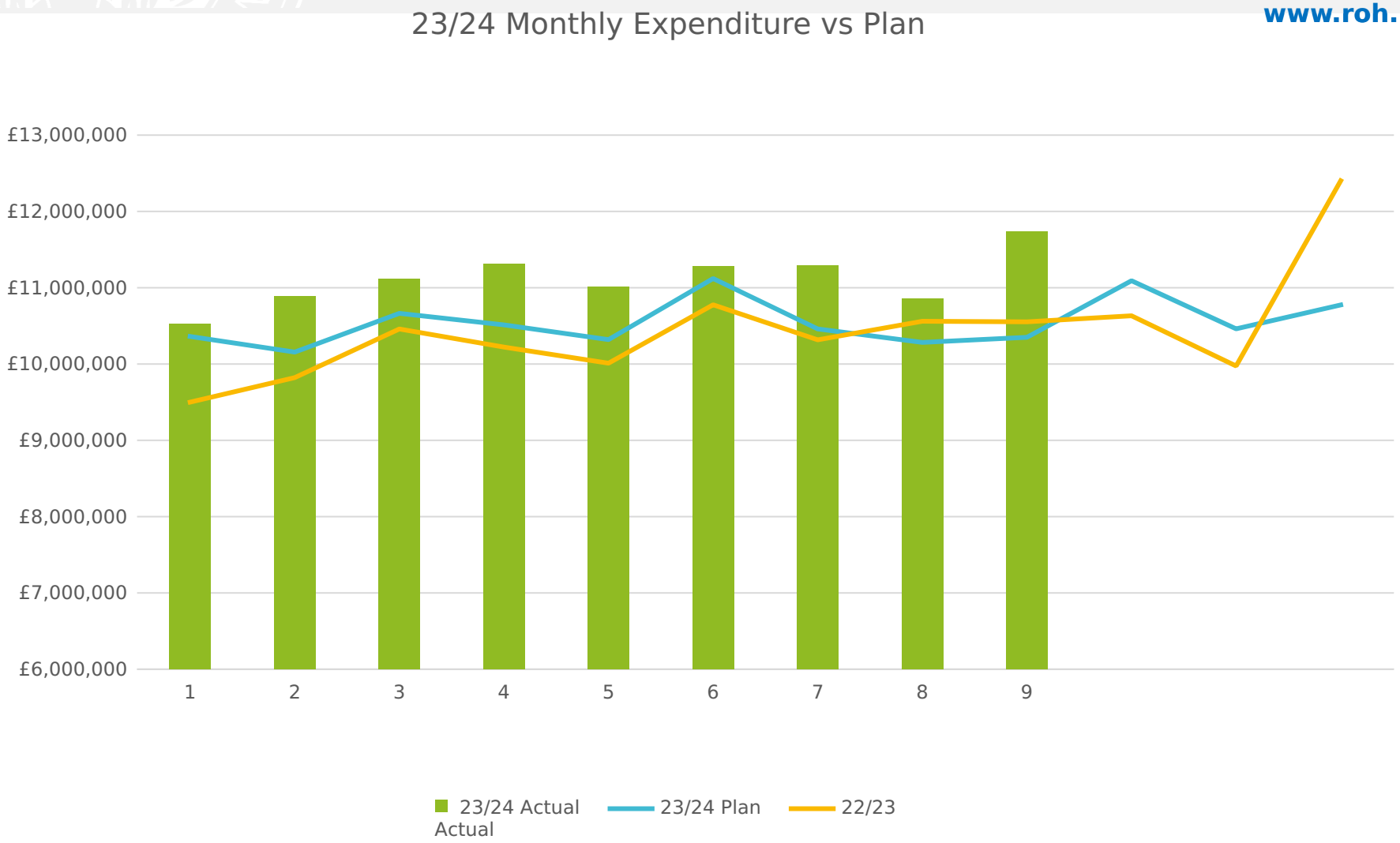
Theatre consumable spend reducing to planned levels.

LLP expenditure reduction.

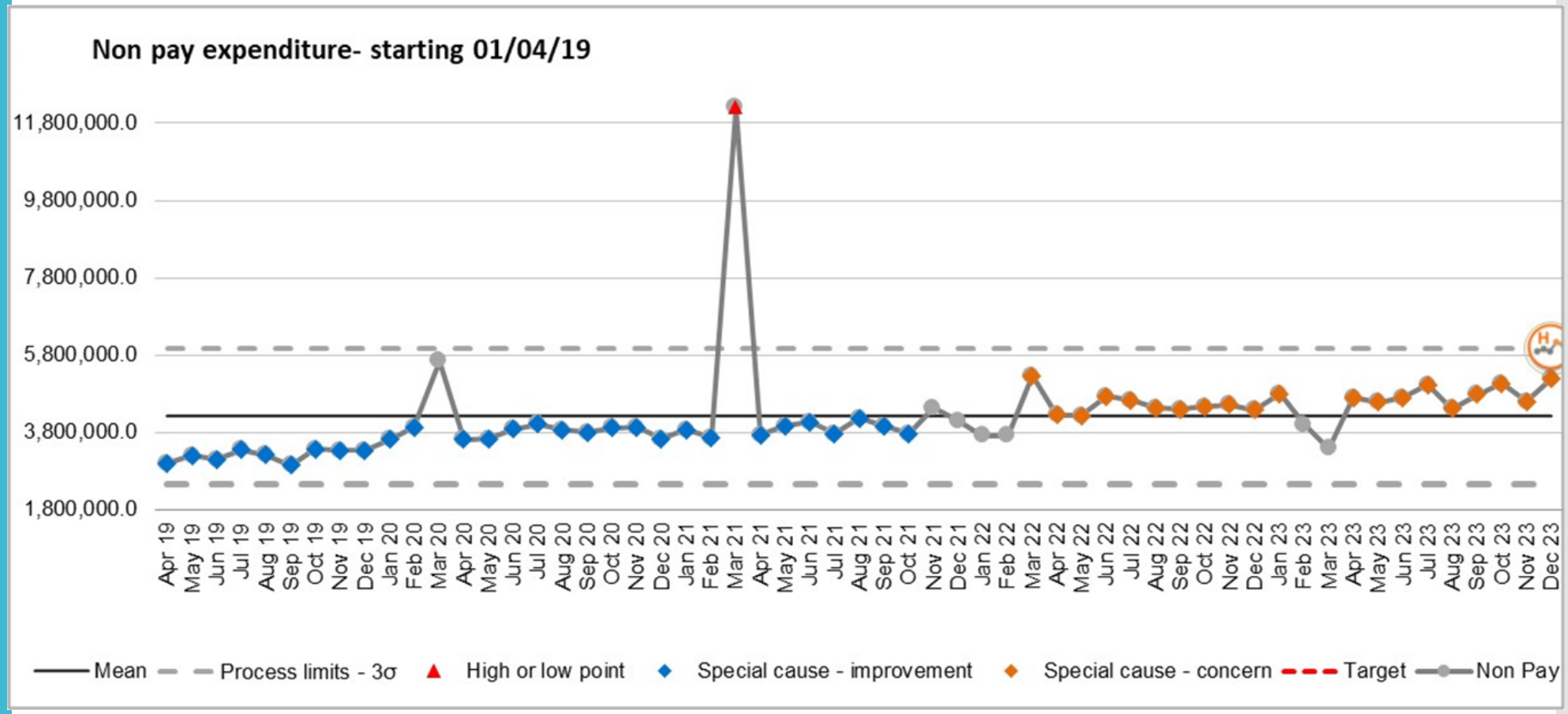
RISKS / ISSUES

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

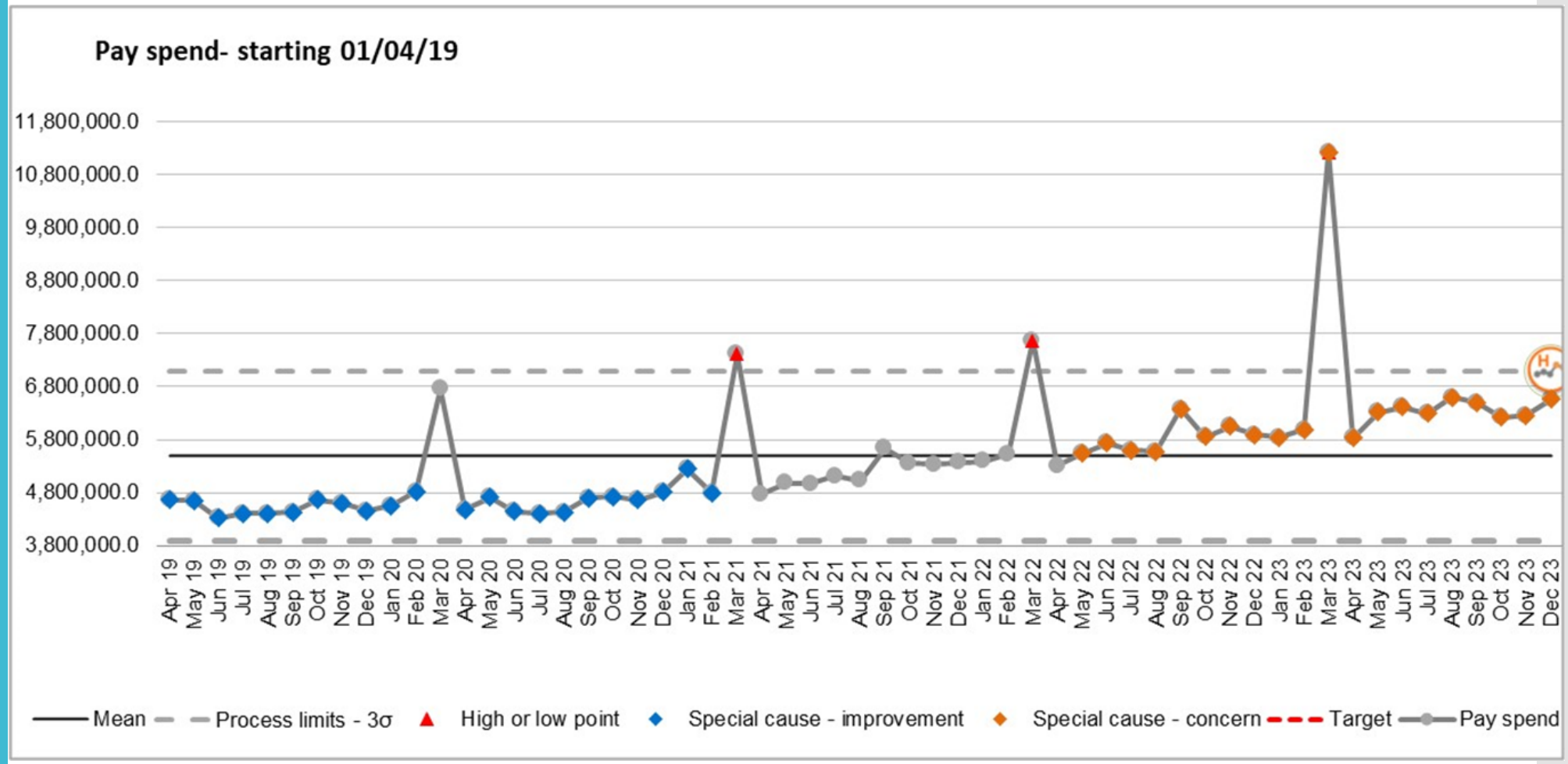
11. Expenditure



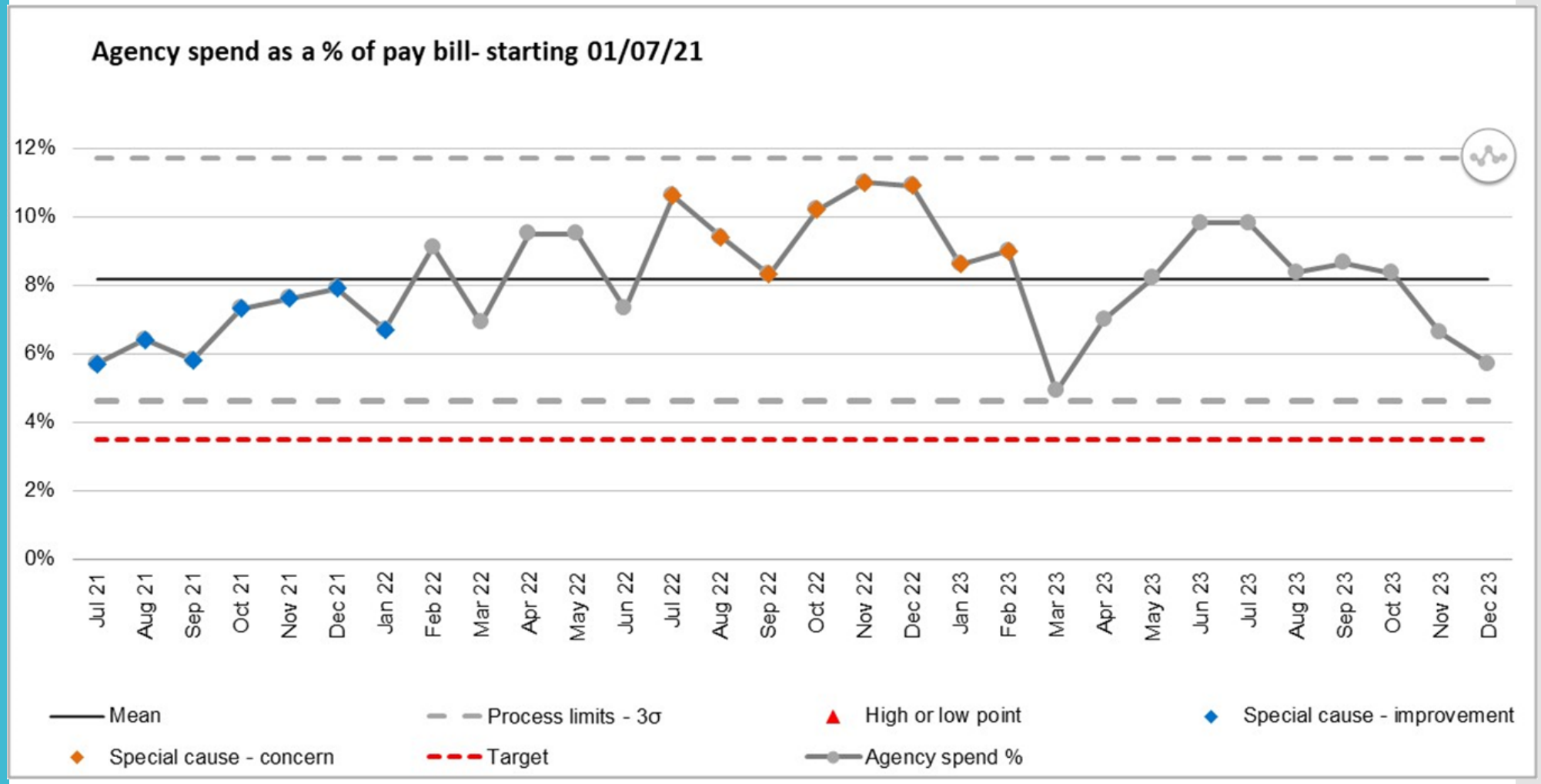
12. Non Pay Expenditure



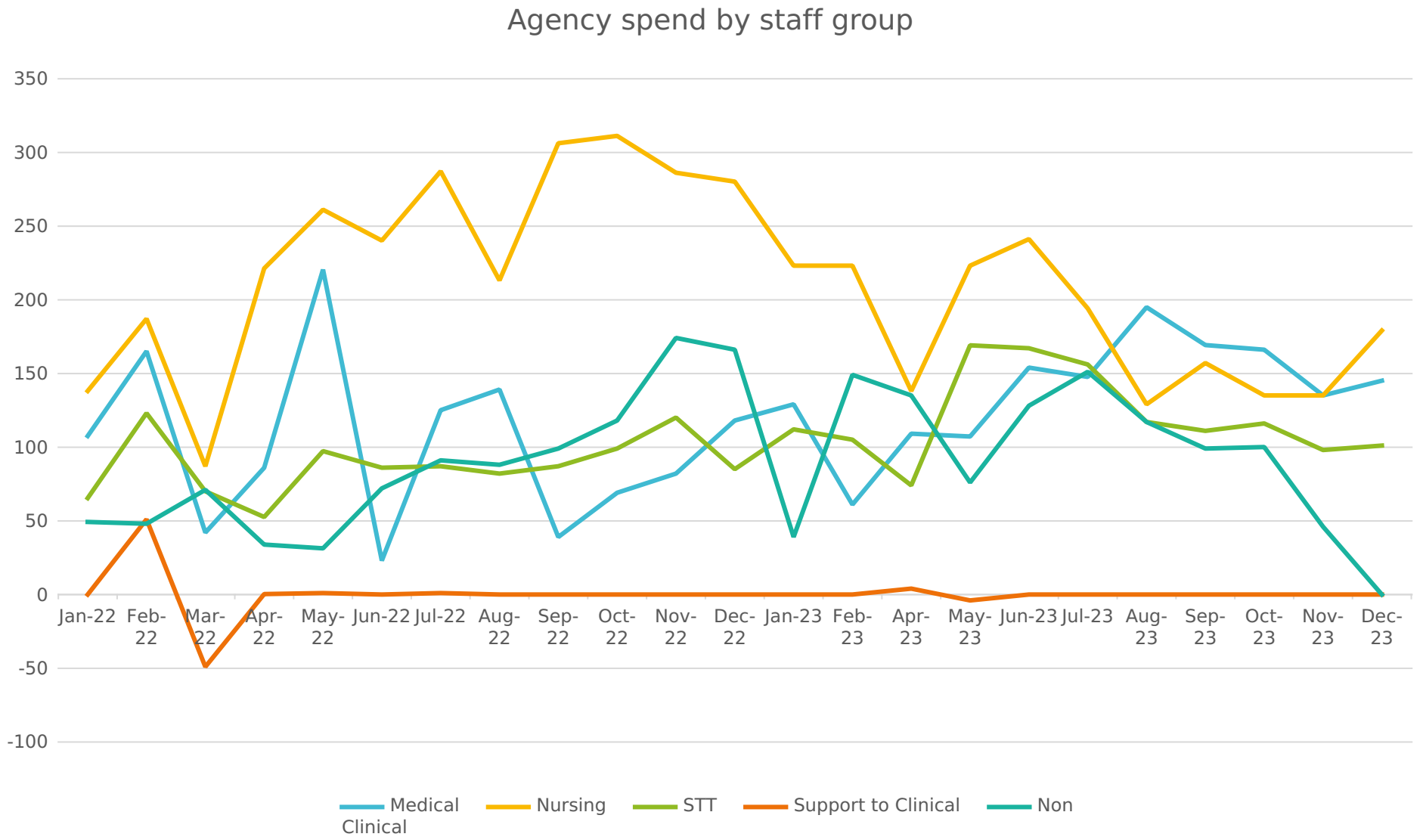
13. Pay Expenditure



14. Agency Expenditure



14. Agency Expenditure



14. Agency Expenditure

Agency Rephasing Reconciliation

Reported	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Total
Nursing	138	223	241	194	129	157	135	135	179	1,531
STT	75	150	138	140	91	202	116	98	101	1,109
Medical	60	70	123	133	138	361	166	135	145	1,328
Non-Clinical	135	76	128	151	117	99	100	46	-53	799
	408	518	630	618	475	818	517	413	372	4,767

Actual	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Total
Nursing	138	223	241	194	129	157	135	135	179	1,531
STT	79	165	167	157	117	111	116	98	101	1,109
Medical	110	109	155	148	194	169	166	135	145	1,328
Non-Clinical	135	76	128	151	117	99	100	46	-53	799
	462	572	691	650	557	535	517	413	372	4,767

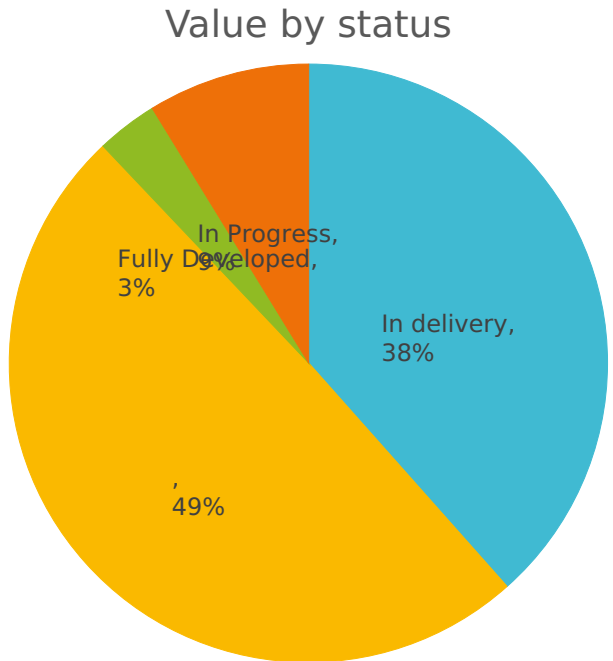
Variance	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Total
Nursing	-	-	-	-	-	-	-	-	-	-
STT	-4	-15	-29	-17	-26	91	-	-	-	-
Medical	-50	-39	-32	-15	-56	192	-	-	-	-
Non-Clinical	-	-	-	-	-	-	-	-	-	-
	-54	-54	-61	-32	-82	283	-	-	-	-

15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £3,807k have been delivered, against a plan of £3,670k, delivering a positive variance of £137k. The newly launched Financial Sustainability and Improvement Group continued this month, with good engagement across the organisation.

£000s				
CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£457	£25	(432)	25
Non pay	£2,838	£3,659	821	4,928
Income	£375	£123	(252)	123
Grand Total	£3,670	£3,807	137	5,076



16. Statement of Financial Position

SUMMARY

The main movements in the balance sheet have been in relation to the reduction in cash and an increase in deferred income (within other liabilities) due to some of the Trust's funding for the full year being received at the start of the year and utilised throughout 23/24.

The cash position remains challenging to manage within the in month peaks and troughs. Continued focus is being places on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.

	2022/23 M12	2023/24 M9	Movement
		(£'000)	
Intangible Assets	1,339	1,076	(263)
Tangible Assets	69,123	66,950	(2,173)
Total Non Current Assets	70,462	68,026	(2,436)
Inventories	19	21	2
Trade and other current assets	12,839	12,320	(519)
Cash	7,591	1,727	(5,864)
Total Current Assets	20,449	14,068	(6,381)
Trade and other payables	(20,229)	(15,663)	4,566
Borrowings	(18,339)	(16,165)	2,174
Provisions	(1,329)	(1,293)	36
Other Liabilities	(273)	(2,557)	(2,284)
Total Liabilities	(40,170)	(35,678)	4,492
Total Net Assets Employed	50,741	46,416	(4,325)
Total Taxpayers' and Others' Equity	50,741	46,416	(4,325)

17. Cash

High/Low Cash Position

£'000

18. Capital

Stream	Scheme Name	Board Approval	Spent to Date	23/24 Forecast	Variance to Plan	24/25 Pre-commitment
Strategic Estates	Oncology office refurbishment/relocation	1,200,000	60,170	696,927	503,073	549,889
Strategic Estates	Appointments team office space *	100,000	0	0	100,000	
Strategic Estates	Relocation of Facilites to the Old Pharmacy building	310,000	253,304	310,000	0	
Strategic Estates	Porters Lodge**	50,000	0	175,978	(125,978)	
Strategic Estates	ROH Creative Design Studio	55,000	51,246	55,000	0	
Strategic Estates	Omnicell installation	70,000	58,471	70,000	0	
Strategic Estates	Replacement for room 3 from a fluoroscopy room to a digital x-ray room	30,000	26,362	30,000	0	
Strategic Estates	Café Royale Refurbishment	210,000	184,712	225,000	(15,000)	
Green estate	Pool	100,000	125,373	125,373	(25,373)	
Estates Maintenance	Pool	375,000	284,111	375,000	0	
Equipment	Anaesthetic machines x 6	477,004	428,032	428,032	48,972	
Equipment	Replacement of 3T MRI scanner	275,000	451,629	554,608	(279,608)	
Equipment	Pool	200,000	124,147	200,000	0	
Information Technology		0	98,151	75,988	(75,988)	
Reserve		46,996	0	177,095	(130,099)	
SCIF		410,000	0	115,000	295,000	
		3,909,000	2,145,709	3,614,000	295,000	549,889

Strategic Estates	2,025,000	634,266	1,562,905	462,095	549,889
Green estate	100,000	125,373	125,373	(25,373)	0
Estates Maintenance	375,000	284,111	375,000	0	0
Equipment	952,004	1,003,808	1,182,640	(230,636)	0
Information Technology	0	98,151	75,988	(75,988)	
Reserve / SCIF	456,996	0	292,095	164,901	0
	3,909,000	2,145,709	3,614,000	295,000	549,889

19. System

SUMMARY

The M9 system position and planned trajectory are shown below. Adjustments to forecasts to account for the impact of industrial action in December and January are shown below. The adjustments to forecast allow for expected lost income in addition to the additional expenditure incurred.

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD	Actual YTD	Variance YTD		Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£000	£000	£000	%	£000	£000	£000	%
Birmingham And Solihull ICB	4,600	22,131	17,531	0.7%	-	26,685	26,685	0.8%
Birmingham And Solihull Mental Health NHS Foundation Trust	-	768	768	0.2%	-	4,002	4,002	0.7%
Birmingham Community Healthcare NHS Foundation Trust	266	304	38	0.0%	-	1,030	1,030	0.3%
Birmingham Women'S And Children'S NHS Foundation Trust	0	(1,305)	(1,305)	(0.3%)	0	4,657	4,657	0.7%
The Royal Orthopaedic Hospital NHS Foundation Trust	767	(4,257)	(5,023)	(5.2%)	0	(479)	(480)	(0.4%)
University Hospitals Birmingham NHS Foundation Trust	(4,500)	(41,932)	(37,432)	(2.3%)	0	(45,700)	(45,700)	(2.1%)
ICS Total	1,133	(24,291)	(25,423)	(1.0%)	0	(9,805)	(9,805)	(0.3%)

Forecast v trajectory adjusted for Dec and Jan IA	Forecast per trajectory £000s	IA Direct costs (cost of cover less on the day costs avoided) £000s	IA Efficiencies lost £000s	IA ERF £000s	Total IA impact Dec & Jan £000s	Total Trajectory plus IA costs £000s
BSMHT	4,053	-51	0	0	-51	4,002
BCHC	1,030	0	0	0	0	1,030
BWC	5,198	-388	0	-158	-546	4,652
ROH	131	-17	0	-593	-610	-479
UHB	-37,123	-5,265	-1,600	-1,800	-8,665	-45,788
Provider Total	-26,711	-5,721	-1,600	-2,551	-9,872	-36,583
ICB	26,711	0	0	0	0	26,711
Total	0	-5,721	-1,600	-2,551	-9,872	-9,872

20. Workforce

Summary/Highlights:

December was a challenging month from a workforce perspective, particularly around sickness absence rates and starters vs leavers . The HR Team are working hard on changing the way we support managers and leaders to address workforce issues providing a more proactive approach. On a positive note, the Trust continued to report levels of turnover within Trust target.

Risk/Issues:

- Absence remains high which is a national trend however we hold one of the highest rates in the system
- We had more leavers than starters in December. This is the first time in several months that this has occurred.

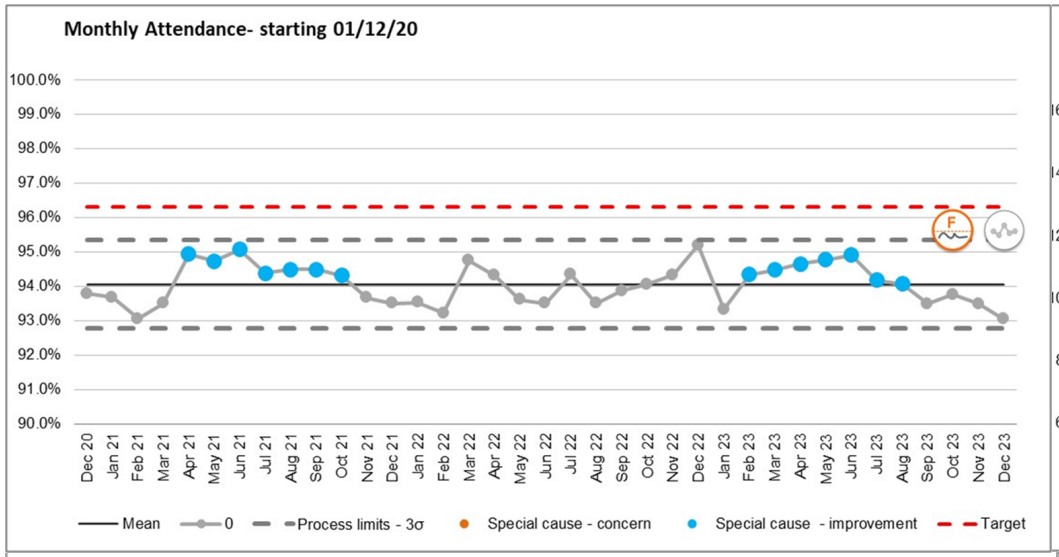
Actions:

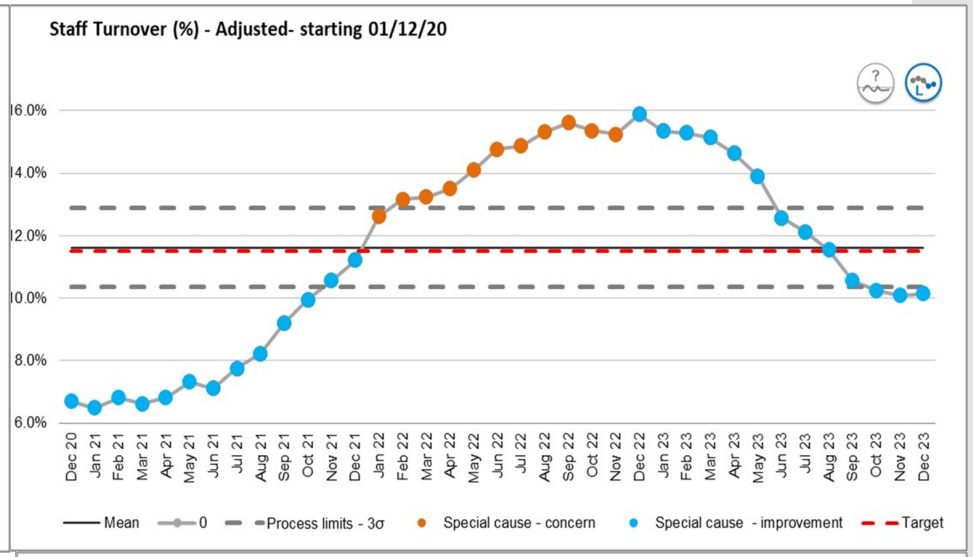
- Various actions to address high sickness rates including the forming of a mental health working group and new sickness absence policy and training.
- Pilot for use of the National Bank is being scoped which can reduce agency expenditure and may act as a supply of temporary staff.
- Atypical Working Regulations will be in affect in October 24. We are waiting on ACAS guidance to be published around this however it is likely to dramatically change the way we can engage temporary staff.

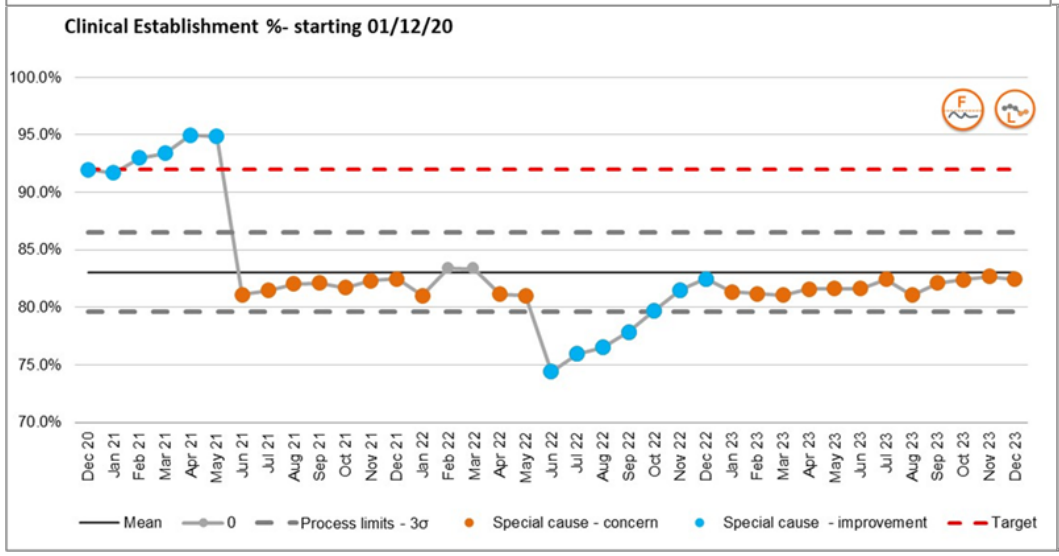
20. Workforce

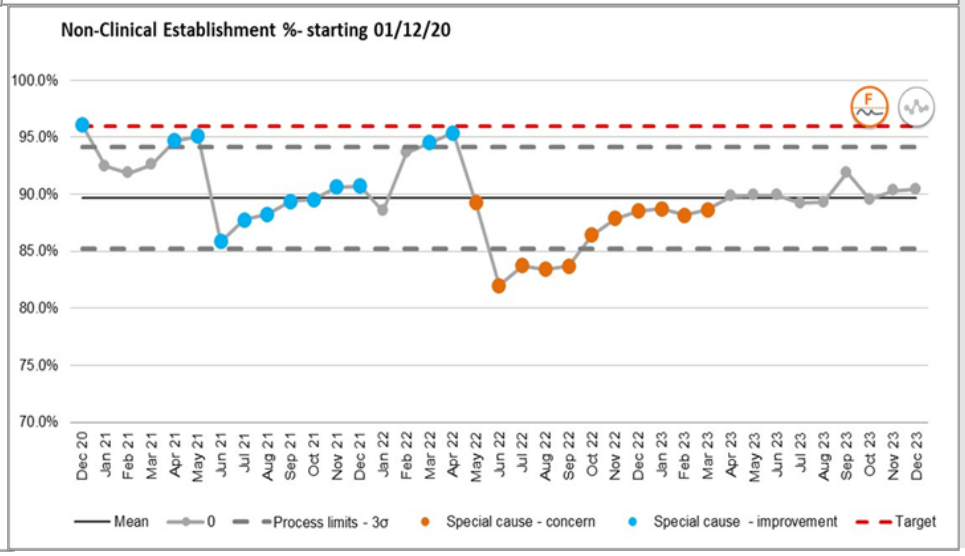
Topic	KPI	December 2023	TREND
Occupied Establishment	93%	85.31%	
Turnover (adjusted)	11.5%	10.15%	
Staff in post - FTE	N/A	1210.31	
Attendance	96.3%	93.04%	
Apprenticeship Levy and Activity	2.3%	1.5%	
Mandatory Training	93%	88.90%	
Performance & Development Reviews	95%	69.99%	
National Staff Survey	60%	60%	=
Disability declaration rate	7.5%	7.6%	
Workforce Wellbeing – A/Leave	75.0%	69.41%	

20. Workforce

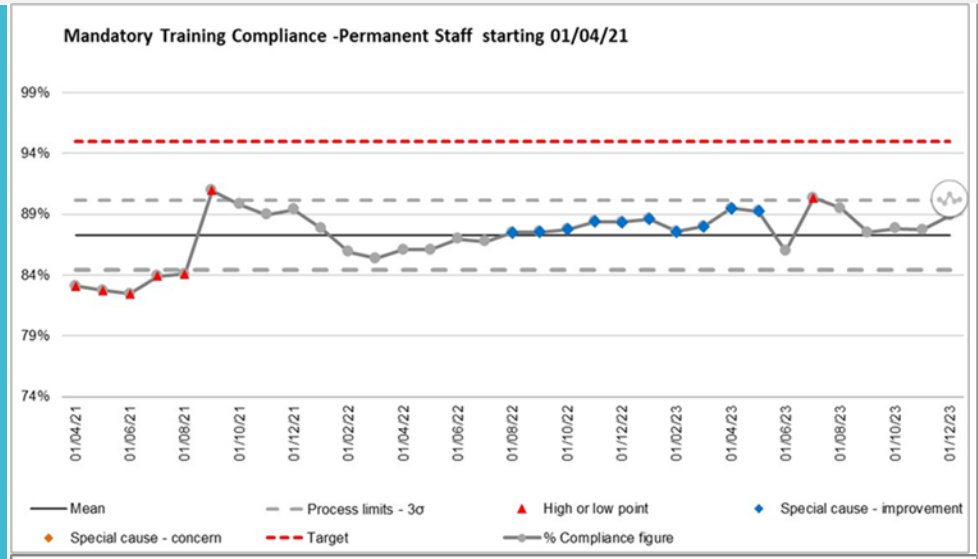


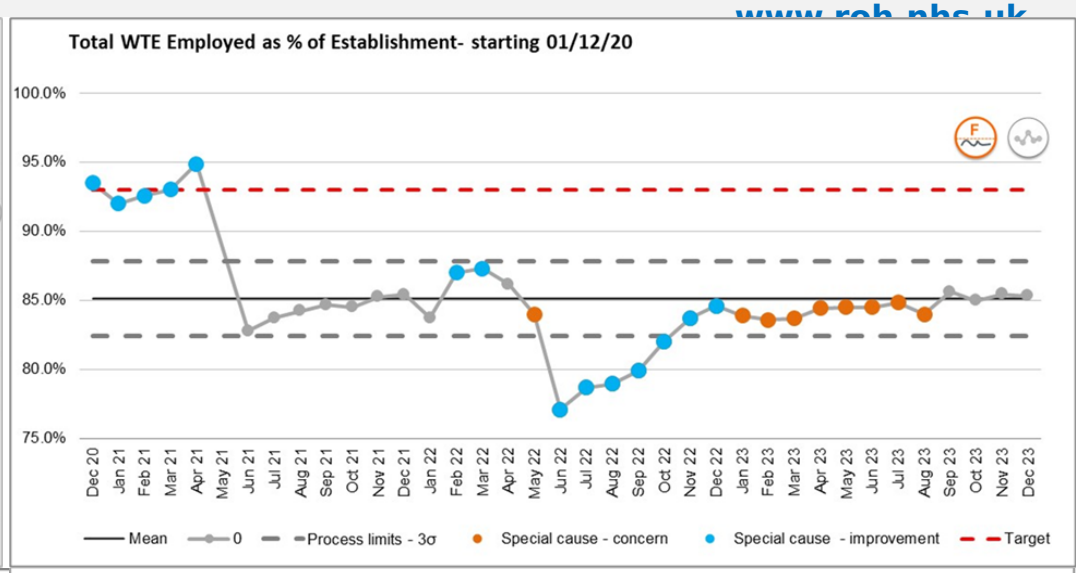


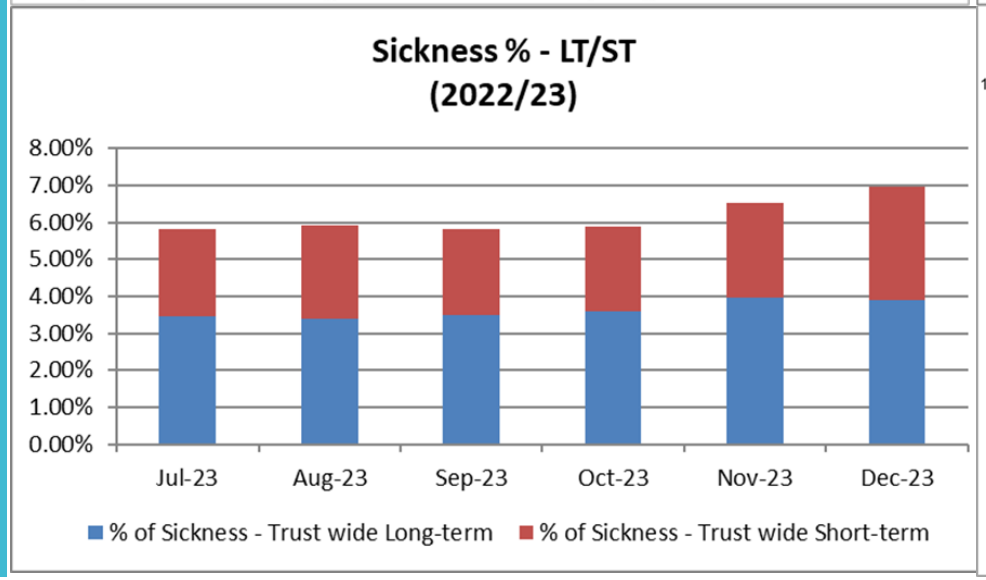


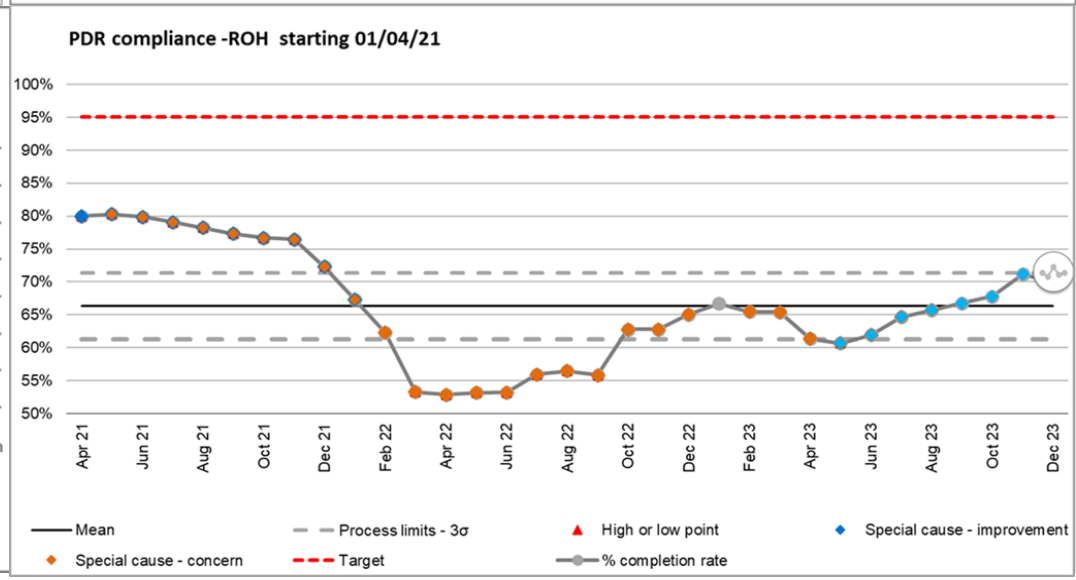


20. Workforce









The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

January 2024 (December 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 – January 2024 (December 2023 Data) – Summary Dashboard

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2022/2023	2023/24
Incidents	310 (↓)	283 (↓)	292 (↑)	374 (↑)	269(↓)	378 (↑)	341 (↓)	323 (↓)	297 (↓)	411 (↑)	354 (↓)	354	303 (↓)		
Serious Incidents	1	0 (↓)	2 (↑)	0	1(↑)	1	0	0	0	0	0	0	0	8	2
Inpatient Deaths	0	0	0	0	0	1 (↑)	0	1 (↑)	0	0	0	0	0	1	2
VTEs (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	9 (↑)	3 (↓)	7 (↑)	5 (↓)	12(↑)	9 (↓)	7 (↓)	7	8 (↑)	8	7 (↓)	8 (↑)	6 (↓)	79	65
Pressure Ulcers: Cat 2 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0
Pressure Ulcers: Cat 3 (Avoidable)	1	0	1	0	0	0	0	0	0	0	0	0	0	2	0
Infections	1	0	1 (↑)	0	0	0	1 (↑)	1	2	1	0	1	1	9	7
Complaints	3	2	4 (↑)	1 (↓)	3(↑)	2 (↓)	2	5 (↑)	1	3		3	1 (↓)	45	15
Litigation	0	0	2 (↑)	2	0	0	0	3 (↑)	0	0	1 (↑)	0	0	9	4
Coroners	0	0	0	0	0	1 (↑)	0	1 (↑)	0	0	0	1	0 (↓)	0	3

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

In the month of December 2023, there were a total of 303 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows;

No Harm = 223
Low Harm = 64
Moderate Harms = 7
Severe Harm = 0
Near Miss = 9

3. Patient Deaths

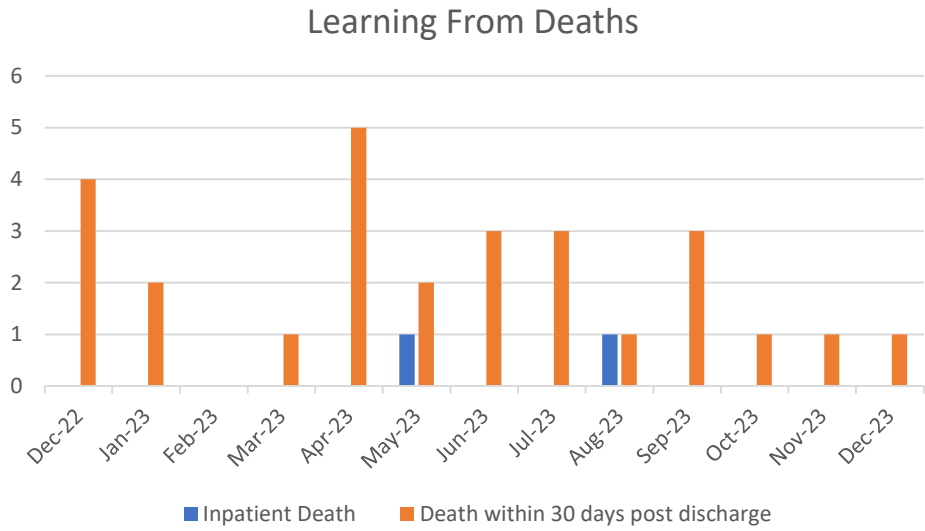
Inpatient Deaths

There were 0 inpatient deaths reported during December 2023

Deaths within 30 days post discharge

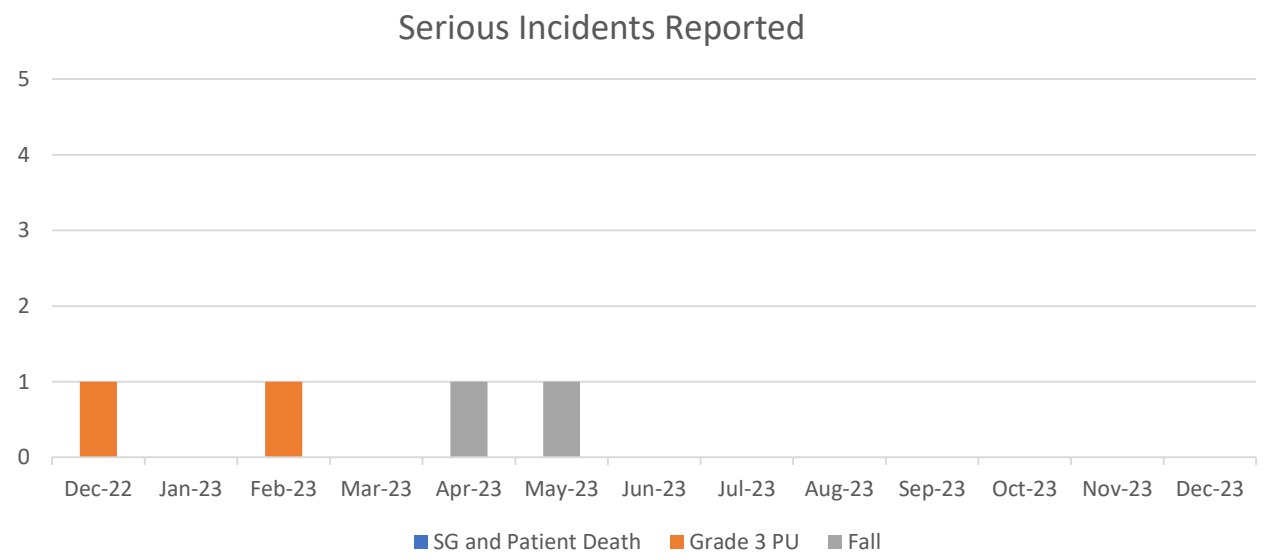
There was 1 patient death that occurred within 30 days post discharge during December 2023.

This death is currently undergoing a Structured Judgement Review (SJR) as part of our learning from deaths process.



4. Serious Incidents

There were 0 Serious Incidents reported in December 2023



5. Potential Moderate Harm & Severe Harm Incidents

There were 7 potential Moderate Harm incidents reported in December 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 Ward 12** – SSI related Incident
- **1 x Ward 3 –** SSI related Incident
- **2 x Appointments –** Appointment Cancellation / Delay
- **1 x Theatre 14 –** Cardiac Arrest Call
- **1 x Rapid Response** – Medical Emergency
- **1 x ADCU** – Inadequate Nursing / Care

6. Update on Moderate Harm Incidents from November 2023

There were 14 potential Moderate Harm incidents reported in November 2023. An update on each of these incidents can be found below:

- **Ward 1,2 and 3 – SSI related Incident**
  Thematic review in progress.
- **2x Ward 3 – Drug Interactions (Medication administration)**
  LOOP Document completed by ward. Learning shared and Epidural policy in process of update.
- **1x Appointment – Patient Pathway (Referral Delay)**
  Under review. Action for NU.
- **1x Ward 2 – Found with Injury Unknown (Unavoidable dislocation)**
  Managed by ward, deemed unavoidable injury.
- **2x Ward 3 – VTE (Provisionally deemed Unavoidable)**
  RCA investigations in progress
- **1x ROH/UHB Joint Pathway – (Specimen Results)**
  Under review.
- **2x Appointments Delay**
  Under review.
- **2x Ward 2 – VTE (Provisionally deemed Unavoidable)**
  RCA investigations in progress

  All remain as potential moderate harm at present pending outcome of investigations

7. Near Miss Incidents

There were 9 Near Miss incidents reported in December 2023

All incidents have been tabled at Divisional Governance Meetings.

Summary of Incidents

1 x Anaesthetics – Inappropriate Patient Pathway

3 x Imaging – Device Unavailable, Device User Error and Delay in Clinical Assessment

1 x POAC – Deterioration in Clinical Condition

1 x Pharmacy – Device Failure

2 x IT –Patient Documentation

1 x ADCU – Documentation Standards Not Met

8. Learning from Serious Incidents (SI), Never Events (NE) and RCAs

There were 2 RCAs closed in December 2023

1. Ward 12 C.Diff RCA

Actions / Learning:

- Medical teams and nursing staff could have looked at data gathered preoperatively where the patients previous CDI information was documented.
- Medical teams and nursing staff could have asked the patient about their bowel history and normal bowel habits.
- Medical team should have documented that the patient had experienced loose stools and awaiting microbiology results.

2. Imaging – Wrong level vertebroplasty (L5 and not L4)

Actions / Learning:

- Not to advance vertebroplasty needles into the vertebral body prior to confirming correct level using a large volume scan (to include L5/S1 and L1) when vertebroplasty needles are on the pedicle landing zone.

9. Venous Thromboembolism (VTE) Incidents

There were 0 VTE incidents reported in December 2023

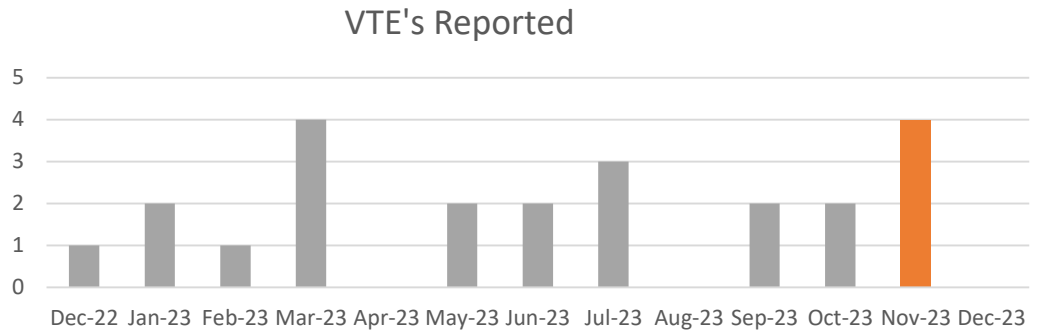
The 4 VTE incidents reported in November 2023 remain under investigation. Provisional conclusion pending sign off at Divisional Governance is that all 4 were unavoidable.

<u>VTE On Admission Assessment Compliance</u>

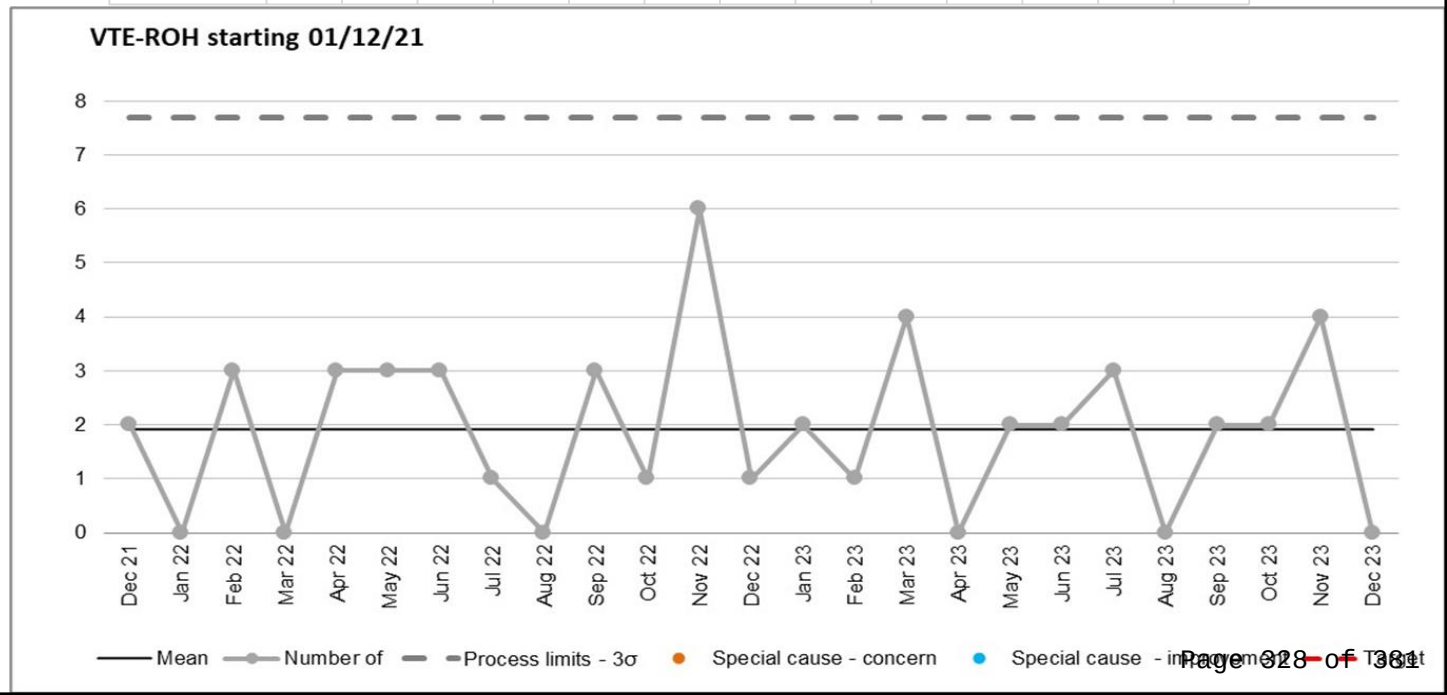
Compliance figure for December 2023 = 99.11**%**

<u>Quality Improvement work underway</u>

Latest NICE Guidance relating to VTE management has been reviewed and discussed at VTE Committee – Trust deemed compliant with Guidance – minor amendment to VTE Policy needed to reflect changes for patients with Covid 19 – this work is underway.



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Unavoidable	1	2	1	4	0	2	2	3	0	2	2	0	0
TBC	0	0	0	0	0	0	0	0	0	0	0	4	0
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0



10. Falls

6 Inpatient falls incidents reported in December 2023

No Harm = 4
Moderate Harm = 2

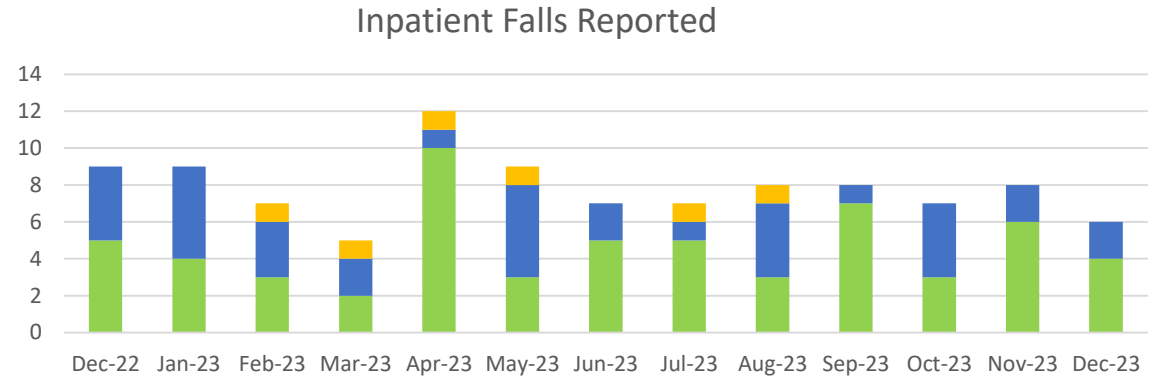
Trends

5 were unwitnessed falls, 1 was a witnessed fall when being supported to the bathroom, 1 was a patient fall in ADCU waiting room and 1 during a Physio session.

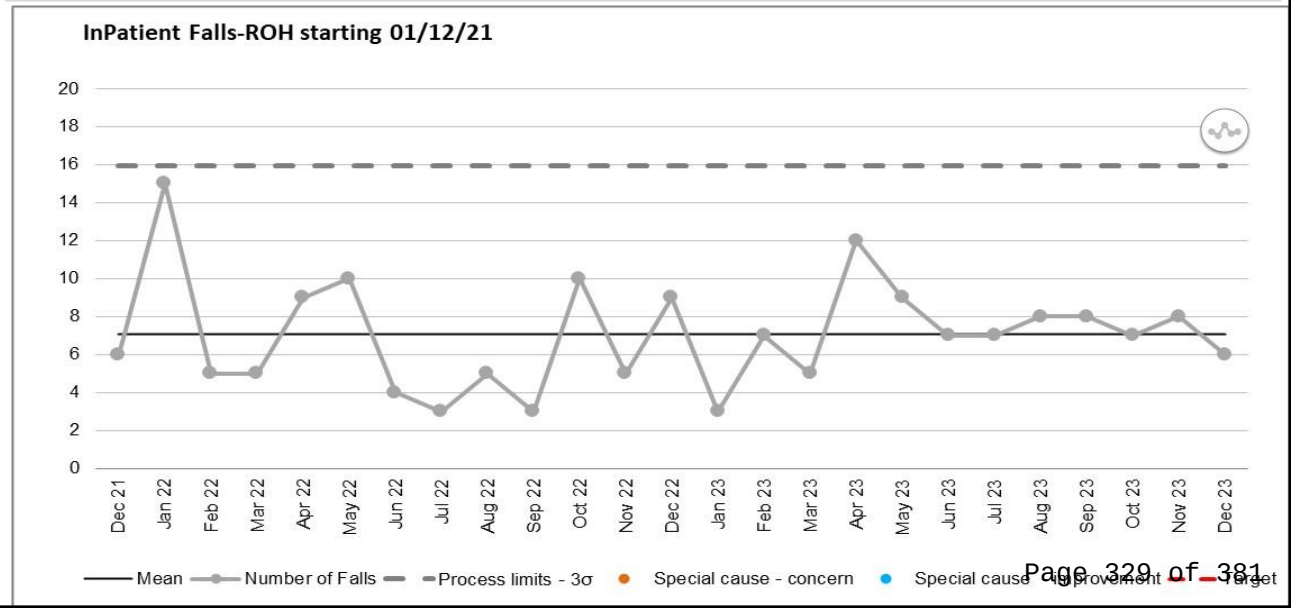
3 of the falls involved patients deemed safe to mobilise however became unstable.
2 of the falls involved patients mobilising against advice.
1 of the falls related to a patient mobilising with frame and their knee gave way.
1 of the falls was during transfer to wheelchair with brakes not applied.
1 of the falls was in ADCU when waiting for surgery.

Quality Improvement Work Underway

- Falling leaves campaign launched at Ward managers meeting for dissemination to all ward staff.
- Training awareness session of falling leaves campaign for portering staff.
- Action plan from Ward 12 review of falls now complete.
- Planned walk round with Estates team to identify outstanding work needed in relation to falls & dementia



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	1	1	1	1	0	1	1	0	0	0	0
Low Harm	4	5	3	2	1	5	2	1	4	1	4	2	2
No Harm	5	4	3	2	10	3	5	5	3	7	3	6	4



11. Pressure Ulcers

0 Category 3 or 4 PU reported in December 2023

0 Category 2 PU reported in December 2023.

Update on PU incident reported in November - Reviewed by TV, no lapse in care identified. Deemed unavoidable.

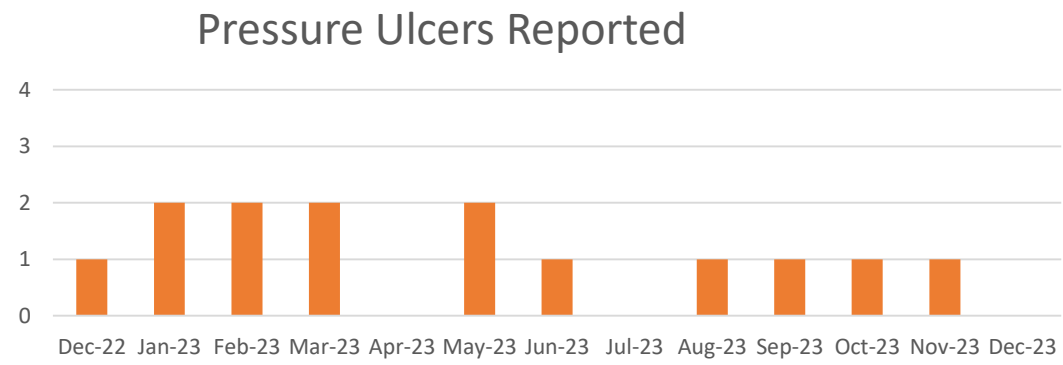
<u>Quality Improvement work planned/underway</u>

The National Wound Care Strategy Programme have issued a consultation document re: Pressure Ulcer Recommendations and Pathway**.** Changes are likely to be made to the PU categorisation and reporting process.

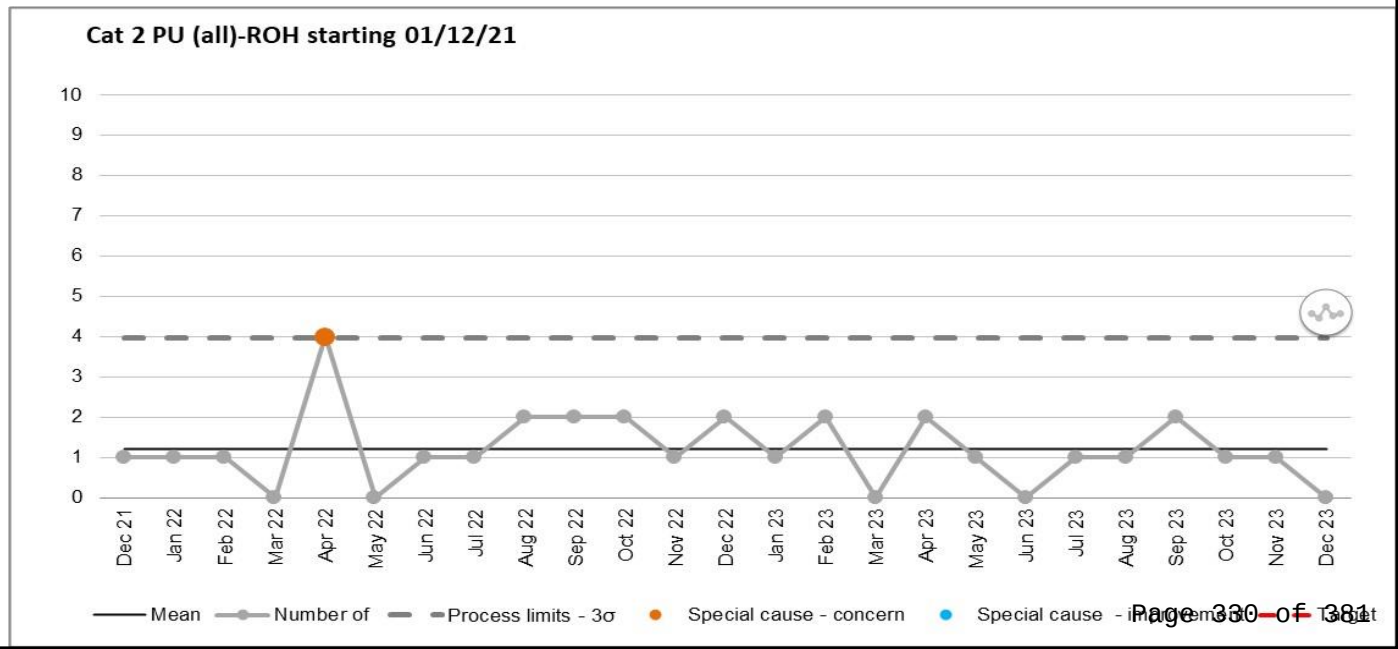
TVN lead will undertake a gap analysis and send to Chief Nurse, Deputy Chief Nurse and Heads of Nursing for initial review

<u>Risks/Issues</u>

PU CQUIN - Q3
Number of Audits – 36
Number Passed – 9
Documentation appears to be improving. Provision of education increased during Q3, therefore a continued improvement with the documentation is anticipated in Q4.



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Sum of TBC	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Unavoidable	1	2	2	2	0	2	1	0	1	1	1	1	0
Sum of Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0



12 (a) - Sepsis - Summary of Q2 sepsis audit outcome.

Objective
To monitor and improve compliance with prescribing and administrating IV antibiotics within 1 hour of recognising Sepsis

Results
Total patients : 5
Total positive sepsis screens: 5
Red Flag: 2
Antibiotics within 1 hour: 1
50% compliance
Amber flag: 3
Antibiotics within 3 hours: 2
66% compliance

Overall Compliance: 60%

Themes
Failure to recognise sepsis and failure to follow escalation procedures were key themes this quarter.

12 (b) - Sepsis - Summary of Q3 sepsis audit outcome.

Objective
To monitor and improve compliance with prescribing and administrating IV antibiotics within 1 hour of recognising Sepsis

Results
Total patients screened: 15
Total positive sepsis screens: 14
Total negative sepsis screens: 1
Total red flag sepsis: 7
Total received antibiotics within 1 hour of red flag sepsis : 3
43% compliance
Total amber flag Sepsis: 7
Total received antibiotics within 3 hour of amber flag sepsis: 6
86% compliance

Overall Compliance: 64%

Conclusions
Failure to recognise sepsis and failure to follow escalation procedures were key themes again this quarter. Both have been escalated through incident reporting and governance meetings due to the patient safety concerns these raise.
Prescribing delay was again identified as an ongoing theme from Q1 and Q2.

Actions
Investigations are ongoing for failure to recognise and escalate sepsis.
Q1 and Q2 reports has been presented at AQILA.
Results will be highlighted in the post-graduate forum as well as Division 1 and 2 governance meetings and resus and deteriorating patient committee.
Compliance will continue to be monitored through Q4 and results acted on as appropriate.
Year compliance summary will be completed following Q4 and compared to 2022-2023 results to assess the effectiveness of changes implemented

13. Infection Prevention Control

Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly. All infections are reported and scrutinised at the IPCC committee.

Infections Recorded in month and Year to Date (YTD)	December 2023	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	1	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	2
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

Complaint Information

The Trust received **1** complaint in December 2023

Below are the summaries for complaints received

1. Large Joints / SARS handling

In December, the complaints team closed **3** formal complaints.

At the time of producing this report we currently have **4** open formal complaints. 1 complaint is a reopened complaint, and a resolution meeting has taken place on the 9.01.2024

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

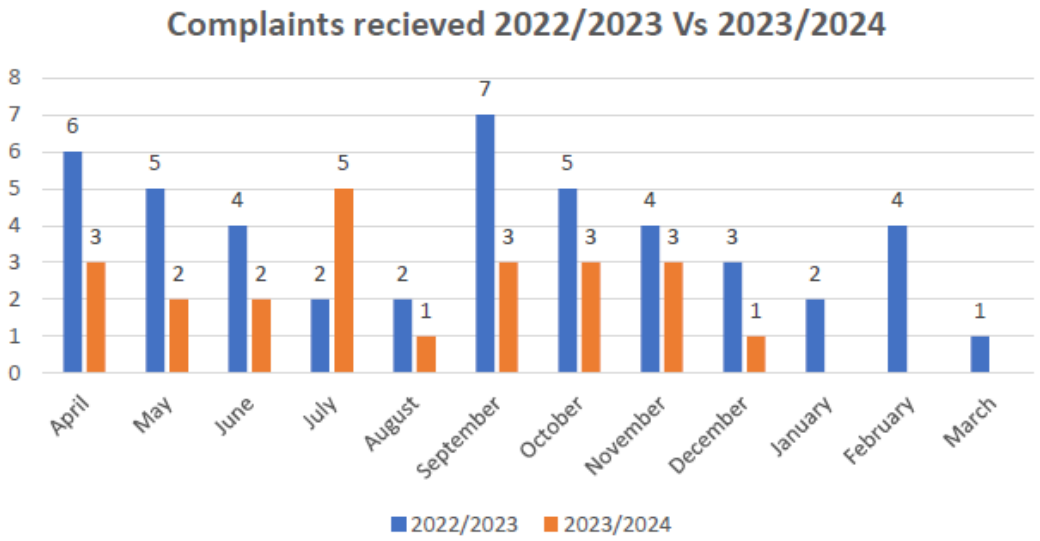
In December, the Trust received **0 reopened complaints.**

In December 2023, the Trust conducted **0 complaint resolution meetings,** however 1 has taken place on the 9th January 2024.

RISK AND ISSUES WITHIN PATIENT EXPERIENCE

The complaint raised in December 2023 was in relation to multiple failings within SARS.

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 – December 2023	22

Complaints KPI's

KPI	Complaints %
April 2023	100%
May 2023	67%
June 2023	75%
July 2023	100%
August 2023	0%
September 2023	100%
October 2023	77%
November 2023	100%
December 2023	0%

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

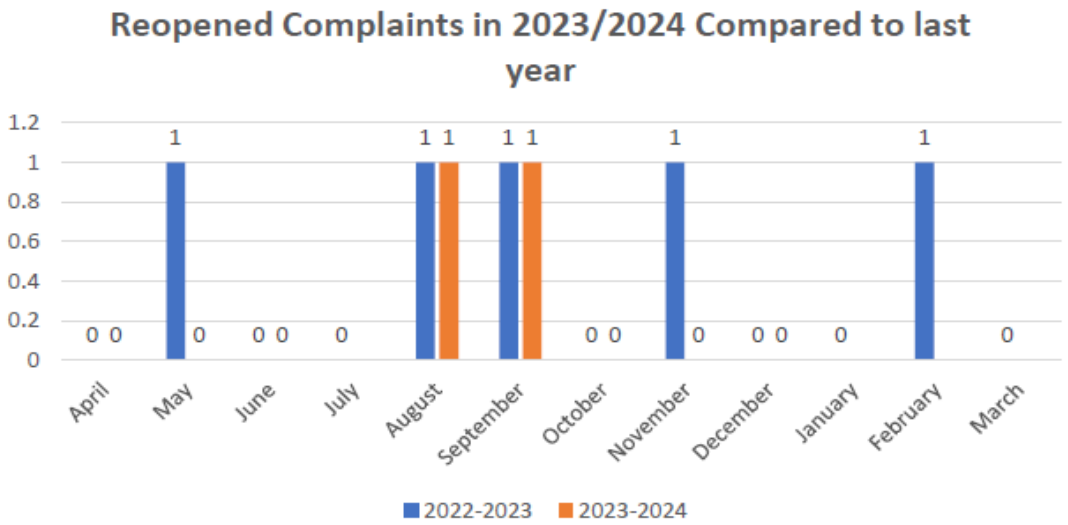
At the time of producing this report the complaint which was received in December 2023 has breached. Unfortunately cases have breached due to lack of communication from specialities to department, despite escalation. Some cases have breached due to awaiting clinical input required however due to annual leave, it resulted in a delay. Also awaiting information/referrals from other trusts.

Actions from Complaints

In December 2023 0 actions identified on the complaint, as the complaint currently remains open.

No Immediate action plans were completed by the triumvirate for any of the complaints received in December 2023.

Complaint Themes



Reopened complaints

The Trust received no reopened complaints in December 2023. This is due to the complaints previously resolved have all been managed to the complainant's satisfaction.

PHSO Cases

The Trust currently has 1 PHSO case open. We are still awaiting an update from the PHSO as to whether they would like to progress with this complaint.

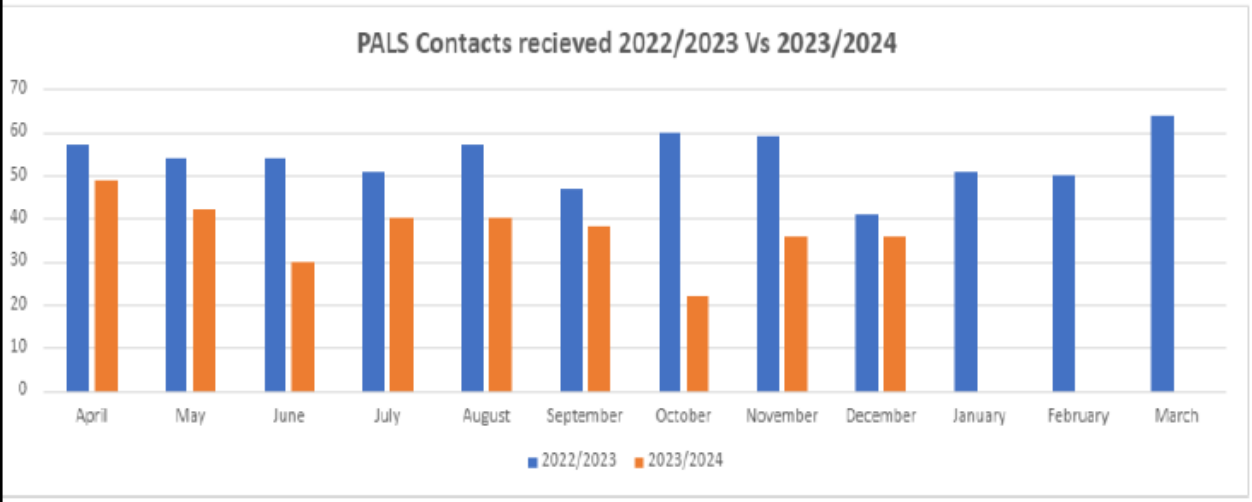
Themes

1. Communication and appointments
2. Treatment / Care provided

What We Did / Are doing

1. Raised in divisional governance meeting to track themes.
2. Tracked in Executive Governance Meeting
3. Ensuring actions are created
4. Ensuring relevant departments are aware of concerns
5. Chasing up outstanding actions in bi-weekly governance meetings

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. This is considered to be due to the PALS department practicing early resolution where practicable.

PALS KPI's

KPI	PALS Contacts %
April 2023	85%
May 2023	93%
June 2023	90%
July 2023	88%
August 2023	50%
September 2023	36%
October 2023	50%
November 2023	56%
December 2023	82%

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

The KPI for PALS Contacts have not been met (90%) since May 2023.
This is due to the lack of responses from the specialities.

PALS Themes

Communication- (6 out of 22)
Appointments – (10 out of 22)

What we have done

Tracked in Executive Governance Meetings
Raised in Governance meetings and with departmental managers.
Escalation to ensure PALS cases are responded too.

15. Litigation and Coroners

New claims

0 new claims were received in December 2023

Pre-Application Disclosure

0 new requests for Pre-Application Disclosure of medical records were received in December 2023

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in December 2023.

16. WHO Surgical Safety Checklist

CT Area Audit

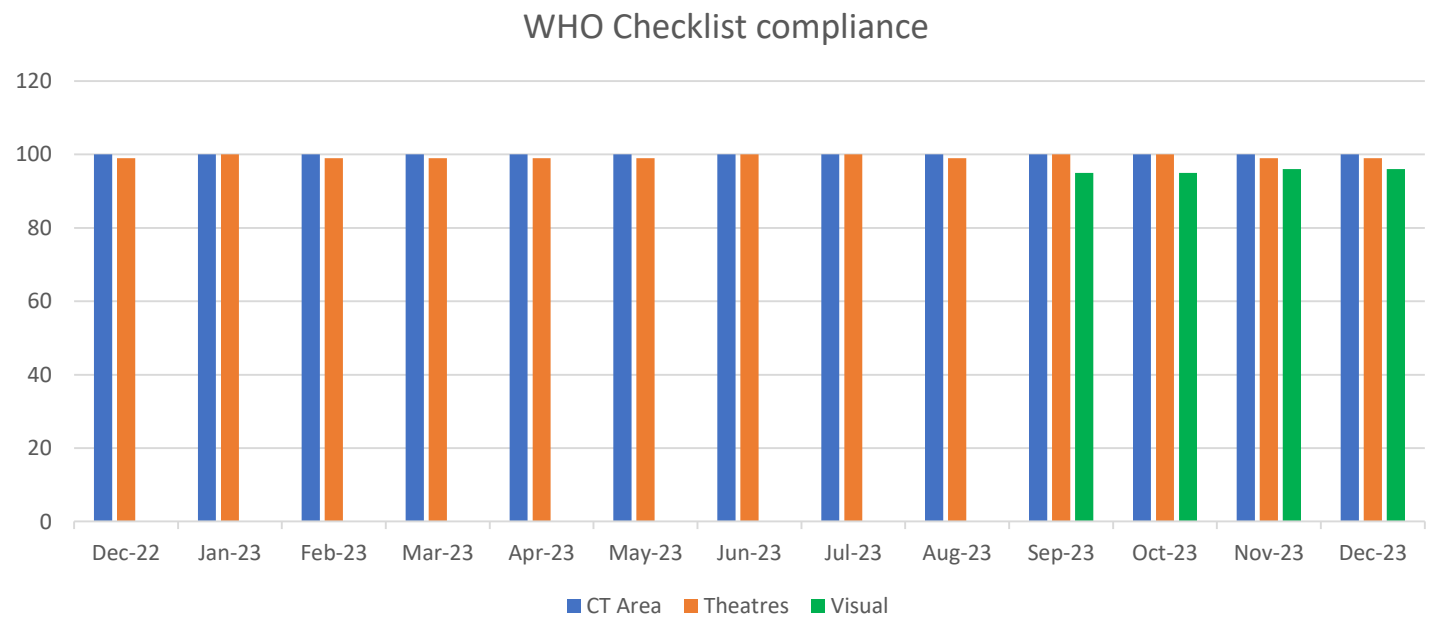
	Scores	Percentages
Team Brief	86/86	100%
Sign In	86/86	100%
Time Out	86/86	100%
Sign Out	86/86	100%
Team Debrief	86/86	100%
Total	86/86	100%

Theatre Audit

	Scores	Percentages
Team Brief	796/796	100%
Sign In	796/796	100%
Time Out	796/796	100%
Sign Out	796/796	100%
Team Debrief	789/796	99%
Total		99%

Visual Audit

	Scores	Percentages
Team Brief	24/24	100%
Sign In	22/24	91%
Time Out	24/24	100%
Sign Out	24/24	100%
Team Debrief	22/24	91%
Total		96%



17. CAS Alerts

There were 4 new CAS alerts issued in December 2023

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
CEM/CMO/2023/003	Influenza Season 2023/24: Use of antiviral medicines. KHSA surveillance data indicates that influenza is circulating in the community. Prescribers working in primary care may now prescribe, and community pharmacists may now supply antiviral medicines (oseltamivir and zanamivir) for the prophylaxis and treatment of influenza at NHS expense. This is in accordance with NICE guidance, and Schedule 2 to the National Health Service (General Medical Services Contracts (Prescription of drugs etc) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS). Antiviral medicines may be prescribed for patients in clinical at-risk groups as well as anyone at risk of severe illness and/or complications from influenza if not treated.	CMO Messaging	14-Dec-23	Forwarded to Pharmacy for information. Response not Required.	n/a

NatPSA/2023/016/DHSC	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba) products A Medicine Supply Notification issued on 24 May 2023, detailed a shortage of Tresiba (insulin degludec) FlexTouch 100units/ml solution for injection 3ml pre-filled pens. Advice on how to manage this supply issue can be found on the Medicine Supply Tool. The Medication Safety Officer (MSO) network has highlighted that in response to this shortage, some patients may have been switched to Tresiba (insulin degludec) FlexTouch 200units/ml solution for injection 3ml pre-filled pens. Tresiba FlexTouch pen delivery devices dial up in unit increments rather than volume. However, a small number of patients have been incorrectly advised to administer half the number of units. MSOs have highlighted five reports of patients being incorrectly advised to reduce the number of units of insulin to be administered. These reports suggest that errors have occurred at the prescribing, dispensing and administration stages of the medicine journey. One case described a patient requiring treatment in hospital for diabetic ketoacidosis because of a reduced insulin dose. This National Patient Safety Alert provides further background and clinical information and actions for providers.	National Patient Safety Alert - DHSC	08-Dec-23	**13 Dec 23:** **Email from Dr Rea:** *'We have taken positive actions to comply with the recommendations as they apply to our organisation, within the timeframe'.* Action completed.	22 Dec 2023

NatPSA/2023/015/UKHSA	Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia - measures to reduce patient risk. UKHSA is investigating an outbreak of Burkholderia cenocepacia involving individuals across the UK. This is an emerging issue and, following testing, B. cenocepacia was recovered from some lubricating carbomer eye products.	National Patient Safety Alert - UKHSA	07-Dec-23	**13 Dec 23: Email from Gavin Boham: -** *'We are compliant. Only a handful of patients in the entire Trust on carbomers. No affected stock in pharmacy (ROH high risk patients end up here). I have requested an alert goes out on PICS as an additional precaution'.* ***13 Dec 23: Email from Chief Pharmacist: -*** *This has come from various routes. But we have checked our stocks as per Gavin's response and we are compliant with the actions'.* Action completed.	17 Dec 2023

NatPSA/2023/014/NHSPS	Identified safety risks with the Euroking maternity information system. Potential serious risks to patient safety have been identified with the use of Magentus Software Limited's Euroking maternity information system. This National Patient Safety Alert asks providers of NHS maternity care to review their systems to identify if the identified issues are present and, where appropriate, take steps to eliminate the risk. ***13/12/2023: The alert pdf has been updated to correct the name of the Euroking software supplier to Magentus Maternity Software Limited. There are no other changes to the alert.***	National Patient Safety Alert - NHS England & NHS Improvement	07-Dec-23	Assessed - not relevant to organisation's services. Alert closed.	07 June 2024

17. Cas Alerts Continued - Outstanding Alerts from Previous Month

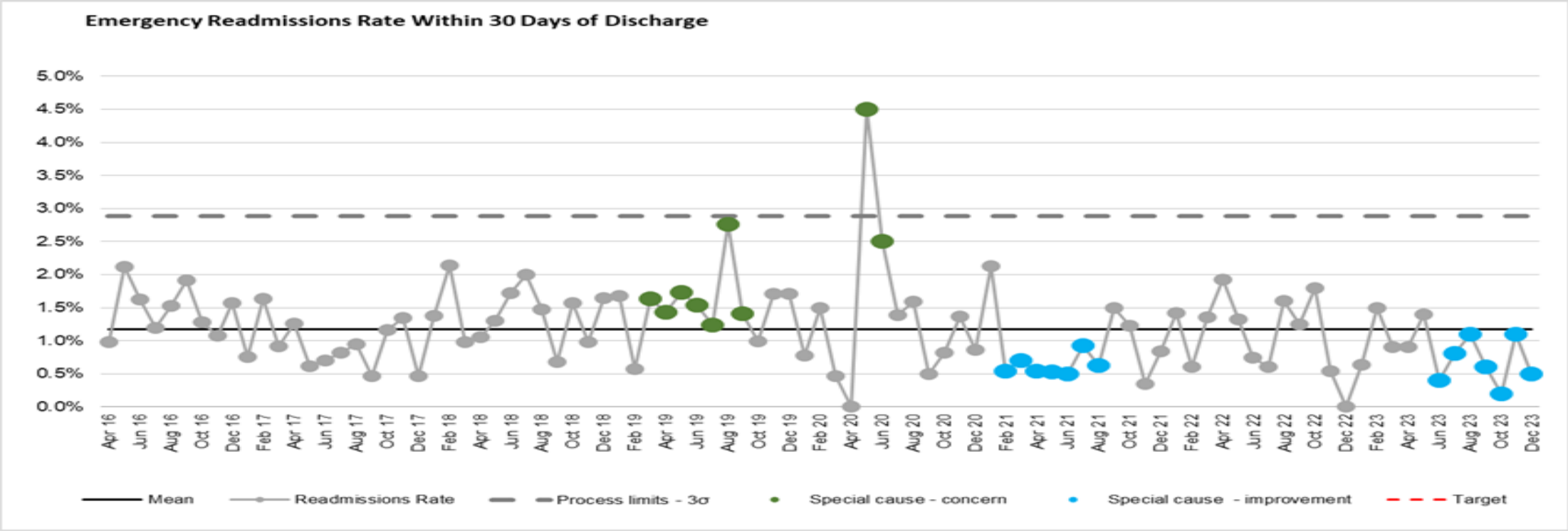
Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS. This National Patient Safety Alert provides further background and clinical information and actions for providers.	MHRA	31 Aug 23	**1 Dec 23: Email from Chief Nurse:** *'Working Group will be set up asap'.* Beds tagged to aid compilation of Estates inventory. Beds & bedrails will now be serviced iaw Arjo's yearly service schedule. On-going…	1 Mar 2024

18. Safeguarding

KPI	Dec-22	Jan-22	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Dec-23
Safeguarding Adult Notifications	31	31	35	17	43	21	44	43	47	37	47	58
Safeguarding Children Notifications	26	26	76	23	37	29	55	51	42	25	35	40
Adult Level 2 - 85%	81.83%	81.83%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)	86.22%	85.48% (↓)	86.86% (↑)	88.70%
Adult Level 3 - 85%	75.68%	75.68%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)	82.06% (↓)	83.15% (↑)	83.83% (↑)	86.03%
Level 4 - 90%	75.00%	75.00%	60% (↓)	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)	100% (↑)	100.00%	80% (↓)	80.00%
Child Level 2 - 85%	81.16%	81.16%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)	86.12% (↓)	85.23% (↓)	86.7% (↑)	88.46%
Child Level 3 - 85%	75.29%	75.29%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)	81.68 (↓)	82.8% (↑)	83.46% (↑)	85.84%
Mental Capacity Act MCA - 85%	81.67%	81.67%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)	86.35% (↓)	85.88% (↓)	87.11% (↑)	88.62%
Deprivation of Liberty Safeguards DoLs - 85%	81.58%	81.58%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)	86.27% (↑)	85.63% (↓)	86.95% (↑)	88.54%
Prevent Awareness - 90%	89.88%	89.88%	89.40%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)	91.32% (↑)	89.98% (↓)	94.48% (↑)	91.38%
WRAP (prevent level 3) - 85%	81.06%	81.06%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)	87.41% (↓)	86.15% (↓)	85.51% (↓)	86.25%
FGM	1	1	2	1	3	0	1	0	5	2	3	1
DOLS	6	6	4	0	7	0	6	4	4	2	5	3
MCA	4	4	0	1	3	4	1	4	2	7	5	6
PIPOT cases	0	0	1	0	0	0	0	1	0	0	0	0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0

Training compliance now achieved against all but 1 KPI (Level 4 Adult training)

19. Patients Readmitted to a Hospital Within 30 Days of Being Discharged



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
No of Readmissions	3	7	5	4	7	2	4	5	3	1	6	3
Denominator	468	468	546	465	494	554	482	469	492	543	553	562
% Readmissions	0.6%	1.5%	0.9%	0.9%	1.4%	0.4%	0.8%	1.1%	0.6%	0.2%	1.1%	0.5%

20. Freedom to Speak Up Update

Concerns Raised

There were 4 concerns raised in December 2023 in relation to the following themes:-

- Patient safety and quality
- Worker safety and wellbeing

Learning and Outcomes:

Staff advised to raise concerns to senior managers to improve communication structure

Operational Performance

December 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 December 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	50.60%	53.47%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	87	77	0	L	F
52 week waits (52 – 64 Weeks)	474	502	0	H	F
All activity YTD (compared to plan)	10,749	9,533	10,633		P
Outpatient activity YTD (compared to plan)	49,332 100.3% Cumulative	44,839 102.1% Cumulative	49,201 YTD Target		P
Outpatient Did Not Attend (YTD)	7.8%	8.1%	8%		P
PIFU (trajectory to 5% target)	392 9.1%	490 9.5%	184 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	8.4%	11.8%	19%		F
FUP attendances(compared to 19/20)	90.6%	91.3%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	110.1%	109.0%	120%		F
Diagnostics volume YTD (compared to plan)	18,571 Cumulative	16,428 Cumulative	14,080 YTD Target		P
Diagnostics 6 week target	99.7%	99.9%	99%		P

Operational Performance Summary

Performance to end December 23	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	87.2%	90.9%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	85.7%	85%	85%		
28 day FDS	100%	75%	75%		
Patients over 104 days (62 day standard)	0	1	0		No Target
POAC activity volume (YTD)	18,978 Cumulative	17,060 Cumulative	17,282 Cumulative		
Bed Occupancy (excluding CYP and HDU)	67.8%	74.1%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.57	3.55	n/a		No Target
LOS - elective primary hip	2.80	3.50	2.7		
LOS - elective primary knee	2.80	3.50	2.7		
BADS Daycase rate (Note: due to time lag in month is Sep'23)	77.0%	76.4%	85%		

Workforce Performance Report

Prepared by:
Matt Dingle, Head of HR;
David Richardson, Head of Education and Training;
Clare Mair, Head of OD & Inclusion

Ref: December 2023 / HR&OPS

Scorecard

Topic	KPI	December 2023	TREND
Occupied Establishment	93%	85.31%	↓
Turnover (adjusted)	11.5%	10.15%	↑
Staff in post - FTE	N/A	1210.31	↓
Attendance	96.3%	93.04%	↓
Apprenticeship Levy and Activity	2.3%	1.5%	↑
Mandatory Training	93%	88.90%	↑
Performance & Development Reviews	95%	69.99%	↑
National Staff Survey	60%	60%	=
Disability declaration rate	7.5%	7.6%	↑
Workforce Wellbeing – A/Leave	75.0%	69.41%	↓

Section One:

HR Operations Team

Prepared by: Matt Dingle, Head of HR

Presented by: Matt Dingle, Head of HR

Ref: December 2023/HR&OPS

HR Operations

Summary:

December was a challenging month from a workforce perspective, particularly around sickness absence rates, starters vs leavers and employee relations. The HR Team are working hard on changing the way we support managers and leaders to address workforce issues providing a more proactive approach. On a positive note, the Trust

Areas for Improvement:

- Atypical Working Regulations come into effect in October 24 which will change how we use temporary staffing. We are pending ACAS guidance around this due shortly.
- Sickness absence rates are high compared to Trust colleagues.

Risks / Issues:

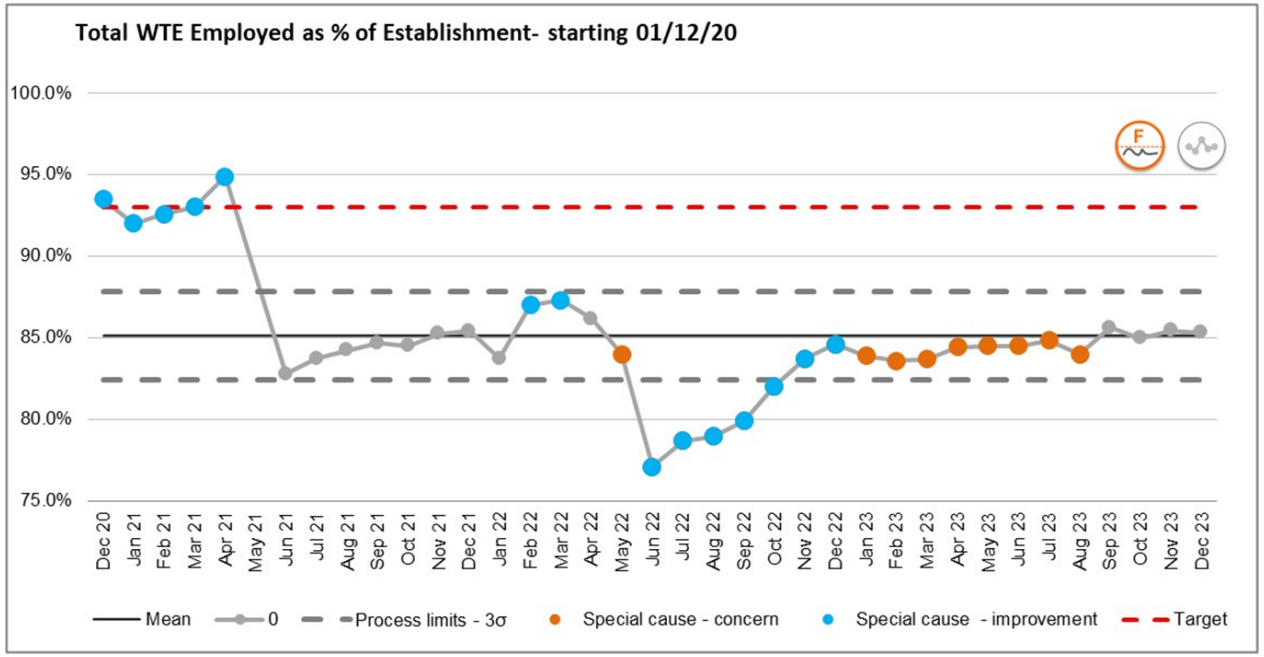
- Absence remains high which is a national trend however we hold one of the highest rates in the system.
- We had more leavers than starters in December. This is the first time in several months that this has occurred

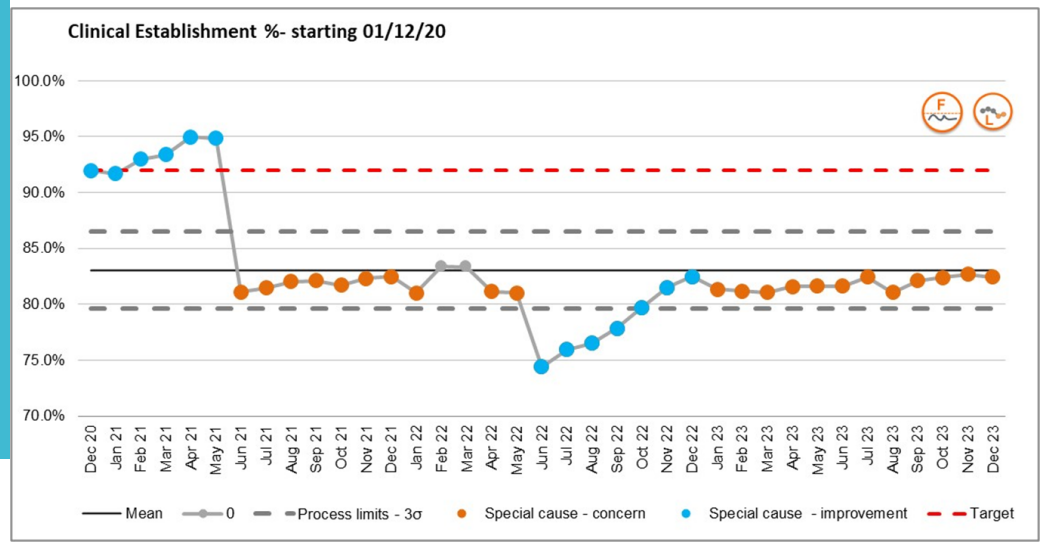
Action Plan:

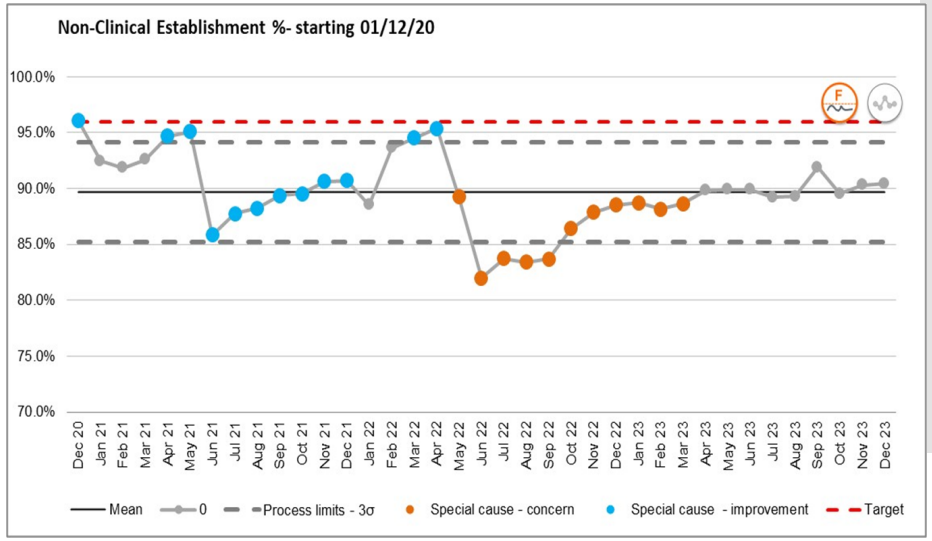
- Various actions to address high sickness rates including the forming of a mental health working group and new sickness absence policy and training.
- Pilot for use of the National Bank is being scoped which can reduce agency expenditure and may act as a supply of temporary staff.
- New Disciplinary policy to launch in coming months with Decision Making Group framework, with a Just and Restorative culture lens.

Occupied Establishment

KPI	93%
Dec-2023	85.31%
Trend	







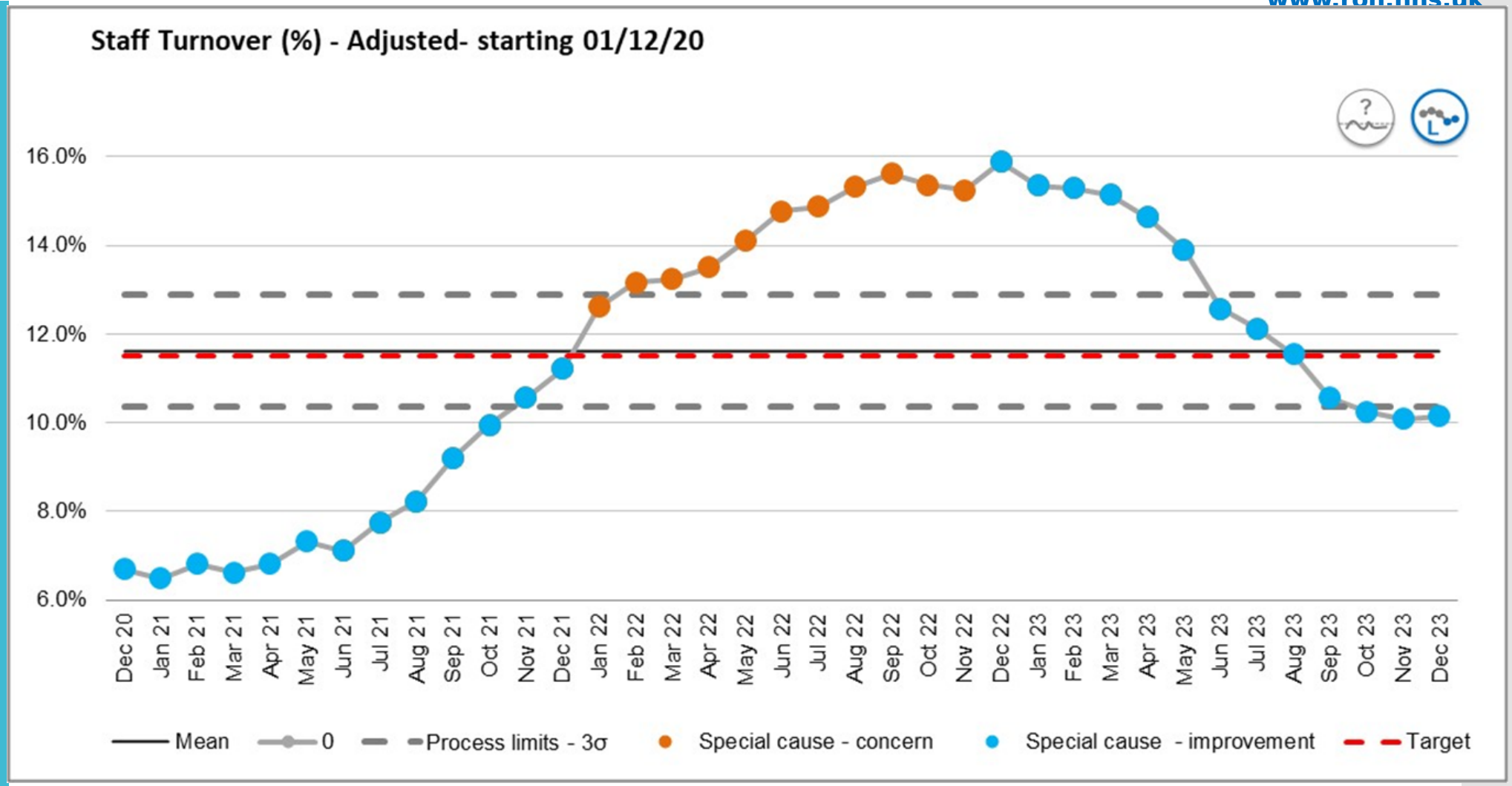
Turnover (adjusted)

KPI	11.5%
Dec-2023	10.15%
Trend	↑

Adjusted turnover is all turnover minus:

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

Adjusting turnover provides more meaningful data around Trust performance



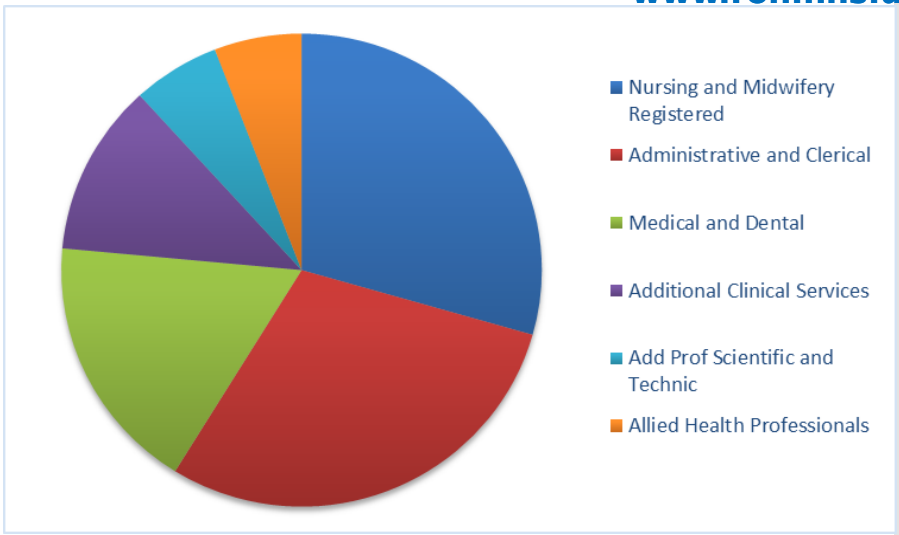
December Leavers

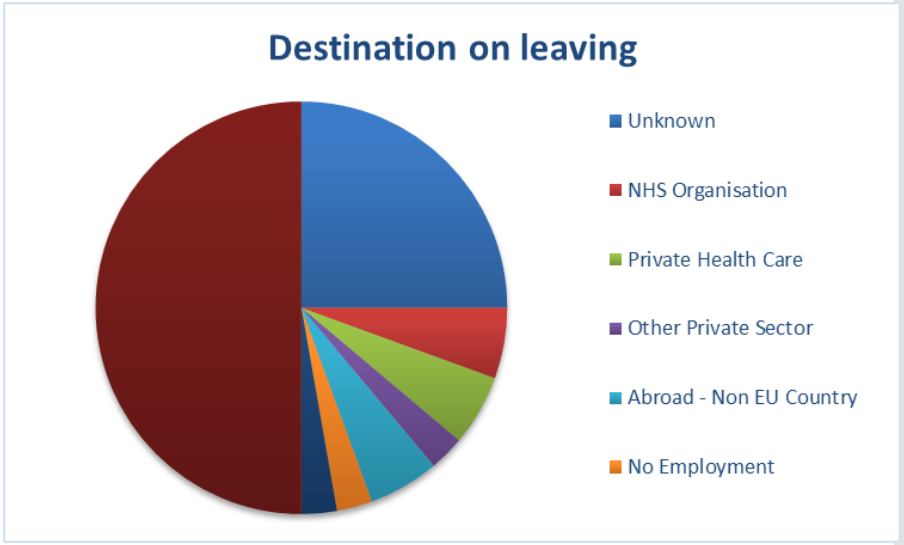
Data has been captured from ESR, extracted on 22 January 24

Reason for leaving	Headcount
Voluntary Resignation - Other/Not Known	5
Retirement Age	3
End of Fixed Term Contract	2
Voluntary Resignation - Relocation	2
Voluntary Resignation - Promotion	1
Flexi Retirement	1
Voluntary Resignation - To undertake further education or training	1
Voluntary Resignation - Work Life Balance	1
Voluntary Resignation - Better Reward Package	1
Voluntary Resignation - Health	1
Grand Total	18

Status	Headcount	Comments
Unpreventable	8	Retirement, end of FTC, relocation
Possibly preventable	9	

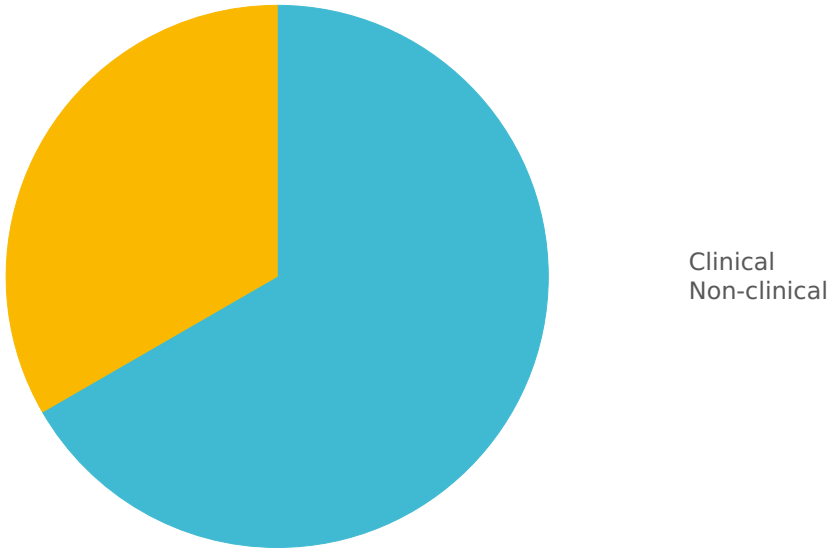
Of the 4 staff who retired in December, 3 have returned



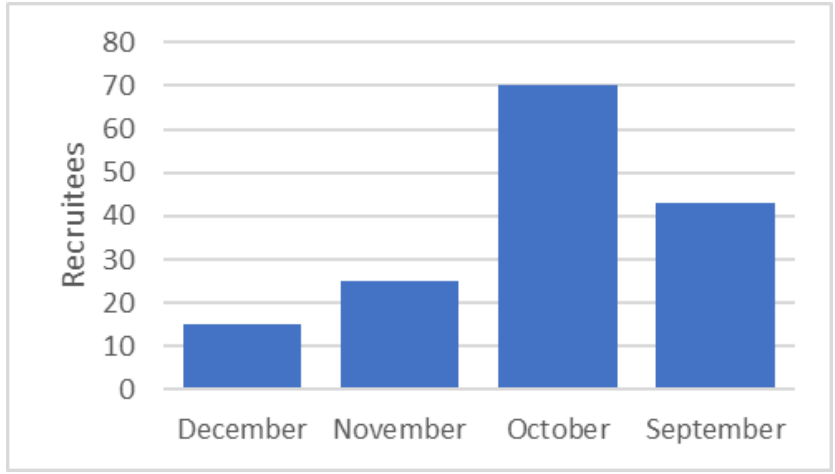


Starters - Dec 23

Staff Group	Headcount
Add Prof Scientific and Technical	1
Admin and clerical	2
Additional Clinical Services	1
Allied Health Professionals	0
Estates and Ancillary	2
Medical and Dental	0
Nursing and Midwifery	4
Bank	5
Total	15



Time to Hire		KPI
Vacancy creation to conditional offer	37.8 days	Not currently set
Vacancy creation to starting letter	63.7 days	Not currently set
Time to clear performance	25.8 days	30 days



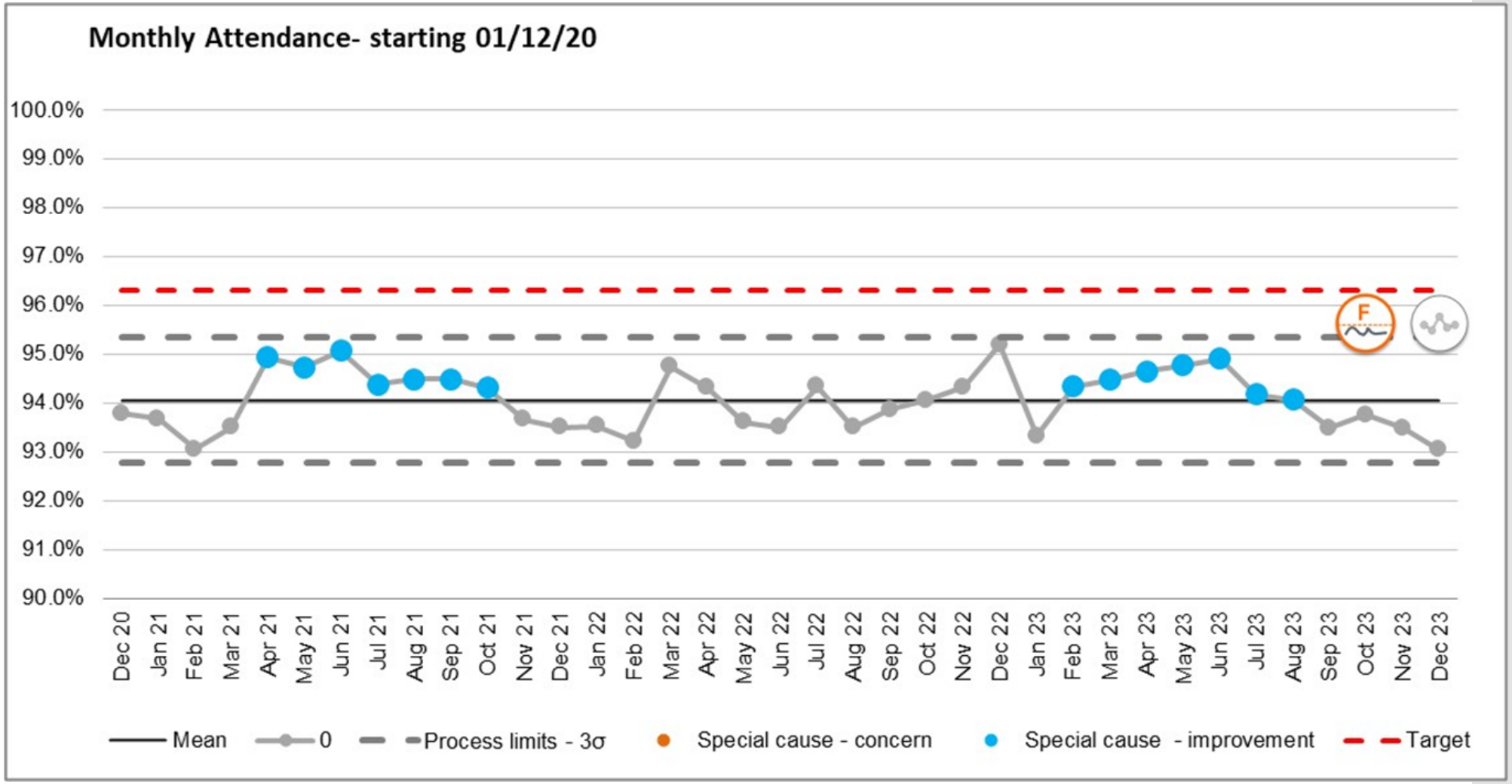
Employee Relations

Case Type	Cases open	Suspended/ Excluded	Cases Closed / Concluded in Oct/Nov
Discipline	5	3	3
Grievance	3	0	2
Formal Capability	0	0	0
MHPS	2	1	0

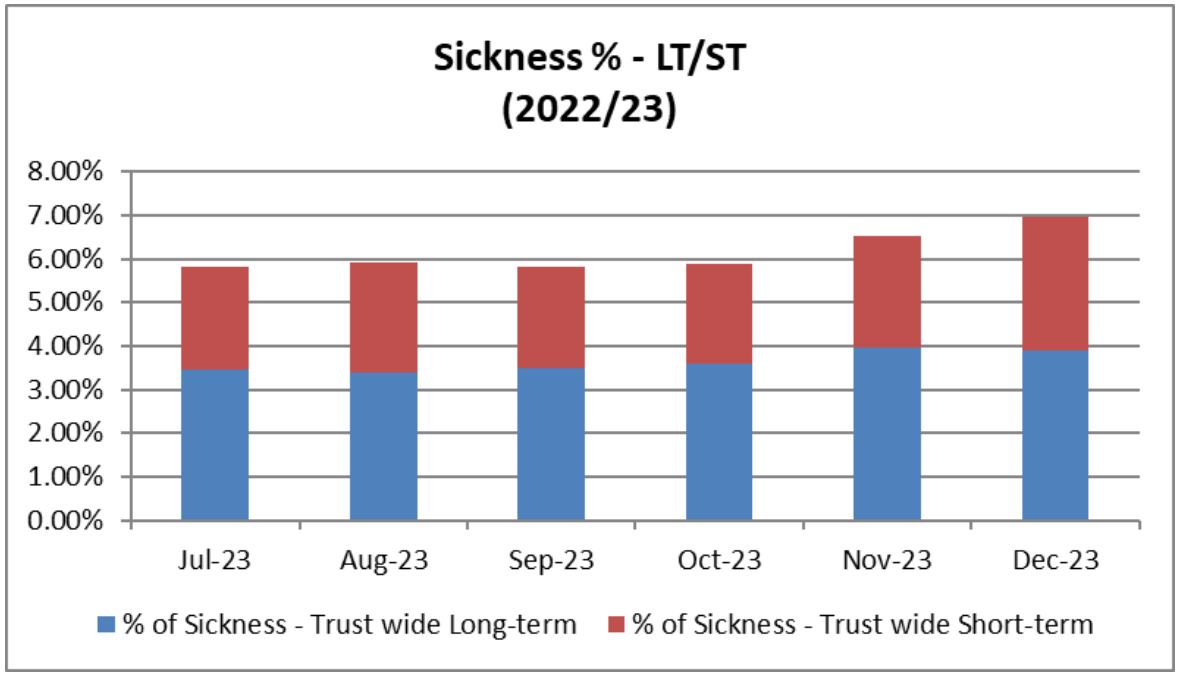
Key Themes:

- Unusually high number of medical cases, not interlinked or systemic.
- Two long-term suspensions are due to ongoing police investigation of a serious nature.
- High number of cases involving staff who are declared as neurodiverse (1 open, 1 resolved)
- Behaviours of colleagues are a key theme of grievance processes.
- Just and restorative learning culture is in practice and supporting reduce the number of cases.

Attendance	
KPI	96.3%
Dec-23	93.04%
Trend	↓



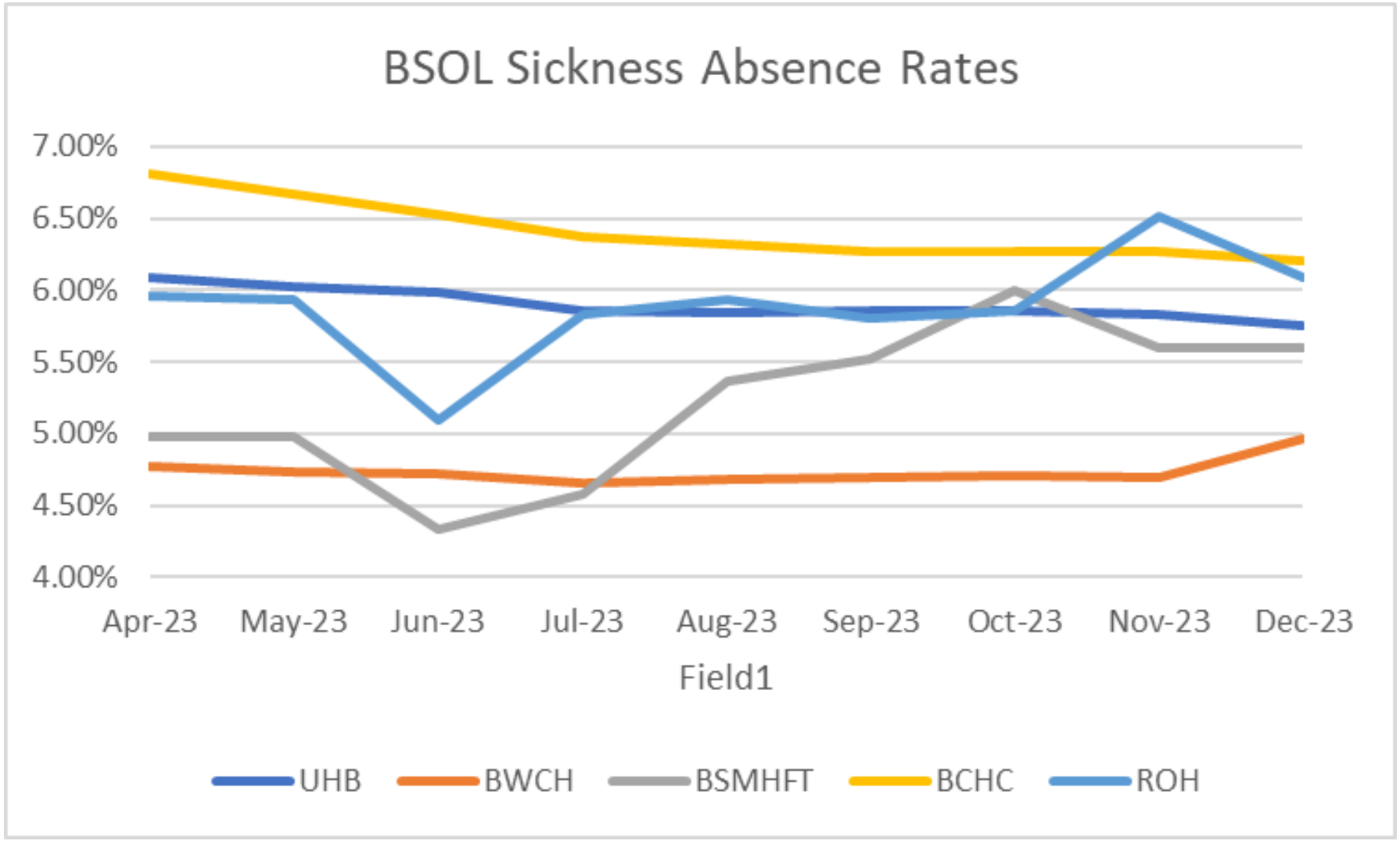
Attendance continued



Absence Reason	% of days lost
S10 Anxiety/stress/depression/other psychiatric illnesses	27.54%
S13 Cold, Cough, Flu - Influenza	15.52%
S12 Other musculoskeletal problems	9.29%

Attendance – Benchmark

Data is most recent available collected by the ICB



PS

Section Two:

Education and Training

Prepared by: Claire Felkin, Training & Development Manager

Presented by: Claire Felkin, Training & Development Manager

Ref: January 2024/HR&OPS

Education and Training

Summary:

Apprenticeships: By the end of the first half of the financial year 2023/24 there have been 18 apprenticeship qualifications commence, with an additional 6 in recruitment or pre-employments stages, with an additional 3 in discussion for commencement in the next 3 - 4 months. If all these commence this will be 26, against our annual target on 29, (Based on a target of 2.3% of workforce). There were 5 potential apprenticeships that were explored but not commenced since April, however there are currently 14 qualifications that are in discussion for potential commencement within the next 6 months of the financial year.
Mandatory Training: The annual renewal modules, Fire and Information Governance with Cyber Security, are tracking at a lower compliance figure than the 3 yearly renewal modules. This reduces the overall average compliance. In July and August 2023, the new Information Governance and Cyber Security compliance modules were introduced which reduced average down from 90.23% to 86.96%. We have introduced The Oliver McGowan figure this month; this was launched in April 2023 and has achieved a good level of compliance.

Areas for Improvement:

- Fire training annual renewal
- Resus training
- Consistency for Bank Mandatory training

Risks / Issues:

- Maintaining increases in resuscitation training compliance
- Release of staff to attend training due high vacancy and turnover rates.
- Not achieving mandatory training compliance and challenge from commissioners .

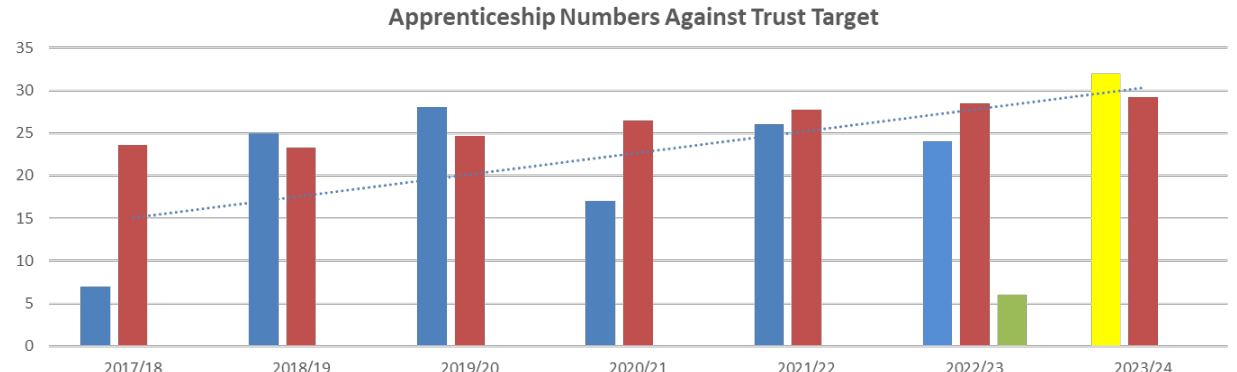
Action Plan:

- Bimonthly assurance review at Training and Development group, with Risks monitored around mandatory training compliance and utilisation of new apprenticeship roles and the levy.
- Strong engagement with SMEs in relation to managing specific training compliance
- Engagement with Clinical Workforce and Development group, and Resus committee
- Apprenticeship Stakeholder Group to be created in early 2024, to develop strategy and plans relating to apprenticeships, and workforce models following outcomes of the NHS LTWP, and the ROH People and Workforce Plan.

Apprenticeship Activity

KPI	2.3%
Current YTD	1.50%
2022/23	1.94%
2021/22	2.16%

Apprenticeship Qualifications At 31st December 2023	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Number apprenticeships on pause	0	0	0	0	1	0	1	2
number staff left during qualification	1	1	3	1	4	2	0	12
Number stopped qualification	0	6	7	7	5	5	0	30
Number on maternity leave / long term absence	0	0	0	0	0	2	0	2
Number currently completing their qualification	0	0	0	2	5	14	18	39
Number completed their qualification	6	17	17	7	11	0	0	58
Number who failed qualification	0	1	0	0	0	1	0	2
Company disolved !	0	0	1	0	0	0	0	1
Number of GIFTED qualifications						2	0	
Number external apprenticeships in recruitment							1	
Number external apprenticeship in pre-employment							6	
Number internal apprenticeships in sign up stage							5	
Number internal apprenticeships in discussion phase							20	
Number new apprenticeship qualifications commenced during the year	7	25	28	17	26	24	19	146
potential apprenticeships in progress	*7*	*25*	*28*	*17*	*26*	*24*	*51*	178
Applications that didn't progress following initial interest	*0*	*7*	*9*	*11*	*6*	*11*	*7*	51
recruited substantive instead				*1*				1
Annual Target: 2.3% of workforce	24	23	25	26	28	28	29	183
Percentage of qualifications to national annual target	29.66%	107.51%	113.77%	64.27%	93.73%	84.22%	65.05%	79.63%
Trust headcount	1026	1011	1070	1150	1206	1239	1270	7972
Apprenticeships as a percentage of workforce headcount (2.3% target)	0.68%	2.47%	2.62%	1.48%	2.16%	1.94%	1.50%	1.83%

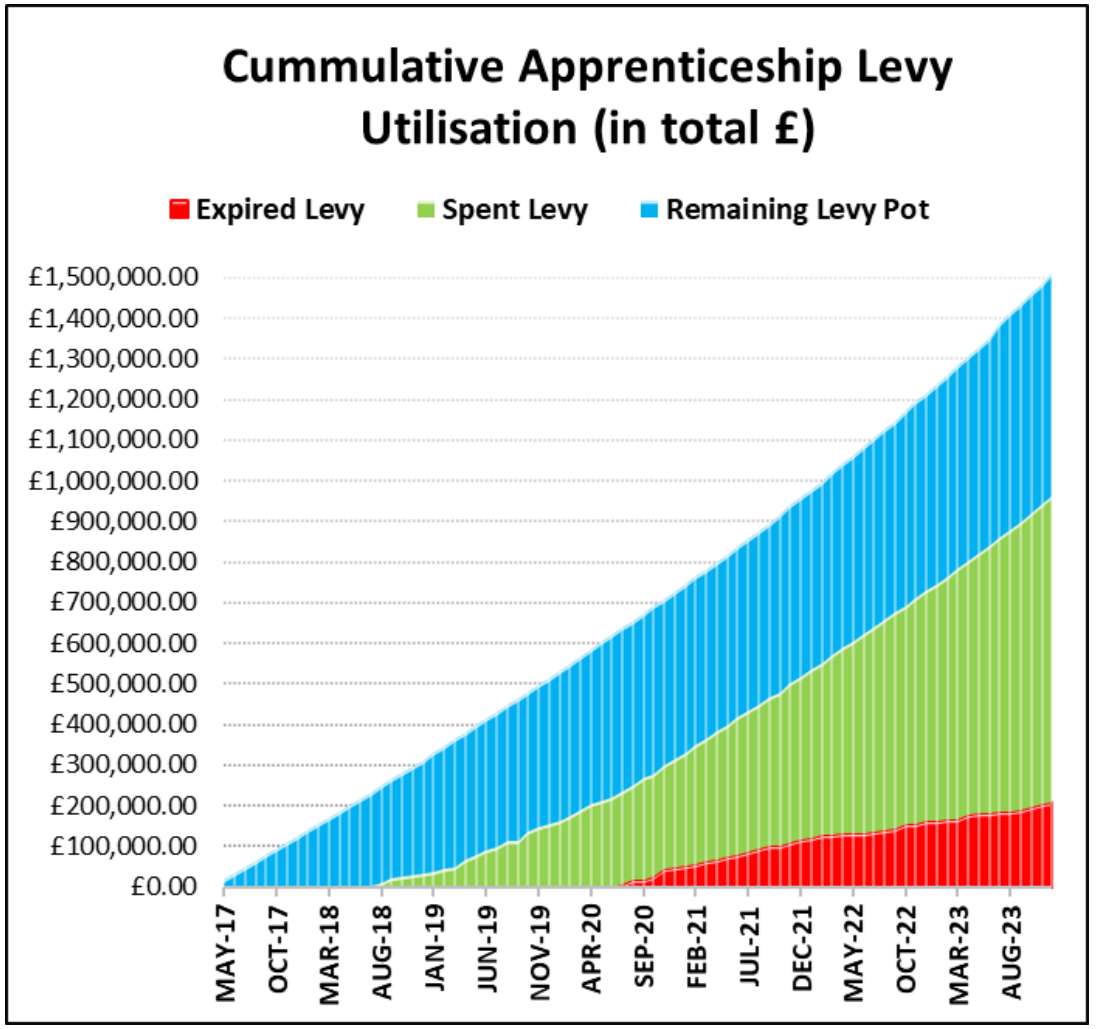


Apprenticeship Levy Funding

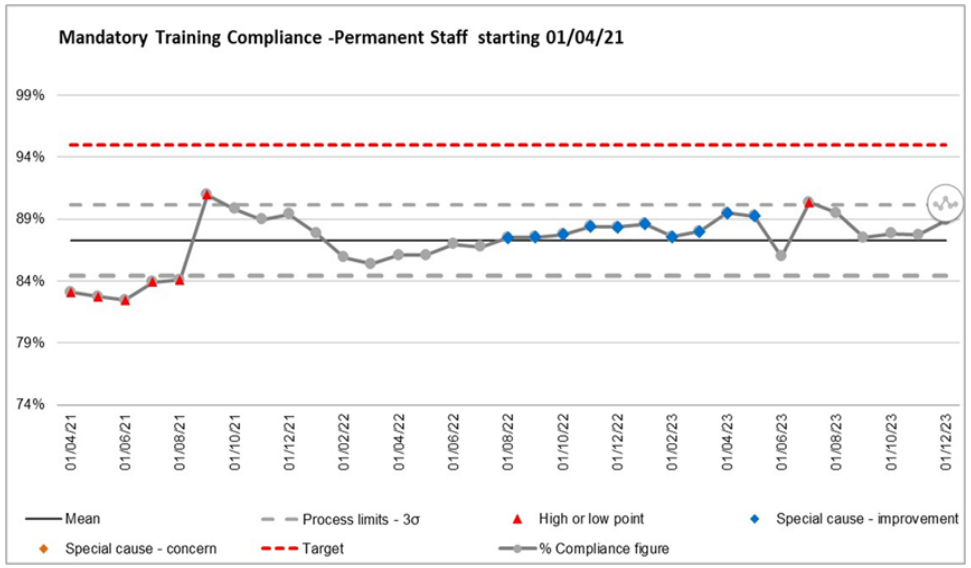
KPI	2.3%
Current YTD	1.50%
2022/23	1.94%
2021/22	2.16%

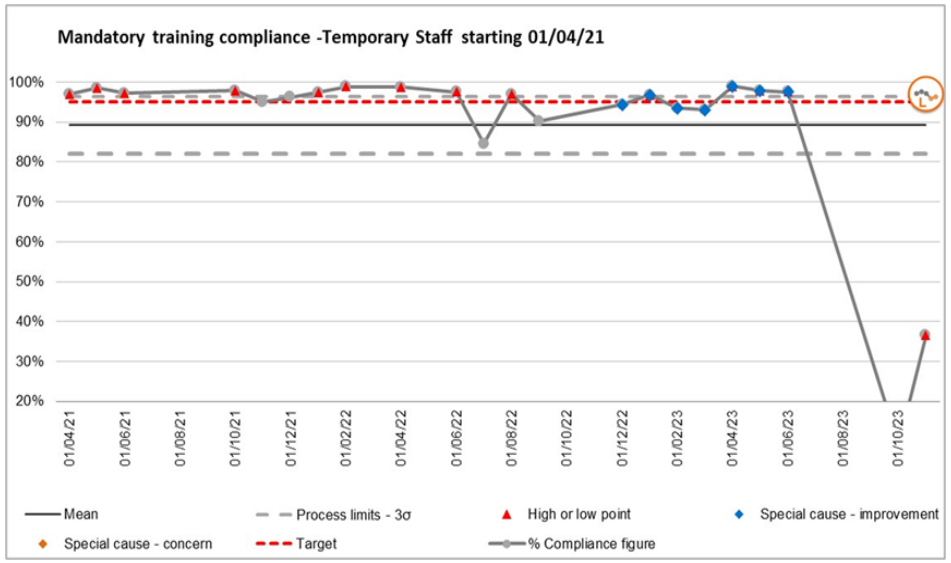
Apprenticeship Levy funding at 31st December 2023

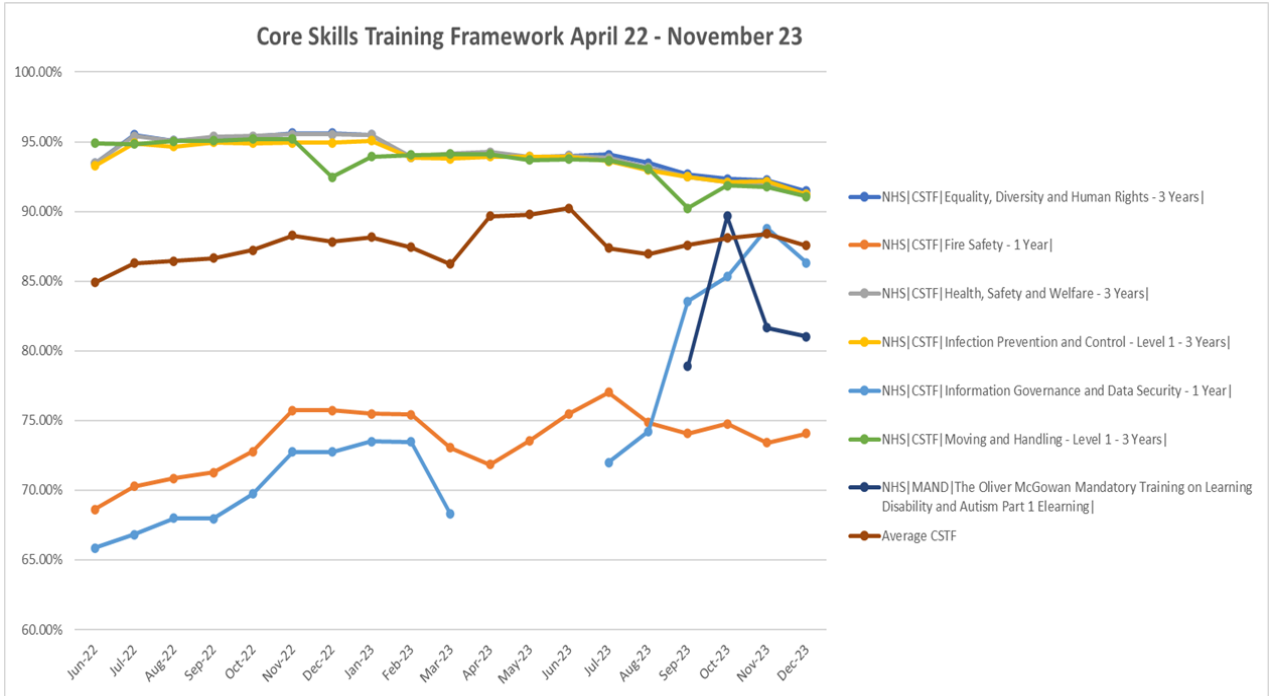
Total Apprenticeship Levy payments from 1st April 2017	£1,508,879.19	
Apprenticeship Levy drawn down by training providers	£755,392.98	50.06%
Expired Levy Charges since August 2020	£205,034.89	13.59%
Remaining Levy funding available	£548,451.32	36.35%
Planned Allocated Levy spend to date	£1,507,659.00	99.92%
Planned Unallocated Levy spend to date	£1,220.19	0.08%
Actual Allocated Levy spend to date	£1,271,673.00	84.28%
Actual Unallocated Levy spend to date	£237,206.19	15.72%



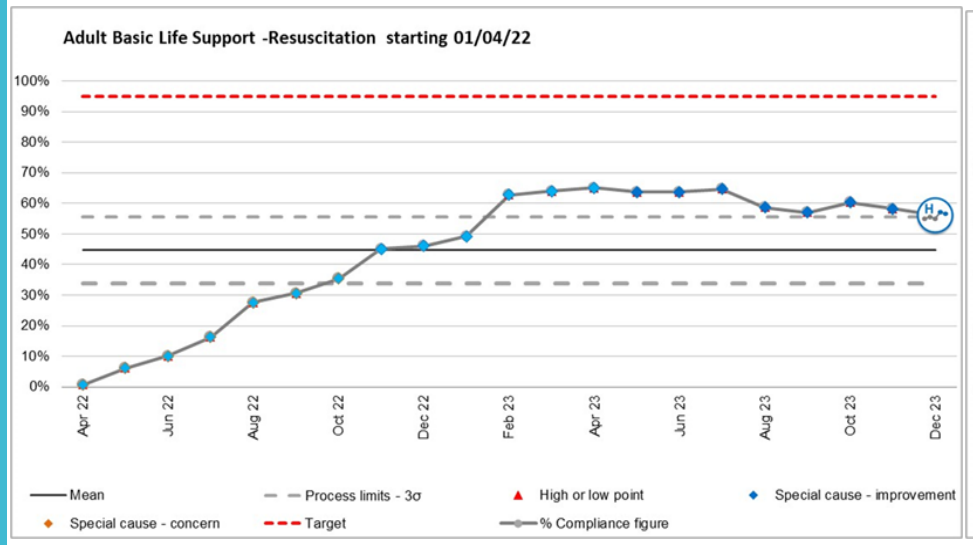
Core Mandatory Training: Permanent and Temporary Staff

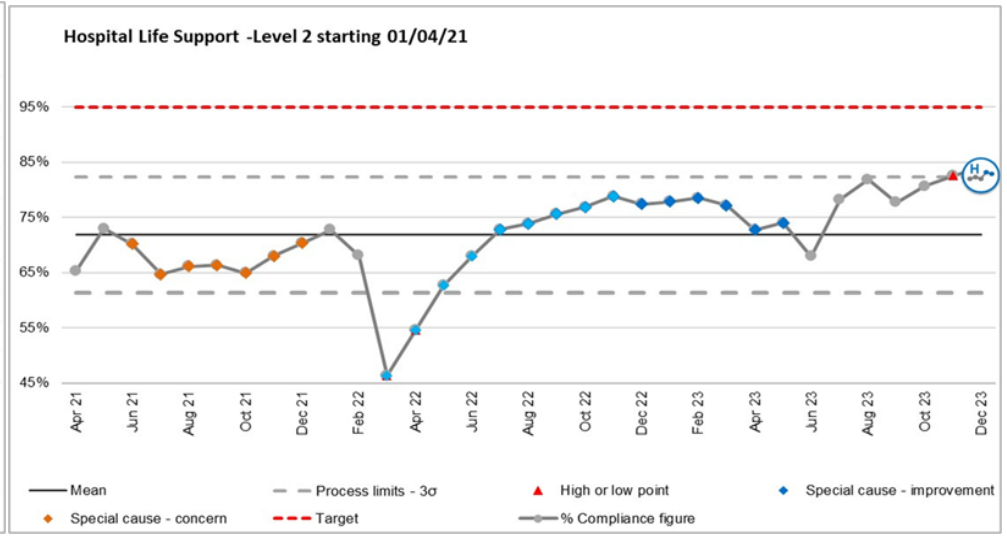


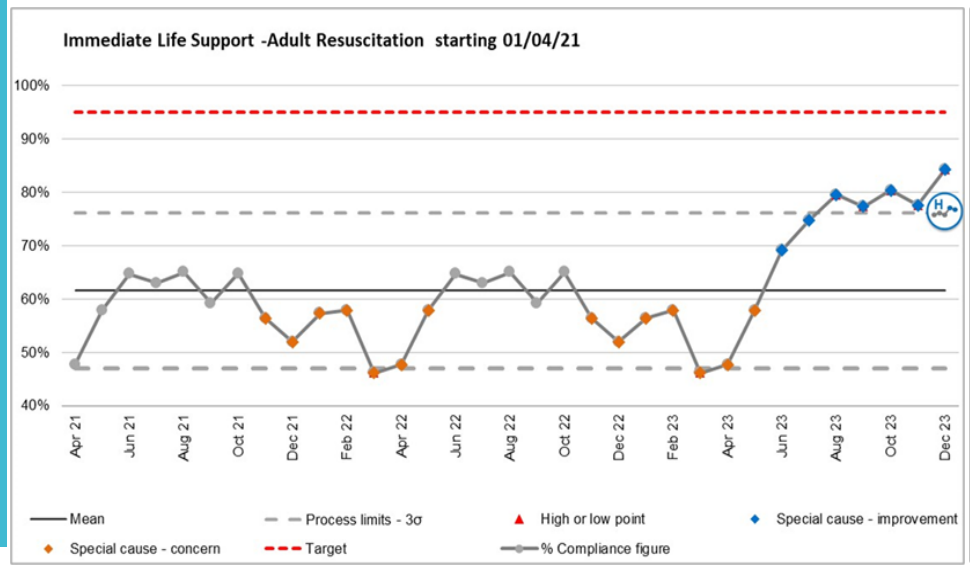


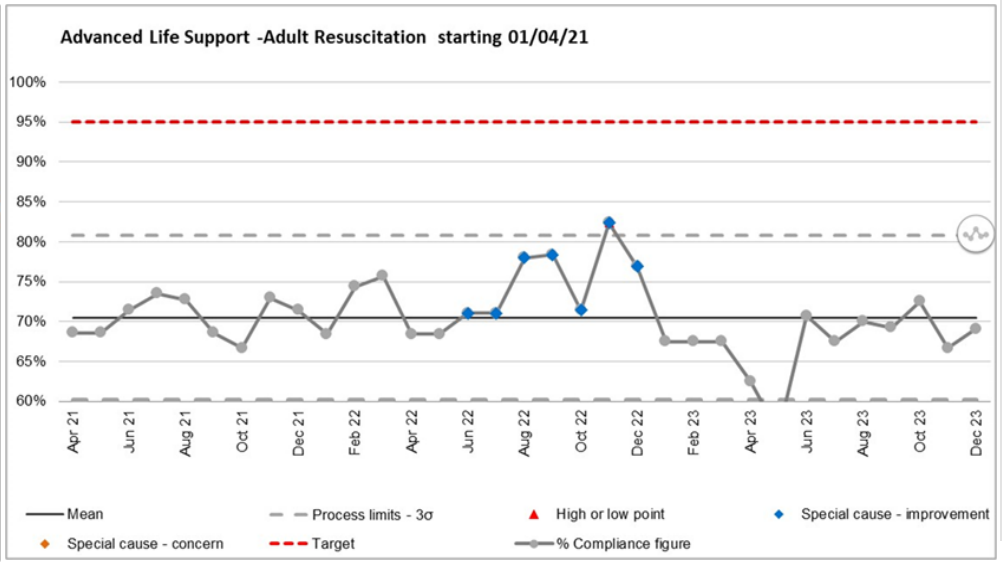


Resuscitation Training: Adult







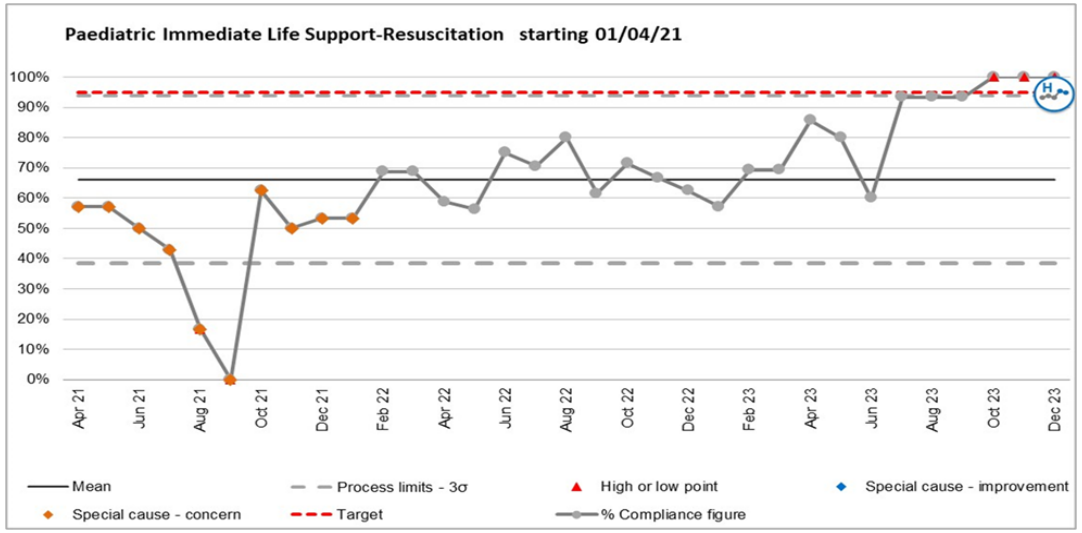


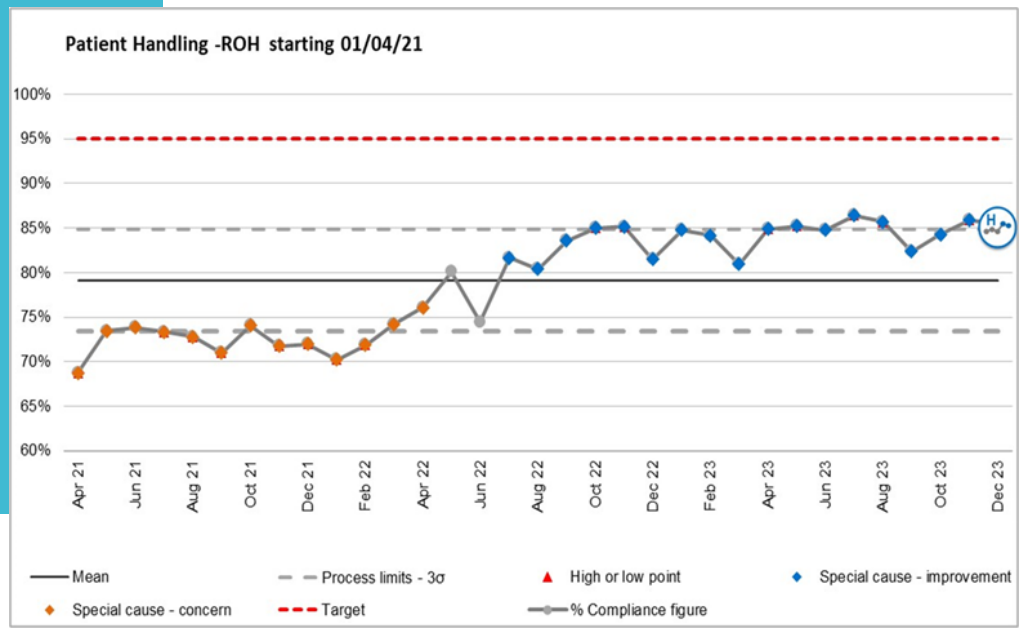
Mandatory Training

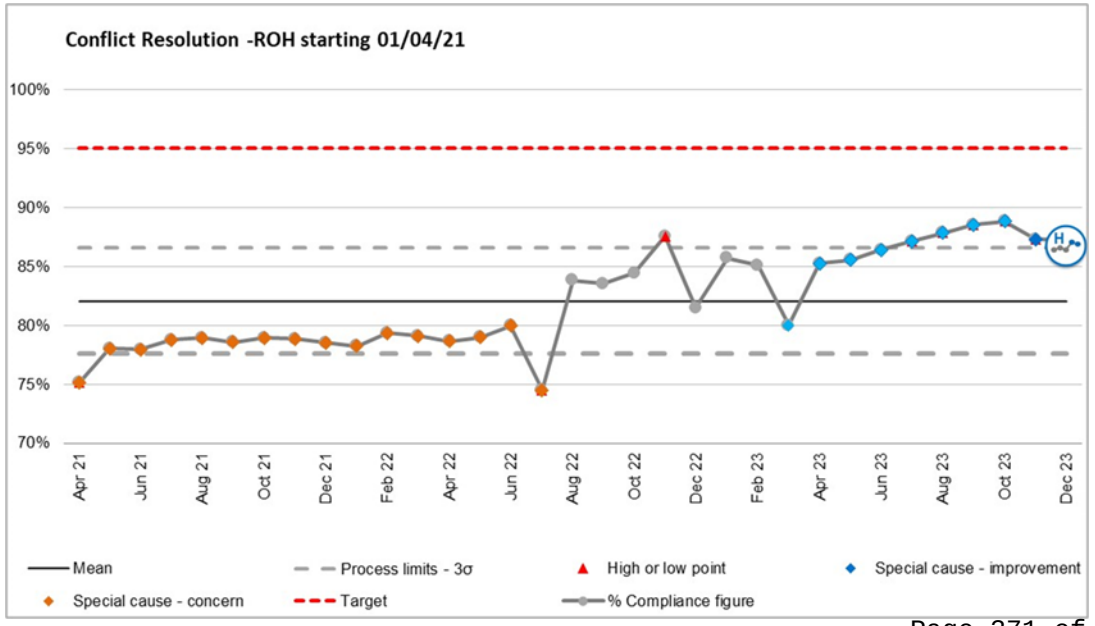
KPI	93%
Dec - 2023	88.9%
TREND	

COURSE	Compliance %age	COMMENTS
Core Mandatory Training – Permanent Staff	88.90%	Compliance is improving. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF).
Core Mandatory Training – Temporary Staff	36.51%	Based on staff working on the Bank who are non-compliant with training
Performance and Development Reviews	69.99%	Decrease on previous month, low percentage compliance. Me as a Manager will support with signposting process and training support.
Basic Life Support – Level 1	56.03%	Despite several target chasers this is our lowest level of compliance overall.
Hospital Life Support – Level 2	**84.18 %**	New module including Paediatric BLS requirements provided to Clinical Staff since April 2022; snapshot reporting now aligned.
Immediate Life Support	80.95%	Still seeing some non-attendance due to not completing the pre-work via elearning, wasting valuable spaces.
Advanced Life Support	69.05%	Anaesthetics staff non-compliant continue to be chased for evidence of completion; as provided externally
Paediatric Immediate Life Support	100%	Target achieved.
Patient Handling	85.65%	Good progress overall this year but less stable during the last few months; need to sustain improvement.
Conflict Resolution	87.24%	Slight decrease this month/continues as elearning only.
NEWS2	98.04%	Consistently achieved over 95% compliance since June 2022.
Safe use of Insulin	89.59%	Staying the same over the last few months.
VTE	92.23%	Stayed the same over the last few months.
CONSENT	85.71%	Slight increase on last months.
IPC2	83.84%	Continual increase during the last few months.
Food Hygiene	90.71%	Slight increase on last month

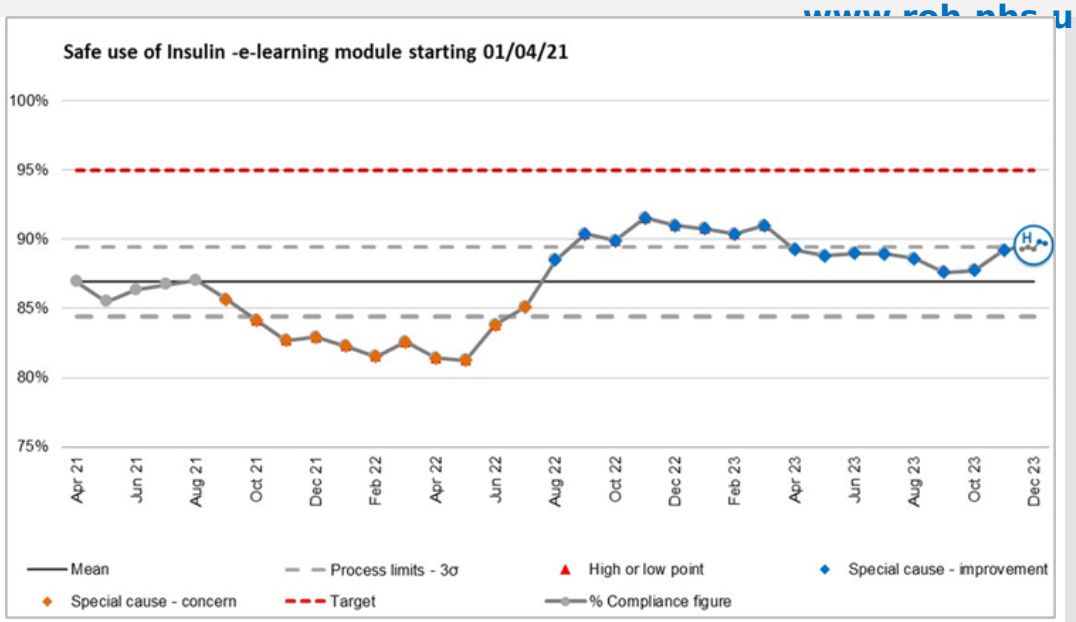
Paediatric Immediate Life Support
Conflict Resolution
Patient Handling

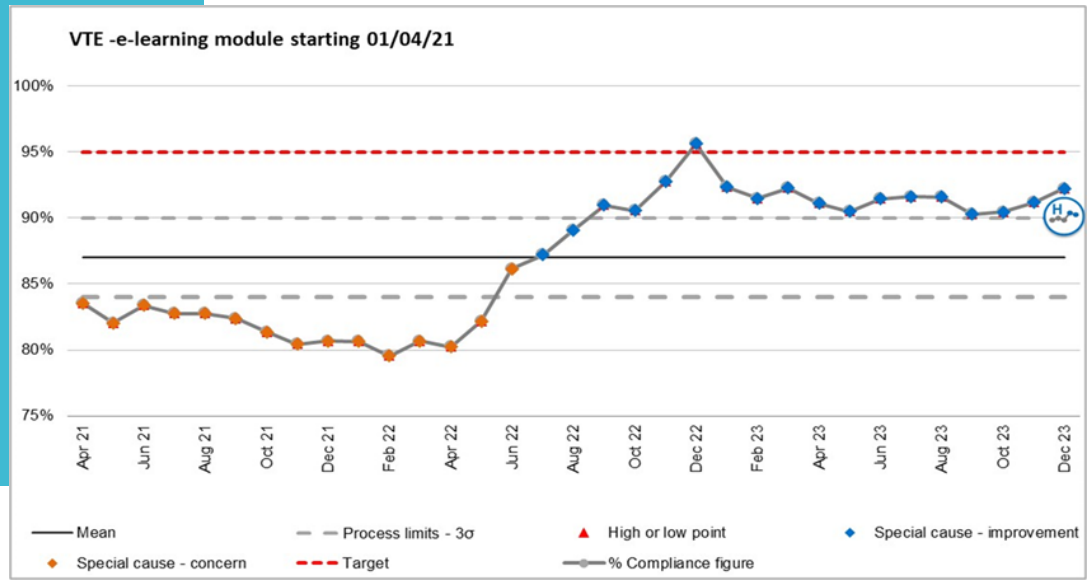


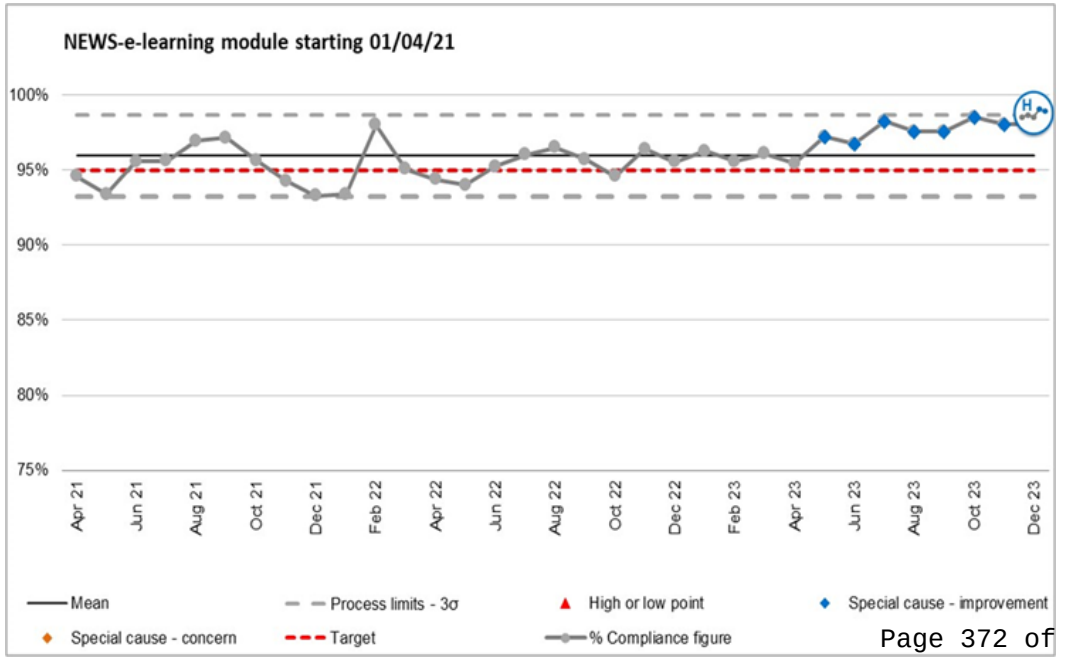




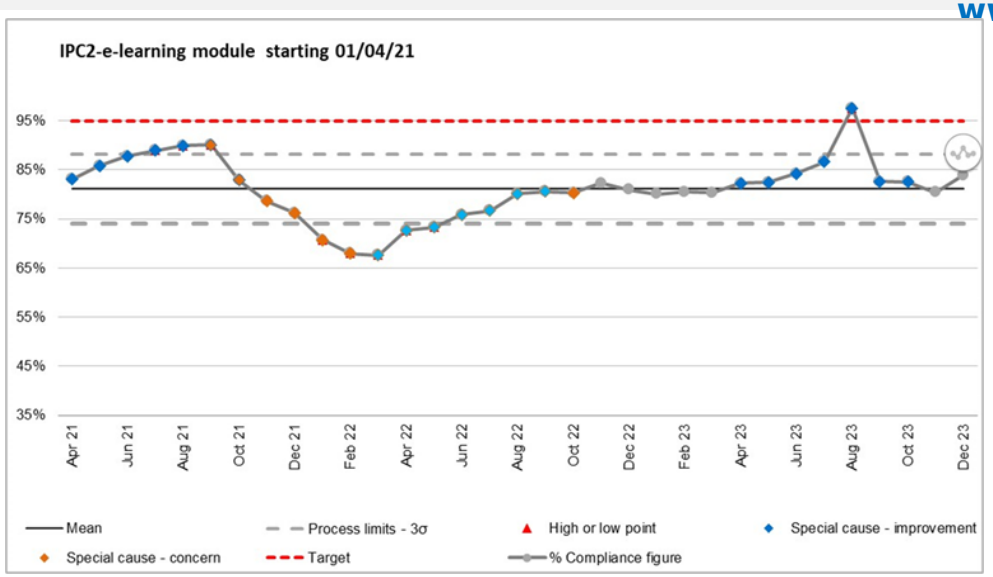
VTE, Safe use of Insulin, NEWS2

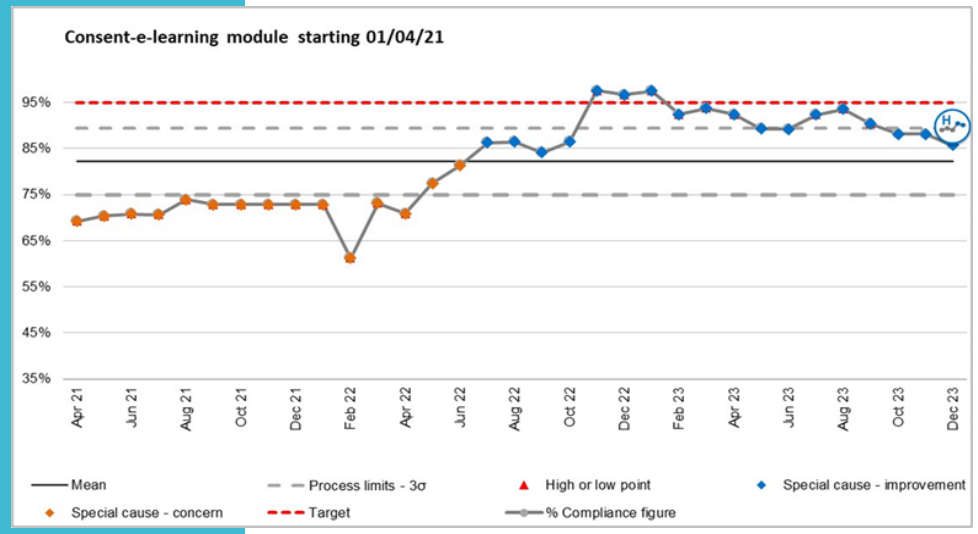


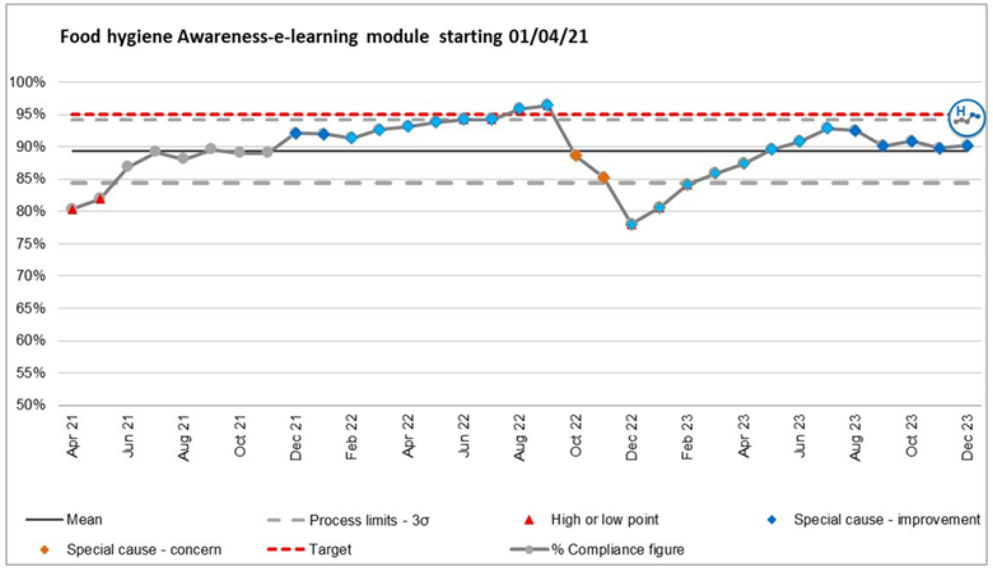




IPC Level 2, Food Hygiene, Consent

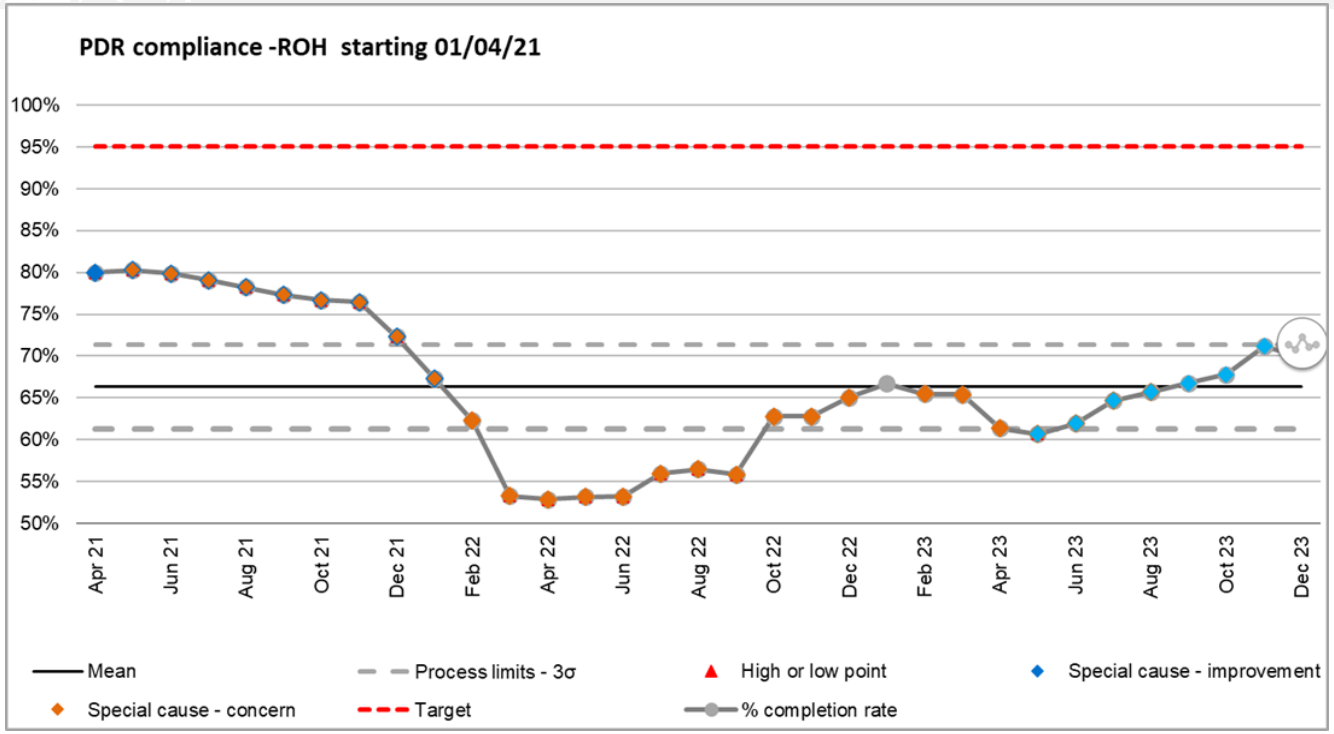






Performance & Development Reviews

KPI	95%
Dec-23	69.99%
Trend	



This data chart shows the Annual Performance and Development Review compliance figure for all Trust staff. This figure is taken from the ESR system, so only relates to information recorded in ESR.

Local figures may be higher dependant on efficiency of ESR maintenance.

Data Observations:

We have moved above the mean - this evidence shows consistent improvement since May 2023, a positive improvement.

The Trust is currently revising its Performance Management and appraisal process, with the aim of improving these outcomes.

Section Three:

Organisational Development Team

Prepared by: Clare Mair, Head of OD & Inclusion

Presented by: Clare Mair, Head of OD & Inclusion

Ref: Dec2023/HR&OPS

Organisational Development

Summary:

- As part of engagement at the ROH, fieldwork for the National staff survey (NSS) is now completed and a plan is confirmed to ensure the data can be analysed and shared with all colleagues in timely manner, in order to make positive changes. This work will be supported by the Executive team and managers across the Trust.
- Initial information from the staff survey has been sent through to the Trust by IQVIA

Areas for Improvement:

- There has been a positive increase in the staff survey completion rate from 52% to 60%
- Attendance by colleagues at OD workshops have increased
- Adverts are currently being shared across the Trust for new Chairs, to support the BeMyself network and the Women's network

Risks / Issues:

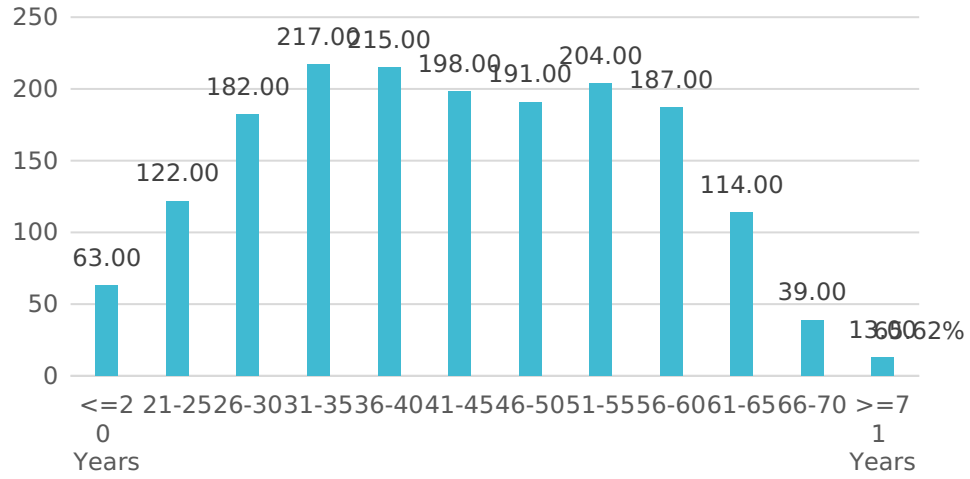
- Annual leave taken by AfC staff is currently at 69.41%% which is lower that the 75% target needed to be achieved to ensure staff are taking breaks regularly to support their wellbeing. Actions are being taken to improve this percentage in this last quarter of the year
- Releasing staff to attend initiatives with current workload pressures

Action Plan:

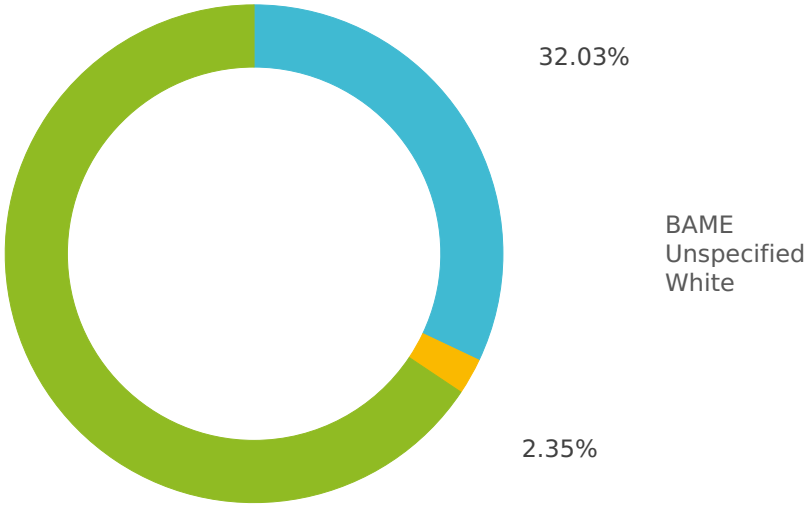
- Work is being completed on an action plan to support the confirmed Wellbeing plan
- Work on the new appraisal approach with robust training for managers and colleagues continues to be developed which is planned to have a positive impact on the quality and completion rate for appraisals
- Work on the Equality Delivery System continues to review and assess how well patients (Domain 1) and staff (Domain 2) are support in an inclusive way at the Trust. A review of Inclusive Leadership (Domain 3) at the Trust is also included

Workforce Demographics

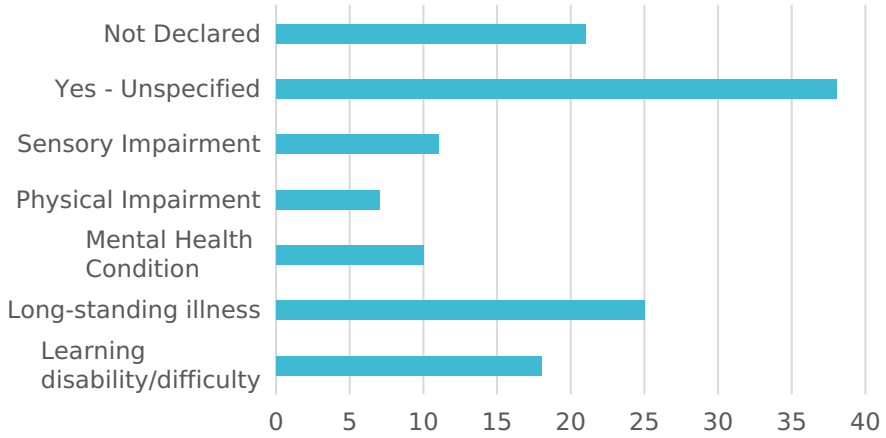
Age Band



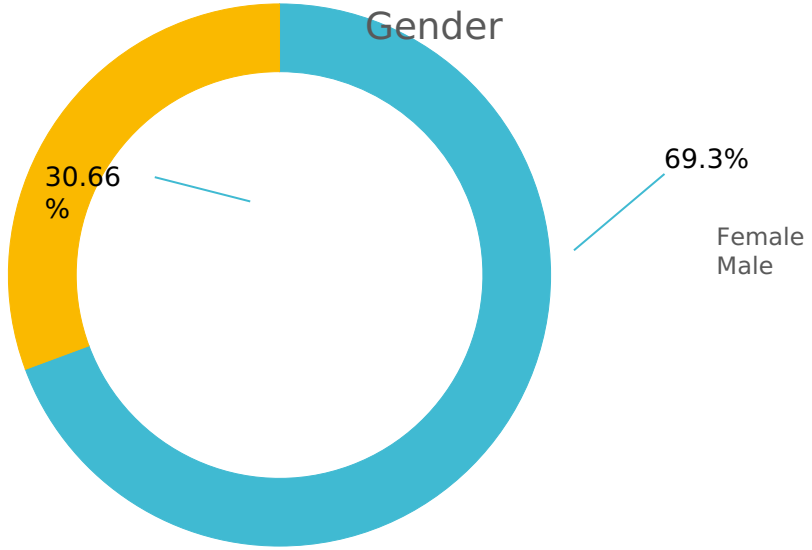
Trust Ethnicity



Disability Declared By Type

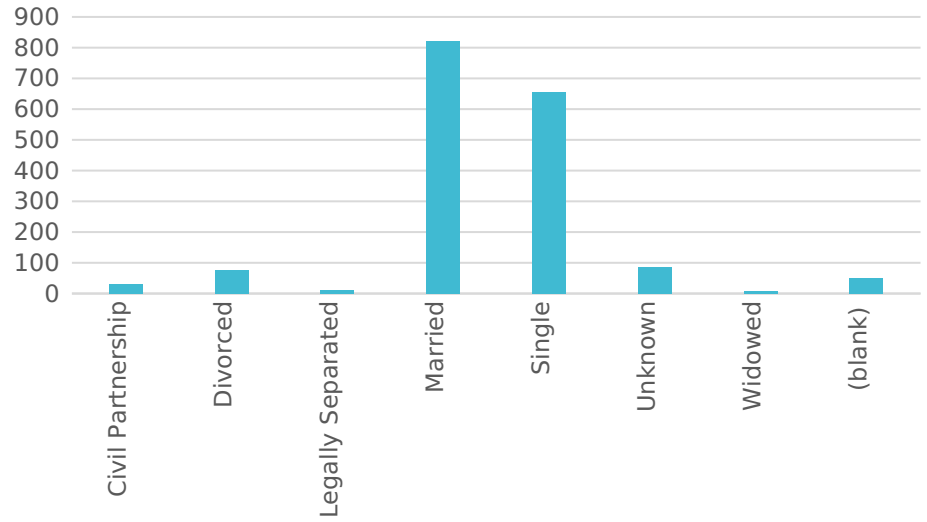


Gender

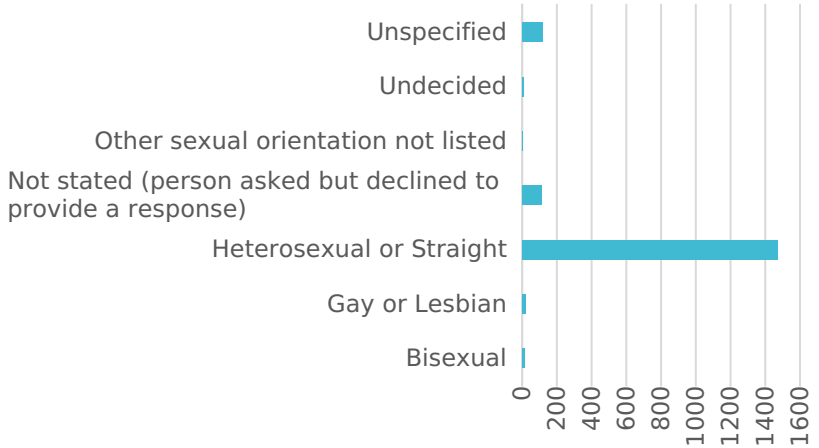


Workforce Demographics

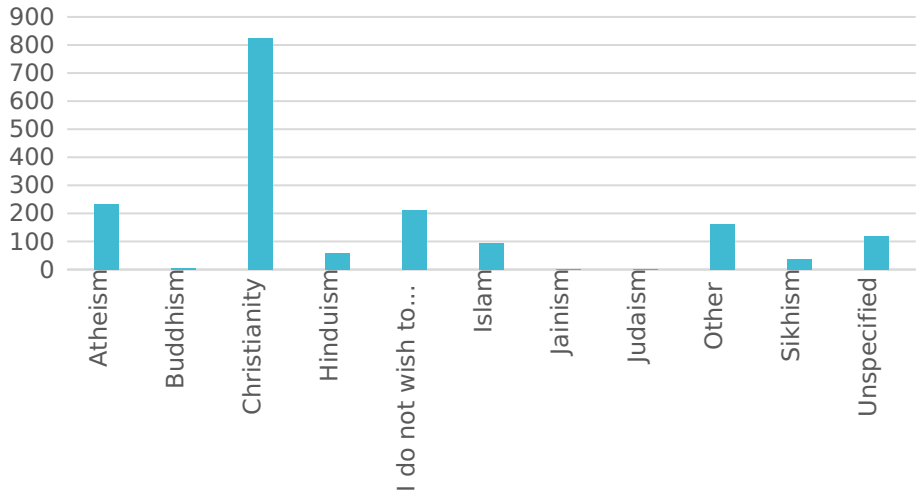
Marital Status



Sexual Orientation

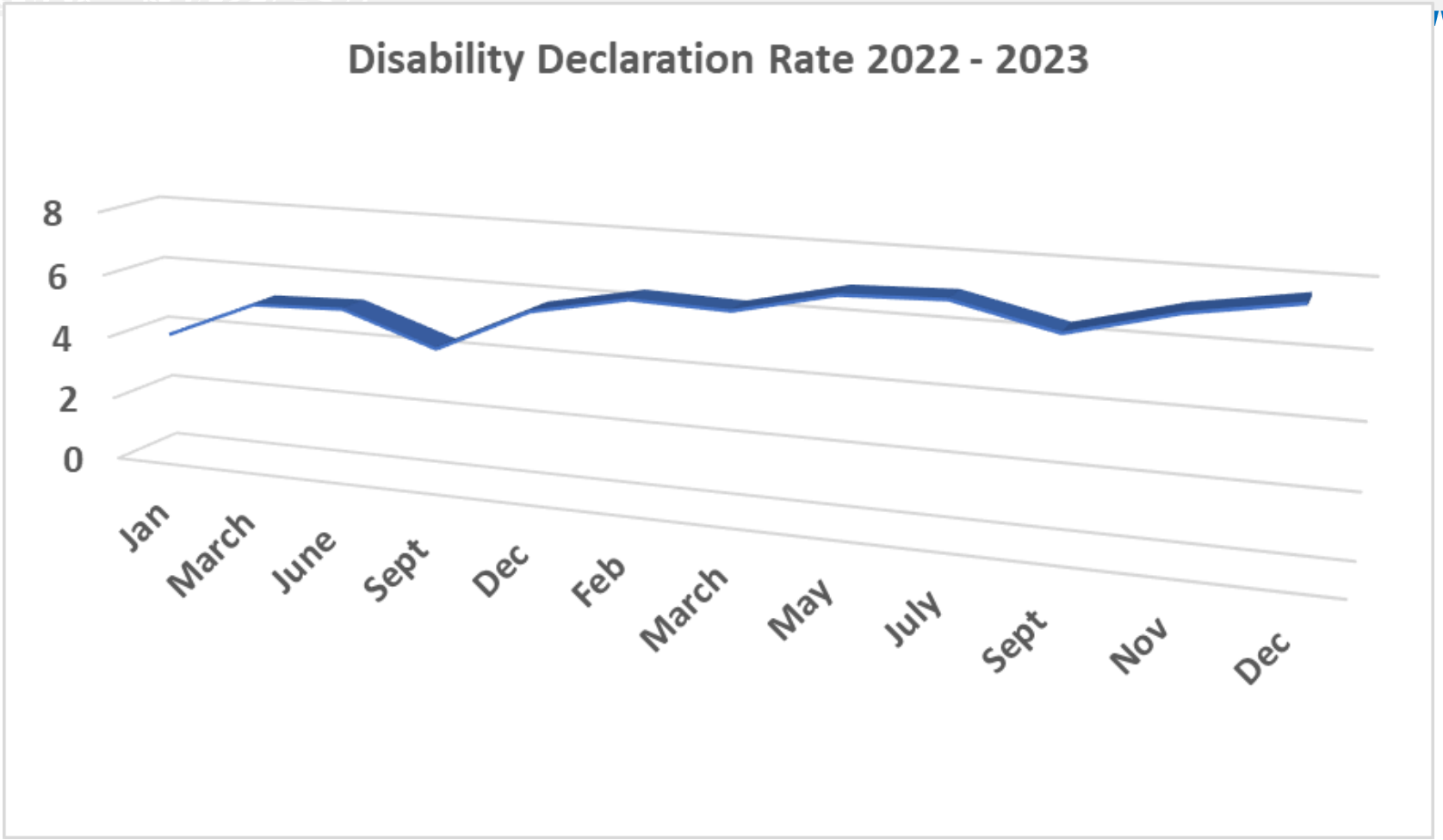


Religion



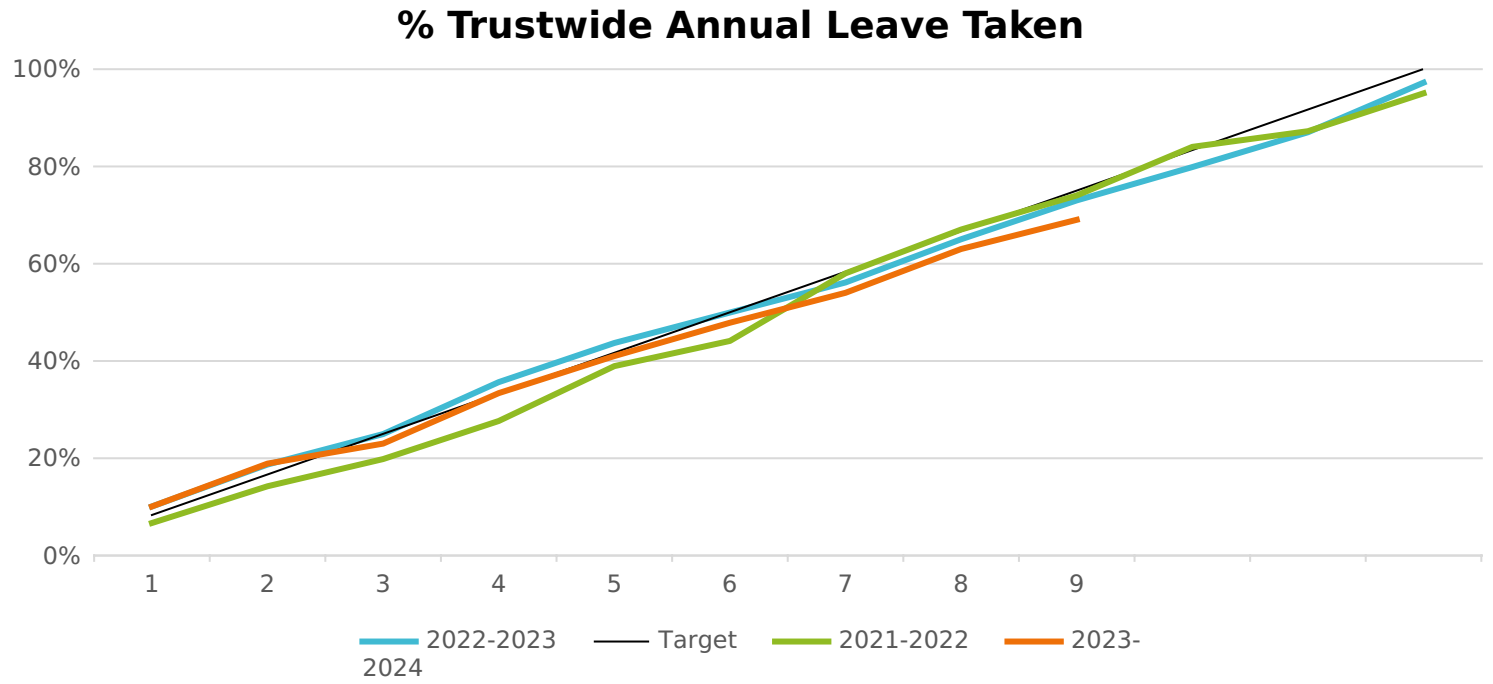
Workforce Experience

KPI	7.5%
January 23	7.6%
Trend	↑



There has been a positive increase for December 23 reporting. With support from the ABLE network work continues to ensure that KPI for the annual WDES reporting in March 2024 is achieved

Workforce Wellbeing: Annual Leave



In this reporting period, AfC staff have taken 69.41%% of their annual leave entitlement. At this point in the year staff are expected to have taken 75% of annual leave to support their wellbeing.
A communication has been sent to all staff regarding annual leave which should positively impact this percentage

Division	% Annual Leave Taken
303 Corporate Directorate	69.82%
303 Division 1 – Patient Services	71.80%
303 Division 2 – Patient Support	66.72%
303 Division 4 – Estates and Facilities	71.78%
Trust total	**69.41%**

Staff Group	% Annual Leave Taken
Add Prof scientific and technic	58.22%
Additional Clinical Services	70.32%
Administrative and Clerical	71.71%
Allied Health Professionals	68.27%
Estates and Ancillary	71.72%
Nursing and Midwifery	71.41%

Workforce Experience

Initiative	June	July		September		November	December
Number of members of staff network meetings – (All members of all staff networks – from June)	310	305		303		307	296
Number of attendees at staff network meetings	6	33		29		42	25
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)	524	40 Viewers 58 Views		77 Viewers 11 Views		90 Viewers 143 Views	21 Viewers 174 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)	405 Viewers 110 Views	59 Viewers 602 Views	149 Viewers 483 Views	52 Viewers 98 Views	120 Viewers 145 Views	84 Viewers 186 Views	54 Viewers 108 Views
Workshop attendance OD	16	158		66		76	121
Workshop attendance Health & Wellbeing	9	52		39		144	83
Entrance swipe to Wellbeing room / Dome (from July)	208	Not Available		266 / 216		Not available	351 /82